The ACO Gamble

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Narcolepsy is an often misdiagnosed, incurable, chronic and potentially disabling neurologic disorder, and is associated with high medical comorbidity burdens and reduced daily function. Narcolepsy has also been shown to have substantial socioeconomic burden resulting from increased healthcare resource utilization and lower work productivity relative to those without narcolepsy.

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ACO Pessimism Is Out of Fashion

By Peter Wehrwein

When I did a Google search on “ACO failure,” I got 488,000 hits and a piece that appeared in these pages was eighth on the list. “ACOs will implode just as capitated HMOs imploded in the 1990s,” was Regina Herzlinger’s gloomy assessment in a 2012 interview with Joseph Burns, one of our contributing editors.

A few months later, another prominent Harvard Business School professor, Clayton Christensen, famous for his theory of disruptive innovation, panned ACOs in an opinion piece published in the Wall Street Journal.

I haven’t contacted Herzlinger or Christensen to see if they have changed their minds. But it’s safe to say that their wet blankets are out of fashion.

In our cover story on page 20, Robert Calandra provides some important insights into the current state of play for ACOs. The federal government certainly isn’t backing off, with CMS rolling out its Next Generation model and proposing changes to the Medicare Shared Savings Program that are designed, among many other things, to make two-sided risk more inviting.

What’s going on with private payers and ACOs is harder to figure out. Take a look at the table on page 24 from Leavitt Partners. That tally includes “ACO-like and other value-based arrangements” as well as ACOs. Still, the momentum is there.

Keep in mind that ACOs are just a means to an end. The idea is to nudge (not drag or push) providers away from fee-for-service toward payment and organization that motivate them to care about quality and cost instead of volume. Most people I talk to in health care are convinced that change is both absolutely necessary and underway. If ACOs in their current form aren’t making that happen, then they can be tweaked and retooled so that they will.

After this issue of Managed Care is safely tucked into bed, I am going to contact Professors Herzlinger and Christensen to see if they agree.

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Will ACOs Pan Out and Pay Off?  
After what looked like a bumpy start, and despite the warnings of some nay-sayers, the organizations designed to wean providers off of fee for service and to take on financial risk begin to make progress.

What We Have Here Is a Failure to Communicate  
That led to problems in Cool Hand Luke. Insurers, too, fail to communicate when using confusing jargon in member communications. “Pneumonoultramicroscopicsilicovolcanoconiosis?” Try “silicosis,” or even “lung disease.”

Opioid Abuse Gets Insurers’ Attention  
Relieving chronic pain while preventing opioid abuse requires vigilance. Enter health plans. Some identify at-risk members as well as prescribers who write an unusually high number of opioid prescriptions.

Boost Those Medicare Advantage Star Ratings!  
An expert’s four steps: focus on quality and consumer perception, develop an integrated governance structure supported with data, improve data and analytics, and minimize the complexity of the Medicare contract portfolio.

Provider-Sponsored Health Plans Will Work  
The ACA is just one reason that providers might want to sponsor their own health plans. Will they be financially viable? Provider-sponsored plans with weak as well as strong cash flows look like they would be.

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Ophthalmologists Blind To Changes in Guidelines

Granted it might be difficult to follow guidelines if you’re a busy physician and hundreds of professional associations are preaching best practices, but you’d think that 20 years should be time enough to get up to speed.

Apparently not, according to a recent study in the New England Journal of Medicine (NEJM), which says that ophthalmology is stuck in the late ’80s and early ’90s when it comes to preoperative tests for routine cataract surgery. Those tests are still given, though they don’t need to be.

Researchers cite a 1993 study in the Archives of Ophthalmology (now JAMA Ophthalmology) that measured the experiences of about 60,000 Medicare beneficiaries who underwent cataract surgery in 1986 and 1987. That study, performed before current guidelines were issued, showed that half of Medicare beneficiaries had at least one unnecessary test or office visit within 30 days before surgery.

What a difference a couple of decades doesn’t make. The NEJM study in the April 16 issue says 53% of Medicare beneficiaries still get at least one preoperative (and unnecessary) test in the month before surgery.

About 441,000 Medicare patients were tracked from Jan. 1, 2010, through Dec. 31, 2011.

There are 1.7 million cataract surgeries performed each year, and it’s a safe procedure with less than 1% risk of cardiac arrest or death.

Most patients are older than 65, and that might be the reason for unnecessary testing, say researchers at the University of California–San Francisco (UCSF) who conducted the study.

Physicians worry about patient safety, legal risks, and the expectation from other doctors that tests will be done.

The preoperative tests include complete blood count, chemical analysis, coagulation studies, urinalysis, electrocardiography, cardiac stress tests, chest radiology, and pulmonary function tests—all of which are not needed for routine cataract surgery.

A patient’s health helps determine whether tests will be ordered. But UCSF researchers found that the ophthalmologist performing the surgery and the occurrence of a preoperative office visit appeared to be more powerful drivers of testing than the characteristics of the patient. About a third of ophthalmologists ordered unnecessary tests for more than 75% of their patients and 8% ordered the tests for virtually all of their patients.

Knowledge Gap Seen In Imaging Surveys

Getting radiologists more involved in educating patients about imaging will go a long way toward bolstering patient satisfaction, according to a study in the Journal of the American College of Radiology.

At a time when the health system promotes patient-centered care and consumer empowerment, researchers at NYU Langone Medical Center found that slightly less than half of patients could identify whether the imaging test they were about to get used radiation.

Researchers used data from 176 surveys of patients waiting to take an imaging test. The surveys, given over three weeks, took less than three minutes to complete.

About 1 in every 5 patients had unanswered questions about the examinations, most of which concerned exam logistics, contrast-agent usage, and when results would be available.

A problem with radiology is that the doctor who orders the test and the doctor who administers it are different physicians, a situation that creates opportunities for miscommunication with patients, who may end up confused or underinformed, or both.

The ordering physician in the study failed to explain the examination in more than 20% of the cases. Even when he did, the patient was not satisfied with the explanation in more than 25% of the cases.

One reassuring finding was that almost all (97.1%) of patients correctly identified the imaging modality. A similar proportion (97.8%) knew the body part being examined.

On the other hand, just over half (51.1%) knew that they would be receiving contrast agents intravenously.

“These gaps in knowledge can diminish patients’ satisfaction with their imaging experience and limit patients’ ability to effectively engage in shared decision,” noted the authors of the study.
Registries Called Underdeveloped

Most clinical registries do not measure up to the challenges of modern medicine, lacking both data geared to specialty care and a way for the public to access those data easily, according to researchers at Johns Hopkins.

The researches looked at 153 registries to see if they could be the foundation of long-anticipated national clinical registries.

Not yet, says a study published in the April 24, 2015, issue of the Journal for Healthcare Quality. The takeaway from the Johns Hopkins researchers is that much more needs to be known about registries and their effectiveness.

They looked at 73 health services registries, 66 disease registries, and 14 combined registries.

“With a few notable exceptions, most registries are underdeveloped, underfunded, and often not based on sound scientific methodology,” senior investigator Marty Makary, MD, said at the time. Researchers conducted their search between July 1, 2012 and Nov. 1, 2012.

The researchers found that 98 of the 117 recognized medical specialties do not have a national clinical registry affiliation, so they are missing out on an opportunity for scientific advancement and quality improvement in health care.

Registries work better when the data are adjusted for and audited. “We found that less than a quarter of registries in our study risk-adjusted or audited their data, suggesting the need for better handling of data in reporting outcomes,” the researchers said.

Obesity Paradox Shows Up In Study

There have been many sightings of the “obesity paradox” through the years, but they haven’t convinced everyone that it actually exists. A new study brings the puzzle into sharper focus but there are still plenty of questions.

The obesity paradox is the phenomenon whereby being heavy seems to have health benefits for some groups of people. For example, people with cardiovascular disease who are overweight and obese tend to live longer than people who are thinner. This study was designed to explore whether the paradox of extra weight having mortality benefits also applies to people with type 2 diabetes.

Researchers at the University of Hull in Great Britain noted that many of the 16 previous studies of the obesity paradox were methodologically flawed with “inconsistent and contradictory” results.

They analyzed data on 10,000 patients with type 2 diabetes who were followed for more than 10 years.

People with diabetes who were overweight (defined as having a body mass index [BMI] of 25 to 29.9) had a mortality rate 3% below that of people with diabetes who were in the “normal” weight range (BMI 18.5–24.9) that is usually considered the healthiest. Adding to the intrigue, overweight people were less likely to die even though they had a higher rate of cardiac events.

Obesity (BMI ≥30) did not confer a survival advantage, but it wasn’t a big disadvantage, either. The mortality rate for people that heavy was close to the rate for people in the normal weight range. Age was a factor in the heaviness mortality benefit, and logistic regression analysis found that it kicked in starting at about age 60.

The British researchers offered several explanations for their findings. Being overweight may have biologic benefits, giving people some metabolic reserve as they get older that protects them from frailty and osteoporosis.

The seeming paradox may be explained by higher tobacco and alcohol consumption among those with low BMIs. In this study, the researchers adjusted for smoking but not pack years, and they didn’t have data on alcohol consumption to work with.

Has weight as a negative risk factor perhaps gotten too much attention? As these researchers note, studies are suggesting that fitness may trump adiposity in some cases.

They cite research showing that in the general population, treadmill tests are a better predictor of cardiovascular events than BMI.

They also mention previous studies of men with type 2 diabetes that have shown that heavier men who are fit are less likely to have a cardiovascular event than men of a normal weight who aren’t.
**Briefly Noted**

Physicians should share their medical notes with patients in order to engage them—and everyone in health care is looking for ways to improve patient engagement these days. A study in *BMJ* says patients who have access to their notes feel that their relationship with their doctor is more collaborative. After a year, virtually all of the patients wanted to continue to have access to their notes and none of the doctors declined…. **Patients want to be asked** if they’d mind being part of studies comparing medication outcomes based on a review of their medical records, according to a study published in the *Annals of Internal Medicine*. The study was spurred in part by an announcement in October 2014 by the U.S. Office for Human Research Protections that it’s considering new guidelines for risk disclosure. Between 70% and 83% of respondents said that they were willing to have permission be sought and given orally…. **Four top-of-the-line hospitals** are trying to improve ICU care by adding more of the personal touch. Staff at Johns Hopkins, Brigham and Women’s Hospital, Beth Israel Deaconess Medical Center, and UCSF Medical Center make an effort to know their patients better, focusing on little things like using nicknames. Also, hospitals are keeping a sharper eye on patients’ personal items…. **Antidepressants might be a better treatment** than statins for some patients who suffer from moderate to severe depression and who are also at risk of heart disease, stroke, and death, according to a study presented at the American College of Cardiology annual meeting. People taking antidepressants had a 53% lower risk of dying, developing coronary artery disease or having a stroke during a three-year follow-up period than patients who were not taking antidepressants or statins, say researchers with the Intermountain Medical Center Heart Institute. Taking a statin, either alone or with an antidepressant, did not reduce the CVD risk…. **Chronic kidney disease** (CKD) threatens to become a bigger burden, according to a study in the *American Journal of Kidney Diseases*. About 14.4% of adults ages 30 or over will have CKD by 2020, and that will jump to 16.7% by 2030, say researchers at RTI International, a not-for-profit research organization. Currently, about 13% of adults have CKD.

— Frank Diamond

**Major antibiotic shortages create clinical woes**

*Trends in drug shortages, 2001–2013*

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*Source: Quadri F et al., *Clinical Infectious Diseases*, June 15, 2015*
Texas’s Corralling of Telemedicine Won’t Start a National Stampede

The Lone Star State may be a lone wolf when it comes to regulating virtual visits.

By Richard Mark Kirkner

When the Texas Medical Board adopted new rules governing the use of telemedicine in April, medical professionals sat up as if the series-ending episode of their favorite TV show just came on. Some see the rules as blocking telehealth. Texas medical officials say they are merely “expanding” existing telemedicine rules governing the doctor-patient relationship. “Essentially the only [telemedicine] scenario prohibited in Texas [under Rule 174] is one in which a physician treats an unknown patient using telemedicine, without any objective diagnostic data, and no ability to follow up with the patient,” the medical board said in a press release.

It is all too easy to get stuck in legal quicksand here. The main issue seems to be how Rule 190.8 (which governs doctor-patient interaction and a physician’s discretion to prescribe medication based on a telephone consultation) and Rule 174 (which governs telemedicine, or video consultations with a health professional physically present) overlap and differ.

Jonathan Linkous, CEO of the American Telemedicine Association, says the Texas ruling does—in a way—open the door to greater use of telemedicine, if you only look at Rule 174. Yet it also shows the state is an outlier in the regulation of telemedicine, according to Jason Gorevic, CEO of Teladoc, the largest telemedicine provider and the subject of the Texas rule change.

The battle has been wending its way through the courts, with the latest ruling coming on May 26 when a U.S. District Court judge in western Texas ruled in Teladoc’s favor.

Texas defines telemedicine

As with so many other terms in health care, telemedicine is used expansively and takes in everything from a remote neurologist observing a patient in an ICU to the old-fashioned telephone call (although these days that call is more likely to be conducted on a smartphone).

In Texas, however, the state medical board has fenced off the terms and given them strict definitions. The board defined telemedicine as a patient–physician interaction using interactive video. A patient can obtain a prescription if the patient is with a medical professional at the time of interaction (with the prescribing physician on the other end of the video feed) or if the physician over the video (or his partner) has done an in-person examination of the patient during the preceding 12 months.

Telehealth, according to the Texas Medical Board rulebook, includes traditional on-call practices whereby a patient speaks with an on-call physician over the phone and refills a prescription, or where a patient talks with his or her regular doctor over the phone and obtains a prescription for a new condition, such as a sinus infection.

“The board is trying to protect the patient...
from care that only involves phone conversation,” says Douglas Curran, MD, a family practitioner in Athens, Texas, and a member of the board of directors of the Texas Medical Association, which supports the new telemedicine rules.

According to Linkous, it is supposedly the concern about telehealth services (i.e., phone call interactions) that prompted the Texas Medical Board to make its latest rule changes. Because of other regulations put in place by the state, all of Teladoc’s telemedicine encounters in Texas are via telephone.

What’s a “relationship”? Expects the patient and doctor to have a relationship before a telemedicine consult might seem like a stick in the spokes of telemedicine, but Curran says Texas needs those rules as more telemedicine providers operate in the state. “I don’t think it’s good care that somebody who doesn’t have a relationship with patients—has never seen them or looked at their past history—treats them. They might be living in another area of the state, and we’re a big state.”

But the new Texas rules, which were slated to take effect earlier this month, permit the use of “appropriate face-to-face telemedicine” to establish a patient-doctor relationship; that initial encounter no longer has to occur in person. Instead, a trained medical professional has to be present with the patient to assist in presenting vital signs and other objective medical information. The new rule also outlaws the longstanding practice of physicians prescribing medications to a patient he or she hasn’t met before, even if that patient’s physician and the covering physician work in the same practice.

Teladoc filed a federal antitrust lawsuit to block Rule 190.8, which Teladoc officials say would actually restrict on-call physicians and extenders from covering for one another. “It is clear that the medical board acted only when Teladoc consultations became sufficiently numerous to be perceived as a competitive threat to brick-and-mortar physician practices,” Teladoc’s Gorevic says. In Texas alone, more than 2.4 million people use Teladoc services.

State regulations of telemedicine vary a great deal. A perfunctory search on the website of the Center for Connected Health Policy of the National Telehealth Policy Resource Center shows that the first four states listed alphabetically—Alabama, Arkansas, Arizona and California—specifically define telemedicine and telehealth in their regulations, whereas the next four—Colorado, Connecticut, Washington, D.C., and Delaware—do not.

Some states require medical professionals who provide telemedicine services in the state to have full licensure from that state. Others have an abbreviated process to grant licensure to telemedicine providers. Some states allow licensed professionals to cross borders without additional requirements. Gorevic of Teladoc says all the physicians who provide Teladoc services in Texas have licenses there. Texas’s rules limit direct-to-patient telemedicine encounters to professionals licensed in Texas except when a person gets most of his or her care out of state.

To simplify the labyrinth of state licensure requirements, the Federation of State Medical Boards last year issued a template to create the Interstate Medical Licensure Compact to speed the process of issuing licenses for physicians who wish to practice in multiple states. However, state participation is voluntary, and the process through which a state would ratify the compact could take years.

A few states have adopted policies similar to the restrictions that CMS has put on Medicare telemedicine, limiting reimbursable telemedicine services to rural and underserved areas and, in other areas, imposing a distance requirement between the patient and provider. Some states limit the type of facility that can be an originating or distant site, often excluding the home as a reimbursable originating site.

Hands-off approach Sixteen states have laws that mandate reimbursement for telemedicine services, but some states have taken a hands-off approach. For example, California lets plans decide if they’ll cover telemedicine (most do). The American Telemedicine Association is tracking 100 or so bills in state legislatures this year, most aiming to expand reimbursement, according to Linkous.

As for Texas setting a precedent, Gorevic doesn’t think it does and, in fact, sees momentum building in the other direction toward greater acceptance and fewer onerous restrictions. “The national trend is strongly in favor of telemedicine and views it as a safe, affordable and cost-effective option,” he says.
The multiple sclerosis medications, a specialty class of therapy that costs $5,000 to $6,000 a month, is about to get its first generic. In April the FDA approved a knockoff of the class-leading, disease-modifying agent Copaxone, which has annual sales of more than $3 billion.

When generic versions of such class leaders as Lipitor and Nexium came out, they turned formulary design on its head and put a real dent in drug expenditures. But that won’t happen in MS. The factors that allowed generics to completely dominate branded drugs in other classes simply don’t exist in MS.

Moreover, experts say that while health plans and PBMs will need to figure out how generic Copaxone fits in, they should also focus on broader issues in MS therapy.

**Limited impact**

MS is an autoimmune disease that attacks the myelin sheaths of the nerves of the central nervous system. Between 250,000 and 400,000 Americans have the disease, which is the leading cause of permanent disability among young adults.

The generic name for Copaxone is glatiramer acetate. It is a synthetic protein that is antigenically similar to myelin basic protein, a component of the myelin sheath that protects nerves. Copaxone works by blocking T cells that damage myelin. How it does so is uncertain.

One reason generic Copaxone will have a limited impact is the lack of branded me-too agents for MS, all with the same mechanism of action. When a generic comes along for a disease with lots of branded copycat drugs, it has ample opportunity to knock out some of those copycats. Copaxone doesn’t have copycats, so the pickings won’t be so easy for generic Copaxone.

Another factor is the lack of strong treatment guidelines for MS that would give a particular drug—or drugs sharing the same mechanism of action—a dominant position in the armamentarium. As a result, clinicians take many different approaches to treating MS, and some of those approaches don’t include Copaxone—or, presumably, the newly available generic,
explains Atheer Kaddis, PharmD, a senior vice president at Diplomat Pharmacy, a specialty pharmacy in Flint, Mich. The new generic kid on the block, from Sandoz, also faces some stiff competition. Teva saw the patent expiration coming, so it rolled out a patented 40-mg version that reduces the frequency of injections from daily to three times per week. The FDA approved Teva’s formulation in March 2014. Since then, the company has shifted more than 60% of its volume to the three-days-a-week version, according to Kaddis.

A market for generic Copaxone

The formularies for MS agents often include Copaxone as a preferred agent, so now it is a question of whether the generic version will get listed instead.

Currently, in highly managed formularies there is usually a preferred interferon, Copaxone, one or more of newer oral agents, and natalizumab (Tysabri), a monoclonal antibody with a unique mechanism of action, according to Kaddis. For less-managed formularies, there may be two interferons, perhaps two orals, Copaxone, and natalizumab.

Rebates are offered by pharmaceutical manufacturers for the brand-name MS therapies, Kaddis explains. The rebates are typically market-share based so additional rebates are offered if greater market share is driven toward formulary preferred therapies.

Kaddis expects there to be a solid market for generic Copaxone. An increasing number of physicians are taking on risk by participating in ACOs and other value-based care. In some of those arrangements pharmacy costs are measured, and physicians are rewarded for reducing them. Even if 60% of Copaxone sales have moved to the new three-days-a-week formulation, 40% of the volume is still open to the generic. That can result in a considerable cost savings, notes Kaddis.

Moreover, new formulary designs may be developed because of generic Copaxone, says Kaddis: “There’s the potential for health plans to implement step therapy or to provide incentives such as a fixed copay in place of a percentage coinsurance.”

<table>
<thead>
<tr>
<th>Drug</th>
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<th>Annual cost</th>
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<tr>
<td>alemuruzumab (Lemtrada)</td>
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*Approximate WAC for one year of treatment at the usual dosage. WAC=wholesaler acquisition cost or manufacturer’s published price to wholesalers. Source: Adapted with permission from The Medical Letter on Drugs and Therapeutics, May 11, 2015; Vol. 57 (1468):68.
Doctors and patients, to say nothing of biotech companies, have high hopes for monoclonal antibodies improving the treatment of MS in a meaningful way. Tysabri is gaining acceptance. Alemtuzumab (Lemtrada) was approved in November 2014, and, in April, Biogen and AbbVie announced the FDA’s acceptance of their application for daclizumab (Zinbryta).

While they are more effective than other medications at slowing relapses, the monoclonal antibodies can have alarming side effects, albeit in a very small number of patients. Tysabri has been linked to progressive multifocal leukoencephalopathy, and Lemtrada to serious autoimmune conditions. The monoclonal antibodies are also extremely expensive. Lemtrada’s price has been reported at $158,000 for two courses of therapy, although they are taken a year apart.

The National Multiple Sclerosis Society says that in many cases, health plans and PBMs focus too much on controlling costs instead of accommodating current treatment philosophies. The counterargument is that payers serve the important function of holding down costs that, ultimately, makes treatment more accessible.

There are 12 disease-modifying therapies. Often formulary designs with a limited number of drugs in preferred tiers do not allow switching among medications without incurring high copayment or coinsurance costs, says Tim Coetzee, MD, chief officer for advocacy, services and research for the MS Society.

“Relapsing patients or those with new lesions may need to switch medicines and the hurdles are significant,” he continues. “People are not switching their medications out of convenience; they are trying to control their disease activity.

“High cost share can really wreak havoc on people with MS,” Coetzee continues. “It’s not like they are shopping for a blood pressure medicine. They are trying to get their immune system under control and minimize brain damage.”

People covered by health plans sold through ACA exchanges may face the most restrictive tiering. Avalere Health analyzed 20 drug classes and found that MS agents were placed exclusively on the specialty tier more often than any other drug class but oncology. This year, 51% of the silver plans put all of the medications for MS on the specialty tier, an increase from last year when 42% did so, according to Avalere. However, patient assistance programs are very common in MS, so many MS patients pay only a fraction of the published copays or coinsurance amounts—or avoid those costs entirely.

Keeping tabs on patients

Criticizing insurers and PBMs for having a blinkered perspective—no matter what the problem—is a well-worn path. But the integrated approach that Geisinger is taking to MS treatment does seem to argue for rethinking MS treatment so it is not so narrowly focused. The Pennsylvania health care system has implemented the concept of integrated practice units for several diseases, including MS.

“It is very important that MS is identified and treated early in the onset of the disease because that is when the inflammatory component is most manageable,” says Bret Yarczower, MD, MBA, head of Geisinger’s P&T committee. To help make that happen, Geisinger has set up multidisciplinary teams. The teams coordinate patient care and keep tabs on MS patients with the goal of improving adherence and medical care of the disease.

“When we started this, we found that there were patients who hadn’t seen their neurologist in two years,” says Yarczower. “We’ve been able to change that and get patients into a routine of comprehensive care.”

Coetzee of the MS Society points out, though, that many patients may not have easy access to a neurologist.

Clearly there may be many opportunities to improve the care of MS patients. Generic Copaxone will probably be only a very small piece of a very complicated puzzle.
A low bar for market entry leaves health plans unsure of the value of devices. Adding a unique identifier for each product could help with decision making.

Many medical devices may be similar, but the value and clinical utility of each are not the same. Bob Wanovich, vice president of market strategy and delivery at Highmark in Pittsburgh, stresses that approval, regulatory, and other issues make it hard for payers to keep up with specific devices’ analytical and technical performance, which ones help providers to make better treatment decisions, and which ones should be paid for.

“Many devices are bundled together through codes,” Wanovich points out, “so you could have many different products, although similar, under a single code. That bundling, and a very low bar and regulatory process for entry into the marketplace, are big issues for payers such as Highmark.”

Payers make decisions from a policy perspective. “At Highmark, we decide what we will pay for from a benefit perspective, not a convenience aspect,” says Wanovich, explaining that a device may provide more of a convenience for the patient and the physician than a true health benefit. Highmark, he says, has a process “where we are contracting with device manufacturers or suppliers to pay for devices that are truly therapeutic.”

Unique device identification codes, or UDIs, are a potential answer, Wanovich says. A UDI is a unique numeric or alphanumeric code that identifies the labeler, which according to the FDA “is the person who causes the label to be applied”—usually the manufacturer but sometimes a specification developer, a single-use device reprocessor, or a repackager.

A UDI also lists the specific version or model of a device, and includes a production identifier, which provides such additional information as the lot or batch number, the serial number, date of manufacture, and expiration date.

“UDIs could help avoid the downward creep,” says Wanovich, “and we are generally in agreement with that because [with them] we could better control the value of the device and also get a better idea of what devices patients are really using.” The UDI, he adds, would help payers to manage both cost and value.

As for medical apps, Wanovich says, they are not considered devices and Highmark does not pay or reimburse members for their use. “We will continue to look at them and work with providers to determine their value and possible coverage.”

On May 4, in response to growing concern about poor or lack of surveillance of medical devices, the FDA and the National Library of Medicine released a medical device postmarket surveillance plan. The plan makes the development of national and international medical device registries for selected products a priority. It also creates a UDI system for medical devices. Data on devices with unique UDIs will be publicly available on the AccessGUDID (Global Unique Device Identification Database) website (http://accessgudid.nlm.nih.gov/).

Device labelers must include a UDI on device labels and packages, except where an exception or alternative exists, and submit device identification information about these devices to the FDA’s Global UDI database (GUDID). The process would also require that a UDI be directly marked on a device that is intended for more than one use or intended to be reprocessed before each use.

Because the UDI system is being phased in over the next several years, labelers currently are submitting data on only the highest-risk medical devices. But as the system is implemented, the records of all medical devices required to have a UDI will be included in the database.

Excise tax again under attack

Sponsors of the bipartisan Protect Medical Innovation Act of 2015 are again aiming to repeal the 2.3% excise tax on medical devices. The tax was enacted as part of the ACA to help pay for health care reform initiatives.

The Advanced Medical Technology Association (AdvaMed), the device lobbying group, also has made repeal of the tax a priority. Under the ACA, imposition of the tax on the sale of any qualifying medical device by either the manufacturer or the importer began in 2013. The tax is levied on the wholesale price of a device, not the price paid by the end user, and does not apply to eyeglasses, contact lenses, hearing aids, wheelchairs,
or any other medical device that is available at retail for individual use. Sales for further manufacture or export are also tax-exempt.

Proponents say that under the ACA, demand for medical devices has increased and that the tax does not affect innovation. Repealing the excise tax would cost $26 billion between 2015 and 2024, and because the ACA is specified by law as budget-neutral, Congress would be required to offset the loss by increasing other taxes or reducing spending. President Obama has threatened to veto any legislation that would defund the ACA. Preliminary data show that the tax raised $913 million in the first half of 2013.

In November 2014, a Congressional Research Service report showed the tax would result in a 0.2% decrease in device industry jobs and output.

—Katherine T. Adams
Biogen’s aducanumab raises hope that Alzheimer’s can be treated at its source

By Krishna Rutvij Patel

The current armamentarium against Alzheimer’s disease consists only of drugs that provide symptomatic relief, and the benefits are modest at best. Medications that can stop, slow, or prevent the underlying pathophysiology of Alzheimer’s disease are desperately needed.

Several companies have developed drugs that act against β-amyloid plaques, which are thought to play a central role in causing Alzheimer’s, only to see them falter in late-stage clinical trials. In fact, some have questioned whether β-amyloid plaque is the right target for treatment drugs. So it caused quite a stir earlier this year when Biogen presented encouraging data from an interim analysis of a phase 1b trial of aducanumab, a high-affinity antibody against β-amyloid, at the International Conference on Alzheimer’s and Parkinson’s Diseases in Nice, France. Based on these results, Biogen plans to start a phase 3 trial of aducanumab later this year.

The multicenter, randomized, double-blind, placebo-controlled study involved people with prodromal or mild Alzheimer’s who were, on average, between 70 and 74 years of age and were confirmed to have β-amyloid plaques using a florbetapir positron emission tomography (PET) scan. One hundred sixty-six subjects were randomized into 1 of 5 treatment groups (placebo, 1 mg/kg, 3 mg/kg, 6 mg/kg, and 10 mg/kg of aducanumab) for 52 weeks.

Change in SUVR

Sources: Sevigny J et al., Neurodegenerative Diseases, March 2015; Sevigny J et al., 12th International Conference on Alzheimer’s and Parkinson’s Diseases and Related Neurological Disorders, March 2015; Biogen news release, March 20, 2015

Reduction in amyloid plaque, as measured by the Standard Uptake Value Ratio (SUVR) of florbetapir, was seen at 26 weeks with further reductions at 54 weeks. With the mean baseline SUVR value between 1.4 and 1.5 among all the study arms, the mean composite SUVR in the highest dose arm was about 1.175 by Week 54 (in healthy people, SUVR is <1.13). Importantly, in addition to the significant reduction in amyloid plaque measurements, aducanumab was also associated with a slower rate of cognitive decline, as measured by the Mini-Mental State Examination (MMSE) and Clinical Dementia Rating Scale-sum of boxes (CDR-sb) scores.

The phase 3 trial has been designed to include more than 1,000 patients. The failures of other β-amyloid drugs are recent enough to guard against unbridled optimism. But if aducanumab were to make it to market, it would be a major advance to have a disease-modifying drug for Alzheimer’s disease.

Krishna Rutvij Patel, PharmD, is a clinical services manager at MediMedia Managed Markets. She is an adjunct faculty member of the Philadelphia College of Pharmacy and a 2012 graduate of the school.
The ACO Gamble

It has been tried again and again. But government and private payers are wagering on ACOs as a way to hit the health care jackpot: managed costs and high quality.

By Robert Calandra

When HHS announced the launch of the Pioneer ACO Model program in 2011, naysayers were quick to predict that these risk-bearing newcomers would fizzle and possibly end up on the scrap heap with other assorted health care entities, programs, and policies sporting forgotten acronyms and initialisms.

At first, it looked as if the doubters might be right. ACOs, much like the ACA that helped bring them into being, stumbled out of the blocks (although to be fair, CMS and many commentators had a more positive spin). Nine out of the original 32 Pioneers dropped out of the program, and only 13 organizations beat their financial benchmarks by enough to earn shared savings payments. First-year results for the Medicare Shared Savings Program ACOs were more encouraging but hardly wrapped ACOs in glory. About half (54 out of 114) of the participating organizations beat their financial benchmarks, but only a quarter (29 out of 114) beat them by enough to get shared savings.

The vibe wasn’t all bad by any means. Commercial insurers were eagerly hopping on the ACO bandwagon. But as is so often the case with trendy developments in American health care, definitional fuzziness was—and remains—a problem. It was hard to figure out what was really going on when the ACO mantle was thrown over almost any payer–provider arrangement that shifts financial risk onto providers. Separating frothy aspirations and good public relations from reality is difficult when commercial payers don’t need to publicly report their ACO results, the way CMS—as a government payer—does.

ACOs are now players

But four years after the Pioneer program began, the transformation of ACOs from unfamiliar, unproven curiosities to important players in the delivery and financing of the most expensive health care system in the world is well underway. Two studies showed that the Pioneer ACOs actually did pretty well in reaching financial and quality goals (see sidebar on page 23). In March, the CMS Innovation Center—an ACA-created skunkworks for federal government health care programs—unveiled the Next Generation ACO Model program as a successor to the Pioneer program. Designed with the expectation that only about 20 organizations would participate, the new program will experiment with dangling incentives in front of beneficiaries to use ACO-affiliated providers, including the possibility of waiving the Part B deduct-

ACOs: What are they?

ACOs are provider-led organizations that have taken on some degree of financial risk for the cost of health care while also meeting quality standards. The amount of risk and the payment mechanism varies, ranging from modest pay-for-performance contracts to shared savings (and losses, if it’s two-sided risk) to full capitation. Financial risk and quality metrics are supposed to work as incentives to coordinate care, improve health information technology, and make other advances. Some ACOs were started from scratch, but many are simply existing provider organizations that have signed contracts with payers that involve taking on financial risk.
ible and coinsurance and making direct payments of up to $50 per year (research has shown that even small amounts of money can nudge people into making certain health care choices). The Next Generation ACOs will also have the option of moving to a capitated payment mechanism, whereby the providers submit claims to CMS as they ordinarily would, but the ACO, not CMS, is in charge of making the payments out of the per-beneficiary, per-month (PBPM) payment it receives from CMS (see diagram below).

Meanwhile, the process of generating new regulations for the Shared Savings Program has been slowly grinding away in the background. Under the rules finalized earlier this month, CMS will create a new Track 3 in the Shared Savings Program that will require participants to take on two-sided risk, which means facing the possibility of having to make a “shared losses” payment to the government if the ACO spends more than its financial benchmark, not just the upside risk of shared savings if it spends less. In exchange for taking on this downside risk, Track 3 ACOs will get 75% of shared savings, a larger cut than what other ACOs in the Shared Savings Program receive. ACO mavens see Track 3 as a successor to the Pioneer program, in which ACOs also shoulder two-sided risk.

The fact that the Shared Savings regulations are taking so long to finalize has furrowed some brows. Still, the new regulations, along with the Next Generation model, have put everyone who knows and cares about the details of health care on notice that the federal government is betting big on ACOs.

Multiple contracts
The commitment from the commercial sector isn’t quite as strong, but private insurers are also definitely at the ACO table. By Oliver Wyman’s count, there are now more than 580 ACOs in the country, and about three quarters of them are Medicare ACOs. But as the consulting firm points out in a research report it issued in April, drawing a sharp distinction between Medicare and commercial ACOs is misleading because most ACOs participating in the CMS programs also have contracts with commercial insurers and serve non-Medicare patients. In that way, ACOs are like any other providers that accept payment from private payers as well as Medicare and Medicaid. In fact, Wyman estimates ACOs in the CMS programs are responsible for 35 million non-Medicare patients.

Leavitt Partners, the health care consulting firm founded by Michael Leavitt, the former governor of Utah and HHS secretary under President George W. Bush, has been tracking ACOs since 2010. In May, Leavitt published an impressive array of reports on ACOs from different perspectives—that of employers, hospitals, physicians, payers. The firm teamed up with different partners—the National

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**How the Next Generation money might flow**
CMS has suggested several different payment mechanisms for Next Generation ACOs. Population-based payments and capitation are two of them.

**Population-based payments**

- All other Medicare providers
- Next Generation affiliates
- Next Generation preferred providers
- Next Generation providers/suppliers

CMS will pay the ACO a monthly PBPM payment with which the ACO pays Next Generation providers/suppliers according to written agreements.

**Capitation**

- All other Medicare providers
- Next Generation affiliates
- Next Generation preferred providers
- Next Generation providers/suppliers

CMS will continue to pay FFS claims for noncapitated entities as normal.

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Source: CMS, Next Generation ACO Model Request for Applications.
Business Group on Health, the American Hospital Association, the AMA, the Blue Cross Blue Shield Association—to produce the report, and the Robert Wood Johnson Foundation provided financial support. This publishing effort speaks not only to the breadth of interest in ACOs but also to their Rashomon effect: People see them differently depending on where they sit in the health care system. As far as the counting game goes, Leavitt Partners’ tally is 744—considerably larger than Oliver Wyman’s and thus a reflection of the blurriness of the ACO definition outside the CMS programs.

But perhaps more important than the number of provider organizations hanging the ACO shingle is the number of payers willing to sign on the ACO dotted line and then send payments to these organizations. In the report on health insurers and ACOs that it developed with the Blue Cross Blue Shield Association, Leavitt Partners says public information shows that 136 unique payers have entered into accountable care contracts. Of these, 117 are commercial payers, and 19 are government payers (CMS is the main government payer but state-run Medicaid programs are also busy signing ACO contracts).

Keeping tabs on the number of ACO contracts a provider organization has signed is a good way to gauge the momentum and staying power of ACOs, according to David Muhlestein, senior director of research at Leavitt Partners and coauthor of all six of the company’s ACO reports. Provider organizations often moved gingerly into becoming ACOs, beginning with a pilot project of some kind, he explains. But if after gaining some experience they sign additional contracts, Muhlestein says, that’s an indication they feel confident about ACOs and their fundamental proposition—possible financial reward in exchange for shouldering some financial risk while meeting certain quality standards. In 2014, 40.5% of the contracts signed by provider organizations were additional contracts (their second, third, fourth, and so on), compared with 31.9% in 2013 and 21.7% in 2012.

**Getting out of the ACO conundrum**

It’s not hard to assemble a cheerleading section for ACOs these days, and the naysayers are pretty much keeping their counsel. Understandably, consultants are among the biggest fans (it’s been said, but the joke is worth repeating: ACO may stand for “amazing consulting opportunity,” not “accountable care organization”).

“What we’re seeing now is ACO 2.0,” says Dennis Butts, director of value transformation at Navigant Healthcare, a business services and management consulting company in Chicago. “We’re moving toward a model that brings the right providers to the table to be more successful for the given populations they are beginning to manage.”

More praise: “I don’t think there is another model of health care where all the incentives align,” says William Bithoney, MD, a managing director with BDO Consulting and chief physician executive for the company’s health care practice. “The hospitals do well when the patient is healthy. The physicians do well when the patient is healthy, and the patient does well by definition. I can’t name another model where the triple aim is so beautifully incented than the ACO.”

And a prediction: “If you are not investing in this trend and momentum, you are going to be left behind,” says Eric Heil, cofounder and CEO of RightCare Solutions, a Philadelphia company that makes software.

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**Number of non-Medicare patients cared for by ACOs in CMS programs**

In millions

<table>
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<th>Year</th>
<th>2013</th>
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Source: Oliver Wyman, ACO Update: A Slower Pace of Growth, April 2015
that risk-stratifies patients. “The major national health systems are moving headfirst into value-based ACOs. So this is clearly the direction we are headed in.”

But ACOs can’t make the mistake of believing their own publicity. The math of ACOs remains difficult and sets up conflicting motivations. On the one hand, these are provider organizations that still realize much, if not most, of their revenue through fee-for-service payment mechanisms. The forces of volume and “heads in beds” are still at play, especially for the Medicare population. On the other hand, their ACO contracts use financial benchmarking, shared savings, and the various shades of capitation that are designed to work against fee-for-service payment and the culture of more-is-better health care it engenders. So to some extent, it’s a-damned-if-you-do, damned-if-you-don’t scenario. If providers succeed as ACOs, they might hurt themselves as organizations that depend on fee-for-service revenue.

There are a couple of ways out of this conundrum. Payers can make ACO incentives rewarding enough to offset fee-for-service payments and incentives. If shared savings are the payment mechanism, payers must set financial benchmarks that are ambitious yet obtainable and shared savings percentages that are sufficiently generous. One of the points of contention in the new Shared Savings regulations was CMS’s proposal to cut the shared savings rate for Track 1—the track that has only upside risk—from 50% to 40%. CMS backed down and agreed to keep it at 50%.

Another way out of the conundrum puts the onus on the providers: They have to excel at being ACOs. That means providers must play an A-game at managing costs while also hitting quality metric marks—the sine qua non of enjoying the fruits of their cost-management labors and getting a cut of whatever money is saved. The tools in the cost-management

"We’re moving toward a model that brings the right providers to the table to be more successful for the given populations they are beginning to manage," says Dennis Butts of Navigant Healthcare.

Pioneer ACOs get props for financial, quality results

The Pioneer ACO Model program has gotten some bad press. A significant number (13 of 32) have dropped out of the program, and under half (13 of 32 in 2012 and 11 of 23 in 2013) have earned the shared savings payments that are supposed to animate the program, so providers work to lower spending while maintaining a high quality of care.

But the Pioneer program has enjoyed a very good spring. Two high-profile studies, one in the New England Journal of Medicine by Harvard researchers and the other in JAMA by CMS officials, painted a rosy picture of the first two years of results.

And in April, both the GAO and the CMS Office of the Actuary came out with upbeat reports and, importantly, the actuary certified that the program could be expanded because it reduces the federal government’s health care bill or, at the very least, keeps it level.

This is not to say that there aren’t some clouds on the horizon. It’s clear from these reports that the results for the first year were better than those for the second year. That raises questions about how the Pioneer ACOs will do over the long haul.

What’s more, some of this early success may be a matter of the program having financial benchmarks that were relatively easy for some organizations to meet. According to the GAO report, the Pioneer ACOs that received shared savings payments from CMS started with financial benchmarks that were about $1,100 higher per beneficiary compared with those ACOs that did not generate shared savings. The benchmarks are based on past spending patterns, so in some cases they may favor high-spending provider organizations.

Still, the takeaway is that the Pioneer ACOs have been successful at managing cost with no apparent decline in quality. The Harvard researchers found that during the first year of the program, the per-beneficiary, per-month cost of the Pioneer ACOs was $29.20 less per quarter than the costs of a comparison group.

The CMS researchers confirmed and amplified what the Harvard researchers reported. In their reckoning, the PBPM costs of the Pioneer ACOs was $35.62 less than a control group in 2012 and $11.18 less in 2013. Most of the savings came from reducing hospital inpatient care.
toolbox are familiar enough: care coordination, narrow networks, patients who are aware and sensitive to cost, IT in sundry manifestations. "You are seeing a lot more investment in case managers and IT infrastructure to really allow ACOs to manage a population," observes Butts, the Navigant Healthcare executive. Heil, at RightCare, says that the more personalized the technology—patient portals, engagement apps, remote monitoring—the more engaged people will be. And if all the research on engagement is correct, that will lead to lower costs, which is good news for ACOs.

Veterans of the '90s managed care wars may grit their teeth (or roll their eyes) when they hear all the happy talk about ACOs coordinating care and engaging patients. Haven't we seen this all before? As Muhlestein, at Leavitt Partners, and others have pointed out, it's not just the tool but who is wield- ing it that matters—and with ACOs, providers are wielding them, not payers. "It is very different when it comes from the provider," Muhlestein says. The other major edge that ACOs have over the payer-driven managed care of two decades ago is cheaper, faster, and better-connected information technology. The technological infrastructure needed to continually measure quality and monitor cost just didn't exist in the previous era, notes Muhlestein. Today's technology also means provider organizations can ramp up to take on the responsibilities of managing care at a speed that would have been unimaginable before. But just because it's cheaper doesn't mean it's cheap. According to a National Association of ACOs survey of its members, the average first-year startup cost for an ACO is $2 million (granted, not all of that is IT), and the average operating cost in subsequent years is $1.5 million. That's not much money for a hospital system, but for the small or midsized physician group, it is. Regardless of the relative effect on budgets, setting up shop as an ACO does create another layer of costs for providers that cuts into shared savings and other financial carrots that payers might use.

**Speed bumps, not stop signs**

At the end of this month, health care as we have come to know it under the ACA may be upended. If the Supreme Court rules in favor of the plaintiff in *King v. Burwell*, the tax subsidies for purchasing health insurance may end in many states, and thus the ACA's main purpose—expanding health insurance—would be thwarted. A ruling against the administration is likely to put a damper on all things related to American health care reform. It won't, though, have any direct bearing on ACOs. Heil says he expects bumps in the road as ACOs continue to evolve, and the Supreme Court's ruling might be one of those bumps. "But there is enough momentum," continues Heil, "particularly with commercial payers who are much farther down this path, that a negative ruling will cause some delays—but ultimately, change is happening."

A problem more integral to ACOs is changing the risk arrangements so that ACOs are taking on both up- and downside risk. The thinking is that carrots without sticks may not be all that effective—in other words, without the possibility of being penalized for exceeding financial benchmarks instead of just being rewarded for beating them, ACOs will not bring down spending enough. Also at issue is the ideal of accountability that gave ACOs their name. Exposing providers to downside risk holds them accountable for the cost (and quality) of health care in a way that upside risk alone does not. But the providers participating in the CMS's Shared Savings program have avoided downside risk like

### Payer-reported ACO, ACO-like, and other value-based payment arrangements

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<tr>
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<td>900</td>
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<tr>
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<td>$38</td>
<td>520</td>
<td>11 million</td>
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the plague. By CMS's count, just three choose Track 2 and two-sided risk compared with the 401 who elected to be in Track 1 and face only upside risk.

CMS is trying to induce more organizations into two-sided risk by creating the new Track 3. It remains to be seen how many organizations can be lured into trying it. Why the reluctance? Judging from comments on the new regulations, even gung-ho ACOs feel that investing in the staffing and infrastructure needed to be an ACO is risky enough. Also, memories of the '90s die hard. Here is an excerpt of comments by Trinity Health, a health care system in Livonia, Mich., on the new Shared Savings regulations when the regulations were at the proposal stage: “It would certainly be easier for CMS to have all ACOs move to tracks with downside risk exposure. However, the reality of the provider marketplace is that as a result of the managed care experience of the '90s, many providers, both hospitals and physicians, view downside risk as an absolute contradiction to being in the program.”

Public relations may be the biggest problem facing ACOs. They are hard to understand and even more difficult to explain, and that’s partly because the ACO label gets slapped on so many different types of payer-provider arrangements. The National Committee for Quality Assurance is considering accrediting ACOs, as they do with patient-centered medical homes. That might help clarify what counts as an ACO and what doesn’t. It might also help businesses get behind ACOs. The Leavitt Partners report says a survey of larger employers found that while 26% had health plans that included ACOs, only 1% used incentives to encourage employees to use ACO-affiliated physicians.

You don’t need to poll to know that the public has little if any understanding of ACOs. Even in rarefied health wonkery circles, ACOs are a niche interest. But ACOs may soon start to leak into the public consciousness—at least the name, if not a full understanding. CMS has proposed that Medicare beneficiaries be allowed to “attest” that they want their care coordinated by an ACO. The Next Generation ACO waivers of Part B deductibles and coinsurance may also boost their name recognition. But do we really need to fret about the fact that the public doesn’t understand or even know about ACOs? Muhlestein doesn’t think so. He compares ACOs to the operating systems on our computers, laptops, and phones. Do we need to understand how they work? No. It’s the applications that we care about and use. “Let consumers focus on what they can understand—narrow networks, cost, some quality measurements,” says Muhlestein. “We shouldn’t try to drag people into payment models.”

Robert Calandra is a freelance writer in Philadelphia with more than 20 years of experience writing about health care.

Did you miss?

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Donald R. Fischer, MD, MBA
James C. Robinson, PhD, MPH
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Lucian Leape, MD
Lee N. Newcomer, MD, MHA
F. Randy Vogenberg, PhD, RPh
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Are confusing, repetitive, jargon-ridden communications souring your member relations? Take a look at how Medica, a Minneapolis health plan, is tackling the problem.

By Timothy Kelley

You gotta grab 'em with your “lede.” Every journalist knows that, and Medica, a not-for-profit health plan in Minneapolis, found it out too. That’s why, in revising a letter it had been mailing to members, it decided to junk the snooze-inducing first few words.

Under the headline “HEALTH BENEFIT PLAN CERTIFICATION OF COVERAGE,” the letter had greeted envelope-opening recipients with the words “The Health Insurance Portability and Accountability Act of 1996 (‘HIPAA’) requires health plans to provide former participants. . . . ”

By then, of course, many of the letters had likely hit the wastebasket or recycling bin. Which was too bad, because one of the main things about this “certification,” as the letter went on to say quite a bit later, was that the plan member was supposed to hang on to it.

“The most important point was highlighted two-thirds of the way through the letter,” marvels Larry Bussey, Medica’s director of corporate communications.

But happily, Medica has given that missive a makeover. The new version greets the member by name under the headline “Important: Keep this Certificate of ‘Creditable Coverage’ or Proof of Coverage.” And the boldfaced opening sentence is clear and plain spoken: “This letter is proof that you had health insurance from Medica.”

The letter’s about-face was part of a concerted effort at Medica to improve written and oral communication with its members. Called Speaking Medica, the program’s goal is to make the health plan’s communication as clear, friendly, and jargon-free as possible. Two years on, Medica is still learning, but it has started on a path that other health plans may wish to travel.

“As health care becomes more commoditized, service becomes the differentiator,” says Lynn Altmann, Medica’s vice president of talent management, whose role in the company’s plain-language initiative began in her previous post as vice president of operations and commercial member experience. “Members have a hard time understanding the ins and outs of how to manage and use their health plan,” she says. “It’s up to us to help make sure they know how to do that effectively.”

Feeling of cookies

Medica began its plain-language initiative by doing a needs assessment to figure out what consumers wanted in their relationship with a health plan. It retained a Minneapolis research firm called Experience Engineering to help with what are called “metaphor elicitation interviews.” Medica members were called at random from a demographically balanced cross section of the health plan’s membership.

Those who agreed to come in for an hour-and-a-half interview in exchange for a $100 stipend were asked to bring pictures clipped from magazines or other sources that illustrated how they wished to feel about their health plan. Participants brought, for example, images of safety nets and sports teammates to suggest the notions of support and partnership.

“One woman brought in a picture of chocolate chip cookies to symbolize the feelings of security and familiarity that her mom’s chocolate chip cookie recipe evoked for her,” Bussey recalls.

Then, in the summer of 2013, Experience Engineering, a Minneapolis company that advises businesses on ways to improve customer service, helped the health plan assess the performance of its call center reps by analyzing hundreds of calls. The challenge of improving call center communications seemed to pull Medica in opposite directions—toward more control of what the reps said on the phone (to make sure they conveyed an appropriate message and attitude) but also toward less (so reps would come off as warm and responsive helpers rather than script-reading automatons).

Another difficulty: Some reps had long-established patterns of how they interacted with members. The company had to find creative ways to change their behavior.
April 4, 2013

Sandy Jones
4567 Taylor St. NE
Minneapolis, MN 55423

Important – Keep this Certificate of “Creditable Coverage” or Proof of Coverage

Dear Sandy,

This letter is proof that you had health insurance from Medica. It’s important that you keep it in a safe place so you can show it, if needed, when getting new health insurance.

Why you need this certificate:
You may need to show this letter if you had medical advice, a diagnosis, treatment or prescription drugs for a condition within six months before enrolling in a new health insurance plan.

When you change your health insurance, some health plans may not cover health problems you had before joining the new plan. This is known as the pre-existing condition exclusion period. The new plan may also require a period of time (known as the “waiting period”) before it will pay for services for pre-existing conditions. With this letter as proof of coverage, the new plan may cover the conditions or shorten the waiting period.

If you become covered under a new group health plan
Check with your plan administrator or employer to see if you need to give them a copy of this certificate.

Have Questions?
If you have additional questions about why you received this certificate or believe any information in this form is not correct, please contact Customer Service at 1-xxx-xxx-xxxx.
Jargon can be hard to part with.
To the person using it, complicated language can seem more precise.

The takeaway from the research by Experience Engineering and the health plan was that members wanted to feel “understood, assured, and unconcerned.”

One of these innovations was the monthly buzz phrase. Group leaders choose a new phrase or statement that typifies the empathy and clarity they seek. Throughout the month, reps are encouraged to work those magic words into their phone conversations—one statement, for example, was “I want to make this simple for you.” When a rep is overheard using the phrase of the month, his or her name is put into a hat for a weekly drawing for a small reward, such as a store gift card.

“You want to be ‘caught’ using the phrase,” says Altmann. “You know you won’t be caught every time, but you get rewarded when you are.”

The leaders also tapped the call center reps for ideas. The centers began having thrice-weekly “huddles” in which reps shared the strategies they’d created for developing a connection with callers and making complex information clear to them. On the theory that the best way to convey knowledge is to draw on one’s own genuine understanding, Medica gave reps the go-ahead to leave the acronyms and lingo behind and use their own words.

“We empowered them to explain things to the consumer based on their own personal understanding instead of using legalese or jargon—whether that meant using an analogy, breaking a concept down into parts, or whatever,” says Altmann.

Call center reps began, for example, to describe the base benefit as “a pot of money the employer gives us” and to liken preventive care to regularly changing the rotors and brake pads in your car. “Deductibles and premiums are like a seesaw,” they’d say, coaching a member on how to compare one coverage option with another. “When one goes up, the other goes down.”

A benefit of the call center initiative, Bussey explains, was to help the health plan “identify where members were experiencing the most confusion or frustration.” Such areas—referrals, preventive care, and out-of-network benefits, for instance—could then be given special attention.

It helped that the call center effort had a natural ally in the executive suite: Dannette Coleman, the company’s senior vice president of individual and family business, had started her Medica career more than two decades ago as a call center rep.

Individual and family business became the focal point of the company’s overhaul of its numerous written communications—like that “certification” letter. Under Coleman’s leadership, Medica had introduced a new technology for enrollment and claims processing for that business segment. The changeover offered a chance to take a fresh look at communications.

“It was a unique opportunity to look at once at every written communication the company regularly sent out—enrollment letters, explanations of benefits, claim letters, denial-of-appeal letters, newsletters, and so forth—and rewrite them all to make them more clear, direct, and understandable,” says Altmann. Medica is now doing a similar review of its communications in its commercial, Medicare, and Medicaid segments.

One thing the health plan has learned is that it was simply sending out too many letters. Of 375 letters in the individual and family business segment, 200 were eliminated.

Medica scrutinized the remaining letters—in many cases, forms to be completed and personalized with a consumer’s specific information—to be sure they were consistent with its goal of making members feel “understood, assured, and unconcerned.” To do so, it established a 10-member Communications Review Board, with members from different departments across the company. Initially, it was a fairly major time commitment; members convened for two-hour sessions twice weekly.

Altmann and Bussey both serve on this board, along with a call center director, a senior director of information technology, and the vice president of communications for the commercial segment. A lawyer is always present because regulatory requirements are frequently involved. If the communication relates to a specific clinical area, a doctor or nurse may also sit in.

Delivering bad news

“The writers who have developed a letter draft will present it, and we’ll go over it for clarity and consistency—for the use of a common glossary of terms, for example,” says Altmann. Adds Bussey: “We try to make the meetings fun. The first time people come, they perhaps feel a bit overwhelmed.”

The board meetings do double duty, Bussey explains. The text in question is improved, and the company’s writers and editors get trained in how to communicate clearly so that their future work needs less revision. The board uses a checklist approach to evaluate a document, using a series of questions: Does it clearly explain the step Medica is taking, what the member needs to do, and how to do it? Does it explain the why? Does it eliminate jargon? Is it written at an eighth-grade level? A text’s...
grade level is evaluated using the “Show Readability Statistics” option that comes with Microsoft Word.

The review process often requires thinking outside the terminology in which even public relations professionals spend their days. An early draft of a reminder letter aimed at members who didn’t appear to be refilling their prescriptions used the word adherence, recalls Bussey: “But that term isn’t part of most people’s everyday vocabulary. It was changed to ‘taking your medicine.’”

Letters that touch on painful topics or that give recipients bad news are a challenge. “We’ve had letters for members who have lost a baby,” says Bussey. “And recently we reviewed a letter to someone who didn’t understand that he or she had gone out of network and was therefore being charged out-of-network rates.”

“Our task in cases like that,” says Altmann, “is to make sure we always address the recipient respectfully—not in cold, transactional language. We present other options, if possible, to help the member make sure such a mistake doesn’t recur and always to keep in mind that this is a person we’re talking to.”

Outsider’s perspective
To test the effectiveness of its effort to make its communications member-friendly, Medica also established an informal external review process using volunteers—some with family connections to Medica employees—who were communications-savvy but didn’t work in the health care or insurance industries. These reviewers received drafts of proposed messages to members and were asked to comment—brutally if need be.

“Sometimes when we thought we’d made something as simple and clean as possible, we’d get it back and it would say, ‘Don’t understand what you’re trying to say in the first paragraph,’” Altmann remembers. “And we’d be like, ‘Really?’ But it’s because we live and breathe this stuff every day.”

One of the external reviewers, Andy Ringgold, says he often thought he was reading rough drafts—but wasn’t. Retired from a career with the National Park Service, where he says he had a reputation as the “editor from hell,” Ringgold says communications from health care companies need to be clear and should always list a contact person with a phone number. And if possible, “They shouldn’t sound like they’re from Big Brother.”

Have Medica’s efforts to clean up its communications been worth the investment of staff time and other resources? The health plan has no return on investment figure but says other indications are encouraging. Last year, the first full year of the Speaking Medica program, phone conversations with Medica’s call center reps had an average “satisfied” rate of 4.59 out of 5.0, the best in the company’s history. Through 2014, Medica’s CAHPS rating in surveys by AHRQ have risen annually for five years running. (In somewhat plainer language, that’s the Consumer Assessment of Healthcare Providers and Systems rating from the U.S. Agency for Healthcare Research and Quality.)

Anecdotes aren’t evidence, but they send a positive signal. A member who commented on the call center volunteered that the Medica rep he had spoken with had used “plain language” without even being prompted with the phrase. A public radio call-in show about people’s health insurance hassles drew a Facebook comment from someone who declared that “my [renewal] letter from Medica gave me all sorts of information, and it was great.”

As for their advice to other health plans interested in launching plain language initiatives, Altmann and Bussey caution that jargon and complicated language are often hard to part with. In any field, people get attached to jargon because it is efficient. To the person using it, complicated language can seem more precise.

“We didn’t get lots of resistance, but there were pockets of it,” says Altmann. “When we tried to break things down to an eighth-grade reading level, some people would complain, ‘That doesn’t sound formal enough. Why would we say it that simply?’”

Timothy Kelley, a senior contributing editor, was editor of Managed Care from 1995 to 1997.
There was a whole world of hurt out there in the mid-’90s. Chronic pain—the kind of pain that lasts for months and interferes with daily functioning—wasn’t being treated very well. Pain was underrated as a health problem. Physicians were justifiably concerned about patients becoming addicted. A defensive mindset might have been part of the problem: Physicians and hospitals didn’t want survivors to sue them for giving loved ones too much medicine.

Then some pharmaceutical companies started promoting new opioid formulations for chronic pain conditions. Critics say their marketing grossly downplayed the dangers of opioids while overselling their benefits, and lawsuits against some of the companies are wending their way through the courts.

Now we are in what the CDC is calling, with ample justification, an epidemic of deadly prescription drug overdoses, many of them from opioid medications, a group that includes hydrocodone, oxycodone, oxymorphone, and methadone.

“Where we once had one public health crisis—unrelieved pain—now we have two,” says pain expert Steven D. Passik, PhD, vice president of clinical research and advocacy at Millennium Health Institute, a health data analytics consulting company in San Diego.

At what cost pain relief?

Pain is usually transitory, but chronic pain is now recognized as a real phenomenon. Often there is an initial provocation—a wrenched back, for example—and the pain persists after it is over. Other times there is an underlying cause like cancer or arthritis that regularly “feeds” the pain. But sometimes there is no discernible reason for the pain but it continues anyway. A 2011 Institute of Medicine report estimated that 100 million Americans suffer from chronic pain, and that the direct costs for medical treatment and indirect costs from lost productivity add up to over $600 billion each year.

Meanwhile, the Coalition Against Insurance Fraud, a group that includes insurers, government regulators, and consumer groups, estimates opioid abuse costs over $70 billion each year.

The death toll from opioid abuse is enormous. In 2012, the last year for which data are available, 16,007 (39%) of the 41,502 American deaths from drug overdoses were from opioids. Consumption of opioids quadrupled between 1999 and 2012, and the age-adjusted death rate from overdoses tripled during that period.

Making matters worse, opioids are often prescribed in dangerous combinations with other medications. In a report titled Nation in Pain issued late last year, Express Scripts, the country’s largest PBM, estimated that almost 60% of Americans taking opioids on a long-term basis had a prescription for another drug that could be dangerous when taken with an opioid medication (the company arrived at national estimates by extrapolating from its claims data).

Express Scripts’s data also shows that once someone starts taking opioids on a long-term basis, there is a good chance that they will continue to do so for years. According to the PBM, nearly half (46.9%) of the new opioid users who take the pain medication for more than 30 days during the first year of use continue to
take them for three years or longer. What’s more, roughly half of those long-term users are taking short-acting opioids, which may make them even more susceptible to addiction.

There are some bright spots in this otherwise grim picture. The rate of increase in opioid overdoses has notably slowed in recent years; in fact, the number of deaths from opioid overdose declined by 5% from 2011 to 2012. Many states have implemented polices that require providers to check databases of prescriptions for controlled substances before they prescribe certain medications. The checks are supposed to make them aware of patients who might be abusing opioids and other potentially dangerous medications. Last year, over the objections of pharmacist groups, the federal Drug Enforcement Agency (DEA) moved all hydrocodone drugs from Schedule III to the more restrictive Schedule II, which, among other things, means prescriptions for hydrocodone products can’t be phoned in.

Health plan efforts

Most of the blame for the opioid abuse epidemic has been directed at the companies that make and market the drugs. But private and government payers have also been criticized for, at the very least, not doing enough to stop it. Stingy coverage of a more integrated approach to chronic pain management means doctors are more apt to depend on opioid prescriptions, say the critics. There’s also been some finger pointing at formularies that put tamper-resistant opioids on more expensive tiers and impede access to the buprenorphine–naloxone combination (Suboxone) used to treat opioid addiction. The GAO and Pro Publica, the not-for-profit investigative journalism organization, have published reports critical of the CMS and its Medicare Part D program for allowing dangerous prescribing practices, including excessive prescription of opioids.

But if you are part of the problem, you can also be part of the solution, and health plans have been taking steps to rein in rampant opioid prescribing. For instance, Aetna implemented a misuse, waste, and abuse program involving clinical pharmacists, care managers, and behavioral health clinicians. The program coordinates efforts across departments to encourage safe prescribing, identify members at risk, and provide appropriate support to fight addiction.

“When an opioid pharmacy claim overlaps with a buprenorphine pharmacy claim, we notify the prescriber within 48 to 72 hours by fax,” explains Celynda Tadlock, PharmD, vice president of Aetna Pharmacy Management. “An Aetna pharmacist then calls the provider three days following the fax notification. Ultimately, we want the provider to contact the member to stop continued opioid use.”

Anthem identifies members who have filled 10 or more prescriptions for controlled substances within a three-month period. (Members with cancer or multiple sclerosis are excluded.) Over 61% of the members identified had a reduction in the number of opioids after the intervention.

CeltiCare Health Plan in Massachusetts looks at providers’ prescribing practices and the percentage of their prescriptions that are controlled substances. Outliers are flagged for educational outreach, typically starting with a letter or phone call sharing the data that compares their prescribing practices to those of their peers.

“We can and do refer them to our behavioral component for face-to-face education,” says Robert LoNigro, MD, CeltiCare’s chief medical officer. Of course, physicians are given a chance to explain their prescribing patterns. CeltiCare is exploring additional programs, including a hot line for providers to obtain real-time information about opioid prescribing and

Some states have more painkiller prescriptions per person than others

Source: CDC

<table>
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<th>Number of painkiller prescriptions per 100 people</th>
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<th>72–82.1</th>
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risk-modeling tools to help them identify which of their patients might be at a higher risk for misusing opioid medications.

Blue Cross and Blue Shield of Massachusetts spotted a problem in its claims data about three years ago when it became clear that a small percentage of its members were being prescribed a disproportionate share of opioid analgesics, says Tony Dodek, MD, the plan’s associate chief medical officer. The insurer introduced a program—developed with an outside panel of physicians, pain experts, and addiction specialists—to reduce the volume of opioid prescribing while protecting those members with legitimate treatment needs. Steps include limiting the supply of short-acting opioid analgesics to two 15-day periods over two months (with some well-defined exceptions) and requiring providers who prescribe long-acting opioids to start with short-acting medications. Dodek says his company also began sending prescribers reports that list their patients for whom they have prescribed opioids. During the first 18 months of this effort, called the Prescription Pain Medication Safety Program, prescriptions for short-acting opioids fell by 20%, and prescriptions for long-acting ones fell by 50%.

Health insurers who document how they deal with the opioid abuse problem are performing an important public service, says Tamara M. Haegerich, PhD, of the National Center for Injury Prevention and Control. “We looked at the whole body of literature, and I think it’s important to note that there’s a lot we don’t know about the effectiveness of these programs,” she tells MANAGED CARE. “When health plans use these techniques, it’s important to gather and publish data on them. Improving the evidence base is critical, and health plans have a vested interest in using and evaluating these techniques.”

CVS identifies outliers

PBMIs and the national drugstore chains are also talking up their efforts to quell opioid abuse. For example, on its website Express Scripts describes a program designed to limit opioid abuse among those getting prescriptions through worker compensation. When an injured worker presents a prescription at the pharmacy, the company’s claims processing system calculates its morphine equivalent dose (MED). If the prescription dose is over certain MED limits, it is submitted to the payer for a special review and the prescribing physician is sent a reminder about the guidelines for prescribing opioids. The company also uses a pharmacy “lock in” program for some claimants. Their prescriptions for drugs likely to be abused can be filled at just one pharmacy and sometimes the script can be written by just one prescriber.

Two years ago, CVS Health executives announced in the pages of the New England Journal of Medicine that the company had identified physicians with unusual patterns of prescribing high-risk drugs (alprazolam, a benzodiazepine, and carisoprodol, a muscle relaxant, as well as hydrocodone, oxycodone, and methadone) by combing through its huge cache of claims data. The company discovered 42 outliers and banned 36 from fulfilling prescriptions at their stores.

But the DEA has gone after CVS—and its rival, Walgreens—as part of a crackdown on prescription drug abuse. Last month, CVS agreed to pay a $22 million settlement after a DEA investigation found that employees at two of its pharmacies in Sanford, Fla., dispensed controlled substances without legitimate prescriptions. In 2013, Walgreens reached an $80 million settlement after the DEA found problems with record keeping and prescribing practices at a distribution center and six of its retail outlets in Florida.

What else can be done?

Although CVS and Express Scripts have databases that are useful in limiting opioid prescriptions and can be shared with payers, the state-run prescription drug monitoring programs (PDMPs) and their databases have been largely off limit to private payers. Experts have called for allowing insurers more access to PDMP information.

Andrew Kolodny, MD, praises payers who are getting involved in fighting the opioid abuse epidemic. Kolodny, the chief medical officer of Phoenix House, a New York City drug and alcohol rehabilitation program, and president of Physicians for Responsible Opioid Prescribing, calls Blue Cross and Blue Shield of Massachusetts’s program “very smart.” It is important, he says, for payers to work on reducing the number of Americans starting opioid therapy for chronic pain because once they are on it, stopping is often difficult. Kolodny spreads blame for the opioid addiction epidemic around: “The FDA has been awful on this issue,” and he mentions a “well-financed misinformation campaign” by pharmaceutical companies. But he would also like to see state medical boards and the medical community get more involved. Tamper-resistance opioids might be helpful but because most people get addicted to the oral formulations he expects them to make “only a very small dent in this problem.” It comes down to this for Kolodny: “Opioids are lousy drugs for most people with chronic pain,” and we have to come up with better ways for helping people suffering with pain that won’t go away. 

Larry Beresford is a freelance medical writer in Alameda, Calif.
A dramatic increase of infants undergoing drug withdrawal seems to have caught the medical world off-guard, according to a study in the New England Journal of Medicine.

In 2004, neonatal abstinence syndrome occurred in 7 out of every 1,000 babies admitted to a neonatal intensive care unit (NICU). By 2013, that number had more than tripled, to 27 out of 1,000.

Not only did the number of infants with neonatal abstinence syndrome increase, the proportion of NICU days devoted to caring for those infants increased to 4% in 2013 from just 0.6% in 2004, according to this study.

Costs almost certainly shot up as well. Although this particular study didn’t crunch the numbers, the total annual cost for caring for such infants is almost $1 billion and shows signs of increasing, according to Alan R. Spitzer, MD, the senior author of the study and a vice president at Mednax, a publicly traded company that provides neonatology and other hospital services.

Researchers looked at multiple cross-sectional analyses and deidentified data in nearly 300 NICUs in the United States. Information included whether the mothers smoked, abused substances, and what specific medications they may have used during pregnancy.

Neonatal abstinence syndrome occurs most often after in utero exposure to opioids. Signs and symptoms include irritability, hypertonia, impaired weight gain, and sometimes seizures. Whether there are long-term effects is uncertain.

The diagnosis is usually made through use of a standardized scale that scores the infant on the presence and severity of common withdrawal symptoms, the study states.

Strong evidence from clinical trials about how to best treat neonatal abstinence syndrome is lacking, so physicians depend on their clinical judgment and the results of small studies.

Spitzer and his colleagues found that the use of morphine has increased, so that by 2013 almost 3 out of 4 infants with neonatal abstinence syndrome were treated with the drug. The use of clonidine has also gone up while the use of methadone has decreased.

The data used to conduct this study came from the documentation and billing software used by Pediatrix, an operating unit of Mednax. The authors say the data encompasses about 20% of the infants admitted to NICUs in the United States.
New Treatment for Melanoma Uses a Form of the Herpes Virus

The investigational product coaxes the immune system into attacking the deadliest skin cancer. But can we afford these expensive cancer drugs?

Thomas Morrow, MD

The American Cancer Society estimates that about 74,000 Americans will be diagnosed with melanoma this year and almost 10,000 will die from this deadliest form of skin cancer. Over the past several years, treatment of advanced cases of melanoma has been transformed as new FDA-approved therapies developed by several different companies have come onto the market. An FDA advisory committee recently approved a therapy that takes a totally novel approach that involves injecting a live attenuated virus directly into regionally or distant metastatic melanoma tumors.

Amgen’s investigational product, talimogene laherparepvec, is an attenuated, replication-competent type 1 herpes simplex virus (HSV-1) that can express a biologically active form of human granulocyte–macrophage colony-stimulating factor (GM-CSF).

Tweaking the genes

HSV-1 infections cause cold sores and sometimes genital herpes, although infection with human simplex virus 2 is more often the cause of genital herpes. Researchers have characterized the virulence genes of the virus. Talimogene laherparepvec, sometimes shortened to T-VEC, is made by depleting those virulence genes and inserting sequences that generate GM-CSF. It’s believed that removal of the virulence genes decreases the chances that the virus will infect nerve cells and will instead home in on tumor cells. By delivering GM-CSF, the genetically engineered virus enhances tumor antigen presentation to the immune system and induction of immune system attack on the malignancy.

Encouraging durable response results

Talimogene laherparepvec was studied in a randomized, open label phase 3 study to compare the new therapy with GM-CSF injections in subjects with unresectable stage IIIB, IIIC, and IV melanoma. A total of 437 subjects were randomized into the study at 64 study sites. The study was designed to demonstrate an improvement in durable response rate, which was defined as a complete response or partial response maintained for at least six months. Subjects were to receive therapy until Week 24, even if their melanoma was progressing. GM-CSF was used for comparison purposes because at the time that this study was designed, it was also in clinical studies as a treatment for melanoma. It is unclear, though, if GM-CSF by itself has any therapeutic value.

To be enrolled in the study, people had to be age 18 or older, have a histologically confirmed malignant melanoma of the stages listed in the previous paragraph, measurable disease of at least 1 cm, injectable disease (either on the surface of the skin or through the use of ultrasound guidance), ECOG performance of 0 or 1, and a life expectancy greater than four months from date of randomization. The study exclusions included active cerebral disease, any bone metastases, history of secondary cancer unless disease-free for at least five years, open herpetic skin lesions, and primary ocular or mucosal melanoma.

The initial dose of talimogene laherparepvec was injected into one or more skin or subcutaneous tumors, followed three weeks later by a more concentrated formulation given every two weeks. The dosing was guided by the size of the lesion and could be increased in a prede-
Determined manner if any injected lesion progressed.

**Durable response**

The analysis of the data was performed by the Endpoint Assessment Committee (EAC), the FDA, and the investigators themselves using different methods. The durable response rate varied some by who was doing the analysis and the methods being used. Analysis of the results was also complicated by the number of people in the study who dropped out.

Even with these caveats, the results for talimogene laherparepvec stood out: 15.6% to 19.0% who received the therapy had durable response versus just 1.4% to 2.1% for the control group. The EAC and investigators agreed on about 85% of the assessments.

Overall survival was the secondary endpoint. The researchers used an event-driven analysis: Once 290 patients had died, they analyzed the data. They found that 189 of the 295 (64%) patients in the treatment arm of the study had died compared with 101 of 141 (72%) in the control arm. Estimates of overall survival in months were 23.3 months for the talimogene laherparepvec group versus 18.9 months for the control arm.

Adverse events occurred in almost all patients in both arms of the study, but a larger proportion of the patients treated with genetically modified HSV-1 had grade 3 events (28.1% versus 16.5% in the control group). The adverse events in the treatment group included fatigue, chills, pyrexia, nausea, influenza-like illness, and injection-site pain and were consistent with treatment with a viral vaccine with a proposed immunological mechanism of action.

Of special interest is the possible viral shedding from the patients in the active arm. Since this is a live virus that is designed to replicate, it is expected to have biological properties similar to wild type HSV-1, including the ability to shed and potential for transmission and lifelong symptomatic reactivation. There are limited data on this issue, but of course it remains a concern for anyone who may come in close contact with these patients.

**Implications for managed care**

The FDA hasn’t approved talimogene laherparepvec. The agency doesn’t always follow the recommendation of its advisory committees. But if Amgen’s new therapy does get the go-ahead from the FDA, it will probably cause a considerable amount of angst for payers.

There are now more than 20 drugs approved for melanoma, including three—ipilimumab (Yervoy), nivolumab (Opdivo), and pembrolizumab (Keytruda)—that are designed to enlist the patient’s own immune system against their melanoma. Immunotherapy, once adventurous, is now an increasingly crowded field. It is also tearing gaping holes in many budgets. Pharmaceutical manufacturers are pricing these ingenious therapies so the annual cost is in the low six figures.

In the clinical practice, it’s likely that patients will receive one very expensive drug followed by another and then perhaps another. I predict that in the very near future, sequential melanoma treatment could cost $500,000.

And as a society, we have not addressed the question of how much each additional month of life with a metastatic malignancy is worth. Given the current state of our national debt and other priorities, can our society afford spending that much?

Immunotherapy will make the balancing act of managing care so that people get the treatment they want at the best possible cost even more difficult. It again proves that Tomorrow’s Medicine will ensure job security for decision-makers in all health disciplines!
A distinct correlation has been found between the number of complaints about Medicare Advantage plans and the number of customers withdrawing from these plans. Here are four steps health plans can take to reduce customer complaints, improve Medicare star ratings, and lower member attrition rates.

CMS created the Five-Star Quality Rating System to drive improvements in Medicare quality—and to help consumers and caregivers easily compare the performance of Medicare Advantage (MA) plans. With 53 measures of quality and the customer experience, the rating system has been cited as a key strategy for health plans in retaining and expanding their customer base because higher star ratings can attract more Medicare beneficiaries. Four- and five-star rated plans are also eligible to receive quality bonus payments.

One of the rating system’s most informative measures is the C30 measure of complaints about the health plan. Members can register concerns with CMS about any aspect of their health plans, ranging from insufficient benefits to poor customer service. For MA plans, keeping complaints to Medicare low and achieving higher Medicare star ratings are essential goals in meeting consumer expectations and retaining customers. The C30 measure can be a beacon of light to health plans in evaluating their performance, indicating where the other 52 measures are falling short and helping plans to transform their operations overall for a better customer experience.

More complaints means lost customers
HealthPocket.com, a website that compares and ranks health plans for consumers, looked at the contracts of 448 MA plans. Their results show that the average attrition rate for two-star plans was 22% and for five-star plans it was only 2%. The website also found that plans with more complaints to Medicare lost more customers.* Customer complaint rates are clearly strong indicators of health plan quality and important to Medicare beneficiaries in plan selection.

To build on these findings, Ernst & Young further analyzed complaints to Medicare for four- and five-star plans. Our goal was to better understand how these organizations are maintaining fewer complaint rates, lowering attrition rates, and achieving higher Medicare star ratings.

What follows are key findings from our research and four action steps for responding more readily to customer concerns, improving customer perceptions, and boosting star ratings throughout your enterprise.

1 Focus on quality and consumer perception

Findings: Our analysis found plans with a four- or five-star Medicare rating also had high ratings in Consumer Assessment of Healthcare Providers & Systems (CAHPS), the CMS patient experience survey, and other customer-service-related surveys (for example, the J.D. Power surveys of health plan members). For these higher-rated plans, the pursuit of quality is not a separate effort, siloed from others, but an integrated, high-priority initiative commanding attention throughout the organization.

Action steps
Here are steps health plans should take to continually gauge quality and consumer perception:

- Conduct parallel surveys and analysis, including yearly comparisons and adjustments based on their Medicare star ratings.
- Focus on quality and consumer perception to improve member enrollment and retention.
- Build closer relationships with providers and create incentive plans for providers to collect data at the member level.
- Develop outreach-centered metrics aligned with their programs and business-to-consumer focus.

• Include cost and benefit impact across all measures while shaping a clear strategy for data management.

2 Develop an integrated governance structure supported with data

Findings: Plans that received a four- or five-star rating for the C30 measure have several organizational features in common, including a structure with a governance model that is integrated not delegated. A centralized senior marketing team exists, evaluates star metrics across the enterprise, and includes liaisons who are aligned with functional areas but connected to the overarching organization across all contracts.

Another common theme is a comprehensive strategy for mitigating star challenges and prioritizing the process to acknowledge improvement steps across all functional areas.

We have also noticed that successful organizations have a proactive alignment of engagement initiatives with enterprise-wide quality and efficiency program strategies, such as Lean Six Sigma, to drive quality, improve operational efficiency, and confirm that all initiatives are moving in the same direction.

Action steps
Here are steps health plans should take to develop an integrated organizational structure for improving their customer complaint ratings:

• Create a governance committee to establish an overarching vision, provide oversight and instill accountability for the stars initiative.
• Develop cross-functional teams, aligned with star ratings and given defined authority and responsibilities, to collaborate on integrated, star-focused improvement initiatives.
• Unify multiple business unit activities and initiatives across operations that can influence star ratings, making sure all projects and decisions taking place in discrete departments are screened for their impact on the other parts of the enterprise and ultimately on the customer.
• Review mitigation strategies to evaluate their likely impact across all measures.
• Prioritize all measures and initiatives to identify key areas that require resource and capital investments.

Different galaxies: How major health plans compare on stars and other key dimensions

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Types of plans

- Health maintenance organization
  - ✔
- Preferred provider organization
  - ✔
- Point of service
  - ✔
- Private fee-for service
  - ✔

Change in number of plans for 2014 star-rating year versus 2013 star-rating year

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*Includes D.C.; † Includes D.C. and Puerto Rico; and § Includes DC, Guam, Puerto Rico, and Virgin Islands.
Complaints to Medicare.
Source: Centers for Medicare and Medicaid Services, cms.gov
3 Improve data and analytics
Findings: Most plans that received a four- or five-star rating for the C30 measure are focused on improving data and analytics and using data to support overall decision making on how to raise star scores. With a focused and automated analysis, forecasting, and reporting approach, plans can more readily identify and prevent low-performing star measures, including C30.

Commonly used tools include integrated and structured data and analytics designed to provide actionable insight for C30 and all other measures, data and analytics geared to “foresee and prevent” rather than “detect and mitigate,” and a sound infrastructure and a mature process for aggregating and reporting data (with integration at the member level).

We have also found that successful health plans don’t limit themselves to health care. They look at other industries and how businesses in those sectors use data-driven customer analysis techniques and tracking methods developed (such as those used in retail and commerce) to understand customer trends and segments. What’s more, they take the additional step of including data-driven customer analysis techniques in a benefit analysis that captures and measures star-related campaigns and activities and integrates data with member information. Robust data management and analytics enable demographic analysis at the member level, accompanied by detailed reporting to target key populations with a consumer-centric focus on benefits.

Action steps
Here are some steps health plans should take to improve their data and analytics:

• Review the current process for data management, assessing data completeness, integration, granularity (the ability to drill down to the member level) and integrity.
• Set clear priorities for the key data that will be the most actionable and will fuel both short- and long-term efforts to improve metrics.
• Use data to create insights, make decisions, and integrate lessons learned into the operating model to interact with your members in a more customer-centric way.
• Use customer-focused initiatives to help identify consumer segments and target outreach efforts using key data to support increased star ratings.

4 Minimize the complexity of the Medicare contracts portfolio
Findings: MA plans that scored a four- or five-star rating on measure C30 have many similar characteristics. These include a low number of contracts (less than 10 contracts), a high member-to-plan ratio (100,000-plus members per plan), and a low number of plans offered in a single state (less than three plans per state).

Additionally, these plans had minimal changes in the number of plans offered and did not offer any regional plans. By minimizing the complexity of their Medicare contracts portfolios, health plans can focus on the specifics of plans being offered and be more nimble when it comes to adjusting plans so they meet member needs and deal with their requests whenever possible.

Action steps
Here are some steps that health plans should take to minimize the complexity of their Medicare portfolios and maximize the flexibility of their offerings:

• Assess the volume and performance of each of their Medicare contracts.
• Review plans with low member-to-contract ratios and consider consolidating plans to increase efficiency, which could improve quality.
• Evaluate the number of plans offered in a single state.
• Assess and track the effects of plan changes as they impact measures.
• Use data to inform future plan changes.

From stars to strategic customer service
High rates of complaints to Medicare are correlated with high customer attrition rates and have a direct, negative impact on Medicare star ratings. To keep the number of complaints low, MA plans need a coherent, multifaceted approach that focuses on quality and consumer perception, uses integrated governance, takes a data-driven approach to decision making, continuously improves data and analytics, and minimizes the complexity of their Medicare contract portfolios. Such a strategy can reduce the number of complaints and drive up Medicare star ratings.

Those are important outcomes. As an added benefit, health plans may also achieve other worthy goals, including gains in operational effectiveness, greater member loyalty, and more success in signing up new members.

We are in a new age of customer engagement. That means health plans must pay attention to what their members need and want from their health plan.

Vanessa Pawlak is a principal at Ernst & Young LLP and on the firm’s Advisory Health Care Sector team.

The views expressed here are hers and do not necessarily reflect the views of Ernst & Young LLP.
Assessing the Financial Condition of Provider-Sponsored Health Plans

Michael J. McCue, DBA

INTRODUCTION

The onset of managed care across both commercial and government payers in the early 1990s led to a surge in the number of hospitals and health systems sponsoring health plans, referred to as provider-sponsored health plans (PSHPs). By 1995, the number of hospitals with some form of sponsorship arrangement (eg, full ownership, system affiliation, network alliance, joint venture) with a health plan totaled 737 (McCue 2000). However, by 1998, growing financial losses from the health plans, eroding capital base of hospitals to fund the plans, and lower Medicare reimbursement from the Balanced Budget Act of 1997 resulted in closures or sale of 80 health plans by hospitals (Rauber 1999). In 2011, 640 hospitals had an affiliated arrangement with a health plan (Myers 2013).

Three underlying forces are expected to create another upward trend in the membership growth of existing provider plans as well as the development of new ones. First, the passage of the Affordable Care Act (ACA) in 2010 contained provisions intended to expand commercial and Medicaid health insurance coverage to under- and uninsured populations. As a result of these forces, more health care systems are expected to acquire or form a health plan or, in the case of existing PSHPs, expand into the commercial or Medicaid markets. A recent analysis of PSHPs from 2011 through 2013 indicates that 10 health care systems have either started a new plan or have acquired an existing one (Myers 2013). Given this changing environment for existing and start-up PSHPs, health care providers and policy makers would want to gain insight into how well these health plans are performing financially. The aim of this study is to assess the financial performance of health plans owned, affiliated with, or sponsored by providers. Providers include hospitals, health systems, and physician groups.

Given the expansion of commercial products on both public and private exchanges and the competition from national publicly traded health insurers, such as Aetna, Cigna, UnitedHealthcare Group, and Anthem and Blue Cross Blue Shield plans, the study focuses on the financial performance and capital adequacy of provider-sponsored organizations (PSOs).

ABSTRACT

Purpose: The aim of this study was to assess the performance of health plans sponsored by provider organizations, with respect to plans generating strong positive cash flow relative to plans generating weaker cash flow. A secondary aim was to assess their capital adequacy.

Design: The study identified 24 provider-sponsored health plans (PSHPs) with an average positive cash flow margin from 2011 through 2013 at or above the top 75th percentile, defined as “strong cash flow PSHPs.” This group was compared with 72 PSHPs below the 75th percentile, defined as “weak cash flow PSHPs.”

Methodology: Atlantic Information Services Directory of Health Plans was used to identify the PSHPs. Financial ratios were computed from 2013 National Association of Insurance Commissioners Financial Filings. The study conducted a t test mean comparison between strong and weak cash flow PSHPs across an array of financial performance and capital adequacy measures.

Results: In 2013, the strong cash flow PSHPs averaged a cash-flow margin ratio of 6.6%. Weak cash flow PSHPs averaged a cash-flow margin of –0.4%. The net worth capital position of both groups was more than 4.5 times authorized capital.

Conclusion: The operational analysis shows that strong cash-flow margin PSHPs are managing their medical costs to achieve this position. Although their medical loss ratio increased by almost 300 basis points from 2011 to 2013, it was still statistically significantly lower than the weaker cash flow PSHP group (P<.001). In terms of capital adequacy, both strong and weak cash-flow margin PSHP groups possessed sufficient capital to ensure the viability of these plans.
offering a commercial product. This study identifies PSHPs that are participating in commercial insurance markets and are generating high positive cash flow from operations relative to those with weaker cash flows. Secondarily, this study seeks to assess the capital adequacy of PSOs with high cash flows. Capital adequacy is critical in financing the expansion of commercial health insurance markets as well as expanding into government markets.

A study of this nature will also identify the financial and operational drivers of PSHPs that are financially strong. In turn, financially weaker PSHPs can utilize these findings to turn around their performance. More importantly, providers either starting or launching a new PSHP can evaluate these performance indicators to gain an understanding of the underlying factors for financial success.

METHODS
To identify the population of health plans sponsored or affiliated with providers (both hospitals and physician groups), the study references the AIS (Atlantic Information Services) Directory of Health Plans for 2014, which samples 2013 plan data. This database listed 71 PSOs that offered a commercial product. The AIS Directory also included 5 PSHPs in California that do not report their financial filings to the National Association of Insurance Commissioners (NAIC).

California’s Department of Managed Health Care does not require managed care plans to submit financial filings to NAIC. Excluding the 5 PSHPs from California resulted in a total of 66 PSHPs. Within the NAIC data, state regulations for PPO and HMO products may require a health system to have separate legal entities and financial filings for health systems offering a HMO and PPO product. As a result, this study identified from the NAIC filings 104 PSHPs in 2013 and 19 health care providers sponsoring more than 1 plan.

Because state and federal regulators view health plans with >1000 members as credible plans, the study excluded 6 PSO plans with less than 1000 members in 2011. In addition, the study excluded 2 plans with missing financial data from 2012 and 2011, resulting in a final sample of 96 plans.

Risk-based capital (RBC) ratio is the primary ratio analyzed by state insurance examiners to assess solvency and is defined as the health plan’s total adjusted capital divided by its authorized control capital or minimum capital level. Total adjusted capital reflects a health plan’s state-authorized control capital plus its surplus or net worth capital. However, state examiners, as well as credit rating companies such as A.M. Best (2014), also assess performance ratios of health insurers. Cash flow margin ratio is a key ratio because changes in cash flow can increase or decrease the health insurer’s capital position (DHCFP 2010). Cash flow margin ratio is defined as cash flow from operations as a percentage of total cash flow.

KEY POINTS
- In health plans with strong cash flows, lower medical loss ratios appear to be the underlying reason for healthy cash flow, although medical loss ratios have increased (from 83.5% in 2011 to 86.4% in 2013).
- The profit margin ratio of provider-sponsored health plans with strong cash flows declined from 2.5% in 2011 to 0.4% in 2013. Rising medical loss ratios may be the reason for the decline.
- In 2013, the average risk-based capital (RBC) ratio for the strong cash flow group was significantly higher (5.75 vs 4.68) than it was for the weak cash flow group in 2013. The RBC ratio for both groups was well above the insurance regulator threshold of 1.5.
- It appears that provider-sponsored health plans have the capital necessary to finance expansion into commercial markets and government programs.

GLOSSARY

Administrative cost ratio
Percentage of premium dollars spent on administrative expenses.

Cash-flow margin ratio
Cash flow from operations as a percentage of total revenues.

Medical loss ratio
Percentage of premium dollars spent on medical expenses.

Profit margin ratio
Profit (total revenues minus medical and administrative costs) as a percentage of total revenues.

Risk-based capital ratio
Total capital (as determined by a formula) divided by the capital adjusted for risk (also determined by a formula).

Strong cash flow PSHPs
Provider-sponsored health plans with an average cash flow margin in the top 25th percentile.

Weak cash flow PSHPs
Provider-sponsored health plans with an average cash flow margin in the bottom 25th percentile.
of total revenues. A.M. Best considers an array of other performance ratios and capital-adequacy ratios in assigning a rating to a health insurer. These ratios include the medical loss ratio, which measures percentage of premium dollars spent on medical expenses, and the administrative cost ratio, which measures the percentage of premium dollars spent on administrative expenses. Finally, for the profit margin ratio, profits are defined as total revenues minus medical costs and administrative costs and were measured as percentage of total revenues (A.M. Best 2014).

In addition, the credit rating agency measures capital adequacy measures. As previously mentioned, RBC is one measure. This study included 2 other adequacy ratios, total liabilities to total assets and capital and surplus per member per month (PMPM). The total liabilities to total asset ratio measures what percentage of its liabilities can be paid off by selling its assets, and it is viewed as a liquidity measure because the majority of health insurers’ assets is invested in securities. The capital/surplus PMPM (capital PMPM) assesses how much capital is accounted for by its membership base. These financial ratios were computed from 2013 NAIC financial filings, which list key financial accounts from 2011 through 2013 from a statement called the “Five-Year Historical Data.” For the performance ratios, the form includes only total revenue and not premium revenue; therefore, this value may be slightly overvalued be-

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<tr>
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<td>Mean</td>
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<td>Medical loss ratio</td>
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SD=standard deviation.
cause it includes other minor accounts such as premium reserves and other nonhealth revenues.

To assess PSHPs generating high cash flow, the study first measured their cash flow margin ratio from 2011 through 2013, which was defined as cash flow from operations divided by total revenue, and computed its average value for each health plan. Because the aim of the study was to identify PSHPs that were performing well financially, the study classified PSHPs with an average cash flow margin in the top 25th percentile, which was 3.9%, and defined them as strong cash flow PSHPs. The study identified 24 high cash flow margin PSHPs. The comparison group was identified as PSHPs with an average cash flow margin in the bottom 25th percentile and included 72 PSHPs that were defined as weak cash flow margin PSHPs. The high cash flow margin group each year had PSHPs with outlier values for cash flow margin, which increased variation of this measure. The study adjusted these outlier values to the top 99th percentile and bottom first percentile values.

The statistical analysis was conducted using t test mean comparison between strong cash flow PSHPs and weak cash flow PSHPs for an array of financial performance and capital adequacy measures. The average membership over the 3-year period for the group with cash flow margin above the 75th percentile was 150,710, which was higher than the average membership of 113,400 for the comparison PSHP group. Thus, high cash flow margin PSHPs were larger in size than weak cash flow margin PSHPs. To identify the health insurance markets in which PSHPs offered products, as well as the membership in these markets, the study collected 2013 health insurers’ data. In 2013, the percentage of total membership in Medicare, Medicaid, and commercial markets for the strong cash flow PSHPs was 10% for Medicare, 27% for Medicaid, and 63% for commercial. The comparison group market percentages were 11% for Medicare, 14% for Medicaid, and 75% for commercial. Thus, the strong cash flow PSHPs insured a higher percentage of Medicaid members and a lesser percentage of commercial members than the comparison group.

**RESULTS**

Table 1 (page 41) shows the findings from 2011 through 2013 for the performance measures. For the PSHPs generating strong cash flow, the cash flow margin ratio was 6.5% in 2011 but declined slightly to 5.9% in 2012. In 2013, however, the ratio increased to 6.6%. For PSHPs generating weak cash flow (PSHPs below the 75th percentile), cash flow was 0.09% in 2011 but declined to a cash flow operating loss of –1.6% in 2012. In 2013, these plans reduced their cash flow operating loss and generated a cash flow margin of –0.4%. For all 3 years, as expected, the 75th percentile PSHPs generated a significantly higher cash flow margin (P<.01).

In the strong cash flow margin group, lower medical loss ratios ap-

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**TABLE 2**

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</tr>
<tr>
<td>Liabilities to total assets</td>
<td>38.4%</td>
<td>18.08%</td>
</tr>
<tr>
<td>Total capital PMPM</td>
<td>$109.60</td>
<td>$146.62</td>
</tr>
</tbody>
</table>

PMPM=per member per month, SD=standard deviation.
pear to be the underlying reason for higher cash flow. In 2011 and 2012, this group's average medical loss ratio was 83.5%. The average medical loss ratio in weak cash flow groups was 89.1% in 2011 and 90.8% in 2012. In 2013, however, for the strong cash flow group, the medical loss ratio increased by almost 3 percentage points, from 83.5% in 2012 to 86.4% in 2013. Despite this rise, the 2013 medical loss ratio value was still significantly lower than that for the weak cash flow group (90.3%, P<.01).

The administrative cost ratio for the strong cash flow PSHP group was significantly higher than the comparison groups for 2011 and 2012 (P=.03). In addition, this group's administrative ratio declined from 14.1% in 2012 to 13.1% in 2013. The weak cash flow PSHP group administrative cost ratio rose from 11.5% in 2011 to 12.2% in 2013 and was no longer significantly different from the higher cash flow group (P=.04).

In terms of profit margin ratios, the strong cash flow group experienced a decline in the profit margin ratio from 2011 to 2013. The ratio was 2.5% in 2011 and declined to 0.4% in 2013, which may stem from rising medical loss ratio. For the weak cash flow group, the profit margin declined from −0.6% in 2011 to −2.5% and −2.6%, respectively, in 2012 and 2013. For all 3 years, the strong cash flow group had significantly higher profit margin than the comparison group (P=.03 [2011], P=.02 [2012], P=.03 [2013]).

Table 2 presents the findings for the capital adequacy ratios for 2011 through 2013. The RBC ratio declined for the strong cash flow group from 7.44 in 2011 to 5.75 in 2013. The RBC ratio for the weak cash flow group was significantly lower and increased slightly from 4.26 in 2011 to 4.68 in 2013 (P<.001, P=.02). Although the strong cash flow group generated higher cash flow over the 3 years, the decline in the RBC ratio may stem from an increase in regulated authorized capital (numerator of the RBC ratio) or outflow of capital to the sponsored provider organization (denominator of the RBC ratio).

For the liquidity measure of total liabilities to total assets, the strong cash flow group experienced a rise in liabilities relative to total assets. In 2011, liabilities accounted for 38% of total assets, while in 2013 the percentage of total liabilities covered by total assets increased to 46%. For the weak cash flow group, the percentage of total liabilities covered by total assets was around 50% for all 3 years. The final ratio of total capital PMPM reflects a significantly higher amount of capital covering the insured base for the strong cash flow group relative to the weak cash flow group (P<.001 [2011], P=.02 [2012], P=.03 [2013]). From 2011 to 2013, the strong cash flow PSHP group's total capital PMPM increased by almost $44 PMPM, to $153 PMPM, while the weak cash flow PSHP group's total capital PMPM grew by only $12 PMPM, to $73.60 PMPM.

There were several limitations to this study. First, the study sample excluded 5 PSHPs from California because they were not required to submit their financial data to NAIC. Second, the sample includes only PSHPs that offer a commercial product. Therefore, the sample excludes PSHPs that insure members covered by Medicare, Medicaid, or both. The Medicaid PSHPs typically are affiliated with safety net providers or major academic medical centers.

Finally, the mean comparison/univariate analysis design does not control for external factors, such as competition from national health insurers, size of commercial insurance market, and type of insurance plan (HMO vs PPO).

Given the descriptive mean difference analysis of the study, it is difficult to tease out other effects related to market and demand factors. An extension of the study would involve a multivariate analysis, which could attempt to control for market effects on the mean values.

**DISCUSSION**

There are several underlying reasons health care providers are either expanding their existing insurance products or starting a new health insurance entity. The first reason relates to the onset of ACA regulation in offering affordable commercial health insurance plans on public exchanges. These plans are made affordable by offering tax subsidies for low-income enrollees who are uninsured and underinsured on the public health insurance exchange (Claxton 2015).

The second reason stems from insurers’ movements toward narrower provider networks and value-based purchasing payment arrangements with providers (Herman 2015). Given this change in the business model of health care, health policy makers, employers, and health care provider systems will have an interest in knowing how health care systems with existing health plans are performing financially.

This study identified a sample of 96 PSHPs in 2013 and computed key financial ratios to measure their financial performance and capital adequacy from 2011 through 2013. The study identified 24 PSHPs that generated an average cash flow margin ratio of 3.9%, which was above the 75th percentile of this ratio.

The analysis shows that strong cash flow margin PSHPs are managing their medical costs to achieve this position. Although their medical loss ratio increased by almost 300 basis points from 2011 to 2013, it was still lower than the weak cash flow PSHP group.

In terms of capital position, both groups had high RBC ratios. State in-
insurance regulators assess this ratio to gauge the overall risk of bankruptcy for the health plan. The ratio accounts for a range of risk factors, including risk of default of reinsurers and other creditors, risk of investments, fixed income and equity; and its underwriting risk of its reserves and premiums. Health plans with RBC ratios valued below 1.5 will be required by state insurers to take correction action.

CONCLUSION
This study found the overall capital adequacy of both groups to be financially sound. Although the average RBC ratio for the strong cash flow PSHP group was significantly higher (5.75 vs 4.68) than the weak cash flow PSHP group ($P = .02$), the ratio value for both groups was well above the regulator threshold. The other capital adequacy of total liabilities to total assets was only slightly lower for the strong cash flow PSHP group relative to its comparison group. This finding implies that either group can pay off its liabilities with less than half its assets.

REFERENCES


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Rauber C. Market deflates for provider-owned HMOs. Survey shows many plans are losing ground to growing national and regional players. Mod Healthc. 1999;29(24):34–38,40–44,46.

Given this assessment, it appears PSHPs have sufficient capital to finance expansion into the commercial markets as well as government programs. Initially, PSHPs entering these new markets may experience capital shortfalls in cash flow from underpricing products and higher medical costs. However, some of the larger regional health care systems are financially strong with sufficient cash and investments on hand to lend to their health plan (McCue 2010) in case they face financial difficulties.
 Accenture told us more than two years ago that the private health insurance exchange market will cover 40 million Americans by 2018. There are now just three years on the clock, but the consulting company is sticking to its high-flying prediction.

Enrollment in private exchanges has doubled, to 6 million, according to Accenture. That’s impressive. But what’s going to happen to put the growth into overdrive, so another 34 million Americans will be getting their health insurance through private exchanges?

Accenture (and others) point to the 40% ACA excise tax on expensive “Cadillac” health benefits that will take effect in 2018. Rather than pay the tax when they buy group insurance, employers will be motivated to have their employees shop for insurance on private exchanges.

By Accenture’s reckoning, 38% of large employers and 17% of all businesses could get hit by the excise tax.

Although a new development for employees, private health exchanges long have been a well-developed market for retirees. Earlier this year, the Blue Cross and Blue Shield Association (BCBSA) announced creation of the “BCBS Marketplace.” The online portal will allow Medicare beneficiaries to shop for Medigap policies, Part D plans, and Medicare Advantage plans.

The Blues aim to enroll 9 million retirees and are considering rolling out something similar for the commercial population.

The private exchanges are not necessarily a competitor to the public exchanges. Employees cannot take company subsidies into public exchanges, but participation in a private exchange could help them figure out what sort of government subsidies they’d need to participate in a public exchange. Public exchanges might be a better deal for many Americans.

The problem private exchanges face may not be so much in convincing employees that they’re a good idea but in convincing employers. Notwithstanding Accenture’s sunny appraisal, BCBSA research shows that only 11% of employers think the private exchanges will control their health care costs.

**Reasons cited by employers for not adopting private exchange**

- Insufficient cost savings to justify disruption
- Waiting for proof of concept
- Evaluating multitude of options

**Private exchange enrollment predicted to swell to 40 million by 2018**

An estimated 6 million members enrolled in private health exchanges for 2015 employer benefits, says Accenture

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated actual</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2015</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2016</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>2018</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

Calculation includes pre-65 employees and dependents. Source: Accenture 2015

**Most employers are reluctant to move active employees to private exchanges**

Share of employers confident that private exchanges will do the following better than employer health plans do today:

<table>
<thead>
<tr>
<th>Feature</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide more choice of plans</td>
<td>77%</td>
<td></td>
<td></td>
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<tr>
<td>Comply with regulations</td>
<td>51%</td>
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<tr>
<td>Support a defined contribution approach</td>
<td>49%</td>
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<tr>
<td>Enroll employees efficiently</td>
<td>32%</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Administer plans</td>
<td>29%</td>
<td></td>
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</tr>
<tr>
<td>Engage employees in better health care decision making</td>
<td>17%</td>
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<tr>
<td>Address employee questions/problems in a timely manner</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Control health care costs</td>
<td>11%</td>
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</tr>
</tbody>
</table>

The data above reflect the percentage of employers who selected “4” or “5” on a 5-point scale, where 5 = very confident. Total survey respondents = 136. Source: National Business Group on Health Large Employers’ Health Plan Design Survey, August 2014