Is Healthcare Ready for BLOCKCHAIN?
Advantages may run into entrenched interests
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PBMI® is pleased to announce that nominations for the 2022 PBMI® Excellence Awards are now open. These awards have been created to recognize and honor those individuals and organizations that have demonstrated fearless innovation, a focus on the improvement of patient care, and reducing the economic burden on the healthcare delivery system.

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PBMI® is now accepting submissions for presentations for the 2022 PBMI® Annual National Conference next September in Orlando. All submissions are due February 28, 2022.

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In this issue of Managed Healthcare Executive®, we have an example of something that is new in healthcare — and also something that is tried-and-true, a throwback to an earlier era.

The “something new” is blockchain. As Jared Kaltwasser writes in our cover story, if you have heard of blockchain, it is probably in the context of cryptocurrencies. So much in healthcare depends on the storage and flow of information and data. Blockchain involves recording data in digital ledgers that are shared across various computer systems. It would replace the client-server database management systems on which the healthcare industry currently depends, systems that a healthcare organization can control but that are also prone to security breaches. As with all new technology, there are major technical challenges to blockchain, to say nothing of the expense of adopting a new way of handling data. IT departments would need to be revamped. But, as Jared reports, the bigger obstacle may be the disruption that blockchain would bring to an industry that has a strong tendency to possess and silo data.

The something that is tried-and-true is delivering healthcare at home. Going back a century or more, healthcare delivery has been migrating out of the home and to hospitals, to outpatient facilities and to physician offices — and with good reason. Medical advances required more sophisticated equipment than what could be carried in a doctor’s black bag. And there were certainly some efficiencies to having patients come to a physician’s office or a hospital instead of the physician traveling from house to house, making old-fashioned house calls. But the COVID-19 pandemic, as well as the expense of hospital and nursing home care, has swung the pendulum back some to delivering care at home — and to delivering the kind of care that lets people stay in their homes. In this issue, Joseph Burns looks at efforts such as the Program for All-Inclusive Care for the Elderly (PACE) that have a track record of preventing hospitalizations and reducing costs.

Progress requires looking ahead to possibilities such as blockchain. But sometimes, as with care delivered in the home, a backward glance can also help if we have the imagination to adapt past practices to meet our current challenges.

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Cost of Aduhelm is more than just the price of the drug

Aduhelm (aducanumab) has been dogged by controversy for many reasons, including questions about the quality of the evidence for its efficacy. But its cost has also stirred the pot. In an attempt to blunt that criticism, Biogen slashed the price in half late last year, from $56,000 to $28,200 per year. In November 2021, before Biogen announced the price cut, CMS announced a 14.5% increase in 2022 Medicare Part B premiums. The premium hike was attributed, in part, to the added cost of covering Aduhelm.

Most of the discussion about Aduhelm’s cost has focused on the price of the drug itself. But a research team led by John Mafi, M.D., M.P.H., of UCLA has put a spotlight on the other costs associated with Aduhelm prescriptions. According to their calculations, about 20% of the cost of Aduhelm would come from spending on positron emission tomography (PET) and MRI scans and other “ancillary” services that Aduhelm prescriptions will trigger.

Before the CMS proposal that might restrict coverage to those enrolled in sanctioned clinical trials, Mafi and his colleagues projected that 1.1 million people might be eligible for Part B coverage of Aduhelm in a “lower bound” estimate that assumes prescribers would stick to the criteria used in the late-stage clinical trials of the drug. Their “upper bound” estimate is 5.7 million people.

Based on those estimates and a projection that 25% of those eligible would be prescribed and take Aduhelm, Mafi and his colleagues found that Medicare spending on the drug could range from $7 billion per year, $1.4 billion of which would be for ancillary services, up to $37.4 billion, $7.5 billion of which would be for ancillary services. They reported their results in JAMA Health Forum, a JAMA spinoff devoted to health policy and public health.

Some of the ancillary services included in these calculations are PET scans ($2,300 per year per patient on average, counting the patient coinsurance), routine MRIs ($555), apolipoprotein E serum testing ($100 per patient), and hospitalization for adverse events ($294).

One of the important predicates for calculations made by Mafi and his colleagues is that a large percentage (41% of those on the highest dose) of the patients in the pivotal clinical trials of Aduhelm developed amyloid-related imaging abnormalities (ARIA) characterized by fluid retention and microhemorrhages in the brain. The ARIAs weren’t necessarily serious or symptomatic, but they would likely mean additional MRI scans and visits with neurologists.
In Brief

The role that HIV antiretrovirals could play in protecting people against COVID-19 is an intriguing subplot that has emerged from the research into COVID-19 among people with HIV. A study published in the Annals of Internal Medicine in October 2020 looked at the incidence and severity of COVID-19 among people with HIV taking antiretrovirals. The study, which was conducted in Spain, included 77,590 people with HIV who were being treated with antiretroviral therapy, 236 of whom were diagnosed with COVID-19 and, of those, 151 were hospitalized and 20 died from the disease. When a team of Spanish researchers led by Julia de Amo, Ph.D., analyzed patients by type of antiretroviral, they found that those taking Truvada (tenofovir disoproxil fumarate and emtricitabine) were 57% less likely to be diagnosed with COVID-19 than those taking Descovy (tenofovir alafenamide and emtricitabine) and 48% less likely to be hospitalized. Similarly, they found a lower risk of diagnosis (37%) and hospitalization (20%) among patients at three hospitals that treated patients predominately with Truvada compared with the patients at 27 hospitals that predominately treated patients with Descovy.

Results from a study conducted in South Africa in 2020 also suggest that Truvada might fend off COVID-19. Miguel Hernán, senior author of the study in the Annals and a professor of epidemiology and biostatistics at the Harvard T.H. Chan School of Public Health, said the researchers are looking to find a sponsor for a trial that would test whether Truvada could be used as an antiviral treatment for anyone with COVID-19. "Given that it is a generic drug, the study is more likely to be funded by a government agency or a nonprofit institution," Hernán said in an email. Hernán is also co-study chair of a randomized trial designed to test whether Truvada might be taken to prevent COVID-19 in the same way it is taken on a pre-exposure prophylactic basis for HIV. The trial also tested whether hydroxychloroquine might be used for COVID-19 prevention. It started in April 2020 with the goal of enrolling 4,000 healthcare workers in Spain. As vaccines became available, the enrollment goal was impossible to meet. Hernán says a paper describing the trial is now under review.

Truvada for COVID-19 protection?

In Brief

Listen to our podcasts!

Telehealth use and finding solutions in health equity have been one of many hot topics in healthcare, lately. In one of our latest episodes of the “Tuning In to the C-Suite” podcast, we hear just that from Briana Contraseras, editor of Managed Healthcare Executive®, and guest Ian Tong, M.D., chief medical officer of Included Health. Contraseras and Tong discuss telehealth use vs. in person care, and more specifically, the racial and ethnic differences in this use of care. The conversation closed with how telehealth use continues to expose more benefits for patients and for the industry through examples like improvements in reimbursement policies and in addressing health equity issues.

“Tuning In to the C-Suite,” is MHE’s home podcast and features healthcare professionals, leaders and executives talking with our editors about the most important issues in managed care — healthcare overall — of the day. Have a suggestion for a future guest? Please drop Editor Briana Contraseras a line at BContraseras@mjlifesciences.com.

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Despite decades of research, there is still no vaccine against HIV. As a result, pre-exposure prophylaxis (PrEP) has emerged as the most promising preventive strategy against the virus that causes AIDS. PrEP is the use of antiretroviral medications by HIV-negative individuals who are at risk of contracting the disease to reduce that risk. But the PrEP regimens have involved taking a pill on a daily basis, which makes them candidates for nonadherence.

On Dec. 20, 2021, the FDA approved Apretude (cabotegravir extended-release injectable suspension), the first injectable formulation of PrEP. Instead of daily pills, Apretude will involve getting an injection in the muscle of the buttock by a healthcare professional every other month, (the first two shots are given a month apart).

“It will not be for everyone; some people may want to continue with a daily oral pill,” notes Carl Schmid, executive director of the HIV+Hepatitis Policy Institute, an advocacy organization funded by several pharmaceutical companies. “They are fairly easy to take and there are limited side effects.”

Gilead’s PrEP formulation, Truvada (tenofovir disoproxil fumarate and emtricitabine), was approved in 2012. The company also developed Descovy (tenofovir alafenamide and emtricitabine) for PrEP.

Generic versions of Truvada have come on the market since, particularly in the past year, and prices have dropped. GoodRx’s lowest price for a 30-day supply of the most common version of generic Truvada is about $35, although under the ACA, health plans are required to cover 100% of the cost of the PrEP because it is deemed a preventive service.

Use of PrEP has fallen off during the pandemic, partly because people haven’t been socializing in person as much and engaging in the risky behavior that would warrant taking the antiviral medications on a prophylactic basis. But before the pandemic, prescriptions were increasing. CDC says about 25% of the 1.2 million people for whom PrEP is recommended were prescribed it in 2020, compared with about 3% in 2015. The agency credits PrEP and other factors with reducing the HIV incidence. New infections fell from 37,800 in 2015 to 34,800 in 2019, an 8% decrease.

Drugmakers are also working on long-acting drugs for HIV treatment as well as for PrEP. The FDA approved Cabenuva (cabotegravir and rilpivirine, injectable formulation), an injectable, once-a-month HIV treatment, in January 2021. Most companies involved in HIV research are developing long-acting drugs for both treatment and prevention, Schmid says. “We are at the beginning stages for both and can look forward to once-monthly oral regimens, once-every-6-month injectables, or once-a-year implants in the future.”

Theodore Gideonse, Ph.D., an assistant professor of teaching, program in public health, at the University of California, Irvine, notes that Gilead also has a very promising injectable for both treatment and PrEP called lenacapavir. “It is a bit further away from approval, but it will be a huge deal if and when it’s approved,” he says. That approval may be a ways off, though. In December, the FDA put a hold on trials of injectable lenacapavir because of concerns about vials made of borosilicate glass and the formation of subvisible glass particles in the solution. Merck’s investigational HIV drug, islatravir, has also run into problems. The FDA put a hold on trials of islatravir in December after the drug was associated with drops in lymphocyte and CD4 cell counts.
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Tired of grappling with the rising costs and poor quality of healthcare, a coalition of major healthcare purchasers is taking things into its own hands, establishing a company that is designing healthcare products to meet its members’ needs. “There’s an incredibly high frustration level among buyers of healthcare,” says Elizabeth Mitchell, president and CEO of the Purchaser Business Group on Health (PBGH) in San Francisco. The nonprofit PBGH represents almost 40 large private employers and public entities that together spend $100 billion each year on healthcare services for more than 15 million Americans and their families. PBGH members include Microsoft, Walmart and American Airlines.

The decision to create the company, Emsana Health, was made about two years ago, with the initial focus on “really understanding the needs on a deep level,” Mitchell says. The company officially launched in the fall, and its first venture is setting up a pharmacy benefit manager (PBM), EmsanaRx, which went started operating on Jan. 1.

EmsanaRx CEO Greg Baker says the PBM is different from its competitors because it was designed to answer to its group members. One of its objectives is to provide members with sound, actionable data, such as what drugs actually cost, as well as information on discounts and administrative fees, Baker says. Companies that use EmsanaRx will pay a fixed price per prescription and a fixed fee to EmsanaRx.

“We do hear the traditional PBMs talk about doing the right thing for their clients, being that a counterweight to the manufacturer, being that intermediary that America needs,” says Baker. “I guess I just fundamentally disagree with that.” Baker says PBMs may be passing on rebates to their clients, but they also charge a variety of fees: “Now I have got a formulary placement fee and a clinical management fee and price protection fees, and those fees do not benefit the employer. Those fees all go back to the PBM.”

Baker says the traditional PBMs often use long, complex contracts that are difficult for clients to understand. EmsanaRx will use simple-language, eight-page contracts, he says, and data will be shared in a way that clients can understand. The account managers will be clinical pharmacists.

EmsanaRx is operating as a for-profit company with shares owned primarily by PBGH and its members. There are also some outside investors. Baker, who wouldn’t disclose their identities, describes them as well-funded individuals looking to bring innovation to healthcare. He says there isn’t pressure on the nascent PBM to generate major profits and describes a three-year plan that involves serving the first clients this year, some PBGH members in 2023, and ramping up to becoming a full-fledged PBM in 2024. “We’ll try to nudge this PBM industry into a better place. But it is really, ‘let’s start slow, let’s be deliberate, let’s do it right.’”

“We’ll try to nudge this PBM industry into better place. But it is really, ‘let’s start slow, let’s be deliberate, let’s do it right.’” —GREG BAKER, CEO OF EMSANARX

Susan Ladika is an independent journalist in Tampa, Florida, who writes about healthcare and business.
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Maternal mortality: Rare but too common

The U.S. maternal mortality rate has been increasing and is the highest among comparable developed countries. by KAREN APPOLD

Maternal mortality can be viewed as a rare event. The rate in the United States is roughly 20 maternal deaths per 100,000 births. Put another way, there are about 700 deaths among the approximately 4 million people who give birth each year.

But seen through a different lens, there are far too many maternal deaths. Experts have found that 60% are preventable, and the U.S. has the dubious distinction of having highest maternal mortality rate among comparable developed countries.

By some estimates, American women today are 50% percent more likely to die because of pregnancy-related health issues than their mothers were, notes Courtney Furrow-White, M.P.M., RN, program director of performance improvement collaboratives at Vizient, a healthcare services company based in Irving, Texas. Focusing exclusively on maternal mortality also misses the larger picture because for every death, hundreds of women experience health difficulties related to pregnancy and birth that can cause serious consequences.

The U.S. healthcare system is poorly equipped to deal with maternal mortality and pregnancy-related health issues for many reasons. Postpartum care is patchy, partly because insurance coverage is. The relative rarity of maternal mortality can translate into lack of readiness. "Because maternal death numbers are relatively small, hospitals sometimes lack the preparation to deal with rare or catastrophic complications," says Furrow-White. "Hospitals have historically put more effort into managing medical emergencies that happen every day and not those that might occur every couple of years depending on a hospital’s size and location."

The issue of maternal mortality has come to light in recently partly because unreliable U.S. maternal mortality data had kept the problem under the radar. In 2003, the CDC added a checkbox to death certificates, which was to be marked if the deceased was pregnant or postpartum, says Furrow-White. It wasn’t until 2017 that all states implemented the protocol.

Many factors cause pregnancy and childbirth to remain unusually risky in the U.S. Based on recent CDC data, the leading causes of pregnancy-related deaths are cardiovascular conditions, infection, and hemorrhage. However, it’s increasingly recognized that the cause varies depending on when the death occurs — during pregnancy, during childbirth or afterward, notes Stephanie Leonard, Ph.D., an epidemiologist at Stanford University School of Medicine.

Leonard’s Stanford colleagues found that comorbidities such as hypertension, asthma, heart disease and other chronic conditions have increased among people having children over the past 15 years. Those conditions are associated with the growing rate of maternal morbidity — outcomes during pregnancy, birth and the postpartum period that are short of mortality but have health consequences.

Maternal mortality is often misunderstood as death during childbirth, but maternal mortality includes periods before and after labor. The inadequacy of postpartum care is a major contributor to maternal mortality, notes Yenupini Joyce Adams, Ph.D., RNC-MNN, visiting assistant professor of global health at Notre Dame’s Keough.
School of Global Affairs. CDC data show that 37% of maternal deaths occur one to 42 days after birth and an additional 23% occur 43 days to one year after birth. “The postpartum period is the time of highest risk for maternal deaths, and mortality risks extend to one year after birth,” says Adams. “Most maternal deaths are from preventable obstetric complications, especially during the postpartum period. There is an urgent need to focus more on access to, and quality of, postpartum care.”

Despite the overall advances in healthcare technology and that the U.S. spends more on healthcare than any other country, there are still disparities in maternal care in the U.S. “Oftentimes, maternity care in the U.S. fails women by not being accessible, safe, equitable, evidence-based or affordable,” Furrow-White says. “Social determinants of health play a major part on the impact of people’s health and well-being.” Factors such as wealth, education, access to health insurance, food security and housing (to name just a few) affect people’s health and therefore birth outcomes.

**High rates among Black women**
The maternal mortality rate for Black women is higher than the rates for any other demographic group; it is a difference that goes back a century, Adams notes. In 2019, the last year for which statistics are readily available, the maternal mortality rate for non-Hispanic Black women was 44 deaths per 100,000 live births, 2.5 times the rate for non-Hispanic White women (17.9 deaths per 100,000 live births), and 3.5 times the rate for Hispanic women. Studies of maternal mortality have shown that Black-White disparities increase with age: The gap is narrowest among women younger than 20 years and highest among those aged 30 to 34 years. Education is not a mitigating factor: Among women with a college education, the pregnancy-related mortality ratio (a statistic similar to maternal mortality) is 5.2 times higher among Black women than among White women.

Several factors contribute to racial disparities in maternal deaths, including differences in access to care and prevalence of chronic diseases, Adams says. Risk factors such as obesity and gestational diabetes are prevalent in Black women. In addition, Black women are also more likely to be readmitted after birth and to suffer life-threatening postpartum complications. Moreover, community determinants such as transportation options and inadequate housing have been shown to contribute to maternal mortality.

Obstetric complications such as hemorrhage, hypertensive disorders, sepsis, cardiac disease, venous thromboembolism, and pulmonary embolism are the leading causes of maternal deaths in the U.S. Among Black women, however, cardiomyopathy, thrombotic pulmonary embolism and hypertensive disorders of pregnancy are major contributors to maternal deaths. While hemorrhage and infections occur more frequently in the immediate postpartum period...
six weeks after a pregnancy is over, conditions such as cardiomyopathy can occur much later after birth (45% within 43 to 365 days postpartum). "Therefore, access to quality postpartum care for up to one year after birth is especially important for Black women," says Adams.

Researchers at the Rutgers Robert Wood Johnson Medical in New Brunswick, New Jersey, reported findings in the journal Hypertension showing that Black women having children are between three to four times more likely to die from hypertension-related causes than their white counterparts. Their research into maternal deaths from 1979 to 2018 shows that deaths associated with preeclampsia and eclampsia have dipped, while those associated with chronic hypertension have gone up. In this context, chronic hypertension is defined as hypertension before pregnancy or during the first 20 weeks. Obese women and those giving birth when they are in their late 40s also had an elevated risk of maternal death that was associated with hypertension.

Several studies show that maternal deaths among Black women extend beyond preexisting educational and socioeconomic inequities that contribute to poorer access to care. Adams points out. Institutional racism across many levels of America’s healthcare system and implicit bias among healthcare providers also factor into the higher maternal mortality among Black women.

**Fixing the problem**

Maternal mortality has not gone unnoticed. Many healthcare organizations and other entities are working on the problem, notes Rikki D. Baldwin, D.O., FACOG, an obstetrician and gynecologist at Memorial Hermann Health System in Houston. The American College of Obstetricians and Gynecologists (ACOG) has been working with the U.S. government and leaders in women’s healthcare to address high maternal mortality rates. The organization spearheaded the creation the Alliance for Innovation on Maternal Health (AIM), a national, data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improve maternal safety and outcomes. There have also been efforts to optimize postpartum care and to standardize the levels of maternal care.

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**Fixing the problem**

Maternal mortality has not gone unnoticed. Many healthcare organizations and other entities are working on the problem, notes Rikki D. Baldwin, D.O., FACOG, an obstetrician and gynecologist at Memorial Hermann Health System in Houston. The American College of Obstetricians and Gynecologists (ACOG) has been working with the U.S. government and leaders in women’s healthcare to address high maternal mortality rates. The organization spearheaded the creation the Alliance for Innovation on Maternal Health (AIM), a national, data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improve maternal safety and outcomes. There have also been efforts to optimize postpartum care and to standardize the levels of maternal care.

Several studies show that maternal deaths among Black women extend beyond preexisting educational and socioeconomic inequities that contribute to poorer access to care. Adams points out. Institutional racism across many levels of America’s healthcare system and implicit bias among healthcare providers also factor into the higher maternal mortality among Black women.
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Is Healthcare Ready for BLOCKCHAIN?
Advantages may run into entrenched interests

By JARED KALTWASSER
In some ways, blockchain seems like a perfect fit for the healthcare industry, yet the data security architecture also “flies in the face” of entrenched healthcare business models.

Blockchain technology is known for being careful and cautious, so one could be forgiven for assuming that healthcare and cryptocurrency have little in common. While the healthcare industry demands safety and risk-mitigation, cryptocurrency is built on a high-risk, high-reward model in which a tiny investment can turn into a fortune and back again at the speed of an eccentric billionaire’s tweet.

Yet the backbone of cryptocurrency — blockchain technology — could soon be a very important part of the healthcare industry. Although best known for its association with cryptocurrency, opaquely named blockchain is actually a novel type of data-storage architecture with many potential applications.

Invented in 2008, the technology involves recording data in distributed ledgers that are duplicated across various computer systems (blocks) within the network (chain). The transparency and redundancy in the system provide a level of data security that previously was hard to attain. It means if one computer system in the blockchain is compromised, the flaw would immediately be obvious to the other systems on the chain. Instead of allowing cybercriminals to steal data in the dark recesses of the internet, blockchain forces would-be data thieves to operate under a spotlight.

HEALTHCARE’S HESITANCY

Given rising cases of ransomware attacks and rising concerns about medical privacy in general, blockchain might seem like a godsend for the healthcare industry. Yet that potential has yet to translate into a quick embrace of the technology.

Tony Little, vice president of solutions architecture at Prescryptive Health, a technology company that provides blockchain-enhanced products and services to the healthcare and pharmacy industries, said it’s nothing new for healthcare entities to be cautious around new technology.

“Case in point, it took government regulation in 2009, in the form of the HITECH Act, to push the industry to adopt the electronic medical record by generously offering money to health systems to implement,” he tells Managed Healthcare Executive.

Little says some of the earliest moves have come in the form of experiments and pilot programs like the Synaptic Health Alliance, which is seeking to streamline provider directories, and the Health Utility Network, which is aimed at improving coordination of benefits. Though such programs are limited in scope, they involve major players in the health insurance industry, including Aetna, Anthem, UnitedHealthcare, and Humana.

PATIENT EMPOWERMENT

Xudong Huang, Ph.D., of Harvard Medical School, believes patients will be a big winner in the blockchain era.

“Compared to other types of data management/security, blockchain-based systems can offer both data security and data ownership at the same time, in my view,” he says.

The idea that blockchain will give patients more data ownership is based on the ability of blockchain-based systems to require patient authorization for data retrieval. In a 2019 paper, Huang and colleagues proposed using multiple-signature — “multisig” for short — contracts in healthcare blockchains. Under a multisig approach, both the patient and his healthcare provider would need to use their own private keys — essentially super passwords — in order to access the patient’s medical record on the blockchain. For patients, it would mean providers could not access their personal medical information without permission. However, it would also mean patients could not alter their health records; only the providers could. “There have been examples of multisig contracts being used in the financial field, property recording, etc.,” Huang said. “I am not aware of its application in the healthcare field.”

To Huang, the benefits of blockchain security in healthcare are about more than privacy for the sake of privacy. As a psychiatrist, one of his areas of interest is Alzheimer’s disease, a neurodegenerative disorder for which there is no known cure. One concern within the Alzheimer’s community is the potential that the presence of biomarkers for the disease could be
inadvertently disclosed in such a way that a patient might face discrimination when applying for life insurance or jobs, among other circumstances. Implementing blockchain would add a significant layer of protection, he said.

**BENEFITS FOR PAYERS**

In a 2020 review published in the *International Journal of Medical Informatics*, Alaa Abd-alrazaq, Ph.D., of Qatar’s Hamad Bin Khalifa University, and colleagues examined the benefits and potential hurdles of blockchain in the healthcare industry. They cited four key characteristics of blockchain that lead to direct benefits for the healthcare industry: immutability, decentralization, transparency and traceability.

Immutability means data cannot be changed without leaving digital fingerprints, and decentralization of data makes it harder for ransomware attackers to target hospitals and insurers because data would not be locked in a single location.

Transparency exists in blockchain because all transactions are visible to anyone with access to the blockchain, and traceability allows participants to understand who is accessing information. For instance, the ability to follow data with verifiable time stamps could help with supply chain issues by allowing vendors such as drug companies to better track their products, they added.

Little explains that blockchain can also lower costs. He noted that often when insurers work with PBMs, the PBM controls certain data, ostensibly for security reasons. “However, this arrangement leaves insurers needing PBM approval for access to this data, including for auditing purposes or to comply with government reporting,” he says. “In many cases, PBMs will charge fees to an insurer to access its own data.”

With blockchain, insurers can have ready access to necessary data without sacrificing data security. This not only cuts costs but also reduces opportunities for error, he adds.

**ENTRENCHED INTERESTS**

But while companies needing access to data might benefit from a more open, decentralized model, that would leave companies that thrive on such access in a losing position. Little notes that many of the most profitable sectors of the modern healthcare economy are built around acquiring and storing data and data-powered services.
Using a blockchain faces in the face of those traditional models, and it is hard for incumbents to get past this to use the technology to solve the big problems that plague the industry, Huang says. He says another issue is how blockchain could change the role of so-called big data in healthcare or whether it will change things at all. Increasingly, healthcare companies and academic researchers have relied on the creation or acquisition of massive datasets to come up with medical insights that would have been impossible in a previous era. “Siloing” data might be problematic in many ways, but the very presence of massive datasets is part of what makes big data healthcare analytics possible.

But blockchain could actually help—not hurt—big data breakthroughs. "An easy solution for this is any de-identified patient’s data can be released to a public database for easy access," he says. "The way Huang sees it, blockchain might make it easier to do data analytics, by broadening and simplifying access among vetted entities with access to the blockchain on which the data are stored.

GENERATING INCENTIVES

As Huang explains, some blockchains are completely public while others are private or based on a permissions system that controls access. The protocol behind the public blockchains, like those associated with cryptocurrencies, is built to generate digital "tokens" that can be sold to help offset the costs of the system, Little says. However, healthcare-focused blockchains use systems with access limited to authenticated entities. Prescryptive, for instance, has partnered with ConsenSys Health, which created a permission-based blockchain product called Quorum Blockchain Service. Permission-based blockchains are a better fit for highly valuable data like medical records, but absent a built-in revenue-generating mechanism, they must win clients based on the potential for cost savings.

"The economic incentive to run a node on a permissioned blockchain proves to be a major hurdle," Little says. "Using the lower audit cost and data sharing may be enough to overcome these concerns, but it adds to the reasons why incumbent players, who hold data today, are unwilling to share, even for the common good."

Jared Kaltwasser, a frequent contributor to Managed Healthcare Executive®, is a freelance writer in Iowa.
There’s no place like home. That is also true for healthcare.

Keeping older people in their homes has cost and care advantages. Yet Medicare and Medicaid are still geared toward paying for care in institutionalized settings. by JOSEPH BURNS

When deaths due to COVID-19 spiked in nursing homes and long-term care settings, the desperate need for better options to keep seniors safe and cared for became clear.

The clearest, simplest choice: Keep older people in their homes. Doing so not only cuts costs but also, when done properly, means better care, according to health plan executives and others who have studied options for home- and community-based services.

The problem with delivering care to older adults at home is that the healthcare system is oriented toward having almost all patients get care in doctors’ offices and even in more costly places, such as hospitals and nursing homes, says Edward McEachern, M.D., executive vice president and chief medical officer for PacificSource Health Plans, a nonprofit health insurer serving members in Idaho, Montana, Oregon and Washington. Traditionally, Medicare and Medicaid programs have also contributed with benefits that cover care in nursing homes and other facilities after hospitalization if people have trouble with living independent-ly and managing the “activities of daily living,” such as bathing, cooking or cleaning, according to Sarah L. Szanton, Ph.D., dean of the Johns Hopkins University School of Nursing. Szanton helped develop the nursing school’s Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program (see “Johns Hopkins program saves money” on next page). The program is now available at 30 sites across the country, and three states — Colorado, Connecticut and Massachusetts — are incorporating it into their Medicaid programs, according to Szanton.

“ A lot of what these patients need is things that providers and health plans don’t typically do, such as food, housing, transportation or other social determinants of health.”

—EDWARD MCEACHERN, M.D., EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER FOR PACIFICSOURCE HEALTH PLANS

Later this year, PacificSource plans to introduce one of the initiatives that health insurers use to keep their members who are eligible for both Medicare and Medicaid at home: the Program of All-Inclusive Care for the Elderly (PACE). The program provides medical and social services to those who are frail and older but who are still capable of living in a place other than a nursing home or a long-term care facility. Most PACE participants are “dual eligibles,” which means they can enroll in both Medicare and Medicaid. They are typically old enough (aged 65 and older) to enroll in Medicare and have a low income to qualify for Medicaid, although the income thresholds for Med-

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people can be insured by Medicare, Medicaid or both. But PACE is available only in states where the Medicaid program has agreed to offer it. Requirements include being at least 55 and having a state-certified need for nursing home care while also being able to live safely in the community with the help of PACE services.

For those enrolled in PACE programs, Medicare and Medicaid pay for medical services that the PACE healthcare professionals deem necessary, such as doctor visits and hospital care and even short stays in a nursing home. PACE also covers services designed to tackle social determinants of health, such as recreational services. Most participants pay nothing, although those that aren’t covered by Medicaid pay a monthly premium for long-term care insurance and a Part D drug plan.

PACE has grown, but it is not a huge program. Since 2012, enrollment in has more than doubled to 55,000 participants in 144 PACE programs in 30 states, according to the National PACE Association, a trade group in Washington, D.C. That’s a small fraction of the more than 12 million dual eligibles.

The skewed distribution of healthcare spending is one of the arguments for doing everything possible to keep people at home. One of the best sources of data about the distribution of costs among patients is the federal Agency for Healthcare Research and Quality (AHRQ). Early last year, AHRQ reported that in 2018, 1% of patients accounted for about 21% of the nation’s total spending on healthcare. Other sources say people with chronic conditions and functional limitations that make the activities of daily living difficult are four times more likely than the general population to be among the 5% costliest users of health services. Yet during most medical visits, people’s ability to function in the community and live at home is rarely addressed. That blind spot, say experts, is one of the reasons people end up in a hospital or a nursing home instead of staying in their homes.

PacificSource’s cost distribution numbers tell the same basic story. About 10% of its 575,000 members account for about two-thirds of the insurer’s annual spending on medical care, McEachern says.

A comprehensive set of post-acute or home-based care options would allow PacificSource to cut the spending for those 58,000 high-cost members by about 33%, McEachern estimates. “That’s what we’re in the process of developing,” he says.

A primary goal of developing home-based care options is to keep members out of the hospital. To do that, PacificSource classifies members into five categories: healthy, stable, at risk, struggling and in crisis. “The struggling and in-crisis folks are easy enough to identify ahead of time because the pathophysiology of their diseases continues to progress,” he explains. Also, physicians and other providers know that when their patients have certain diseases, their functional health status could very likely decline.

The problem for PacificSource — and much of American healthcare — is that identifying future high-cost patients is easier than getting them the care they need. “A lot of what these patients need is better suited to care at home.

In addition, about 20 million people need more care than they are getting at home because they have trouble completing activities of daily living, says Szanton. “It might be difficult for them to take a shower or to get off the toilet,” she added. “They’re either getting help from a family member or they’re not. And, if they’re not, plenty of people basically sit in the chair all day. I’ve had patients who crawled into their kitchen on their hands and knees because that was the only way they could get there.”

Home-based supportive care is vastly underfunded, partly because Medicaid and Medicare policies are geared more toward institutional care, Szanton says. “Having presumptive eligibility for institutional care is just backwards,” she says.
There’s no place like home. That is also true for healthcare.

things that providers and health plans don’t typically do, such as food, housing, transportation or other social determinants of health,” McEachern notes. “These patients need a different system of support, and that’s where the PACE program can help us.”

For the past year or more, McEachern and colleagues at PacificSource have been gathering information about what works by studying the example of Fallon Health, a nonprofit health plan in Worcester, Massachusetts, that started a PACE program in 1995 and is one of the oldest programs in country.

Today, Fallon has about 250,000 members, 62% of whom are in government programs such as Medicare and Medicaid, including 1,195 PACE participants in Massachusetts and 130 members at Fallon Health’s Weinberg-PACE program.

Buffalo, New York, says Robert Schreiber, M.D., vice president and medical director for Fallon’s PACE program.

In Fallon’s PACE programs, doctors serve as primary care physicians and deliver care at home along with other providers on a clinical and support team for each participant either in the member’s home or in an adult day center, depending on which site is best for the patient, says David Brumley, M.D., Fallon’s interim chief medical officer and vice president of medical affairs. The goal is to ensure that each participant gets the proper medication and timely care for their conditions.

“Ultimately, if you do that correctly, it saves money,” Brumley continues. “If we can help them get the care they need in the place that they need it most effectively, then the financial piece will follow.” National PACE Association data show that 95% of its PACE participants live in places other than nursing homes or other long-term care settings and that Medicaid programs pay 13% less on average than the cost of caring for a comparable population getting more traditional care. PACE participants also have a 24% lower hospitalization rate than beneficiaries who are dual eligible and get nursing home care under Medicaid and fewer than one emergency room visit, on average, per member per year, according to the association.

In addition to its PACE program, Fallon runs a program called NavCare for older adults enrolled in MassHealth, the state’s Medicaid program, some of whom are dual eligible with Medicare coverage.

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NaviCare is a special needs plan for 9,200 older adults who want to remain at home but are ineligible for PACE. A primary care team works with each member to coordinate care with family members and other health care providers. In NaviCare, MassHealth and Medicare (if applicable), covers all health care costs so that most participants have no monthly premiums, copayments, coinsurance or deductibles. For NaviCare members in long-term care, however, MassHealth defines how much some patients must pay based on their income.

If needed, NaviCare members can get in-home care, including help with bathing, dressing and making meals. They also get transportation to an adult day care setting for recreation, shopping and social visits with friends and family.

Joseph Burns is an independent journalist in Cape Cod, Massachusetts.

PACE by the Numbers 30 states have PACE programs

Since 2012, enrollment has more than doubled to 55,000 participants in 144 PACE programs in 30 states

Source: National PACE Association
Difficulty gaining access to behavioral healthcare is nothing new, but the COVID-19 pandemic threw the imbalance between need and access even more askew. The pandemic has led to more people experiencing mental health conditions such as anxiety and depression disorders (or a combination of the two). In 2019, 11% of adults screened positive for anxiety or depression symptoms. In April and May of 2020, during the first few months of the pandemic, that proportion tripled to about 33%, according to U.S. Census Bureau data. Barriers to access include the ability to reach and travel to providers; provider availability; social factors, such as a reluctance to get help; and, most importantly, cost.

Access to services is especially important to Medicaid enrollees, who have also experienced increased levels of behavioral health problems during the pandemic, according to a Kaiser Family Foundation (KFF) report on Medicaid expansion of behavioral health services. The foundation’s annual budget survey of state Medicaid officials showed that all the states responding to the survey reported implementing at least one behavioral health initiative to expand access during the past couple of years by, among other things, offering crisis service and expanding telehealth. “You really see so clearly that every single state that we surveyed reported at least one initiative to expand behavioral healthcare initiatives,” says Madeline Guth, a policy analyst on the KFF and author of the Medicaid behavioral health report.

Many attempts
This isn’t the first time the government has stepped in and attempted to improve access to mental health services. The 2008 Mental Health Parity and Addiction Equity Act banned payers from making mental health coverage more restrictive than physical health coverage, although there are still plenty of parity gaps. A 1996 law with the same name ensured that large group health plans could not impose less favorable lifetime or annual mental health benefit limits compared with medical/surgical benefits. The Affordable Care Act required all health plans to categorize mental health and substance abuse disorder services as essential health benefits.

Medicaid coverage is a critical piece of behavioral health coverage in the U.S. because the programs cover a disproportionate share of the people with behavioral health issues. As of July 1, 2021, Medicaid programs in 44 states and the District of Columbia covered telehealth services for mental health issues, including audio-only services, according to Guth’s report. In the past, behavioral health services have often been carved out of Medicaid managed care contracts, which, in some cases, undercut parity. Guth’s report shows that about three-quarters of the 41 states that have Medicaid managed care programs have carved in behavioral health services.

Newer government initiatives are also addressing access to behavioral health. The American Rescue Plan Act provided expanded Medicaid funding for some behavioral health providers and crisis centers, and the Build Back Better Act, if enacted, would provide additional community mental health services funding.

One way to provide better access is through care integration. Nearly half the states in the KFF survey reported integrated services initiatives whether by allowing for behavioral health and medical service payments on the same day or providing these services in the same location. “We may be seeing elevated behavior health needs for some time to come,” notes Guth.

Deborah Abrams Kaplan writes about medical and practice management topics.
The hot new healthcare investment vehicle may soon be yesterday’s news, as company underperformance and an increased focus by regulators have decreased interest in special purpose acquisition companies (SPACs).

SPACs grabbed attention as a way for start-ups in healthcare and other industries to go public as an alternative to an initial public offering (IPO). A SPAC or “blank check company” doesn’t make any products or sell anything. Instead, it is formed by investors in order to raise money through an IPO so it can then go out and acquire another company.

The trend took off in healthcare in 2020, marked by deals such as telehealth company Hims & Hers Health’s announced merger with Oaktree Acquisition Corp., and Medicare insurance start-up Clover Health’s announced merger with Social Capital Hedosophia Holdings Corp.

By the first quarter of 2021 there were 40 healthcare and life sciences IPOs tied to SPACs, raising almost $11 billion, according to S&P Global Market Intelligence data. “It came as a whirlwind,” with impressive activity between December 2020 and April 2021, says Sari Kaganoff, general manager of consulting at Rock Health.

But in the second quarter of 2021 there were just eight SPAC deals in the healthcare and life sciences sector, according to S&P Global Market Intelligence. Now, “many in the life science sector are pursuing IPOs over SPACs because the gloss seems to be wearing off SPACs due to SEC (Security and Exchange Commission) scrutiny, the shareholder dilution that comes with SPACs and the fact companies that have gone public via SPACs have generally underperformed from a stock price perspective,” observes Steve Sapletal, healthcare and life sciences deal advisory and strategy industry leader at KPMG.

Taking off

SPACs took off in healthcare because they provide quickest exit strategy for smaller and start-up companies and are not as tightly regulated as IPOs, Sapletal says. For SPACs, “healthcare has presented opportunities to invest in assets with clear earnings visibility as well as new growth verticals such as digitally enabled healthcare service provisions or healthcare data analytics,” he notes.

Although SPACs have been around for decades, they have taken off as an investment vehicle in recent years. Harvard Business Review reported that just 59 SPACs were created in 2019, with about $13 billion invested across all industries. The following year, 247 were created, with $80 billion invested. The first quarter of 2021 saw 295 SPACs created, with $96 billion invested. In 2020, SPACs represented more than half of the new publicly listed companies in the United States, according to the Harvard Business Review.

“It’s just another form of access to capital markets,” says Peter Micca, a partner in life sciences and healthcare at Deloitte. But a SPAC merger usually takes less time to complete than an IPO, and the mergers have a fixed value “so there’s no road show to determine...
the value of the company,” comments Micca.

When a SPAC is created, it typically has 18 to 24 months to acquire a company. If that doesn’t happen, the SPAC must disband and return money to its investors, according to Sapletal. Kaganoff says that they are “very incentivized not to fail in finding a target.”

Demand for digital
Digital health has had a strong appeal to SPACs. In healthcare, “demand for technology is at an all-time high,” Micca says, and the COVID-19 pandemic only accelerated the awareness of digital health options, such as telehealth. Changes in reimbursement, licensing and regulation made it easier for providers to offer telehealth to patients at a time when many have shied away from in-person healthcare, Micca says.

In the first quarter of 2021 there were two completed SPAC mergers involving digital health companies, while nine others were announced, according to a report by Rock Health. The announced mergers included the online therapy company Talkspace and the well-known personal genomics and biotech company 23andMe. The first quarter of 2021 also saw two completed IPOs, Rock Health reported. Digital health companies that were targeted by SPACs during 2020 and the first quarter of 2021 were on average five years younger than those that did an IPO, according to Rock. SPAC targets raised an average of $43 million less in total funding than those that were involved in an IPO.

Coming down to earth
SPACs were going strong until April, when they began attracting more attention from regulators, Kaganoff says. Since the SEC began to issue more regulatory guidance, interest has slowed considerably. “It’s a little bit less wild West than it used to be,” says Kaganoff.

Although they are perhaps less of a hot ticket now, many SPACs were launched before the cooldown. At the end of the third quarter, 458 SPACs were looking for a company to acquire, and almost 70% had less than 18 months to do so, according to a KPMG report. Technology, media and telecom companies were the top targets, with more than one-third of SPACs seeking a company to merge with in those fields. But healthcare and life sciences ranked second, with 59 of those SPACs, or 13%, hunting for companies in that sector, according to KPMG.

From 2018 until the end of the third quarter, 50 mergers in the healthcare and life sciences sector had been completed, KPMG found. The estimated merger value in the sector was, on average, more than $1.5 billion.

But a number of the deals have failed to live up to expectations. Talkspace agreed to go public in January 2021 in a SPAC merger with Hudson Executive Investment Corp. The deal was valued at $1.4 billion. It debuted on the Nasdaq in June, with shares listed at $8.90. As of early January, the stock price was $1.82 per share. A year later it was trading at slightly more than $3 a share.

Looking ahead
While SPACs will continue to seek out new targets in the new year, deal activity is expected to continue to cool. Going forward, Micca expects “a modulation in all forms of access to the public market in 2022.”

Sapletal expects a substantial drop in the number of SPAC IPOs in 2022 compared with 2021. However, almost 60 SPACs are looking for healthcare and life sciences targets, “and given their finite life, they will be more desperate to make a deal.”

Kaganoff says she doesn’t expect a lot of new SPACs will be created. Even if a company might be a candidate to merge with a SPAC, some prefer doing an IPO or want to be acquired by a larger company, Kaganoff says. There are also limitations, she says, because “there aren’t that many companies that are of the size and scale to go public.”

Susan Ladika is an independent journalist in Tampa, Florida, who covers business and healthcare.
Patients Benefit with Coordinated Care Among PBM and Provider

JOSEPH LEACH, M.D.
Senior vice president, chief medical officer at Prime Therapeutics

Dr. Leach is responsible for providing clinical leadership and expertise, informing and influencing internal and external stakeholders about Prime’s specialty and total drug management capabilities, contributing to innovation in these capabilities and driving client growth. He is also a practicing oncologist at Minnesota Oncology.

For more information on Prime Therapeutics’ HighTouchRx program visit https://www.primetherapeutics.com/products/hightouchrx/.

1. https://hpi.georgetown.edu/rxdrugs/
2. https://www.psconsults.com/specialtyreport

The average annual cost for one specialty medication used on a chronic basis was $84,442. Imagine a patient paying that much to manage their health for one single medication. Now imagine them unknowingly paying even more than is necessary because of non-optimized dosing, duplicative therapy or not utilizing a lower cost alternative.

As a practicing physician at Minnesota Oncology and chief medical officer at pharmacy benefit manager (PBM) Prime Therapeutics, I see endless possibilities for the provider and PBM segments of the health insurance industry to work better together for the benefit of members and patients.

HighTouchRx™ is one approach to help ensure patients are viewed holistically by their PBM/insurer and their provider. HighTouchRx starts with the integrated pharmacy and medical claims data being fed into a clinical rules engine, that utilizes machine learning, created by and continuously trained pharmacists empowered with data. This rules engine analyzes these claims and reports on opportunities for intervention based on impact of potential savings. Prime’s dedicated rules committee meets regularly to identify gaps in existing rules engine outputs, improve the quality of the engine output, identify medications to add or remove from the engine, and generate ideas for new rule categories.

One example is when a member is taking a large number of a low-dose tab medication. Consolidating those tabs to fewer, higher-dose tabs may result in tens-of-thousands of dollars of savings. The member’s pill burden was reduced, resulting in better care at a lower cost. A savings that large rises to the top of the rules engine report. Our rules engine ranks savings opportunities using several factors including savings potential, potential successful drug therapy optimization and member recent health care utilization patterns.

But how does this happen? Specially trained pharmacists empowered with data. High-touch pharmacists use Prime’s rules engine knowledge to conduct personalized outreach to providers. Health plans have the option to have Prime-embedded pharmacists take on this work or equip their own in-house pharmacists to execute the outreach. Truly coordinated care with the member at the center.

And machine learning only gets better with larger volumes of data over time. As this program continues and grows, Prime’s analytics engine will intuitively learn how to better prioritize higher impact interventions. This makes changes more significant for the member. And the provider can know they, too, are making positive changes for their patients.

The introduction of HighTouchRx comes after several successful pilots. One Prime study showed savings of a net $2.4 million in health care costs in one year. A second study analyzed the success of drug therapy programs where managed care pharmacists recommended drug therapy optimization with members and providers. It delivered $7.8 million in net cost avoidance. These pilots have already received The Pharmacy Benefit Management Institute (PBMI) 2021 Excellence Award in the category of cost containment.

When 16% of the total cost of care is driven by non-optimized medication, opportunity is ripe to work differently. With HighTouchRx, Prime is continuing to maximize the data we have and giving providers new insights while continuing to keep the member at the center of decision-making.
As the COVID-19 pandemic’s third winter begins, the omicron variant is sweeping the U.S., swamping understaffed emergency departments and filling hospital beds.

If there is a glimmer of good news, it’s that the omicron version of the SARS-CoV-2 virus that causes COVID-19 seems less virulent with far fewer hospitalizations and deaths as a proportion of cases. But it’s also now clear that an impressive number of people who have had COVID-19 will likely have what the National Institutes of Health calls “post-acute sequelae of SARS-CoV-2 infection (PASC),” more commonly called “long COVID.” It is too soon to tell, though, whether cases caused by the omicron variant will result in long-term health problems.

The CDC defines long COVID as “a range of symptoms that can last weeks or months after first being infected with the virus that causes COVID-19 or can appear weeks after infection.” Long COVID can happen to anyone who has had COVID-19, says the CDC, even if their illness was mild or asymptomatic.

If a batch of new studies is correct, that “anyone” could be up to half of all COVID-19 survivors. That means millions of Americans, and perhaps 100 million people worldwide, will live with the lingering, in some cases debilitating, aftereffects of the novel respiratory virus.

“I am seeing people now who have gotten COVID a second time,” says Gary Rogg, M.D., co-director of the Post-COVID-19 Recovery Program for the Westchester Medical Center Health Network in New York. “Those who have long-hauler, post-COVID symptoms the first time will be remarkably worse again.”

Pooh-poohed no longer

“Long hauler” — that was the sobriquet for cross-country truckers. Not anymore. Today it’s anyone who is experiencing any of an array of post-COVID-19 symptoms: fatigue, cough, shortness of breath, chest pain, kidney dysfunction, joint stiffness, loss of smell and taste, and headache. Long-haulers also report a variety of emotional and neurological symptoms, including “brain fog,” which includes difficulty concentrating, memory loss, anxiety and depression.

Early in the pandemic, when researchers and doctors were struggling to get a handle on the virus, few understood that symptoms could persist after the virus had cleared the body. Instead, they told patients who reported the symptoms that it was all in their head.

“A lot of physicians pooh-poohed patients,” Rogg says. “People got very, very distressed about that. We’re finding in a lot of people that it creates a reactive depression and creates anxiety, almost like post-traumatic stress disorder.”

Researchers are now doing work to understand the causes of long COVID. Older people and those who were hospitalized for COVID-19 seem to be at greater risk of lingering disease, but younger people with milder cases also experience long COVID. It is not as simple as age and hospitalization causing long COVID.

Susan Vehar, M.D., a pulmonologist at Cleveland Clinic, and her colleagues published an article in the Cleveland Clinic Journal of Medicine about long COVID. They noted that the sickest, hospitalized patients had the highest prevalence of protracted symptoms of long COVID, citing research that has found that more...
than two-thirds of these patients have continued symptoms six months after recovery from acute COVID-19. The article also cites studies from Italy and Michigan showing that two-thirds of patients recovering from COVID-19 had symptoms 60 days after the acute infection was over. The Italian study found that only 18 of 143, or 13%, of patients were “completely free” of aftereffects from an acute case of COVID-19. In the Michigan study, the risk of the long COVID was higher among previously hospitalized patients versus those seen on an outpatient basis, and long COVID was twice as likely in patients with severe symptoms at 30 days. But the researchers also found that 20% of otherwise healthy young people, ages 18 to 34 years, with no previous chronic illnesses and mild COVID-19 cases, experienced long-haul symptoms.

Vehar and her colleagues mentioned that other studies have shown at least one persistent COVID-19 symptom, most commonly fatigue or dizziness, in more than half of patients after 110 days or 180 days, suggesting the possible duration of long COVID has yet to be determined.

Meanwhile, a meta-analysis of 40 studies from 17 countries conducted by researchers at the University of Michigan School of Public Health published as a preprint in November 2021 found that 43% of COVID-19 patients who were not hospitalized, and 57% who were, had long COVID symptoms.

Rogg says most patients experience fatigue. The second most common complaint is brain fog. “They describe it like someone waking you from a really deep sleep and they ask you a question,” he explains. “You know who they are, you’re aware of what is going on, but getting the answer out is the problem.”

So far, the best theory about what causes long COVID is that the virus tricks the immune system into creating or activating autoantibodies that mistakenly target the body’s own tissue.

“One of the things we hear from everybody is that there is this wave-like pattern” says Rogg. “They feel like they are getting better and then it feels like it starts all over again. As time goes by those peaks, feeling miserable, do get a little bit less, and the frequency of the wave also gets less.”

In a preprint, researchers from the National Institutes of Health said they found COVID-19 in almost every organ, including brain tissue from autopsied patients who died from the disease. If the findings hold up, they suggest that the virus can cross the blood-brain barrier.

Even if the leading theory (about brain fog) is that it is caused by an inflammatory response of the brain, the question then is: Why is (the brain) having an inflammatory response?” Rogg asks. “The idea is, of course, that the virus gets in there.”

Treatment for long COVID at the Westchester recovery program depends on the individual’s symptoms. Patients are first examined and evaluated, including cardiac, pulmonary, and neurological tests. Those complaining of fatigue are treated with anti-inflammatory agents like naproxen, ibuprofen and, in some cases, steroids to quiet the immune system response. Those for whom concentration is an issue are given puzzles, word scrambles and crossword puzzles, while patients with chest pain or breathing complaints enter a carefully monitored, graded rehab program. For every patient, the care involves managing expectations, says Rogg.

“I tell them, ’Do not focus day to day,’ he says. “I tell them to look back every week or two and see how they feel compared to a month ago. If you can get people to refocus that way, they will come back and say, ’I’m not good yet, but I’m better than I was a month ago,’ then you start to see that glimmer of hope in their eyes.”

Robert Calandra is an independent journalist in the Philadelphia area.
Cancer seems to put people in harm’s way when it comes to COVID-19. Studies conducted early on in the pandemic — well before the delta variant and now omicron started circulating — strongly suggested that cancer patients were more likely to suffer a severe case of COVID-19.

For that reason and others, public health officials and others see vaccination as being especially important for people with cancer. “Yes, it is recommended for all cancer patients to get COVID-19 vaccinations as they are at higher risk for poor outcomes if they get infected with COVID-19,” says Richard Parker, M.D., chief medical officer of Arcadia, a healthcare data and population health company in Boston.

There may, however, be some lingering hesitancy among cancer patients. People with active malignancies were, by and large, excluded from the clinical trials of the vaccine, but there is now wide experience with the vaccines, and no safety issues specific to cancer patients have been seen.

“The main concern about getting the vaccine is not whether it will be, especially in people with weakened immune systems,” Jalal S. Baig, M.D., a medical oncologist at the Cancer Treatment Centers of America in suburban Chicago, says cancer patients who contract COVID-19 may have poorer outcomes. Whether the vaccination generates a robust immune response depends, he says, on how long ago they were in active treatment. “Those who have been off of any cancer treatments like chemotherapy for more than six months are better protected by two vaccine doses,” says Baig. “But patients who are actively receiving chemotherapy generate poorer protection from two doses. A booster shot becomes more important for them.”

There’s evidence to back up what Baig is saying. Results of a study of 131 cancer patients reported in Cancer Cell last year showed that 94% developed a strong antibody response — seroconversion — after being vaccinated with either the Pfizer-BioNTech or the Moderna COVID-19 vaccine. And the Swiss and American research team found no difference in the antibody response between the two vaccines. They did, though, find that patients who had been treated with conventional chemotherapy or monoclonal antibodies within six months before their first vaccine dose had a less robust antibody response.

Especially vulnerable
Louis Potters, M.D., senior vice president and deputy physician-in-chief at Northwell Health Cancer Institute in Lake Success, New York, notes that patients with hematologic cancers such as chronic lymphocytic leukemia (CLL) may not make antibodies against the SARS-CoV-2 virus that causes COVID-19 following vaccination. Those patients are still encouraged to get vaccinated and boosted. Parker makes the same point: “Some patients with hematologic or blood-based cancers such as multiple myeloma and leukemia have a greatly reduced immunological response to the vaccines, meaning that they may not get as much protection as a person with a normal immune system.”

A review article published in European Journal of Cancer late last year included comparisons between people with hematologic cancers and those with solid tumors, such as breast and prostate cancer. The review encompassed 21 studies with a cumulative total of just over 5,000 patients. In the 17 studies that looked at the antibody response to a second dose of the Pfizer or the Moderna vaccine, the response was signifi-

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Solving the puzzle of cancer and COVID-19 vaccination

Recent treatment may affect the antibody response, particularly among those with hematologic cancers. by KEITH LORIA and PETER WEHRWEIN

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Managed Healthcare Executive
Solving the puzzle of cancer and COVID-19 vaccination

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Bruce Feinberg, D.O., chief medical officer at Cardinal Health Specialty Solutions, says he has seen through research that some hematologic malignancies and their respective therapies will hamper immune response post-vaccination. It is critical that these patients discuss risk avoidance with their doctors. “The truth is that the greatest risk to cancer patients is the same to anyone who is vaccinated: that is, the risk of new variants that might evade vaccine-induced immune response,” he says.

Oncologists are still working out how to manage cancer treatment and vaccination. Some guidelines suggest that patients scheduled for chemotherapy should be vaccinated three weeks before therapy starts or between cycles. “It is important to talk with your treating physician before receiving the vaccine, as some medications that impact the immune system may need to be held for a period of time around the vaccine administration,” Potters says.

Prominent multiple myeloma experts wrote an opinion piece published in JAMA Oncology in December 2021 that argued strongly for monitoring the antibody levels of multiple myeloma patients in active treatment to keep tabs on their risk of contracting COVID-19. They described multiple myeloma patients as being in double jeopardy: Those who are most likely to have a poor antibody response to vaccination are the same patients who are at highest risk of severe COVID-19.

Understandably, much of the discussion about cancer and COVID-19 vaccination has focused on people in active or very recent treatment because of the well-characterized immunosuppression. The immune systems of people whose cancers have been successfully treated or managed tend to bounce back. “Once they are in remission, many patients will have some rebound of their underlying immune responses to vaccines,” Parker says. “It is important to again emphasize the need to be vaccinated regardless of where the patient is on their cancer journey, either during treatment or post-treatment. And this includes the need for booster shots with either the Moderna or Pfizer mRNA vaccine.”

“Yes, it is recommended for all cancer patients to get COVID-19 vaccinations, as they are at higher risk for poor outcomes if they get infected with COVID-19.”

—RICHARD PARKER, M.D., CHIEF MEDICAL OFFICER OF ARCADIA

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Very occasionally there are breakthroughs, but change is usually a slowpoke when it comes to healthcare, inching along or nibbling on the margins, entrenched interests and ways of doing things standing in its way.

But then there was March 2020, a health crisis like no other, and clumsy healthcare got up on the balls of its feet and pivoted. Parents who previously would have had an in-person doctor’s visit for a marginally sick child now replaced those visits with a telehealth consultation. Patients tested for COVID-19 now checked their smartphone electronic health record apps to get their results. And people worried they might have COVID-19 symptoms looked to their Apple Watches to check their blood oxygen levels.

“Companies like Amazon and Apple have taught consumers how to engage digitally,” says Amanda Baethke, M.S., director of corporate development at Aeroflow Healthcare, a durable medical equipment maker based in North Carolina. “Then the COVID-19 pandemic dramatically accelerated the adoption of digital healthcare, which transformed the patient experience and left patients consuming healthcare digitally more than before.”

Even older patients, many of whom are better-late-than-never adopters, began to embrace technology such as home monitoring devices to keep touch with providers.

Baethke said the pandemic brought into focus the new paradigm of “hybrid healthcare.” It is not about digital replacement of in-person healthcare, but layering in tools and services that allow for remote care and give patients (and their families) options.

“A hybrid model enables both convenience and cost-effective healthcare through telehealth while still providing vital face-to-face care when appropriate,” Baethke says. “As patients become more familiar and health plans adopt more services, our tech-savvy consumers would be able to receive timely care from the convenience of their homes.”

However, the pandemic also brought into focus just how much work has yet to be done to make hybrid healthcare an authentic, sustainable way of delivering healthcare. In some ways, the technology and its gee-whizness is the easy part. What’s harder and multidimensional is figuring out ways to fold that technology into existing processes so it is used to improve people’s health.

**Appreciate the data points**

For payers, the new health-tech paradigm comes as both an opportunity and a challenge. Patients who might normally see a physician within a 50-mile radius might suddenly want to see a physician on the other side of the state — or country — using a telehealth app while still paying in-network rates. Consumers might also expect...

“There seems to be a disconnect between what consumers want and what insurers are willing to provide.”

—AMANDA BAETHKE, M.S., DIRECTOR OF CORPORATE DEVELOPMENT AT AEROFLOW HEALTHCARE
coverage for medical devices that may not be approved by the FDA. Take the Apple Watch, for example. Despite a heavy marketing campaign positioning it as a health and fitness device, users who take a blood oxygen reading on their Apple Watch will see a disclaimer warning that the reading is “not intended for medical use.”

Baethke said some insurers have been quick to align with changing consumer expectations, but she said there are too many exceptions. “Insurers seem to be slow to evaluate the various services that can be offered via telehealth,” she says. “There seems to be a disconnect between what consumers want and what insurers are willing to provide.”

Tension about which services insurers choose to cover is not new and will never go away. But remote care adds a new dimension. Baethke offers the example of a new mother who needs assistance breastfeeding. Although lactation consultation would traditionally be done in person, it can also be offered online. In order for such services to be covered, though, insurers need to be prepared to expand their networks to include new types of services and providers.

“In addition to providing prompt care, telehealth also creates more robust networks,” she says. “If the new mom was based in a rural area where access (to lactation consultants) was limited, the use of telehealth would provide support she would otherwise not be able to reach.”

“If telehealth provides an opportunity for a consumer to engage where they may not have otherwise done so,” Baethke adds, “health plans should appreciate the additional data point and leverage this behavior to align with their goals for patient journeys.”

The wait-and-seers
The early adopters among us (and the companies making the products they have adopted) may put some pressure on insurers to cover digital health services. But there is also a large swath of the population that will probably need to see the services offered before they are willing to take the leap into hybrid health. Baethke says that creates a communication challenge for insurers.

“We have, arguably, the most knowledgeable and engaged population of patients that we have ever had.”

—AMANDA BAETHKE, M.S., DIRECTOR OF CORPORATE DEVELOPMENT AT AEROFLOW HEALTHCARE

“We have, arguably, the most knowledgeable and engaged population of patients that we have ever had,” she observes. “With the rising healthcare costs, patients want to be informed of their benefits and how it impacts them.” For instance, in competitive markets such as Medicaid managed care plans, the availability of hybrid health options is becoming more important.

“We do see consumers eliciting feedback from each other on plans that produce the most value for them, the consumer,” she comments. “It is important that plans look at how consumers are engaging and why they are joining their plans and programs.”

In the employer-based healthcare market, insurers have an incentive to drive down costs not only for themselves, but also for their employer clients. Baethke says insurers can leverage go-betweens like employers to facilitate communication of their benefits.

“There may be an opportunity to review historical services that have been provided and promote that they may be covered in another setting (such as via telehealth),” she says. “Similarly, there may be campaigns that can be run with providers in order to promote that an in-office service a patient received could have also been provided via telehealth.”

Such communication can take place on a macro level, but also on a micro level, targeting consumers individually to let them know of lower-cost, more convenient options.

However, she says the opposite should also be available: Patients should have an easy way to communicate directly with their health plans about obstacles to care. “Consumers will oftentimes have insightful ideas that should be listened to, which is why it’s important to create a space where their opinions can be heard, and a dialogue can be had.”

Baethke says the world of hybrid health has greatly expanded the range of services available and made it much more convenient to receive those services. However, those services are valuable only if they are successfully integrated into the economic model of healthcare.

“If we want to ensure patients achieve their healthcare goals, we have to continuously review the reasons why they are not doing so, such as access and availability, and ensure we are making adjustments accordingly.”

Jared Kaltwasser is a freelance writer in Iowa.