9/14/2018

THE ACADEMY ADVISORS

SUMMARY & HIGHLIGHTS:

CEO MEETING WITH HEALTH & HUMAN SERVICES LEADERSHIP

INTRODUCTION

On September 11th, The Health Management Academy (The Academy) and The Academy Advisors (TAA) convened a group of Chief Executive Officers from Leading Health Systems across the country to meet with leaders from the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). The meeting served as an opportunity to lay the foundation for ongoing dialogue and engagement with HHS and CMS leadership, establishing this group of providers as a powerful resource to the Administration. This brief presents a summary of the meeting and an overview of next steps.

ATTENDEES	ORGANIZATIONAL AFFILIATION
MARC HARRISON, MD	Intermountain Healthcare
NICK TURKAL, MD	Advocate Aurora Health
TERRY SHAW	Adventist Health System
JANICE NEVIN, MD	Christiana Care Health System
RUSS COX	Norton Healthcare
STEVE SAFYER, MD	Montefiore Medicine
PETER FINE	Banner Health
PETER URBANOWICZ	Chief of Staff, Office of the Secretary
ERIC HARGAN	Deputy Secretary of the Department of Health and Human Services
ADAM BOEHLER	Director, Center for Medicare and Medicaid Innovation
JOHN O'BRIEN	Senior Advisor to the Secretary for Health Reform
DEMETRIOS KOUZOUKAS	Principal Deputy Administrator of CMS and Director of the Center for Medicare
JAMES PARKER	Senior Advisor to the Secretary for Health Reform
JACK KALAVRITINOS	Director of Intergovernmental and External Affairs
TOM SCULLY	Partner, Welsh, Carson, Anderson & Stowe
GARY BISBEE, PHD	Executive Chairman, The Health Management Academy

MEETING OBJECTIVES & DISCUSSION AGENDA

In advance of the meeting, The Academy Advisors developed a set of meeting objectives:

1) Develop a sustainable, solutions-oriented relationship to further generate support for meaningful delivery reforms from innovative, forward-thinking delivery systems.
2) Create a non-political cooperative policy mechanism for Leading Health Systems and policymakers to:
    a) Identify this group of engaged providers as a resource for HHS/CMS leaders to work with as they evaluate policies—for example, in designing innovative care delivery reforms
    b) Clarify and magnify the Secretary's policy priorities by communicating directly with Leading Health Systems to collaborate with HHS/CMS policymakers and achieve mutual policy goals.
3) Identify and prioritize policy opportunities in which this group can support and collaborate with the Administration.

There were two specific policies this group has developed that served as the foundation for discussion, though the group expressed support for all of the Secretary's policy priorities he articulated during his Senate confirmation hearings.

STARK REFORM

The Administration is committed to reforming Stark, and they intend to bundle Stark reform with reforms to the Anti-Kickback Statute.

HHS officials were highly receptive to the need to modernize the Stark Law. Dr. Nick Turkal (Advocate Aurora Health) initiated the discussion, emphasizing the need for a broad value-based exception to allow providers to move into new Alternative Payment Models and improve the coordination of care.

Deputy Secretary Hargan was supportive, laying out the parallel processes of Stark and Anti-Kickback reform that the Administration is seeking to implement. He referenced the Stark Request for Information (RFI) that HHS issued in June and Anti-Kickback Statute (AKS) RFI HHS issued in August. As expected, he contended the agency could not substantively comment on their approaches to Stark before reviewing all comments. While he seemed receptive to a value-based exception, The Administration is looking for a more comprehensive approach.

Along with Peter Urbanowicz, Deputy Secretary Hargan stressed that the Administrated wants to develop a comprehensive solution to Stark that includes requisite reforms in the Anti-Kickback Statute. To achieve these aims, he noted the Administration's efforts to communicate with all stakeholders including the Department of Justice (DOJ) and the Inspector General's Office (IG), so that both Stark and AKS can be simultaneously addressed. Both the DOJ and the IG are prepared to address Stark, although both agencies are currently aligning on the correct approach.

While Deputy Secretary Hargan and others from HHS acknowledged there will be additional need for Congressional action to modernize Stark that extends beyond the reach of their authority, they made clear they are not waiting on Congress to act before taking action on this front. In terms of timing, Deputy Secretary Hargan noted that the issuance of the AKS RFI in August could delay regulatory action on Stark and that the agency is going through the considerable number of thoughtful, regulatorily specific comments to come up with a comprehensive solution.

KEY TAKEAWAY: The administration is committed to reforming Stark—however, HHS's regulatory approach may be disjointed from legislative action. The exact timing of a regulatory fix is still uncertain, though providers can likely expect changes to regulation on Stark in the next year. The Administration's agenda is largely focused on reconciling approaches to regulatory reform through the multiple RFIs issued this year as part of their "Regulatory Sprint to Coordinated Care" effort.

VALUE-BASED CARE

The Administration appeared supportive the Medicare Advantage Plus model; however, they are seeking programs with significant scalability and national impact. Demonstrating the potential for such a model to gain broad-based support and adoption will be key in advancing towards implementation.

Much of the discussion around value-based care centered around the Medicare Advantage Plus (MA+) Model and its potential to align with the Secretary's priority to advance value-based care. Peter Fine (Banner Health) initiated the discussion, positioning MA+ as an opportunity to "graduate" Accountable Care Organizations (ACOs) out of the ACO program, which has not shown an ability to deliver savings to Medicare on the magnitude predicted, and into Medicare Advantage (MA). Fine spoke about how an MA environment that supports predictability, strengthens accountability for costs, and increases resources to deliver services to beneficiaries would build on the successes of the ACO program. In accordance with the other providers in the room, Fine noted that a predictable, reasonable per-member-per-month arrangement is preferred to an ACO benchmark against which an organization cannot compete.

Deputy Secretary Hargan, Peter Urbanowicz, and Deputy CMS Administrator Demetrios Kouzoukas were very receptive to the model's core design, noting that there is alignment with the ways in which the Administration is looking to grow MA. Deputy Administrator Kouzoukas, who was previously exposed to the proposal, sought further information on the components of the model most necessary to a successful implementation. In particular, he focused on the role of risk scores, quality metrics, and auto-attribution in defining and delimiting the model. His approach suggests that The Administration is seeking a lean and efficient approach to achieve the model's core aims. He also questioned what changes could be enacted through Medicare without going through the Innovation Center, opening the possibility that the model could be made possible through a multi-agency effort.

A significant consideration in implementing the model is the auto-enrollment of ACO beneficiaries into MA plans. Though reactions to auto-enrollment were not overtly negative, such an allowance would be a major shift from current policy and Administration officials emphasized the need for opt-out provisions and robust marketing efforts to beneficiaries to ensure they are appropriately engaged to make a decision about moving into MA. Consensus suggested that auto-enrollment would likely need to come through the Innovation Center. Model proponents emphasized that the auto-enrollment provision is a core component of the MA+ initiative, effectively allowing provider-owned MA plans to gain sufficient scale to compete in the marketplace.

Most notably, reaction to the model suggested a potential mismatch between the current approach to improve MA penetration and the way that model implementation has been conceptualized. The MA+ model was designed to be a pilot through CMMI; however, both Urbanowicz and Deputy Secretary Hargan appeared to be averse to small-scale experiments. They emphasized the need to champion programs that can gain scale when implemented in a broad-based manner through regulatory change as opposed to piecemeal efforts. Deputy Secretary Hargan, in particular, remained sensitive to the time constraints of aligning a potential model with the regulatory process. The HHS team noted their desire to move quickly with regards to evaluation and scale up.

Dr. Marc Harrison (Intermountain Healthcare) proposed that The Academy could play a role in identifying a national subset of providers that would support this model, representing a significant proportion of beneficiary lives. By ensuring a critical mass of adopters, the model could be rolled out with near-national scale as a proof of concept before putting in place more significant regulatory changes. Such a phased approach would allow for tweaks to be made to the programs as it was implemented and ensure the migration into MA that the Administration continues to prioritize. This approach seemed to be well received —the notion of national scalability and the engagement of large delivery systems in the model appealed to Deputy Secretary Hargan, Deputy Secretary Kouzoukas, and Urbanowicz. The HHS officials appeared interested in utilizing this model to drive broader impact in a way that does not add additional burden to CMMI. They spoke at length about how each new model takes away resources and mindshare from CMMI, and by extension, CMS. Regulatory flexibilities

enabling the model would allow stakeholders to move quickly and nimbly, as opposed to being beholden to the existing model timelines and evaluation criteria.

Adam Boehler entered the meeting near the end of the hour and did not allude to specific components of the initiative. He did, however, question the ability of large providers to take on risk outside of the MA framework. Boehler seemed to believe that the scale of the providers represented would allow them to take on risk for a significant share of Medicare fee-for-service lives on their own without needing MA to create incentives to do so. Dr. Nick Turkal and Peter Fine both noted that even as large providers, their organizations did not control sufficient portions of the market in order to take risk in the way Boehler suggested. The limitations of existing data and attribution would limit their capacity to care for this population without a framework like MA. Turkal and Fine emphasized the need for ground rules in order to predictably invest resources into managing their Medicare FFS population.

The Administration concluded with the desire to continue the conversation with this group. They expressed appreciation for the thoughtful comments and discussion. Subsequently, several follow up calls and emails between HHS personnel and HMA have been conducted.

KEY TAKEAWAY: The Administration was supportive of the proposal to transition ACO beneficiaries into MA. There is considerable work to be done in understanding how best to align the scale and timing of this model with the administration's broader agenda around MA, including the potential for a national-scale program. There are portions of the proposal that need to be further developed to rationally delegate regulatory changes and waiver authority to the various agencies involved, as well as limiting the burden placed on CMMI.

NEXT STEPS & OPPORTUNITIES FOR THE ACADEMY ADVISORS

- Continuing to engage on Stark is warranted in the face of impending regulatory change. Though we have submitted comment, continuing to build visibility of this group of systems will improve the chances of ensuring that the value-based exception approach gains traction with the Administration.

- Building a realistic picture of support for the MA plus model is a critical next step in moving the model forward. Understanding which organizations from HMA's broader membership would be eligible and supportive of such a capacity to transition will build momentum and serve as a proof of the scalability and adoptability of such an approach.

- Creating a proposal or other deliverable outlining the next steps for the MA+ model will build from this meeting to continue to engage the Administration in our efforts to implement MA+. Specifically, we will research and present a distribution of responsibilities regarding what changes proposed in the model design can be made through the Medicare program what changes must go through the Innovation Center. In further proposal developments, we will finalize the methodology for transferring risk scores and ACO quality scores to MA, with the recognition that CMS is unlikely to directly equate ACO performance and MA performance to ensure that participants in this model enter on a level playing field and aren't given an unfair advantage over other plans in the market.

- Determining how best to follow up, potentially in the form of another meeting with HHS leadership, including Secretary Azar.