The Academy
The Health Management Academy

THE HEALTH MANAGEMENT ACADEMY

OCTOBER 2018 GOVERNMENT AFFAIRS MEETING SUMMARY

HEALTHCARE TRANSFORMATION: AN OPEN (DATA) QUESTION

Aneesh Chopra, President, CareJourney; Former U.S. Chief Technology Officer

Aneesh Chopra provided a comprehensive overview of the current national health data framework as well as the broad trends in data-driven healthcare transformation. Chopra remains a key resource for the current Administration and has worked with them in their open data efforts. He described how the healthcare industry, despite existing interoperability hurdles, is moving in the direction of an open Application Program Interface (API) approach. APIs have the potential to work across electronic health records and other vendor environments, consolidating data across different sources. Chopra believes that broader culture change in healthcare will improve API adoption, alongside a renewed focus on data security concerns, recalibrating patient privacy requirements, and finding low-cost avenues to improve data availability and reduce physician burden. He urged providers to support such a shift and lead a push for more application substitutability, increased patient access to cost data, and open sharing of data across networks and platforms.

Key Takeaway: Open API frameworks have the potential to redefine current approaches to interoperability. While concerns exist about the potential market disruption, the benefits of an open data system in healthcare are clear. Pilots of open data sharing platforms have produced tangible improvement in health outcomes and cost savings for payers, providers, and patients.

GOVERNMENT AFFAIRS OPEN DISCUSSION

Government Relations Executives from Leading Health Systems were asked about their key policy priorities in this open discussion. Key questions about the viability of the ACO program, in light of recently proposed changes, were raised. While CMS has proposed to extend the length of ACO agreement periods, GROs expressed frustration at CMS's regulatory inconsistency within the model. While opinions were mixed on the ACO model, most GROs agreed that CMS needed to improve the consistency of their regulatory approach and work with providers as a good faith business partner to ensure that models like ACOs could provide savings both to providers and the Medicare program.

GROs also discussed the importance of engaging on Stark modernization. While most GROs have discussed Stark Law reform with their delegations, they consistently find that knowledge about the current state of the law is limited and appetite for legislative reform is still developing.

Broader discussions of advocacy strategy highlighted the evolving role of the GRO—while GROs traditionally have acted as lobbyists for Congress, their focus has shifted from legislative to regulatory advocacy. Their understanding of the regulatory process is still evolving, and GROs emphasized a need to better understand the rulemaking and comment process to improve their ability to influence the final forms of regulatory policy. Local advocacy has also become a bigger component of the GRO role, particularly as health systems are increasingly being held accountable to their communities and working with community-based organizations to improve care for their patients.

Key Takeaway: Additional collaboration and communication with CMS is warranted to improve health system's capacity to influence regulatory change. As the role of the GRO shifts from legislative towards regulatory engagement, GROs will have to efficiently channel limited resources into balancing their federal, state, and local approaches.

MEDICAID TRENDS

Moira Forbes, Policy Director, Medicaid and CHIP Payment and Access Commission ("MACPAC")

Moira Forbes of MACPAC, a nonpartisan group providing technical legislative assistance on Medicaid, covered overarching trends in the Medicaid program as it faces a tumultuous election season in which issues of Medicaid expansion and rising program costs are top-of-mind. Forbes shared that, despite increased medical spending, Medicaid cost growth has increased at a much lower rate than Medicare and private payers. MACPAC is tracking the four states receiving waivers to implement Medicaid work requirements and is currently tasked by Congress to investigate the ways that states are making Medicaid Disproportionate Share Hospital (DSH) payments to providers. Improving the tracking of Medicaid payments to providers and improving the quality of Medicaid quality and cost reporting is a key goal Congress has set for MACPAC.

Key Takeaway: Providers and state agencies providing Medicaid coverage are under increased scrutiny, particularly as Medicaid faces existential expansion and design threats. Better understanding and tracking Medicaid payments is an issue garnering bipartisan support in Congress and will likely inform future policy adjustments.

BALANCED HEALTH KENTUCKY

Riggs Lewis, System Vice President, Health Policy, Norton Healthcare

Riggs Lewis shared the Balanced Health Kentucky plan that Norton Healthcare and other leading providers across Kentucky have developed to build a political and financial case for Medicaid expansion. Lewis and his team worked closely with state agencies to collect geographic enrollment and financial data for Medicaid after Governor Matt Bevin threatened to end the program. Knowing a rollback of Medicaid expansion would be devastating for the 500,000 Kentuckians who have received coverage through expansion, Lewis and his team worked to provide a comprehensive view of the impact of Medicaid contraction. His team created Balanced Health Kentucky, a plan and legislative strategy to educate policymakers about financing Medicaid through comprehensive tax reform on industry stakeholders. The Balanced Health Kentucky tool also provides an estimate of how many people would lose coverage in each State Legislature District, State Senate District and U.S. Congressional District if Medicaid expansion was ended.

Key Takeaway: Balanced Health Kentucky's early success has reverberated beyond the state of Kentucky and the group has received national attention on how to fund Medicaid expansion, even in Republican states, without increasing state budgets. The tool is public and can be made available to other providers who wish to duplicate his program in their own states.

THE FUTURE OF HEALTH INSURANCE MARKETS

Chris Condeluci, Principal, CC Law & Policy

Chris Condeluci shared information on the introduction of short-term and association health plans. Through regulatory change, the Trump Administration has increased the Obama-era limit on short-term health plans from 3 months to one year, guaranteeing the ability to renew such a plan. While many states, particularly those with Democratic legislators, oppose the proposal on grounds that it will decimate the existing individual marketplace established under the ACA, Condeluci emphasized that these regulations will not supersede state authority and are still subject to individual state Multiple Employer Wellness Arrangements (MEWA) laws. Thus, employers, tradespeople, and insurers must go state by state to talk to insurance commissioners to obtain approval. Such efforts have already begun in receptive states, and the association marketplace looks to be one that will grow and offer quality plans to its members.

Key Takeaways: Though these ACA alternatives are subject to executive approval, which could change from administration to administration, outlook appears to be positive for the significant adoption of both association and short-term health plans.

A PROVIDER LED DRUG MANUFACTURER: CIVICA RX

Martin VanTrieste, CEO, Civica Rx

Martin VanTrieste shared the model that Civica Rx, a generic drug manufacturing startup led by providers including Intermountain, Providence St. Joseph, Mayo Clinic and HCA among others, is using to address market failures in the production and pricing of essential generic drugs. Civica Rx seeks to reduce generic drug costs for essential hospital administered drugs by developing a stable supply chain and preventing profit-driven markups. Civica's model relies on consistent and high-volume buy-in across provider partners; in return, Civica operates a price transparent model that will charge providers equally for the drugs purchased. By targeting non-patent-protected drugs, Civica aims to launch next year with 19 medications and plans to expand to as many as 200 different drug offerings. They note, however, that their existence could serve a regulatory function in the market, compelling other producers to adjust their prices accordingly. Civica's approach has been met with bipartisan support and considerable industry interest.

Key Takeaway: Civica proposes a novel market approach which has the potential to reset market pricing and significantly drive down the costs of essential hospital-administered drugs. Though Civica's business model will require cooperation from its partners, it has significant potential to disrupt the pharmaceutical market.