POLITICS & HEALTHCARE
- A FEDERAL VIEWPOINT -

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS
Never allow process to trump mission.
KEY TAKEAWAYS

• The government is not a thing – it’s people

• What the people and congress want is never executed

• Learn to read the internal politics

• Politics of politics creates polarization

• **SO MUCH** good happens because of government

• Nobody wants the government to decide their fate (me included)
MY JOURNEY

• Medicaid baby – foster child
• Marine Corps Combat Veteran
• Health IT consultant for hospitals and medium to large practices
• Department of Defense Clinical Applications Director (AHLTA EHR)
• Centers for Medicare and Medicaid Services (5 years)
  • Regional Health IT Coordinator
  • Technical Director for Health IT
  • Senior Technical Director for Medicaid IT
• Currently:
  • Director for Healthcare Technology Services/MSLC
  • Adjunct Professor, School of Public Health, George Washington University
  • President and Co-Founder of Squadleaders.org (non-profit for veterans)
  • Radio Co-Host on the Military Network Radio
  • Soon-to-be-father!
The largest national CPA and consulting firm dedicated to government health programs.

✓ Independent, not affiliated with or provide services to any health plans, health care providers or private organizations
✓ Guided by strong AICPA professional and ethical standards
✓ A long-time partner with 47 State Medicaid agencies
✓ Provide services and support to HHS, HHS OIG, FBI, United States Department of Justice, and various states’ Attorney General
✓ Experienced in all facets of Medicaid, Medicare, and social service operations / administration
✓ A national leader in benefit program design and delivery system reform, audit, reimbursement consulting and rate setting, managed care consulting and auditing, program integrity and compliance, and litigation support (decades as the incumbent in some domains)

WHO IS MYERS AND STAUFFER?
GOVERNMENT
GOVERNMENT IS SCARY!
GOVERNMENT IN REALITY!
LAWS, BILLS AND DELEGATED AUTHORITY

• The original “want” is never executed
• Influencers will always prevail
• Delegated authority isn’t always welcomed either
• The “modern” government is listening
INTERNAL POLITICS
- Slow walkers
- Stagnant staff (don’t you rock that boat)
- Motivated staff
- Balance
POLITICS OF POLITICS
**ZOOMING OUT FOR A MOMENT**

- Publicly suggesting one view and executing another (slide of hand)
- Changing momentum to support party ideas (knowing the results anyway)
- Executive and legislative branches highly political / you hope the judicial is not
- Politics of politics prevent crucial conversations (e.g., end of life rights, abortion)
THE “GOOD” OF POLITICS IN HEALTHCARE
MEDICAID TRENDS/FACTS

• 50th Anniversary
• Medicaid and CHIP cover over 71 million Americans
• 22% increase in enrollment post-ACA
• Expenditures
  • >$13 Billion CHIP (2013)
  • Medicaid $529 Billion (2015 projected)
Medicaid Expenditure Data: 1966 through 2015 (Projected)

Expenditure in billion U.S. dollars

DIRECTION OF CHANGE

Historical State

• Key characteristics
  • Provider-centered
  • Incentives for volume
  • Unsustainable
  • Fragmented Care

• Systems and Policies
  • Fee-For-Service Payment Systems

Evolving Future State

• Key characteristics
  • Patient-centered
  • Incentives for outcomes
  • Sustainable
  • Coordinated care

• Systems and Policies
  • Value-based purchasing
  • Accountable Care Organizations
  • Episode-based payments
  • Medical Homes
  • Quality/cost transparency
MEDICARE FFS PAYMENT SHIFT TO QUALITY

Historical Performance

Goals
- Alternative payment models
- FFS linked to quality
- All Medicare FFS

2011
- 0% Alternative payment models
- 68% FFS linked to quality

2014
- 22% Alternative payment models
- 85% FFS linked to quality

2016
- 30% Alternative payment models
- 85% FFS linked to quality

2018
- 50% Alternative payment models
- 90% FFS linked to quality
In three words, CMS’ vision for improving health delivery is about \textit{better, smarter, healthier}.

• If we find better ways to pay providers, deliver care, and distribute information:
  • We can receive better care.
  • We can spend our health dollars more wisely.
  • We can have healthier communities, a healthier economy, and a healthier country.

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<tr>
<th>Focus Areas</th>
<th>Description</th>
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<tr>
<td>Incentives</td>
<td>■ Promote value-based payment systems</td>
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<td>– Test new alternative payment models</td>
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<td>– Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
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<td>■ Bring proven payment models to scale</td>
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<td>Care Delivery</td>
<td>■ Encourage the integration and coordination of clinical care services</td>
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<td>■ Improve population health</td>
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<td>■ Promote patient engagement through shared decision making</td>
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<td>Information</td>
<td>■ Create transparency on cost and quality information</td>
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<td>■ \textbf{Bring electronic health information to the point of care for “meaningful use”}</td>
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<td>■ Rapid learning environments</td>
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IMPROVING: “THE WAY PROVIDERS ARE INCENTIVIZED”

• Health homes are incentivizing patient outcomes and better care
  24 programs in 15 states

• Shared Savings states are improving quality while reducing costs
  5 states

• Medicaid Managed Care Management is improving
  New contract language, measurements, and accountability (OR)

• Delivery System Reform Incentive Pools are transforming payment, delivery and information
  5 states
IMPROVING: “THE WAY CARE IS DELIVERED”

- Supporting providers to align services across sectors in service of beneficiary (Health homes, 1915s, duals, 1115s)
- Money Follows the Person and Balancing Incentives Program (and crossing the threshold to HCBS)
- Expanded use of quality improvement and quality metrics across multiple programs (Adult Quality Grants, spread of core set, increased use of metrics in 1115 waivers and SPAs)
- Specific initiatives such as the Maternal and Child Health Initiative (and early elective deliveries have dropped by almost half)
- Series of informational bulletins and SMDs from multiple groups
- Innovation Accelerators Program (IAP) - $175 million in contract support
IMPROVING: “THE WAY INFORMATION IS DISTRIBUTED”

- Electronic health records
- Health Information availability
- Medicaid Statistical Information System (public use files and program management)
- Transparency of performance metrics and quality performance
MEDICAID MANAGED CARE

Risk-Based Managed Care (RBMC)
Primary Care Case Management (PCCM)
RBMC and PCCM
No Managed Care
PATIENT CENTERED MEDICAL HOME

MAP OF PATIENT CENTERED MEDICAL HOME IMPLEMENTATION

- **In Place in FY 2014**
- **Plan to Implement in FY 2015**
- **No Plans to Implement**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
MEDICAID HEALTH HOMES

In Place in FY 2014
Plan to Implement in FY 2015
No Plans to Implement

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
DEVELOPMENT SYSTEM REFORM INCENTIVE PAYMENT
STATE INNOVATION MODELS (SIM) – ROUND 1

Source: Centers for Medicare & Medicaid Services
STATE INNOVATION MODELS (SIM) – ROUND 2

Source: Centers for Medicare & Medicaid Services
SUM OF ALL STATES
POLITICS HELPED CHANGE MEANINGFUL USE!

1. Align with Stage 3 rule to achieve overall goals of programs

2. Synchronize reporting period objectives and measures to reduce burden

3. Continue to support advanced use of health IT to improve outcomes for patients
Previous Stage 1 EP Objectives

• 13 core objectives
• 5 of 9 menu objectives including 1 public health objective

Modified Stage 2 EP Objectives for 2015-2017

• 10 objectives including 1 public health
• Down from 18 in prior stages

EP Objectives Stage 3

• 8 measures (same measure total for EHs)
• Public Health flexibility
• Use of APIs, focused on quality improvement goals, etc.
WHAT A GREAT BRIDGE!!!
OR NOT...
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