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Mission: Managed Healthcare Executive provides healthcare executives at health plans and provider organizations with analysis, insights, and strategies to pursue value-driven solutions.

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Three Emerging Leader Qualities That Guarantee Success

We are at an inflection point in healthcare.

At Cigna, we continue to tackle the toughest challenges, addressing the most pressing issues impacting our clients, customers and patients. This means using technology, data, and analytics to make healthcare more personal and more affordable, to improve whole person health, and ultimately to give those we serve peace of mind.

The best leaders anticipate the challenges and opportunities that we’ll confront tomorrow, not just today. Having this longer-term view prepares your team to influence the environment rather than react to it.

To best put the future into focus, I recommend a clear lens aimed on three areas: continuous learning, servant leadership, and an outside-in, customer-first view.

**Servant leadership: The role of empathy**

An organization is only as good as its people; it’s all about talent. Take care of your people and you in turn take care of your customers. It’s about modeling the behaviors you want and showing caring values in words and actions.

At Cigna, we are laser focused on attracting, developing, and retaining top talent; it is the essential element for success. A new generation of talent is entering the workforce: Generation Z. This generation is predicted to change the norms of the workplace by putting culture and experience first in what they’re looking for from employers. Leaders need to break out of their comfort zones when it comes to managing Gen Z talent.

But I would suggest all employees are looking for leaders who help them succeed by empowering them and removing barriers. Empathic servant leadership means having the ability to understand, relate to, and be sensitive to employees’ changing needs. That means creating an inclusive, flexible, and empathetic workplace for all.

**Continuous learning: Stay curious**

Education and learning level the playing field. With the move to value-based care and evidence-based medicine, supported by digital engagement, healthcare has never been more complex.

In healthcare, we’re witnessing the digital disruption and drive to retail-centricity that many other industries have seen. By studying other sectors, we can apply that learning to our own system. Forward-looking leaders remain curious throughout their careers and find opportunities to keep learning through both formal and informal means.

**An outside-in view: Challenge yourself to think customer first**

Customer-centric thinking is critical and needs to be a well-developed skill. Consumer demands and preferences will continue to drive healthcare’s evolution; expectations are rising. The best leaders will anticipate consumer needs and virtual solutions. For example, as Forbes predicts, nearly half of the U.S. workforce may be in the gig economy by 2020. They will certainly have different expectations and healthcare needs.

We know that technology advances will shape the experience. For example, artificial intelligence, virtual reality, and intelligent automation are becoming increasingly ubiquitous and will influence next-generation customer experiences. However, we will only be effective leaders if we listen to our customers and design solutions that work for them on their terms, meeting them where they are. The best customer-empowered leaders take the time to talk to customers, listen carefully, and take their feedback unvarnished.

Thousands of years ago, Aristotle said leadership is about ethics and action. This is as true today as it was back then. Being an effective leader is not complicated; for me, it always comes down to acting on the three basic concepts I outlined above—developing yourself, focusing on your talent, and being relentless about tuning into the customer. By focusing on these areas, emerging leaders can acquire the skills and mindset needed to manage today’s opportunities, anticipate future needs, and lead their organizations to success.

Dr. Mark Boxer is executive vice president and global chief information officer for Cigna, where he is responsible for driving the company’s worldwide technology strategy.
Six Mid-Year Healthcare Trends to Watch

LINDSAY R. RESNICK

As we hit the halfway mark of 2019, it’s worthwhile to step back as take a look at what’s trending, what’s getting attention, and most importantly, what’s impacting your business in the healthcare landscape. There are big policy issues to resolve, practical product and operating decisions to be made, and increased pressure from customers making new, market-altering demands. The following healthcare trends provide context as you manage obstacles and opportunities ahead.

THE “MEDICARE FOR ALL” DEBATE WILL RAGE ON

Current proposals falling under the moniker of Medicare for All can be slotted into four categories:

- **Single payer.** Replace private health insurance markets with a government run system.
- **Public option.** Create a new public health insurance plan available to individuals.
- **Medicare/Medicaid buy-in.** Expand access to current federal and state insurance coverages.
- **Public/private partnership.** Structure a program for individuals similar to Medicare Advantage.

At the heart of all these approaches (and their viability) is cost—how will it be paid for? Cost has been the death knell for most healthcare proposals in the past, and with predictions that the current Medicare program is expected to go bankrupt in seven years, cost will remain the biggest obstacle going forward. Add to the mix that paying hospitals Medicare rates would bankrupt that sector and support from private insurers and pharmaceutical companies is non-existent, and the stars would have to line up for Medicare for All to become reality. Progressives would have to win the presidency with a Medicare for All as a key agenda item and Democrats have to hold the House and take the Senate with a large majority to pass a bill. And even then, there are no guarantees.

**Action:** No need to panic. Jump into the debate in preparation for the 2020 election.

UNINSURED AMERICANS ON AN UPWARD TRAJECTORY

The number of Americans without health insurance has increased by 7 million since 2016. Congressional Budget Office (CBO) projects that under current ACA rules (i.e., no further interference from the Trump Administration) 32 million Americans will be uninsured by 2020.

Should the President and Department of Justice’s unwavering efforts be successful in having ACA completely struck down, the total uninsured population in the U.S. would quickly top 50 million. Closing insurance marketplaces and exchanges, ending Medicaid expansion, and eliminating protections for Americans with pre-existing conditions would be significant contributors. Demolishing Obamacare also threatens ACO survival, HIV and opioid program funding, and Medicare Part D out-of-pocket costs.

What’s the endgame? On the eve of the final ACA enrollment deadline this past December, a U.S. District Court judge ruled the ACA unconstitutional. An appeal to the Fifth Circuit Court will resume the ACA challenge (beginning July 2019) and ultimately, it’s likely the next ruling will go to the U.S. Supreme Court for final resolution—stay tuned.

**Action:** Contingency planning would be smart as the individual and small group insurance markets would be severely impacted if ACA goes away, and uncompensated care and provider bad debt would skyrocket as all those insurance ID cards disappear.

TEAMWORK MAKES THE DREAM WORK

Vertical integration, consolidation of companies that own different parts of the value chain, is reshaping the business of healthcare. On top of the dominance of large multi-hospital systems and national mega-health insurers, we’re seeing retail behemoths aggressively stake their claim across verticals in the healthcare market—from big box store clinics to data analytics to aging-at-home to digital commerce. It’s a true ‘blurring of the lines’ in healthcare delivery. The lure of two organizations combining resources in a joint venture, alliance, or partnership is too good to pass up in a turbulent marketplace like healthcare.
The result is collaboration never before thought possible—some are competitors playing defense, others are seeking scalability, and still others simply want to take advantage of a perfect storm of an industry in transformation. Alas, these associations don’t come easy. Balancing financial, operational, and customer needs between multiple parties takes extraordinary discipline, common vision, and mutual trust.

Action: Given the integrators, disruptors and disintermediators reshaping traditional healthcare markets, can you really go at it alone? Cross-industry teamwork brings access to new markets, delivers cost-critical efficiencies, and enhances customer experiences.

HEALTHCARE CONSUMERISM IS A JOURNEY

Whether GenY, millennial, or boomer, they don’t want to engage with the healthcare system the way it is currently structured. They are demanding virtual health, telemedicine, community clinics, wearables, and active aging. They want relationships with companies they can trust to make healthcare simple: be there when I need you, communicate with me honestly, deliver an experience that respects me, and do the right thing for my health.

As more and more financial responsibility shifts to the consumer, you have their attention: give me the most for my money for what’s most meaningful and important to me. But, healthcare purchases—from insurance to prescription drugs to routine check-ups—aren’t easy, given health literacy disparities, variations in sites-of-care, and in general, bureaucracy extraordinary. Getting to the point of being a savvy healthcare shopper able to make confident, value-based choices takes time and experience. In healthcare, the path to self-reliance is long and full of impediments.

Action: Help your customers! As consumers take more personal responsibility for healthcare decisions they need help making personalized, value-based choices. Engaged healthcare consumers drive better care, better experiences, better outcomes, and better value.

HEALTHCARE TECHNOLOGY: AN UNSEEN TOOL

Healthcare’s future isn’t about wearables, virtual care, and artificial intelligence—it’s about experiences, services, and convenience, all powered by subtle, behind-the-scenes technologies that the customer barely sees. Healthcare innovators are using technology to deliver value to their customers that improves experiences and health outcomes. They are leveraging technology to enhance the healthcare value chain by containing costs, introducing infrastructure efficiencies, increasing individual productivity, promoting self-management, and extending life expectancy.

Take the wearable sector, where one in six consumers own and use one. They started out as a wellness tool, a fitness tracker. Now they have shifted to real-time monitoring of a wide range of patient vital signs with promises of becoming an auto-integrated part of the electronic health record, all unseen by the patient. Tomorrow’s health and medical technology solutions will be invisible in our everyday life, removing barriers, creating convenience and inspiring healthcare action. It’s the new normal.

Action: Connected healthcare consumers are ready to embrace innovation and willing to be engaged through digital health touchpoints. There’s unprecedented opportunity for health brands to emerge as trusted, go-to resources that are there to help consumers take responsibility for their health.

START TODAY

As competitors realign, market rules change, and customer demographics shift, successful healthcare companies don’t sit still, they take a critical look at business plans, operating models, customer experiences, and growth strategies. To do this, context is critical: what’s getting attention in the marketplace that may (or may not) have influence on your future. Here’s a few additional health trends to add to your watch list:

Primary health. Physician shortage or not, primary care is at the center of modern care delivery through large organized networks, medical home care models, proliferation of retail clinics, value-based payment, and in-home care delivery.

Social health. An individual’s economic situation and social determinants have twice the impact on their health than biology, DNA, and clinical care.

Weed health. Cannabis, both medical and legal recreational, is estimated to emerge as a $166 billion industry segment and will become a part of America’s healthcare fabric (medical claims, treatment protocol, workplace rules).

Inspired health. Changing peoples’ behavior to deal with and improve their health—breaking health inertia—means motivating them to action through personalized emotional drivers and gut-level appeals such as fear, joy, self-esteem, and hope.

Mental health. Crisscrossing generations—depression, anxiety, addiction, psychoses, dementia—means identifying and paying attention to warning signs and removing the stigma for getting timely, professional support will help turn mental illness to mental wellness.

Action: Empowered healthcare consumers are using their newfound influence to choose, challenge, and change the conversation with preferred brands. Healthcare is a complex domain—make sure you’re prepared.

Lindsay Resnick is executive vice president of Wunderman Thompson Health. He can be reached at lindsay.resnick@wunderman.com and followed on Twitter @lresnickR.
With readmission rates on the line due to the ACA’s 2012 Hospital Readmission Reduction Program (HRRP)—which imposes penalties for higher-than-expected risk-standardized, 30-day unplanned readmission rates for six conditions—hospitals would be remiss if they didn’t establish an effective program to improve their measures.

The Medicare Payment Advisory Council (MedPac) estimates that 12% of readmissions are potentially avoidable. Preventing even 10% of them could save Medicare $1 billion.

As pharmacists move farther away from their traditional role of only dispensing medications and accept responsibility for medication therapy management, hospitals are leveraging their expertise and placing them at the forefront of readmission reduction programs.

Role of pharmacists in readmissions programs

Eric Maroyka, PharmD, director, Center for Pharmacy Practice Advancement, ASHP, believes that pharmacists could play many roles in readmissions programs:

- Conducting full medication reconciliation from hospital admission through discharge.
- Offering recommendations, such as eliminating unnecessary or harmful medications, optimizing dosing, and suggesting alternative therapies to a medical team.
- Making changes independently to medication therapy based on practice scope and collaborative practice agreements.
- Assisting with care coordination and patient navigation near the time of discharge, providing patient education, and scheduling follow-up visits for medication management services.
- Coordinating with pharmaceutical assistance programs, insurance carriers, and community or outpatient pharmacies to access and afford medications.
- Ensuring medication adherence.

"An interprofessional and complementary approach using the pharmacist as the medication expert will add a necessary dimension to ensure an experience every patient deserves to improve access, cost, quality, and overall interprofessional team resilience," Maroyka says.

While he has pinpointed the extensive role of pharmacists in readmission reduction programs, Maroyka is well aware of the challenges of such endeavors.

"Electronic health record interoperability remains a significant barrier across patient care settings," he says. “This contributes to communication breakdowns and making less-informed decisions about patient care when accessing disparate data systems with incomplete or incorrect patient information.

"In addition, it is necessary to ensure staff competency enabling the pharmacy to have the capability and capacity to consistently support interprofessional care transition efforts across a continuum of care," Maroyka says.

Pharmacists at BayCare

BayCare Health System, a not-for-profit healthcare system in Tampa, Florida, introduced its Pharmacy Transitions of Care Program (PTOC) as a pilot in 2014, with two pharmacists in one of its 15 hospitals. The program has since grown to 23 pharmacists and has expanded to all its hospitals. It targets Medicare A and B beneficiaries with primary diagnoses of a CMS core measure who are discharged from a hospi-
tal to home or an assisted living setting.

Timothy L’Hommedieu, PharmD, director of pharmaceutical services, East Region, BayCare Health System, credits the healthcare industry’s shift to value-based care for the initiation of PTOC.

“The program’s goal is to decrease 30-day hospital readmissions. With drug therapy as the best way to treat acute and chronic conditions, the program provides an opportunity for pharmacists to play a significant role in transitional care,” he says.

Participating pharmacists are specially trained in ambulatory and transitions of care and hired just for that role, L’Hommedieu says. They are board certified and/or have received residency training.

Collaborating with inpatient and outpatient care teams—which include social workers, home care experts, and physicians—pharmacists conduct two patient visits after discharge and telephonic encounters within seven and at 21 days after discharge, providing comprehensive medication review, medication therapy management, and counseling.

They also evaluate patient clinical status, help identify and solve any problems with medications—side effects, wrong dose, or inappropriateness or ineffectiveness—and ensure patients understand their medications and can afford and access them.

“Clinical pharmacists have always assumed these responsibilities but not in the transitional setting. BayCare has specifically invested in them to provide these services,” L’Hommedieu says.

The health system conducted a study using data from September 2016 to May 2017, comparing 2,200 patients eligible for a readmission penalty enrolled in PTOC with a control group of 1,335. The readmission rates were 8.3% versus 23.7%, respectively.

Pharmacists documented 13,855 interventions (including 1,503 contacts with members of the interdisciplinary team), delivered 175 medication assistance programs, and provided 12,177 counseling interventions.

The program demonstrated a 63% relative reduction in all-cause readmission rates during that time period.

Although L’Hommedieu says HRRP is not the primary reason for developing the program, he is aware that results are publicly reported and can influence which hospitals patients select. “The law serves as justification for our investment in the value-based PTOC, which serves as a support program offering optimal patient outcomes,” he says. “If we deliver best practices, we set our patients up for success, and we can reduce readmissions.”

He emphasizes the importance of the team-approach to reducing readmissions, but admits it isn’t always easy to coordinate such a group and provide a seamless experience for patients.

Dignity Health Northridge targets chronic disease

Dignity Health-Northridge Hospital Medical Center’s chronic disease transitional care program involves a team of physicians, nurse practitioners, nurses, social workers, and pharmacists who collaborate with an inpatient care team. They provide clinical oversight and discharge planning for a chronic disease population during a hospital stay and for 30 to 90 days after discharge.

After discharge home or to a long-term care environment, the team provides clinical oversight to patients in conjunction with external community partners, such as home health agencies and local pharmacies, and focuses on patient safety, health, satisfaction, and mitigation of avoidable readmissions.

By using an interdisciplinary approach to care, pharmacists can reach out to other experts on the team to help develop an individualized care plan and assist in creating strategies to support positive patient outcomes, says Jasmen Esfandi, PharmD, clinical pharmacist for the program.

Northridge in Southern California initiated the program in 2015, as an enhancement to its palliative care program, spreading population health and care throughout the continuum of chronic disease.

“The objective is to address an aging population within the community, ensuring a safe and appropriate level of care for patients after discharge and promoting self-care management,” Esfandi says.

The number of patients affected by the program has nearly doubled to 7,500 since its inception.

— ERIC MAROYKA, PHARMD, CENTER FOR PHARMACY PRACTICE ADVANCEMENT, ASHP
“The objective is to address an aging population within the community, ensuring a safe and appropriate level of care for patients after discharge and promoting self-care management.”

– JASMEN ESFANDI, PHARMD, DIGNITY HEALTH NORTHRIIDGE HOSPITAL MEDICAL CENTER’S CHRONIC DISEASE TRANSITIONAL CARE PROGRAM

Through medication therapy management, pharmacists and nurse practitioners provide recommendations for changes in patient medication regimens based on diagnoses. Pharmacists also perform discharge medication reconciliation for patients returning home or transferring to one of Northridge’s skilled nursing facilities.

If discrepancies or errors in medications—incorrect doses, drug interactions—are found, physicians join pharmacists in resolving problems.

Pharmacists take an additional step by making home visits to help patients understand their medication, ensuring patients have access to their medications, can account for any missing drugs, and know how to administer them.

Like pharmacists in similar programs, Esfandi says data collection is one of her biggest challenges; prompting the hospital to engage data coordinators to collect measures that communicate productivity, efficiency, and positive outcomes of the program.

She also agrees with her colleagues that while HRRP has helped drive the transitional care program, presenting estimated Medicare penalty savings indicates the effectiveness and value of the program.

Northridge has experienced a yearly decrease in readmission rates of 10% over the previous year. Esfandi says these rates are aligned with California goals.

**Einstein REACH Program takes off**

After a pilot targeting adult patients admitted to a cardiac care unit from 2010 to 2011, Einstein Medical Center in Philadelphia developed its Medication REACH (Reconciliation, Education, Access, Counseling, Healthy Patient at Home) intervention in 2012, with a single pharmacist.

Since that time, Einstein has incorporated transition of care services into existing clinical pharmacist roles. Pharmacists collaborate with physicians, residents, and nurse practitioners from admission through post-discharge. The center added two pharmacy technicians, one to complete medication reconciliation in the emergency room and one as a discharge liaison to facilitate access to medications at the time of discharge.

The primary goal is to reduce hospital readmissions by improving medication management in the hospital, home, and during transition from these settings.

A 667-patient study, which appeared in the May 1, 2018 issue of *American Journal of Health-System Pharmacists*, evaluated whether REACH was feasible as part of routine care at a safety net hospital and could reduce hospital readmissions for Medicare fee-for-service.

Using a multifaceted approach, Einstein sought to improve medication management through direct pharmacist involvement and multidisciplinary communication between pharmacists and a clinical team.

Pharmacist intervention included reconciling medications, patient-centered education, ensuring access to medication, and follow-up at patients’ homes.

The study compared 30-day readmissions in patients with full and partial intervention with those receiving standard care. The results indicated 9.8% unplanned readmissions for the managed group versus 20.4% for the control group.

“It is important to establish collaboration not just between pharmacists and a medical team but also with care managers, insurers, and community pharmacists,” says Mariel Shull, PharmD, pharmacy utilization management coordinator for NYU Langone and the dedicated pharmacist in the Einstein study and its coauthor.

She sees pharmacists as an ideal fit for their role in a transition of care program that demands continuous coordination because of its complexity. “Pharmacists are medication experts that can ensure access to medications, improve adherence, and monitor patients.”

“It is important to measure [the pharmacist’s] impact to support expansion of services and advocate for resources, but efficient documentation is difficult or challenging in many existing electronic medical records,” says Shull, concurring with Esfandi.

Shull also agrees with L’Hommedieu that a readmissions program helps justify involvement of pharmacists and makes a business case for the program.

“Hopefully,” say Shull, “pharmacists and other team professionals will adapt this kind of transition of care model to other programs used in everyday care.”

Mari Edlin, a frequent contributor to Managed Healthcare Executive, is based in Sonoma, California.
Healthcare Policy in 2019: A Look Ahead

by JEFFREY BENDIX

Lawmakers, judges and regulators are poised to take (or at least consider) steps that could affect the nation’s $3.5 trillion healthcare system for years to come.

From the ACA to changes to ACOs, here is what 2019 may hold for healthcare policy.

The future of the ACA
Since becoming law in 2010, the ACA has survived several near-death experiences, including a 5-4 U.S. Supreme Court vote to uphold it in 2012, an effort to defund the law via a government shutdown in 2013, and a 51-49 vote in the U.S. Senate against repealing it in 2017.

The latest threat to the ACA came in December 2018, when a federal judge in Texas declared the law unconstitutional. The judge agreed with the plaintiffs that when Congress zeroed out the financial penalty for not having health insurance (which was part of the 2017 tax reduction law) and because the Supreme Court had previously ruled that the penalty was actually a tax, both the tax and the entire statute unconstitutional doesn’t really work.

A group of Democratic attorneys general is appealing the judge’s decision in various U.S. Courts of Appeals. That process is likely to take up much of the year, Gary says, adding that the losing side will almost certainly appeal the circuit court’s decision to the Supreme Court. If they decide to hear the case—which Gary says is not certain—it could wind up issuing its ruling just before the 2020 presidential election.

Gary attributes the courts’ frequent involvement with the ACA to Congressional dysfunction, noting the long and often convoluted process the required to get the law passed, and the fact that no Republicans voted for it.

“When Congress can’t make decisions, the courts step in to try and do that, and courts aren’t particularly well-suited to the task. And what you end up with is a lot of surprise.”

— C. TIMOTHY GARY, JD, DICKINSON WRIGHT

Expanded coverage
In the wake of Democrats gaining control of the U.S. House of Representatives and with the 2020 presidential election already in full swing, extending healthcare insurance to more Americans is again being widely discussed.

For many in the public and the media—and some Democratic presidential candidates—the discussion translates into some version of “Medicare-for-All,” a slogan popularized by Vermont Sen. Bernie Sanders during his 2016 bid for the Democratic nomination. And while that term does apply to some of the ideas being floated for expanding coverage, others are more limited in scope.

In a study published last year, the nonprofit Kaiser Family Foundation identified eight pieces of legislation aimed at making insurance more widely available, which it groups into four categories:

- Two proposals for instituting single-payer coverage for all Americans—in effect, Medicare for All.
- Three plans for creating a Medicare-
like “public option” that would be available to all individuals and some or all employers via the ACA insurance exchanges.

- Two bills enabling Americans younger than 65 to buy into Medicare. One proposal would allow buy-ins starting at age 55, the other at age 50.
- One proposal allowing states to offer their residents a Medicaid buy-in option through the ACA marketplaces.

A ninth bill, the Medicare for America (MFA) Act of 2018, was introduced after the study was published. It would cover the uninsured, those who buy insurance on the individual market, and individuals on Medicare and Medicaid. Employer-sponsored insurance would remain, but employees who have it would have the option of enrolling in MFA coverage instead.

While all the proposals would come with tradeoffs, the most difficult would come from a single-payer system. Some method would be needed to pay for coverage of people who get insurance through their employer, says Joseph White, PhD, a professor of public policy at Case Western Reserve University and author of False Alarm: Why the Greatest Threat to Social Security and Medicare is the Campaign to “Save” Them.

“The transition to what we’re really talking about, which is financing through the tax code the portion of healthcare which is currently collected through employers, is really hard,” White says. “There are likely to be a lot of losers, or at least people who think of themselves as losers in the short run, and that’s going to create a lot of political backlash.”

Moreover, White notes, none of the single-payer proposals address what to do about Medicare patients who get their benefits via commercially-administered Medicare Advantage programs.

While a single-payer system would have the benefit of eliminating many of the administrative headaches that comes from dealing with multiple payers, it would also likely mean a reduction in income, since Medicare traditionally has reimbursed at lower rates than commercial insurers.

White and other policy experts caution that with the presidency and Senate in Republican hands, the chances for any type of Medicare expansion occurring before 2021 are virtually nonexistent. Nevertheless, they say, the fact that the idea is being discussed—and will likely be the subject of Congressional hearings—is significant.

“The advantage of hearings is that members of Congress, as well as the general public, will begin to sort of kick the tires and learn more about the mechanics of these proposals and the trade-offs they would involve,” says Tricia Neuman, ScD, MS, director of the Kaiser Foundation’s program on Medicare policy and a co-author of the study on Medicare expansion.

Her views are echoed by Robert Doherty, senior vice president for government affairs and public policy for the American College of Physicians. “Having a debate of ideas ultimately is in the best interest of finding lasting policy solutions,” Doherty says.

**Prescription drug prices**

Escalating drug prices have angered physicians and patients alike for years. Congress and the administration began to address the problem last year, and those efforts are likely to accelerate.

Congress made its intentions clear late in January when committees in both the House and Senate held hearings on drug prices on the same day. U.S. Rep.
Elijah E. Cummings (D-MD), chairman of the House Committee on Oversight and Reform, said that a “strong bipartisan consensus” exists in Congress for reinining in “out-of-control price increases.”

But translating general agreement that prescription drug prices are too high into actual legislation won’t be easy, warns David Pugach, JD, senior vice president for public policy for the American Osteopathic Association. “Everybody recognizes there is a problem, but the source of the problem is going to be viewed differently and the proposed solutions are going to vary significantly,” he says.

Pugach cites a proposal the Trump administration developed last year for lowering the cost of drugs administered under Medicare Part B, where the price paid for certain drugs would be tied to an index of prices paid for those drugs in other wealthy countries. While Pugach calls the proposal well-intentioned, he adds that the AOA is concerned it could stifle pharmaceutical innovation and make it harder for Medicare beneficiaries to obtain medications. “It has to be a balancing act,” he says.

Doherty is hopeful that Congress will pass some sort of legislation in 2019 addressing drug prices, given a Democrat-controlled House. Fueling his optimism is the Senate Finance Committee, (which holds a lot of sway over healthcare legislation), now chaired by Sen. Charles Grassley, (R-Iowa) who has a reputation for ferreting out wasteful government spending.

One possibility for legislative action on drug prices, says Doherty, is a vote on the Creating and Restoring Equal Access to Equivalent Samples Act. First introduced in 2016, the law, which has bipartisan support, would allow generic drug manufacturers to sue pharmaceutical companies for refusing to provide them with enough samples of brand-name drugs to create generic equivalents.

Grassley has already signaled his interest in the bill. “His emphasis has always been on cost-effective government and going after wasteful spending,” Doherty says. And with the House now under Democratic control, “We’re cautiously optimistic that we could see this legislation advanced through Congress,” Doherty says.

According to Kaiser Health News, other drug-price-related legislation that senators are considering include:

- Allowing the government to manufacture generic drugs in cases where there aren’t enough competitors to keep prices down;
- Letting Medicare negotiate directly with drug manufacturers;
- Prohibiting drug companies from pricing drugs higher than median prices charged in Germany, France, Canada, Japan, and the U.K.;
- Allowing drugs to be imported from Canada, and possibly other countries later on, and
- Abolishing the practice whereby manufacturers pay generic producers to keep competing drugs off the market.

“[Drug pricing] is an issue that is on Congress’s mind, and public support for government action in this area is pretty clear and crosses party lines,” says Neuman.

Meanwhile, the Trump administration has announced its own plan for lowering drug prices. In early February it released a proposed rule that would prohibit pharmaceutical companies from offering rebates to PBMs who administer drug plans under Medicare Part D or Medicaid managed care organizations, but could offer rebates directly to patients.

**Changes to ACOs**

For ACOs, the biggest issue in 2019 almost certainly will be of “Pathways to Success,” the CMS rule overhauling the Medicare Shared Savings Program that will take effect on July 1. It reduces the length of time an ACO can remain on the program’s “upside only” track, where it shares in savings if its spending is lower than its benchmark, but does not incur losses if its spending exceeds its benchmark. Currently, an ACO entering the program can be on an upside only track for up to six years. The rule lowers that to two or three years, depending on revenue.

“Pathways” consolidates the program’s four tracks into two—a “basic” track that allows new ACOs to start by sharing only in savings and begin transitioning after two years to a model where it also incurs financial risk, and an “enhanced” track that provides an ACO with potential for greater financial rewards, along with greater financial risk.

The rule also creates a distinction between “low revenue” and “high revenue” ACOs, extends the ACO contract length from three years to five, and reduces the rate of shared savings available to newly formed ACOs from 50% to 40%.

Clif Gaus, ScD, president and CEO of the National Association of Accountable Care Organizations, says that while it will take time for the effects of the “Pathways” rule to play out, the association is concerned that the lower shared savings and decreased time allowed for transitioning to a risk-sharing model could inhibit the new ACO formation.

“We believe two years is too short a time for ACOs to get their bearings in no-risk models before they’re forced to take on risk,” he says. “Studies show it takes three or four years before ACOs are fine-tuned enough to operate with the necessary degree of efficiency.”

Jeffrey Bendix is senior editor for Managed Healthcare Executive. Our sister publication in which this article first appeared.
Managed Healthcare Executive has selected 10 emerging industry leaders, working in the areas of pharmacy, health plans, health systems, and technology

By KAREN APPOLD

KATHERINE DI PALO
PharmD, clinical program manager, Hospital Readmissions Reduction Program, Montefiore Health System, Bronx, New York

In a role she created, Di Palo, 32, has translated her experience as a pharmacist who worked at the bedside to the boardroom at Montefiore Health System, the University Hospital for Albert Einstein College of Medicine. She co-chairs the executive Hospital Readmissions Steering Committee, connecting historic silos to ensure vulnerable patients safely transition from hospital to home. Di Palo directly leads working groups that tackle key initiatives including care infrastructure, information technology changes, clinical data analysis, multidisciplinary education, and care continuum partner engagement to improve outcomes established by the Institute for Healthcare Improvement’s Triple Aim.

MHE: Why did you choose your profession?
Di Palo: Administration is in my DNA. My father started as an orderly and through education and perseverance rose through the ranks to hospital CEO. Similarly, I began my career as a teenager at a local independent pharmacy and quickly found that clinical pharmacists are integral in evidence-based medicine delivery and patient advocacy. As a result of infinite curiosity, strong mentors, and a desire to challenge the status quo, I shifted from optimizing care at an individual patient level to a systems level within a visionary organization.
MHE: What has been your biggest learning experience in the industry? What did it teach you?
Di Palo: To successfully transform an initiative from a pilot program to the standard of practice, bidirectional communication is key. Listening to clinicians, leaders, care providers, and most importantly—patients—allows for the development of innovative and common-sense solutions that fit the culture.

MHE: What change would you like to see in healthcare in the next five to 10 years?
Di Palo: Patient access, especially to primary care in underserved areas, is integral to quality and cost reduction in chronic disease management. Currently, pharmacists are not considered healthcare providers under Medicare Part B despite robust evidence demonstrating their positive impact on outcomes. Many primary care models integrate pharmacists for longitudinal medication management consistent with state scope practice laws and regulations, however lack of reimbursement prevents patients from clinical pharmacy services. Recognition of pharmacists as healthcare providers at the federal level could facilitate team-based, patient-centered care.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
Di Palo: Given the opportunity I would like to meet Hippocrates—the Father of Medicine. I admire his revolutionary thinking, discipline, compassion, and ethics. Finally, the modern translation of the Hippocratic Oath—that there is an art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug—is something I firmly believe.

PATRICK FENNINGHAM

chief product officer and executive vice president, EIR Healthcare, Philadelphia

Fenningham, 31, started his career at Johnson & Johnson as a biomedical engineer, before earning an MBA and relocating his talents to Siemens Healthcare, where he focused on market analytics and product management. He went on to become the head of commercial operations

“Patient access, especially to primary care in underserved areas, is integral to quality and cost reduction in chronic disease management.”

— Katherine Di Palo
at Thomson Reuters Intellectual Property and Science (now Clarivate Analytics). Today, his work includes developing an enterprise-wide product strategy, defining research and development roadmaps, and driving innovation to help strengthen EIR’s position as a leader in modular technology in the healthcare industry.

MHE: Why did you choose your profession?
Fenningham: Ever since my grandfather died of cardiac complications when I was 12 years old, I wanted to understand why it happened. This drove me to enter the medical field. I began my college education by taking the pre-med cardiology track. While there, my interests transformed from cardiology to biomedical engineering. My goal grew to helping patients with all kinds of ailments. I am now focused on improving the overall healthcare experience for patients and caregivers.

MHE: What has been your biggest learning experience in the industry? What did it teach you?
Fenningham: If you truly want to make a difference in your space, sit with the people who actually do the work. Early on in my career, I found those who really knew what was going on with the products and services within a company are the boots on the ground, not the executives or board of directors. As I climbed the ladder into management roles, I always felt my greatest asset was my ability to connect with the people on the front lines. They can tell you everything you need to know if given the chance.

MHE: What change would you like to see in healthcare in the next five to 10 years?
Fenningham: I would like to see an open-source collaboration across the industry using data analytics to create predictive indicators that will be used to directly impact patient outcomes.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
Fenningham: Babak Parviz, PhD, who heads the Amazon Grand Challenge, a division of Amazon primarily focused on cancer research and electronic health record technology. I find it incredibly fascinating when very successful and well-educated groups outside of the healthcare world bring a new perspective to the industry. Understanding his high-level approach on how he plans to tackle healthcare would be exciting.

VIVEK GARIPALLI
co-founder and CEO, Clover Health, San Francisco, California

In his current role, Garipalli, 40, is addressing a demographic that is commonly ignored: seniors living with complex health issues that the healthcare system is unable to manage effectively. Under his leadership, he has grown Clover, which uses proprietary artificial intelligence and machine learning models to improve health outcomes, to nearly 40,000 Medicare Advantage plan members and more than 500 employees.

Prior to Clover, Garipalli founded CarePoint Health, a fully integrated healthcare system serving Hudson County, New Jersey; Ensemble Health Partners, a national revenue cycle company headquartered in Huntersville, North Carolina; and a network of outpatient facilities.

MHE: Why did you choose your profession?
Garipalli: When I first entered healthcare, I saw it solely as an economic opportunity. But I stayed in healthcare because I knew it would offer me the chance to add value to the world. At Clover, our company’s success is directly related to our members’ health; that alignment of mis-
sion and business model is something incredibly special and unique. We believe that by leveraging technology in a logical way, we can have a dramatically positive impact on our current and future members' health.

**MHE: What has been your biggest learning experience in the industry? What did it teach you?**

Garipalli: Four years ago at Clover, we had an idea to offer the same cost-sharing in and out of network and remove that friction for customers. Therefore, we created marketing materials and launched a plan. But CMS had a very different interpretation regarding physician obligations to see customers out of network, and we had to immediately cease the marketing approach. That experience taught me that the learning curve on compliance in Medicare Advantage was much steeper than I had realized. That’s when we hired a chief compliance officer. That experience taught me the importance of hiring subject matter experts, even if it’s a space you’re familiar with.

**MHE: What change would you like to see in healthcare in the next five to 10 years?**

Garipalli: I’d like to see more healthcare companies focus on underserved populations and helping the most vulnerable members of society. High-quality healthcare should not be restricted to the wealthy. At Clover, we’re committed to making healthcare more equitable, by serving a population that’s far more diverse than the industry average.

**MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?**

Garipalli: Someone who’s been on my mind lately is Jonas Salk, the inventor of the polio vaccine. In the midst of the public debate of pharma pricing and research costs, he was an incredibly important figure who had zero interest in personal profit, sought no patent for the vaccine, viewed public health as a moral commitment, and in turn was responsible for saving hundreds of thousands, and potentially millions, of lives.

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**ROSE JOSE**

PharmD, chief operating officer, Outpatient and Specialty Pharmacy Services, LifeBridge Health, Baltimore

Jose, 38, earned her doctorate in pharmacy in 2004 and became a licensed pharmacist at 23 years old. In 2008, she assumed a role in pharmacy administration at the University of Maryland Medical System in Baltimore. In 2012, she joined LifeBridge Health as the director of outpatient pharmacy services, where she is now the chief operating officer of outpatient and specialty pharmacy services.

**MHE: Why did you choose your profession?**

Jose: I decided to pursue pharmacy after my father and I were in a serious car accident when I was a young teenager. I was hospitalized and wheelchair bound for months. My mother, a cardiothoracic nurse, took amazing care of us once we came home from the hospital. When my mom had to go back to work, I took on ad-

“I’d like to see more healthcare companies focus on underserved populations and helping the most vulnerable members of society. High-quality healthcare should not be restricted to the wealthy.”

—Vivek Garipalli
ditional responsibilities around the house, including giving my dad each of his many medications at the right time. I felt that I made a real difference in my dad's recovery and wanted to continue making a positive impact in the lives of people who need it most.

**MHE: What has been your biggest learning experience in the industry? What did it teach you?**

Jose: Entering the pharmaceutical industry at 23 years old was a challenge. When you're young in the profession, you're sometimes perceived as "green" and need to establish credibility to gain your peers' respect. I had to work extra hard to earn trust from my colleagues over time, and that gave me confidence in my abilities as I took on more advanced positions and leadership roles.

**MHE: What change would you like to see in healthcare in the next 5 to 10 years?**

Jose: I'm fascinated by the rapid advancements in genetic testing. Pharmacogenomics presents an incredible opportunity for personal medication management, and I'd like to see how we can leverage the widespread availability of testing to improve patient outcomes. A patient's prescription could be tailored to their individual DNA test results, meaning we eliminate waste, decrease side effects, and create optimal therapeutic outcomes.

**MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?**

Jose: CEO of GlaxoSmithKline Emma Walmsley. She's fascinating for many reasons. She was named *Fortune's* most powerful international woman in business and is the first woman to run a major pharmaceutical company. I'd like to learn about her perspective of the drug industry and other hot topics such as drug pricing transparency or lowering drug prices. One of her main focuses is on drug development. I'd like to hear about her outlook on vaccines in development for conditions such as cancer, HIV, and other illnesses that affect so many people, and how these advances can shape healthcare's future.

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**PETER KELLY**

MBA, executive director and business development leader at CareMount Medical, Mount Kisco, New York

Kelly, 36, feels fortunate to have spent six years in his early career as an Avalere Health consultant. The firm grew from 45 staff to more than 200 during his tenure. There, he gained specialized knowledge in U.S. healthcare reimbursement and finance, especially for governmental programs. After business school, he joined Universal American as director of strategy and then served as executive director of the New York Medicare Advantage and accountable care organization.
Kelly: The importance of building a team. Integrating the healthcare provider and managed care operations spans so many critical functions—finance, clinical operations, contracting, data analytics, quality, med management, and pharmacy. To do it well, you need leaders or rising managers across these areas. Experience has taught me the importance of organizing people and aligning them with a core mission and narrative. For my team at CareMount, the goal is to achieve total quality outcomes for our patients.

MHE: What change would you like to see in healthcare in the next five to 10 years?
Kelly: I think a responsible expansion of Medicare Advantage is good public policy. Along with it, we need a regulatory framework that creates a transparent and credible glide path for providers to take delegated premium risk under the plans.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
Kelly: I would ask Jeff Bezos how he views patients as customers and how to streamline the customer experience in healthcare. We probably could go to a good restaurant, too.

—I think a responsible expansion of Medicare Advantage is good public policy.”
— Peter Kelly, MBA

DAN LAVALLEE

director of Government & Business Relations for Government Programs, University of Pittsburgh Medical Center Health Plan (UPMCHP), Pittsburgh

After earning a master’s degree in health policy, LaVallee, 31, joined America’s Health Insurance Plans in 2010. He then became one of the youngest Democratic nominees for Congress in Pennsylvania’s 3rd congressional district in 2014 at age 26. When he didn’t win his bid, he joined UPMCHP in 2015. His work focuses on underserved populations such as the Medicaid population, the LGBTQ community, the homeless, people with unstable housing, and individuals with intellectual or developmental disabilities, among others.

MHE: Why did you choose your profession?
LaVallee: Ever since I was a child, making an impact for those in need was important to me. I chose this profession to be able to have the greatest impact on the largest number of people—especially the underserved, disadvantaged, and those left behind.

MHE: What change would you like to see in healthcare in the next five to 10 years?
LaVallee: In order to provide the best and most effective health outcomes, we need to continue to make progress in realizing that each patient—especially those who are often left out of the healthcare system—is a person of worth and dignity. We cannot assume that they will

“I learned that it is possible to create innovative models to serve underserved and at-risk populations that can then be driven to scale and leveraged.”
— Dan LaVallee
appropriately access the healthcare system if they don’t feel listened to and understood. Hearing directly from the individual—such as the woman who is homeless or the transgender man looking for non-judgmental and competent care—is the only way to effectuate the meaningful change we seek.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
LaVallee: I would love to have dinner with Lee Bass, MD, my childhood pediatrician. He was the type of doctor who treated his patients not just as patients, but as people that he valued. After my brother died when I was six years old, Bass came to my house with a gift of a toy truck and played on the floor with me—not as a child who needed treatment, but as a child who was grieving my brother. I would love to thank and tell him that I am trying to follow in his footsteps.

SINEAD MADIGAN

chief operating officer, Health Alliance Medical Plans, Champaign, Illinois

Madigan, 46, started at Health Alliance in 2008 as a pharmacy Medicare specialist. After less than two years, she moved into the corporate relations manager role, advancing the next year to become the director of government relations. After serving as executive director of Medicaid and government relations, she became a vice president in 2016 and then assumed the senior vice president of government relations and business operations position in July 2018, and was recently named chief operating officer. She is responsible for building its business and helping forge new relationships, as well as providing better customer service, and maintaining and expanding key provider partnership operations and compliance.

MHE: Why did you choose your profession?
Madigan: I started my career in state government. I believe in servant leadership, and have a keen desire to help others achieve their healthcare goals and understand how to be advocates for their own well-being through health literacy, strong provider-patient relationships, and optimal use of health plan benefits, including those beyond the plan itself.

MHE: What has been your biggest learning experience in the industry? What did it teach you?
Madigan: Our industry has been slow to focus on the customer experience. I’ve realized that our teams need to really think like a consumer in everything we do. We continue to break down internal and external silos to achieve continuous improvement for our patients and members.

MHE: What change would you like to see in healthcare in the next five to 10 years?
Madigan: I believe innovation is vital to improving healthcare. While government regulations serve as important guideposts, I would like to continue helping policy makers focus on ways to give the healthcare industry greater flexibility to innovate so we can best serve patients and members to achieve the positive health outcomes we all desire.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
Madigan: At the risk of jumping on the thought-leader bandwagon, I would spend time with Bill and Melinda Gates. I would soak up details about their health-focused global initiatives, as well as their big ideas to address healthcare and poverty for more specific needs—ideas our enterprise and industry can springboard off closer to home. Innovation isn’t just a buzzword with the Gates Foundation. It’s a way of life to help people reach their potential.

BRIGITTE NETTESHEIM

president, North Central Region and Joint Ventures, Aetna, Chicago

Nettesheim, 46, began leading strategy for Aetna’s joint venture markets in 2016 and its North Central territory as well in 2018. In these roles, she is responsible for deepening Aetna’s relationships with consumers, employers, and providers, with a focus on transforming the way healthcare is delivered.
locally. Previously, she led Aetna’s Accountable Care Solutions and was a principal at The Chartis Group. She also held roles at Aetna in strategy, sales, service, and network management. Nettesheim served in the U.S. Army, rising to the rank of Captain.

**MHE: Why did you choose your profession?**

Nettesheim: As I transitioned out of the Army, I wanted to continue to serve the common good. I saw healthcare as a way to help improve people’s lives. I also saw opportunities to lead and drive change in healthcare. The military teaches you to have focus, agility, and the confidence to be decisive—all great leadership qualities.

**MHE: What has been your biggest learning experience in the industry? What did it teach you?**

Nettesheim: I learned that achieving better health goes far beyond the physician’s office and is heavily influenced by social determinants of health, such as conditions where we live, work, and play. I also learned the importance of having patience. In a large, complex industry like healthcare, sometimes things don’t move as quickly as you would like.

**MHE: What change would you like to see in healthcare in the next five to 10 years?**

Nettesheim: Our industry has an opportunity to sharpen its focus on consumers and their need for better and more affordable care. Accomplishing that takes teamwork and collaboration, which can be challenging at times due to the industry’s complexity, misaligned incentives, and the wide variety of stakeholders. That’s one reason why I’m so encouraged by some of the more progressive value-based care arrangements like joint ventures that create the aligned incentives among payers and providers needed to deliver greater value to consumers.

**MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?**

Nettesheim: I’d love to sit down with Lyndon Johnson after he signed Medicare and Medicaid into law. Such programs drew debate during his and previous administrations. It would be fascinating to learn more about what drove his commitment to those programs and what he thought about their sustainability at that time.

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**I learned that achieving better health goes far beyond the physician’s office and is heavily influenced by social determinants of health.” — Brigitte Nettesheim**

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**DARREN J. SOMMER**

DO, FACOL, founder and CEO of Innovator Health, and assistant professor of medicine and technology, New York Institute of Technology College of Osteopathic Medicine at Arkansas State University, both in Jonesboro, Arkansas

Sommer, 47, created Innovator Health with the intent to provide life-like telemedicine experiences for patients so they can continue to build strong relationships with their physicians. The technology allows a physician to be at the patient’s bedside in their life-size form, with
direct eye contact and in 3D. He also personally uses his technology to ensure that more than 3,000 rural and underserved patients have access to telemedicine services annually.

In addition, Sommer created and teaches the first-ever integrated telemedicine curriculum for first- and second-year medical students. Hundreds of student physicians are now more comfortable providing telemedicine services after having participated in his training program.

Furthermore, Sommer has more than 23 years of active and reserve military service and is currently a lieutenant colonel in the Army Reserves.

MHE: Why did you choose your profession?
Sommer: As a college drop-out, I never imagined I’d become a physician. However, after spending a few years in the military and being trained as an emergency medical technician, I fell in love with healthcare and helping people. Following the military, I was blessed to meet an osteopathic physician who mentored me and supported my pursuit of medicine.

MHE: What has been your biggest learning experience in the industry? What did it teach you?
Sommer: My most significant learning experience in healthcare was during my first clinical rotation when a frustrated, bitter physician trained me. This physician spoke in detail about the issues plaguing the healthcare industry, yet never once discussed how he planned to make it better. Listening to this physician made me realize that I didn’t want to find myself in the same place 20 years down the road. As a result, I’ve focused my career on finding ways to make the healthcare industry a better place for future physicians and their patients.

MHE: What change would you like to see in healthcare in the next five to 10 years?
Sommer: I would like to see the complete integration of all electronic health records. Having a ubiquitous exchange of patient information will allow for a better quality of care and dramatically reduce the costs of healthcare services.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?
My healthcare hero is Joseph Murray, MD. As the physician who successfully completed the first human organ transplant, I’d like to know how his peers received such a radical concept back in 1954 and how he persisted through what must have been a challenging experience both clinically and politically.

“I would like to see the complete integration of all electronic health records.” — Darren J. Sommer, DO, FACOI
CATHERINE TURBETT

executive director of national performance operations, Steward Health Care Network, Dallas

Turbett, 33, began her career in practice operations, responsible for the patient experience and efficiency. She went on to work for Steward Health Care Network’s ACO, tasked with improving quality performance at point of care. She became responsible for organizational strategies and, in 2018, became executive director of national performance operations. She oversees a team of 300, who are focused on improving performance in Steward’s health plans and ACOs.

MHE: Why did you choose your profession?

Turbett: My mom spent years in and out of the healthcare system as a patient, so I became an expert in navigating its complexities and knowing good components of care when I saw them. When she waited weeks for necessary appointments, I realized that our healthcare system has challenges for everyday consumers. When I worked as the operations manager at a physical therapy practice, the owners became my mentors, leading me to the idea that there was more than one way to impact the continuum of care. They suggested I explore a master’s in healthcare administration.

MHE: What has been your biggest learning experience in the industry? What did it teach you?

Turbett: When I joined Steward Health Care, it had just begun working to improve how patients experienced care. I developed and implemented a strategy to improve our Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance. At the time, our ACO consisted of Medicare and commercial patients; our efforts improved performance from -0.7 to 2.0 in patient experience in three years, a 230% improvement in commercial patient experience scores. In 2017, we implemented a Medicaid ACO. When we received our baseline CAHPS performance, it became clear that this segment experiences care differently than others as it rated us 5% to 10% lower than Medicare and Commercial populations—even though we achieved national benchmarks in CAHPS for Medicaid populations. Therefore, our teams had to implement efforts in different ways than before.

MHE: What change would you like to see in healthcare in the next five to 10 years?

Turbett: I would like to see greater transparency on CAHPS and quality performance. Patients should have access to information in an easily consumable way to make decisions about where and from whom they receive care. This includes access to ratings regarding experience of care and quality. At Steward, we’re taking steps in this direction, asking for feedback and reporting quality across our organization.

MHE: If you could sit down to dinner with anyone involved in healthcare who would it be?

Turbett: Margaret Chan, former director-general of the World Health Organization, would be a fantastic date. I’d like to discuss her statements around universal coverage being a powerful equalizer and a concept that rules public health debates in the modern world.

“...I would like to see greater transparency on CAHPS and quality performance.”

—Catherine Turbett

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

Selection criteria and process

MHE identified more than 35 finalists based on nominations received and independent research. Then, the editorial advisory board reviewed the finalists and selected 10 standouts.

To be considered, candidates had to meet the following requirements:

❖ Worked in the industry 15 years or fewer;
❖ Led key initiatives at their organizations or relevant organizations;
❖ Took actions that led to measurable, positive industry impacts;
❖ Accomplished something new or unique in the industry; and
❖ Continued to take on more advanced roles and responsibilities.
Specialty Drugs Demand Close Management to Keep Costs Down

The tools health execs use to add value while balancing costs

by MARI EDLIN

The cost of specialty drugs compared to the volume used is somewhat akin to the long-supported statistic that 20% of patients represent 80% of healthcare costs.

While specialty drugs comprise only 1.9% of total prescription volume, they account for 37.4% of spending within the retail and mail order distribution channels, according to a report by the IQVIA Institute.

PBMI estimates that by 2020, specialty drugs will account for half of total U.S. drug spend. They have increased 55% under the medical benefit since 2011.

“Today hundreds of specialty drugs are available, giving patients access to potentially life-changing treatments. Specialty pharmaceuticals are the fastest growing and most expensive segment of pharmacy care. As a result, specialty conditions drive a disproportionate segment of total health care costs,” says Michael Zeglinski, senior vice president of specialty pharmacy at OptumRx, UnitedHealth Group’s pharmacy care services business.

Almost half of the 150 specialty drugs studied by America’s Health Insurance Plans in 2016 cost in excess of $100,000 per year, with expenditures for 3% of the drugs studied exceeding $500,000 dollars per patient per year.

**Tools/strategies for lowering costs**

Industry players continue to seek ways to manage specialty pharmaceutical costs in light of the many triggers pushing prices well above those for regular branded drugs.

PBMI says many employers have introduced high-deductible plans to encourage members to make better decisions; create specialty drug tiers; use coinsurance for cost sharing; place prior authorization and step therapy on certain drugs; and exclude certain specialty drugs.

Benefit design is one of the most efficient ways to keep drug prices in line, says Ken Majkowski, PharmD, chief pharmacy officer of Bethlehem, Pennsylvania-based FamilyWize—a discount prescription program partnership—pointing to closed formularies that exclude certain medications.

For example, when new hepatitis C drugs began entering the marketplace in 2014, Express Scripts, a St. Louis-based PBM, only covered Viekira Pak (ombitasvir/paritaprevir/ritonavir and dasabuvir) for the condition but added Harvoni (ledipasvir/sofosbuvir) in 2017.

In 2019, its National Preferred Formulary (NPF) lists Eclusa (sofosbuvir/velpatasvir), Harvoni, Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) for hepatitis C. CVS Health recognizes Sovaldi and Harvoni.

Express Scripts rolled out its National Preferred Flex Formulary on January 1, 2019, to provide a way for plans to cover lower list price products, such as new autho-
Contributors to the High Costs of Specialty Drugs

Michael Zeglinski, RPh, of OptumRx highlights several factors that contribute to the high cost of specialty drugs:

**New product entry and drug price inflation** A recent study published in *Health Affairs* found that rising specialty drug costs were due to a combination of new product entry and existing product price inflation. Average costs of specialty drugs increased 13 times faster than general inflation.

**Lack of competition** Zeglinski is looking at biosimilar drugs to foster greater competition and increased savings as specialty drug patents expire. He expects that after several years of competition, biosimilars would be priced as much as 40% below their reference products.

**Scientific advances** Referring to another study in *Health Affairs*, Zeglinski says pharmaceutical companies can set prices however they want when entering new categories. The study found that premiums pharmaceutical companies earn from charging substantially higher for their medications in the United States compared to other countries generates substantially more than what the companies spend globally on research and development.

“Lowering the magnitude of the U.S. premium to a level where it matches global R&D expenditures would have saved U.S. patients, businesses, and taxpayers approximately $40 billion in 2015,” he says.

“Adding to the cost of biologics are the multiple drugs taken by people with chronic disease, making it important to focus on total costs, not just the cost of a single drug,” Ken Majkowski PharmD, of FamilyWize says. Jennifer Fuhrmann-Berger, PharmD, of Benecard says that specialty drugs consume about 30% of her employers’ drug spend, but that the specialty drug trend has slowed to 8.91% in 2018. She prefers to look at drugs with the highest utilization, not the most expensive drugs that are often taken only by a small population.

“From a tactical perspective, prior authorization, including documentation of a particular condition and eligibility for the treatment, are essential,” says Bruce Sherman, MD, chief medical officer, National Alliance of Healthcare Purchaser Groups. “Because some of the identified treatments...”

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address only one specific mutation, it’s critical that genetic abnormality has to be in evidence for the treatment to be effective."

He sees novel contracting approaches as one solution to nibbling away at costs. "Most of these contracts are value-based, in that the patients have to respond to treatment for the drug manufacturer to be paid," he says. "Amortized payments are another potential solution."

Jennifer Fuhrmann-Berger, PharmD, senior vice president, clinical services, at Benecard PBF, a pharmacy benefits administrator headquartered in Bonita Springs, Florida, believes in the power of communication. To overcome what she considers potential issues related to specialty drugs—such as fear of injections, lack of adherence, switching drugs but continuing to get both prescriptions, and improper drug storage—she says Benecard communicates with pharmacists and nurses to monitor these issues, along with potential side effects, and contacts physicians if non-adherence becomes a problem. "We are continually looking at claims and trends for safety and appropriateness issues," she says.

She says Benecard relies on pharmacogenetics—not trial and error—to determine whether a patient can metabolize a drug or not. "If one doesn’t work, then we choose a different drug or dosage," she says.

“We believe that putting the client at the center of care and pharmacists at the point of sale, enabled by clinical edits, keeps our trend down.”

—JENNIFER FUHRMANN-BERGER, BENECARD PBF

OptumRx uses a variety of strategies to manage the continuing high cost of specialty drugs:

**Therapy solutions model.** OptumRx provides patients with healthcare specialists and counselors who offer education and support via routine medication monitoring, personalized follow-ups, and in-home onboarding for patients new to treatment.

**OptumRx’s oncology Split Fill program.** Through the Split Fill program, OptumRx takes an individualized approach to patients who take cancer medications that may cause severe side effects by providing half a month’s supply to patients for the first six fills. Pharmacy care providers check in with them early and often to manage potential clinical side effects, discontinuations, or adherence issues. In addition, pharmacy clinicians conduct regular drug utilization reviews and then notify a patient, caregiver, and provider of any recommended changes in dosage or medication.

Early results from these programs have shown 96% of enrolled patients are more likely to tolerate therapy. For those who don’t, OptumRx helps them through discontinuation, resulting in pharmacy savings of $2,500 per patient per year.

**OptumRx’s PreCheck MyScript.** The tool helps prescribing physicians identify alternative, equally effective treatments at a lower cost, view a patient’s drug coverage, and determine if prior authorization is required. To date, one out of five transactions with a recommended alternative resulted in the provider choosing an alternative drug, delivering significant cost savings for patients and payers, Zeglinski says.

Mari Edlin, a frequent contributor to Managed Healthcare Executive, is based in Sonoma, California.

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**Hospital prescription drug spending**

Average drug spending per hospital admission increased between FY2015 and FY2017

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<th>Type of spend</th>
<th>Increase</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Outpatient</td>
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<td>28.7%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$9.6</td>
<td>90.3%</td>
</tr>
</tbody>
</table>

90.3% of hospitals had to identify alternative therapies to manage spending

1 in 4 hospitals had to cut staff to mitigate budget pressures

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Source: American Hospital Association
HealthPartners’ President and CEO Andrea Walsh’s approach to leadership in healthcare can be summed up in a single word: people.

While Andrea Walsh might be relatively new in her CEO position at HealthPartners—she just finished up her first full year this past summer—she’s certainly not new to the organization. Walsh has been with HealthPartners for over 24 years, but says that she is still excited by what attracted her to the organization in the first place: being a part of an organization that partners with communities to focus on improving health—in other words, an organization that partners with a variety of people to care for people.

“Many organizations have similar missions,” she says, “but not many have our range of capabilities in health, health care, financing and coverage, and research and education. We bring these capabilities together in unique ways to better support and care for people and to partner more effectively in the community. I can’t imagine more meaningful work, and it is what attracts me most to the role.”

When Walsh says that not many organizations have the same scope as HealthPartners, she isn’t hyperbolizing. After all, HealthPartners, headquartered in Bloomington, Minnesota, is the largest consumer governed nonprofit health care organization in the country. It boasts over 90 clinics and hospitals with over 26,000 employees. It offers health insurance in six states and includes over 1.8 million insured members.

**Constant improvement**

Walsh isn’t resting on those laurels, however. Her three main goals for her first year on the job were growth, improvement, and innovation—and through her hard work her vision has been realized in a variety of areas.

In the growth category, HealthPartners added Hutchinson Health to their care system, a 66-bed hospital in central Minnesota. Walsh also says that being named a Top 15 Health System by IBM Watson Health in 2018 for the second year running is a clear sign of improvement, and that her team’s creation of a 24/7 online clinic—virtuwell.com, which she says costs about $105 less per episode than a traditional clinic visit and has saved over 750,000 hours for HealthPartners’ patients—indicates that innovation is alive and well in the company culture.

But Walsh is most excited about what that growth and technology mean for people. “When I talk with other health leaders,” Walsh says, “I especially like exchanging ideas that broaden our concept of health and well-being. Here’s why: We know that 80% of what makes people live healthy, long lives doesn’t happen in a doctor’s office...
or through a health plan. It results from good nutrition and lifestyle choices, good environments, strong educational systems, and more. High-quality, affordable care and coverage is a cornerstone, but it’s not enough. In other words, if our mission is health, we in the healthcare industry have to keep reaching across our traditional boundaries and partner with other sectors for the good of the community.

One of the things she’s most proud of is partnering with her team and the organization’s surrounding communities to work on making diversity a priority. “Every day I’m grateful for our team of 26,000 and proud of our strong ‘Head + Heart, Together’ culture, which blends the science of medicine with the compassion and humanity of our hearts,” she says. “I’m proud of our work on diversity and inclusion. We aspire to be an organization where everyone is welcomed, included and valued.”

One practical way they did this was through an in-home FIT test program designed to help Spanish-speaking patients receive colon testing. The program saw 70% of that patient population screened, compared to an average rate of 54%.

Another example is the organization’s efforts to promote mental health in the Twin Cities, where they have partnered with schools, law enforcement, social service agencies, faith organizations, and even competing health systems to share ideas and combine resources. From this, they’ve released a public information campaign to destigmatize mental illness—

**“I can’t imagine more meaningful work, and it is what attracts me most to the role.”**

and partner with other sectors for the good of the community.

The key challenges were clear and still are. Health reform is in constant flux. Federal and state funding for health care programs is under pressure. Health care consumers and employers are fed up with healthcare costs and complexity. It’s a time of overall change and uncertainty in our industry and, like all health organizations, we’re working to navigate it.

Walsh also says that another more personal challenge was navigating a new role. So how did she overcome these challenges?

The answer is simple: she listened. “In my first year, I did a lot of listening, spending time with leaders and teams across our system. I shadowed physicians and care teams to listen, learn, and better understand our opportunities to innovate and improve. I also spent time in our community with patients, members, employers and community partners. I knew I’d learn a lot, but I couldn’t have predicted just how rewarding and fulfilling this time would be.”

She credits that dedication to listening and learning in shaping strategic directions and helping to create a more intentional second year.

That commitment to learning has long been a part of Walsh’s career. She says that she has been fortunate to have learned from and been inspired by strong women in leadership roles, saying that HealthPartners “has an especially rich history of women at all levels of management and a culture that genuinely supports equal opportunity for all.” Her advice for other emerging women leaders is to do the same, “to build and make strong mentoring connections with others, and to look for organizations who are on the forefront of workplace equality and opportunity.”

When asked what advice she would give to her younger self, she again stressed the importance of people. “Achievement is not a solo effort. Slow down to build a team and the culture that will enable you to execute,” adding that “success is not a zero-sum game. Look for win-win solutions.”

And her number one tip for new leaders? “Use mission, vision, and values as your compass so that you can confidently embrace ambiguity and change.”

**Lessons learned**

All of that growth wasn’t without its challenges, something Walsh knew would be the case coming into her role. Overall, she says, “The key challenges were clear and still are. Health reform is in constant flux. Federal and state funding for health care programs is under pressure. Health care consumers and employers are fed up with healthcare costs and complexity. It’s a time of overall change and uncertainty in our industry and, like all health organizations, we’re working to navigate it.”

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**Nicholas Hamm** is an editor with Managed Healthcare Executive.
Here are five important metrics that should have the attention of executives as they manage a business in today’s healthcare environment.

**Customer satisfaction**

“The long-discussed movement of the baby boom generation into the ranks of the retired will continue to occur, while millennials and other younger patient cohorts will exert more and more influence over healthcare delivery models.”

—KPMG Consulting’s Healthcare 2030

“A millennial views their experiences around convenience,” says Ash Shehata, principal at KPMG and partner of the firm’s Global Healthcare Center of Excellence. “Health plans have to be able to offer their capabilities at a millennial’s moment of need. Those capabilities have to be offered on multiple platforms, both digital and non-digital, and in person or off premises.”

**Managing Medicare Shared Savings Program**

“The number of measures within the four key domains (patient/caregiver experience, care coordination/patient safety, at-risk population and preventative health) has changed over time to reflect changes in clinical practice, moving toward more outcome-based measures and to align with other quality reporting programs and to reduce burden. However, the structure of the measure domains and their equal weighting has remained consistent in determining an ACO’s quality score.”

—Medicare Shared Savings Program Quality Measurement Methodology and Resources, CMS, February 2019

“The individual MSSP measures don’t really have any disproportionate weighting (23 measures across 4 domains),” says S. Lawrence Kocot, leader of KPMG’s Center for Healthcare Regulatory Insight. “Each measure is worth two points, and each domain is weighted at 25%. The at-risk population and care coordination/patient safety measures are worth more since there are fewer measures in the domain.”

**Emergency department vs. urgent care**

“Over the last two decades, the healthcare market has seen rapid change due in large part to consumer demand for more choices, more control, and more perks. And urgent care is no exception. The entire industry was born, cut its teeth, and grew—at breakneck speed—based on this ‘retailization of healthcare.’”

—Urgent Care Trends to Watch in 2019, DocuTap, January 2019

“With an aging population, increased prevalence of poly-chronic illness and ever-increasing budgetary pressures amongst plan sponsors relative to medical and pharmacy cost management, emergency department utilization is a key cost driver and key area of focus,” saysManaged Healthcare Executive Editorial Advisor David Calabrese, RPh, MHP, senior vice president and chief pharmacy officer for OptumRx.

**Customer service**

“It is clear that technology disruptors—with established data architectures and deep understanding of consumer behavior—will play a crucial role in the consumerism of healthcare.”

—KPMG Consulting’s Healthcare 2030

“In the future, expectations that consumers have for financial services companies, retailers (both brick and mortar and online), and others will raise expectations for their health plan experience,” Shehata says. “Technology will become much more available and consumable. Consumers are demanding this type of interaction, and health plans can no longer use excuses to avoid upgrading their infrastructure to meet this expectation. It is an unavoidable future.”

**Medicare Part D plans**

“Measures in Part D plans can help with a health plan’s overall Star ratings more than the others.”

—CMS’ Part C and D Performance Data, January 2019

“The most highly rated D measures are the Drug Plan Quality Improvement Measure and the three drug adherence measures: Medication Adherence for Diabetes Medications Intermediate Outcome Measure, Medication Adherence for Hypertension (RAS antagonists) Intermediate Outcome Measure, and Medication Adherence for Cholesterol (Statins),” Kocot says.

Ken Krizner is a freelance writer in Cleveland, Ohio.
11 Books You Can’t Miss

What you should be reading this year by Tracey Walker

Managed Healthcare Executive asked key opinion leaders “What is the one book healthcare executives should read this year?” Here are their selections.

Crooked Letter, Crooked Letter
By Tom Franklin
"Set in Mississippi, the title refers to how children are taught to spell the state’s name. The story is about childhood friends who are reunited amid a murder investigation. It touches on themes of prejudice, acceptance of people who are different from us, and forgiveness."
—Virginia Calega, MD, vice president, medical affairs, Facilitated Health Networks Independence Blue Cross, and Managed Healthcare Executive editorial advisor

The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care
By T.R. Reid
“I found it helpful to ensure we look at how other countries deal with costs and access."
—Roy Beveridge, MD, former chief medical officer, Humana, and Managed Healthcare Executive editorial advisor

Voices of Innovation: Fulfilling the Promise of Information Technology in Healthcare, 1st Edition
By Edward W. Marx
“Some of the most important technology innovations for the world center around health and wellness. When people are well, they can work, learn, teach, achieve, take care of families, and contribute to society. ‘Voices of Innovation’ steps up to the challenge, not only describing some amazing medical innovations, but providing a much needed ‘how-to’ guide for other technology and medical leaders to follow for future advancement.”
—Sue B. Workman, vice president University Technology and CIO University Technology, Case Western Reserve University

Wooden on Leadership
By John Wooden
“I am fond of all the books by legendary basketball player and beloved coach John Wooden. This is among my favorites. Wooden’s approach is relevant in business today. Wooden taught his players to compete at a furious pace with no stalling, time-outs, or slowdowns. The media sometimes called it a ‘fire wagon’ style because the running never ceased. This is a result of preparation, practice, conditioning, and the will to win! These qualities transcend basketball. In business, laser focus on the task at hand, be fully prepared, and out-work your competitors.”
—Alan B. Miller, chairman and CEO, Universal Health Services

Sing, Unburied, Sing
By Jesmyn Ward
“The novel is set in present-day rural Louisiana, presenting a deep dive into the local culture built on race, poverty, and a wholly different take on ‘health.’
The relevance to healthcare is the window into a brutally impoverished, barrier-ridden environment that most of us will never experience—and yet, these realities must guide our path as we develop accountable, value-based healthcare. As healthcare executives approach risk-based payment and improvement of outcomes and cost, they will need to innovate by understanding how to navigate barriers to good health, especially in high-risk populations. —Theresa Hush, CEO, Roji Health Intelligence

America’s Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System
By Steven Brill
“Steven is the founder of Court TV and explores health policy through the lens of the Obama Administration’s efforts to draft and implement the ACA. He provides a clearer understanding of where the ACA succeeded and where it failed.” —Linda Bolland, PharmD MBA, senior advisor—Access Experience Team, Precision for Value

Thinking, Fast and Slow
By Daniel Kahneman
“Kahneman’s book offers insights into how we make decisions as patients and healthcare professionals, and has implications for the development of patient engagement and population health models, leveraging System 1 (intuitive) thinking for engagement and System 2 (rational) thinking for change.” —Maureen Hennessey, PhD, CPCC, CPHQ, senior vice president, director of Value Transformation, Precision for Value

Built to Last
By Jim Collins
“One book I read every few years and re-read this January was Jim Collins’ book “Built to Last.” In our current VUCA (volatile, uncertain, complex, and ambiguous) Healthcare Landscape, this timeless book focuses on fundamentals and principles to help leaders and companies stay grounded, endure, and be successful in spite of the turbulent environment. It focuses on what should remain constant and what should continuously change to stay relevant amidst change and transformation.” —Elizabeth Oyekan, PharmD, FCSHP, CPHQ, senior director—Access Experience Team, Precision for Value

Nudge
By Richard H. Thaler and Cass R. Sunstein
“Thaler and Sunstein’s book thoughtfully examines ways that ‘choice architecture’ can be used to influence choices in many spheres of our lives, including those impacting our health.” —Hennessey

Connected: The Surprising Power of Our Social Networks
By Nicholas Christakis and James Fowler
“Christakis’ and Fowler’s book studies human social networks and their influence on our health, emotions, and life choices; the book expands our appreciation for the power of social connections to potentially impact the health and happiness of populations and sub-populations.” —Hennessey

Pigeon Series
By Mo Willems
“Why a children’s book? In addition to being the CEO of healthcare quality competencies leader, NAHQ, I am a mom to two young sons. I think a lot of parents will relate to my recommendation of Willems’ ‘Pigeon’ series because their evenings are also spent reading this popular series to their kids as well. The author’s approach to life lessons is not only relatable and entertaining for children, but also provides valuable opportunities for teachable moments for adults too. Pigeon brings levity to daily tasks like taking a bath, which offers just the right amount of comic relief after a busy day in the office.” —Stephanie Mercado, executive director and CEO, National Association of Healthcare Quality (NAHQ)
Hyperlipidemia is an increased amount of lipids, such as cholesterol and triglycerides, in the blood. Hypercholesterolemia, a high level of low-density lipoprotein cholesterol (LDL-C) in the blood, increases fatty deposits in arteries and, in turn, the risk of blockages, according to the American Heart Association (AHA).

“Cholesterol is one of the primary causal factors in the development of atherosclerotic cardiovascular disease which leads to strokes and heart attacks,” says Luke Laffin, MD, a cardiologist at Cleveland Clinic. “Hyperlipidemia screening occurs in about 70% of U.S. adults and, based on more contemporary American cholesterol guidelines, it has been estimated that, between 2016 and 2025, 12.24 million more Americans will be treated with statins, increasing treatment costs by $3.9 billion.”

Laffin also says that with the increasing availability of therapies for hyperlipidemia to decrease patients’ cardiovascular risk, managed care systems will have to balance the increased costs and multiple choices for cholesterol and triglyceride reducing medications. He adds that absolute cardiovascular risk reduction in an asymptomatic population may only derive benefits 15 to 20 years down the road.

Newly approved and pipeline treatments

One of the most recently-approved classes of medications for the treatment of high LDL-C is the proprotein convertase subtilisin-kexin type 9 (PCSK9) inhibitors. PCSK9 inhibition increases the number of available LDL receptors on hepatocytes to clear LDL-C, resulting in decreased plasma LDL-C. There are currently two PCSK9 Inhibitors approved by the FDA: Sanofi/Regeneron’s Praluent (alirocumab) and Repatha (evolocumab) from Amgen.

“The high cost of the PCSK9 Inhibitors presents a huge barrier for patient access, as a number of health insurance companies do not want to cover them,” says Megan Harrington, PharmD, clinical staff pharmacist, Gerald Champion Regional Medical Center in Alamogordo, New Mexico.

“Measuring these drugs against treatments like statins will prove to be difficult because these traditional methods are tried and true with years of safety and efficacy data at a very affordable price tag.”

Cholesterol-lowering agents

- Vascepa (icosapent ethyl) from Amarin Corp. recently showed significant cardiovascular risk reduction by lowering serum triglycerides in the REDUCE-IT trial, according to Laffin. A similar study using AstraZeneca’s Epanova (omega-3-carboxylic acids), is slated to be completed by the end of 2019.

- Bempedoic acid from Esperion, a once-daily, oral therapy is a first-in-class, non-statin, targeted therapy designed to inhibit cholesterol biosynthesis. Bempedoic acid reduces LDL by 15% to 20% and...
is currently in clinical trials to see if this decrease in LDL results in fewer strokes and heart attacks, according to Laffin.

Inclisiran from The Medicines Company is an investigational medication designed to inhibit the synthesis of PCSK9 protein in hepatocytes, thereby reducing LDL-receptor turnover and lowering plasma LDL-C. Initial study results show patients with a 52% reduction in cholesterol levels six months after their first injection of inclisiran, according to Harrington. She says that phase 3 trials have a scheduled completion date in the third quarter of 2019. “Time will tell how much this treatment will cost and how the insurance companies plan to help their patients have access to these treatments,” she says.

A bright future?
“T he future of these new treatments might be a little brighter than in previous years as the AHA and the American College of Cardiology (ACC) just released new cholesterol management guidelines in November 2018,” says Harrington. “For now, insurance companies will continue to see statins as first-line medication therapy in control of cholesterol; however, there are evidence-based guidelines from trusted institutions that could change the way insurance companies view these medications.”

Managed care organizations and payers will have to decide how to prioritize drugs and treatments for cardiovascular disease, including hyperlipidemia, while maintaining reasonable costs, Laffin says.

“The hope would be that increased availability of therapies to reduce LDL and triglycerides results in more comparative effectiveness studies and more competitive pricing from drug companies,” says Laffin. “It may also encourage payers and pharmaceutical companies to think outside the box when it comes to paying for novel therapies, including outcomes-based contracts or other strategies to align incentives for the patient and provider, insurer, and payer.”

Erin Johanek, PharmD, RPh, is a staff pharmacist at Southwest General Health Center, Middleburg Heights, Ohio.

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— LUKE LAFFIN, MD, CLEVELAND CLINIC

THE COST OF CARDIOVASCULAR DISEASE

$230 Billion
annual direct costs of cardiovascular disease per year by 2030

1.5 Million
The number of heart attacks and strokes in the U.S. per year

<1/2
of patients with high LDL cholesterol get treatment

800K
The number of deaths attributable to heart disease

1 in 6
healthcare dollars is spent on cardiovascular disease

Every 5 years
How often patients should be checked for high cholesterol

Sources: HHS, CDC
Improving the patient experience is a goal that makes sense for every healthcare provider. “The evidence continues to show that organizations that focus on patient experience drive outcomes: financial, loyalty, and clinical outcomes,” says Sam Hosokawa, vice president patient experience at Children’s Healthcare of Atlanta. Consumer expectations, which are higher than ever before, are being shaped by innovations and experiences outside of healthcare, according to Hosokawa. As a result, committing to improving patient experience is no longer optional.

Given this reality, how can healthcare providers make patients happier? Here are 10 helpful perspectives on simple ways to pursue this goal.

1. Treat the whole person. “Treating patients’ whole selves beyond the drug therapy is increasingly important,” according to Jeff Patton, MD, president of physician services, OneOncology and CEO, Tennessee Oncology, Nashville. “From financial and nutritional counseling to yoga and acupuncture, patients say they are happier, feel valued, and have a more positive outlook on their treatment when physicians, providers and staff listen and help address all aspects of patients’ treatment. It sounds obvious, but listening to patients and treating them like family goes a long way to improving their experience.”

2. Partner with patients. “Foster an authentic partnership with patients,” says Christopher Palmieri, President and CEO, Commonwealth Care Alliance, Boston. “Promote a patient-centered culture that collaborates with individuals and encourages participation in decision-making, ensuring that the patient’s voice is embedded into all aspects of the design and delivery of healthcare your patients receive. Partnering with patients facilitates healthcare experiences that meet patient needs and that help patients achieve their desired health outcome.”

3. Share useful information. “Healthcare providers can make patients happy by providing them with transparency into the cost of care. Patients want to know how much the x-ray is going to cost and what their deductible is—providing them with this information up front is important in removing the enigma around what a visit to the doctor’s office is going to cost,” says Louis Levitt, MD, vice president, The Centers for Advanced Orthopaedics, Washington, D.C. “It’s also important to provide today’s patients with documentation from their visit, as they will likely not have the same relationship with a singular healthcare provider and thus will opt to keep their own health records,” Levitt says.

4. Increase time spent with patients. “One way to improve the patient experience is for healthcare organizations to give physicians more time to interact with patients, according to Christopher Maiona, MD, chief medical officer, PatientKeeper, Inc., Waltham, Massachusetts. “It has been reported that for every hour a doctor spends with a patient, he or she spends two more hours on data entry to feed the EHR system. If we equip doctors with more intuitive, less-intrusive technology tools that support the physician workflow and make their administrative tasks less time consuming, they’ll be able to better connect with patients, which will go a long way toward improving both patient and physician satisfaction,” Majona says.

5. Build trust. “Patients and families need to know that someone is on their side in uncertain times,” says Hosokawa. “They want to know that someone is advocating for them, fighting with them, and that they can count on. Make them feel that you’re their person. Introduce yourself
and your team upon entering the room. Introductions add seconds to a provider’s routine but makes a lasting impression on the patient and family. Be willing to change. The skills that have made you successful in connecting with patients and families up to this point, may need to evolve to meet the needs of today’s empowered consumer.”

6 Use technology wisely. Using mobile technology designed for patient interactions can guide conversations and facilitate meaningful engagements, according to Sue Murphy, RN, BSN, MS, chief experience officer, patient experience and engagement program, UChicago Medicine, Chicago. “Feedback captured in a mobile rounding app can easily be tracked throughout the hospital stay. It can also be used post-discharge during follow-up calls to ensure any patient concerns or identified risks for readmission are addressed. Use intelligent technology to get ahead of potential service issues, pinpoint opportunities for improvement in processes, and identify high-performing staff members. The most rewarding employee recognition is based on patient feedback.”

7 Listen and understand. “The most important thing we can do is listen—really hear what’s happening to our patients and their opinions about what’s going on with their bodies,” says Kevin Gwin, chief patient experience officer, University of Missouri Health Car, in Columbia, Missouri. “It demonstrates how much we care and allows them to participate in their treatment.” Second, according to Gwin, understanding how this illness or condition impacts patients’ lives is key. “When we do, it provides an opportunity to be truly empathic. For example, I’m sorry you feel so poorly. This must be difficult for you. I’m glad you’re here. We’re going to help. Listening and understanding connects us to our patients, and we begin a relationship that brings trust and healing to both the patient and the provider.”

8 Adjust to patient expectations. “When looking to improve patient experience, it’s important to take into consideration the population you are targeting,” says Levitt. “The ideal patient experience today is much different than the needs and wants of Baby Boomers. It’s also going to be different than the one projected in the future, as millennial preferences drive industry changes. For example, a practice’s online presence could make or break a patient’s decision to pursue care at that facility.”

According to Levitt, wherever millennials receive care, they want the process to be efficient—minimal wait time, effective problem solving, and complete resolution of symptoms. There is less emphasis on building an interpersonal relationship with the provider, especially since they may not see the same one again as urgent care centers and local clinics surge in popularity.

9 Make best use of patient portals. “The patient portal is an excellent way to boost patient empowerment, but providers need to do a better job of endorsing portal use and articulating to the patient how they should be using it,” according to Cathleen McBurney, patient engagement manager, VisionTree Software, Austin, Texas. “The information held within the portal, if used properly, can help patients ask proper questions, learn about their condition and advocate for themselves with both current and future healthcare providers. Giving patients the information they need at the tip of their fingertips, without having to search blindly online makes them more knowledgeable, and even more important, content.”

10 Practice self-care. Nnamdi Ezeanochie, MD, DrPH, senior manager, behavior science and analytics team, Johnson & Johnson Health and Wellness Solutions, New Brunswick, New Jersey, recommends that healthcare providers practice self-care during their workday. “If they are feeling burned out, their patients might not be receiving optimal care,” Ezeanochie says. “While there are no magic tricks to ward off or prevent burnout, it’s important for providers to focus on the basics of good physical and mental health. Find times during the day to take a moment, rest and reflect. Improving provider well-being, and in turn patient outcomes, has to begin outside of the workplace. While it can be tempting to recoup in front of the TV during time off—getting enough physical activity in our daily lives is important to everyone, and that includes providers.”

Mark Rowh is a Virginia-based freelance writer whose interest areas include healthcare, business, and higher education.
6 Ways to Improve Medication Adherence

Key ways healthcare executives can improve therapy compliance  by STEPHANIE STEPHENS, MA

Although estimates of the cost of medication nonadherence differ, everyone agrees it’s too high. A 2014 study in Risk Management and Healthcare Policy cited a number between $100 and $300 billion, while a late 2018 analysis in the Annals of Pharmacology posited more than $528 billion.

Here are six things healthcare executives should know about improving medication adherence.

1/ Align incentives

“One of our taglines at the American Pharmacists Association (APhA) Foundation is ‘Align the Incentives. Improve the Outcomes. Control the Costs,’” says Benjamin M. Bluml, RPh, and the Foundation’s senior vice president of research and innovation. “If we properly invest in and align the incentives for patients, providers, and payers, we consistently observe significant improvements in care delivery, quality of care, and reductions in the total cost for care over time,” he says. “This means collaborating in a team-based care effort—that includes a pharmacist—to change and improve the way care is delivered,” says Bluml. “After all, the primary treatment modality for chronic disease is medication, so if we don’t get medication right and help people understand its value we’re never going to ‘get there.’”

The Foundation has realized excellent success with patient-centered, team-based care initiatives to improve adherence, Bluml says, specifically citing cardiovascular disease, depression and diabetes. For example, patients made 30-minute appointments with pharmacists on a quarterly basis to review finger-stick blood glucose readings and discuss cholesterol, diet, and exercise goals. “This gives patients a focus for their role, then an incentive to follow up with their provider,” he says. “Here’s an idea for payers: Tell patients if they keep regularly scheduled visits with their pharmacist for diabetes-related care they’ll get a free BG monitor and test strips to stay on track, and you can even take care of the copayment. You’ll spend your per-member dollars differently, but save $1,000-plus per person per year when they’re not in the ER or hospital as much, eliminating huge costs. The member becomes a more engaged, informed decision maker.”

2/ Not just ‘one and done’

“Payers already know they’re paying for medications and that there will continue to be more highly specialized therapies,” says Deborah Hauser, RPh, MHA, and network director of pharmacy for Einstein Medical Center in Philadelphia.

She seconds strategic use of medication management therapy programs that incorporate pharmacist “touch points” with patients during the course of therapy and result in engagement. “This is not about just filling a prescription and walking away,” Hauser says. “If a patient doesn’t take their medication, a pharmacist can also assess whether there’s a lack of motivation, a socioeconomic reason, intolerable side effects, or the inability to follow proper instructions.”

When they wonder out loud if their medication is “doing anything,” the pharmacist can explain the medication is not for symptomatic control, but to treat underlying disease, she says. “Especially with costly therapies, when a health plan has standards that apply to their use, there must be accountability. Is the medication being used as intended?”

At Einstein’s specialty pharmacy, pharmacists call members to ask, “How many have you taken?” or “Do you have any left over?” and then re-educate and reinforce how important the medication is to overall health status. “There are a lot of stakeholders here, so who’s going to do the work?” says Hauser. “A pharmacist is the best stakeholder to assess and...
engage the patient about the importance of medication adherence.”

3/ Realize one-size-fits-all isn’t long term
At the clinical services and analytics company RxAnte, Kerri Petrin, MPH, and vice president of client services, knows that effecting behavior change in members remains a major challenge.

“We’re first approached by clients because they notice that a static approach to adherence outreach has resulted in flattening population-level adherence rates,” says Petrin. “We see a tremendous value materialize when we’re able to help our clients adopt an evidence-driven, member-centric approach that identifies the best method and time to engage a member-based upon their predicted risk of nonadherence, past receptivity to interventions, and the most effective time to intervene.”

When plans use these concepts to drive intervention strategy, Petrin says, two critical markers of a successful adherence program emerge. “There are steadily improving adherence rates while remaining within the health plan’s target intervention budget. The result is that plans are better able to plan for future member needs and can effectively quantify what it takes to achieve their adherence goals each year.”

4/ Dial into digital connectivity
Many health plans have been using phone calls, mailings, and emails to encourage patient adherence. “Now they’re looking for innovative ways to meet patients when they want and where they want, and that’s where smartphones come in,” says Kyle Amelung, PharmD, director of clinical solutions for Express Scripts.

Since nearly 80% of adults in the United States own one and check them nearly 80 times a day—and they’re different ages, have different demographics and incomes, and live in both rural and urban areas, Amelung says. He cites apps as a way to “affect and send a message in real time, receive data back and act on it right away.”

It is, in a word, “convenient.” Conditions really can be managed with digital connectivity and yield improved outcomes for patients and lower costs for health plans.

“A smartphone is not the overall solution but it can certainly be the means to a solution,” he says. “You must have uptake and believability from patients, providers, and payers. And you must remember that none of this will move the dial unless you tie in a human element. Our job is to create that therapeutic formulary for smart devices.”

5/ Know this is personal
Don’t forget the member probably sees their pharmacist probably once a month, while seeing the physician one to two times a year, says Amelung.

However, when reaching out to a member about medical adherence, remember their health is a personal and intimate topic, says Lindsay Conway, managing director at the Advisory Board. “Maybe they don’t feel well and don’t want to confide in someone with whom they don’t have an existing relationship. You must earn the right to have what may be an intimate conversation and to earn their trust.”

Having a professional sit down for face-to-face time with a patient costs money, Amelung says.

“If a patient doesn’t take their medication, a pharmacist can also assess whether there’s a lack of motivation, a socioeconomic reason, intolerable side effects, or the inability to follow proper instructions.”

— DEBORAH HAUSER, RPH, MHA, EINSTEIN MEDICAL CENTER

“We see those kinds of programs most often with the sickest and most complex patients who stand to benefit most from medication. It can be difficult to determine what makes a financially sustainable model,” he says.

6/ Train and coordinate
Whatever the model, the professional doing interface needs skills and training, says Conway. Most important and most challenging is “coordination, coordination, and coordination.”

“When it’s missing, patients sometimes have to jump over hurdles with automated systems or phone messages,” she says. “We’re seeing more hospitals, health systems and physician groups operate their own pharmacies to solve coordination challenges and offer better care and continuity,” she says.

“If you’re a provider managing a complex population, some patients may be getting medication management from their health plans, others from pharma companies, and each program is a little different,” Conway adds. “So, it’s a challenge to keep track of which patients are getting support; what kind of support; and when you need to step in and provide support.”

Experts agree that with coordination, innovation, support, and education, medication adherence goals can benefit both payer and provider.

Stephanie Stephens, MA, is a journalist, producer, and host in Orange County, California.
Even before Trump’s oft-quoted sentiment that pharmaceutical manufacturers are “getting away with murder,” high drug prices have been in the national conversation. But renewed governmental interest has thrust the debate over drug costs into an even brighter spotlight.

Measurements for total drug spending show a growing problem: CMS estimates that between 2012 and 2016, drug spending increased 26.8%, while a recent PEW study found that net spending on drugs skyrocketed from $250.7 billion to $341.0 billion in that same time-frame—an increase of 36%.

Patients respond
Evidence shows that while prescription abandonment due to cost is still relatively low, a not insignificant number of patients are either not initiating or not filling current prescriptions—and many more are paying for their medications but struggling to do so.

The PEW study shows that manufacturer rebates also skyrocketed from 2012 to 2016 (from $39.7 billion to $89.5 billion) and that those rebates have played a role in at least partially offsetting those list prices. It also found that policies with capped out-of-pocket expenses, along with manufacturer cost-sharing policies, helped to shelter patients from rising costs.

However, other reports show that patients are struggling under the weight of skyrocketing prices. One of the most recent larger-scale studies from GoodRx found that 42% of Americans struggle to pay for medications, even though the majority (94%) had some kind of health coverage. That same study found that around one-third of patients had purposely missed filling a prescription due to cost at least once in the last year—of that group, 5.6% said they had skipped prescriptions three or more times.

The CDC estimates from 2013, while lower, also paint a bleak picture: 7.8% of adults did not take their medication as prescribed in order to save money, while a further 1.6% bought their medications outside of the country and 4.2% used alternative therapies. A 2017 Truven Health Analytics-NPR Health Poll found that 29% of Americans had stopped taking medications at some point without telling their doctor. Ten percent cited cost as the reason.

The problem drugs
A 2010 Annals of Internal Medicine study found that insulin and proton pump inhibitors (PPIs; examples include omeprazole or lansoprazole) were the most likely drugs to be abandoned. Although the abandonment was not directly related to price, the study also found that the larger the copay, the more likely a prescription was to be abandoned.

A 2016 survey found that the average per month out-of-pocket costs for patients with diabetes was $360. Additionally, a recent American Diabetes Association survey, 25.5% of patients said that they had used less insulin than prescribed due to costs. That underuse was associated with a three-fold increase in high HbA1c compared with patients who didn’t underutilize the medications—potentially resulting in further complications that could add to the $327 billion cost of diabetes.

In response to public outcry, Eli Lilly announced that it will release a lower-cost generic version of its insulin Humalog. According to the company, its list price will be 50% lower than the brand name version—though analysts disagree about the impact this will have on the overall cost of medication.

Nicholas Hamm is an editor with Managed Healthcare Executive.
Around the web

“Like all complex problems, the solutions lie in a combination of policies and actions that can be continuously refined. Fortunately, the crisis in drug pricing is occurring at a time when a new evidence-generation system can realistically provide actual measurement of benefits and costs.”

—Former FDA commissioner Robert Califf, MD writing in WW on the state of drug pricing

**CEO’s and the economy**

- 17% of healthcare CEOs expect the economy to improve in the year ahead
- 60% of healthcare CEOs plan to expand their workforce in the next year
- 77% of healthcare CEOs expect to increase revenue next year
- 49% of healthcare CEOs expect to increase investments in the year ahead

**Opioids diversion significant problem**

- 12% of all hospital prescriptions have discrepancies
- 10 drugs accounted for 85% of discrepancies, including fentanyl, oxycodone, propofol, and lorazepam.

**Source:** Kit Check

“We are at an inflection point in healthcare. We exist within an unsustainable system. As leaders in healthcare, we have an obligation to address the underlying issues that challenge the ecosystem. This requires us to be incredibly focused on developing our leadership skills, now and for the future.”

—Mark Boxer on the skills leaders need. See more on page 3.
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