MARKET UPDATES

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Call to Action: Insurance Premiums

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THE KAISER FAMILY FOUNDATION

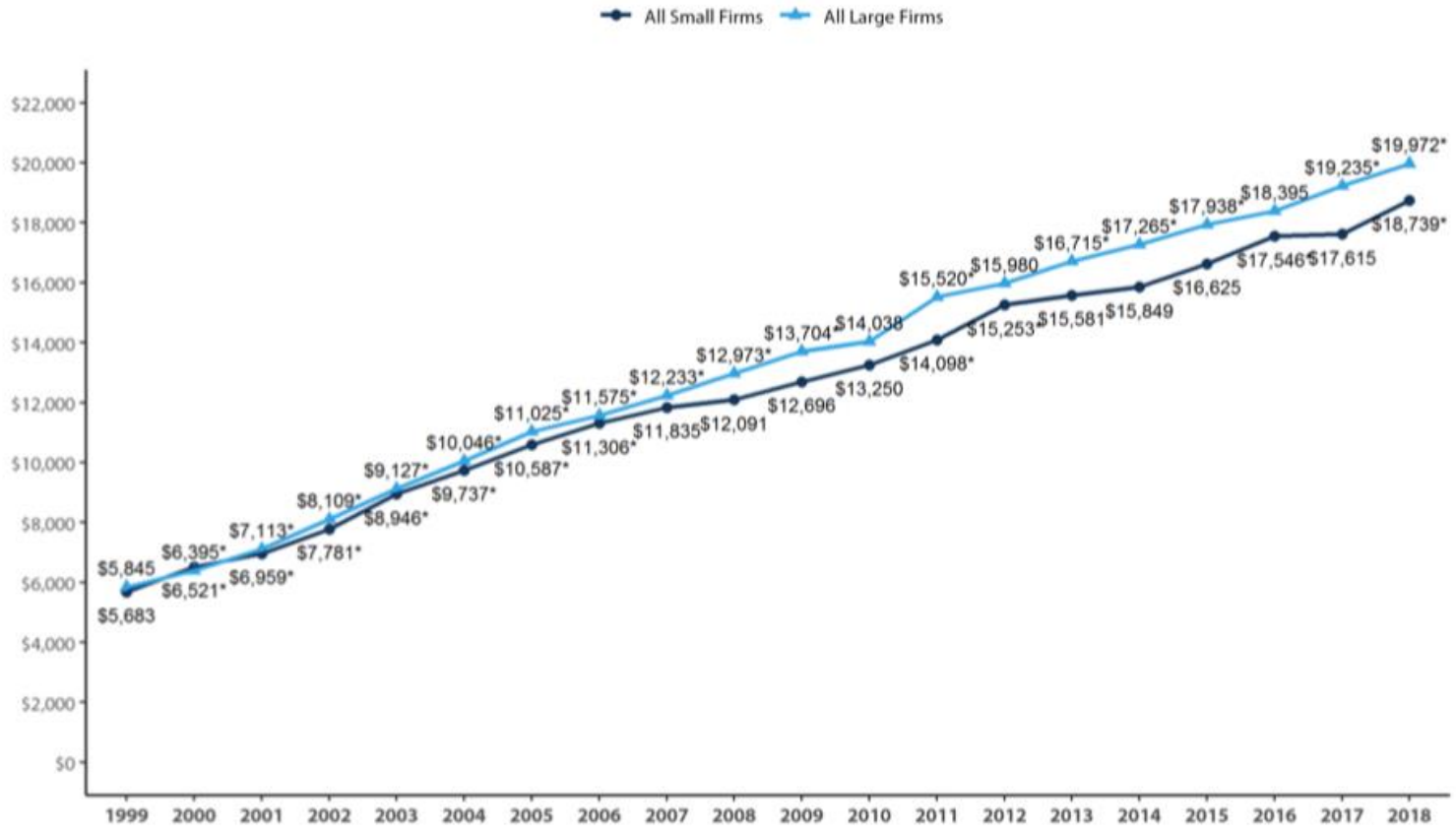
Employer Health Benefits

2018

ANNUAL SURVEY

Figure 1.12

Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Call to Action: Growth of High Deductible Plans

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THE KAISER FAMILY FOUNDATION

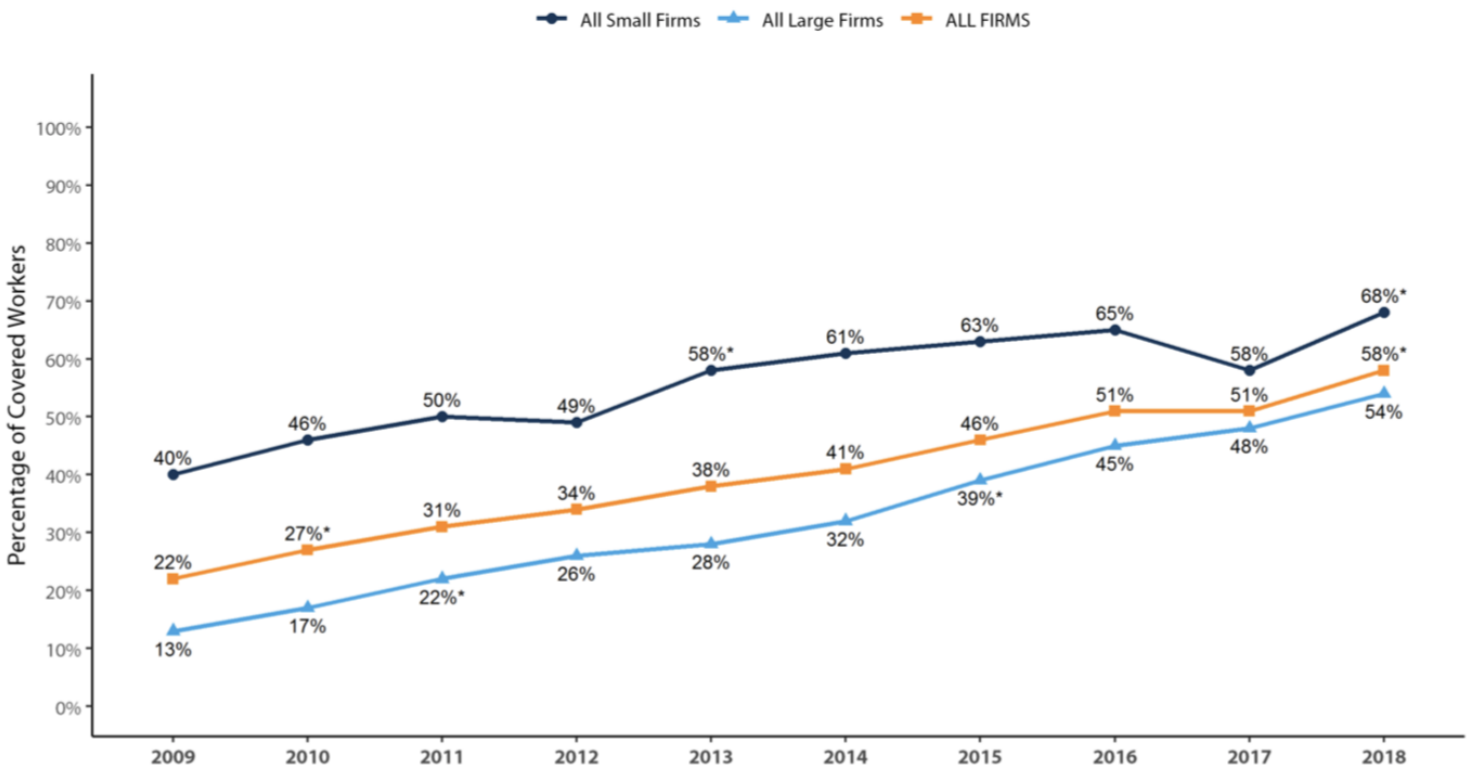
Employer Health Benefits

2018

ANNUAL SURVEY

Figure 7.13

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018

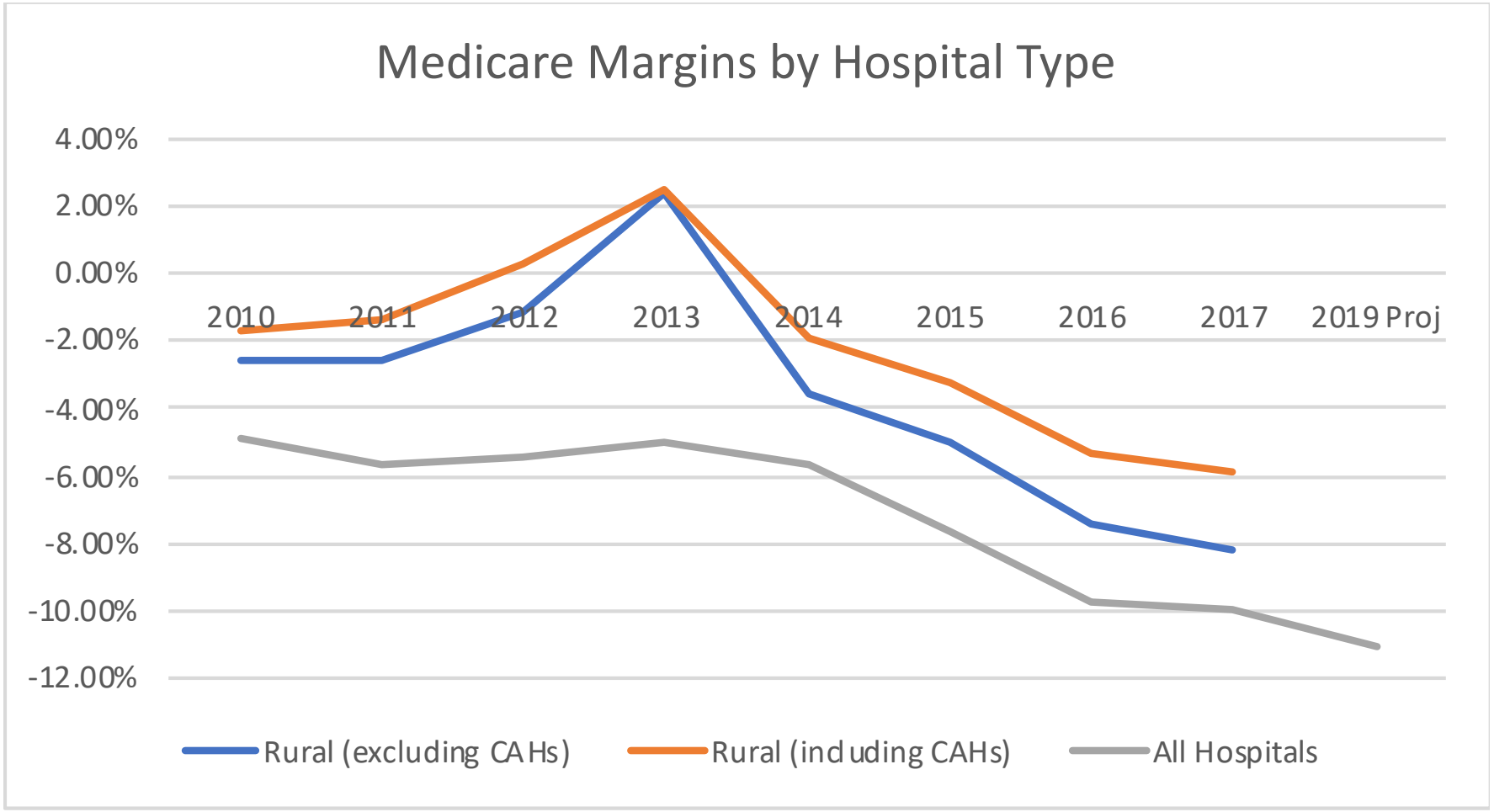


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Call to Action: Declining Medicare Margins

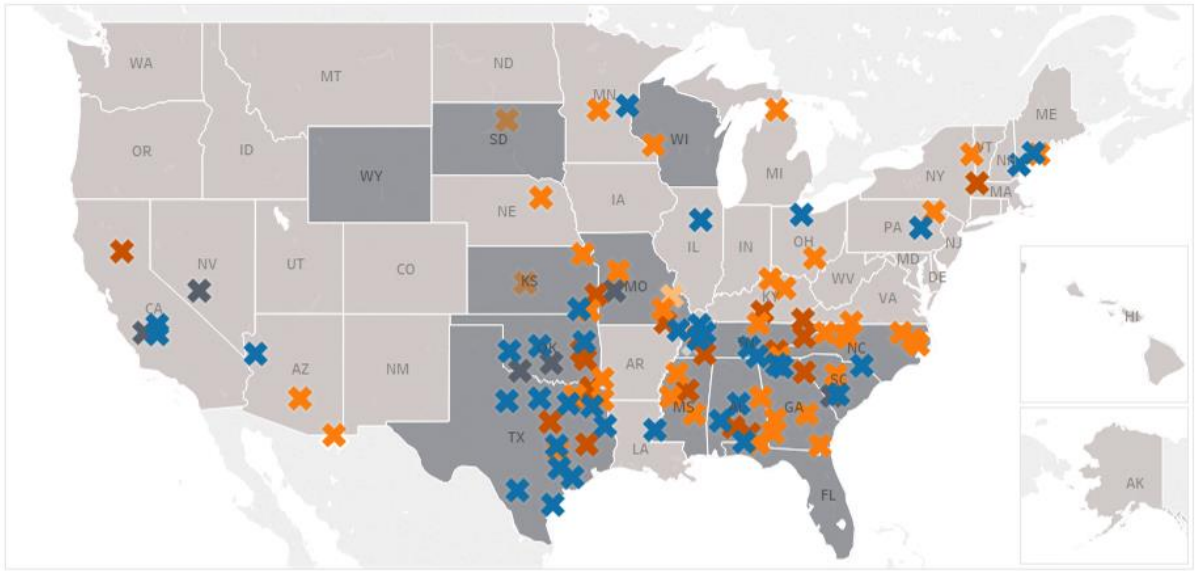


Source: MedPac Report to Congress, March 15, 2019

Rural Hospital Closures

106 Closed Rural Hospitals

There have been 106 Rural Hospital closures since 2010 and 148 since 2005. These counts do not include those that have closed and re-opened.



Closure Year	Hospital Name
2019	De Queen Medical Center-AR
	Mercy Hospital El Reno-OK
	Takoma Regional Hospital-TN
	Horton Community Hospital-KS
	Georgiana Medical Center-AL
	Cumberland River Hospital-TN
	I-70 Community Hospital-MO
	Washington County Hospital-NC
	Oswego Community Hospital-KS

StateAbv	# Closed
TX	17
TN	11
GA	7
OK	7
AL	6
MO	6
NC	6
KS	5
MS	5
CA	4
KY	4
SC	4
AZ	3
ME	3
MN	2
OH	2
PA	2
VA	2
AR	1
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	6	1	2					9
Total	39	37	20	6	2	1	1	106

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

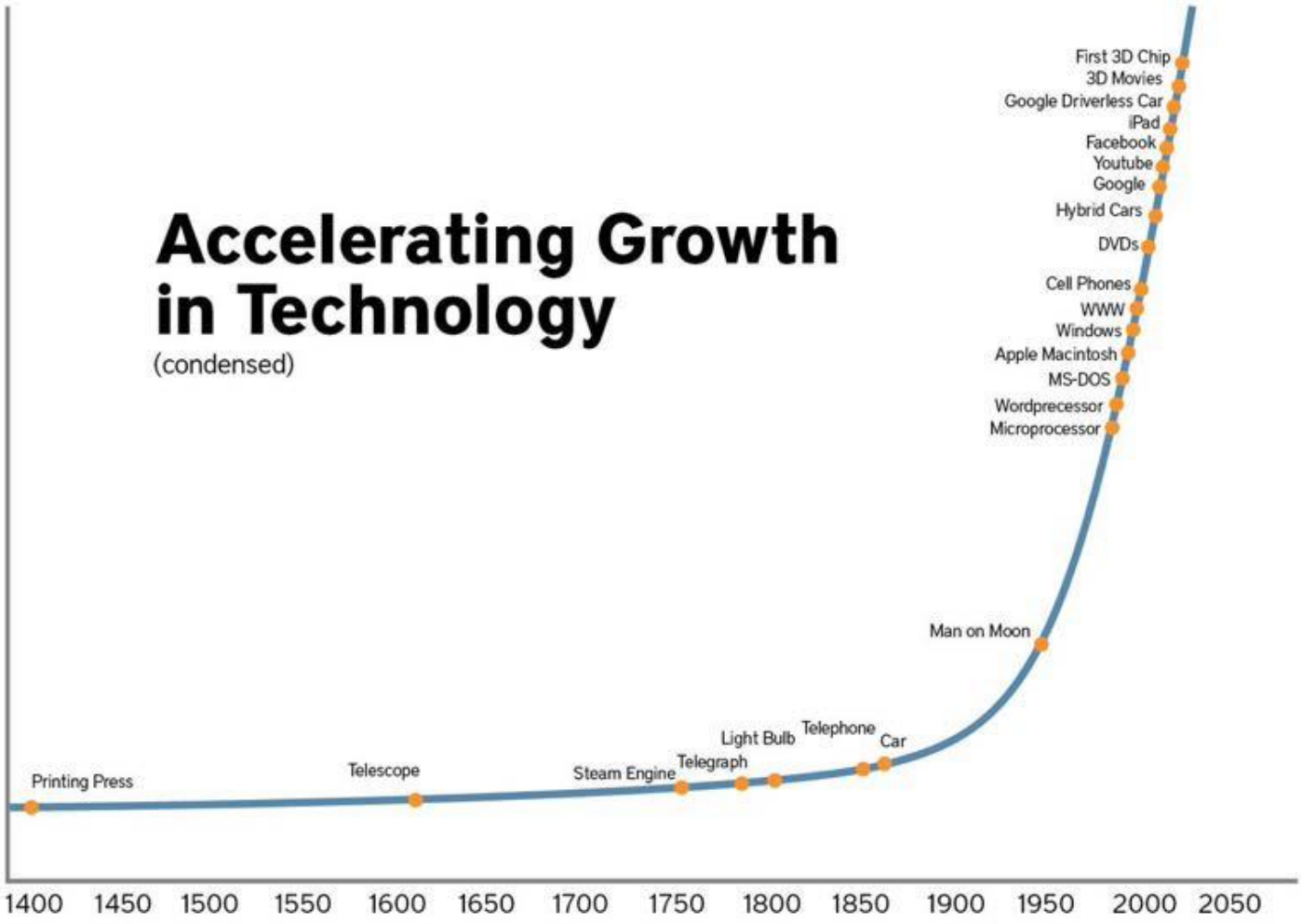
Updated:5/15/2019

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

Call to Action: Advances in Technology



Source: Khalid Hamdan, Accelerating Growth in Technology

Call to Action: What Could This Mean for Healthcare

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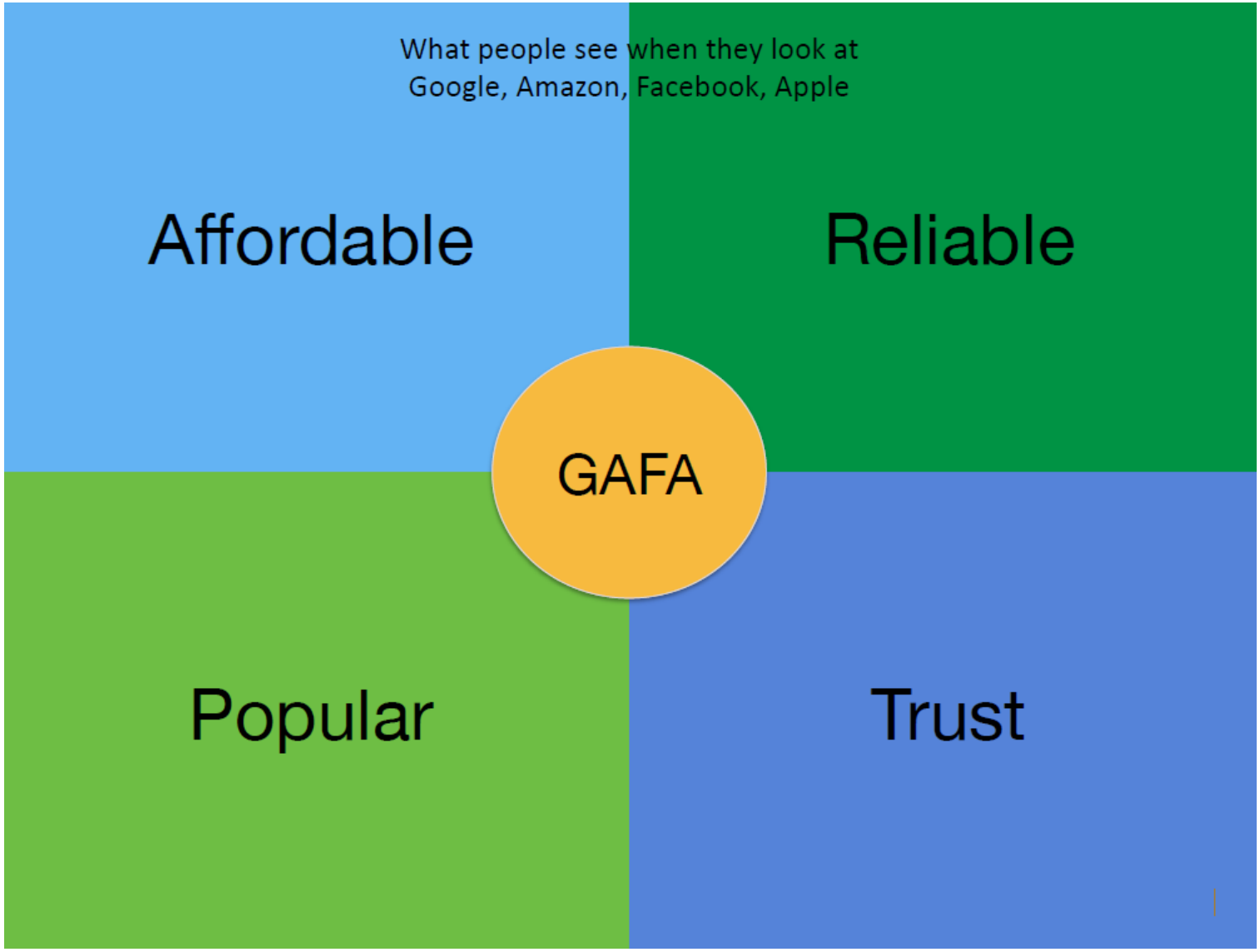
- Virtual medicine
- Mobile medicine
- Artificial intelligence
- Interoperability
- Wearables
- Environmental sensors
- Personalized medicine
- Big data
- Virtual reality
- Robotics
- Genomics
- Personalized health record

Healthcare Disruptors

STROUDWATER



(Spring Street Exchange presentation, June 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

Image source: *By MikeMozartJeepersMedia - Own work, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=32354206*

New Delivery Models: Walmart-Humana Potential Impact on Hospitals

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- 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

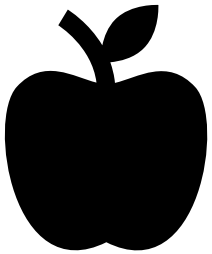
("A Walmart-Humana giant scares hospitals: 5 reasons why", Morgan Haefner; Becker's Hospital CFO Report: April 02, 2018.)
("If CVS Bets Big on Urgent Care, Hospitals Should Worry"; HealthLeadersMedia.com: November 5, 2018.)

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.
- **The Department of Justice approved the CVS-Aetna merger in mid-October 2018,** contingent on Aetna selling its Medicare Part D Prescription Drug Plan business to WellCare Health Plans, Inc.
- **However, the merger is still pending its final step:** a Tunney Act hearing to approve a consent decree between CVS (ticker: CVS) and the Justice Department. This process was not yet complete as of early June pending a decision by US District Court Judge Richard Leon.
- Despite regulatory and legal challenges, on June 4, 2019, after a successful pilot, **CVS announced plans to open 1,500 HealthHub stores by the end of 2021**
  - HealthHubs are CVS's health-focused concept stores with space dedicated to helping customers manage such chronic conditions as diabetes, hypertension and asthma
  - Each store features an expanded health clinic with a lab for blood testing and health screenings as well as wellness rooms equipped to handle yoga classes and seminars

Sources: *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; Becker's Hospital Review, *CVS to open 1,500 HealthHub stores by the end of 2021,* Alia Paavola, 6/4/19 https://www.beckershospitalreview.com/pharmacy/cvs-to-open-1-500-healthhub-stores-by-the-end-of-2021.html?origin=ceo; Barron.com, *CVS Bought Aetna Last Year. Now a Judge Is Sowing Doubts, Robert Teitelman, 6/11/19 https://www.barrons.com/articles/why-a-federal-judge-is-causing-uncertainty-about-the-cvs-aetna-merger-51560276449*;
Image source: *By Calmon1 - Own work, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=15442423*

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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- 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

STROUDWATER

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

4.8 (13 Customers) | Be the first to ask a question

HSA/FSA eligible

$299.99 or $50.00/mo.* suggested payments with 6-Month Financing Show me how >

Add to Cart

Save for Later

Help

Compare

FREE Shipping: Get it by Wed, Apr 24

Want it faster? More shipping options are available in checkout to 04021.

Store Pickup: Order now & Portland will have it ready for pickup by Thu, Apr 25.

Cardmember Offers

6 Month Financing

Get 5% Back in Rewards

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 .

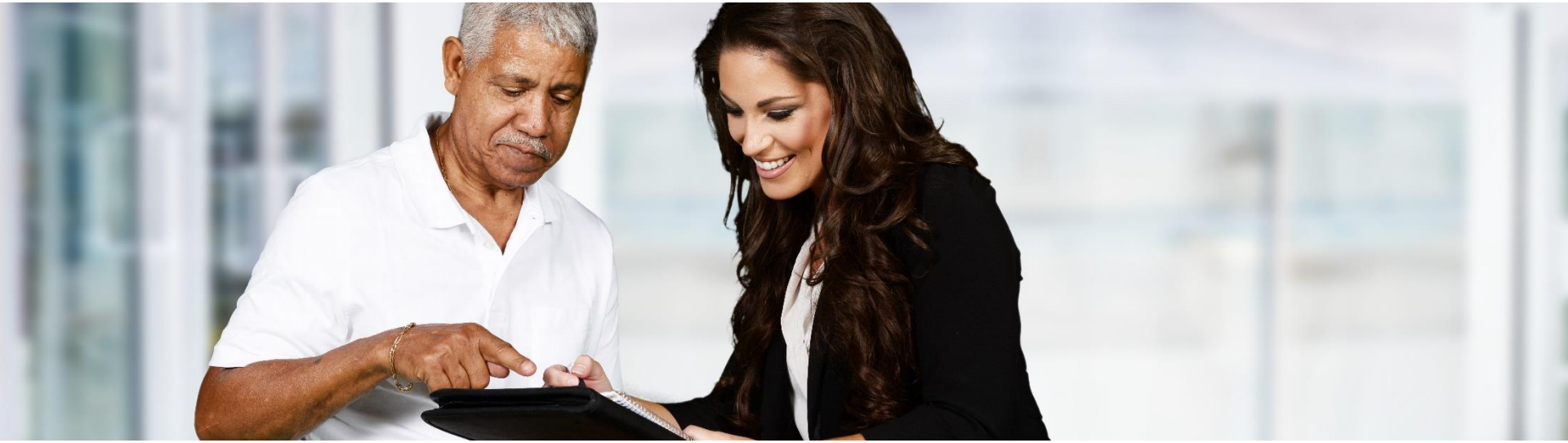
Best Buy expands reach into digital health space with Tyto Care partnership

- Tyto Care is a 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
- Sanford Health, one of the biggest rural hospital systems in the Upper Midwest, recently announced a partnership with Tyto Care linking Sanford patients to their providers through the device

Source: Fierce Healthcare, April 17, 2019

Medicare for All Bill Proposes a Global Budget Model:
Overview

- A January 14 draft of the House Democrats' Medicare for All bill proposes a national system that would pre-pay hospitals with lump sums while keeping a fee-for-service model for individual physicians
- The proposal, from Rep. Pramila Jayapal (D-Wash.), lays out specific details of a nationalized global budget system.
- The preamble to the legislation lays out the pitch for the broad national system, including the statistic that **29 million remain uninsured after implementation of the Affordable Care Act**.



Source: Modern Healthcare, *New Medicare for All draft bill sets a global budget model,* Susannah Luthi, 2/7/19
https://www.modernhealthcare.com/article/20190207/NEWS/190209939/new-medicare-for-all-draft-bill-sets-a-global-budget-model

Medicare for All Bill Proposes a Global Budget Model:
Detail

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- ✓ The proposed bill would set up **regional directors** to oversee all hospitals, healthcare facilities and physicians in specific geographic areas
- ✓ Regional directors **would then negotiate each year with the facilities to set a lump sum, or global budget,** that the government would pay out in advance
- ✓ **The current prospective payment system** would serve as the baseline rate to jump-start the global budget negotiations
- ✓ Once the budget is set, hospitals and other institutions would need to stick to it for all outpatient and inpatient treatment
- ✓ **Individual physicians would be paid through fee-for-service** according to a fee schedule set by the HHS secretary. **Some physicians could opt to receive a salary** from a hospital or other provider subject to the global budget.
- ✓ Emergency transportation; prescription drugs and medical devices; mental health and addiction treatment, including for inpatient stays; laboratory tests; dental and vision care; podiatry; and even dietary and nutritional therapies as approved by the HHS secretary would all fall under the law

Source: Modern Healthcare, *New Medicare for All draft bill sets a global budget model,* Susannah Luthi, 2/7/19
https://www.modernhealthcare.com/article/20190207/NEWS/190209939/new-medicare-for-all-draft-bill-sets-a-global-budget-model

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 by 3.7 percent in fiscal 2020 after other proposed changes, Uncompensated Care, New 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 are 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.

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**

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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 (4/23/2019): Summary

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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

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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

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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

STROUDWATER

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

CMS Considers Revising HCAHPS (4/2019)

- CMS requested permission from the Office of Management and Budget to collect feedback on the HCAHPS survey. The request is still pending approval.
- CMS specifically raised the possibility of offering **an electronic version of the HCAHPS survey,** which is currently only administered via mail, phone or a mix of both
  - The 29-question survey has a response rate of 27%, according to the most recent time period data are available
- **A CMS spokeswoman said the CMS also wants patient insight "about what aspects of hospital quality are important to them"**

HCAHPS
Hospital Consumer Assessment of Healthcare Providers and Systems

Source: Modern Healthcare, *CMS looks at revising HCAHPS survey,* Maria Castellucci, 6/4/19 https://www.modernhealthcare.com/safety-quality/cms-looks-revising-hcahps-survey?utm_source=modern-healthcare-alert

CMS Issues Draft Guidance on Hospital Co-location – 5/3/2019

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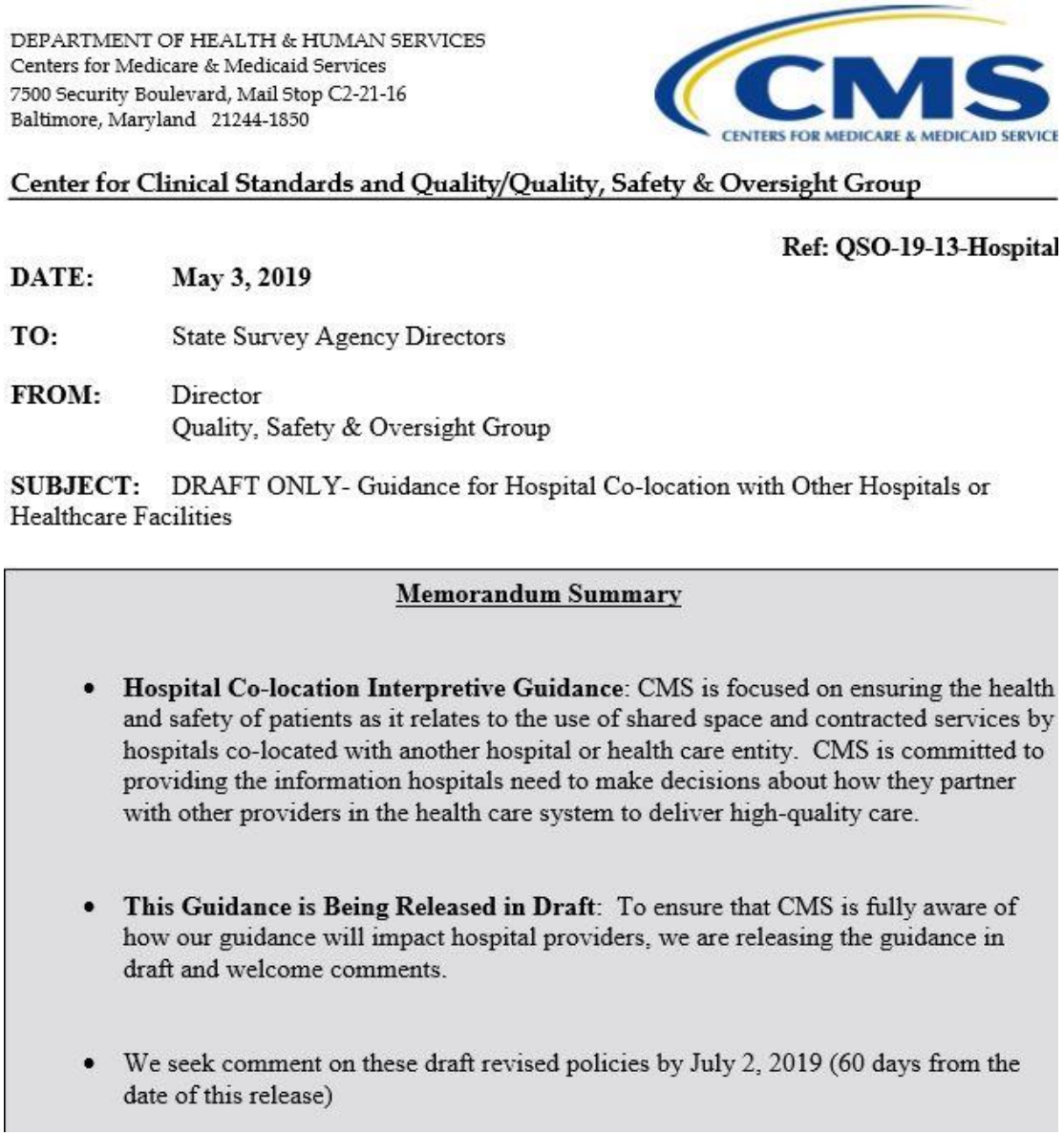

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-19-13-Hospital

DATE: **May 3, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: DRAFT ONLY- Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities

Memorandum Summary

- **Hospital Co-location Interpretive Guidance**: CMS is focused on ensuring the health and safety of patients as it relates to the use of shared space and contracted services by hospitals co-located with another hospital or health care entity. CMS is committed to providing the information hospitals need to make decisions about how they partner with other providers in the health care system to deliver high-quality care.

- **This Guidance is Being Released in Draft**: To ensure that CMS is fully aware of how our guidance will impact hospital providers, we are releasing the guidance in draft and welcome comments.

- We seek comment on these draft revised policies by July 2, 2019 (60 days from the date of this release)

- CMS issued the guidelines in response to industry pressure.
  - AHA expressed concern that hospitals were dismantling co-location.
    - **Urged CMS to clarify its co-location policy as part of a roadmap to rescue rural hospitals.**
- The draft guidance aims to **ensure that hospital space-sharing arrangements comply with Medicare's conditions of participation** while providing flexibility so that organizations can benefit from shared efficiencies.

CMS Issues Draft Guidance on Hospital Co-location – 5/3/2019 (cont.)

- CMS issued draft guidance for state survey agencies on the shared use of spaces, services or personnel by different hospitals or a hospital and other healthcare entities.
  - Hospitals, federally qualified healthcare centers, imaging centers, etc.
- **Co-location** refers to staff, services or equipment used by separate entities that are located in the same physical space but are not fully integrated with one another.
  - Increased access to care, streamlined referrals and improved care coordination.
- Prior sub-regulatory interpretations prohibited co-location of hospitals with other healthcare entities.
- This guidance **opens the door for hospitals, notably CAHs, to co-locate provider-based departments (clinics)** with other healthcare entities.
  - "Distinct spaces" are clinical care areas defined under §482.13(c) to include the right to personal privacy and to receive care in a safe environment; and §482.13(d) provide the right to confidentiality of patient records.
    - **These areas are not to be co-mingled.**
  - "Shared spaces," those considered public spaces and public paths of travel, are able to be co-located.
    - Public lobbies, waiting rooms and reception areas, restrooms, lounges, elevators and main corridors through non-clinical areas, and entrances.

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

STROUDWATER

- FROM LAST MEETING!

- 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

Lower Health Care Costs Act: Background (5/23/2019)

STROUDWATER

- Senate released draft legislation to tackle healthcare costs
  - Claims hospitals and insurers use contracts to dominate their competitors, consolidate their business and keep patients in the dark
  - Aims to clear up some of the system's opaqueness; mend loopholes; and cut fat out of the healthcare industry
- Sponsored by Sen. Lamar Alexander (R-Tenn.) as head of the Senate health committee
- Package includes the much debated ban on surprise medical bills, but falls short of settle the contentious question of how Congress should implement the ban

Sources: Modern Healthcare, *Senate committee unveils sweeping healthcare bill package,* Susannah Luthi, 5/23/19 https://www.modernhealthcare.com/government/senate-committee-unveils-sweeping-healthcare-bill-package;

Lower Health Care Costs Act: Ban on Surprise Medical Bills

STROUDWATER

- **Ban on surprise medical bills:** doesn't settle the "how," instead posits three ideas:

Option 1	Option 2	Option 3

• Require a hospital to guarantee patients that all its physicians are in-network
  • Physicians could either contract with the hospital's insurers or stay out of network but submit their charges through the hospital so the insurer gets only one bill
	• Insurers, hospitals or physicians could choose arbitration to resolve disputed charges higher than $750
	  • Arbiter would look at median insurer-negotiated rates from the same geographical area as a guideline
		• An insurer would pay the surprise bill at the median contracted rate for that region to the hospital or doctor in question

Source: Modern Healthcare, *Senate committee unveils sweeping healthcare bill package,* Susannah Luthi, 5/23/19
https://www.modernhealthcare.com/government/senate-committee-unveils-sweeping-healthcare-bill-package

Lower Health Care Costs Act: Consumer Protection Measures

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Other consumer protection measures include:

- Air ambulances to separate out medical charges from the transport costs in bills sent to patients and health plans
- **Patients receive their full bill within 30 business days**
  - If received after day 30, the patients wouldn't be obligated to pay
    - Hospitals must ensure their revenue cycle is operating at peak to ensure timely billing
- **Give patients "good-faith" estimates of their out-of-pocket costs within 48 hours of a request**
  - *Small and rural hospitals with bare-bones staff struggle with bandwidth and knowledge to be able to provide*
- If patients can prove steering to an out-of-network physician or hospital, they would only be responsible for in-network co-pay
- Elimination of "anti-tiering" or "anti-steering," where hospitals through their insurance contracts keep patients from choosing treatment at competing health systems
- Elimination of "all-or-nothing" clauses where hospitals force insurers to contract with all their facilities by saying if they don't contract with all of them they can't contract with any
- **Pharmacy Benefit Managers (PBMs) to no longer profit off health plans or patients by demanding higher drug prices than they paid the manufacturers**
  - Have to pass along 100% of the manufacturer rebates or discounts to their plan sponsor

Source: Modern Healthcare, *Senate committee unveils sweeping healthcare bill package,* Susannah Luthi, 5/23/19
https://www.modernhealthcare.com/government/senate-committee-unveils-sweeping-healthcare-bill-package

Lower Health Care Costs Act: Other Highlights & Key Points

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Insurer contracts to be scrutinized	• Dominant health plans banned from using their market leverage to hold local hospitals and physicians hostage. • Small and rural hospitals to benefit.
Creation of not-for-profit "transparency" group to gather anonymous claims data	• Get a grip on how to lower costs. The legislation authorizes grants to spur states to launch similar efforts.
Drug pricing a top issue	• Includes measures to stop manufacturer gaming of exclusivity periods and boosts for more generics and biologics.
Addresses public health	• Seeking to boost vaccination rates and check the U.S.'s dismal maternal mortality rates.

Source: Modern Healthcare, *Senate committee unveils sweeping healthcare bill package,* Susannah Luthi, 5/23/19
https://www.modernhealthcare.com/government/senate-committee-unveils-sweeping-healthcare-bill-package

Lower Health Care Costs Act: Provider Compensation Update

- On 7/19/17, in response to intense provider lobbying pressure, hospitals and doctors scored several amendments to the Act that could boost their pay even within the proposed benchmark cap
- Reps. Ruiz (D-Calif.) and Bucshon (R-Ind.) "secured an amendment to give doctors and hospitals recourse in special cases if they don't like the benchmark rate, authorizing an arbiter to step in and resolve disputes with insurers as long as the median in-network pay amount is higher than $1,250 and it relates to complex cases…
- The amendments include the option for doctors to appeal to an independent arbiter to collect additional money for certain out-of-network treatment, as well as a potential increase for out-of-network care at pricier facilities."

Source: Modern Healthcare, *Providers notch wins in House surprise billing legislation, Susannah Luthi,* 7/17/19
https://www.modernhealthcare.com/politics-policy/providers-notch-wins-house-surprise-billing-legislation?utm_source=modern-healthcare-am-thursday

Executive Order on Healthcare Price Transparency (6/24/2019)

- **On 6/24/19, President Trump issued an executive order directing DHHS and other agencies to require hospitals to disclose what patient and insurers "actually pay" for services**
- The goal of the order is to bring price transparency to the healthcare system
- The rules will also require providers and insurers to tell patients about the out-of-pocket costs they'll face before they receive health care services
- Secretary Azar believes the increase in transparency will drive prices down by increasing competition as patients shop around for the best price

"Everyday American patients are being taken advantage of by a system that hides critical information from them that they need to make decisions for them and their families,"

-Secretary Alex Azar

Source: The Hill, *Trump issues executive order to bring transparency to health care prices,* Jessie Hellmann, 6/24/19
https://thehill.com/policy/healthcare/449994-trump-issues-executive-order-to-bring-transparency-to-health-care-prices

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

STROUDWATER

- 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 (PCF)?

- 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?

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Practices participating in the PCF Payment Model Option must:

- ✓ Include **primary care practitioners** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Provide health services to a **minimum of 125** attributed Medicare beneficiaries*
- ✓ Have primary care services account for the **predominant share** (e.g., 70) of the practices' collective billing based on revenue*
- ✓ Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, and alternative to fee-for-service payments
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)
- ✓ Attest via questions in the Practice Application to a limited set of **advanced primary care delivery** capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team

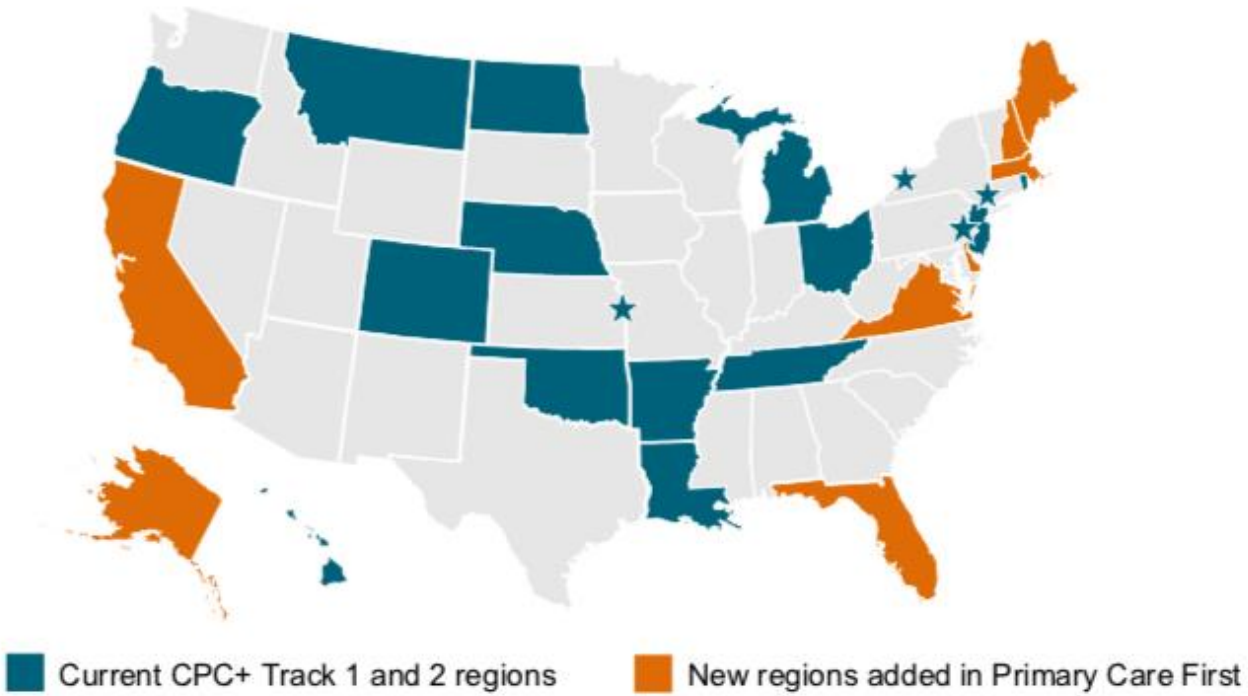
Note: Practices participating only in the SIP option are not subject to these specific requirements.

Primary Care First Regions

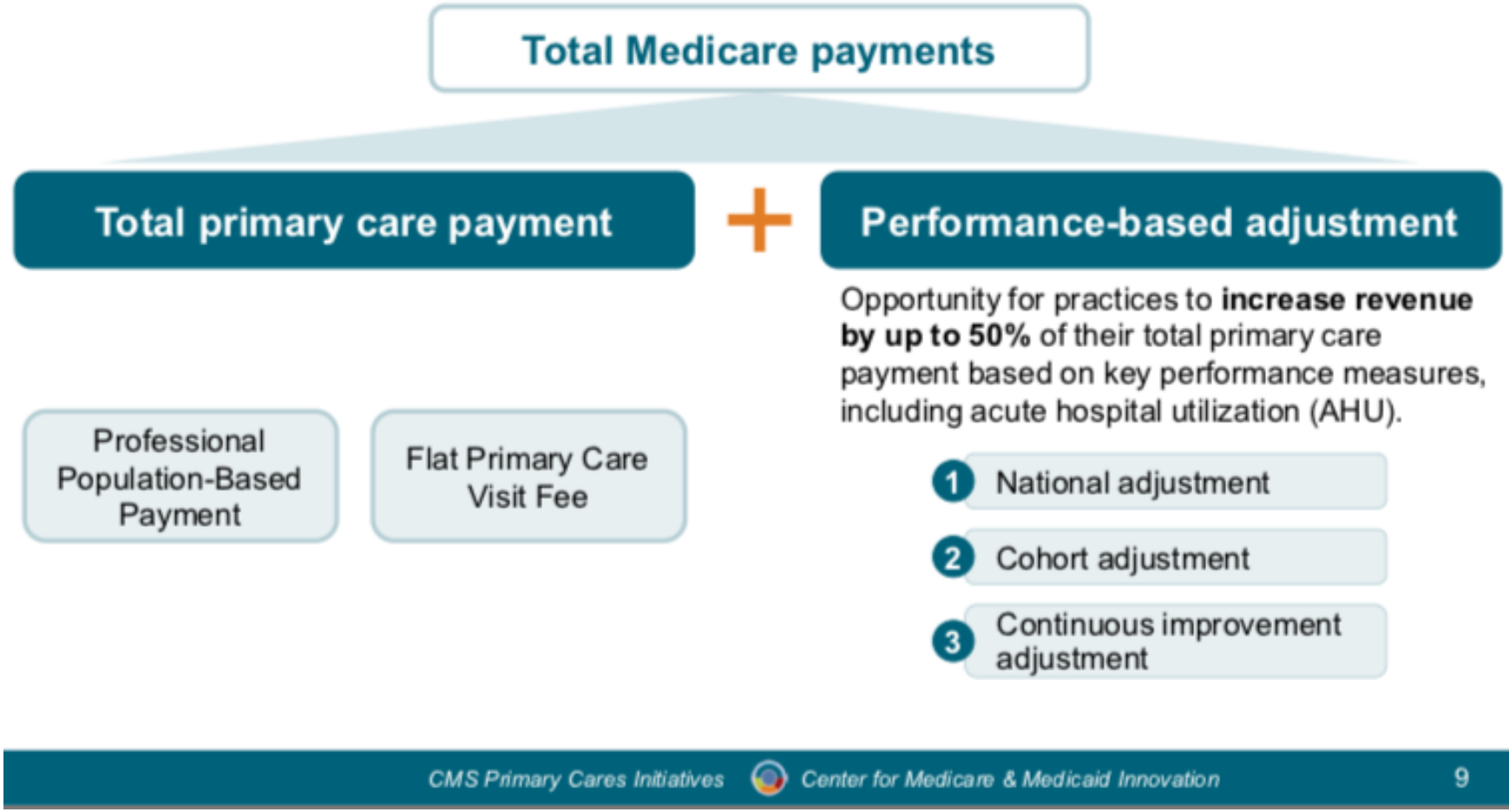
STROUDWATER

Primary Care First Will Be Offered in 26 States and Regions Beginning in 2020

In 2020, Primary Care First will include 26 diverse regions:



PCF Payment Model: Overview



PCF Payment Model: Total Primary Care Payments

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Hybrid Total Primary Care Payments replace Medicare fee-for-service payments to support delivery of advanced primary care.

Professional Population-Based Payment

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

Practice Risk Group	Payment *Per beneficiary per month*
Group 1 (lowest average HCC)	$24
Group 2	$28
Group 3	$45
Group 4	$100
Group 5 (highest average HCC)	$175

Payment adjusted to account for beneficiaries seeking services outside the practice.

+

Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

$50.52

per face-to-face patient encounter

Adjusted for geography

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

PCF Payment Model: Performance-Based Payment Adjustments

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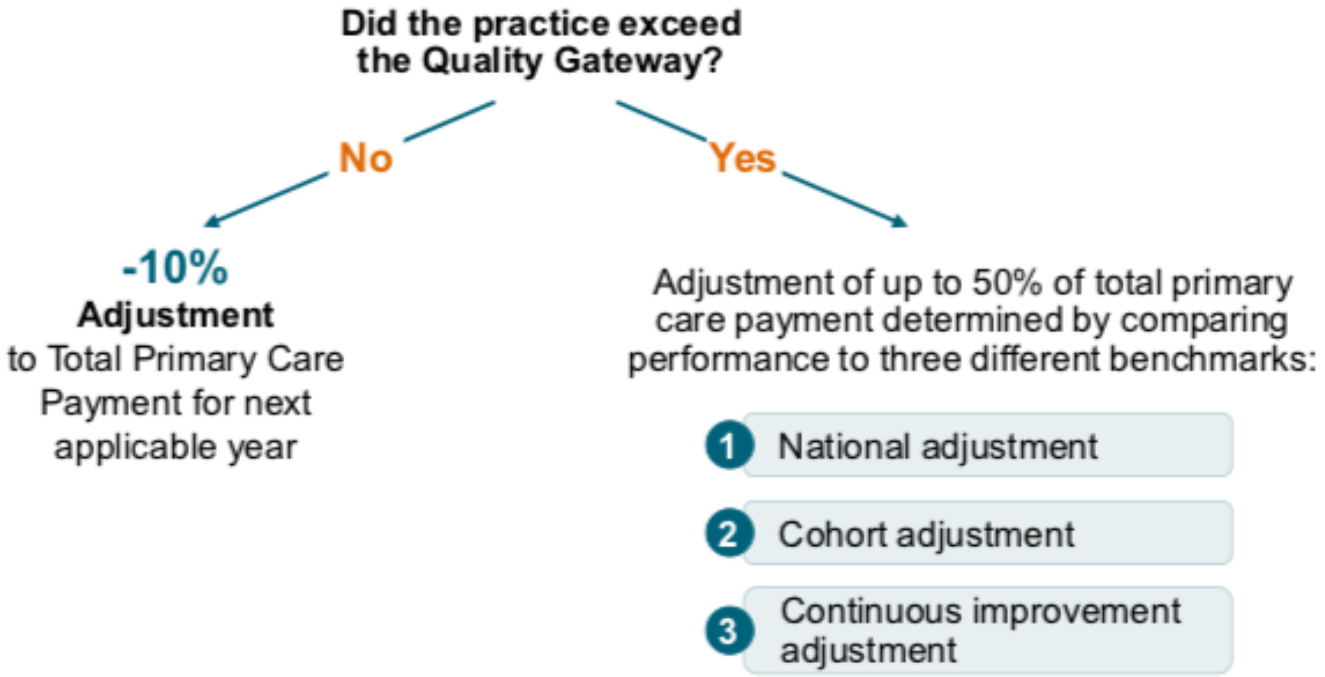
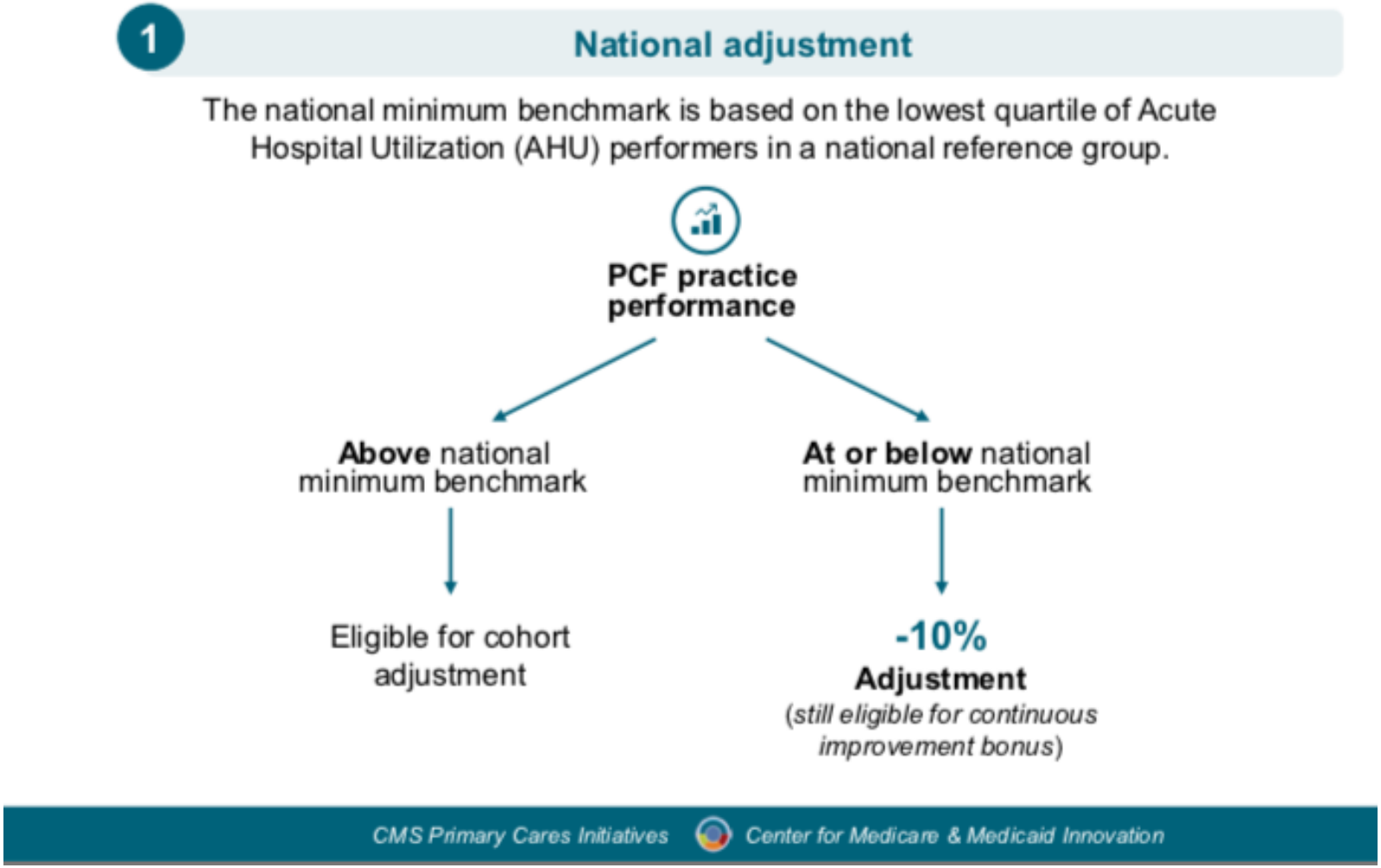
In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.



Performance-Based Payment Adjustments – National Adjustment



PCF Performance-Based Payment Adjustments - Cohort Adjustment

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2 Cohort adjustment

Practice performance is next compared against other PCF participants to determine the performance-based adjustment.

Bottom 50% of PCF practices based on performance

0%
Adjustment

Top 50% of PCF practices based on performance

Performance Level	Adjustment to Total Primary Care Payment
Top 20% of eligible practices	34%
Top 21–40% of eligible practices	27%
Top 41–60% of eligible practices	20%
Top 61%–80% of eligible practices	13%
Top 81–100% of eligible practices	6.5%

PCF Performance-Based Payment Adjustments - Cohort Adjustment

STROUDWATER

3 Continuous improvement adjustment

Practices are also eligible for a **continuous improvement bonus of up to 1/3rd of total Performance-Based Adjustment amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

Performance Level	Potential Improvement Bonus
Top 20% of PBA-eligible practices	**16%** of Total Primary Care Payment
Top 21–40% of PBA-eligible practices	**13%** of Total Primary Care Payment
Top 41–60% of PBA-eligible practices	**10%** of Total Primary Care Payment
Top 61%–80% of PBA-eligible practices	**7%** of Total Primary Care Payment
Top 81–100% of PBA-eligible practices	**3.5%** of Total Primary Care Payment
Practices performing above nationwide benchmark, but below top 50% of practices	**3.5%** of Total Primary Care Payment
Practices performing at or below nationwide minimum benchmark	**3.5%** of Total Primary Care Payment

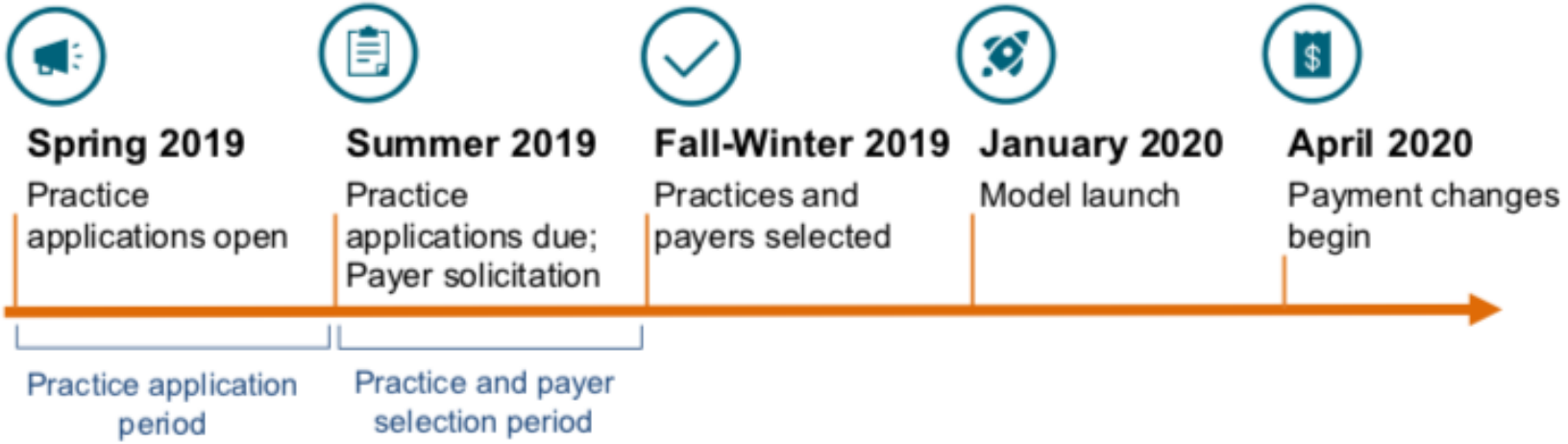
PCF Payer Partners

In PCF, CMS will encourage other payers to engage practices on similar outcomes. **CMS is soliciting interested payers starting in summer 2019.**

Multi-payer alignment promotes:

- An alternative to fee-for-service payments
- Performance-based incentive opportunity
- Practice- and participant-level data on cost, utilization, and quality
- Alignment on practice quality and performance measures
- Broadened support for seriously ill populations

Timeline



Prepare for model application release by confirming your organization's eligibility and willingness to participate today. Email our mailbox to join our listserv for updates on application release.

What Is Direct Contracting?

STROUDWATER

- 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

QUESTIONS?