# State of the Healthcare Industry: Updates for Rural

NOSORH Quarterly Updates for Rural Strategy

April 13, 2022

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# Panelist

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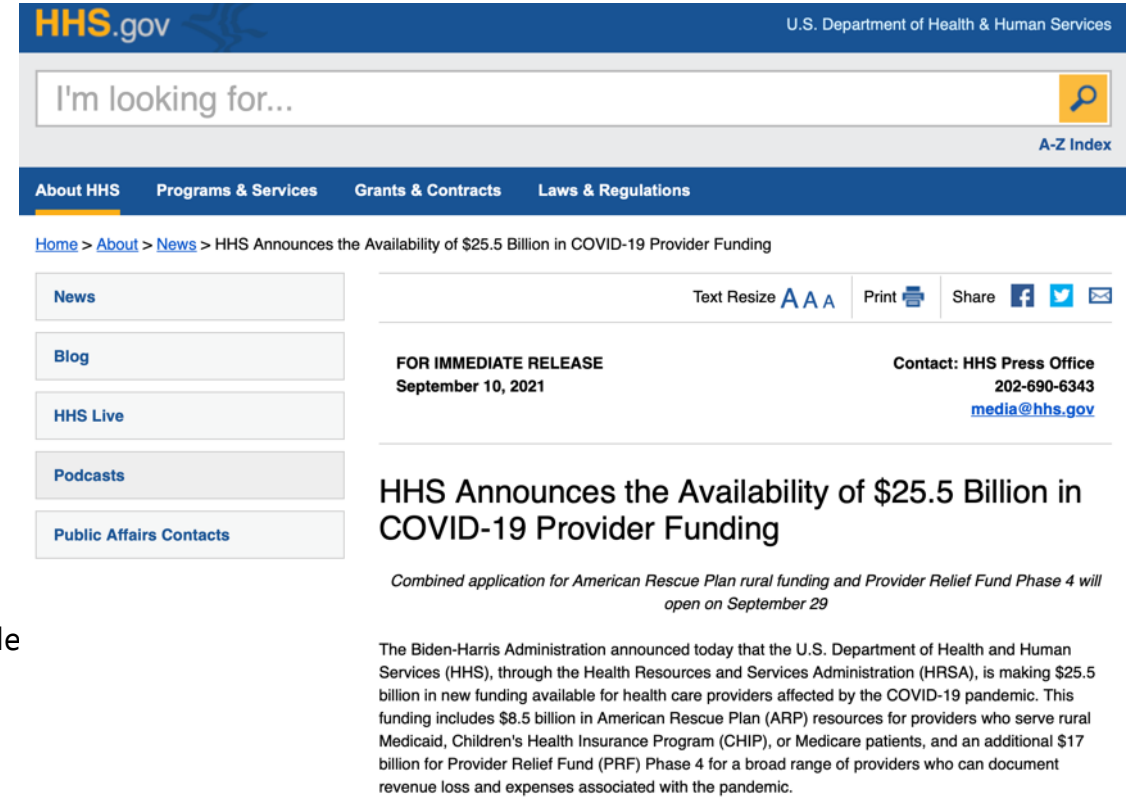
# Agenda

1. COVID-19 Updates
2. Legislative/Regulatory Updates
3. Other Market Events

# COVID-19 Updates

# Provider Relief Funds – Phase 4 General Distribution plus ARPA Rural Distribution (9/10/21)

- Phase 4 General Distribution - $17B
  - Based on providers lost revenue or changes in operating expenses between 7/1/20 - 3/31/21
  - Smaller providers to be reimbursed a higher % of lost revenue/higher expenses
  - Provide bonus payments based on services provided to Care, Caid, CHIPs
  - Will have until 12/31/22 to spend
  - 75% based on lost revenue/higher exp
    - Small providers will receive base payment plus supplement with smalle providers receiving highest supplement
    - No providers will receive more than 100% of lost rev/higher exp
  - 25% as bonus payments based on amount/type of services provided to Care/Caid/CHIP patients
    - Providers serving rural patients will receive a minimum payment



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FOR IMMEDIATE RELEASE
September 10, 2021

Contact: HHS Press Office
202-690-6343
media@hhs.gov

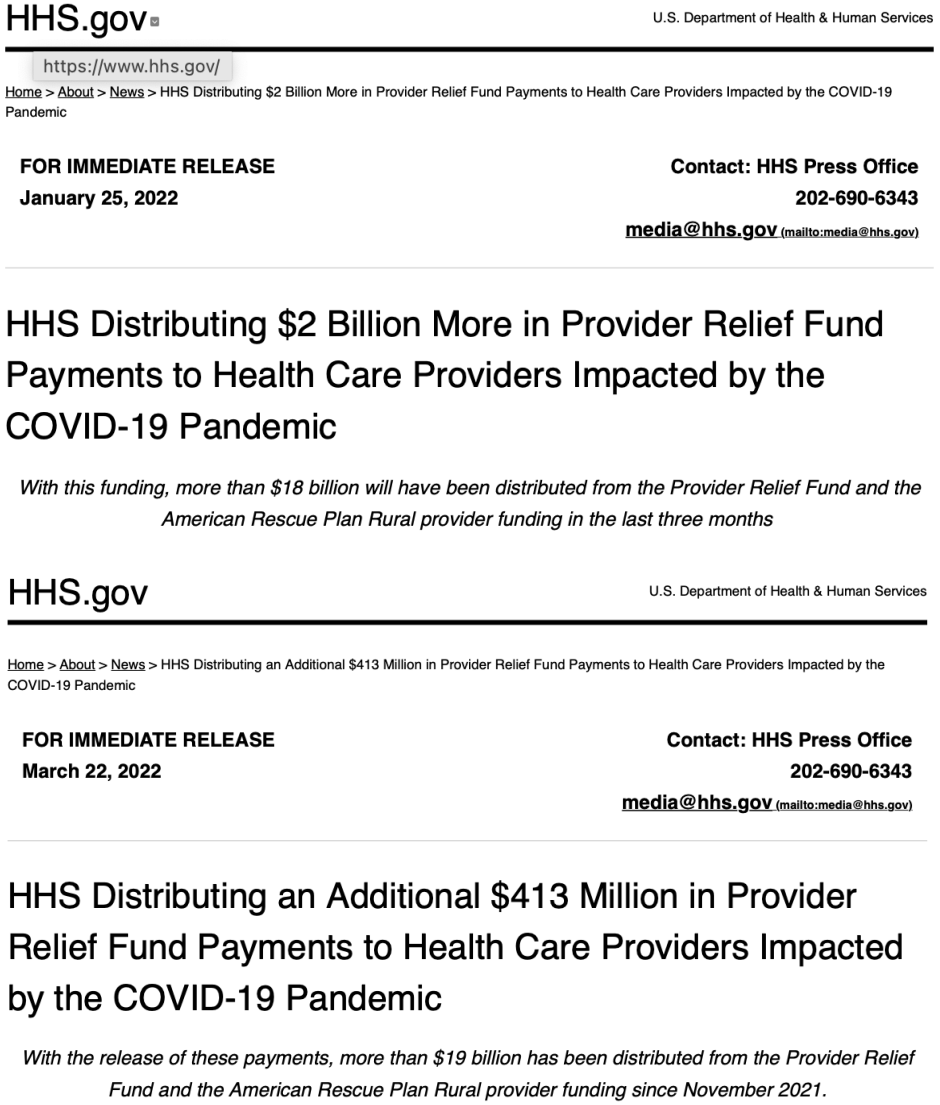
## HHS Announces the Availability of $25.5 Billion in COVID-19 Provider Funding

*Combined application for American Rescue Plan rural funding and Provider Relief Fund Phase 4 will open on September 29*

The Biden-Harris Administration announced today that the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is making $25.5 billion in new funding available for health care providers affected by the COVID-19 pandemic. This funding includes $8.5 billion in American Rescue Plan (ARP) resources for providers who serve rural Medicaid, Children's Health Insurance Program (CHIP), or Medicare patients, and an additional $17 billion for Provider Relief Fund (PRF) Phase 4 for a broad range of providers who can document revenue loss and expenses associated with the pandemic.

# Provider Relief Funds – Phase 4 General Distribution plus ARPA Rural Distribution (12/14/21, updated 3/22/22)

- Phase 4 General Distribution (continued)
  - $9B of the $17B to be distributed week of 12/14
    - Average payment amounts of $58K for small providers, $289K for medium providers, and $1.7M for large providers
  - $2B of the remaining $8B distributed week of 1/25
  - $413M distributed week of 3/22
  - PRF funds received during Q1 of 2022 can be used through 6/30/23
  - 89% of all Phase 4 applications have been processed



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

https://www.hhs.gov/

Home > About > News > HHS Distributing $2 Billion More in Provider Relief Fund Payments to Health Care Providers Impacted by the COVID-19 Pandemic

**FOR IMMEDIATE RELEASE**
**January 25, 2022**

**Contact: HHS Press Office**
**202-690-6343**
**media@hhs.gov** (mailto:media@hhs.gov)

HHS Distributing $2 Billion More in Provider Relief Fund Payments to Health Care Providers Impacted by the COVID-19 Pandemic

*With this funding, more than $18 billion will have been distributed from the Provider Relief Fund and the American Rescue Plan Rural provider funding in the last three months*

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

Home > About > News > HHS Distributing an Additional $413 Million in Provider Relief Fund Payments to Health Care Providers Impacted by the COVID-19 Pandemic

**FOR IMMEDIATE RELEASE**
**March 22, 2022**

**Contact: HHS Press Office**
**202-690-6343**
**media@hhs.gov** (mailto:media@hhs.gov)

HHS Distributing an Additional $413 Million in Provider Relief Fund Payments to Health Care Providers Impacted by the COVID-19 Pandemic

*With the release of these payments, more than $19 billion has been distributed from the Provider Relief Fund and the American Rescue Plan Rural provider funding since November 2021.*

# Provider Relief Funds – Phase 4 General Distribution plus ARPA Rural Distribution (11/23/21) (Continued)

- ARP Rural Distribution - $8.5B
  - Eligible to providers who serve Care/Caid/CHIP patients in rural areas
  - To promote equity, HHS will price Caid/CHIP claims data at Medicare rates
  - Providers serving patients in rural areas will receive a minimum payment
  - ARP rural payments cannot be allocated to non-rural subsidiaries
- $7.5B of the $8.5B Rural Distribution paid on 11/23/2021
  - ARP Rural payments are based on Medicare, Medicaid, and CHIP claims for services to rural beneficiaries from January 1, 2019 through September 30, 2020

HHS.gov

U.S. Department of Health & Human Services

Home > About > News > Biden-Harris Administration Begins Distributing American Rescue Plan Rural Funding to Support Providers Impacted by Pandemic

**FOR IMMEDIATE RELEASE**
**November 23, 2021**

**Contact: HHS Press Office**
**202-690-6343**
**media@hhs.gov** (mailto:media@hhs.gov)

## Biden-Harris Administration Begins Distributing American Rescue Plan Rural Funding to Support Providers Impacted by Pandemic

Today, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), began distributing $7.5 billion in American Rescue Plan (ARP) Rural payments to providers and suppliers who serve rural Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries. The Biden-Harris Administration is committed to providing much-needed relief to rural providers who historically operate on thin margins and have had their financial challenges further exacerbated during the pandemic. The average payment being announced today is approximately $170,700, with payments ranging from $500 to approximately $43 million. More than 40,000 providers in all 50 states, Washington, D.C., and six territories will receive ARP Rural payments.

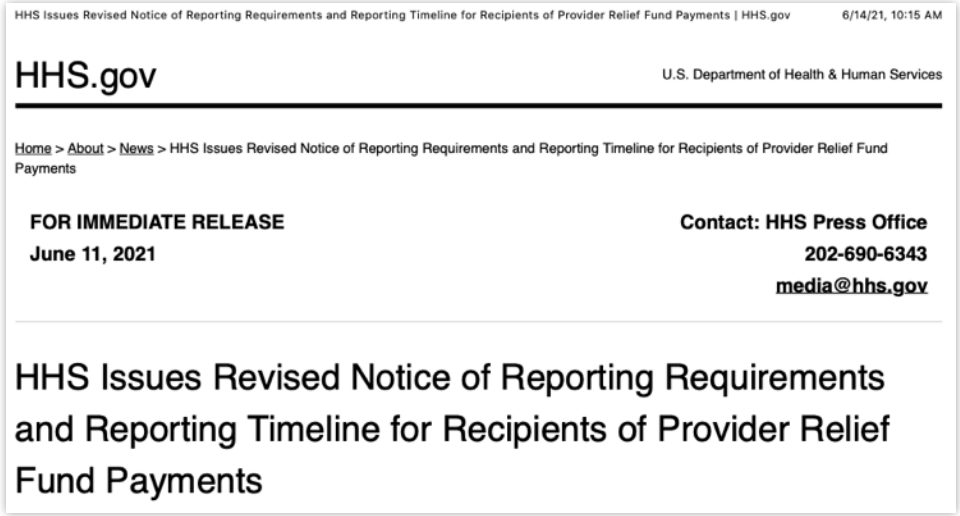
# Provider Relief Funds – Revenue Recognition

## PRF Grants

- 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"

# Provider Relief Funds Revised Notice of Reporting Requirements (6/11/2021 with 9/10/21 updates)

- Important Updates
  - Period of availability of funds based on the date payment is received
  - Recipients are required to report for each Payment Received Period in which they received greater than $10K
  - Recipients will have 90 days to complete reporting (rather than 30 days)
  - PRF reporting portal opened 7/1
  - Effective 9/10, Period 1 reporting was extended to November 30, 2021
- Reporting requirements do not pertain to
  - RHC Covid-19 Testing program,
  - Covid-19 Uninsured program, and
  - Covid-19 Coverage Assistance Fund



HHS Issues Revised Notice of Reporting Requirements and Reporting Timeline for Recipients of Provider Relief Fund Payments | HHS.gov 6/14/21, 10:15 AM

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

Home > About > News > HHS Issues Revised Notice of Reporting Requirements and Reporting Timeline for Recipients of Provider Relief Fund Payments

**FOR IMMEDIATE RELEASE**
**June 11, 2021**

**Contact: HHS Press Office**
**202-690-6343**
**media@hhs.gov**

HHS Issues Revised Notice of Reporting Requirements and Reporting Timeline for Recipients of Provider Relief Fund Payments

| | Payment Received Period (Payments Exceeding $10,000 in Aggregate Received) | Deadline to Use Funds | Reporting Time Period |
|---|---|---|---|
| Period 1 | From April 10, 2020 to June 30, 2020 | June 30, 2021 | July 1 to September 30, 2021 |
| Period 2 | From July 1, 2020 to December 31, 2020 | December 31, 2021 | January 1 to March 31, 2022 |
| Period 3 | From January 1, 2021 to June 30, 2021 | June 30, 2022 | July 1 to September 30, 2022 |
| Period 4 | From July 1, 2021 to December 31, 2021 | December 31, 2022 | January 1 to March 31, 2023 |

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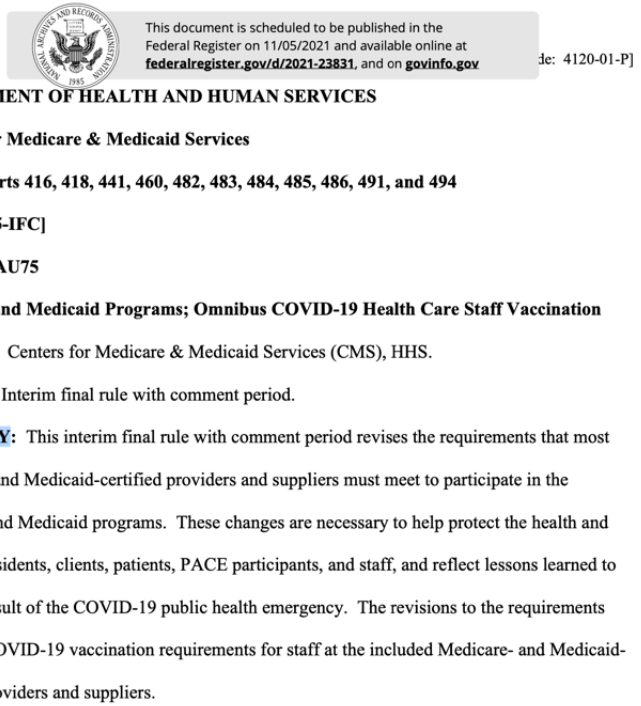
Source: HHS.Gov Press Office Immediate Release, June 11, 2021
https/www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-june-2021
https://www.bennet.senate.gov/public/index.cfm/press-releases?id=30B1B192-23CE-4DA6-A303-2CB458552BCA, July 28, 2021

# Covid 19 Health Care Staff Vaccination Interim Final Rule (IFR) (12/15/21)

- Requires applicable providers and suppliers to develop and implement policies and procedures under which all staff are vaccinated for COVID-19.
  - Individuals who provide services 100 percent remotely, such as fully remote telehealth or payroll services, are not subject to the vaccination requirements of this IFC.
  - Exemptions are allowed for certain conditions including vaccine allergies and religion,, but plans to be in place by provider to accommodate
  - This IFC directly applies only to the Medicare- and Medicaid-certified providers and suppliers. It does not directly apply to other health care entities, such as physician offices, that are not regulated by CMS.
- Effective Dates:
  - December 6th – Phase I (30 days post publication)
  - January 4th – Phase II (60 days post publication)
- Enforcement:
  - CMS may use enforcement remedies, such as civil monetary penalties, denial of payment, and even termination from the Medicare and Medicaid program as a final measure.
- **10/29 Update: Federal Judge in MO blocked enforcement of the IFR in 10 States based on mandate exceeded CMS's authority**
- **10/30 Update: US District Court judge in LA issues preliminary injunction halting rule**
- *11/30/2021 Update: Federal judge issued preliminary injunction to halt start of mandate*
- *12/13/2021 Update: 8th Circuit Court of Appeals upheld federal judge's preliminary injunction*
- **12/15 Update: 5th US Circuit Court of Appeals rules that prior court decision halting rule should only apply to states that had been part of the lawsuit reinstating mandate for 26 states**
- **1/13 Update: Supreme Court affirms vaccine mandate for healthcare workers**



This document is scheduled to be published in the Federal Register on 11/05/2021 and available online at **federalregister.gov/d/2021-23831**, and on **govinfo.gov**

de: 4120-01-P]

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 416, 418, 441, 460, 482, 483, 484, 485, 486, 491, and 494**

**[CMS-3415-IFC]**

**RIN 0938-AU75**

**Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Interim final rule with comment period.

**SUMMARY:** This interim final rule with comment period revises the requirements that most Medicare- and Medicaid-certified providers and suppliers must meet to participate in the Medicare and Medicaid programs. These changes are necessary to help protect the health and safety of residents, clients, patients, PACE participants, and staff, and reflect lessons learned to date as a result of the COVID-19 public health emergency. The revisions to the requirements establish COVID-19 vaccination requirements for staff at the included Medicare- and Medicaid-certified providers and suppliers.



Source: 11/5/2021 Federal Register; 11/30/21 NRHA Grass Roots Advocacy Forum email alert; Modern Healthcare 10/29 and 10/30

# RHC Productivity Waivers (3/31/22)

- **Exception to the Productivity Standards for RHCs**
  - *Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID- 19 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, exceptions to the productivity standard may be granted by your MAC during the COVID-19 PHE. Further direction* will be forthcoming from your MAC.


## RHC Productivity Standard Exceptions

Per CMS Publication 100-02, Chapter 13 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf) (PDF, 400 KB), Section 80.4, productivity standards require 4,200 visits per physician and 2,100 visits per practitioner.

If you are having difficulty meeting productivity standards as a result of COVID-19 PHE, you may request an exception to the productivity standards. The following information is required.

- Visit count that you are requesting as an exception to the standard of 4,200 for physicians and 2,100 for mid-level practitioners
- Documentation to justify an exception to the standard

A separate request is required for each facility/clinic, and we may ask for additional information after receipt of the request.

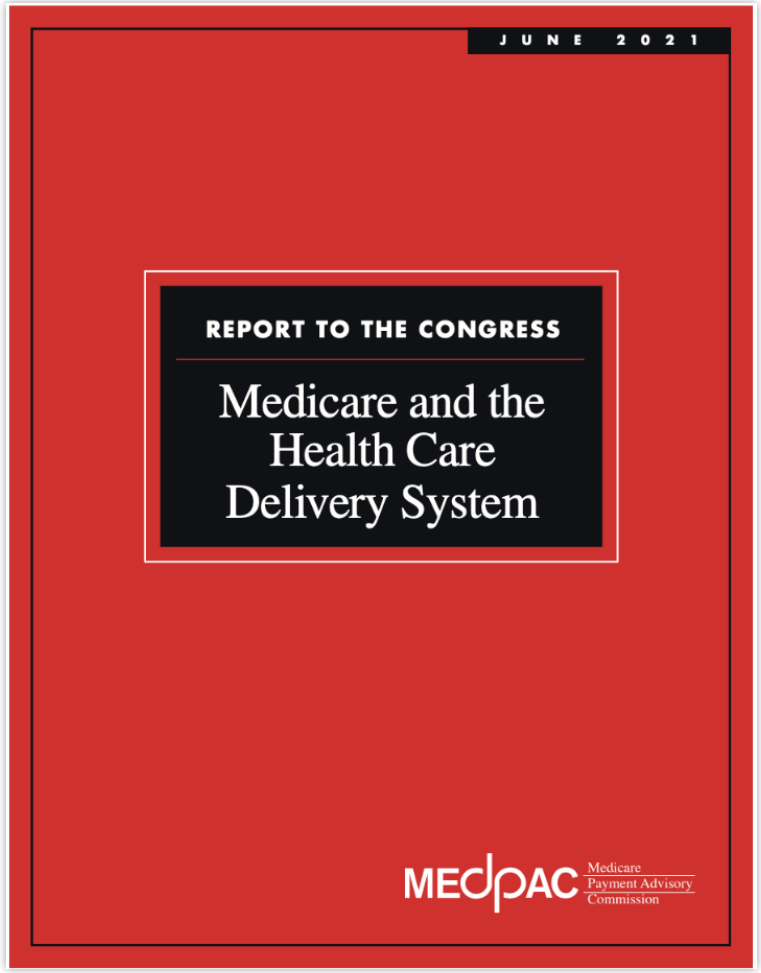
(/)

Last Updated: 07/21/2020

# Legislative/Regulatory Updates

# June 2021 MedPAC Annual Report: Major Considerations (6/15/21)

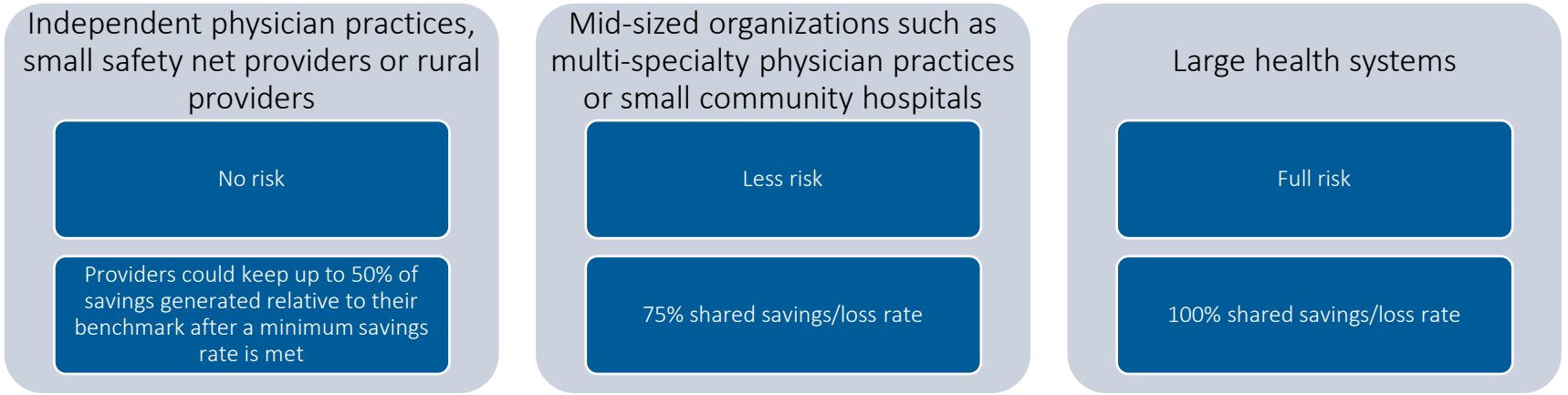
- **Rebalance Medicare Advantage benchmark**
  - Require 2% discount
  - Uses a relatively equal blend of per capita local area FFS spending and standardized national FFS spending
- **Streamline portfolio of Alternative Payment Methods (APMs) and harmonize them Medicare Vaccine Coverage and Payment**
  - Medicare Part B to cover vaccine payment
  - Vaccine fee schedule changed from average wholesale price to 103% of average wholesale cost
- **Replace the SNF VBP with a Value Incentive Program**
- **Study of rural beneficiary access to care**
  - Rural and urban beneficiaries have comparable utilization
  - Rural hospital close primarily because patients opting to bypass their local hospital for IP care
  - 4 drawbacks of cost-based payment including:
    - Does not prevent closures,
    - Distorts competition,
    - Benefits wealthier communities, and
    - Distorts incentives for cost control




Source: Report to the Congress: Medicare and the Health Care Delivery System, MedPAC, June 2021
http://www.medpac.gov/docs/default-source/reports/jun21_reporttocongress_sec.pdf?sfvrsn=0

# MedPAC Proposes Hypothetical Alternative Payment Model (1/14/22)

- In an effort to move more providers and beneficiaries toward risk-based payment models, MedPAC has outlined a hypothetical new model with three risk tracks and administratively-set savings benchmarks
  - Administratively-set benchmarks would encourage participation by allowing provider organizations to avoid the current "ratchet effect" where benchmarks are based on past performance, making them increasingly difficult to exceed
- The three-track model would divide providers into three categories with different levels of risk:



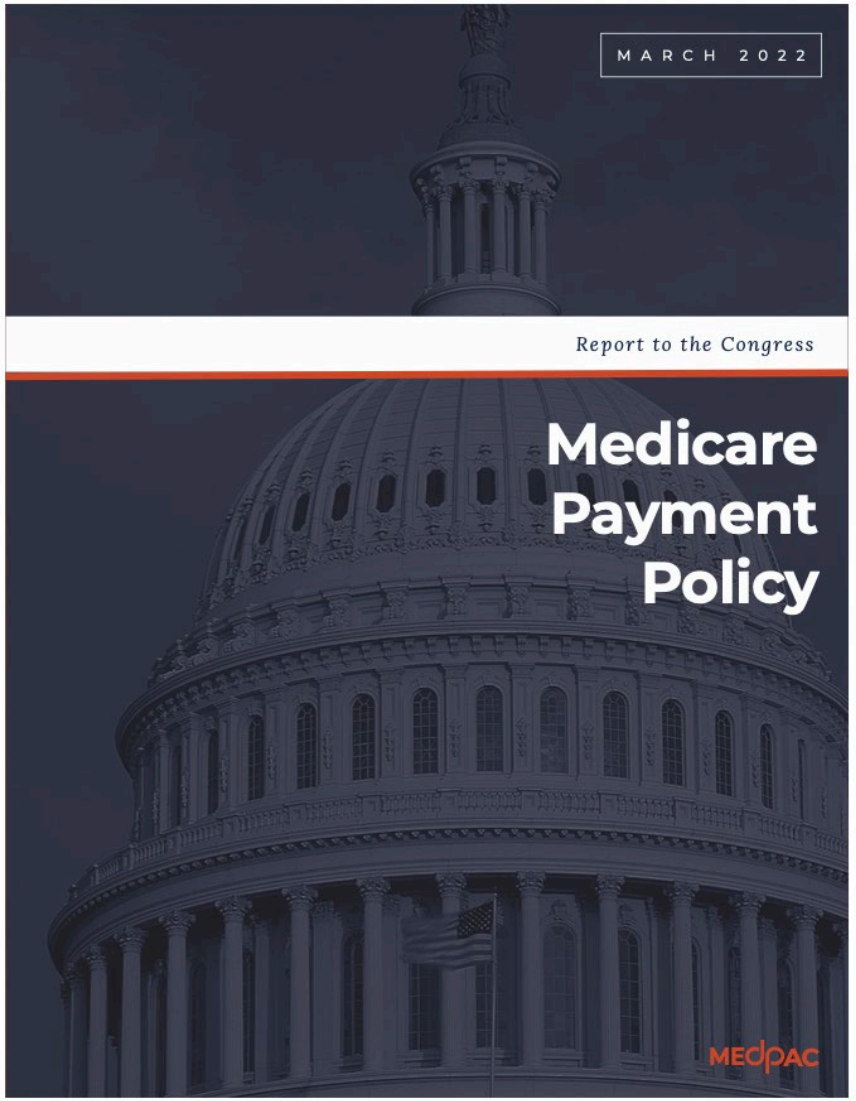

- Industry reaction to the hypothetical model was mixed, with some leaders questioning whether risk should be based on size and questioning how long providers could stay in lower-risk models
- *CMS has set a goal to have all Medicare beneficiaries in a value -based payment arrangement by 2030*



Source: Modern Healthcare, *MedPAC: Increase hospital pay, no changes for physicians,* Maya Goldman, 1/14/21; AHA MedPAC Update – MedPAC votes on 2023 payment recommendations; https://www.aha.org/news/headline/2022-01-13-medpac-votes-2023-payment-recommendations

# MedPAC March 2022 Report to Congress: Highlights (3/15/22)

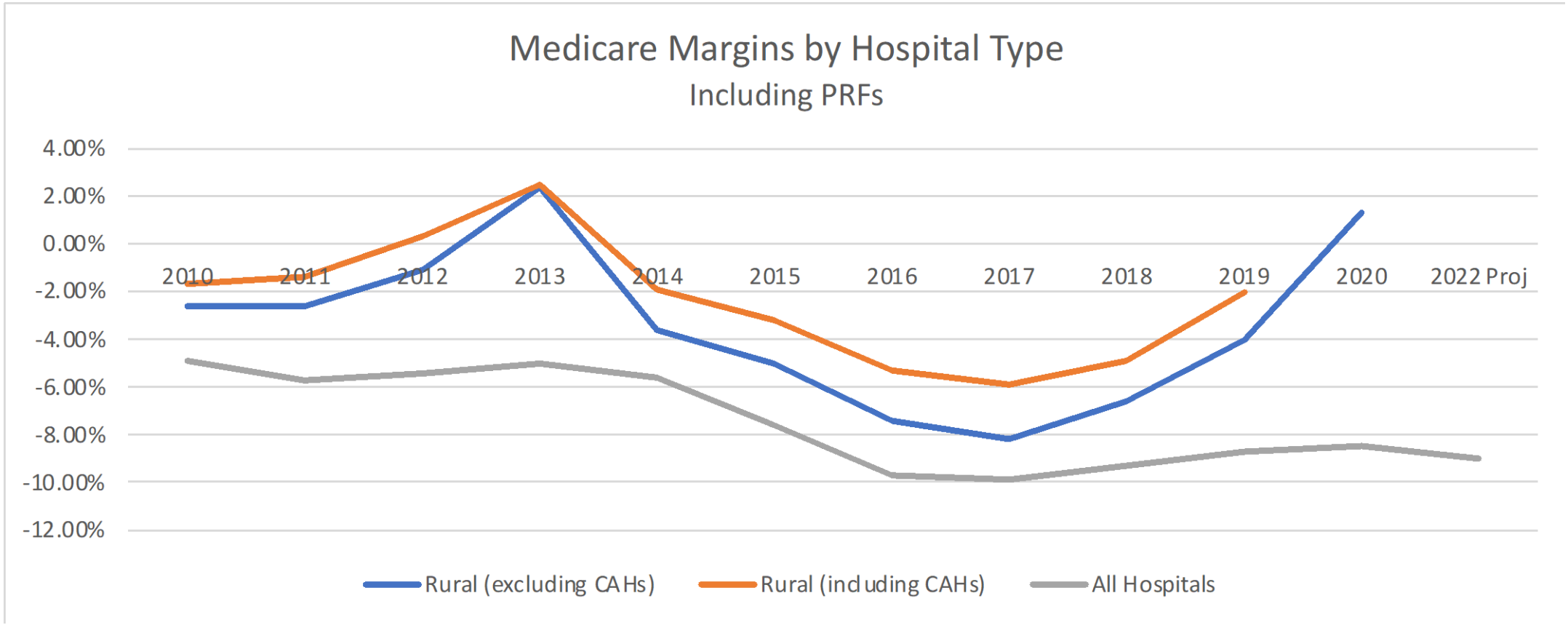
- MedPAC recommends Congress update 2023 inpatient and outpatient payment rates by 2.5% and 2%, respectively, and limited by statutory change
  - However, based on changes to wages, the healthcare market basket could be impacted
- MedPAC recommends that the 2023 payment rate for physician and other health professional services be updated by the amount specified in current law
- MedPAC recommends no payment rate increase for ASCs,  OP dialysis facilities and hospice
- MedPAC recommends 5% decrease in payment to SNFs and home health agencies






Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2022
http://medpac.gov/docs/default-source/reports/mar22_medpac_report_to_the_congress_sec.pdf

# Medicare Margins by Hospital Type




Source: MedPac Report to Congress, March 15, 2022

# MedPAC March 2022 Report to Congress: Medicare Challenges

- Long-Running Medicare Challenges include:
  - 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 spending on drugs is growing rapidly
    - Recommendation: Strengthen Medicare's payment systems to address rising drug prices and costs
  - Medicare is required to pay providers' claims, regardless of clinical appropriateness
    - Recommendation: Scrutinize claims more closely
  - Quality in MA is difficult to evaluate, and payments to MA plans have not captured savings
    - Recommendation: Collect more complete MA data and set appropriate payment to MA Plans
  - FFS Medicare lacks strong incentives to improve population-based outcomes and the coordination of care
    - Recommendation: Incentivize improving population-based outcomes



Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2022
http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf

# CMS 2022 Inpatient Perspective Payment Proposed Rule 4/27/21, Finalized 8/2/21

- Payment Rate Update

| PROPOSED **FY 2022 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS** | | | | |
|---|---|---|---|---|
| **FY 2022** | **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 | 2.5 | 2.5 | 2.5 | 2.5 |
| Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act | 0 | 0 | -0.625 | -0.625 |
| Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act | 0 | -1.875 | 0 | -1.875 |
| Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act | -0.2 | -0.2 | -0.2 | -0.2 |
| **Proposed Applicable Percentage Increase Applied to Standardized Amount** | **2.3** | **0.425** | **1.675** | **-0.2** |

  - Proposed payment increase of 2.3% for 2022 plus statutory increase of .5%
    - Finalized combined payment increase of 2.5%
- Price Transparency
  - Finalized repeal requirement that hospitals report median payer specific negotiated rates by MS-DRG with Medicare Advantage plans
- Disproportionate Share Payments
  - Distribute $7.6B, a reduction of $660M from 2021
    - Finalized distribution of $7.2B, a reduction of $1.1B from 2021



Source: Beckers Healthcare: CMS' proposed inpatient payment rule for 2022: 8 things to know; CMS Fact Sheet, 4/27/2021; CMS 2022 Inpatient Final Rule; 8/2/201

# CMS 2022 IPPS Proposed Rule 4/27/21, Finalized 8/2/21 (continued)

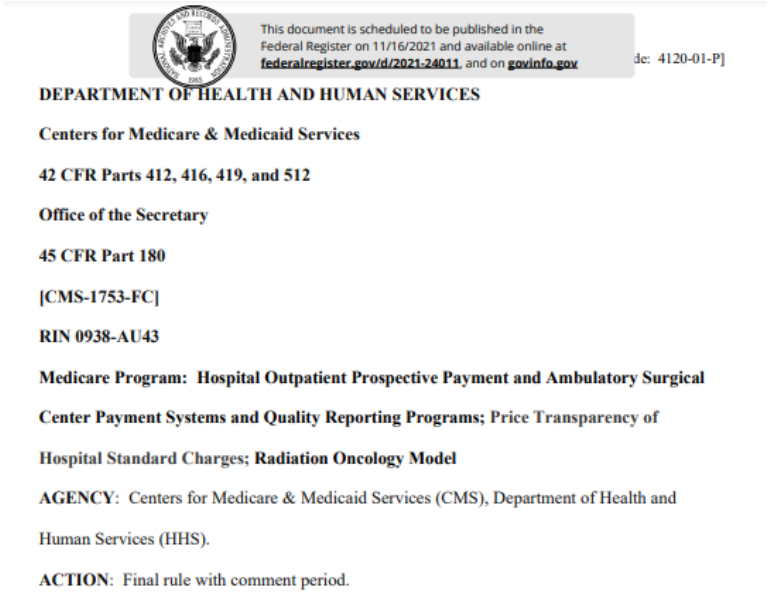
- Covid-19 Add-On Payment
  - Finalized the proposed extension of 20% add-on through end of fiscal year in which PHE ends
- Value Based Payment programs
  - Finalized the proposed suppression of VBP program measures during PHE
- Inpatient Quality Reporting
  - Finalized the proposed addition of 5 new measures including Covid-19 vaccination rates among healthcare professionals
- Medicare Shared Savings Program
  - Finalized the proposal that ACOs participating in the BASIC track are allowed to forgo automatic advancement to higher levels of risk for PY 2022



Source: Beckers Healthcare: CMS' proposed inpatient payment rule for 2022: 8 things to know; CMS Fact Sheet, 4/27/2021; CMS 2022 Inpatient Final Rule; 8/2/201

# Calendar Year (CY) 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (7/19/2021) and Final Rule (11/2/2021)

- On July 19th, CMS issued the CY2022 Medicare OPPS proposed rule that announces and solicits public comments on proposed policy changes for Medicare OPPS, on or after January 1, 2022
  - *Final Rule was issued on 11/2/21*
- Key elements include:
  - Payment rate updates
  - Price transparency
  - Temporary polices for the public health emergency (PHE)
  - Rural Emergency Hospital (REH)
  - Inpatient Only list (IPO)
  - OPPS payment for 340B drugs



This document is scheduled to be published in the Federal Register on 11/16/2021 and available online at federalregister.gov/d/2021-24011, and on govinfo.gov

de: 4120-01-P]

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 412, 416, 419, and 512**

**Office of the Secretary**

**45 CFR Part 180**

**[CMS-1753-FC]**

**RIN 0938-AU43**

**Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model**

**AGENCY**: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

**ACTION**: Final rule with comment period.



Sources: CMS CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P); https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center;CMS .gov Fact Sheet *CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC)* https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

# CY 2022 Medicare Hospital OPPS Proposed Rule (7/19/2021) and Final Rule (11/2/21) (continued)

- Key elements include:
  - Payment Rate Updates
    - Update OPPS payment rates for hospitals meeting quality reporting requirements by 2.3% *payment rate finalized at 2%, based on the projected hospital market basket increase of 2.7 percent reduced by 0.7 percentage point for the productivity adjustment*
  - Price Transparency
    - For non-compliance, proposed minimum civil monetary penalties beginning at $300/day for hospitals less than 30 beds, increasing by $10/bed/day not to exceed maximum of $5,500/day. *Finalized*
      - Maximum annual penalty between $110K and $2.0M. *Finalized*
    - Require that machine-readable file is accessible to automated searches and direct downloads *finalized*
    - Online price tool estimator, in lieu of posting standard charges for 300 shoppable services, to provide a cost estimate to an individual that accounts for that individual's insurance information *finalized*
    - Seeking comment on best practices for online price estimator tools, expectations related to "plain language", methods to iden tify and highlight best practices, etc. *comments are being considered*
  - Temporary Policies for the PHE for Covid-19
    - CMS seeking comment on whether stakeholders believe certain policies should be permanent *comments are being considered*
      - Mental health services billed by hospitals for services furnished in homes through communication technology
      - Presence of physicians for direct supervision of pulmonary and cardiac rehab to include virtual options (currently set to exp later of end of PHE or 12/31/21)



Sources: CMS CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P); https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center;CMS .gov Fact Sheet *CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC)* https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

# CY 2022 Medicare Hospital OPPS Proposed Rule (7/19/2021) and Final Rule (11/2/21) (continued)

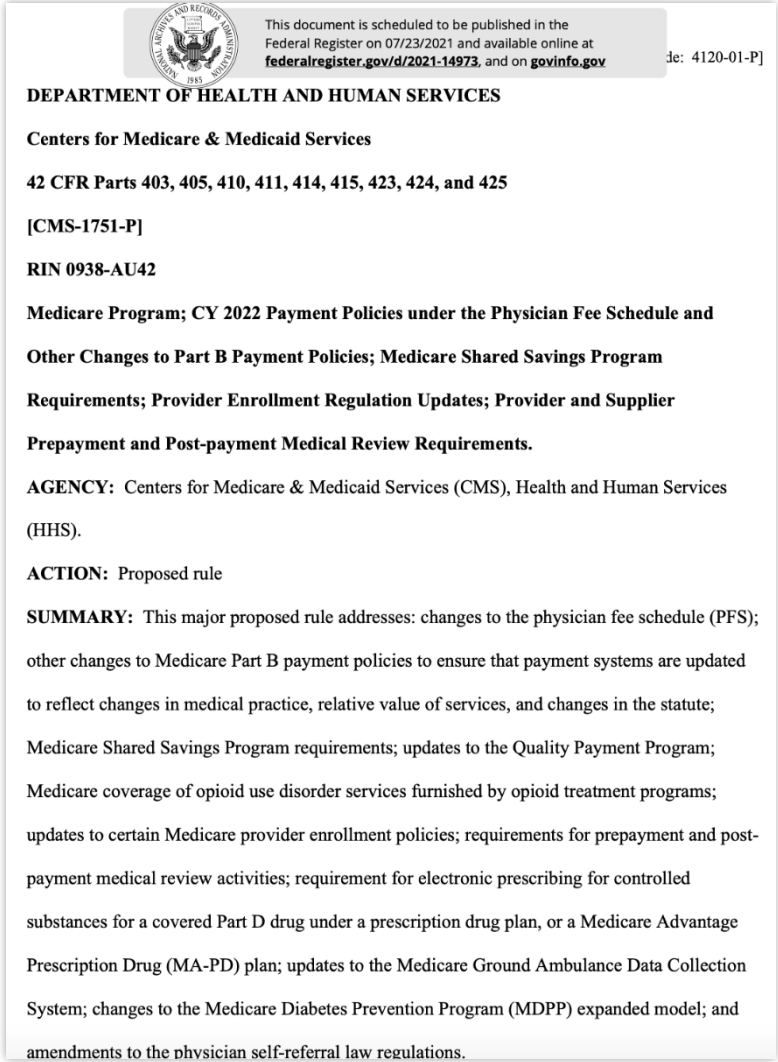
- Key elements include (continued):
  - Rural Emergency Hospital (REH)
    - Per the Consolidated Appropriations Act:
      - Facilities that convert from either a CAH or rural hospital with less than 50 beds, that do not provide acute care inpatient services, and are required to provide emergency department services and observation care
      - Payment based on 105% of APCs, plus fixed monthly payment
        - Fixed monthly payment will be calculated by (a) subtracting from the total amount paid to all CAHs in 2019 by the amount that would have been paid under PPS rates, (b) dividing that number by the total number of CAHS in 2019 (about 1,350), and (c) dividing that number by 12
    - CMS has included a Request for Information (RFI) to seek public input on a broad range of issues including health and safety standards, payment policies and quality measures *comments are being considered*
  - Inpatient Only (IPO) List
    - Proposing to halt the elimination of the IPO list, and add back the 298 services removed from the IPO during CY 2021 *finalized*
    - Codify the criteria for removal of procedures from the IP list *finalized*
  - OPPS Payment for Drugs Acquired through the 340B Program
    - Maintain payment rate of ASP minus 22.5% for certain separately payable drugs acquired through the 340B program *finalized*
    - Exempted from the program are rural sole community hospitals and CAHs *finalized*



Sources: CMS CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P); https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center;CMS .gov Fact Sheet *CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC)* https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

# CY2022 Payment Policies under the Physician Fee Schedule (PFS) and other Part B Payment Policies (7/13/2021) and Final Rule (11/2/21)

- CMS issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the PFS, and other Part B issues, on or after January 1, 2022.
  - *Rule was finalized on 11/2/21*
- Key elements include:
  - Conversion factor reduction from $34.89 in CY21 to $33.58 in CY22 *Finalized at $33.59, a decrease of $1.30 from the CY 2021 PFS conversion factor of $34.89*
  - Expansion of telehealth by allowing certain services added during the pandemic to remain until 12/31/23 *finalized*
    - Allows Medicare patients to access telehealth services from their homes
  - Physician Assistants would be able to bill Medicare directly for services and then reassign payment for services *finalized*
  - MIPS performance threshold for allowing providers bonuses to be increased *finalized*



This document is scheduled to be published in the Federal Register on 07/23/2021 and available online at federalregister.gov/d/2021-14973, and on govinfo.gov

de: 4120-01-P]

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 403, 405, 410, 411, 414, 415, 423, 424, and 425**

**[CMS-1751-P]**

**RIN 0938-AU42**

**Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS).

**ACTION:** Proposed rule

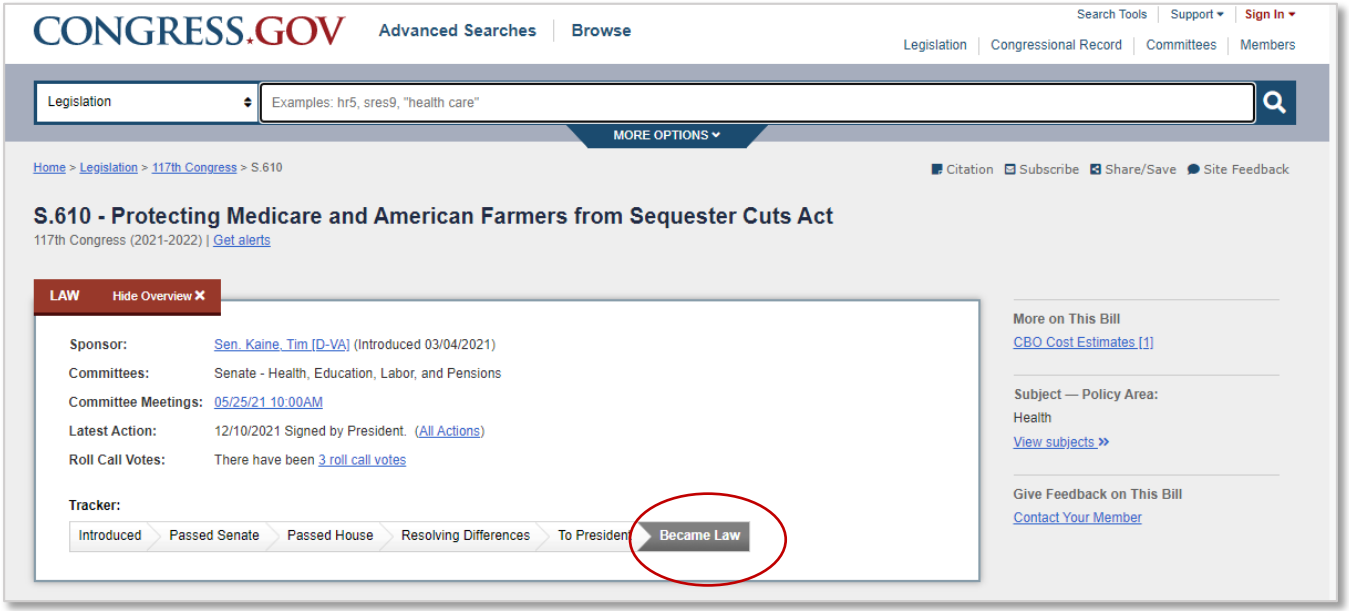
**SUMMARY:** This major proposed rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; Medicare Shared Savings Program requirements; updates to the Quality Payment Program; Medicare coverage of opioid use disorder services furnished by opioid treatment programs; updates to certain Medicare provider enrollment policies; requirements for prepayment and post-payment medical review activities; requirement for electronic prescribing for controlled substances for a covered Part D drug under a prescription drug plan, or a Medicare Advantage Prescription Drug (MA-PD) plan; updates to the Medicare Ground Ambulance Data Collection System; changes to the Medicare Diabetes Prevention Program (MDPP) expanded model; and amendments to the physician self-referral law regulations.



Source: Becker's Hospital CFO Report: CMS Pitches Physician payment rule for 2022: 9 things to know; July 14, 2021

# Protecting Medicare and American Farmers from Sequester Cuts Act (12/10/2021)

- On 12/10/21, President Biden signed into law the Protecting Medicare and American Farmers from Sequester Cuts Act, a law that:
  - Delays the 2 percent federal Medicare spending sequester until April 2022
  - Stops a 4 percent statutory pay-as-you-go sequester
  - Reduces the mandatory Medicare sequester to 1 percent from April-June 2022
  - *Increases provider pay by 3% under the Medicare physician fee schedule*
- The law prevents billions of dollars in Medicare cuts from taking effect in 2022, and industry groups had urged the government to pass the law
- The bill passed the House 222-212 and the Senate 59-35






Sources: Becker's Hospital Review, *Medicare cuts averted,* Alia Paavola, 12/13/21 https://www.beckershospitalreview.com/finance/medicare-cuts-averted.html; https://www.congress.gov/bill/117th-congress/senate-bill/610

# President Releases $1.76T Budget Plan for FY2023 (3/28/22)

President Biden released his budget proposal for FY2023, which includes major initiatives for the healthcare industry.

While many items are unlikely to pass, the budget plan prioritizes:

- Public health investment, including
  - Preparedness for public health crises
  - Mental health treatment
  - Addressing the opioid epidemic
  - Improving the well-being of children, families, and seniors
  - Advancing research to improve health
- Continuing the transformation to Modernize the food safety system
- The economy and job creation
- The climate crisis
- Advancing equity and supporting marginalized communities

# President Releases $1.76T Budget Plan for FY2023 (3/28/22)

Specific healthcare-related initiatives in the President's plan were focused on **improving public health infrastructure, fighting the opioid epidemic, and increasing research funding,** including:

- $127.3B to Department of Health and Human Services ($19B inc.)
  - $374M to Federal Office of Rural Health Policy to carry out rural health activities ($43M inc.)
    - $57.5M for Medicare FLEX ($5M dec.)
    - $12.5M for SORHs (no change)
    - $12.7M for Rural Residency Development Program ($2.2M inc.)
    - $165M for Rural Communities Opioid Response Program ($30M inc.)
    - $10M for new RHC Behavioral Health Initiative
  - $13.3B to Health Resources and Services Administration (HRSA)
    - $210M for National Health Service Corps ($92M inc.)
    - $44M for telehealth ($10M inc.)
  - $9.9B for Centers for Disease Control ($1.4B inc.)
- $28.5B to USDA ($3.4B inc.)

Source: HHS Budget in Brief Document (as summarized by NRHA 3/28/2022)

# Interim Final Rule to Ban Surprise Billing (7/1/2021)

> No patient should forgo care for fear of surprise billing… Health insurance should offer patients peace of mind that they won't be saddled with unexpected costs. The Biden-Harris Administration remains committed to ensuring transparency and affordable care, and with this rule, Americans will get the assurance of no surprises.
>
> HHS Secretary Xavier Becerra

On July 1, CMS unveiled an interim final rule banning surprise billing for emergency services and high out-of-network cost-sharing for emergency and non-emergency services

The rule also bans out-of-network charges for ancillary services as well as other out-of-network charges without advance notice. Health plans must reimburse for these services regardless of whether the provider is in-network or an emergency provider, and insurers cannot charge higher out-of-pocket costs for out-of-network providers.

This rule applies to providers, air ambulance providers, group health plans, health insurance issuers and Federal Employees Health Benefits Program carriers, and takes effect in 60 days

Per CMS, two-thirds of all bankruptcies in the U.S. are tied to medical expenses, and an estimated 1 in 6 emergency department visits result in an unexpected bill



Source: Modern Healthcare: CMS bans surprise billing, 7/1/21 https://www.modernhealthcare.com/finance/cms-bans-surprise-billing

# 2022 Consolidated Appropriations Act (3/15/22)

- The 2022 Consolidated Appropriations Act is a $1.5T omnibus spending bill passed by Congress on 3/14 and signed into law on 3/15/22
  - Funds the federal government through the rest of the year
- The Act temporarily maintained expanded eligibility for 340B participation
  - Hospitals that lost eligibility for 340B due to payer mix changes brough on by COVID-19 may stay in the program based on cost report data
- The bill also extends telehealth flexibility that was introduced at the outset of the COVID-19 pandemic for an additional 5-months following the end of the PHE

MARCH 8, 2022

**RULES COMMITTEE PRINT 117–35**

**TEXT OF THE HOUSE AMENDMENT TO THE SENATE AMENDMENT TO H.R. 2471**

**[Showing the text of the Consolidated Appropriations Act, 2022]**

In lieu of the matter proposed to be inserted by the Senate, insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Consolidated Appropriations Act, 2022".

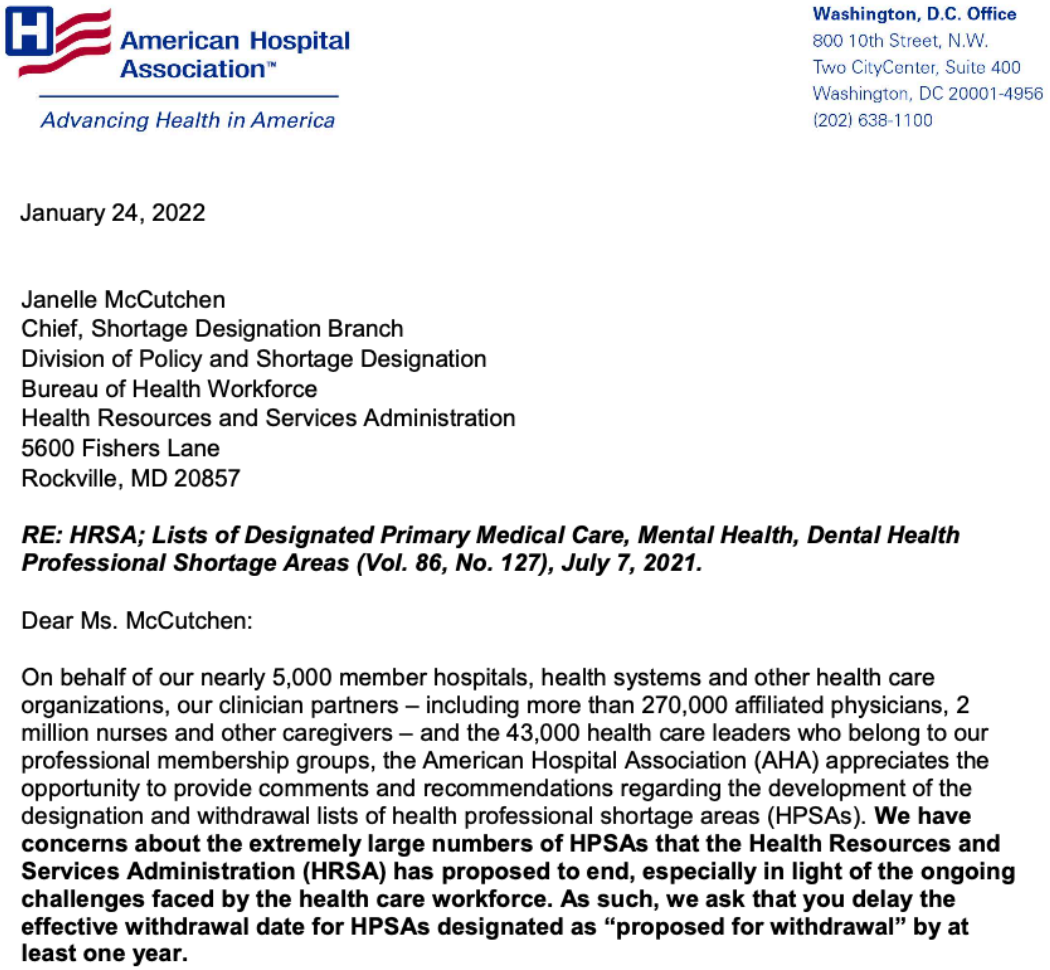
- Unfortunately for other industry stakeholders, the bill
  - Fails to include COVID-19 funding
  - Does not add funds to the Provider Relief Fund
  - Maintains the schedule for the Medicare payment sequester
  - Does not offer relief on repayment terms for Medicare advance payments



Sources: https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-117HR2471SA-RCP-117-35.pdf; hfma.org, *Federal funding bill addresses 340B eligibility concerns but not some other points of interest for hospitals,* Nick Hut, 3/10/22 https://www.hfma.org/topics/news/2022/03/federal-funding-bill-addresses-340b-eligibility-concerns-but-not.html?utm_medium=email

# Health Professional Shortage Area Withdrawals (1/24/22)

- As of January 2022, 1,178 primary medical care HPSAs are proposed for withdrawal representing 15% of all primary care HPSAs.
- In addition, 515 mental health HPSAs are proposed for withdrawal, representing 8% of all mental health HPSAs.
- Further, these numbers may increase because stakeholder requests for designations are reviewed continuously by HRSA.
- Most recently published on April 30, 2021. HPSAs that have been "proposed for withdrawal" after April 30 will remain as "proposed for withdrawal" until the publication of the next federal notice
- The effective date of a withdrawal will be the next publication of a notice regarding the list of designated HPSAs, generally around July 1, 2022
- AHA asks for one year delay in effective withdrawal date



American Hospital Association™
Advancing Health in America

**Washington, D.C. Office**
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

January 24, 2022

Janelle McCutchen
Chief, Shortage Designation Branch
Division of Policy and Shortage Designation
Bureau of Health Workforce
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

***RE: HRSA; Lists of Designated Primary Medical Care, Mental Health, Dental Health Professional Shortage Areas (Vol. 86, No. 127), July 7, 2021.***

Dear Ms. McCutchen:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments and recommendations regarding the development of the designation and withdrawal lists of health professional shortage areas (HPSAs). **We have concerns about the extremely large numbers of HPSAs that the Health Resources and Services Administration (HRSA) has proposed to end, especially in light of the ongoing challenges faced by the health care workforce. As such, we ask that you delay the effective withdrawal date for HPSAs designated as "proposed for withdrawal" by at least one year.**

# CMS Pushes for Value-Based Care, Stresses Accountable Care (10/21/21)

- Per CMMI Chief Strategy Officer Purva Rawal, **the Biden administration wants to accelerate the push toward value-based healthcare by encouraging participation in ACOs and other risk-based models**
- Trump-era policies that required providers to take on higher levels of risk led to lower participation in these programs, but CMMI hopes to increase participation by increasing opportunities for providers
- Rawal emphasized the **Direct Contracting model, which includes more provider types, and the VBID model, which tests health plan innovations**
- In a recent webinar, CMS Director Liz Fowler laid out specific strategies for the agency to improve health outcomes and increase health equity, leading with accountable care

The agency's primary goal is to increase the number of people in relationships with providers that are accountable for patients' costs and improving their care history

To achieve this goal, CMS must increase beneficiary access to advanced primary care and healthcare organizations

Rawal cited the CMS vision for "a future where every Medicare beneficiary and most Medicaid beneficiaries are in an accountable care relationship by 2030"

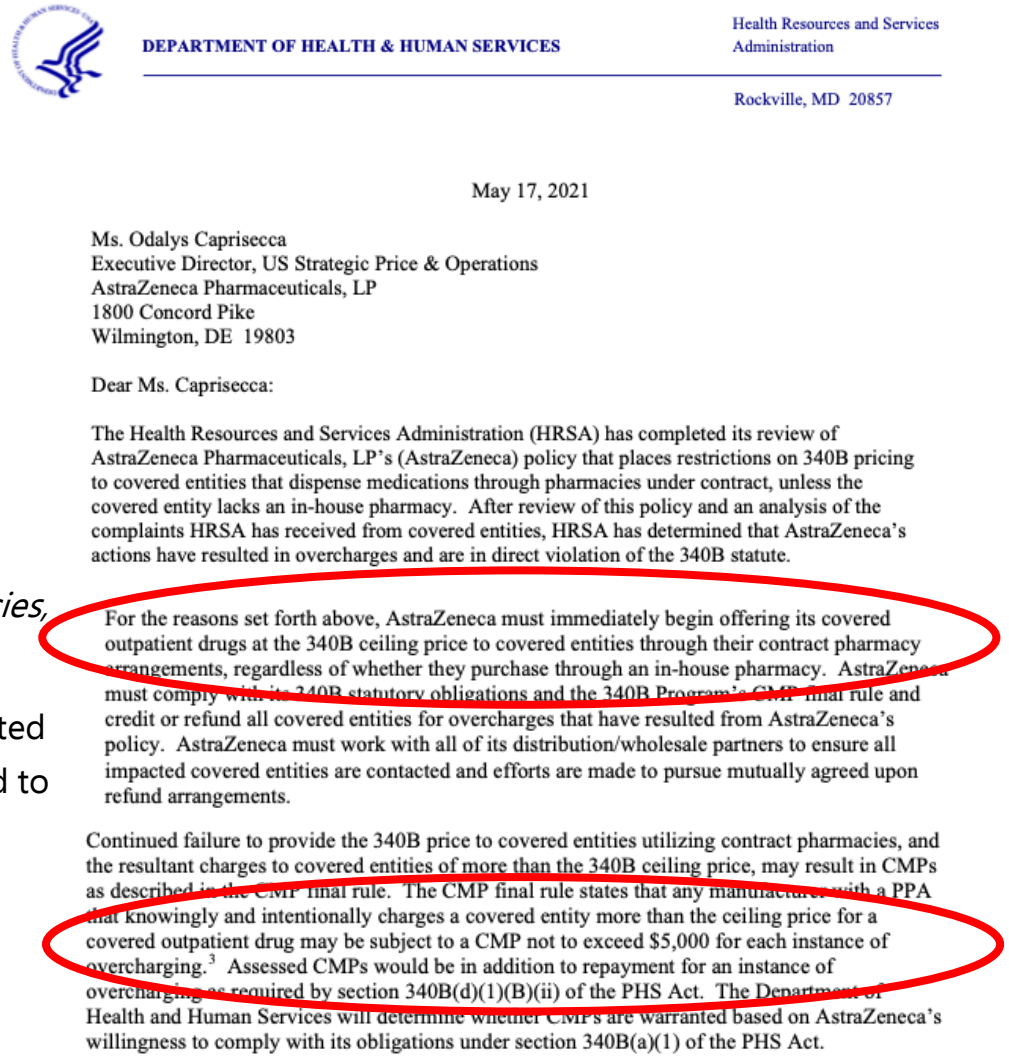
- Other top agency goals include
  - ✓ Advancing health equity
  - ✓ Supporting innovation
  - ✓ Addressing affordability, and
  - ✓ Partnering to achieve system transformation

STROUDWATER

Sources: ModernHealthcare, *'Proof will be in the execution': CMS plan focuses on accountable care,* Mari Devereaux, 10/20/21 https://www.modernhealthcare.com/payment/cmmi-official-pushes-more-participation-value-based-care-models; ModernHealthcare, *CMMI official pushes for more participation in value-based care models,* Jessie Hellmann, 10/20/21 https://www.modernhealthcare.com/payment/cmmi-official-pushes-more-participation-value-based-care-models

# HSS Letter to Drug Manufacturers (10/29/21 update)

- 5/17 Letter from HHS to drug manufacturers instructing them to:
  - *"Begin offering covered OP drugs at the 340B ceiling price to covered entities through their contract pharmacy arrangements, regardless of whether they purchase through in-house pharmacy"*
  - *"Continued failure to comply could result in not to exceed penalty of $5,000 for each instar overcharging"*
- On 5/20, Eli Lily requested to a federal court a preliminary injunction and temporary restraining order
- *On 10/29, federal district court judge in IN agreed with the government's contentio that the 340B statute would permit DHHS to require that the drug company Eli Lilly offer 340B discounts for drugs distributed by hospitals through community pharmacies, finding that this was the best reading of the what the 340B statute requires.*
  - The court's decision only applies to the government's enforcement action related to Lilly; it does not impact efforts related to HHS' enforcement decision related to other drug companies that also have challenged the agency's efforts



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

May 17, 2021

Ms. Odalys Caprisecca
Executive Director, US Strategic Price & Operations
AstraZeneca Pharmaceuticals, LP
1800 Concord Pike
Wilmington, DE 19803

Dear Ms. Caprisecca:

The Health Resources and Services Administration (HRSA) has completed its review of AstraZeneca Pharmaceuticals, LP's (AstraZeneca) policy that places restrictions on 340B pricing to covered entities that dispense medications through pharmacies under contract, unless the covered entity lacks an in-house pharmacy. After review of this policy and an analysis of the complaints HRSA has received from covered entities, HRSA has determined that AstraZeneca's actions have resulted in overcharges and are in direct violation of the 340B statute.

For the reasons set forth above, AstraZeneca must immediately begin offering its covered outpatient drugs at the 340B ceiling price to covered entities through their contract pharmacy arrangements, regardless of whether they purchase through an in-house pharmacy. AstraZeneca must comply with its 340B statutory obligations and the 340B Program's CMP final rule and credit or refund all covered entities for overcharges that have resulted from AstraZeneca's policy. AstraZeneca must work with all of its distribution/wholesale partners to ensure all impacted covered entities are contacted and efforts are made to pursue mutually agreed upon refund arrangements.

Continued failure to provide the 340B price to covered entities utilizing contract pharmacies, and the resultant charges to covered entities of more than the 340B ceiling price, may result in CMPs as described in the CMP final rule. The CMP final rule states that any manufacturer with a PPA that knowingly and intentionally charges a covered entity more than the ceiling price for a covered outpatient drug may be subject to a CMP not to exceed $5,000 for each instance of overcharging.[3] Assessed CMPs would be in addition to repayment for an instance of overcharging as required by section 340B(d)(1)(B)(ii) of the PHS Act. The Department of Health and Human Services will determine whether CMPs are warranted based on AstraZeneca's willingness to comply with its obligations under section 340B(a)(1) of the PHS Act.

Source AHA 340B Advocacy Alliance notice;
US District Court Case 1:21-cv-00081-SEB-MJD Document 144 Filed 10/29/21

# 340B Cuts Threaten Safety Net Hospitals; Administration Must Withdraw Warning to AstraZeneca (3/25/2022)

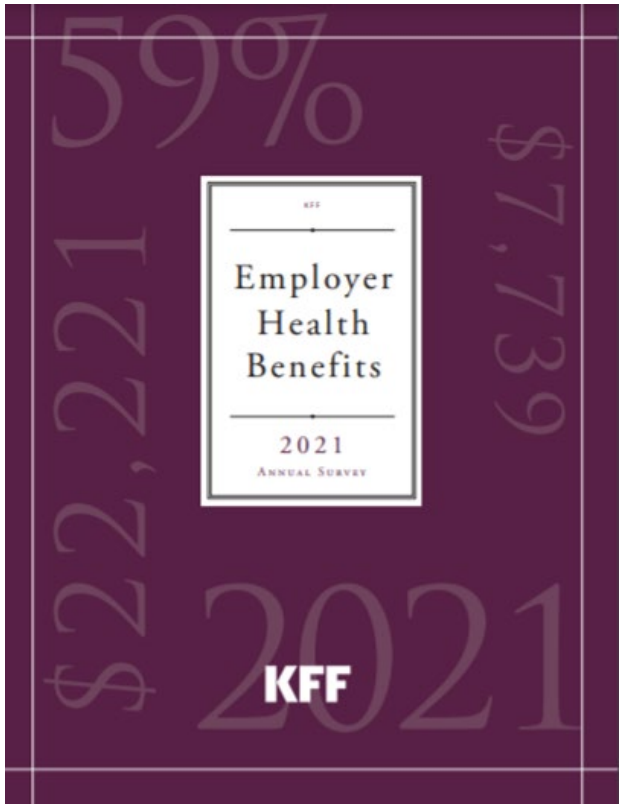
- As of March 2022, 16 drug companies had announced plans to limit 340B discounts to hospitals, causing alarm to hospitals that benefit from the program.
  - Johnson and Johnson is the latest drugmaker to restrict discounts.
  - In January '22, Bristol Myers Squibb became the 12th company to restrict sales of drugs discounted under 340B.
    - If the covered entity does not have an in-house pharmacy, the drugmaker will only send 340B-discounted products to two contract pharmacies.
    - AbbVie announced a similar policy in December.
- Per a late 2021 survey by 340B Health:
  - **Drugmaker restrictions on drug discounts are costing safety net hospitals hundreds of thousands to millions of dollars in savings**
  - **CAHs report losing an average of 39% of the savings they would have seen from the program, or $220,000 dollars per CAH**
  - **Larger 340B hospitals such as disproportionate share hospitals, sole community hospitals and rural referral centers reported missing out on 23% of their community pharmacy savings**
- In November 2021, a federal judge ruled that drug companies cannot unilaterally restrict sales of products discounted under the 340B program to contract pharmacies, but a separate ruling found that manufacturers don't have to provide discounts at all. The rulings are being appealed.
- In a blow to the Biden administration's attempt to control drug prices, a federal judge ruled on 2/16 that a warning letter from HRSA to drug company AstraZeneca must be withdrawn. While HRSA asserted that 340B-covered entities can use an unlimited number of third-party contract pharmacies to dispense medications, the drugmaker argued that HRSA did not follow procedure in its warning and that the warning was based on a legal opinion that had already been struck down.

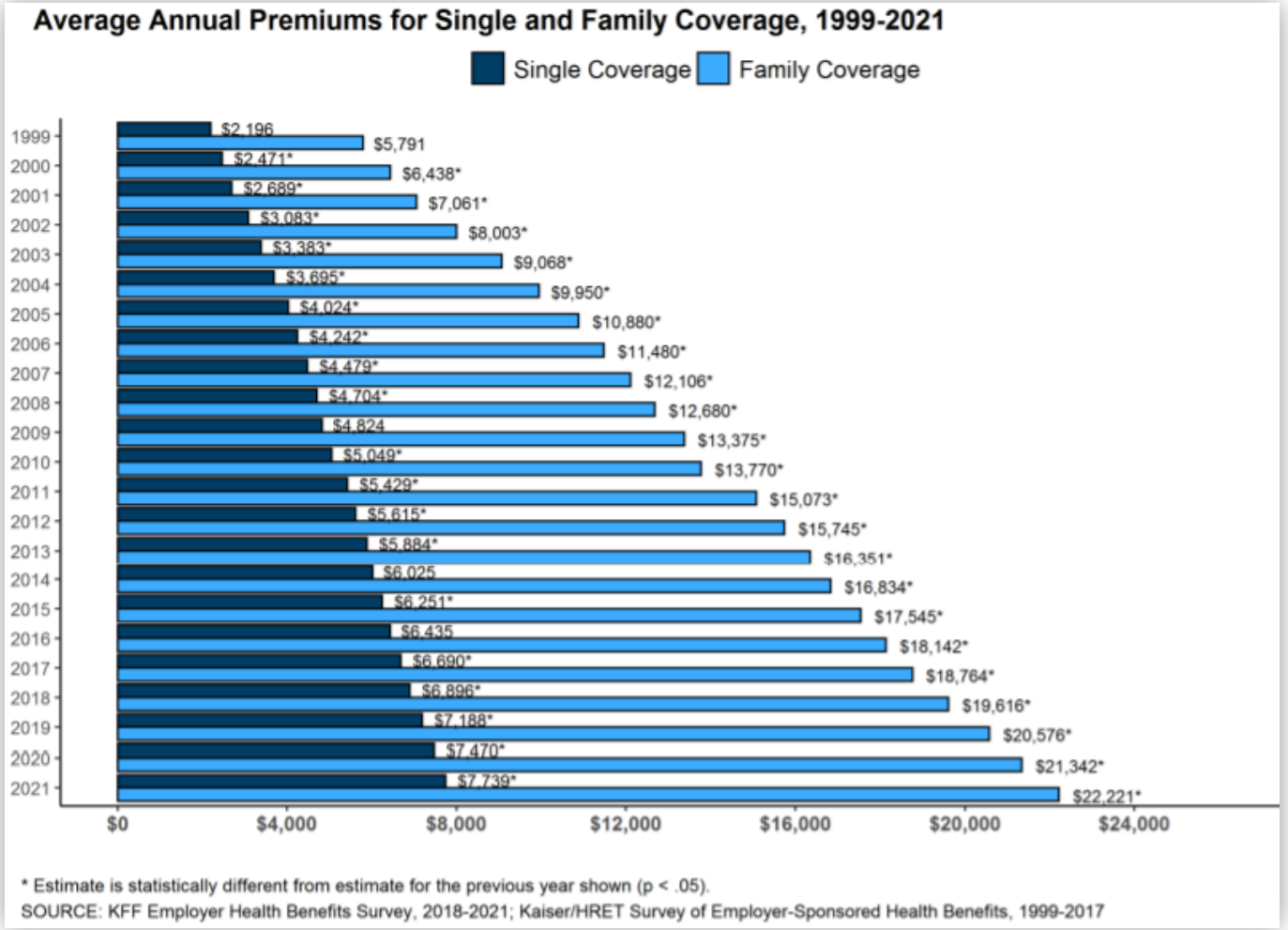


Sources: Fierce Healthcare, *Safety net hospitals say pharma's 340B drug restrictions already endangering future services,* Dave Muoio, 1/31/22 https://www.fiercehealthcare.com/hospitals/safety-net-hospitals-say-pharmas-340b-drug-restrictions-are-already-endangering-future; *Bristol Myers Squibb becomes 12th drugmaker to announce 340B contract pharmacy restrictions,* Robert King, 1/19/22; *Drugmakers get mixed bag in lawsuit rulings over 340B contract pharmacy moves,* Robert King 11/8/21 https://www.fiercehealthcare.com/hospitals/drug-makers-get-mixed-bag-lawsuit-rulings-over-340b-contract-pharmacy-moves; Fierce Healthcare, *Judge strikes down HRSA's warning to AstraZeneca over 340B contract pharmacy restrictions,* Robert King , 2/17/22 https://www.fiercehealthcare.com/providers/judge-strikes-down-hrsas-warning-astrazeneca-over-340b-contract-pharmacy-restrictions; Modern Healthcare, *Hospital groups worry as more drugmakers limit 340B discounts,* Maya Goldman, 3/25/22 https://www.modernhealthcare.com/safety-net-hospitals/hospitals-worry-more-drugmakers-limit-340b-discounts?utm_source=modern-healthcare-am-friday

# Other Market Updates

# Insurance Premiums

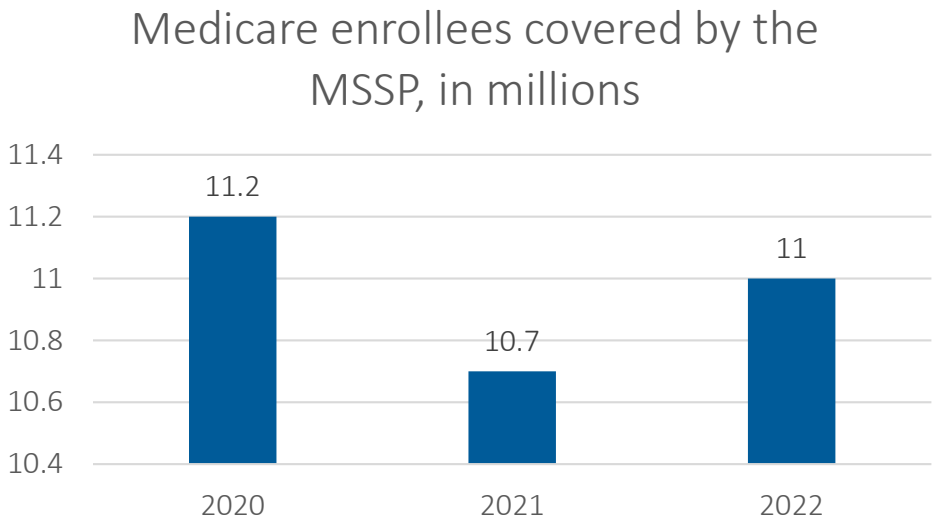


# Medicare ACO Participation Increases Slightly in 2022

- CMS has announced that 66 new ACOs joined the Medicare Shared and 140 ACOs continued their participation bringing the total number of ACOs in the program to 483 in 2022
- As of January 1, 2022, over 11 million people with Medicare receive care from a health care provider in a Shared Savings Program ACO, up 324,000 (3%) from the 2021 total but still lower than in 2020
- The number of ACOs accepting risk has increased to 59% in two-sided risk tracks from 41% in 2021

- Although CMS presented the data as encouraging, the National Association of ACOs urged the industry to view the modest increase as a call to action
- CMS  has expressed a goal to have all Medicare beneficiaries in a value-based payment arrangement by 2030
- Note that on 2/22, CMS withdrawal the ACO Transformation Track as it has "broader efforts underway"






Sources: https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-grow-and-deliver-high-quality-person-centered-care-through; Modern Healthcare, *Medicare Shared Savings ACO participation grows slightly for 2022,* Maya Goldman, 1/26/22 https://www.modernhealthcare.com/accountable-care/medicare-shared-savings-aco-participation-grows-slightly-2022?utm_source=modern-healthcare-am-thursday

# Medicare ACO Participation Increases Slightly in 2022: MSSP Fast Facts

## Shared Savings Program Fast Facts – As of January 1, 2022

CMS | MEDICARE SHARED SAVINGS PROGRAM

### SHARED SAVINGS PROGRAM INFORMATION

PROGRAM CHARACTERISTICS (as of January 1st of each year)

| Performance Year | ACOs | Assigned Beneficiaries |
|---|---|---|
| 2022 | 483 | 11.0 million |
| 2021 | 477 | 10.7 million |
| 2020 | 517 | 11.2 million |
| 2019 | 487 | 10.4 million |
| 2018 | 561 | 10.5 million |
| 2017 | 480 | 9.0 million |
| 2016 | 433 | 7.7 million |
| 2015 | 404 | 7.3 million |
| 2014 | 338 | 4.9 million |
| 2012 / 2013 | 220 | 3.2 million |

PERFORMANCE YEAR (PY) RESULTS

| Performance Year | Total Earned Shared Savings | Average Overall Quality Score |
|---|---|---|
| 2020 | $2.3 billion | 97% |
| 2019 | $1.5 billion | 92% |
| 2018 | $983 million | 93% |
| 2017 | $799 million | 92% |
| 2016 | $700 million | 95% |
| 2015 | $645 million | 91% |
| 2014 | $341 million | 83% |
| 2012 / 2013 | $315 million | 95% |

### 2022 SHARED SAVINGS PROGRAM ACO INFORMATION

ACO TRACKS

| | ACOs | Percent |
|---|---|---|
| One Sided (41% of ACOs) | | |
| BASIC Track Levels A&B | 199 | 41% |
| Two Sided (59% of ACOs) | | |
| BASIC Track Levels C&D | 40 | 8% |
| BASIC Track Level E* | 98 | 21% |
| ENHANCED Track* | 146 | 30% |

*Qualifies as an Advanced Alternative Payment Model (APM)
Note: tracks 1, 2, and 1+ are no longer applicable as of PY 2022

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

| | ACOs | Percent |
|---|---|---|
| Prospective | 184 | 38% |
| Preliminary Prospective with Retrospective Reconciliation | 299 | 62% |

### 2022 MEDICARE BENEFICIARY DEMOGRAPHIC DISTRIBUTION

| Enrollment Type | Beneficiary Person-Years | Percent |
|---|---|---|
| Aged Non-Dual | 9,048,056 | 84% |
| Disabled | 1,032,983 | 9% |
| Aged Dual | 646,646 | 6% |
| End Stage Renal Disease (ESRD) | 62,162 | 1% |

### ACO COMPOSITION

HIGH / LOW REVENUE ACOs

| | ACOs | Percent |
|---|---|---|
| High Revenue | 214 | 44% |
| Low Revenue | 269 | 56% |

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

| | |
|---|---|
| ACOs approved for a SNF 3-Day Rule Waiver | 155 |
| Total number of SNF affiliates | 2,270 |

ACO PARTICIPANT LIST COMPOSITION

| | |
|---|---|
| Participant TINs | 16,013 |
| Physicians and non-Physicians | 528,966 |
| Hospitals | 1,353 |
| Federally Qualified Health Centers (FQHCs) | 3,708 |
| Rural Health Centers (RHCs) | 1,643 |
| Critical Access Hospitals | 430 |

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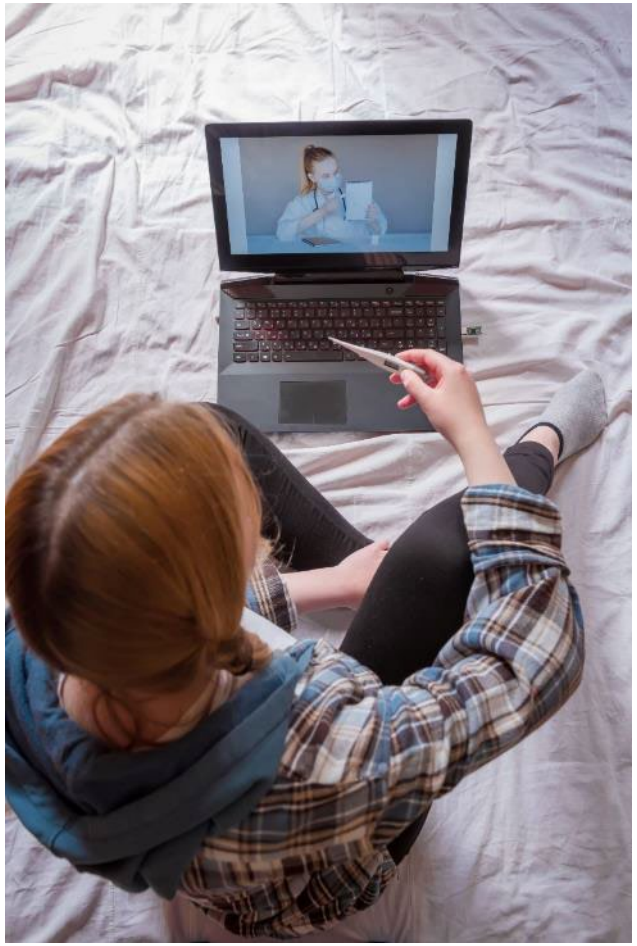
Source: https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf

# Amazon Care Expands Further Into Primary Care Outside Its Workforce (updated 2/28/22)

- On March 17, 2021, Amazon announced the expansion of Amazon Care, its first primary care offering accessible by non-Amazon employees.
  - *In February '22, the company announced that its telehealth services are now available nationwide.*
- Amazon Care was originally limited to Amazon employees in Washington State. It is now available to employees in every state and to employees of new customers including Whole Foods, Silicon Labs and TrueBlue.
- In-person locations are now in Seattle, Baltimore, Boston, Dallas, Los Angeles, Washington, D.C., Austin, Texas, and Arlington, Virginia, with further expansion planned for this year targeting 20 cities
- Amazon Care has two components
  - Telemedicine
  - In-person care, where a professional is dispatched to a patient's home
- Amazon Care provides both urgent and non-urgent services including such as COVID-19 testing, vaccinations, prescription refills and preventive care
- *As of February, '22, through a partnership with Teladoc Health, patients can access Amazon's telehealth services through Amazon Alexa: "Alexa, I want to talk to a doctor"*



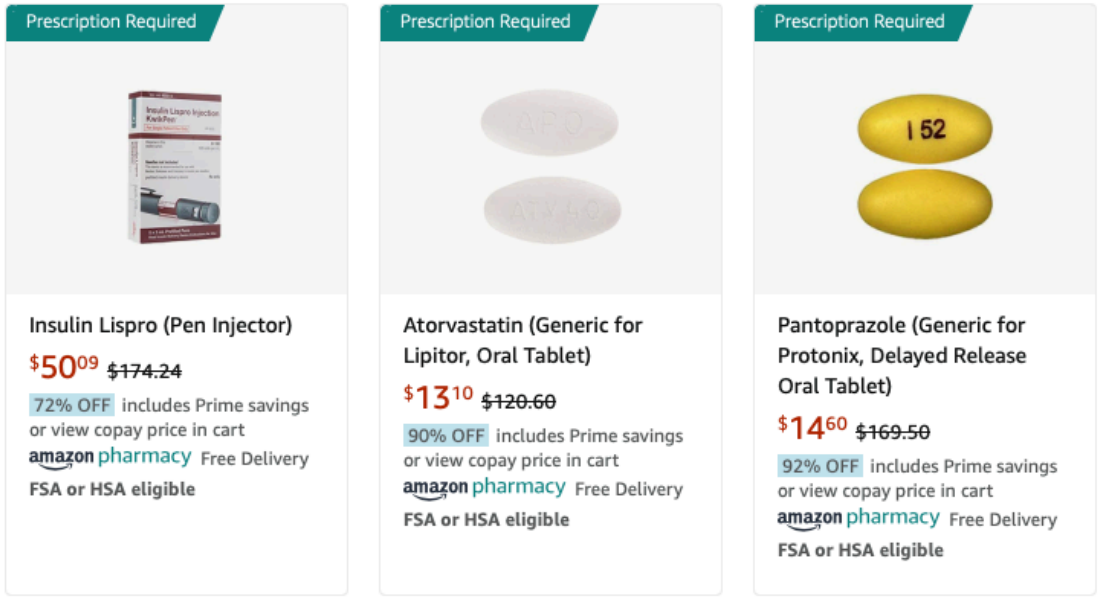


Sources: Becker's Hospital Review, *Amazon Care rolls out telehealth services nationwide: 4 notes,* Katie Adams 2/8/2022 https://www.beckershospitalreview.com/disruptors/amazon-care-rolls-out-telehealth-services-nationwide-4-notes.html?origin=CIOE https://www.aboutamazon.com/news/workplace/amazon-care-to-launch-across-u-s-this-summer-offering-millions-of-individuals-and-families-immediate-access-to-high-quality-medical-care-and-advice-24-hours-a-day-365-days-a-year; https://www.modernhealthcare.com/information-technology/amazon-jumps-healthcare-telemedicine-initiative?utm_source=modern-healthcare-am-Thursday; mHealth Intelligence, *Teladoc, Amazon Partner to Enhance Direct-to-Consumer Telehealth,* Anuja Vaidya, 2/28/22 *https://mhealthintelligence.com/news/teladoc-amazon-partner-to-enhance-direct-to-consumer-telehealth*

# Amazon Introduces Amazon Pharmacy (12/3/2021)

- Amazon introduces pharmacy services
  - Consumers can shop for best price with known prices
  - Pharmacists that work with prescriber and insurance
  - Deliver medications

**Shop common medications**




amazon pharmacy

**There's more to Amazon Pharmacy**

| BENEFITS | The average pharmacy | Amazon Pharmacy |
|---|---|---|
| Accepts most insurance plans | ✓ | ✓ |
| Reviewed by pharmacists | ✓ | ✓ |
| Available to you 24/7 | | ✓ |
| Show prices upfront | | ✓ |
| Delivers to your door | | ✓ |
| Meds are as low as $1/month | | ✓ |
| Offers 6-month supply | | ✓ |

# Walmart Plans to Become Major Force in Healthcare (updated 4/5/22)

- **Walmart seeks to become a major healthcare provider and transform the way Americans engage with their health.**
  - **As many Walmart stores are located in rural and/or underserved communities, the retail giant sees an opportunity to provide healthcare to people who may struggle with healthcare access.**
- Walmart plans to use technology to streamline the consumer healthcare experience and capitalize on its reputation for low-cost products to build trust and confidence in its healthcare offerings
- Walmart has added **virtual care, discount drug programs, a unified EHR system, and a discount drug program to its healthcare services for both consumers and employees, and acquired telehealth provider MeMD in May '21 to expand its telehealth services**
- Among other healthcare ventures, Walmart currently operates and/or provides Walmart Health Centers within its stores; freestanding health centers in Georgia, Texas, Arkansas and Chicago; direct-to-consumer telehealth through purchased app Ro; and a telehealth partnership with Doctor on Demand to offer services to its 1.3 million workers at a reduced price

Cheryl Pegus, M.D.,
executive vice president of Health & Wellness at Walmart:

**"We are committed to providing care to customers and the communities we serve through an integrated, omnichannel approach that improves engagement, health equity and outcomes"**

- In October, it began a partnership with healthcare technology platform Transcarent to streamline its self-funded healthcare offerings for employers, the first time Walmart has made such an agreement to offer its prices on pharmaceuticals and other healthcare services to other employers
- *In early April '22, Walmart opening five clinics in Florida, partnering with tech platform Epic to coordinate its telehealth offerings with its in-person services.*



Sources: Becker's Hospital Review, *Walmart to bring telehealth nationwide with acquisition of MeMD: 8 details,* Jackie Drees and Hannah Mitchell, 5/6/21 https://www.beckershospitalreview.com/telehealth/walmart-health-to-acquire-telehealth-provider-6-details.html?origin=CIOE; FierceHealthcare, *Walmart unveils employer market team-up with Transcarent,* Paige Minemyer, 10/15/21 https://www.fiercehealthcare.com/payer/walmart-unveils-employer-market-team-up-transcarent?utm_source=email; Fierce Healthcare Tech; *Tech HLTH21: Where Walmart is focusing its health efforts in the next 5 to 10 years,* Dave Muoio, 10/19/21; Fierce Healthcare, *Walmart Health is opening its latest clinics in Florida. Here's how they fit into its 'omnichannel' vision,* Paige Minemyer, 4/5/22 *https://www.fiercehealthcare.com/retail/walmart-health-opening-its-latest-clinics-florida-heres-how-they-fit-its-omnichannel-vision*

# Walgreens Pushes Into Primary Care, Aiming to Keep People Out of Healthcare System (2/17/22)

**"Imagine a day when 45 percent of our Walgreens stores … where you can walk in and see a primary care physician that's attached to a Walgreens drugstore. And you come into this beautiful lobby and there are eight exam rooms with two physicians and a staff…And they can do the testing that you need that day. … That's our goal."**

Walgreens CEO Roz Brewer

Like other major retailers including CVS and Walmart, Walgreens has made major investments in primary care and post-acute services

As of October '21, Walgreens Boots Alliance had invested $5.2 billion in VillageMD to roll out physician-staffed clinics across the country and $330 million in post-acute and home care company CareCentrix

As of February '22, the partnership is on track to open more than 200 co-branded primary care practices by the end of the year

Walgreens and VillageMD have now opened over 80 primary care practices in Arizona, Florida, Texas, Kentucky and Indiana

At a Forbes Healthcare summit, CEO Roz Brewer shared that Walgreens' push into primary care aims to keep people healthy enough to avoid returning to the healthcare system



Source: Becker's Hospital Review, *Walgreens' care goal is to keep people away from the healthcare system, CEO says* Georgina Gonzalez, 12/3/21 https://www.beckershospitalreview.com/hospital-management-administration/walgreens-care-goal-is-to-keep-people-away-from-the-healthcare-system-ceo-says.html; Healthcare Dive, *Walgreens, VillageMD on track to open 200 co-branded clinics this year,* Rebecca Pifer, 2/17/22 https://www.healthcaredive.com/news/walgreens-villagemd-to-open-200-clinics-2022

# CVS Targets 65B Healthcare Interactions by 2030, Invests $185M in Affordable Housing (updated 3/4/22)

- In an overall effort to support community health, CVS continues its expansion into retail healthcare, setting a goal to facilitate 65 billion healthcare interactions over the next 10 years and investing $185M into affordable housing
- Key retail strategies include
  - Continuing to grow HealthHUB stores
  - Rethinking care delivery based on lessons learned during COVID-19
  - Investing in community health
- CVS opened 650 HealthHUBs in 2020 and is on track to reach 1500 by the end of 2021
  - HealthHUB stores offer both in-person and virtual services
- CVS grew during the pandemic, becoming the largest private provider of COVID-19 testing and providing over 20k visits at its newly launched telehealth platform E-clinic
- *CVS housing investments went towards creating over 6,570 housing units in 64 cities across 28 states and Washington DC, including 736 permanent supportive housing units targeted toward those facing homelessness*
  - *Supportive housing residents have access to CVS healthcare services*


Sources: FierceHealthcare, *CVS wants to facilitate 65B healthcare interactions by 2030. Here's how,* Paige Minemyer, 3/31/21 https://www.fiercehealthcare.com/payers/cvs-wants-to-facilitate-65b-healthcare-interactions-by-2030-here-s-how ; *CVS invested $185M in housing last year. Here's where those funds went,* Paige Minemyer 3/4/22 https://www.fiercehealthcare.com/payers/cvs-invested-185m-housing-last-year-heres-where-those-funds-went

# BCBS Benefits Will Include Amazon Drug Discount Card (3/8/22)

Blue Cross Blue Shield plans in New Jersey, Nebraska, Alabama, Florida, and Kansas will now offer members the option of paying for medications with the MedsYourWay drug discount card from Amazon's InsideRx and Prime Therapeutics

The MedsYourWay card allows subscribers to pay the cash price for a prescription, which can be up to 80% cheaper than the price negotiated with their drug formulary. Having the option to compare prices creates transparency and choice for patients.

In alignment with Amazon Pharmacy's goal to reduce healthcare costs for patients, the cost of drugs bought through the MedsYourWay card can be applied to a member's copay or deductible

- "If there are other insurers out there who want to work with us to drive a better customer experience through this program, a similar program or a completely different program, we're open. We are here to work to make the pharmacy experience better, and we want to work with partners who want to do that as well."
  - Dr. Nworah Ayogu, Amazon Pharmacy CMO

Source: Modern Healthcare, *Five Blues plans add Amazon's drug discount card to benefits,* Nona Tepper, 3/8/22 https://www.modernhealthcare.com/insurance/five-blues-plans-add-amazons-drug-discount-card-benefits

# Anthem Expands Virtual Primary Care Services (2/8/22)

- On 2/8/22, Anthem announced the expansion of its telehealth primary care services to 11 new states, with plans to offer virtual services to all of its service area and cover 10 million self-insured lives by the end of 2022
- Anthem launched its "virtual-first" program during open enrollment this year.
  - Requires members to see a provider via telehealth before visiting one in person and is available in six states.
  - Expansion of this type of plan depends on regulatory approval.
- While other insurers expanding into primary care tend to buy up physician practices, Anthem differentiates itself by using technology to connect independent physicians and promote value-based care through facilitating use of new payment models
- The company also invests heavily in value-based care companies including Vera Health, Privia Health, Caremax and K Health
- In 2021, approximately 60% of Anthem's 45.4 million members' medical spend came from value-based relationships

"Our strategy is being a digital platform for health… That being the case, it's what can we connect and interoperate is the primary driver for us, versus needing to own our care delivery."

Rajeev Ronanki, chief digital officer



Source: Modern Healthcare, *Anthem expands digital health partnerships,* Nona Tepper, 2/8/22
*https://www.modernhealthcare.com/insurance/anthem-expands-digital-health-partnerships?utm_source=modern-healthcare-am-wednesday*

# Anthem and Kroger Partner to Promote Health and Wellness in New MA Plans

To promote health and address food insecurity among seniors, Anthem and grocery/pharmacy chain Kroger are partnering to offer Medicare Advantage plans that facilitate access to healthy food and wellness items

The first plans will be offered in Ohio, Kentucky, Georgia and Virginia, with intention to expand to other states

Plan members will receive monthly stipends to purchase food and wellness items at Kroger stores, and all Kroger pharmacies will be in-network

Members may also consult with Kroger dieticians at no charge and receive a monthly home delivery of pantry staples

"By partnering with Anthem, we are able to offer seniors in our communities access to affordable high quality healthcare services. And through the enhanced nutrition and OTC benefit, we can also provide preventive care using food as medicine,"

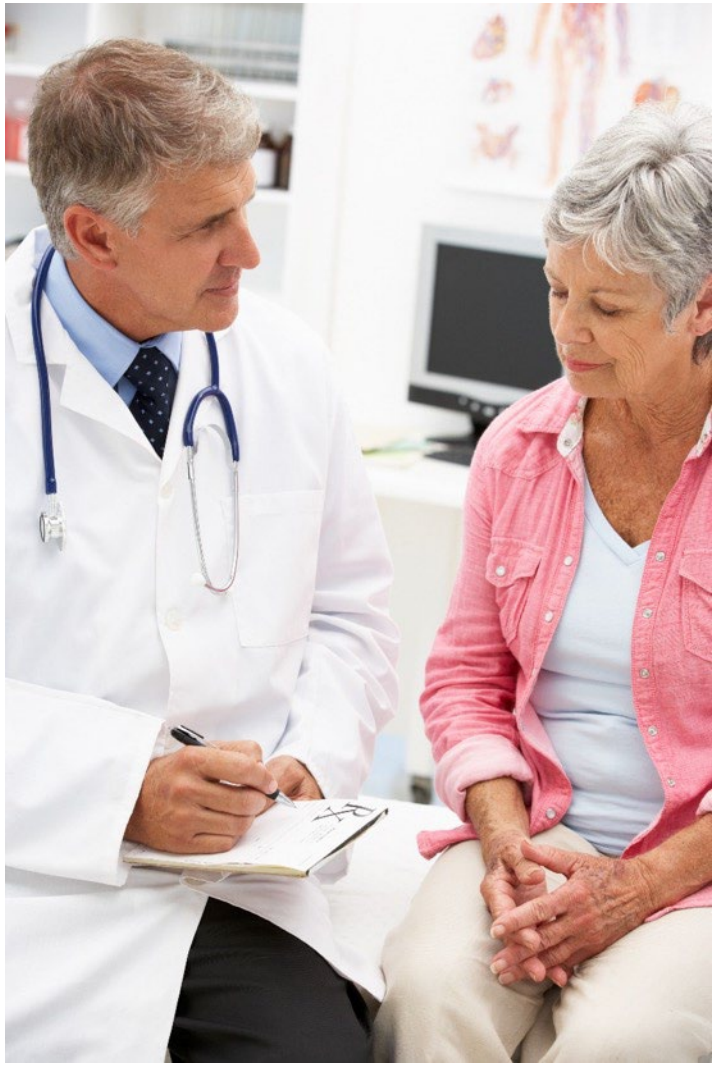
Jim Kirby, senior director of business development for Kroger Health



Source: Fierce Healthcare, A look at Anthem, Kroger's new co-branded Medicare Advantage plans, Paige Minemyer, 10/27/21 https://www.fiercehealthcare.com/payer/a-look-at-anthem-kroger-s-new-co-branded-medicare-advantage-plans

# Anthem and CareMax To Build Value-Based Care Medical Centers (8/13/2021)

- Miami-based provider CareMax has partnered with Anthem to open about 50 medical centers across the country, with Anthem incorporating value-based care into its benefits for members who visit the new locations
- CareMax is a technology-enabled care platform providing value-based care and disease management to seniors
- **"We know that value-based care helps seniors live healthier lives, and we are excited to partner with Anthem to bring healthcare with heart to the populations who need it most."**
  - CareMax CEO Carlos de Solo





Source: Modern Healthcare, CareMax, Anthem to open 50 value-based care medical centers, Ginger Christ, 8/13/21
https://www.modernhealthcare.com/insurance/caremax-anthem-open-50-value-based-care-medical-centers

# UnitedHealth Buys OptumCare and Home Health Firm LHC (3/29/22)

"When you begin to pencil out the math, as we move people into value-based arrangements, that will be a major driver of how we'll move to a $100 billion book of business."

Wyatt Decker, MD
OptumHealth CEO

Managed care company UnitedHealth Group has purchased OptumCare, which comprises 56,000 physicians and 1600 clinics, and plans to grow it to a $100B business through value-based arrangements

It also agreed to purchase home health group LHC, which employs about 30,000 people, operates in 37 states and cares for over 500,000 patients annually

Per OptumHealth (OptumCare parent) CEO Dr. Wyatt Decker, under the new arrangement, physicians will be paid to keep patients healthy instead of for treating them when they are sick

OptumCare is also launching a virtual care platform called Optum Virtual Care that supports its plan to integrate virtual care, home care, and care clinics across all 50 states

The acquisition of a home health company may impact hospital patient volumes, as patients will remain at home instead of in the hospital



Source: Becker's Hospital Review, How UnitedHealth plans to make Optum a $100B business, Ayla Ellison, April 23, 2021, https://www.beckershospitalreview.com/finance/how-unitedhealth-plans-to-make-optum-a-100b-business.html?origin=CIOE; Beckerspayer.com, *UnitedHealth to buy home-health firm LHC Group*, Andrew Cass, 3/29/22 https://www.beckerspayer.com/m-and-a/unitedhealth-to-buy-home-health-firm-lhc-group.html?origin=CFOE

# Humana's Primary Care Investment Backed by Private Equity (1/20/22)

Humana has announced plans to continue expanding its health centers for older adults, with the current expansion partly funded by $600M investment from private equity firm Welsh, Carson, Anderson & Stowe

Through its CenterWell and Conviva brands, Humana currently operates around 200 health centers in nine states, and plans to increase to 260 health centers by the end of 2022

By directing its 4.3 million Medicare Advantage members to outpatient sites for care, and addressing their social determinants of health needs, Humana aims to inspire better patient outcomes and lower healthcare costs.

Humana is the second-largest Medicare Advantage insurer in the US and serves 4.3 MA members. The company aims to serve seniors by improving care quality, lowering costs, and addressing social determinants of health.



Source: Modern Healthcare, *Humana grows private equity-backed primary care*, Nona Tepper, 1/20/22 https://www.modernhealthcare.com/insurance/humana-grows-private-equity-backed-primary-care?utm_source=modern-healthcare-am-friday

# Northwell Health to Skip Traditional Insurance for Employees, Offer Direct Contracting (10/11/21)

- NY-based not-for-profit integrated health system Northwell Health announced plans to provide health benefits to its 75,000 employees and dependents through a new direct contracting system, signaling a disruption in traditional employer-sponsored health benefits
- **The state's largest healthcare employer will use Northwell Direct, its own for-profit subsidiary, for direct network contracting approach with providers**
- Per Northwell Health leadership, a small pilot of Northwell Direct's network contracting program led to reduced healthcare spending, better network access, and enhanced customer experience. **Northwell Direct says its approach generally results in a 20% drop in employer healthcare costs compared to traditional insurance plans.**
- Northwell Direct also direct contracting services to Whole Foods Market and care management services to employers, such as COVID-19 tools for JetBlue

**"Because this is allowing us to provide care directly to our team members without an intermediary through the network, it allows us to focus on care of our team members as our number one priority,"**

Gregg Nevola, vice president and chief rewards officer, Northwell Health



Source: Modern Healthcare, *Northwell Health ditches insurers for direct network contracting*, Nona Tepper, 10/11/21
https://www.modernhealthcare.com/payment/northwell-health-ditches-insurers-direct-network-contracting?utm_source=modern-healthcare-am-tuesday

# Primary Care Investments & Alignment with Non-Traditional Players (Recent Highlights)

## Q1/2021

CVS targets 65B healthcare interactions by 2030, driven by investments in HealthHub and community health[1]

Digital health companies offering primary care brought in the second most funding in Q1 2021, driven by Ro ($500M), Dispatch Health ($200M), and Eden Health ($60M)[2]

## Q2/2021

**UnitedHealthcare buys OptumCare,** which comprises 56,000 physicians and 1,600 clinics, and plans to grow it to a $100B business through value-based arrangements[3]

OptumCare is also launching a virtual care platform called Optum Virtual Care that supports its plan to integrate virtual care, home care, and care clinics across all 50 states

## Q3-Q4/2021

Carbon Health banks another $350M from PE firm to become 'largest primary care provider in the U.S.'[4]

**OneMedical acquires Iora Health,** a leading value-based primary care group serving Medicare patients at 47 offices. "Together, we'll deliver exceptional, human-centered, technology-powered primary care to more people in more places — across every stage of life"[5]

## Q1/2022

Humana plans to expand its health centers for older adults with $600M investment from PE firm[6]

PE firm invests $500M in FL-Florida based primary care physician group and managed services organization[7]

Aledade (software company helping physicians and primary care transition to value-based care) launches new health services unit via an acquisition of Iris healthcare[7]


Sources:

1. https://www.fiercehealthcare.com/payer/cvs-wants-to-facilitate-65b-healthcare-interactions-by-2030-here-s-how
2. https://rockhealth.com/insights/q1-2021-fundmg-report-digital-health-is-all-grown-up/
3. https://www.beckershospitalreview.com/finance/how-unitedhealth-plans-to-make-optum-a-100b-business.html?origin=CIOE
4. https://www.fiercehealthcare.com/tech/carbon-health-banks-another-350m-to-become-largest-primary-care-provider-u-s
5. https://www.onemedical.com/about-us/
6. https://www.modernhealthcare.com/insurance/humana-grows-private-equity-backed-primary-care?utm_source=modern-healthcare-am-friday
7. https://www.fiercehealthcare.com/finance/physician-partners-kinderhook-500m-investment-value-based-care?utm_source=email
8. https://www.fiercehealthcare.com/tech/jpm-2022-aledade-scoops-up-advance-care-planning-startup-iris-healthcare-to-build-out-health

# Rural Health System Imperatives

- “Shaky Bridge” crossing will require planned, proactive approach
  - Market forces at play will require new strategies
  - Strategic thinking is essential - Doing next year “a little better” will no longer suffice
  - A foundational premise of all health system strategic plans is a transitioning payment system
    - Changes the future functional imperatives 180 degrees
- Important elements that must be addressed include:
  - Operating efficiencies, quality, patient engagement
  - Medical staff alignment
  - Service area rationalization
  - Population health management
  - Transitioning payment systems
- Immediate priorities
  - Meet with commercial insurers to discuss increasing costs and imperative for higher reimbursement
  - Prepare interim cost reports that recognize higher labor/non-labor
  - Leverage goodwill received during the pandemic to recapture lost market share
  - New consumer-oriented strategies (i.e., open access in clinics, telehealth)
  - Aggressive and proactive approaches to maintain/enhance staffing
  - Political advocacy recognizing rural is disproportionately impacted by staffing shortages

# Questions?

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