MARKET UPDATES
May, 2019

Eric Shell, MBA, CPA

Judge Rules ACA Unconstitutional (12/14/2018)

STROUDWATER

- U.S. District Judge Reed O'Connor rules that the ACA was invalidated by the 2017 Tax Cuts and Jobs Act, which eliminated the individual mandate penalty
- Per O'Connor, the ACA can only stand as it was originally designed by Congress; the individual mandate is "essential" to require people to sign up for health insurance
- Healthcare industry leaders expressed deep concern at the ruling, saying it would risk the health coverage tens of millions of Americans and make it harder for hospitals to provide high quality care

"Because rewriting the ACA without its 'essential' feature is beyond the power of an Article III court, the court thus adheres to Congress' textually expressed intent and binding Supreme Court precedent to find the individual mandate is inseverable from the ACA's remaining provisions"

Judge Reed O'Connor

- The Urban Institute estimated that more than 17 million people would lose coverage through the individual market or Medicaid expansion if the courts strike down the law, increasing the number of uninsured Americans by 50%
- Democrats are expected to appeal the ruling, and for now, the ACA still stands

Source: Modern Healthcare, *Judge strikes down ACA as unconstitutional,* Erica Teichert and Susannah Luthi, 12/14/18
https://www.modernhealthcare.com/article/20181214/NEWS/181219936?utm_source=modernhealthcare

DOJ: Entire ACA Should Be Struck Down (3/25/19)

STROUDWATER

- Department of Justice released a letter calling on the 5th U.S. Circuit Court of Appeals to **affirm a District Court ruling invalidating the entire Obamacare law**
- Administration had previously promised to leave in place certain ACA protections, such as those for Americans with preexisting conditions
- Beyond the protection for those with preexisting conditions, overturning the law would have far-reaching consequences, including
  - **Loss of coverage for the millions of people who get their health insurance on the exchanges or through Medicaid expansion**
  - **Loss of discounts for senior citizens on their Medicare coverage and prescription drugs**
  - **Children could no longer stay on their parents' health insurance plans until they turn 26**
- Health Insurance Plans came out against the Justice Department's letter, calling it a "significant reversal of the government's position."

"This harmful position puts coverage at risk for more than 100 million Americans that rely on it." -AHIP CEO Matt Eyles

Sources: Modern Healthcare, *DOJ changes course: Entire ACA should be struck down,* Susannah Luthi, 3/25/19 https://www.modernhealthcare.com/government/doj-changes-course-entire-aca-should-be-struck-down; CNN.com, Trump administration now says entire Affordable Care Act should be struck down, Ariane de Vogue and Tami Luhby, 3/26/19 https://www.cnn.com/2019/03/25/politics/trump-administration-aca/index.html

Democrats' and Republicans' Healthcare Plans

STROUDWATER

GOP Health Plans: Key Points

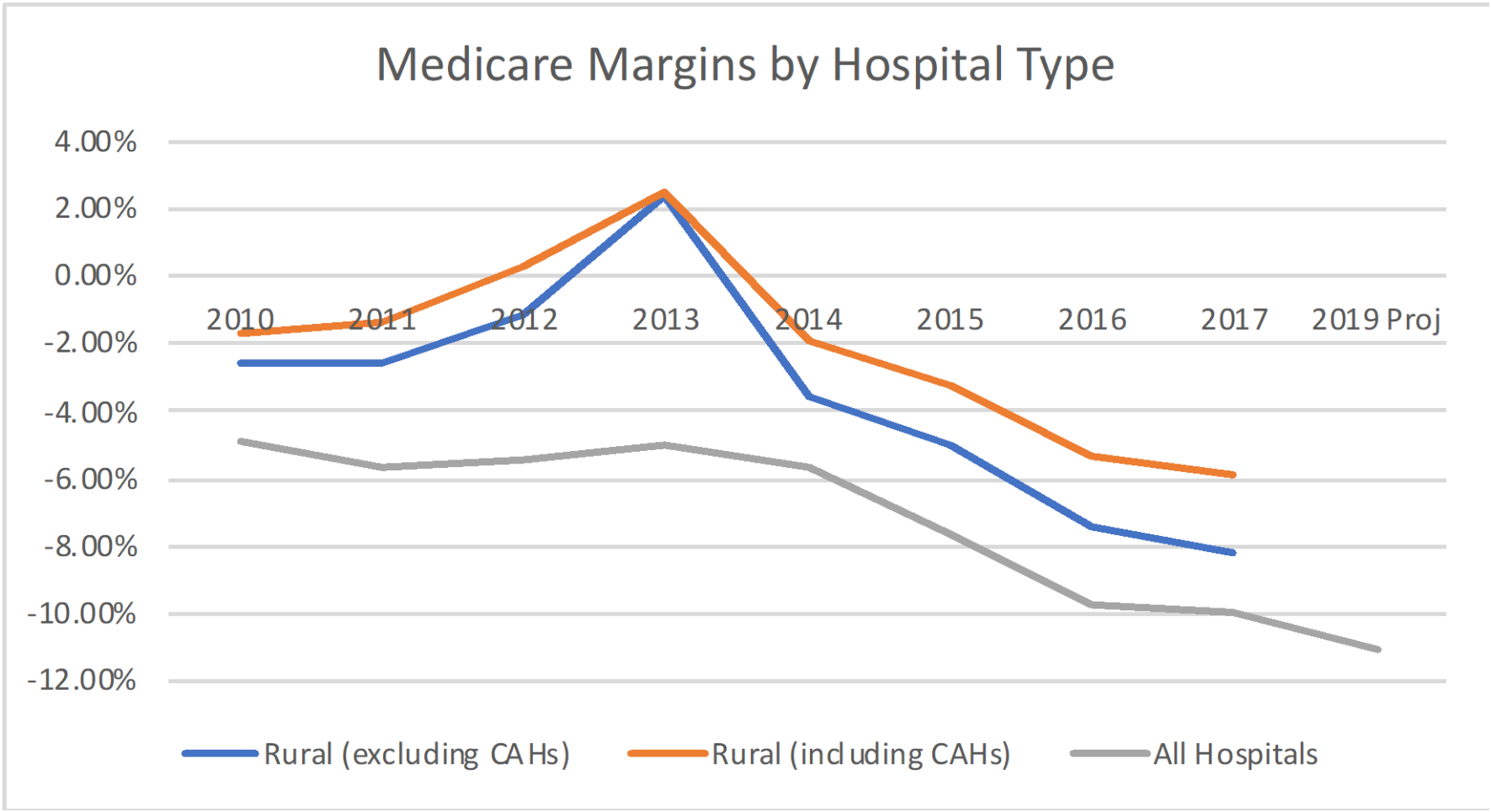
- President Trump is calling the GOP "the party of health care," but the party has not coalesced behind one clear plan
- Proposal to reboot version of 2017 Graham-Cassidy bill, which
  - ✓**Replaces Medicare and ACA subsidies with a block-grant program**
  - ✓**Lets states alter ACA rules including those for pre-existing conditions**
  - ✓**Allows states to change pricing rules so that younger people could see premiums lower while older adults could see them rise**
- A coalition of conservative groups and GOP state representatives rolled out the Health Care Choices Proposal, which
  - ✓**Gives states more control over a fixed amount of money**
  - ✓**Relaxes federal mandates and strengthens the private insurance market**
  - ✓**Calls for bolstering Health Savings Accounts**

Democratic Health Plan: Key Points

- On March 26, Democrats released a plan to strengthen the ACA and expand healthcare
- Per Speaker Pelosi, the plan is designed to protect people with preexisting conditions and lower Americans' health costs. The plan would:
  - ✓**Expand ACA insurance subsidies to everyone**
  - ✓**Cap payments on insurance premiums at 8.5 percent of income**
  - ✓**Establish a federal reinsurance program to offset costs for insurers**
  - ✓**End the federal government's decision to expand availability of short-term health plans**
  - ✓**Require the Trump administration to spend federal dollars on ACA enrollment outreach**
- Does *not* include a "Medicare for All" plan
- Does *not* restore cost-sharing payments to insurers
- Reportedly, house Democrats will try to pass provisions of the bill one at a time rather than all at once

Sources: CNN.com, *Here's what the GOP plans for health care look like,* Tami Luhby, 3/29/19 https://www.cnn.com/2019/03/28/politics/republican-health-care-proposals/index.html; Becker's Hospital Review, *House Democrats unveil healthcare bill: 8 things to know,* Kelly Gooch, 3/27/19 https://www.beckershospitalreview.com/hospital-management-administration/house-democrats-unveil-healthcare-bill-8-things-to-know.html; image: By Sagearbor - Own work, CC BY-SA 4.0, https://commons.wikimedia.org/w/index.php?curid=75168357

Medicare Margins by Hospital Type



Source: MedPac Report to Congress, March 15, 2019

August 2018: Per Moody's, Margin Contraction Puts Nonprofit Hospitals on Unsustainable Path

STROUDWATER

- According to Moody's, **expense growth for nonprofit and public hospitals outpaced annual revenue growth in FY2017**
  - The median annual expense growth rate was 5.7 percent in FY2017, down from 7.1 percent the previous year
    - The lower expense rate was largely due to better control of supply and labor costs
  - However, the annual revenue growth rate declined faster, falling from 6.1 percent in fiscal 2016 to 4.6 percent in fiscal 2017
    - The lower revenue growth was attributable to factors including the shift to outpatient care, increased ambulatory competition and lower reimbursement rates
- Moody's expects **nonprofit hospital margins will continue to be suppressed through 2018** after median operating margins and cash flow margins fell to all-time lows of 1.6 percent and 8.1 percent, respectively, in fiscal 2017
- The medians are based on an analysis of audited fiscal year 2017 financial statements for 303 freestanding hospitals, single-state health systems and multistate healthcare systems, representing 78 percent of all Moody's-rated healthcare entities

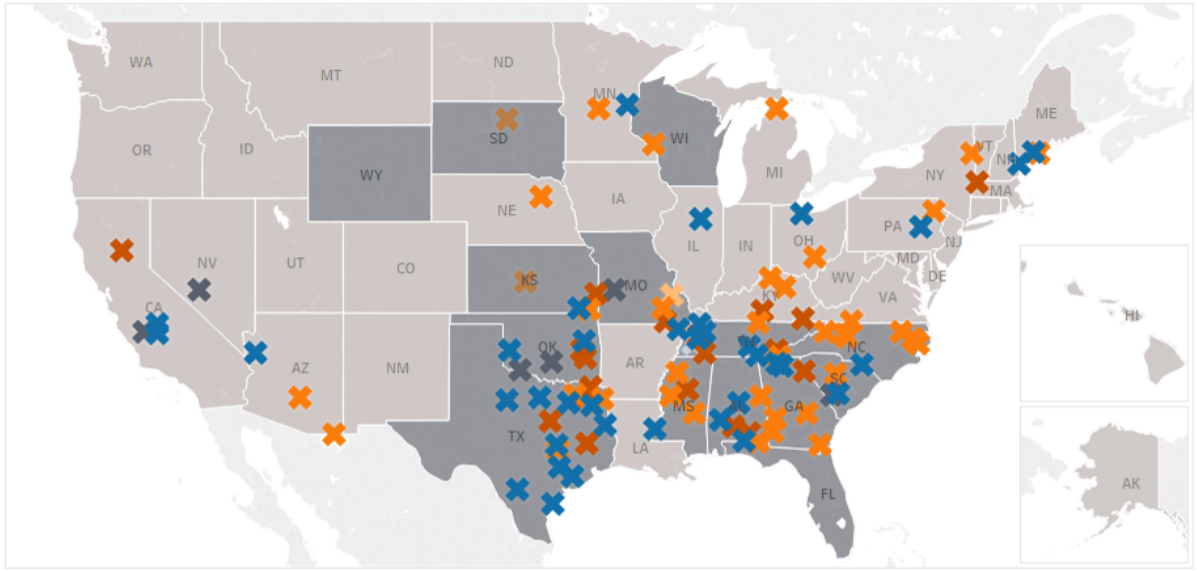
MOODY'S

Source: Becker's Hospital Review, *Moody's: Margin contraction puts nonprofit hospitals on unsustainable path, Ayla Ellison, 8/29/18*
https://www.beckershospitalreview.com/finance/moody-s-margin-contraction-puts-nonprofit-hospitals-on-unsustainable-path.html

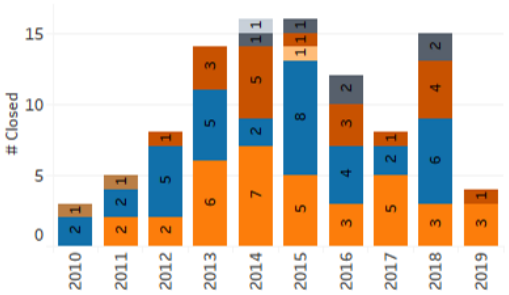
Rural Hospital Closures

101 Closed Rural Hospitals

There have been 101 Rural Hospital closures since 2010 and 143 since 2005. These counts do not include those that have closed and re-opened.



Closure Year	Hospital Name
2019	Georgiana Medical Center-AL
	Cumberland River Hospital-TN
	Washington County Hospital-NC
	Oswego Community Hospital-KS
2018	Mercy Hospital Fort Scott-KS
	Fairfield Memorial Hospital-SC
	Little River Healthcare Cameron Hospital-TX
	Little River Healthcare Rockdale Hospital-TX
	Adventist Health Feather River-CA



StateAbv	# Closed
TX	17
TN	10
GA	7
AL	6
NC	6
OK	6
MO	5
MS	5
CA	4
KS	4
KY	4
SC	4
AZ	3
ME	3
MN	2
OH	2
PA	2
VA	2
FL	1
IL	1
MA	1
MI	1
NE	1
NV	1
NY	1
SD	1
WI	1

Closure Year	Critical Access Hospital	Prospective Payment System	Medicare Dependent Hospital	Sole Community Hospital	Re-based Sole Community Hospital	Disproportionate Share Hospital	Rural Referral Center	Total
2010		2			1			3
2011	2	2			1			5
2012	2	5	1					8
2013	6	5	3					14
2014	7	2	5	1		1		16
2015	5	8	1	1			1	16
2016	3	4	3	2				12
2017	5	2	1					8
2018	3	6	4	2				15
2019	3		1					4
Total	36	36	19	6	2	1	1	101

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Disproportionate Share Hospital
- Rural Referral Center

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:3/12/2019

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

Design:@GreggLathrop

Source: NC Rural Health Research Program at the Cecil G. Sheps Center for Health Services and Research and KFF.org

Hospitals Targeted in Federal Cost-Cutting Push (3/6/19)

STROUDWATER

- Led by Sen. Lamar Alexander (R-Tenn.), a bipartisan group including the Brookings Institution and the American Enterprise Institute submitted a set of healthcare cost-cutting recommendations that target hospitals
- Recommendations in the letter include:
  - **Targeting merger-and-acquisition (M&A) activity**
    - Specifically, increased for antitrust enforcement by the Federal Trade Commission and the Department of Justice's Antitrust Division against both provider and health plan M&A
  - **Eliminating any willing provider rules governing network participation**
  - **Requiring participation in all-payer claims databases**
  - **Repealing certificate of need laws**
  - **Requiring contracts to eliminate surprise bills**
  - ***Expanding site-neutral payments***
  - **Expanding bundled payments**
  - ***Narrowing 340B***

"There's just no getting around the fact that hospitals make up a huge chunk of healthcare spending in the United States…So, if you want to save any substantial amount of money, it's going to be hard to do that without having any effects on the hospitals."

Benedic Ippolito, an author of the joint letter and an economist at AEI

Source: hfma.org Healthcare Business News, *Hospitals Targeted in Federal Cost-Saving Ideas, Rich Daly,* 3/6/19, https://www.hfma.org/Content.aspx?id=63470

Hospitals Targeted in Federal Cost-Cutting Push (3/6/19)

STROUDWATER

- Per AEI economist Ippolito, the proposed initiatives most likely to pass are those targeting **surprise medical bills** and pushing **all-payer claims databases**
  - The proposed approach to reducing **surprise medical bills** would require physicians practicing at hospitals to participate in the same insurer contracts as the hospital
  - The effort to establish **all-payer claims databases (APCDs)** would entail federal requirements for self-insured plans to contribute data to the repositories that collect claims records from all public and private payers operating within a state
- Health plan leaders expressed support for many proposed measures, including the request for antitrust funding
- Provider groups advocated for a range of cost-cutting measures including value-based payments and incentives for APMs

Source: hfma.org Healthcare Business News, *Hospitals Targeted in Federal Cost-Saving Ideas, Rich Daly,* 3/6/19, https://www.hfma.org/Content.aspx?id=63470

MedPAC Expected to Call for National Medicare ED Coding (3/7/19)

STROUDWATER

- MedPAC is expected to formally call on the CMS to revisit creating **a national guideline for coding OPPS emergency department visits** by 2022
- Hospitals currently develop their own internal guidelines for reporting an ED visit or can follow models created by the AHA, and the ACEP, or other guidelines for coding
- MedPAC's call was prompted by:
  - A report showing that hospitals are **seeking higher payments from the CMS for ED visits,** with the number of level five visits increasing 20% from 2005 to 2017
  - Data from the National Hospital Ambulatory Medical Care Survey from 2011 to 2016 showing an **increased use in screening services such as CT scans and EKGs for ED visits** but no change in lab tests and procedures

Source: Modern Healthcare*, MedPAC to call for national Medicare ED coding approach,* Robert King, 3/7/19
https://www.modernhealthcare.com/medicare/medpac-call-national-medicare-ed-coding-approach

MedPAC March 2019 Report to Congress: Highlights

STROUDWATER

Key takeaways from the March 2019 MedPAC report include:

- MedPAC recommends Congress update inpatient and outpatient payment rates by 2%
- MedPAC recommends a new hospital Value incentive program (HVIP) that aligns with our principles for quality measurement and replaces the current quality incentive programs
  - MedPAC recommends eliminating the penalties associated with the current quality incentive programs which will have the effect of increasing payments by .5%
- MedPAC recommends that the 2020 payment rate for physician and other health professional services be updated by the amount specified in current law

Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2019
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0

MedPAC March 2019 Report to Congress: Hospital Payment Updates

STROUDWATER

- Background
  - In 2017, hospitals aggregate Medicare margin was -9.9%
    - Medicare margin for efficient providers was -2%
  - 2019 aggregate Medicare margin is projected to decline to -11%
  - Payment policy goal is to improve program's value to beneficiaries and taxpayers
    - Will require knowledge about costs and health outcomes of services
    - Looking for opportunities that provide incentives for high-quality care
  - "In the longer term, pressure on providers may cause them to increase their participation in alternative payment models"
  - During FY 2017, inpatient payments increased by 2.2% and outpatient payments increased by 8.1%
    - Growth in outpatient payments due to rapid growth in Part B drug spending and a continued shift in site of service billing from physician offices to outpatient departments
- For 2020, the commission recommends that the Congress update Medicare IP and OP payment rates by 2%
  - Difference between 2% update and update amount specified in law (2.8%) to be used to increase payments to the new HVIP
  - HVIP will eliminate penalties in current quality programs resulting in .5% increase
  - After net effect of new HVIP, update amount expected to be 3.3%

Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2019
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0

MedPAC March 2019 Report to Congress: Hospital Value Incentive Program

STROUDWATER

- Background
  - Four hospital quality incentive programs which have proven to improve quality:
    - Hospital Inpatient Quality Reporting Program
    - Hospital Readmission Reduction Program
    - Hospital-Acquired Condition Reduction Program
    - Hospital Value-based purchasing program
  - Quality measurement should be patient oriented, encourage coordination, and promote delivery system change
  - New HVIP can incorporate existing quality measure domains such as readmissions, mortality, spending, patient experience, and hospital-acquired conditions
- For 2020, the commission recommends that the Congress replace Medicare's current hospital quality programs with the HVIP that:
  - Includes a small set of population-based outcome, patient experience, and value measures;
  - Scores all hospitals based on the same absolute and prospectively set performance targets; and
  - Accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping
- The commission recommends that payments in the HVIP be increased by the difference between the Commission's update recommendation and the amount specified in current law

Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2019
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0

Other MedPAC Findings in 2017

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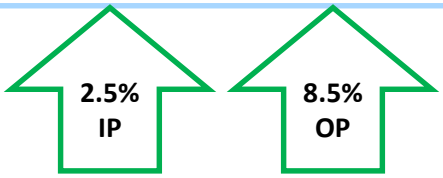
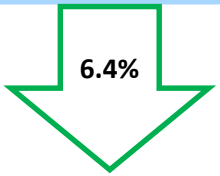
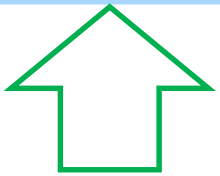


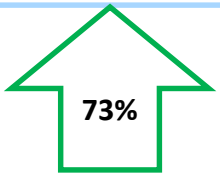
Hospital FFS Medicare revenue



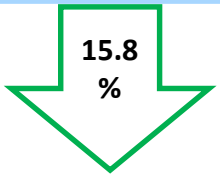
Uncompensated care payments



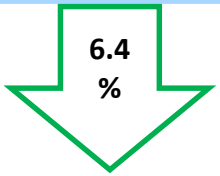
Hospital quality for Medicare patients



Patients rating their overall hospital experience at a 9 or 10, compared with 71 percent in 2012



Patients readmitted, compared with 16.4 percent in 2012



Mortality rates, from 7.7 percent in 2012

Hospital occupancy rates remained low (62.5 percent) in 2017. Rates were lower (40.2 percent) for rural hospitals.

Outpatient spending per beneficiary increased by 8.4 percent. Total outpatient spending increased by $4.9 billion.

Bond issuances ($35 billion) in 2017 were described as consistent with 2016

Source: hfma, *Hospital Medicare Margins Decline Further,* Rich Daly, 12/7/19
https://www.hfma.org/Content.aspx?id=62592&utm_source=Real+Magnet&utm_medium=email&utm_campaign=135259243#.XBQEUeLQnS0.linkedin

CMS Seeks Public Input on Star Ratings (3/2/19)

- After years of hospital advocacy, CMS acknowledged common complaints about star ratings and is seeking input on the model it uses to assign them
- **CMS is considering replacing the controversial "latent variable model" (LVM), a statistical approach that gives more emphasis to certain measures over others based on a number of aspects and causes star ratings to be unpredictable**
- CMS will consider **"replacing LVM…with an explicit approach (such as an average of measure scores) to group score calculation"**
  - Instead of the latent variable model, the CMS suggested assigning weights to each measure in the domains
- In the July 2018 preview of the ratings, the LVM gave much more emphasis to hip and knee complication rates in the safety-of-care domain instead of the PSI-90 measure, which received the most emphasis in that domain in previous iterations of the ratings
- CMS also wants feedback on whether it should separate hospitals into peer groups, group measures differently, and release the ratings once a year
- **AHA supports only three of the proposed 14 changes:**
  - **Replacing the current methodology, separating hospitals by peer groups and establishing a new criteria to group quality measures.** They also called for CMS to remove the currently posted star ratings.

Sources: Modern Healthcare, *Hospitals hopeful big changes are coming to the CMS' star ratings,* Maria Castellucci, 3/2/19 https://www.modernhealthcare.com/safety-quality/hospitals-hopeful-big-changes-are-coming-cms-star-ratings; Modern Healthcare, *AHA pushes back on proposed changes to CMS' hospital star ratings,* Maria Castellucci, 3/27/19 https://www.modernhealthcare.com/safety-quality/aha-pushes-back-proposed-changes-cms-hospital-star-ratings

CMS Releases Proposed Rule to Increase EHR Interoperability: Overview (2/11/2019)

STROUDWATER

- CMS released proposed rules that would **require health insurers to provide electronic health data in a standard format by 2020**
- The rules would **require healthcare providers and insurers to implement data-sharing technology** that would ensure data can move from one health insurance plan to another
- CMS also released two RFIs on how to promote interoperability and reduce any burden on providers regarding health IT

"By ensuring patients have access to their information and that information follows them on their healthcare journey, we can reduce burden, eliminate redundant procedures and testing, and give back valuable clinician time to focus on improving care coordination,"
-CMS

HHS.gov
U.S. Department of Health & Human Services

HHS Proposes New Rules to Improve the Interoperability of Health Information

New innovations in technology promote patient access and could make no-cost health data exchange a reality for millions

The U.S. Department of Health and Human Services (HHS) today proposed new rules to support seamless and secure access, exchange, and use of electronic health information. The rules, issued by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), would increase choice and competition while fostering innovation that promotes patient access to and control over their health information. The proposed ONC rule would require that patient electronic access to this electronic health information (EHI) be made available at no cost.

Source: Modern Healthcare, *CMS proposes interoperability rules to increase EHR access,* Robert King, 2/11/19
https://www.modernhealthcare.com/article/20190211/NEWS/190219999

CMS Releases Proposed Rule to Increase EHR Interoperability: Requirements for Hospitals (2/11/2019)

STROUDWATER

As proposed, the CMS rule would:

- Require psychiatric hospitals, **critical-access hospitals and facilities that participate in Medicare** to send "electronic notifications when a patient is admitted, discharged or transferred“ in order to improve care transitions
- Give CMS the power to name hospitals and practices that "unreasonably limit the availability, disclosure and use of electronic health information"
  - The rule details exceptions for providers where information-blocking is acceptable, such as preventing patient harm and improving health IT performance

Source: Modern Healthcare, *CMS proposes interoperability rules to increase EHR access,* Robert King, 2/11/19
https://www.modernhealthcare.com/article/20190211/NEWS/190219999

CMS Releases Proposed Rule to Increase EHR Interoperability: Requirements for Payors (2/11/2019)

STROUDWATER

As proposed, the CMS rule would:

- Require insurers on MA, Medicaid, CHIP and ACA plans to provide enrollees with immediate access to medical claims and other information by 2020
- Expand requirements for insurance plans to use standardized application program interface (API) technology to make their provider networks available for enrollees and prospective enrollees
- Require payers in agency programs like CHIP, MA, Medicaid managed-care and ACA plans to participate in a trusted exchange network to let them **"join any health information network they choose and be able to participate in a nationwide exchange of data"**

Source: Modern Healthcare, *CMS proposes interoperability rules to increase EHR access,* Robert King, 2/11/19
https://www.modernhealthcare.com/article/20190211/NEWS/190219999

CMS 2020 IPPS Proposed Rule (April 23, 2019): Summary

STROUDWATER

Payment Rate Update

- Acute care hospitals that report quality data and are meaningful users of EHRs will receive a 3.2 percent increase in Medicare rates
- CMS projects the rate increase will boost total IPPS payments to 3.7 percent in fiscal 2020 after other proposed changes, Uncompensated Care, Ne Technology Add-on Payments, Low Volume, Capital, and other adjustments

Disproportionate Share Hospital payments

- CMS proposes distributing roughly $8.5 billion in DSH payments in fiscal 2020, an increase of approximately $216 million
- Adjusted for the change in uninsured
- Seeking comment to decide whether to distribute based on S-10 data of FY15 or S-10 FY17 because of instruction changes that in FY17

Wage index changes

- Increase wage index for hospitals with a wage index value below 25th percentile
- Decrease wage index for hospitals above the 75th
  - Capped at no more than 5% decrease
- CMS is proposing changes to the "rural floor" calculation, which requires the wage index values for urban hospitals to be no lower than the wage index values for rural hospitals in the same state.

CAR-T therapy payment update

- CMS would increase the maximum add-on payment for new technology, including CAR-T cancer therapy, from 50 percent of estimated costs to 65 percent. The American Hospital Association said the payment update would help hospitals in the short term.

Sources: Becker's Hospital Review, *CMS' proposed inpatient payment rule for 2020: 9 things to know,* Ayla Ellison, 4/24/19 https://www.beckershospitalreview.com/finance/cms-proposed-inpatient-payment-rule-for-2020-9-things-to-know.html; Source: cms.gov Fact sheet *Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information,* 4/23/19 https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute

CMS 2020 IPPS Proposed Rule (4/23/2019): Summary

STROUDWATER

Hospital-Acquired Conditions (HAC) Reduction Program

- Payments reduced by 1% if they fall in worst-performing quartile
- Specify the dates to collect data used to calculate hospital performance for the FY 2022
- Adopt eight factors CMS would use when deciding whether a measure should be removed from the HAC Reduction Program; all of these factors were previously adopted by the Hospital IQR and Hospital VBP Programs

Hospital Readmission Reduction Program (HRRP)

- CMS finalized a payment adjustment methodology in which hospital performance is assessed relative to the performance of hospitals within the same peer group.
- Hospitals are stratified into five peer groups, or quintiles, based on proportion of dual-eligible stays.

Hospital Inpatient Quality Reporting (IQR) Program

- The Hospital IQR Program is a pay-for-reporting quality program that reduces payment to hospitals that fail to meet program requirements.
- CMS proposes updating the Hospital IQR Program's measure set, among other changes
  - Remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace with the proposed Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure

Promoting Interoperability Programs

- CMS proposes a continuous 90-day reporting period in calendar year (CY) 2021 for eligible hospitals
- CMS proposes making voluntary the measure that requires hospitals to query a prescription drug monitoring program
- CMS is proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants in the Medicare Promoting Interoperability Program attesting to CMS.

Sources: Becker's Hospital Review, *CMS' proposed inpatient payment rule for 2020: 9 things to know,* Ayla Ellison, 4/24/19 https://www.beckershospitalreview.com/finance/cms-proposed-inpatient-payment-rule-for-2020-9-things-to-know.html; Source: cms.gov Fact sheet *Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information,* 4/23/19 https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute

CMS Medicare Hospital IPPS and LTCH Prospective Payment System Proposed Rule: Proposed Changes to Payment Rates Under IPPS

STROUDWATER

PROPOSED FY 2020 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS				
FY 2020	**Hospital Submitted Quality Data and is a Meaningful EHR User**	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User**
Proposed Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.8	-0.8
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.4	0	-2.4
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.7**	**0.3**	**1.9**	**-0.5**

Source: cms.gov, 42 CFR Parts 412, 413, and 495 [CMS-1716-P] RIN 0938-AT73
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

CMS 2020 IPPS Proposed Rule: CAH-Specific Summary

CAH Residents and Graduate Medical Education

- To support the training of residents in rural and underserved areas, CMS proposes that beginning October 1, 2019, a hospital may include FTE residents training at a CAH in its FTE count as long as it meets the non-provider setting requirements currently included at 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g)
- "CAH(s) may continue to incur the costs of training residents in an approved residency training program(s) and receive payment based on 101 percent of the reasonable costs for these training costs"
- "If this proposal is finalized, CMS will work closely with HRSA and the Federal Office of Rural Health Policy to communicate the increased regulatory flexibility to CAHs as well as existing residency programs and the options it affords for increasing rural residency training"

Source: https://www.federalregister.gov/documents/2019/05/03/2019-08330/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

CMS 2020 IPPS Proposed Rule: CAH-Specific Summary

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Proposed Change Related to CAH Payment for Ambulance Services

- Generally, payment to ambulance providers and suppliers for ambulance services are made under the Ambulance Fee Schedule
- "Revising (CMS) interpretation of the requirement in section 1834(l)(8)(B) of the Act that the CAH or the entity owned and operated by the CAH be the only provider or supplier of ambulance services that is located within a 35-mile drive of such a CAH, to ***exclude consideration of ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals either to or from the CAH***"
- "For example, consider the scenario where an ambulance supplier is located within a 35-mile drive of a CAH, but in a different State, and the ambulance supplier is not legally authorized [..] to furnish services"

Source: https://www.federalregister.gov/documents/2019/05/03/2019-08330/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

CMS 2020 IPPS Proposed Rule: CAH-Specific Summary

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Frontier Community Health Integration Project (FCHIP) Demonstration

- "The RFA identified four interventions, under which specific: waivers of Medicare payment rules would allow for enhanced payment for telehealth, skilled nursing facility/nursing facility beds, ambulance services, and home health services, respectively"
- Ten CAHs were selected for participation in the demonstration, which started on August 1, 2016 (Montana, Nevada, and North Dakota)
  - 8 participating in telehealth
  - 3 participating in nursing facility/nursing facility bed intervention
  - 2 participating in ambulance service intervention
  - 0 participating in Home Health intervention
- "If analysis of claims data for Medicare beneficiaries receiving services at each of the participating CAHs, as well as from other data sources, including cost reports for these CAHs, shows that increases in Medicare payments under the demonstration during the 3-year period are not sufficiently offset by reductions elsewhere, we will recoup the additional expenditures attributable to the demonstration through a reduction in payments to all CAHs nationwide"
- "Based on actuarial analysis using cost report settlements for FYs 2013 and 2014, the demonstration is projected to satisfy the budget neutrality requirement and likely yield a total net savings"

Source: https://www.federalregister.gov/documents/2019/05/03/2019-08330/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

The CMS Primary Cares Initiative (4/22/2019): Primary Care First and Direct Contracting

- HHS and CMS announced a set of new payment models called the Primary Cares Initiative to **transform primary care through value-based options** and to **test financial risk and performance-based payments for primary care providers**
- The payment model options are provided under two paths: **Primary Care First (PCF)** and **Direct Contracting (DC)**

Primary Care First	Direct Contracting

• Addresses importance of primary care by creating a seamless continuum of care and accommodating interested providers at multiple stages of readiness to assume accountability for patient outcomes
• Two payment model options:
  • Primary Care First (PCF) – General
  • Primary Care First – High Need Populations
	• Set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare FFS
	  • Three payment model options
	  • Direct Contracting – Professional
	  • Direct Contracting – Global
	  • Direct Contracting – Geographic

Sources: cms.gov, *Delivering Value-Based Transformation in Primary Care*, https://innovation.cms.gov/Files/x/primary-cares-initiative-onepager.pdf; HealthExec.com, CMS launches 5 primary care models in new value-based push, Amy Baster, 4/29/19 https://www.healthexec.com/topics/policy/cms-launches-primary-cares-initiative

What Is Primary Care First (PFC)?

- PFC is a set of **voluntary five-year payment model options** intended to reward value and quality by offering innovative payment model structures to support delivery of advanced primary care
- PFC is based on the underlying principles of the existing CPC+ model design:
  - **Prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients, reducing administrative burden, and focusing financial rewards on improved health outcomes**
- Multi-payer collaboration building on the experience of previous models such as CPC+ that pay for value and place the patient at the center
  - Multiple proof of concept examples showing up to 15-fold return on investment in primary care
    - Biggest driver or success was acceleration in Care Management and Care Coordination efforts
    - Reductions in total cost of care were realized largely through decreased inpatient utilization, ED visits, and specialty care

Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

What is PCF payment model?

- Most sweeping attempt to date to change primary care--per Secretary Azar, **"the new primary care experiment will transform the U.S. health system"**
- **Capitated payment structure is simplified**
  - ✓ Capitated risk-based payment along with flat primary care visit fee
  - ✓ Performance-based adjustments providing upside of up to 50%
  - ✓ Small downside (10%) incentivizes practices to reduce costs and improve quality
  - ✓ Includes a payment model option that provides higher payments to practices that specialize in care for high need patients
- **Model seeks to reduce regulatory and administrative burdens for primary care physicians by increasing panel size capacity and promoting attribution and retention of patients**
- **Capitated payment model incentivizes proactive team outreach and non-visit care**
  - ✓ Establishes more options for patient engagement, such as secure text, email, and virtual visits
  - ✓ Increases convenience for patients by providing access to care teams through multiple channels
  - ✓ Allows for regular communication and closer collaboration between patients and care teams
  - ✓ Leaves office appointments open for longer, more detailed and complex patient encounters

Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

Who Can Participate in PCF?

- Participation is open beginning January 2020 to **all primary care practices with advanced primary care capabilities located in 18 existing CPC+ regions plus a list of newly-added regions**
  - Unlike pilot programs that preceded Primary Care First, this model invites **broader participation from practices with the infrastructure and financial preparedness to accept risk**
- Success in value-based payment models is dependent on efficient delivery of services in a team-based model of care
  - Requires incorporation of actionable population health data analytics delivered in real-time to the point of care
    - Access to regional data through HIE (Health Information Exchange) programs is strongly encouraged by CMS in order to achieve success

Source: cms.gov, *Primary Care First: Foster Independence, Reward Outcomes,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

What Is Direct Contracting?

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- Direct Contracting (DC) is a **set of voluntary payment model options** aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare FFS
- The payment model options available under DC create opportunities for organizations to participate in testing the next evolution of risk-sharing arrangements to produce value and high quality health care
- DC creates **three payment model options for participants** to take on risk and earn rewards, and provides them with choices related to cash flow, beneficiary alignment, and benefit enhancements
- The payment model options are anticipated to
  - Reduce burden
  - Support a focus on beneficiaries with complex, chronic conditions
  - Encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models
  - Broaden participation in CMS Innovation Center models

Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

Direct Contracting: Three Payment Models

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Professional PBP

- Offers the lower risk-sharing arrangement—50% savings/losses
- Provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for enhanced primary care services
- CMS will offer primary care capitation equal to 7 percent of the total cost of care for enhanced primary care services, along with 50 percent shared savings/shared losses with CMS

Global PBP

- Offers the highest risk sharing arrangement—100% savings/losses
- Provides two payment options:
  - Primary Care Capitation
  - Total Care Capitation, capitated, risk-adjusted monthly payment for all services provided by DC Participants and preferred providers with whom the DCE has an agreement
- CMS will offer the choice of Primary Care Capitation or Total Care Capitation, in addition to 100 percent shared savings/losses

Geographic PBP

- CMS is seeking public input through an RFI
- Would offer a similar risk-arrangement as the Global PBP option as potential participants would assume responsibility for the total cost of care for all Medicare FFS beneficiaries in a defined target region.

Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

Direct Contracting: Payment Model Goals

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- Intended to **engage a broader variety of organizations than have previously participated in CMS models and programs**
- While CMS expects that current NGACO and MSSP participants may participate, **CMS also seeks to attract organizations that are new to Medicare FFS,** such as those who are currently only in MA, and Medicaid MCOs that are ready to take on accountability for Medicare FFS spending for their dually eligible members
- DC's current design seeks to create **a competitive delivery system environment** based on regional payment neutrality, in which organizations bear appropriate risk, and population-based benchmarks are applied equitably across all model participants in the same market (i.e., accounting for risk adjustment factors)

Flexible Risk-Sharing and Payment Model Options	*Benefit Enhancements*	*Voluntary Alignment*
• Aligns payment and benchmarks consistently across organizations through use of regional payment rates and patient-level adjustment factors. • Offers greater payment predictability through prospective beneficary alignment.	• Offers a suite of tools that increases beneficiary engagement and affordability, as well as improves quality of care.	• Enables and encourages beneficiaries to choose the providers with whom they want to have a care relationship. • Empowers beneficiaries to seek high value providers i.e., providers that offer high quality services at low cost.

Source: cms.gov, *Fact Sheet: Direct Contracting,* 4/22/19, https://www.cms.gov/newsroom/fact-sheets/direct-contracting

2019 Physician ROI

Physician Generated Revenue vs. Average Salaries

	2019 Survey			2016 Survey		
Specialty	Average Revenue	Average Salary	ROI	Average Revenue	Average Salary	ROI
Cardiology (Invasive)	$ 3,484,375	$ 590,000	5.9	$ 2,448,136	$ 525,000	4.7
Cardiology/Non-Inv.	$ 2,310,000	$ 427,000	5.4	$ 1,260,971	$ 291,000	4.3
Cardiovascular Surgery	$ 3,697,916	$ 425,000	8.7	NA	NA	NA
Family Practice	$ 2,111,931	$ 241,000	8.8	$ 1,493,518	$ 198,000	7.5
Gastroenterology	$ 2,965,277	$ 487,000	6.1	$ 1,422,677	$ 455,000	3.1
General Surgery	$ 2,707,317	$ 350,000	7.7	$ 2,169,673	$ 339,000	6.4
Hematology/Oncology	$ 2,855,000	$ 425,000	6.7	$ 1,688,056	$ 350,000	4.8
Internal Medicine	$ 2,675,387	$ 261,000	10.3	$ 1,830,200	$ 207,000	8.8
Nephrology	$ 1,789,062	$ 272,000	6.6	$ 712,054	$ 275,000	2.6
Neurology	$ 2,052,884	$ 301,000	6.8	$ 1,025,536	$ 277,000	3.7
Neurosurgery	$ 3,437,500	$ 687,000	5.0	$ 2,445,810	$ 553,000	4.4
OB/GYN	$ 2,024,193	$ 324,000	6.2	$ 1,583,209	$ 276,000	5.7
Ophtalmology	$ 1,440,217	$ 300,000	4.8	$ 1,035,577	$ 249,000	4.2
Orthopedic Surgery	$ 3,286,764	$ 533,000	6.2	$ 2,746,605	$ 497,000	5.5
Otolaryngology	$ 1,937,500	$ 405,000	4.8	$ 1,066,221	$ 334,000	3.2
Pediatrics	$ 1,612,500	$ 230,000	7.0	$ 665,972	$ 195,000	3.4
Psychiatry	$ 1,820,512	$ 261,000	7.0	$ 1,210,586	$ 226,000	5.4
Pulomonolgy	$ 2,361,111	$ 418,000	5.6	$ 1,190,870	$ 331,000	3.6
Urology	$ 2,161,458	$ 386,000	5.6	$ 1,405,659	$ 412,000	3.4

Average Revenue: Net inpatient and outpatient revenue generated annually for a facility by a single FTE physician (employed or independent) through hospital admissions, procedures performed at the hospital, tests and treatments ordered, prescriptions written, etc. For primary care physicians it DOES NOT include indirect revenue through referrals to specialists utilizing the hospital.

Source: Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey

Azar Lays Out Agenda for Value-Based Care (3-6-2018)

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*"**There is no turning back to an unsustainable system that pays for procedures rather than value.** In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us. This administration and this President are not interested in incremental steps. We are unafraid of disrupting existing arrangements simply because they're backed by powerful special interests."*

- In an address to the Federation of American Hospitals on March 5, Secretary Azar laid out his four priorities for value-based care transformation

Give consumers control over their health information through improved HIT. Azar advocated for "putting the technology into the hands of the patients themselves," stressing the importance of empowering consumers.

Increase transparency. Azar stated that boosting transparency of services will help patients better shop for care, citing personal experience. He believes that Americans have the right to know what healthcare services and pharmaceuticals will cost.

Use of MACRA and CMS Innovation Center. The secretary cited the importance of Medicare and Medicaid in value-based transformation and cost control. He advocated for tools such as MACRA and the CMMI's ACOs that are already in place and asserted that "we will use these tools to drive real change in our system."

Reduce government burdens. Azar referred to regulatory burdens such as certain Medicare and Medicaid price reporting rules, restrictions in some FDA communication policies, and current interpretations of various well-meaning anti-fraud protections.

Sources: HHS.gov https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html; Politico.com, *What Alex Azar wants on value-based care (and how it resembles Obama's goals),* Dan Diamond 3/6/2018 https://www.politico.com/newsletters/politico-pulse/2018/03/06/what-alex-azar-wants-on-value-based-care-and-how-it-resembles-obamas-goals-123351

CMMI Direction: Blow Up Fee for Service (11/29/2018)

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- If there was any doubt about the Trump administration's desire to push healthcare towards a value-based system, Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler makes things clear:

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to ***blow up fee for service…*** *That's one of our prime goals—is to get rid of fee for service."*

- However, getting rid of fee for service is easier said than done given the industry's current reliance on the existing infrastructure.

34%
of healthcare payments tied to an APM in 2017

10.5%
of Medicare payments in traditional legacy arrangements not linked to quality

>50%
of Medicare FFS payments with some level of pay-for-performance

Source: FierceHealthcare, *CMMI's Adam Boehler wants to 'blow up' fee for service,* Evan Sweeney, 11/29/18
https://www.fiercehealthcare.com/payer/cmmi-s-adam-boehler-wants-to-blow-up-fee-for-service

Healthcare Disruptors

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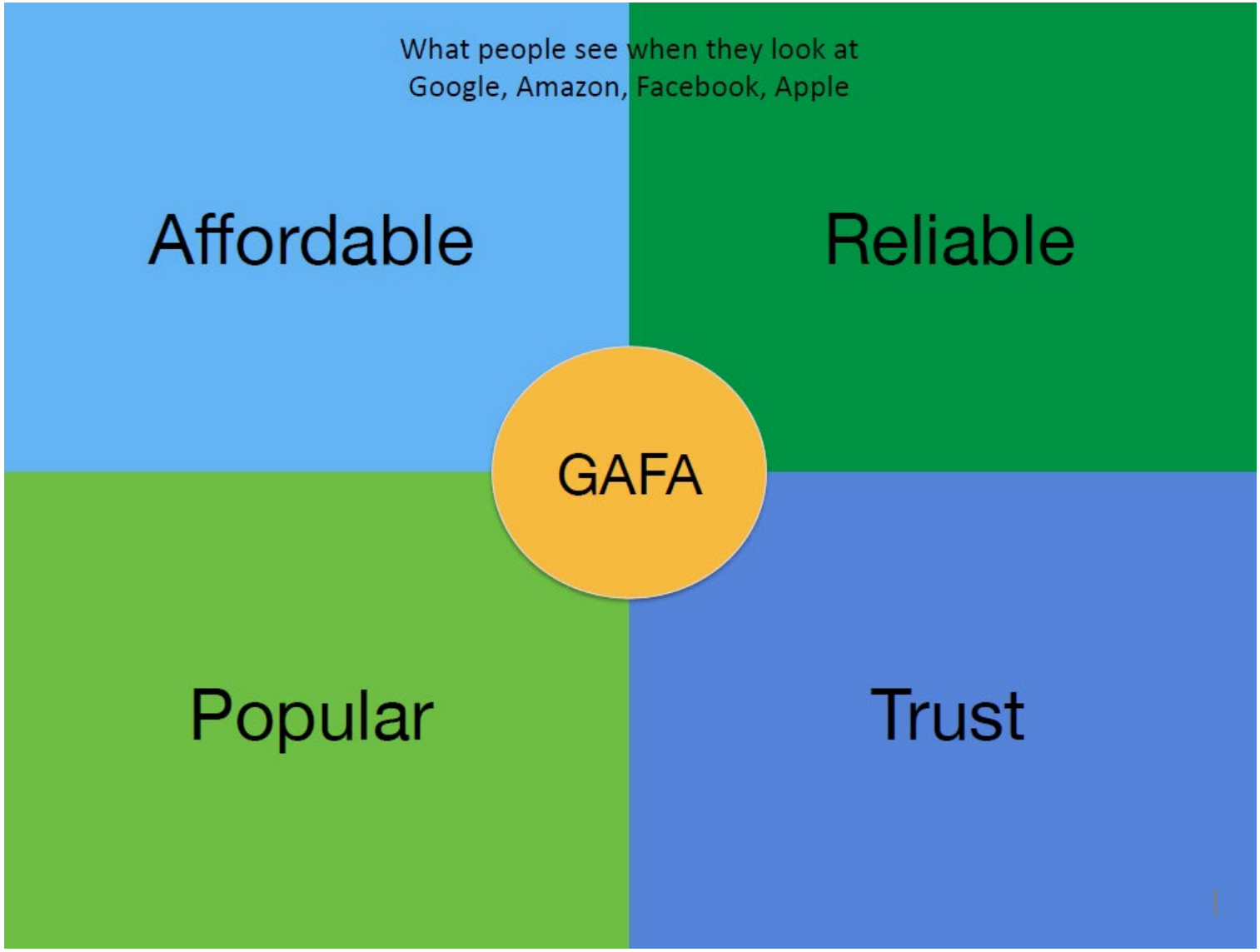

(Spring Street Exchange presentation, June 2018)

Substitution

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Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care

By NICK WINGFIELD, KATIE THOMAS and REED ABELSON JAN. 30, 2018

- Partnership to provide healthcare to organizations' employees and eventually expanded to benefit all Americans
- "Free from profit-making incentives and constraints" (Jamie Diamond, CEO JPMorgan Chase)
- "Reducing health care's costs and burden on the economy while improving outcomes would be worth the effort" (Jeff Bezos, CEO Amazon)

Source: New York Times, January 30, 2018

New Delivery Models: Direct Contracting

Ochsner Health Network and Walmart to launch new health plan

- Ochsner Accountable Care Plan will cover 6,600 Walmart/Sam's Club Associates who will have access to more than 200 PCPs and 1,300 specialists
- "Plan will simplify copays, coordinate care and provide access to thousands of providers in dozens of locations"
- Ochsner Accountable Care Plan will provide patient engagement specialists via 24-hour call center as well as case managers for complex patients
- The Ochsner Health Network, which launched in June 2015, includes five partner health systems and 30 hospitals

Source: Modern Healthcare, October 30, 2018

New Delivery Models: Walmart-Humana Potential Impact on Hospitals

Humana®

- The potential Walmart- Humana merger follows two other healthcare mega-deals: CVS Health's $69 billion bid for Aetna and Cigna's $54 billion offer for Express Scripts.
- These insurer pairings could mean a shift toward less expensive care provided at clinics and pharmacies, cutting into spending on hospital services. Analysts anticipate CVS may also enter the Urgent Care market, offering more services than their current MinuteClinic model.
- Industry consultants and executives also look to Walmart's negotiating power for employee health benefits as a reason for hospitals to be nervous.
  - Combining Walmart's employee benefit negotiating clout with Humana's data and infrastructure could position a combined entity to offer competitive health plans.
    - Walmart has 1.5 million employees and over 4700 stores in the U.S. in 2018.

    For the fiscal year ended January 31, 2018, Walmart's total revenue was $500.3 billion. (https://corporate.walmart.com/newsroom/company-facts)
  - Hospitals excluded from those networks would see increased operating pressure, the WSJ reports

("A Walmart-Humana giant scares hospitals: 5 reasons why", Morgan Haefner; Becker's Hospital CFO Report: April 02, 2018.)
("If CVS Bets Big on Urgent Care, Hospitals Should Worry"; HealthLeadersMedia.com: November 5, 2018.)

New Delivery Models: CVS-Aetna Merger

- CVS Health comprises 10,000-plus clinics and pharmacies across the U.S. These spaces could become local options for preventive care, filling prescriptions and treatment, which may sway Americans from entering the healthcare system only when they're in need of extensive care, Bertolini added.
- The Department of Justice approved the CVS-Aetna merger in mid-October, contingent on Aetna selling its Medicare Part D Prescription Drug Plan business to WellCare Health Plans, Inc.
  - Five states still must also approve the transaction
  - According to CEO Larry Menlo, CVS anticipates closing the deal this month and expects the combined companies to realize “substantial” cost savings by better managing common chronic conditions, optimizing and extending primary care, and reducing avoidable hospitalizations.

“(Aetna CEO: CVS deal will open '10,000 new front doors to the healthcare system’”, Morgan Haefner; Becker’s Hospital Review: February 26, 2018.)

(“CVS, Cigna Preview What’s in Store After Their Deals Close”; AISHealthDaily@aishealth.com; Leslie Small: November 12, 2018.)

New Health Focus: Apple

- In recent months, Apple has ramped up its health records project, an effort to integrate patient health records into their iPhone Health app.
  - In less than a year, more than 100 hospitals and clinics have joined Apple's health records project
- In August, the company closed enrollment for the Apple Heart Study, a joint heart rhythm research project with Stanford University School of Medicine in California and telehealth vendor American Well.
- A patent application made public in June suggested the tech giant may soon offer a wearable device that monitors blood pressure.
- Apple has received clearance from the Food and Drug Administration for its latest Apple Watch, which can now conduct electrocardiograms and deliver alerts to the user, if atrial fibrillation is detected. Data is stored on the Health app and can be retrieved and shared with providers.

("Apple is Hiring for its Health Business"; Becker's Health IT & CIO Report: September 4, 2018".)
("Apple Scores FDA Clearance for Heart Rhythm Sensing Apple Watch"; Modern Healthcare.com; Rachel Z. Arndt; September 12, 2018.)
("100+ Hospitals, Clinics Are Now Live on Apple's Health Records Feature"; Becker's Health IT & CIO Report: November 12, 2018)

Substitution – Lab Testing

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EverlyWell®

WHAT'S INSIDE

The Test

- Kit Registration Information for Physician Review
- Easy-to-Follow Instructions
- Sterile Collection Tools
- Pre-Paid Return Shipping
- A Warm Welcome to the EverlyWell Community!

841 views | Apr 16, 2019, 05:18pm

EverlyWell Raises $50 Million To Make At-Home Lab Testing More Accessible

- Founded in 2015 to offer validated at-home lab tests that are reviewed by physicians at a certified lab
- Offers 35 different types of tests including ones for food sensitivity, hormone levels, Lyme disease, and sexually transmitted diseases
- Tests currently available at Target, CVS, Humana and the EarlyWell website

Source: Forbes, April 18, 2019

Substitution – New Retail Services

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Walgreens LabCorp

Walgreens and LabCorp to open 600 in-store testing sites

- Part of Walgreens broader effort to expand from retail into healthcare service companies
  - *"Reflects commitment to transform stores into neighborhood health destinations that provide a differentiated, consumer-focused experience, while provided access to a broad range of affordable health care services"*
- Handheld device that can examine heart, lungs, ears, throat and abdomen as well as measure body temperature to enable remote diagnosis of acute care situations like ear infections, sore throats, fever, cold, flu, allergies, stomachaches, upper respiratory infections and rashes
  - Information sent to a primary are provider for diagnosis through a telehealth platform
- Acquisition in line with Best Buy 2020 Strategy to enrich human lives through technology by addressing human needs

Source: Fierce Healthcare, October 11, 2018

Substitution – New Retail Services

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TytoCare - TytoHome Medical Exam Kit - White

Model: G 1.5 SKU: 6332714

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Get a complete medical exam wherever you are with TytoCare TytoHome. This electronic health care device allows you to receive on-demand physical exams via live video chat with a doctor's office using an exam camera and a basal thermometer and otoscope, stethoscope and tongue depressor adapters. This HIPAA-secure TytoCare TytoHome digital device transmits test results to an electronic health record for easy monitoring .

Best Buy expands reach into digital health space with Tyto Care partnership

- Handheld device that can examine heart, lungs, ears, throat and abdomen as well as measure body temperature to enable remote diagnosis of acute care situations like ear infections, sore throats, fever, cold, flu, allergies, stomachaches, upper respiratory infections and rashes
  - Information sent to a primary are provider for diagnosis through a telehealth platform
- Acquisition in line with Best Buy 2020 Strategy to enrich human lives through technology by addressing human needs

Source: Fierce Healthcare, April 17, 2019