STATE OF THE HEALTHCARE INDUSTRY: UPDATES FOR RURAL

NOSORH Quarterly Updates for Rural Strategy

January 10, 2025

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NOSORH

STROUDWATER

Agenda

1. Legislative/Regulatory Updates
2. Other Market Updates

Legislative/Regulatory Updates

CMS 2025 Inpatient Perspective Payment System (IPPS) Final Rule (8/1/24)

- Payment Rate Update

FY 2025 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2025	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
Market Basket Rate-of-Increase	3.4	3.4	3.4	3.4
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.85	-0.85
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.55	0.0	-2.55
Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Applicable Percentage Increase Applied to Standardized Amount	**2.9**	**0.35**	**2.05**	**-0.5**

  - Originally proposed 2.6% increase increased to 2.9% with higher market basket rate
  - Overall expected inpatient payments to hospitals to increase by $3.2B
- Uncompensated Care (UC) payments to Disproportionate Share Hospitals to decrease by $235M
  - FY 2025 proposed rule had an increase of $568M

Source: CMS Fact Sheet, 8/1/2024; https://www.beckershospitalreview.com/index.php?option=com_content&view=article&id=213736; https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page

CMS 2025 IPPS Final Rule (8/1/24) (continued)

- Hospital and CAH Data Reporting
  - CMS has finalized replacing the COVID-19 and Seasonal Influenza reporting standards for hospitals and CAHs with a new standard that will address acute respiratory illnesses
  - Beginning on October 1, 2024, hospitals and CAHs would have to electronically report certain data elements about COVID-19, influenza, and respiratory syncytial virus (RSV)
    - The information for which reporting would be required includes confirmed infections of respiratory illnesses, including COVID-19, influenza, and RSV, among hospitalized patients; hospital bed census and capacity; and limited patient demographic information, including age.
  - CMS has finalized that, outside of a public health emergency (PHE), hospitals and CAHs would have to report these data on a weekly basis
- ***Continuation of Low-Wage Hospital Policy***
  - ***Finalized policy that was finalized in FY 2020 that addresses wage disparities in low-wage index areas, is extended an additional 3-years beginning in 2025***
  - ***On 7/23/2024, US Court of Appeals for DC Circuit backed a district court's decision that CMS acted unlawfully to increase payments to hospitals in the lowest quartile of Medicare wage index and must vacate policy***
  - ***On 10/3/2024, CMS issued 2025 IPPS Interim Final Action with Comment Period which reduced payments to low-wage hospitals, capped at a 5% reduction, and is recalculating the IPPS wage index and removing the wage index budget neutrality negative adjustment factor***
- Expanded Low Volume Adjustment (LVA) and Medicare Dependent Hospitals (MDH)
  - Unless Congress extends programs which they have done in previously, they will expire 12/31/2024

Source: CMS Fact Sheet, 8/1/2024; https://www.beckershospitalreview.com/index.php?option=com_content&view=article&id=213736; https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page; https://www.federalregister.gov/documents/2024/10/03/2024-22765/medicare-program-changes-to-the-fiscal-year-2025-hospital-inpatient-prospective-payment-system-ipps

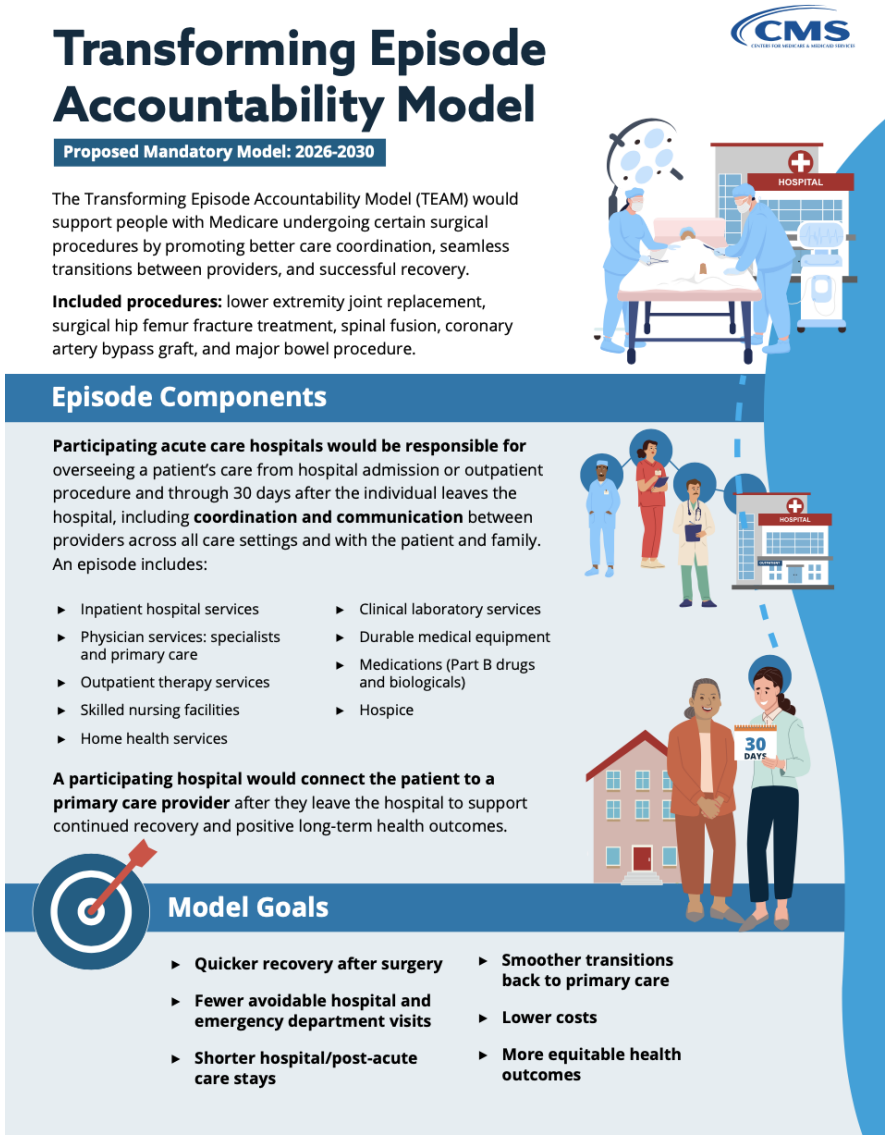
CMS 2025 IPPS Final Rule (8/1/24) (continued)

- ***Transforming Episode Accountability Model (TEAM)***
  - ***CMS has finalized many provisions in the TEAM including:***
    - ***Mandatory participation for IPPS hospitals in certain areas of the country***
    - ***Bundled payments for five types of surgical episodes***
    - ***5-year program beginning 1/1/2026***
    - ***See next slide for additional information***
- Social Determinants of Health (SDOH) Diagnosis Codes
  - CMS finalized to change the severity designation of the seven ICD-10-CM diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity (Non CC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes
- Inpatient Quality Reporting
  - CMS has finalized the adoption of seven new quality measures, removed five existing quality measures, and modified one current electronic clinical quality measures (eCQMs)
  - CMS has finalized two changes to the current policies related to data validation: an increase over two years in the total number of mandatory eCQMs reported by hospitals and cross-program modifications to the HCAHPS Survey measure

Source: CMS Fact Sheet, 8/1/2024; https://www.beckershospitalreview.com/index.php?option=com_content&view=article&id=213736; https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page

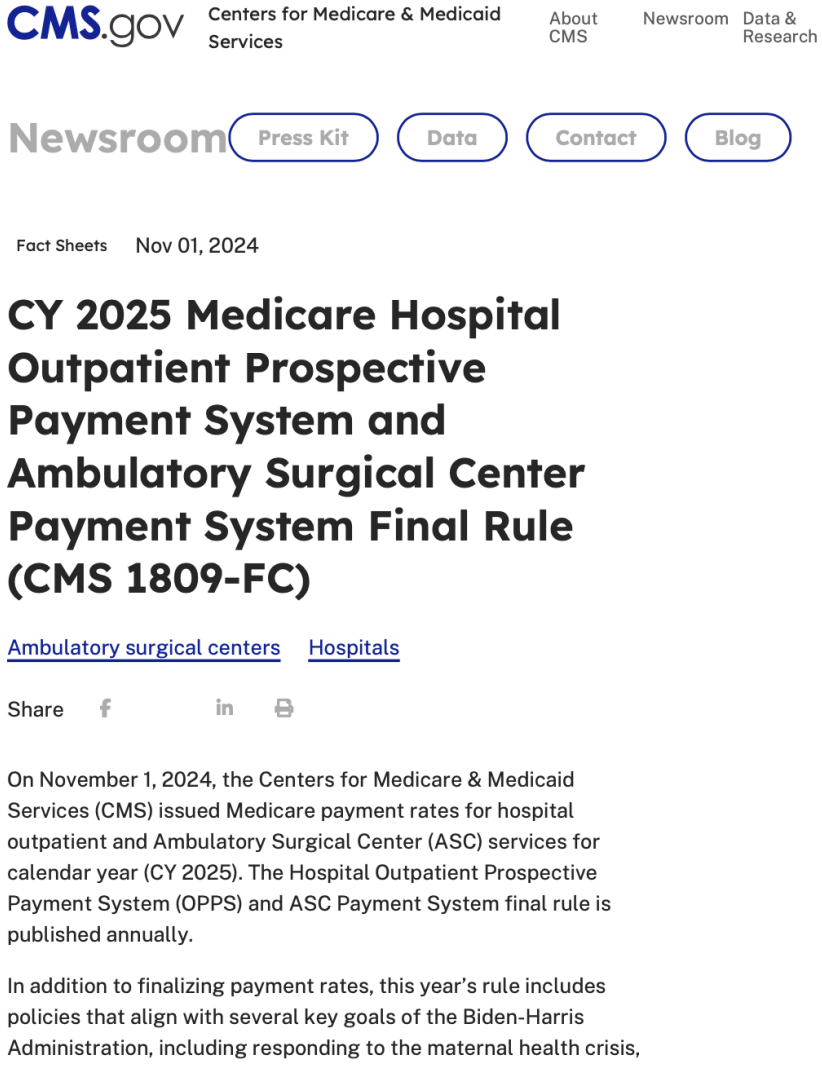
Transforming Episode Accountability Model "TEAM" (4/19/2024)

- Overview/Goal
  - Mandatory 5-Year payment model beginning 1/1/26 that will improve quality for certain high-expenditure, high volume surgical procedures, reducing rehospitalization and recovery time will lower Medicare spending
- TEAM Payment Model
  - Five-year, mandatory episode-based payment for hospitals in selected geographic regions (Core-Based Statistical Areas) with graduated risk through different participating tracks
    - Track 1 - No downside risk and lower levels of reward for one year
    - Track 2 – Lower levels of risk and reward for certain hospitals, such as safety net hospitals, for years 2-5
    - Track 3 – Higher levels of risk and reward for years 1-5
  - Episodes of focus would be Lower Extremity Joint Replacement, Surgical Hip Femur Fracture Treatment, Spinal Fusion, Coronary Artery Bypass Graft, and Major Bowel Procedure
  - Hospitals would receive a target price based on all non-excluded Medicare Part A&B items and services included in an episode
    - Subject to quality adjustment, an incentive payment for hospitals if actual FFS costs are below target price and a penalty for hospitals whose FFS costs exceeded the target price



CY2025 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule (11/01/2024)

- On November 1, 2024, CMS finalized Medicare payment rates and policies for hospital outpatient and ASC services for calendar year (CY) 2025
  - Proposed rule was issued on 7/10/2024
- Key elements finalized include:
  - OPPS Update factor of 2.9% based on 3.4% projected market-basket increase, reduced by .5% productivity adjustment
  - Intensive Outpatient Program (IOP) rate setting
  - Finalized Obstetrical Services Conditions of Participation
  - Finalized revisions to the hospital and CAH emergency services requirements
  - New quality assessment and performance improvement (QAPI) program requirements for hospitals and CAHs
  - Finalized new measures applicable to both the Rural Emergency Hospital Quality Reporting program (REHQR) and Hospital Outpatient Quality Reporting (HOQR):



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CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)

Ambulatory surgical centers | Hospitals

Share

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services for calendar year (CY 2025). The Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System final rule is published annually.

In addition to finalizing payment rates, this year's rule includes policies that align with several key goals of the Biden-Harris Administration, including responding to the maternal health crisis,

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

CY2025 Medicare OPPS and ASC Payment System Final Rule (11/01/2024) (continued)

- Additional Details on Key elements finalized:
  - OPPS Update Factor
    - OPPS Update factor of 2.9% based on 3.4% projected market-basket increase, reduced by .5% productivity adjustment
  - Intensive Outpatient Program (IOP) rate setting
    - CMS has finalized the existing rate structure, with two IOP APCs for each provider type: one for days with three services per day and one for days with four or more services per day
    - For CY 2025, CMS has finalized the calculation of both hospital outpatient and CMHC IOP payment rates for three services per day and four or more services per day based on cost per day using OPPS data that includes PHP and non-PHP days.

TABLE 201: ESTIMATED IMPACT OF THE FINAL CY 2025 CHANGES FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

		(1)	(2)	(3)	(4)	(5)
		Number of Hospitals	APC Recalibration (all changes)	New Wage Index and Provider Adjustments	All Budget Neutral Changes (combined cols 2 and 3) with Market Basket Update	All Changes
ALL PROVIDERS *		3,562	0.0	0.1	3.0	3.0
ALL HOSPITALS		3,460	0.1	0.2	3.2	3.2
	(excludes hospitals held harmless and CMHCs)					
URBAN HOSPITALS		2,775	0.1	0.1	3.2	3.2
	LARGE URBAN	1,311	0.2	-0.4	2.7	2.9
	(GT 1 MILL.)					
	OTHER URBAN	1,464	0.1	0.5	3.5	3.4
	(LE 1 MILL.)					
RURAL HOSPITALS		685	-0.4	0.9	3.3	3.2
	SOLE COMMUNITY	350	-0.4	0.8	3.3	3.0
	OTHER RURAL	335	-0.4	1.0	3.5	3.4

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

CY2025 Medicare OPPS and ASC Payment System Final Rule (11/01/2024) (continued)

- Additional Details on Key elements finalized (continued):
  - Obstetrical Services Conditions of Participation
    - Finalized requirements for organization, staffing, and delivery of OB services and staff training including:
      - OB services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care of pregnant, birthing, and postpartum patients.
      - Labor and delivery rooms must be supervised by an experienced registered nurse (RN), certified nurse midwife, nurse practitioner (NP), physician assistant (PA), or doctor.
      - Obstetrical privileges must be delineated for all practitioners providing obstetrical care in accordance with the competencies of each practitioner. The obstetrical service must maintain a roster of practitioners specifying the privileges of each practitioner.
      - Labor and delivery rooms must have a call-in-system, cardiac monitor, and fetal doppler or monitor.
      - There must be adequate provisions and protocols consistent with nationally recognized and evidence-based guidelines for OB emergencies, complications, immediate post-delivery care, and other health and safety events as identified as part of the QAPI program. Provisions include equipment, supplies, and medication used in treating emergency cases.
      - The hospital or CAH must develop policies and procedures to ensure that relevant staff are trained on select topics for improving maternal care delivery

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

CY2025 Medicare OPPS and ASC Payment System Final Rule (11/01/2024) (continued)

- Additional Details on Key elements finalized (continued):
  - Revisions to the hospital and CAH emergency services requirements
    - Hospitals and CAHs must have adequate provisions and protocols to meet emergency needs of patients that are consistent with nationally recognized and evidence-based guidelines for patients with emergency conditions, including OB emergencies and complications.
    - Applicable staff must be trained annually on protocols and provisions pursuant to this section.
    - Hospitals and CAHs must establish procedures under which a doctor is immediately available by phone or radio on a 24/7 basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the hospital or CAH or other appropriate locations.
  - New quality assessment and performance improvement (QAPI) program requirements for hospitals and CAHs
    - OB services leadership must engage in QAPI for OB services.
    - If a maternal mortality review committee (MMRC) is available at the state or local jurisdiction in which the CAH is located, the facility leadership, obstetrical services leadership, or their designate(s) must further have a process for incorporating MMRC(s) data and recommendations into the CAH QAPI program as specified in this section.
    - CAHs must use their QAPI program to assess and improve health outcomes and disparities among OB patients.

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

CY2025 Medicare OPPS and ASC Payment System Final Rule (11/01/2024) (continued)

- Additional Details on Key elements finalized (continued):
  - Phased approach for hospitals and CAHs to meet these new standards
    - **Phase 1** requires facilities to comply with the following requirements six months following the effective date of the final rule:
      - Emergency services' readiness for hospitals and CAHs.
      - Transfer protocols for hospitals only.
    - **Phase 2** requires facilities to comply with the following requirements one year following the effective date of the final rule:
      - Organization, staffing, and delivery of services for hospitals and CAHs.
    - **Phase 3** requires facilities to comply with the following requirements two years following the effective date of the final rule:
      - OB staff training in hospitals and CAHs.
      - QAPI program for OB services in hospitals and CAHs.

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

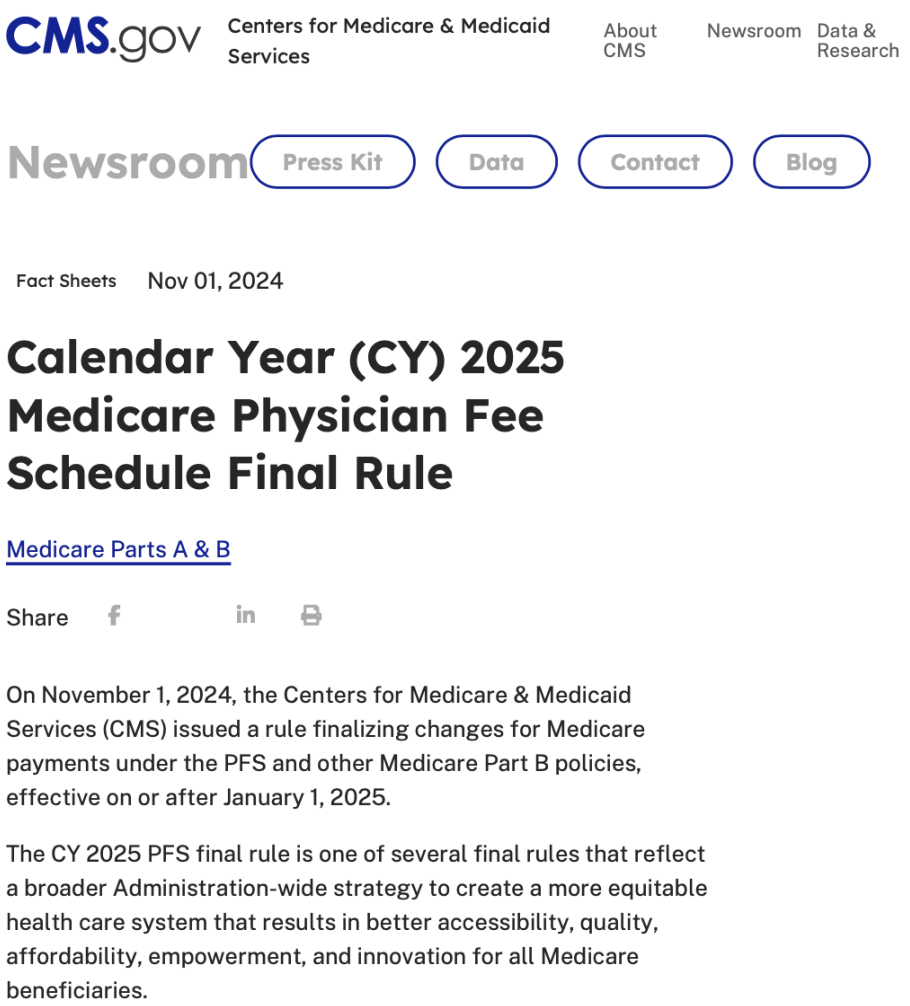
CY2025 Medicare OPPS and ASC Payment System Final Rule (11/01/2024) (continued)

- Additional Details on Key elements finalized (continued):
  - Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency hospital Quality Reporting (REHQR) Program
    - CMS has finalized the adoption:
      - (1) the Hospital Commitment to Health Equity (HCHE) measure beginning with the CY 2025 reporting period/CY 2027 payment determination;
      - (2) the Screening for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and
      - (3) the Screen Positive Rate for Social Drivers of Health (SDOH) measure, beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination
    - CMS has finalized the requirement that Electronic Health Record (EHR) technology be certified to all eCQMs available to report in the Hospital OQR Program measure
    - Clarify that data reporting to REHQR begins on the first day of the quarter following the date that a hospital has been designated as converted to an REH

Source: https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center; https://public-inspection.federalregister.gov/2024-25521.pdf

CY2025 Medicare Physician Fee Schedule (PFS) Final Rule (11/1/2024)

- CMS issued a final rule that announces finalized policy changes for Medicare payments under the PFS, and other Part B issues, on or after January 1, 2025.
  - Proposed rule was issued on July 10, 2024
- Key elements include:
  - Conversion factor reduced by 2.93% from $33.29 in CY24 to $32.35 in CY25
  - Finalized coding and payment under a new set of Advanced Primary Care Management (APCM) services
  - Finalized addition of several services to the Medicare Telehealth Services list on a provisional basis
  - Finalized new coding and payment for caregiver training services (CTS)
  - Finalized changes to RHC and FQHC
  - Summarized information requested to be considered for future rule making
    - Improved coordination of specialty care through value-based care; and
    - Newly implemented community health integration, principal illness navigation and social determinates of health services engaging stakeholder on policy refinements



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Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule

Medicare Parts A & B

Share

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a rule finalizing changes for Medicare payments under the PFS and other Medicare Part B policies, effective on or after January 1, 2025.

The CY 2025 PFS final rule is one of several final rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, empowerment, and innovation for all Medicare beneficiaries.

Source: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule

CY2025 Medicare PFS Final Rule (11/1/2024) (Continued)

- Additional details on key elements include:
  - Conversion factor reduced by 2.93% from $33.29 in CY24 to $32.35 in CY25
    - Based on statutory update of 0% and the expiration of 2.93% enhancement enacted by Congress for FY 2024
      - Will likely lead to Congressional action
  - Advanced Primary Care Management (APCM) services
    - CMS has finalized that beginning January 1, 2025, physicians and non-physician practitioners (NPPs) who use an advanced primary care model of care delivery can bill for APCM services when they are the continuing focal point for all needed health care services and responsible for all the patient's primary care services, as described in the proposed service elements of the codes.
    - CMS has created 3 new G-codes to recognize the resource costs associated with furnishing APCM services to beneficiaries
      - The APCM services will incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management
    - This new coding and payment will better recognize and describe advanced primary care services, encourage primary care practice transformation, help ensure that patients have access to high quality primary care services, and simplify billing and documentation requirements, as compared to existing care management and CPT-based services codes

Source: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule

CY2025 Medicare PFS Final Rule (11/1/2024) (Continued)

- Additional details on key elements include (continued):
  - Telehealth provisions
    - Beginning January 1, 2025, CMS will permanently allow payment for audio-only telehealth services where the beneficiary does not have the ability to or does not consent to use of audio-video technology.
    - Temporarily continuing to define direct supervision to permit the presence and immediate availability of the supervising practitioner through audio-video technology through December 31, 2025.
    - Delaying the in-person requirement before receiving behavioral health care via telehealth until January 1, 2026 (This applies to RHCs and FQHCs as well)
    - Allowing general supervision of physical therapy assistants and occupational therapy assistants for all applicable services.
  - Caregiver Training Services (CTS)
    - For CY 2025, CMS established new coding and payment for caregiver training for direct care services and support
    - CMS will allow CTS to be furnished via telehealth

Source: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule

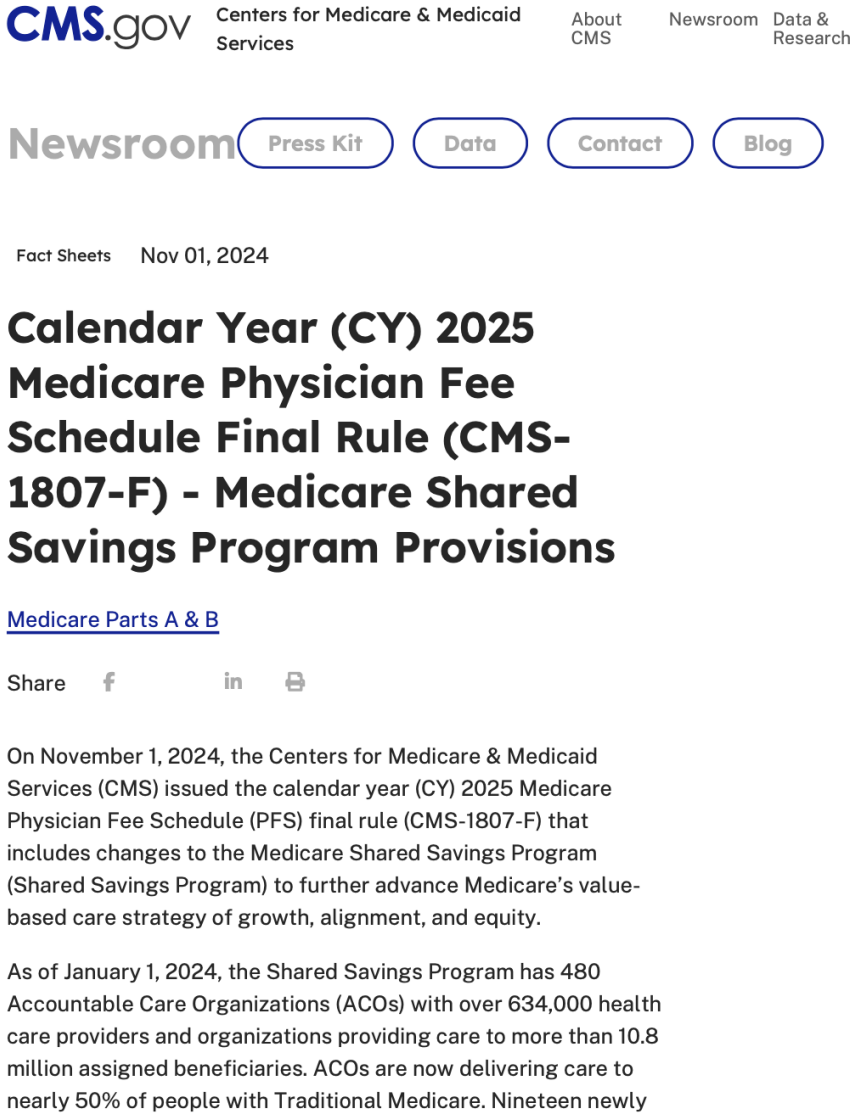
CY2025 Medicare PFS Final Rule (11/1/2024) (Continued)

- Additional details on key elements include (continued):
  - RHC/FQHC finalized Changes
    - ***Removal of RHC productivity standards***
    - ***RHCs "must provide primary care services" vs. "primarily in the business of primary care"***
      - RHC is not a rehab agency or primarily for the care and treatment of mental health diseases
    - Beginning January 1, 2025, RHCs and FQHCs will report the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS code G0511.
      - Permit billing of the add-on codes associated with these services.
      - RHCs/FQHCs will be allowed 6 months (7/1/2025) to update billing systems
    - CMS has adopted the coding and policies regarding Advanced Primary Care Management services for RHC and FQHC payment.
      - Payment to RHCs and FQHCs will be made at the national non-facility PFS amounts when the individual code is on an RHC or FQHC claim, either alone or with other payable services and the payment rates.
      - Services will be paid in addition to the RHC AIR or FQHC PPS

Source: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule

CY2025 Medicare PFS Final Rule – Medicare Shared Savings Program (MSSP) Provisions (11/1/2024)

- CMS issued a final rule that announces policy changes for Medicare payments under MSSP on or after January 1, 2025
  - In general, incremental refinements to the CY 2024 Final rule
- Key elements related to MSSP include:
  - Prepaid shared savings
  - Health equity benchmark adjustment
  - Reopening ACO Payment redeterminations
  - Beneficiary Assignment methodology



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Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule (CMS-1807-F) - Medicare Shared Savings Program Provisions

Medicare Parts A & B

Share

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) final rule (CMS-1807-F) that includes changes to the Medicare Shared Savings Program (Shared Savings Program) to further advance Medicare's value-based care strategy of growth, alignment, and equity.

As of January 1, 2024, the Shared Savings Program has 480 Accountable Care Organizations (ACOs) with over 634,000 health care providers and organizations providing care to more than 10.8 million assigned beneficiaries. ACOs are now delivering care to nearly 50% of people with Traditional Medicare. Nineteen newly

Source:: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule-cms-1807-f-medicare-shared-savings

CY2025 Medicare PFS Final Rule – MSSP Provisions (11/1/2024) (continued)

- Additional details on key elements include:
  - Prepaid shared savings
    - CMS has established a new "prepaid shared savings" option for eligible ACOs with a history of earning shared savings
      - Eligible ACOs will receive advances or earned shared savings that they can use to make investments that would aid beneficiaries
        - At least 50% of prepaid shared savings would be required to be spent on direct beneficiary that have a reasonable expectation of improving or maintaining the health or overall function of the beneficiary, such as meals, transportation, dental, vision, hearing, and Part B cost-sharing reductions
        - Up to 50% of the prepaid shared savings can be spent on staffing and healthcare infrastructure
  - Health equity benchmark adjustment (HEBA)
    - CMS will adjust an ACO's historical benchmark using a HEBA based on the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid

Source:: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule-cms-1807-f-medicare-shared-savings

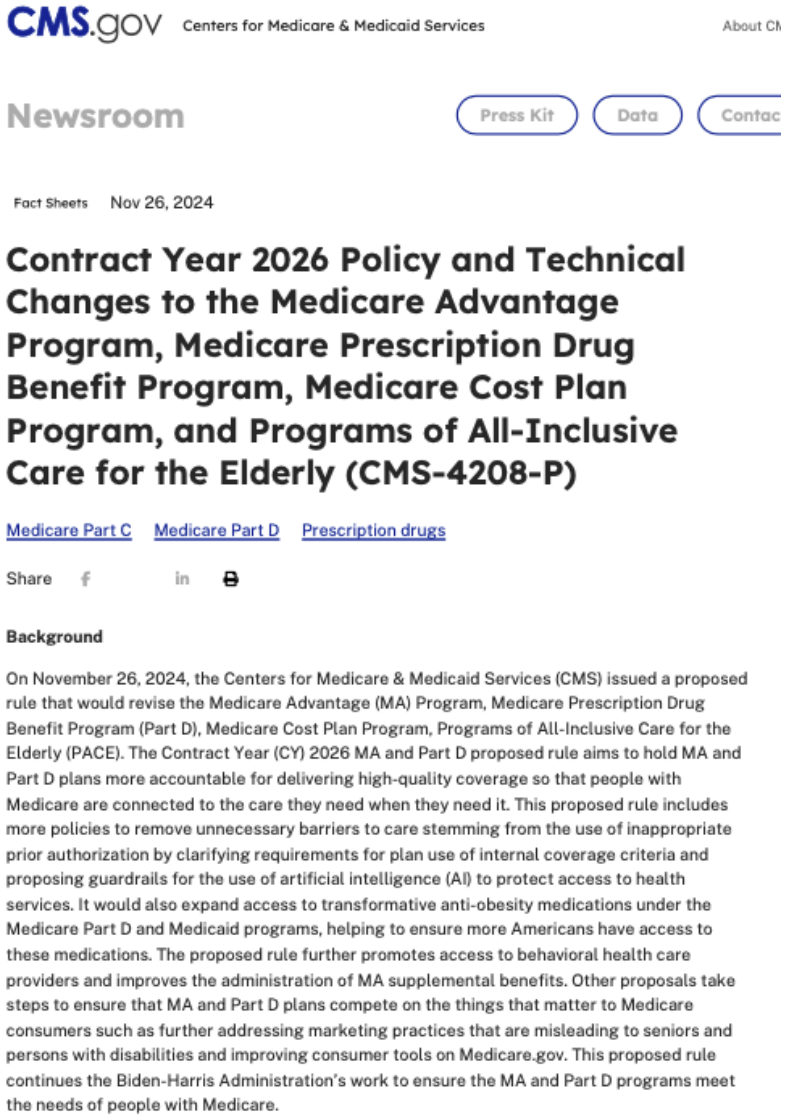
CY2025 Medicare PFS Final Rule – MSSP Provisions (11/1/2024) (continued)

- Additional details on key elements include:
  - Reopening ACO Payment redeterminations
    - CMS will establish a calculation methodology to account for the impact of improper payments in recalculating expenditures and payment amounts used in Shared Savings Program financial calculations upon reopening a payment determination.
  - Beneficiary Assignment methodology
    - CMS is revising the definition of primary care services used for purposes of beneficiary assignment under the Shared Savings Program to align with payment policy proposals under the Medicare PFS
      - New primary care services include Safety Planning Interventions; Post-Discharge Telephonic Follow- up Contacts Intervention; Virtual Check-in Service; **Advanced Primary Care Management Services**; **Direct Care Caregiver Training Services**; and Individual Behavior Management/Modification Caregiver Training Services

Source:: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule-cms-1807-f-medicare-shared-savings

Contract Year 2026 Policy and Technical Changes to MA Program, etc. (11/26/2024)

- CMS issued a proposed rule for 2026 with several aims:
  - Hold MA and Part D plans accountable for delivering high-quality coverage
  - Remove unnecessary barriers to care stemming from the use of inappropriate Prior admissions
    - Clarify requirements for plan use of internal coverage criteria and proposing guardrails for use of AI
  - Proposing new standards for MA plan Medical Loss Ratio reporting to better align with Medicaid and commercial plan requirements
  - Expand access to anti-obesity medications under Part D and Medicaid programs
  - Promotes access to behavioral health care providers and improves administration of MA supplemental benefits
  - Address MA and Part D plan misleading marketing practices
- Unclear whether proposed rule, which will not be finalized until after new administration, will be finalized or withdrawn



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Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)

Medicare Part C Medicare Part D Prescription drugs

Share

Background

On November 26, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would revise the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program (Part D), Medicare Cost Plan Program, Programs of All-Inclusive Care for the Elderly (PACE). The Contract Year (CY) 2026 MA and Part D proposed rule aims to hold MA and Part D plans more accountable for delivering high-quality coverage so that people with Medicare are connected to the care they need when they need it. This proposed rule includes more policies to remove unnecessary barriers to care stemming from the use of inappropriate prior authorization by clarifying requirements for plan use of internal coverage criteria and proposing guardrails for the use of artificial intelligence (AI) to protect access to health services. It would also expand access to transformative anti-obesity medications under the Medicare Part D and Medicaid programs, helping to ensure more Americans have access to these medications. The proposed rule further promotes access to behavioral health care providers and improves the administration of MA supplemental benefits. Other proposals take steps to ensure that MA and Part D plans compete on the things that matter to Medicare consumers such as further addressing marketing practices that are misleading to seniors and persons with disabilities and improving consumer tools on Medicare.gov. This proposed rule continues the Biden-Harris Administration's work to ensure the MA and Part D programs meet the needs of people with Medicare.

Source:: https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-...technical-changes-medicare-advantage-program-medicare-prescription

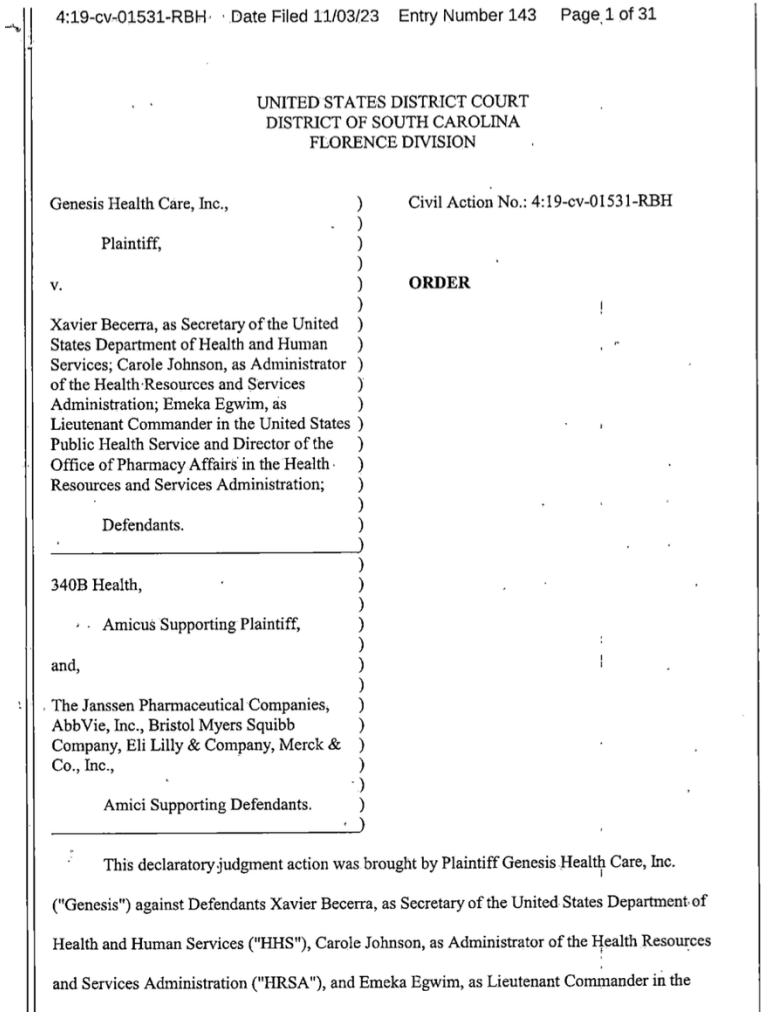
STATES TAKE ACTION TO PROTECT 340B DISCOUNTS; Supreme court may be next

- At least 28 US states have passed or are considering laws to protect healthcare providers' access to 340B discounts, with Arkansas in the lead
- In an ongoing legislative battle over the 340B Drug Pricing Program, the Eight Circuit Court of Appeals ruled in mid-March '24 to uphold an Arkansas law ensuring that provider organizations receive the same discounts at community pharmacies as they do at in-house pharmacies
  - This ruling represents a win for hospitals and community health centers, many of which provide care to low-income and uninsured patients and rely on the 340B program for their bottom line
- The precedent set by the Arkansas ruling may influence legislation in Louisiana, which has a similar case ongoing
- In May '24, Maryland became the next state to uphold 340B discounts when the District Court denied an attempt by PhRMA, Novartis, AbbVie, and AstraZeneca to block state law prohibiting drugmakers from restricting pharmacies' access to discounted drugs
- The state of Mississippi followed in June '24 when Novartis sued to challenge a law prohibiting pharmaceutical companies from restricting 340B discounts. Southern District of Mississippi Judge Halil Ozerden denied the drugmaker's request for a preliminary injunction blocking the law, and Novartis has appealed.
- A final decision may end up in the Supreme Court

Sources: Modern Healthcare, 340B drug pricing ruling could spur state legislation, Alex Kacik 3/15/24 https://www.modernhealthcare.com/legal/340b-drug-program-discount-arkansas-laws; Modern Healthcare, 340B contract pharmacy battle may spur Supreme Court showdown, Alex Kacik, 9/11/24 https://www.modernhealthcare.com/providers/340B-contract-pharmacy-lawsuits-supreme-court-maryland-arkansas-mississippi

340B Update: Genesis Healthcare Ruling (11/03/2023)

- In 1996, HHS defined a 340B eligible patient as follows:
  1. The covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's healthcare; and
  2. The individual receives health care services from a health care, professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity; and
  3. The individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding or Federally-qualified health center look-alike status has been provided to the entity. DSH hospitals are exempt from this requirement.
  - An individual will not be considered a "patient" of the entity for purposes of 340B if the only health care service received by the individual from the covered entity is the dispensing of a drug or drugs
- In 2015 proposed guidelines, withdrawn in 2017, HHS changed the definition to include “Under this proposed guidance, an individual will be considered a patient of a covered entity, on a ***prescription-by-prescription or order-by-order basis,”*** and included language that
  - The individual receives a health care service provided by a covered entity provider who is either employed by the covered entity or who is an independent contractor for the covered entity, such that the covered entity may bill for services on behalf of the provider; and
  - The individual receives a drug that is ordered or prescribed by the covered entity provider as a result of the service described above
- On 11/03/2023, The U.S. District Court, South Carolina Florence Division ruled in favor of Genesis and the 1996 interpretation of a 340B eligible patient
  - Genesis used a 2-year look back to determine if a 340B eligible patient had received services at its covered entity



4:19-cv-01531-RBH Date Filed 11/03/23 Entry Number 143 Page 1 of 31

UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Genesis Health Care, Inc.,

Plaintiff,

v.

Xavier Becerra, as Secretary of the United States Department of Health and Human Services; Carole Johnson, as Administrator of the Health Resources and Services Administration; Emeka Egwim, as Lieutenant Commander in the United States Public Health Service and Director of the Office of Pharmacy Affairs in the Health Resources and Services Administration;

Defendants.

340B Health,

Amicus Supporting Plaintiff,

and,

The Janssen Pharmaceutical Companies, AbbVie, Inc., Bristol Myers Squibb Company, Eli Lilly & Company, Merck & Co., Inc.,

Amici Supporting Defendants.

Civil Action No.: 4:19-cv-01531-RBH

ORDER

This declaratory judgment action was brought by Plaintiff Genesis Health Care, Inc. ("Genesis") against Defendants Xavier Becerra, as Secretary of the United States Department of Health and Human Services ("HHS"), Carole Johnson, as Administrator of the Health Resources and Services Administration ("HRSA"), and Emeka Egwim, as Lieutenant Commander in the

HOW THE INCOMING TRUMP ADMINISTRATION COULD AFFECT HEALTHCARE

The election of Donald Trump for a second term brings the potential for significant changes in the healthcare industry, particularly to the ACA, Medicare/Medicaid, and other federal programs. With RFK Jr. and Dr. Oz tapped to lead HHS and CMS, the direction of both agencies is still being determined. Kennedy has expressed skepticism about vaccines and the food and water supply. Although aligned with Republican policies, Oz has supported the ACA and mandatory insurance coverage. Other potential changes include:

Hospital-centric provisions. The new administration's policies could affect the 340B Drug Pricing Program, site-neutral payment and price transparency. The Biden administration backed hospitals on 340B, and how Kennedy will side is unclear. Support for expanded site-neutral payment is likely.

Private insurance coverage. Attempts to repeal the ACA during Trump's first term failed, and the administration may not make ACA repeal a priority in the second term. Traditionally, the Republican party under Trump has favored short-term health plans, reimbursement arrangements, association health plans, and HSAs.

Government-sponsored coverage. The new administration is likely to return more control of Medicaid to the states in the form of block-grant programs, potentially exacerbating healthcare workforce shortages. Medicare Advantage spending is likely to be reined in.

Regulatory rollbacks. Current regulations prohibiting medical debt from being reported to credit agencies could be rolled back, and Trump is likely to cancel 2023 mandatory staffing ratios for SNFs. Antitrust oversight and enforcement of the False Claims Act, Stark Law, and Anti-Kickback Statute may be relaxed

Source: hfma.org, *An eventful period for healthcare policy looms as Trump and GOP members of Congress prepare to govern,* Nick Hut, 11/15/24 https://www.hfma.org/payment-reimbursement-and-managed-care/an-eventful-period-for-healthcare-policy-looms-as-trump-and-gop-members-of-congress-prepare-to-govern/

Permanent Subcommittee on Investigations (PSI) Report to US Senate on Medicare Advantage Plans (10/17/2024)

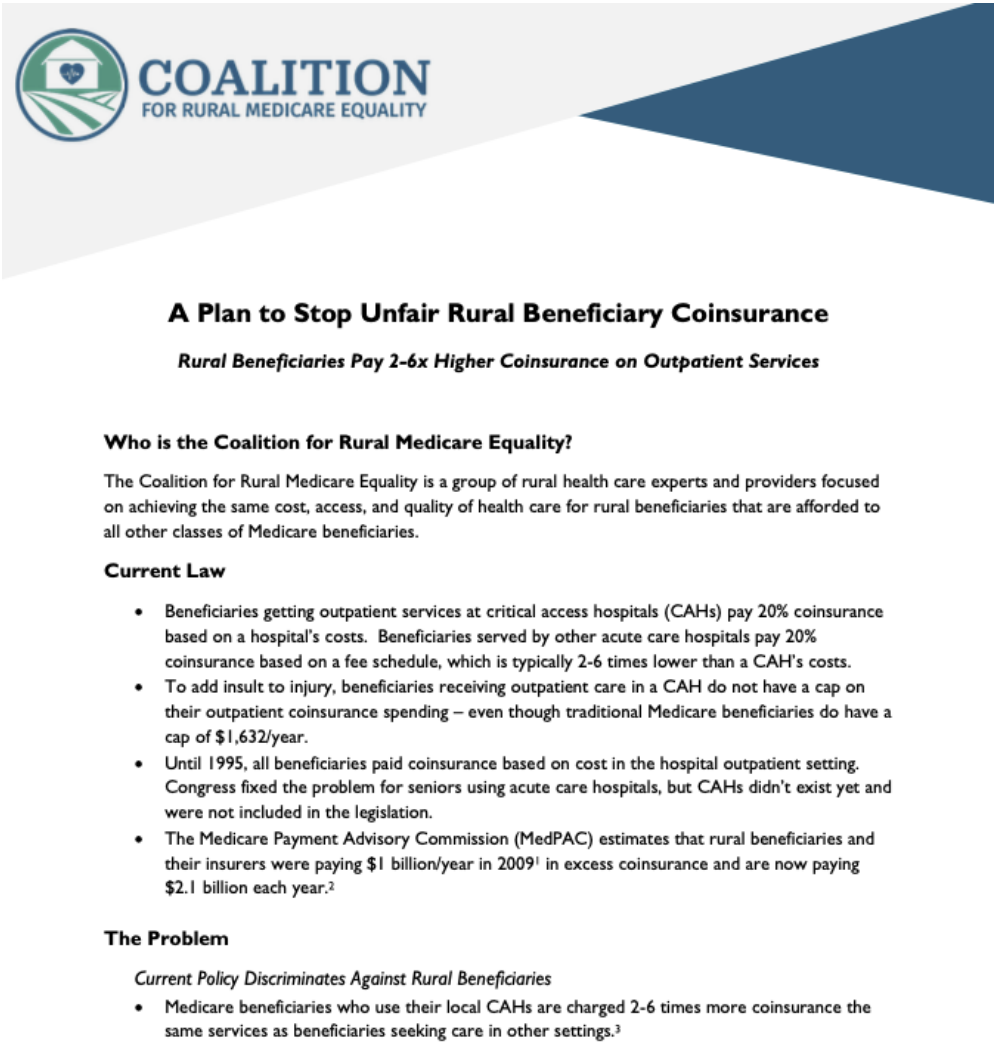
- On May 17, 2023, the PSI launched an inquiry into the barriers facing seniors enrolled in Medicare Advantage in accessing care
  - Final report was issued on 10/17/2024 with key findings as follows:
    - *"Between 2019 and 2022, UnitedHealthcare, Humana, and CVS each denied prior authorization requests for post-acute care at far higher rates than they did for other types of care"*
      - *"In 2022, both UnitedHealthcare and CVS denied prior authorization requests for post-acute care at rates that were approximately three times higher than the companies' overall denial rates for prior authorization requests. In that same year, Humana's prior authorization denial rate for post-acute care was over 16 times higher than its overall rate of denial."*
    - *"The data obtained so far is troubling regardless of whether the decisions reflected in the data were the result of predictive technology or human discretion. It suggests Medicare Advantage insurers are intentionally targeting a costly but critical area of medicine—substituting judgment about medical necessity with a calculation about financial gain"*

MedPAC Report: Cost Sharing for Outpatient Services at Critical Access Hospitals (9/5/2024)

- On September 5, 2024, MedPAC staff presented a report to MedPAC Commissioners on the issue with CAH OP Coinsurance and a possible solution
  - Important Findings (based on FY 2022)
    - 50% of CAH's OP costs are paid by coinsurance
    - 1.9M Medicare beneficiaries (or supplemental plans) were billed an average of $1,750 in CAH cost sharing (84% by supplemental plans)
    - No cap on CAH coinsurance vs. $1,632 cap on OPPS services
  - Proposed Solution
    - Set CAH coinsurance at 20% of payment rate
      - Total payment to CAH remains the same
      - Consistent with how OP supplement payments work for Sole Community Providers
  - Impacts (based on 2022 data)
    - Taxpayers would have funded 75% of $3.2B and Part B premiums would have increased by $0.8B or $13/beneficiary

Plan to Stop Unfair Rural Beneficiary Coinsurance (11/26/2024)

- On November 26, 2024, Coalition released new approach focusing singularly on CAH coinsurance
  - Proposed Solution
    - Calculate the CAH coinsurance based on 20% of costs (proposed by MedPAC at September 2024 meeting)
    - Annual OP out-of-pocket cap would be set at $1,632 for rural beneficiaries (equal to cap for urban beneficiaries)
  - Costs
    - MedPAC's proposal would lower rural beneficiary coinsurance by $2.1B or $350/year per rural beneficiary
    - Increase beneficiary premiums by $13 year
    - Increase payments to Medicare Advantage Plans by $1.3B due to the benchmark being changed to reflect Medicare covering 80% of costs versus the current 50%
- ***New approach does not address alternative payment models and Medicare Advantage plans from diverting services from CAHs***



COALITION FOR RURAL MEDICARE EQUALITY

A Plan to Stop Unfair Rural Beneficiary Coinsurance

Rural Beneficiaries Pay 2-6x Higher Coinsurance on Outpatient Services

Who is the Coalition for Rural Medicare Equality?

The Coalition for Rural Medicare Equality is a group of rural health care experts and providers focused on achieving the same cost, access, and quality of health care for rural beneficiaries that are afforded to all other classes of Medicare beneficiaries.

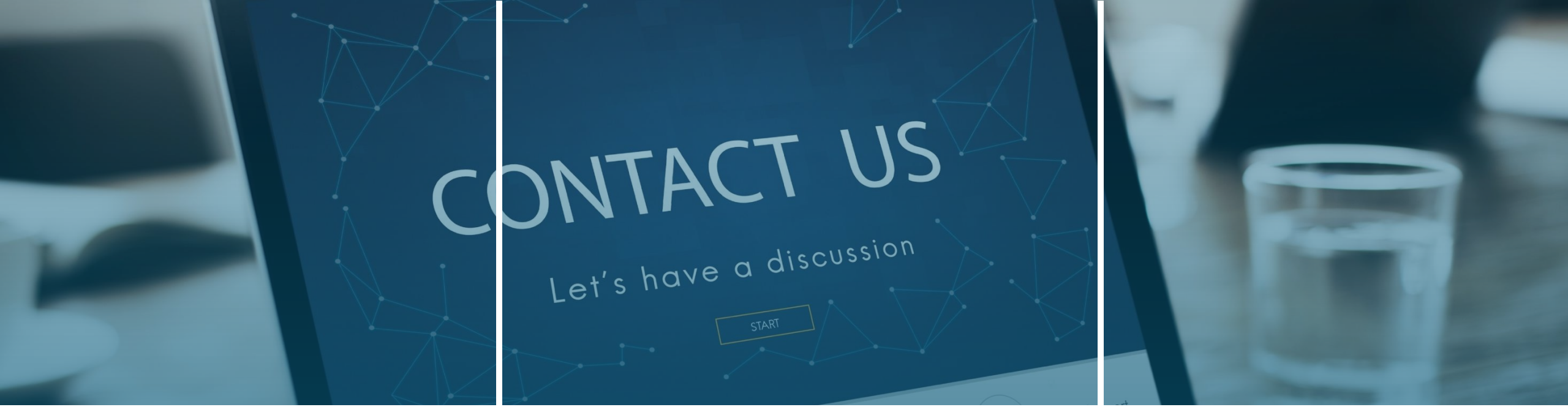
Current Law

- Beneficiaries getting outpatient services at critical access hospitals (CAHs) pay 20% coinsurance based on a hospital's costs. Beneficiaries served by other acute care hospitals pay 20% coinsurance based on a fee schedule, which is typically 2-6 times lower than a CAH's costs.
- To add insult to injury, beneficiaries receiving outpatient care in a CAH do not have a cap on their outpatient coinsurance spending – even though traditional Medicare beneficiaries do have a cap of $1,632/year.
- Until 1995, all beneficiaries paid coinsurance based on cost in the hospital outpatient setting. Congress fixed the problem for seniors using acute care hospitals, but CAHs didn't exist yet and were not included in the legislation.
- The Medicare Payment Advisory Commission (MedPAC) estimates that rural beneficiaries and their insurers were paying $1 billion/year in 2009[1] in excess coinsurance and are now paying $2.1 billion each year.[2]

The Problem

Current Policy Discriminates Against Rural Beneficiaries

- Medicare beneficiaries who use their local CAHs are charged 2-6 times more coinsurance the same services as beneficiaries seeking care in other settings.[3]



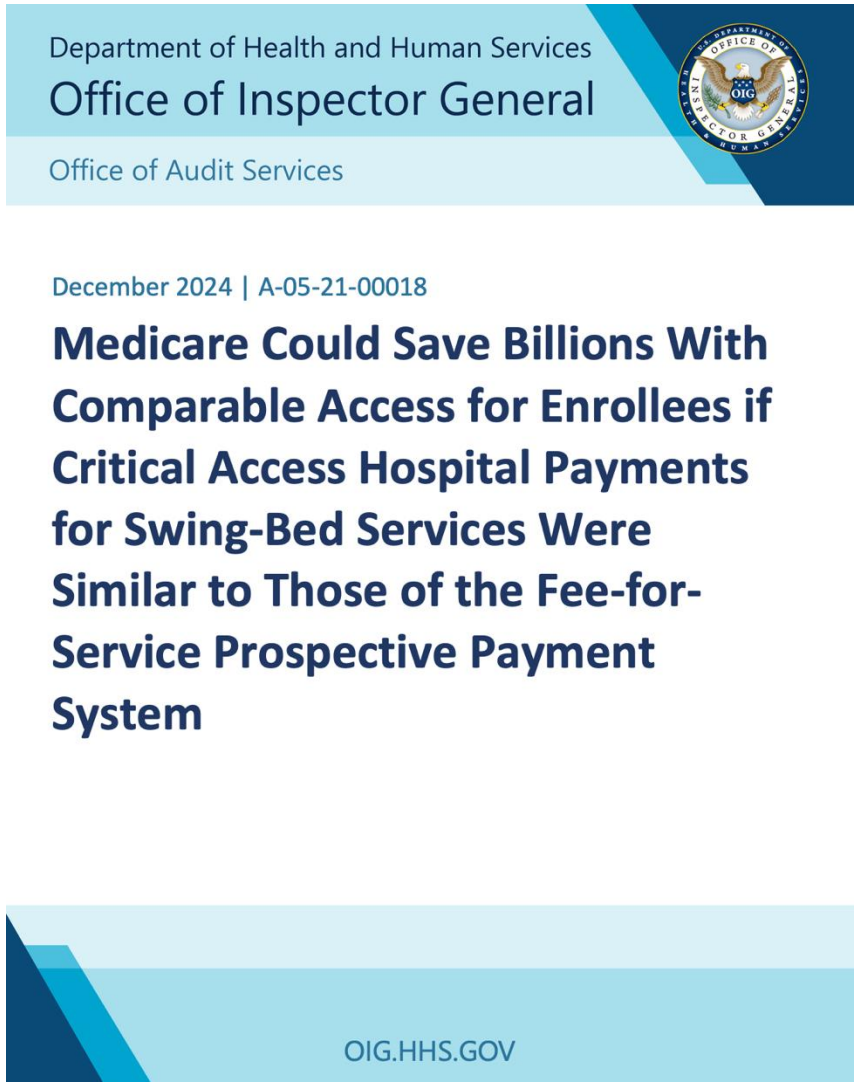
Coalition for Rural Medicare Equality

stopunfairruralcopays.org

jbell@stopunfairruralcopays.org

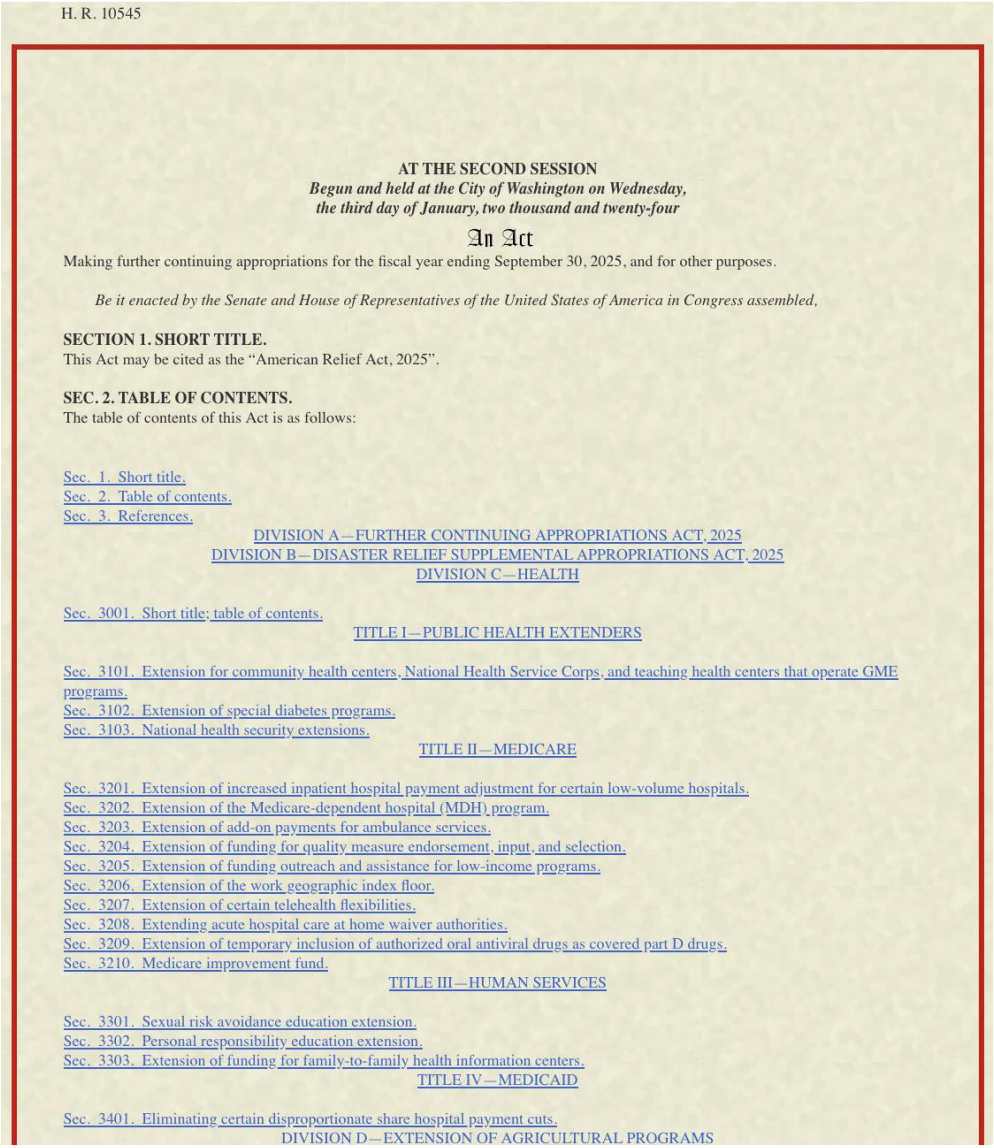
Office of Inspector General (OIG) Report: Savings on CAH Swing Beds (12/2024)

- In December 2024, OIG released a report on findings from an audit of CAH swing bed services between FY 2015 and FY 2020
  - Findings
    - Swing bed utilization increased by 2.8% while average reimbursement increased 16.6%
    - For a sample of 100 CAHs, 87 had alternative facilities for which patients could receive inpatient skilled care
    - Medicare could save $7.7B over a 6-year period if payments made at CAHs were reimbursed using SNF PPS rates
  - Recommendations
    - CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when similar care is available
      - Note: CMS did not concur with the recommendation
- ***What the audit did not consider is the cost to CAH acute care services when swing bed patient days are removed from the routine cost per day calculation***



American Relief Act of 2025 (ARA)/FY 2025 Continuing Resolution (CR) (12/21/2024)

- On 12/21/2025, the American Relief Act of 2025 was signed into law averting a government shutdown
  - Key provisions
    - Extends a short-term CR through 3/14/25 at FY 2024 levels
    - Extends certain designations and programs through 3/31/2025
      - Medicare Dependent hospital designation,
      - Medicare Low-Volume hospital adjustment,
      - Medicare add-on payments for rural Ambulance services,
      - Medicare Telehealth flexibilities, including geographic requirements, in-person requirements for behavioral health services, allowance of audio-only services,
      - Mandatory funding for Community Health Centers, National Health Service Corps, and Teaching Health Center GME,
      - Acute Hospital at Home waiver authorities,
      - Funding for Family-to-Family health information centers,
      - Medicare physician quality programs,
      - State Health Insurance Assistance programs for Medicare enrollment support
    - Delays payment cuts through April 1, 2025:
      - Disproportionate Share Hospital payment cuts,
      - Physician Fee Schedule payment cuts.



H. R. 10545

AT THE SECOND SESSION
Begun and held at the City of Washington on Wednesday, the third day of January, two thousand and twenty-four

An Act

Making further continuing appropriations for the fiscal year ending September 30, 2025, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the "American Relief Act, 2025".

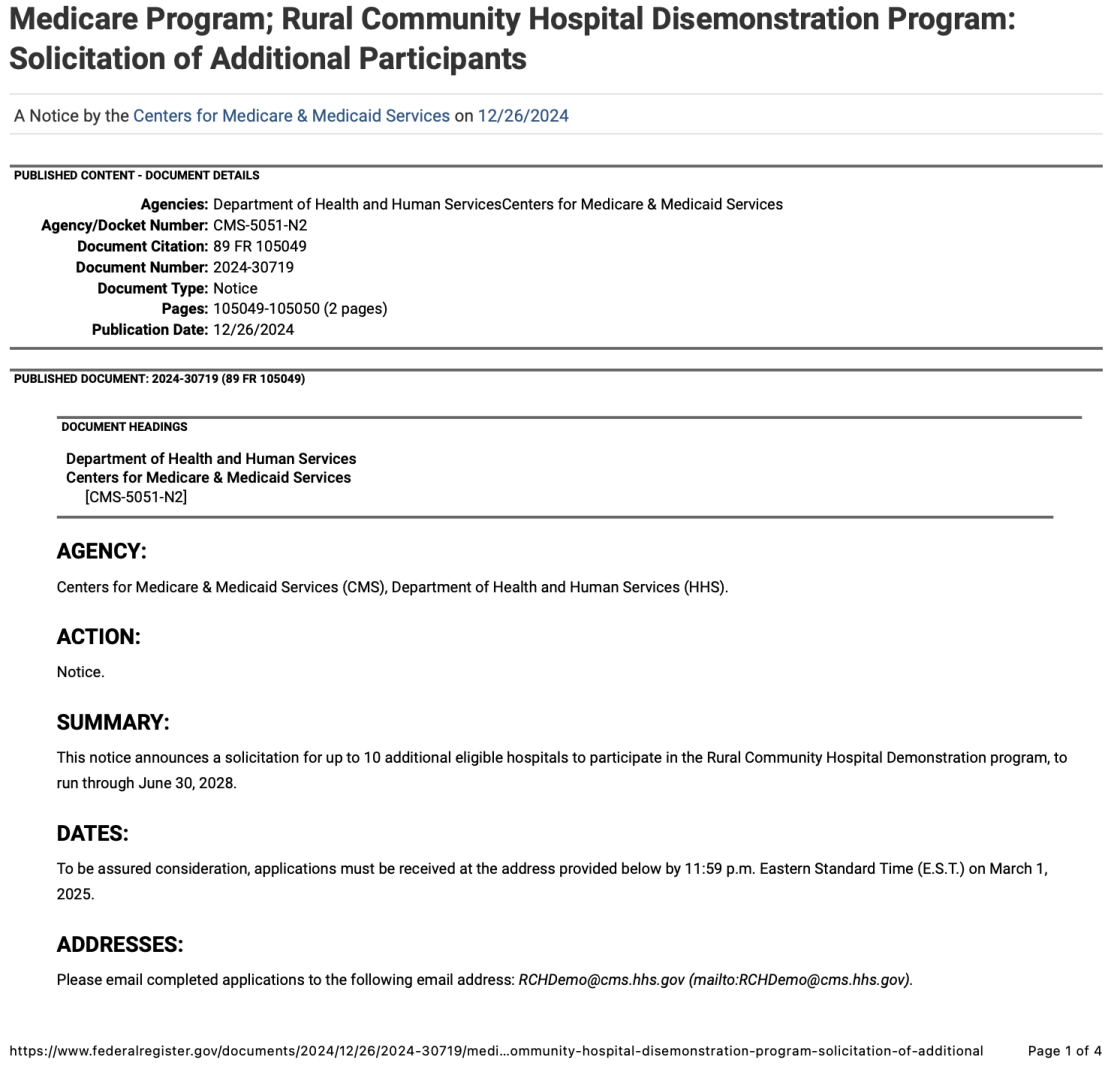
SEC. 2. TABLE OF CONTENTS.
The table of contents of this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.
Sec. 3. References.
DIVISION A—FURTHER CONTINUING APPROPRIATIONS ACT, 2025
DIVISION B—DISASTER RELIEF SUPPLEMENTAL APPROPRIATIONS ACT, 2025
DIVISION C—HEALTH
Sec. 3001. Short title; table of contents.
TITLE I—PUBLIC HEALTH EXTENDERS
Sec. 3101. Extension for community health centers, National Health Service Corps, and teaching health centers that operate GME programs.
Sec. 3102. Extension of special diabetes programs.
Sec. 3103. National health security extensions.
TITLE II—MEDICARE
Sec. 3201. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.
Sec. 3202. Extension of the Medicare-dependent hospital (MDH) program.
Sec. 3203. Extension of add-on payments for ambulance services.
Sec. 3204. Extension of funding for quality measure endorsement, input, and selection.
Sec. 3205. Extension of funding outreach and assistance for low-income programs.
Sec. 3206. Extension of the work geographic index floor.
Sec. 3207. Extension of certain telehealth flexibilities.
Sec. 3208. Extending acute hospital care at home waiver authorities.
Sec. 3209. Extension of temporary inclusion of authorized oral antiviral drugs as covered part D drugs.
Sec. 3210. Medicare improvement fund.
TITLE III—HUMAN SERVICES
Sec. 3301. Sexual risk avoidance education extension.
Sec. 3302. Personal responsibility education extension.
Sec. 3303. Extension of funding for family-to-family health information centers.
TITLE IV—MEDICAID
Sec. 3401. Eliminating certain disproportionate share hospital payment cuts.
DIVISION D—EXTENSION OF AGRICULTURAL PROGRAMS

Sources: https://www.congress.gov/bill/118th-congress/house-bill/10545/text; Grassroots Advocacy Forum / Government Shut Down Avoided with Short Term Extension of Key Programs.pdf

Rural Community Hospital Demonstration Program: Solicitation for Additional Participants (12/26/2024)

- Background:
  - Medicare Modernization Act of 2003 established a demonstration program to test feasibility and advisability of establishing cost-based reimbursement for rural community hospitals
  - Criteria
    - Located in a rural area;
    - Fewer than 51 beds;
    - Providers 24-hour emergency care; and
    - Is not a CAH
  - Payment for inpatient services tied to inpatient costs
  - The original 5-year demonstration has been extended three times and terminates in 2028
  - 20 hospitals are currently participating
- Solicitation seeking 10 additional hospitals, from low population density states (AK, AZ, AR, CO, ID, IA, KS, ME, MS, MT, NE, NV, NM, ND, OK, OR, SD, UT, VT, and WY), to participate in program between 5/1/2025 and 6/30/2028
  - Applications must be received by 3/1/2025



Medicare Program; Rural Community Hospital Disemonstration Program: Solicitation of Additional Participants

A Notice by the Centers for Medicare & Medicaid Services on 12/26/2024

PUBLISHED CONTENT - DOCUMENT DETAILS

Agencies: Department of Health and Human ServicesCenters for Medicare & Medicaid Services
Agency/Docket Number: CMS-5051-N2
Document Citation: 89 FR 105049
Document Number: 2024-30719
Document Type: Notice
Pages: 105049-105050 (2 pages)
Publication Date: 12/26/2024

PUBLISHED DOCUMENT: 2024-30719 (89 FR 105049)

DOCUMENT HEADINGS

Department of Health and Human Services
Centers for Medicare & Medicaid Services
[CMS-5051-N2]

AGENCY:

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

ACTION:

Notice.

SUMMARY:

This notice announces a solicitation for up to 10 additional eligible hospitals to participate in the Rural Community Hospital Demonstration program, to run through June 30, 2028.

DATES:

To be assured consideration, applications must be received at the address provided below by 11:59 p.m. Eastern Standard Time (E.S.T.) on March 1, 2025.

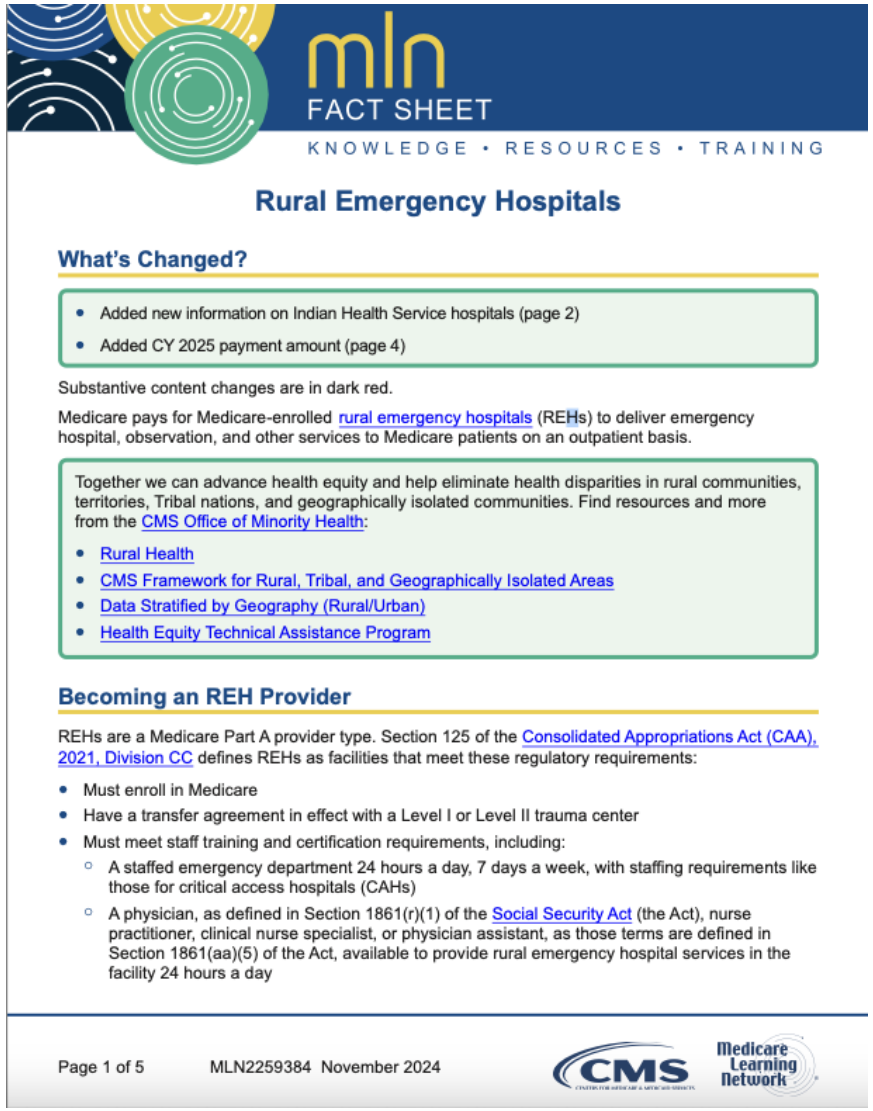
ADDRESSES:

Please email completed applications to the following email address: *RCHDemo@cms.hhs.gov (mailto:RCHDemo@cms.hhs.gov).*

https://www.federalregister.gov/documents/2024/12/26/2024-30719/medi...ommunity-hospital-disemonstration-program-solicitation-of-additional Page 1 of 4

Rural Emergency Hospital (REH) Updates/Fact Sheet (1/1/2025)

- REH Fact Sheet released on 1/1/2025 by CMS with updates for 2025
- Background: REH provider type created by the Consolidated Appropriations Act of 2021
  - Important criteria include:
    - Must have transfer agreement in effect
    - Must staff emergency department 24/7 with staffing requirements similar to a CAH
    - Must meet certain licensure requirements
    - Meet REH COPs
    - Does not exceed annual per patient observation length of stay of 24 hours with no inpatient services
    - Were CAHs or small rural hospitals with no more than 50 beds on 12/27/2020
- 1/1/2025 Updates
  - Consistent with other REHs, allow IHS-REHs to have flexible staffing requirements, access to TA, and additional monthly REH facility payment
  - ***Monthly REH facility payment amount increased to $285,626***



mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Rural Emergency Hospitals

What's Changed?

- Added new information on Indian Health Service hospitals (page 2)
- Added CY 2025 payment amount (page 4)

Substantive content changes are in dark red.

Medicare pays for Medicare-enrolled rural emergency hospitals (REHs) to deliver emergency hospital, observation, and other services to Medicare patients on an outpatient basis.

Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find resources and more from the CMS Office of Minority Health:

- Rural Health
- CMS Framework for Rural, Tribal, and Geographically Isolated Areas
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

Becoming an REH Provider

REHs are a Medicare Part A provider type. Section 125 of the Consolidated Appropriations Act (CAA), 2021, Division CC defines REHs as facilities that meet these regulatory requirements:

- Must enroll in Medicare
- Have a transfer agreement in effect with a Level I or Level II trauma center
- Must meet staff training and certification requirements, including:
  - A staffed emergency department 24 hours a day, 7 days a week, with staffing requirements like those for critical access hospitals (CAHs)
  - A physician, as defined in Section 1861(r)(1) of the Social Security Act (the Act), nurse practitioner, clinical nurse specialist, or physician assistant, as those terms are defined in Section 1861(aa)(5) of the Act, available to provide rural emergency hospital services in the facility 24 hours a day

Page 1 of 5 MLN2259384 November 2024

CMS Medicare Learning Network

Source: REH CMS Fact Sheet 1-1-2025.pdf

Consumer Financial Protection Bureau (CFPB) Final Rule (1/7/2025)

- On 1/7/2025, the CFPB finalized a June 2024 proposed rule to block medical debt from appearing in a consumer's credit report
  - In addition, credit reporting agencies generally will be barred from including medical debt in information sent to lenders
  - Final rule will remove $49B in unpaid medical bills from the credit reports of 15M Americans
  - Credit scores from affected individuals can be expected to rise 20 points
- New administration could freeze implementation of new regulations on or after 1/20/2025
- Legal challenges are also expected
  - On 1/8/2025, the Consumer Data Industry Association and the Cornerstone Credit Union League filed suit in the Texas federal court to stop the rule

JANUARY 07, 2025

FACT SHEET: Vice President Harris Announces Final Rule Removing Medical Debt from All Credit Reports

Today's final rule will remove $49 billion in unpaid medical bills from the credit reports of 15 million Americans. In addition, the Vice President is announcing that States and Localities have already Eliminated Over $1 Billion in Medical Debt Thanks to Biden-Harris Administration Support

Sources: https://www.hfma.org/revenue-cycle/in-pushing-through-restrictions-on-medical-debt-reporting-cfpb-brushes-off-criticisms-and concerns/ ?utm_medium=email&utm_source=rasa _io&utm_campaign=newsletter; FACT SHEET: Vice President Harris Announces Final Rule Removing Medical Debt from All Credit Reports | The White House

Senate Budget Committee Investigation: Private Equity in Healthcare (1/6/2025)

- On January 6, 2025, Senate Budget Committee released the results of a year-long investigation of private equity (PE) ownership of healthcare institutions
  - Important Findings
    - PE equity investment in healthcare has grown from $1T in 2004 to $13T in 2021
    - Prior studies have shown negative consequences for hospitals during first 3-years of PE ownership
    - Investigation focused on two PE firms
      - Leonard Green & Partners (LGP)/Prospect Medical Holdings (PMH)
      - Apollo/Lifepoint Health (220 hospitals)
    - LPH/PMH's primary focus was on financial goals rather than quality of care leading to multiple health and safety violations as well as understaffing and closure of several of the hospitals
  - Conclusions
    - *"The findings of the investigation call into question the compatibility of private equity's profit-driven model with the essential role hospitals play in public health.*
      - *The consequences of this ownership model—reduced services, compromised patient care, and even complete hospital closures—potentially pose a threat to the nation's health care infrastructure, particularly in underserved and rural areas"*
    - *"This Report serves as a call to action for greater oversight, transparency, and reforms to ensure that PE-driven financial strategies in health care do not come at the expense of patient well-being or the sustainability of critical hospital services."*

https://www.grassley.senate.gov/imo/media/doc/profits_over_patients_budget_staff_report.pdf

Other Market Updates

KAISER FAMILY FOUNDATION: 2024 INSURANCE PREMIUMS

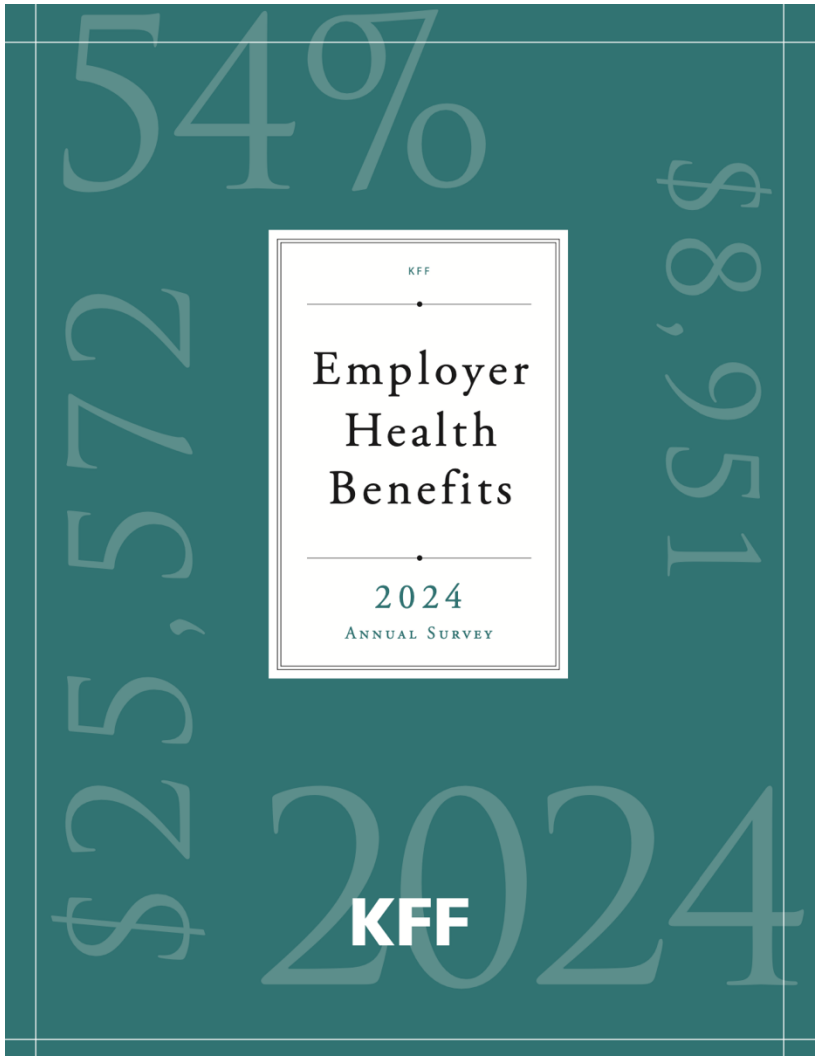
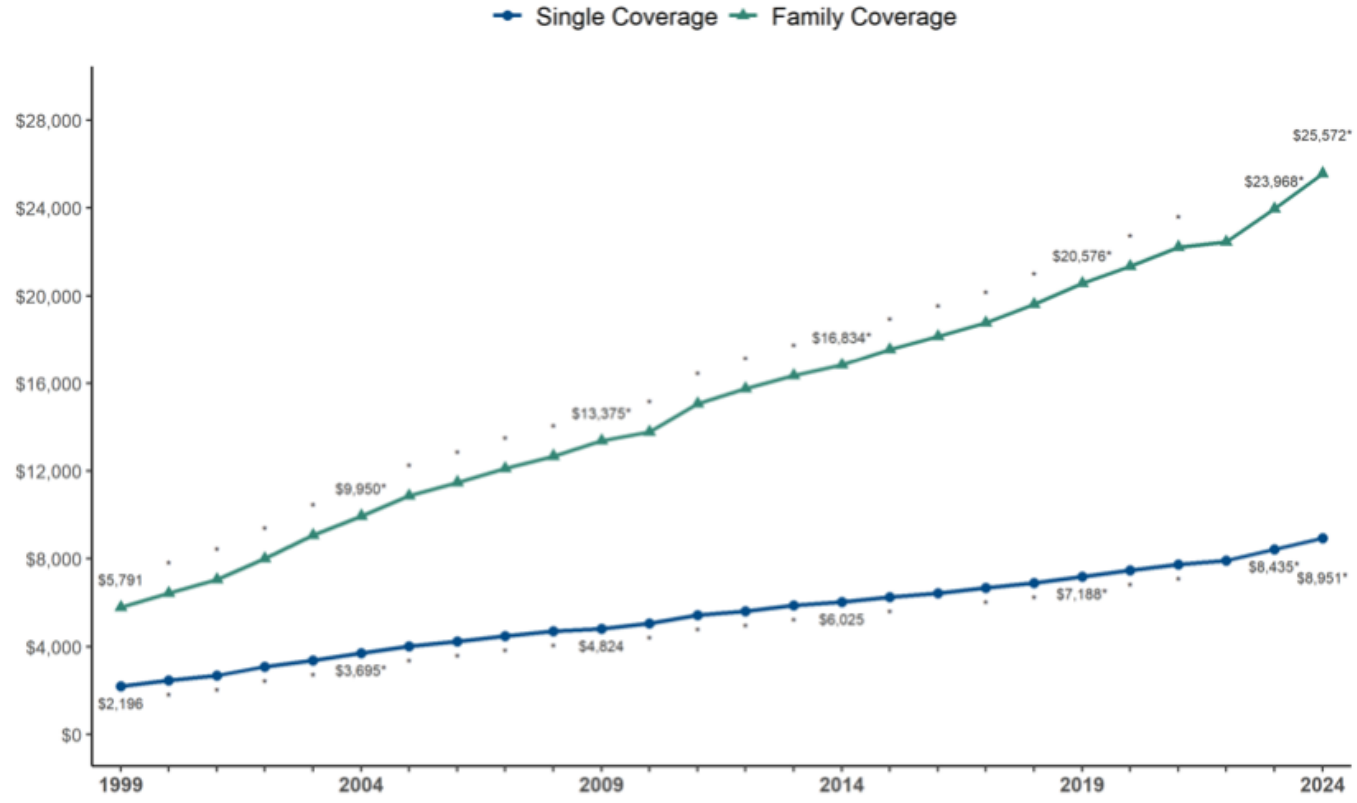


Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

KAISER FAMILY FOUNDATION: 2024 INSURANCE PREMIUMS

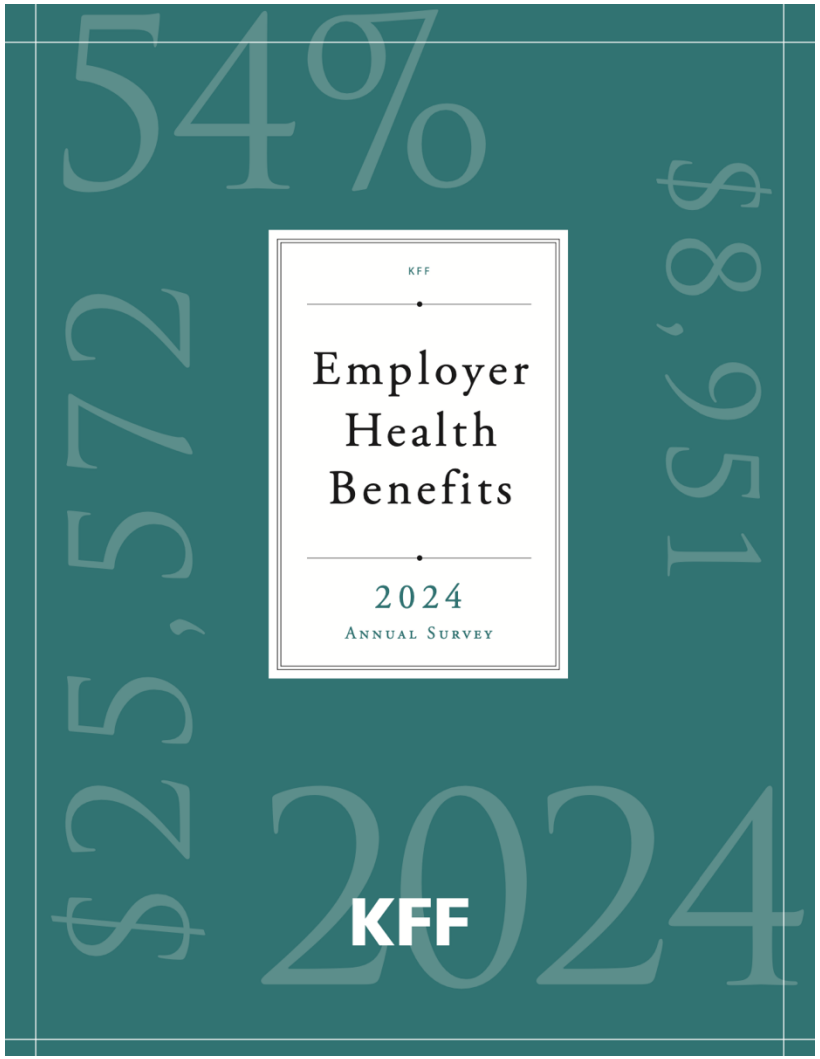
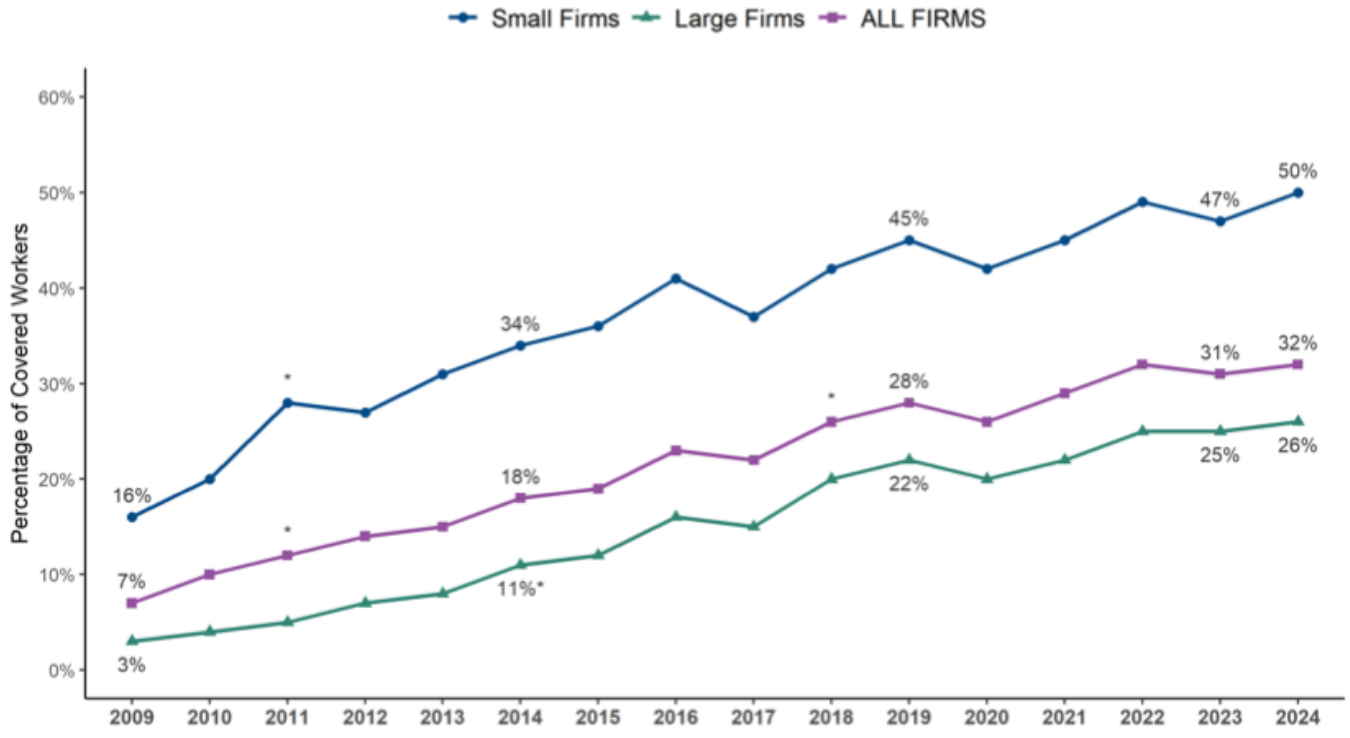


Figure 7.14
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AMAZON'S TRAJECTORY OF HEALTHCARE DISRUPTION*

2018

- Amazon acquires online pharmacy PillPack, setting the stage for its Amazon Pharmacy service
- Haven partnership is announced with JPMorgan Chase & Co. and Berkshire Hathaway to use negotiating power to lower prices

2019

- Amazon Care launches, beginning as a virtual clinic for employers enrolled in Amazon health insurance plans

2020

- Amazon Pharmacy rolls out, giving customers in 45 states access to unlimited, free deliveries of prescription medications

2021

- Haven disbands, citing lack of scale to negotiate effectively

2022

- Amazon Care shuts down, with healthcare CEO saying the offering was not complete enough for large customers
- "Virtual healthcare storefront" Amazon Clinic launches, offering users access to third-party telehealth providers for common conditions

2023

- Amazon begins RxPass, a low-cost drug subscription service aimed at consumers with common medical conditions
- OneMedical is acquired for $3.9B, then partners with Health Transformation Alliance; **now providing primary care to 67 employers and approximately 5m employees**
- Amazon Web Services announces HealthScribe, a new generative AI model to help providers with clinical notes
- Amazon Clinic expands to all 50 states

2024

- Amazon partners with chronic care management company Omada to launch Amazon's health conditions program, which connects people with chronic conditions to existing management resources at no cost
- In Q3 '24, virtual mental health provider Talkspace partners with Amazon and joins the health conditions program, helping people access and use their mental health benefits
- RxPass meets regulatory requirements and becomes available to 50 million Medicare members in 46 states through Amazon Prime
- Amazon's OneMedical announces plans to provide primary care through partnering with The Cleveland Clinic, with the first office to open in OH in 2025
- Amazon launches Hims and Hers-type telehealth service for Prime members for five common conditions including ED, men's hair loss, eyelash growth, motion sickness and anti-aging skin care

**Please see bibliography on corresponding "Sources" slide*

AMAZON'S TRAJECTORY OF HEALTHCARE DISRUPTION: SOURCES

- Sources: Modern Healthcare, *How Amazon built its healthcare strategy from Haven to One Medical*, Brock E.W. Turner and Caroline Hudson, 2/23/23
- Fierce Healthcare, *AWS rolls out generative AI service for healthcare documentation software*, Heather Landi, 7/27/23
- Modern Healthcare, *Amazon brings direct-to-consumer telehealth to all 50 states*, Brock E.W. Turner, 8/1/23
- FierceHealthcare, *One Medical partners with Hackensack, large employer group (fiercehealthcare.com)*, Heather Landi, 11/14/23
- Healthcare Dive, *Amazon launches chronic condition management portal; Omada nabs first partnership*, Rebecca Pifer, 1/8/24
- Healthcare Dive, *Amazon expands drug subscription program to Medicare members,* Rebecca Pifer, 6/16/24
- Fierce Healthcare, *Amazon inks digital health partnership with Talkspace, adds mental health provider to health conditions program*, Heather Landi, 9/17/24
- Becker's Hospital Review, *Cleveland Clinic, Amazon's One Medical partner,* Giles Bruce, 10/21/14
- Modern Healthcare, *Amazon One Medical launches service to compete with Hims & Hers*, Brock E.W. Turner, 11/14/24

CVS AND PRIMARY CARE: NOVEMBER 2024 UPDATE*

In early May 2023, CVS Health reported that it had finalized the purchases of both private-equity-backed Signify Health and Oak Street Health for a combined $18.6 billion. Oak Street Health, which serves a 42% dual-eligible population, provides primary care that addresses social determinants of health.

CVS's ACO division and Chicago-based Rush University System for Health are now collaborating to coordinate care at area MinuteClinics as participants in the Medicare ACO REACH program

In April 2024, CVS announced plans to add 50 to 60 Oak Street Health clinics within the year, most as stand-alone locations but some within its retail pharmacy stores. Competitors Walmart and Walgreens have both walked back some of their primary care clinics in recent months. [11/24 update: Despite company-wide restructuring, Oak Street Health expansion plans will move ahead]

In October 2024, following other retail giants like Walgreens and Amazon in the healthcare space, CVS announced layoffs of 1% of its workforce as part of a plan to cut $2B in costs, and is reportedly considering a corporate breakup of its retail and insurance arms. The retailer cited high costs and underperformance of health plan Aetna and issues with Medicare Advantage reimbursement.

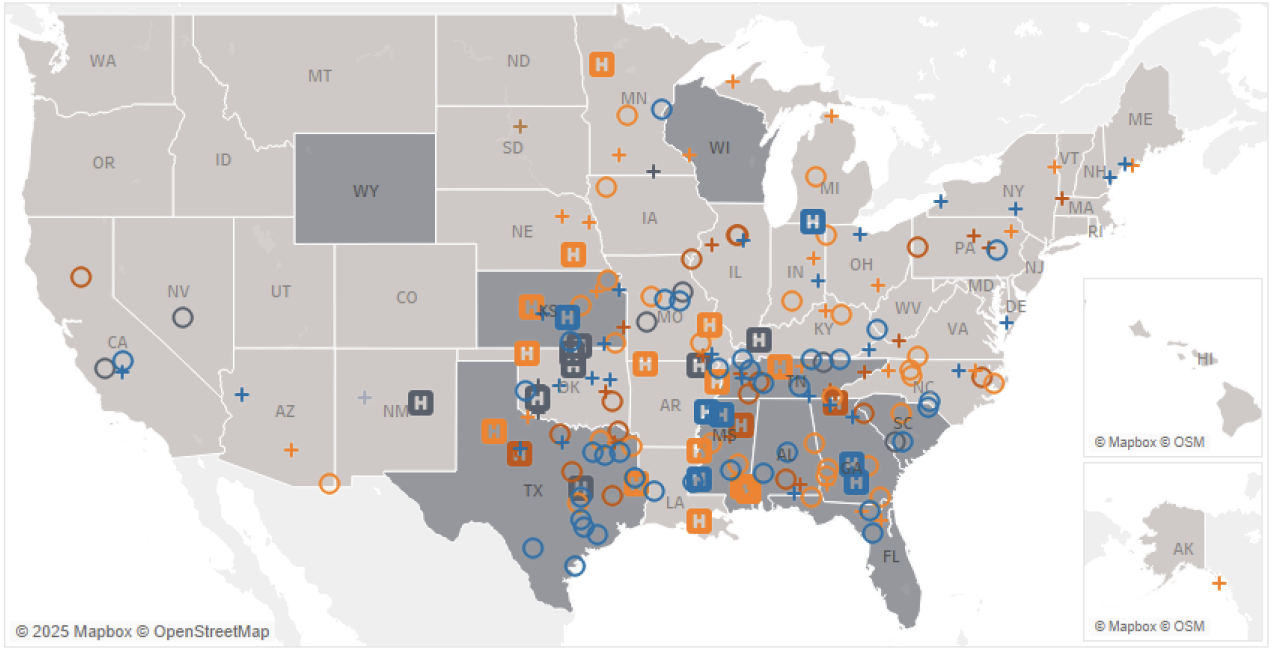
As of late October 2024, Aetna members in select Texas, Georgia, and Florida locations can use Minute Clinic as their in-network primary care provider, with plans to add North Carolina in the coming weeks

Modern Healthcare, *CVS Health taps Rush for ACO REACH collaboration,* 1/23/23; hfma.org, *Healthcare News of Note: CVS finalizes purchases of Signify Health, Oak Street Health, moving into home healthcare and primary care,* Deborah Filipek, 5/8/23; Modern Healthcare, *CVS' Oak Street Health to open clinics at retail pharmacies,* Caroline Hudson, 4/16/24;Healthcare Dive, *CVS to lay off 2,900 employees amid reports of strategic review,* Rebecca Pifer, 10/1/2024;Modern Healthcare, *Oak Street Health expansion to continue amid CVS review,* Caroline Hudson, 10/10/24 https://www.modernhealthcare.com/providers/oak-street-health-expansion-cvs-strategic-review;Modern Healthcare, *CVS expands MinuteClinic primary care services*, Caroline Hudson, 10/29/24 https://www.modernhealthcare.com/providers/cvs-health-minuteclinic-primary-care-aetna

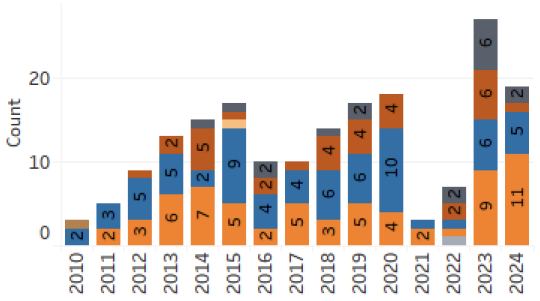
RURAL HOSPITAL CLOSURES (1/3/2025)

187 Closed or Converted Rural Hospitals

There have been 187 Rural Hospital closures or conversions since 2010 and 226 since 2005, these numbers include **thirty-two (32) REH Conversions since 2023**



Year	Hospital Name
2024	REH- Progressive Health Group of Houston..
	MercyOne Primghar Medical Center-IA
	Thomasville Regional Medical Center (TRM..
	REH- Elkview General Hospital-OK
	REH- Taylor Regional Hospital-GA
	REH- Sharkey Issaquena Community Hospit..
	Community Memorial Hospital-OH
	Aspirus Ontonagon Hospital-MI
	REH- Mahnomen Health Center-MN
	REH- Rush County Memorial Hospital-KS
	REH- South Mississippi County Regional M..



ST	Count
TX	26
TN	16
KS	12
OK	12
GA	11
MO	11
MS	11
NC	8
AL	7
FL	5
MN	5
PA	5
AR	4
CA	4
IL	4
KY	4
MI	4
SC	4
AZ	3
IN	3
ME	3
NE	3
NY	3
OH	3
IA	2
LA	2
NM	2
VA	2
WV	2
AK	1
MA	1
MD	1
NV	1
SD	1
WI	1

Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	IHS	Re-based Sole Community Hospital	Rural Referral Center	Total
2010	2					1		3
2011	3	2						5
2012	5	3	1					9
2013	5	6	2					13
2014	2	7	5	1				15
2015	9	5	1	1			1	17
2016	4	2	2	2				10
2017	4	5	1					10
2018	6	3	4	1				14
2019	6	5	4	2				17
2020	10	4	4					18
2021	1	2						3
2022	1	1	2	2	1			7
2023	6	9	6	6				27
2024	5	11	1	2				19
Total	69	65	33	17	1	1	1	187

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

Current Status
- REH
- Complete Closure
- Convert to Other

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

Updated:1/3/2025

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

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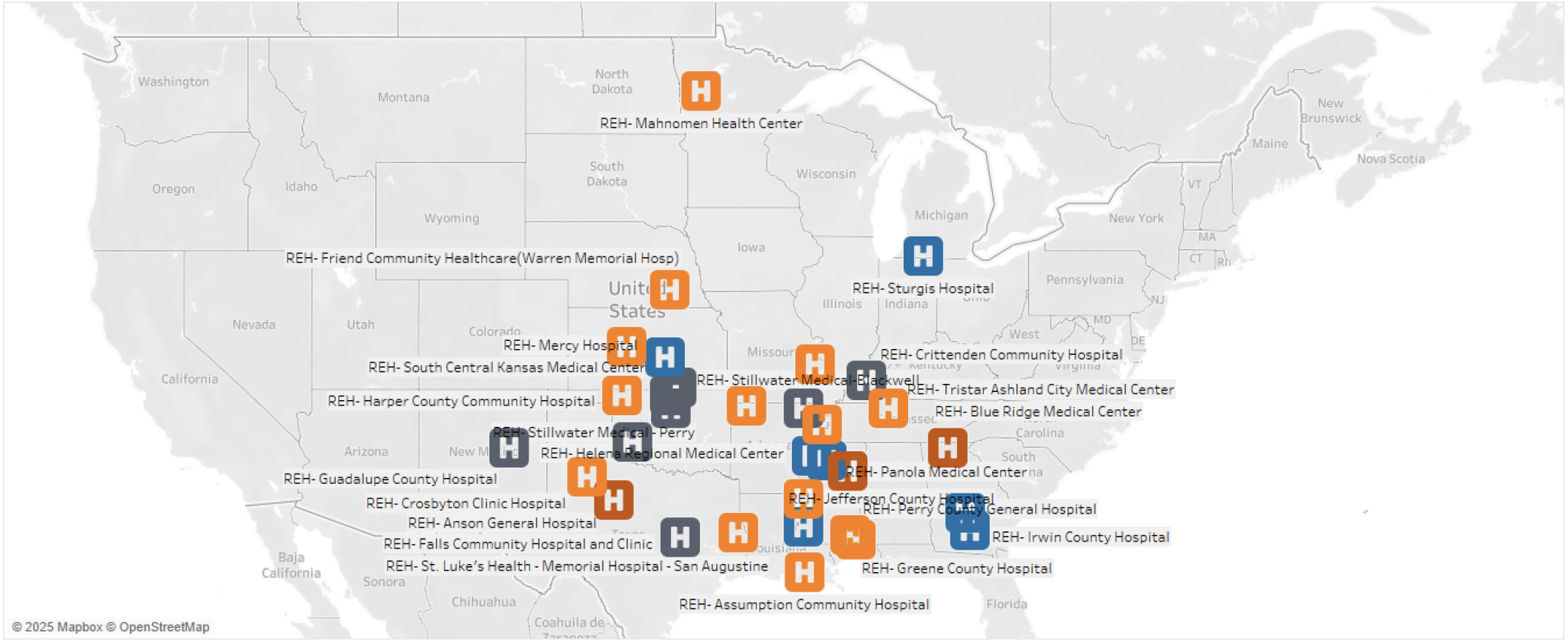
RURAL EMERGENCY HOSPITAL CONVERSIONS (1/3/2025)

32 Rural Emergency Hospital (REH) Conversions



"To be eligible for REH status, hospitals must have 50 or fewer beds and either be in a rural area or have an active rural reclassification. The Centers for Medicare & Medicaid Services (CMS) uses Office of Management and Budget's Core Based Statistical Areas (CBSA) to identify micropolitan and noncore counties as rural counties." Source:www.ruralhealthinfo.org

Medicare Payment Type
- Critical Access Hospital
- Medicare Dependent Hospital
- Prospective Payment System
- Sole Community Hospital

Updated:1/3/2025

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

Questions?

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