A Physician-Senator’s Look into the Crystal Ball of Healthcare Reform

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February 6, 2017
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1. Washington Outlook
2. Learning from the Past
3. Care Model for Oncology
1. Washington Outlook:

ACA Repeal & Replace
For the first time since 1929, the GOP controls Congress, the White House, most governorships and state houses, as well as the Supreme Court.
Over Obama’s Tenure, America Has Moved Radically Toward Republican Principles

Source: “These 3 maps show just how dominant Republicans are in America after Tuesday,” Washington Post, 11/12/16
25 States with Both GOP Governor & Legislature

A Red America

Source: Americans for Tax Reform; 2016 election results

THE WASHINGTON POST

2017 Cancer Center Business Summit
Only 5 “True Blue” States

Blue America

Five states with a Democratic governor and Democratic state legislature

*Connecticut’s state Senate is technically a tie, but a tie breaker goes to Democrats

Source: Americans for Tax Reform; 2016 election results

THE WASHINGTON POST
115th Congress – GOP Maintains Control

House of Representatives

- 240 Republicans
- 193 Democrats
- 2 Vacant

U.S. Senate

- 52 Republicans
- 46 Democrats
- 2 Independents (Caucus with Dems)
## Ambitious Congressional Agenda with Numerous Healthcare Priorities

<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 <strong>Defense</strong> spending</td>
<td><strong>Miners’</strong> pensions bail-out</td>
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<td>Comprehensive <strong>Tax</strong> Reform</td>
<td>Trump <strong>Infrastructure</strong> program</td>
<td><strong>Post Office</strong> reform</td>
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<td>Secure <strong>Border</strong> / Wall</td>
<td><strong>Veterans</strong> Administration reform</td>
<td><strong>Criminal Justice</strong> reform</td>
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<tr>
<td>Rollback regulations (CRA): ~150 Obama regs @ risk</td>
<td>Comprehensive <strong>Energy</strong> bill</td>
<td><strong>IoT cyber</strong> security (drones, cars, etc.)</td>
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<td>Intelligence reauthoriz. / Patriot Act §702</td>
<td>Dodd-Frank <strong>banking</strong> reforms (CHOICE Act)</td>
<td><strong>Trade</strong>: CFIUS reform, currency</td>
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<td><strong>FDA User Fees</strong></td>
<td><strong>Budget process</strong> reform</td>
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<tr>
<td>FAA reauthorization</td>
<td>Comprehensive <strong>Telecom</strong> 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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In 2018 **GOP** Will Pick Up Senate Seats

*Dems defending 25 total states, 10 Trump won*

*GOP defending 8 total, only 1 Clinton state (NV)*

![Map showing Senate seats up for election with states colored to indicate Democratic incumbents, Independent incumbents, Republican incumbents, and states with no election.](image-url)
What Could Repeal Look Like?

Look to the 2015 GOP Reconciliation Bill

• Effectively **repeals the individual and employer mandates** by eliminating the tax penalties

• Ends all premium subsidies

• Ends Medicaid expansion
What Could Replacement Look Like?

Paul Ryan’s “A Better Way”

Cassidy-Collins “Patient Freedom Act” allows states to choose one of three options
What’s the Administration’s Role?

Power of the Pen – Trump’s Executive Orders

Executive Order Minimizing the Economic Burden of the ACA:
“It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act…”

Source: www.whitehouse.gov
What’s the Administration’s Role?

Regulatory Changes – HHS & Dr. Tom Price

Possible Changes:

○ Rewrite numerous ACA rules

○ Use Medicaid waivers to give states more flexibility

○ CMMI
The Key Players – Members to Watch

The Party Leaders

The Committee Chairmen

The 33 GOP Governors
Projected ACA Repeal & Replace Timeline

2017

January

March/April – ACA Repeal (Reconciliation)

Fall 2017 – First ACA replace bill(s) considered (piecemeal approach)

2018

January

Spring/Summer 2018 – ACA replace bills considered

9/30 – CHIP funding runs out (1-yr ext.)

2018 Midterm Elections

12/31 – Tax extenders & ACA taxes

Fall 2018 – Omnibus ACA replacement

12/31 – ACA repealed, replacement goes into effect
State of U.S. Coverage Today

156m Employer-Sponsored

55m Medicare

74m Medicaid

6m VA-Tricare

20m Individual market

28m Uninsured

(only half in ACA markets)
2. Learning From the Past:

My Years as a Physician-Senator
Three Legislative Events We Can Learn From Today

• **Block Granting Medicaid** – President Bush’s 2003 Proposal

• **Medicare Part D** Enactment

• Failed Effort to **Privatize Social Security**
Lesson 1: Don’t Discount the Influence of Governors in Federal Politics

In 2003, President Bush proposed converting Medicaid to a block grant program.

Bush tasked bipartisan National Governors Association (NGA) with developing proposal

Concern with health care inflation falling on shoulders of states over time
What Could Replacement Look Like?

GOP Governors on Medicaid Expansion

In addition to Paul Ryan’s plan and the Cassidy-Collins Act, another proposal to keep in mind:

- 2011 Republican Governors Public Policy Committee report on how to reform Medicaid – supported by 31 GOP governors

- Includes 31 possible reforms to improve Medicaid
Lesson 2: Build Bipartisan Alliances; Unilateral Accomplishments Rarely Endure

Built to Last

Medicare Pt. D

42 Republicans + 12 Democrats

2003

Bipartisan

Walking Dead

Obamacare

Senate: 60 Democrats + 0 Republicans

2010

Partisan
Lesson 2: Build Bipartisan Alliances

Republicans can pass REPEAL without Democratic support

... but will need 60 votes in the Senate to pass REPLACEMENT – so must have some Dem support

Want to avoid owning it unilaterally ("you break it, you own it")
Lesson 3: The Third Rail of Politics – Social Security & Medicare
Will Trump Turn Medicare into a Voucher Program?

My crystal ball says no...
Will Trump Turn Medicare into a Voucher Program?

Trump on Campaign Trail pledged not to cut Medicare

Price in HHS Confirmation Hearing confirms Trump has not changed mind: “I haven't had extensive discussions with him about the comments that he made, but I have no reason to believe that he's changed his position [on Medicare].”

BUT … Medicare is THE MOST IMPORTANT DRIVER of our increasing debt … the unfunded mandates must be addressed in the future.
3. Care Model for Oncology: The Role of Palliative Care
CMMI under President Trump

• It will continue.

• With Trump as President, in the short term, I see a pause in CMMI value-based activity as the new administration gets settled.

• My longer-term view is that the Trump/Price era will drive significant new growth in bundled (Value) payments in both the commercial and governmental payer markets.
CMMI and the Oncology Care Model

- OCM represented the most significant growth in bundled payment participation in 2016 with 196 cancer care providers and 17 health plans participating. 25% of oncologists participate as of today.

- And it is one of the first models that qualifies as a specialist driven Alternative Payment Model (APM) within MACRA.
The Palliative Care Approach
Palliative Care and Oncology: The Reality

- Palliative Care is a core competency of oncology including both advanced care planning and advanced symptom management.

- The super-specialization of medicine due to advances in pharmacologicals and technology has made the oncologist’s job infinitely more complex.
Palliative Care and Oncology: **The Barriers**

- Time is the currency of palliative care

- It is difficult to support the volume (in FFS system) needed to pay for a palliative care provider and team
The Solution: An Alternative Payment Model

• Payment for currently non-billable activities
  – Coordination of care
  – Salary of team members

• Outcomes-based payment with
  – Achieved Quality Metrics
  – Cost reduction for
    • Prognostically appropriate care
    • Avoidable or preventable costs
AT LEAST Four OCM Metrics Can be Met Directly by a Palliative Care Provider

<table>
<thead>
<tr>
<th>OCM Measure #</th>
<th>Measure Description</th>
<th>Source</th>
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<tbody>
<tr>
<td>OCM-1</td>
<td>Risk Adjusted proportion of patients with all-cause hospital admissions</td>
<td>Claims</td>
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<tr>
<td>OCM-2</td>
<td>Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission</td>
<td>Claims</td>
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<tr>
<td>OCM-3</td>
<td>Proportion of patients who died who were admitted to hospice for 3 days or more</td>
<td>Claims</td>
</tr>
<tr>
<td>OCM-4</td>
<td>Pain assessment and management</td>
<td>Practice</td>
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<tr>
<td>OCM-5</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Practice</td>
</tr>
<tr>
<td>OCM-6</td>
<td>Patient-reported experience of care</td>
<td>Survey</td>
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<tr>
<td>OCM-7</td>
<td>Timeliness of adjuvant chemotherapy for colon cancer</td>
<td>Practice</td>
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<tr>
<td>OCM-8</td>
<td>Timeliness of combination chemotherapy for hormone receptor negative breast cancer</td>
<td>Practice</td>
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<tr>
<td>OCM-9</td>
<td>Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer</td>
<td>Practice</td>
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<tr>
<td>OCM-10</td>
<td>Hormonal therapy for stage I-IIIIC estrogen receptor/progesterone receptor positive breast cancer</td>
<td>Practice</td>
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<tr>
<td>OCM-11</td>
<td>Documentation of current medication</td>
<td>Practice</td>
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Hospitalization and ED Utilization in a cohort of cancer patients with and without Palliative Care

Partnership Example

Aspire Health

TENNESSEE ONCOLOGY

2017 Cancer Center Business Summit
Aspire Home-Based Program Shows Increased Care Planning Discussions

Advance Care Planning:
Aspire Program vs. National Benchmark

- Advance Care Plan / Living Will / POST Completed: 61% (Aspire) vs. 50% (AHRQ Benchmark)
- Recent Advance Care Plan Discussion: 95% (Aspire) vs. 12% (AHRQ Benchmark)

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Aspire Home-Based Program Reduces Hospital Admissions

Admissions Per Thousand: Aspire Program vs. Non-Aspire Program

- Non-Aspire Patients Who Met Enrollment Criteria & Died Within 9 Months: 3,196
- Non-Aspire Patients Who Met Enrollment Criteria & Died Within 12 Months: 2,524
- Aspire Patients: 1,209

Reduction:
- 66%
- 56%
Prediction:

The fate of the OCM will depend on 2 things:

1. Successful integration of palliative care and population health management to reduce inpatient hospitalizations and share responsibility for achieving quality metrics

2. Reduction percentage spend on chemotherapy
Prediction:

The most significant barrier for integration of palliative care will be patient identification and selection, as well as successful integration of a multispecialty interdisciplinary team.
Integrating Palliative Care into Oncology

Figure 1: The balance between anti-tumor therapy and palliative care across the continuum of cancer care.

Roenn, Temel. The Integration of Palliative Care and Oncology: the Evidence. Oncology 25(13): 1258-60 (2011)