The Future of Healthcare Reform and What it Means for Quality

Keith Kosel, PhD, MHSA, MBA
Senior Vice President, Government Affairs

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What is Government Affairs?

- **Office of Public Policy and Government Relations** – Vizient’s Washington DC Office
  - Works to build strong relations with Congress and the Administration to advance Vizient member’s interests
  - Identifies and disseminates information on new regulations, policies and demonstration programs that will impact Vizient members

- **Office of Government Programs** – Corporate Office, Irving, TX
  - Procures federal funding and provides administration and oversight for all federal healthcare contracts held by Vizient
    - Hospital Improvement Innovation Network (HIIN)
    - Transforming Clinical Practice Initiative (TCPI)
    - Various CMMI Innovations Awards, AHRQ Grants
    - Any new federal/state contracts/grants
Four questions we should be asking ourselves:

- What do we know?
- What do we think we know?
- What don’t we know?
- What must we do?
*Everything was going along and then we had an election...
Election Night - Big win for the GOP

HOUSE: D+7

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SENATE: D+2

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President Trump’s healthcare positions

- Repeal the ACA and replace it with a solution that includes HSAs and returns regulating health insurance to States
- Purchase insurance across state lines and re-establish high-risk pools
- Protect innocent human life from conception to natural death
- Advance research and development in healthcare
- Reform the Food and Drug Administration
- Modernize Medicare
- Maximize flexibility for states in Medicaid
Trump Administration Healthcare Leadership

• Rep. Tom Price, M.D. (R-Ga.) – Secretary of Health and Human Services (HHS)
  • Orthopedic surgeon; 12 years as Congressman
  • “Empowering Patients First”
  • “The Secretary shall” 1,005 times in the ACA
  • Lots of discretion – birth control, Medicare payment changes, tobacco, Planned Parenthood, conscience protections

• Seema Verma – CMS Administrator
  • Best known for her work in redesigning Indiana’s Medicaid program using waivers – strong support from physicians and hospitals
  • Similar work in IA, OH, MI, TN, KY
ACA in the crosshairs

Repeal Effort is Certain – but how will that effort look?

A) Bipartisan Engagement – Redo the whole process – engaging stakeholders and lawmakers from both parties. Once thought unlikely, now maybe not so, though still a very, very long-shot

B) Partisan Overhaul – Full repeal effort excluding Democrats – likely fails in Senate without 60 votes to overcome filibuster. Not likely

C) Reconciliation – Use of reconciliation procedure to repeal components of the law. Process is messy – but GOP was successful using it to get bill to President’s desk in 2016
Current State of Play: “Repeal and Delay, Repair, Replace, Repeal Plus…”

• Congress was moving aggressively to fulfill campaign promises of repealing the ACA…now?
• Targeting repeal through budget reconciliation process to avoid filibuster in the Senate.
Reconciliation process is not easy…

• Requires budget resolution authorizing budget reconciliation

• Only items impacting spending or revenue are “germane”

• Congress must approve the package – Filibuster in Senate can be avoided
But GOP has had practice

Republican-controlled Congress successfully navigated procedure last year – bill was vetoed by President Obama

*Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*

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<tr>
<th>Reconciliation-eligible changes</th>
<th>Provisions without budget effects</th>
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<tr>
<td>Previously passed provisions:</td>
<td>Antidiscrimination provisions:</td>
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<tr>
<td>» Repeal mandate penalties</td>
<td>» Pre-existing conditions</td>
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<tr>
<td>» Roll back Medicaid expansion</td>
<td>» Gender-based cost differences</td>
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<td>» Block “Risk Corridors”</td>
<td>» Meaningful access for disabled</td>
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<td>» Repeal ACA taxes</td>
<td>» Language assistance</td>
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<td>• Medical devices</td>
<td>Kids age 26 and under on parents’ plans</td>
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<td>• “Cadillac” tax</td>
<td>Mandates aren’t eligible for reconciliation on their own</td>
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<td>• Tanning tax</td>
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<td>• Changes to flexible arrangements</td>
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<td>» Eliminate cost sharing subsidies</td>
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<td>» Eliminate mandatory funding streams</td>
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<tr>
<td>• Prevention &amp; Public Health Fund</td>
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<td>• Exchange setup funds</td>
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The American Health Care Act (3/24/17)

• No individual or employer mandate but penalties for failure to maintain coverage
• Protections for individuals with pre-existing conditions, but only if they maintain continuous coverage
• Eventual repeal of enhanced FMAP for expansion adults in Medicaid, except those already enrolled as of Dec. 31, 2019
• Creates a per-capita cap model in Medicaid beginning in 2020 with 2016 as base year
• Repeals the Medicaid DSH cuts for non-expansion states in 2018; for expansion states in 2020
• Provides $10 billion over five years to non-expansion states for safety net funding
• $100 billion for a Patient and State Stability Fund (lower patient costs, stabilize insurance market)
• Repeal of subsidies and cost-sharing reductions and replaced with age-based, refundable tax credits ($2,000-$4,000)
  • Income restrictions (phased out for individuals making more than $75,000, $150,000 for couples)
• Increase HSA contribution limit
• Prohibits federal funding for Planned Parenthood for one year
• Does not repeal the tax on high-cost health plans but delays it until 2025
• Repeals high-earner Medicare tax, medical device tax, tanning tax, insurance tax, and tax on pharmaceuticals
• Repeals the Prevention and Public Health Fund
• **No mention of value-based delivery system reform repeals or elimination of CMMI!**
Congressional Budget Office (CBO) Report

- Reduction in the deficit by $337 billion (net) over ten years
  - $880 billion reduction in Medicaid payments due to capping federal contributions as well as lower tax credits

- 14 million more uninsured in 2018; 24 million by 2026; total uninsured in 2026, 52 million vs 28 million under the ACA
  - Largely due to avoidance of mandate penalties in early years and less federal Medicaid spending in later years

- 15-20% increase in premiums prior to 2020, 10% decrease after that
  - Significant increase for older Americans due to new age band ratings
The Key Players

House and Senate Leadership

The Freedom Caucus – Conservative-leaning Senators

The “Moderate” Dealmakers

GOP Governors

Democrats
Friday March 24, 2017

• 215 votes needed to pass the legislation; no more than 22 Republicans could vote against the bill in the House

• The votes lined up this way:
  – 150 in favor
  – 45 undecided
  – 42 no or leaning no

• The votes weren’t there so the legislation was pulled by Speaker Ryan

• *Post-mortem*: The President blamed the Democrats and Ultra-Conservatives; Speaker Ryan blamed the Ultra-Conservatives; the Ultra-Conservatives blamed the President and House Leadership; Moderates blamed everyone but themselves! What a mess!
*Value and delivery system reform left untouched

What would repeal of the ACA mean for Value-based delivery system reforms?
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

Key characteristics:
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics:
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care
The framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- Serves as the foundation for generating evidence about what works and lessons learned
- Provides a road map for payment reform capable of supporting the delivery of person-centered care
- Acts as a "gauge" for measuring progress toward adoption of alternative payment models
- Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities

The framework situates existing and potential APMs into a series of categories.
CMS continues to move away from FFS

In January 2015, HHS announced goals for VBP within the Medicare FFS system

- **Goal 1:** Tying Medicare FFS payments to quality or value through alternative payment models (categories 3-4):
  - 30% of Medicare Payments by the end of 2016
  - 50% of Medicare Payments by the end of 2018

- **Goal 2:** Tying Medicare FFS payments to quality or value (categories 2-4):
  - 85% of Medicare Payments by the end of 2016
  - 90% of Medicare Payments by the end of 2018

- **Category 1:** FFS with no link of payment to quality
- **Category 2:** FFS with a link of payment to quality (VBP, HRRP)
- **Category 3:** Alternative payment models built on FFS architecture (ACOs, bundled payments)
- **Category 4:** Population-based payment

**SOURCE:** “Better, smarter, healthier. Delivery system Reform”, US Department of Health and Human Services, March 10, 2015
Medicare and CHIP Reauthorization Act

Congress passed MACRA last year, finally repealing the SGR formula for physician reimbursement!

Strong bipartisan support

Replaced it with:

- Payment modifications based on performance
  - Merit-Based Incentive Payments (MIPs)
  - Alternative Payment Models (APMs)
  - Will consolidate multiple IT programs (MU, PQRS, VM)

Final Rule released October 14, 2016
The Innovation Center portfolio aligns with delivery system reform focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
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<tbody>
<tr>
<td>Pay Providers</td>
<td>Test and expand alternative payment models</td>
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<tr>
<td></td>
<td>- Accountable Care</td>
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<td></td>
<td>- Pioneer ACO Model</td>
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<td>- Medicare Shared Savings Program (housed in Center for Medicare and MSSP +1)</td>
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<td>- Comprehensive ESRD Care Initiative</td>
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<td>- Next Generation ACO</td>
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<td>- Primary Care Transformation</td>
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<td>- Comprehensive Primary Care Initiative (CPC) &amp; CPC+ Demonstration</td>
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<td>- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<td>- Independence at Home Demonstration</td>
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<td>- Graduate Nurse Education Demonstration</td>
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<td>- Home Health Value Based Purchasing</td>
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<td>- Medicare Care Choices</td>
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<td>- Frontier Community Health Integration Project</td>
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<td>- Medicare Diabetes Prevention Program</td>
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<td>- Bundled payment models</td>
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<td>- Bundled Payment for Care Improvement Models 1-4</td>
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<td>- Oncology Care Model</td>
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<td>- Comprehensive Care for Joint Replacement</td>
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<td>- Initiatives Focused on the Medicaid</td>
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<td>- Medicaid Incentives for Prevention of Chronic Diseases</td>
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<td>- Strong Start Initiative</td>
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<td>- Medicaid Innovation Accelerator Program</td>
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<td>- Dual Eligible (Medicare-Medicaid Enrollees)</td>
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<td>- Financial Alignment Initiative</td>
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<td>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td>- Integrated ACO</td>
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<td>- Medicare Advantage (Part C) and Part D</td>
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<td>- Medicare Advantage Value-Based Insurance Design Model</td>
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<td>- Part D Enhanced Medication Therapy Management</td>
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<tr>
<td>Deliver Care</td>
<td>Support providers and states to improve the delivery of care</td>
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<td>- Learning and Diffusion</td>
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<td>- Partnership for Patients</td>
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<td>- Transforming Clinical Practice</td>
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<td>- Health Care Innovation Awards</td>
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<td>- Accountable Health Communities</td>
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<tr>
<td>Distribute Information</td>
<td>Increase information available for effective informed decision-making by consumers and providers</td>
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<td></td>
<td>- Health Care Payment Learning and Action Network</td>
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<td>- Information to providers in CMMI models</td>
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* Many CMMI programs test innovations across multiple focus areas
Linking payments to quality and APMs

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<tr>
<th>Accountable Care Organizations</th>
<th>2014</th>
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<td>Bundled Payments for Care Improvement (BPCI)</td>
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<td>Episode Payment Model*</td>
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<td>BPCI-2*</td>
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<td>Advanced Primary Care</td>
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<td>Multipayer Advanced Primary Care Practice</td>
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*Proposed. ACO = accountable care organization; ESRD = end-stage renal disease.
Source: Valinda Rutledge, Sg2 Fellow, 2016.
New “mandatory” Episode Payment Models

New start date of Oct. 1, 2017; possible delay to Jan. 1, 2018

The final rule supports Administration’s goal to increase Medicare funding to APMs from 30% (current) to 50% by 2018

- Creates two new mandatory episode payment models (EPMs): heart attack and cardiac bypass surgery services and a Cardiac Rehabilitation (CR) Incentive payment model
- Expands Comprehensive Care for Joint Replacement (CJR) model to include surgical services for hip and femur fractures (SHFFT)
- Hospitals in 98 randomly selected MSAs required to participate in new cardiac bundle
- Preliminary details on new Medicare ACO Track 1+ model to begin in 2018
*Will the Republicans try again? If so, when?*

- Not clear. Ultra-Conservatives are pushing the Administration to re-open talks around a new piece of legislation.

- The President and Speaker have gone on record to say they are moving on to Tax Reform and Regulation Reform;
  - “We will focus on other promises we made to the American people to Make America Great Again”
  - “Obamacare is alive and is the law until it implodes”
  - “When that happens and it will, we’ll talk with anyone who has a plan”

- The next shoe to drop may be more insurance companies withdrawing from the individual and non-group marketplace; many predict an insurance “death-spiral” isn’t far off.
# Ambitious Congressional Agenda

<table>
<thead>
<tr>
<th>TOP GOALS / MUST DO</th>
<th>MAJOR PUSH</th>
<th>ACTION POSSIBLE</th>
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<tr>
<td>Repeal / Replace Affordable Care Act</td>
<td>Restore Defense spending (fix sequester)</td>
<td>Miners’ pensions bail-out</td>
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<td>Comprehensive Tax Reform</td>
<td>Trump Infrastructure program</td>
<td>Post Office reform</td>
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<td>Secure Border / Wall</td>
<td>Veterans Administration reform</td>
<td>Criminal Justice reform</td>
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<td>Rollback regulations: ~150 Obama regs @ risk</td>
<td>Comprehensive Energy bill</td>
<td>IT cyber security</td>
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<td>Intelligence reauthoriz. / Patriot Act §702</td>
<td>Dodd-Frank banking reforms</td>
<td>Trade: currency reform</td>
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<td>FDA User Fees</td>
<td>Budget process reform</td>
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<td>FAA reauthorization</td>
<td>Comprehensive Telecom Act</td>
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<td>CHIP reauthorization / Medicare extenders</td>
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<td>Raise debt ceiling + pass ‘17 &amp; ‘18 budgets</td>
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What will Medicaid reform look like?

- Eventual repeal of expansion and enhanced FMAP
- Per capita cap model begins in 2020; state spending in 2016 is base year
- Indexed by medical consumer price index
- Fewer enrollees, lower benefits will lead to lower provider reimbursements…implications for quality?

**Per-Capita Caps**
Set amount of federal funds annually, based on spending per enrollee.
Does eventual repeal = refund?

Not likely…Hospitals’ payment cuts under ANA…at least $155 billion over 10 years will remain…”You Bet On the Wrong Horse”

What about penalties? Those tied to safety and quality not likely to disappear…

- Readmissions
- VBP
- HACs
- Meaningful Use ??
- Ongoing Productivity Adjustments
Fate of Innovation Center?

- Will future ACA repeal efforts target CMMI? The goal to move towards value-based care remains bipartisan but...
  - Part B and mandatory demos have raised opposition to its authority (plus it is still a part of the ACA)
  - Funding questions remain after 2018; CBO says that elimination could cost $34 billion
  - Now closely tied to MACRA as APM/AAPM incubator
  - Full repeal could have dramatic impact on ongoing programs…
  - So far CMMI remains untouched but…
Fate of Innovation Center?

• It is likely that CMMI will continue, possibly in a smaller state, with a new mandate and new goals
  – Look for continued model building to drive APM/AAPMs and net cost-savings (ROI)
  – Look for bundles to continue but without a mandate to participate; quality measures may be scaled back
  – Look for demonstrations around dual-eligibles and new ways to fund Medicaid and Medicare
  – Look for 1332 Waivers to be prevalent
  – Look for less “provider support programs”…the market will play that role going forward
*Cost-savings, cost-savings, cost-savings...
Quality is not negotiable

Lots of evidence that focusing on quality and patient safety pays off for ALL STAKEHOLDERS

National Scorecard on Rates of Hospital Acquired Conditions, 2010 to 2015 (AHRQ)

- **3.1 million fewer patient harms** were experienced
- 21% decline in HACs (from 145/1000 discharges to 115/1000)
  - 42% reduction in ADE
  - 23% reduction in pressure ulcers
  - 15% CAUTI
- Nearly **125,000 fewer deaths** due to HACs
- A **reduction of $28.2 billion** in healthcare spending
- Partnership for Patients (PfP) initiative
- “**Safety Across the Board**”
Patient Engagement and Care Coordination are key

The more involved you are in your own health care, the better health care you get

**MORE Involved Patient**

- Readmitted to the hospital within 30 days of discharge: 12.8% vs. 28%
- Experienced a medical error: 19.2% vs. 35.8%
- Have poor care coordination between health care providers: 12.6% vs. 41.8%
- Suffer a health consequence because of poor communication among providers: 13.2% vs. 48.6%
- Lose confidence in the health care system: 15.1% vs. 59.8%

**LESS Involved Patient**

- SOURCE: VHA-UHC Alliance NewCo Research
“Population Health” is an evolving concept with variable meanings and rate of adoption
What can we do to help drive the goals of Better Care, Smarter Spending and Healthier People?

- **Eliminate** patient harm
- **Focus** on population health; integrate public health into delivery system reform
- **Move** away from FFS by engaging in APMs to achieve better outcomes at lower cost
- **Invest** in quality infrastructure necessary to improve outcomes
- **Highlight** data and performance/price transparency
- **Make** patient-centered, coordinated care the norm
- **Relentlessly pursue** improved health outcomes
- **Shift** focus from federal to state and community innovation and delivery system reform
Key points to keep in mind…

• ACA repeal and replace efforts have stalled for the time being – but it’s likely they will be revisited in the future.

• Hospitals should aim to remain compliant with the law as it currently stands, while recognizing that there are likely to be changes on the horizon.

• Overall drive toward value-driven healthcare unlikely to change – but the approach will be different…expect market mechanisms to play a bigger role.

• Hospitals will continue to face pressure to reduce costs and improve quality…the government may or may not be in the business to facilitate/fund it…look for market mechanisms to be the preferred lever.
Keith Kosel, PhD, MHSA, MBA
Senior Vice President, Government Affairs

keith.kosel@vizientinc.com

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