

# Making Sense of Changes in Healthcare: Lessons From the AcademyHealth National Health Policy Conference

.....

JAIME ROSENBERG

The US healthcare system is experiencing a sea change, with new, complex therapies entering the market and innovative approaches to healthcare delivery being implemented. Concurrently, health policy is trying to keep pace, with new legislation being introduced to address major issues like rising drug prices, challenges facing vulnerable populations, and persistent epidemics.

Health policy also represents the infrastructure that allows for these innovations in healthcare to be effective and sustained, and during the AcademyHealth National Health Policy Conference, held February 4-5, 2019, in Washington, DC, healthcare experts from around the country sought to make sense of the abundance of changes occurring in the healthcare system. In addition to policy changes meant to address prescription drug prices, these experts discussed the implications of recent midterm elections,<sup>1</sup> innovative ways of delivering care, and challenges facing certain patient populations.

HHS Secretary Alex Azar opened the conference by discussing the steps that the Trump administration is taking to lower healthcare costs, beginning with tackling the current rebate system. Taking aim at pharmacy benefit managers, which he called the middlemen of the drug supply chain, Azar explained that more than \$150 billion in rebates float around the drug pricing system each year, but patients reap no benefit. In response, the administration has proposed ending the current rebate system and replacing it with a new one in which rebates will be passed directly to patients at the pharmacy counter.<sup>2</sup>

Additionally, President Donald J. Trump has proposed significant change to the Anti-Kickback Statute safe harbor that exempts rebates from antikickback laws, which Azar called the “single biggest change to the way Americans’ drugs are priced at the pharmacy counter ever.”

Azar also highlighted other measures taken by the administration, including prohibiting the so-called gag clauses<sup>3</sup> that bar pharmacists from telling consumers when it would cost less for them to pay cash for a prescription than to pay the co-payment through their insurance, as well as requiring TV ads to disclose the list prices of drugs if they cost more than \$35 for a month’s supply.<sup>4</sup>

## Health Policy in Washington, DC, and the States

The first panel of the conference dove into the November 2018 midterm elections, in which healthcare played a role, but not in the way that most expected. Rather than hoping for major change, voters largely wanted healthcare to stay the same, with concerns that patients would lose Medicare benefits or their health insurance, explained Melinda J. Beeuwkes Buntin, PhD, a professor in the Department of Health Policy at Vanderbilt University Medical Center.

Voters also demonstrated increased awareness of surprise or unexpectedly high medical bills, with 2 in 3 respondents from a Kaiser Family Foundation health poll reporting that they were actively concerned about getting such a bill.<sup>5</sup> Policy makers have turned their attention to these bills, with some pitching the idea of tying them into the Medicare fee schedule in some way.

States have also emerged as incubators for innovation, often taking the reins in addressing the challenges facing their populations. Some have touted the idea of importing certain drugs from other countries as a way to lower drug prices. For example, Vermont last year introduced legislation that would allow the state to import drugs from Canada.<sup>6</sup>

In January 2018, the Trump administration released guidance<sup>7</sup> for states interested in imposing a requirement for able-bodied Medicaid recipients to work or take part in volunteer or job-training activities. Since then, multiple states have introduced work requirements; some have been approved.<sup>8</sup>

Grace-Marie Turner, president of the Galen Institute, explained that the administration also gave more flexibility to states through section 1332 waivers. These allow states to pursue innovative strategies for providing high-quality, affordable care to their residents, as well as through a finalized rule for short-term, limited-duration health plans that expands such plans' duration to 12 months, with renewal for up to 3 years.

The panel agreed that the role of states in determining health policy will continue to evolve in the year ahead.

### Innovations Changing the Delivery of Healthcare

During one conference session that looked toward the future of healthcare, experts took a comprehensive view of innovations shaping the new wave of healthcare delivery. Bechara Choucair, MD, senior vice president and chief community health officer of Kaiser Permanente, began by underscoring the importance of health systems' leaders thinking about their patients' social needs, how to predict and screen for those needs, and how to then address them.

"It's not fair to expect patients to live healthy lives if they don't have a stable, safe roof over their head," he said, as he explained that people who are homeless live, on average, 27 years fewer than people who are housed; they also have an increased rate of, and length of stay during, hospital readmissions. They are additionally at increased risk of infectious disease, chronic disease, addiction, and mental health issues, he said.

Stakeholders ranging from health systems to providers to employers have paid increased attention to these social needs, experimenting with different ways of addressing them. Kaiser Permanente, for example, last May launched a \$200 million impact investment to address housing instability and homelessness. Since then, Kaiser has started to implement 3 initiatives through partnerships with both national and local organizations:

- Investing in a multiunit building in Oakland, California, to preserve and expand affordable housing.

- Anchoring a \$100 million loan fund to protect affordable housing across its healthcare system.
- Identifying 515 homeless people in Oakland older than 50 years with at least 1 chronic condition, and working with community partners to obtain housing for them.

Choucair emphasized the importance of partnerships like these, explaining that to effectively implement strategies that address social determinants of health, federal, state, city, county, and local governments all need to be involved.

However, addressing these social needs doesn't necessarily solve the problem facing many Americans, which is access to care, said Naomi Fried, PhD, founder and chief executive officer of Health Innovative Strategies. Digital tools like virtual health and telemedicine have worked to erase this barrier, allowing providers to reach patients who are in rural areas or in other situations in which they cannot easily access a provider in person.

"Digital health leverages technology to deliver care and information to patients and providers that's more convenient, cost-effective, and often more personalized," she said. "It has potential to decrease costs, improve quality, improve efficiency, and deliver care and information in ways that could not be done before."

In recent years, digital technologies have expanded beyond virtual health and now include technologies like clinical-grade digital information and digiceuticals, explained Fried.

Starting with clinical-grade digital information, Fried explained that these technologies collect information from the patient that can be acted upon by their provider, who can then make a therapy decision and evaluate that patient's condition. For example, researchers from Massachusetts Institute of Technology have created an algorithm that analyzes a person's typing patterns to determine if they have Parkinson disease or to track Parkinson progression.

Meanwhile, digiceuticals are digital therapeutic products that allow providers to change patient behaviors and improve outcomes, said Fried. A computer program from GAIA Therapeutics has been clinically demonstrated in randomized controlled trials to be as effective as drugs for treating depression linked to multiple sclerosis, for instance.

Fried also outlined the necessary next steps with these technologies, including addressing privacy and security challenges, increasing patient engagement, and bridging the digital divide that exists between older and younger generations. Panelists agreed that these technologies must close inequalities rather than exacerbate them.

### Health Challenges Facing Rural America

Despite advances like these, certain patient populations in the United States continue to struggle with access to adequate healthcare. With higher numbers of Medicare and Medicaid beneficiaries and significantly fewer providers, rural communities face unique challenges and disparities compared with metropolitan and urban settings, agreed panelists during a discussion focused on health in rural communities.

From 1999 to 2010, there was a 50% quicker decrease in mortality rates compared with prior years for both metropolitan and nonmetropolitan areas, the panelists explained. However, from 2010 to 2016, mortality rates remained flat in nonmetropolitan areas but continued to decline, albeit at a slower rate, in metropolitan areas. As a result, the 6% mortality gap in 1999 grew to 18% in 2016, explained Mark Holmes, PhD, professor of health policy and management at the University of North Carolina Gillings School of Public Health.

Individuals in rural communities continue to experience higher rates of motor vehicle and other types of accidents, suicide by firearm, as well as heart attacks, cancer mortality, and chronic lower respiratory disease. These populations are also sicker, older, lower-income, and more often unemployed, thus presenting challenges to providers in the area.

At the same time, these communities continue to see a shift away from inpatient care and toward outpatient care, struggle with recruitment and retention of providers, and have negative profit margins. Holmes went on to explain that rural hospitals around the country, especially in the South, have been closing in response; this has resulted in not just closures of whole units, but also service lines. Between 2004 and 2014, for instance, 9% of rural communities lost their obstetrician services.

Rural health clinics (RHCs) have also seen management shifts, said Bill Finerfrock, executive director for the National Association of Rural Health Clinics. Between 2012 and 2016, a significant number of independent or physician-owned RHCs converted to provider-based or hospital-owned RHCs. According to Finerfrock, provider-based or hospital-owned RHCs accounted for 51% of visits in 2012 and this proportion grew to 63% in 2016.

Often, when these independent or physician-owned RHCs are converted, they are converted to small hospitals. Finerfrock explained that this is largely because of payment challenges that independent and physician-owned RHCs face. The per-visit reimbursement rate for Medicare is capped at \$84.70 for independent and physician-owned RHCs in 2019, whereas the rate is uncapped for small hospitals, with the per-visit reimbursement rate averaging \$206 in 2018.

Looking at rural health policy, there has historically been a focus on taking measures to combat the financial and workforce challenges facing these communities, explained Thomas Morris, MPA, of the Health Resources and Services Administration of HHS.

“While the focus on finance and workforce is important, I’m not sure all of the tweaks in the world to how we reimburse providers or train them [are] necessarily going to get at addressing these disparities,” he said.

To fully and effectively address these challenges, he said, it’s crucial to support access and capacity building through enhanced payments via Medicare and Medicaid; workforce training and clinician placement programs; commitment to improving public, community, and mental health; investments in technology, like telehealth; and key federal resources beyond HHS.

### REFERENCES

1. Joszt L. 5 healthcare-related ballot measures from the 2018 midterm elections. *AJMC*® website. [ajmc.com/newsroom/5-healthcarerelated-ballot-measures-from-the-2018-midterm-elections](http://ajmc.com/newsroom/5-healthcarerelated-ballot-measures-from-the-2018-midterm-elections). Published November 9, 2018. Accessed February 21, 2019.
2. Inerro A. HHS proposes to end drug rebates in Medicare, Medicaid managed care. *AJMC*® website. [ajmc.com/newsroom/hhs-proposes-to-end-drug-rebates-in-medicare-medicaid-managed-care](http://ajmc.com/newsroom/hhs-proposes-to-end-drug-rebates-in-medicare-medicaid-managed-care). Published February 1, 2019. Accessed February 21, 2019.
3. Caffrey M, Inerro A. Senate votes 98-2 to ban pharmacist gag clauses. *AJMC*® website. [ajmc.com/newsroom/senate-votes-982-to-ban-pharmacist-gag-clauses](http://ajmc.com/newsroom/senate-votes-982-to-ban-pharmacist-gag-clauses). Published September 18, 2018. Accessed February 21, 2019.
4. Caffrey M. Trump officials outline plan to put drug prices in TV ads. *AJMC*® website. [ajmc.com/newsroom/trump-officials-outline-plan-to-put-drug-prices-in-tv-ads](http://ajmc.com/newsroom/trump-officials-outline-plan-to-put-drug-prices-in-tv-ads). Published October 16, 2018. Accessed February 21, 2019.
5. Rau J. Surprise medical bills are what Americans fear most in paying for health care. Kaiser Health News website. [khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care](http://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care). Published September 5, 2018. Accessed February 21, 2019.
6. Luthra S. Vermont legislators pass a drug importation law. So what? Kaiser Health News website. [khn.org/news/vermont-legislators-pass-a-drug-importation-law-so-what](http://khn.org/news/vermont-legislators-pass-a-drug-importation-law-so-what). Published May 18, 2018. Accessed February 21, 2019.
7. Caffrey M. CMS tells states how to require work for Medicaid. *AJMC*® website. [ajmc.com/newsroom/cms-tells-states-how-to-require-work-for-medicaid](http://ajmc.com/newsroom/cms-tells-states-how-to-require-work-for-medicaid). Published January 11, 2018. Accessed February 21, 2019.
8. Caffrey M. Kentucky first state approved for Medicaid work requirements. *AJMC*® website. [ajmc.com/newsroom/kentucky-first-state-approved-for-medicaid-work-requirements](http://ajmc.com/newsroom/kentucky-first-state-approved-for-medicaid-work-requirements). Published January 12, 2018. Accessed February 21, 2019.