State of the Healthcare Industry: Updates for Rural Strategy

NOSORH Quarterly Updates

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COVID-19 UPDATES

Immediate recommended/preferred course:

- Prepare cash forecast
- Immediately file for Accelerated/Advanced payments to support operations for next 90 days
- Recognize receipt of your organization’s Public Health and Social Services Emergency Fund (PHSSEF) Grant. $50B distributed on 4/10 and 4/24, $10B targeted rural allocation on 5/7, $10B targeted Covid-19 Hot Spot allocation, $10B targeted allocation on 6/9 and an additional $3B on 7/9 to safety net providers, and $1B targeted allocation on 7/9 for certain rural providers and other providers from small metropolitan areas, and submit information to support:
  - Incremental costs of COVID-19 patients
  - Lost revenue due to deferring elective services
  - Claims information for uninsured Covid-19 patients
- Recognize that additional grant revenue under the PHSSEF program will be distributed via an additional $75B with the passage of the Paycheck Protection Program and Health Care Enhancement Act
- Recognize Small and Rural Hospital Improvement Program (SHIP) grant
- Recognize receipt of Rural Health Clinic (RHC) funding for testing
- If applicable, reach out to local Small Business Administration (SBA) lenders and submit application to receive Paycheck Protection Forgivable Loan program (PPP) funds
- For organizations not eligible for SBA PPP program, evaluate payroll tax credits and deferrals
- File Federal Emergency Management Agency Request for Public Assistance document and begin tracking eligible costs
- Evaluate Economic Injury Disaster Loan (EIDL) and Emergency Economic Injury Grants (EEIG)
- Evaluate Main Street Lending program as source of additional capital
- Request 12-month principal and interest deferral on USDA Community Facilities Direct Loans
- Critical Access Hospitals (CAHs) to prepare interim prospective cost report and submit to Medicare Audit Contractors (MACs)
  - File updated Medicare rates with Medicare Advantage (MA) plans
- Negotiate Periodic Interim Payments (PIPs) with third party payers
- Work with bank to open and/or expand line of credit
Financial Projection

✓ Prepare 26-week, weekly cash flow projection to enable better short- and medium-term decision making

✓ Minimum of 26-week cash projection

• Necessary for hospitals to understand variables impacting cash including:
  ✓ Beginning cash balances
  ✓ Reduced volume (and possible increase) and timing of cash impact
  ✓ Increased expenses for personal protective equipment
  ✓ Cash impact on changing labor costs
  ✓ Changes in cash from CARES Act provisions
    ✓ Receipts and payments (i.e., accelerated payments, General and Targeted Distributions, Payroll Protection Program)
  ✓ Opportunity for other balance sheet accounts affecting cash
    ✓ Long-term debt

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Financial Projection

  - Beginning cash balance of $1.0M
  - COVID-19 Funding from Medicare accelerated payments, SBA PPP loan, PHSSEF and SHIP grants (other programs not included)
  - Assumed volume declined 50% beginning 3/15 and continuing through projection period
  - Assumed expenses remained constant during the projection period
  - After 26 weeks, cash was $6.9M, $5.9M greater than start

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Public Health and Social Services Emergency Grant Fund (PHSSEF)

- Recognize receipt of your organization’s Public Health and Social Services Emergency Fund (PHSSEF) Grant $50B distributed on 4/10 and 4/24, $10B targeted rural allocation on 5/7, $10B targeted Covid-19 Hot Spot allocation, $10B targeted allocation on 6/9 and an additional $3B on 7/9 to safety net providers, and $1B targeted allocation on 7/9 for certain rural providers and other providers from small metropolitan areas, and submit information to support.

- Recognize that additional grant revenue under the PHSSEF program will be distributed via an additional $75B with the passage of the Paycheck Protection Program and Health Care Enhancement Act.
  - Uncertainty regarding distribution method.

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PHSSEF Grants (continued)

- Qualifying expenses include all non-reimbursable expenses attributable to COVID-19 including:
  - Building or retrofitting new Intensive Care Units (ICUs)
  - Increased staffing or training
  - Personal Protective Equipment (PPE)
  - Building of temporary structures
  - Foregone revenue from cancelled procedures
    - Revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care
    - “HHS encourages the use of funds to cover lost revenue so that providers can respond to Covid-19 by maintaining healthcare delivery capacity”
POSSIBLE REVENUE RECOGNITION EXAMPLE

<table>
<thead>
<tr>
<th>ASSUMPTIONS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Covid Revenue</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Pre Covid Expense</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Cost-Based Payer Mix</td>
<td>50%</td>
</tr>
<tr>
<td>Payroll Protection Funds Received</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>PHSSEF Funds Received</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Covid Volume Change</td>
<td>-50%</td>
</tr>
<tr>
<td>Change in Expense due to Volume/Covid</td>
<td>-10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>Pre-Covid</th>
<th>PPP Funds (1)</th>
<th>Covid Exp Impact</th>
<th>Covid Rev Impact</th>
<th>Reduced Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Based</td>
<td>$15,000,000</td>
<td>$-</td>
<td>$-</td>
<td>$(4,000,000)</td>
<td>$11,000,000 (2)</td>
</tr>
<tr>
<td>Non Cost-Based</td>
<td>$15,000,000</td>
<td>$-</td>
<td>$-</td>
<td>$(7,500,000)</td>
<td>$7,500,000</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$30,000,000</td>
<td>$-</td>
<td>$-</td>
<td>$(11,500,000)</td>
<td>$18,500,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-Based</td>
<td>$15,000,000 $(2,500,000) $(1,500,000) $- $11,000,000</td>
</tr>
<tr>
<td>Non Cost-Based</td>
<td>$15,000,000 $(2,500,000) $(1,500,000) $- $11,000,000</td>
</tr>
<tr>
<td>Total Expense</td>
<td>$30,000,000 $(5,000,000) $(3,000,000) $- $22,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Margin:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$-</td>
<td>$5,000,000 $3,000,000 $(11,500,000) $3,500,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHSSEF Funds Received</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unused (Deficit of) PHSSEF Funds</td>
<td>$4,500,000</td>
</tr>
</tbody>
</table>

(1) PPP funds assumed as a reduction in allowable cost base
(2) Cost-based revenue is equal to cost-based expense under any volume or expense scenario

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PHSSEF Grants (continued)

- $10B allocated to rural hospitals and rural health clinics (RHCs) and rural Federally Qualified Health Centers (FQHCs)
- On 5/7, $10B allocated to rural hospitals, RHCs and rural FQHCs according to the following formula:
  - CAH and Rural PPS Providers
    - Base Payment ($3M on $10M of operating expense):
      - 50% of first $2M op exp = $1M
      - 40% of second $2M op exp = $.8M
      - 30% of third $2M op exp = $.6M
      - 20% of fourth $2M op exp = $.4M
      - 10% of fifth $2M op exp = $.2M
    - Add-on to base payment:
      - 2% of operating expense including the base portion (approximate 2%)
  - Rural Health Clinics
    - Freestanding RHCs: $103,253K each plus a 3.7% add-on payment
    - Provider-based RHC: No base per RHC (expenses included hospital expenses)
  - Federally Qualified Health Clinics
    - All Sites located in a rural area will receive $103,253K per site

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$13B targeted distribution ($10B on 6/9 and $3B on 7/10) allocated to safety net hospitals

- On 6/9, $10B allocated to safety net hospitals that met the following criteria:
  - Medicare disproportionate share (DSH) of 20.2%
  - Cost of bad debt and charity care greater than $25K per hospital bed
  - FY 2018 net profitability less than 3%
- On 7/9, an additional $3B allocated to safety net hospitals that met first two criteria and had less than 3% profitability averaged consecutively over two or more of the last five cost report periods.
Within 90 days of receipt of payments, providers must attest to receipt and accept terms and conditions which include, but are not limited to:

- Providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
Public Health and Social Services Emergency Grant Fund (PHSSEF)

PHSSEF Grants (continued)

- HHS Guidance on June 10, 2020
  - Providers have until June 3, 2020 to submit the following into portal and apply for a portion of the additional $20B general distribution:
    - An accounting of their annual revenue by submitting tax forms or financial statements; and
    - Agree to program Terms and Conditions
  - Providers that do not submit will no longer be eligible to receive additional funding from the general distribution fund
Small Business Association (SBA) Payroll Protection Program (PPP)

- **If applicable, submit application to Small Business Administration (SBA) Paycheck Protection Program (PPP) ($349B and an additional $310B with the passage of the Paycheck Protection Program and Health Care Enhancement Act)**
  
  - **Loans**
    - 2.5 times borrower’s average monthly payroll costs, not to exceed $10M
      - Note that payroll costs include salary, wages, vacation, payment for group healthcare benefits, and state and local taxes assessed on the compensation
    - Excluded costs include compensation of an individual in excess of an annual salary of $100K, as prorated for the period 2/15/20-6/30/20
  
  - **PPP Flexibility Act, signed into law on 6/5**
    - Extends covered period for forgiveness from 8 weeks to 24 weeks or 12/31
    - Extends the period for allowable uses of the loan from 6/30 to 12/31
    - 75% payroll requirement for amount to be forgiven reduced to 60%
    - Loan deferral has been extended from 6 months to the date on which the amount of forgiveness is determined or 10 months after the last day of the covered period if the borrow fails to apply for forgiveness
    - Loan maturity extended from two years to five years
    - Borrowers who applied for loan forgiveness can also take advantage of Section 2032 of Cares Act (Payroll tax delayed payment)

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Critical Access Hospitals (CAHs) Interim Cost Reports

✓ **File updated Medicare rates with Medicare Advantage plans to ensure appropriate revenue received from MA plans**

• As CAH volumes decline, unit costs increase as a result of 80%-90% of total costs are fixed or step-fixed
  • Further, increased personal protective equipment will increase variable costs in addition to total unit costs
• Cost-based payment rates with change with changes in volume and variable cost increases
• CAHs should prepare interim cost reports reflecting changes in volume and variable costs
  • Interim cost reports submitted to MACs so that future cash flow matches expected changes in unit cost structure

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Enhanced COVID Patient Payments

✓ **Recognize enhanced COVID patient payments**

- Enhanced COVID patient payments
  - **120% for inpatients**
    - 20% add-on for patient admitted with COVID-19 through duration of emergency period
  - **Telehealth services**
    - During emergency period, removes criteria that established patient and allows beneficiary to be seen in their home
    - Allows FQHCs and RHCs to act as distant sites
      - Payment rate to be $92, after reprocessing of claims in July 2020
      - Costs excluded from the RHC all-inclusive rate
  - **Discontinuation of Sequestration**
    - Temporary lift Medicare sequester from 5/1/20-12/31/20
  - **Delay Medicaid Disproportionate Share (DSH) reductions**
    - Delay implementation of State DSH reductions through 11/30/20
  - **RHC Productivity Standards Waiver**

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Grow Patient Volumes

✓ **Target grow in patient care services**
✓ **Recognize that your community has concerns about their safety in your hospital and proactively address these concerns**

- Actively communicate with community the steps your organization is taking to create a safe environment
- Fully engage telehealth for clinic visits
- Develop plan to restart elective surgeries/procedures

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COVID-19 Ravages Hospital Margins in April, Some Recovery in May - Kaufman Hall’s National Hospital Flash Report

<table>
<thead>
<tr>
<th>April Report:</th>
<th>May Report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Operating EBITDA margins for April fell 174% compared to the same period</td>
<td>• Operating EBITDA margins for May fell 9% compared to the same period last</td>
</tr>
<tr>
<td>last year and were down 118% from March</td>
<td>year and were up 105% from April</td>
</tr>
<tr>
<td>• Operating margins fell 282% year-over-year and 120% compared to March</td>
<td>• Operating margins fell 13% year-over-year but rose 100% compared to April</td>
</tr>
<tr>
<td>• Median hospital operating margins fell to –29%, as measured by the Kaufman</td>
<td>• Gross Revenue was up 29% from April but down 14% compared to 2019</td>
</tr>
<tr>
<td>Hall Hospital Operating Margin index</td>
<td></td>
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</tbody>
</table>

Telehealth Visits Skyrocket, With Benefits for Patient and Providers

- At the Washington-based Providence Medical Group, telehealth visits have skyrocketed from an average of 700/month to 70,000/week
- Telehealth providers at the same practice ramped up from 50 to 7000 within seven business days
- Both patients and providers noted benefits of telemedicine, including:
  - A Sanford Health patient whose endocrinology visits typically took two hours with the commute, now reduced to 30 minutes
  - Providers reporting more time available to spend with their families
- Industry leadership expressed that higher telehealth utilization would likely last under fully capitated payment models, citing reimbursement issues as the reason telehealth had not previously grown at this level

“Initially, a lot of providers were against telemedicine because they weren’t getting enough work (relative value units) or didn’t think it was good for patients...But telehealth is tailoring care to both patients and individual physicians. The crisis brought them together.

Dr. Allison Suttle, chief medical officer at Sioux Falls, S.D.-based Sanford Health
Report Predicts Up to $250B of US Healthcare Spend Could Shift to Virtual

- The increase in telehealth use due to the COVID-19 pandemic could shift about $250B to virtual care, per a recent McKinsey report.
- According to the report, about 20 percent of all Medicare, Medicaid and commercial operating expenses, office and home health spend could potentially be virtualized.
- Report insights include:
  - 20% of emergency department visits could potentially be avoided by offering virtual urgent care services.
  - 24% of healthcare office visits and outpatient encounters could be delivered virtually, and an additional 9 percent could be delivered "near-virtually" at a retail clinic or testing site.
  - 35% percent of home health services could be virtualized.
  - 2% of all outpatient office visits could be moved to the patients' home setting through tech-enabled medication administration services.

FCC to Add $197 Million for Rural Telemedicine (6/30/2020)

• FCC added an additional $197.9M in funding to its Rural Health Care Program, which gives rural providers access to broadband and telecommunications services.

• FCC officials have underscored the agency’s commitment to telemedicine, which has been a lifeline for rural providers and patients during the COVID-19 pandemic.

• The program now totals $802.74 million in funding for eligible healthcare providers in 2020 and is the highest funding amount the FCC has offered through the Rural Health Care Program in the program's history.

Source: Modern Healthcare, FCC adds $197 million to rural telemedicine program, Jessica Kim Cohen, 6/30/20
https://www.modernhealthcare.com/information-technology/fcc-adds-197-million-rural-telemedicine-program
On 4/30/20, CMS issued a round of sweeping regulatory waivers and rule changes that “gives individuals and entities that provide services to Medicare, Medicaid, Basic Health Program, and Exchange beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the coronavirus disease 2019 (COVID-19)”. Changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS’s efforts to further expand beneficiaries’ access to telehealth services.
New Rules to Support and Expand COVID-19 Diagnostic Testing for Medicare and Medicaid Beneficiaries

- Under the new waivers and rule changes, Medicare will no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests required as part of a COVID-19 diagnosis.
- Pharmacists can work with a physician or other practitioner to provide assessment and specimen collection services, and the physician or other practitioner can bill Medicare for the services.
  - Pharmacists also can perform certain COVID-19 tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist’s scope of practice and state law.
  - With these changes, beneficiaries can get tested at “parking lot” test sites operated by pharmacies and other entities consistent with state requirements.


New Rules to Support and Expand COVID-19 Diagnostic Testing for Medicare and Medicaid Beneficiaries

- CMS will pay hospitals and practitioners to assess beneficiaries and collect laboratory samples for COVID-19 testing and make separate payment when that is the only service the patient receives.

- CMS is announcing that Medicare and Medicaid are covering certain serology (antibody) tests, which may aid in determining whether a person may have developed an immune response and may not be at immediate risk for COVID-19 reinfection.
  - Medicare and Medicaid will cover laboratory processing of certain FDA-authorized tests that beneficiaries self-collect at home.
Increase Hospital Capacity - CMS Hospitals Without Walls

- CMS is giving providers flexibility during the pandemic to increase the number of beds for COVID-19 patients while receiving stable, predictable Medicare payments.
  - Hospital systems that include rural health clinics can increase their bed capacity without affecting the rural health clinic’s payments.
- CMS is highlighting flexibilities that allow payment for outpatient hospital services -- such as wound care, drug administration, and behavioral health services -- that are delivered in temporary expansion locations, including parking lot tents, converted hotels, or patients’ homes (when they’re temporarily designated as part of a hospital).

Healthcare Workforce Augmentation

• Since beneficiaries may need in-home services during the COVID-19 pandemic, **nurse practitioners, clinical nurse specialists, and physician assistants can now provide home health services**, as mandated by the CARES Act.

• CMS is allowing physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants in outpatient settings.

• CMS is waiving a requirement for ambulatory surgery centers to periodically reappraise medical staff privileges during the COVID-19 emergency declaration.


Further Expand Telehealth in Medicare

- For the duration of the COVID-19 emergency, **CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services.**
  - Practitioners such as physical therapists, occupational therapists, and speech language pathologists can provide telehealth services.
- Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital.
- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

Further Expand Telehealth in Medicare

• As mandated by the CARES Act, **CMS is paying for Medicare telehealth services provided by rural health clinics and federally qualified health clinics.**

• Since some Medicare beneficiaries don’t have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services.


CMS Adjusts Innovation Models in Response to COVID-19

- In response to the COVID-19 pandemic, CMS has adjusted certain Innovation Center models as follows to increase flexibility, ensure equity and consistency, and minimize risk and reporting burden.
- Adjusted models include Bundled Care, ESRD Care, Joint Replacement (CJR), Kidney Care Choices, Home Health Value-Based Purchasing, and others.
- Detail for selected models below.

<table>
<thead>
<tr>
<th>Model</th>
<th>Financial Methodology Changes</th>
<th>Quality Reporting Changes</th>
<th>Timeline Changes</th>
</tr>
</thead>
</table>
| Direct Contracting     | Adjust model to reflect change in duration of 2021 Performance Period due to April 1, 2021 start | Adjust quality benchmarks, if necessary, to reflect change in duration of 2021 Performance Period due to April 1, 2021 start | • Delay start of the first Performance Period for cohort #1 to April 1, 2021  
• Create application cycle during 2021 for second cohort to launch January 1, 2022 |

### CMS Adjusts Innovation Models in Response to COVID-19, cont.

<table>
<thead>
<tr>
<th>Model</th>
<th>Financial Methodology Changes</th>
<th>Quality Reporting Changes</th>
<th>Timeline Changes</th>
</tr>
</thead>
</table>
| Medicare ACO Track 1+ Model  | • Remove episodes of care for treatment of COVID-19  
• Medicare Shared Savings Program Extreme and Uncontrollable Circumstances policy applies to 2020 financial reconciliation | • 2019 Web Interface quality measure reporting deadline extended from March 31, 2020 to April 30, 2020  
• Medicare Shared Savings Program Extreme and Uncontrollable Circumstances policy applies to 2019 and 2020 reporting  
• Continue to monitor impact on 2020 quality reporting | Extend model through December 2021                                                      |
| Next Generation ACO (NGACO)  | • Reduce 2020 downside risk by reducing shared losses by proportion of months during the PHE.  
• Cap NGACOs’ gross savings upside potential at 5% gross savings  
• Remove episodes of care for treatment of COVID-19  
• Use retrospective regional trend, rather than prospective, for 2020 Remove 2020 financial guarantee requirement | • 2019 Web Interface quality measure reporting deadline extended from March 31, 2020 to April 30, 2020  
• 2019 quality audit canceled  
• Continue to monitor impact on 2020 quality reporting | Extend model through December 2021                                                      |
| Primary Care First—Serious Illness Component | No change                                                                                     | No change                                                                              | Delay implementation of the start of the Performance Period for the Serious Illness component until April 1, 2021; Primary Care First only component will still start on January 1, 2021 |
REGULATORY/LEGISLATIVE UPDATES
Price Transparency: CMS Announces the 70 Services Hospitals Must Post Online (2/12/2020)

- CMS’s healthcare price transparency rule, finalized in November 2019, requires hospitals to post online the rates they negotiate with insurers for 300 “shoppable services” that can be scheduled directly and in advance by the consumer.
- Seventy of the services are mandated by CMS, while hospitals may choose the remaining 230 services.
- The CMS mandated services include the following:

**Evaluation and Management Services**

1. Psychotherapy, 30 minutes (90832)
2. Psychotherapy, 45 minutes (90834)
3. Psychotherapy, 60 minutes (90837)
4. Family psychotherapy, not including patient, 50 minutes (90846)
5. Family psychotherapy, including patient, 50 min (90847)
6. Group psychotherapy (90853)
7. New patient office or other outpatient visit, typically 30 min (99203)
8. New patient office of other outpatient visit, typically 45 min (99204)
9. New patient office of other outpatient visit, typically 60 min (99205)
10. Patient office consultation, typically 40 min (99243)
11. Patient office consultation, typically 60 min (99244)
12. Initial new patient preventive medicine evaluation, for those ages 18 to 39 (99385)
13. Initial new patient preventive medicine evaluation, for those ages 40 to 64 (99386)

Source: Becker’s Hospital Review, The 70 CMS-mandated services hospitals must post online next year, Alia Paavola, 2/13/20 https://www.beckershospitalreview.com/finance/the-70-cms-mandated-services-hospitals-must-post-online-next-year.html
## Laboratory and Pathology Services

<table>
<thead>
<tr>
<th>14.</th>
<th>Basic metabolic panel (80048)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Blood test, comprehensive group of blood chemicals (80053)</td>
</tr>
<tr>
<td>16.</td>
<td>Obstetric blood test panel (80055)</td>
</tr>
<tr>
<td>17.</td>
<td>Blood test, lipids (80061)</td>
</tr>
<tr>
<td>18.</td>
<td>Kidney function panel test (80069)</td>
</tr>
<tr>
<td>19.</td>
<td>Liver function blood test panel (80076)</td>
</tr>
<tr>
<td>20.</td>
<td>Manual urinalysis test with examination using microscope (81000 or 81001)</td>
</tr>
<tr>
<td>21.</td>
<td>Automated urinalysis test (81002 or 81003)</td>
</tr>
<tr>
<td>22.</td>
<td>Prostate specific antigen (84153 or 84154)</td>
</tr>
<tr>
<td>23.</td>
<td>Blood test, thyroid stimulating hormone (84443)</td>
</tr>
<tr>
<td>24.</td>
<td>Complete blood cell count, with differential white blood cells, automated (85025)</td>
</tr>
<tr>
<td>25.</td>
<td>Complete blood count, automated (85027)</td>
</tr>
<tr>
<td>26.</td>
<td>Blood test, clotting time (85610)</td>
</tr>
<tr>
<td>27.</td>
<td>Coagulation assessment blood test (85730)</td>
</tr>
</tbody>
</table>

## Radiology Services

| 28. | CT scan, head or brain, without contrast (70450) |
| 29. | MRI scan of brain before and after contrast (70553) |
| 30. | X-Ray, lower back, minimum four views (72110) |
| 31. | MRI scan of lower spinal canal (72148) |
| 32. | CT scan, pelvis, with contrast (72193) |
| 33. | MRI scan of leg joint (73721) |
| 34. | CT scan of abdomen and pelvis with contrast (74177) |
| 35. | Ultrasound of abdomen (76700) |
| 36. | Abdominal ultrasound of pregnant uterus, greater or equal to 14 weeks 0 days, single or first fetus (76805) |
| 37. | Ultrasound pelvis through vagina (76830) |
| 38. | Mammography of one breast (77065) |
| 39. | Mammography of both breasts (77066) |
| 40. | Mammography, screening, bilateral (77067) |

## Medicine and Surgery Services

| 41. | Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities (216) |
| 42. | Spinal fusion except cervical without major comorbid conditions or complications (460) |
| 43. | Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (470) |
| 44. | Cervical spinal fusion without comorbid conditions or major comorbid conditions or complications (473) |
| 45. | Uterine and adnexa procedures for non-malignancy without comorbid conditions or major comorbid conditions or complications (743) |
| 46. | Removal of 1 or more breast growth, open procedure (19120) |
| 47. | Shaving of shoulder bone using an endoscope (29826) |
| 48. | Removal of one knee cartilage using an endoscope (29881) |
| 49. | Removal of tonsils and adenoid glands patient younger than age 12 (42820) |
| 50. | Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope (43235) |
| 51. | Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope (43239) |
| 52. | Diagnostic examination of large bowel using an endoscope (45378) |
| 53. | Biopsy of large bowel using an endoscope (45380) |
| 54. | Removal of polyps or growths of large bowel using an endoscope (45385) |
| 55. | Ultrasound examination of lower large bowel using an endoscope (45391) |
| 56. | Removal of gallbladder using an endoscope (47562) |
| 57. | Repair of groin hernia patient age 5 or older (49505) |
| 58. | Biopsy of prostate gland (55700) |
| 59. | Surgical removal of prostate and surrounding lymph nodes using an endoscope (55866) |
| 60. | Routine obstetric care for vaginal delivery, including pre-and post-delivery care (59400) |
| 61. | Routine obstetric care for cesarean delivery, including pre-and post-delivery care (59510) |
| 62. | Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care (59610) |
| 63. | Injection of substance into spinal canal of lower back or sacrum using imaging guidance (62322 or 62323) |
| 64. | Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance (64483) |
| 65. | Removal of recurrent cataract in lens capsule using laser (66821) |
| 66. | Removal of cataract with insertion of lens (66984) |
| 67. | Electrocardiogram, routine, with interpretation and report (93000) |
| 68. | Insertion of catheter into left heart for diagnosis (93452) |
| 69. | Sleep study (95810) |
| 70. | Physical therapy, therapeutic exercise (97110) |
Hospitals Lose Price Transparency Lawsuit (6/23/2020)

• U.S. District Judge Carl Nichols in Washington D.C. sided with the Trump administration and ruled that starting 1/1/21, HHS can force hospitals to reveal the prices they negotiate with insurers for healthcare services.

• The AHA had claimed the rule would violate hospitals’ First Amendment rights and would negatively affect hospitals’ negotiations with payers, potentially increasing costs.

• Nichols argued that "that informed customers would put pressure on providers to lower costs and increase the quality of care."

• The AHA plans to appeal the decision.

<table>
<thead>
<tr>
<th>REVENUE CPT</th>
<th>DESCRIPTION</th>
<th>CHARGE</th>
<th>CAH COINS</th>
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<td>$176.45</td>
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</table>
The proposed rule would raise Medicare payment rates for acute care hospitals.

Per CMS, the rule “focuses the agency’s efforts on a singular objective: transforming the healthcare delivery system through competition and innovation to provide patients with better value and results.”

Changes to CMS Hospital Star Ratings are on hold due to the COVID-19 pandemic.

FY 2021 Medicare Hospital IPPS Proposed Rule (CMS-1735-P) (continued)

• Building on the **price transparency rule** it finalized last year, CMS proposes to require hospitals to list their median payer-specific negotiated rates for inpatient services by Medicare Severity-Diagnosis Related Group on Medicare cost reports.

• In addition, the agency is **requesting information regarding the potential use of these data to set relative Medicare payment rates for hospital procedures.**

Sources: cms.gov Fact Sheet: Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P), May 11, 2020; Becker's Hospital Review, CMS' proposed inpatient payment rule for 2021: 8 things to know, Ayla Ellison, May 12, 2020; Field experience of Stroudwater consultants
Payment Rate Update

- The increase in operating payment rates for STACH paid under the IPPS that successfully participate in the (IQR) Program and are meaningful EHR users is approximately 3.1 percent
  - +3.0% Market basket 3%
  - -0.4% Productivity Adjustment
  - +0.5% Required by legislation
  - =3.1%

<table>
<thead>
<tr>
<th></th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User</th>
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<tr>
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<td>Proposed MFP Adjustment under Section 1886(b)(3)(B)(xii) of the Act</td>
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<td>Proposed Applicable Percentage Increase Applied to Standardized Amount</td>
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<td>0.35</td>
<td>1.85</td>
<td>-0.4</td>
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</tbody>
</table>

### Disproportionate Share Hospital payments

- CMS proposes distributing roughly $7.8B in uncompensated care payments in FY 2021, a decrease of approximately $0.5B from FY 2020.
- CMS proposes to use a single year of data on uncompensated care costs from Worksheet S-10 of the FY 2017 cost report to distribute these funds, in part because they have conducted audits of this data.
- In addition, CMS is proposing for all eligible hospitals, except Indian Health Service and Tribal hospitals, to use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments for all subsequent fiscal years.

### Hospital-Acquired Conditions (HAC) Reduction Program

- Incentivizes hospitals to reduce the incidence of hospital-acquired conditions by reducing payment by 1% for hospitals that rank in the worst-performing quartile.
- CMS is proposing to:
  - Automatically adopt performance periods for measures beginning with the FY 2023
  - Refine validation procedures used by the Program to align with the Hospital IQR Program’s validation procedures

 Administration urged a panel of three federal appeals judges to defer to HHS and resurrect its site-neutral payment policy for office visits.

Per Department of Justice attorney Alisa Klein, Congress gave HHS the power to reduce the number of office visits taking place in hospital outpatient departments, which increase taxpayer spending under Medicare's outpatient prospective payment system.

- Klein argues to the panel that since Congress defined site-neutral payment methods broadly under the Medicare statute, the justices should defer to HHS’s interpretation of the law.

Last fall, in a win for hospitals, U.S. District Judge Rosemary Collyer rejected this argument and ruled that HHS did not have the authority to change reimbursement rates to lower utilization and that the law required payment changes to be budget-neutral.

- Two final rules passed on 3/9/2020
  - ONC’s Cures Act Final Rule
    - Finalizes the reasonable and necessary activities that do not constitute information blocking and establishes new rules to prevent information blocking
    - Advances common data through US Core Data for Interoperability (USCDI)
    - Establishes secure, standards-based application programming interface requirements
  - CMS Interoperability and Patient Access Final Rule
    - Intended to improve patients’ access to their health information by requiring health plans to share claims data electronically with patients
    - Establishes new condition of participation for hospitals requiring them to send electronic notifications to another healthcare facility or provider when a patient is admitted, discharged, or transferred
    - Requiring states to send enrollee data daily beginning 4/2022 for beneficiaries enrolled in Medicare and Medicaid
  - As part of the MyHealthEData initiative, these final rules are focused on driving interoperability and patient access to health information by liberating patient data using CMS authority to regulate Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFE).

- CMS-regulated payers are required to implement and maintain a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice.

- CMS-regulated payers noted above (except QHP issuers on the FFES) are required by this rule to make provider directory information publicly available via a standards-based API.

- CMS-regulated payers are required to exchange certain patient clinical data (specifically the U.S. Core Data for Interoperability (USCDI) version 1 data set) at the patient’s request, allowing the patient to take their information with them as they move from payer to payer over time to help create a cumulative health record with their current payer.

- States must exchange certain enrollee data for individuals dually eligible for Medicare and Medicaid, including state buy-in files and “MMA files” daily instead of monthly.


- Beginning in late 2020 and starting with data collected for the 2019 performance year data, CMS will publicly report eligible clinicians, hospitals, and critical access hospitals (CAHs) that may be information blocking based on how they attested to certain Promoting Interoperability Program requirements.
- CMS will begin publicly reporting in late 2020 those providers who do not list or update their digital contact information in the National Plan and Provider Enumeration System (NPPES).
- CMS is modifying Conditions of Participation (CoPs) to require hospitals, including psychiatric hospitals and CAHs, to send electronic patient event notifications of a patient’s admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner.

OTHER MARKET UPDATES
The Biden-Sanders Unity Task Force released a report outlining healthcare policy recommendations. Significant recommendations include:

- **Public insurance option**
  - Be open to all Americans regardless of whether they were offered insurance through their employer, and low-income Americans ineligible for Medicaid would be enrolled automatically.
  - Achieve cost savings by negotiating prices with doctors and hospitals, “just like Medicare.”

- **Crackdown on healthcare M&A**
  - To lower healthcare costs, the report recommends pursuing antitrust lawsuits against hospital, insurance and pharmaceutical companies.

Other recommendations include:

- Lowering Medicare eligibility to the age of 60
- Ensuring free COVID-19 testing, treatment and vaccines for patients
- Allowing Medicare to negotiate drug prices tied to prices charged internationally, and capping out-of-pocket drug costs
- Paying healthcare workers at least $15 per hour, and addressing racial inequities in healthcare

MedPAC March 2020 Report to Congress: Highlights

Key takeaways from the March 2020 MedPAC report include:

- Medicare payroll tax to be immediately raised from 2.9% to 3.7% or Part A spending to be reduced by 18%
- MedPAC recommends Congress update 2020 inpatient and outpatient payment rates by 2% for 2021
- MedPAC recommends a Hospital Value incentive program (HVIP) that aligns with 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 2021 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, 2020
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0
Medicare Margins by Hospital Type

Source: MedPAC Report to Congress, March 15, 2020
MedPAC March 2020 Report to Congress: Hospital Payment Updates

• Background
  • In 2018, hospitals aggregate Medicare margin was -9.3%
    • Medicare margin for efficient providers was -2%
  • 2020 aggregate Medicare margin is projected to improve to -8% because of increases in case mix and growth in outpatient drugs with high margins due to 340B
  • During FY 2018, inpatient payments increased by 1.1% and outpatient payments increased by 7.3%
    • 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 2021, 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, 2020
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0
MedPAC March 2020 Report to Congress: Medicare Challenges

• Long-Running Medicare Challenges include:
  • Medicare’s payments for some types of providers are excessive
    • Medicare margins high for freestanding home health agencies, inpatient rehab, hospice providers, freestanding SNFs, and Part B 340B drugs
    • Recommendation: Better align payments with costs
  • Medicare pays higher prices in some care settings than others – for the same service
    • Recommendation: Make payments site neutral
  • Medicare undervalues primary care and overvalues specialty care
    • Recommendation: Improve the accuracy of payments and increase payments to primary care
  • Medicare is required to pay providers’ claims, regardless of clinical appropriateness
    • Recommendation: Scrutinize claims more closely
  • FFS Medicare lacks strong incentives to improve population-based outcomes and the coordination of care
    • Recommendation: Incentivize improving population-based outcomes, develop new payments for care coordination, and adopt value-based payment programs based on meaningful measures

Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2020
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0
Per MedPAC’s 2020 Annual Report to Congress, *Medicare should move quickly from fee-for-service to “payment to accountable systems of care” or face out-of-control costs*

MedPAC recommended Medicare Advantage and accountable care organizations as models.

The commission plans to start researching specific ways to accelerate Medicare's transition to value-based payment and will make specific recommendations.

Medicare is expected to grow from 3.6% of GDP in 2018 to 4.7% of GDP in 2027, but there will be just 2.5 workers per Medicare beneficiary in 2029 compared with 3 workers for every enrollee in 2019. This situation would leave Medicare financially unsustainable.

"Under an improved Medicare program, most beneficiaries would be able to opt to receive their care through accountable entities," MedPAC said. "Medicare could design incentives that encourage beneficiaries to choose one of these entities and give providers incentives to participate in them."

Source: Modern Healthcare, *MedPAC: Medicare needs to move faster to value-based payment*, Michael Brady, 6/15/20

June 2020 MedPAC Annual Report: Major Considerations

- **Realizing the promise of value-based payment in Medicare: An agenda for change.** The Commission outlines a multiyear effort to lay out a strategic direction for Medicare payment policy and delivery system design that broaden the use of value-based payment.

- **Challenges in maintaining and increasing savings from accountable care organizations (ACOs).** The Commission evaluates past savings, examines strategies to increase savings, and recommends a technical change that will reduce the risk that program vulnerabilities might result in unwarranted shared savings payments to ACOs.

- **Replacing the Medicare Advantage quality bonus program.** Medicare’s quality bonus program (QBP) for assessing and rewarding quality performance in the Medicare Advantage (MA) program is flawed and not consistent with the Commission’s principles for quality incentive programs. In this report, the Commission recommends that the Congress replace the QBP with an MA–VIP that includes five key design elements.

The COVID-19 pandemic has further awakened the US to the severe access and resources challenges that rural hospitals were already facing before the pandemic hit.

The Bipartisan Policy Center’s (BPC) Rural Health Task Force has developed recommendations to stabilize the rural health care system over the long term.

The Task Force consists of healthcare experts, business leaders, and elected officials.

The goals were to stabilize rural health infrastructure, promote value-based and virtual care, and increase access to local providers.
### BPC Rural Health Task Force Policy Recommendations: STABILIZING AND TRANSFORMING RURAL HEALTH CARE INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Provide immediate financial relief to rural hospitals.</th>
<th>Make certain rural hospital designations or payment adjustments permanent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide rural hospitals <strong>relief from Medicare sequestration payment reductions</strong> (from FY2021-2023) and <strong>Medicare bad debt payment reductions</strong> (from FY2021-2023).</td>
<td>• Take rural facilities out of the ongoing extender and needing to be renewed cycle.</td>
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<tr>
<td>• Increase reimbursement for Medicare Critical Access Hospital, or CAH, services by 3% starting in FY2021.</td>
<td>• Make the Medicare Dependent Hospital designation permanent.</td>
</tr>
<tr>
<td>• Re-establish the CAH necessary provider designation process.</td>
<td>• Make permanent adjustments for rural hospitals receiving low-volume payments.</td>
</tr>
<tr>
<td>• Make available capital infrastructure grants or loans that rural hospitals could use to modify service lines or improve structural or patient safety.</td>
<td>• Allow Sole Community Hospitals to permanently receive additional payment for outpatient services.</td>
</tr>
</tbody>
</table>

BPC Rural Health Task Force Policy Recommendations: STABILIZING AND TRANSFORMING RURAL HEALTH CARE INFRASTRUCTURE

Allow new flexibilities around rural hospital care delivery and expand opportunities for rural hospitals and clinics to coordinate service offerings.

- Evaluate whether to modify and update the CAH 96-hour patient length of stay rule and provide increased flexibility around physician certification requirements.
- Clarify rules around co-location or shared space agreements that allow rural hospitals to partner with other health care providers.
- Enact payment reforms to shore up rural health clinics and expand access to advanced practice clinician services in rural clinics.
- Increase the Medicare-capped reimbursement rate for physician-owned rural health clinics.
- Allow advanced practice clinicians to work up to their state scope of practice in rural health clinics.
### Support rural communities in conducting a community needs assessment and developing an action plan.

- Establish a process for rural facilities and communities to develop a Hospital Transformation Plan as a first step in the transformation process.

### Establish a Series of New Rural Transformation Models.

- Establish a new Rural and Emergency Outpatient Hospital designation that recognizes the shift away from inpatient centric care.
- Establish an Extended Rural Services Program.
- Advance new multi-payer, global budget models.
- Promote Centers for Medicare and Medicaid Innovation, or CMMI, initiatives to increase coordination and integration of rural hospital and clinic services.

### Support Opportunities to Advance Rural Health Care Quality.

- Require all rural hospitals to begin reporting on a core set of rural relevant quality measures.
- Study and offer recommendations on establishing a quality reporting program for rural health clinics.

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## BPC Rural Health Task Force Policy Recommendations: TRANSFORMING CLINICIAN PAYMENT AND DELIVERY IN RURAL AREAS

### Eliminate Barriers to the Adoption of Value-Based Care
- Exempt chronic care management services from beneficiary cost-sharing
- Exempt rural Medicare beneficiaries from the prohibition against same-day services.
- Increase the number of rural-specific CMMI demonstrations and expedite national expansion of promising models.
- Leverage patient engagement incentives to decrease rural bypass and incentivize local care utilization.

### Improve reimbursement for clinicians practicing in rural areas.
- Provide a nominal payment update for rural clinicians reporting data under the Quality Payment Program.
- Extend bonus payments for new advanced Alternative Payment Model participants.
- Exclude enrolled accountable care organization beneficiaries when determining the regional benchmark in rural areas.
- Evaluate Merit-based Incentive Payment System, or MIPS, data to ensure that rural providers are not disadvantaged by the structure of the program.

### Reduce administrative burden for providers.
- Direct CMS to utilize readily available claims data to assess quality performance.
- Decrease qualifying participation thresholds for rural providers operating under advanced Alternative Payment Models, Rural Health Clinics, and Federally Qualified Health Centers.

### BPC Rural Health Task Force Policy Recommendations:  
ENSURING AN ADEQUATE RURAL HEALTH CARE WORKFORCE

<table>
<thead>
<tr>
<th>Improve utilization of currently available workforce.</th>
<th>Strengthen the Health Resources and Services Administration rural workforce programs.</th>
<th>Expand federal rural workforce recruitment and retention initiatives.</th>
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</thead>
</table>
| • Evaluate the potential effect of expanding reimbursement to additional types of providers in rural and Native communities.  
• Add marriage and family therapists and licensed mental health counselors to the list of Medicare-covered providers.  
• Remove regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.  
• Eliminate the U.S. Drug Enforcement Administration, or DEA, buprenorphine waiver requirement.  
• Direct CMS to assign a medical specialty to advanced practice nurses and physician assistants. | • Require a comprehensive evaluation of all rural HRSA programs.  
• Allow federal funding for Rural Training Tracks to be dispersed prior to the program start date. | • Exempt Indian Health Service loan repayment funds from federal income tax.  
• Establish a federal tax credit for providers practicing in rural areas.  
• Reauthorize the J-1 visa waiver program and increase caps for doctors practicing in rural areas.  
• Direct the National Advisory Committee on Rural Health and Human Services to evaluate and develop recommendations for interagency coordination. |

Amazon’s Growing Healthcare Presence: A Timeline

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<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td>June 12, 2019</td>
<td>Amazon's online pharmacy PillPack is accused of violating customer privacy.</td>
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<tr>
<td>Sept. 24, 2019</td>
<td>Amazon launches Amazon Care, the company's virtual health clinic program for Seattle employees.</td>
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<tr>
<td>Oct. 30, 2019</td>
<td>Amazon partners with University of Texas Health Science Center at Houston, Cardinal Health and IT and Virtusa find best treatment and management strategies for subarachnoid hemorrhage and diabetes.</td>
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<tr>
<td>Nov. 4, 2019</td>
<td>Haven, the healthcare venture formed by Amazon, JPMorgan Chase and Berkshire Hathaway, begins testing some of its new insurance offerings on employees.</td>
</tr>
<tr>
<td>Nov. 26, 2019</td>
<td>Amazon and Pittsburgh-based supermarket and pharmacy chain Giant Eagle form a partnership that will allow Amazon Echo devices to offer Giant Eagle pharmacy patients medication reminders.</td>
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<tr>
<td>Dec. 2, 2019</td>
<td>Amazon Web Services announces it will launch a voice transcription service for physicians called Amazon Transcribe Medical.</td>
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<tr>
<td>March 9</td>
<td>Amazon pledges $1 million to a COVID-19 Response Fund in Washington's Puget Sound region.</td>
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<tr>
<td>March 24</td>
<td>Amazon joins 17 large health systems and tech companies to form the COVID-19 Healthcare Coalition, to coordinate pandemic response efforts using data analytics.</td>
</tr>
<tr>
<td>April 8</td>
<td>Amazon Web Services makes its COVID-19 data lake available to the public to support hospitals, researchers and public health officials.</td>
</tr>
<tr>
<td>May 28</td>
<td>CB Insights reports that Amazon’s next move could be launching a benefits marketplace for employers and payers.</td>
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</table>

Source: Becker’s Health IT, Amazon deepens its healthcare presence: A timeline of the past year, Jackie Drees, 6/9/20
Humana Launches Joint Venture to Expand Primary Care for Seniors (2/3/20)

- On 2/3/20, major insurer Humana announced plans to expand primary care centers for seniors through its subsidiary Partners in Primary Care, potentially doubling its current 47 locations in Kansas, Missouri, North Carolina, South Carolina, Texas and Florida.
- The expansion is a joint venture with private equity firm Welsh, Carson, Anderson & Stowe.
- Humana is the country’s second-largest provider of Medicare Advantage (MA) plans, and the move is likely a strategy to boost interest in its plans.
- Humana’s plan follows a similar announcement by UnitedHealthcare (the country’s largest MA provider) that it will open 14 Medicare service centers in Walgreens stores starting this year.

Rural Hospital Closures (7/15/2020)

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