WINSTON FELLOWSHIP REPORT: WEEK 5

July 17

Amy Basson and James Sharpe, CMMI

We traveled up to Baltimore to meet with Ms. Basson and Mr. Sharpe at CMMI. Ms. Basson and Mr. Sharpe discussed some of the challenges in developing the models CMMI is currently testing, including how big the models should be, where to offer the models geographically, and how many rounds of evaluation should occur to test the impact of a particular model on improving quality and reducing costs. We also talked about the challenges of working on population models that might have longer term – rather than shorter term – effects and how to evaluate the shorter term results for those models in that context. Ms. Basson also described the collaborative work environment at CMMI and the division's focus on transparency. When asked how, if at all, the division's work has changed under a new administration, Ms. Basson explained that the priorities have shifted a bit toward the private sector, competition, and the individual physician experience, but the day-to-day work remains largely the same.

Laura Trueman, HHS

Ms. Trueman spoke of her path from the Hill – where she worked for an Oklahoma senator, who was on the HELP Committee – to her current position at HHS. In between, she said, she previously worked for HHS, the Coalition for Affordable Health Coverage, for United, for the Heritage Foundation, and, finally, for House Majority Whip Steve Scalise. At Heritage, she said, she spent her time working on both health care and entitlement reform, fighting against the ACA. In her current role as an appointee at HHS, Ms. Trueman said her office focuses on four areas: 1) inter-government affairs, 2) tribal governments, 3) faith-based governments, and 4) external affairs. Currently, the Secretary's priority issue areas are: opioids, serious mental illness, and childhood obesity, the latter two of which are still in the planning phase.

Bipartisan Policy Center

BPC's health team welcomed us to their office to discuss the range of projects they are currently working on in their health policy and health and housing divisions. Staff described the origins of the organization, which was started by four senators on both sides of the aisle, and how the bipartisanship has driven the organization's mission since its founding a decade ago. Unlike other research organizations, BPC has its policies scored to more concretely inform the policy debates. We learned about the different products/initiatives BPC delivers, including technical assistance to the Hill, research reports, stakeholder coalitions, etc. Specifically, staff discussed the work BPC is doing around "the future of health care," which has included the creation of a group of 10 leaders in health care from both sides of the aisle, who will be convening to consider bipartisan health reform policies. We also learned a bit about the organization's newest product on long-term services and supports.

July 18

Jack Ebeler, Health Policy Alternatives

Mr. Ebeler provided us with his perspectives on the many hats he wore throughout his career – in career positions at HHS, the private sector, the Hill, and as an appointee at HHS. Across his career, Mr. Ebeler said, the ingredient for professional success has been effective mentorship. As such, he suggested we consider relationships when weighing our placement – and also future job – options. He suggested that working on the Hill during our placements is probably a good idea, unless we have a specific portfolio and autonomy in a position in the administration. He also described his work at ASPE as an appointee, explaining the office does well-respected analytic work but oftentimes finds itself at the intersection of politics and policy. He suggested that it could be a great option for future job considerations.

Dean Rosen, Mehlman, Castagnetti, Rosen & Thomas

Mr. Rosen was kind enough to take us to lunch near the Winston office and talk to us about our experience to date with the fellowship as well as considerations for our placements. He asked whether we had experienced any issues with the fellowship – or areas that could be going more smoothly – and we both said that everything has been going great with our meetings. I asked whether he had any insights in how to approach the placements in terms of whether we should be reaching out to the offices we are most interested in or whether we should expect they will reach out to us if they have openings for a fellow. Mr. Rosen said we should be proactive in contacting offices in a few weeks if we are interested – but he suggested continuing to keep an open mind when considering placements. More specifically, he said we ought not to discount positions in the House, as the faster pace may serve us well as fellows in terms of giving us broader exposure to various issues.

Don Rucker, Office of the National Coordinator for Health Information Technology

Dr. Rucker provided us with a graph from a 2012 New England Journal of Medicine article of Mass General's adjusted cost per patient alive at discharge from 1821 until 2010. He pointed out the year 1965 and noted that price was taken out of the equation for patients with the introduction of the Medicare and Medicaid programs that year. Since then, prices have steadily climbed (when asked, he said he did not think that technology/innovations in medicine had a huge effect on the increase in spending). He predicted that, as a result, America's health care system will experience one of two divergent events: 1) either the system will deteriorate to a place where it will "explode" and some kind of drastic government intervention will ensue (he compared this moment to recent trends in urban public transportation systems, or 2) the system could bypass the regulatory environment and encourage private-sector innovations that will turn it around (he compared this moment to the airline industry, consumer banking, or the ride-sharing economy).

Marc Boutin, National Health Council

We had a fascinating conversation with Mr. Boutin about the National Health Council and its role as a multi-stakeholder patient advocate in today's health care landscape. Mr. Boutin explained that NHC's No. 1 issue right now is "repeal and replace," and the council's position rests on three key needs: 1) more money in the system, 2) granular reinsurance to ensure insurers do not have the

incentive to adversely select patients, and 3) transparency for patient costs. He said that the silver lining of today's health reform climate is that real change often comes out of chaos – and while we haven't reached chaos yet, we may be moving closer to that point. Mr. Boutin also provided us with a broad picture of NHC's daily objectives, describing some of the work the company has undertaken in spearheading efforts to ensure patients remain at the center of chronic care delivery and their goals of care are considered and form the backbone of their respective care plans. More specifically, he described a "chronic care trifecta," which includes clinical outcomes, personal circumstances, and goals of care. Finally, we learned briefly about NHC's involvement in drafting 36 provisions in the ACA and 12 modifications to implementation of the law.

July 19

Laird Burnett, Fish Brown, Prue Fitzpatrick, Joe Williamson, and Ann Kempski, Kaiser Permanente

We met with the government relations/public policy team at Kaiser Permanente and learned more about the structure and mission of the integrated health system as well as its approach to lobbying on Capitol Hill. The group explained that Kaiser is unique in that it not only is a health plan but also comprises eight physician medical groups. We also discussed Kaiser's closed-network plan (technically an HMO, although the group said that it likes to stay away from using that phrase due to its stigma) and how that structure – and the organization's non-profit status – spurs Kaiser to focus on improving the health of the communities it serves, including individuals who are outside its network. We closed by discussing the current Senate legislation and the individual marketplaces. Unsurprisingly, Kaiser is in favor of moving away from discussions about "repeal" and toward market stabilization. Cost-sharing reduction payments, interviewees said, are the biggest issue on the table right now, as Kaiser's pricing structure was based on the assumption that it would receive those payments. We also discussed the importance of setting up a long-term reinsurance program.

Robert Canterman and Alpa Davis, Federal Trade Commission

It was a privilege to speak with Mr. Canterman and Ms. Davis about their respective roles in the FTC's Bureau of Competition within the Health Care Division. Having had no prior exposure to the FTC and, specifically, its health care work, I learned a significant amount from this meeting. Mr. Canterman and Ms. Davis provided us with a comprehensive slide deck of the FTC's mission and their individual roles – Ms. Davis on the pharmaceutical industry and Mr. Canterman on health care providers. Broadly, the division is concerned about: 1) price-fixing, 2), monopolization, and 3) mergers. Within the pharmaceutical industry, Ms. Davis talked about impediments to generic entry in the market and the work she does on pay-for-delay settlements, through which pharmaceutical brand companies compensate generic companies for delaying their entry into the market. While not all such settlements are in violation of anti-trust laws, some cases can be anti-competition, which requires the FTC's involvement. Ms. Davis estimated that consumers lose out on $3.5 billion a year as a result of these pay-for-delay settlements. Mr. Canterman described his work on provider consolidations, which, of late, has included many ACO arrangements. He explained that FTC's key concern in these cases is when providers come together *only* to fix prices;

this phenomenon was more frequent in the early 2000s, he said. We asked Ms. Davis and Mr. Caterman about the missing piece of the puzzle – insurance companies – and they explained that the anti-trust division at DOJ typically handles those cases.

July 20

Jeanne Lambrew, The Century Foundation

A number of people had suggested we meet with Dr. Lambrew during our previous interviews, so it was great to finally get the chance to sit down and talk to her about her work at HHS and in the White House during ACA implementation. Dr. Lambrew provided us with some information on her personal biography, explaining that when she graduated from UNC with her PhD in health policy in 1994, she felt ill-prepared to engage in actual policy work. She observed that, in some ways, earning a PhD is the opposite of federal-level policy work, where there are quick turnarounds, work has political implications, and everything is based on collaboration. Given our similar academic backgrounds, Dr. Lambrew suggested I continue to think outside the box for my placement and consider opportunities that include some level of analytic work. Specifically, she mentioned the Senate Aging Committee and the Joint Economic Committee. She also suggested that both Michael and I try to meet with individuals engaged in oversight on the Hill in both the House and Senate. She suggested that the nature of the work we do during our placements would likely depend on the fate of the BCRA in the coming weeks, as failure of that bill will continue to keep health care at the top of the Congressional agenda into the fall. During her time working on the ACA, Dr. Lambrew said she learned the importance of assembling a team with a diversity of skillsets – and not just "policy wonks." She said that ACA work taught her the importance of learning her own limitations and then finding experts to fill in the gaps.

Jane Hyatt Thorpe, Milken Institute of Public Health

Ms. Thorpe took us out to lunch at District Commons near her office at GW. We learned about some of her work in the Office of Policy at CMS (pre-ACA) and at ONC (post-ACA) as well as her academic position at GW. She suggested that an administration job in the future could be an incredible learning opportunity. We discussed the work she did prior to the ACA to create a data office within CMS, which has grown exponentially over the last 10 years. When discussing our placement options, Ms. Thorpe said that the Hill could be a great opportunity for us to see how the "sausage" gets made. Ms. Thorpe kindly offered to be a resource for us as we consider our placement options, noting that, as the academic representative on the committee, she might have different insights.

Patrick Conway, CMMI

Having traveled to Baltimore to meet with Amy Bassano and James Sharpe earlier in the week, we enjoyed the opportunity to meet with Dr. Conway to hear more about CMMI and his vision for the office moving forward. We learned about the alternative payment model development process, which he equated to the rule-making process in terms of level of detail. When asked about the challenges of evaluating relative "success" of models when many providers are enrolled in multiple programs (and so isolating the effects of a particular model is difficult), Dr. Conway

admitted that that is a challenge CMMI continues to struggle with, but he pointed to the number of participants directly touched by models nationwide (27 million) and felt it was worth the tradeoff. He also said that CMMI is trying to randomize enrollment into models to the extent possible to make for a much cleaner evaluations. Finally, we discussed the future of alternative payment models, and he said that they are here to stay, and suggested that ACOs, PCMHs, and bundles will continue to be important payment mechanisms moving forward.

July 21

Tom Bradley, CBO

With so much of the current health care debate revolving around CBO scores, it was timely to sit down with Mr. Bradley and his team at CBO. Mr. Bradley and his colleagues explained that while they are mostly protected from the current public criticism due to their Medicare focus, their colleagues on the Medicaid side – with whom they frequently collaborate – have been under the microscope of late. Mr. Bradley and his team explained that such criticism is part of the job of being an independent and non-partisan research group. Such critiques are not uncommon or specific to a certain party: During the meeting, we learned about the cyclical nature of CBO's estimates and reports – hinging on the federal fiscal year and the president's budget in February – as well as the way CBO updates its baseline estimates every year to reflect a growing population, inflation, and overall increases in health care spending.

Health TechNet lunch meeting

David Main invited us to his Health IT group's (Health TechNet) monthly lunch meeting to hear a panel discuss federal health care legislation. Former Winston Fellow, Colin Goldfinch, spoke, along with J.P. Paluskiewicz (Energy and Commerce Committee, majority) and David Quam (Nelson Mullins). It was interesting to hear representatives of the House, Senate, and state governors engage in a lively dialogue on recent and current legislation. Much of the discussion revolved around recent bipartisan legislation – the 21st Century Cures Act, specifically – and some of its health IT-focused provisions. Naturally, the conversation turned to the current Senate bill later in the session.

Bruce Siegel and Beth Feldpush, America's Essential Hospitals

Drs. Siegel and Feldpush provided us with a broad overview of America's Essential Hospitals – its policy priorities/principles, its membership, and its affiliated organizations (i.e., a 501(c)(3) foundation and a PAC). Having had no prior exposure to this organization, I found it interesting to learn about the distinct feature of its growing group of member organizations (i.e., public hospitals, state university/public academic medical centers, private non-profit hospitals, and hospitals providing high acuity services). Broadly, they said, AEH's members agree on the importance of Medicaid funding and the 340b drug pricing program, which has led AEH to come out strongly against the AHCA and now the Senate bills.