SPECIAL REPORT Specialty ACOs: A promising option

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TOP 5 INDUSTRY CHALLENGES

IN 2015

- Capitalizing on new opportunities
- Reining in costs while improving care
- Keeping up with policy shifts
- Investing in technology
- Pharma challenges

And what's being done about them

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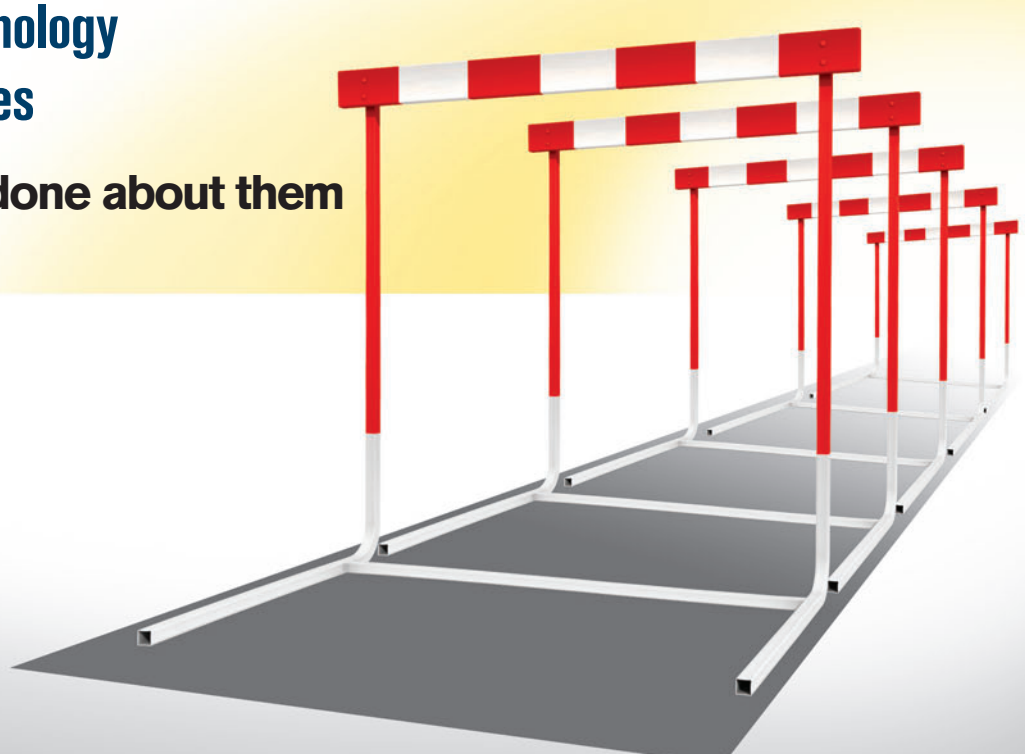

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formulary watch

Study: Specialty drug spending up considerably

Specialty drug spending has increased, but still represents a small portion of overall drug spending per beneficiary, according to a study. **http://bit.ly/1zp23hz**

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[BLOG] How to position your hospital pharmacy as a strategic asset

Hospital pharmacies can, and should, substantially help to grow revenue, improve efficiency, reduce waste, improve patient outcomes, and create a competitive advantage. **http://bit.ly/1qlyodY**

MARY BAXTER

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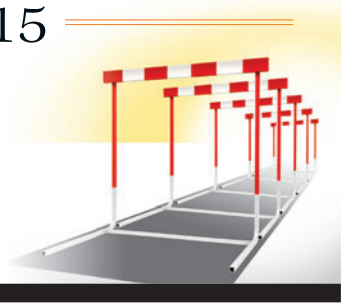

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from JOEL V. BRILL, MD, FACP, AGAF

GAIN NARROW NETWORK BUY-IN

8 ways to achieve broader acceptance

As health plans and purchasers struggle to keep premiums low and quality high, many are turning toward narrower networks. However, limited networks have sparked concern among consumers, plan sponsors and policy makers who worry that they will unduly limit patients' access to care and lead to increased patient use of out-of-network providers with higher out-of-pocket costs. New York has passed a new law to protect consumers from unexpected out-of-network costs and many states are considering tougher standards for network adequacy.

When plan members face unexpectedly high costs or receive a bill for services they thought were covered, it affects how they value their benefits and, in the case of employer-sponsored plans, the sponsor's overall satisfaction with the plan. In addition, insurers may find themselves spending valuable time and resources dealing with frustrated members or time-consuming appeals. For narrow networks to work, they must work for everyone—plans, purchasers, plan sponsors, participants and providers. That means delivering access to timely, accurate and user-friendly information to ensure that plan members get the most out of their provider network.

Plans and benefits advisors will need to:

Support plan sponsors. Insurers, consultants and brokers who advise plan sponsors can support the decision-making process by providing customers with clear, concise resources and tools that outline the specifics of their health plan options, and what they mean for members. It is important to help decision-makers understand the costs beyond premiums—deductibles, encounter fees and cost sharing in both in- and out-of-network scenarios.

Communicate from the beginning. It is critical that members understand their network options before they enroll. Health plans should provide linguistic, culturally specific, easy-to-read educational tools and benefit summaries at the point of enrollment. Plan members should understand they are signing up for a limited network, and that costs may be significantly higher if they seek care out of network. Consider providing side-by-side comparisons that outline each plan's cost-sharing obligations and out-of-network coverage for services.

Communicate regularly. Make sure members know the cost consequences of going outside their network, and some unexpected but common ways that can happen—for example, receiving care from an out-of-network anesthesiologist at an in-network hospital. Remind members to inquire whether all the healthcare professionals and facilities involved in their treatment participate in their network before they receive care.

Provide context for decision making. Offer cost estimation tools alongside the provider network lookup on your plan's website to help members understand the higher costs they might incur if they go outside their network.

Keep the provider directory current and accessible. Make sure that plan sponsors and members have easy access to complete, accurate and current information about healthcare organizations, professionals and services in their network."

It's also important to remember that providers need this information, too. Plans must also take steps to:

Support the front-line staff by making sure it has current, accurate information about their network status to refer to when making appointments.

Help keep referrals in-network to avoid cost surprises. Make update network rosters available online to assist physicians when referring patients.

Providing customers, plan members and providers with the tools to understand coverage and network details will ensure the long-term viability of plans that provide access to high-quality care, while keeping premiums down. ◘

ABOUT THE AUTHOR

Joel V. Brill, MD FACP, AGAF, is the medical director at FAIR Health (www.fairhealthconsumer.org), an independent not-for-profit with dedicated to bringing transparency to healthcare costs and insurance information. Brill serves as an editorial advisor for MHE and is an assistant clinical professor of medicine at the University of Arizona School of Medicine and an adjunct assistant professor of medicine at Midwestern University.

HEALTH INSURANCE EXCHANGES FOR SMALL BUSINESSES DEBUT

Employees can sign up online for employer-sponsored plans

LISA SMITH
CONTRIBUTING EDITOR

AFTER A year's delay, the federally facilitated (FF) Small Business Health Options (SHOP) marketplace opened for business on November 15, the start of the second open enrollment period.

SHOP is the small business portal created under the Affordable Care Act (ACA) for businesses with 50 or fewer employees. Businesses with 25 employees or fewer are eligible for a tax credit.

Its original 2013 launch date was delayed as the U.S. Department of Health and Human Services grappled with a host of access and data problems on the consumer exchanges.

Five states—Delaware, Illinois, Ohio, Missouri and New Jersey—were given early access to the site in a controlled launch that let HHS troubleshoot problems and fix them in advance of a full-scale launch.

The SHOP marketplace can be accessed at Healthcare.gov, where individual consumer plans also reside. Qualifying employers in all 50 states can compare, purchase, and enroll in 2015 SHOP health and dental coverage entirely online through healthcare.gov, according to the U.S. Centers for Medicare and Medicaid Services (CMS) which oversees the SHOP marketplace and state exchanges. Employers set basic limits by deciding which category of plans to offer and what contribution to make to employees' premium costs. Employees can then view offers of insurance from their employer and enroll online. Employers receive just one bill from the SHOP, even if employees choose different plans, says CMS.

The marketplace can also connect employers with a SHOP-registered agent or broker in their area to provide online help with enrollment and acount management, according to CMS.

PENT-UP DEMAND FROM NEW MEDICAID PATIENTS DISSIPATES QUICKLY, STUDY FINDS

LISA SMITH
CONTRIBUTING EDITOR

A surge in emergency department (ED) visits and hospitalization rates on the part of newly-insured Medicaid patients is mostly a temporary phenomenon created by pent-up demand, according to a report by UCLA's Center for Health Policy Research (HPR).

The study, released October 21, eases fears that large numbers of new Medicaid patients would overwhelm the system and strain budgets.

As of July 2014, California had logged 1.5 million new Medicaid enrollees due to that state's decision to expand Medicaid as part of the Affordable Care Act. That number includes 650,000 who were transitioned from the state's Low-Income Health Program (LIHP).

The study looked at claims data from two Medicaid voucher programs in California, the Health Care Coverage Initiative (HCCI), which ran from September 2007 to October 2010, and LIHP, which ran from July 2011 to December 2013.

Both provided coverage to individuals who were not eligible for Medi-Cal or other low-income programs at the time, and who would have been eligible for Medicaid under Medicaid expansion.

Results were that individuals with the highest pent-up demand initially had 600 ED visits for 1,000 enrollees, but the rate quickly dropped and then remained relatively constant, eventually falling to 183 per 1,000 individuals during the second year of analysis.

The next highest-demand group showed a significantly smaller initial number of visits that then remained constant, and the lowest-demand group had a had a smaller number of initial visits that remained constant.

Hospitalization rates among those with the highest pent-up demand followed a similar trend, spiking at first and then rapidly declining.

The report notes that ED use and hospitalization rates fell to numbers comparable to previously insured populations with access to comprehensive care.

"We believe Medicaid expansion is sustainable because the initial high cost of newly enrolled beneficiaries does not persist beyond the first year of enrollment for the vast majority of new enrollees," Gerald F. Kominski, Ph.D., director of the HPR, told *Managed Healthcare Exective.*"

FATE OF OBAMACARE UNCERTAIN

Insurers struggle to expand coverage, improve care

The healthcare industry has experienced momentous change in the past year, and recent developments indicate no let-up in the coming months. The implementation of the Affordable Care Act (ACA), with its expanded benefits, curb on underwriting, greater transparency in costs and coverage, and shift to outcomes-related reimbursement, stands to alter the U.S. healthcare system and the role of private insurance.

The difficulties and opportunities with these developments will be even more evident in 2015, as Republican control of Congress opens the door to ACA revision. An early total repeal measure will be largely for show, but more select measures will follow. Top reform priorities are to repeal the medical device tax, eliminate the never-formed Independent Payment Advisory Board, and revise the employer mandate: Republicans want a 40-hour work week floor (up from 30 hours), if not a total repeal.

Looming over all is the renewed threat that a Supreme Court decision limiting subsidies for low-income individuals will deal a mortal blow to Obamacare. The ACA specifies that tax credits are available through exchanges operated by states, and program critics have filed suits to block subsidies to those obtaining coverage through the federally facilitated exchange.

These troubling developments may have encouraged Health and Human Services (HHS) Secretary Sylvia Mathews Burwell to reduce predictions for total enrollment next year through state and federal exchanges—down to about 9 million from earlier estimates of 13 million. The good-news piece is that fewer individuals are expected to lose employer coverage. But the numbers indicate that only 4 million new customers may sign up, while re-enrollment snafus may prompt some beneficiaries to drop out.

Medicaid programs also may see limited growth, as Republican victories in many gubernatorial races limit prospects for further adoption of expanded Medicaid coverage. Some states may continue seeking HHS approval of more limited Medicaid expansion, which the feds are under pressure to authorize. Meanwhile, the state Children's Health Insurance Program is up for renewal by Congress next year, and reauthorization legislation may provide a vehicle for added changes in Medicaid and other health programs.

Insurers will be looking for future legislation to again extend the Medicare formula for reimbursing physicians, and to restore healthier rates for the Medicare Advantage (MA) program. Analysts predicted a notable decline in MA plans due to ACA rate cuts, but enrollment continues to grow as insurers have worked to keep premiums down and benefits attractive. Slower growth in healthcare spending deserves credit for helping plans hold the line on rates while also reducing federal outlays for Medicare and Medicaid. Insurers also seek to control costs by limiting provider networks, for both Medicare and commercial plans, a strategy that has generated loud protests. Other approaches are to shift costs to beneficiaries through higher copayments and deductibles; to offer barebones policies where still permitted; to protest rising prices on specialty medicines; and to oppose consolidation among hospitals and health systems.

In lowering enrollment expectations for 2015, HHS indicated that it may take up to five years to fully implement the ACA. Insurers will be looking hard at whether they can continue to offer adequate benefits and care options at affordable rates during that time.

Finally, after more than 10 years covering these issues for *Managed Healthcare Executive*, I am signing off, and will leave it to our other editors to continue examining health policy and political developments for you in the coming months. ■

ABOUT THE AUTHOR

Jill Wechsler, a veteran reporter, has been covering Capitol Hill since 1994.

2015: HEALTHCARE'S YEAR OF TRUSTABILITY

Can healthcare make over its opaque image?

The three giants driving America's $3 trillion healthcare economy—health insurers, hospital systems, and pharmaceutical companies–all face the same dilemma: how to engage customers effectively to earn trust and improve the consumer healthcare experience. This is no easy task at a time when consolidation and oligopoly-type market domination describes today's healthcare landscape:

- **The 10 largest health insurers now control more than 60% of all Americans' health benefits; Blue Cross Blue Shield organizations alone cover almost 100 million Americans. In 45 states two health insurers have combined market share of 50% or more.**
- **More than half of the 5,724 U.S. hospitals are now part of multifacility health system. Add to this mix a new face of today's physician: 42% of doctors are practicing as salaried employees of corporate hospital-owned systems.**
- **The top 10 global biotech and pharmaceutical companies have combined revenue of approximately $443 billion. Total spending on medications in the U.S. was $329.2 billion in 2013, fueled by more than half of all Americans taking at least two prescription medications.**

It should be no surprise that earning trust among today's consumer is a tough job. Entire industries have seen reputations tarnished and public trust eroded as a result of missteps and inadequate controls—data breaches, automobile recalls, government corruption, and most recently, politicization of Ebola.

As the nation's healthcare is being defined by personal accountability, bigger isn't always better. Buying health insurance is now a retail shopping experience, in-store and online, but not close to Nordstrom or Amazon. Hype regarding price "transparency" confuses the most sophisticated consumers as they attempt to navigate the complexities of the cost of a medical procedure or prescription drug. And understanding definitions of certification, accreditation, and "quality clinical outcomes" leaves consumers frustrated and paralyzed in their decision making.

Value and respect

People need to sense that they are valued and respected. When surveyed about what they want from a healthcare company, customers agree on these priorities:

1. Put me before profits.
2. Be there when I need you.
3. Communicate with me clearly and honestly.
4. Provide customer service I can depend on.
5. Do the right thing when it comes to my health.

Healthcare's giants face an enormous challenge in changing the way customers think about them. Consumer engagement has not been a core competency. Today's healthcare consumer lifecycle is often a series of disconnected, fragmented events. Communications have been an outbound monologue rather than an integrated, mutual value exchange.

Engagement should encompass every aspect of a healthcare consumer's experience with your services, products and people—the sum total of everything they see, hear and experience as part of their dealings with an organization. It means interacting with them on their terms and through communication channels they prefer.

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TOP 5 INDUSTRY CHALLENGES IN 2015

What to watch and what's being done

By **LISA SMITH**

Challenge 1

REINING IN COSTS WHILE IMPROVING CARE

Reducing healthcare costs while improving patient care is a common goal and continuing challenge for the industry, and there's a lot of room for improvement. The United States has the most expensive healthcare system in the world, but is last or near last on dimensions of access, efficiency and equity, according to The Commonwealth Fund's 2014 international healthcare review.

A number of initiatives are being pursued, among them accountable care organizations (ACOs), telehealth and bundled payments, but their implementation carries its own set of challenges.

TELEHEALTH

If all currently deployed telehealth applications were to replace physician, emergency department, and urgent care visits today, it would save $6 billion annually in healthcare costs, according to a study by global consultant Towers Watson.

"While this analysis highlights a maximum potential savings, even a significantly lower level of use could generate hundreds of millions of dollars in savings," says Allan Khoury, MD, a senior consultant at Towers Watson.

Senior healthcare executives are optimistic about telehealth's ability to cut costs and improve outcomes, but agree that progress has been impeded by reimbursement and regulatory challenges, according to a recent survey by Foley & Lardner LLP.

Forty one percent of respondents said they do not get reimbursed at all for telemedicine services; and 21% reported receiving lower rates from managed care companies for telemedicine than for in-person care.

That's changing somewhat, notes Nathaniel Lacktman, JD, partner in Foley & Lardner's Health Care Practice. Currently 22 states plus the District of Columbia have enacted laws requiring health insurers to cover telemedicine services, and there's widespread bipartisan support for telehealth-specific regulations.

One example is the Medicare Telehealth Parity Act of 2014, introduced last summer, which proposes a three-phase rollout of changes to the way telemedicine services are reimbursed by Medicare and expands coverage to urban areas.

Secondary obstacles include licensure and scope of practice barriers, and the need for pro-

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Relationship of trust

A relationship of trust grows out of leveraging individual motivators as well as emotional and rational drivers that work to change behavior.

It takes a personalized dialog with each customer throughout their healthcare journey—from awareness to acquisition to activation to resale. The payoff is a superior user experience, high satisfaction ratings, and better retention.

Healthcare enterprises able to reverse the tide of negative consumer perceptions will realize significant competitive advantages:

- **By being honest and authentic about what you can and cannot help people with, customer communications will reach a more receptive audience willing to respond to suggested actions.**
- **By being compassionate and empathetic in your interactions customers will be more satisfied with their experience, reinforcing their purchase decision and building a more proactive base of customer loyalists.**
- **By being an advocate and a knowledgeable champion on issues such as healthier behavior, cost containment, and improved condition management, you will be met with greater acceptance and confidence.**

Trust is an outcome. Consumer-centric healthcare companies that demonstrate respect for their customers' time and individual needs will see greater "stickiness" throughout the shopping process and generate significantly better customer LifeTime Value. Those that proceed with a sense of urgency, and deliver a customer experience with meaningful market-facing interactions, will emerge as industry leaders. Trustability is fundamental to the future of America's healthcare.

Relevant engagement yields customer respect. Customer engagement encompasses every aspect of a healthcare consumer's experience with your services, products and people. It's the sum total of everything they see, hear, feel and experience as part of their dealings with an organization. It means interacting with them on their terms and through communication channels they prefer. Ask the central question: how well does every brand touchpoint respect customers' needs, drive engagement and promote trust? ◘

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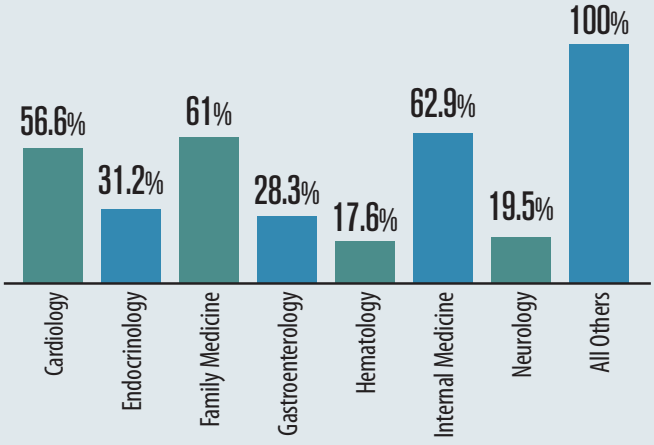
Lindsay Resnick, MHA, is chief marketing officer of KBM Group: Health Services. He is a frequent blogger, author and speaker on trends in healthcare, insurance, marketing and business strategy. He can be reached at lindsay.resnick@kbmg.com and followed on Twitter @ResnickLR

What specialties are best suited to an ACO?



Source: *Managed Healthcare Executive* original research, October 2014

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viders to better understand that there are models and approaches available to build out telemedicine programs, Lacktman adds.

Nine out of 10 health plans, looking to harness their payer networks, are pursuing telemedicine programs, says Lacktman. As a way to overcome current challenges, Lacktman suggests that managed care executives "seek out ways to partner with providers under risk sharing or subcapitated arrangements to promote and incentivize telemedicine as a key tool to manage population health of their subscribers, reduce acute inpatient stays, and improve quality care."

ACOs

ACOs are provider-led groups in which payments are linked to quality improvements for a defined population. If providers reduce expected spending while meeting quality metrics, they receive a portion of the savings. Under certain models, providers also share in losses if targets aren't met.

ACO formation is gaining momentum, but the start-up investment and downside risk are keeping some on the sidelines.

Because ACOs use 33 metrics to measure quality, a key challenge involves capturing and reporting measurement data effectively and efficiently. ACOs typically work with multiple providers and practices, all with differing IT systems, and an initial investment in infrastructure is often needed to get ACOs off the ground.

Insight into those investment costs can be gained by looking at the Shared Savings ACO program overseen by the Centers for Medicare and Medicaid Service (CMS). Of the 114 particpating ACOs in 2012, 29 met the financial target, saving $128 million and receiving $126 million in bonus payments, according to CMS.

But administration, compliance and technology costs for the group totaled $64 million, according to the *Wall Street Journal*. In addition, just 64 of 243 ACOs in the program in 2013 met financial targets.

The Pioneer ACO program run by CMS carries a penalty if providers fail to meet cost-reduction benchmarks. When the program debuted two years ago, one-third of the 32 participants reduced costs, but all met the quality metrics. In 2013, of 19 participating ACOs, all met the quality metrics but half didn't realize any cost savings, and the worst-performing ACO recorded losses of more than $9.3 million, or 7% of expected expenditures.

On the plus side, the best performer of the group saved about $23 million. As a group, they saved Medicare more than $372 million. Still, the losses prompted some participants to drop out of the program.

Losses coupled with a significant up-front investment are hard for some providers to justify in the current environment, says Doug Chaet, Independence Blue Cross senior vice president and *MHE* editorial advisor. Chaet says some insurers have selectively offered to advance funds to ACOs, which are recouped prior to the distribution of gains. His organization has developed ACO "tool kit" capabilities for its provider partners that leverage existing health plan/population health functionality.

Insurers "would like to see these ACOs succeed as many of these organizations also have performance-based agreements with health plans for their commercial and Medicare Advantage members," says Chaet.

BUNDLED PAYMENTS

Bundled payments tie financial and performance accountability to episodes of care, encouraging hospitals, post-acute care providers, physicians and other practitioners to work closely across specialties and settings.

Though widely touted, the model presents challenges to payers and providers alike, as evidenced by a 2010 California pilot program, organized by the Integrated Healthcare Association (IHA) to test the feasibility and scalability of bundled payment episodes for orthopedic services in a multi-payer environment.

Six commercial health plans and eight hospital systems attempted to form a consensus regarding episode definitions, eligibility parameters, pay-

ment amounts and consumer cost sharing. The result was that "the design and implementation of episode payment has proven far more difficult than any one anticipated," according to a report by the IHA. Only a few health plans signed contracts with orthopedic providers, and not enough data were collected to test the bundled payment hypothesis on quality and costs.

Chaet agrees that bundled payment arrangements can be challenging due to the administrative complexity and politics involved. "This challenge is undoubtedly compounded when multiple payers and provider groups have to agree on the parameters like cost-sharing," he says.

As an example, he cites the baseline cost, which may differ among the various health plans and provider groups, making the establishment of targets difficult. To overcome those challenges, Chaet recommends retaining a third party to develop the program methodology, with provider and payer input. "Once developed, the program could then be offered to various payers and provider organizations and those who have an interest could opt in," says Chaet.

Challenge 2

KEEPING UP WITH POLICY SHIFTS

Trying to plot strategy while key provisions of the Affordable Care Act (ACA) remain unresolved is an ongoing issue for payers and healthcare organizations. Legislative challenges to the law loom large in 2015. The U.S. Supreme Court will hear arguments on the legality of the federal tax subsidies in March and a new GOP-controlled Senate has vowed to dismantle the law piecemeal.

MEDICAID EXPANSION

Twenty-seven states and the District of Columbia have chosen to expand Medicaid since the U.S Supreme Court decision in June 2012 made expansion a state option, according to HHS. Three states have implemented or are pursuing a customized expansion option: Indiana, Utah and Wyoming. Two additional states, Tennessee and Virginia, are considering a customized expansion option.

But most of the remaining states are firmly opposed to expansion, including the country's two poorest states, Mississippi and Louisiana. More than 15% of the population in those states between the ages of 18 and 65 remains uninsured, according to the *New York Times*.

In Tennessee, where expansion could mean coverage for 363,000 residents, three hospitals have closed or stopped offering in-patient services since January, according to Craig Becker, president of the Tennessee Hospital Association. Becker said the closures were due in part to the state's decision not to expand Medicaid.

The uncertainty surrounding Medicaid expansion makes planning a challenge, notes *MHE* Editorial Advisor Don Hall, M.P.H., of DeltaSigma L.L.C., a managed care advisory firm. As states continue to expand, insurers can leverage experience from previous expansion states about staffing, enrollment issues, and new member education, he notes.

COURT CHALLENGES TO SUBSIDIES

The Supreme Court, in a decision expected by July 2015, will hear arguments on the legality of the federal tax subsidies available to low and moderate income consumers that are a key component of the ACA.

The justices accepted an appeal from the Fourth U.S. Circuit Court of Appeals for *King v. Burwell,* which argues that the language of the ACA allows subsidies to be applied only to healthcare plans offered on marketplace exchanges "established by the state."

Because only 16 states and the District of Columbia have set up their own exchanges, a Supreme Court ruling affirming the plaintiff's argument would eliminate subsidies now offered on the remaining 34 federally-facilitated exchanges.

Federal tax subsidies reduce premium costs for healthcare plans purchased through the federal marketplace and state exchanges. The credits are tied to income and are available at the time of purchase or can be claimed as a tax deduction at the time of filing.

Eight-five percent of those who signed up for health insurance during the first open-enrollment period qualified for a tax subsidy, according to HHS. The average premium was $346, the average tax credit was $264, and the average after-tax credit premium was $82.

Hall notes that the loss of premium subsidies would have a serious impact on insurers' ability to retain their customers who receive subsidies. "It could create death spirals among the remaining high utilizers, because the premium on this smaller group would not cover their costs," says Hall.

If subsidies are eliminated, 11 million people would lose their health insurance, marketplace enrollment would drop 68%, and premiums would rise by as much as 43%, according to a study by the RAND Corporation.

Hall doesn't think affected states will sit by and allow the subsidies to be reversed. "I would expect states to alter contracts for management of their exchanges so that they are in effect managing them," he says.

CONGRESSIONAL CHALLENGES

The 2014 midterm elections ushered in a GOP majority in the Senate, and with it, renewed vows from leaders to repeal Obamacare.

And while President Barack Obama has vowed to veto any repeal measure, Republicans have said they plan to use tactics that would force him to compromise on certain aspects of the legislation. House Speaker John Boehner, (R-Ohio), and incoming Senate Majority Leader Mitch McConnell, (R-Kentucky), writing in a *Wall Street Journal* op-ed the day after the midtern elections, said they will challenge the hourly work week that currently defines the employer mandate portion of the ACA.

Under the law, companies with 50 or more employees have to provide healthcare coverage to full-time employees or face a penalty. To prevent employers from dropping hours to just below the common 40-hour-a-week threshold, the ACA set the definition of full-time at 30 hours a week.

Putting the threshold at 40 hours is a move supported by business groups including the National Retail Federation and the National Restaurant Association.

About 7 million employees would be affected if the threshold is raised from 30 to 40 hours, according to The Commonwealth Fund. Many would be pushed to the federal marketplace and state exchanges for insurance, and it's estimated that over 500,000 would be eligible for tax subsidies, which would raise government spending.

But the impact would likely also be less than the GOP may hope, says Hall, because the job market has improved considerably since the ACA was enacted. "Its also likely that many of the people affected are dependents of full-time employees who could cover them on their plan," says Hall.

Challenge 3

CAPITALIZING ON NEW OPPORTUNITIES

The ACA has accelerated the shift to a consumer-centric market for health plans, and that presents a huge challenge for an industry that evolved over time to support an employer-group model rather than individual consumers.

"Health plans have a lot of siloed activity that doesn't support customer service," says Greg Scott, national health plans sector leader for Deloitte LLC.

In fact, health plans ranked last out of 14 sectors for customer service in Forrester's 2014 industry survey, he notes.

In order to capitalize on new opportunities, insurance providers first have to look at business structure and culture, says Scott. "Right now, [they've] not run organizations where there's an overarching cultural emphasis on anticipating and resolving customer questions and issues." Most health plans, says Scott, now have put improving customer service, customer engagement, and retail capabilities at the top of their strategic plan.

Next, they need to change the way they conduct business. "It requires a good old fashioned business process transformation: looking at roles and functions and how those basic business processes should be recast in order to be anticipatory and responsive to actual consumers," says Scott.

Finally, and perhaps most important, data systems need to be updated, because, says Scott, "Even when [health plans] figure out what's needed, the market demands simply aren't supportable by legacy IT systems."

The move from volume to value in healthcare calls for new models, some of which are beginning to emerge, notes Scott. He points to cloud-based solutions that can facilitate new provider collaborations and support customer service ini-

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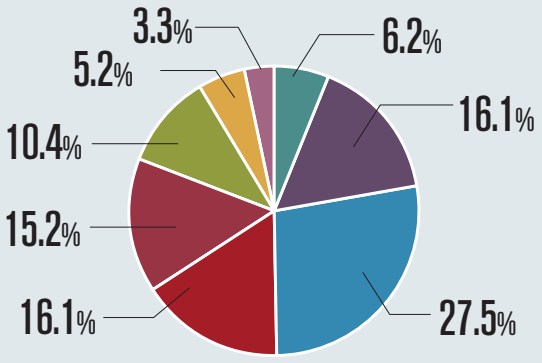
By 2018, how much of the commercial business do you anticipate will have moved to the private and public exchanges?



Source: *Managed Healthcare Executive* original research, October 2014

Continued from page 26

tiatives. But the shift is a "multi-year undertaking that requires a lot of investment." Smaller plans may not be able to make the level of investment needed to stay competitive, adds Scott.

The ACA has been good for health plans, and they're committed to changing. Four of the country's top five insurers reported positive third-quarter news in 2014. Aetna, WellPoint and UnitedHealth Group all posted third quarter results that exceeded Wall Street expectations, and shares of all three companies are also at all-time highs. Kaiser reported third quarter spending was down and revenue was up by $1.1 billion. And though Humana's third quarter earnings dropped, it expects revenue to increase 10% in 2015, from $53.5 billion to $54.5 billion.

All five insurers also maintained or added to the number of plans offered on the federal marketplace and state exchanges during the ACA's second enrollment period, which began November 15.

CHANGING EMPLOYER MARKET

The individual market expansion comes at a time when small employers are cutting back on healthcare plans and pointing employees to the exchanges for coverage. While just 4% of all large employers believe it is likely that they will terminate their employee health plans within the next five years, according to global consultant Mercer, the country's third largest insurer, WellPoint, reported last fall that its small business plan membership is shrinking faster than expected. In a call to analysts on October 29, the insurer said it has lost 300,000 small-business enrollees since the start of the year, according to the Wall Street Journal. But it offset those losses by adding 751,000 insureds to its rolls through state exchanges, as well as 700,000 new Medicaid customers, according to the Associated Press (AP).

Aetna also reported losing customers in employee-driven plans, but it, too, offset losses in those plans with 600,000 new enrollees through the exchanges, according to the AP.

But the shift away from employer plans will be gradual, says Scott. "It's an evolution, not a revolution." In fact, as a percentage of revenue and membership, the group business remains the health insurance industry's largest segment, notes Sally Poblete, M.B.A., chief executive officer of Wellthie, a healthcare technology company. "The industry evolution toward the individual consumer paying the bill is still relatively new. The shift to retail requires a big organizational, cultural, operational and technological change," she says.

It's a shift that's blurring the traditional lines of business, says Poblete. "Small group members are moving to individual insurance as businesses decide not to offer group coverage. Consumers buying commercial insurance with tax credits will be blending in with Medicaid-eligible members, as consumers' incomes fluctuate within a year." It's estimated that up to 29.4 million consumers under age 65 will 'churn' across coverage lines in the next few years, says Poblete.

NEW MARKETING STRATEGIES

Marketing strategies are also changing, says Poblete, with health plans welcoming partnerships with innovative companies, including early stage start-ups, to provide new software platforms, mobile tools, data analytics and novel ways to engage with the consumer.

Consumers are going through the entire shopping experience using different channels, including public marketplaces like Healthcare.gov, private online marketplaces, and broker and health plan websites, says Poblete. "In a retail environment, health plans have the biggest opportunity to differentiate their brand and their offerings within their own domain—their websites, retail locations, and customer service/sales associates on the phone and in the community. It is very difficult to stand out in an online marketplace with 100 products that are easily sorted by premium and where the benefit details start to look alike. Health plans that focus on being the most simple, educational and transparent in their approach with consumers will win the retail game," she notes.

Challenge 4

INVESTING IN TECHNOLOGY

Two technology challenges related to the digitization of healthcare records now confront the industry: interoperability, and cyber-risks.

INTEROPERABILITY

In an ideal world, electronic health records (EHRs) would follow a patient across a chain of providers and stakeholders, leading to lowered costs and improvements in care. In the real world, dozens of different proprietary systems that don't talk to each other have created silos of information, or roadblocks to interoperability.

Interoperability of EHRs is now a top priority for the U.S. government, which has funneled $19.2 billion in incentive payments since 2009 to promote their adoption.

But according to the most recent Black Book survey of payers and providers, 81% of hospitals and 94% of insurers/payers remain meaningfully unconnected in regards to intelligent interoperability. In addition, 82% of all payers and providers agree that an operational national public health information exchange (HIE) is at least a decade off.

The survey polled 1,550 provider organizations utilizing health information exchanges and 794 payers and insurers in the last six months of 2013.

"There are two major reasons why interoperability has and remains a challenge for the industry," says MHE Editorial Advisor Dennis Schmuland, M.D., FAAFP, chief health strategy officer for Microsoft's U.S. Health & Life Sciences division. "First, the majority of health information exchanges today originated from provider-centric designs that prioritized the needs of the provider within a facility above the needs of the patient beyond the facility. Second, the business case for interoperability hasn't been strong enough to divert scarce capital away from existing boardroom priorities. In the absence of a compelling business model, the lives of most HIEs have been artificially prolonged by grant dollars or local hospital subsidies."

Major progress toward interoperability was made last spring when the Office of the National Coordinator for Health Information Technology (ONC) released its commissioned JASON report, says John Kelly, principal business advisor at Edifecs, an information exchange for payers and providers. The report, authored by a group of highly credentialed but anonymous scientists and technology luminaries, "essentially indicted the U.S. healthcare IT community as being grossly negligent at best and completely incompetent at worst," says Kelly.

The industry has responded to the Jason Report challenge to make the data locked within EHRs more accessible and usable. Current plans, says Kelly, call for a rapid adoption of the Fast Healthcare Interoperability Resources Specification (FHIR), an operable standards framework. Adoption of the FHIR will require major EHR vendors to build standards-based application programming interfaces (APIs) that will allow open access to their data.

"To date, the lack of free and open access to that data has been a source of revenue for the vendors, so we are yet to see what it will take to move from public statements to fully implemented technical interoperability," notes Kelly.

Payers are also challenged by public HIEs, which provide data from public health departments and community organizations. The majority were initially funded by grants. As that funding dries up, operators are forced to find alternate forms of revenue, including access fees. Just 31% of payers reported participating in a public HIE, and 86% objected to the annual fees, according to the Black Book survey.

As a result, private HIEs are growing, with payers saying they expect to take a leading role going forward. In addition, 33% of multi-provider networks and hospital systems are considering private HIEs for more standardized sharing of patient data, according to the survey.

Stakeholders are also moving from provider-centric, everything-to-everything connections to patient-centric, everything-to-one HIEs, says Schmuland. "A patient-centric HIE offers the potential to drastically reduce the complexities, costs, delays and errors of the conventional provider-centric HIE model," he says.

CYBER THREATS

Cyber threats are another data challenge, and one that is growing. In 2013, breaches in the healthcare sector (43.8%) surpassed even those in the business sector (34.4%) according to the Identity

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Theft Resource Center.

Since 2009, 32 million Americans have had their medical records compromised, according to the HHS. Some of the breaches resulted from employee carelessness, but many point directly to password vulnerabilities and encryption issues.

Schmuland calls 2014 a "cyber security wake-up call" that has the industry and its executives playing catch up. "Many organizations have mistakenly assumed that a 'security by compliance checklist' would protect them from present-day threats," says Schmuland. "The problem is that the HIPAA privacy and security regulations were drafted when the greatest cyber threats came from basement hobbyists looking for fame and notoriety, not sophisticated bankrolled cyber terrorists."

Medical records are an attractive target of cyber thieves because they contain enough information to build a full identity, worth $500 on the black market, according to the FBI. In April, the federal agency warned healthcare organizations that the industry is at risk for wide-scale breaches because it is not as "resilient" as financial and retail sectors.

Several factors contribute to healthcare organization's vulnerabilities to hacking, according to a recent brief by Forrester, a research and advisory firm. They include:

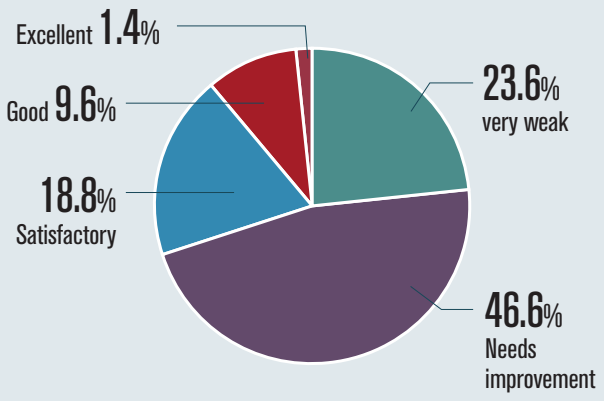
- **unclear regulations surrounding end point data protection,**
- **perception within management that healthcare data is not an attractive target for hackers, and**
- **modest security budgets.**

By 2015, as healthcare continues to grow more connected, 50% of healthcare organizations will have experienced from one to five cyber attacks in the last 12 months, says Schmuland. Those statistics mean healthcare organizations need to invest in a multi-pronged security strategy to avoid disruptions to normal operations and incurring fines and notification costs, he notes.

But the weakest link in the security chain, says Schmuland, "will always be people." As such, executive leaders "can't afford to miss the opportunity to instill a perpetual culture of privacy and security wherein everyone recognizes that they are accountable for protecting [data] from unauthorized access, use, destruction, and loss.

"The entire workforce must become maniacal defenders of patient privacy and that includes the large, extended workforce of non-employed physicians and their office staff," says Schmuland.

Rate the integration of electronic health records between payers and providers:



Source: *Managed Healthcare Executive* original research, October 2014

Challenge 5

CONTROLLING DRUG COSTS

A variety of challenges confront pharmacy managers in 2015 including the high cost of specialty pharmaceuticals.

Only 1% of all patients take specialty pharmaceuticals, but they represent 30% of total drug expenditures, says *MHE* Editorial Advisor Perry Cohen, Pharm.D., FAMCP, chief executive officer of the Pharmacy Group. In 2012, the U.S. spent about $87 billion on specialty pharmaceuticals, according to a study by UnitedHealth's Center for Health Reform and Modernization.

The cost challenge posed by specialty pharmaceuticals came into focus in early 2014 when Gilead Sciences priced its breakthrough hepatitis

> Another challenge for a managed care pharmacy practice will be developing systems needed to track patients across the healthcare system and monitor use."
>
> —PERRY COHEN, PHARM.D., FAMCP

C drug, sofosbuvir (Sovaldi), at $1,000 a pill, or $84,000 for a three-month course of treatment. Payers were outraged, but in spite of complaints, there was little they could do.

In correlated developments that show just how much the drug has benefitted its owner and how much it has cost insurers, Gilead Sciences announced 2014 third quarter sales of Sovaldi totaled $2.8 billion, while the country's number five insurer, Humana, attributed 2014 third quarter losses in part to "higher specialty prescription drug costs associated with a new treatment for hepatitis C."

Gilead Sciences defends the price, saying it actually saves money compared with the alternative, which is a lifetime of chronic disease and a possible liver transplant. Hepatitis C affects about 3.2 million Americans and is the leading cause of liver transplants in the U.S.

Employers and insurers are responding to costs of expensive drugs like Sovaldi with step therapy, or higher tiers of drug-payment categories, and shifting the site of care from hospitals to physician offices, says John Santilli, partner in Access Market Intelligence.

Payers and pharmacy benefit managers (PBMs) are also employing strategies like prior authorization and the use of specialty pharmacies to control specialty drug costs.

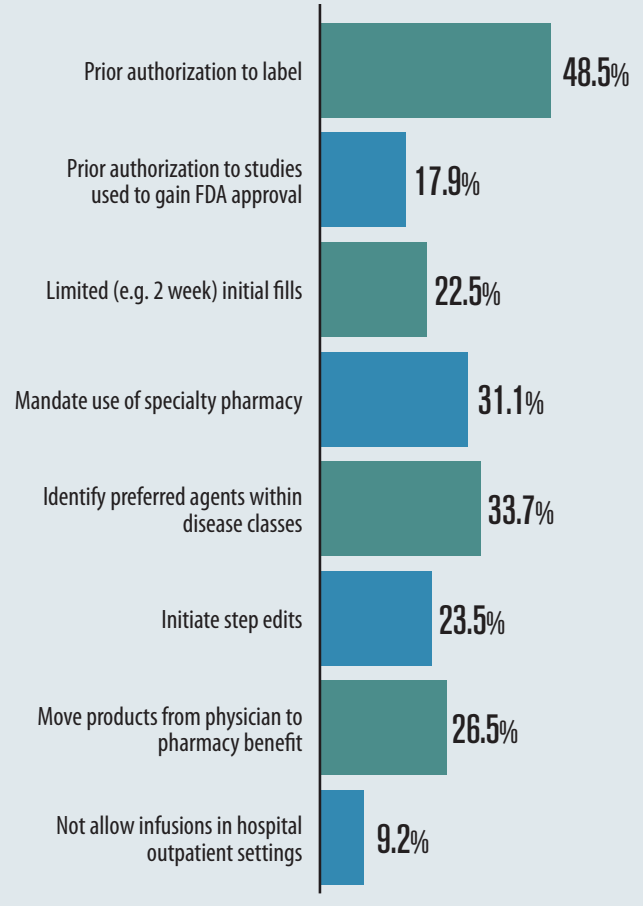
Specialty pharmacists are a growing trend, says Cohen. "The next 10 years will also see the emergence of a specialty pharmacist, based in the physician's office, who will manage the patients taking certain specialty medications."

PBMs are also controlling costs by limiting their formularies. CVS Health Corp.'s unit will keep 95 drugs off of its main formulary in 2015, up from 70 in 2014, according to *Bloomberg News*, while Express Scripts will exclude 66 brand-name drugs including the multiple sclerosis drug Rebif, an injection that costs $5,000 for a four-week supply.

Another challenge for a managed care pharmacy practice will be developing systems needed to track patients across the healthcare system and monitor use, says Cohen.

"When pharmaceuticals were considerably less expensive, if patients tried a drug and it didn't work even 35% of the time, the cost-risk was acceptable to most stakeholders," he says. "Conversely, when the therapeutic window is narrow and adverse events are possible, we will need more tools to predict effectiveness versus risk. This applies to all medications, including specialty products."

What steps are you taking to control costs of oncology and specialty pharmaceuticals?



Source: *Managed Healthcare Executive* original research, October 2014

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Specialty ACOs: A promising option

First limited to primary care, accountable care organizations now also target patients with specific diseases

by **SUSAN KREIMER**

When accountable care organizations (ACOs) originated in 2011, their founders sought to reduce costs and improve outcomes in primary care. Recently, these aims have broadened to include overseeing patients with cancer, end-stage renal disease and certain other diseases and chronic conditions. Contracting with specialty physician groups has become the hallmark of care management for these patients.

As with traditional ACOs operating in the realm of primary care, specialty ACOs reward providers for meeting key quality measures—for example, by reducing hospital readmissions and lowering overall drug costs. But specialty ACOs must be able to stratify their patient pool based on a chronic condition or contributing risk factors, and they need to collaborate with primary care ACOs in providing care for chronically ill patients.

The Affordable Care Act (ACA) has been the impetus for revamping traditional healthcare payment models, shifting from a volume-based to a value-based framework. And while it's early to say definitively whether forming or joining a specialty ACO would be a better option than establishing or participating in a traditional ACO, there are some factors managed healthcare executives should consider in their decision-making.

"When we first started moving to this concept of accountable care organizations, one of the thoughts was that care should be delivered differently," says Raena C. Akin-Deko, MHSA, assistant vice president of product development at the National Committee for Quality Assurance (NCQA) in Washington D.C., which accredits ACOs.

"Most of the care that we have right now is organized around the site of care," she adds, with patients typically seeing a primary care physician for preventive health needs and specialists for complex conditions. Over time, with the growth and fine-tuning of ACOs, "the care should transcend the boundaries of a particular site of care and really focus on how to care for a population over time and across different settings."

VALUE VERSUS VOLUME

Emphasizing value over volume in service delivery, specialty ACOs can be structured to operate in partnership, rather than conflict, with primary care ACOs, says Shelley Price, M.S., FHIMSS, director of payer and life sciences at the Healthcare Information and Management Systems Society (HIMSS) in Arlington, Virginia.

"There's tremendous opportunity across the healthcare system to take advantage

of new accountable care approaches," she says, citing as an example the high costs and quality of life challenges associated with an aging population in need of medical care.

In the vast field of oncology, new therapeutics have transformed some forms of cancer care into chronic, treatable conditions. This allows healthcare to "attack the treatment of cancer and specialty care in a more valued-based perspective," Price adds. "We will see that there are some commonalities between specialty ACOs and traditional primary care ACOs in that they both have opportunities to standardize care, care pathways, and coordinate care."

Specialty ACOs can accomplish these goals by "wrapping in care coordination" and transitions of care for patients from one type of facility to another—such as from the hospital to home care or to skilled nursing facilities—which isn't a common occurrence for traditional ACOs. Coordinating with specialty pharmacies and leveraging the knowledge of patient navigators also could have a positive influence on outcomes and costs, Price says.

Proponents of specialty ACOs view targeted care as more effective in managing specific disease states, not only cancer and end-stage renal disease, but also chronic kidney disease and some pediatric illnesses—mainly cystic fibrosis, muscular dystrophy and juvenile diabetes. Consistency of care, which relies heavily on evidence-based protocols and utilizes specialists, also provides a more natural "medical home" that lends to better patient experience and support, says Scott Kolesar, principal and national leader of the value-based care practice at Deloitte Consulting LLP.

In order to succeed, a disease-specific ACO must have a large established patient base as well as access to an extensive managed care population, usually within a major metropolitan area. If not, it must create a significant base through aggregation or collaboration. Otherwise, it won't be an attractive proposition to payers in setting up group purchasing arrangements, Kolesar says.

A challenge many specialty ACOs face, Kolesar adds, is that, "many chronic diseases typically have low patient volume and the population may not have enough members to assume a risk-based contract."

The path to developing a high-functioning ACO begins with an analysis of a particular patient pool's health status. Then it's a matter of figuring out which services and providers can help improve the health of that population while also eradicating waste in the fragmented healthcare system, says Julian D. (Bo) Bobbitt Jr., J.D., a partner and head of the health law group at Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan LLP, in Raleigh, North Carolina.

This methodology contrasts the current health status with the ideal health status for that population. "Primary care providers have been the darlings of early ACOs," adds Bobbitt, author of guides for the Toward Accountable Care Consortium and Initiative, spearheaded by the North Carolina Medical Society to help specialists successfully integrate into ACOs. "Even so, virtually every specialty can contribute significantly to accountable care's population health management."

As structured under the Medicare Sharing Savings Program, ACOs focus on primary care rather than specialties. The role of oncology in ACOs has yet to be fully defined, says Matthew Farber, director of provider economics and public policy at the Association of Community Cancer Centers in Rockville, Maryland.

"For example, with variables like the high cost of cancer care, oncologists being able

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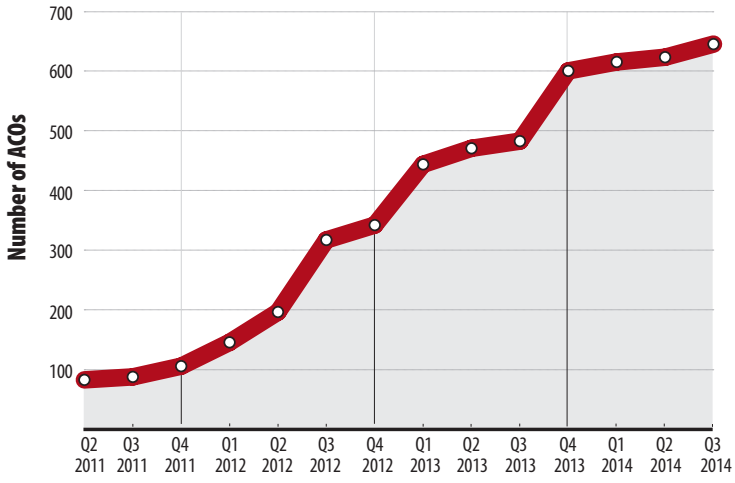
Growth of ACOs



Source: Leavitt Partners Center for Accountable Care Intelligence, 2014

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"As private payers are looking for innovative models, specialty-specific ACOs are a viable option, as long as the payer is willing to work with providers on the development of benchmarks, quality reporting and risk sharing."

--MATTHEW FARBER, DIRECTOR OF PROVIDER ECONOMICS AND PUBLIC POLICY, ASSOCIATION OF COMMUNITY CANCER CENTERS, ROCKVILLE, MARYLAND

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to join multiple ACOs, and the annual setting of benchmarks, it is not clear how cancer providers have taken to the Medicare ACO model," he says.

THE ONCOLOGY ACO

However, the rise of oncology ACOs shows promise as an alternative payment model. Much like the oncology medical home model, this type of ACO tries to streamline care for patients by reducing duplication of services, keeping them out of the emergency department or the hospital entirely, and reducing care at the end of life by increasing advanced planning and education at the front end.

"As private payers are looking for innovative models, specialty-specific ACOs are a viable option, as long as the payer is willing to work with providers on the development of benchmarks, quality reporting and risk sharing," Farber says.

Nephrology is also making inroads in ACO formation. Specialty ACOs called End-Stage Renal Disease Seamless Care Organizations (ESCOs) would facilitate better care management for patients by "fixing the gap between hospital and dialysis provider," says Thomas H. Hostetter, M.D., a professor of medicine and vice chair for research at Case Western Reserve University School of Medicine in Cleveland, Ohio.

In the past, many hospitals operated their own dialysis units for inpatient as well as outpatient needs. "That's rapidly going away, so it's like one hospital system talking to another. That is not a seamless operation," says Hostetter, chair of the American Society of Nephrology's public policy board.

"Without some more organized way of getting the discharge summary and some direct communication with the hospital, the hospital admission can be a mystery to the outpatient dialysis unit," he adds. "Almost always, there are things that happened in the hospital that have a bearing on how their dialysis is being conducted as an outpatient."

In pediatrics, the adult model for ACOs does not easily apply, making it difficult to include both children and adults in the same ACO. Many pediatric healthcare organizations and state Medicaid programs are experimenting with different scenarios to design ACO structures that would provide similar benefits to children, says Deborah Wells, M.S., CPHIMS, senior strategy consultant in information systems at the Children's Hospital of Philadelphia..

Effective management of adults with chronic conditions can reduce hospital stays, emergency department visits, and other complications that may lead to big healthcare spending. For the small number of children with severe congenital disorders, additional proactive intervention may not avoid catastrophic expenditures resulting from their complex disease states. Meanwhile, Wells says, "improved preventive care for well children—vaccines and checkups, for example—will not provide high enough near-term cost savings to help an ACO meet its shared savings goals."

Managing large numbers of patients with the same underlying illness and comorbidities makes it easier for an ACO to perform care coordination and use common approaches to resolve similar problems, says David B. Muhlestein, Ph.D., J.D., director of research at Leavitt Partners LLC, a healthcare intelligence business located in Salt Lake City, Utah.

"With volume comes experience. That's the theory behind it," he says. "In practice, it's really too early to say if the specialty ACOs are going to do better than the basic ACOs."

Even with traditional ACOs, however, the results have been mixed. Some providers and disease states have demonstrated better results than others. Muhlestein, who oversees a database of mainly non-specialty ACOs, is looking into possible explanations for the variability. As of October, when Leavitt Partners released its most recent tracking numbers, there were a total of 646 ACOs—a surge from 82 ACOs in the second quarter of 2011.

"We're spending a lot of time studying that right now and trying to figure out what is correlated with results. It's a challenge," he says. "A lot of times the ACOs themselves don't necessarily know what they did that made a difference. It's not like a randomized trial where they try one thing at a time and see what the effect was. They're trying 50 different things at once—changing their practice patterns and changing their technology platforms and hiring additional workforce people to manage populations. It's a little bit tricky to figure out what's making a difference."

***Susan Kreimer** is a New York-based freelance medical writer.*

HOSPITAL AND INSURER LAUNCH CO-BRANDED PLAN

Collaboration drives efficiencies, market share

by **CATHERINE GAFFIGAN, MD, AND CHRISTOPHER LLOYD**

In the shift from volume to value, Texas-based Memorial Hermann Health System and Memorial Hermann Physician Network faced a common, yet significant, challenge: How could they operate more efficiently and drive market share growth?

Between downward rate pressures, declining reimbursement and increased competition, the 12-hospital system and its clinically integrated physician network needed to offset any decline in patient volume as it moved toward a value-based care model. Despite its position as the local leader with nearly 25% market share, Memorial Hermann knew it needed to act quickly.

Taking action

In 2011, Memorial Hermann leadership began exploring possible collaborations with insurers. These relationships would help increase revenue, keep patients in-network and expand the patient base.

The health system had already made great strides in improving quality and lowering costs through its physician network's clinical integration program. By building on the success of this program the health system would be able to participate in the financial rewards of its progress. This process set the stage for the formation of Memorial Hermann Accountable Care Organization (Memorial Hermann ACO).

By mid-2012, Memorial Hermann ACO had received approval from the Centers for Medicare and Medicaid Services to join the Medicare Shared Savings Program. Shortly after, the organization decided to expand its accountable care strategy to include commercial value-based arrangements.

While Memorial Hermann offered health insurance products through its own health plan, expanding its ACO's reach to include other payers' products would help to drive more volume. In April 2013, Memorial Hermann ACO teamed with Accountable Care Solutions from Aetna (ACS) to launch Aetna Whole Health.

This co-branded product is available to fully insured and self-insured employers in the greater Houston market. It helps achieve Aetna's and Memorial Hermann's mutual goals through a shared-risk arrangement. The collaboration directly addresses the Triple Aim of ACOs—providing high-quality, low-cost care with an enhanced member experience. Memorial Hermann ACO is rewarded based on its ability to reduce costs and improve quality. The organization is at risk if cost and quality goals are not met.

Key factors for success

To launch the co-branded insurance product, Memorial Hermann ACO and Aetna took advantage of each organization's unique strengths.

For Memorial Hermann ACO, these included:

- a clinically integrated physician network with aligned financial incentives and access to actionable data and scorecards,
- evidence-based medical practices developed by doctors and implemented across the organization through point-of-care tools,
- industry-leading patient safety and quality protocols,
- an infrastructure to support population health, and
- a physician-led governance structure across the hospital system and physician network to reduce variations in care, enhance quality, and improve efficiency.

For Aetna, these included:

- actionable analytics and reporting at the member and physician level, as well as claims data,
- a dedicated engagement team to ensure success across sales, marketing, distribution, care coordination and health plan operations,

- care delivery and informatics support to coordinate care management and coordination activities and take effective action based on data and member needs, and
- a product plan design to encourage patients to stay in the Memorial Hermann ACO network.

Lessons learned

Launching a co-branded health plan product between an insurer and health system takes work. Both organizations must rethink their traditional roles. They must also apply innovation to bring about change.

Memorial Hermann ACO and Aetna credit several best practices for their success:

JOINTLY SHARING AND ANALYZING DATA

Payers rarely make claims (and other) data available to providers, but Aetna gives the ACOs it works with broad access to claims data where legally permissible. This data helps create a complete picture of a patient's treatment history and health status. Aetna's Informatics team provides analytics and reporting information about members most in need of attention. Memorial Hermann ACO physicians and care managers can then proactively provide those members the care they need. The reporting includes members recently discharged from the hospital, members with frequent visits to the emergency department, and members in need of complex case management and who Aetna has been unable to reach and engage in its programs.

Launching a co-branded health plan product...takes work. Both organizations must rethink their traditional roles.

TAPPING NEW MARKETS

Aetna's marketing and distribution capabilities helped bring the new co-branded product to market quickly and efficiently. The product has been delivering strong, consistent membership growth in Houston over the past 18 months. Aetna's national presence and relationships have led to numerous sales opportunities across self-insured and fully-insured business lines.

COLLABORATING ON CARE MANAGEMENT AND COORDINATION

The Memorial Hermann ACO's clinically integrated physician network, combined with Aetna's portfolio of more than 40 case management and disease management programs, lead to more proactive care. Both organizations can identify opportunities for improvement and track the results. Providers have a better understanding of the individuals they serve. This insight is enables them to more effectively target at-risk individuals, engage them in their health and support positive behavior change.

USING TECHNOLOGY

Aetna's approach to working with ACOs is extremely flexible and tailored to each ACO. Through their collaboration, Memorial Hermann ACO was able to leverage its existing IT investments. Today, Memorial Hermann ACO uses electronic health records (EHR), population health management tools and health information exchange capabilities. This technology enables quick and secure data-sharing among facilities, providers and patients. It allows the entire organization to take advantage of the data and analytics provided by Aetna.

The collaboration between Memorial Hermann and Aetna required both organizations to rethink their traditional roles to take advantage of each other's strengths and integrate them to achieve success. Over the past 18 months, Memorial Hermann ACO and Aetna have honed their strategy, refined care management processes, and improved care coordination by taking advantage of the lessons learned and focusing on continuous improvement of their collaboration. Employers and patients in the Houston market are now positioned to achieve better health outcomes and cost savings for their healthcare services. And Memorial Hermann ACO is driving both market share growth and operational efficiencies, paving the way to a more sustainable future. ◘

Catherine Gaffigan, MD, *is executive director of strategy and operations for Accountable Care Solutions from Aetna.* ***Christopher Lloyd*** *is chief executive officer of the Memorial Hermann Physician Network and Memorial Hermann Accountable Care Organization.*

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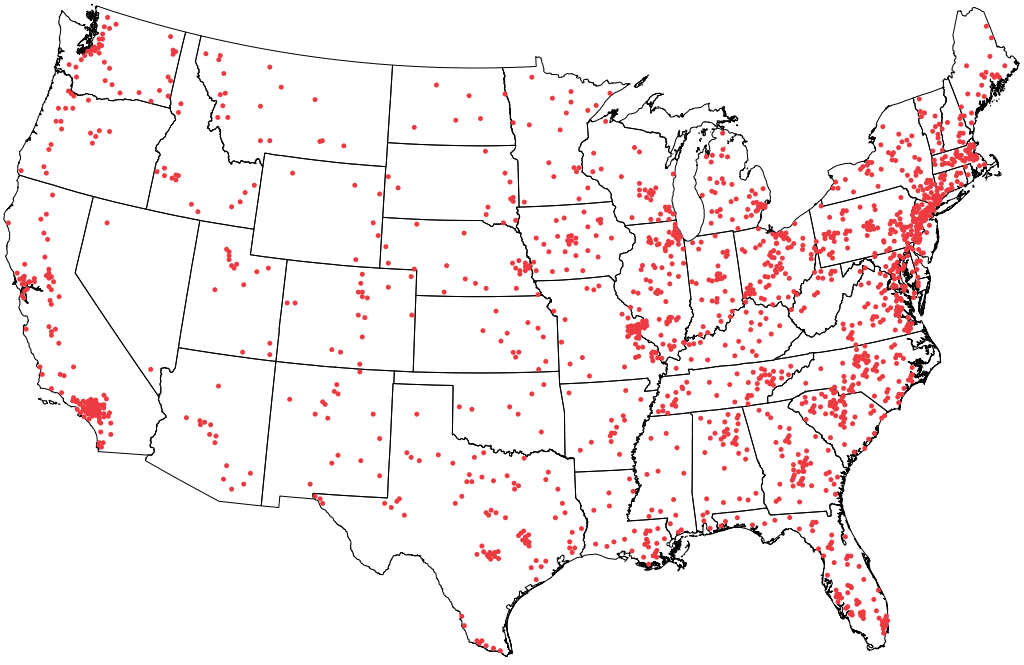

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MANAGING POPULATIONS WITH COMPLEX MORBIDITIES

Analytics, house calls, can improve outcomes

by **BOB PIEPER**

Patients with complex morbidities have long been known to be among the costliest segments of the U.S. healthcare population. The federal Agency for Healthcare Research and Quality (AHRQ) estimates that more than 25% of all Americans have at least two chronic physical or behavioral health problems. However, treatment for those with multiple chronic conditions (MCC) represents some 66% of the nation's health care costs, according to the AHRQ.

An Urban Institute study, conducted for the U.S. Centers for Disease Control and Prevention (CDC) prior to implementation of the Affordable Care Act (ACA), found 47.2% of the nation's uninsured population may have at least one serious health condition, with 19.8% having more than one (see Chart 1). The study also found 39.6% of the nation's uninsured population has diabetes, hypertension or hypercholesterolemia, with 14.2% having more than one of those conditions (see Chart 2). Serious health conditions were found to be uncontrolled in up to 77% of the uninsured population, the study notes.

With up to 10 million people gaining healthcare coverage under the ACA through Marketplace plans, employer-sponsored insurance (ESI) and Medicaid expansion, health plans have reason to be concerned about increases in costs for the care of complex chronic conditions in newly covered populations.

Researchers at Dartmouth and other institutions have widely attributed high costs for patients with complex conditions to care that is often uncoordinated, fragmented or unnecessary. Lack of timely diagnosis and patient noncompliance with care regimes are also widely recognized as significant contributing factors.

Researchers generally agree that intense, highly-coordinated care, with an emphasis on changing patient behavior to encourage compliance, will be key to improving outcomes and reducing costs for complex morbidities.

With that in mind, at least four care management organizations around the nation now offer specialized care management programs to help insurers address complex chronic conditions. Most offer advanced analytics to identify patients with, or at risk for, complex morbidities, as well as case management, disease management, and utilization review. At least two also offer specialized intervention services to modify patient behavior that could adversely affect cost and outcomes.

PopHealthCare

The Tempe, Arizona-based healthcare services organization PopHealthCare offers integrated solutions in risk adjustment, high risk population care, and quality improvement, facilitated by the company's proprietary tools and technology.

"Our high-risk population care programs use a combination of old fashioned house calls, modern day analytics, cutting edge technology, and best practice guidelines," explained Mike Tudeen, CEO of PopHealthCare. "Improving lives one individual at a time, improving outcomes one population at a time, and contributing to the overall improvement of our healthcare system are the cornerstones of PopHealthCare."


TUDEEN

CareSight, PopHealthCare's comprehensive high-risk population care program, uses advanced analytics to predict members most at risk for avoidable hospitalizations and complications due to their conditions and delivers face-to-face, in-home treatment and care support that lowers costs while delivering better health outcomes, improved star ratings and greater risk score accuracy. The program works with health plan physician networks to supplement in-office care with longitudinal care delivery, including house-call visits to provide care in the homes of high risk members with chronic illness or those who may have difficulty traveling to primary care regularly.

"While other analytics services may provide lists of patients who need care or lists of services that should be provided to those patients, those results may leave the health plan saying 'I don't have the resources to provide that care.' PopHealthCare provides end-to-end solutions for high-risk population care, including analytics and the delivery of care," Tudeen said.

CareSight provides a comprehensive system of care with a mobile team of clinicians led by a physician, nurse practitioner, or registered nurse (RN), according to Tudeen. Care is provided through in-home visits supplemented by telephonic outreach, 24-hour access, and other critical services such as improving medication adherence and integrating physical and behavioral interventions.

PopHealthCare's mobile clinical team uses field-based diagnostic tools and assessments used to document care and quality guideline compliance for diagnosed conditions, and proactively evaluates patients with comorbid risk factors for undiagnosed chronic conditions. The team then coordinates with client network care teams to ensure seamless quality of care and proper documentation.

Tudeen emphasizes the service is available "24/7", an important factor in improving patient compliance and avoiding unnecessary emergency room visits.

"When a patient with a complex condition calls after hours, they don't get an answering service, they speak directly with a clinician who is ready to help provide care, over the phone or in person. The concept of 'taking care to the member versus taking the member to care' lowers costs and ultimately delivers better health outcomes for the member," Tudeen said. "In addition to improving quality of care and improving member satisfaction, CareSight quickly decreases the number of avoidable acute admissions by 30% to 60% ."

The PopHealthCare approach is working. With over a decade in business, PopHealthCare has more than 30 health plan clients with members in 49 states and Puerto Rico. Their clients include commercial health plans/health insurance exchanges, Medicare Advantage plans, Managed Medicaid plans, dual eligible/dual integrated plans and MLTC plans.

Health Integrated

Patients with chronic health conditions commonly have underlying psychosocial problems that hinder care and adversely affect outcomes, notes Sam Toney, MD, the executive vice president and chief medical officer of Tampa-based Health Integrated, Inc.


TONEY

Health Integrated—through its flagship Synergy Targeted Population Management service—offers a chronic care management program that includes both medical and behavioral management for patients, including intensive intervention for those deemed at high risk for contributing psychosocial disorders.

Up to 40% of patients with chronic physical conditions also suffer from psychosocial disorders that could affect outcomes, according to a 2008 Milliman Research Report.

However, Toney believes Health Integrated is the only health care management organization offering a comprehensive analytics and interventional program to coordinate medical and behavior care management for chronic disease patients at this time.

Like many healthcare management organizations, Health Integrated offers utilization review, case management and disease management. Like others, the firm uses sophisticated software systems to stratify patients according to risk for various chronic conditions. However, Health Integrated also classifies patients according to risk for related behavioral disorders.

In cases of high risk for chronic disease with underlying psychosocial problems, patients are assigned a licensed psychotherapist who provides an intensive intervention program, with a typical duration of nine months. The interventions include regularly scheduled telephone counseling sessions, generally 30 or 45 minutes in length, as well as print and online resources.

The company also offers a special needs plan (SNP) care model to help ensure patients receive the necessary medical and behavioral care.

Reaction to the Synergy program among patients so far has been favorable with satisfaction ratings generally in the 90% to 95% range, according to Toney.

Moreover, data indicates the Health Integrated Synergy

Chart 1 Incidences of various health conditions among uninsured population

Has physical, mental, or emotional limitation	**25.5%**
Fair/poor health	**25.2%**
Medical conditions	
Diabetes	**6.8%**
Hypertension	**27.5%**
Hypercholesterolemia	**22.8%**
Heart disease	**3.6%**
Stroke	**1.7%**
Emphysema	**1.5%**
Asthma	**7.9%**
Cancer	**4.5%**
Depression	**2.0%**
Any of the above conditions	**47.2%**
At least two of the above conditions	**19.8%**

Source: Urban Institute

Chart 2 Knowledge and control of chronic conditions among the U.S. uninsured populations

(Diabetes, hypertension, hypercholesterolmia)

Has at least one condition	**39.6%**
Has at least two conditions	**14.2%**
Has all three conditions	**2.6%**
Among those with diabetes	
Undiagnosed	**31.9%**
Uncontrolled	**77.5%**
Among those with hypertension	
Undiagnosed	**22.1%**
Uncontrolled	**48.7%**
Among those with hypercholesterolemia	
Undiagnosed	**9.7%**
Uncontrolled	**57.9%**
Among those with at least one of the above	
At least one undiagnosed	**23.9%**
At least one uncontrolled	**61.2%**
Among those with at least two of the above	
Multiple undiagnosed	**4.2%**
Multiple uncontrolled	**39.5%**

Source: Urban Institute

program is effective in improving outcomes and thereby reducing costs, Toney says.

Implementation of the Synergy system by the Community Health Plan of Washington contributed to an eight percentage point reduction in the plan's medical expense ratio (MER) last year. Community Health Plan provides medical coverage for 20,000 Medicare Advantage and Medicare Dual Eligible SNP enrollees in the Evergreen state.

The plan also reported marked improvements in key clinical utilization measures among chronic disease patients, including a:

- 15% increase in Office/Home Visits
- 54% increase in Physical Exams
- 7% reduction in overall Inpatient Utilization with declines of 19% in Surgical Utilization
- 9% reduction in Outpatient Utilization
- 14% reduction in Radiology in All Settings

Based on those results, Community Health Plan is expanding use of the full suite of integrated services to the 285,000 members in its Medicaid program.

Researchers at Portland University have compiled a formal study on the results of Synergy implementation, which demonstrates higher levels of improvement in HEDIS scores over a comparison group.

Toney first came up with the idea of coordinating medical and behavioral care for chronic disease patients while completing his psychiatric residency program at the University of South Florida. He has published an article in the *Journal of Managed Care Pharmacy*, related to the efficacy of early efforts of Synergy program. The publication revealed not only improved treatment outcomes for psychosocial conditions, with more appropriate utilization of resources (drugs) and reduced overall costs, but similarly improved outcomes for physical conditions in those patients, with similar utilization and cost improvements.

With both commercial and public plans facing new pressure to control costs for chronic disease patients, coordinated medical and behavioral care management may be an idea whose time has come, Toney says.

Complex morbidities with high risk underlying psychosocial drivers represent 5% to 7% of commercial insurance plan members, 7% to 12% of the Medicare population, and 9% to 15% of Medicaid plan enrollees, but account 30% to 40% of care costs across those insurance programs, Toney says.

A growing opportunity

The Urban Institute report suggests that newly covered populations may actually be somewhat less prone to complex chronic conditions than previously thought.

Compared to Medicaid enrollees, uninsured adults were found to be less likely to be in fair or poor health, to have chronic conditions and functional limitations, and to exhibit certain health risk factors such as obesity or lack of exercise, the institute found.

However, one in three are obese or have conditions such diabetes, hypertension, or hypercholesterolemia, according to the institute's report. They are also less likely than the Medicaid population to know about those conditions or have them controlled.

"Even as potential new Medicaid enrollees are less impaired on average than current enrollees, they still have relatively high risk factors and prevalence of chronic conditions," the Urban Institute concludes.

Toney agrees incidences of complex chronic conditions among the newly insured may not be quite as high a previously anticipated. However, pent-up demand among newly insured populations will still prompt a spike in care for complex chronic conditions over the short run, both Toney and the Urban Institute predict.

And while that demand for acute care may eventually level off, the demand for ongoing management of complex chronic conditions is likely to grow steadily over the long run, both Toney and Tudeen agree. ◘

Bob Pieper *is a freelance healthcare writer based in St. Louis.*

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THE RISING COST OF GENERIC DRUGS

Shortages, industry mergers: major causes of generic drug increases

by **MARI EDLIN**

Drug shortages and manufacturer consolidation are leaving their imprint on the price of some generic drugs, which are rising but not to the extent of branded products.

During the past 12 months, half of all retail generic drugs increased in cost, with one out of 11 more than doubling—some as much as 1,000%—according to Adam Fein, Ph.D., president of Pembroke Consulting in Philadelphia. Those generics represented a median increase of 11.8% compared to the median decrease of 6.8% for the other half of retail generic drugs.

In his analysis for the period between November 2012 and November 2013, one-third of generic drugs were more costly.

The drugs representing the largest jumps, according to Fein's analysis based on the National Average Drug Acquisition Cost (NADAC) per unit are tetracycline capsules (250 and 500 mg), which are antibiotics whose prices rose 17,714% and 7,340%, respectively; captopril tablets (12.5, 25, 50 and 100 mg), ACE inhibitors; and clomipramine capsules (75 mg), an antidepressant.

Tetracycline faced a shortage when manufacturer Teva Pharmaceuticals said the capsules were unavailable due to a lack of raw materials, while Watson Pharmaceuticals (now Actavis) stopped manufacturing the capsules in October 2013.

The increases in the cost of these drugs, along with others such as antibiotics doxycycline and digoxin used to treat congestive heart failure, prompted U.S. Senator Bernie Sanders (I-Vt.) and U.S. Representative Elijah Cummings (D-Md.) to investigate the causes of the significant hikes in the prices of some generics. They are working with 14 generic drug companies to undercover the source of the problem.

The National Community Pharmacists Association (NCPA) surveyed its members and documented that prices for many generic drugs are skyrocketing by 1,000% or more virtually overnight, according to a recent blog. Pharmacists said the trend forces some seniors into their Medicare drug plan's coverage gap or "donut hole" sooner and that other patients forego their medication altogether.

Pharmacy benefits managers (PBMs) may wait months to update reimbursement rates, leaving independent community pharmacies with losses of $40 to $100 or more per prescription, NCPA says

On the bright side, generics saved Americans nearly $239 billion last year, an increase of 14% over the previous year, according to the Generic Pharmaceutical Association.

Generic price inflation: Not a new trend

"We are seeing inflation with some generics—not a new trend—but we are paying more attention," says Sharon Frazee, Ph.D., M.P.H., vice president, research and analytics, Express Scripts, a PBM based in St. Louis. "In any given year, there are price increases on some generics primarily caused by shortages in ingredients and mergers between manufacturers, suppliers and facilities."

She points to the increase in the price of captopril, which she estimates to be 1,022%. "But the cost of generics is still low compared to brands," Frazee says. "I believe that generics will demonstrate deflation in general with a few anomalies."

As a pharmacy benefit manager, Express Scripts plans ahead for shortages and consolidation that might affect the cost of generics in the home delivery marketplace, Frazee says.

"We watch the market carefully on a monthly basis and stockpile certain drugs to ensure that they are accessible and affordable for our customers," she says. "Adherence is impacted by the out-of-pocket spend."

Frazee says that without affordable medications, plan sponsors might be forced to limit

Continued on page 57

or eliminate coverage for their employees. "But with so many generics on formulary, we can always replace the ones facing shortages with a drug of equal value," she says.

Two-tiered generic drugs

The price of tetracycline rose so significantly that Ryan Cox, director, clinical pharmacy services for Highmark in Pittsburgh, says chain stores such as Walmart dropped the drug from its $4 discount generic drug program. He attributed some of the higher generic prices to manufacturers who decided to discontinue certain drugs and focus on those with higher volume, thus decreasing competition.

Highmark uses a five-tier formulary, with the first two tiers being preferred and non-preferred generics, followed by third and fourth tiers of preferred and non-preferred brands and a fifth for special pharmacy.

"Quality and access are our priorities but with all things being equal, we will consider cost in determining which generics to put on the first tier," Cox says. "We want to normalize the playing field and encourage consumers to pay less for drugs they really need and more for those they don't need."

He says that the copayment differential between the first two tiers is generally big enough to encourage the use of the preferred tier.

The differential also allows for a decrease in the amount a plan pays for the non-preferred generic (higher member copay) and thus an opportunity to better control the impact of rising generic prices.

Still a good deal

Rick Bruzek, Pharm.D., vice president of pharmacy services, HealthPartners based in Bloomington, Minnesota, says that during the third quarter of 2014, the average price for a 30-day supply of generics covered by HealthPartners was $20 versus $240 for branded drugs. "If the price of a generic goes up $100, it would still be $200 less," he says. "They are still a good buy; let's not throw generics under the train."

Bruzek points out that when some brands go off patent, such as antidepressant Cymbalta did in late 2013, they still remain expensive until generic manufacturers enter the market.

HealthPartners added a second tier for non-preferred generics for its Medicare formularies for 2014 that require prior authorization. Bruzek says that there are only a few drugs on the second tier, such as extended release diabetes agents. HealthPartners plans to roll out two-tiered generics to its self-insured and individual members soon.

"We made this decision before price inflation to block the use of higher priced generics when there are multiple choices available," he says. He anticipates that if the first tier requires a $5 copayment and the second tier $20, pharmacy costs will decrease.

Bruzek also says that FDA's stricter requirements and more intense scrutiny of manufacturers could slow down production as producers fix any deficiencies.

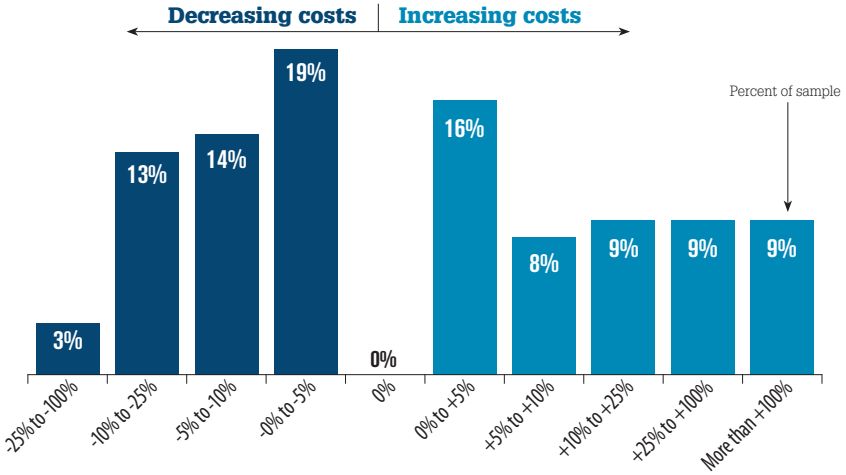
"Besides new higher cost generic introductions, price increases on older products are also causing the higher cost of generics," Bruzek says. "The exact contribution of each differs in time and is dependent on the utilization of the product."

He foresees that the higher prices will add costs to insurers and plan sponsors, and for consumers—those who pay co-insurance and/or cash—costs will increase for those generic products that might land on a higher tier.

Although Bruzek expects generic prices to continue to increase, he is confident that they will bring value. "Generics have a proven track record in safety and efficacy," he says. ■

Mari Edlin is a freelance writer based in Sonoma, Calif.

Generic Drugs, Change in NADAC per Unit, July 2013 vs July 2014



N=2,376 products

NADAC = National Average Drug Acquisition Cost

Source: Pembroke Consulting analysis of Center for Medicare & Medicaid Services data files.
Published on Drug Channels (www.DrugChannels.net) on August 12, 2014.

TELEMEDICINE POISED FOR GROWTH

Large employers turn to telehealth initiatives to lower costs, improve quality

by **JAMIE J. GOOCH**

Being diagnosed via video may sound like the stuff of science fiction for some, but it is a reality for many people whose employers have embraced telehealth for its potential to improve employee health while reducing costs and time off work.

Telehealth (aka telemedicine) is becoming increasingly popular, according to a survey by the National Business Group on Health (NBGH). The group found that about 28% of large companies currently offer telehealth options, and 48% of the employers it surveyed in states where telehealth is permitted plan to provide such services in 2015. The survey also shines a light on what may be the biggest hurdles to more widespread telehealth adoption: Spotty federal government and state-by-state acceptance.

"The main challenge revolves around state laws and regulations affecting employers' and insurers' ability to provide telehealth services," says Brian Marcotte, NBGH chief executive officer. "The scope of services that telehealth initiatives can provide differ by state, which makes it a challenge for multi-state employers."

The National Conference of State Legislatures reports that 43 states and the District of Columbia provide some form of Medicaid reimbursement for telehealth services. The American Telemedicine Association (ATA) says Medicare covers many physician services, including videoconferencing for traditional fee-for-service beneficiaries living in rural areas. Medicare Advantage plan members have more flexibility when using telehealth, according to the ATA.

"Most of the commercial market has made the decision to embrace telehealth," says Roy Schoenberg, MD, chief executive officer of American Well, a telehealth services company. "The problem is, with Medicare and Medicaid there are good intentions — lots of bills have been submitted — but when it comes down to the Congressional Budget Office, they have to put a number on costs. Telehealth acceptance has happened so fast, there is no track record."

While telehealth services are not new, several factors have recently converged to bring them more widespread attention. Among these are improved technology, greater acceptance by insurers, physicians and consumers, and demand for medical services that outstrips supply. Jason Gorevic, CEO of Teladoc, a telehealth company founded in 2002, says he saw an inflection point in the company's growth curve in 2012.

"We did 1,200 telemedicine visits yesterday, and expect to do half a million next year," he says. "It really points to a wave that's building. It started in the private sector, but now we're seeing significant movement in the federal and state governments."

Part of that growth can be attributed to the impact that newly-insured consumers created by the Affordable Care Act are having on an already strained primary care system. Part of telemedicine's promise is that more people can engage in their health and wellness in a way that is more efficient for primary care physicians without affecting the quality of care.

Changing cultural norms

In addition to a patchwork of federal and state government acceptance, telehealth proponents face the cultural hurdles typical to any new initiative, especially one involving technology. Employees may not be comfortable with the idea of video conferencing, receiving wellness texts or using online portals for medical care. That's where employers may have an advantage.

"Employers are in the unique position of having a captive audience, so they can do more communication and education," says Marcotte. "They can showcase the benefits of telehealth."

For employees, chief among those benefits is what has already been shown to be a strong driver of cultural change: convenience. Employees no longer have to schedule an appointment during their doctors' often limited office hours, or take time off work to drive to their doctor's office and wait to be seen.

The most convenient telehealth initiatives provide employees with quick access to their physicians while at home, at work or on the road, before, during and after traditional office hours.

"There is an initial hurdle to get employees comfortable with it, but it's not a huge barrier," Marcotte says.

Employers are using a variety of methods to overcome that hurdle. Employees must feel their privacy

concerns have been addressed, both as they are conferencing with care providers and with their medical information. Some large employers are easing the acceptance of telehealth via on-site clinics for employees and telehealth kiosks in branch offices. Many employers are also offering attractive telemedicine options alongside high-deductible plans to allow employees to have more direct control of their healthcare costs.

Technology integration

The healthcare industry is moving toward better integration and communication along the entire care continuum. Payers, providers, pharmacies and labs are not yet able to communicate seamlessly with one another on a patient-by-patient basis.

"There are many silos in the healthcare industry, and telemedicine integration is going to be key," says Alan Roga, MD, founder and chief executive officer of Stat Health Services, provider the Stat Doctors e-health services. "That's why we are seeing a greater demand for 'big data' in this industry. To be successful, data has to follow the patient independent of the currently fragmented healthcare market."

Schoenberg agrees that the infrastructure needed to institute telehealth is key to its success. He says the idea that videoconferencing is the only necessary technology is one of the biggest misunderstandings surrounding telehealth.

"Videoconferencing technology is maybe 1% of the investment that needs to be made," Schoenberg says. "It has to come with the integration to claims, eligibility, prescribing, scheduling, auditing systems, encoding systems … all the important pieces of the puzzle. If you try to cut corners and not integrate or interact with one of those systems, it breaks. You can't just turn on Skype."

Telehealth may represent an additional technology integration consideration, especially if patients are not using their primary care physician. That could become less of an issue as more physician groups and insurers warm to the idea of telemedicine.

"We're seeing more and more patients beginning to use the technology with their own physicians, not just to access the next available physician, but as one of the channels you're using to interact with your doctor," says Schoenberg. "We're seeing completely different populations now of people who have chronic conditions or need long-term treatments."

He says the majority of telehealth users still access it for convenience, but he sees a growth in longitudinal care. "The biggest growth is from hospital patients," he says. "They use telehealth to connect pre- and post-surgery. That will grow rapidly."

Larry Boress, president and chief executive officer of the Midwest Business Group on Health and executive director of the National Association of Worksite Health Centers, also sees hospitals driving telemedicine growth. "Of employers who have their own on-site health centers — about 30% are doing telehealth themselves. About 40% to 50% are contracting with a third party, and the rest are contracting with local health providers. It's a growing trend for providers. They see it as new business opportunity."

Likewise, more insurance plans are expanding their telehealth coverage, according to the ATA. The association lists 21 states and the District of Columbia as requiring private insurers to cover telehealth the same as they cover in-person services.

"More employers and insurance carriers are seeing the value, as telemedicine enhances convenience while significantly reducing costs," says Roga.

Cost saving estimates vary. Gorevic pins savings at as much as $700 per consultation. Schoenberg says savings depend on the population and geography, but approximates an urgent care center visit at $150, and an emergency room encounter at $500. By contrast, he says, a telehealth visit costs around $50, including all the technology needed.

If telehealth applications replaced physician, emergency department and urgent care visits, it would save $6 billion annually in healthcare costs, according to a recent study by Towers Watson.

Of course, telemedicine isn't applicable for every situation. "If you're having a heart attack, get on an ambulance, not your iPhone," Schoenberg advises. But for those non-emergency situations that send many consumers to the ER unnecessarily, telehealth could have a significant impact.

"The cost savings are meaningful for payers, whether they are employers or health insurance plans, and also for consumers in this age of high-deductible health plans," Gorevic says. ■

Jamie J. Gooch is a freelance writer based in Northeast Ohio.

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