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COVID-19 UPDATE

WHAT ARE THE TOP PHARMA CHALLENGES RIGHT NOW?

SATISFYING PATIENT NEEDS ACROSS THE GENERATIONS

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Chairman’s Letter

COVID-19: The Before and After

E ven though it is only April, it’s a safe — no, a certain — bet that the COVID-19 outbreak will be the biggest healthcare story of 2020. Going into this year, we had ideas about what would dominate the healthcare news and what we might cover in these pages: the continuing efforts to address the opioid epidemic, high list prices for drugs, advances in oncology, surprise billing, all the different value-based models, the politics of healthcare in a presidential year. But as March went on and the public health and economic consequences of the outbreak became more apparent, those headliners faded. On the podium of importance, COVID-19 was first, second, third — and just off the podium, in fourth, fifth, and sixth place.

This is issue of Managed Healthcare Executive® reflects the seeming splitting of these times of ours into the pre- and post-COVID-19 eras. From pre-COVID-19, we have a story that examines the growing popularity of Medicare Advantage plans. The tilting of Medicare toward MA plans is a profound change in how the roughly $750 billion in annual Medicare spending is managed. We take a look at the current version of diabetes disease management, a tech-enabled marriage of digital tools and personal contact, and the complexities of hospital observation status. Healthcare executives interested in advancing their careers should read our story about promotions. A promotion — that is always a good thing, right? Our story advises that you take a close, thoughtful look before you leap just to be sure.

But then COVID-19 hit. We spoke to healthcare executives from various sectors about how their organizations have re-responded. The outbreak is a moving target; some of them may have already adjusted and adapted in other ways. We spoke to managers about how they are handling the new, work-from-home norm. We took a look at the impact of COVID-19 on insurers and its implication for telehealth.

But let’s step back from what is appearing in these pages. Families have lost loved ones. Physicians, nurses, and other healthcare workers have put themselves in harm’s way. Companies and government officials have been working tirelessly to “flatten the curve,” which really amounts to saving lives. It is a time for better angels, a time of condolence, caring, admiration, and gratitude.

Mike Hennessy, Sr.
Chairman and Founder
of MJH Life Sciences
Mission: Managed Healthcare Executive® provides healthcare executives at health plans and provider organizations with analysis, insights, and strategies to pursue value-driven solutions.

Mark Boxer, PhD, is executive vice president and global chief information officer for CIGNA, where he is responsible for driving the company’s worldwide technology strategy.

Lili Brillstein is a nationally recognized thought leader in the advancement of Episodes of Care as a value-based approach for specialty care. She is the CEO of BCollaborative, which works with stakeholders across the healthcare continuum to successfully make the move from fee for service to value-based healthcare.

Joel V. Brill, MD, is the chief medical officer for Predictive Health, LLC, which partners with stakeholders to improve coverage of value-driven care that optimizes health for people.

David Calabrese, RPh, MHP, is senior vice president and chief pharmacy officer at OptumRx, a pharmacy benefits firm that provides pharmacy care services for more than 65 million lives nationally.

Virginia Calega, MD, is vice president, medical affairs, Facilitated Health Networks at Independence Blue Cross. She oversees utilization management, medical cost, and health outcomes data, and interventions that optimize these outcomes.

Douglas L. Chaet, FACHE, is chief managed care officer, Cleveland Clinic, and chairman, American Association of Integrated Healthcare Delivery Systems.

Perry Cohen, PharmD, is chief executive officer of The Pharmacy Group and the TPG family of companies, which provides services to associations, healthcare and information technology organizations, payers and pharmaceutical companies.

Damell Dent, is principal of Dent Advisory Services, LLC, a management consulting practice focused on helping leadership improve organizational effectiveness and overall performance. He most recently served as president and chief executive officer for the past seven years of a managed care organization.

John D. Halamka, MD, MS, is president of the Mayo Clinic Platform, and leads a portfolio of new digital platform businesses focused on transforming health by leveraging artificial intelligence, the internet of things, and an ecosystem of partners for Mayo Clinic.

Don Hall, MPH, is principal of DeltaSigma LLC, a consulting practice specializing in strategic problem solving for managed care organizations. He most recently served as president and chief executive officer of a nonprofit, provider-sponsored health plan.

Cynthia Hundorfean is president and CEO of Allegheny Health Network (AHN), an integrated healthcare delivery system that serves Western Pennsylvania. AHN is part of the Highmark Health family of companies.

John Mathewson is chief operating officer for America’s Health Insurance Plans (AHIP), the national trade association that advocates for the health insurance community and the consumers they serve across the nation.

Margaret A. Murray, MPA, is the founding chief executive officer of the Association for Community Affiliated Plans, which represents 54 nonprofit safety net health plans in 26 states.

Kevin Ronneberg, MD, is vice president and associate medical director for health initiatives at HealthPartners, an integrated, nonprofit provider and health insurance company located in Bloomington, Minnesota.

David Schmidt, is president of the TPG International Health Academy, which hosts trade/study missions around the world for U.S. healthcare executives. He also provides strategic consulting to health plans and health systems.

Paul J. Setlak, PharmD, MBA, is director of field health outcomes at AstraZeneca, where he is responsible for leading field-based clinical and health outcomes activities with payers, integrated delivery networks, health systems, and other groups.

William Shrank, MD, is Humana’s senior vice president and chief medical officer. In this role, he is responsible for leading and implementing the company’s integrated care delivery strategy. This strategy emphasizes a consumer-friendly, evidence-based, technology-enabled approach to personalized health improvement for the company’s more than 16 million Humana health plan members.
Diabetes: The Quiet Epidemic That Is Not Going Away

When most people think about epidemics, they think of Ebola, SARS, and now, especially, the new coronavirus. But until COVID-19, when healthcare executives had thought about epidemics, they should also be thinking about diabetes, because it is growing, expensive — and deadly.

The impact of diabetes on the lives of patients can be absolutely devastating. It is the underlying cause of serious complications, such as heart disease and stroke. Many people with diabetes are afflicted with chronic pain; it is also the leading cause of kidney failure, blindness, and amputations. Diabetes, and the complications resulting from it, ranks third behind heart disease and cancer as a cause of death in this country.

Over 34 million Americans have been diagnosed with diabetes, mostly with the type 2 variety that is linked with being overweight or obese. Another 88 million Americans have prediabetes: They have blood sugar levels and other risk factors that could put them on the road to having full-blown diabetes. Nearly $250 billion is spent on healthcare costs related to diabetes, with an average medical expenditure of $15,000 per person with the disease. As far as drug costs are concerned, diabetes is the most expensive traditional therapeutic class on a per-member, per-month basis.

The causal factors of the type 2 diabetes epidemic are well characterized: poor diet, obesity, lack of exercise, and aging. Diabetes also occurs more frequently in some groups because of social determinants of health, such as unsafe neighborhoods with a lack of access to recreation.

The good news is that managed healthcare can have a significant impact on all aspects of diabetes prevention and management. Through analytics and health risk appraisals, health plans can identify members with diabetes and those who are prediabetic. Focused disease management programs, combined with value-based provider contracts, can encourage engagement of members and incentivize providers to improve outcomes. Health plans can help by, among other things, covering smartpens that can monitor injections. The same goes for stick-free glucose monitoring, which improves adherence to blood testing and insulin management. Health plans are also well positioned to work with community organizations to support efforts to educate people about proper nutrition, exercise habits, and weight management.

When and how is difficult to say, but COVID-19 will recede. Diabetes will not. It will continue to grow as our society struggles to control the impacts of poor lifestyle habits. However, managed healthcare plans continue to play an important part in ensuring that members receive the most impactful information and care possible to manage and ultimately stop this epidemic.

Don Hall, MPH and Sherry Rohlfing are principals of DeltaSigma, a consulting firm that specializes in strategic problem solving for managed care organizations.
A Missed Opportunity to Recognize Narcolepsy Symptoms Can Have a Significant Impact on Pediatric Patients

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* Based on a health-related quality of life (HRQL) study assessed through a questionnaire completed by children and adolescents with narcolepsy (N=117) and control subjects (N=69). Academic performance was evaluated in the study.⁴
³ Based on a retrospective, cross-sectional, case-control, claims-based analysis of health care utilization and costs, that included narcolepsy patients ≤18 years of age (N=1427) and control subjects (N=4281).³

Technologies That Keep Your Health System HIPAA Compliant

When deploying technology that keeps personal health information and other healthcare data safe, health systems stay proactive. by DONNA MARBURY

In the past five years, HHS’ Office of Civil Rights (OCR) has increased enforcement of Health Insurance Portability and Accountability Act (HIPAA) violations, according to the HIPAA Journal. In 2015, there were only six HIPAA penalties, compared with 11 in 2018. Not only have enforcements increased, but fines and settlement amounts are also on the rise. In 2018, more than $28 million in penalties was paid to OCR. The mean penalty amount for 2018 was $2.6 million. Anthem settled for $16 million for failure to respond to breaches that had occurred since 2015 and for lacking technical controls to prevent unauthorized electronic personal health information (PHI) access.

Because OCR enforcement continues to grow, costing healthcare organizations in both dollars and damage to their brands, it is important that health systems stay proactive when deploying technology that keeps PHI and other healthcare data safe. As the healthcare industry becomes more connected, through providers and payers, PHI and other data are transferred between more vendors, says Tim Eades, CEO of VArmour, an applications security company in Los Altos, California. “As health insurance carriers begin or mature within their digital journey — think digital health ID cards held in digital wallets or mobile healthcare policy apps — the potential for PHI and personally identifiable information exposure increases,” Eades says.

But with interoperability, there’s a greater risk involved, with data becoming increasingly accessible, says Rich Temple, vice president and CIO of Deborah Heart and Lung Center in Brown Mills, New Jersey. “Ironically, the push for interoperability, and the goal to bring to a provider a patient’s entire medical history across many different arenas of care, poses some serious challenges in the HIPAA realm,” Temple says. “As the flow of PHI increases in the three V’s — volume, velocity and variety — more opportunities open up for that sacred information to be compromised, either by hackers or even by, ostensibly, well-meaning providers who may be using the patient’s data for use cases that go beyond what HIPAA allows.”

Ultimately, healthcare executives must stay on the hunt for technologies that can keep data protected, because threats from hackers continue to grow and become more sophisticated every day, says David Williams, general manager of the healthcare provider division of Conduent, a healthcare technology company in Florham Park, New Jersey. “Whether you’re talking about a national level or international level, the ability to hack healthcare data is fairly alarming.”

The security of cloud-based applications

With the explosive growth of cloud-based technology, especially with many healthcare organizations using third- and fourth-party vendors, the fact that EHR systems are being moved to or connected with cloud-based platforms is a concern. Cloud-based applications can help with data security because the major providers have capabilities that can be used to enable strong security overall, says Eades. “However,” he adds, “if any system is brought from a non-cloud space to full cloud — lift and shift — or a fully on-premise platform is suddenly connected to the cloud, data security — and overall security — can be threatened if the naturally exponential relationships cloud introduced aren’t managed correctly.”

Although cloud-service vendors can stay abreast of security issues, often faster than their clients, working with a third-party also has its risks, says Temple. “The challenge
is that the healthcare organization is now dependent on yet another party, or business associate, to maintain HIPAA standards, and any breach on the part of the business associate will come back to bite the provider, even if the provider themselves didn’t do anything wrong,” Temple says.

Being able to visualize or map data flow is critical to applying appropriate protection technologies, says Eades. “Healthcare platforms must have the means to map network and systems topologies against data flow. As in the EHR to cloud/cloud-connected example, it’s critical that hybrid cloud and multi-cloud environments are considered as well.”

Since 2009, more than 189 million healthcare records have been stolen or exposed in over 2,500 breaches, according to the HIPAA Journal. The number of breaches in the past decade amounts to nearly 60% of the U.S. population possibly being affected.

As more connected devices become available for patients, Temple says, providers have to stay alert when they interact with a health system’s data network. Medical devices themselves, such as balloon pumps and patient monitors, and the growing array of healthcare devices classified as the “internet of things,” are alluring targets for criminals, notes Temple. Having technologies that are monitoring data and how it’s being used can be one of the best ways to catch a possible HIPAA violation early and take steps to fix it, Williams says. “Health systems should have technology to identify a threat, monitoring on a daily basis, if not hourly," Williams adds.

Building in redundancy is also important if a primary system gets compromised through a malware attack. “We go well beyond the standard anti-virus, anti-malware that most organizations have deployed. We have robust backup regimens so in the event of an attack, we are as well positioned as we possibly can be to recover a legitimate dataset,” Temple says. “We are continuing to enhance our security toolset to monitor packets crossing our firewall and our endpoint assets for irregular activity. We even have some redundancy in our monitoring to make sure we have that extra layer of protection.”

**Keeping staff on guard**

Although increased technological advances can keep healthcare organization in compliance with HIPAA, ultimately educating staff on data safety is a first barrier, says Temple. A 2019 analysis by Bloomberg Law found that the fifth most common cause of data breaches in healthcare is from staff having inappropriate access to team members’ or patients’ information. Though the intent of the staff’s inappropriate access wasn’t always clear, the analysis found that some employees had looked up patients’ or other staff members’ data out of goodwill, such as to send a sympathy card. However, many staff breaches are due to mistakes, carelessness, and ignorance of HIPAA laws, the Bloomberg analysis found.

Because of the real risk in human error, Temple also suggests endpoint and perimeter protections that can monitor for unusual behavior on the network and alert key players to that behavior. “A big technology gap is the human beings who work at healthcare organizations,” says Temple, noting that bad actors gain access to systems through phishing emails. We constantly have to keep our people vigilant to not click or open things when they are not absolutely certain of the legitimacy of the source.” Technology that provides encryption, two-factor authentication, secure messaging portals and automatic log offs can help when human error leaves PHI vulnerable, says Michelle Garvey Brennan, associate and healthcare attorney at Buchanan Ingersoll and Rooney, a Pittsburgh law firm and lobbying group.

“Technology that is as close to fool-proof as possible may limit vulnerabilities and associated risk,” Brennan adds. “This is particularly important in the HIPAA space where one negligent or bad actor can create high dollar exposure.”

Donna Marbury is a writer in Columbus, Ohio.
To help its members prevent or manage diabetes, Blue Cross and Blue Shield of Minnesota opted for a virtual solution.

The Minnesota health insurer has partnered with Omada Health, based in San Francisco, to offer technology-enabled disease education and management programs to its members with diabetes or prediabetes. Omada Health has separate programs for each disease that are based on nationally recognized training and education programs.

The Omada programs feature live coaches who help patients improve their biometric data, such as weight or A1C levels. Using data analytics to parse data collected through connected devices, including scales and glucose monitors, Omada Health derives a personalized program for each participant. Using a digital app on their smartphones, members connect with their coaches through texting or virtual visits.

The intimacy of a personal coach and the convenience of virtual care is especially important for individuals with diabetes, she adds “because they have so many decisions to make every day.”

Omada Health is not alone in selling technology-enabled programs to help people prevent or manage diabetes. These programs are moving quickly from being novelty items for early adopters into mainstream use. The move from the fringe is something to encourage, says Michael Sturmer, senior vice president of health services for Livongo, a publicly traded disease management company in Mountain View, California.

“Whatever we are really focused on with our health plan partners and our PBMs is really changing their mindset from digital health as this add-on or buy-up to digital health as part of the core benefits that a member expects to get when they sign up for their health plan,” says Sturmer.

Virtual, tech-enabled programs for diabetes are catching on for any number of reasons. First, there is prevalence of diabetes and the associated expense. The American Diabetes Association says about 30 million Americans have diabetes and estimated that in 2017, an American diagnosed with the disease incurred, on average, $16,750 per year in medical expenses. Second, the programs seem to be producing promising results. Independent studies are few and far between, but the vendors have released their own study results showing weight loss and improved A1C levels.

Virta Health, a San Francisco company that says its goal is not just to manage type 2 diabetes but reverse it, uses technology to help participants limit carbohydrate intake. The company released results that it claims show that its technology reversed type 2 diabetes in 60% of its patients. This means the patients’ blood glucose readings are in a normal range, without diabetic-specific medications. For some of its earliest patients, those results have been sustained for four years, according to CEO and co-founder Sami Inkinen.
**Meaningful weight loss**

Blue Cross and Blue Shield of Minnesota began using Omada’s diabetes-prevention program in 2015. The program for individuals with full-blown type 2 diabetes was adopted in 2019.

The prevention program includes intensive coaching for weight loss, goal setting, and an online peer-support group. It is designed to last 16 weeks, but members can remain engaged in the program for as long as they wish, say Benner, the Minnesota Blues clinical products manager. Participants also get a wireless digital scale that sends weight readings to Omada’s database.

Benner says the cellular feature of the scale is important because not all consumers have internet access at home. Since 2015, 37,000 members of Blue Cross and Blue Shield of Minnesota have enrolled in the virtual program and lost a combined 200,000 pounds, an average of 5.4 pounds per person.

Intermountain Healthcare, which also has invested in Omada Health, has seen similar results. The Salt Lake City health system began offering Omada’s diabetes prevention program to its employees in 2019. From January 1 through November 30, 2019, 1,533 Intermountain employees lost a total of 9,800 pounds, an average of 6.4 pounds per person.

“Type 2 diabetes is largely preventable for the vast majority of people by making lifestyle changes that result in relatively minimal weight loss,” Joy continues. “That is a really important point to make, because we get saturated with TV shows like ‘The Biggest Loser’ that basically say the only weight loss that is meaningful is a 50- to 100-pound weight loss. Clinically meaningful weight loss is 3% to 5% from baseline.”

The potential market for tech-enabled diabetes management could be gigantic because of the number of people with diabetes and relative lack of alternative offerings. In 2014 study, for example, the CDC found that only 6.8% of commercially insured, newly diagnosed patients received formal diabetes education.

Blue Cross and Blue Shield of Kansas City offers its members access to a diabetes management program from Livongo. The insurer, known as Blue KC, launched a pilot program in 2016 and made the Livongo program available to all of its members during the fourth quarter of 2019. As of January 2020, Blue KC had enrolled 1,237 members in Livongo’s diabetes management program, according to Tim O’Brien, vice president and executive director of care delivery at Blue KC.

Blue KC plans to integrate patient data generated by Livongo’s platform into the electronic health records at Spira Care, which is Blue KC’s combined health insurance and primary care plan. Spira’s seven care centers provide members with access to primary care and behavioral health providers, health coaches, generic prescriptions, laboratory services, and digital X-rays.

Livongo says its customers, which include self-insured employers as well as health plans, yield savings. For example, Livongo compared health claims data for 3,664 participants in its diabetes management program with data from 12,065 people with diabetes who were not enrolled in Livongo’s program. Livongo found that participants in its diabetes management program netted a mean reduction of A1C ranging from 7.8% to 6.9% and a 5.8% decrease in the cost of healthcare claims.

Some of the tech-enabled programs offer value-based pricing. Virta bases its charges on clinical outcomes. “If we hit certain thresholds, we get paid, and if not, we don’t get paid,” says Inkinen. The metrics Virta uses are improvements in blood sugar control, reductions in medications, and weight loss. The company bills customers monthly for patient cases meeting specified thresholds.

“To me, that is how healthcare should be,” says Inkinen. “We shouldn’t be here to do more transactions. We should be here to make the patients better.”

Linda Wilson is an experienced writer and editor specializing in the healthcare industry.

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The prevention program includes intensive coaching for weight loss, goal setting, and an online peer-support group.

—JEN BENNER, MINNESOTA BLUES CLINICAL PRODUCTS MANAGER
COVID-19 Update

Healthcare’s Early Response to the Outbreak

The SARS-CoV-2 virus has upended American healthcare — and the country as a whole. For now, it is a question of adapting, adjusting, staying safe, and being smart. It is a time when leadership, ingenuity, compassion, and some true bravery has been on display. This month may test us even further.
How Health Execs and Employees Are Responding to COVID-19

Managed Healthcare Executive® interviewed six healthcare executives about how they and their organizations have responded to the outbreak.

By KAREN APPOLD

As the number of COVID-19 cases climbed and the death toll rose, healthcare organizations of all kinds and sizes took steps to combat the disease, keep their workers and the people they serve safe while also maintaining their operations, often in some scaled-down way. Managed Healthcare Executive® interviewed six healthcare executives about how they and their organizations have responded to the outbreak.

Here’s what they had to say:

**Steve A. N. Goldstein, MD, PhD, vice chancellor of health affairs and a professor at the University of California, Irvine (UCI)**

Since the first day the virus was recognized, UCI Health researchers and medical experts began working closely with other hospitals and healthcare providers both regionally and across the nation to share best practices while staying current with the latest information, treatments, and tools.

UCI Health infectious disease experts are also assisting with statewide and national efforts to develop policy, track the outbreak, and contain the spread of COVID-19. We are in regular contact with the CDC, the California Department of Public Health, and the Orange County Health Care Agency.

Teams of UCI researchers are partnering with other UC medical centers on studying the antiviral drug remdesivir as a COVID-19 therapeutic drug. Backed by the NIH, the clinical trial is considered the first that has possible efficacy and should be ready for patients soon. Other UCI groups are testing cutting-edge methods to test who is infected and who was infected previously to tailor treatments and to understand how the disease is spread and how it can be controlled.

**Genevieve D. Caruncho-Simpson, MPA, president and chief operating officer, Texas Health Aetna, Dallas**

The health plan’s front door is the Anytime-MD app, where members can receive free or low-cost care support from a local emergency room physician. As a text-first app, without any time limit, it supports swift and ongoing communication.

Our doctors are working closely with local hospitals, other providers, and a mobile urgent care provider, Dispatch Health, to make sure members’ questions are being answered via the app in a timely manner. The app allows our doctors to perform ongoing clinical support and virtual triaging of suspected COVID-19 cases. Members can have prescriptions delivered straight to their door through a CVS free delivery program. Free emotional well-being support is also available, as heightened anxiety can occur during this time.

We are also waiving cost sharing related to COVID-19 testing, providing care package to people who have been hospitalized because of COVID-19, waiving limits on early refills, and through some of our care management programs reaching out proactively to patients who are most at risk for COVID-19.

**Romilla Batra, MD, MBA, chief medical officer, SCAN Health Plan, Long Beach, California**

Seniors are at the heart of SCAN, and we’re working diligently to keep them safe, healthy, and independent during this pandemic. In addition to implementing all state-of-emergency measures related to access to care, we’re identifying high-risk members—those on ventilators and oxygen—and reaching out to ensure they have everything they need.

We recently checked in on a member who lives alone and learned that she was running out of food. To ensure that she could continue to shelter in place, we arranged for meal deliveries starting the next day.

SCAN’s free telehealth benefit is key, and we’re
COVID-19 Update

Although the burden of providing direct care and treatment of COVID-19 patients is falling on hospitals and other providers, payers will be bearing the costs of that care. COVID-19 costs this year will almost certainly result in premiums increases in 2021. How much of an increase will depend on the number of COVID-19 cases and, more specifically, the number of Americans who will need expensive hospitalizations and the fraction of those who will need to be treated in the ICU. Researchers at the University of Washington published a model in late March showing the demand for ICU beds in April will exceed the supply by 17,000. In a policy brief published earlier in the month, Covered California said the 2021 premium increase for employers and Americans buying in the individual market could range from a modest 4% up to an astounding 41%. Covered California is the government organization that runs the ACA exchange in California.

Vincent Nelson, MD, vice president, medical affairs

We have made a systemwide commitment to ensure that members can swiftly and smoothly access the right care in the right setting during the COVID-19 outbreak. This includes covering, with no cost share to the member, the appropriate medically necessary diagnostic testing for COVID-19 when it is not covered as part of the public health service response. Any care for a COVID-19 diagnosis will be covered consistently with the standard provisions of a member’s health benefits. Additionally, BCBS companies will waive prior authorization for medically necessary services and diagnostics related to COVID-19 to ensure patients receive the right care when and where they need it.

Charles A. Peterson II, MD, president and chairman of the board of directors, Proliance Surgeons, Seattle, Washington

Because excellent medical and surgical care involves spread waiving of cost sharing, including for treatment. Large insurers like Cigna, Humana, and Aetna, which is now part of CVS, made splashy announcements in March that their members with COVID-19 don’t need to be worried about medical bills.

But an increasing number of employers, including relatively small ones, have elected to self-insure, and they may not have the same amount of reserves on hand as the major insurers. Some self-insured plans have stop-loss coverage, but the academy said the majority of COVID-19 claims will fall below the large claim threshold, so the stop-loss may not help with the surge of COVID-19-related expenses as much as one might think.

A great deal of evidence shows older people and people with co-morbidities are far more vulnerable to becoming seriously ill from an infection with the SARS-CoV-2 virus that causes COVID-19 than younger, healthier people. That pattern could mean that cost burden of COVID-19 falls disproportionately on public payers, especially Medicare. As a result, Medicare Advantage (MA) plans and Medicaid managed care plans could be facing much higher medical costs this year than they had anticipated. Seniors who have flocked to MA plans in recent

COVID-19 Costs Hit Insurers

They are waiving cost sharing for COVID-19 treatment. How large will premium increases be next year?  

By MARI EDLIN AND PETER WEHRWEIN

Although the burden of providing direct care and treatment of COVID-19 patients is falling on hospitals and other providers, payers will be bearing the costs of that care. COVID-19 costs this year will almost certainly result in premiums increases in 2021. How much of an increase will depend on the number of COVID-19 cases and, more specifically, the number of Americans who will need expensive hospitalizations and the fraction of those who will need to be treated in the ICU. Researchers at the University of Washington published a model in late March showing the demand for ICU beds in April will exceed the supply by 17,000. In a policy brief published earlier in the month, Covered California said the 2021 premium increase for employers and Americans buying in the individual market could range from a modest 4% up to an astounding 41%. Covered California is the government organization that runs the ACA exchange in California.

The American Academy of Actuaries noted in a FAQ this year’s premiums are locked in, so the insurers without large reserves could have solvency problems because of expenses related to COVID-19 care and the wide-
Close physician-patient interaction, on March 15 we chose to postpone all elective (i.e., non-urgent and non-emergent) surgeries in our ambulatory surgery centers and temporarily suspend similar patient care at all of our facilities during the coronavirus outbreak in the region. The postponement will be effective from March 17 until at least March 27 when we will re-evaluate the crisis’s status.

As a specialty-care surgical organization, we are offering our surgical teams to provide urgent and emergent surgical care in our centers as a critical backup to Puget Sound area hospitals. We are offering assistance in delivering acute care for patients with fractures, trauma, or urgent surgical care in seven different surgical specialties. Giving hospitals the option of providing surgical services at our centers ensures that our hospital colleagues can focus on COVID-19 patients. This maintains social distancing standards, preserves personal protective equipment, and lowers the potential for COVID-19 exposures.

Years (see page 21) may find the plans are not quite as attractive as they used to be if they wind up shouldering large COVID-19 costs. And governors and state legislatures may see some pressure on their Medicaid budgets if the Medicaid care plans take on huge new costs this year.

There may be offsetting factors for insurers. COVID-19 has meant widespread cancellation of elective surgeries — and those are procedures insurers would have otherwise covered. In fact, use of many kinds of medical services may tail off as American hospitals and clinicians grapple with the outbreak. New, expensive drugs may come on to the market at a slower pace this year both because the FDA is preoccupied with COVID-19 and the reluctance of pharma to launch product during such uncertain times. It is a complex situation, however. There may very well be some upward pressure on medical spending if the management of conditions like diabetes and hypertension suffers and people with those conditions develop complications.

As we went to press, the course of the outbreak was nothing if not uncertain, which makes projections of the costs and therefore the effect on insurers equally subject to uncertainty. Covered California’s estimate of COVID-19 costs for commercial insurers ranged from $31 billion to more than seven times that amount — $237.6 billion — with a “medium” estimate of $94.6 billion. One key factor in Covered California’s calculation is an estimate that COVID-19 hospitalizations will cost $72,000. That was far higher than the $20,000 figure that the Kaiser Family Foundation put out in mid-March, although the Kaiser figure was an estimate based on past experience with inpatient pneumonia admissions.

The classic insurance function is to buffer the shock of large, unexpected expenses, and Gary Shaw of Deloitte wrote in mid-March that “insurers are expected to continue to serve as shock absorbers for the economy and society.”

In the early days of the outbreak in early and mid-March, insurers moved quickly to waive the cost of COVID-19 tests. Waiving out-of-pocket costs for treatments came later. Here are some other steps that insurers have taken:

- Telehealth services are being used at a pace never seen before and without a copayment attached.
- Some plans have waived prior authorizations for COVID-19 diagnostic tests and for services that are consistent with CDC guidance, along with referrals and step therapy.
- Plan members are being encouraged to turn their 30-day maintenance prescriptions into 90-day mail order delivery at the same cost. Some plans are waiving early refill limits on 30-day maintenance medications.
- Some plans have made a point of announcing they will cover the cost of a COVID-19 vaccine when it is available.
- Blue Cross Blue Shield of Arizona announced it will eliminate cost sharing for nonpreferred medications if a preferred drug is unavailable because of a shortage or other access issues.

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Peter Wehrwein is senior editor of Managed Healthcare Executive.

Shea Harrelson, PA-C, and Scotty Branch, co-founders, Vikor Scientific, Charleston, South Carolina

As a pioneer in antibiotic stewardship and advanced diagnostics, Vikor Scientific’s first plan of action was to dedicate 2,000 square feet of space in its new Charleston headquarters specifically for COVID-19 testing. This will enable us to do high-volume testing and serve as many patients as possible. Vikor Scientific is currently validating COVID-19 testing. Once approved, Vikor Scientific will be able to test 1,500 patients daily with a 24-hour turnaround-time from sample arrival. Vikor purchased new equipment and supplies as well as hired additional staff to execute our plan. We have also dedicated our Pennsylvania location for COVID-19 testing, which will enable us to perform twice as many tests.

Karen Appold is a medical writer in the Lehigh Valley region of Pennsylvania.
Use of Telehealth Services Increases Amid Pandemic

The telehealth industry and its observers have been surprised by how quickly the healthcare system has pivoted to telehealth and providing care remotely.  

They say in any crisis, one sound is opportunity knocking. COVID-19 certainly seems to have found telehealth’s door.

No one is cheerleading for the pandemic, but the telehealth industry and its observers have been surprised by how quickly the healthcare system has pivoted to telehealth and providing care remotely. The course of the outbreak and its consequences are far from certain, but one of the lasting effects may be a fundamental shift in how American healthcare is delivered.

“I don’t think we can put the genie back in the bottle,” says Michael Barnett, MD, an assistant professor at the Harvard T.H. Chan School of Public Health who has studied telehealth and a primary care physician at a clinic associated with Brigham and Women’s Hospital in Boston.

Cynthia Hundorfean, CEO and president of Allegheny Health Network in Pittsburgh and a member of the Managed Healthcare Executive editorial advisory board said in an email interview at the end of March that her COVID-19 has launched a massive natural experiment in work-from-home (WFH) policies and practices for employers and employees. Obviously, people involved in the direct provision of medical care can’t work at home, but, just as obviously, many people involved in office-based functions can.

Here are six tips for healthcare executives who are managing WFH employees:

1. Communicate often and comprehensively
   Mary Anne Jones, senior vice president of finance and operations at Priority Health, a health insurer in Grand Rapids, Michigan, encourages healthcare leaders to communicate frequently and comprehensively. Every day during the COVID-19 outbreak, Priority Health’s executive team has communicated with employees about topics that range from staffing news to best practices to protect against infection with the SARS-CoV-2 virus to updates on resources available to WFH staff. Employees also receive information about compassionate and emergency paid-time-off opportunities.

   Joe Tye, a former hospital administrator and founder and CEO of Value Coach, a consulting business, observes that healthcare workers are dedicated to their patients. One way to help remote workers feel connected, he says, is to share stories in a HIPAA-compliant manner on the organization’s intranet that illustrates how employees’ work affects patients. He offers the hypothetical example of a supply-chain clerk working from home who exceeded expectations to secure a shipment of surgical masks for the hospital. That effort might be acknowledged with a comment that “this shows how we are all caregivers and can all make a difference for the patient and for fellow caregivers,” says Tye.

2. Be flexible and provide support
   Tina McKinney, regional vice president of human resources at Partners Healthcare in Boston, says WFH team members often need flexibility. Employees may need to start work early, before their children wake up, and then take a break to get their children involved in an at-home activity. McKinney says that Newton-Wellesley Hospital, one of the two hospitals where she heads up human resources for Partners, is extending the hospital’s employee assistance program to employees’ family members so they can get short-term counseling and other support.
The Advisory Board, advises hospitals meeting software. 

accessing virtual tools, such as online IT services, setting up equipment, and employees also receive tips on contacting other computer equipment. Priority Health gives staff the equipment they need remotely. In response, the health insurer employees aren’t used to working 

Jones says many of Priority Health’s tools they need 

3. Set up staff with the home-office tools they need

Jones says many of Priority Health’s employees aren’t used to working remotely. In response, the health insurer gives staff the equipment they need to furnish a home-office environment. Employees were allowed to take home their monitors, docking stations, and other computer equipment. Priority Health employees also receive tips on contacting IT services, setting up equipment, and accessing virtual tools, such as online meeting software.

Craig Pirner, a managing director at The Advisory Board, advises hospitals to use virtual-meeting technology, such as Zoom or Cisco Webex. He encourages managers to use video whenever possible to help reduce social isolation. Nonverbal communication is missing during phone-based team meetings, he explains.

4. Launch a virtual book club

Tye says that launching a virtual book club can be a good way to increase engagement among employees. “Choose a book, either fiction or nonfiction, that’s not directly work related and that inspires the heart and soul. A good start would be “The Last Lecture” by Randy Pausch, says Tye. One way to run the club is to schedule a weekly conference call with each person assigned to provide a recap and their observations about different chapters. After the book conversation, the call can be used to check in on team members.

5. Maintain focus on other problems to solve

COVID-19 has swept attention on other problems to solve. But that doesn’t mean that people can’t share some lighthearted moments. Managers should inject a little fun into their interactions with employees, says McKinney. Some employees at Newton-Wellesley Hospital have been sharing fun videos about what they’re doing with their kids or their dogs, says McKinney, and she is perfectly OK with that.
What Are the Top Pharma Challenges Right Now?

The opioid epidemic is far from over, but it may slip behind other challenges. COVID-19 obviously tops the list of new problems. And drug pricing and affordability will continue to soak up time and attention. by MARI EDLIN

In an interconnected world, epidemics of viral diseases are inevitable but unpredictable. When 2020 began, no one would have put a new coronavirus among the top pharma challenges of the year. But obviously the pandemic has become the most important healthcare story of the year. As we went to press, there were an estimated over 200,000 cases in the United States and about 900,000 worldwide. Gilead and other companies are scrambling to test antiviral medications in hopes of identifying effective treatments. Meanwhile, some of pharma’s biggest companies, including GlaxoSmithKline, Johnson & Johnson, Sanofi, and several smaller ones, such as Moderna Therapeutics and CureVac, are in the race to develop a vaccine.

COVID-19 looks like it will eclipse most everything else in healthcare this year, although the issues of drug prices and affordability aren’t going away; they are just in the background for the time being. Specialty drugs, in particular, are a big portion of the price and affordability problem — and a much bigger bite than the average consumer can chew. They accounted for just 2.2% of prescription volume in 2018, but the number of specialty prescriptions grew twice as fast as the number of traditional medications, according to the IQVIA Institute for Human Data Science’s latest annual drug expenditure report.

More important than the number of prescriptions is their cost, and the IQVIA report says the specialty drug share of net spending across institutional and retail settings rose from roughly a quarter of net spending in 2009 to just shy of half (49.5%) in 2018. Two drugs illustrate just how expensive specialty medications have become. Spinraza (nusinersen), a drug approved in 2016 for spinal muscular atrophy, costs $750,000 in the first year of treatment and about $375,000 the following year. Zolgensma (onasemnogene abeparvovec-xioi), a drug approved by the FDA in May 2019 for the same disease, costs $2.1 million, making it the most expensive drug to ever hit the market. Coinsurance for these drugs, in theory, could run as high as $420,000 a year.

“While these drugs are very expensive, they are effective and are the only ones on the market to treat the condition,” notes Sharon Frazee, PhD, senior vice president of research and data innovation for the Pharmacy Benefit Management Institute (PBMI).

Frazee says she realizes the financial burden that medications like these two could have on a small insurance plan or a small, self-insured employer. But she emphasizes the importance of weighing an effective drug and its high cost against the possibility of an alternate scenario of high healthcare costs for people with a condition that doesn’t have appropriate treatment. Frazee recommends that employers consider buying stop-loss insurance. Meanwhile, Cigna and Express Scripts have launched the Embarc Benefit Protection plan, which is designed to create a large risk pool for Zolgensma and Luxturna (voretigene neparvovec-rzyl), the new gene therapy for inherited retinal disease, and eliminate coinsurance for patients.

Steven Lucio, RPh, vice president of pharmacy solutions for Vizient, a healthcare services company headquartered in Irving, Texas, agrees with Frazee that affordability is a top concern. Lucio says he wonders how one can put a price on life-saving drugs for small populations.

“It’s difficult for payers to
figure out how to pay and deliver medications to their members and requires additional resources, such as people,” Lucio says.

Affordability is not among the virtues of the current drug pipeline; it is full of specialty drugs and gene therapies. Lucio says he would like to have more biosimilars prescribed. As of December 2019, the FDA had approved 26 biosimilars. Far fewer are actually on the market because of patent challenges, rebate policies, and other impediments.

A survey conducted in April 2019 by the Academy of Managed Care Pharmacy highlighted what members believed were the largest barriers to biosimilar uptake, as well as some strategies for remedying the situation. Rated as “extremely difficult” or “difficult to overcome” were the safety and efficacy of biosimilars (61%), pricing and contracting (57%), and state laws and regulations for substitutions and interchangeability (53%).

The strategies that might be used to overcome this hurdle were prescriber education on switching studies (91%), clear FDA guidance on substitution (90%), and formulary policies for treatment-naïve patients (87%).

Affordability has risen to the top of Remedy Analytics’ list of pharmacy challenges for 2020. Although it is difficult to imagine footing the bill for treatments with million-dollar (or more) price tags, the cost must follow the patients, says Steve Maike, RPh, chief pharmacy officer for the Milwaukee-based company that provides data analytics in the pharmacy space.

Maike worries that paying for high-cost drugs might affect access to traditional drugs, leading to rationing. On the other hand, he suggests that squeezing out waste in the traditional drug market could free up resources that would help cover all costs.

“It takes a lot of work to keep ahead of inflation and to stamp out waste,” he says. “Payers must find creative ways to manage the total cost of drugs because they are not saying, ‘I won’t cover high-cost specialty drugs.’” In his presentation at the PBMI national conference last month in Orlando, David Calabrese, senior vice president and chief pharmacy officer at OptumRx and a member of the Managed Healthcare Executive editorial advisory board, talked about how his company uses the Vigilant Drug List as a waste-reducing effort, because it keeps expensive or ineffective drugs off OptumRx’s formularies.

Maike mentions a one-payer system as a potential solution or, for the Medicare population, moving some expensive drugs under Part B as a way to reduce costs. “Part of the conundrum is that list prices for drugs have increased, while managed healthcare plans say their cost trend has stabilized,” says Maike.

Lack of transparency
Maike also sees lack of affordability as an access problem and, ultimately, affecting adherence. He blames the access issue on his No. 1 pet peeve: vertically integrated hospital systems and horizontal integrations of insurers with PBMs.

Maike is concerned that these types of mergers and partnerships are not only confusing but undermine the opportunity to reach unbiased medical opinions. “There are unbelievable levels of conflict of interest,” says Maike’s boss, Scott Martin, co-founder and CEO of Remedy Analytics. “It is difficult to make a reasonable decision when you are bombarded by players in the system pushing their products and by incentives that can lead to bias, such as rebate dollars.”

Maike sees consumerism as another problem, but he believes it is a knot that can be untied. “It’s a challenge to be a consumer and have to make value-based decisions with limited information,” Maike says. “How can we tell patients what their copay is and not let them know the cost for the medication? How can they take financial responsibility if they don’t know the cost? Vendors must be able to provide price transparency so that consum-
ers can make a decision."
Susan A. Cantrell, RPh, the CEO of Academy of Managed Care Pharmacy, also lends her voice to the affordability Greek chorus. "Affordability," she says, "continues to be a challenge with the arrival of new treatments to address conditions that previously had no existing drug alternatives."
In 2017, her organization established a three-part strategy for coping with high costs:
- Establishing value for outcomes through prior authorization and other technologies.
- Paying for value.
- Fostering competition by making lower-cost alternatives available, such as biosimilars, when appropriate.
Cantrell would like to see more flexibility and improved efficiencies around prior authorization and step therapy, emphasizing their importance, disseminating best practices, and collecting real-world evidence.
In December 2019, the academy hosted a forum on improving specialty drug benefit and reimbursement designs, with an eye on cutting drug prices, improving access, supporting incentives for innovation, and removing adverse reimbursement incentives.

Pharmacy vs. the medical benefit
Frazee looks at the cost challenge as the delicate balance between the pharmacy and medical benefit, because often specialty drugs are covered under both. It is second on her 2020 list of pharmacy challenges.
One of the most important considerations, she says, is choosing the right location — an infusion or outpatient center or a physician’s office instead of a hospital, for instance — for dispensing services. "There needs to be parity across benefits so that patients face similar costs under each plan and no longer have to shop around for the best cost," says Frazee.
It is not unusual for the consequences of a medication under a pharmacy benefit to show up on the medical side. For instance, when patients pick up a prescription, they pay for it on the spot, but they might receive a medical bill later that is associated with a drug. "Insurers might be left holding the bag for these extra costs, or consumers might be forced to go bankrupt to pay for services," she adds.
Cantrell says the key to balancing both pharmacy and medical benefits is integrating data from both areas. An AMCP Partnership Forum met recently to discuss how to bridge the divide between the pharmacy and medical benefit and place more emphasis on the total cost of care. Among the topics were using health IT to streamline access to data, cost transparency, and aligning incentives.
Frazee says attention to the total cost of care is picking up steam. Insurers are realizing that a drug might be jarringly expensive at the outset but that it saves money on the medical side in the long run. Value-based contracts, which tie payment to patient outcomes, are also becoming more common.

Pipeline management
The management of new drugs that come out of the pipeline and onto the market is an issue that keeps healthcare executives up at night, Frazee says. It can be an enormous problem for self-insured employers and nonprofit health plans who have no way of planning ahead for the sky-high cost of some specialty drugs. Frazee says smaller plans should turn to their risk management departments to develop different scenarios based on cost and prevalence.
Lucio also agrees with Frazee that pipeline management is a formidable challenge, especially as it relates to the integrity of the supply chain that can cause drug shortages down the line.
Last October’s shortage of vincristine, a vital chemotherapy agent used to treat several pediatric cancers, is a good example of the fragility of the supply chain for some medications. Teva stopped making it, leaving Pfizer as the only supplier. The shortage could lead to rationing and a failure to provide appropriate treatment to a vulnerable population, Lucio says.
Lucio would like to see more transparency around the origin of drugs and more awareness of the supply chain. Vizient is studying ways to increase the awareness and communication necessary for a sustainable supply of drugs by planning in advance to ensure adequate supplies.

"Payers must find creative ways to manage the total cost of drugs because they are not saying, ‘I won’t cover high-cost special specialty drugs.’"
— STEVE MAIKE, RPH, CHIEF PHARMACY OFFICER, REMEDY ANALYTICS
In 2010, Pat A. Basu, MD, MBA, was teaching medical and MBA students at Stanford University when he took a leave of absence to become a White House Fellow and senior adviser during the Obama administration and, for many healthcare reformers, those heady days when the ACA was signed into law.

“I always wanted to make an impact on our country and society and help to build a better American healthcare system — one that is more accessible, higher quality, safer, and more economically sustainable,” Basu said.

At the White House, he had a bird’s-eye view of the country’s healthcare problems and opportunities, and Basu used his time there to understand how the tangled and expensive American healthcare (non)system might be reformed.

Since April 2019, Basu has had the chance to use those insights as president and CEO of Cancer Treatment Centers of America (CTCA), a for-profit network of cancer hospitals and clinics competing in an area of healthcare dominated by some of the most recognizable names in American medicine: MD Anderson, Dana-Farber, Memorial Sloan Kettering, and Fred Hutchinson.

CTCA, which is headquartered in Boca Raton, Florida, has hospitals in the Atlanta, Chicago, Philadelphia, Phoenix, and Tulsa metro areas, and two outpatient facilities in the Chicago area and three in Arizona.

According to the results of the CTCA’s latest treatment report, Georgia residents made up the largest proportion of new patients from July 1, 2017, to June 30, 2018, on a state-by-state basis, accounting for 12% of the total (1,158 of 9,192).

“[Becoming president of the] CTCA was an opportunity to have a great impact on making the country a better place, making society a better place, and also building a better healthcare system,” says 40-year-old Basu. “Fundamentally, cancer has impacted me as a person, as a physician, and as a family member, so the opportunity to lead an organization that is fighting something that I have spent a career trying to defeat, with a platform that could leverage some of the things I have done in the past, was an incredible opportunity.”

Former Democratic Senate Majority Leader Tom Daschle was among those who showered Basu with praise when CTCA announced that he was taking the company’s top job. However, Basu took the helm of an organization that has weathered some criticism about the way it reports survival statistics; the latest treatment results report makes a point of mentioning that two outside experts reviewed the statistics. In Georgia, CTCA won a prolonged political and regulatory battle last year to expand its hospital in the Atlanta area.

Basu says treatment results released in early 2020 show that “our survival rates and patient symptoms have only gotten better, even though we manage very complex and very sick patients.” He adds, “I want to give a great deal of credence and credit to those who’ve come before me, but I think we’ve even further upped the bar there.”

Basu has also been working on increasing the number of payers who will cover patients treated at the organization’s centers.

“We have really expanded our access with new insurance contracts with a variety of large payers across the country, he says. “We’ve gone from a large amount of people who had trouble accessing us because we might not have had an insurance contract to now 98%, 99% in-network with these commercial agreements.”
Combining 1.0 and 2.0

Basu says that when he speaks to medical students today about becoming physicians, he talks about how interacting with humanity is fulfilling and learning the scientific facts, interesting. “I just knew that I always loved helping people and making an impact, and, fundamentally, the science and innovation are so dynamic and stimulating. But putting together my love of people with the intellectual pursuit, this career drew me in from a pretty young age.”

Basu, who is from Naperville, Illinois, a western suburb of Chicago, earned his bachelor’s degree in mechanical engineering from the University of Illinois and his medical degree from the University of Chicago, while simultaneously getting his MBA from the university’s Booth School of Business. He went on to complete the Stanford Business School’s Faculty Leadership Program and became founding faculty director of health policy and finance.

After leaving the White House, Basu became president and chief medical officer of vRad, a “teleradiology” company that delivers radiology services remotely. “What I learned there is that you have to be good at 1.0 healthcare, which is the traditional taking care of patients within the four walls, but start to bring in 2.0 type of solutions, such as technology and telehealth,” he says. “That leadership experience taught me that if you’re going to build the best healthcare system, you can’t just do 2.0; you need the scale and reality of 1.0.”

Before CTCA, his work included senior executive positions at UnitedHealth Group and two Chicago private equity firms, Chicago Pacific Founders and the Pritzker Group. He also helped start Doctor on Demand, a telehealth company.

The new job

At CTCA, Basu says he is blending 2.0 skills with 1.0 elements. He is ramping up telehealth efforts and pushing the envelope on precision medicine and clinical trials. Like so many others in healthcare, Basu sees a need for collaboration: “For too long, we’ve operated in silos, so every large portion of the [cancer] ecosystem — providers, payers, employer, pharma — we’ve all worked really well...in our own verticals, but we can do much more together, and frankly, we have to do more together.

In a typical week, Basu spends a significant amount of time reaching out to partners to see what they can do together to solve problems. For instance, there might be a hospital in Seattle where CTCA has a patient in treatment for advanced or complex cancer care; Basu looks for ways to improve service for that patient by partnering with the hospital to keep them closer to home or better coordinating the care. There’s also the work of partnering with employers and insurance companies to find better solutions for value-based care and developing evidence-based pathways for the patient population at affordable rates.

Basu says he is also working with pharmaceutical companies; he explains that CTCA is in the business of delivering their treatments, so he is looking for ways that CTCA and pharma can work together to help more people on a larger scale. “We have hundreds of thousands of sets of data that comprehensively can unlock a new therapy, a new method of diagnosis, [or] a new piece of discovery that can help develop a better cure. So we want to work with them in those capacities,” he says.

One of Basu’s latest initiatives is the launch of a dedicated value-based care oncology effort, which looks to work with employers and payers on best practice principles. He says the first nine months have been “remarkably successful.” Looking ahead, Basu is optimistic about advances in therapy, precision medicine, and telemedicine. “What I see ahead is a patient can get our expertise while potentially not having to leave their geographical area,” he says. “We can do telehealth in oncology and coordinate care with a local provider, and there will be some network model to best care for the patient. My vision for CTCA is to help make that care more seamless.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.

“| I always wanted to make an impact on our country and society and help to build a better American healthcare system.”

— PAT A. BASU, MD, MBA
By almost any measure, these are good times for Medicare Advantage (MA). Enrollment is growing, the number of insurers in the market is increasing, and gross margins are higher than in other health insurance markets. Some critics say the deck has been stacked in favor of MA and that the federal government is overpaying the insurers who offer MA plans relative to traditional Medicare. But for the legions of baby boomers who have become eligible for Medicare once they turn 65, the allure of MA plans — many with low or zero premiums, built-in Part D coverage, dental coverage, and other additional benefits — is strong. The trade-offs for beneficiaries are a narrower network of providers and managed care hoops to jump through, such as prior authorization and step therapy.

The boom times are enticing new, smaller companies into the MA market, and some are bringing innovative offerings into the market. Meanwhile, private insurers, such as UnitedHealthcare and Humana, are working to move members over from employer-sponsored plans into MA plans when they hit their 65th birthday, and the federal government is making some effort to expand MA into rural and low-income populations where MA availability lags.

Medicare Advantage used to be called Medicare Part C, and it used to be the overlooked “middle child” of the Medicare program, sandwiched between Part A (for hospital coverage) and Part B (for physician services), and the upstart, Part D (for prescriptions), which became available in 2006. But according to data compiled by the Kaiser Family Foundation, enrollment in Medicare Advantage has been climbing steadily since 2004, when 5.3 million Medicare beneficiaries (13% of the total) were enrolled in MA plans. By 2019, that number had quadrupled to 22 million, and the proportion had grown to 34%. The Congressional Budget Office has projected that enrollment will continue to climb, so that by 2029, close to half (47%) of Medicare beneficiaries will be in MA plans. Twenty years from now, when the youngest baby boomers will be turning 76 and the oldest, 94, some projections show that 70% of Medicare beneficiaries in MA plans.

Provisions of the ACA that had the effect of lowering payments for

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**STATE OF MEDICARE ADVANTAGE**

**These Are Boom Times for MA**

by DEBORAH ABRAMS KAPLAN

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Average gross margins per covered person per year, 2016-2018

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<tr>
<th>Market</th>
<th>Average Gross Margin</th>
<th>Simple Loss Ratio</th>
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The Congressional Budget Office has projected that enrollment will continue to climb so that by 2029, close to half (47%) of Medicare beneficiaries will be in MA plans.

MA plans were expected to reduce MA enrollment because it would make the program less attractive to insurers and beneficiaries. Quite the opposite has happened: Enrollment has doubled since 2010. Experts are still trying to figure out why. A 2019 Urban Institute report on the MA payment and enrollment question concluded that the payment cuts to the plans under the ACA weren’t as deep as expected for a variety of reasons. Indeed, the Kaiser Family Foundation’s math shows that between 2015 and 2018, the total of annual quality bonuses paid to Medicare Advantage plans has more than doubled, from $3 billion to $6.3 billion. The bonus payments are tied to quality scores, but some critics say they are flawed as indicators of the MA plan performance, instead rewarding plans for other factors, such as the relationship they have with providers and demographics of the beneficiaries.

The overall upswing in MA enrollment does obscure some of the underlying variability. For example, geographically, enrollment is quite uneven. In six states (Florida, Hawaii, Minnesota, Oregon, Pennsylvania, and Wisconsin), more than 40% of Medicare beneficiaries are in MA plans, while in two states (Wyoming and Alaska), virtually none are.

**Land rush**
The Medicare Advantage market is brimming with plans today. For this plan year, over 3,000 plans were available, according to a Kaiser Family Foundation tally. CMS says that the average number of Medicare Advantage plan choices per county increased from 33 plans in 2019 to 39 plans this year. Kaiser’s numbers are lower (28 instead of 39) but still show an uptick.

Insurance start-ups, such as Oscar and Bright Health, who were originally targeting the individual ACA exchange market, are part of the MA land rush. Oscar, based in New York City, started selling MA plan coverage in New York City and Houston this year. Bright Health, a Minneapolis company, started selling MA plans in seven additional markets. Devoted Health, in Waltham, Massachusetts, which bills itself as a “next-generation” MA plan, got started out in Florida markets and expanded into Houston for this plan year.

Meanwhile, the large insurers continue to be the dominant players in the Medicare market, and they are adding hundreds of thousands of beneficiaries to their MA plans. UnitedHealthcare is the leader by far, with 26% of MA enrollees, followed by Humana, with 18%. Those two companies, along with CVS/Aetna and Blue Cross Blue Shield, have about 70% of MA enrollees in their plans.

The smaller companies bring innovations, while traditional

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**Why MA? The money.**

Insurers are getting into the MA market because the markets have favorable margins. According to L.E.K. Consulting, the per-member, per-month (PMPM) operating margin of MA plans is between $30 and $60, which is three times the $10 to $18 PMPM operating margins for Medicare supplemental (Medigap) plans.

The Kaiser Family Foundation looked at MA plans through the lens of gross margins — the difference between premiums collected and medical expenses, without considering administrative costs. Annual gross margins in the MA market averaged $1,608 per covered person between 2016 and 2018, according to an issue brief that the foundation put out last year. That’s more than double the average gross margin per covered person of $779 among plans sold in the individual market during that period and just under twice the gross margin ($855) per covered person in the group market.

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**The Congressional Budget Office has projected that enrollment will continue to climb so that by 2029, close to half (47%) of Medicare beneficiaries will be in MA plans.**
healthcare companies cover the mainstream, observes Katie Guhr, president of Advantasure, a healthcare technology and information MA company in Glen Allen, Virginia. “It keeps the product from getting stagnant.”

Some of the major insurers that have been less active in MA market are recognizing the opportunity to provide coverage from the commercial market on through the MA, observes Guhr. She sees a resurgence of healthcare insurance companies recognizing that they have a place in the MA market: “There are more joint ventures than I’ve seen in a long time, leveraging subject matter expertise with unique fit in [the] marketplace."

Additionally, provider-insurer partnerships are popping up in the MA markets. Ascension Complete is an MA plan that is a partnership of Ascension, the large, not-for-profit Catholic health system, and Centene, which has expanded beyond its home turf, Medicaid managed care, into MA and other markets. Acquisitions are also reshaping the contours of the MA market, notes Guhr. Centene completed its acquisition of Wellcare in January. Anthem purchased a fast-growing MA plan in Florida called HealthSun in 2017; it bought another Florida plan, America’s 1st Choice, about a year later.

New populations
MA enrollment tends to lag in rural areas. Many of the roughly 700 “low-penetration” counties, where 10% or less of Medicare beneficiaries are enrolled in MA plans, are in rural areas. Ramping up telehealth is one of the main goals of the Trump administration’s Rural Health Strategy. And starting this year, MA plans are allowed to include telehealth as part of their basic package, not just in the supplemental benefits.

In the past few years, CMS has also focused on “dual eligibles,” low-income seniors who qualify for Medicaid as well as Medicare coverage. Dual eligibles make up roughly 20% of the Medicare population. According to a 2019 report on MA by L.E.K. Consulting, enrollment in Dual Eligible Special Needs Plans, which are a kind of MA plan for dual eligibles, has been growing faster than enrollment in MA overall.

CMS has also opened up MA rules so plans can now cover services to address the social determinants of health, including transportation, meals, and even cleaning. “We’re seeing a lot of organizations really trying to get their arms around community health,” says Guhr. And they’re recognizing the large variability in communities; a cookie-cutter approach doesn’t work for the dual eligibles.

65 years young
Both CMS and the Medicare Advantage plans understand that the senior population they serve is chronologically the same but changing in other ways. More marketing campaigns are conducted digitally and contain social media dimensions, says Guhr. The MA plans see that they need to get smarter about how they approach the consumer. “There’s recognition that a 65-year-old today is still relatively young, healthy, and active. The way 65-year-olds saw themselves in the 1990s or early 2000s is maybe in a state of relaxation — they earned their retirement,” Guhr says. MA plans have started to adjust by changing their marketing and communication strategies and adding benefits designed to prevent disease, not just treat it.

Deborah Abrams Kaplan covers medical and practice management topics.
COVID-19 has disrupted American healthcare. But there are still important non-COVID-19 trends to keep an eye on.

1) Wellness: Real Deal, Not a Passing Fad
As the cost of healthcare in this nation continues its relentless climb, health system and managed care executives are focusing on the development of strong population health programs and preventive care initiatives as a way to keep patients healthy and avoid chronic conditions that drive up drug and medical services expenditures.

Anthony Viceroy, CEO of Westmed Medical Group, a multispecialty group in Westchester County, New York, and Fairfield County, Connecticut, believes that “wellness” is not just a popular trend or a passing fad. “By preventing or delaying chronic diseases, such as diabetes, hypertension, and heart disease, we can help improve the quality of care for patients, while reducing unnecessary costs in the system,” he says. “It is our belief that the only way to bend the cost curve of healthcare is to champion disease prevention and to promote healthy habits outside of the exam room.”

Viceroy says at Westmed they have noticed that millennials are better than boomers and other generations when it comes to being participants in their own healthcare. They are proving to be more mindful of activities that promote wellness and disease prevention. “This demographic readily adopts innovation and technology to help them track their heart [health], weight, nutrition, and fitness,” says Viceroy.

He adds large medical groups like Westmed have an important role to play in partnering with patients to help them stay out of the hospital and be the healthiest versions of themselves. “I think as a result, you will see more outpatient practices and healthcare systems using data and community health programs to keep patients healthy outside of the doctor’s office.”

2) Data Mastery: Do or Die
As 2020 unfolds, Scott D. Hayworth, MD, believes there will be a growing—and increasingly urgent—need to collect and analyze data.

“Over the past decade, value-based reimbursement and compensation have become more dominant. Providers who cannot tap into the power of data collection, analysis, and guided action will simply not survive,” says Hayworth, who is president and CEO of CareMount Medical in Chappaqua, New York. “Patients are demanding, and payers are rewarding more cost-effective, versatile, and accessible systems of care.”

Depending on in-house resources likely won’t be the way to go. Data management service businesses will become essential partners to many provider groups and institutions, to manage both population health and the increasingly personalized care, says Hayworth.

3) Focus on Individual Impact
John Showalter, MD, MSIS, chief product officer of Jvion, a healthcare analytics and AI firm in suburban Atlanta, says that with a CMS evaluation showing that the next generation of ACOs aren’t saving money, population health will be seen as less effective. “I think that will lead to a trend of increasing focus on individual impact,” he says. “There will be a move from cohort management to individual risk management; specifically, there will be an increased discussion about how AI can help.”

4) The Medical-Social Support “Mash-Up”
Don McDaniel, CEO of Canton & Company, a Baltimore healthcare consultant, believes there will be a continued focus on “mash-ups” that go beyond traditional healthcare services spending and include social services, housing, nutrition, and the like.
“This is the year that I think we’ll find out if SDoH [social determinants of health] can be more than a science experiment,” he says. “There’s been lots of money spent on initiatives, but the jury is out in terms of return. So, can the various actors positively impact detrimental communities, social and environmental impacts to improve health status and to reduce the amount spent on vulnerable, underserved populations?” In McDaniel’s estimation, integrated delivery systems that are at risk for the cost of caring for populations are in the strongest position to tackle SDoH projects.

5) Data as Barrier Breaker
Kurt Waltenbaugh, founder and CEO of Carrot Health, a Minneapolis SDoH and health data company, says greater access to consumer information will increase the industry’s ability to pinpoint barriers to health at the individual level. “Access to a broader array of consumer information will expose the role that upstream barriers, the so-called social determinants of health, play in continuously rising healthcare costs,” Waltenbaugh says. “More data will help us better understand how to remove those barriers and pinpoint healthcare down to the individual consumer level.”

Part of the reason for the lack—until recently—of insight into SDoH until recently, he says, is the barriers are not evenly distributed. They tend to cluster in disadvantaged communities, which are disproportionately affected by declining health and rising costs. This year, Waltenbaugh says, he expects to see interventions based on broader consumer information emerge from the pilot stage and be deployed on a larger scale. “However,” he adds, “this scale deployment will only happen in areas where ROI has been demonstrated over a 12-month period. Any longer will require policy and funding changes, which are not currently on the horizon.”

6) Pharmacists as Deliverers of Medication Optimization
Varun Goyal, co-founder and CEO of Indiana-based Illuminate Health, believes medication optimization—making sure patients get the right dosage and support to stay adherent—is needed for every disease. “Who better to deliver on the promise of medication optimization than pharmacists?” Providers and payers are now rethinking the role of pharmacists on their care teams,” he says. “Across the country, healthcare organizations are attempting to expand the scope of practice to allow pharmacists to extend patient oversight and assist with outpatient care.”

Healthcare organizations of all stripes are recognizing that pharmacists can help them realize the potential of value-based care. “By realizing the value of pharmacists and incorporating them to provide this patient-centered care model, they can help to reduce costs, ensure safe and accurate medication therapy, and help prevent patient readmissions and chronic disease progression,” says Goyal.

7) Big Data’s Second Act: Security
For the past several years, the transformative power of big data and AI has been a hot topic of conversation, and there’s some reality behind it too. “More recently, however, thanks to well-publicized incidents around data security and access, the conversation has pivoted to the dangers of increased access to data, and how to manage this risk,” says Eric Peterson, healthcare expert at PA Consulting. “Solving this problem will require significant cross-industry collaboration, which can obviously be challenging.”

8) Developing a Holistic Access Strategy
Bill Stinneford, senior vice president and healthcare lead at Buxton, a healthcare intelligence company in Fort Worth, Texas, notes that one of the hottest healthcare trends is a “holistic access strategy.” Stinneford notes, “In the last five years, there has been a tremendous rise in outpatient location expansion within the healthcare industry. Retailers like CVS and Walgreens have opened thousands of clinics, and urgent care facilities have boomed. Even health systems have jumped on the trend by partnering with retailers or opening their own outpatient facilities.”

Among the reasons for this shift: It’s where the money is. “The money is there because of reimbursement rates and incentives to keep nonemergency patients out of the emergency department. “Outpatient facilities are an important tool in the strategy to lower healthcare costs,” Peterson says. “But the factors that make a healthcare provider successful in an outpatient setting are very different from the factors that lead to success in a traditional inpatient environment.”

In Peterson’s view, success in outpatient healthcare hinges on understanding and integrating three factors into a holistic strategy: consumer knowledge, retail real estate fundamentals, and traditional healthcare performance drivers.

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
Patients in Observation Status

How are healthcare systems addressing the shift from inpatient to observation? by KEITH LORIA

To patients, observation status in a hospital can seem exactly like being an inpatient. Patients in observation status can be in the hospital several days just like fully admitted inpatients. They can be in a hospital bed, receiving pretty much the same kind of attention.

But the financial implications of outpatient status are worlds apart from being an inpatient for both patients — especially for those covered by Medicare—and for hospitals. For Medicare beneficiaries, outpatient status stays are billed under Part B, which means 20% cost sharing and out-of-pocket costs for medications not directly related to the primary diagnosis. Outpatient status may also expose people to nursing home bills once they leave the hospital that would have been covered by Medicare if they had been admitted as inpatients for at least three days. For hospitals, outpatient status means reimbursement at far less than if the patient had been admitted.

"Doctors get paid either way, but the hospitals get about half or even less for observation," says Keith Lind, JD, MS, a senior policy adviser with AARP’s Public Policy Institute. "Outrage over the ‘surprise billing’ aspects of observation status and the fact that many patients didn’t realize they were classified that way led to the Medicare Outpatient Observation Notice (MOON) rule, which requires hospitals to notify patients if they are in outpatient status. Still, some physician and patient advocacy groups remain critical of outpatient status. They see loopholes in the MOON rule and cases when patients are put in observation status when, medically, they needed inpatient care. Some groups have mounted legal challenges; in late March, a federal judge ruled that some patients in the observation status could bring an appeal to CMS challenging that status.

Not everyone is a critic, though. Christopher McCann, CEO of Current Health, a Boston company that provides patient monitoring and other services, notes healthcare systems are using the shift from inpatient to observation as a strategy in their value-based contracting agreements.

"Both private and public payers have been seeking to reduce the overall cost of healthcare delivery," McCann says. "The hospital is the most expensive part of that delivery system, so one area of focus has been on reducing hospitalizations." Because of the increasing reliability of remote monitoring and application of artificial intelligence, "we’ll see a reduction in both inpatient and observation stays," he predicts, "and that observation status [care] will be delivered in the person’s own home.

Lindsey Osting, chief nursing officer and vice president of patient care at OhioHealth Doctors Hospital in Columbus, says hospitals have started to group observation patients together.

"From a nursing perspective, while they get the same quality care you would get from being considered inpatient, if we put them together on the unit, it’s easier to develop protocols and ways of doing things in a way that is best for the patient," Osting says.

Numbers went up

The number of hospitals put into observation status started to increase significantly about 15 years ago. In some cases, hospitals were responding to Medicare auditors that challenged decisions to admit patients, especially for short periods. And there was some evidence that some fraction of inpatient admissions was at least questionable and perhaps motivated by a high reimbursement rate for inpatient care and the overall “heads in beds” incentives. In an effort to clarify...
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Patients in Observation Status | Industry Analysis

What the studies show

A study published in the Journal of Arthroplasty last year showed 16.7% of a hospital’s readmission after total knee or hip replacements were less than 48 hours and that if they had been reclassified as observation status, the hospital’s readmission penalty would have been reduced by 39%, or $334,512.

A study published in the American Journal of Medicine in 2018 showed poorer Medicare beneficiaries were more likely to be treated in observation status than their wealthier counterparts. The researchers also found that low-income observation patients had higher out-of-pocket costs.

A study published in the Journal of Hospital Medicine in 2017 showed between 2009 and 2015 observation stays among private pay patients grew by 12% while inpatient admissions declined by 28.2%. Among Medicare patients, observation stays grew by 32.9%, while inpatient admissions declined by 17%.

when inpatient admissions were acceptable, CMS established the “2-midnight” rule in 2013. The rule states that if a doctor believes, with evidence to back it up, that a person needs to be hospitalized for a period that will span two midnights, then that person can be admitted as an inpatient. CMS adjusted the rule in 2016 to add back some physician judgment.

“If a doctor thinks the patient is going to stay at least two days, they can admit them, and that claim will not get close scrutiny,” says Lind at the AARP. “If the patient is only there for one day, that claim is likely to be denied.”

Many see the 2-midnight rule as giving hospitals even more of a reason to put patients into observation status, notwithstanding the lower reimbursement (better a smaller claim is paid than a larger claim denied). Hospitals may also use observation status because it may help with their readmission rates.

Eric Burch, principal at Vizient, a member-owned healthcare services company in Irving, Texas, says with the rollout of the 2-midnight rule, hospitals began placing patients in observation status to avoid denial of payment. Commercial payers followed suit and, in some instances, downgraded patients from inpatient to observation status when calculating reimbursement.

“Hospitals now leverage utilization review committees and have dedicated care teams and observation units to ensure they follow CMS and payer guidelines to provide the appropriate care for all patients,” he says.

Hard to predict

Grouping patients into observation status or inpatient as well as the push for quicker discharges has led to an improvement in the transitions of care, say some healthcare executives, according to many in the industry. There are now guidelines in place so that medication reconciliation and hospital treatment summaries are supposed to be provided to primary care physicians.

Maria Vila, DO, a family medicine specialist in New Jersey, says healthcare systems have adapted by creating observation units with hospitals, emphasizing case management and hiring physician advisers to determine the appropriate status. “Physician advisers can review the assigned status by the treating physicians and provide guidance if needed or challenge the assigned status of either inpatient or observation,” she says.

Teryl K. Nuckols, MD, director, division of general internal medicine at Cedars-Sinai Medical Center in Los Angeles, says it is still hard for clinicians because they are expected to make guesses about whether patients may stay longer than two midnights “often at a point when they are still sorting out the diagnosis.”

“In some cases, it’s the luck of the draw whether the observation patients end up on the ‘observation units’ or on regular hospital nursing floors,” Nuckols says. “The literature also talks about hospitals creating protocols for certain categories of observed patients, such as those with chest pain, but now observation status applies to any patient with an anticipated short stay, so protocols seem to not play as large a role.”

Vila notes the main challenge includes unforeseen circumstances such as an inability to predict if a patient will truly improve and be able to be discharged within the appropriate time frame once determined as observation status.

“Another challenge is that by discharging patients quickly, we need to ensure that they have proper follow-up with their primary care physicians and sometimes other services,” Vila says. “These issues must be handled by the case management team prior to discharge.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
G

erenational differences make it difficult to satisfy the needs and wants of patients across varying age groups. Not long ago, it was expected that patients would be, well, patient and deferential. They may not have been thrilled about thumbing through magazines in a waiting room, but they tolerated it. Today, younger patients have much different expectations.

Kaveh Safavi, MD, JD, senior managing director for Accenture’s global healthcare business, says younger patients want prompt service and see availability as paramount; if you cannot see them in a timely way, they will move on to the next doctor. Or maybe skip seeing a doctor altogether and go to a retail health clinic or use a telehealth service. Meanwhile, older patients may want more time and attention. You may be seeing them with an adult child with lots of questions. Their schedules may be inflexible because they depend on family or friends to drive them to an office for an appointment.

“We live in a world of instant gratification, and patient satisfaction is paramount,” Safavi says. “Think in terms of what you would want in a restaurant. A reservation that is not honored or a rude staff member not only takes that place off your favorite list, but also sends you to the keyboard for a harsh review.” That’s why he suggests not overbooking appointments and hiring front-office staff with good customer service skills.

“If you are fully booked, do not just leave it at that. Give patients a solution that is appropriate,” Safavi advises. “Whether it be urgent care, minute clinic, or a direct referral to the proper specialist or emergency room, explain why the referral is appropriate for their need. This is something that people of any generation will appreciate.”

Appointments and conversations

Geeta Nayyar, MD, chief medical officer at Greenway Health, a health information technology and services provider, notes that the typical 25-year-old patient is going to have different medical needs than the typical 65-year-old patient. Healthcare providers and organizations cannot use a one-size-fits-all approach — and the need for generational sensitivity applies to everything from how people schedule appointments to the one-on-one conversations they have with clinicians.

“With younger patients, physicians have to be more educational and consultative, speaking with them more about prevention of conditions and diseases,” she says. “With older generations, conversations are a bit more sensitive in nature and may include discussions about end-of-life planning and how to stay healthy and active during retirement.”

In addition, Nayyar notes, it’s important for older patients to be held more accountable for their care and health outcomes, ensuring they know where and how to find their health records so that information can be shared with all members of their care team.

Thomas Horowitz, DO, a family medicine specialist at CHA Hollywood Presbyterian Medical Center in Los Angeles, says the key to working with people of all age groups and from different generations is to understand their preferences so that organizations can respond and adjust accordingly.

“The challenge is that preferences are constantly evolving,” he says. “Further, behaviors around healthcare services are redefining how consumers engage with provid-
ers across each stage of care. Expectations for convenience, affordability, and quality are shifting.

“Younger generations, in particular, are increasingly dissatisfied with healthcare’s status quo and are looking to nontraditional providers for services.”

**The need for tech**

Digital capabilities are influencing how younger generations choose their medical providers. Accenture research shows that 13% of baby boomers and the generation before them — some are calling it the Silent Generation — use remote or telemonitoring devices. The proportion is double among millennials and the 1995-2015 birth cohort that has been dubbed Gen Z.

The Accenture research found that younger consumers (millennials and the Gen Zers) are dissatisfied with many aspects of traditional healthcare services. They are increasingly looking for effective, convenient means for receiving healthcare. The waiting room is not for them.

“Healthcare providers should consider investing in nontraditional means to engage with younger generations,” says Horowitz. “This could include setting up online patient portals where they can view lab results and making them aware that they can reach their HCP [healthcare provider] via email if they have any questions.”

Safavi notes that the younger the patients, the more likely they will expect a doctor’s office to be digitally up to date.

“This is not only important for the electronic medical record in the exam room, but also on the website where portals and online scheduling are expected more and more among patients,” he says. “The doctor’s offices that look best online are conveying a service mindset to their patients.”

**“With younger patients, physicians have to more educational and consultative.””**

—GEETA NAYYAR, MD, CHIEF MEDICAL OFFICER, GREENWAY HEALTH

Younger patients will appreciate — and may even expect — Wi-Fi availability in the doctor’s office. The phone has replaced the magazine as a time killer.

The generational split may not be as wide as it is commonly portrayed, in Nayyar’s view.

“Regardless of whether you’re a millennial or a baby boomer, all patients want quick access to their healthcare records and to find helpful information online,” she says. “As long as physicians today provide that accessibility and quality care, combined with good bedside manner, people of all ages will remain engaged and satisfied.”

But Nayyar acknowledges that healthcare providers and organizations need to be attuned to generational differences.

“Younger generations, for example, want their healthcare experiences to be quicker and more transactional, so it’s no surprise that 60% of millennials support the use of telehealth options to eliminate in-person visits,” she says. “The challenge here is ensuring critical information is not lost during these swift transactions.”

Meanwhile, older patients prefer face-to-face interactions. Many want to establish a more personal relationship with their physician. Of course, it remains to see whether millennials and Gen Zers will feel the same way come the mid-21st century, when they will start to experience old age and health issues that are often more complex and frequently chronic.

**Err on the side of formality**

Laura Reyher, MSN, RN, is a member of the nursing faculty at West Texas A&M University in Canyon, Texas, and has 42 years of experience in healthcare. She notes that while some older patients may be tech savvy, doctors shouldn’t make any assumptions.

“Many don’t own a computer and don’t have internet access,” she says. “A critical issue that many older patients fear is that they will be overlooked because they are elderly. Senior adults worry that they are viewed as helpless and hopeless, which is very discouraging to them.”

Even something as simple as how you address patients may benefit from some generational awareness, notes Reyher. Younger patients are used to being called by their first names right from the beginning. Older adults should always be addressed as Mr, Mrs, or Ms, until they ask to be called by their first name, advises Reyher.

“It seems like a no-brainer, but you can never go wrong by being respectful — with all ages,” she continues. “Too often, patients feel that everyone is rushed; they are viewed as another item on the checklist and no one has time to hear their concerns. Most patients are fearful. All of us in healthcare need to guard against being oblivious to these fearful situations and take the time to let the patient — of any age — know that they are in safe hands and that we’re here for them. All patients respond positively when they know that we care.”

**Keith Loria** is an award-winning journalist who has been writing for major newspapers and magazines for close to 30 years.
How to Know if This Promotion Is Right for You

by STEPHANIE STEPHENS

You’ve just been offered a promotion. Congrats! This should be great or you — and your career.

But hang on. Not every promotion is the right fit. The wrong one can kink a career path instead paving the way forward.

David Wildebrandt, a managing director at the Berkeley Research Group’s healthcare practice, notes that promotions and leadership are earned privileges and not given rights. If most of the following are applicable, then you should think “go” and not “no” about this promotion.

· The promotion is aligned with your capabilities and not occurring just because someone left the organization so now there’s a void to fill. For people who should be already working at this level, the promotion is an acknowledgment of their abilities.
· It is matched with your skill set and allows you to showcase your hard and soft skills.
· It’s not a high-risk venture in general, meaning you can feel safe taking this next step. This should be a calculated risk to push yourself, but you also need to be realistic.
· You can actually see and understand what success looks like in this next role. Clarity is everything.
· You don’t have to do a lot of soul-searching or think about reinventing yourself because the promotion means a role that seems to require totally new or unpredictable skill sets.
· You have a clear understanding of what your team looks like and a feeling of how they will work with you. You shouldn’t have to use a lot of “I” statements because your job will be less about you, and more about successfully developing the people under you.
· Your future hiring philosophy will be to replace yourself, and you’ll have the bandwidth and scope to do just that. You have the support of the organization to assemble the team and resources you need instead of having to be a superstar every day to get it done yourself.
· If you are switching employers, is the new employer keeping up? Does your new employer make sure the customer is at the center of everything and offers customers the technology and access they are used to in other facets of their lives?

"Anyone in the post-ACA era of operational efficiency and reimbursement degradation must understand how to deliver high-quality care and services while receiving less," says Kevin Groves, PhD, an associate professor of management at the Pepperdine Graziadio Business School in Malibu, California, and president of Groves Consulting Group, a succession-planning and leadership talent development firm. Here are some of the attributes of a job or an employer that he advises clients to be on the lookout for:
· The organization is cognizant of the mass consolidation taking place in healthcare and is reacting appropriately with a well-aligned, integrated delivery model.
· The top management team has stability and longevity in defining the strategic direction of the organization. Research shows that when a CEO departs, half of the top team will also leave.
· Succession planning and the talent development process are robust. Management is methodical and thoughtful about both.
· You sense that your own career interests and needs are being weighed and valued as you’re being considered for the promotion.
· If it’s a smaller organization, you will have opportunities to exert a broader influence and engagement in different functions and business units as you seek to broaden your own capabilities and skill sets. Some might be more external-facing, perhaps with involvement in, for example, fundraising.
· There is a perceived or real sense of alignment of working styles that complement those of the CEO. Executives are willing to collaborate with you on specific areas such as operations and finance. There’s a strong, symbiotic relationship between a well-developed board and the CEO.
· Your career won’t stall once you accept the role, and career development is supported.
· The organization utilizes a comprehensive onboarding and acculturation process — a formal transition experience throughout the first year that effectively facilitates one’s transition into a new organization and local community. Management knows that where you live and what you can do there when you’re not working is as important as the work you do.

If much of the above applies to your next healthcare job opportunity, chances are you’re on your way to a rewarding new chapter, your professional life. Congrats! If it doesn’t, pause and consider.

Stephanie Stephens, MA, is a journalist, producer, and host in Orange County, California.
They say healthcare is a team sport, but teams can sag, get discouraged, lose focus, and stop functioning as, well, a team. Anyone in a leadership position must stay attuned to how the team members are feeling and keep people motivated. Keeping your team motivated and maintaining enthusiasm requires attention, creativity, and planning.

Here are five examples of how healthcare organizations have worked to keep motivation high:

**Turn in, turn on the bright ideas**
UMass Memorial Health Care, in Worcester, Massachusetts, uses the "idea system" to motivate teams to transform care delivery and save lives. For example, the neonatal intensive care unit's (NICU) pharmacy team wanted to reduce the time it took to provide antibiotics to its most vulnerable patients. These changes included streamlining the process for a clinician to order an antibiotic and having it verified and prepared by a pharmacist. As a result of the NICU pharmacy team's work, the time to get critical medications to sick infants dropped from 75 minutes to 53. Since the idea system started six years ago, team members at UMass Memorial have submitted more than 78,000 ideas, says Eric W. Dickson, MD, president and CEO.

**Rest and recharge with team members**
Kelly M. Johnson, PhD, RN, NEA-C, vice president of patient care services and chief nursing officer at Stanford Children's Health in Palo Alto, California, brings together members of the patient care services team at the end of the fiscal year at a retreat to reflect, recharge, and connect. "We share and celebrate accomplishments in the division and solidify priorities for the coming year. More importantly, the time is critical for team building, self-care, and reflection on the important work we do," says Johnson, who's also chief nursing officer at the hospital, which provides pediatric and obstetric care in the San Francisco Bay area.

**Recognize team members' triumphs**
Cigna finalized its acquisition of Express Scripts in December 2018. During the integration, the company featured a "Thursday Thank You" segment on its intranet to celebrate team members' successes, says Kristen Gorodetzer, senior vice president of total rewards, talent acquisition, and employee services at Cigna. "The intranet posts focused on a different team each week and garnered significant engagement by because "people want an opportunity to say thanks to each other," she says. Gorodetzer.

**Use team huddles to solve problems**
Patients calling to schedule appointments with UMass Memorial's call center were waiting an average of 11 minutes, up from between 40 to 50 seconds. That spike in wait time was driven by the healthcare system's electronic health record implementation, says Dickson. He credits a dedicated leader on the call center team with using daily team huddles to sustain team members' enthusiasm for streamlining the call greeting, activating an auto-answer feature to remove the 18-second ring cycle, and shortening the pre-recorded appointment information.

The end result is that the average call wait is now 5.6 seconds; it has been maintained by continuing to meet daily, review metrics five times a day and providing training when necessary.

**Add the fun factor**
Sujata Sanghvi, deputy chief financial officer at AllWays Health Partners, a Somerville, Massachusetts, not-for-profit payer, says recognition of employee success is crucial. "It's not only important for leaders to recognize their teams but also to encourage their teams to recognize each other," he says. Sanghvi has a few ideas to make it fun: tie it to a reward, a raffle, even a silly rotating "trophy" to highlight the recognition.

"By integrating opportunities like these into your regular practices, you can help create a sense of camaraderie to build a high-performing team that takes pride in their work and can depend on one another," she says.

Aine Cryts is a writer based in Boston.
Ten Habits That Lead To Success

by MICHELE MEYER

Your success depends on more than your vision and long-range planning. What you do in the short term — indeed, each day — can make you a more effective leader and colleague, help the bottom line, and tilt probabilities toward your success.

Top healthcare executives shared 10 surprising ways to up your game daily with Managed Healthcare Executive.

1 Write thank-you notes
Jennifer Vachon, executive vice president at Blue Cross Blue Shield Association in Chicago, ends her workday with emails thanking staffers. “We tend to quickly move to the next thing, but this forces me to reflect,” says Vachon, who may commend a small gesture or a major effort. “It doesn’t take long but means so much to my team, making it a great time investment.”

2 Learn staff members’ names and special traits
A casual conversation led to a daily resolution for Mooyeon Oh-Park, MD, MS, senior vice president and chief medical officer at Burke Rehabilitation Hospital. Oh-Park had just joined the physical rehab center in White Plains, New York, when an employee revealed knowledge about what her job required. “Our strength as an institution is the diversity of our people,” she says. “I develop closer connections and know who can troubleshoot creatively.”

3 Hold morning huddles to problem solve
At Stanford Health Care in Palo Alto, California, leaders hold daily 15-minute meetings with their teams to brainstorm solutions for the day’s challenges. “It helps formalize touching base with your team each day,” says Alpa Vyas, vice president of patient experience. “Leaders understand what needs to be done, and employees are less reluctant to report problems because they know there’s a mechanism to solve them.”

4 Use your commute to bone up on business skills with audiobooks
Alexander Ronzino, founder and CEO at Coalition Recovery, a substance abuse treatment center in Tampa, Florida, listens to nonfiction management and finance books en route. “I find the perspectives of CEOs and entrepreneurs most candid and useful versus those of management consultants.” Military strategy and priority-setting audiobooks are most appealing to Oh-Park. Her recent favorites are “Essentialism: The Disciplined Pursuit of Less” by Greg McKeown and “The Art of War” by Sun Tzu.

5 Smile and breathe deeply
“During moments of high anxiety, I noticed my mood could be felt by those around me — and was
infectious,” says Oh-Park. “That didn’t help anyone.” Smiling eased her distress and the distress of others. “A positive mindset helps us find the best solutions.”

6 Get in early, before the members of your team
It pays to arrive a half-hour to an hour before anyone else, say several healthcare executives. “I never was a morning person — until I opted to become one,” quips Ronzino. The extra time and clear head give him a chance to prepare mentally and adjust his schedule to face potential challenges. “It’s made a tremendous difference in my overall productivity,” says Ronzino. Likewise, Ernie Schwefler, chief contracting officer for the University of Southern California’s Keck School of Medicine, arrives early to focus “before fires have to be put out. Knowing my priorities enables me to be nimble.”

Rhonda Mims, executive vice president and chief public affairs officer at WellCare Health Plans in Tampa starts her workday at home with her eyes shut and mind open. “That helps balance me,” she says, adding that as a mother it’s her sole chance at solitude. “I run through any talking points mentally.”

7 Prepare for the next day before leaving the office
Karen Murray, MD, physician in chief of Cleveland Clinic Children’s and president of the Cleveland Clinic Children’s Hospital for Rehabilitation, ends her day by getting ready for the next one. She might study an applicant’s CV, review the topics to be discussed at a meeting, or reserve time to talk with influencers. “I walk into the office with clear goals and the security of knowing people’s likely decisions,” says Murray.

8 Truly listen
Talking can be so easy, especially if others believe they must listen to you because you’re the boss. But Murray strives to listen — and listen intently. “Ultimately, everything is my responsibility,” she says. “So, if someone comes to me with an opportunity or concern, I try to really hear what they’re saying and what they’re not saying.”

9 Touch base with subordinates informally
Don’t wait for organized meetings to check in with your team, suggests Schwefler. He keeps his door open and regularly strolls through the workspace to speak with his team. “You have a view of what’s happening in your organization, but those in the trenches may have a different one,” Schwefler says. For Ronzino, “casual chats foster a culture of collaboration and result in projects getting completed faster.”

10 Schedule tasks for when you will do them best
With so many roles at Cleveland Clinic, Murray is careful to block out time for each function, whether it is an administrative task, a clinical visit, or writing papers. “I block time for what I’m most productive at that task,” she says. She also checks in with staff beforehand. “Medicine is a team sport, and the workflow needs to be best for everyone involved.”

Michele Meyer is a freelance writer from Houston.
We are not finished.

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