In This Issue

Quote of the Month
"It is imperative that cost and utilization trends are understood and that the drugs are used effectively. Predictive modeling presents a solution to both problems. To anticipate trends, models can be built to identify people likely to begin using specialty drugs, based on personal, market and clinical factors."

Swati Abbott, Chief Executive Officer, Blue Health Intelligence

Tidbits
Just In Time For Your August Vacation: Quest Diagnostics Examines Lyme Disease

If you're not cursed with a school district that starts classes in August that would tie down your children there as opposed to accompanying you on vacation, then perhaps you're headed to the great outdoors....

Continue on page …..14

Factoid
84% of Consumers Prefer to Interact Digitally With Their Health Plan

Read more on page ……..20

Source: Sutter Health Plus

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Best and Worst States for Healthcare

Best States For Healthcare Cost, Accessibility and Outcomes

- Vermont
- Massachusetts
- New Hampshire
- Minnesota
- Hawaii

#1: Vermont
With an overall score of 66.3,
it has the lowest infant mortality rate and heart disease rate.

#50: Louisiana
With an overall score of 41.14,
it has the fewest dentists and 4th highest infant mortality rate.

Worst States For Healthcare Cost, Accessibility and Outcomes

- Louisiana
- Mississippi
- Alaska
- Arkansas
- North Carolina

Medicaid Managed Care Enrollment Penetration Rates

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A Growing Number of Large Employers Will Play Activist Role in Disrupting Health Care Delivery System and Supporting New Models of Care.

While high deductible health plans will continue to be popular and even grow over the next few years, the most significant change occurring in the commercial market segment is the new activist role large employers are planning to play in disrupting the healthcare delivery and financing system, and supporting new models of care.

In 2019 nearly half of all large employers plan to drive changes in the health care delivery system directly or through their health plans, by leveraging digital solutions, or both according to a new National Business Group on Health Survey of 170 large corporations which offer coverage to 19 million employees and their dependents. Large employers are frustrated by the failure of traditional cost sharing mechanisms to curb healthcare inflation, and are embracing innovations aimed at strengthening their workforce well-being and productivity, while also testing new ways to reign in health care costs. Implementing more virtual telehealth solutions, for instance, will be the top healthcare initiative for many corporations in the coming year and was barely on their radar a few years ago. The use of virtual care as part of employee health is branching out well-beyond physician consultations to include areas such as remote monitoring, condition management, physical therapy, and cognitive behavioral therapy. Perhaps because of the growing interest in consumer technology, over 70% of employers believe new startup entrants from outside the traditional provider market will be needed to disrupt the current delivery system, and provide lower cost more accessible prevention and primary care.

High Deductible Health Plans (HDHPs) which hold consumers and health plans responsible for resource utilization, of course, have grown steadily in the past five years, a trend that is likely to continue in 2019. Over 70% of large employers now offer HDHPs, and the projections are that by 2022 over 90% of all employer sponsored insurance will offer HDHPs. Interestingly, the availability of Consumer Directed Health Plans (CDHPs) which use high deductibles coupled with tax advantaged savings accounts, may actually shrink from approximately 39% of employers offering them as an option now to 30% in 2019.

We expect there will be expanded employer support for the implementation of alternative payment and delivery models such as ACOs, High Performance Networks and Centers of Excellence. Intel, Boeing, and Walmart, and Lowe’s have pioneered direct, total cost of care and bundled payment provider agreements over the past five years. This approach appears to be taking hold. Direct contracting between large employers and health systems and providers will increase from 3% in 2018 to 11% in 2019 according the NBGH survey as result of large employers increasing frustrations working through their existing third part administrators. Employers are also sharply increasing their use of Centers of Excellence for select tertiary and quaternary services which will grow from 12% of large employers in 2018 to 18% in 2019. Many of these agreement include fixed bundled payment pricing and guarantees.

While CMS Administrator Seema Verma’s announcement of major changes in the Medicare Shared Savings Program received most of the attention this month, the growing activism of employers may have more long term significance for the health care market, affecting more lives and more dollars. We would not be surprised if the health care delivery and financing system of the future may be hatched and shaped outside of Washington and the provider world, and in the Fortune 500 C-Suites, Board rooms, and HR Departments.
Kaiser Family Foundation ("KFF") recently reported that, during the 10 year period 2006-2016, average payments for deductible and coinsurance among people with large employer coverage rose considerably faster than the total cost for covered benefits. Indeed, average deductibles increased from $303 to over $1,200. KFF also found that deductible now account for almost half of total cost-sharing (deductibles, copayments and coinsurance) up from less than 30% ten years before.

Is the high (HDHP) or higher deductible tool having a beneficial impact and will employers continue to adjust deductibles to accomplish health plan goals? An October 2017 meta analysis of twenty-eight studies published in Health Affairs finds the track record of high deductible health plans to be mixed. Eight of twelve studies reported a significant reduction in use of preventive services among HDHP beneficiaries. Both of the studies that looked at diagnostic testing reported lower utilization among HDHP beneficiaries. Thirteen studies reported significant reduction in medication adherence.

We also hear anecdotally that large employers believe that the HDHP lever has little play left in it. Many apparently would welcome alternative or at least supplemental tools. My belief is that, given these conditions, large employer plans will incent their beneficiaries by removing deductible barriers to those beneficiaries accessing care from provider groups and networks that provide a range of procedural and chronic bundles below a plan established reference price.

Employer plans have a material opportunity for savings through direct contracts with providers. Opportunities exist around key procedural (orthopedic, GI, cardiology and maternity) episodes. They also exist around key chronic conditions (COPD, diabetes CHF to name a few) that drive cost and for which outcome improvements would be welcome.

Today, the leading vendors/conveners for the Medicare BPCI program are ready to turn their attention to producing savings and higher outcomes for the self-funded market. They will soon bring their contracting and episode administration prowess to bear in this part of the commercial market. The market will materialize as they learn to solve certain plan design challenges and power their solutions with advanced beneficiary education and engagement tools.

Over 150 million Americans get their health insurance from their employer. More than 40% are enrolled in a high deductible health plan (HDHP)...ten years ago it was fewer than 15%. In the Individual marketplace, HDHPs are the norm. At a time when one-in-three Americans say healthcare is their biggest financial burden, plans with employee cost shifting have gone mainstream...and they’re not going away.

It wasn’t long ago that health insurers collected a majority of premium dollars from people who had group health coverage through their job. But now, by growing their stake in government health care programs—Medicare, Medicaid and ACA—we’ve seen employer premiums represent a much smaller share of total revenue over the past decade. This direct-to-consumer market trend will continue.

Healthcare’s shifting financial burden is forcing consumers to take a close look at their family budget. A quarter of Americans have avoided, postponed or refused medical treatment because of cost. The good news: out-of-pocket responsibilities are fueling the healthcare consumerism movement. Once consumers are responsible for spending health dollars out of their own wallet you have their attention.
Lindsay Resnick, Wunderman Health, continued

However, buying healthcare services—from insurance to prescription drugs to routine check-ups to MRIs—isn’t easy given health literacy disparities, providers’ control of resources, and inconsistent access to consumer-centric information.

Being a smart healthcare shopper able to make confident, value-based choices challenges every American. We’ve seen this with consumers’ reluctance to question their physician about cost or site of care. For example recent research on MRI scans, one of the easiest services to price compare, shows that if consumers shopped local MRI sites, price variation is significant and savings would be substantial. However, doctors’ suggestions proved to carry more weight with patients than the potential for savings, with most doctors referring to only a single MRI provider (often the higher-priced option operated by their affiliated hospital).

The retailization of healthcare is here to stay. A retail mindset means consumers compare products and services, ask friends, read and publish reviews, price check, and quickly cast aside brand loyalty for a better deal. Shopping for healthcare may not follow a traditional retail path-to-purchase, but for most Americans it’s one of the most important buying decisions they make. That’s where health care companies AND employers can play a critical role: create reliable, understandable information and decision support tools to help consumers and employees navigate healthcare’s massive maze of bureaucracy. Turn employees into savvy customers. Replace consumer healthcare insecurity with healthcare confidence.

WEBINAR: Thursday, September 13, 2018
1-2 PM Eastern

- Five key findings from new Deloitte analyses of commercial health plan financial performance
- Specific revenue, enrollment and underwriting performance indicators and market data
- The impact of rapid enrollment fluctuation on risk pool stability and adverse selection
- The implications of commercial health plan performance trends going forward

Faculty:
Andreea Balan-Cohen, Ph.D., Deloitte Center for Health Solutions
Maulesh Shukla, Deloitte Center for Health Solutions

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- Additional selected articles on a variety of topics are also available in the Article Library.

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- A searchable archive of powerpoint presentations from HealthcareWebSummit events is available in the Premium Member website.

- If you're looking for specific content in the member web site and aren’t sure how to find it, feel free to e-mail or call MCOL anytime and we’ll assist you with your search, free of charge.

- If you haven’t joined already, you’re encouraged to join the LinkedIn Managed Care On-Line group where you can network and discuss issues with other MCOL members. You’ll find a link to the group in the premium member web site main menu.
CMS this week announced that Part D premiums are expected to fall from $33.59 this year to $32.50 in 2019. Of course it’s not that simple. First of all, $32.50 is the “basic” premium rate. What Medicare beneficiaries actually pay is income adjusted on a sliding scale. Here are the 2019 “income-related monthly adjustment amounts” just released by CMS:

CMS informs us that:

- “the base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount”
- "the national average monthly bid amount is a weighted average of the standardized bid amounts for each stand-alone prescription drug plan and MA-PD plan. The weights are based on the number of enrollees in each plan."
- “The national average monthly bid amount for 2019 is $51.28.”
- “The beneficiary premium percentage (“applicable percentage”) is a fraction, with a numerator of 25.5 percent and a denominator equal to 100 percent minus a percentage equal to (i) the total reinsurance payments that CMS estimates will be paid for the coverage year, divided by (ii) that amount plus the total payments that CMS estimates will be paid to Part D plans based on the standardized bid amount during the year, taking into account amounts paid by both CMS and plan enrollees.”
- Using the above calculations “the Part D base beneficiary premium for 2019 is $33.19”
- Then the Income-Related Monthly Adjustment Amounts “are determined by multiplying the standard base beneficiary premium by the following ratios: (35% – 25.5%)/25.5%, (50% – 25.5%)/25.5%, (65% – 25.5%)/25.5%, (80% – 25.5%)/25.5%, or (85 – 25.5%)/25.5%.

Clear as mud?

On the enrollment side of PDP world, here’s a look compiled from July 2018 CMS data:

- Total PDP Contracts: 63
- PDP Drug Plan Enrollment: 25,459,900
- MA Drug Plan Enrollment: 18,004,980
- PACE/Cost/Dual Drug Plan Enrollment: 689,113
- Total Drug Plan Enrollment: 44,153,993

(continued on page 8)
Medicare Part D Premiums and Enrollment by the Numbers...continued

The top five states for PDP enrollment penetration are:

- North Dakota – 63.9%
- Vermont – 62.6%
- Delaware – 62.6%
- Iowa – 60.5%
- Wyoming – 58.9%

This compares to a national average of 41.2% penetration. As one might expect, the high PDP penetration states have correspondingly lower Medicare Advantage penetration. For example, North Dakota has 2.7% MA penetration. Conversely, Puerto Rico has only 2.1% PDP penetration, but has the highest MA penetration at 71.1%. (national average MA penetration is 33.8%)

There are 114 counties with PDP penetration rates above 70.0%, mostly concentrated in the above states. Leading the pack is Dubuque County, Iowa at 72.3%. The bottom 77 of the 3,218 counties listed are all in Puerto Rico, as mentioned above. The first mainland county just above them is Clackamas County, Oregon with 17.6% penetration.

Value-Based Specialty Care: Anthem’s Approach

WEBINAR: Thursday, September 20, 2018
1-2 PM Eastern

- Why specialty care must be part of the move to a value-based health care system
- Anthem's multi-pronged approach to value-based contracting across the medical neighborhood
- How value-based specialty care arrangements help consumers and employers
- How specialty providers can succeed under value-based payment arrangements

Faculty:
Robert Kebbs, Anthem, Inc.
Erin Smith, Anthem, Inc.
Here are 25 major points to note in the CMS Pathways to Success Proposed Rule introduced on August 9th:

1. The redesigned Medicare Shared Savings program is called “Pathways to Success.
2. There are five stated goals Pathways to Success is intended to advance: Accountability, Competition, Engagement, Integrity, and Quality.
3. The CMS projected financial impact of the proposal would be savings to Medicare of $2.2 billion over ten years.
4. CMS notes that 460 of the 561 or 82% of all ACOs in the Shared Savings Program in 2018 – are not taking on risk for increases in costs.
5. The amount of time that an ACO can remain in the program with upside-only risk would be limited to two years (or one year for ACOs identified as having previously participated in MSSP under upside-only risk) instead of the current timetable of up to six years.
6. A 6-month extension would be provided for current ACOs whose agreements expire at the end of 2018, along with a special one-time July 1, 2019 start date that will have a spring 2019 application period for the new participation options.
7. The number of tracks would be reduced to two, the “BASIC” track and the “ENHANCED” track, and would allow providers to pick between these two tracks.
8. The length of ACO participation agreements would expand from three years to five years.
9. The BASIC track would feature a glide path for taking risk. It would begin with up to two years of upside-only risk and then gradually transition in years three, four, and five to increasing levels of performance risk, concluding in year five at a level of risk that meets the standard to qualify as an Advanced Alternative Payment Model (APM) under MACRA.
10. Current upside-only ACOs would be limited to one year without risk before being required to transition to the risk level in year three of the glide path.
11. The ENHANCED track would allow providers to take on risk and qualify as an Advanced APM immediately. This track would offer the same amount of risk for each of the five years of the agreement period, at a level of risk sharing higher than the maximum amount reached in the BASIC track.
12. Eligible ACOs (ACOs that are inexperienced with two-sided risk in Medicare) would be able to enter at any level of risk in the BASIC track’s glide path or go straight to the ENHANCED track.
13. After completing a five-year agreement under the BASIC track, low revenue ACOs would be able to renew for a second agreement period at the highest level of risk in the BASIC track, while high revenue ACOs would be required to move to the ENHANCED track and take on additional risk.
14. Each ACO would provide a standardized written notice to its Medicare beneficiaries, informing them at their first primary care visit of a performance year that they are in an ACO and what that means for their care.
15. CMS would allow certain two-sided ACOs to provide an incentive payment of up to $20 to each assigned beneficiary for each qualifying primary care service that the beneficiary receives, as an incentive for taking steps to achieve and maintain good health.
16. CMS is seeking comment on an approach that would allow beneficiaries to opt in to an ACO as an alternative to assignment.
17. CMS would streamline the measures that ACOs are required to report, to ensure that all measures have a meaningful impact on patient care.

(continued on page 10)
25 Things to Know About The CMS Medicare ACO Proposed Rule: Pathways to Success...continued

18. CMS would require a specified percentage of the eligible clinicians participating in an ACO to adopt the 2015 edition of Certified EHR Technology (CEHRT) as part of the Administration’s MyHealthEData initiative promoting interoperability of medical data and patient control of their data.
19. Physicians in ACOs that take on risk could receive payment for telehealth services provided to patients regardless of the patient’s location.
20. Regional (county-level) spending would be incorporated into ACO benchmarks starting in their first agreement period.
21. Methodology for risk adjustment would more accurately account for changes in beneficiaries’ health status.
22. When calculating and updating benchmarks, CMS would factor in national spending growth rates in addition to regional rates, so ACOs that constitute a large fraction of their local market would not be penalized if they reduce the market growth rate.
23. ACOs in two-sided models would be accountable for losses even if they exit mid-way through a performance year.
24. Termination of ACOs with multiple years of poor financial performance would be authorized.

Healthcare costs – not grandchildren gone wild – the top retiree concern

By Clive Riddle, August 17, 2018

What’s the top concern about retirement years voiced by retirees as well as retirement plan sponsors? It’s not grandchildren gone wild, keeping up with new technology, staying ahead of future inflation, or even staying in good health. Instead, it’s paying for that health.

Results just released from the 2018 TIAA Plan Sponsor Survey of 1,001 plans sponsors from nonprofit and for-profit organizations found that 91% of plan sponsors believe that healthcare costs are the most significant retirement security issue today. 54% answered very significant and 26% said somewhat significant, while 2% were neutral and – the plan sponsors I’m curious about: 3% said not at all significant.) After health care at 91%, the next highest concern of the top six: Ensuring employees are prepared to retire on a timely basis total 81% saying it was very or somewhat significant.

Meanwhile, another new survey tells us even affluent retirees are plenty scared about those retirement costs. A new Nationwide Retirement Institute survey of adults age 50+ with household income exceeding $150k, conducted by the Harris Poll indicates that 73% of affluent, older adults “list out-of-control health care costs as one of their top fears in retirement and 64 percent of future retirees say they are ‘terrified’ of what health care costs may do to their retirement plans.”

Here’s more of Nationwide’s survey findings:

(continued on page 11)
Healthcare costs – not grandchildren gone wild – the top retiree concern, continued...

- 72% wish they better understood Medicare coverage
- 42% admit they would give away all their money to their children so they could be eligible for Medicaid-funded long-term care.
- 53% do not know that Medicare Part B is not free even if you have worked and paid Social Security taxes for at least 10 years
- 23% do not know you cannot enroll in Medicare at any time
- 29% do not know Medicare does not cost the same for everyone
- 62% do not know that future changes will impact the ability to sign up for Medigap/Medicare supplement plans
- 53% are unsure or can't estimate what their annual health care will be
- 65% are unsure what their long-term care costs will be
- 27% of even these affluent, older adults say they couldn't cover more than $1,000 in unplanned expenses: 44% couldn't cover more than $4,000 and 60% couldn't cover more than $5,000 of unplanned expenses
- 50% have access to a Health Savings Account (HSA) through their employer, with 30% participating in or contributing to the HSA

Out of Network Services: Not Just Surprise Medical Bills, They Also Erode Care Coordination and Patient Retention

By Clive Riddle, August 23, 2018

Last week, Kaiser Family Foundation released a study of medical bills in large employer plans that found "a significant share of inpatient hospital admissions includes bills from providers not in the health plan’s networks, generally leaving patients subject to higher cost-sharing and potential additional bills from providers." The report stated "almost 18 percent of inpatient admissions result in non-network claims for patients with large employer coverage. Even when enrollees choose in-network facilities, 15 percent of admissions include a bill from an out-of-network provider, such as from a surgeon or an anesthesiologist."

The focus of the KFF study of course was surprise medical bills. This week, Kyruus released their 12-page 2018 Referral Trends Report: Positioning for Patient Retention which examines out of network services from a different perspective – when referred by an in-network physician, with the issue focus being on care coordination and patient retention.

The report presents physician survey findings that indicate “one-third of out-of-network referrals would be avoidable with more robust information about in-network colleagues,” and “while 77 percent of providers surveyed recognize the importance of keeping patients in-network for care coordination, a notable 79 percent say they refer patients out of network.” (continued on page 12)
Out of Network Services: Not Just Surprise Medical Bills, They Also Erode Care Coordination and Patient Retention...continued

The report tells us:

- Among those who refer out of network, 45 percent say that it’s difficult to determine who is in the network.
- On average, providers that refer out of network send almost 1/4 of patients out-of-network.
- 42 percent of patients leave a provider’s office without a necessary referral appointment booked, despite over 60 percent of providers considering point-of-service scheduling extremely or very important.
- Personal networks drive current referral behaviors: 72 percent of providers say they or their staff usually refer to the same provider for a given specialty.
- 40 percent of providers report always knowing whether or not their referral was appropriate for the patient or whether the patient needed to be re-referred, hindering care coordination.

The report concludes that "providers understand the importance of keeping patients in network to improve care. However, without the right tools to facilitate clinically appropriate and in-network referrals, providers will not necessarily break from familiar patterns."

First, Let’s Blow Up All the Hospitals

By Kim Bellard, August 27, 2018

A few recent stories are, I believe, reaffirming one of the big problems about healthcare: hospitals are 19th century institutions operating under 20th century business models in the 21st century. It’s time to rethink what we want a “hospital” to be.

The Boston Globe reported on Stanford’s new Lucile Packard Children’s Hospital, which cost a cool $1.3 billion and is touted as, of course, the “hospital of the future.” As they describe it, it doesn’t look like a hospital at all, but rather: “It is some hybrid of hotel, museum, and high-tech laboratory.” The Globe notes a similarly ambitious, $1.2 billion renovation at Boston Children’s, along with big hospital projects in numerous other cities.

The problem is that hospitals are big and getting bigger, going from building to buildings to campuses. They are expensive and getting more expensive. At some point, we have to ask: is this really how we want to spend our healthcare dollar?

Some hospitals are figuring other ways to spend their—I mean, “our”—money on our health. Take Nationwide Children’s Hospital. Located in a somewhat blighted neighborhood of Columbus (OH), its Healthy Neighborhoods Healthy Families (HNHF) program “treats the neighborhood as the patient,” as their summary in Pediatrics put it.

The hospital is leading a partnership that has built 58 affordable housing units, renovated 71 homes, given out 158 home improvement projects, and helped spur a 58 unit housing/office development. They’ve also hired 800 local residents and instituted a jobs training program. They’re already seeing lower murder rates, higher high school graduation rates, and are studying impacts on emergency room visits, inpatient days, and rates of specific conditions such as asthma.

“This is a national trend,” Jason Corburn, professor of city and regional planning at the University of California, Berkeley, told NPR, “It’s happening in cities across the country,” citing similar efforts in Atlanta, Boston, New York, and Seattle.

(continued on page 13)
First, Let’s Blow Up All the Hospitals...continued

It is true that hospitals (excuse me, “health systems”) are diversifying—building/buying satellite locations, free-standing emergency rooms, urgent care centers, and physician practices—but those big buildings remain the locus, and their sunk costs weigh on hospitals’ finances.

There’s a great quote from Philip Betbeze of HealthLeaders: “the future of the hospital is not a hospital.” The future requires, as Richard Darch, CEO of Archus, more recently wrote, “radically and fundamentally rethinking the hospital, and even discarding the term ‘hospital’ to the history books.”

I’d go further: not a building, not even a campus, but as a dispersed array of services—some medical, many not—that are delivered as close to our homes as possible (and, preferably, in our homes).

It requires us blowing up our concept of a “hospital.”

Don’t donate money for hospital expansion/renovation plans. Don’t buy bonds for them either. Don’t sit passively on hospital boards that push for them or expensive new equipment. Instead, we should be questioning: how can a “hospital” most impact our communities’ health? What kinds of investments in our communities’ health can they be making? How we do push healthcare and health down as close to where and how people live as possible?

The argument will always be, well, payors won’t pay for those kinds of things. The business models don’t support them. To that I say: it’s time not just for new kinds of “hospitals,” but also new kinds of business models.

Let’s get to it.

This post is an abridged version of the posting in Kim Bellard’s blogsite. Click here to read the full posting

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**Episode Analytics – More Than Just Bundled Payments**

*Co-sponsored by Change Healthcare®*

**WEBINAR: Tuesday, September 25, 2018**

2-3 PM Eastern

- Seven ways episode analytics are being used across health plans
- What insights are possible through episode of care analysis
- How to use episode analytics to identify cost and care improvement opportunities

**Faculty:** Marc Berg – Partner, Value Based Care and Payment Reform, McKinsey & Company
Chris Simpkins – VP Analytics, Value Based Payments, Change Healthcare

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If you're not cursed with a school district that starts classes in August that would tie down your children there as opposed to accompanying you on vacation, then perhaps you're headed to the great outdoors for your last big summer trip. With that in mind, let's turn our attention to a nine-page report released this week by Quest Diagnostics on Lyme Disease. They tell us that based on more than six million de-identified laboratory test results conducted over the past seven years "the prevalence of Lyme disease is increasing in the United States, spiking significantly between 2016 and 2017, and has spread to all 50 United States and the District of Columbia.

"Quest reminds us that "spread by tick bites from infected blacklegged and deer ticks, Lyme disease is an infection by the bacterium Borrelia burgdorferi that causes more than 300,000 illnesses each year in the United States, according to the Centers for Disease Control and Prevention (CDC). It is the most commonly occurring vector-borne disease and the sixth most commonly reported notifiable infectious disease. Common signs of potential Lyme exposure include the tell-tale "bullseye" shaped mark that frequently forms on the skin at a tick-bite location, or a presence of flu-like and/or other symptoms associated with Lyme or tick-borne infections."

Quest Diagnostics "found that outside of the northeastern U.S. which is historically associated with Lyme disease, California and Florida saw the largest absolute increases in positive test results. California found 483 infected patients in 2017, a 194.5 percent increase over 2015 levels. Florida found 501 infected patients in 2017, a 77 percent increase over 2015 levels."

Additional tidbits from their study include:

- Lyme disease remains most prevalent in the Northeastern United States Combined, Pennsylvania and the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont) accounted for 60.6 percent of the total number of positive Lyme disease test results found in the United States in 2017."
- "Pennsylvania tops the nation in Lyme disease cases. With 10,001 cases in 2017, Pennsylvania saw the most positive Lyme disease test results of any state in the nation, and nearly as many found in all New England states combined (11,549)."
- "Notable increases also observed in other states between 2015 and 2017 including Georgia, Arizona, Ohio, Texas, Tennessee, and Virginia.

For More Information:
Health Trends: Lyme Disease
Quest Diagnostics, July 30, 2018
Navigant this week released a eight-page study that found "despite steady improvements....academic medical centers (AMCs) generally trail non-AMCs across a variety of cost and quality metrics," and "that quality outcomes are not significantly better at high-cost AMCs and non-AMCs, compared to low-cost ones."

Navigant reports that their analysis "is based on data from 387 U.S. hospitals (175 AMCs, 212 non-AMCs) with more than $500 million in annual net patient revenue and 10,000 annual discharges. Facilities that didn’t report financial data in 2016 and CMS value-based program scores for FY 2018 were excluded from the analysis."

Tidbits from the study included:

- Medicare median wage and case mix index (CMI)-adjusted cost per case was 5.8% higher at AMCs versus non-AMCs for 2017
- A 22% cost per case disparity exists between high (25th percentile) and low (75th percentile) performing AMCs, compared to 19.8% for non-AMCs
- AMCs received more overall value-based program penalties from 2016-2018, with 40% getting seven or more of nine possible penalties versus 23.1% of non-AMCs.
- AMC overall weighted performance on CMS readmission, hospital-acquired condition, and value-based program measures increased 10.4% from 2016 to 2018, AMC scores still trail non-AMCs by 1.3 points.

This isn't the first warning flares fired about AMC weakened position going forward.

A year ago Definitive Healthcare conducted a study finding "there are roughly 350 hospitals classified as AMCs in the US. Most of them are large, non-profit acute care facilities, with a median of 477 staffed beds and 25,500 annual discharges for 2016. In addition to being larger, they have a much higher median case mix of 1.87 and Medicaid payor mix of 10.5 percent (compared to a median of 1.24 and 5.9 percent, respectively, for non-AMCs). A sicker, less wealthy population generally puts downward pressure on hospital finances, and the data shows that AMCs have been suffering declining margins compared to the national median. From 2010 to 2016, the median decline in operating income at AMCs was 11.54 percent, compared to a roughly 10 median increase for all other hospitals during the same period."

On another front, Roji Health Intelligence last September cautioned that "AMC research is under increasing public and professional scrutiny for its failure to focus on well-designed studies of treatment efficacy. There are also frequent allegations of collusion in AMC-run clinical trials funded by Pharma and device manufacturers, as well as conflict of interest in papers that promote publication over content. But an even more significant challenge to AMC research is the growing potential for practice-based research as data becomes more available for evaluation of outcomes and efficacy, as well as the development of stand-alone research operations that can facilitate precision medicine fueled by greater genetic information. Unless they embrace such totally new directions in data-facilitated research, AMCs risk irrelevance."

So what should AMC's do? A HealthLeaders article a year ago that cited initiatives at Banner University Medical Center Phoenix and quoted their CEO, Steve Narang, MD, states "In order to improve their value to those who pay for healthcare, AMCs should adapt to what the consumer is looking for. Narang says what's been developed at Banner University Medical Center as the Institute Model can help patients navigate their way through an expensive and confusing experience. For Banner, this means collapsing the structure of traditional academic medicine departments. The design mantra is simple, if difficult to execute. 'If the customer has a condition, let's develop a center for it,' he says. To facilitate that redesign and to make quality and reductions in cost the basis of change, he and his executive team began to hire data analysts and engineers more than a year ago. In concert with physician leaders who are excited to redesign the system, those engineers and data analysts came up with 13 specialized-care institutes, each focused on specific health conditions, with multiple sub-specialty centers."

(continued on page 16)
The Fate of AMCs is Not Academic...continued

Today Navigant prescribes that AMCs should:

- Utilize industry-wide benchmarking data comparing performance against peers.
- Engage leadership, physicians, and other staff for buy-in on enhancement strategies.
- Leverage evidence-based clinical protocols to address clinical variation.
- Focus on retaining customers by building tight provider network relationships across the care continuum and common standards for access, quality, and cost.

For More Information:

Study: Despite Improvements, Academic Medical Centers Trail Non-Academics on Cost and Quality Metrics
Navigant, August 8, 2018

Can Academic Medical Centers Be A Force For Health Care Reform?
Roji Health Intelligence, September 13, 2017

The Unique Struggle of Academic Medical Centers
Definitive Healthcare, August 15, 2017

The Academic Medical Center Model is Broken. Here's How to Fix It.
HealthLeaders, August 10, 2017

Understanding MSSP Pathways to Success
Milliman Analysis and Implications

WEBINAR: Friday, September 21, 2018
1-2 PM Eastern

- Elements of the new BASIC and ENHANCED tracks
- CMS calculation of revenue versus the benchmark-based cap, and changes to the benchmark calculation
- Criteria determining at what level ACOs would enter the BASIC track "glide path"
- Implications of the proposed regulation for the Medicare Shared Savings Program and its stakeholders

Faculty:
Colleen Norris, FSA, MAAA, Consulting Actuary, Milliman

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Surprise medical bills are the much-discussed problem that seemingly just won't go away. Kaiser Family Foundation this week released a study of medical bills in large employer plans that found "a significant share of inpatient hospital admissions includes bills from providers not in the health plan’s networks, generally leaving patients subject to higher cost-sharing and potential additional bills from providers."

The report states "almost 18 percent of inpatient admissions result in non-network claims for patients with large employer coverage. Even when enrollees choose in-network facilities, 15 percent of admissions include a bill from an out-of-network provider, such as from a surgeon or an anesthesiologist."

The study analyzed a sample of large employer medical claims from the Truven Health Analytics MarketScan Commercial Claims and Encounters Database from 2016 that includes claims for almost 20 million people representing about 23% of the 85 million people in the large group market. Claims analyzed were limited to under age 65 patients and weighted to match the Current Population Survey mix for large group enrollees by sex, age, state and whether the enrollee was a policy holder or dependent.

The report noted that "for both inpatient admissions and outpatient services, use of an emergency room is associated with higher rates of out-of-network bills. Treatments for mental health and substance abuse also have a much higher chance of including a claim from an out-of-network provider, potentially reflecting difficulty in finding a participating provider."

Tidbits from the study included these percentages with out of network provider claims:

- 17.6% of all inpatient admissions
- 15.4% of inpatient admissions with only in-network facility claims
- 7.7% of outpatient service days
- 9.2% of outpatient service days with a facility claim
- 5.3% of outpatient service days with only in-network facility claims
- 19.5% of outpatient service days that include an emergency room claim
- 17.8% of outpatient service days that include an emergency room claim with only in-network facility claims
- 33.5% of all behavioral health admissions
- 19.6 of behavioral health admissions with only in-network facility claims
- 7.7% of outpatient mental health services
- 26.4% of outpatient mental health services with Therapeutic Psychiatric Claim
- 15. % of outpatient service days that include an anesthesia claim (13.4% with only in-network facility)
- 12.1% of outpatient service days that include an pathology claim (10.6% with only in-network facility)

Earlier this year, A Rutgers Center for State Health Policy study funded by the Robert Wood Johnson Foundation polled 1,052 New Jersey families and found:

- 48 percent said they received surprise bills from in-network providers
- 43 percent from out-of-network providers
- 9 percent said they didn’t know whether the bills were from in or out of their network

For More Information:

An analysis of out-of-network claims in large employer health plans
Peterson-Kaiser Health System Tracker, August 13, 2018

Rutgers Poll Reveals Widespread Surprise Medical Bill Problem
Rutgers Center for State Health Policy, May 31, 2018
Prioritizing Predictive Modeling Activities

Appearing in the August 24, 2018 MCOL Weekend

This week, MCOL and Predictive Modeling News released results from the annual stakeholder e-poll on Prioritizing Predictive Modeling Activities. This year's results indicate that while Identification of High-Risk Patients for Care Management continues to be the highest priority among various initiatives, there was much more reduction in the gap between this and other initiatives compared to previous years. Participants were asked to respond to two items:

1. Please categorize your organization: (Provider; Payer or Vendor/Other)
2. Suppose you had to prioritize how an organization could spend its funds on predictive modeling initiatives involving health benefits, and you were given a list of 10 items to prioritize. How would you rank them? (1= highest priority / 10 = lowest priority; rank them 1 through 10)

The items to rank were as follows, with their abbreviated version, referred to subsequently, indicated in parentheses:

- Identification of High-Risk Patients for Care Management
- Plan Design Modeling and Development
- Fraud Prevention
- Treatment Guideline Development
- Provider Performance Profiling
- Provider Value Based Payment Initiatives
- Premium Rate Development
- Population Health Initiatives
- Prescription adherence and Management
- Readmission Prediction Initiatives

Most of the respondents (41.3%), ranked identification of high-risk patients for care management as the highest priority for how an organization could spend its funds on predictive modeling initiatives. No other item came close in the number of respondents ranking it as the number one priority. However, compared to prior years, the average priority ranking for identification of high-risk, materially changed, dropping from the range of 2.1 – 2.7 from 2013 – 2017 to 4.4 in 2018. This means there is less agreement in 2018 that this initiative is the highest priority compared to other initiatives.

Fraud prevention was ranked as the number one priority by 13.0% of respondents, treatment guideline development by 11% of respondents, plan design modeling and development by 7%, and premium rate modeling and development by 7%. All other items were ranked as the number one priority by 4.0% or less of respondents.

As expected from the percentage of respondents who ranked it as the top priority, when assessing the average rank of each item, identification of high-risk patients for care management had the highest priority rank (lowest numerical value) with an average of 4.4. The next average highest rank for an item was treatment guideline development, which had an average rank of 5.3. The items with the lowest average rank (highest numerical value) were fraud prevention and premium rate development at 6.4 and 5.7 respectively.

There were numerous differences when considering the participant organization category of the respondents. Identification of high-risk patients for care management had the highest average rank among providers and payers at 3.9 and 4.9 respectively. However, vendors/others ranked population health initiatives as their highest priority at with an average of 4.9.
A featured column in each edition of the MCOL Weekend e-newsletter

Prioritizing Predictive Modeling Activities...continued

- 2018 Average Rank (1=Highest, 10=Lowest)
- Identification of High-Risk Patients for Care Management: 4.4 (2.6 in 2017)
- Treatment Guideline Development: 5.3 (5.5 in 2017)
- Plan Design Modeling and Development: 5.4 (5.6 in 2017)
- Provider Value Based Payment Initiatives: 5.4 (5.8 in 2017)
- Population Health Initiatives: 5.6 (4.2 in 2017)
- Readmission Prediction Initiatives: 5.6 (5.6 in 2017)
- Prescription Adherence and Management: 5.6 (5.6 in 2017)
- Provider Performance Profiling: 5.6 (6.1 in 2017)
- Premium Rate Modeling and Development: 5.7 (7.5 in 2017)
- Fraud Prevention: 6.4 (7.8 in 2017)

WEBINAR: Thursday, September 27, 2018
2-3 PM Eastern

- The importance of sharing data with hospitals and other providers for alignment of goals
- How extending the traditional “network” to community resources helps both payers and providers understand the holistic patient
- Why meaningful communication with providers helps enable lower costs and improve patient outcomes, with shared gains for all stakeholders

Faculty:
Jose Vazquez, University of Maryland Medical System Health Plan
Harry Merkin, HealthEdge

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84% of Consumers Prefer to Interact Digitally With Their Health Plan

Sutter Health recently released an infographic on consumer insights regarding health plans. Here are some key findings:

- 2 in 3 consumers would see a health provider through a video visit.
- 90% say the doctor-patient relationship is the most essential part of quality care.
- 3 in 4 health plan members will renew their membership if they feel valued.
- 84% prefer to interact digitally with their health plan.

Source: Sutter Health Plus, August 7, 2018

41% Were Surprised At How Expensive Their Medical Bill Was

Bankrate recently conducted a survey on healthcare cost concerns for U.S. adults. Here are some key findings from the report:

- 22% went without necessary medical care because of cost concerns.
- 3 in 10 of those without insurance avoided going to the doctor when they needed to.
- 54% are very/somewhat worried about affordable health insurance in the future.
- Of those who received care, 41% were surprised at how expensive their bill was.

Source: Bankrate, August 8, 2018
Top Ten Pharmaceutical Companies by 2017 Rx Sales

1. Pfizer - $45.3B
2. Novartis - $41.9B
3. Roche - $31.7B
4. Merck - $35.4B
5. Johnson & Johnson - $34.4B
6. Sanofi - $34.1B
7. GlaxoSmithKline - $28.7B
8. Abbvie - $27.7B
9. Gilead Sciences - $25.7B
10. Amgen - $21.8B

Source: Pharm Exec's Top 50 Companies 2018

Beckers: 6 things to know about high-deductible health plans

1. The number of high-deductible plans grew after the ACA enabled millions of previously uninsured people to gain coverage
2. The number of U.S. workers choosing high-deductible plans continues to grow
3. High-deductible plans have grown among individuals with private insurance coverage
4. Adults with employer-provided high-deductible plans may decide to also enroll in a health savings account
5. Amid the rise of high-deductible plans, Americans have had opportunities to shop for care
6. Only 3.4 percent of payers said they believe high-deductible plans are the best way to spur consumerism among members, according to a survey commissioned by Change Healthcare

Source: Becker's Hospital Review
Lyme disease is a bigger risk to more people in the United States than ever before. Our data show that positive results for Lyme are both increasing in number and occurring in geographic areas not historically associated with the disease. We hypothesize that these significant rates of increase may reinforce other research suggesting changing climate conditions that allow ticks to live longer and in more regions may factor into disease risk.”

Harvey W. Kaufman, M.D., Senior Medical Director, Quest Diagnostics

While AMCs have earned strong reputations for cutting-edge and specialty care, our previous experience has found most AMC admissions and procedures could also be performed at non-AMCs. As healthcare transparency increases, AMCs performing poorly on analyzed measures of care may face lower patient volumes, a decrease in revenue through CMS and commercial value-based payment models, and less favorable payer partnership opportunities.”

Christopher Stanley, M.D., Director, Navigant

A meaningful share of inpatient admissions result in the patient receiving a claim from an out-of-network provider, even when enrollees choose in-network facilities…. In many instances, it is doubtful that enrollees could reasonably anticipate or control their use of out-of-network providers.

Gary Claxton, Vice President, Kaiser Family Foundation

It is imperative that cost and utilization trends are understood and that the drugs are used effectively. Predictive modeling presents a solution to both problems. To anticipate trends, models can be built to identify people likely to begin using specialty drugs, based on personal, market and clinical factors.

Swati Abbott, Chief Executive Officer, Blue Health Intelligence

These [new] hospitals are kind of high-tech hotels. Everybody’s competing by building cooler hotels. They can do more, save more lives, all good stuff — but not cheap.”

Mark Wietecha, President, Children’s Hospital Association