Modern Healthcare

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Dr. Julian Trivino, above left and in other photos, and other caregivers from the U.S. mainland have provided life-saving support as Puerto Rico contends with a public health crisis.

Answering the call Page 6

UP&COMERS Read profiles of all 15 honorees / Page 12

Davidson

Guzman

McVay

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late news

CMS officials say they're willing to talk about MIPS changes

A top CMS official agrees with a congressional advisory panel that a new payment model for physicians should focus more on outcomes and less on performance. She said the agency will seek providers' opinions on changing the measurements.

Goodrich

The Medicare Payment Advisory Commission last week said that MIPS, the Merit-based Incentive Payment System created by the Medicare Access and CHIP Reauthorization Act, should be repealed because it weighs too heavily how doctors perform, such as whether they ordered appropriate tests or followed general clinical guidelines, rather than if patient care was ultimately improved by that provider's actions.

Dr. Kate Goodrich, chief medical officer of CMS' Center for Standards and Quality, said on Oct. 13 that she agreed with the criticism but did not go so far as saying MIPS should be repealed. "There are more outcomes measures in the MIPS portfolio than I think people realize, but it is still too heavily weighted on process measures," Goodrich said at a MACRA summit.

MedPAC proposed that all Medicare physicians remaining in fee-for-service have 2% of their payments withheld. Providers could get their money back if they joined a group of clinicians evaluated on performance-based measures. Goodrich said the proposal was intriguing but would require legislation. The CMS has the authority to develop new measures that evaluate outcomes over process and is working aggressively to do so, Goodrich said. The agency in the coming weeks plans to request proposals from providers and other stakeholders.

"If we are holding providers accountable for outcomes, they have got to be at the table and help drive this change," Goodrich said. **—Virgil Dickson**

Dignity and CHI still pursuing merger

While the deal is progressing more slowly than expected, Dignity Health still plans to merge with Catholic Health Initiatives, Dignity executives said in a call with investors Friday, marking nearly a year since the plans were initially announced.

The merger would create one of the nation's largest not-for-profit hospital systems, with combined annual revenue of around $28 billion and 142 hospitals.

The merger has been drawn out largely due to the complexity of joining two large organizations, said Dan Morissette, Dignity's chief financial officer and senior executive vice president.

San Francisco-based Dignity saw its operating loss widen to $66.8 million in 2017, up from $63.4 million last year. The system reported a net income of $383.6 million on the year, up from a net loss of $237.8 million.

Englewood, Colo.-based CHI is in the midst of a turnaround plan that includes selling money-losing hospitals in Louisville, Ky., and exiting the insurance business. The 103-hospital system saw operating losses widen to $585.2 million in 2017 from $371.4 million last year. **—Alex Kacik**

Corrections & Clarifications

In "Bundled-payment joint replacement programs winning over surgeons" (Oct. 9, p. 16), the correct title for Dr. Geoffrey Cole is executive director of operations at Piedmont Athens (Ga.) Regional Medical Center.

Briefs

■ **Healthcare spending growth in August dropped below 4% for the first time since 2014 and was just slightly above the all-time low, according to data from the Altarum Institute.** The slow growth was attributed to the Medical Consumer Price Index rate growing at a historical low of 1.8%. That rate indicated a "possible signal of relief for healthcare consumers with substantial out-of-pocket expenditures," according to the report released last week. The study revealed that healthcare spending fell 3.5% in the second quarter of 2017, compared to slightly more than 5% in the year-ago quarter. Prescription drug costs grew 5.2% in the second quarter while hospital spending rose 1.3%.

■ **The Office of Congressional Ethics said former HHS Secretary Dr. Tom Price has refused to cooperate in the investigation of Rep. Chris Collins (R-N.Y.) related to stock sales of Australian biotechnology firm Innate Immunotherapeutics.** Collins sits on Innate's board and is the company's largest shareholder. The OCE said there is "substantial reason to believe" Collins violated federal law and House rules and recommended that a subpoena be issued for Price to determine what he knew about the stocks. The Wall Street Journal reports that Innate sold nearly $1 million in stock in discounted shares to Price while he was still a congressman.

■ **Veterans Affairs Secretary Dr. David Shulkin has directed officials to overhaul how the agency identifies and punishes providers who deliver subpar care, following a USA Today investigation that found the VA concealed poor patient care.** Shulkin ordered staff to expedite the process for reporting bad actors to state licensing boards. In addition, legislation introduced in Congress last week would require VA physicians to report directly to state licensing boards within five days of witnessing unacceptable behavior by colleagues. The USA Today report found that the VA national database for reporting adverse incidents left out thousands of providers, including nurses and physician assistants.

Modern Healthcare

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the week ahead

Senate committee seeks answers on drug pricing

Follow the money. If only it were that simple when it comes to understanding how much prescription drugs cost—and why.

Davis

The Senate Health, Education, Labor and Pensions Committee will take another journey down the rabbit hole on Oct. 17, this time focusing on the delivery system. The committee started its probe in June with a hearing aimed at getting a basic understanding of the issue.

"More than 4 billion prescriptions are written for drugs each year for Americans who then receive those drugs at 60,000 drug stores, from doctors or hospitals and from online pharmacies. The total cost to the overall health system of these prescriptions each year is $450 billion, to be paid by taxpayers, patients, hospitals and insurers, among others," committee Chairman Lamar Alexander (R-Tenn.) said during the June hearing. "This is a discussion that affects the well-being of every American family. It is important that we work together to conduct this fact-finding in a bipartisan way."

While the June hearing was billed as a bipartisan effort, several Democrats used it as an opportunity to blast the GOP's efforts to derail the Affordable Care Act.

At the Oct. 17 hearing, the committee will listen to testimony from officials representing big pharma, generic drug manufacturers and pharmacists. One topic that's sure to come up is trying to understand where the money goes.

A study published in June in Health Affairs tried to trace exactly that. Looking at a hypothetical $100 prescription, researchers combed through Securities and Exchange Commission filings and other analyses and projected gross profit for branded-drug manufacturers to total $58 and $18 for generic-drug makers. The study also found that pharmacy benefit managers raked in four times as much on generic drugs versus brands.

The concern is that policymakers will rush to judge the entire industry through a single lens, rather than assessing each player differently, said Chester "Chip" Davis, CEO of the Association for Accessible Medicines, which represents generic-drug manufacturers. Davis is slated to testify at Tuesday's hearing. **—Matthew Weinstock**

The Meter

A bi-weekly poll taking the pulse of the Modern Healthcare audience

Shamelessly borrowing from Dr. Atul Gawande's latest New Yorker article, do you think healthcare is a right?

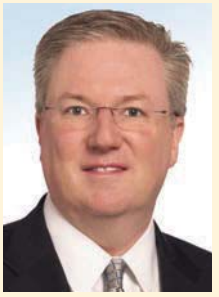
To participate and see other poll results, go to ModernHealthcare.com/TheMeter

regional news

MIDWEST

Cleveland Clinic inks another Medicare Advantage deal

Cleveland Clinic is working with Anthem Blue Cross and Blue Shield in Ohio to offer a new Medicare Advantage plan, continuing the health system's recent pattern of partnerships with insurance companies.



Sears

The Anthem MediBlue Prime Select plan, an HMO, has no monthly premium. Plan members can receive physician and hospital services exclusively through the Cleveland Clinic, while some services—such as outpatient dialysis and skilled-nursing facilities—will be available through independent providers.

It's Anthem's only exclusive network arrangement in northeast Ohio.

"In collaboration with Anthem, we will be able to work with patients across the state of Ohio, providing high-quality, coordinated care to help improve their health and well-being," Kevin Sears, executive director of Cleveland Clinic Market & Network Services, said in a prepared statement.

The clinic this month announced a similar partnership with Humana to create two new no-premium Medicare Advantage health plans in Cuyahoga County. And in June, the clinic announced it was making its first entrance into the insurance market with a product bearing its name in collaboration with New York City-based Oscar Health. **—Lydia Coutré, Crain's Cleveland Business**

MIDWEST

CMS stops Via Christi from enrolling dual-eligibles

The CMS earlier this month barred Via Christi Health from enrolling any more patients in its plan for people who are dually eligible for Medicare and Medicaid.

The ban applies to Via Christi HOPE, the Wichita, Kan.-based health system's managed-care plan that launched in 2002 under the Programs of All-Inclusive Care for the Elderly, or PACE.

"The CMS has concluded that VCH failed substantially to provide its participants with medically necessary items and services that are covered PACE services," the agency said in a letter sent to Via Christi.

The CMS cited Via Christi, which is owned by Ascension, for at least a dozen instances of substandard care coordination.

Via Christi must submit a corrective action plan and then attest to the CMS that it implemented the plan. An Ascension spokesman said Via Christi is addressing the issues identified by the CMS. **—Virgil Dickson**

WEST

Costly earthquake protections force L.A. hospital to close

Los Angeles-based Pacific Alliance Medical Center will shut its doors in December, citing the massive costs to retrofit its facilities to meet seismic requirements.

The building does not meet current California seismic standards and it is not "economically viable for us to invest nearly $100 million to build a hospital on land that we would not own," the company said in a statement. The physician-owned hospital's closing was "in no way related" to a $42 million settlement with the federal government regarding allegations that it provided kickbacks to referring physicians, the company added.

Pacific Alliance reported a $12.2 million net loss and a negative operating margin of 17.9% in this year's first quarter, according to public financial data. All 638 employees will be out of jobs, according to a Worker Adjustment and Retraining Notification sent last week. **—Alex Kacik**

Calif. law calls for greater drug price transparency

Drug companies doing business in California will soon have to notify the public two months in advance of dramatic price spikes under legislation signed last week by Gov. Jerry Brown.

It is one of the strictest drug-price transparency laws in the country, as states move to shine a spotlight on rapidly rising costs in the hopes of pressuring drugmakers to keep them down.

Approximately 1 in 4 Americans has trouble affording prescription drugs, according to the Kaiser Family Foundation. Price spikes in EpiPen and other critical drugs in recent years have sparked outrage from consumers and lawmakers.

California's law applies to any prescription drugs that sell for a wholesale cost of more than $40, including drugs purchased by the state for Medi-Cal and Medicare. **—Associated Press**

GNYHA Ventures President Lee Perlman, center, Danielle Butin, executive director of humanitarian group aid group Afya Foundation, to Perlman's right, and an army of healthcare workers assembled supplies for relief missions to Puerto Rico. They have delivered more than 29,000 pounds of relief items to the island in 10 missions.

Mainland providers lead relief efforts as Puerto Rico fights public health crisis

By Steven Ross Johnson

It was around 11 p.m. on Sept. 27 when the plane carrying Dr. Julian Trivino, an emergency medicine physician at Florida Hospital Orlando, arrived in Puerto Rico.

One of the first things Trivino noticed as the plane made its approach was the vast darkness that enveloped the island, with the exception of a long line of lights about 2 to 3 miles long.

"The line of lights was actually cars waiting at gas stations to fill up," Trivino said.

Trivino was one of five emergency physicians who recently returned to Florida after spending two weeks providing medical relief on the island. About 30 of Florida Hospital Orlando's clinicians have either visited or are currently in Puerto Rico or the Virgin Islands as part of a humanitarian relief effort that began after two hurricanes severely damaged much of the region's healthcare infrastructure in late September.

For more on policies that could help Puerto Rico, see the editorial on p. 26

Immediate attention remains focused on providing emergency medical care to residents and getting Puerto Rico's 69 hospitals fully operational. Just 25 were connected to the electrical power grid as of Oct. 10, according to updates provided on the website of the Puerto Rico governor's office.

Approximately 40% of residents still have no access to potable water, according to the Federal Emergency Management Agency, with the death toll reportedly at 43 as of Oct. 10.

House lawmakers last week passed a proposal to provide $36.5 billion in emergency funding for hurricane and wildfire relief as requested by the Trump administration, which includes a $4.9 billion loan to Puerto Rico.

The measure includes $18.7 billion to go toward FEMA's disaster relief fund and another $16 billion to fund the nation's flood insurance program.

Overall, the federal government's response

THE TAKEAWAY

Amid a political war of words over relief efforts in Puerto Rico, providers in the states are sending supplies and other assistance to help keep the island's hospitals open.

to the disaster in Puerto Rico has been roundly criticized for being too slow compared to its efforts in Texas after Hurricane Harvey or Florida after Hurricane Irma. And late last week, President Donald Trump continued his Twitter war with island officials: "Electric and all infrastructure was disaster before hurricanes. Congress to decide how much to spend..." Followed by, "We cannot keep FEMA, the Military & the First Responders, who have been amazing (under the most difficult circumstances) in P.R. forever!"

Sidestepping the political show, the urgent need for relief has prompted mainland healthcare providers to take a lead role in providing support.

Kaiser Permanente last month announced it was contributing $1 million to the Centers for Disease Control and Prevention Foundation to assist in its public health efforts on the island.

Relief workers > from Florida Hospital provided care and comfort to patients across the island. Concerns remain about the long-term impact of the public health crisis.

< GNYHA President Kenneth Raske, right, joined New York Gov. Andrew Cuomo to talk about efforts healthcare providers in the state are taking to help in Puerto Rico, including sending 100 to 200 clinicians to provide direct medical care.

Along with Florida Hospital, providers based in New York have been among the leaders in the relief effort. With more than 700,000 residents of Puerto Rican descent, New York City has the largest Puerto Rican population in the mainland U.S.

"The bond between New York and Puerto Rico has been long and strong," said Kenneth Raske, president of the Greater New York Hospital Association. The group has raised $5 million in donations toward funding its relief efforts.

In addition, the GNYHA led a series of medical supply missions over the past two weeks resulting in the direct delivery of thousands of medical and non-medical supplies to several hospitals on the island.

The organization, with the help of the humanitarian aid group Afya Foundation, delivered more than 29,000 pounds of supplies over the course of 10 missions with the use of personal aircraft loaned to them by wealthy private citizens.

The experience of performing disaster relief during Superstorm Sandy in 2012 helped to make the organization more nimble in its response to aiding Puerto Rico, said Lee Perlman, president of GNYHA Ventures, the association's business arm. Perlman said assembling each shipment and delivering it to the island takes 24 to 48 hours.

"Our model was to deal directly with providers in Puerto Rico and try and take care of what they need," he said, adding that three more shipments were scheduled to be delivered this week, with an emphasis on supplying providers with more medications, such as insulin for diabetics.

But the continued lack of electrical power has been one of the greatest challenges for both island providers and for those visiting to help with the relief effort. A number of hospitals and clinics have been left to rely on a single generator that can only power parts of their facilities. Trivino said those facilities are likely to see a spike in deaths once their generators begin to give out.

Trivino recalled when the doctors first arrived in Puerto Rico, they had received word that a hospital in the northwestern town of Aguadilla, about 70 miles from the island's capital of San Juan, was close to shutting its doors due to a lack of electricity, diesel fuel and drinking water.

Trivino and his fellow physicians drove two hours to the hospital to try help keep the facility running.

With the use of satellite phones, they were able to communicate with federal emergency relief officials and got supplies to the hospital within 24 hours.

"If you don't have a generator, you have no hospital," Trivino said. His team's work in providing medical care as well as delivering supplies they brought from Florida Hospital was hampered due to a number of logistical concerns.

Despite such relief efforts, questions linger as to the fate of the island's hospitals after the current situation subsides.

"The real question is what is going to be the long-term relationship between the hospitals in New York and the hospitals in Puerto Rico," Perlman said.

For its part, GNYHA is currently developing an "adopt a hospital" program in coordination with the American Hospital Association and the Healthcare Association of New York State to form partnerships that would allow mainland providers to assist with island hospitals' long-term needs.

Though plans are still in development, Perlman said he envisioned an initiative that would have stateside healthcare organizations making regular visits to Puerto Rico to help provide logistical, engineering and clinical expertise for the purpose of creating a new care model as the island rebuilds.

"It's really matching facilities around the states and New York that have specific (capabilities) in areas and trying to match them to see how we can be helpful," Perlman said. ●

Executive actions likely to disrupt ACA marketplaces

By Harris Meyer and Matthew Weinstock

Frustrated by the GOP's failure to repeal the Affordable Care Act, President Donald Trump last week took matters into his own hands. The administration announced two sweeping actions that could dramatically disrupt the insurance marketplace.

The administration on Thursday said it would stop making payments that help insurers offset the cost of reducing low-income people's deductibles and copayments. Earlier that day, Trump signed an executive order aiming to ease ACA insurance rules and give individuals and businesses access to cheaper health plans with fewer benefits and consumer protections.

"Obamacare is a broken mess. Piece by piece we will now begin the process of giving America the great HealthCare it deserves!" Trump tweeted on Friday.

Industry leaders were critical of both steps, fearing that the changes will not only drive up insurance costs, but reduce coverage options for patients.

"We are alarmed by news of administration decisions that could create turmoil across insurance markets and threaten healthcare coverage for millions of working Americans, especially people who face financial hardships," said Dr. Bruce Siegel, CEO of America's Essential Hospitals.

The Trump administration had been making the cost-sharing reduction payments on a month-by-month basis, creating uncertainty for insurers. With the payments in place, average deductibles for people with incomes below 150% of the federal poverty level fell from $3,609 to $255; for people with incomes between 150% and 200% of poverty, deductibles were $809. The cost for people between 200% and 250% of poverty was $2,904, according to the Kaiser Family Foundation.

AP PHOTO

The president and other conservatives have labeled the $7 billion the government spent in subsidies this year a bailout.

The president and conservatives have called the $7 billion the government spent in subsidies this year a bailout, a claim the insurance industry denied. "These payments are not a bailout—they are passed from the federal government through health plans to medical providers to help lower costs for patients," America's Health Insurance Plans and the Blue Cross and Blue Shield Association said in a statement.

It's widely anticipated that insurers will sue the government to recover the CSR funds promised by the ACA, as some insurers have successfully sued to recover ACA risk corridor funding. "Plans are definitely exploring that," said said Margaret Murray, CEO of the Association for Community Affiliated Plans, which represents safety net insurers.

Meanwhile, the president's goal to trim ACA coverage rules will have to be implemented through time-consuming rule-making, lessening the chance the changes will take effect in time for 2018. And experts said the executive order is likely to face legal challenges.

The administration is pushing to offer more affordable coverage to people if they band together through business and occupational associations. It could go a long way toward achieving the Republican goal of gutting ACA market rules and allowing consumers to buy stripped-down coverage in a less-regulated market.

But many insurance leaders, state regulators and policy experts fear that Trump's order, depending on how it's implemented, could drive up premiums and make coverage less available in the regulated individual market. That's because healthier customers likely would move into the cheaper, leaner plans, leading insurers to raise rates for more comprehensive plans or exit the market.

The American Academy of Actuaries warned that the changes sought by Trump risk tilting the market in favor of plans with weaker benefits and solvency.

Trump's order directs his administration to develop regulations within 60 days to expand coverage through low-cost, short-term health plans that are exempt from ACA market rules. The plans would not have to comply with requirements to cover 10 categories of minimum essential benefits o r a ccept all applicants at the same rates regardless of pre-existing medical conditions. The o rder a pparently w ould a llow i ndividuals to buy such short-term plans lasting up to 364 days, rather than the current 90 days.

The new regulations could trigger legal challenges over whether they comply with the ACA and other statutes.

"Many commentators, including me, think the law should be changed to foster competition across state lines," said Stuart Gerson, partner at Epstein Becker & Green. "But I don't think you can solve this problem without changing the law. ●

THE TAKEAWAY

President Donald Trump took steps to dismantle Affordable Care Act insurance rules, but new regulations could trigger legal challenges over whether they comply with the ACA and other federal statutes.

Undocumented parents fear enrolling their U.S.-born children for insurance

By Virgil Dickson

AP PHOTO

ICE arrested 75,045 undocumented immigrants from January to June of 2017. Of those, 19,752 or 26% were classified as non-criminals.

The National Immigration Law Center is hearing more stories of undocumented citizens skipping medical appointments or not signing up their U.S.-born children for healthcare coverage over concerns they'll be deported.

"When you are hearing stories of people being picked up off the street, it has created a level of fear that wasn't there before," said Alvaro Huerta, a staff attorney at the center.

Huerta is referring to the rise in arrests of people living in the U.S. illegally. There was a 40% increase in the number of arrests made in the first six months of this year, compared with the same period last year, according to data from U.S. Immigration and Customs Enforcement.

ICE arrested 75,045 undocumented immigrants from January to June of 2017. Of those, 19,752 or 26% were classified as non-criminals. In the same period for 2016 under the Obama administration, ICE made 54,683 arrests, of which 15%, or 8,053, were noncriminal.

Children Now, a nonpartisan research firm, earlier this year said that a survey of undocumented residents in California reported reluctance in sharing information, decreases in the number of child health appointments and a bump in the number of no-show appointments.

If continued, those actions could have huge ramifications. About 11 million undocumented people live in the U.S. and an estimated 80% of their children are American citizens.

A federal advisory panel that includes providers has asked the CMS to issue guidance or outreach materials assuring undocumented parents of U.S.-born children that they can sign their kids up for Medicaid or CHIP without fear of that information flagging them for deportation.

Earlier this year, President Donald Trump drafted an executive order that declared the Privacy Act, a federal law that protects individuals' information in government databases, applies only to U.S. citizens and lawful permanent residents. Trump has yet to sign the order.

Attorneys cautioned that information submitted on Medicaid and CHIP applications is used only to determine eligibility for the program, but the order still had a chilling effect.

Last month, HHS' Advisory Panel on Outreach and Education said the current increased attention around immigration could help outreach efforts.

"We had created documents, resources and handouts for families, but that has been put on hold for the time being," said Jessica Beauchemin, who works in the strategic marketing group in the CMS' office of communication, at one of the panel's meetings. She did not say why the effort was halted.

A CMS spokeswoman declined comment on the effort and said the agency doesn't gather data on how many U.S.-born children with undocumented parents are on Medicaid or CHIP.

Beauchemin noted that the CMS regularly schedules enrollment outreach for all eligible children. She cited two webinars—one that took place late in the Obama administration aimed at increasing enrollment in Hispanic communities and one that took place back in January aimed at encouraging enrollment for multi-generational families. Neither appeared to specifically target undocumented parents.

It may be too late to reassure the skittish population, said Nadereh Pourat, a UCLA professor who studies the use of health services among the undocumented. After the arrests earlier this year of Oscar and Irma Sanchez, an undocumented couple detained at a Texas hospital after admitting their baby for emergency surgery, many worry about seeking medical care without facing deportation.

"You cannot place ICE agents in hospitals or other places where people are likely to request benefits for emergencies and then assure people they are safe to apply for citizen children," Pourat said.

A spokesperson for Customs and Border Protection told NPR that agents are required to monitor subjects in custody "at all times" and tried to do so at the hospital "in the least restrictive manner possible." ●

THE TAKEAWAY

Federal actions are likely having a chilling effect on undocumented-immigrant parents enrolling their U.S.-born children into healthcare coverage.

Kaiser plays a starring role in CMS' Medicare Advantage ratings

By Maria Castellucci

Any good news found in the release of the 2018 star ratings of Medicare Advantage plans was clouded a bit by the fact that the five-star category is predominantly made up of Kaiser Permanente plans.

So, even as both the number of contracts and number of enrollees in five-star plans offering insurance and prescription drug coverage rose in 2018, 72% of the covered enrollees are in Kaiser-run plans. It's unclear why Kaiser was rated so highly while the total MA plan contracts receiving an overall five-star rating was stagnant, rising to 15 from 14, and the percentage of enrollees in five-star plans rose to 11.2% from 9.8%. Kaiser Permanente officials could not be reached for comment.

A CMS spokesperson said the dominance of Kaiser in the broad five-star category shouldn't overshadow the fact that most Americans have access to several four- to five-star plans, with a four-star rating considered to be "above average" and five stars being "excellent."

Still, the data released last week show that the number of Medicare Advantage plans that performed well in the CMS' star-ratings program dropped slightly from 2017. At the same time, the number of insurers that receive certain ratings hasn't changed significantly in recent years. The CMS bases the 2018 ratings on quality data reported in 2017 and 2016.

Although the overall number of four-star or higher plans dropped, more beneficiaries will be covered by the highest-performing plans in 2018 than this year, the CMS said. Nearly 73% of Medicare Advantage enrollees are in plans with four or more stars, compared to about 69% of enrollees in such plans for 2017.

The data also reveal a drop in highly rated plans with prescription drug coverage. About 44% of the 384 active MA plans in 2018 that also have drug coverage earned four stars or higher for their overall rating, down from 2017, when about 49% of the 363 active plans earned four stars or higher.

Richard Lieberman, chief data scientist at Mile High Healthcare Analytics, said it's not surprising that the figures have remained largely stagnant in recent years. Higher performers tend to be companies that have the most experience in Medicare Advantage. Those with 10 years or more experience in a Medicare Advantage program accounted for about 21% of 4½-star ratings and 31% of four-star and 3½-star ratings. Insurers that invested in the infrastructure and culture to improve quality of care did so years ago and continue to perform at four stars or higher, Lieberman said. On the other hand, some insurers still haven't made the investments needed to achieve higher performance.

The CMS also makes it harder every year to perform well on the various measures, which pushes out bad performers from the program, Lieberman said.

Plans earning at least four stars receive a 5% boost to their monthly per-member payments from Medicare, while those with lower scores receive nothing extra. The CMS bonus for a lot of plans is the "difference between profitability and not," Lieberman said.

The bonuses have allowed insurers to foster plans with additional benefits that are appealing to beneficiaries.

In addition, the CMS found that the number of Medicare Advantage plans with Part D prescription drug coverage rose by 21 from 2017 to 2018. Medicare Advantage contracts have become a lucrative revenue opportunity for insurers with many increasing enrollees in such plans.

"More high-quality choices mean improved quality care and better customer service at lower cost," CMS Administrator Seema Verma said in a news release.

For the first time, no insurers were labeled consistently low performers after just two were so designated in 2017. Low performers—plans with ratings of 2½ or fewer stars for three years in a row—can be terminated from the Medicare Advantage program. ●

Five-star Medicare Advantage plans, by enrollment

More than 11% of Medicare Advantage enrollees are in five-star plans offering drug coverage, but 72% of those are in Kaiser plans

Parent organization		
Kaiser Foundation Health Plan	1,440,602	72.3%
Blue Cross and Blue Shield of Minnesota	251,069	12.6%
Tufts Associated HMOs	101,005	5.1%
America's 1st Choice Holdings of Florida	53,203	2.7%
Providence Health & Services	52,895	2.7%
HealthSun Health Plans	39,534	2.0%
Kelsey Seybold Medical Group	31,481	1.6%
University of Wisconsin Hospitals and Clinics	14,827	0.7%
Capital District Physicians' Health Plan	3,954	0.2%
SSM Health	2,517	0.1%
Anthem	2,003	0.1%
	1,993,090	

Note: Because of rounding, total equals more than 100.
Source: CMS

THE TAKEAWAY

Most of the enrollees in five-star Medicare Advantage plans are covered by Kaiser Permanente.

ACOs slow to make progress on risk-based contracts

By Maria Castellucci

While accountable care organizations are gravitating toward risk-based contracts, they are still largely focused on the low-hanging fruit when it comes to saving money and improving quality, according to a new analysis.

Roughly 50% of ACOs are involved in at least one downside risk contract, such as shared savings and capitation contracts, according to a Leavitt Partners and National Association of ACOs report recently published in Health Affairs. About 47% of ACOs plan to participate in shared-savings, risk-based contracts in the next year or so.

"Even though ACO providers say they are preparing for and assuming risk, the care delivery system is not advancing as quickly as the payment system reforms," said Kate de Lisle, an author of the study and a senior analyst at Leavitt Partners. "In order for these payment models to be successful, providers need to change the way they deliver care."

Most ACOs still largely focus on "first wave" care-delivery changes such as preventing readmissions, emergency department use and chronic care management, according to the report. ACOs haven't tapped into other reforms that will also help them prepare for downside risk like behavioral health integration and medication optimization and management.

Approximately one-fourth of all ACOs, or 240, responded to the survey. The respondents ranged from urban to rural ACOs as well as physician-led, hospital-led and integrated ACOs.

About 48% of hospital-led ACOs said they currently had a risk-based contract, compared with 28% of physician-led ACOs. Physician-led ACOs might have stalled because they have fewer resources than large health systems to secure the capital needed to participate in risk-based contracts, de Lisle said.

Most ACOs still largely focus on "first wave" care-delivery changes such as preventing readmissions, emergency department use and chronic care management, according to the report.

Previous research has shown that physician-led ACOs are more likely to be successful in the model because they have a deeper understanding of their patient populations, she added.

But delivery system reform hasn't kept pace with payment reform. The CMS and other payers haven't offered providers much of a road map for adopting changes to care management. As a result, physicians are trying many different tactics all at once to see what does and doesn't work, de Lisle said.

That hasn't stopped providers with several years of ACO experience from generating savings. A recent study from HHS' Office of Inspector General found that the 423 ACOs participating in the CMS' Medicare Shared Savings Program reduced spending by about $1 billion in three years.

The ACO model is by the far the most popular in the push to value-based care. As of the first quarter of 2017, 923 private and public ACOs were in operation, covering more than 32 million patients, according to a June 2017 post in Health Affairs by Leavitt Partners. ●

THE TAKEAWAY

Accountable care organizations are slowly entering more risk-based contracts, but delivery system reform isn't keeping pace with payment model changes.

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Modern Healthcare UP&COMERS

Finding a greater purpose in helping people

Talk to members of the 2017 class of Up & Comers and one common trait will come through loud and clear: a deeply rooted desire to improve patients' lives. Whether it is launching a health plan aimed at easing consumer angst, using technology to help patients manage their medications, or pushing performance excellence across a service line, the 15 members of this year's class are focused on putting patients at the center of the delivery system.

Take Dr. Michael Rosenbloom, for example. After being drawn to patients suffering from memory loss during medical school, Rosenbloom finds himself at the forefront of advancing innovative treatments for Alzheimer's disease.

For Angela Lalas, working in healthcare was a matter of faith. As a senior vice president for finance, Lalas is on the financial side of the industry, but she knows her "faithful fiscal stewardship" ultimately allows clinicians to do their jobs better.

Selecting each year's class of Up & Comers is never easy. Modern Healthcare received 105 nominations this year. The editors reviewed all of the profiles and narrowed the list down to 15. We think you'll find that this year's selection represents a diverse mix of rising stars who are pushing the industry forward.

39
Vice president of operations

DANIEL **BARR**

Nationwide Children's Hospital
Columbus, Ohio

Who'd play me in a biopic:
Matt Damon

When Daniel Barr joined the staff at Nationwide Children's Hospital five years ago, his office was located just outside the pediatric intensive-care unit, which ensured that he had no truly bad days.

"It just gave me great perspective," he said. "You realize you don't have any problems that compare to what those kids and parents are going through."

Barr has moved through the healthcare ranks, advancing from a compliance officer for Tenet Healthcare Corp. to director of service line development for women's and children's services at University Hospitals Case Medical Center in Cleveland.

As vice president of operations for Nationwide Children's in Columbus, Ohio, Barr manages the hematology, oncology and bone marrow transplant service line. He is currently responsible for over $200 million in revenue, approximately 230 full-time employees and more than 30 physicians, as well as the clinical research and translational research team that supports clinician scientists within the Research Center for Childhood Cancer and Blood Diseases. During his tenure, the service line has seen a 55% increase in net margin.

As the father of two daughters, he sees healthcare, especially the care of children, as a higher calling.

"In college, the one class that really sparked me was a bioethics course, because you go through all these case studies that simulate what parents and physicians go through and you realize how personalized healthcare is. If you can help people through those impossibly tough decisions, that's a greater purpose."

In his role, Barr also co-leads the employee safety program, which is focused on achieving zero preventable employee injuries and improving mental health wellness. He is a fellow of the American College of Healthcare Executives and has held leadership roles at ACHE Philadelphia as an executive member of the regent advisory committee. —*Valerie Lapointe*

> "If you can help people through those impossibly tough decisions, that's a greater purpose."

36
Chief operating officer

GENEVIEVE **CARUNCHO-SIMPSON**

Texas Health Aetna
Arlington

Who'd play me in a biopic:
Natalie Portman

For Genevieve Caruncho-Simpson, healthcare was the family business. Growing up in Seattle with a mother and brother in the industry, she had an initial interest in clinical social work. After a practicum at the Veterans Affairs Department where she worked directly with veterans, she started to see some of the industry's biggest challenges and opportunities.

"I got to work with veterans who were transitioning back from active duty and facing challenges in behavioral health, physical health and mental health," she said. "Seeing the challenges they faced was eye-opening. I saw how affordable access to healthcare can make a sizable impact in so many lives, especially the most vulnerable."

Since then, she's focused her career on helping marginalized populations. While serving as the system director for strategy and business development at Miami Children's Hospital from 2011 to 2013, she launched four urgent-care centers. This was a multimillion-dollar investment that resulted in a joint venture with a multidisciplinary ambulatory center and Florida International University. She also helped develop a maternal-fetal medicine strategy that resulted in a partnership with Brigham and Women's Hospital in Boston. Later, she helped Humana launch Medicaid managed care across Florida and headed the insurance giant's Medicare Advantage operations.

After working for Ascension Health for a little more than a year, Caruncho-Simpson became COO of Texas Health Aetna in April.

While there may be gridlock in the federal government, Caruncho-Simpson isn't discouraged, as she sees the potential for innovation locally.

"On the grassroots level, there is tremendous opportunity to make market changes. Fundamentally healthcare is local and the local solutions are what will transform the industry," she said. "We can't wait for the federal government to solve all our problems; the transformation drivers in each market are locally based." —*Valerie Lapointe*

> "We can't wait for the federal government to solve all our problems; the transformation drivers in each market are locally based."

UP&COMERS

40
CEO

DR. BRIAN DAVIDSON

St. Mary's Medical Center, Grand Junction, Colo.

Dr. Brian Davidson's medical career began at the ripe age of 12. His father had been a U.S. Navy corpsman who flew medical rescue missions during the Vietnam War before returning home to Colorado to teach classes for fire department first responders. When he asked his pre-teen son if he wanted to take one, it opened a door.

"From that point on I didn't want to do anything else," Davidson said. "I didn't even want to be a fireman; I wanted to be a doctor."

He did his general surgery internship at St. Joseph Hospital in Denver and his residency in anesthesiology and fellowship in healthcare administration at University of Colorado Hospital. Immediately after his residency, Davidson petitioned the American Board of Anesthesiology to let him take his board exam a day early so he could start his MBA program the very next day.

Who'd play me in a biopic:
A young Tommy Lee Jones

"I was really interested in learning something different after going through all this clinical training," he said. "Sitting there with all these other students, I really felt like a kid in a candy store, learning about all the policy and administrative things going on around me. If you can handle the clinical and the administrative side of things, then your world becomes a lot bigger."

"I didn't even want to be a fireman; I wanted to be a doctor."

He currently serves as one of only three physician/CEOs in Colorado. St. Mary's Medical Center, in Grand Junction, is a Level 2 trauma center and the largest hospital between Denver and Salt Lake City.

The hospital is exceeding budgeted operating margin performance by more than 10% in a market where the economy is still struggling and net patient revenue is growing less than 2%.

During his tenure, which began in 2014, he has helped achieve formidable reductions in lengths of stay, especially via newly developed partnerships with local critical-access hospitals for long-term acute-care-eligible patients.

"I always knew what I wanted to do, but looking back on it, I guess it was pretty unique that I did a nonmedical fellowship in hospital administration," he said. "That has made all the difference." —*Valerie Lapointe*

32
Associate vice president

VANESSA GUZMAN

Montefiore Health System, New York City

Fresh out of college in 2007, Vanessa Guzman took a run at her American dream and started her own business, a healthcare staffing agency. But timing is everything and unfortunately for Guzman, the Great Recession hit.

Layoffs were more prominent than hirings and the business floundered. But from a business failure, she found career success and learned a lot in the process.

"I tried to do it all on my own and when I failed my confidence was shaken," Guzman said, "But I learned that in order to succeed, you really need to build the right team."

Humbled but motivated, she began anew. In 2010, she was hired as a clinical systems optimization manager at Montefiore Information Technology, a division of Montefiore Health System in Yonkers, N.Y. Over a handful of years, she transitioned to quality improvement and is now associate vice president of quality improvement and network management for the health system. During her tenure, she has played a strategic role in streamlining and maximizing revenue. She created a program to consolidate regulatory and quality requirements, initiated a multiyear patient engagement program and has helped the health system thrive in the CMS' Next Generation accountable care organization program.

Who'd play me in a biopic:
Halle Berry or Kerry Washington

Under her leadership, Montefiore is also helping hospitals across the Hudson Valley leverage $230 million in state funds to embrace value-based purchasing and quality improvement initiatives. Their work focuses on reducing administrative costs, minimizing hospital-acquired conditions and ensuring that patients receive timely primary care and follow-up visits following their hospital stays.

She credits her early career failure as a key ingredient to her achievements.

"It's only when you fail that you learn what the best approach is the next time you make the attempt."

"It's only when you fail that you learn what the best approach is the next time you make the attempt," Guzman said. "Sometimes you have to be disrupted or else you stop innovating." —*Valerie Lapointe*

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FIVE TAKEAWAYS

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BEYOND APPEARANCE: HOW THE CLINICAL ENVIRONMENT AFFECTS VALUE-BASED CARE

As providers evolve to meet the demands of value-based care, it's more important than ever that they connect processes, equipment and caregivers to ensure patient care is efficient and error-free. During a Sept. 19 webinar, experts discussed simple steps that health systems can take to provide a foundation for success under the Quadruple Aim.

The webinar was led by Dr. Tom Schwieterman, CMO and vice president of clinical affairs at Midmark Corp., and Roger Gruneisen, manager of consulting at Versus Technology. The entire webinar can be accessed at www.modernhealthcare.com/BeyondAppearance.

1

The Connected Point-of-Care Ecosystem lays a strong foundation for value-based care

A Connected Point-of-Care Ecosystem integrates processes, equipment and caregivers to create a seamless, well-coordinated patient and provider experience that positively impacts clinical outcomes. Providers shouldn't underestimate the significance of exam room design and technology in enabling providers to be efficient and accurate. By investing in technology that improves data, advances care management and eases provider workflows, leaders can ensure providers are equipped to meet new requirements and protocols.

2

Improvements at the point-of-care can combat physician burnout

The adjustment to value-based care initiatives like MACRA hasn't been easy for physicians, leading to an increase in early retirement and a decrease in provider satisfaction. As with other new requirements, many physicians feel it constitutes a burden. If healthcare organizations can make it easier for physicians to comply, they may be able to stem the tide of burnout.

3

Better equipment and processes can reduce costs

When equipment allows for seamless documentation in the electronic health-record, providers are more efficient and less prone to errors. Organizations that automate the vitals acquisition process, for example, are less likely to make dangerous mistakes that can occur when clinicians manually type them into the EHR. When equipment allows for documentation to be performed in the exam room instead of at stations in the hallway, providers can take more accurate patient notes and move more quickly from patient to patient.

4

Invest in technology that creates a better patient experience

Consumers have become increasingly selective in where they spend their healthcare dollars, so providers need to pay close attention to the patient experience. Patients who experience long wait times or bad customer service are less likely to be return customers. Providers should consider investing in Real-Time Locating Systems, which can help track both patients and devices, and alert administrators when a patient has been waiting too long to be seen by a physician.

5

A Connected Point-of-Care Ecosystem contributes toward the Quadruple Aim

All of the above best practices contribute to the Quadruple Aim – reduced costs, improved outcomes and higher satisfaction among both patients and providers. Equipment and technology shouldn't be an impediment to care – it should be an augmenting force in perfecting care. Performance is strengthened when healthcare organizations let doctors be doctors. When workflows, devices and people are connected, the administrative burden on physicians is lessened, and they're better positioned to achieve these critical goals.

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UP&COMERS

40
Assistant professor of clinical medicine and program director

DR. FARZANA RASHID HOSSAIN

Penn Medicine Philadelphia

Dr. Farzana Rashid Hossain's career has been all about helping women, both inside and outside the healthcare system. She credits her parents for instilling in her a sense of community outreach and an appreciation for math and medicine.

"My mother is a physician and my father was a professor, so math and science were always emphasized in our household, but we also did a lot of volunteering, so when I started thinking about a career I wanted something that incorporated all of that," she said.

As director of the women's gastrointestinal health program at Penn Medicine in Philadelphia, she has focused on changing working methods, challenging policy and promoting innovative ideas for sustainability performance. She is a results-oriented leader, whose empathy and vision have helped her to promote innovative ideas for sustainability and performance at Penn Medicine. She has played a key role in delivering high quality of care to patients, increasing patient throughput and helping generate higher satisfaction for all stakeholders.

Outside the hospital, she is one of 27 members of the Philadelphia Commission for Women, a group that works with community organizations and social service agencies to advance gender equality, assist with entrepreneurship and economic empowerment, and promote public discussion on issues that impact women and girls. She was recognized in Philadelphia magazine's annual Top Docs issue for 2017 and was awarded the Health Care Heroes Award from Penn Medicine and the Radhika Srinivasan Award for Humanism and Professionalism from Penn Medicine's gastroenterology department.

"I care about patients, I care about the community, I care about individuals, and that is what drives me," she said. *—Valerie Lapointe*

> "I care about patients, I care about the community, I care about individuals, and that is what drives me."

37
Pediatric service line director and director of operations

CHANTEL JOHNSON

Palo Alto (Calif.) Medical Foundation

The impetus to get into healthcare for Chantel Johnson was a specific one; she knew who she wanted to help. As a Carol Emmott fellow, she participated in a 14-month self-guided program for female leaders in healthcare. When asked to craft a legacy statement, she focused entirely on improving the health and wellness of women and children.

Johnson, who began here career as a registered nurse, oversees the Palo Alto (Calif.) Medical Foundation's 21 pediatric clinics in the San Francisco Bay Area. She is experienced in both ambulatory care and acute care, having served in several leadership positions in neonatal intensive-care units in the Seattle area prior to landing in her current role. Working as a nurse manager, she learned how important it is to empower the team behind you.

Who'd play me in a biopic:
Reese Witherspoon

"You can't just sell a new idea, you have to work on buy-in and prepare your team to make it a successful venture. Everything must start with engaging your team, or else any effort will fall flat no matter how great the design," she said.

Under her leadership, quality has been benchmarked at the 90th percentile for pediatric pay-for-performance initiatives, and employee satisfaction is in the 95th percentile.

"Every day, I want to try and improve the quality of care and access to care for women and children. I want to empower them in the communities that they live in and all the work I do toward that goal I see as tying into my legacy, and it's great to know that I still have 30-plus years to keep doing that," she said. *—Valerie Lapointe*

> "You can't just sell a new idea, you have to work on buy-in and prepare your team to make it a successful venture."

40
President of health systems

KEVIN KUMLER

Zocdoc
New York City

Kevin Kumler has been around healthcare his whole life. His mom was a dental hygienist and his dad was an orthopedic surgeon whom Kumler would sometimes accompany on hospital rounds. Kumler also gained the patient perspective from a young age since he grew up with asthma.

"I was drawn to the business side of it," Kumler said of his interest in the industry. After graduating from business school—around the time the first iPhone came out, he noted—he spent nearly a decade in McKinsey & Co.'s healthcare practice in the U.S., the U.K., and India. "I was seeing consumer technology starting to transform backward industries," he said.

Aiming to put that experience to use in healthcare, in 2013 Kumler joined Zocdoc, a company focused on the importance of putting patients—that is, consumers—at the center. Zocdoc has successfully rethought one of the most critical interactions between patients and providers: scheduling an appointment.

Who'd play me in a biopic:
Edward Norton

As head of Zocdoc's health systems business, he helped the company grow its footprint; the firm boasts nearly 6 million patient users every month. Now president of health systems for the 10-year-old company, Kumler is in frequent contact with healthcare leaders across the country. He's expanded the unit from five clients to about 80. Working with them, he can see that the pace of innovation is picking up.

"It's an exciting time to be in this space," he said, but technology developers have to make sure that their solutions, however innovative, are in the best interest of the patient.

Every day, Kumler said, he's excited to come into the office, where he floats around, working wherever there's an open space. "My desk is generally my lap, where I put my tablet and get to work," he said. He's proud of what Zocdoc has achieved, but, he said, "there's so much we haven't solved yet." That only motivates him more.

"I love jigsaw puzzles," he said, "and I can't walk away until the problem's done." *—Rachel Z. Arndt*

"I love jigsaw puzzles and I can't walk away until the problem's done."

37
Senior vice president for finance

ANGELA LALAS

Loma Linda (Calif.) University Health

For Angela Lalas, finding the right career was a matter of faith. "Growing up as a Seventh-day Adventist, it's almost like you're expected to go into healthcare" Lalas said. "My family encouraged me to become a medical doctor, but God led me to be in healthcare administration instead, especially here at Loma Linda."

Since January 2015, Lalas has provided oversight of financial operations for the four licensed hospitals of Loma Linda University Health, a $2 billion, 1,071-bed academic health system. She has also served as chief financial officer for the organization's shared services corporation and provided strategic direction and oversight for data governance, business intelligence and analytics, and unified administrative systems.

Who'd play me in a biopic:
My daughter

Under her leadership, the hospitals have improved financial performance for two consecutive years, achieved financial targets and maintained their corporate credit rating after consecutive downgrades prior to her tenure. The system's hospitals have improved combined net operating income from $14.4 million in 2014, for a 0.9% margin, to $104.7 million in 2016, for a 5.9% margin.

"I love that while I am not directly involved in the provision of care, I have an impact on it," she said. "I help support our providers in delivering top-quality care through faithful fiscal stewardship. I could have done finance in another industry, but I wanted to do something of meaning and significance, and it is in the healthcare industry that I am able to positively impact the most lives." *—Valerie Lapointe*

"It is in the healthcare industry that I am able to positively impact the most lives."

37
Chief of staff, vice president of corporate services and governance

JOSE **LOZANO**

Hackensack Meridian Health, Edison, N.J.

"What energizes me is being part of an organization that is moving the ball forward on improving healthcare."

Five years ago, Jose Lozano took his first job in healthcare as vice president for corporate services and governance at Hackensack Meridian Health. Prior to that, he had a 10-year run in government at the state and federal levels, most recently as the deputy chief of staff at the U.S. Environmental Protection Agency.

Lozano faced quite a learning curve switching industries, but has found the two environments to be more alike than different.

"In both jobs, you have to deal with a lot of crises that fall outside of the 9-5 working hours, and it's all about the quick learn and leaning on team members around you," Lozano said.

At Hackensack Meridian, he was put in charge of the communication and rollout of the 2016 merger between Hackensack University Health Network and Meridian Health, one of the largest mergers in New Jersey.

"Typically, in interactions like that, someone has the upper hand, but this was a merger of equals and we had to devise a structure and a framework to support that challenge," he said.

Who'd play me in a biopic: **Jon Stewart**

Part of his challenge now is serving as chief of staff to two CEOs, because both were retained in the creation of the new organization.

"It's a bit like being a single parent to twins. I'm managing two of everything, but both our CEOs are visionary and inspiring guys and part of the success of this dual-CEO model is that we have one center point for both of them, and that's me."

Lozano also managed the design and construction process for new corporate offices of the merged entity that houses approximately 250 employees, a project that was finished on time and below budget.

"What energizes me is being part of an organization that is moving the ball forward on improving healthcare," Lozano said. "Some days it's a half-inch, some days it's a few feet, but we are always striving to change and improve the way healthcare is delivered." —*Valerie Lapointe*

39
Vice president and chief analytics officer

BETSY **McVAY**

UnityPoint Health, Des Moines, Iowa

"Wanting to improve access and lower costs for people, that is my passion."

Becoming an analytics officer for UnityPoint Health was a meeting of skills and passion for Betsy McVay. She knew that was where she wanted to be after her sister was diagnosed with multiple sclerosis and she witnessed firsthand the challenges people face in terms of paying for and getting access to care.

"Wanting to improve access and lower costs for people, that is my passion, and I have an ability for math and numbers, so that's my skill set," she said.

She prides herself on being able to leverage data to see things from a fresh perspective. In just four years, McVay's team at Des Moines, Iowa-based UnityPoint Health has identified $57 million in organization-wide cost savings. They've worked closely with the chief financial officer to provide analytics support and rejigger finances and transition away from a traditional fee-for-service approach.

Who'd play me in a biopic: **Elizabeth Shue**

"We are using data and information to think differently. We now have the ability to inform our clinicians that if they discharge a patient today, when is it likely that they will be readmitted and what would our plan be if they show up again on day 15 versus day 20 or 30?" she said.

Her passion lies in creating a data-driven organization and figuring out what information her staff needs to help them think differently about patient care. McVay and her team focus on the use of both descriptive and predictive analytics, which has helped put UnityPoint in the top decile for performance measures. —*Valerie Lapointe*

39
Clinical director

DR. MICHAEL ROSENBLOOM

HealthPartners Center for Memory and Aging, St. Paul, Minn.

When Dr. Michael Rosenbloom was an undergraduate student at Johns Hopkins University, he took an entry-level psychology course that set him on a path to become one of the principal investigators for a potentially game-changing discovery in the treatment of Alzheimer's disease.

"I was fascinated by how you could relate brain structure to abstract things like memory and behavior," Rosenbloom said.

He went on to medical school at Columbia University. During a rotation at Harlem Hospital, he was consistently drawn to the patients with memory loss issues and has been working with that population ever since. After completing his fellowship in behavioral neurology in 2010, he began work at HealthPartners on a possible treatment for Alzheimer's that works by spraying a mist of intranasal insulin directly into the brain, bypassing the blood-brain barrier. Additionally, he is leading the trial for IDEAS (Imaging Dementia Evidence for Amyloid Scanning) to help identify Alzheimer's patients and give them a definitive diagnosis.

Who'd play me in a biopic: **Tobey Maguire**

"I think we are understanding this disease much better than we ever have before," Rosenbloom said. "We used to only see patients with late-stage or advanced dementia, and now there is a push to treat and identify the disease much earlier."

Rosenbloom also created the health system's Partners in Dementia program, which pairs first-year medical students with memory loss patients in an effort to get them to learn from each other.

"There are so many exciting developments in this field, so many clinical trial opportunities. Even 10 years ago, we weren't this sophisticated, and you even see the enthusiasm for this research in the National Institutes of Health funding. I think we are going to have new and better ways to treat this disease very soon." —*Valerie Lapointe*

"I think we are going to have new and better ways to treat this disease very soon."

39
CEO

MARIO SCHLOSSER

Oscar Health, New York City

Mario Schlosser's path into the healthcare industry was an unconventional one. After emigrating from Germany in 2001, he founded and served as CEO for Vostu, the largest social games developer in Brazil and Latin America. Then, the birth of his first child steered him in a different direction.

Going into the maternity ward for his daughter's birth, he took a printout of C-section rates for various doctors in the hospital. His wife wanted to have a natural birth and he wanted to make sure no doctor was going to push her too hard on that choice.

"When Oscar Health got started, my wife was going through her first pregnancy and I experienced firsthand how complicated the healthcare system was to navigate, and how expensive it was," said Schlosser, who co-founded the company in 2012. Oscar has raised $720 million in six rounds of funding and some estimates put the company's value at $2.7 billion. It is the first technology-based health insurance company and serves more than 100,000 enrollees across multiple states.

Who'd play me in a biopic: **Some unknown German art house actor**

"There isn't any entity in healthcare that has enough data visibility to help you navigate the system. This is the data-driven way that I like to think about the world and I didn't think anyone else was applying that thinking to insurance," he said.

Schlosser is currently leading Oscar in forming an innovative partnership with the Cleveland Clinic to offer the clinic's first-ever health insurance plan. The company is also a national leader in telemedicine utilization—23% of Oscar members use telemedicine—saving patients the cost of an expensive specialist or urgent-care visit. In the past year, Oscar ramped up its efforts to build tools for providers, empowering them with contextual patient data and generating clinically relevant alerts driven by machine learning. —*Valerie Lapointe*

"This is the data-driven way that I like to think about the world."

UP&COMERS

37
CEO
OMRI **SHOR**
Medisafe
Boston

"It almost brought us to tears to hear that Medisafe was the solution that saved her."

When Omri Shor's diabetic father accidentally took a double dose of his medication five years ago and had to be taken to the hospital, Shor and his brother were worried, but they also saw an opportunity.

"We started to think about how people manage their medication and decided that the right tools didn't really exist," Shor said. "We looked at all the different medication management tools on the market and saw an opening for personalization."

Thus, Medisafe was born. Medisafe is a cloud-based medication management platform designed to understand a patient's personal causes of non-adherence and use that information to create better patient engagement and improve medication adherence. The app has 1.9 million users recording over 160 million doses taken correctly and scores 4.5 out of 5 stars in Apple's App Store.

But for Shor, the experience has been far more than just the numbers.

"One of the beautiful things about the company is that we are very exposed to the patient side. We have millions of happy users and their stories are truly exciting," he said.

Who'd play me in a biopic: **George Clooney, from his "ER" days**

One user story really sticks out for Shor. A woman got a notification through the app that her mother hadn't taken her medication. When the daughter called her mom and didn't get an answer, she dialed the paramedics who discovered that her mother had suffered a stroke. The notification and timing allowed the paramedics to revive her and save her life.

"It almost brought us to tears to hear that Medisafe was the solution that saved her," Shor said. "Seeing how we help patients better manage their healthcare and improve their outcomes is such a motivating factor for me and my team. We understand the value we are bringing to their lives." —*Valerie Lapointe*

Throughout her career, Dr. Lisa Tseng has learned the importance of listening and hearing. Five years ago, Tseng and her team from UnitedHealth Group embarked on a series of listening tours and town hall meetings to try and figure out how they could better serve their healthcare members.

One of the issues that kept coming up was access to affordable hearing aids. Tseng went on to found hiHealth Innovations, a direct-to-consumer hearing aid company that allows patients to save 60% or more on custom-programmed hearing aids, making them more accessible for 48 million Americans with hearing loss.

Who'd play me in a biopic: **Meryl Streep**

"We opened up healthcare coverage of hearing aids and now our members can get a hearing aid for anywhere from free to $599," she said. "We engaged primary-care providers to emphasize hearing as a part of their healthcare counseling."

In her current role as executive vice president at Optum, she has led the development and operation of a post-acute transition program in more than 47 markets and 30 states, improving the continuity of care for members discharged from hospitals and nursing facilities. The end-to-end clinical model enables clinicians to be by the member's side within 24 hours of notification and gives them a full view of the patient's medical and pharmaceutical history.

"I think we are delivering innovation at a reduced cost, understanding that a lot of people are living with more chronic conditions," she said. "The challenge is tremendous, but we are making swift progress on many fronts and there is a lot of movement toward better outcomes and better value for healthcare dollars spent." —*Valerie Lapointe*

37
Executive vice president
DR. LISA **TSENG**
Optum
Eden Prairie, Minn.

"I think we are delivering innovation at a reduced cost, understanding that a lot of people are living with more chronic conditions."

35
Senior medical director

DR. BALIGH YEHIA

Johns Hopkins Medicine, Baltimore

"Where most saw risk, I saw opportunity."

The Veterans Affairs Department often gets bad press for being entrenched in inefficiencies, but where most see disaster, Dr. Baligh Yehia saw an opportunity and a worthy challenge.

Formerly an assistant professor of medicine at the University of Pennsylvania, Yehia joined the VA in 2016 as assistant director of community care. In barely a year, he blazed a path to deputy undersecretary for health.

"I came to the VA right when they were going through the rockiest time," Yehia said. "A lot of folks were asking me, 'Are you sure you want to go there?' But it was a no-brainer. Where most saw risk, I saw opportunity."

While many health systems may get bogged down in the way things have always been done, at the VA Yehia knew he had the best raw material—a willingness among colleagues to innovate and think differently.

"The one thing we had that many healthcare systems didn't was a platform for change and the momentum that things needed to be different. That is very hard to create, but the VA had it," said Yehia, who this month left the VA to become senior medical director at Johns Hopkins Medicine.

Who'd play me in a biopic:
A young Michael J. Fox

In his VA role, Yehia managed an operating budget of more than $10 billion along with 7,000-plus employees and five business lines. To improve patient outcomes and gain operational efficiencies, Yehia and his team deployed over 50 innovating clinical and business solutions nationwide, including launching a care-coordination model that used predictive analytics to match patient needs with the right level of support.

—Valerie Lapointe

Medical students at NYU School of Medicine can enhance their learning through real-world data exploration. JULIANA THOMAS

Med schools aim to train new breed of physician

By Alex Kacik

Medical students at New York University shape their own curriculums.

NYU School of Medicine at NYU Langone Health arms students with a trove of de-identified public data—type of procedure; length of stay; race and age of patient; payers; variation of charges across markets; outcomes by market and individual providers; and more—provided by the university, the New York State Department of Health and the Centers for Disease Control and Prevention.

They can also analyze NYU's fictitious healthcare organization—Lacidem Care Group—which aggregates patient access barriers and visit types from de-identified data drawn from electronic health records, payers, demographics and laboratory tests and measurements. Lacidem presents them in three different practice models.

The students sift through the information, come up with research questions and work with a medical librarian and faculty member to determine if it's feasible and then hone the focus.

The students ideally can find treatment gaps, eliminate medical waste, better coordinate care and improve quality with the tools to treat not just individuals but an entire population, said Dr. Marc Triola, associate dean for educational informatics at NYU. They are more engaged because they can pursue topics that pique their interests, he said.

"We are giving them the power to ask questions that align with their goals or personal experiences or thoughts that they can turn into a research project they're motivated and interested to pursue, as opposed to a homework assignment," Triola said.

"We want to arm them to look out for system, policy and environmental issues that explain a fair amount of the differences in outcomes," said Dr. Mark Schwartz, professor of population health at NYU.

NYU School of Medicine is one of the schools reforming its coursework to fill gaps in traditional programs to better prepare students. Today's physicians are tasked with adapting to new technology, payment models, leadership roles and collaborative approaches to care delivery. But they are often unprepared if their medical school offers an outdated curriculum.

In response, schools are offering opportunities like NYU's that seek to engage in or simulate the environment in which medicine is headed, not where it's been, including such approaches as putting students to work as patient navigators or

THE TAKEAWAY

Many schools are reforming their coursework to fill gaps in traditional programs and better prepare students for adapting to new technology, payment models, leadership roles and collaborative approaches to care delivery.

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Leadership tools prepare med students for new world

By Alex Kacik

Georgetown University School of Medicine: Master's degree in clinical quality, safety and leadership

A systematic, evidence-based program focused on improving patient safety and quality of care while effectively leading organizations through a team-based approach.

"THE GOAL IS TO CREATE CONTINUOUSLY LEARNING ORGANIZATIONS that generate and transfer knowledge from every patient interaction to yield greater performance, predictability and reliability," said Anne Gunderson, associate dean of innovation in clinical education at Georgetown.

Indiana University School of Medicine: Teaching EHR

Familiarize students with using electronic health record platforms with real clinical data to help them follow patients throughout the entire continuum and better coordinate care.

"THE IDEA IS TO LEVERAGE ACCESS OF REAL EHR DATA for students to gain an appreciation of what the EHR can do for them and their practice of medicine, as well as the potential downsides," said Dr. Bradley Allen, Indiana University senior associate dean of medical student education.

NYU School of Medicine: Health Care by the Numbers

Student-directed study of real clinical data to better understand patient and population management and answer clinical questions at the health system level.

"IF THEY DON'T BECOME NAVIGATORS OF THESE DATA, they will become victims of these data. Physicians for the most part have been victims of these data up to this point. We hope this project and the consortium as a whole is trying to empower this new generation to really play a much more enlightened role in all of this," said Dr. Marc Triola, associate dean for educational informatics at NYU.

OHSU School of Medicine: Your M.D.

Trains future physicians to be self-directed lifelong learners through a customized curriculum that guides them through clinical experiences where they build upon patient interviewing, physical diagnosis and communication skills.

"PREVIOUSLY, STUDENTS WERE NOT PREPARED on how to do quality improvement, how to work in a complex healthcare system, expanding from a one-size-fits-all treatment approach, and how to use all the technology and an EHR through a systems approach. We wanted to totally transform the curriculum and put all the sciences on equal par," said Dr. Tracy Bumsted, associate dean for undergraduate medical education at Oregon Health & Science University.

Penn State College of Medicine: Patient navigators

Students work with patients to help them overcome barriers to receiving quality healthcare, giving students more clinical experience and a better grasp on population health.

"STUDENTS NEED MORE EXPOSURE TO CLINICAL WORK. They are working with patients, learning about the social determinants of health, communicating and collaborating with other professionals in the practice, learning about population health and about systems competencies," said Jed Gonzalo, associate dean for health systems education at Penn State.

giving them access to practice EHR systems.

"We think about teaching the science of medicine, but we have some students leaving medical school who don't know the difference between Medicaid and Medicare—and that's not on them, it's on us," said Dr. Susan Skochelak, group vice president of medical education at the American Medical Association. "If you are going to be a real leader, you have to understand some of these real basics so you can influence change."

NYU Langone is one of 11 founding medical schools that received $1 million grants in 2013 through the AMA's Accelerating Change in Medical Education Consortium. The schools are working with 22 other medical schools that joined the consortium in 2015 to largely implement curriculum projects created by the original members. The goal is that the ideas will catch on throughout the country and they will be tweaked and refined to best deliver care.

The AMA effort advocates teaching students health system science, which emphasizes the role of human factors in value-based care delivery, collaboration throughout systems, leadership and patient improvement strategies.

"Once upon a time, the physician could get away with focusing on patient care and letting someone else worry about insurance and the economics of it," AMA President Dr. David Barbe said. "Those times are way past."

Medical schools often don't teach future physicians how to function and communicate in a coordinated-care environment, particularly in ambulatory settings, Skochelak said.

"The other part that we haven't talked about is chronic care—how to direct changes in lifestyle and how to deal with some of the current problems like the opioid epidemic," she said.

Students as patient navigator

Students often leave medical school without enough clinical experience, experts said.

Penn State College of Medicine, a member of the AMA consortium, created a patient navigator program that immerses students in a clinical site for nine months. Student navigators guide patients through healthcare continuums at the university or partner systems—spanning primary-care clinics to nursing homes— where they educate patients, offer emotional support and help coordinate care.

It presents a patient-centered approach to students who have been taught to think of the disease or diagnosis first, said Jed Gonzalo, associate dean for health systems education at Penn State. Students work in

teams and with social workers, nurses and other non-clinicians to grasp how the system is interconnected and to best use community resources to keep patients healthy. They also get to work with more complicated patients with chronic conditions or barriers to access, which was atypical, he said.

"We start with patients of high need who don't have access to cars, have high no-show rates, low education levels or someone with six chronic conditions who has coverage gaps," Gonzalo said. "It's a whole different ballgame."

Yet, the new direction has met some opposition from students and teachers. Some students say they are overwhelmed by juggling clinical work and their classes, while care coordinators are reluctant to step into an entirely new teaching or mentorship role, Gonzalo said.

But it creates a collaborative culture and gives students the chance to be leaders, skills that many physicians traditionally lacked, he said.

"A lot of the teaching role has been M.D.-centric," Gonzalo said. "In reality, we are a learning organization. We are all in this together."

Teaching EHR

Some of the big EHR system vendors are reluctant to let students use their platforms, so Indiana University created its own.

Indiana University School of Medicine, in collaboration with its affiliate the Regenstrief Institute, developed a teaching EHR system that helps students navigate clinical data.

The teaching EHR system renames real patient data and allows students to follow treatment through each clinic visit and hospital stay. Students can become familiar with different EHR formats that they will interact with daily and figure out how to use them to coordinate care within and outside of the organization.

The aim is for students to learn how EHRs can best aid their practice as well as what barriers the systems can present, whether through inaccurate information or lack of functionality, said Dr. Bradley Allen, IU senior associate dean of medical student education. IU, another member of the AMA consortium, hopes the teaching EHR will help students recognize the impact of social factors in addressing the needs of individual patients and patient populations, he said.

"Many of the large EHR vendors were reluctant to allow learners access into their EHR prior to them getting to the later stages of their career," Allen said. "We felt it was important to create a platform where they could feel free to experiment with an EHR in a nonthreatening manner."

Several other medical schools across the country are using or considering IU's teaching EHR platform, he said.

"We are capturing the voices and input of a generation of future users on how we can improve communication between all parties that deliver patient care," Allen said. ●

Fair play for Puerto Rico

MERRILL GOOZNER *Editor Emeritus*

The Puerto Rican healthcare system, which serves the 3.4 million people devastated by Hurricane Maria, operates under patently unfair Medicaid and Medicare funding rules.

As Americans gear up to help their fellow citizens, it's critical that Congress and the Trump administration correct this injustice. Not only should they offer immediate aid, they should revise the inequitable formulas that systematically shortchange the 69 hospitals and 20 federally qualified health centers with nearly 90 facilities that dot the Caribbean island.

Scant attention has been paid to this long-standing policy blunder. But as a recent report by the Puerto Rican consulting firm Impactivo noted, it has been a major contributor to the ongoing exodus of people and medical personnel from the island and has actually been a net drain on the U.S. Treasury.

Puerto Rico, a U.S. territory, is poor. Nearly half of its households (46%) earn less than the federal poverty level.

While those wage earners are exempt from federal income taxes, they pay Social Security and Medicare taxes, which makes them eligible for federal entitlement programs. As a result, an estimated 49% of its residents are on Medicaid or the Children's Health Insurance Program, including nearly 300,000 seniors who are dually eligible for Medicare and Medicaid.

Yet what Puerto Rico draws from the federal government for those two programs remains far below the levels in the states. Medicaid's federal match has a statutory floor of 50% of the total cost of the program. In states with high poverty levels, the match can go substantially higher.

In Mississippi, for instance, the federal match will be 76% in the next fiscal year, according to the Kaiser Family Foundation. Another nine states and the District of Columbia had federal matches over 70%. Just 12 states received the statutory minimum.

Puerto Rico's Medicaid program, on the other hand, receives just 19% of its total cost in federal matching funds, an arbitrary cap contained in the Social Security Act. The Affordable Care Act sought to correct the injustice with a one-time appropriation that grossed up the island's reimbursement to about 55% of total costs.

However, the special appropriation of about $1.3 billion a year runs out at the end of this year. While the CHIP reauthorization bill pending before Congress contains an additional $1 billion for Puerto Rico, that's less than previous funding and well short of the 83% match the island would get if operating under the same rules as the states.

Medicare rules also shortchange Puerto Rico. Island residents are not eligible for Social Security Supplemental Income, leaving that component for setting hospital disproportionate-share payments at zero. The result is Medicare payments that are 42% below the U.S. average.

The Federal Emergency Management Agency, the Centers for Disease Control and Prevention and other federal agencies face the immediate challenge of heading off a public health catastrophe. About 40% of the island still does not have potable water. Electricity outages are common, leaving hospital and clinic backup generators, designed to operate for a few hours or days, running for weeks on end.

The incidence of water-borne diseases is growing. A boil-water alert was issued in response to widespread gastroenteritis, and a few reported cases of leptospirosis (spread through animal wastes) are fueling fears of wider, more serious infectious-disease outbreaks.

Charitable efforts can help fill some gaps in the short run. The Greater New York Hospital Association led the way by marshaling private planes to deliver needed medicines. The American Hospital Association and its Puerto Rico affiliate have teamed up to create a fund to help displaced hospital employees continue working. (You can donate at thecarefund.net.)

But Puerto Rico and the U.S. will eventually turn their attention to rebuilding the island's ailing infrastructure, including healthcare. Putting its Medicaid and Medicare reimbursements on an equal footing with the rest of the country will make that task a lot easier. ●

Consumerism transforming marketing in healthcare; today it's all about the individual

By Nick Ragone

Notwithstanding the ongoing debate about how to finance healthcare in this country, we know that the healthcare sector is experiencing a dramatic transformation, with consumerism at the heart.

Digitally driven consumers have inspired all healthcare organizations—including providers, payers and retailers—to alter the way they market, communicate and, most importantly, deliver care.

Consumers now have instant access to information about their choices, which has heightened expectations about what a seamless, end-to-end healthcare experience looks and feels like. And it has intensified the need for true direct-to-consumer marketing to win these consumers at every point of engagement.

Put in its simplest terms, healthcare marketing today is all about delivering the right message, to the right person, at the right time—and then measuring it. Gone are the days when brand awareness alone—through broadcast, billboards, sponsorships—is enough to persuade consumers on the best options for their healthcare needs.

Healthcare marketing is no longer about qualitative awareness, but rather it's about quantitative, targeted tactics and prescriptive modeling. For large, integrated systems such as Ascension, it means doing grass-roots research and consumer behavior and language testing so that we can fully understand the populations we serve and anticipate their needs before they even enter our doors. It also means having a strong, accessible brand that consumers trust and find convenient and connected.

It requires looking beyond audience segmentation and understanding the individual—a segment of one. Doing this properly necessitates understanding search trends, consumer behavior, media consumption, clinical and non-clinical health risk factors, and other data to truly understand the best way to reach individuals.

Nick Ragone is senior vice president and chief marketing and communications officer for Ascension.

These changes also push us to think bigger than billboard and newspaper ads. We have to be visible and available to our patients both before and right when they need us.

We must also be committed to more-accessible, more-convenient and more-seamless care delivery. We need to make it easier for consumers to navigate our sites of care, both physically and online, and with mobile devices. This is no longer a nice to-do; it's a must-do.

Case in point: Nearly 80% of healthcare engagements now begin with some type of online search, and the vast majority of those searches begin on a small device. That being the case, healthcare marketing needs to be geared toward winning at the point of engagement. Translation: less qualitative awareness, more quantitative marketing, and making sure the experience is mobile-friendly.

When I speak to different organizations or groups about healthcare marketing, or even internally when I discuss it with leadership at Ascension, I begin by flipping the old marketing model on its head. Healthcare marketing used to be described as an upside-down pyramid, with the base on top representing awareness and the tip at the bottom representing consumer engagement, and lots of other things happening in between.

In today's consumer-centric landscape, we have moved our marketing closer to the point of conversion.

The top of the pyramid now represents access points, mostly online, through mobile-friendly physician scheduling tools and urgent-care appointments. The middle part of the pyramid is now a world-class web design that's mobile-friendly and connected directly to sites of care. And the base is now sophisticated, analytics-driven consumer relationship management.

For this new quantitative, data-driven approach to work, healthcare providers must understand the needs of consumers better. As an organization, we have begun to readjust our marketing and clinical focus to see our hospitals through the consumer lens. Consumers are no longer peripheral to the equation; they are the equation. Consumers have begun taking their encounters in other industries and applying them to healthcare. This is a new approach that we wouldn't have considered a few years ago, but we're evolving in response to the dynamic needs of consumers today. ●

best practices

Johns Hopkins uses electronic tool to improve triage of ED patients

By Maria Castellucci

Triage nurses in the emergency department at Johns Hopkins Hospital in Baltimore face a hard task. Just like in EDs across the country, they must decide in just a few minutes how critical a patient's condition is and assign them a score that will determine how quickly they are treated.

The nurses use the Emergency Severity Index to help make their decision. The ESI, a tool used widely in EDs across the U.S., is a way for caregivers to identify patients' conditions by assigning them to one of five groups, or levels. Level 1 indicates the patient needs immediate attention and is experiencing something along the lines of cardiac arrest, while Level 5 means their needs aren't urgent—a rash, for example.

That's important, obviously, because it gets the patient the right treatment more quickly. The problem is the ESI isn't always right and relies heavily on nurses' subjectivity, said Scott Levin, associate professor of emergency medicine at the Johns Hopkins University School of Medicine.

Research on the ESI shows that about 70% of patients are lumped into the medium category—Level 3—even though there can be wide variance in the severity of their symptoms and ultimate diagnoses. "The major challenge of the ESI is that it's completely subjective," Levin said. "When something is completely subjective, there can be untoward variability."

In an attempt to make the triage process more objective, Levin and his colleagues developed an electronic tool last year that is now used by triage nurses at Johns Hopkins Hospital.

The tool uses an algorithm based on data from roughly 200,000 patients treated at the six hospitals in the Johns Hopkins system to predict a patient's severity of illness. It takes into account how patients with the same symptoms were treated and what their likelihood was for dying, being admitted to the intensive-care unit or needing an emergency procedure. The tool then assigns the patient a level score using the ESI.

Nurses have been using the tool since last December and find it's helpful to guide their clinical decisionmaking.

But it took some time for staff to warm up to the tool, admits Sophia Henry, a triage nurse in the Johns Hopkins ED. Henry said she and other nurses were initially worried that the tool would take away their autonomy or that they would be "replaced by a computer."

"We were very resistant at first because for us, being trained as a triage nurse is an honor. It shows clinical excellence and that you understand clinical decisionmaking," she said.

Levin said he spent months with the triage nurses to ensure they understood that the tool was not to replace their clinical judgment but merely to support them in their work. Levin said he tells nurses they should disagree with the tool when they think it is appropriate. After all, the tool can't interact with patients the way a nurse can.

Levin, however, said he's confident in the tool's results because it's targeted at Johns Hopkins' unique patient population. He said healthcare tools that rely on algorithms aren't usually widely adopted because providers don't trust the data. But caregivers trust the accuracy of data used to develop this tool's algorithm.

The e-triage tool "is more meaningful to the people who are using it," Levin said. "Every ED is so different—the patient populations they treat, the resources they bear and the care processes they use."

The tool has been shown to work effectively. A recent study led by Levin published in the Annals of Emergency Medicine found that the tool identified 14,000 patients, or 10%, triaged to ESI Level 3 who should have been categorized as a Level 1 or 2. The tool also increased the number of patients assigned lower priority levels like Levels 4 or 5.

Identifying patients with less serious conditions sooner decreases the time they have to spend in the ED, Levin said. EDs often "fast track" patients who aren't ill enough to require prolonged care.

"If we put these patients in line with the very sick, they would never get out," he said. "The hope is to not have them wait and get out quickly." ●

STRATEGIES

Create a tool in the electronic health record that assigns patients an Emergency Severity Index score.

Ensure the tool uses an algorithm that includes the health information of patients previously treated at the system to improve accuracy.

Train triage nurses to use the tool but also ensure that staff members retain their autonomy in clinical decisionmaking.

news makers

Former Aetna exec Zubretsky named CEO of Molina

Who: Joseph Zubretsky, 60

New role: CEO of Molina Healthcare, effective Nov. 6. The insurer offers Medicaid plans in 12 states and sells individual-market plans on a number of state exchanges, covering 4.7 million members overall. He succeeds interim CEO Joseph White, who took over after the insurer's board ousted CEO Dr. J. Mario Molina and Chief Financial Officer John Molina, sons of the company's founder, in May.

Background: Zubretsky joins Molina with more than 35 years in the insurance and financial services industries, most recently as CEO of the Hanover Insurance Group. Earlier, he served almost nine years with Aetna, where he most recently was CEO of Healthagen Holdings, a group of healthcare services and IT firms. Other roles at Aetna included serving as CFO for six years.

Challenges ahead: The new CEO will lead a transition following the company's July announcement that it planned to lay off 1,400 employees, or 10% of its workforce, to offset losses from its ACA exchange business.

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INFORMATION TECHNOLOGY

Modern Healthcare, *Chicago, IL*

Modern Healthcare is pleased to welcome ***Emily Olsen,*** who is joining the team as a web producer. Emily will work on our online content, eNewsletters and social media promotion. She graduated in June from Northwestern University with a master's degree in journalism. Before completing her master's, she worked with Reboot Illinois as a staff writer and at Rivet Radio as a producer.

QUALITY & PATIENT SAFETY

JLL, *Chicago, IL*

George Mills joins JLL as Director of Healthcare Technical Operations. Formerly the Director of the Department of Engineering at The Joint Commission, George is one of the foremost experts in the field of healthcare operations. He will lead JLL's efforts to optimize hospital operations with an emphasis on patient safety.

TO SEE OTHER INDUSTRY MOVES, VISIT MODERNHEALTHCARE.COM/PEOPLEMOVES

Q&A

"In all my 40 years in healthcare, this is by far the most successful clinical program I've ever seen launched. … This is clinically a home run; but financially, it's just a train wreck."

'We are caring for that circle of family and friends and supporters, too. That's what makes those last weeks, days, months, hours, so meaningful'

Villa Marie Claire, a residential hospice, opened in 2010 in Saddle River, N.J. Previously an orphanage and later an assisted-living facility, the property was turned over to Holy Name Medical Center after the Sisters of St. Joseph of Peace found they could no longer afford to keep it open. Holy Name's goal was to raise the state's ranking from last in the country when it came to dealing with end-of-life care. Hospital officials put together a business plan, and consultants were skeptical. But the officials pitched it to the sisters, who ultimately donated the property. Now, the 20-bed facility is widely lauded by patients' families but struggling to make ends meet. In September, Villa Marie garnered $5 million in funding from the state to re-imagine how end-of-life care is delivered. **Michael Maron is CEO of Holy Name and Villa Marie Claire**. He recently talked with Modern Healthcare Managing Editor Matthew Weinstock about some of the challenges he faces. The following is an edited transcript.

Modern Healthcare: Hospice is historically underpaid. So what was the conversation like within the leadership team, to say, "Let's go after something with no margin in it?"

Michael Maron: That is part of the culture of Holy Name. We've never shied away from what we thought were compelling services, even if the reimbursement mechanism was not existent at the time. We have a long history of getting out ahead of the curve, sometimes painfully so, to try to push awareness. I'll give you an example. Holy Name opened a dialysis center in the '60s at the behest of physicians in the community, because too many people were dying from end-stage kidney disease two years before there was any reimbursement formula, or even any hearings in Washington, to talk about the need to reimburse for dialysis.

MH: How are you measuring success with hospice care?

Maron: In all my 40 years in healthcare, this is by far the most successful clinical program I've ever seen launched. The impact it has on the people is greater than anything I've seen. The feedback is almost universally 101% outstanding, gratitude. So the positive impact on people's lives is just off the charts.

Financially, it's a train wreck. I came up the ranks as a chief financial officer, so it's always hard for me and a little humbling for me to say, "This is clinically a home run; but financially, it's just a train wreck."

MH: What are you losing?

Maron: We lose a little over $1 million a year.

MH: And how are you making that up?

Maron: Like everything else in healthcare, right? It's cross-subsidized, if you will. We make a conscious decision: is the overall system's operating margin at the end of the year going to be $1 million lighter because we keep this service? And the overwhelming decision by executive management and the board is yes. We're not abandoning it. But the commitment now is to become an advocate for changing how it's paid for and to create the awareness in what we're doing.

MH: That's obviously been successful because you were able to get $5 million in state funding.

Maron: We requested over the last five years to have some appropriation considered in the state budget to help pay for this. New Jersey has a long track record of propping up charity care, propping up

graduate medical education, propping up behavioral health and other certain programs, but that funding comes out of the state's general revenue budget. We're always able to get something because it's kind of hard for people to say, "No, I'm not going to support end-of-life care," especially anybody who has ever gone through it with a relative. But it's also easier then to turn around and say, "We tried, but the political process got in the way. Unfortunately we didn't make it."

This year, we took a much different approach. We made sure that all of the leadership in the Senate and the governor's office, the commissioner of health, visited Villa Marie, because until you actually walk through the doors you just don't understand what's happening there. And it just so happened that a few of those leaders were, at the time, struggling with parents who were at end of life and understood wholeheartedly the challenges. Just to give you an idea, one of the biggest problems is that hospice care is paid on a per diem basis. And one-third of the people who get referred to us die before they even get here. I pay my staff to go out to the hospitals, nursing homes, wherever the patient is at the time. My staff does the assessment, but if the patient doesn't get into my facility, I'm not allowed to bill. I get zero.

MH: And they've died before they get there because the referral came too late?

Maron: Yes, too late. If I were to title the book, it would be *It's Going to be Too Late*. The providers are so uncomfortable with the topic. One, because every day that you're in their ICU they can churn and bill you, but there's also a professional incentive. They don't want to quit and they see death as defeat and a loss. And the patients and their families often can't accept it either. That's why I say it's a societal thing. They push and push until the very, very end, and then they finally say, "You know, this is horrible. I can't even talk to mom or dad because they have so many tubes in them." And wouldn't it have been nice to hold their hand and have somewhat of a conversation before it was too late.

All those things swell up and cause rage. And we try to console, right? So one of the things that we do that is different, and again, not reimbursable, is for those families who don't even make it there, that one-third, if those families want to continue bereavement counseling support, we provide it to them. We don't turn them away, because our philosophy is this is generational. And if I don't move the needle on those people who just went through it, if we don't help them become aware, then we're going to be dealing with this in perpetuity. It'll just be a never-ending cycle.

MH: What about the rest of the patients? The other two-thirds?

Maron: The second third of people who get referred to us are there less than 24 hours. So say I get to bill one day and the problem is, in Medicare's and Medicaid's math, the per diem is actually based on an average length of stay of about six weeks. And yet, one-third of the business is zero. Then the next third die within 24 hours, and the last third, on average, are with us for about six days.

MH: The $5 million appropriation is supposed to help the state create a new model for palliative care and hospice. What's that going to look like?

Maron: First and foremost, is to free up the losses so the constant daily pressure on my staff is off and I can release them to do some creative initiatives. One of those initiatives is to enhance education by capturing the stories of family members.

Also, we have a very big simulation lab, so we're creating modern simulation education scenarios—immersive scenarios that we're then going to encourage the medical society, the board of medical examiners and, if we can get the different colleges to accept this as part of re-credentialing, to have physicians go through this process in order to maintain their licenses. So first is to admit it's a problem. Second is admit I'm part of the problem. Third, start to move forward to that solution.

Part of our own re-credentialing on the Holy Name staff, regardless of the discipline, you have to go through and have documented Holy Name continuing medical education, that you've understood and participated in this. We also insist that all of our physicians record their own living will.

MH: What are your benchmarks for the next two to five years?

Maron: One of them is to change that one-third, one-third, one-third dynamic and to actually see our census grow.

When I opened a 20-bed facility, the people in the hospice world came to me, and said, "You're crazy, you can never support 20 beds." And I said, "No, you've got it all wrong. There should be a waiting list at 20 beds." You're talking about close to 10 million people who could take advantage of this thing. And so our goal is to get those beds filled, and to actually have the waiting list, and to have the appropriate length of stay in the interaction. And then, ultimately, if I can get the CMS and other payers to agree on a different formula, that would also be a home run.

For example, if I had a 95-year-old patient come to Villa, he's the last surviving member of his family, never married, had no children, basically is alone. We care for that individual and guide him through the transition to the end of life. On the other hand, a 38-year-old married mother of four whose parents are still alive, has siblings, has all sorts of friends and community support. If that mother shows up, we're not just comforting her, we've got to comfort all the people rallying to support her. We get paid the same for both patients. We are caring for that circle of family and friends and supporters, too.

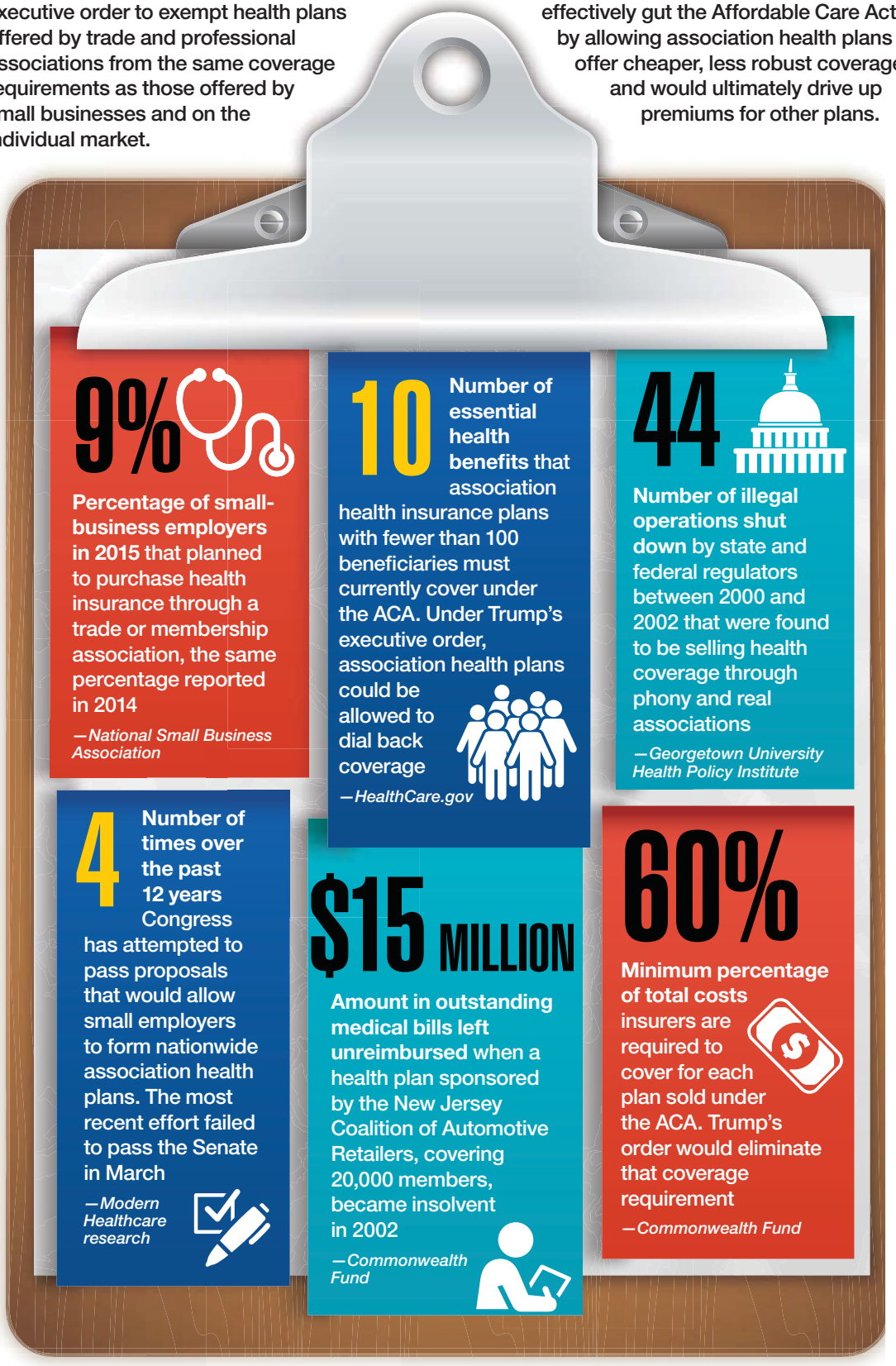
That's what makes those last weeks, days, months, hours, so meaningful. And that's the value in it; but the system doesn't acknowledge that value at all. ●

data points

New life for association health plans?

In light of repeated failed efforts by lawmakers to repeal the Affordable Care Act, President Donald Trump last week signed an executive order to exempt health plans offered by trade and professional associations from the same coverage requirements as those offered by small businesses and on the individual market.

The goal, he said, is to lower premiums and expand coverage options for small businesses. Many fear that such a move would effectively gut the Affordable Care Act by allowing association health plans to offer cheaper, less robust coverage and would ultimately drive up premiums for other plans.



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New toothpaste looks beyond fluoride

GETTY IMAGES

The toothpaste uses "bioactive" glass to help strengthen teeth and protect against tooth decay.

An unlikely ingredient is behind some new toothpastes researchers say can help restore teeth.

A research team from Queen Mary University of London developed a very fast dissolving "bioactive" glass that can be used in toothpaste or dental fillings to repair decayed teeth.

The team created a company, BioMin Technologies, and is launching its second product, a remineralizing toothpaste called BioMin C, designed for people who don't want to use a fluoride toothpaste or anyone who wants to combat natural tooth decay. The company already sells a fluoride version, BioMin F, which it touts as slowly releasing calcium, phosphate and fluoride ions. "These combine to form fluorapatite that could help reduce the risk of tooth decay, sensitivity and acid erosion," the company said.

But BioMin C loses the fluoride. "This toothpaste is unique because it can put back the mineral lost from your teeth after consumption of an acidic drink, but without the use of fluoride," said professor Robert Hill of Queen Mary University's Institute of Dentistry. "This isn't just for people who have bad teeth, everyone can potentially benefit from using this new toothpaste."

The research behind the fluoride-free version has shown the potential of a glass that uses chlorine rather than fluorine. (Fluorine is an element, and fluoride is its negative ion.) The chlorine atoms and ions are much bigger than those of fluorine, which enables them to incorporate much more of it into the glass. The resulting compound releases a chemical that mimics tooth and bone mineral. So the researchers incorporated it into toothpaste and dental fillings to replace the mineral lost when teeth decay. ●

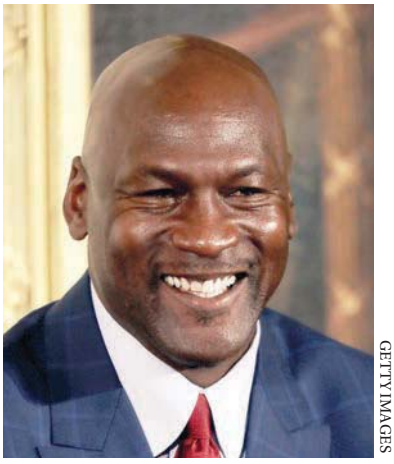
Michael Jordan gives $7M assist to Novant Health

Basketball legend Michael Jordan is scoring his biggest philanthropic donation ever with a $7 million gift to Novant Health.

The donation from Jordan, who owns the NBA's Charlotte (N.C.) Hornets, will be used to fund two Novant Health Michael Jordan Family Clinics, which are projected to open in 2020 in at-risk communities in that city.

"Through my years of working with Novant Health, I have been impressed with their approach and their commitment to the community," Jordan, who grew up in North Carolina, said in a release Monday. "It is my hope that these clinics will help provide a brighter and healthier future for the children and families they serve."

Jordan spokeswoman Estee Portnoy said the former Chicago Bulls star was motivated by a study that found poor children in Charlotte have the worst odds of those of any of the top 50 cities in the U.S. to lift themselves out of poverty.



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Jordan's gift will be used to fund two clinics in at-risk communities.

A release from Winston-Salem, N.C.-based Novant stated the clinics will provide an avenue to affordable, high-quality care—including behavioral health, physical therapy, social work, oral health and family planning—to individuals in the community who have little or no healthcare.

The clinics have the potential to decrease emergency room utilization by 68% and decrease hospitalization by 37% for the residents of these neighborhoods, according to Novant.

Novant added that the clinics are projected to care for nearly 35,000 children and adults who do not currently have access to primary and preventive care or who use the ER for non-urgent medical needs.

"This gift will transform the lives of thousands of families and children living in poverty-stricken communities," Novant CEO Carl Armato said. ●

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