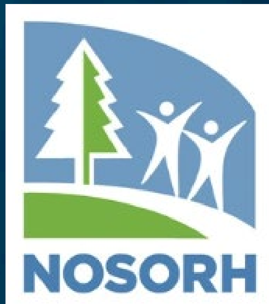
State of the Healthcare Industry: Updates for Rural

NOSORH Quarterly Updates for Rural Strategy

July 6, 2022

Eric K. Shell, CPA, MBA



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 (12/14/21, updated 3/22/22 and 4/13/22)

- 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
  - 75% based on lost revenue/higher exp
    - Small providers will receive base payment plus supplement with smallest 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

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

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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 (12/14/21, updated 3/22/22 and 4/13/22)

- Phase 4 General Distribution (continued)
  - $9B of the $17B 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
  - $1.75B distributed 4/13/22
    - $13.5B of $17B has been distributed as of 4/13/22
  - PRF received during Q4 of 2021 can be used through 12/31/22
  - PRF received during Q1 of 2022 can be used through 6/30/23

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

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

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HHS Distributing $1.75 Billion in Provider Relief Fund Payments to Health Care Providers Affected by the COVID-19 Pandemic

U.S. Department of Health & Human Services
Health Resources and Services Administration

HRSA NEWS ROOM
http://newsroom.hrsa.gov

FOR IMMEDIATE RELEASE
April 13, 2022

CONTACT: HRSA PRESS OFFICE 301-443-3376
Press@hrsa.gov

The Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), today announced more than $1.75 billion in Provider Relief Fund payments to 3,680 providers across the country. With this disbursement, HRSA has distributed approximately $13.5 billion from the Provider Relief Fund to nearly 86,000 and nearly $7.5 billion in American Rescue Plan (ARP) Rural payments to more than 44,000 providers since November 2021.

Provider Relief Funds –ARPA Rural Distribution (updated 5/11/22)

- 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
- *$450M distributed 5/11/2022*
- 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.

Information related to the COVID-19 pandemic changes frequently. The content of this presentation is accurate to the best of our knowledge as of the day and time it was presented and will not be updated continuously once it is posted. Please reach out to the presenters with any questions or concerns

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”

Information related to the COVID-19 pandemic changes frequently. The content of this presentation is accurate to the best of our knowledge as of the day and time it was presented and will not be updated continuously once it is posted. Please reach out to the presenters with any questions or concerns.

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)
- 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

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

RHC Covid Testing and RHC Testing and Mitigation Program - Updates (5/22/22)

- RHC Covid-19 Testing Program (RHCCT) - $49K
  - HRSA notice on 1/18/2022 reminding recipients of January 31, 2022, reporting deadline
    - Funds were to be used by 12/31/2021
  - RHCs that have unused funds must complete the "complete or partial return process" by March 2, 2022
- RHC Covid-19 Testing and Mitigation Program (RHCCTM) - $100K
  - RHCs who received funding from the RHC COVID-19 Testing and Mitigation (RHCCTM) Program ($100k) must continue to report the number of COVID-19 tests conducted and the number of positive COVID-19 tests until January 2023 on the Rural Health Clinic COVID-19 Reporting Portal.
  - Reporting Deadlines:

Reporting Deadline	Monthly Data
April 30, 2022	March 2022
May 31, 2022	April 2022
June 30, 2022	May 2022
July 31, 2022	June 2022
August 31, 2022	July 2022

Source: HRSA email notice on 1/18/2022

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.

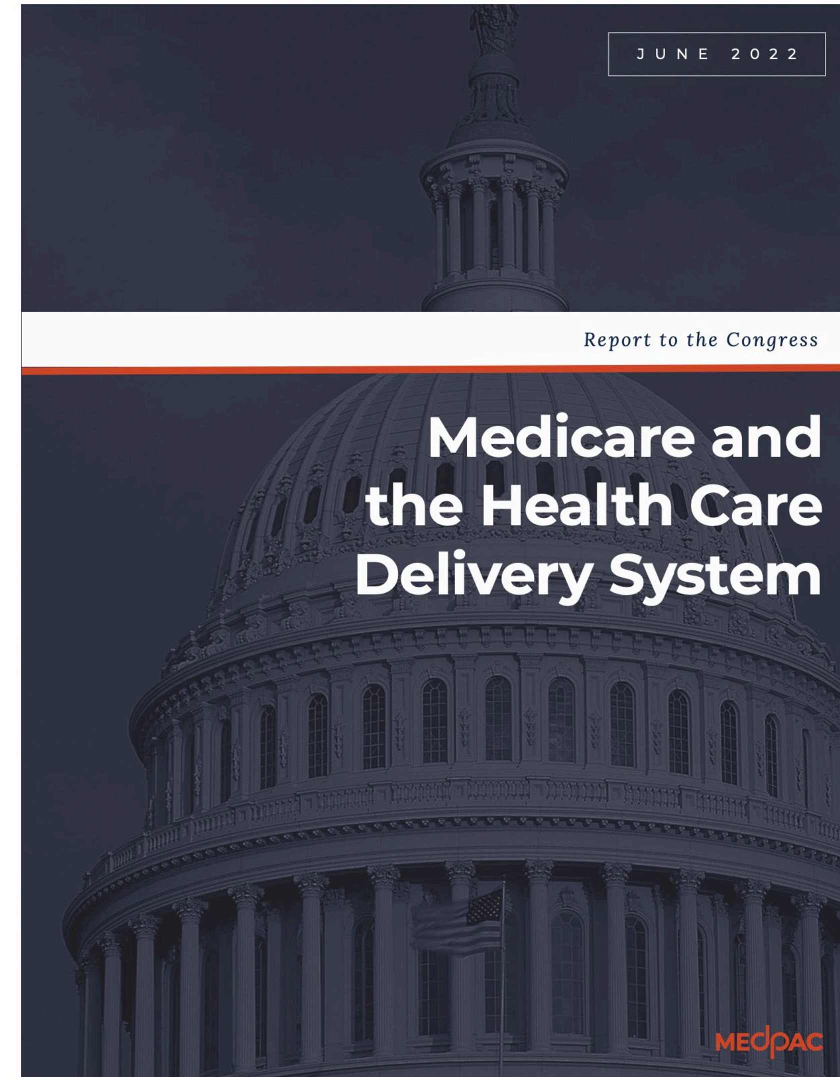
(/)

Last Updated: 07/21/2020

Legislative/Regulatory
Updates

June 2022 MedPAC Annual Report: Major Considerations (6/15/22)

- Streamline/Harmonize Medicare's Portfolio of Alternative Payment Models
  - Reduce the number of ACOs from 7 to a small number geared towards providers of different size and with different degrees of risk
  - Move away from rebasing benchmarks every few years based on actual spending and rely on periodic administrative updates based on an update factor unrelated to the ACO actual spend
  - Implement a national episode-based payment model (EBPM) for certain types of clinical services
    - Require certain providers to participate in these models
    - For beneficiaries concurrently attributed to the EBPM and ACOs, allocate EBPM bonuses between ACOs and EBPN participants
- Supporting Safety Net Providers
  - Developed a new framework for identifying safety net providers using low-income Medicare beneficiaries as well as those receiving partial Medicaid benefits
  - Modeled effect of these patients on financial performance of safety new providers
  - Modeled a redistribution of current DSH funding using Safety Net Income (SNI) which increased DSH payments to safety net providers



Source: Report to the Congress: Medicare and the Health Care Delivery System, MedPAC, June 2022
https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf

June 2022 MedPAC Annual Report: Major Considerations (6/15/22) (Cont.)

- Aligning FFS Payment Rates Across Ambulatory Settings
  - Identified 57 APCs for which payment could be standardized across Hospital OP departments, ASCs, and freestanding offices
    - APCs for EDs, critical care, and trauma were excluded
  - With standardized payment across settings, net savings to Medicare in FY 2019 would have been $6.6B (4.1%) and $1.7B (13.2%) to beneficiary cost sharing
  - Policy makers should consider an alternative to budget neutrality rule
- Other topics including:
  - Addressing Medicare vulnerable beneficiaries' access to care final report
  - Addressing high prices of drugs under Part B
  - Segmentation in the stand-alone Part D market
  - Improving Accuracy of Medicare Advantage Payments by Limiting Influence of Outliers in Risk Adjustment Model

Source: Report to the Congress: Medicare and the Health Care Delivery System, MedPAC, June 2022
https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf

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*

STROUDWATER

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

CMS 2023 Inpatient Perspective Payment Proposed Rule (4/18/22)

- Payment Rate Update

PROPOSED FY 2023 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS				
FY 2023	**Hospital Submitted Quality Data and is a Meaningful EHR User**	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User**
Proposed Market Basket Rate-of-Increase	3.1	3.1	3.1	3.1
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.775	-0.775
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.325	0	-2.325
Proposed Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.7**	**0.375**	**1.925**	**-0.4**

  - Payment increase of 2.7% for 2022 plus statutory increase of .5%
- Disproportionate Share Payments
  - Distribute $6.6B, a reduction of $654M from 2022

Source: CMS Fact Sheet, 4/18/2022

CMS 2022 IPPS Proposed Rule (4/18/22) (continued)

- Discontinuation of the Medicare Dependent Hospital (MDH) effective 10/1/2022
  - MDHs have opportunity to apply for Sole Community Hospital (SCH) status by 9/1/22 and have SCH designation begin on 10/1/22
- Measure Suppression or Refinement Policies in Response to COVID-19 PHE in Certain Value-Based Purchasing Programs
  - Hospital Readmissions Reduction Program
  - Hospital-Acquired Condition (HAC) Reduction Program
  - Hospital Value-Based Purchasing (VBP) Program
- Hospital commitment to Health Equity
  - CMS proposed adding a measure on a hospital's commitment to health equity, which would capture strategic planning activities, data collection and analysis, quality improvement and leadership engagement.
  - Adds a measure on screening for social drivers of health, which would start with voluntary reporting in 2023 and move to mandatory reporting in 2024.

Source: CMS Fact Sheet, 4/18/2022

2022 Consolidated Appropriations Act Addresses 340B and Telehealth, Leaves Other Key Concerns Unresolved (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
- Unfortunately for other industry stakeholders, the bill
  - Failed to include COVID-19 funding
  - Did not add funds to the Provider Relief Fund
  - Maintained the schedule for the Medicare payment sequester
    - 1% 4/1/22, 2% 7/1/22, 4% 1/1/23
  - Did not offer relief on repayment terms for Medicare advance payments

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:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Consolidated Appro-

3 priations Act, 2022".

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

Medicare Proposed Rules on Rural Emergency Hospital (REH) and CAH Conditions of Participation (CoP) Updates (6/30/22)

- Background: Consolidated Appropriates Act of 2021 established a new Medicare rural provider type: Rural Emergency Hospital (REH)
  - These providers will provide ED and observation care (not to exceed 24 hours), and other specified OP medical care
  - Eligible hospitals include CAHs and rural hospitals with not more than 50 beds, that were open on date of enactment
  - Payment based on 105% of OP payment plus a fixed monthly payment amount
  - Program to begin 1/1/2023
- CoP modeled after CAH
  - Required services:
    - REH must provide emergency care necessary to meet needs of patients
    - REH must provide basis laboratory services 24/7
    - REH must meet hospital requirements for radiologic services
    - REH must operate a pharmacy or drug storage area
    - REH must have a referral system in place to another level of care
  - Optional services include distinct part SNFs

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 485 and 489

[CMS-3419-P]

RIN 0938-AU92

Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish conditions of participation that Rural Emergency Hospitals (REH) must meet to participate in the Medicare and Medicaid programs. These requirements are intended to ensure that a high quality of care is furnished by REHs. This proposed rule also includes changes to the requirements Critical Access Hospital would have to meet to participate in the Medicare and Medicaid programs. Proposed payment policies and enrollment policies for REHs will be developed under separate rulemaking.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by **August 29, 2022**.

Sources:https://public-inspection.federalregister.gov/2022-14153.pdf?mkt_tok=NzEwLVpMTC02NTEAAAGFWbKiaYyGBicQgLriWciyI3uPm2f64c73Xqig2f2UeicCuMOs7qJRuOKHb9NHwgfquHRgA5k3cX4kHnU1UTzCc4TFSc2ZxaTUIwm7F6frFGNK: NRHA Grass Roots Advocacy email dated 7/1/2022

Medicare Proposed Rules on REH and CAH CoP (6/30/22) (Continued)

- CoP modeled after CAH (continued)
  - Staffing
    - REH may grant medical staff privileges to NPs or PAs if allowable under state law
    - Must have adequate medical and nursing staff qualified in emergency care
    - ED must be staffed 24/7 and doctor, APP, or clinical nurse specialists be on call and immediately available by phone
    - Must have nursing services available 24/7 and a director of nursing who is a licensed registered nurse
  - Telemedicine
    - REH can be originating site
    - Telemedicine payment to be determine in future rule setting

Sources:https://public-inspection.federalregister.gov/2022-14153.pdf?mkt_tok=NzEwLVpMTC02NTEAAAGFWbKiaYyGBicQgLriWciyI3uPm2f64c73Xqig2f2UeicCuMOs7qJRuOKHb9NHwgfquHRgA5k3cX4kHnU1UTzCc4TFSc2ZxaTUIwm7F6frFGNK: NRHA Grass Roots Advocacy email dated 7/1/2022

Medicare Proposed Rules on REH and CAH CoP (6/30/22) (Continued)

- CoP modeled after CAH (continued)
  - Other areas addressed in proposed rule
    - Infection prevention and Antibacterial stewardship
    - Patient rights
    - QAPI program
    - Transfer agreements
- To be addressed in future rule-making include payment, quality reporting and enrollment
- Comment period ending 8/29/2022

Sources:https://public-inspection.federalregister.gov/2022-14153.pdf?mkt_tok=NzEwLVpMTC02NTEAAAGFWbKiaYyGBicQgLriWciyI3uPm2f64c73Xqig2f2UeicCuMOs7qJRuOKHb9NHwgfquHRgA5k3cX4kHnU1UTzCc4TFSc2ZxaTUIwm7F6frFGNK: NRHA Grass Roots Advocacy email dated 7/1/2022

Medicare Proposed Rules on REH and CAH CoP (6/30/22) (Continued)

- CAH CoPs
  - Added a definition of primary roads to the location and distance requirements
    - Proposed that primary road for determining the driving distance of a CAH and its proximity to other providers as a numbered Federal highway, including interstates, intra-states, expressways or any other numbered Federal highway; or a numbered state highway with two or more lanes each way.
    - **CMS is soliciting comments** on whether the definition should include numbered Federal highways with two or more lanes (similar to the state highway definition) and exclude Federal highways with one lane in each direction.
  - Established a patient's rights CoP; and
  - Allowed for unified and integrated systems for their infection control and prevention and antibiotic stewardship program, medical staff, and quality assessment and performance improvement program (if the CAH is part of a health system containing more than one hospital or CAH).

Sources:https://public-inspection.federalregister.gov/2022-14153.pdf?mkt_tok=NzEwLVpMTC02NTEAAAGFWbKiaYyGBicQgLriWciyI3uPm2f64c73Xqig2f2UeicCuMOs7qJRuOKHb9NHwgfquHRgA5k3cX4kHnU1UTzCc4TFSc2ZxaTUIwm7F6frFGNK: NRHA Grass Roots Advocacy email dated 7/1/2022

Hospitals Win 340B Supreme Court Ruling (6/15/22)

- Background: In 2018 and 2019, CMS cut payment to 340B eligible drugs administered in a hospital outpatient setting from average sale price (ASP) plus 6% to ASP less 22.5% reducing payments to 340B providers by $1.6B
  - Savings were redistributed to all hospitals through OPPS update factor
- *"We conclude that, absent a survey of hospitals' acquisition costs, HHS may not vary the reimbursement rates for 340B hospitals. HHS's 2018 and 2019 reimbursement rates for 340B hospitals were therefore contrary to the statute and unlawful."*

SUPREME COURT OF THE UNITED STATES

Syllabus

AMERICAN HOSPITAL ASSOCIATION ET AL. *v.* BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20–1114. Argued November 30, 2021—Decided June 15, 2022

The Medicare statute lays out a formula that the Department of Health and Human Services must employ annually to set reimbursement rates for certain outpatient prescription drugs provided by hospitals to Medicare patients. 42 U. S. C. §1395*l*(t)(14)(A)(iii). That formula affords HHS two options. Option 1 applies if HHS has conducted a survey of hospitals' acquisition costs for each covered outpatient drug. Under this option, the agency may set reimbursement rates based on the hospitals' "average acquisition cost" for each drug, and may "vary" the reimbursement rates "by hospital group." §1395*l*(t)(14)(A)(iii)(I). Absent a survey, option 2 applies, and HHS must set reimbursement rates based on "the average price" charged by manufacturers for the drug as "calculated and adjusted by the Secretary." §1395*l*(t)(14)(A)(iii)(II). Option 2 does *not* authorize HHS to vary reimbursement rates for different hospital groups. From the time these provisions took effect in 2006 until 2018, HHS did not conduct surveys of hospitals' acquisition costs, relied on option 2, set the reimbursement rates at about 106 percent, and did not vary those rates by hospital group. For 2018, HHS again did not conduct a survey. But this time it issued a final rule establishing separate reimbursement rates for hospitals that serve low-income or rural populations through the 340B program and all other hospitals. For 2019, HHS set reimbursement rates the same way.

Other Market Updates

Kaiser Permanente Invests an additional $200M in affordable housing (4/14/22)

- Kaiser Permanente doubled its investment in Thriving Communities, and fund set up to address the health of economically underserved communities by creating access to affordable housing
- The integrated health system believes the additional $200M will allow it to create or preserve 30,000 affordable housing units before 2030
- The new investment is intended to offset the negative financial impacts of the COVID-19 pandemic on low-income communities and communities of color

"There's a clear link between economic stress and poor health…We find that there is more opportunity for us to have a positive effect on the underlying health conditions and the future health of communities if we can find ways for them to be housed, fed and take care of their basic needs."

Steve Shivinsky, Kaiser Permanente national media relations director

Source: Modern Healthcare, *Kaiser Permanente adds $200 million to its affordable housing fund,* Max Abrams, 4/14/22
https://www.modernhealthcare.com/hospital-systems/kaiser-permanente-doubles-its-affordable-housing-fund?utm_source=modern-healthcare-am-friday

CVS Targets 65B Healthcare Interactions by 2030, Invests $185M in Affordable Housing, Launches Virtual Primary Care Platform (updated 5/30/2022)

- 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
- *Starting in 2023, the retailer's virtual care platform, CVS Health Virtual Primary Care, will be available to Aetna and Caremark members*
  - *The new platform will provide on-demand care, chronic condition management and mental health services and will leverage an interoperable EHR to facilitate care coordination*
- The CVS housing investments went towards creating over 6,570 housing units in 64 cities across 28 states and Washington DC, with access to CVS healthcare services provided for residents
- 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

Sources: FierceHealthcare, *CVS wants to facilitate 65B healthcare interactions by 2030. Here's how,* Paige Minemyer, 3/31/21 https://www.fiercehealthcare.com/payer/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/payer/cvs-invested-185m-housing-last-year-heres-where-those-funds-went; *CVS Health rolls out virtual primary care service,* Heather Landi, 5/30/22 https://www.fiercehealthcare.com/health-tech/cvs-health-rolls-out-virtual-primary-care-service

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-funding-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?