Kitchen-table consult: Erica Jensen multitasks, conferring remotely with her endocrinologist at Brigham and Women's Hospital in Boston about her diabetes while holding her five-month-old daughter.
INDICATION
LUCENTIS® (ranibizumab injection) 0.5 mg is indicated for the treatment of patients with:
• Neovascular (wet) age-related macular degeneration (wAMD)
• Macular edema following retinal vein occlusion (RVO)

IMPORTANT SAFETY INFORMATION
LUCENTIS is contraindicated in patients with ocular or periocular infections or hypersensitivity to ranibizumab or any of the excipients in LUCENTIS.

WARNINGS AND PRECAUTIONS
Intravitreal injections, including those with LUCENTIS, have been associated with endophthalmitis, retinal detachment, and iatrogenic traumatic cataract. Proper aseptic injection technique should always be utilized when administering LUCENTIS. Patients should be monitored during the week following the injection to permit early treatment, should an infection occur.

Increases in intraocular pressure (IOP) have been noted both pre-injection and post-injection (at 60 minutes) with LUCENTIS. IOP and perfusion of the optic nerve head should be monitored and managed appropriately.

Although there was a low rate of arterial thromboembolic events (ATEs) observed in the LUCENTIS clinical trials, there is a potential risk of ATEs following intravitreal use of VEGF inhibitors. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause).

Fatal events occurred more frequently in patients with DME and DR at baseline treated monthly with LUCENTIS compared with control. Although the rate of fatal events was low and included causes of death typical of patients with advanced diabetic complications, a potential relationship between these events and intravitreal use of VEGF inhibitors cannot be excluded.

ADVERSE EVENTS
Serious adverse events related to the injection procedure that occurred in <0.1% of intravitreal injections included endophthalmitis, rhegmatogenous retinal detachment, and iatrogenic traumatic cataract.

In the LUCENTIS Phase III clinical trials, the most common ocular side effects included conjunctival hemorrhage, eye pain, vitreous floaters, and increased intraocular pressure. The most common non-ocular side effects included nasopharyngitis, headache, influenza, sinusitis, cough, and nausea.

Please see Brief Summary of LUCENTIS full prescribing information on adjacent page.

NOW FDA APPROVED!

LUCENTIS 0.5 mg has been studied in 6 clinical trials* and is now available in a prefilled syringe.†‡

Single-use syringe designed for the treatment of a single eye.

The following randomized, double-masked pivotal trials were conducted for the 2 LUCENTIS indications: wAMD: MARINA—Phase III, multicenter, 2-year, sham injection-controlled study; primary end point at 1 year. ANCHOR—Phase III, multicenter, 2-year, active treatment-controlled study; primary end point at 1 year. PIER—Phase I/II, 2-year, sham injection-controlled study; primary end point at 1 year. HARBOR—Phase III, multicenter, 2-year, active treatment-controlled dose-response study; primary end point at 1 year. RVO: BRAVO—Phase III multicenter, 1-year, sham injection-controlled study; primary end point at 6 months. CRUISE—Phase III, multicenter, 1-year sham injection-controlled study; primary end point at 6 months.

6.2 Clinical Studies Experience

Because clinical trials are conducted under widely varying conditions, abnormal adverse reaction rates observed in one clinical trial of a drug cannot be directly compared with those of another trial and may not reflect the rates observed in practice.

The data below reflect exposure to 0.5 mg LUCENTIS in 440 patients with neovascular AMD in Studies AMD-1, AMD-2, and AMD-3; in 259 patients with macular edema following RVO. The data also reflect exposure to 0.3 mg LUCENTIS in 250 patients with DME and DR at baseline and 276 patients with DME and DR at 3 years in the LUCENTIS clinical trials (see the full prescribing information).

Safety data observed in Study AMD-4 and in 224 patients with macular edema were consistent with these results. On average, the rates and types of adverse reactions in patients were not significantly affected by dosing regimen.

Table 1 shows frequently reported ocular adverse reactions observed in LUCENTIS-treated patients compared with the control group.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Ocular Reactions in the DME and DR, AMD, and RVO Studies</th>
<th>0.5 mg LUCENTIS</th>
<th>Control</th>
<th>N = 123</th>
<th>N = 125</th>
<th>N = 248</th>
<th>N = 250</th>
<th>N = 250</th>
<th>N = 250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td></td>
<td>0.5 mg LUCENTIS</td>
<td>Control</td>
<td>N = 123</td>
<td>N = 125</td>
<td>N = 248</td>
<td>N = 250</td>
<td>N = 250</td>
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</tr>
<tr>
<td>Year 1</td>
<td></td>
<td>0.5 mg LUCENTIS</td>
<td>Control</td>
<td>N = 123</td>
<td>N = 125</td>
<td>N = 248</td>
<td>N = 250</td>
<td>N = 250</td>
<td>N = 250</td>
</tr>
<tr>
<td>Year 0</td>
<td></td>
<td>0.5 mg LUCENTIS</td>
<td>Control</td>
<td>N = 123</td>
<td>N = 125</td>
<td>N = 248</td>
<td>N = 250</td>
<td>N = 250</td>
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<td>N = 248</td>
<td>N = 250</td>
<td>N = 250</td>
<td>N = 250</td>
</tr>
</tbody>
</table>

6.3 Immune reactivity

As with all therapeutic proteins, there is the potential for an immune response in patients treated with LUCENTIS. The immunogenicity data reflect the concentrations of antibodies to LUCENTIS in immunosuppressed and non-immunosuppressed patients. Antibodies to LUCENTIS in immunosuppressed and non-immunosuppressed patients are positively correlated.

The pre-treatment incidence of immunoreactivity to LUCENTIS was 0%-5% across treatment groups. After monthly dosing with LUCENTIS for 6 to 24 months, the percentage of patients with antibodies to LUCENTIS increased in approximately 1%-9%. The clinical significance of immunoreactivity to LUCENTIS is unclear at this time. No data are available regarding the implications of immunoreactivity in patients with neovascular AMD.

7 DRUG INTERACTIONS

No interactions have been conducted with LUCENTIS intravitreal injection has been used adjuvantly with verteporfin photodynamic therapy (PDT). Twelve (12) of 101 (11%) patients with neovascular AMD received a verteporfin PDT course following a single eye injection at the recommended clinical dose. No statistically significant differences were observed in trends from historical controls between patients who received PDT treatment and those who did not.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

There are no adequate and well-controlled studies of LUCENTIS administration in pregnant women.

Animal reproduction studies have not been conducted with LUCENTIS intravitreal injection. Because animal reproduction studies are not always predictive of human response, and because of the potential for adverse reaction in a nursing woman, administer to a pregnant woman. No data are available regarding the implications of exposure to ranibizumab injection from an ophthalmologist.

Advise patients that in the days following LUCENTIS administration, patients are seen.

8.2 Lactation

There are no data available for the presence of ranibizumab in human milk, the effects of ranibizumab on the breastfed infant or the effects of ranibizumab on breast milk. Caution should be exercised when LUCENTIS is administered to a nursing woman.

8.3 Females and Males of Reproductive Potential

No studies on the effects of ranibizumab injection on fertility have been conducted, and it is not known whether ranibizumab can cause fetal harm. Therefore, caution is advised when LUCENTIS is administered to a pregnant woman. The safety and effectiveness of LUCENTIS in pregnant women have not been established.

8.4 Pediatric Use

There are no adequate and well-controlled studies of LUCENTIS administration in pediatric patients aged less than 18 years.

Because many drugs are excreted in human milk, and because the potential for serious adverse reactions in nursing children when a drug is administered to the mother cannot be ruled out, a decision should be made whether to discontinue nursing or to discontinue the drug.

8.5 Geriatric Use

In the clinical studies, approximately 76% (2449 of 3227) of patients randomized to receive LUCENTIS had 65 years of age or older. There were no clinically significant differences in the safety and efficacy of ranibizumab between these studies.

17 PATIENT COUNSELING INFORMATION

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MANAGED CARE publishes original papers and feature articles dealing with diverse elements of the health care system. Among these are impartial peer-reviewed research and review articles examining clinical and financial aspects of managed care.

ALAN G. ADLER, MD
Senior Medical Director
Independence Blue Cross

PARKTHA S. ANBIL
Principal
The ConfluenceElite Group LLC
West Chester, Pa.

JAN BERGER, MD, MJ
President
Health Intelligence Partners
Chicago, Ill.

THOMAS BODENHEIMER, MD
Family and Community Medicine
University of California–San Francisco
San Francisco, Calif.

PETER BOLAND, PhD
President, Boland Healthcare
Berkeley, Calif.

LARRY S. BORESS, MPA
President & CEO
Midwest Business Group on Health
Chicago, Ill.

H. ERIC CANNON, PharmD
Chief of Pharmacy
SelectHealth/Intermountain Healthcare
Salt Lake City, Utah

GEORGANNE CHAPIN, MPhil, JD
President & CEO
Hudson Health Plan
Tarrytown, N.Y.

VIVIAN H. COATES, MBA
Vice President
Information Services and Health Technology Assessment
ECRI Institute
Plymouth Meeting, Pa.

HELEN DARLING
Strategic Adviser
Former President and CEO
National Business Group on Health
Washington, D.C.

GARY SCOTT DAVIS, JD
Partner, Health Law Department
McDermott, Will & Emery LLP
Miami, Fla.

D.S. (PETE) FULLERTON, PhD, RPh
Strategic Pharmacy Innovations
Seattle, Wash.

ARCHHELLE GEORGIOU, MD
Founder
Georgiou Consulting
Minneapolis, Minn.

JEFF GOLDSMITH, PhD
President, Health Futures Inc.
Charlottesville, Va.

ALICE G. GOSFIELD, Esq.
Principal, Gosfield & Associates

MICHAIL T. HALPERN, MD, PhD
Associate Professor of Public Health
College of Public Health
University of Arizona
Tucson, Ariz.

JAN HIRSCH, PhD
Associate Professor of Clinical Pharmacy, Scaggs School of Pharmacy and Pharmaceutical Sciences
University of California–San Diego
San Diego, Calif.

GEORGE J.ISHAM, MD
Senior Adviser
HealthPartners
Minneapolis, Minn.

LUCY JOHNS, MPH
Independent Consultant
Health Care Planning and Policy
San Francisco, Calif.

ROBERT C. JOHNSON, MS
President, R.C. Johnson & Associates
Former President, American Pharmaceutical Association
Scottsdale, Ariz.

THOMAS KAYE, RPh, MBA
Pharmacy Consultant
Louisville, Ky.

RANDALL KRAKAUER, MD, FACP, FACR
Vice President, National Medical Director,
Medical Strategy
Aetna
Princeton, N.J.

PETER KONGSTVEDT, MD, FACP
President
P.R. Kongstvedt Co.
McLean, Va.

THOMAS H. LEE, MD, SM
Chief Medical Officer
Press Ganey Associates
Wakefield, Mass.

ATEE MEHROTRA, MD, MPH
Associate Professor of Medicine and Health Care Policy
Department of Health Care Policy
Harvard Medical School
Boston, Mass.

MICHAEL L. MILLENSON
President
Health Quality Advisors LLC
Highland Park, Ill.

THOMAS MORROW, MD
Chief Medical Officer
Next IT
Spokane, Wash.

SAM NUSSBAUM, MD
Executive Vice President
and Chief Medical Officer
Anthem
Indianapolis, Ind.

MATT NYE, PharmD
Vice President
Pharmacy Care Support Services
Kaiser Permanente
Downey, Calif.

BURTON I. ORLAND, BS, RPh
President
BioCare Consultants
Westport, Conn.

STEVEN R. PESKIN, MD, MBA, FACP
Associate Clinical Professor of Medicine
University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School
New Brunswick, N.J.

UWE E. REINHARDT, PhD
James Madison Professor of Political Economy
Princeton University
Princeton, N.J.

EMAD RIZK, MD
President & CEO
Accretive Health
Chicago, Ill.

JONO RROGLIERI, MD, MBA
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New York Life Insurance Co.
New York, N.Y.

TIM SAWYER, BPharm, MBA, PAHM
Director of Account Management
Magellan Rx Management
Nashville, Tenn.

JAMES M. SCHIBANOIFF, MD
Editor-in-Chief, Milliman Care Guidelines
Milliman USA
San Diego, Calif.

STEPHEN W. SCHONDELMEYER, PharmD, PhD
Professor & Director, PRIME Institute
University of Minnesota College of Pharmacy
Minneapolis, Minn.

JAAN SIDOROV, MD, MPhA
Chief Medical Officer
medSolis
Frisco, Texas

THOMAS D. SNOOK, FSA, MAAPA
Principal & Consulting Actuary
Milliman Inc.
Phoenix, Ariz.

RICHARD G. STEFANACCI, DO, MPH, MBA, AGSF, CMD
Chief Medical Officer, The Access Group
Jefferson College of Population Health
Thomas Jefferson University

F. RANDY VOGENBERG, PhD, RPh
Partner
Access Market Intelligence
Greenville, S.C.

JONATHAN P. WEINER, DrPH
Professor and Director of the Center for Population Health
Johns Hopkins University
Bloomberg School of Public Health
Baltimore, Md.
Telehealth Still Being Screened

By Peter Wehrwein

Read Hastings, the co-founder of Netflix, was inspired to found the company partly by a problem he worked on as a graduate student in computer science at Stanford. The exercise involved calculating the advantages of transporting computer tapes by car. As it turns out, the bandwidth of moving large quantities of data physically—via the ”sneakernet”—can be amazingly high. So when a friend told him about DVDs, Hastings saw bandwidth: 5GB chunks of data that could be sent cheaply through the mail.

“I realized that is a digital-distribution network,” Hastings said at a mobile communications meeting last year.

Of course, the bandwidth of today’s internet, along with the processing power of devices, has made streaming possible and snailmailed DVDs obsolete. Netflix adjusted, figured out streaming, and is now a $62 billion company.

Its proponents believe that telehealth can emulate Netflix and envision health care leaving its sneakernet days—as well as earlier eras—behind.

Enormous amounts of health care information can now travel digitally. That information may be in the form of an MRI or CT scan; the American Telemedicine Association says there are 8 million users of teleradiology (see page 20). It may be in the tone of voice, and gestures during a telemental health visit (see page 26).

Henry DePhillips, MD, the chief medical officer of Teladoc, says flu is an ideal application of telehealth because an accurate diagnosis can be made based on a patient’s description of her symptoms during a teledermatology visit and whether flu is circulating in the community (see page 30).

But Netflix has had outages, and telehealth is not without its problems. Teladoc has had to work to keep antibiotic and steroid prescribing for acute respiratory infections in check. Researchers have cast doubt on the cost effectiveness because an accurate diagnosis can be made based on a patient’s description of her symptoms during a telemedicine visit and whether flu is circulating in the community (see page 30).

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How telehealth plays out is going to be must-see viewing.
That’s Reality Knocking
The hard truth is that telehealth’s future—its size, its contours—will depend a lot on what payers will be willing to pay for. Currently, commercial plans cover only a limited number of services. By Susan Ladika

Worker Wariness Stifles Telehealth’s Acceptance
A lot hinges on this question: Do you feel comfortable getting a diagnosis or being treated for a condition by someone on a screen? By Frank Diamond

Irrational Telehealth Exuberance
Investors are plowing millions into telehealth startups, but it could take years and regulatory changes for profits to materialize. By Robert Calandra

Telehealth Quality Is All Over the Place
Researchers are ironing out the methodological problems, so it is difficult to pin down how the technology affects quality. By Richard Mark Kirkner

‘Telemental’ Health Makes Great Strides
People with severe depression oft en have diffi  culty leaving home. Telemental health helps by bringing the therapist to them. By Timothy Kelley

Q&A With Henry DePhillips, MD
The CMO of telemedicine provider Teledoc sings the technology’s praises. He can handle devil’s advocate questions, too. Interview by Peter Wehrwein

Prior Auth Is Dangerous for Opioid Addicts
The results can be tragic. Patients are unlikely to wait the time it takes for insurers to approve needed anti-addiction medications. By Joseph Burns

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Mayo Clinic’s Telemedicine NICU Study Shows Some Success, But Also Tech Glitches

The first study to examine the effectiveness of telemedicine consultations for newborn resuscitation demonstrates the technology’s strengths and weaknesses, according to Mayo Clinic researchers.

One of the strengths is that telemedicine consultations can improve the quality of care in local hospitals, possibly reducing the necessity of transfers to hospitals with higher levels of care, said the study published in the December 2016 issue of Mayo Clinic Proceedings. After the telemedicine consultation, a third (27 of 84) of the infants with breathing problems were treated in the local hospital.

“If the remote neonatologist had not been able to visually assess the newborn and provide remote-guided care, many of these infants may have otherwise been transferred to the NICU unnecessarily,” the study stated.

And money was saved. Helicopter transfers to higher-level neonatal intensive care units would have cost anywhere from $12,000 to $25,000, according to lead author Jennifer Fang, MD, and her colleagues in Mayo’s Division of Neonatal Medicine.

The 84 consultations for high-risk deliveries at six local hospitals were conducted between March 16, 2013, and Dec. 1, 2015. The hospitals in the study are 40 to 120 miles from the main Mayo Clinic Hospital in Rochester, Minn.

Among the problems identified in the study was the amount of time that lapsed between the incoming phone call and establishment of a video connection. On average, it took nine minutes, when it should happen in less than five minutes, said the authors. They suggested that process improvements, such as revising call triage algorithms, would help deal with this problem.

But there were also problems with the equipment and connectivity. When the neonatologists and referring providers were surveyed, 25% (16 of 64) rated the audio quality as poor or unusable, and 19% (12 of 64) put the video quality in that category.

Fang and her colleagues noted that “time-critical” telemedicine needs simple and highly reliable video technology and that the wireless mobile devices used by the community providers didn’t meet those requirements, as evidenced by the difficulty establishing and maintaining a video connection. “These issues were likely due to multiple factors, including insufficient wireless network bandwidth, user error, and software upgrades that changed the user interface or required action before the consult,” they said.

They also sounded an optimistic note, though, concluding that “with the appropriate telemedicine technologies, high levels of agreement between remote physicians can be achieved on multiple physical examination findings, including genetic and neurologic examinations.”

Anthem CEO Gives Trump Some Advice

Make sure that federal cost-sharing subsidies for health insurers continue and keep the funds flowing into Medicaid, Anthem CEO Joseph Swedish advised President Trump when the two met last month. Bloomberg reports that Swedish also wants the administration to stay on course regarding eliminating the ACA’s limit on corporate tax deductions for top health plan executives, effectively encouraging the companies to pay those executives more.

John Gallina, the company’s CFO, told attendees at the Barclays Global Healthcare Conference: “We’re extremely engaged with the leaders and the American public. We feel very good, very encouraged, by the fact that the president and his team are listening and actually making changes based on feedback that the industry is providing.”

As Bloomberg reports, Anthem sells Blue Cross and Blue Shield health plans in 14 states. It is one of the biggest insurers to continue selling on the ACA exchanges. In addition, “Anthem has also expanded its Medicaid business, fueled by the ACA’s expansion of that program to more low-income individuals.”

Drug Contracts Gauge Value and Outcomes

High drug costs are a cause célèbre. Executives at Harvard Pilgrim Health Care have responded with value-based contracts for two expensive medications, etanercept (Enbrel) and teriparatide (Forteo).

Enbrel treats autoimmune diseases, most often moderate-to-severe cases of rheumatoid arthritis. Under the two-year contract signed in late February with Amgen, Harvard Pilgrim’s payment for the drug will depend on six effectiveness criteria, including patient adherence, switching or adding drugs, steroid interventions, and dose escalation. “If patient scores are below a specified level, Harvard Pilgrim will pay less for Enbrel because its real-life effectiveness will have been lower,” the insurer said in a news release. Harvard Pilgrim is touting this as the only outcomes-based contract for a rheumatoid arthritis drug between an insurer and the drugmaker.

Michael Sherman, MD, Harvard
Pilgrim’s chief medical officer, said in the news release that “real world performance of new medicines frequently differs from the well-controlled clinical trial setting and we know that historically, only about a third of patients on Enbrel and others in this class meet all six criteria. By linking the ultimate cost of this drug to its real-world clinical efficacy, this agreement truly puts patients at the center of focus.”

Measuring adherence is a key component of the contract Harvard Pilgrim signed with Eli Lilly (also in late February) for Forteo, a medication used to treat people who are at an elevated risk for fractures. Forteo is administered via self-injection every day for 24 months, and inconsistent administration can reduce its effectiveness.

The contract uses the baseline level of use among Harvard Pilgrim beneficiaries and then tracks improvement. If a certain level of adherence isn’t reached, then Eli Lilly will cut the cost of the drug for Harvard Pilgrim.

Sherman noted in a news release that for Forteo to be most effective, patients need to take it daily for two years. “Greater adherence makes for a more effective treatment for osteoporosis, and by effectively reducing the unit cost of the drug in return for regular use, Eli Lilly is improving the value proposition of its therapy, which matters to all of our stakeholders.”

### Patients believe there’s more interoperability than actually exists

Ninety-seven percent of patients think it is important for any health organization anywhere to have access to their full medical history, according to an online survey conducted by Transcend Insights, a subsidiary of Humana. Unfortunately, that’s not the reality. Prior studies—one in *JAMA* in 2011, the other by the American Hospital Association in 2015—show that interoperability falls far short of patient hopes. The *JAMA* study is about specialist–primary care communication in general, not necessarily via electronic means. The study found that only 34.8% of specialists obtain data about a patient by the primary care physician doing the referring, even when the primary care physician tries to share that information. That’s the case even though 69.3% of primary care physicians reported “always” or “most of the time,” sending “notification of a patient’s history and reason for consultation to a specialist.” The AHA study, which is about interoperability, found that only a quarter of hospitals can exchange data in a functional way.

The Transcend Insights survey was conducted in January. The respondents were 2,597 adults in the United States who have seen a doctor within the last year.

### What patients think their health care providers offer

<table>
<thead>
<tr>
<th>Service</th>
<th>Not sure if this is available</th>
<th>Not available</th>
<th>Available but I don’t use this</th>
<th>Available and I do use this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your doctor provides you with access to your personal medical history</td>
<td>12%</td>
<td>7%</td>
<td>29%</td>
<td>52%</td>
</tr>
<tr>
<td>Your doctor provides care that addresses both physical and mental health</td>
<td>15%</td>
<td>11%</td>
<td>27%</td>
<td>48%</td>
</tr>
<tr>
<td>The ability to schedule same-day appointments to see a doctor or health care professional</td>
<td>13%</td>
<td>18%</td>
<td>23%</td>
<td>46%</td>
</tr>
<tr>
<td>Your doctor(s) can easily share/access important information about your medical history—no matter when or where you need care</td>
<td>20%</td>
<td>9%</td>
<td>27%</td>
<td>45%</td>
</tr>
<tr>
<td>Access to an online portal to manage all your health needs in one place, allowing you to pay bills, order prescription refills, find health information, and schedule appointments</td>
<td>16%</td>
<td>16%</td>
<td>26%</td>
<td>42%</td>
</tr>
<tr>
<td>Your doctor is able to predict how your health may change over time—based on your health record</td>
<td>27%</td>
<td>13%</td>
<td>23%</td>
<td>38%</td>
</tr>
<tr>
<td>Treatments and therapies based on your genetic makeup</td>
<td>34%</td>
<td>19%</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>Technology that allows you to have virtual consultations with a doctor or health care professional from home or someplace other than a doctor’s office</td>
<td>29%</td>
<td>31%</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>Your doctor offers wearable devices and/or mobile health apps to engage you in your health</td>
<td>35%</td>
<td>27%</td>
<td>23%</td>
<td>16%</td>
</tr>
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</table>

Pediatric Drugs’ Costly Incarnation

There’s a new twist in the recent uproar about how pharmaceutical companies are spiking costs for variations of medicines that have been around for decades. Little children often have a difficult time swallowing pills. Pharmacists can make liquid versions, but there’s a risk of an adverse reaction to these ad hoc versions. So it figures that standardized liquid forms of older medications would find a market.

Unfortunately, insurers may have a difficult time swallowing the prices. Lisinopril and enalapril are ACE inhibitors that can be used to treat hypertension in children, a relatively rare condition. But the liquid formulation of lisinopril, Qbrelis, is priced 775 times higher than the generic tablet, and the liquid formulation of enalapril, Epanol, is priced 121 times higher than the generic tablet. Both formulations are made by Silvergate Pharmaceuticals in suburban Denver.

Luke A. Probst and Thomas R. Welch, MD, of Upstate Golisano Children’s Hospital, Syracuse, N.Y., wrote in the February 23 issue of the New England Journal of Medicine that “once liquid preparations are available, pharmacies are precluded from dispensing ad hoc formulations. In many instances, instead of a month’s supply of an extemporaneously compounded preparation costing a pharmacy less than $20, the commercially marketed liquid will have a wholesale acquisition cost of $1,000 or more.”

Probst and Welch acknowledge that the development and marketing of a pediatric liquid drug can be costly. The complexity of the drug, preclinical and clinical testing, regulatory filings, the size of the market, and the length of market exclusivity all add to the costs.

“Intuitively, though, the costs should be less than the costs to develop an entirely new drug,” they write. “Pricing models should take such a difference into consideration. Streamlining the regulatory requirements related to the development of pediatric drug formulations as well as responsible pricing models could preclude the call for legislative cost controls.”

Molina Argues For ACA Tune-up

What Obamacare gave, Obamacare taketh away. But it doesn’t have to be that way, argues J. Mario Molina, CEO of Molina Healthcare. The insurer serves mostly Medicaid beneficiaries, and that’s why it made a profit on the exchanges in the first couple of years.

The 4 million-member company was expected to rake in $16 billion by the end of 2016. “The thing that surprised us is that we actually exceeded our growth expectations,” Molina told the Hill in September 2016.

That was then. In February, Molina showed a net loss of $47 million in the fourth quarter of 2016 compared with a $30 million profit in the fourth quarter of 2015.

Molina told Kaiser Health News that the reversal is due to what he sees as a structural flaw in the ACA known as risk transfer. It’s one of the subsidies accorded insurance companies who wind up losing money for serving a sicker, poorer population. Except this subsidy doesn’t come from the government directly but from other insurers who don’t have as many sicker, poorer patients.

Molina likes the idea but says the formula used to carry it out is flawed. It punishes efficiency rather than helps companies that have had some bad luck in the risk pool.

“Let’s put it this way,” he told Kaiser. “Currently, Molina Healthcare is returning 25% of our premiums to the government, which are then distributed to our competitors. So we are really subsidizing our competitors and helping them, rather than forcing them to compete.”

Still, Molina said in the Kaiser interview that he is an ACA supporter, notwithstanding his company’s recent disappointing financial performance (although this was weeks before the House Republicans unveiled the American Health Care Act). Obama-care needs neither repealing nor replacing, just a tune-up, Molina said.

Going against the grain of some large insurers (Aetna, UnitedHealthcare, and Humana) who’ve either exited or are planning to exit the ACA exchanges, Molina Healthcare intends to stay.

The Aetnas, Humanas, and United-Healthcare of the industry are used to creating extensive insurance benefit packages for large employers, Molina told Kaiser. Molina Healthcare has narrow physician networks and does not contract with every hospital in a region, and that has helped the company do well on the ACA exchanges.

Joshua Weisbrod, a health care consultant with Bain & Co., told Kaiser that it’s easier to work up from a lower-cost position than it is to work down from a higher-cost one: “For an insurer that is used to selling employer plans with rich benefit designs and broad networks, it is difficult for them to transition that to a narrow network of lower-cost providers.”

MS Patients Want Goals To Be Known

Pharmaceutical companies seem to show little interest in what a patient with multiple sclerosis wants from a medication. But that might change because the pharmaceutical industry itself is beginning to examine this disconnect, according to STAT. Research funded by the Pharmaceutical Research and Manufacturers of America involved a review of over 300 clinical studies and surveys of 30 payers, doctors, and patients each.

Pharmaceutical manufacturers take their cues from insurers and physicians who want medications that thwart the progression of MS and prevent or at least lessen the intensity of relapses. But patients are also concerned about out-of-pocket costs and dangerous but rare side effects, especially progressive multifocal leukoencephalopathy.

Roger Longman is CEO of Real Endpoints, the research company that conducted the analysis. He told STAT that the main takeaway is that cover-
age decisions and physician prescribing do not reflect patient preferences. Drugmakers have tended to follow the lead of the payers and physicians in designing clinical trials. “So their notion of value is much different than what the patient values.”

Conclusion? It’s important to know what the patient wants, but that information isn’t readily available, says Kimberly Westrich, vice president of health services research at the industry-backed National Pharmaceutical Council, which studies medication access.

She told STAT that “you can’t capture this information in a traditional competitive effectiveness analysis. But if the pharmaceutical industry knows there’s an appetite for this kind of information, which can be shared with payers and treatment guidelines developers, they may choose to start building these points into their trials so there are available data.”

Briefly Noted
Short-term health plans may be making a comeback, according to Kaiser Health News. These plans do not qualify as health plans under the ACA so the buyers don’t get the law’s premium tax credits and protections against the ban on pre-existing condition exclusions. But they’re popular, and may become more so as the ACA is replaced, because the premiums are lower than premiums for the ACA-approved plans…. The Boston Globe looks at how medicine’s being taught at the University of Vermont medical school, where “the professor has little to say” because the students must work together to find the answers. The Globe says the school offers medical education that produces the kind of doctor today’s patients need. “Toward that end, the school has pledged to eliminate all lectures by 2019,” the Globe reports…. Hospitals are penalized by CMS for readmissions under 30 days for six common conditions, including heart failure, pneumonia, and COPD. A study published in JAMA suggests that maybe sepsis should be added to that list. Researchers said that sepsis accounted for 12.2% of readmissions. Compare that with heart failure (6.7%), pneumonia (5%), COPD (4.6%), and heart attack (1.3%). … CMS-revised regulations governing nursing homes started going into effect last November, with more to be rolled out over the next few years. It’s the first time that regulations for long-term care facilities have been revised since 1991. One change is that “the rules allow people to receive any visitor they choose (not just relatives) whenever they choose, without restricted hours, as long as visitors don’t disturb other residents”…. The Veterans Choice and Accountability Act of 2014 included this simple goal: Use $2.5 billion of the allocated $16 billion to hire more staff to take care of veterans. NPR has been following the money and reports that there are about the same number of VA staff as when the law was passed…. A device that injects a life-saving dose of naloxone to save people who’ve overdosed on opioids has gone from $690 per two-pack in 2014 to $4,500, Kaiser Health News reports. The device, Evzio, is manufactured by a small drug company called Kaleo. It talks somebody through the process of injecting naloxone, which counteracts the harmful effects of heavy painkillers and heroin…. The ongoing debate about the effectiveness of wellness programs seems not to have registered with many who receive concierge care and the doctors who provide it, according to the Los Angeles Times. These doctors focus on wellness, not illness. “They work on health and fitness goals with their patients, and are available to speak with them regularly by cell phone to help them make better lifestyle choices,” the newspaper reports. …

Getting patients to the hospital as soon as possible is good; even better is getting a patient’s information to the hospital right away. Paramedics with the Houston Fire Department consult with doctors through telehealth and electronic health records using iPads, reported Health Data Management. The program “is designed to reduce ambulance transport to the hospital, saving money and having more resources available when actual urgent emergencies arise”…. Pressure sores in hospitals have declined over the last decade, but not so in long-term care facilities, according to a study in the Journal of Wound, Ostomy and Continence Nursing. Pressure sore rates rose from 3.8% in 2013 to 5.4% in 2015…. Massachusetts is launching a program that’s meant to help infants and toddlers of parents addicted to opioids—yet one more indication of just how entrenched the nationwide opioid problem has become. The Boston Globe reports that “the government-funded initiative will pay for weekly home visits to 36 low-income families in New Bedford, a city south of Boston, where the number of children born with opiates in their bloodstream is four times the state average”…. Thanks to the dismantling of the ACA, high-risk pools could very well make a comeback, the New York Times reports. High-risk programs separate people with pre-existing conditions or who are very ill—whose medical costs are likely to be high—from those who are relatively healthy. Before the ACA, 35 states had such programs in place. “Insurers could charge higher prices to those with existing medical conditions, but they would also rely on other sources of funding, including from the government, to cover their costs,” the Times reports. For some people, the high-risk programs worked—at least for a while. The Times relates a story about a couple paid $375 a month for a plan that covered breast cancer treatments. That high-risk program closed, and the couple had to search for a plan that met the requirements of the ACA.

— Frank Diamond
Telehealth Wave: Surf’s up For Fed, State Policymakers

Repeal and replace could create an opening for telehealth. Meanwhile, state health officials are working through gnarly parity and licensure issues.

By Richard Mark Kirkner, Contributing Editor

Telemedicine may be the wave of the future, but federal and state policymakers are surfing it in different ways. In Washington, the Republican plan to replace the ACA is dominating everything related to health care, including telehealth. Repeal and replace could be telemedicine’s big chance to assume a leading role in the Medicaid and Medicare programs. Statements from HHS Secretary Tom Price suggest he is favorable toward the technology.

Meanwhile, in state capitals, health officials and regulators have been dealing with telehealth as an emerging technology for quite some time. Responses have varied, and the result is a hodgepodge of rules at the state level.

But the uncertain future of insurance coverage in the country will affect both the perception and reality of telehealth in the years ahead. If millions of Americans lose Medicaid or private health insurance coverage because of the unACAing of American health care, telehealth may seem like a gimmicky sideshow rather than a good-faith effort to bring health care into the digital century.

Medicare reset

At the American Telemedicine Association (ATA), Latoya Thomas has been inundated with questions about whether the repeal and replacement of the ACA will have an adverse effect on telemedicine. “The short answer is no, only because telemedicine is a way of delivering care and not a service itself,” says Thomas, director of the state policy resource center.

The long answer? That involves Medicaid, for which the ACA encourages broader use of telemedicine than it does for a Medicare program that limits telemedicine coverage to settings like rural clinics. “We’re very much looking at what may happen with Medicaid specifically,” Thomas says.

Actually, the GOP idea of capping Medicaid aid funding for states could boost telehealth, says Mario Gutierrez, executive director of the Center for Connected Health Policy, a not-for-profit organization that was originally set up by the California Health Care Foundation but has since branched out and become national. “Assuming that individual states have less money,” says Gutierrez, “there would be greater incentive to employ telehealth to be able to continue to serve Medicaid beneficiaries and manage to live within more limited resources per capita.”

Repeal and replace could provide an opportunity to reset Medicare policy on telemedicine and telehealth. Section 1834(m) of the Social Security Act places a variety of restrictions on telemedicine services for Medicare beneficiaries. For example, they must be delivered in a designated rural setting, like a health clinic, and not at home, and only certain types of providers can deliver them. CMS also restricts the codes reimbursable for telehealth services.

“Whatever sense the Medicare restrictions in section 1834(m) made in 2000 are at least greatly outdated,” the ATA said in a letter to Congressional leaders in 2014. “Telehealth is the only Medicare benefit limited by the geographic location of the patient—thus, unequal treatment under the law.”

The ATA wants Congress to remove those restrictions and allow services delivered wherever the beneficiary is, including in the home, and, essentially, recognize telehealth as a delivery platform, not as a separate service.

Gutierrez says there’s growing recognition that “something needs to be done with Medicare to allow for all of the benefits of virtual care.”

However, would-be tacklers await—namely the Medicare Payment Advisory Commission (MedPAC) the independent nonpartisan agency that advises Congress on Medicare issues.

“The concern with MedPAC is that they’ve historically taken a conservative view regard-
ing telehealth-delivered services, particularly when it comes to fee-for-service payments,” says Gutierrez. The Congressional Budget Office that scores all bills for budget impact also takes a narrow view of telehealth, Gutierrez says. He sees ACA repeal as a possible threat to telemedicine. “What does that mean in terms of the impact on emergency departments and people not getting care at all, which means that by the time they do get care they have much more complicated and expensive conditions?” he says. “That puts a greater burden on health care providers who likely will not be reimbursed.”

Price’s support may run interference. “It seems that in health care we put roadblocks up to the expansion of technology, especially in rural areas, and we ought to be incentivizing that,” Price said at one of his confirmation hearings.

**States are updating**

What happens at the federal level is undoubtedly important, but state legislatures and state regulators have already been down in the trenches with telemedicine. Thirty-two states have parity laws—that is, they put a telemedicine encounter on par with an office visit, although these laws vary on what types of encounters they cover. Some only cover behavioral health or psychiatric services, while others cover the gamut. Forty-eight states provide reimbursement for some form of live video in Medicaid fee for service, and 29 states have some form of new or revised legislation pending. Only six states—Alabama, West Virginia, Wisconsin, South Dakota, North Carolina, and Ohio—have neither existing nor pending regulations or legislation on the books.

But telehealth is moving into areas unimaginable in the early days of the internet. Today, 12 states reimburse for store-and-forward services that allow for the electronic transmission of information like digital images, documents, and pre-recorded videos through secure email. Nineteen states have passed legislation to reimburse for remote patient monitoring, and 30 states provide for a transmission or facility fee.

“The states that were sort of on the vanguard of telemedicine, now have parity laws or telemedicine laws that are pushing 10 or more years old,” says Jonathan Neufeld of the Great Plains Telehealth Resource Center in Minneapolis. “Technology and practice have moved a lot in 10 years, and those states are finding they need to go back and update their laws.”

**Across state lines**

Most of those updates fall into two categories, says Thomas: licensure portability to allow providers to practice across state lines; and expansion and clarification of the definition of telehealth itself. Today, telehealth regulations have a lot of questions to answer, Thomas says: “If you’re a licensed or certified health care provider, what does telehealth mean? What does it look like? What is an appropriate mechanism or platform for you to engage with your client or patient? Who needs to be involved? Who can contact whom? Can the patient contact you?”

And it’s not only physicians who are asking those questions. “It’s happening with counselors, it’s happening with speech language pathologists and audiologists, it’s happening with every health care profession you can think of,” Thomas says. “They’re trying to determine what’s appropriate for their profession and also what’s appropriate for the patients they serve.”

As for looking for a model state for telehealth laws, Gutierrez isn’t so sure there is any. He says California has the most comprehensive definition of telehealth, although the California Department of Managed Health Care, which oversees managed care in the state, has been reluctant to recognize it. Minnesota and Mississippi have embraced telehealth more fully than other states. Mississippi’s legislature has taken up the Nurse Licensure Compact (NLC) that would make it easier for out-of-state nurses to provide telehealth services to consumers in the state. Nine states in all have adopted the NLC.

The Federation of State Medical Boards issued a template for a compact for physicians, called the Interstate Medical Licensure Compact. But contrary to the NLC, this compact does not allow portability across state lines. Instead, it lays out a voluntary process for physicians to apply for a medical license in another state, encouraging the use of telemedicine as a result. To date, 18 states have adopted it.

Then there’s a state like Iowa that went from a law that did not define telemedicine to one that states that a video encounter should be treated the same as an in-person doctor’s visit. Says Neufeld, “That’s just about all they said; it’s very simple.”
Basaglar, an Insulin ‘Follow On,’ Prepares To Do Battle With Lantus

At last, there’s a biosimilar-like competitor in the U.S. insulin market. Can Basaglar put some downward pressure on prices?

By Thomas Reinke, Contributing Editor

In December, Eli Lilly and Boehringer Ingelheim became proud parents, launching a new insulin product into the world. They dubbed it Basaglar, and it bore a striking resemblance to Sanofi’s Lantus, the world’s top-selling basal insulin.

Whether Basaglar can be deemed a biosimilar is a question that veers into the arcana of FDA approval pathways. But there is no doubt that Basaglar is coming on the scene during tumultuous times for insulin products. Manufacturers are under attack for price hikes. There are allegations of backroom rebate deals. And a class-action lawsuit has been brought on behalf of uninsured patients, charging insulin makers with setting artificially high prices.

But turmoil can open windows of opportunity. Industry observers say the timing could be perfect for Basaglar, a cheaper rival to one of the best-selling insulin products on the market. Payers would love to see some downward pressure on insulin prices. So would the millions of Americans with diabetes who have difficulty paying for their diabetes medications.

But any kind of Basaglar effect on prices and expenditures may be brief and modest. Eli Lilly, Novo Nordisk, and Sanofi, the three companies that dominate the market for diabetes drugs, continue to roll out new products. This steady stream benefits some patients but it also swamps payer budgets. Diabetes was second only to inflammatory conditions on the list of the most expensive therapeutic classes in Express Scripts’s 2016 Drug Trend Report (see below), and insulin products account for 40% of the diabetes drug spend, according to the PBM.

The billions spent on diabetes medications each year in the United States is an equation that includes new products, price increases, and the growing number of Americans categorized as having diabetes. According to federal health statistics, 11.9% of American adults have diabetes (see chart, next page). That works out to about 28 million people—a lot of potential customers if you are a pharmaceutical company and a lot of members to manage if you are an insurer.
The origin story

Putting the cost issues aside, we now take insulin treatment for diabetes pretty much for granted, so it is easy to forget that the discovery and widespread availability of insulin was one of the monumental medical advances of the 20th century. Prior to insulin treatment, type 1 patients almost invariably died from the disease.

A Canadian physician, Frederick Banting, working with a medical student, Charles Best, is usually given credit for isolating insulin for the first time in 1921 in a series of experiments that involved disabling or removing the pancreases of dogs. Medical research was more idealistic in Banting’s day. He sold the patent rights to the University of Toronto, where he conducted his research, for the grand total of one dollar. The university, in turn, entered into agreement with Lilly, which began selling insulin in October 1923. A forerunner to Novo Nordisk also commercialized insulin that year.

This all happened almost a century ago, but it shows the enduring effect of getting there first with a pharmaceutical product. Lilly, Novo Nordisk, and, more recently, Sanofi, dominate the insulin market to this day—and it is a gigantic market worth $24 billion in 2014 worldwide sales, according to P&S Market Research.

A different approval pathway

Basaglar is often referred to as a biosimilar to Lantus, and it is classified as such in Europe. But it has not received that designation in this country. The FDA has been careful to call it a “follow on” to Lantus. Gillian Woollett, a senior vice president at Avalere and a leading authority on biosimilars, explains that in the context of FDA approval, Lantus is technically a new drug licensed under a new drug application, not through the 351(k) pathway for biosimilars.

But Basaglar did travel a road less taken: It was the first insulin product approved under the FDA’s 505(b)(2) pathway, which has been set up as an abbreviated process that allows at least some of the information required for approval, such as safety and efficacy information on the active ingredient, to come from studies not conducted on the drug in question.

Beyond these finer points about the approval process, the much more important—and interesting—question is whether Basaglar will compete effectively against Lantus. It should help that it has Lilly behind it. The Indianapolis-headquartered company has a large portfolio of insulin products and other diabetes medications, but it lacked a basal insulin. Basaglar rounds out Lilly’s offerings, so it can now compete across the insulin spectrum.

This is not your parents’ insulin

What sometimes gets lost in the current uproar about diabetes medications and their prices is that the current batch of products is quite a bit different from the insulin harvested from porcine and bovine pancreases that dominated the market through the 1970s. For one thing, recombinant DNA technology has been used to make insulin since the late ’70s and ’80s. That technology and other techniques have also allowed researchers to tinker with insulin, changing an amino acid here and there so it behaves differently in the body. Some of these insulin analogues, as they are called, have been changed so they act rapidly in imitation of the surge of insulin after a meal and then their activity falls off. Others, called basal insulin, are more like the tortoise than the hare: They come on slowly and stay active in the body much longer in the way that a healthy pancreas secretes relatively small amounts of insulin more or less continuously.

These variations in the onset of action and other characteristics help people with diabetes avoid weight gain, reduce the number of hypoglycemic events, and promote medication adherence.
Basaglar, which is sold as Abasaglar in Europe, racked up $86 million in sales there in 2016, with almost half ($39 million) of it coming in the fourth quarter. In this country, Basaglar scored an impressive victory against Lantus even before its official launch when CVS Caremark announced that it would exclude Lantus and Novo Nordisk’s Levemir from its national formulary and make Basaglar the only basal insulin on the list. A PBM’s national formulary doesn’t bind all of its customers, but there’s no question that it has an influence on individual market and small group plans. CVS’s imprimatur also sends a salient signal to the rest of the market that it is safe to swap out Lantus for Basaglar.

Other payers have not followed CVS’s lead. Express Scripts kept Lantus and Levemir on its preferred national formulary. Levemir is UnitedHealthcare’s exclusive tier 1 basal insulin and Coventry’s preferred basal insulin. The choices of the national PBMs show the highly competitive nature of the market for both rapid-acting (sometimes called bolus) and basal insulin. CVS’s decision will force some prescribers to switch some of their patients from a brand-name product to Basaglar.

A lawsuit about high prices
This switch—and the fact that patients have little, if any, say in it—does not sit well with many clinicians. Yehuda Handelsman, MD, an endocrinologist in Los Angeles and past president of the American Academy of Clinical Endocrinology, says it is unfair and unrealistic to place doctors and patients in a situation where they have no choice about a medication. Moreover, he says forced switching could be harmful to patients who were stable and doing well on an existing insulin product.

The proliferation and size of rebates and other price concessions to PBMs has widened the gap between list prices and those paid by PBMs. In February, a class-action lawsuit was filed in federal district court in New Jersey against Lilly, Novo Nordisk, and Sanofi on behalf of people who have paid full price for insulin products, which includes those without insurance, in high-deductible health plans, and in the Medicare Part D donut hole. The lawsuit charges the three companies with “exponentially” increasing their benchmark prices while lowering the real prices for PBMs so the PBMs can make more on the spread and will keep the insulin products made by the companies on their formularies.

Pushback before Basaglar
But PBMs—and other payers—want to be viewed as wielding formulary exclusions, rebates, and other tactics to good effect and as a countervailing force against higher prices. Sanofi’s 2015 annual report notes that U.S. sales of Lantus decreased by 20.5% in 2015 as a result of larger discounts, a slowdown of basal insulin market growth, and “an unfavorable mix effect toward highly-discounted government channels such as Medicaid.” The annual report predicts that sales of Lantus will continue to decline over the next several years.

Meanwhile, another “follow-on” basal insulin is waiting in the wings. In August 2016, Merck filed a 505(b)(2) abbreviated pathway application for its Lantus competitor. In support of its application, Merck filed lawsuits against 10 Sanofi patents for Lantus. Sanofi turned around and filed its own suits against Merck.

Of course, there’s nothing unusual about patent tit-for-tats in this part of the pharmaceutical industry. In fact, patent disputes between Lilly and Sanofi resulted in Lilly paying a royalty to Sanofi and a one-year delay in the launch of Basaglar.

Sanofi has countered the attack on Lantus by increasing its emphasis on Toujeo, an improved basal insulin. Similarly, Novo Nordisk is promoting Tresiba as an advance over Levemir, which could also lose market share to Basaglar and Merck’s follow-on product.

New combination products are also hitting the market. In November 2016, the FDA approved Sanofi’s Soliqua and Novo Nordisk’s Xultophy. Soliqua combines Lantus with lixisenatide, a GLP-1 receptor agonist, and Xultophy combines Tresiba with liraglutide, a GLP-1 receptor agonist sold as Victoza.

There’s a lot of commotion in diabetes treatment these days. Drug companies, payers, and, to some extent, patients—they are all pushing and pulling and jockeying for position. There’s no calm in sight.

But the high level of activity may be a good sign. It shows that diabetes therapy is evolving rapidly. That means more choices. The hope is that it will benefit patients but not bankrupt them—and payers—in the process. 

It is unfair to place doctors and patients in a position where they have no choice about a medication, says Yehuda Handelsman, MD, past president of the American Academy of Clinical Endocrinology.
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Telehealth is one of the buzziest areas of American health care, with hundreds of startups, lots of state and federal legislative action, and plenty of breathless talk about efficiency and that holy grail, cost savings.

But there is almost invariably a boom–bust cycle to buzz. Experience (or research) serves up some reality checks. Expectations settle down. Telehealth isn’t quite there yet, but researchers, insurers, and health care systems are now in the process of sifting through its various applications, trying to figure out what works, what doesn’t, and maybe some reasons for the difference.

So, if not a full-on buzzkill, the results from a study reported last month in *Health Affairs* were a bit sobering. Lori Uscher-Pines, a respected Rand researcher who has conducted many of the most important telehealth studies, and her colleagues found that the Teladoc services provided to California Public Employees’ Retirement System beneficiaries increased annual spending on acute respiratory illness by $45 per telehealth user. What’s more, about 88% of the usage was new utilization, not a replacement for more expensive care at a physician’s office or in an emergency department.

In an interview with Managed Care, Henry De-Phillips, MD, Teladoc’s chief medical officer, said the company’s research, which has not been published in a peer-reviewed journal, has found just about the opposite: considerable cost savings and a minor increase in utilization (see page 30). And the company had criticisms, noting that the study was at odds with “numerous other independent studies,” that the cost calculations were based on a limited period (the day of the Teladoc “visit” and two days after), and that it used claims data that are a few years old.

Several studies have shown an association between telehealth and overuse of antibiotics (see page 23). And the findings of a study published last year in *JAMA Dermatology* were “pretty disappointing,” acknowledges Jack Resneck Jr., MD, the lead author and a professor at the University of California–San Francisco. In that study, medical students posed as patients with skin conditions and used photos from the internet to show the telemedicine doctors their problems. The results showed that major diagnoses were repeatedly missed and that the treatments prescribed were sometimes at odds with existing guidelines.
This is not the stuff of ringing endorsements and enthusiastic acceptance by the American public.

But there’s also good news—and not just from self-serving sources. The federal Agency for Healthcare Research and Quality published a review last year that concluded that telehealth could be effective for monitoring and counseling patients with chronic conditions and for psychotherapy. Interest in and use of “telemental health” is cresting (see page 26).

And other research by Uscher-Pines and her colleagues at Rand have found benefits from telehealth. A 2014 study—also published in *Health Affairs* and of retired California public sector employees using Teladoc services—showed increased access to care for minor illnesses and that the telemedicine visits usually resolve the matter. They didn’t look at cost in that study.

Another Rand study evaluated services from two organizations that provide telehealth services, the MAVEN project and Direct Dermatology, which are designed to improve health care access for underserved communities. The review found that the introduction of telehealth services to those communities created new demand for procedures and tests that can’t be done remotely. “There aren’t enough specialists,” Uscher-Pines says. “If health care service is dysfunctional, there is trouble meeting the needs that telehealth creates.”

**Broader coverage**

Direct-to-consumer telemedicine remains one of the growth areas in telehealth. What’s more, Jason Gorevic, Teladoc’s CEO, says the number of Teladoc visits is growing faster than the number of people who have access to the company’s service: “We see an inflection point of consumer adoption.”

Uscher-Pines sees the evidence of the effect of direct-to-consumer telehealth on the quality of care as mixed. One study she did showed similar antibiotic prescribing rates between doctor’s offices and telehealth services. Another suggested that there might be underuse of diagnostic testing.

Many employers now provide telehealth services for minor acute illnesses to their employees, calculating a favorable return on investment from employees not having to leave work for a doctor’s appointment or head to the emergency room in the middle of the night, says Roy Schoenberg, MD, CEO of American Well. But he wants employers and insurers, through their coverage policies, to allow telehealth to branch out. No one has calculated what it means to envelop a cancer patient at home with care, says Schoenberg. “The people who might benefit the most from telemedicine are the people not allowed to use it,” says Schoenberg. “It’s a social injustice.”

Resneck, who also serves as secretary of the AMA’s board of trustees, also wants to see more insurance coverage. Some of his patients drive three hours for an appointment. Being able to schedule a virtual follow-up visit would save the patient—and the health care system—time and money. “That would be wonderful,” says Resneck, “but their insurance won’t cover that.”

Health care systems are seizing telehealth opportunities, in part, perhaps, to play some defense against the direct-to-consumer companies and their insurance company clients. Some 200 members of the American Telemedicine Association are health care systems, according to Jonathan Linkous, the association CEO.

**Range of services**

New York–Presbyterian Healthcare System in New York City launched NYP OnDemand last summer, offering a whole range of services from emergency and urgent care to second opinions and various kinds of follow-up care. Daniel Barchi, the system’s chief information officer, says the system, which uses American Well technology, doesn’t mean any additional revenue at this point: “We’re not reimbursed for anything. It’s just the right thing to do.” Meanwhile, the investment arm of the system has invested in Avizia, a telehealth startup in Reston, Va. The virtual ER has been a hit, Barchi says. ER patients are triaged, and those with minor conditions like a mild sprain or earache can opt for a virtual visit, rather than waiting for two or three hours to receive in-person care. Those who want virtual care are connected with a physician via video.

Virtual follow-up care is now being used in urology and surgery. If someone receives a kidney transplant, for example, the physician can have a 10-minute...
follow-up to do such things as check the incision and look for signs of infection, Barchi says.

The University of Pittsburgh Medical Center began rolling out telehealth services a decade ago, and now offers services spanning the spectrum. Officials have found that using its UPMC AnywhereCare urgent care service saves $86 per episode of care, compared with seeing other types of providers, says Natasa Sokolovich, executive director of UPMC’s telehealth program. UPMC is one of the few hospital systems that offers its own health insurance plan, and it covers telehealth.

UPMC provides telestroke service to 28 hospitals both within and outside its health care system; teleconsultation in more than 30 subspecialties, including Parkinson’s disease and multiple sclerosis; and behavioral health care. With behavioral health, there’s “lots of demand, but not enough supply under the current system. We really need to take better care of our mental health patients,” Sokolovich says.

It will follow the money
But the plain truth is that telehealth’s future—its size, its contours—will depend on what payers will be willing to pay for. Many commercial payers cover only a narrow band of services. Medicaid reimbursement varies from state to state, and traditional Medicare reimbursement is limited.

Among commercial payers, “it’s getting better,” says Schoenberg of American Well. “I can’t think of a payer who doesn’t reimburse for telehealth in some shape or form.” But payment can vary widely, he says, and that’s “a little bit disheartening.” The variability and uncertainty mean doctors sometimes tell patients to just come to the office in person just to be on the safe side. “When doctors have lots of questions about being paid, they always default to certainty,” he says.

Parity laws will presumably help, although parity is a bit of a misnomer because it doesn’t mean that payment for a telehealth service is going to be the same as one delivered in person. Thirty-one states and the District of Columbia have parity laws that require private insurers to reimburse providers for telehealth services, and several more are considering them.

Medicaid programs are using telehealth. According to the American Telemedicine Association, every state program offers some kind of reimbursement, although two states and the District of Columbia have taken steps to reduce or restrict coverage.

These days, traditional Medicare is the stingiest payer, with rules that limit telehealth to rural areas and only in certain specific circumstances.

“Reimbursement remains the most challenging piece for us,” says Sokolovich at UPMC. “Most ins-

surers have the fear that allowing reimbursement for telehealth would somehow open up the floodgates for care, says Natasa Sokolovich of UPMC.

Bipartisan support
Overall, the current political climate is favorable for telehealth. The Republicans’ American Health Care Act might be a blessing because tighter funding and less generous insurance coverage could spur interest in cheaper ways of delivering health care. HHS Secretary Tom Price has expressed support for telemedicine. In February, Reps. Morgan Griffith, a Virginia Republican, and Joyce Beatty, an Ohio Democrat, reintroduced legislation that would expand Medicare coverage of telestroke treatment, regardless of where the patient is located. There is also bipartisan support in the Senate for a bill that would expand Medicare payments for telehealth services for people with chronic diseases.

A different piece of legislation, the CONNECT Act, would expand Medicare coverage of telehealth services. The CONNECT Act would “help remove the geographic restrictions under CMS” and help providers meet MACRA goals. The changes are long overdue, she says, and the growing use of telehealth services would “bring health care to the same model as other consumer experiences,” such as banking or online shopping. “Every other segment of society has progressed,” she says. “Health care is kind of behind.”

Susan Ladika is a regular contributor to Managed Care and an independent journalist in Tampa, Fla.
Employers love telehealth and insurers love offering anything that their employers want to buy and that—debatably—can save money. One problem: Workers don’t share this enthusiasm, at least not yet.

A survey of 133 large employers (at least 5,000 workers) by the National Business Group on Health (NBGH) found that while 70% of companies offer telemedicine, only 3% of employees use it. The survey looked at the first half of 2016; a new one is coming out in the summer. Last year’s survey predicted that 90% of large employers will offer telehealth services this year, so if lack of employee buy-in worries companies, they’re not showing it.

“It’s still relatively new,” says Steve Wojcik, the NBGH’s vice president of public policy. “It’s a matter of employers communicating and making it as familiar as possible to employees.”

Gamify it
Anthem is taking a hands-on approach through its affiliate LiveHealth Online. A study sponsored by LiveHealth Online that was published recently in the Journal of Medical Internet Research found that telehealth lowers testing rates while maintaining the quality of care. In a press release, the president of the company, John Jesser, said that the study “is a great step in boosting confidence among consumers” in telehealth visits.

“It’s a nice quote, but I’m not sure that this study is going to drive a lot of consumer adoption,” Jesser tells MANAGED CARE. “Consumers don’t follow these academic reviewed medical journals.”

Consumers are mostly won over when they log in on their smartphone or tablet and suddenly see live doctors. “Until you do that, actually go in and have some sort of a visit, you can’t comprehend that you’re carrying around a medical group in your pocket,” says Jesser. Employers don’t have the ability to go one person at a time and demonstrate this sort of digital interaction, however. “There’s a million-and-one things we’re all being asked to do,” says Jesser. “We found that the greatest success comes with some sort of significant prizes, you know, a contest, or you gamify a registration drive.”

Jesser declines to disclose just how many Anthem beneficiaries use LiveHealth Online because “people count in all different ways.” But in general, he says that large employers who don’t actively campaign for telehealth usage might see as little as 2% adoption. It can get as high as 50% for employers who tout the service. “We have people who spend all day working with these employers and they’re coming up with clever and creative ways to engage their employees,” says Jesser.

Still, lack of employee buy-in is enough of a problem that LiveHealth Online is considering conducting a study that essentially asks employees, “Why aren’t you using the telehealth service that’s being offered to you?”

As the NBGH suggests, large employers are where telehealth companies are placing their bets. They can “drive the message,” Jesser says.

Wojcik says that if the employer has an on-site clinic, so much the better. It’s a way for employees who are not on site to access the clinic’s services. Also, any telehealth program that’s designed correctly incorporates the patient’s in-person provider; everything done online gets put into the medical record.

Jesser’s job is to tout the benefits of telehealth, but he recognizes that it’s only a tool. “Let’s be clear: Nothing replaces an in-person physical exam from a physician. To be a health insurance company or an employer and start trying to get into that space and saying, ‘OK, you can’t see a doctor in person,’ you’re not going to see that. There’s no replacement for a good relationship with a doctor.”

Possible Employee Wariness Stifles Telehealth’s Acceptance
A lot hinges on this question: Do you feel comfortable getting a diagnosis or being treated for a condition by someone on a screen?
Last summer, Stephen Fatum went to a telemedicine meeting thinking that the industry was on the fringes of medicine. On a huge screen, attendees watched a video of a surgeon in the United States telementoring a surgeon in another country through an operation. The remote surgery was no big deal. Doctors have been doing remote robotic surgeries for more than 15 years now. But the picture, now that was amazing. It was so sharp, so crystal clear, that Fatum, a partner in Barnes and Thornburg, a large Midwestern law firm, who specializes in health care, was dazzled. “I thought somehow, some way, this can help from an education perspective, a mentoring perspective, and have a radical transformation of how health care is delivered in a cost-efficient manner around the world,” says Fatum.

Fatum has lots of company. According to Tracxn, an analytics firm co-founded by Sequoia and Accel alumni to track data about startups, more than 600 companies worldwide were flying the telemedicine flag at the end of 2016. They ranged from small practices caring for patients via teleconsulting to specialists hired by hospitals to remotely monitor patients to companies selling platform technologies, software solutions, and medical devices. Many are niche players. Telemedicine is so white hot right now it makes *Shark Tank* look like an aquarium in a dentist’s office. Worldwide, more than $4 billion poured into industry deals during the first three quarters of 2016, according to the Marcom Capital Group. “Everything indicates that telemedicine is ready to take off,” says Henry Grady, health care industry manager for Sun-Trust Bank in Atlanta.
“I would say that it is poised to grow in leaps and bounds. The model is ready. The technology is ready. The demand is ready.”

In its Physician Trends 2016 Report, Jackson Healthcare, a health care staffing and technology company, projected that telemedicine’s value is on its way to more than doubling from $14.3 billion in 2014 to $36.2 billion in 2020. The report projects that 70% of employer health plans will include telemedicine services as a benefit by the end of this year, and that 90% of health care executives interviewed are developing or implementing a telemedicine program.

IHS Technology’s 2016 report estimates that by next year, 7 million people in the United States will use telemedicine, up from under a half million in 2013.

High-flying numbers like this are impressive, but they also bring up the question of what people are counting as telemedicine. Jonathan Linkous, the CEO of the American Telemedicine Association, defines telemedicine as a “big broad idea of providing care using telecommunications.” That’s a broad definition, and his association has 10,000 members partly because of it, including 220 health systems and 250 companies. Telemedicine is growing partly because more people are using existing services but also because more types of medical services are incorporating a telemedicine component to how they operate, says Linkous.

Four companies—Teladoc, American Well, MD Live, and Doctors on Call—dominate the direct-to-consumer part of the industry, but Linkous says there are at least 20 to 30 startups jockeying for venture capital and a position in that part of the industry. “The big movement at the moment is the direct-to-consumer, or consumer-initiated, care where health insurers will provide telemedicine as a benefit for their clients,” says Linkous.

The less visible—at least to the public—part of the industry involves doctors communicating with other doctors or checking on devices that monitor patients.

Hospital-based telehealth platforms

- Telestroke
- Teleradiology
- Tele-ICU
- Telemental health
- Telepathology
- Cybersurgery
- Remote monitoring
- Telepharmacy
- Consultations

Source: American Hospital Association, 2015

According to the association’s 2017 statistics, teleradiology accounts for 8 million telehealth users, cardiac monitoring for 1.9 million, and ICU monitoring for 650,000. The association tallies the online primary and urgent care users at 750,000 users.

Teleradiology services and capabilities have grown so much that nearly every major hospital uses it, says Linkous, and vRad, headquartered in suburban Minneapolis, is the largest vendor; the company’s website says it has a workforce that includes 500 radiologists.

Fatum represents a neurologist responsible for some fraction of the neurology monitoring encounters. The client works for a telemonitoring company that contracts with hospitals across the country and is paid to sit in his basement and watch surgeries from across the country on several high-definition screens. “He monitors whatever measures physicians use for the neurology system, and if there is a problem he is immediately communicating with the surgeon in the operating room,” Fatum says.

Some telemedicine companies are making money, says Linkous. “If you are a company with your own physicians, yes, there are profitable companies,” he says. But if you are a Mayo or some other large health care system, says Linkous, you may not see telemedicine as a revenue center but as a way to improve quality, lower costs of other services, and expand your reach. Fatum concurs, noting that hospitals hire telemonitoring services to add value and improve the quality of care even though the service may not be reimbursable.

CRG, a Houston venture capital firm that specializes in health care, invested in two telemedicine companies last year, Specialists on Call and Advanced ICU Care. Specialists on Call handles everything from stroke...
consults to psychiatric evaluations. Advanced ICU Care does remote ICU monitoring. According to a company press release, CRG invested $50 million in Specialists on Call in combination of equity and credit. The firm is a minority investor in Advanced ICU Care and has not disclosed its stake in that company.

Red to black

Scott Li, a CRG principal, says his company put money into the companies because hospitals, especially small or rural hospitals, have a hard time hiring specialists. Even some fully staffed medical centers don’t always have a neurologist hanging around the emergency room at 3 a.m. just in case a stroke patient rolls in. “There is a rationale for any type of hospital to employ these services,” Li says.

“These companies have already developed a nice revenue profile,” he says “The next step is for them to grow into a very long-term, sustainable profitability profile.” Don’t expect that to happen overnight; the medical profession, Li says, is skeptical about adopting new modes “of receiving care through or from a different provider.” He sees the direct-to-consumer telemedicine sector becoming a multibillion industry—with this proviso: “One thing I want to caution is that it takes health care a little bit longer to reach those forecasts,” Li says. “The adoption cycle within health care is not like that of an iPhone.”

The slower adoption cycle doesn’t seem to be deterring investors. In its August 2016 Telemedicine Landscape Report, Tracxn counted 528 startups focused on teleconsulting. A majority—336—were launched between 2013 and 2016. Among the best funded are most well known: Specialists on Call, American Well, Teladoc, and Doctor on Demand. When Teladoc went public, its stock traded at $28 a share, fell to $9.77 in May 2016 and was back trading at about $23 a share in March, giving the company a market capitalization of about $1.1 billion. The company’s revenues increased 59% in 2016, to $123 million, but it has yet to turn a profit, although the $39.7 million in losses last year were $7.6 million less than the 2015 losses.

Realistically, telemedicine companies will probably be splashing around in at least some red ink for a while. Many bottom lines in the industry would benefit from some wins in Washington and in state capitals. For example, it would help the industry if the federal government were to loosen the rules on telehealth payment within traditional Medicare.

Calling all millennials

Fatum says state licensing boards can be an obstacle (Teladoc has been in a protracted battle with the Texas Medical Board that may be ending). “The state licensing boards are autonomous government units that take very seriously their jobs,” he says. “They could care less about other states. They have a vested interest in preserving the status quo.”

Public acceptance will be another factor in the profitability equation. A 2015 survey by the American Hospital Association suggests that plenty of folks would be receptive to telemedicine. The hospital association survey found that 76% of Americans feel access to care is a higher priority than seeing a doctor in person, and 70% agreed it was “perfectly acceptable” to communicate with a health care professional via text, email, or video rather than in person.

Demographics would seem to favor telemedicine as the baby boomers age and die off, replaced by tech-savvy millennials. “Once [telemedicine] moves to large cities, it will be adapted very rapidly by the millennial population,” predicts Grady, the Atlanta banker.

Linkous sees a logical progression at play: “It has been kind of an evolutionary revolution where we went from the emergency room to urgent care centers and from urgent care centers to retail clinics. The next stop will be online.”

And Grady, from his perch as a banker, has a follow-the-money sensibility: Solve the reimbursement problems and telemedicine will have “significant penetration,” he says. “Commercial insurers are encouraging their hospitals and major doctor practices to have a proactive strategy,” he says. “For those that do it efficiently and have a strategy, I believe insurers are going to be aggressive in their reimbursement rates because it will save them money.”

Robert Calandra is an independent journalist in the Philadelphia area with more than 20 years of experience writing about health care.
One of the big selling points for telemedicine is the price. A newly published industry-sponsored study of telemedicine found that a visit to a retail clinic can cost $74 on average, an urgent care center about $134, a doctor’s office $109, and an emergency room $1,400. The cost of a virtual visit: about $49. Employers have taken notice. Fully two thirds of them offer electronic physician encounters to their employees today, and by next year, 90% could, the consulting firm Willis Towers Watson reports.

People may be getting more amenable to the idea of seeing their doctor on a laptop, tablet, or smartphone. An American Telemedicine Association consumer survey last year found that 22% of respondents used a virtual visit to see a provider, and a majority of those who didn’t said they would if they could.

So, how good is that care they’re getting for their money?

**Overdoing antibiotics**

Evaluating the quality of telemedicine care is about as easy as evaluating the quality of health care, period, and researchers are still ironing out the methodological kinks. That may be one reason research results are all over the place. This article involved reviewing nine such studies, and the findings are a mixed bag.

Adam Schoenfeld, MD, an internal medicine resident at the University of California–San Francisco who has led a couple of studies of telemedicine, explains...
the allure of the research: “We’re interested in studying this because this is somewhat uncharted territory. There’s no model or guideline for this type of care.”

Last year, Schoenfeld led a study of “commercial virtual visits” that used secret shoppers to initiate encounters at eight different commercial telemedicine websites (Ameridoc, Amwell, Consult a Doctor, Doctor on Demand, MD Aligne, MDLIVE, MeMD, and NowClinic). “What we found was that certain companies do much better than others,” Schoenfeld says. “And the companies do well for certain conditions in certain settings and they do poorly in other conditions and other settings.” So, for example, the percentage of virtual visits with complete histories and physical examinations ranged from 51.7% to 82.4% by company—although Schoenfeld and his colleagues do not identify which companies were better or worse. On the other hand, the study found that the companies did uniformly poorly when it came to conditions where additional testing was needed. Providers adhered to clinical guidelines in only 54.3% of encounters, but they were less adherent for two specific conditions: ankle pain, for which they followed the guideline recommendation of X-rays only 15.5% of the time; and urinary tract infections (UTIs), for which providers ordered the recommended urine culture only 34% of the time. To be fair, Schoenfeld’s study, published in the May 2016 issue of *JAMA Internal Medicine*, analyzed 599 virtual visits—not a huge sample size.

Ateev Mehrotra, MD, of Harvard Medical School, and a member of Managed Care’s editorial advisory board, has studied telemedicine encounters from several angles. In 2013, he led a study that compared 574 e-visits and 7,545 in-person visits at four primary care practices within the University of Pittsburgh Medical Center. The same doctors conducted both the e-visits and in-office visits. The primary care physicians were more inclined to prescribe antibiotics for the two conditions studied, sinusitis and UTI, when they performed an e-visit compared with when they saw patients in the office for the same conditions.

A commentary Mehrotra co-authored for *JAMA Internal Medicine* in 2016 points out that efforts to curb antibiotic overuse have stalled and the use of broad-spectrum antibiotics is increasing. Overuse of broad-spectrum antibiotics contributes to the development of antimicrobial-resistant organisms, and the CDC estimates that 23,000 Americans die each year from antibiotic-resistant bacteria. “We already have a problem that roughly half of all antibiotic prescriptions that are written in doctors’ offices for acute respiratory illness are not indicated. So we have this horrible problem of antibiotic overuse in general, and in this case, e-visits could make the problem worse.”

Mehrotra’s is not an isolated finding. A study published in 2015 in *JAMA Internal Medicine* led by Lori Uscher-Pines of the Rand Corp. compared antibiotic prescribing rates for acute respiratory infections by Teladoc providers, one of the major telemedicine companies, and physician offices. Overall, the prescribing rates were similar, but the Teladoc providers prescribed broad-spectrum antibiotics 86% of the time compared with 56% for physician offices. Henry DePhillips, MD, Teladoc’s chief medical officer, says the company has taken steps to curb broad-spectrum antibiotic prescriptions (see page 30).

But a just-published study of almost 60,000 visits in the *Journal of Medical Internet Research* suggests that antibiotic prescribing is no worse among telehealth providers. The prescribing rates for six infections were only slightly higher for virtual than for in-person office visits (70.5% vs. 64.2%), and there wasn’t any difference in the use of broad-spectrum drugs. However, this was an industry-sponsored study and the authors are with HealthCore, Anthem’s outcomes research unit, and Anthem itself, which owns Health Management Corp. and its LiveHealth Online telehealth arm.

There is, of course, more to telemedicine than the prescription of antibiotics. A 2014 *Health Affairs* study by Rand’s Uscher-Pines and Mehrotra found that Teladoc seems to be expanding access to patients who don’t have a primary care provider, although telemedicine patients have fewer follow-up visits than those who go to a doctor’s office. As far as drawing a conclusion about the quality of care, Uscher-Pines, Mehrotra, and their colleagues weren’t ready to go there: “Future research should assess the impact of...”
Teladoc and other telehealth interventions on the quality and cost of care,” their study concluded.

However, the Anthem study reported similar follow-up rates between virtual and in-person care. The study concluded that care between the two settings was comparable.

Trying to get an accurate read on any quality in health care is not easy, says Jonathan Neufeld, PhD, director of the Great Plains Telehealth Resource Center in Minneapolis, a grant-funded program that serves as a resource for telehealth programs in the northern plains states. “There are no significant studies that have found a quality difference between care provided in person and care provided in video,” he says, noting that “maybe dozens” of such studies have been conducted.

Independence Blue Cross in Philadelphia rolled out its telemedicine program using MDLive last year. The jury is still out. “We’re really trying to gauge the value of it moving forward; the uptake by both members and physicians, and the value that both of them see with this type of a service,” says Medical Director Ron Brooks, MD. At this point, utilization of the IBX telemedicine program is “low,” says Brooks, but he did not have specific numbers.

The idea is to use telemedicine as a “bridge” between primary care visits, says Brooks. “This is one component of the armamentarium of providing care for members,” he says. “We still think there is value to the touch of the physician and the amount of time that they can typically allot, and their flexibility for doing things like an EKG in the office.”

Anthem started offering access to telehealth, through LiveHealth Online, in 2013 and now provides services in 48 states. LiveHealth Online President John Jesser says post-encounter surveys show patients rate both the experiences with providers and the web portal a score of 4.8 out of 5. Seventy percent say it saved them two to three hours in getting an appointment, and 75% to 80% say they completely resolved their issue in one or more visit. “We’re actually comfortable with that because if you go to a doctor, it’s not going to resolve the issue every time,” Jesser says.

To stay on top of quality, LiveHealth Online tracks complaints and compliments about telemedicine encounters, the same similar follow-up as in-office visits. “A good doctor’s a good doctor whether they’re seeing you in person or through live video,” Jesser says. “You have to work with quality doctors, credential them, and have oversight.”

Evaluating telemedicine as a standalone may be an anachronism. The better metric may be to consider the outcome that accounts for both virtual and in-person encounters.

“That’s where I’m hoping we’re going and I think the brighter minds in health care are going there,” says Neufeld of the GPTRC.

“For years, the telemedicine research community said we need the gold-standard study, the randomized clinical trial that will settle the question for once and for all whether telemedicine services are equal to in-person services. I think we are moving past that now. I think we’ve realized that telemedicine is not one thing any more than in-person services are just one thing.”

A sampling of quality studies of telemedicine


Analysis of Teladoc Use Seems To Indicate Expanded Access To Care for Patients Without Prior Connection to a Provider. By Lori Uscher-Pines and Ateev Mehrotra. Health Affairs. February 1, 2014. http://content.healthaffairs.org/content/33/2/258.full.pdf+html

‘Telemental’ Health Is Becoming the Norm

When it’s time for a session, your therapist’s face is on your phone or computer instead of in the room. Telemental health doesn’t mean the end of in-person sessions, but it’s increasingly part of the therapy mix.

By Timothy Kelley
Senior Contributing Editor

When Chris Gethard’s psychotherapist moved to Mexico three years ago, the comedian faced a choice: Find a new therapist or start doing sessions by video. Choosing the latter, he became part of the burgeoning world of telehealth, which is transforming the way care is delivered for mental and emotional ills.

Gethard regularly packed a small Off-Broadway theater last fall with Career Suicide, an autobiographical monologue about “suicide, depression, alcoholism, and all the other funniest parts of life.” But there’s one thing even Gethard doesn’t find funny: the millions of Americans suffering from mental illness who don’t get help. The National Institute for Mental Health says that in a given year, almost a fifth of American adults have diagnosable mental disorders and, by one estimate, a little more than half are treated. That the others threaten to send the U.S. health care system to the poorhouse because of subsequent hospitalizations, ER visits, poor physical health maintenance, and substance abuse with its associated domestic violence, home accidents, and traffic fatalities is, of course, only part of the tragedy.

Can some of these people be reached with assessment, support, and even therapy itself delivered by video and other digital means? The telehealth industry, approaching the $1 billion mark in annual investment, seems to think so. Last year, Mercer’s annual survey of large employers found that 59% offered telemedicine services, almost double the percentage...
that did in 2015. Major telehealth companies like Teladoc, MDHealth, and American Well are ratcheting up their mental health offerings, connecting patients with psychiatrists, psychologists, and social workers via their smartphones, tablets, or home computers.

This is a return to telehealth’s roots. In 1955, Cecil Wittson, MD, of the Nebraska Psychiatric Institute worked with Bell Telephone to create an interactive closed-circuit television system with live transmissions of therapy sessions. It was just for training purposes, though. By the late 1960s, Massachusetts General Hospital was providing “telepsychiatry” services to airport employees through a bidirectional hookup with Logan International Airport.

That’s long before the internet, smartphones, tablets, and the petabytes of digital information scurrying around the world brought us the instant connectivity of today. Still, the evidence supporting telehealth is patchy. Rigorous studies “that show improvements in care or health have been few and in many cases have failed to show benefit,” wrote Eric Topol, MD, and E. Ray Dorsey, MD, in a review article published in the New England Journal of Medicine last July—and they’re hardly tech skeptics. But Peter M. Yellowlees, MD, a professor of clinical psychiatry at the University of California–Davis and president-elect of the American Telemedicine Association, says that what many are now calling “telemental health” has more high-quality randomized controlled trials with positive results supporting it than any other application of telehealth.

Some of these studies simply show that doing X is better than not doing it, which doesn’t tell much about net cost-effectiveness or reaching the untreated. But others show telemental health’s power to reduce expensive hospitalization, either in the psych ward itself or for other conditions triggered or exacerbated by emotional woes.

**Experience with veterans**

Yellowlees points first to the Veterans Administration, which without the headaches of state licensure and other impediments, has been using telehealth for nearly a quarter century. A 2012 study of almost 100,000 patients who came to the VA from 2006 through 2010 showed a 24.2% drop in psychiatric hospitalizations among those who enrolled in a telemental health program. Total inpatient days declined by a similar percentage.

Veterans with PTSD who are reluctant to leave their homes often prefer video to in-person psychotherapy, says Yellowlees, and, in many cases, so do child and adolescent patients. “Say you’re a female who’s been raped, and you’re assigned a male psychiatrist,” he adds, noting that such a patient may feel less vulnerable with a video connection than an in-person session.

Apply to these instances of preference the many people in remote rural areas and correctional institutions, where regular visits by mental health clinicians may not be practical—particularly with an estimated national shortage of 10,000–20,000

**It can take** 45 minutes to travel five miles” in highly populated areas, says psychologist Mary Alvord, PhD. Telehealth isn’t just for rural, fairly isolated counties.

Substantial empirical evidence supports the use of telemental health, he and his coauthors concluded in a 2016 review, also noting that “positive trends are shown in terms of cost savings.” Applying certain filters to a comprehensive literature search from 2005 through February 2015 (methodology had to be rigorous, usually randomized controlled trials, and sample sizes of at least 150), the authors identified 59 studies. They were a bouillabaisse: the patient groups varied and sometimes the telemental health employed just the phone or the internet—or both—rather than video. All of the studies investigating the effects of telemental health on depressive symptoms reported positive outcomes, and improvement of symptoms was found in
patients with comorbidities such as diabetes, COPD, and cardiovascular illness.

The authors found five studies that looked at cost head-on, often with less-than-mind-blowing results. A 588-person study of a behavioral intervention with hypertension patients was called cost-effective despite “no apparent lowering of health care utilization and costs during two years of follow-up.” A stress-reduction app for the military, it was determined, would start to save money at the 1,600-user mark. And in one 2010 U.S. study, 278 telemental health consultations given to 106 rural nursing-home residents saved $3,700 in gasoline costs by avoiding trips to the nursing homes—but that slipped to $925 if one figured they’d have covered four nursing homes per trip. More vital than those saved nickels, the review authors surmised, was that telemental health promised to “fill a gap” in nursing homes “to provide essential care that would not otherwise be available.” There it is again—access.

Yellowlees helped run a 2012 study investigating “asynchronous” telepsychiatry, in which a trained interviewer talked with the patient and then filed a report that a psychiatrist assessed at his or her convenience. The approach was compared with in-person psychiatry sessions and remote communication with a psychiatrist. Asynchronous telepsychiatry became the most cost-effective choice after 249 consultations, the study found, and the researchers concluded that it could allow “more affordable health care to be delivered to a larger population of patients.”

Other recent research identifying possible cost savings from telemental health has been conducted everywhere from rural Kansas to northern Norway. Volume is often the critical piece in making savings significant, and that could be a steep climb for programs just getting off the ground. An analysis of rural telepsychiatry notes, for example, that after a program’s launch, planners may find that “recruiting additional providers to serve rural areas, full or part-time, puts them in competition with existing organizational psychiatry resources.” Without a commitment to change from the top, the report warns, new telepsychiatry programs are “doomed to limited success at best.”

**Not just for blizzards**
The biggest hurdle facing a system seeking to embrace telemental health, says Yellowlees, isn’t winning patients over; “it’s getting providers to take up new approaches to work. It’s not surprising when you think about it. We all believe we’re doing a good job in the traditional way, and it worries us to change.” Often, he says, there’s a generational divide, with younger professionals (like younger patients) adapt-
University School of Medicine and Health Sciences, Alvord is a past president of the American Psychological Association’s Division Society for Media Psychology and Technology. She first embraced videoconferencing in 2005 as a way to hold staff meetings without shuttling between two offices to say everything twice. Soon it became a tool for supervising psychologists: She wrote her state’s board of examiners asking to use it that way and was given permission. And while visiting the VA in Washington to give a talk on the ethics of media interviews, she asked to see how the agency ran its telemental health program.

She’s pleased that Maryland now permits her psychologists to use telemental health—and that Arizona law allows 20 sessions a year without licensure in that state, enabling the practice to serve the snowbird patients who winter there. Licensure and coverage issues remain a challenge with the use of tech, but the picture is brightening. Twenty-nine states now have parity laws requiring insurers to cover telehealth services at the same level as in-person care, although Medicare still reimburses for telehealth only outside metropolitan areas or in “health professional shortage areas.”

Like many boosters, Alvord is also a stickler. “You need a HIPAA-secure video, which means you have to have a business associate agreement with the vendor,” she explains. Skype won’t cut it. (Such agreements apply also to IT and any HIPAA-protected confidential patient information, she explains. Vendors such as Webex and VSee provide secure video platforms and cost providers from $15 to $150 monthly—there’s no charge to patients for the hookup.) You need an informed consent agreement that in advance identifies someone—besides 911—to contact in case of an emergency. And a therapist has to be tech-savvy enough to help someone get back online in the event of a glitch. Alvord gives her staff a detailed checklist for providing telemental health services safely, ethically, and in compliance with regulations.

As for comedian Gethard, he’s happy with his long-distance therapy—and in a man who mines his miseries for a living, happy is hard to argue with. If he were choosing a new therapist he wouldn’t necessarily pick one with an all-video business plan for fear that might signal an emphasis on quantity over quality. But if telemental health has a complication, he says, it’s his own temptation, when his computer “dings” during a session, to break away for a second to see who has emailed him. “I have to effectively pretend the rest of the internet doesn’t exist,” he explains.

“I get that some people resist technology,” says the comedian. “But to me, this is another option for those who need help to find it. That can’t be a bad thing.”

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General interest

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The 10 most important people in managed care

SEPTEMBER
How doctors are paid now—and why it is changing

OCTOBER
Autoimmune diseases

NOVEMBER
Medical directors and chief medical officers

DECEMBER
Our 3rd annual Year in Preview
Being a chief medical officer is nothing new to Henry DePhillips, MD. He has held that title at several companies, including Audax Health, PDR Network, and Medem. But none of those jobs were as prominent as his current one as chief medical officer of Teladoc, the country’s largest telemedicine company by several measures. DePhillips, a board-certified family and community medicine physician, was interviewed by phone in March.

Interview by Peter Wehrwein

Telehealth or telemedicine—which one do you use and is there a meaningful difference? First, there is not a standard definition for either term, and as a result of that, there is a variety of definitions in legislation, regulation, different federal agencies, and even in the private sector. We tend to view telemedicine as a form of medicine, rendering patient care using technology to connect to parties that are not in the same proximity. Telehealth includes health-related education, health monitoring of ongoing chronic conditions, and so forth.

So, Teladoc, you think of yourselves as a telemedicine company? I think based on the definitions that I just shared with you, as of today, yes, I think you would characterize us as a telemedicine company. But if you follow our company, you’ll see we’re expanding our offerings exponentially at this point, and it’s only a matter of time before we implement telemedicine programs around things that are more broadly defined as telehealth.

There’s been a lot of investment in primary care and the patient-centered medical home in American health care. Doesn’t telemedicine undercut those efforts that are trying to make American health care more holistic? I certainly understand how you might come to that observation, but at Teladoc specifically, we work incredibly hard to not only not impede the existing physician–patient relationship, but actually to support it. So, I think the answer is it really depends on the telemedicine company’s business model.

In our primary care program, which is our largest program to date, our marketing materials are very specific about saying we provide access to U.S. board-certified physicians in the scenario when you cannot get in to see your own primary care physician in a timely way.

On top of that, every patient must establish a full electronic health record prior to their first visit with us, and we ask every single patient who has a visit with us permission—required under HIPAA—to share that electronic health record with their primary care physician, if they have one.

We actually ask the questions: Do you have a medical home? Do you have an ongoing care relationship with a primary care physician? And if the answer is no, then several of our health plan clients would like to know that, so that subsequent to a visit with us, they can connect that patient with a primary care physician in the health plan’s network.

We also have a partnership with Compass, which is specifically designed to help identify a medical need, and then, identify an in-person provider who is best suited to provide that need.

Have you done an analysis of how many of your encounters result in a follow-up visit to a primary care physician in person? We have a 92% complete resolution rate for the reason for the initial call over a 30-day follow-up period. In other words, 92% of Teladoc users do not need any subsequent care for the reason they called over a period of 30 days.

The 8% breaks down roughly half and half. About 4% are contacting us with issues that are totally inappropriate for remote care—drug seekers and people...

The transcript of this interview was edited for length and clarity.
with medical issues that just are clearly not appropriate. And the other 4% are folks who, despite appropriate care need additional care. This is the human body we're talking about here. Sometimes people will get worse.

What are the three or four most common problems people call Teladoc doctors with? We now have multiple lines of business. Our episodic primary care program is our busiest program. The top three diagnoses there are sinusitis, bronchitis, and urinary tract infections, rounded out by influenza, which, by the way, is an example of a diagnosis that is ideally suited for telemedicine.

In our dermatology program, chronic recalcitrant acne is among the top. Suspicious lesions, which you would think would be popular, are our number three diagnosis. And then rashes are number two.

In our behavioral health program, it tends to be disorders that you would expect—depression, anxiety. Our number three diagnosis is PTSD. That tends to be very amenable to telemedicine care because some folks are not comfortable venturing out in the community, being seen with others, going to in-person care.

And then, we have a sexual health program that anonymously allows folks to get comprehensive testing and treatment for the entire range of sexually transmitted diseases. The anonymity and the remote nature make it more comfortable for many people.

Why is flu ideal? I think influenza is a prototypical diagnosis for telemedicine. Influenza, when it is epidemic, you can make the diagnosis very, very accurately based on history. You know that if one third of the teachers in the school are out and a quarter of the students are out and all of them have influenza, and you develop prototypical symptoms, chances are really good you have influenza. And unless you have some kind of complications or complicated health history, the CDC actually recommends that you stay out of physician offices so as not to expose other patients, as well as the medical staff.

Also Tamiflu is a prescription medication—non-DEA controlled—which when prescribed very early in the course of influenza significantly reduces the duration and severity of symptoms.

Shifting focus, what did you think of the Rand study in the March issue of Health Affairs that found that 88% of Teladoc use by CalPERS beneficiaries was new utilization and that it added $45 of cost per acute respiratory patient? The gist—and I think this has been found with urgent care clinics—is that telemedicine is feeding new utilization and is going to cost more. We know the author well. She is a very knowledgeable researcher. But that study, I think, illustrates the fact that study design will have a significant impact on study outcomes.

For example, that study used telemedicine visit data that was four- to five-years old—somewhere in there. The design also had a very short follow-up time period. So, there were a number of factors that caused that study to be very different from some of the much more extensive, current, and exhaustive studies that we have done.

When we look at much more recent data and have a 30-day follow-up period, our studies actually show results that are the exact opposite of the study in Health Affairs. That is, about 88% of utilization would have happened anyway in some other setting, whether someone would have gone to the ER, or whatever, and about 12% to 13% of utilization is what we call “new” utilization.

The financial ROI in many of the very large, multi-state, longitudinal studies that we've done demonstrates substantial cost savings in the neighborhood of $472 or so per visit saved over the weighted average cost of that same visit in another setting—a blend of other settings. Also, we have found, give or take, about a $20 per-member, per-month reduction in medical costs across the entire population served by telemedicine.

Have you published those results in a peer-reviewed journal? We have not. It's a very fair question. Having a study peer reviewed adds a significant amount of time to the time of publication, and because we are a publicly held company and we have specific business objectives, we prioritized the importance of getting those studies out to the market sooner, rather than having them peer reviewed. So, we did the next best thing, and that was have very knowledgeable industry, well-known Harvard Medical School researchers actually do that work. We didn't do the work; they did the work. And they went right to our clients for the data. And we chose to publish it in that format, mostly because of speed to market.

\footnote{In a follow-up email, a Teladoc public relations representative said the company looked at data for 482,642 visits for acute respiratory infections during the first 11 months of last year and found that 13% of users indicated, at the point of visit, that they would not have sought treatment if Teladoc were not available.}

\footnote{After the interview, Teladoc shared two case studies by Veracity Healthcare Analytics that were paid for by the company. One of the studies was of Teladoc’s services for Rent-a-Center and the other was of the company’s services for “the nation’s largest home improvement retailer,” which is not named but is presumably Home Depot. The authors of both analyses are listed as Niteesh Choudhry, an associate professor at Harvard Medical School; Arnie Milstein, a professor at Stanford; and Joshua Gagne, an assistant professor at Harvard Medical School. The Rent-a-Center analysis found that the 30-day costs for}
I have questions about quality-of-care issues. I’m interested in the JAMA Internal Medicine study that showed that broad-spectrum antibiotics were more likely to be prescribed in a Teladoc encounter than an in-person physician encounter. Do you see that as a credible finding and, if so, have you taken steps to address the problem? Obviously as chief medical officer of Teladoc, my number one, two, and three responsibilities are quality of patient care. Specific to your question, we do think that the results were credible, and we do think they were correct, and we did take that as constructive feedback to our program. So, not only have we looked at the basis for those results, but we have taken extensive actions to improve our performance in that area. That study shined a nice light on something we needed to go to work on, and we did.

A couple things. During the study period—which was a few years back—there were multiple states that had a legislative three-day prescription limitation for any telemedicine-related encounter. I think that was a regulatory or legislative effort to try to get patients to circle back to their own primary care physician after a telemedicine encounter.

Unfortunately, it had some unintended consequences. There’s a broad-spectrum antibiotic available where you can give a three-day course that results in a full course of treatment. So, there was about a 40% increase in those types of prescriptions in the states that had that legislation or regulation in place. Since then, all states except one have done away with that limitation, which has been helpful in dealing with the broad-spectrum issue.

Everything through the Teladoc program occurs on the Teladoc platform, so we have the ability to look at every single aspect of every single encounter. So, the quality oversight committees—of which we now have five—looked specifically at broad-spectrum prescribing rates and appropriate antibiotic utilization.

And as a result of very specific, very targeted, very focused quality interventions, very often physician-to-physician and peer comparison interventions, our employees that used Teladoc services were $754 less than those that used office visits or the emergency department. The analysis of the home improvement company’s employees showed a 30-day cost savings of $1,157 relative to users of physician and emergency departments and a per-member, per-month savings of $21.30.

Most of Teladoc’s customers are commercial insurers and employers. Medicare? Not so much. Medicaid makes “perfect sense.”

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ost of Teladoc’s customers are commercial insurers and employers. Medicare? Not so much. Medicaid makes “perfect sense.”

Is there anything that resembles the broad-spectrum antibiotic problem that you said you’ve dealt with—when you have found something that was, systematically, maybe a little off-kilter? The other issue that has come up that we’re now looking at is the use of steroid prescriptions for respiratory illnesses. And it looks like in the community there’s a fair amount of that, and we’ve seen more than we’re comfortable with, issuing a prescription for steroids in the setting of acute respiratory infections. So, we now have a very analogous—very similar to the broad-spectrum issue—quality intervention going on where we have updated our clinical practice guidelines and they call out the appropriateness or lack of appropriateness for using steroids. And we have a very similar crackdown-type intervention on folks that tend to be a little more generous with steroids.

Once the docs know that you’re looking, and once you identify that it is not the standard care for certain diagnoses, and once you compare them to their peers, which seems to be very effective, the rates tend to come down very nicely. And we are seeing that in our program.

A different subject. Has Medicare Advantage been a growth area for you? My understanding is there are restrictions on telemedicine in traditional Medicare, but a Medicare Advantage plan has a fair amount of discretion on how it uses telehealth. Traditional Medicare has severe restrictions on the use of telemedicine. Medicare Advantage plans are at liberty to use telemedicine as they see fit. So, the direct answer to your question is, we do have some Medicare Advantage business, and that’s increasing over time. It’s not a huge part of our portfolio. And, don’t forget, there’s legislative capability, and then there are resources. So, although Medicare Advantage organizations are able to use telemedicine, there’s no incremental funding for the addition of a telemedicine program within Medicare Advantage. It all comes under the umbrella of the payment that’s made today. Because there are not additional resources applied, you’re not seeing adoption grow quite as quickly as it would if there were additional resources.

In a follow-up email, a Teladoc public relations representative said the company could not provide information about antibiotic prescribing rates for publication without first disclosing them publicly via an earnings report.
Which payers have been your biggest growth area?

Commercial payers? The commercial health insurance companies are a huge growth area for us. When we began Teladoc back in 2002, we targeted employers. And I think we have 7,000 or so employers with plans at this point. About nine years ago, we started selling to health plans. We now have over 30, although it might be higher than that. We have more in the pipeline. Aetna is obviously one of our flagship clients. We have multiple Blues plans, we have some multistate Medicaid plans. But commercial insurance is huge as far as adopting telemedicine. The biggest benefits are seen initially with self-insured employers, for some reason. And then, fully insured employers are on the heels of that.

Because of the Medicare limitations, we're not seeing quite as much deployment across Medicare. We are seeing an increase in deployment across Medicaid. If you think about it, it makes perfect sense. If you combine the improved access, the reduction in non-emergency care, emergency room utilization, and the medical cost savings, all Medicaid plans could benefit from those three things. So we are seeing significant adoption in Medicaid programs.

Do you have good data in the Medicaid population that telehealth reduces ER use? We don't have data that is as robust as we have in the commercial populations. The studies we will send you on cost savings are all done in a large, 50-state commercial employers—Fortune 1,000 companies, basically. We don't have near as much data on the Medicaid populations, which is why we're excited about the Medicaid clients that we have enrolled and are getting up and running.

The good news is that the outcome studies don't take too long to run. One of the landmark studies that demonstrates cost savings was done with an 18-month pre- and post-implementation time for a 50-state home-improvement retailer, whose color is orange. The studies don't take too long, and we hope to have some very, very robust Medicaid outcomes data in the not-too-distant future.

Home Depot—is that a self-insurance situation? They are a self-insured organization, as are some of the other companies that we've studied, which you will receive information on. It was really an ideal company to study because they have a presence in all 50 states, which cuts across all care settings, models, ER costs, things like that, across all 50 states. The results blew me away. I expected some medical cost savings. I did not expect anywhere near the magnitude that study demonstrated.

Maybe it's because all of those employees are used
to doing do-it-yourself projects. You can put that quote in your article if you'd like to. I'm fine with that.

Anything in the repeal and replacement of the ACA that Teladoc and the industry is looking for? Telemedicine is a very nonpartisan issue. Regarding the ACA and whatever the replacement is going to be, we think that the benefits of telemedicine are going to occur whatever happens. There were benefits under the ACA; there will be benefits under whatever new program is implemented.

There's no particular piece of what the Republicans are talking about—Medicaid block grants or larger HSAs—that you see as being particularly advantageous, either to Teladoc, or to the industry in general? I would say that's correct, with one comment. To the extent that any legislation—this or future legislation—continues to place responsibility for the cost of care on to the providers of care, which is sort of what the ACA was about, any time that becomes more important, telemedicine has a larger role.

If you extend your practice with telemedicine, you're allowing patients, when you're not in the office, to be able to access you or your colleagues for care, which prevents leakage—going outside of your system to maybe an unaffiliated ER, where the costs are going to be astronomical. So, to the extent that new legislation partners being responsible for the cost of care—the outcomes—together with the provision of care, telemedicine will actually have an increasing role in that scenario.

What are your membership goals? Our goal for this year—and you'll see it in our filings—we plan to end the 2017 calendar year with between 21.5 and 23 million members. Growing from about 17.5 million, which is where we ended 2016. One measurement of our growth is membership, but we think a far more important measure of our growth is utilization. The number of visits that our members are using telemedicine for is increasing quite a bit faster than the increase in membership.

What about revenues and losses? I see that your revenues are up, but you also have net losses. When does Teladoc expect to become profitable? That's also in the filings. We have published to the markets that we will achieve EBITDA breakeven in the fourth quarter of 2017. And we are aggressively pursuing that goal.

The interview was conducted before the House Republicans’ American Health Care Act was made public.

In a follow-up email, a Teladoc representative said that the company had 952,081 visits in 2016, an increase of 65% from 2015.
Telehealth, you’ve got some fans among MANAGED CARE’s readers.

In an online survey conducted in late February and early March, 37% of the 174 respondents rated the likelihood that telehealth will reduce health care costs as high, and 50% favored laws and regulations that would encourage its adoption.

About a third of respondents had had a firsthand experience with telehealth as a provider or as a patient (either themselves or a family member). From both perspectives, it was a good experience. As providers, 40% gave the experience a high quality rating (a 6 or 7 on a 1–7 scale). As patients, it was more favorable, with 59% giving the experience high marks.

Chronic disease management (68% of respondents) and mental health therapy (52%) were picked most often as the best applications of telehealth.

MediMedia Research, which conducted this poll, is a unit of MediMedia Managed Markets, an Icon plc company. MANAGED CARE is owned by MediMedia Managed Markets.

### Likelyhood TeleHealth Will Reduce Health Care Costs

![Likelihood TeleHealth Will Reduce Health Care Costs](chart)

### Satisfied with TeleHealth Services Provided

![Satisfied with TeleHealth Services Provided](chart)

### Best Applications of TeleHealth

- Chronic disease management: 68%
- Mental health therapy sessions: 52%
- Primary care: 43%
- Dermatology: 36%
- Geriatrics: 32%
- Urgent care: 29%
- Palliative care: 28%
- Acute stroke care: 21%
- Other: 14%
- No good applications at this time: 4%

Source for all charts: MediMedia Research

**Other Responses**
- Addiction medicine
- Advice line
- After in-person evaluation
- Home health monitoring
- Long-term care
- Medication adherence
- Post-surgical care
- Simple ailments
- Symptom management
The health care industry is here to stay, but meeting the ever-growing demands of an aging, consumer-minded population is not without its challenges. Physician demand in this country outstrips supply by a significant margin. According to a recent report commissioned by the Association of American Medical Colleges, by 2025 this gap will be somewhere between 60,000 and 95,000 physicians. By some estimates, as many as 20% of Americans don’t have access to a primary care provider. And for those who do, the average wait for a family practice visit is 19.5 days.

How can we overcome these challenges? Enter virtual care, the “next-gen” solution to all our problems. On the surface, virtual care promises to be just that. For consumers it is convenient, accessible, and available around the clock. In a recent survey, 72% of the population indicated a willingness to see a physician via video. For providers, payers, and other economic stakeholders, virtual care promotes an efficient marketplace. It eliminates a mismatch between physician supply and patient demand and encourages competition based on delivering greater value at lower price points. That’s just the beginning. With a little imagination, the potential for virtual care may be limitless. For example, it no longer seems far-fetched that a surgeon might perform a complex procedure at a site hundreds or even thousands of miles away using a remotely-controlled robotic system (think drones, but for health care). With geography removed as a barrier, concepts like “centers of excellence” could be redefined overnight.

It’s a struggle

It is easy to dream big. Meanwhile, back in the real world, most provider organizations are struggling with how to make even the most basic virtual care program work—and payers with how to reimburse for them. Upfront investments can be staggering. Market players are reticent to place capital bets of such magnitude when the answers to fundamental business model questions remain unclear. Consumers, while intrigued by the innovative access, expect discounted pricing relative to traditional physician office visits, making it difficult for the stand-alone economics to pencil out. Antiquated regulations create significant barriers to growth by, for example, limiting virtual care delivery across state lines. Niche players with point solutions are chasing targeted segments of the market, further fragmenting the landscape. With challenges like these, it is no wonder that virtual care’s progress is lagging in its promise.

New waves of interest

Siphon off some of the froth, and the reality is that virtual care is simply another access mechanism—version 2.0 to telemedicine, which has been around since the mid-’60s. Technology advancement and consumer activation are sparking new waves of interest and innovation.

Once you get beyond the convenience aspects, virtual care is not so much different than the rest of health care today. It provides consumers with fragmented, reactive solutions to “in the moment” problems. It only achieves its true potential when it becomes part of a broader portfolio that brings people into integrated, longitudinal health care. When that happens, it can support individuals on a wide range of health care journeys, from wellness to emergent episodes to ongoing chronic disease. Under this paradigm, an effective virtual care program is much more complex than simply signing on with a vendor partner or adding one to a network. The “wiring” necessary to deliver high-value connectivity into a truly integrated health system is complicated, but those who figure out how to do it will win over consumers in the long term.

It’s a lot of work. The good news is that great progress is already being made. As technology and consumer expectations continue to evolve, we can expect virtual care to play an increasingly important role in ushering in truly integrated care.

Just be sure to watch out for providers wandering the hallways glued to their iPads the next time you’re in your physician’s office.

By Zachary Hafner
Advisory Board

Zachary Hafner leads the Advisory Board’s strategy consulting practice.

Finding the Virtue in Virtual Care

Virtual care offerings come with no shortage of complexities, but their potential for value has many asking when, not if, to invest.
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Telemedicine Seems To Work But Payment Creates a Disconnect

The cost savings go to payers, but providers often wind up footing the bill. Value-based care could solve the problem.

By Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD
Medical Directors Forum Steering Committee

With telemedicine services growing each and every day, the effective use of these options requires the answering of at least four questions:
- Which patients will benefit?
- When and where should this service be utilized?
- What service is optimum?
- Who should pay for the services?

This last question is the primary driver because organizations are typically reluctant to invest upfront for anticipated savings as opposed to spending on something sure to increase their revenue, such as radiology equipment or new doctors. Unfortunately, most telemedicine opportunities are on the cost-savings, not the revenue-producing, side of the ledger.

There are some limited examples where telemedicine is paid for directly and thereby provides a source of revenue. One example is Medicare’s payment for a limited number of Part B clinical consultative services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. Currently, for Medicare eligible telehealth services, the use of a telecommunications system substituting for an in-person encounter must occur in parts of the country that CMS classifies as rural Health Professional Shortage Areas.

Who pays?
In addition to the heavy restriction on revenue support for telemedicine, exactly how the cost savings are experienced is a problem. Currently, the payer (commercial, Medicare, Medicaid) responsible for the total cost of care usually gets the economic benefit of telemedicine. But is it the hospital system or skilled nursing facility (SNF) that pays for the service?

Take, for example, use of virtual after-hours SNF services offered by some primary care providers. While the savings are attributed to either the Medicare fee-for-service program or a Medicare Advantage plan, neither is typically willing to pay directly for telemedicine services.

Instead others, such as SNFs, are leading the telemedicine investment for primary care provider after-hours coverage. Further complicating the support of this activity is the fact that SNFs’ support of telemedicine in primary care may actually end up decreasing their Medicare Part A revenues because telemedicine may reduce avoidable admissions. So why do it? The goal is to improve patient care. But there’s the potential for increased volume by virtue of being a preferred SNF in the narrowing post-acute health care network.

As American health care shifts from fee-for-service, disconnected health care to value-based, holistic care, an alignment between providers and total cost of care should encourage the use of telemedicine—especially in cases where it has been shown to reduce costs and improve individual care and population health. If value-based care can begin to iron out the problems about how telemedicine is paid for, we can then begin to focus on the important questions of where, when, and what telemedicine services are needed to improve health care outcomes.

Your turn: Post your response at medicaldirectorsforum.com/curbsideConsult
Prior authorization is one of the major tools in the insurer toolkit for managing cost and utilization. Most providers hate it, none like it. But prior approval for medical treatment for those addicted to opioids, including heroin, and other drugs is in a different category, says Corey Waller, MD, a senior medical director at the Camden Coalition for Healthcare Providers in New Jersey.

"Any delay equals an increased risk of death, and we’ve removed that risk from almost every other disease entity where we have a known lifesaving intervention," says Waller, an addiction and emergency medicine physician and expert in caring for patients with high-cost conditions.

Patients with addictions are unlikely to wait the hours or days it takes health insurers to approve the medications they need, says Waller.

Insurers are changing their practices, but not without some outside pressure. After Eric Schneiderman, New York State attorney general, investigated the prior authorization practices of Anthem and Cigna, the companies dropped the process for what are called medication-assisted therapies, which include buprenorphine and naloxone. Although Schneiderman’s reach does not extend beyond New York, both insurers implemented the changes nationwide. Buprenorphine is prescribed to help people quit or reduce their use of opioids. Naloxone is used in emergencies to treat opioid overdoses.

Attorneys general throughout the country can reach similar agreements with all health insurers, the AMA said in a February letter to the National Association of Attorneys General. For patients with opioid use disorder, utilization management rules can have a negative effect on their care and health, wrote AMA CEO James L. Madara, MD. “With respect to opioid use disorders, that could mean relapse or death from overdose,” the letter said.

Shortly after the AMA letter, Aetna announced it was removing prior authorization rules on all buprenorphine products effective March 1 for all commercial formularies. Aetna did not explain what prompted the change, except to say it was committed to reducing the rate of opioid-related overdoses, emergency department visits, and deaths.

Even if some important insurers have changed their prior authorization requirements, many haven’t. Waller asks whether such restrictions are legal when none exist for other life-threatening conditions. “For many conditions, there is no wall between the patient and the lifesaving intervention,” he explains. “But for addiction, where there is stigma and actually discrimination against these patients, putting a barrier between the patient and a definitive treatment is almost the standard of care.”

Consider, for example, the no-questions-asked approach in how hospitals treat heart attack patients. Like opioid addicts, they come to the emergency department. And while a heroin addict might wait hours or days, a patient with chest pains sees a specialist right away. Cardiologists do diagnostic tests and maybe a procedure that costs tens of thousands of dollars, Waller says. The insurer pays the bill.

“There’s no prior authorization for a $50,000 intervention that decreases mortality at the same or lesser rate than a prescription for buprenorphine or naloxone would,” Waller comments. “No one would stand for that. Yet, there’s a prior authorization process for something that costs pennies on the dollar compared to that big intervention.”

The 2008 law that established parity for mental health and addiction treatment was supposed to prevent such disparities. Yet, insurers routinely ignore the law, Waller argues.

The counterargument, insurers say, is that prior authorization allows for exceptions and, if applied correctly, helps get patients the most appropriate drugs and perhaps counseling, says Susan A. Cantrell, CEO of the Academy of Managed Care Pharmacy.

“Certainly, there are drawbacks to prior authorization, but there’s also a reason for it in terms of taking care of the patient,” she says. “And that is to ensure that you’re not just focusing on the medication, and that the wraparound treatment—the support system that the patient needs—is taken into consideration and that all the resources are brought to bear to help treat that patient.”

Are Insurers’ Prior Authorization Rules Killing Opioid Addicts?

Some insurers are changing their rules after the AMA and others said prior authorization could result in treatment delays that can be deadly.

By Joseph Burns
Contributing Editor
The subtitle of this book is “Why you should care,” and the authors present a compelling case why everyone should and why the current national policy debate goes far beyond the pros and cons of the ACA and its proposed replacement, the American Health Care Act (AHCA). The debate is fundamentally about the role and reach of government. The book challenges the policy assumptions of both Democrats and Republicans. It explains how our country is so ideologically polarized that a consensus on health care is unlikely to emerge for the foreseeable future.

One of the most intriguing insights of the book is how often Republican leaders advanced progressive health care programs in the past but, in the last decade, how little they have contributed to pragmatic health care legislation because of a change in political ideology.

The authors, Harry Nelson and Rob Fuller, are well-respected health care attorneys in Los Angeles. They trace the contours of the current debate back to the controversy over the passage of Medicare and Medicaid in 1965. Many of the lessons learned from legislative battles fought more than 50 years ago are contrasted with Clinton-era failures and then how the Obama administration learned from them, fashioning a strategy that quelled the potential opposition of health care providers and pharmaceutical companies. Concessions were made to providers and payers. One result was that the provisions of the ACA that might have tackled costs were blunted.

The ACA’s bumpy road to implementation reflects the deep-seated political and philosophical divide between the two parties about the role of government and pros and cons of market-driven solutions. Some Republicans want the AHCA to go much further—it is disparaged as Obamacare Lite in some circles. But relative to the ACA, there’s no doubt that the AHCA reflects the prevailing Republican belief in a much narrower role for government. The new law will place far more financial responsibility for health care on individuals and give states more discretion over their Medicaid programs.

The AHCA will remove current subsidies for individuals who buy coverage through the exchanges and replace them with tax credits that, starting next year, can be used to purchase coverage either through an exchange or outside one. The ACA subsidies are indexed to income and premium; the AHCA’s are indexed only to age and in amounts that, along with other changes, favor the young and disadvantage the old.

AHCA also loosens the rules on the types of health plans that can be sold in the nongroup market and will nearly double the allowable contribution to health savings accounts. The approach the House Republicans have taken to tax credits for health insurance is in keeping with the party’s current philosophy of using tax policy as a vehicle for redefining a smaller, less obtrusive role of government.

But ideologically pure the AHCA is not. In fact, it keeps many of the most popular provisions of the ACA: the ban on pre-existing conditions exclusions and premium differences, allowing adult children to stay on their parents’ policy till they are 26, caps on out-of-pocket expenses, and no annual or lifetime limits.

Nelson and Fuller anticipated many aspects of the AHCA and the negative consequences that the ACA’s repeal will have for low-income and elderly Americans. They see the legislation—correctly—as a pivot away from prior Republican administrations that expanded coverage for seniors.

From Obamacare To Trumpcare uses common sense to analyze health care. And even knowledgeable readers will appreciate the authors’ efforts to demystify the jargon that often obfuscates the underlying political agenda of both parties. Nelson and Fuller skillfully present a balanced perspective, so readers will leave their book with something that’s in scarce supply—understanding and context.

Peter Boland of Boland Healthcare is a health care management consultant in Berkeley, Calif., and a member of Managed Care’s editorial advisory board.
Federal per capita funding of Medicaid deals a wild card to the states

Republicans say it brings efficiency and flexibility. Others see dire consequences for beneficiaries and state budgets.

How the federal government funds Medicaid would change dramatically under House Republicans' American Health Care Act (AHCA).

Since its inception, the federal government has financed a certain percentage of Medicaid expenditures. The percentage has varied with a state's per capita income relative to the national average and other factors. The current federal share ranges from 50% to 75%. It has increased in recent years both because of provisions in the 2009 fiscal stimulus bill and, of course, ACA Medicaid expansion.

The AHCA legislation that House Republicans unveiled on March 6 would ditch the percentage funding and replace it with a set amount per Medicaid beneficiary. The bill calls for using each state's spending in 2016 as the base year to arrive at the per Medicaid beneficiary amount.

In its report on the AHCA, the Congressional Budget Office projected that by 2026, 14 million fewer Americans would be covered under the AHCA, as it was proposed, than under the ACA if the law was left on the books. The CBO also predicted big savings for the federal government from changing the way Medicaid is funded. Starting this year through 2026, the savings would add up $880 billion, by the CBO's figuring.

Moving to per capita funding of Medicaid was discussed at some length in the A Better Way plan that House Speaker Paul Ryan released last summer, so it wasn't a big surprise to see it in the AHCA. Ryan argued in A Better Way that per capita funding will reduce federal spending, a priority for budget hawks, and help modernize Medicaid by improving the incentives for states to better manage the program. Ryan also said that it makes sense to put federal Medicaid funding on what is, effectively, a per-member, per-month basis when about two thirds of Medicaid beneficiaries get their benefits through a managed care plan.

But Republicans have also talked about changing federal Medicaid funding so states would get the money in lump sums as block grants. Sen. Ted Cruz of Texas attacked per capita funding in the initial version of the AHCA as having too many federal strings attached. So, to win conservatives over, Ryan and his allies amended the legislation to allow states to choose either block grant or per capita funding.
Earlier this year, before the AHCA was out, Avalere Health published a report that compared the block grant approach with the per capita one. Avalere’s projections were based on a boatload of assumptions, so the specifics aren’t as important as the general point that block grants would reduce federal spending more than per capita funding.

In Avalere’s pre-AHCA calculations, block grants would mean a decrease in federal Medicaid dollars for every state except North Dakota, whereas per-capita funding would increase funding for about half of the states. Why the difference? Block grants, because they are lump sums, would squeeze state Medicaid programs from two sides: enrollment and per-beneficiary health care costs.

Under a per-capita scheme, federal funding will, to some extent, keep pace with Medicaid spending in states with growing numbers of Medicaid beneficiaries. “Per capita caps involve a little less risk for the states, but they still shift a great deal of financial risk from the federal budget to state budgets,” David Grande, MD, an assistant professor at the University of Pennsylvania School of Medicine and a senior fellow at the Penn’s Leonard Davis Institute of Health Economics, noted in an email to Managed Care.

While Republicans talk about efficiency and flexibility, Grande and others see the per capita funding as putting a new, onerous limit on federal support of Medicaid that will have many negative consequences: reduced payments to an already dwindling supply of providers, barebones benefits, incentives for states to avoid enrolling higher cost individuals. “States would end up much better off [financially] if the sickest did not enroll,” noted Grande.

New treatments, if they are expensive, will hit state budgets hard under per capita Medicaid funding, according to Grande, who pointed to the hepatitis C drugs like Sovaldi as an example. “And we shouldn’t forget,” he wrote, “that unlike the federal government, states have to balance their budgets, even during a recession when revenues fall and safety-net demands increase.”
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