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Medical Loss Ratio Minimums: Turning Regulation into Opportunity



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Introduction/Background

As if the mounting evidence of health information technology's benefits isn't enough to justify investments by health insurers, recent health reform regulations dealing with medical loss ratio provisions present a compelling reason to make health IT central to quality improvement strategies and programs.

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The Affordable Care Act requires health insurers to meet specific medical loss ratio (MLR) thresholds or else rebate premiums to enrollees. Medical costs, which include reimbursement for health care services and expenses associated with quality improvement, must comprise 80 percent to 85 percent of premiums generated from small group and large group plans, respectively. By funding projects promoting the electronic exchange of health information across the health care system, a health insurer can strengthen its medical management programs and quality initiatives with investments that improve its MLR.

Criteria defining what expenses qualify as quality improvement activities for purposes of calculating the medical costs numerator were recently published in the Department of Health and Human Services interim final rule for implementation of MLR requirements by health insurers. In developing the MLR criteria, the agency adopted the recommendations submitted by the

National Association of Insurance Commissioners in October 2010. The NAIC model for calculating the MLR defines five areas of quality improvement where investments would be included in medical costs. Expenses for HIT infrastructure are listed as a fifth, distinct area, but a closer look reveals it is foundational to all the other quality improvement elements in NAIC's model.

HHS and the architects of the NAIC recommendations clearly intended to have the quality improvement elements align with other health care system reform efforts, especially the adoption of electronic health record (EHR) systems that support the exchange of health information to enable patient-centered models of care.

For example, electronic health information exchange (HIE) among patients and their providers—a key element of the access and continuity standards for patient-centered medical homes (PCMH)—can be counted as a quality improvement expense. Investments by Accountable Care Organizations to collect data from various sources for the purposes of identifying population health needs and aid in the coordination of care would also qualify. These examples illustrate the strategic importance of HIT and more specifically HIE in payer's quality improvement efforts.

The exchange of health information among all caregivers, including the patient, and access to the comprehensive longitudinal electronic health record that is created in the process, are key enablers of each of the quality improvement areas included in HHS's calculation of medical expenses. Thus, investments in HIE infrastructure and applications which use data from the HIE not only contribute to the health insurer's achievement of the government MLR thresholds, but can also accelerate the transformation underway of care management models to improve quality and reduce medical expenses.

Below, we take a look at each of the four quality improvement areas outlined in the HHS rule and how HIE technology plays a critical factor in "moving the needle" on quality.

Improving Health Outcomes with a Collaborative Care Model

Investments to foster collaboration of care among providers, their patients, and health insurers' care management resources qualify as quality improvement expenses under the MLR model. Principal areas of focus in the improving health outcomes category are activities supporting coordination of care, chronic disease management, and support of patient self-management.

The intent of the definition is clearly to support infrastructure investments that replace the silos of insurer-sponsored disease management and provider-centric episodic care with a patient-centered platform, enabling the sharing of information and communication among health plan care managers, providers, and their patients. Implementation of the patient-centered medical home is explicitly identified in this quality improvement area of the regulations; investments to support the patient access and self-management functions of the PCMH would qualify as quality improvement expenses.

Electronic access to the comprehensive, longitudinal record of patients' health care made possible with an HIE results in care guidelines that are more meaningful and actionable at the point of care.

Evidence of patient non-compliance with recommended lab work, screening and medication regimens

sourced from a HIE is likely to be more precise compared to an insurer's claims database or physician office's medical records. Physicians can be notified at the point of care of tests needing to be performed so the physician can be more proactive, especially in managing patients with chronic diseases.

Daily updates on critical HEDIS measure scores and NCQA star ratings can be delivered to providers, enabling focused and timely adjustments to care management strategies. Reminders to schedule appointments for check-ups and screenings can be sent electronically to members/patients who are not complying with care guidelines for maintaining their health. Using longitudinal medication histories available via an HIE, applications can detect possible adherence problems, alert clinicians, and suggest evidence-based approaches to fostering better self-management of medications by patients.

HIE in Practice

Using data from an HIE of payer- and provider-sourced health records, a decision support system generates clinical alerts for members of the Vanderbilt University health plan in need of possible interventions (e.g. high cholesterol with no medication therapy) or health screenings. Evidence-based clinical alerts that are electronically generated based on longitudinal health records identify potentially serious medical errors, help reduce hospitalizations, and are associated with a reduction in medical expenses (Vanderbilt University, 2009).

Improving Patient Safety and Reducing Medication Errors

Activities designed to help detect possible drug interactions and treatment contraindications are included in quality of care expenses for MLR calculation. This is an area where clinicians' access to patients' comprehensive EHRs via an HIE clearly makes a difference in quality.

Electronic access to a patient's medication history using a basic web portal helps physicians detect fraud and abuse, polypharmacy, and potential contraindications before writing a new prescription. During the electronic prescription writing process, the prescriber is alerted to possible drug-drug, drug-allergy, and drug-condition interactions. A comprehensive and accurate review of interactions is made possible with connectivity of the e-prescribing application to an HIE.

Although one-third of office-based prescribers are e-prescribing, most do not have access to a HIE, and the majority of physicians are still using prescription pads. Broader and sustained involvement by health insurers in promoting e-prescribing linked to HIEs is critical to further reductions in medication errors, especially since the investment will now be included in the medical expense component of the MLR.

HIE in Practice

The use of electronic prescribing by physicians caring for employer and health plan members of the Southeast Michigan e-Prescribing Initiative (SEMI) has resulted in a substantial reduction in medication-related errors. E-prescribing applications with access to comprehensive medication histories generate drug-to-drug and medication allergy alerts, triggering changes or cancellations of almost half of these orders by the prescribers (PR Newswire, October, 2007).

Avoiding Hospital Readmissions with Robust Transition of Care Processes

Processes to facilitate the sharing of information for discharge planning and post-discharge patient management and counseling qualify as quality improvement expenses.

The “hand-off” of a patient being discharged from a hospital to the care of his or her physician or post-acute care facility involves the reconciliation of medications, ordering of post-discharge treatments, and ensuring the patient and his or her family understands the discharge instructions and self-management responsibilities. Access to a comprehensive EHR at the time of discharge can lead to a faster and smoother transition, and reduce the number of mistakes in this complex process.

Referral mechanisms integrated with the HIE-enabled EHR can display preferred vendors (e.g. home health agency). As a result, readmission rates decrease, compliance with post-discharge instructions increases, and savings are achieved from use of the most effective post-acute providers.

HIE in Practice

Dr. Frank Lonergan is a primary care physician at North Texas Specialty Physicians (NTSP) who has experienced firsthand the benefits of having access to a longitudinal EHR when making clinical decisions involving a patient about to be discharged. A patient’s daughter called Dr. Lonergan to express her concern that the family was unprepared to care for the patient at home. Using NTSP’s health information exchange service, Dr. Lonergan was able to quickly learn about the patient’s hospital stay and order the appropriate home health services. Physicians using the HIE sponsored by NTSP are better equipped to eliminate guesswork and ensure smooth patient discharges, avoiding extra days in the hospital (Sandlot, 2010).

Promote Health and Wellness

Quality improvement activities covered under the promote-health-and-wellness category are focused on outreach to members, encouraging them to become more actively engaged in their health and health care.

Health education and coaching, and providing tools for individuals to assess their health risks are examples of investments that qualify as medical expenses for purposes of the MLR calculation.

Web-based health applications designed for consumers and tethered to an HIE provide these population health outreach programs with scale and the ability for the different stakeholders to communicate quickly and efficiently. EHR systems and data warehouses connected to the HIE are the source of data on members’ health to target interventions to the specific needs of a particular member, such as health education for a long-time diabetic.

Web-based health risk assessments from a trusted source (e.g. a health care provider connected to the HIE), personalized for the recipient, with known health information filled in are more likely to be completed. To foster patient engagement and use of these self-care applications, health coaches and care managers can communicate securely in an asynchronous environment with each other and with patients.

HIE in Practice

An HIE can be used to detect the health care needs of an underserved population. The regional HIE implemented by the North Piedmont Care Network (NPCCN) in North Carolina is used to detect Medicaid beneficiaries who are likely to be in need of active care management based on their episodic encounters with the health care system. The HIE’s sentinel event detection application identifies one in five beneficiaries on average with a chronic medical condition who visited an emergency department, were admitted to the hospital, or missed preventive care appointments. Health care providers receive sentinel alerts informing them of the need for patient follow-up. This proactive approach to population health management is expected to improve access to, and quality of health care services in the region (Lobach et al., 2007).

Conclusion

Reporting a higher MLR and a better bottom line sounds like an oxymoron. Not so for health insurance executives who view the MLR quality improvement expenses as a strategic investment in HIT to accelerate the move from disease management program silos to a collaborative care management platform. All areas of quality improvement qualifying for medical costs can benefit from an HIE that supports clinical and consumer applications and access to a comprehensive electronic health record. As the situations described above show, HIEs help clinicians make more informed decisions, are the foundation for scalable member self-care programs, and serve as the mechanism for proactive, evidence-based care interventions. An investment in HIE infrastructure for quality improvement is an investment in a health insurer’s physician network, enhancing its readiness to implement the patient-centered medical home model, develop accountable care organizations, and achieve pay-for-performance targets. In contrast to tac-

tics that simply re-allocate funds that would otherwise be lost, HIE-based quality improvement strategies in response to the MLR regulation will accelerate the transformation of how health insurers interact with their providers and members.

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Recommendations for Action

- Leave the sidelines and become engaged as communities build their HIEs. Health insurers at the table can influence the HIE's investment priorities to align with the health insurer's PCMH and ACO initiatives. Care managers' direct access to providers and patients via a shared EHR can be pivotal to transforming chronic care management.
- Work with HIE initiatives and health care providers implementing EHRs on the development or selection of quality management applications. A health insurer's expertise in the usability and effectiveness of different care guidelines can be instrumental in the successful adoption of a clinical decision support system by clinicians.
- Promote the adoption by physicians of EHR applications in areas which have demonstrated concrete evidence in reducing medical costs: ePrescribing, clinical decision support, self-management tools are prime areas. Encourage the use of EHR applications that are connected to a health information exchange.