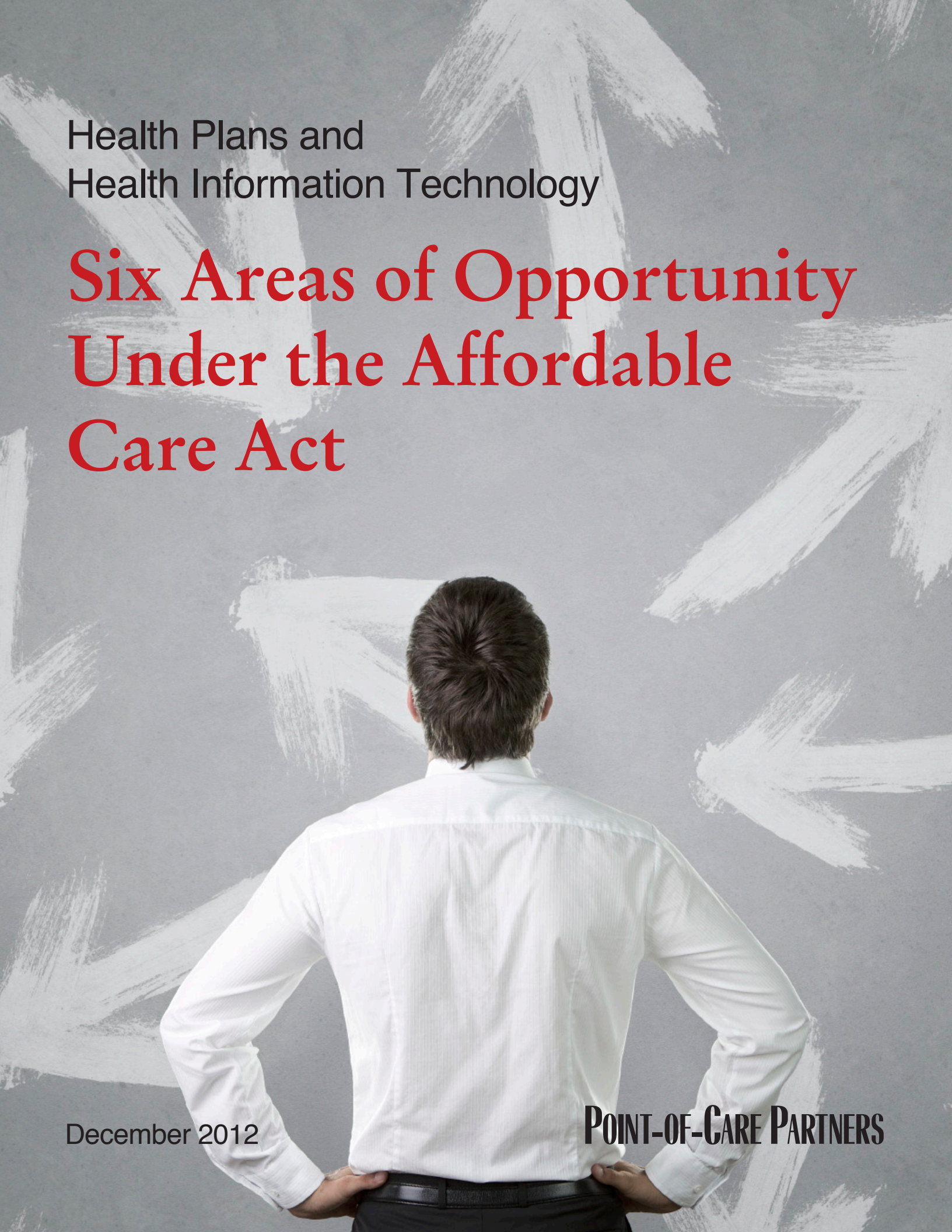
Health Plans and
Health Information Technology

Six Areas of Opportunity Under the Affordable Care Act



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POINT-OF-CARE PARTNERS

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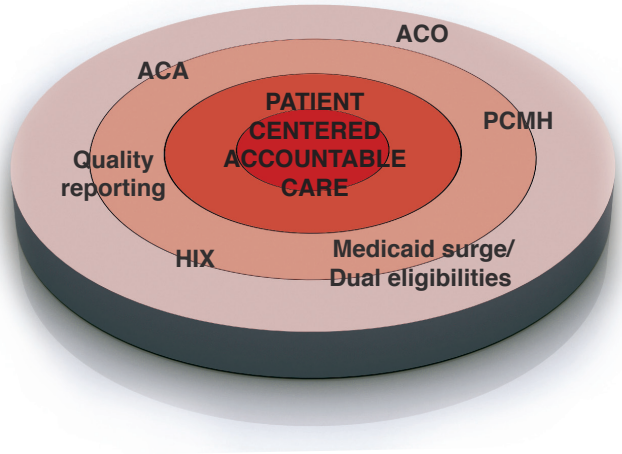
Executive Summary

Much has been written about the problems with the Affordable Care Act (ACA), particularly related to its costs and complexities. Instead, the healthcare industry, and specifically health plans, should regard the legislation as a positive catalyst to make the strategic health information technology (HIT) investments that have been postponed thus far. The tumultuous forces roiling the industry were set in motion long before the ACA was enacted in March 2010, but while the ACA unquestionably has accelerated and influenced much of that upheaval, healthcare was already changing. Although many stakeholders put ACA implementation on hold pending election results, it is now time for industry players to think strategically about the ACA, decide how to respond to best advantage, and then execute on those strategies.

This is especially true for health plans. The ACA covers a lot of ground, but there are several areas of opportunity that will reward their consideration and can deliver both competitive advantage and attractive return on investment. This white paper identifies six strategic areas of opportunity that merit consideration for the health plan looking to optimize its response to the ACA and provide a positive return on investment. In addition, these areas frequently complement and overlap each other, translating into gain across multiple areas within the enterprise. These six areas of strategic opportunity are:

- The Medical Loss Ratio: A Catalyst for HIT Investment
- ACOs and PCMHs: New Models Require New Technologies
- Quality Management and Reporting
- The Enrollment 'Surge' in Medicaid and Commercial Plans
- Consumerism and Health Insurance Exchanges: The Inflection Point for Health Plans
- Enhancements in Electronic Transactions

Transformation toward patient centered accountable care



The effective use of technology—and particularly health information technology—will be one of a health plan's best assets to control costs and service levels as membership increases, as well as the corresponding demand increases on care and services. In reality, health plans should consider the ACA as a potential justification for HIT investments that can simultaneously make a beneficial contribution to both the business and the bottom line. In a future environment where the pressure to control costs and improve quality will only increase, capitalizing on these areas will quickly become a necessity—not simply an opportunity.

Six Areas of Opportunity Under the Affordable Care Act

Healthcare Reform – Better the Devil You Know

With the presidential election now comfortably behind us, those in healthcare can look forward to a world less populated by polls and pundits and instead can start to expect more clarity—specifically around what the Affordable Care Act (ACA) means to their business. "Let's wait and see what happens on November 6th" was the de facto strategy across the industry, and understandably so. The future direction of healthcare was obscured and indefinite, forestalling the decision-making for those at the helms of many healthcare vessels.

But the fog is clearing and the horizon is coming into focus. Over the next several months and more, various important ACA regulations and their interpretations will be announced and the paralysis can be replaced by action and investment. And while no one disputes that the law is complex, imperfect and onerous to implement, it is nonetheless the law. The pre-election stasis needs to be replaced with thought and action, using the law as an impetus to respond to the challenges and opportunities it has created for the healthcare industry.

Yes, *opportunities*. Much has been written about the ACA's costs and complexities. However, an equally valid perspective worth considering is how the healthcare industry—and health plans in particular—can view the legislation as a positive catalyst to make the strategic health information technology (HIT) investments that have been postponed thus far. The tumultuous forces roiling the industry were set in motion long before the ACA was enacted in March 2010 but while the ACA unquestionably has accelerated and influenced much of that upheaval, healthcare was already changing. It now is time for industry players to think strategically about the ACA, to determine how to respond to best advantage and then execute on those strategies.

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Admittedly, this is not an all-inclusive list. For example, there is no focus on investments in ICD-10 compliance, adoption of electronic health records (EHRs) or electronic prescribing. Nor is special attention paid to such topics as Meaningful Use (MU) incentives or data security. These areas are more mature, required by other legislation or otherwise outside of the scope of the ACA. In contrast, each of the six highlighted in the following pages is fundamental to the evolution of healthcare, and each is inextricably connected to the ACA through statute, regulation or outcome. Simply put, any sound investments that health plans can make in these areas will contribute positively on the compliance, financial and competitive fronts.

1 The Medical Loss Ratio: A Catalyst for HIT Investment

A core component of the ACA is the requirement that health plans submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR; see figure), and to issue rebates to members if this percentage does not meet minimum standards. MLR also stipulates that health plans to spend at least 80% or 85% of premium dollars on medical care, with review provisions that impose tighter limits on rate increases. Failing to meet the standard means the health plan is now required to provide rebates to its customers.

Given these requirements, it is common to view the ACA's MLR requirements as onerous. But viewed differently, these same requirements can be used positively in the financial and business calculus for a range of strategic HIT investments that health plans will need to make to compete in a post-ACA world. For example, federal initiatives like the National Quality Strategy and the National Prevention and Health Promotion Strategy specifically emphasize investments in "Care Coordination through HIT" and "secure information exchange to facilitate care delivery." Similarly, each of the areas of opportunity outlined in this paper either contribute as Quality Improvement Expenditures or as investments to reduce administrative expenses—both of which help improve the health plan's MLR.

The effective use of technology—and particularly health information technology—will continue to be one of a health plan's best assets to control costs and service levels as membership increases, along with the corresponding demands on care and services. And with the ACA, greater emphasis should be placed on the effective use of HIT investment to have a favorable effect on the health plan's medical loss ratio (MLR).

Formula for Calculating the MLR

$$\text{MLR} = \frac{\text{Medical Claims + Quality Improvement Expenditures}}{\text{Earned Premiums – Taxes, Licensing and Regulatory Fees}}$$

The MLR numerator can be enhanced by HIT-related investments in quality improvements, such as EHRs, health information exchange (HIE) and personal health records/ portals. Even HIT-related investments in administrative efficiency can indirectly help to improve the MLR by reducing administrative expenses. In short: both actions work to *optimize* a health plan's MLR.

In addition, investments in HIT to improve the MLR can help health plans avoid giving rebates to enrollees. If not managed well, rebates can quickly add up to major outlays. In fact, more than $1 billion in rebates were distributed by late 2012 in response to regulations that went into effect in 2011.

2 ACOs and PCMHs: New Models Require New Technologies

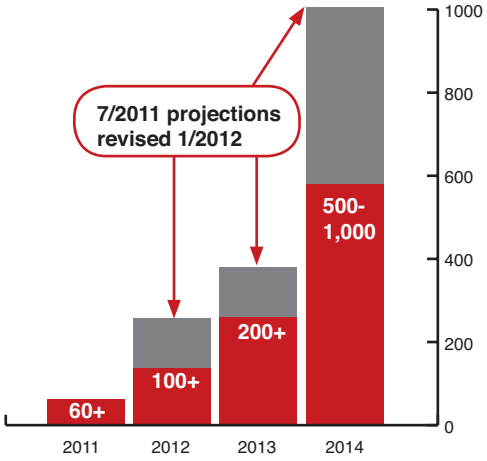
The ACA provided impetus to the formation and use of two new integrated healthcare delivery and payment models: accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). To be sure, these models already were on the rise before the ACA was enacted. However, the ACA has accelerated their growth.

To stimulate innovation in integrated care delivery, the ACA called for the Medicare Shared Savings pilot program and the related Pioneer ACO initiative. These programs give providers the opportunity to participate in financial savings realized by the Medicare program by better coordinating care and managing quality. The ACO model that underlies these programs is designed to bring care providers together to integrate clinical and financial management. And, as will be emphasized later in this report, the ACA has been a strategic catalyst for the formation of ACOs beyond Medicare.

These new models of care and reimbursement require new training, workflow processes and technology to achieve any reasonable level of success. Shared risk, shared savings, bundled payments and pay-for-performance (P4P) have led the industry toward more patient-centered care—and each flavor requires new methodologies and systems to be effective. By investing in the HIT needed by ACOs and their PCMHs, health plans contribute to the improved performance of their provider networks, while at the same time improving their own quality improvement programs and MLRs.

The nucleus of an ACO is the PCMH, a transformed primary care delivery model that pre-dates the ACA and the notion of ACOs. As its name suggests, the PCMH serves as the main point of access for patients, especially those with chronic conditions. It also is responsible for overseeing a multi-disciplinary care plan and coordinating the various providers needed to care for the patient. Effective HIT is essential to the operation of the PCMH nucleus of the ACO, with EHRs enabled for HIE to facilitate planning, tracking, and coordinating patient care and clinical decision support applications as the cornerstone for measuring and improving patient outcomes.

Prevalence of ACOs



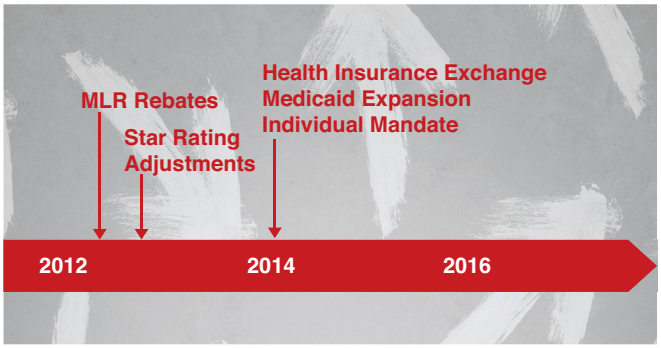
Introducing innovative care delivery programs offer health plans both reward and risk: Reward in the promise of bending the health care cost curve, and risk in the potential for disintermediation as the ACO or PCMH takes on a closer relationship with the member. To date, health plans have largely viewed patient-centered accountable care models as the next chapter in the value-based payments story and a key tool to control medical expenses. ACOs in particular have already begun to gain traction in more progressive markets, and the accelerating rate of new ACOs demand that health plans respond quickly and strategically. And so far, they have. Commercial payers have been notably engaged: an estimated 500-1,000 ACOs are expected to be in operation by 2014, and the majority will have commercial health plan support. That support will need to manifest itself in a number of areas if the health plan is going to effectively reap the rewards of a successful ACO and mitigate the risk of being cut out of the relationship with the consumer.

ACOs and PCMHs: New Models Require New Technologies

Areas where HIT investment can accomplish both objectives include:

- **Care coordination processes, resources and systems –** This trend reflects the migration of disease management, care coordination and other such medical management into the provider domain. Health plans are arguably still better suited to provide the infrastructure to ensure that the care is "coordinated" and without gaps. At a minimum, plans can provide much of the data needed to underpin successful care coordination.
- **EHR adoption and interoperability –** Although significant effort has already been invested in these areas, opportunities for improvement exist. Examples include the need for greater adoption of electronic prescribing, better point-of-care messaging, and improved medication adherence. A good example of the promise of HIT is illustrated in a 2011 study, which found that slightly more than half of patients in EHR-based systems received care that met all of the endorsed standards—and had 44% better outcomes—than those being treated in paper-driven practices.
- **Clinical decision support (CDS) –** CDS technologies can provide actionable communications to providers about potential gaps in care, and when clinical EHR data is combined with claims data, the result is a more meaningful solution to clinicians at the point of care.
- **Patient portal, self-management and communication tools –** Consumer uptake has been painfully slow, but new requirements and technologies are beginning to show promise. This area should be of particular interest for health plans that are looking to stay engaged with their members.
- **Health information exchanges (HIEs) –** EHRs alone fall short of supporting provider care coordination and quality improvement efforts. A comprehensive longitudinal view of a patient's care is possible when all providers are using EHRs connected to the community's HIE. Taking this one step further, innovative health plans can combine EHR data with their claims databases to identify and distribute gaps in care alerts to members through the HIE. (See also this recent HIMSS article on the importance of HIE to payers.)
- **Quality and outcomes reporting, business intelligence and analytics –** Health plans have a significant advantage in data management and analysis, which can be leveraged to help the ACO/PCMH satisfy the complex reporting requirements that the ACA places upon the provider. (See the next section.)
- **Population health management –** Outreach to a health plan's members before they have a medical episode is critical to "moving the needle" on quality improvement. Using web-based health risk assessments, interactive self-education and self-management tools, as well as predictive analytics technologies, health plans can identify and engage patients upstream before they develop health problems needing acute interventions.

Affordable Care Act Provisions



3 Quality Management and Reporting

It's an axiom in business that "what gets measured gets done." And the ACA has made quality—and specifically quality reporting—a measurement priority. This should be good news for health plans. According to a 2011 Point-of-Care Partners survey, health plans have almost universally made big investments in data warehousing, reporting and analytics. Those investments will certainly pay off when it comes to MLR compliance reporting, and can be further leveraged to assist their Administrative Services Only employer customers with their reporting requirements, such as preexisting conditions, lifetime benefit limits, wellness programs, and prior authorization.

These HIT investments also can create opportunities to collaborate with providers around data sharing and compliance reporting. But they can be further extended to more innovative ends, while at the same time addressing MLR requirements. Health plans should be looking closely at the following quality reporting opportunities:

- **Medicare assessments –** Medicare has a number of quality measures on which plans are judged. These include: Medicare Advantage STAR ratings, HEDIS performance measure reporting and changes to the hierarchical condition categories (CMS-HCC) model from the Centers for Medicare and Medicaid Services (CMS). All are driving greater accountability for quality at the payer level. Beyond the requirement to report, four- and five-star rankings translate into sizable bonus payments in 2014.
- **Clinical decision support –** As mentioned above, CDS can be a dividend of an effective data architecture. Health plans that can acquire and incorporate clinical data (through EHRs, HIEs and other third-party sources) are well positioned to operate impactful population health and CDS applications.
- **Quality reporting –** The Medicare Shared Savings program, Meaningful Use criteria, CMS' Physician Quality Reporting System, and numerous other quality initiatives are coalescing around a universal set of quality measures, such as measures 28, 31, 34 from the National Quality Forum. Provider scorecards and quality reporting spanning care providers in an ACO that track these measures are needed. Health plans that invest in quality reporting applications for their provider networks gain new insights into the networks' performance and help them to meet a complicated and onerous set of reporting requirements.
- **Advanced analytics –** Health plans should be looking forward and outward, toward the sorts of complex, leading-edge analytics being used in consumer markets, pharma and the 2012 presidential election. Advanced data modeling, such as network mapping and pattern recognition, can provide health plans with tremendous competitive advantages. Designing ACOs, analyzing member and provider influence networks, or conducting actuarial risk modeling for health insurance exchanges (HIX) can each benefit from innovations that are becoming commonplace in other industries.

"What gets measured gets done."

4 The Enrollment 'Surge' in Medicaid and Commercial Plans

Perhaps the most significant impacts of the ACA will be the enrollment of the millions of new members flooding into the commercial market and Medicaid due to the ACA requirements. Most states are expected to expand their Medicaid program, which is now an optional ACA requirement due to the 2012 Supreme Court ruling. Expanding Medicaid in every state would add 21.3 million people to the Medicaid rolls, including 14.3 million who will be newly eligible for the program and 7 million people who already are entitled to benefits but are not signed up. New entrants would include those living below or close to the poverty line and adults who dually are eligible for Medicare and Medicaid.

In another key element of the health reform law, states must have an online HIX, which will use HIT to facilitate enrollment for some 9 million uninsured Americans in commercial plans. These must have a federally determined "essential benefit package" comparable to employer-sponsored plans, with four different levels of cost sharing. They HIX must be up and running in 2014, with or without government assistance. Private exchanges are also springing up in response to the market demand created by the ACA, although they are not specifically mandated by the law. The private HIX are primarily targeted toward employers and are going beyond medical insurance to offer coverage for dental, vision, life and disability, for example.

It is unclear how many states will expand Medicaid services, how the HIX will be configured across the country, or how many will be enrolled in Medicaid and the commercial plans via the HIX. Nonetheless, health plans can expect that demand for services will surge—and likely at a greater rate than membership. This is because demographics suggest that these new members have greater incidence of poor health and chronic conditions, which will consequently burden the health plans programs and systems. A health plan's ability to efficiently manage population health will become increasingly important. At a minimum, core systems will need to address basic operations like processing of prospective members' eligibility and demographics. However, the real differentiators separating the winners from the rest of the market will be the effective application of sophisticated population management tools, such as health risk assessments, identification and stratification tools, predictive analytics and patient engagement programs. All will be essential to manage the increased service demand.

Health plans can expect that **DEMAND for SERVICES** will surge — and likely at a greater rate than membership.

The Enrollment 'Surge' in Medicaid and Commercial Plans

Nonetheless, there are proactive steps that can be made once again to deliver direct ROI, address the core requirements of the ACA, and also contribute favorably to the MLR equation. These include such investments as:

- **Leveraging EHRs and HIEs –** As mentioned previously, the benefits of a broad data connectivity/sharing strategy are significant and well-documented. They can also provide value in addressing the anticipated increase in resource demand. Health plans should be thinking about how HIT can help optimize care and connectivity effectively.
- **Patient identification and stratification –** Again, the ability to proactively identify and quickly engage high-demand members in appropriate interventions will pay important dividends. The right HIT infrastructure can satisfy reporting requirements. Just as importantly, it can also augment self-care programs, population health management strategies, health risk assessments and other outreach to deliver cost effective and value-based care.
- **Self-care and population health programs –** With the accelerating trend towards consumerism (see the next section), self-care will become a critical component in the care delivery mix. Patient involvement and behavior change will take on greater importance, and the health plans that can break the code on driving patient engagement will reap sustainable competitive advantage.
- **Other HIT infrastructure changes –** New technologies will be needed to enroll members through the exchanges and significantly alter the ways in which plans reach out to members and monitor their progress. To do this, for example, payers will need state-of-the-art administrative systems and use telehealth and mobile applications for patient outreach.

5 Consumerism and Health Insurance Exchanges: The Inflection Point for Health Plans

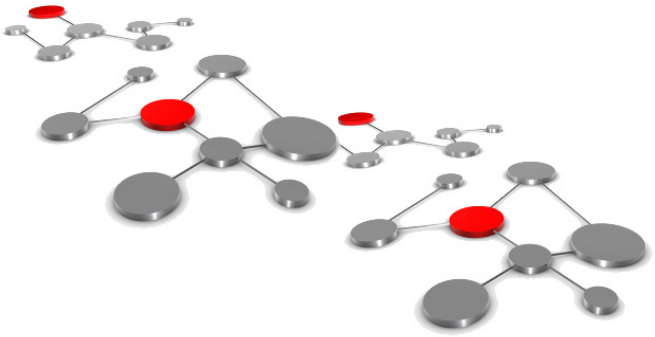
A major political hot button surrounding the ACA's implementation concerns the creation of HIXs. Basically, each state has the option to either 1) create and operate an HIX itself, 2) choose to have the federal government take on that responsibility or 3) opt for a state/federal partnership. How it shakes out depends on geography, politics and cost.

What has garnered less attention is that incorporating HIXs into the ACA is a clear recognition of an established trend toward greater consumerism that has been weaving its way throughout the healthcare industry for years. Thus, HIXs can be reasonably considered an industry inflection point with a specific go-live date: October 1, 2013.

It is academic that health plans need to invest in a coherent HIX strategy and the infrastructure to go with it. But it shouldn't stop there. Instead, health plans should consider an HIX investment as part of a comprehensive consumer engagement strategy and platform. This should translate into many of the same capabilities and infrastructure as outlined above (self-service tools, self-care programs, patient engagement solutions, robust analytics, member identification and stratification, etc.). The focus needs to be on a direct-to-consumer/member-health plan connection. And those capabilities should be used to create engaged, brand-loyal members that *then* go to the HIX to select their individual or small group coverage, and *not* the other way around.

6 Enhancements in Electronic Transactions

Enhancements in electronic transactions are perhaps the easiest and most tactical area of HIT investment opportunity to go along with the ACA's requirements—albeit not the most exciting. Notably, the mundane, commoditized world of electronic transactions is getting a bit of a facelift, and the result might be worth a good look. Also, there are other transactions (long overdue) poised to become electronic. Health plans will find the opportunity to assess and adopt several specific, tactical improvements in core operational areas, and, in doing so, take out transaction cost with the potential to improve the clinical outcome and user experience.



There are a number of electronic enhancements and innovations for health plans to consider. They include:

- **EDI definition enhancements –** Section 1104 of the ACA "…establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs." Specifically, financial and administrative transactions will get an upgrade, particularly around eligibility, referral and authorization, claims and payment processing. These can be leveraged to improve administrative costs, reduce paper processes, and even enhance clinical transactions, such as gaps in care messaging and facilitating medication therapy management.
- **SMTP –** Now the standard transport protocol for EHR and part of the base EHR definition, this will further simplify integration between health plan systems and those of their providers. And it should make HIEs more viable, lowering the barrier for health plan participation.
- **Emerging standards and process improvements –** Health plans should be looking at other promising areas to streamline transactions. In particular, electronic Prior Authorization for medications is beginning to see broad acceptance, and states, pharmacies and EHR vendors are now starting to support electronic prescribing for controlled substances. Similarly, medication reconciliation and gaps-in-care messaging solutions adopted in the provider/hospital setting show potential to reduce errors and created a more coordinated, comprehensive care experience, which incidentally complements HHS' Safe Use Initiative.

In short, the otherwise unsung back office infrastructure of the health plan can be called up to deploy new transactions and standards that have the potential to streamline current processes, reduce administrative costs and paper, and add meaningful clinical content at the point of care. And the good news is that these, too, can be leveraged to satisfy the ACA's MLR requirements.

Conclusion

The sweeping scope of the ACA is a two-edged sword for health plans. On one hand, its provisions place many requirements on health plans, which can reasonably be considered burdensome and costly. On the other, the ACA creates genuine opportunities for health plans to increase their book of business through an intelligent, informed HIT strategy to manage the member experience, improve the quality of care, report on quality, lower costs and enhance the bottom line. To be sure, the ACA is a work in progress. But health plans that act now and do so strategically with innovative HIT solutions will gain both a competitive edge and a significant return on their investment.

About Point-of-Care Partners

Point-of-Care Partners, LLC (POCP) is a boutique HIT strategy and management consulting firm focused on helping health plans, PBMs, pharmaceutical companies and HIT vendors maximize their technology and workflow investments.

We specialize in two primary areas:

- eMedication Management – medication adherence, medication reconciliation and post-marketing surveillance.
- eCare Management – personal health records, health information exchanges, payer-based health records, electronic health records and mobile health under the umbrella of chronic care management.

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