Josh Seidman, Former Director of Meaningful Use at the Office of the National Coordinator

Mark Masselli: This is Conversation on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, we just returned from the annual gathering of the nation's Community Health Center Organizations, the National Association of Community Health Centers represents thousands of care delivery organizations, which serve the health needs of some 25 million Americans. It was an energized gathering this year as healthcare providers come together to share best practices, but also to embrace themselves for some of the challenges that lie ahead.

Margaret Flinter: Boy, you are right; there is so much concern about what's to come next from the health policy perspective. While the GOP Health Plan failed to get off the ground, there is still so much uncertainty about what is likely to happen next and that's very challenging for people.

Mark Masselli: And looming over all of us is the President's budget cuts to significant chunk of money from the Department of Health and Human Services and HHS secretary Tom Price has indicated that he will seek to roll back Medicaid Expansion across the country, which could significantly impact the nation's Community Health Centers, which provide care to a large sector of the Medicaid population.

Margaret Flinter: Well, that is something that our guest today is keeping a close eye on Mark. Dr. Joshua Seidman is the Senior VP of Payment and Delivery Innovation at Avalere Health, but of note he served as the Director of Meaningful Use at the Office of the National Coordinator for Health IT. So, we are looking forward to hearing from him.

Mark Masselli: And we are also looking forward to hearing from Lori Robertson, the Managing Editor of FactCheck.org, but no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Margaret Flinter: And as always if you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter, because we love hearing from you. Now, we will get to our interview with Josh Seidman in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. The setback for one State that it saw to expand Medicaid for more residents living close to the poverty line, Kansas law makers failed to produce enough votes to override Governor Brownback's Veto of the Medicaid Expansion, which would

have provided health coverage to 180 thousand uninsured residents. Governor Brownback has been a staunch opponent of Government spending and viewed the Medicaid Expansion as too costly for the state, although the Medicaid Expansion is largely covered by the Federal Government for the initial few years of expansion. Meanwhile, those who received subsidies to help underwrite the cost of purchasing health insurance on the online exchanges are concerned about the outcome of a case launched by House Republicans. They sued the Obama administration last year challenging the legality of the subsidies, saying the funds were not appropriated by Congress. Meanwhile, Congressman Greg Walden, a Republican from Oregon and Chairman of the House Energy and Commerce Committee vowed to protect those subsidies at least for the rest of 2017. President Trump took his Healthcare Diplomacy approach to the links inviting Libertarian Senator Rand Paul to Mar-a-Lago for some golf and conversation over healthcare. Members of the Republican Freedom Caucus were vehemently opposed to the GOP Healthcare proposal, saying it didn't go far enough to eliminate provisions of Obama care. Trump publicly vilified the Freedom Caucus on Twitter saying if they refuse to negotiate, the President would "make a deal with the Democrats." While the President has said he has moved on after the defeat of the AHCA, he is still carrying on talks with the new approach. In the wake of the anti-vaccination movement, some once thwarted childhood infections have made quite a comeback, whooping cough once a scourge of the 19th Century has become a persistent foe once again. Researchers at California's Kaiser Permanente examined data on almost 149 thousand infants born in California, they found babies whose mothers got the Tdap booster vaccine for Tetanus, Diphtheria, and Pertussis were 91% less likely to get whooping cough during the first two months of life, a critical period before U.S. infants typically get their first dose of the vaccine. I am Marianne O'Hare with these Healthcare Headlines.

Mark Masselli: We are speaking today with Joshua J. Seidman, PhD, Senior Vice President of Payment and Delivery Innovation at Avalere Health, a Washington D.C. based consulting firm dedicating to solving challenges in the healthcare system. Dr. Seidman also served as Director of Meaningful Use at the Office of the National Coordinator for Health IT at the Department of Health and Human Services. He earned his Bachelor's degree in Political Science from Brown University and Masters and PhD in Health Service Research from Johns Hopkins University. Josh, welcome to Conversations on Healthcare.

Josh Seidman: Good to be with you.

Mark Masselli: Yeah, so you are somebody who is very familiar with Washington and also health policy and I am sure you've been quite busy in the recent days with the GOP version of health reform, the American Healthcare Act failing to make it through even the House. Well, President Trump and House Speaker Ryan have said they are moving onto other issues. There's much talk on the hill of another attempt at health reform of some kind and I am wondering if you could

share with your listeners, were you surprised by the swift derailment of the legislation.

Josh Seidman: It was not a surprise to me that they had a lot of challenges in actually implementing something or actually agreeing on legislation. It is much harder to actually craft legislation than to critique legislation. Once a law is established and embedded into how healthcare is done in the country, it becomes very difficult to take things away from people. I mean of course there would have been CBO said 24 million people who would have lost health insurance over the next decade and you know that becomes an issue for members of Congress, who are trying to get reelected by who so might be losing coverage. When the CBO score came out with those numbers, it definitely reinforced in a very real way for members of Congress what they were facing and then of course, there is a polarization even within the Republican party right now over how far to go.

Margaret Flinter: Well, Joshua, the Affordable Care Act, we certainly agree has some flaws. There really isn't a lot of doubt that it has done an enormous amount to expand coverage and also to positively impact population health, but still we have this very entrenched disconnect between the two competing political parties on what health reforms should look like, but we've paid attention to this kind of slowly rising course of Republican policy makers, who are calling for a more bipartisan approach to reform. What's the likelihood we'll see some kind of bipartisan solutions coming forward?

Josh Seidman: I think it's actually going to be very difficult to do that. First of all, it is a very polarized environment and I think that, as I said, it's just very complicated to do this kind of thing and it becomes a question of how you are going to change things that for a lot of people are working reasonably well. They are going to have to make some decisions about how much time and how much political capital to spend on this one issue. Obviously, there are lot of things that the Congress and the new administration want to accomplish and they are beginning to realize how time intensive and resource intensive it's going to be to get things done on any kind of changes to the ACA.

Mark Masselli: So Secretary Tom Price seems pretty determined to make changes in the Medicaid Program, as well as other population health and issues. I am wondering if you could talk about some likely scenarios for changes to the Affordable Care Act and what aspects of the health law do you view as vulnerable.

Josh Seidman: Yeah, there are certain things that they in a sense have already begun. You know, we saw in the last open enrollment period that they really pulled back on a lot of the active efforts to try to get people signed up, but there is certainly the issue of the subsidies right now, where there is a law suit the house had filed against the administration and it is going to be very interesting to

see what happens there because, the subsidies, obviously are a huge part of this excess of getting people signed up along with the Medicaid Expansion and so without the subsidies, that would potentially unravel a lot of the coverage in the marketplaces. I think it is pretty clear that both the current secretary, secretary Price, as well as the new CMS Administrator Seema Verma have a lot of interest in using Medicaid to experiment with a number of things and how to manage Medicaid. So I think we are going to see this administration approve a lot of Medicaid waivers and those could you know test out a lot of the things that they wanted to do with the AHCA, per capita caps or block grants, and I think we'll see them pushing some of the limits there.

Margaret Flinter: Well, Joshua, I am going to let us take a breath from the AHCA for just a moment and ask about some of your time at the office of the National Coordinator for Health IT, where you tasked with advancing what we came to know as the Meaning Use of Health Information Technology. Certainly, that first big grand challenge which is to shift the health industry from paper to electronic health records was well executed, but the requirement to use that technology has been a harder lift. Talk with us about your experiences advancing the Meaningful Use throughout the industry and the progress that has been made.

Josh Seidman: Yeah, there is no doubt that the transition to digitization of health records has been mostly accomplished, so you know, it just didn't happen until of course 2009, when the stimulus by the American Recovery and Reinvestment Act passed and the high tech part of that actually did simulate the digitization, where you know, it was less than 10% of hospitals in 2009 and now more than 90% of hospitals are electronic. You know, that bill did focus, not just on digitization, but as you said, on the Meaningful Use of EHR and we were very concerned at that time that just focusing on moving to electronic might just make the same bad processes happen faster and I would say that we have you know achieved pieces of that, but we still have a long way to go. The high-tech Act was constructed with a series of carrots and sticks. All those carrots were the tens of billions of dollars of incentive payments to providers and those of course are now all gone and what's left really are the sticks. I think that we are in a place, where there is this bill challenge in this balancing act. Certainly that we faced when we implemented, you know, from the beginning stage one Meaningful Use all the way to the present, which is that we wanted to provide enough direction that people were driven to Meaningful use by doing more than just a check-the-box activity, trying not to be overly prescriptive and that balancing act is you know one the most challenging things of writing legislation or implementing regulation and I think that that is still a challenge that is being faced. We have a lot of the infrastructure now to make it possible.

Mark Masselli: We are speaking today with Joshua J. Seidman, PhD, Senior Vice President of Payment and Delivery Innovation at Avalere Health. Dr. Seidman also served as Director of Meaningful Use at the Office of the National Coordinator for Health IT at the Department of Health and Human

Services. Josh, you know, changes in administration always bring policy, uncertainty, and we still need to focus in on what will move the healthcare system forward in. Your work at Avalere Health is specifically focused on Innovations in Payment and Care Delivery, trying to move the country from volume to value, but the table for that was really set with the passage of MACRA and that's the Medicare Reimbursement and CHIP Reauthorization Act. A recent study found that 20% of smaller physician practices are ready to meet the MACRA requirements, but with so much uncertainty around policy directors, what kind of forces do you see moving these policy and issues forward and how should the healthcare stakeholders be preparing for MACRA?

Josh Seidman: We, definitely, I think are in a place, where we have set in motion this movement from fee for service, basically a place where we historically have paid providers for doing things to people. Now, trying to think about we actually pay for helping people to be healthier and I think that we are very much in a transition and it is something that is going on in both public and the private sector. Certainly, the ACA helped to stimulate a lot of that as well, but it is something that is now very much embedded both publicly and privately in the healthcare system. So, MACRA certainly is reshaping how physicians will be paid under Medicare, but there clearly is a long way to go for them to be prepared as you say. It also is again a question of this balancing act of making sure that they are accountable for more than just check-the-box activity, but also trying to make sure that the measures that we are using to asses whether we are getting value, actually do measure things that matter to patients and I think that that is a big challenge. But, I think it is also important to keep this mind this was a bipartisan bill, one of the very few healthcare bills passed on a bipartisan basis and we can expect to see continuation of the basic tenets of it, whether the new administration tinkers to create more flexibility for physicians, I think is something that we will be watching because there are other levers in ACA that they can use and you know, there is the Center for Medicaid and Medicaid Innovation, which has been testing out new payment delivery models, but there may be again some tweaks; one of things that the secretary has been critical of in the past is mandatory bundle payments. The last administration has put in place for comprehensive joint replacement, which is already in place and then a final rule was finalized at the end of the last administration on some cardiac bundles and hip and femur fractures and those bundled payments are mandatory for fifth to a quarter of all hospitals. It is now something that I think is a little bit in question as to whether that will continue to move forward. If it does not, it means that those hospitals that have been sitting on the sidelines would be able to continue sitting on the sidelines as the new payment methodology will swerve it.

Margaret Flinter: I know you recently participated in a political panel with former White House Chief Technology Officer Anish Chopra and VA Secretary Dr. David Shulkin, both of whom I would note were former guests on the show and you know, it seems we heard so much about the VA and it's need to grapple with an address to the wait-time issue, but it is also important to remember they've made

very significant inroads in telehealth, as well as widespread use of data that is mined from their very longstanding electronic health records, so it seems like a lot to be learned from their experience as well.

Josh Seidman: They really have done a lot of important things that we can learn from. What they certainly did, I think were probably three things, one is that, you know, very early on, they did make a commitment to electronic health information and figuring out ways to use that and not just ways to digitize, but actually to do things to actually help Veterans get better healthcare. So that, you know, that was the first that commitment to this to early on means that they were really ahead of the curve in that respect. The second is that they applied that to their quality improvement efforts and you know demonstrated very high quality on a number of performance measures. Certainly in areas like diabetes care and cardiovascular care, the VA has performed very well and in part because they have made Meaningful Use and some of those systems through Vista and then the third thing I would say is they made a commitment early on to engaging patients in the use of that technology. You know they implemented something called My Healthy Fad, which was a personal health record or PHR or a pool for patients to get into their records and to be able to engage electronically with their clinical teams. I think that is you know something that now we see it all over, but they were again definitely ahead of the curve and that is something that we should be trying to replicate elsewhere and similarly, they were one of the leaders in the Federal Government with the use of something called Blue Button, which allows for download of information and over a million Veterans have made use of that Blue Button to download their information.

Mark Masselli: Speaking of great places and your old stumping ground, the Office of National Coordinator will have a new lead, Dr. Donald Rucker was just named to the position at HSS, a former Medical Director at Siemens, recently a Professor of Bioinformatics at Ohio State School of Medicine. Any thoughts on the appointment and what direction he is likely to take at ONC and obviously lot of important dates coming up in terms of Meaningful Use in the like and there is certainly lot of political pressure to slow things down, but what are your thoughts?

Josh Seidman: I think that what confronts Dr. Rucker now is some of the challenges we were talking about before. There is this issue of not having a lot of carrots and trying to figure out how to use the sticks that do exist under MACRA to continue to move forward, particularly around health information exchange, removing barriers to interoperability, trying to crack down on any information blocking that is going on and you know maintaining strong certification standards while trying to allow for flexibility. You mentioned earlier one of the other changes that could happen from the current administration in healthcare, is what they do on the budget and if the current proposed budget from the administration were to move through, it would obviously constrict the funding for most agencies, you know that was one of the things that certainly was very helpful in advancing the cause of electronic health records, was having

sufficient resources to be able to support providers and the industry in making that kind of progress, I think that it will be interesting to see what happens with the budget and what kinds of resources Dr. Rucker has to move forward.

Margaret Flinter: We've been speaking today with Dr. Joshua Seidman, Senior VP of Payment and Delivery Innovation at Avalere Health. You can learn more about his work by going to Avalere.com or you can follow him on Twitter at Jseidman.. Josh, thank you so much for joining us on Conversations on Healthcare today.

Josh Seidman: You are welcome.

Mark Masselli: At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: In seeking to repeal and replace the Affordable Care Act, Health and Human Services Secretary Tom Price has said "one out of every three physicians in this nation aren't seeing Medicaid patients. It is the common criticism of the Medicaid Program that the doctor participation rate is lower than the rate for Medicare beneficiaries or the privately insured. We looked at why that is and what this means for patients. There are no continuous measures on Medicaid participation, but Federal statistics gathered over recent years show that the percentage of physicians accepting new Medicaid patients has remained around 70%. We found no support for the idea that the rate has declined under the ACA. The participation rate varies by State. In 25 States, the rate was significantly higher than the nationwide figure of about 70% and in 5 states it was significantly lower. That variation largely reflects reimbursement rates. For example, Montana pays primary care doctors the same rates for Medicaid and Medicare and has a Medicaid doctor participation rate of 90%. If a State expands eligibility, it may have to cut the reimbursement rate to limit spending. While doctors who take no or only some Medicaid patients overwhelmingly cited low payment as the reason. Three-fourths also cited delayed payments and billing requirements; what does this mean for access to care? Well, participation rates are limited measures in that the supply of doctors and their geographic distribution are important factors. Studies show Medicaid beneficiaries fare as well as the privately insured on key measures of access to care. 74% of adults with Medicaid coverage have seen a doctor in the previous 12 months, while 69% with private insurance have done that's my FactCheck for this week, I am Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like

checked, email us at www.chcradio.com, we will have FactCheck.org, Lori Robertson, check it out for you, here on Conversations on Healthcare.

Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Stanford based bioengineer Manu Prakash has a simple goal. He wants to create a portable medical lab small enough to fit in a backpack and has already developed a tool that fits the bill. While sitting under a tree in Uganda, he noticed that the local medical clinics door was propped open by an expensive centrifuge machine, now broken and no longer in use and he wondered how could he create a portable centrifuge that would be inexpensive to make, easy to operate, and easy to replace. His inspiration came from a simple ancient childhood toy, the whirligig.

Manu Prakash: Before us, nobody had actually understood how this fully works. So we spent a significant portion of his time truly understanding the mathematical phase for how you can convert linear motion into rotational motion and there is some beautiful mathematics hidden inside this object.

Margaret Flinter: So he took this simple toy idea to another level, creating a human power centrifuge made from simple components, paper, twine, and plastic, all together each Paperfuge, as he calls it, can be constructed in under 2 minutes and costs only 20 cents and yet, remarkably it works extremely efficiently.

Manu Prakash: We were able to make essentially make a centrifuge that's spins all the way to 120,000 RPM. In the lab, we can separate and pull out malaria parasites from blood, separate blood plasma.

Margaret Flinter: It is currently being tested for malaria diagnosis, but is being readied for fare more complex diagnostic challenges.

Manu Prakash: This is a tool that requires no electricity; you can carry them around in your pockets for a price point of 20 cents.

Margaret Flinter: The Paperfuge, a cheap, but highly effective field tool for clinicians creating a quicker pathway to diagnosis and treatment. Now, that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University, streaming live at wesufm.org and brought to you by the community health center.