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Putting customers first in an era of rapid tech innovation

What you can learn from Cigna’s approach

We are in a time of tremendous technology opportunity in healthcare innovation. For example, it is now possible to create patient-specific, biodegradable implants using 3D printing, use artificial intelligence tools to put the evidence base into the clinician’s hands at the point of care, and perform common diagnostic tests via a smartphone.

At Cigna, technology is viewed as a strategic enabler that powers our business strategy—creating closer, more meaningful connections with our customers during the moments that matter. It is during those critical moments, when our customers most depend on us, that we use innovation to meet their needs, provide support and deliver the best possible clinical outcomes. At the same time, our customers are pulling from experiences outside the healthcare industry that shape their expectations of how they want to be engaged. They’ve come to expect personalized, easy to use, digital services from retailers and other companies—and they expect the same with healthcare.

Understand your customer

The innovation conversation is centered on first understanding customer needs and expectations—and then evaluating how technology enables the solution. We have deployed this approach at a local market level. For example, employees of one large Cigna client, based in the United Kingdom, were challenged with the queues for urgent care in the government-sponsored National Health System. To complement the existing healthcare system, we partnered with the client to develop a completely mobile virtual health team app, WinstonQED. This app brought together telemedicine, e-prescribing, instrumentation, and virtual health and wellness support in a manner that was unique in the marketplace.

Another client, based in China, was focused on addressing the stress-related issues of their customer service representatives. Given the client’s interest in virtual and augmented reality, we brought to market a virtual relaxation solution through virtual gaming headsets. Other client companies around the world have now requested similar solutions. The result: Cigna Virtual Health, a portfolio of virtual reality apps, is changing the way clients manage high-stress situations for their employee populations.

Finally, one of our global clients was seeking a solution that would help guide its employees through critical healthcare decision points, such as selecting a plan, choosing a primary care physician or receiving preventive services. Through a new app called Cigna One Guide, customers can personalize their tool kit and receive timely information that helps them make more informed, engaged decisions. The degree of personalization is unparalleled, and truly represents a significant advancement in applying CRM concepts to help customers navigate the complexities of the healthcare experience.

The learning for the healthcare vertical is this: First understand your customers—their needs and their preferences—and then build the technology solution set, rather than chasing the new shiny object. Our focus on localized and targeted innovation aligned to our strategic imperatives enables Cigna to make the mission real: improving health, well-being and sense of security.

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Tech improves disease management

Real-world tools underscore the potential

by DONNA MARBURY

Finding technology solutions to diagnose and manage chronic conditions is critical. Half of Americans currently suffer from chronic conditions, and 25% of Americans have two or more chronic diseases, according to the CDC. This number is expected to skyrocket as the Baby Boomers age.

“Technology has made inroads into the patient consult and clinical workflow in ways physicians could have scarcely imagined just a decade ago,” says Edward I. Ginns, MD, PhD, DABCC, neurology franchise medical director at Quest Diagnostics. “Today, physicians can access clinical, prescribing and other patient data at their fingertips using electronic medical records and associated technologies, such as clinical analytics and mobile devices.”

Quest Diagnostics is just one of many companies working to find solutions to help patients be more accountable for their healthcare, while being cost effective and interoperable. It’s a challenge to balance multiple healthcare goals, Ginns says.

“While these technologies have yet to fulfill their potential to contribute to good medical practice, it is evident that they afford opportunities to better manage patient care, improve efficiency, and consider population-health insights in medical decision-making,” he says.

Here are some upcoming technology solutions to keep an eye on:

Non-invasive blood glucose monitors
Up to 67% of patients with diabetes say finger-pricking and other glucose testing is invasive and painful. Researchers have worked for years to find easier, less painful methods.

Ronny Priefer, PhD, professor of medicinal chemistry; and Michael Rust, PhD, associate professor of biomedical engineering; both of Western New England University, presented a handheld device that measures blood glucose levels based on a patient’s breath at the 2016 American Association of Pharmaceutical Scientists Annual Meeting and Exposition. The device is now the size of a small book, but Priefer says once it hits the market it will be the size of a smartphone.

“A technology that is non-invasive will improve the compliance levels of blood glucose monitoring for the diabetic population,” says Priefer. “Improved compliance equals decreased diabetic complications. Diabetic complications are a $250 billion annual problem within the United States.”

The device detects a correlation between blood glucose levels and breath acetone in people with type 1 and type 2 diabetes. “It has been tested against a common blood-glucose monitoring finger-prick device, which has a reported accuracy of ±15%,” Priefer says.

The researchers hope the device will be on the market by 2020. Priefer adds that it will have Bluetooth technology and be available to both patients and clinicians.

Artificial pancreas
Type 1 diabetics will be able to monitor insulin levels without checking blood sugar and administering insulin multiple times per day thanks to a new wearable pump called an artificial pancreas.

The Medtronic MiniMed 670G system uses algorithms to deliver insulin to patients on a continuous loop. The system can be programmed by the user to deliver insulin at a predetermined rate, or can be programmed to automatically adjust based on insulin need. A glucose sensor is inserted into the skin near the abdomen to monitor glucose levels and administer medicine. A separate, handheld device displays alerts and tracks glucose trends.

“The system delivers a variable rate of insulin 24 hours a day based on the personalized needs of the individual, maximizing the time glucose levels are within the target
range. It is designed to learn what an individual’s insulin needs are and to take action to minimize both high and low glucose levels,” says Hooman Hakami, executive vice president and group president of Medtronic Diabetes. “As a result, the system requires minimal input. Users only need to enter mealtime carbohydrates, accept bolus correction recommendations, and periodically calibrate the sensor.”

The device was approved by the FDA in September 2016, and will be available to purchase this spring, according to Hakami.

Digital dementia testing
Most dementia and cognitive impairment testing is paper-based, but that could change soon. Quest Diagnostics developed CogniSense, a digital dementia assessment test that can be downloaded on iPads and other tablets, and aligns with nearly 600 electronic health records.

“CogniSense was piloted by Primary PartnerCare, which is the largest ACO focused on primary care in Long Island, New York,” Ginns says. “Over the four-month pilot, CogniSense helped identify numerous cases of cognitive impairment due to a number of causes, and may have reduced referrals to neurologists.”

The app is currently available in the iTunes store and costs $15 per patient assessment, but Ginns says most health plans reimburse the cost.

Portable COPD testing devices
There are nearly 12 million undiagnosed people with COPD. That’s why diagnostic tests that can diagnose COPD earlier, while also working with existing medical office technology and other pulmonary function tests, are most valuable to healthcare providers, says Georg Harnoncourt, CEO of ndd Medical Technologies, Inc.

“Pulmonary function tests have drastically changed over the years. In the past, the vast majority of diagnostic tests for COPD have only taken place in lung function labs,” Harnoncourt says. “Conventional lab equipment requires specialized personnel, who are primarily trained to maintain the equipment and to coach the patients through a series of tests—not to provide the level of care and attention that a patient would receive from their primary care physicians. Many lung function labs are overwhelmed and incredibly busy and primarily focus on maintaining the equipment rather than ongoing patient care.”

Harnoncourt says that ndd has two portable COPD testing devices: the EasyOne measures how much air and how quickly the patient inhales and exhales, with a direct connection to a printer, computer or electronic health records system; the EasyOne Pro performs diffusion capacity testing, spirometry and full lung volumes in 20 minutes at the point of care.

“In addition to being able to quickly test patients at the point of care, [the devices] can reduce wait times, increase the accuracy of diagnosis and decrease patient transport costs,” Harnoncourt says. “Since these devices are simplified and user-friendly, there is less need for training, which can improve work flow and drastically increase the efficiency of the health system.”

Donna Marbury is a writer in Columbus, Ohio

"Technology has made inroads into the patient consult and clinical work flow in ways physicians could have scarcely imagined just a decade ago.”

- EDWARD I. GINNS, MD, QUEST DIAGNOSTICS

85% of physicians see advantages for digital health solutions in caring for patients. Slightly more PCPs (87%) feel this way than specialists (83%).

Source: American Medical Association survey of 1,300 practicing U.S. physicians, July 2016
Do physicians dismiss patients’ financial concerns?

It’s time to start the conversation by AINE CRYTS

With access to information about the cost of care, patients can make better choices about treatment paths that are aligned with their financial goals. Absent that information—or conversations with their physicians about costs—it’s virtually impossible for patients to incorporate this information into their decision-making.

Herein lies the problem: When physicians don’t talk to their patients about the cost of the care they receive, patients who are blindsided by medical bills may stop showing up for appointments, stop taking medications, and/or decide against pursuing their recommended treatment plans, which reduces the cost of care in the short term but can result in higher costs—for payers, providers, and patients—in the long term.

“We as physicians are trained to try to help patients weigh pros and cons [of treatment paths], but we don’t do that well when it comes to costs.”

PETER UBEL, MD, DUKE UNIVERSITY

What physicians often forget is that the cost of that ultrasound—which could be as much as $500—can “invade our patients’ wallets,” he says.

Go-to strategies aren’t working

Ubel dove deeper into this topic for a study published in Health Affairs in 2016. After analyzing 1,775 clinical interactions between physicians and patients, Ubel and his research team found that physicians typically demonstrated two types of behavior when patients brought up financial concerns about the cost of care:

1. They were dismissive of such concerns from patients; or,
2. They were uncertain about discussing patients’ out-of-pocket costs or leaned on short-term solutions—such as 14-day discount cards for a prescription drug or free samples that happened to be in the office—rather than discussing treatment alternatives aligned with patients’ financial concerns.

Ubel and the researchers focused on encounters between patients and their physicians regarding breast cancer, depression, and rheumatoid arthritis. These conditions were chosen because they often require expensive treatments that can lead to high out-of-pocket costs.

Root of the problem

One reason physicians don’t discuss out-of-pocket costs as much as they should is because they’re busy, says Ubel. But focusing on treating a condition without discussing costs can have serious implications. Take diabetes, for example, he says. If a physician wants his or her patient to try a new medication to lower their blood sugar, and the physician hasn’t taken the time to screen for the patient’s financial concerns, the patient may stop taking the medication or not fill the prescription.

While doctors might assume they know what’s medically best, they need to become comfortable talking to patients about what might be “medically second best or good enough,” says Ubel. This conversation could be the difference between a patient opting for
Cost-related conversations between physicians and patients are essential because there’s a “national spotlight on cost transparency,” says Robin Gelburd, president of FAIR Health. In a departure from the past when only payers and employers needed to focus on the cost of care, consumers are being “plucked from the chorus line” and put “in a starring role” in terms of their treatment expenses, she says.

Currently, most patients only discover the cost of care when they receive a bill. These bills are always a surprise, says Gelburd, who insists that if consumers have access to the cost of care in advance they will file fewer complaints and express a greater level of satisfaction with the clinical aspects of their care.

Plus, it’s in the physician’s best interest to educate patients about the cost of care, she says. “If patients can’t pay for the care they receive, providers might not be able to collect on balance bills.”

Aine Cryts is a writer based in Boston.

No longer an option

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Aine Cryts is a writer based in Boston.

Q: What patient-centered areas is your organization most focused on to expand and secure market share? (select all that apply)

51.6% Expanding our customer experience improvement initiatives
42.7% More cost/quality transparency
42% Increasing consumer outreach
32.5% Expanding consumer relationship management capabilities
12.7% Providing more financial counseling
7% Other (please specify)


TOOLS THAT HELP

So now that the necessity is established, how can physicians begin incorporating cost into patient conversations? Here are some tips:

1. Use technology

Hard-coding information into the electronic health record (EHR) about prescription drugs and procedure costs can make it easier, says Ubel. That’s because physicians typically have access to the EHR during patient visits.

2. Ask the right questions

Physicians also need to find a way to screen for financial distress. Ubel recommends physicians ask patients, “Do you want to talk about healthcare expenses?”

3. Refer patients to helpful resources

Gelburd reinforces that physicians don’t need to be experts in patients’ out-of-pocket costs, but they can refer patients to resources that are written in patient-friendly language. For example, FAIR Health’s consumer-facing website, www.fairhealthconsumer.org, provides data on billions of billed medical and dental services.

“Nothing makes a patient angrier than receiving a $500 bill they didn’t expect. They get very upset because no one told them,” says Richard L. Gundling, senior vice president of healthcare financial practices at the Healthcare Financial Management Association (HFMA).

In addition to suggesting that patients contact their insurance company to learn about the cost of a particular procedure, Gundling recommends that physicians refer patients to “Understanding Healthcare Prices: A Consumer Guide,” which was developed by HFMA.

4. Rely more on payers for information

Ubel encourages payers to provide more comprehensive information to providers and patients about the true cost of care. “That’s part of the insurance company’s role,” he says. Not only that, it’s in payers’ best interest to provide cost information to patients, especially to those with high-deductible plans, he says. “That saves [payers] money.”
ALL EYES ARE ON WASHINGTON, D.C., as the nation looks to see what imprint President Trump puts on healthcare and other issues that face the country and the world. Meanwhile, provider executives need to focus on delivering high-quality patient care and payer executives need to continue to retain members—all with an eye on quality, cost, and patient and member satisfaction. To be sure, both payer and provider executives will continue to plan for the projected 80 million Medicare beneficiaries in 2030. Still, millennials will soon outnumber seniors as the patients most demanding healthcare.

All of these potential changes and transitions will have a huge impact on health IT in 2017 and in future years. Here’s more on how technology in healthcare is changing, and how your organization can stay ahead of the curve.

EXECUTIVE VIEW

Telehealth growth is spurred by consumer interest, efforts to cut costs
Cost transparency tools are a win-win for consumers, plans
EHR vendors are struggling to keep up with demands
Interest in more advanced data analytics is growing
A ‘breakout year’ for telehealth

According to a 2016 Partners HealthCare study, few seniors are going online to obtain information or accomplish healthcare-related tasks. Only 16% of seniors say they use the Internet to obtain health information, 8% fill prescriptions, 7% contact physicians, and 5% attend to their insurance needs online. Younger patients, particularly millennials, are not surprisingly further along when it comes to incorporating technology into their healthcare. Sixty percent support the use of telehealth (i.e. sharing health information via mobile health applications and engaging in video chats with their physicians), and 71% want their physicians to adopt mobile health applications, according to a Salesforce report.

While different demographics are accepting technology at different rates, managed care executives can bet that more patients and members, including the elderly, will start demanding telehealth services. Pam Jodock, senior director of health business solutions at the Healthcare Information and Management Systems Society, uses the Center for Connected Health Policy’s definition of telehealth; namely, that it’s “a collection of means or methods for enhancing healthcare, public health, and health education delivery and support using telecommunications technologies.” Examples of this type of care include a physician answering patient questions via secure e-mail or a patient portal, or a live video conversation in which a clinician serves as an intermediary between the patient who’s there in person and a specialist located miles away, says Jodock.

Consumers are much more digitally attuned than ever before, and they want the delivery of their healthcare to be convenient and easy, says Jodock. Still, telehealth visits are reimbursed at lower rates than “brick-and-mortar-based” visits, largely because it’s easier for providers to administer such visits. There are upfront costs, of course, for the investment in technology to enable remote visits, she says.

For providers who remain hesitant to embrace telehealth, alternative payment models could be a motivator. For example, providers that face value-based measures related to diabetic patient care may need to embrace telehealth devices, such as remote glucose monitors, that provide real-time patient monitoring capabilities. “The success of ACOs will hinge upon their ability to increase their use of connected health technologies and convert that information into action,” says Jodock, who points out that 98% of outcomes are based on what happens outside the physician’s office—and, therefore, outside the physician’s control. “Physicians need to develop partnerships with patients to allow them to have real-time information about their health status so that [their physicians] can intervene in a more rapid and efficient way,” she says. “This also allows patients to be more engaged in their own outcomes and helps them do a better job of adhering to their blood pressure medications or their insulin for diabetes.”

That’s why Mitch Morris, MD, vice chair and global healthcare sector leader at consulting firm Deloitte, expects 2017 to be a “breakout year” for telehealth solutions—despite budgetary pressures. He says that access to real-time data about illnesses such as diabetes or chronic obstructive pulmonary disease or asthma will be a must for providers. In addition, there will be a continuing drive toward care provided outside of the hospital and into home and school environments.

More employers are also recognizing the benefits of telehealth. Deloitte, for example, offers its employees in all 50 states the option to pay a $25 copay for a virtual visit with a doctor via tablet or smartphone.
Tools that provide consumers with cost information about healthcare are in greater demand for two reasons, says Morris, who notes that Deloitte is studying this behavior. For one, consumers are accustomed to an online retail experience where they can comparison shop across several online vendors in less than a minute if they want to buy a pair of Nike sneakers, for example.

The second reason is more consumers have high-deductible plans that can hold them responsible for $5,000 or more of their spending. From the consumer’s point of view, this is “their” money, so they want to ensure they’re getting a good deal on their MRI or specialist visit or blood panel, he says.

Morris, who prefers to use the more consumer-friendly “price” terminology—rather than “cost”—anticipates that providers will increasingly provide pricing for healthcare services in 2017.

One such tool, the MyHealthcare cost tool, was developed by UnitedHealthcare about five years ago. Today, the tool covers 875 different services, which means that members have access to personalized estimates of the costs of care, says Craig Hankins, vice president of digital products at UnitedHealthcare.

One of the payer’s new initiatives is to integrate cost and quality information into members’ searches for providers. That means when a member searches for a physician, in addition to learning about their credentials and location, they’ll also learn how that physician compares to others in terms of cost and quality.

A member experiencing knee pain, for example, might use the tool to find out about outpatient facilities, physical therapy, and compare physicians. The member could also use it to review consumer reviews from HealthGrades.

Members who use UnitedHealthcare’s transparency resources more frequently select high-quality healthcare providers across all specialties, including primary care physicians (7% more likely) and orthopedists (9% more likely), says a company spokesperson. They also pay, on average, 36% less than non-users, according to a 2015 claims analysis.

For a Q&A with Hankins, see page 21
of care or the healthcare outcomes.”

While providers are increasing their adoption of alternative payment models, vendors are struggling to keep up with the EHR functionality required to support the administration of these models. What healthcare vendors need is clear direction on how to build platforms that will support these new payment models, she says.

Morris, who once served as chief technology officer at MD Anderson Cancer Center, expects that MACRA requirements will push more providers to put additional pressure on EHR vendors to improve existing systems through improved work flow and software improvements (i.e., removing “bugs” from the systems). One specific area where providers will increasingly place demands on their EHR vendors is on functionality that will help them demonstrate quality and capability of embracing alternative payment models.

While in the past, the industry has witnessed the consolidation of EHR vendors, Morris anticipates that there will be less of this behavior in 2017. It was once common practice for a large EHR vendor to acquire a smaller specialty EHR that caters to gastroenterology, for example. Going forward, there’s a greater likelihood that the large EHR vendor will focus on developing this capability in-house.

While EHR vendors are facing more pressure from providers, providers are not necessarily in a position to invest more in EHR systems. Morris expects there to be modest investment in EHRs this year, as reflected in new sales reported by the major vendors in the third quarter of 2016.

Healthcare systems face a lot of uncertainty regarding the future of health insurance exchanges and the Medicaid expansion, which could impact patient cost-sharing responsibilities and patient volumes. Both could have a negative impact on healthcare systems’ finances, says Morris. As a result, healthcare CEOs and CFOs will likely wait to see what happens—and, in the meantime, they’ll conserve cash and not increase debt levels, which means fewer capital expenditures and less EHR investment.
Big data solutions for population health management

While it’s unclear how the Trump administration will impact value-based care, payers across the country continue moving forward with these new care models. Thus, Morris notes that providers will be under increased pressure to use data to drive decision-making around new payment models, lower unit costs, and engage with consumers.

Still, as with EHRs, the limiting factor is the needed capital investment for these types of platforms. While vendors could make a strong argument that investments in these solutions today will lead to savings and enhanced revenue tomorrow, a Deloitte Center for Health Solutions survey of 50 large provider chief information officers indicated that healthcare IT spending will be flat in 2017, says Morris.

Further complicating matters, providers will continue to be under pressure to measure performance on population health measures, specifically. “There is a new age of expectations for dashboard builds from both customer and analytics team perspectives,” says Morris. “Gone are the days of lengthy report requests, aged data, and untimely information.”

Users today are demanding access to drillable, interactive, and current information, he says. That’s everything from basic Excel-based platforms, to machine-learning, voice recognition, real-time data analytics on a mobile device—and having that information on one, easy-to-use dashboard.

Morris is starting to notice some payers and providers working to better share data and data analysis. What matters to both payers and providers is the ability to jointly deliver high-quality care and drive down costs, while driving market share. That’s their goal, which is incenting both parties to collaborate, he says.

Risk is going to continue to shift from payers to providers, and the only way for providers to manage that risk is through prevention, says Tony Jones, MD, chief commercial officer at Lumia, which provides analytics tools to help payers and providers assess risk. For example, to prevent patients with diabetes and chronic kidney disease from progressing to fairly advanced diabetes or stage 3 or 4 kidney disease, providers need to be able to easily access lab and claims data.

But that’s not the extent of the data providers and payers will need going forward. “There’s some truth to the fact that you can tell more about the health of a person by their zip code than by their claims history,” says Jones. “If a patient is living in a neighborhood where they’re surrounded by Fast Food restaurants and no good supermarkets, you can make pretty good predictions about their health, especially when you combine it with lab and claims data. Access to this data gives you a much better indication [that] they’re likely to have diabetes or kidney disease.”

It’s in payers’ interest to work together to develop and share this data with providers because it supports value-based reimbursement, says Jones.

“Whether it’s an ACO or a shared savings plan, payers and providers are asking the same question: How do I avoid costs?” he says. “There’s a fairly big shift, in that there are doctor groups within ACOs that are hungry for this data because they want to know how to treat these patients. They want to be able to identify who’s at risk; these are people they may not see until they show up [in their hospitals or clinics].”

Aine Cryts is a writer based in Boston.
Diabetes medications were the most expensive among traditional therapy drug classes with an overall trend of 14% in 2015, according to the Express Scripts 2015 Drug Trend Report. The positive trend is reflective of increases in both utilization and unit cost.

"Diabetes is a national epidemic with more people being diagnosed on an annual basis," says April Kunze, PharmD, senior director, clinical formulary development and trend management strategy, Prime Therapeutics. "Overall, Prime has seen a 20% increase in trend from the third quarter of 2015 to that of 2016. This is driven by approximately a 7% increase in utilization and a 12% inflationary increase."

An increase in brand drug use is contributing to the spend, Kunze explains. Prime is seeing more use of glucagon-like peptide-1 receptor agonists (GLP-1s), sodium-glucose co-transporter 2 (SGLT-2) inhibitors, and dipeptidyl peptidase 4 (DPP-4) inhibitors, and less use of low-cost generics, such as the sulfonylureas. Insulin is also a mainstay in therapy, with the basal insulins such as insulin glargine (Lantus, Sanofi) and insulin detemir (Levemir, Novo Nordisk) garnering a significant portion of the utilization and spend.

The Drug Trend Report also predicts that diabetes will continue to be a significant contributor to trend as new cases continue to occur with approximately 27.8% of adults with diabetes currently undiagnosed. Additionally, as type 2 diabetes progresses, patients may require more than one therapy to adequately control the disease. As patients switch from older regimens that require multiple tablets per day to new combination products, increased spend is anticipated, since these combination therapies are branded.

**Diabetes drugs that lower CVD risk**

Diabetes and cardiovascular disease (CVD) are intimately linked, according to Kathleen Kaddis, BS, PharmD, senior clinical pharmacist, Priority Health.

According to the CDC, death from cardiovascular disease is 70% higher in adults with diabetes, and patients with diabetes have a decreased life expectancy driven in large part by premature cardiovascular death.

"Some argue that diabetes is a metabolic disease with cardiovascular complications, while others claim that it is a cardiovascular disease with metabolic complications," Kaddis says. "Regardless of your opinion, management of diabetes and cardiovascular risk is of utmost importance. Diabetic patients are given medications for glycemic control, as well as for treatment and prevention of cardiovascular risk factors, like aspirin and statins. Cardiovascular morbidity and mortality are still too common in diabetics."

Death from cardiovascular disease is 70% higher in adults with diabetes.

Patients with diabetes have a decreased life expectancy driven in large part by premature cardiovascular death.

*Source: CDC*

Recently, empagliflozin (Jardiance, Boehringer Ingelheim) was the first diabetes drug shown to decrease cardiovascular mortality, says Kaddis. The FDA recently approved Jardiance’s secondary indication to reduce the risk of cardiovascular death in adult patients with type 2 diabetes mellitus and cardiovascular disease.

Empagliflozin also decreased
hospitalization and death from heart failure, says Kaddis. “While other diabetes drugs have been able to show neutrality with regard to CVD outcomes, this is the first one to show a significant decrease.”

Nordisk’s liraglutide (Victoza) significantly reduced the risk of major cardiovascular events and death in adults with type 2 diabetes in the Liraglutide Effect and Action in Diabetes — Evaluation of Cardiovascular Outcome Results trial. Results showed that, over a mean of 3.8 years, the glucagon-like peptide 1 receptor agonist Victoza, reduced risk for three-point major adverse cardiac events by 13%, for all-cause death by 15%, and for cardiovascular (CV) death by 22% vs. placebo, while reducing HbA1c and body weight.

A positive impact
While diabetes continues to be the number one driver of non-specialty pharmacy cost trend, drug treatment has not advanced significantly over the last few years, explains Nadina Rosier, health and group benefits practice leader at Willis Towers Watson.

According to Rosier, drugs approved in 2016 were largely considered “me-too” products and/or combinations comprised of existing drugs. One is Xultophy (Novo Nordisk), a once-daily, fixed-dose combination of Tresiba (insulin degludec) and Victoza, indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. Xultophy is expected to launch in the first half of 2017.

Also noteworthy is a device recently approved by the FDA known as the “artificial pancreas.” The MiniMed 670G (Medtronic), is intended to automatically monitor glucose and provide appropriate basal insulin doses in patients aged 14 years and older with type 1 diabetes, according to the FDA.

Another new therapy that came to the market in 2016 was lixisenatide (Adlyxin, Sanofi), a GLP-1 receptor agonist, a hormone that helps normalize blood sugar levels.

Andrew Lyle, director of business development, Curexa Pharmacy, cites the December 2015 approval of Eli Lilly’s and Boehringer Ingelheim’s Basaglar 100 units/mL (insulin glargine injection), a long-acting insulin with an identical amino acid sequence to Lantus, another U-100 insulin glargine. “Unfortunately, there may not be a huge discount on price, but due to rebates to the PBMs, there will be much better formulary placement and easier access for patients who need Lantus,” Lyle says.

Kaddis says diabetes can be individualized to a greater degree than ever before. “With more drugs in the armamentarium, the diabetes team can work with the patient for improved management and glycemic control.”

Pipeline treatments
Anticipate more introductions to the already established classes of diabetes medications as well as new classes of drugs, says Kaddis. “Biosimilars to insulin may be hitting the market soon, which will hopefully provide some relief to the drastic price increases that insulin has had in the past few years,” she says.

Rosier cites several novel phase 3 pipeline agents:

**Semaglutide (Novo Nordisk)**, an investigational GLP-1 analogue administered once-weekly, which significantly reduced the risk of the primary composite end-point of time to first occurrence of either CV death, non-fatal myocardial infarction (heart attack) or non-fatal stroke by 26% vs. placebo, when added to standard of care in 3,297 adults with type 2 diabetes at high CV risk.

**Bexagliflozin** (Thebaco), a highly specific SGLT2 inhibitor for the treatment of type 2 diabetes, which works by diverting excess blood sugars out through the urine to harmonize glucose levels in patients.

**Sotagliflozin** (Lexicon Pharmaceuticals), a first-in-class, oral dual SGLT1 and SGLT2 inhibitor for type 1 diabetes. The drug is also in phase 2 for type 2 diabetes.

Another phase 3 drug to watch is ertugliflozin (Merck and Pfizer), an investigational oral SGLT2 inhibitor for the treatment of patients with type 2 diabetes, says Lyle.

Upcoming therapies to watch are new combinations of existing drugs, including ertugliflozin plus sitagliptin (Merck and Pfizer), ertugliflozin plus metformin (Merck and Pfizer), as well as linagliptin plus pioglitazone (Boehringer Ingelheim and Eli Lilly).

Stem cell research is also looking into potential cures for diabetes by stimulating production of insulin-producing beta cells or injecting insulin-producing cells that would work for up to a year or more, says Kaddis.

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**Erin Bastick, PharmD, RPh**, is a graduate intern at University Hospitals Elyria Medical Center in Elyria, Ohio.
When it comes to clinicians discussing end-of-life care with patients and their families, too often decisions must be made quickly. The reasons why are complex, with many physicians struggling to determine when and how to have these tough conversations.

Nearly 70%, in fact, report that they have not been trained to discuss end-of-life care, and 73% of Medicare patients over the age of 65 have not discussed it with physicians, according to a *JAMA* study released in November 2016.

As data analytics plays a larger role in care, some are wondering how it might help address these difficult decisions. Yet most health systems don’t have the technology capabilities and the corporate mindset to take a comprehensive look at end-of-life care that better serves patients, says Dan Hogan, founder and CEO of Medalogix.

“Most hospitals aren’t using data analysts or data-driven tools to look at end-of-life care and imminent decline,” says Hogan, whose company specializes in population health analytics-based solutions for end-of-life care. He says that factors including increased readmissions, multi-episode hospital stays, and falls are part of a landscape of data that can help health systems identify patients who may need end-of-life conversations.

“Many times, once a patient gets to the emergency department they are already imminent,” Hogan says. “At that point, the doctors may try to stabilize them and get them out the door, or they may have already missed their mark.”

Hogan adds that the data also allows systems to look at population statistics and make predictions on which patients need hospice care.

“There’s the benefit of averted costs to hospitals,” Hogan says. “The real benefit lies in patients and families being satisfied with how they and their loved one are treated. They are very grateful for a higher level of care during that time.”

**Untapped promise**

Data that could be used to create more accurate end-of-life timelines for patients is often unavailable to clinicians, says Ziad Obermeyer, MD, MPhil, assistant professor of emergency medicine at Brigham & Women’s Hospital, assistant professor of healthcare policy at Harvard Medical School, and faculty affiliate of the Harvard Institute for Quantitative Social Science and Ariadne Labs at the Harvard School of Public Health.

“If you think about all the data living in an electronic medical record today, it’s an incredibly dense collection of lab tests, X-rays and CT scans, notes—a record of every point of contact you have with the medical system,” Obermeyer says. “It’s overwhelming, and hard for doctors to process. I think there’s...”

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**Many people aged 65 years have not discussed end-of-life (EOL) care with a physician**

![Illustration of data analysis](chart.png)

Many people aged 65 years have not discussed end-of-life (EOL) care with a physician.

- 27% have discussed
- 60% have documented
- 73% have not discussed
- 40% have not documented

Technology

a major role for algorithms here to digest and synthesize these complex data into usable information for both doctors and patients.”

In 2012, Obermeyer received the National Institutes of Health Director’s Early Independence award to research patients who died unexpectedly after medical encounters. He realized that in many cases, too many factors were not being considered that led up to the patient’s seemingly quick death. For example, in many cases, patients who were candidates for palliative care were not receiving appropriate treatment.

“As I was researching these cases, I also found a lot of people who died after seeing doctors, but where death couldn’t have been unexpected: People with end-stage cancer, dementia, and other long-standing serious illnesses. And yet, these people were still getting very aggressive care, in and out of the hospital and emergency department,” Obermeyer says.

Obermeyer hopes more systems will be developed that can cross reference data to help empower clinicians to have these discussions with patients and their families earlier, when appropriate.

“Surveys of these patients show that they want to plan their legacy, get their affairs in order, and make decisions about how to spend their time,” Obermeyer says. “Doctors often don’t give them that information—because it’s really hard to have these conversations, but also because it’s really hard to predict. We’re going to see a big change in the availability of that kind of predictive information in the next few years.”

**Technology gaps**

Unfortunately, most electronic health record systems (EHRs) lack the ability to provide in-depth analysis of end-of-life factors, says Lee Goldberg, project director of improving end-of-life care for The Pew Charitable Trusts.

Most physicians report not being trained to discuss EOL care

There’s a lot of variation and not a lot of standardization for end-of-life care. Some hospitals have customized modules in the EHRs. This can be very different based on location and very expensive to implement across an entire system,” Goldberg says, adding that poor care coordination and interoperability issues between EHRs can cause important documents to be overlooked. “Hospitals are important, but not the only players. The post-acute sector was not eligible for meaningful use dollars, and they typically lack the very robust EHR systems.”

Goldberg says that though most EHRs prominently feature life or death illnesses or allergies, it can take up to 12 screens and 1.3 minutes to find advance care plans. The Care Planning Act sponsored by Sen. Johnny Isakson (R-Ga.) and Sen. Mark Warner (D-Va.) in 2015, would mandate that Medicare develop and test quality measures around end-of-life care, including care coordination.

Goldberg says that patients have more than three facility transitions in the last three months of their lives, and their advance care plans are sometimes misplaced.

“With some EHR systems, advance care plans can be uploaded in patient-generated fields. But a lot of other things may be in those fields, including Fitbit information, glucose monitoring, or data from another type of wearable device. Advance care plans can get lost,” Goldberg says.

**Overlooked source**

There is another unused source of data that can help health systems improve end-of-life care: surveys from bereaved families. Currently, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are for living patients. But VHA hospitals also give surveys to bereaved families. These surveys ask families about care quality, and whether care was in accordance with the patient’s desires, says Goldberg. “We are hoping that [CMS] will create a CAHPS survey more like the VA,” he says. “A big question surrounds whether care received is what the patient wanted, and how are those wishes honored. Currently, there’s not a good quality measure for that, but technology and data mining could answer that.”

Donna Marbury is a writer in Columbus, Ohio.
ith Donald Trump as the new commander in chief, the healthcare industry is in the midst of many changes. In order to survive as a managed care organization, it’s important to stay on top of policy changes and reimbursement trends, such as those related to Medicare, Medicaid, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Healthcare executives also need to know if trends, such as consumerism and consolidation, will continue as is or change course. Industry experts weigh in on what to watch as the year unfolds.

POLICY CHANGES
Trump’s presidency has already brought a flurry of activity and discussion around healthcare policy. Pathways exist for Congress and the administration to repeal many key elements of the Affordable Care Act (ACA) quickly. “But developing and enacting a replacement will be much more difficult,” says Ankur J. Goel, partner, McDermott Will & Emery. “We may see a second effort at healthcare reform but with Republicans in charge of developing the replacement and from a different starting point with Medicaid having been expanded in many states, millions of individuals with subsidized coverage, and consumer protections for individuals purchasing insurance in the individual markets. Republican efforts to enact a replacement will need to take the current landscape into account—as well as assemble the necessary votes.”

Bob Atlas, president of Epstein Becker Green’s consulting affiliate, EBG Advisors, says that beyond repealing many key elements of the ACA, Trump and the Republican-controlled Congress may look to reshape Medicaid and Medicare into more of

“Waiting and hoping [policy changes] won’t affect you is not an option for a responsible healthcare leader.”

–BOB ATLAS, EBG ADVISORS

Prepare now or fall behind

BY KAREN APPOLD
a defined contribution for the federal government. For Medicaid, this means converting federal financing to block grants or per capita spending caps. For Medicare, it may entail a shift to more of a premium support (or voucher) approach that would have the effect of moving most beneficiaries into private plans.

The impending ACA “repeal and replace” is likely to put an end to Medicaid expansions. But states do see its value to their citizens and their economies, including many states governed by Republicans. One way Medicaid expansion might survive is if Republicans insert “personal responsibility” features of the nature found in Indiana, where then-Gov. Pence led an expansion effort. Personal responsibility in this context translates to participant cost sharing, incentives for healthy behaviors, and work requirements, says Atlas.

Also, some ACA provisions must stay in place for other laws to operate, Atlas says. For example, MACRA, enacted in 2015 with strong bipartisan support, can only work if the “advanced alternative payment models” (APMs) spawned by the ACA, such as accountable care organizations, continue. And then there are technical provisions of the ACA that aren’t visible to the public but matter a lot to the healthcare industry, such as the payment formula for Medicare Advantage plans.

To prepare for big policy changes, Atlas advises anticipating what may be coming and modeling how it could affect your organization and its key stakeholders. “While right now there is no certainty about the shape of legislation, there are proposals from conservative groups that could be the basis of new policy,” he says. “Sketch out possible scenarios, then prepare action plans for different potential outcomes. Then get going. For some, action will mean advocating early and assertively in the political arena. For most executives, action also means tailoring the healthcare organization’s strategy and tactics to suit the new, altered reality. Waiting and hoping it won’t affect you is not an option for a responsible healthcare leader.”

**REIMBURSEMENT CHANGES**

Louis J. Goodman, PhD, CAE, executive vice president and CEO, Texas Medical Association, and past president, Physicians Foundation, does not expect many significant changes in physician payment in the first quarter of 2017.

One reason is that MACRA final rules provide for a one-year transition with a minimal data submission requirement. Goodman does, however, expect major challenges as physician payment migrates to value. “The 2017 MACRA Quality Payment Program (QPP) transition year will be a critical year for physicians and healthcare executives preparing for full implementation ... in 2018.”

–LOUIS J. GOODMAN, TEXAS MEDICAL ASSOCIATION

What is MACRA?

MACRA, a new CMS reimbursement program, began January 1. Providers who don’t participate will receive a negative 4% payment adjustment in 2019. This penalty increases each year.

MACRA offers two ways for providers to be rewarded for delivering high-quality patient care:

1. Join an advanced alternative payment model, which will offer incentives for participating in innovative reimbursement models.

2. Join the Merit-Based Incentive Payment System, which will provide a performance-based payment adjustment.
Commission to combine Medicare Parts A and B—especially considering that hospital costs are attributed to total physician spending under value-based systems that employ population management technology, Goodman says.

Another reimbursement-related issue that Valerie Barckhoff, principal and practice leader for Healthcare Advisory Services, Windham Brannon, foresees in 2017 and beyond is organizations’ readiness for bundled payments. The final rule on CMS’ new episode payment models has a go-live date of July 1, 2017. “This will be a significant data analytic opportunity for healthcare organizations as they will have unprecedented access to healthcare data across the continuum,” she says. “The need to understand the episode spend and identify opportunities to reduce Medicare’s costs to improve an organization’s profit margins are critical in 2017.”

Regardless of any changes, Philo Hall, associate, Health Care and Life Sciences, Epstein Becker Green, says providers working with public and private payers can expect to face either lower fee-for-service rates or more demands to take risk (e.g., capitated payments, APMs), or both. “Executives should be cautious to not take on risk for costs that are outside of their control and therefore seek partners who can help them increase efficiencies and spread risk,” he says.

Goodman says technology will play an ever-increasing role in healthcare; strong oversight of electronic health record vendors and the reliability of their reporting to governmental and non-governmental entities can make the difference between penalty and bonus payments in the new MACRA environment.

**CONSOLIDATION CHANGES**

In one stroke of a pen, the ACA changed health plan leaders’ views of their total imaginable market. “Suddenly, their market became everyone in the market,” says J Pegues, managing director, Huron. “With the doors of opportunity wide open, health plans have sought out potential target plans as they looked to merge local markets and corporate operations. The search for the right target includes rigorous analysis of a plan’s local market demographics and share of that market, competitors, economics, and leadership.”

Pleasing shareholders, strategic leverage, and increasing scale are among the key reasons why consolidation in health plans is occurring. “Shareholders have an endless demand for growth,” says Christopher Kane, principal, DHG Healthcare. “Strategic leverage is a blunt force. If a large health plan has significant geographic coverage, it expands its opportunities and a contract may become essential for the area’s hospitals and physicians.”

Regarding scale, for the past 20 years health plans have been designed to compete on price. “The primary factor in achieving any market’s lowest cost position is its ability to acquire the raw materials to provide service at the lowest cost,” Pegues says. “The more members a health plan has, the greater the ability to drive the best deal with care providers and the greater likelihood the plan can achieve the lowest cost position.”

So how will Trump’s presidency affect consolidation? Gil Irwin, partner, Strategy&, a member firm of PwC, expects the trend toward consolidation to continue. “There are significant market pressures, particularly since the ACA was passed—including pressure on margins, a need to innovate and respond to changes in the marketplace,”

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CMS New Episode Payment Models

These models, some of which begin in July, will reward hospitals that avoid complications, prevent hospital readmissions, and speed recovery. They include:

1. Three new payment models will support clinicians in providing care to patients who receive treatment for heart attacks, heart surgery to bypass blocked coronary arteries, or cardiac rehabilitation following a heart attack or heart surgery.
2. One new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture, other than hip replacement. In addition, CMS is finalizing updates to the Comprehensive Care for Joint Replacement Model, which began in April 2016.
3. The new Medicare ACO Track 1+ Model will have more limited downside risk than Tracks 2 or 3 of the Medicare Shared Savings Program in order to encourage more practices, especially small practices, to advance to performance-based risk.
The increasing consolidation of providers and payers will:

- 59.5% Lead to higher overall healthcare costs
- 24.1% Lead to lower overall healthcare costs
- 16.4% Will not impact healthcare costs

Source: Managed Healthcare Executive's State of the Industry Survey, findings based on responses from more than 160 executives.

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Karen Appold is a medical writer in Lehigh Valley, Pennsylvania.

and access to capital,” he says. “If done well, consolidation can bring access to new markets (as well as any products or services that a plan may provide), as well as access to a plan’s capabilities, capital, and its pool of investing capacity.”

Although it is yet to be seen whether the new administration will be friendlier to mergers, Trump is clear that he wants less regulation, so Irwin thinks the country will become more merger friendly.

“If Trump makes it a more open market, that will drive the healthcare industry to become more scale sensitive and lean toward consolidation,” Irwin says. “If it becomes easier to sell insurance across state lines, that will also promote consolidation.”

CONSUMER CHANGES

Healthcare consumerism shifts the focus to the end user—the consumers. Joseph V. Sabatina, CPA, director, PricewaterhouseCoopers LLP, says the rise in consumerism has occurred, in part, as a result of the value-based care transition and the focus on population health and longitudinal care. The increase in high-deductible health plans and the resulting cost shift to consumers has also played a large part. As a result, consumers are demanding more education, more accurate information, more value-based options, and more transparency.

Rohan Kulkarni, MBA, vice president of strategy and portfolio, Conduent, adds that the rise of health insurance exchanges and patient engagement initiatives also play a role. What’s more, advancements in technology have created consumer expectations for on-demand, everywhere access to everything from banking to booking airline tickets, to buying shoes to ordering takeout.

Like those who work in the retail industry, executives can embrace this trend by adopting a consumer-centric approach to providing healthcare-related services, Sabatina says.

Further, “Organizations should analyze their charges and modify them so the result is a reasonable and defensible charge structure that can be publicized in the marketplace along with providing front-end price capabilities in an effort to attract patients who shop for select services,” Sabatina says. He advises having call centers to address patient inquiries regarding charges, patient out-of-pocket costs, and payment-related issues. Likewise, the ease in which a patient can be apprised of the registration process, scheduling availabilities, costs, and financial counseling all help to provide a favorable patient experience.

Sabatina also advises thinking outside the box regarding patient convenience. It’s important to provide ease of access, such as web-based patient portals for patients interested in cost information, scheduling procedures, accessing financial counseling information, making payment inquiries, and making payments. More innovative solutions worthy of consideration are mobile technologies via smartphones, tablets, and so forth that allow access through handheld devices. “All of these efforts toward providing a patient-centric experience build trust and loyalty, and ultimately win customers,” he says.

In addition, Kulkarni says payers need to communicate with their members throughout the year, and not just by mailing flyers or emailing information without taking relevancy into account. “They should follow up on active patients and encourage their patient population to meet preventive needs in collaboration with their payers,” he says.

Lastly, payers should make consumer engagement a metric that they track along with profitability. “We are at an inflection point; those that make the cultural shift will win both the race to the financials and the health outcomes for their membership,” says Kulkarni.
UnitedHealthcare embraces price transparency tools

Providing healthcare prices to consumers, healthcare professionals and other stakeholders could reduce U.S. healthcare spending by more than $100 billion during the next decade, according to a 2014 report by the Gary and Mary West Health Policy Center.

However, Managed Healthcare Executive’s 2017 Technology Survey found that 63.4% of the more than 120 respondents do not provide patients with tools to help them estimate the cost of healthcare services.

UnitedHealthcare is one health plan that is committed to providing access to quality and cost transparency resources, "an effort that will help improve the broader healthcare system and empower people to take charge of their health," says Craig Hankins, vice president of digital products, UnitedHealthcare.

Hankins spoke to Managed Healthcare Executive about what tools they are using to accomplish this, the types of tools being used, and where quality fits in.

Q: MHE: When did UnitedHealthcare decide to start using tools to help consumers estimate healthcare costs?

Hankins: UnitedHealthcare has long recognized the importance and need for people to have access to information about the quality and cost of healthcare services. Our commitment to transparency stretches back more than 11 years to when we first introduced the Treatment Cost Estimator (TCE). Since then, we have invested significant time, money and creativity to develop new mobile and online resources that make it simple and easy for people to comparison shop for healthcare based on quality and cost.

The Health4Me app was launched in 2012 and has been downloaded more than 2 million times. UnitedHealthcare is currently revamping our online resource to combine quality and cost information into a singular search function that makes it easier and more convenient for people to access this important information, with early users of the integrated experience more than twice as likely to review cost information compared to users of the stand-alone healthcare provider search feature.

Between our online and mobile resources, the services provided more than $3.8 billion in cost estimates during 2015 to UnitedHealthcare plan participants.

“People can compare costs for more than 875 common medical services across nearly 600 health events.”

–Craig Hankins, UnitedHealthcare

69% of people want insurance companies to disclose what they pay physicians and hospitals for procedures.

Q: MHE: Tell us a little more about the tools you are using. What method has been the most effective?

Hankins: UnitedHealthcare members have access to quality and cost estimates via online and mobile resources. We know more consumers are using digital resources to comparison shop for healthcare. According to a new study from UnitedHealthcare (conducted by ORC International), 32% of Americans have used the Internet or a mobile app to comparison shop for healthcare services during the last year. That’s up from 14% of Americans in 2012.

People can compare costs for more than 875 common medical services across nearly 600 health events, including inpatient and outpatient procedures. Estimates are available through “guest versions” of the Health4Me app and online at www.myuhc.com.

Q: MHE: How effective have your cost transparency tools been?

Hankins: A growing number of UnitedHealthcare members are using our transparency resources, with the number and dollar value of estimates growing each year. In addition, people who use UnitedHealthcare’s transparency resources are more likely than nonusers to save money and select high-quality healthcare providers, according to studies from UnitedHealthcare. The resources enabled people to more frequently select high-quality healthcare providers across all specialties, including primary care physicians (7% more likely) and orthopedists (9% more likely). Also, UnitedHealthcare members who use the transparency resources before receiving care pay, on average, 36% less than nonusers, according to a 2015 claims analysis.

Q: MHE: How does quality fit with these tools?

Hankins: People can use the resources to access quality ratings based on the UnitedHealth Premium designation program, which recognizes physicians who meet or exceed quality and cost efficiency standards. The program uses more than 300 quality measures for 75 conditions to evaluate physicians. The UnitedHealth Premium designation program uses national industry, evidence-based and medical specialty society standards to evaluate physicians across 27 specialties to promote access to quality and cost-effective healthcare.

- The program bases its methodology on clinical information from physicians’ healthcare claims.
- The program uses criteria and measures based on evidence-based, medical society, and national industry performance measurements from organizations such as the National Quality Forum, the Ambulatory Quality Alliance, the National Committee for Quality Assurance, and the American College of Cardiology. Practically speaking, evidence-based guidelines are those standards, based on science, which define how a patient should be treated to receive optimal care for his or her condition.
- The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

In addition, UnitedHealthcare commercial members can also access consumer reviews and information provided by Healthgrades, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Leapfrog Hospital Survey, and Leapfrog Safety Scores.

Q: MHE: What are the data sources for your transparency initiatives?

Hankins: UnitedHealthcare members access estimates based on actual contracted rates and their real-time account balances, including any applicable deductibles or copayments.

Q: MHE: Does this look only at physician? Facility?

Hankins: Both. Estimates are displayed as “care bundles,” providing a comprehensive view of what people should expect throughout their course of treatment for nearly 600 health events.
2nd.MD
This app offers patients direct access to second opinions via video or phone from doctors at Boston Children’s Hospital, Memorial Sloan Kettering, Mayo Clinic, and Cleveland Clinic. Patients either pay through insurance or out of pocket, says Mayank Gandhi, senior director of information management and analytics, Healthcare & Life Sciences, NTT DATA. “This direct-to-consumer—or via employer—model is empowering patients who are seeking additional clinical opinion before embarking on a treatment plan.”

b.Well
The app stores medical records and insurance information, integrates with wearable and genomic data, and lets users view financial information about their benefits plans. Users can also search for a provider, schedule appointments and search for price comparisons on prescription drugs. “This technology encourages consumerism in healthcare, using data and technology to help simplify the experience of managing health and insurance,” says Michael Levin, co-founder and CEO of Vericred.

CareZone
John Santilli, partner, Access Market Intelligence, says this app offers patients a platform to store and organize all paperwork and appointment dates related to their care. “Visits to physicians can generate a great deal of paperwork for patients to keep organized,” Santilli says. “CareZone can be used to manage all family members’ care. The CareZone app is automatically updated with medication information, a journal for easy reference and notes, and relevant health news.”

HRProMobile
“HRProMobile is the first mobile app designed to make HR compliance easier. It provides instant access to live HR consultants, along with exclusive content, tools, and training materials,” says David A. Reid, founder and CEO of Easement. “HR rules and regulations are changing all the time. HRAnswerLink’s HRProMobile app puts a team of HR professionals by your side whenever you need them.” The app is available through HRAnswerLink’s network of insurance broker partners.

Pillsy
Pillsy is a smart pill bottle and app. The bottle syncs to the Pillsy smartphone app, helping patients keep track of when they take their medications and when to refill their prescription. “The app allows patients to communicate directly with...
healthcare providers to quickly address questions and enables self-care, relieving a portion of the burden on healthcare providers,” Levin says. “Healthcare providers can use Pillsy to remotely monitor their highest-risk patients, improving medication adherence and reducing hospital readmissions.”

**Stroll Health**

Levin recommends Stroll, an imaging referral management application used by hospitals, physicians and clinics. It is an application that can output to any device, mobile or desktop.

“When a patient is referred by a doctor for medical imaging, they are not always sent to the best value imaging sites,” he says. “And if patients don’t know that they have a choice, they can end up overspending thousands of dollars. Stroll brings transparency and efficiency to this process by delivering personalized recommendations based on what is covered by the patient’s insurance plan, where they live and how much they can afford.”

**My Care app, Group Health Cooperative**

This is a favorite app of Gandhi. The app, which is available to members of Group Health Cooperative, serves as an example of what other plans might consider providing. Members can schedule appointments, check wait times and receive directions through the app. In addition, they can call a 24/7 phone number through the app to check on their symptoms. Some future features include the ability to update personal information and share it with providers to eliminate duplicative, repetitive paperwork or connect with an online community to share symptoms, treatment and dietary regimens based on specific conditions.

**Mobile Health Library (MHL)**

“MHL enables an integrated patient journey and brings brand education, dosing reminders, forms and enrollment, and patient diaries—think clinical trial even before mass market—into the hands of the patient with access by the trial doctors and researchers,” says Adam Nelson, vice president of Healthcare & Life Sciences, NTT DATA. “...For the providers, tracking a community of patients and their adherence, outcomes, and side effects becomes an integrated and aggregated view, and with the shift to outcome-based payments and risk sharing, providers benefit from this approach.”

**HealthLoop**

HealthLoop works by automating the routine aspects of care while tracking patient progress and monitoring clinical areas of concern. The app sifts through patient data in real time, providing outreach when most needed and tracking patients through an episode of care. "Patients rate their doctors with a five-star experience and providers realize better efficiencies with an automated patient check-in approach,” Santilli says.

**Zest Health**

Santilli recommends this consumer-focused “smart concierge” app. It provides a medical condition research tool and uses third-party pricing and quality measures to steer patients to the most effective, quality-based providers based on the network doctors. Tracey Walker is content manager for Managed Healthcare Executive.
Which of the following represents your most pressing information technology problem?

- Difficulty turning data into actionable information: 34.7%
- Securing funding for IT initiatives: 21.3%
- Training staff and/or physicians on new technology: 15.7%
- Difficulty exchanging claims/patient data with other entities: 10.2%
- Keeping patient data secure: 7.1%

Other: 11% Responses included: EHR implementation, explaining telehealth to patients, and dealing with upgrades.
Social media

Q: Does your organization use social media to communicate about your business?

- Yes: 69%
- No: 31%

Q: Do you believe the time/effort invested in social media is worth it for your business?

- Yes: 80.7%
- No: 19.3%

Policy

The federal government should...

- Mandate that payers pay for telemedicine services.
  - Agree: 62.2%
  - Disagree: 37.8%

- Eliminate the requirement that providers must obtain licensure in whatever state they provide telemedicine.
  - Agree: 44.9%
  - Disagree: 55.1%
**Tech tools**

**Q:** Which of the following technology tools does your organization use? (select all that apply)

- **64.5%** Business intelligence and analytics
- **56.5%** Health information exchanges to share data with other organizations
- **47.6%** Patient registries
- **34.7%** Organization-specific apps for patients
- **30.6%** Remote health monitoring/telemedicine/wearable devices

**Q:** Has your organization successfully used remote monitoring devices to improve patient care?

- **32.8%** Yes
- **67.2%** No

**Q:** Does your organization provide patients with tools to help them estimate the cost of healthcare services?

- **35.7%** Yes
- **64.3%** No
On a scale of 1-10, how would you grade your organization’s use of big data to reduce costs and improve quality?

**AVERAGE**

**6.35**

Q: What is your organization’s biggest challenge related to big data?

- **34.7%** Difficulty turning data into actionable information
- **32.3%** Not having enough staff members with adequate expertise in data analytics
- **25.0%** Difficulty exchanging information between systems
- **8.0%** Difficulty gathering information
**Technology survey**

**Organization**

**Q:** How much do you expect to invest in technology in 2017?

- 3.1% Less than we invested in 2016
- 25.8% The same amount we invested in 2016
- 50.8% More than we invested in 2016
- 20.3% Not sure

**Q:** What technology has had the most positive impact on your organization in the past year?

- 30.8% Data analytics tools
- 25.4% EHRs
- 14.0% Clinical decision support tools
- 18.4% E-prescribing
- 4.4% Remote monitoring tools/wearable devices
- 7.0% Other

**Q:** How is your organization doing when it comes to exchanging information with other plans/providers?

- 44.0% We are exchanging some information in real time
- 39.7% We are exchanging very little information in real time
- 15.5% We are exchanging most information in real time
- 0.8% We are exchanging all information in real time

**Q:** Do you use mobile apps to assist you in your work?

- Yes: 61.4%
- No: 38.6%
Technology survey

Q: Have you created new technology roles at your organization in the past 12 months?

- Yes 46.2%
- No 53.8%

Q: Does your organization employ data scientists whose sole job is to analyze and interpret data, spot trends, and provide feedback to your organization?

- Yes 37%
- No 48.6%
- Don’t know 14.4%

How will your IT staff numbers change in 2017?

- Decrease 2.7%
- Stay the same 51.4%
- Increase 31.5%
- Don’t know 14.4%
Health plan decreases unsafe dose opioids by 73%

Approach helps derail epidemic

by TRACEY WALKER

verdose deaths involving prescription opioids have quadrupled since 1999, according to the CDC, and so have sales of these prescription drugs. From 1999 to 2014, more than 165,000 people died in the U.S. from overdoses related to prescription opioids.

Opioid prescribing continues to fuel the epidemic. Today, at least half of all opioid overdose deaths involve a prescription opioid.

Here’s what Partnership HealthPlan of California (PHC), a nonprofit health plan that works with the state to administer Medi-Cal benefits to more than 570,000 members, is doing to address the problem.

Managing Pain Safely (MPS) initiative

In 2013, PHC leaders and staff began evaluating internal and external opioid data, and evaluating best practices across the country. The result: An internal framework and altered internal processes related to opioid use, beginning in January 2014.

“Partnership started the MPS initiative hoping to reduce the number of opioids inappropriately prescribed, ultimately hoping to increase the quality and quantity of life of our members,” says PHC Chief Medical Officer Robert Moore, MD, MPH. “The intention of the program was not to save costs, although we anticipate a potential impact on cost and utilization due to this project.”

The most unique aspect of the program is its comprehensive approach. “We focus heavily on provider education to complement our formulary changes,” says Moore. “We also work strongly in the communities to help establish local community coalitions aimed at reducing opioid misuse and abuse. This comprehensive strategy has helped shift knowledge and norms within the prescribing community, and is working to do the same at the community level.”

Provider education efforts include:

- Posting opioid-safety blogs, written by PHC medical directors, on PHC’s Primary Care Physician blog;
- Providing educational events and webinars, through which continuing education credits are offered; and
- Providing toolkits on safe opioid prescribing practices.

PHC also sponsors providers to attend Project Echo. The program, offered through UC Davis, provides training in caring for patients with chronic pain.

Community efforts include:

- Developing local opioid safety coalitions. “This support looks different in every county, depending on localized need,” Moore says.
- Working closely with the California Health Care Foundation (CHCF) in support of the Opioid Safety Coalition Network. Three primary objectives are to:
  - Increase access to naloxone;
  - Increase access to medication-assisted treatment; and
  - Develop standardized community prescribing guidelines.
- Partnering with CHCF to fund and provide technical assistance and advisory support to county coalitions. Efforts include lunch-and-learn sessions and working with county sheriff departments to stock naloxone.

The volume of prescriptions for painkillers written by providers throughout the year would allow each American enough prescriptions to have one bottle of pills.

Source: CDC, 2012
**Game-changing ideas**

**Formulary enhancements:**
To reduce excessive and/or inappropriate prescribing of opioids and limit the flow of patients becoming dependent, PHC instituted formulary and policy enhancements. Enhancements made in October 2014 and since include:

1. Implementing restricted quantity limits on all PHC formulary opioids for each single-dose strength not to exceed a maximum daily dose of 120 Morphine Equivalent Per Day (MED).

2. Designating morphine 100 mg. and 200 mg. extended-release tablets as non-formulary.

3. Designating methadone concentrate and methadone 40 mg. tablets as non-formulary.

4. Implementing a “refill-too-soon” policy, which requires at least 90% of the prescription’s daily supply to have elapsed before an opioid prescription can be refilled.

5. Implementing a “taper plan” for all patients on high-dose opioids, who do not have a justification for continuing a stable dose.

6. Creating a registry of all high-dose patients.

7. Adding fentanyl patches 12 and 25 mcg/hr to the formulary for patients with a history of prior opioid use.

8. Designating alprazolam and methadone 10 mg. tablets as non-formulary for new starts.

9. Limiting schedule II, III, IV prescription fills to a 30-day supply/fill.

As of June 2016, patients not tak-

**In 2014, more than 5% of U.S. adults used prescription pain medications non-medically.**

Source: “A Nation in Pain,” Express Scripts, December 2014

**Policy, structural changes**
Studies show that patients with limited access to alternative treatments have higher rates of prescription opioid use, according to a December 2014 Express Scripts report. For this reason, PHC implemented a set of enhanced benefits for select members, such as:

- Chiropractic
- Acupuncture;
- Podiatry and
- Osteopathic manipulation therapy.

MPS also created six internal workgroups related to opioid safety. For example, a pharmacy workgroup identifies interventions to improve internal/external prescription processes; and a provider network workgroup evaluates and identifies delivery mechanisms and processes to reduce opioid overuse.

There is also a care coordination workgroup/utilization management workgroup, legislative/policy workgroup, community work group, and data management workgroup.

“The effort was truly collaborative, and the work of each workgroup impacted and directed the path forward for other workgroups,” Moore says.

**Dollars and sense**
Since the initiative started, PHC has seen a 73% decrease in the rate of members on unsafe dose opioids (more than 120 mg. MED) per member per month.

The program has resulted in beneficial cross-sector relationships within PHC, among its providers, and throughout the communities, says Moore.

Externally, PHC works to collaborate with local coalitions to ensure cross-sector representation is at the table—providers, law enforcement, education, hospitals, medical associations, etc.

“This collaboration has the potential to reach beyond this project and impact other health outcomes,” Moore says. “This framework shows success in reducing the number of opioids prescribed at a plan and community level, which has a great impact on the health of our members.”

Key lessons learned are two-fold, says Moore:

1. Formulary changes put the policies in place to drive change.

2. Provider education is essential.

“Combining education with policy change has led to an increased understanding of the importance of the issue, as well as more provider buy-in,” Moore says. “We encourage other programs to follow similar models.”

Tracey Walker is content manager for Managed Healthcare Executive.
Automated health tracking boosts engagement

Study has promising results

Tracy Walker
Content Manager

AUTOMATED HEALTH tracking can significantly improve long-term health engagement, according to a study in the Journal of Medical Internet Research.

The study, from Walgreens Boots Alliance and Scripps Translational Science Institute, provides insights into the utilization patterns of individuals participating in an incentivized, web-based self-monitoring program, says study co-author Greg Orr, vice president, digital health at Walgreens Boots Alliance.

Research professionals from Walgreens and Scripps collaborated to examine activity tracking data—including exercise, weight, sleep, blood pressure, blood glucose, tobacco use and oxygen saturation—from more than 450,000 members of Walgreens’ Balance Rewards for healthy choices (BRhc) program.

PARTICIPATION TRENDS

The results demonstrated that 77% of users manually recorded their activities and participated in the program for an average of five weeks. However, users who entered activities automatically using the BRhc supported devices or apps remained engaged four times longer and averaged 20 weeks of participation.

“With the rise of consumerism in healthcare and the increased usage of smartphones and apps, it is the absolute perfect time for the industry to start rethinking our approach to health interventions,” Orr says. “…This study demonstrates the value of leveraging automated tracking through apps and wearable devices as part of an incentivized health engagement solution.”

EASE OF USE IS KEY

Executives should think broadly about their programs and look to existing successful programs to model or partner with, says Orr.

“This study has further demonstrated that if you make something easy to do—such as automatically tracking health engagement instead of requiring manual entry—people are more likely to do it consistently. Walgreens is very interested in partnering with other entities in the healthcare continuum and leveraging this approach to better serve our shared customers.”

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