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Weekly insights from the Health Research Institute pwc.com/hri

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Week of 1/13/2014

This week's regulatory and legislative news:

- **Young invincible exchange sign-up at 24%, improving**
- **CMS releases final home and community-based services rule**
- **Maryland shifts hospital payment, eyes population health model**
- **Three important changes slated for Medicare Part D**
- **FDA rethinks regulations as new technology empowers patients**
- **OIG advises CMS to revamp process for identifying fraud in electronic records**

Young invincible exchange sign-up at 24%, improving

Of the 2.2 million individuals who signed up for health insurance coverage through the ACA exchanges between October and December, 24% were between the ages of 18 and 34 – short of the administration's 40% target. Yet young adult sign-ups increased eight-fold in December, suggesting the goal may still be met by the end of open enrollment in March. Concerns that most of the so-called "young invincibles" would gravitate toward cheaper catastrophic plans seem to be unfounded: just 1% of shoppers picked a catastrophic plan, with most selecting subsidy-eligible silver plans. Nearly 80% are expected to receive federal premium assistance, very close to the Congressional Budget Office's 86% estimate. Nearly 1.2 million sign-ups were in the 36 states using the federal exchange, while 957,000 were in the 15 state-based exchanges.

HRI impact analysis: Some in the insurance industry, such as Humana, expressed concern about drawing a more costly mix of patients, known as adverse selection. But the Kaiser Family Foundation points out that more young adults are expected to sign up toward the end of open enrollment. If the percentage of younger enrollees doesn't climb past 25% in the first year, insurers could face reductions in profit margin. It's unlikely, however, that this scenario would trigger a "death spiral" of unsustainably high costs – as Kaiser notes, a 1-2% increase in premiums would be more likely. Regardless, insurers are protected from the severe financial effects of adverse selection under the risk adjustment, risk corridor, and reinsurance programs. Others in the industry, including Aetna, Wellpoint, and Cigna, don't see the current enrollment mix as a major issue. For more information on 2014 exchange premiums and ways to engage the young invincible population, see HRI's Health exchanges: Open for business.

CMS releases final home and community-based services rule

Last Friday, CMS released a final rule that changes how Medicaid home and community-based care is defined. In the final rule, CMS characterizes these services by the type and quality of an individual's experience, rather than by specific physical characteristics such as location. It allows states to combine federal waivers to provide services for subpopulations, such as the developmentally disabled. This will likely reduce the administrative burden of serving multiple separate groups.

HRI impact analysis: The final rule, which implements part of the ACA, moves Medicaid long-term care in a more consumer-centered and outcomes-based direction. It gives flexibility to providers such as assisted living and residential care communities, which may not otherwise qualify for reimbursement. It also allows states to have more control over their Medicaid waiver programs. The new rule reflects an industry-wide shift toward home and community-based care that is likely to accelerate with the aging

baby-boom generation. For more on Medicaid's movement to long-term care, read HRI's Top health industry issues of 2014.

Maryland shifts hospital payment, eyes population health model

More than four decades after first adopting a unique hospital payment model that requires all insurers to pay the same rate, Maryland hospitals are poised to test another new reimbursement method. Federal health officials last week approved the state's revised Medicare waiver, which caps hospital spending over five years and shifts providers away from fee-for-service to a system based on global payments. Under the new model—which extends from Medicare to commercial payers--Maryland will tie hospital payments to the growth in its overall economy, capping spending at roughly 3.5% annually. The waiver requires the state to save Medicare about $330 million over a five-year window.

HRI impact analysis: The waiver allows Maryland to experiment with a host of programs, such as gainsharing, accountable care organizations, and global payments as a way to improve the quality and efficiency of care while lowering costs. After the fourth year, state health officials must develop a roadmap to include other providers, such as primary care doctors, home health nurses and medical specialists. The proposal won the endorsement of the Maryland Hospital Association, but individual health systems expressed concerns about how the program will be implemented.

Three important changes slated for Medicare Part D

A recent proposal from CMS would institute several important changes to Medicare's prescription drug program, known as Part D. Starting in 2016 insurers would be limited to offering two drug plans per service area. Currently insurers can offer three plans, but the agency wants to limit the confusion beneficiaries experience when faced with many plan options. The agency also has proposed a dramatic expansion of its medication therapy management program, which helps patients comply with their drug regimens. The proposal would increase the number of people eligible to participate from 2.5 million to 18 million, which would cover more than half of all Part D beneficiaries. CMS is also considering sharing more Part D claims data with the research community, including prescriber, pharmacy and plan identifier information. The additional information may help researches track the prescribing patterns of physicians.

HRI impact analysis: The expansion of the medication therapy management program could help improve drug adherence among the elderly. HRI's report on customer experience in the pharmaceutical sector notes that baby boomers with multiple chronic conditions are less likely to take their drugs correctly. As more retail pharmacies become full-service health centers, pharmacists will have a greater opportunity to influence behavior by providing medication management services. CMS' push to share more Part D claims data is part of a larger push in 2014 for more transparency by government and employers.

FDA rethinks regulations as new technology empowers patients

As consumers increasingly turn to home testing and remote monitoring services, the FDA is taking note and adjusting expectations for approval. In recent draft guidance, the agency distinguishes the regulatory requirements for blood glucose monitors used by healthcare professionals in a clinical setting versus products that are sold over-the-counter for patients to administer themselves. Meters developed for home use may need a more robust design to account for varying conditions. In a separate blog post an agency official explained that, "patients who use over-the-counter glucose meters and test strips at home vary in age, how much they know about how to use blood glucose tests, and other critical factors that might affect the accurate use of the device."

HRI impact analysis: In the new health economy, consumers are turning to technology to help manage their own health. Social, mobile, analytics and cloud technologies will fundamentally alter how health organizations interact with patients. Regulatory agencies will have to keep up as new mobile technology changes healthcare delivery. According to HRI's recent Top Issues report, 27% of physicians encourage patients to use mobile applications, and 59% of doctors and insurers believe that the widespread use of mobile health applications in the near future is unavoidable.

OIG advises CMS to revamp process for identifying fraud in electronic records

Last week OIG reported that many CMS contractors looking for fraud have not modernized their medical record review process to account for known vulnerabilities in electronic health records (EHR). Specifically, OIG cited two common culprits of EHR fraud: the copy and paste function –which providers use to avoid typing the same information multiple times in a patient's record – and overdocumentation, the act of entering inaccurate information to support billing for higher level services than the ones provided. The agency recommends that CMS educate contractors on detecting fraud specifically in EHRs and order its contractors to review providers' audit logs, which can be used to uncover data inconsistencies.

HRI impact analysis:
More pressure on CMS to curb fraud means physicians and hospitals should expect an increased level of scrutiny of their claims. In a separate report the agency released last month, OIG said only about 25% of hospitals that have implemented EHRs as part of the government's meaningful use program have copy-paste policies in place.

Upcoming events & deadlines

- **January 27 –** Comments due for Medicare hospital outpatient prospective payment system and the Medicare ambulatory surgical center payment system rates for 2014.
- **February 3 –** Comments due on FDA's draft guidance on compounded pharmaceuticals.
- **February 4 –** Federal Trade Commission workshop on naming conventions around biologics.
- **March 31** – Open enrollment in health insurance exchanges closes for 2014.

Quote of the week

"With a scribe, I can think medically instead of clerically," said Dr. Marian Bedner, a Dallas based emergency room physician. Dr. Bedner is one of many doctors choosing to employ scribes to update patient electronic medical records. There are an estimated 10,000 scribes working in hospitals and practices around the country, with demand continuing to grow. A recent article published by Health Affairs found that two-thirds of a primary care physician's day is spent on administrative work, of which many of those hours could be reduced by the use of scribes.

In the news

In advance of the JP Morgan Healthcare Conference this week, Aetna CEO Mark Bertolini announced that sign-ups for Medicare Advantage were better than projected, abating fears that reimbursement cuts to the program would lead to a loss. The Global Post reports that Aetna anticipates its 2014 operating revenue to be $54 billion, up from the $53 billion projected.

Factually correct

6,000 - The number of healthcare jobs the Bureau of Labor Statistics reported cut in December.

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