Disruption in the Revenue Cycle! Gads!

1

AR Systems, Inc & Patient Financial Navigator Foundation, Inc.

Transforming the hassle factor in healthcare…thru education

Four categories of Impact:

2

Patients
Hospitals and Doctors
Payers
National ++
“The Idaho Story”

“Signs of Disruption in the Revenue Cycle”

- **What are three C’s that keep CFO’s up at night**? Compliance? Cash flow? Customer service? Cybersecurity? Complaints? Competition? HINT: How about Cash flow, Customer service and CRAP… yep, just CRAP!!
- Or Claims Requiring Additional Processing/CRAP!
- Instead of ‘without margin there is no mission.’ How about re-thinking the new world of revenue cycle.

  MISSION DRIVES MARGIN

  DEMONSTRATING MISSION WILL ENSURE MARGIN

“I am worried about the cost of my healthcare; not the cost of healthcare.” It is always personal.

Patient Impact- Convenient Care Movement & Contracts impacting patients

- Access 'healthcare' thru social media
- Research their own healthcare needs – internet
- Insurance directed care vs physician directed care..
- *EX) Physician orders care. Payer denies as 'not medically necessary.' Catch phrase for multiple denials – broad and difficult to challenge. No payment from the payer.*
- Closed Networks – payer/provider specific services
- Out of Network/OON= significant financial impact
- EX) *Penalty: Two distinct deductibles due, plus full billed charges. (No contract between payer and provider = no reduction in charges.)*
- *20% of all inpts had to deal with out of network – ER providers, reference labs, etc. 8-18*
- *Congress urges Federal Trade Commission to investigate anti-competitive provisions in payer/hospital contracts. Such as anti-steering restrictions to keep from going to lower cost providers. 10-18*

Convenience is the most important factor for more than half of healthcare consumers
*Meet patients were they are**

- NRC Health released their 2019 Healthcare Consumer Trends Report. Here are the 4 key findings:

1) 80% of patients say they would switch providers for convenience factors alone.
2) Half say that convenient care access is the most important factor in decision-making.
3) 39% of patients say brand reputation is most important in their decision-making.
4) Care quality is the most important factor to 34.6% of consumers.

Patient Impact- M&M

- Medicare's change for Total Knee Replacement, 1-1-18
- Procedure is off the "Inpt only".
- Physician must document all extenuating circumstances to try to make the patient an inpatient: 2 Midnight Rule. (2020-Audits start with DOS 2020)
- Patient needs after care – Skilled Nursing Facility. Must have 3 medically necessary days/not counting the day of discharge in a hospital for any Medicare coverage.
- If patients cannot return home, Aged for Aged, Blind and Disabled/AABD is an option for Long Term Care.
- Medicaid (state tax funded with federally matching funds)-patient must 'spend down resources' to be eligible for help with the fee to cover 'living in the LTC center."
- Medicare Savings Program –to help low income seniors with premiums and patient portions.

Medicaid –Coverage for low income 2016- 76M low income; 32 states expanded

- State specific programs –tax based with matching federal funds
- Covers 1 in 5 Americans including many with complex and costly needs for care.
- It is the principle source/payer of long term care. 6 in 10 are pd by Medicaid- after all resources are 'spent down.'
- Covers: 76% of poor children; 48% of children with special healthcare needs; 50% of births: 45% of nonelderly adults with disabilities-such as autism, traumatic brain injury, serious mental illness, & Alzheimer's disease.
- 1 in 5 low income seniors receive help with their Medicare premiums and cost-sharing.
- Most eligibility is based on Federal Poverty Level. US Census Bureau poverty threshold/2016: two adults & 1 child= $19,318 yr income

Kaiser Family Foundation 2018

Patient – New Medicare Cards- no longer SS#

Between 4-18 and 4-19,
New Medicare Beneficiary Identifier.
MBI # will be a combination of
numbers and uppercase letters.
EX) 1EG4-TE5-MK72
Ensure address is current.
SSA.gov/my account
Transition period thru Dec 2019.

BIG: Plan F & G Supplemental changes 1-20 for new pt .

Change so pt pays more 1st $ - like Part B Deductible

Patient: Medicare electronic data

- Medicare is launching a new initiative called: MyHealthEData aimed at increasing patient access to their own health records.
- Medicare announced: *"Blue Button 2.0. This will allow patients to access and share their healthcare information, previous prescriptions, treatments, and procedures with a new physician, leading to fewer duplicate tests and procedures. The tool will also help patients in the traditional Medicare program to input their claims data into the secure applications , providers, services and research programs of their choosing."* CMS Administrator Seema Verma, 3-18
- "Health Endeavors' launches National Quality Care Exchange using the Get Your Health Record mobile app to *facilitate the record exchange in all 50 states. This exchange provides access to 50M+ Medicare claims history and 200m+ electronic health records." The patient accesses the exchange using app. After syncying their health records, the pt may share their records with a family member, caretaker or new MD. Provider uses E H R'; payers participate by having the pt sync their claims history into the app." 8-18*

More on MyHealthEData & Interoperability (means?) 2019 Final PPS rule

- Closer to agency's goal of creating a patient-centered healthcare system by increasing price transparency and fluid information exchange.
- CMS is considering future actions that would be most useful to stakeholders and how to create **patient-friendly interfaces that allow consumers to more easily access relevant healthcare data and compare providers.**
- Previous CMS required hospitals to make publicly available a list of standard charges upon request, CMS has updated it guidelines to specifically **require hospitals to post this information/pricing on the internet in a machine-readable format.** (*who is taking the pt calls?
- Overhauls interoperability programs – like meaningful use. More flexible; **emphasize measures that require the exchange of health information between providers and pts.**

More Patient Impact Potential Changes

- HHS Sec Azar 'mulls ' change to HIPAA privacy that impedes the ability of doctors, hospitals and payers to coordinate better delivery at lower costs. Exploring changes to the Federal Privacy act that protects privacy of substance abuse and mental health who seek treatment in federal assisted programs. 8-18

- "American Patients First" – Gag clauses would no longer be acceptable. Congress passed legislation banning the clauses and signed into law 10-18. Pharmacist can show difference in pricing between using insurance and cash payment.
- Lots of pharmacy initiatives with HHS. Stay tuned…

Stats on Privacy concerns:

- 49% of adults are very concerned about health information security.
- 36% currently use online portal to access health information
- Those aged 35+ are more likely to use a portal than those aged 18-34. (39% to 28%)
- 31% of adults are most concerned about diagnosis diseases being shared. (SCOUT survey, Cision, 7-25-18)

- **HEY - United is creating their own Individual Health Record/IHR. 11-18**
- Accessible by 50 M patients. Create their own data base. States it will interface with the hospital's E HR. WOW! Costs to do? Privacy? Using /sampling in ACOs.

Patients – Healthcare perceptions – the challenges of the healthcare community to 'meet the need." New 'words' in healthcare but means what to the community? Population health, Volume vs Value, etc.

- EBRI March 2018
- More likely to have a Primary care provider:
  - 85% Baby boomers
  - 78% Gen Xers
  - 67% Millennials

Think CVS, Walgreens, Walmart, Apple, Amazon, employers

Much more likely to use walk-in clinics:

- 14 % Baby boomers
- 18% GenX
- 30% Millennials

Generational Different Approaches to Healthcare - CHALLENGE

- **Much more interested in Telemedicine: Not the Jetsons but…**
  - **19% Baby boomers**
  - **27% GenX**
  - **40% Millennials**

Much more likely to research healthcare options:

- 31% Baby boomers
- 34% GenX
- 51% Millennials

"Virtual Care moves to the frontline of provider-patient relationships." Healthcare Dive 5-18

- Kaiser Permanente and United Healthcare are using telehealth for primary care visits and quick patient consultations.
- Using for primary care appts and quick consultations. Ease-no time off work. (Think diabetes. Also pts reach out to the provider with results, etc.)
- Hold potential to improve quality, cut costs and improve accessibility to specialty services. Recent Accenture report = 70% of consumers are interested in virtual healthcare. Only 20% have actually received it.
- Kaiser: grown to more than ½ of their 100M encounters. **Big: paid a per member per month for their 11.7M members. 95% are covered thru a capitated program. Makes engaging physicians easier - no payment for volume.**
- ++1 in 4 organization –remote pt monitoring improved patient satisfaction.
- ++38% say it reduced hospital admissions.
- ++1 in 4 say – decreased ER visits. (Becker Review/KLAS research 10-19)

CMS advocating Comparisons of charges. 11-18

- JAMA Internal Medicine Study/9-18 = ***Only 21% of hospitals*** had the ability to provide a complete hospital price estimate for a common procedure.
- CMS has created an online pricing comparison tool for outpt procedures. Part of Exec Order to Increase Choice and Reduce Cost.
- Medicare.gov. It compares average prices for a procedure in BOTH ambulatory surgery centers and outpt hospital departments.
- EX) Input name= Release and/or relocation of median nerve of hand.

Pt pays: $157 ASC or $322 in hospital Medicare pays: $628 ASC vs $1289 in outpt hospital.

- Disclaimers: no physician fees are included, treatment may include additional procedures, ask your doctor.

More Patient Engagement- Protecting Patients from Surprise Billing (Arbitration 7-19)

- CMS – Proposed legislation: "No More Surprise Medical Bills Act" The bill would create a 'binding arbitration' process to determine the appropriate provider payment rate in surprise OUT –OF-NETWORK scenarios. (survey: 39% surprise bill, 1 in 6 ER visits)
- Defined as: when seeking care from IN- NETWORK but providers who provided services where the pt would not know were out of network. Limit pt's cost sharing to the amt the pt would owe to an in-network provider and prohibit providers from engaging in balance billing…
- *EX) Pt went to in-network hospital. But the ER providers nor the consultant cardiologist were in their network. Most plans - pt ends up paying full billed charges. (No discounting as no contract)*
- Debated: Who pays up to the in-network amount? Payer? Provider? All about protecting the patient –but no consensus. (7-19)

Trustee report on Social Security and Medicare 'financial health.' 6-19

- Social Security/SS- Becomes insolvent in 2034. Same as last year.
- By 2035, 77% of benefits payable then.
- 62 M retirees, disabled workers, spouses and surviving children.
- Ave payment is $1294
- By 2030, 1 in 5 over 65.

- Medicare –Becomes insolvent in 2026- 3 yrs earlier than previously forecast. Inpt/Part A care won't be able to cover projected bills. (Tax based)
- Part B and Part D are solvent for 10 years and beyond. (Premium)
- SS drain has begun: higher expenditures than revenue collected for the first time since 1982. By 2034, the excess will be completely gone. Resulting in 21% cut to benefits.

How many Srs are still working past retirement age?

- Only about ½/50% of all employees are covered by a retirement plan.
- Recent study by Bankrate.com:
  - 70 % of non-retired Americans plan to work as long as possible during retirement.
  - 2% say they have NO plans to work during retirement.
  - Of those who plan to work as long as possible, 38% say its because they like to work, 35% need the money, and 27% say it's a mix.
  - Largest # of working after retirement since 1965.
  - Medicare as Secondary payer – after age 65 – but still working and covered by major commercial insurance.

Patients –Premiums and Out of Pocket $

- Only 39% of American households can cover a $1,000 ER visit with savings.
- Over 50% patients have an average out of pocket of $1000 for any healthcare bill. (Think high deductibles…)
- 50% of plans have high deductibles; which essentially means no insurance coverage until it is met. **83% never hit their deductible**/so essentially a self pay patient. *Walgreen presentation,Region 8/HFMA 8-18
- In 2019, per employee health benefit costs are projected to increase 5% to $14,800. $14,099 is the estimated per-employee health benefit cost for 2018.
- 30% of the total premium is covered by employees, so in 2019 the employee contribution is estimated to be $4,500. (mcol, National Bus Group on health, 8-18)

Affordable Care Act- Dec 2018 update

- **Affordable Care Act/ACA - Big Chaos over the Texas Ruling**

- With the ruling from the Texas judge (since the individual mandate requiring people to have insurance can no longer be sustained as an exercise of Congress's tax power-therefore, ACA is unconstitutional).
- Both Congress & CMS have stated nothing will change while the ruling is appealed. (It was brought by states: TX, WI, AL, AZ, AR, FL, GA, Ind, KA, LA, Maine, Miss, MO, Neb, ND, SC, SD, TN, UT and WV.) What does it mean if the ACA is gone?

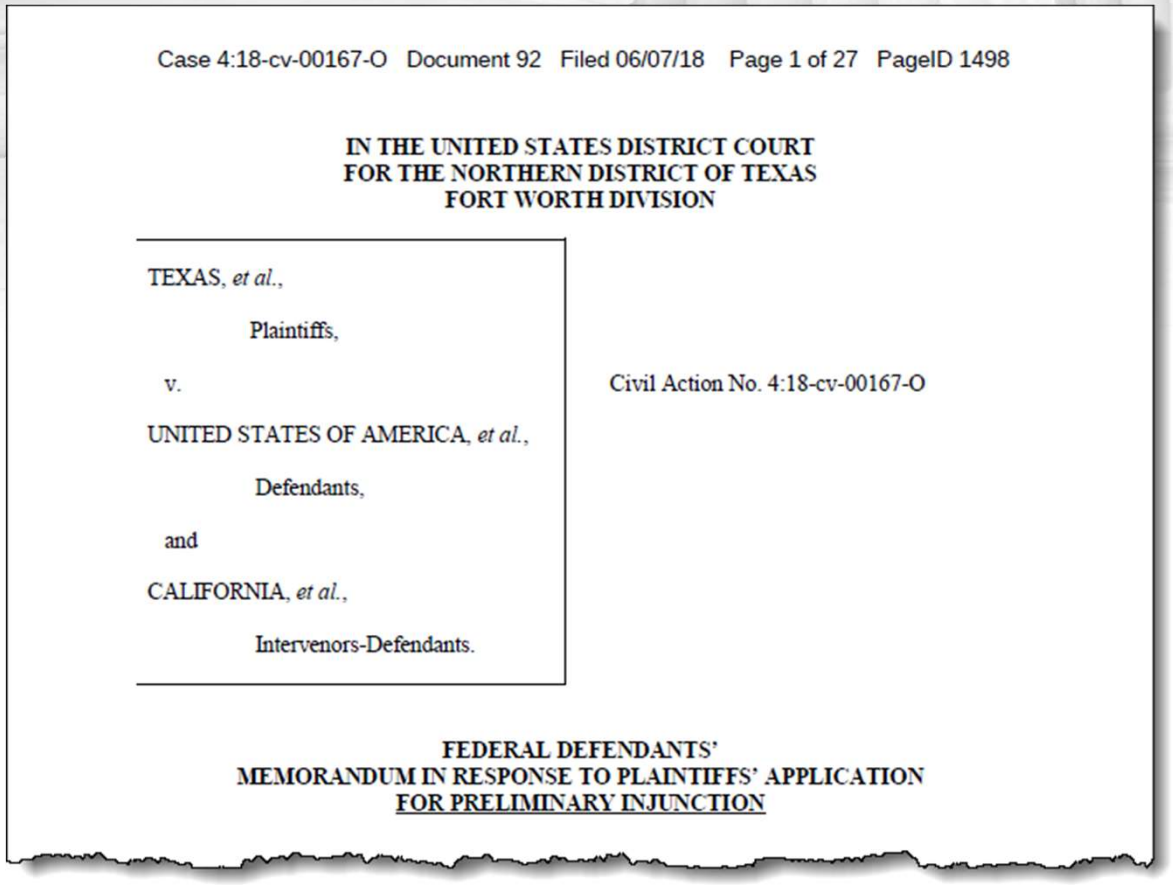
- Think back prior to 2008. Look at the ACA or the Disruption class on our webpage.

10 years of ensuring every employer over 50 employees had to offer Essential Benefits, with no limit to coverage, 26 yr olds covered/even if married, pre-existing coverage, no waiting periods... It also created the Health Exchanges - where individuals PLUS small employers under 50 could have their individual employees get coverage, retirees without coverage until 65 = all the potential of a reduction in premiums based on financial need/poverty level. Hospital took a cut in payments due to more insured than prior to 2008. Premiums were to be addressed as 'more people to share risk, less costs...'which has been questionable . And the Medicaid Expanded program for a new group of poverty-level families.

Patients - Cost

- Affordable Care Act – mandated 10 essential benefits, no allowance to limit coverage due to pre-existing conditions, no rating a patient based on health history, no lifetime limits, coverage of children thru age 26, insurance required for employers with **over 50 employees**.
- Allowed for Subsidies for lower income adults who could not afford premiums in the healthcare exchanges/individual and gap coverage.
- Continued problematic conversations regarding funding of the Cost Sharing Subsidies/CSR. Tax funds paid to insurance companies to be made 'whole' as premiums are reduced for the subscriber. Unclear of path forward.
- Premiums continue to be a primary area of concern! ******92% businesses under 20 employees. How are they getting insurance?***
- 2019 Budget – 'Trumps budget calls for ACA repeal , cuts to Medicare and Medicaid"

The Law Suit that Finally Found a Chink in the ACA's Armor…



Case 4:18-cv-00167-O Document 92 Filed 06/07/18 Page 1 of 27 PageID 1498

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, *et al.*,

Plaintiffs,

v.

UNITED STATES OF AMERICA, *et al.*,

Defendants,

and

CALIFORNIA, *et al.*,

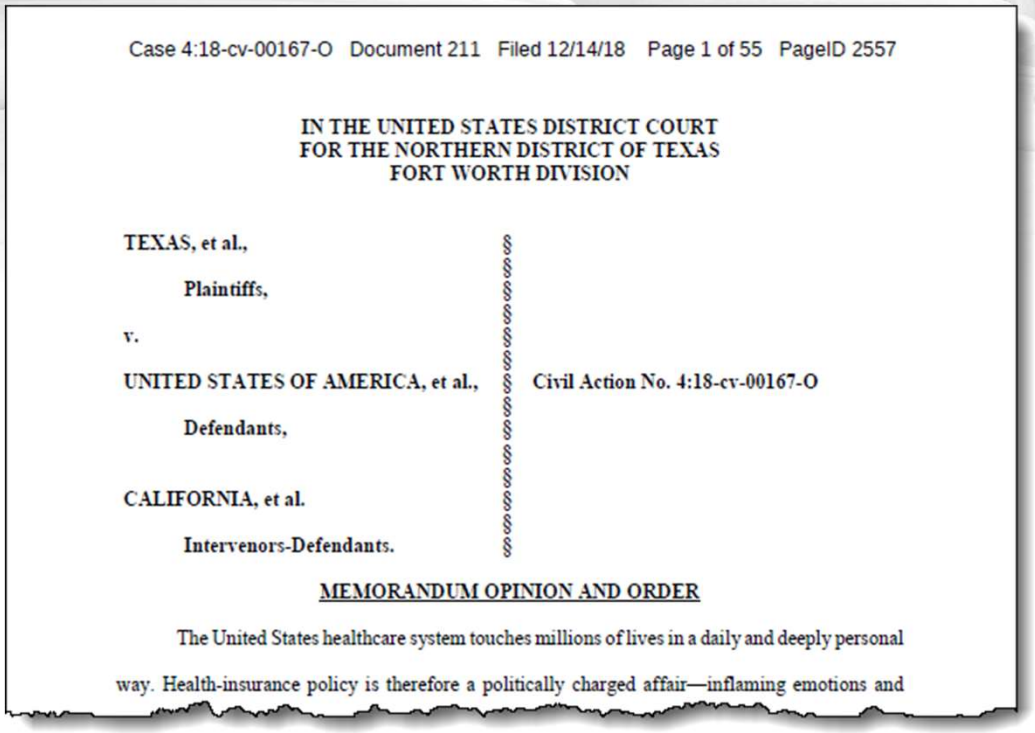
Intervenors-Defendants.

Civil Action No. 4:18-cv-00167-O

FEDERAL DEFENDANTS'
MEMORANDUM IN RESPONSE TO PLAINTIFFS' APPLICATION
FOR PRELIMINARY INJUNCTION

APPEAL ACADEMY

…The Judge allowed for the ACA to stay in effect… for who knows how long



Case 4:18-cv-00167-O Document 211 Filed 12/14/18 Page 1 of 55 PageID 2557

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MEMORANDUM OPINION AND ORDER

The United States healthcare system touches millions of lives in a daily and deeply personal way. Health-insurance policy is therefore a politically charged affair—inflaming emotions and

Affordable Care Act 2010 created "ESSENTIAL BENEFITS" - Commercial Ins.

Only employers with 50 employees must offer insurance

+Pre-existing protection *Go to Idaho Exchange/less 50

+Children covered until 26 No cap for coverage

10 Essential Benefits	
Ambulatory Patient services	Emergency Services
Hospitalization	Maternity & Newborn care
Mental health, substance abuse including behavioral treatment	Prescription drugs
Laboratory services	Rehabilitative services
Preventive and wellness	Pediatric services

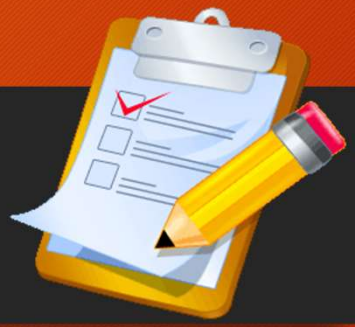
Healthcare -- An American Issue

- 27.4 M Americans were uninsured in 2017. 3 in 4 adults who were uninsured in 2017 had been uninsured for over a year. 77% of uninsured had at least 1 full time worker in the family. (Dec 17/Kaiser Family Foundation)
- 27% /over 1 in 4 of US adults have a pre-existing condition. 44% reside in a household in which someone has a pre-existing condition. 38% of sr citizens say they have a pre.. (Dec 18, Gallup) PS Once pt get Medicare age/benefits, no pre-existing clause.
- Almost 1/2 of adults age 50-64 fear losing health insurance. In the past year, 11% of adults 50-64 thought about going without health insurance. 45% have little confidence that they will be able to pay for insurance after retirement. (THINK EXCHANGE for under 65 and retired....) (Jan 2019, National poll on healthy aging..

Short Term Health Insurance – 4 things to know (Becker Hospital Review 8-18)

- Administration released FINAL rule for short term health insurance plans/STP. Open ended with coverage.
- "State Relief & Empowerment Waiver/1332" – state can offer less **10-18 (Judge upheld selling 7-19)**
- Previously could only offer 3 months, now can last up to 3 yrs.
- 1) STP do not have to abide by the rules by the ACA requiring coverage of essential health benefits and pre-existing protection. Nor do they have to abide by insurance plans imposing limits on how much care is covered or the requirement that at least 80% of premium money go toward care.
- ***7-19 Judge ruled to allow to be sold.***
- 2) Not abide by ACA, STP do not cover as much as more comprehensive plans. They tend to not cover: maternity, prenatal care, mental health, drug treatment and prescription drugs. May not cover sports injuries and other specific services like cataract treatment, immunizations, and chronic fatigue or pain treatment.
- 3) Some do not cover $250,000 - $2M. Others only covered inpt on weekdays, others with waiting periods.
- 4) Generally they are cheaper than the ACA plans. Kaiser study found ex) 40 yr old single man in Atlanta was $371/ACA compared with $47 for STP.
- BUYER BEWARE! Less coverage = more out of pocket if healthcare is used.

Hospitals and Physicians= Change



- Healthcare deals announced/Merger Mania: 115 done in 2017
- Providers must be able to adapt to the changing payer environment – federal, state and local. Potential loss of personal financial 'touch."
- Federal rules implemented. Then after $ expended, discontinued and/or changed.
- EX) New payment model for physicians. "MedPAC votes to kill MIPS, recommends alternative/VVP voluntary value program. 1-12-18"

- Transition from 'volume ' to value. "Outcome based payments." "Accountable care. Pop Health"
- What does this mean to the pt?
- (EX) What if the payer does not pay for a service as the outcome was not within the payer-specific guidelines?
- (EX) Physician believes a course of treatment will help the pt. The payer denies as not medically necessary or experimental. Now what happens to the patient?

"Healthcare Experts Unable to Define "value based care" or "population health." Humana convened a group of healthcare experts to build consensus on definitions.. They found common ground on value based -PAYMENT – they couldn't agree on Value-based care or population health. Fierce Healthcare 7-19

CMS making changes – impacts all payers? Physician E&M office visit leveling system

- "CMS is proposing to move from a system with separate documentation requirements for each of the 4 levels that physicians use to a system with just one set of requirements and one payment for all new and a different payment for all established. (Level 1 is primarily used by nonphysician practitioners.)
- Most specialties would see changes in their overall Medicare payments in the range of 1-2% up or down but we believe that any small negative payment adjustment would be outweighed by the significant reduction in documentation burden." Seema Vera 7-18
- **Delayed until 2021 $: New & Established: L1 ; Levels 2-4 same $ *Leave 5 paid separately**
- **Add on codes -time, Medical decision making, or others to add code/additional $**
- **No reduction when E&M and procedure same visit. Big win.**
- **New prolonged visit codes for levels 2-4 over about 35 mins.**
- **Allows doctors to bill for talking to pts on phone or via internet/virtual. Telehealth too?**
- All provider groups would receive the same payment (??Other payers??)

55% /1550 of hospitals to earn bump in payments under Value-based purchasing program 12-18

- CMS released results for fiscal year 2019 (Medicare payments)
- Hospitals are improving quality and costs. Program gives hospitals a total performance score based on clinical care, safety, engagement and cost reduction.
- Between fiscal years 2018 & 19, the average total performance score rose from 37.4 to 38.1.
- Rural hospitals outperformed urban hospitals. Rural excelled in safety, engagement and cost reduction categories while urban hospitals performed best in clinical care emergency.
- Average payment adj is .17%. Positive performers = .61 Penalized providers = net decrease .39%
- Based on compared to their peers and their own past performance.

About 1 in 5 healthcare payments are tied to value-based model. (Healthcare dive 1-11-19)

- Value-based payments make up about 22% of all care delivery payments, up from 18% for 2018
- Providers continue to determine best ways to report quality and clinical data to improve value-based and population health efforts.

Patients: Do patients understand Value Based? How does it impact them?

- "5 Health Systems sign landmark deal with BCBS NC."
- Under the model, called Blue Premier, payments to physicians and hospitals are tied to the value of services provided. Total payments to the health systems will be based on their collective ability to manage cost and quality performance.
- BCBS NC wants to shift all within 5 yrs
- Cone Health, Duke University Health System, UNC Healthcare, Wake Forest Baptist Health, WakeMed Health & Hospitals.

Payers – Traditional vs. Medicare Advantage/Part C challenges

By 2035, all baby boomers will be 65. 2 workers to pay for 1 Medicare pt and 1 SSA $

Traditional Medicare – Began in 1965

- **65 year olds or disabled**
- **Part A = out of pocket -$1340 each 60 days. No monthly premium.**
- **Part B = $134 monthly premium (adjusted for income)**
- **Part B = $183 1x yearly deductible; coinsurance due with each outpt service**
- **Part D= prescription. "Tiered drugs'. Average $50 monthly premium**
- **19% of Americans will work past 65. Working Aged = Commercial primary.**

- Medicare Advantage/Part C:

1-17 ***Privately run health plans have enrolled more than 17 M elderly and disabled people – about 1/3 of those eligible for Medicare –at a cost to tax payers of more than $150B a year. ****

- Each insurance company who sells Part C insurance creates their own 'rules' – must offer same benefits as Traditional –but can establish own out of pocket costs, maximum amt of pocket yearly, and additional benefits.
- Part C insurance plans are paid yearly bonuses regarding low complaints. Insurance plans are paid a per member, per month, to manage the patient's care.

Medicare Advantage/Part C/MA –increase enrollments

- **By 2020, it is forecast that Medicare Advantage/MA will constitute 50% of the Medicare market.**
- Significant changes were made to allow revision/expansion supplemental benefits –like hearing aides, health club memberships, in home visits, home delivered meals, glasses, and others 'patient specific needs."
- 2019 – allow negotiation with pharmacy pricing
- 2019- more 'enticing' payments for providers
- Significant payments to plans for "Star Rating"(4&5) rated by pts.
- Limiting out of pocket yearly expense .
- But not all plans are sold in all counties of the country.
- No out of country benefit, no out of community benefit (Emergency/exception)
- No ability to have a Medicare Supplemental – pt pays all out of pocket plus monthly premium.

Change of payer/provider relationships

- Walmart buys Humana/discussion

  Same impact of where pharmacy can be purchased

  Walmart lost Pill Pack to Amazon/purchased… 9-18

  Walmart 'taps' HUMANA executive to head up health unit. *Put more focus on its wellness business* 7-18

  Joining with Anthem's MA plans to pay for over the counter items – braces, etc.

- Rise of "Convergence" in healthcare. Means?
- Cigna Corp agrees to buy Express Scripts, the nation's largest pharmacy benefit manager.
- **Convergence: Where a company merges its capabilities with another organization in an adjacent industry. Only works if the industry's solutions are not comprehensive, compelling or able to satisfy customer needs.**
- Expand group purchasing efforts.
- Deloitte : Convergence is innovation for healthcare, but converge to what? 4-10-18; Newsroom 2-18

Payers – Changing Climate

- ‘CVS agrees to buy Aetna in $69 B deal that could shake up healthcare industry.”
- “We want to get closer to the community as all healthcare is local. “ CVS would provide a broad range of health services to Aetna’s 22 M member at its nationwide network of pharmacies and walk-in clinics.
- More competitive with United Health Group/for-profit largest insurer.

- Payer audits – each payer defines ‘coverage’ rules. Each provider has to try to stay aware of payer ‘interpretations.’ *Using External Companies*
- EX) *VA hires a 3rd party audit company- CGI. Went back 3 yrs-like Medicare.*
- *EX) Medicare pays external audit companies to Audit all providers/service. Paid a % of what is denied/upheld/RAC.*
- *EX) Medicaid audits and pays an outside company to audit providers for compliance.*
- *EX) All payers do post-payment audits.*
- *EX) Payers do not guarantee payment when doing ‘authorizations.”*

More Convergence ---Walgreens & Microsoft

- Walgreens: Consumer Facing Care.
- In-store visual clinics, lab services, retail clinics. Telehealth services. Using ‘smart technology”.
- Partnering with payers/Humana and local providers/Seattle area.
- “Walgreens partners with Microsoft to develop new Healthcare delivery models.” 1-15-19
- Walgreens Boots Alliance and Microsoft signed a seven year deal ‘ to develop new healthcare delivery models, technology, and retail innovations to advance and improve the future of healthcare.”
- Walgreens will test ‘digital health centers’ in some of its stores, which are aimed at merchandising and sale of select healthcare-related hardware devices. They will also collaborate on software research.
- “WBA will work with Microsoft to harness the information that exists between payers and healthcare providers to leverage, in the interest of patients and with consent, our extraordinary network of accessible and convenient locations to deliver new innovations, greater value and better health outcomes in healthcare systems across the world.”

Employer direct to Provider= Walmart ACO

- Atlanta –based Emory Healthcare and Walmart are teaming up to create an ACO for Walmart employees based in the metro Atlanta area PLUS a bundled payment program for spine surgeries and joint replacement surgeries.
- "More and more large self insured employers like Walmart are looking for new and creative solutions as a potential way to decrease costs and improving care."
- Employees at 55 Walmart, Sam's Club and Walmart Distribution Centers locations will have the option of to select Emory Accountable Care Plan.
- Under the bundled payment program, which Walmart calls: "Centers of Excellence/COE" – Walmart employees who have a Walmart-sponsored health plan do NOT pay anything out of pocket for spine and joint replacement surgeries at those locations.
- Walmart is also footing the bill for any travel-related costs to Emory locations. 4-19. There are 10 other joint replacement COE including UH Medical Center in Cleveland.

More Payer Challenges- Anthem and Imaging
Anthem is the largest for-profit organization of BXBS

- Anthem BC – Discontinuing coverage of outpt imaging at hospital. **"Imaging Clinical Site of Care."**
- Directing patients to Free Standing Imaging Center for CT and MRI.
- 2017- Ky, Ind, MO, WI. Added CO, GA, NV, NY, OH, CA. March 2018- added CT, Maine and VA. 13 states impacted
- Pt steerage, limiting pt choice and labor cost to do prior authorization for CT and MRI. Some exceptions – Rural, tied to pre-op services.
- Quality of care, availability of the reports, interoperability limitations, Rad provider interpreting = all listed as concerns.
- United is very interested. But looking at a different approach??

Payers- United – largest payer –
It is all in the contract. Mid –year changes?
United revenues will hit $243B-$245B in 2019

- United Healthcare
- Continues to buy companies that work directly with hospitals. Advisory Group, Optum, physician groups.
- NEW: Site of Service determinations for outpt procedures. *URG-11.03 eff 5-18.* "Certain elective procedures should be performed in an ambulatory surgical center/ASC vs outpt hospital."

- United Healthcare-owns Optum
- Effective 3-18, **ER Facility E&M** Coding Revision for commercial and Medicare Advantage plans.
- Polices focus on ED level 4/99284 and level 5/99285 – whether the provider is contracted or not.
- Using Optum ED Claim (EDC) Analyzer tool which uses presenting problems, dx services provided, and associated pt's co-morbidities.

More Payer Anguish- "If the plan approved the furnishing of a service thru an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual. YAHOO! (PI Manual, Chp 6, Section 6.1.3)

- United MA – doing pre-audits/pre payment and then having another company doing post audits for the same accounts.
- Challenge them – Medicare Managed Care Manual, Cpt 4, Section 10:16.
- NJ Medicaid- NJ legislature passed bill 6-21 to limit any non-emergent ER visit $ to $140. AHA: "Hospitals should not be penalized for doing the right thing by providing quality care to patients who show up at our doors because insurance companies have failed to provide a network of providers available to these pts."
- United- NYC Health and Hospital (largest public health system) sued UnitedHealth for $11M. Medicare Advantage and Medicaid mgt. Inpatient denials. Non coverage. (5-18)
- BCBS of Texas- for ER out of network claims after 6-4, the members will be on the hook for the entire out of network ED bill if they use it for what the insurer deems not serious or life threatening. (Updating)

Payer + Provider: 'Long road from Contention to Cooperation."

- '**Anthem/BC (Indianapolis-based) determines ER visits are not covered for 300+ diagnosis. *Non-emergent***
- Impacts Kentucky, GA, Ohio, Indiana and Missouri. 40M+ BC members.
- Exceptions: under 14, on IV/new, no other care weekends, physician referrals to the ER, a lack of urgent care available.
- American College of ER Physicians:

"The changes do not address the underlying problem..pts have to decide if their symptoms are medical emergencies or not BEFORE they seek treatment. "

Anthem believes 10% reviewed/4% denied

- If the diagnosis does not warrant 'emergent' under the payer-specific guidelines, there is on payment to the hospital and providers.
- EX) ***Pt in Frankfort, KY -after experiencing increasing pain on her right side of her stomach, thought appendix had ruptured. ER tested, diagnosed with ovarian cysts.***
- ***Patient owed full $12,000***
- Denials are based on FINAL diagnosis; with little 'weight' for presenting diagnosis.
- BCBS TX physicians: "This will create deaths. This will make the pt think twice before going to the ER."

More Payer-Provider Challenges -Cigna No longer paying drug administration

- Effective 5-19: Reimbursement policy for infusion and injection.
- "We routinely review our coverages, reimbursement and administrative policies… In that review, we take into consideration one or more of the following: evidence-based medicine, professional society recommendations, CMS guidance, industry standards and our other existing policies."
- 'As a result of this review, we want to make you aware that we will NO LONGER SEPARATELY REIMBURSE infusion and injection administration services billed by facilities because infusion and injections administration services are considered INCIDENTAL TO THE PRIMARY SERVICE and are not separately reimbursable."
- "The affected CPT codes: 96360-96379 and 96521 thru 96523. This aligns with our current reimbursement poslicies for facility routine supplies. (EXCLUDES: Chemo 96400-530 and sub-inj 96372)
- NOTE:" In Nov, 2018, we began applying this update to claims from the ER DEPARTMENTS. This updates expands to all areas within a facility." (No observation or ER. What if have chemo and non-chemo drugs at the same treatment time?)
- WOW! A) What is the primary service that is being paid? B) If it is drugs, are you getting full billed charges as it must now cover all visit and all infusion costs C) What about the ER visit or HBC visit?

Payer + Provider = New payment relationships

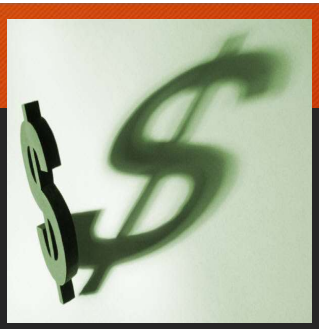
- AHA, AHIP and 4 other associations (AMA, BC/BS and MGMA) join to improve prior **authorization processes**.1-18
- Six healthcare groups agreed to take steps to make prior authorization processes more effective and efficient.
- Decrease the # of providers required to comply with prior authorization based on their 'performance, adherence to evidence-based medical practices or participation in a value-based agreement with the health insurance provider."

- Disney partners with 2 Florida health systems to offer HMO. 2-18
- Directly contracted with Orlando Health/6 acute hospitals and Florida hospital, Orlando/20 campuses to roll out two insurance plans for Disney employees.
- Goal: lower healthcare costs, higher outcomes
- Using Cigna/Allegiance to administer the program.
- NOTE: Remember employer-owned insurance is still looking for ways to reduce their costs..
- 11% of employers are looking at Direct to health system./ National Bus Group 8-18

Payers /Physicians– "Really really hate Prior Authorizations/PA" - AMA survey 3-18

- New survey of American Medical Association –examined the attitudes of 1,000 physicians regarding prior authorization.
- Insurance companies: As an effort to deliver the best possible therapy to the patient and to avoid unnecessary care.
- Physicians: Simply a tactic to make expensive care more onerous, driving down the costs to the insurance companies.
- Q: **How would you describe the burden: 84% very high.**
- 86% report that the burden has increased over the past 5 yrs.
- 79% reported having to repeat prior auths even for pts previously approved.
- Ins requests prior auths 29.1 x per week.
- 78% reported that PA can at lead to treatment abandonment.
- **Dedicate an average of 14.6 hrs per week for Prescription and medical services per practice = 2 business days**
- **IDEA SUGGESTED: If ins really cares about appropriate tx, tie to the electronic medical record; make it fast and give results before the pt leaves our office.**

National



- ‘Fed Up With Drug Companies, Hospitals **Decide to Start Their Own.” 1-18**
- Intermountain Healthcare, Trinity Health, Ascension, SSL Health/SSM and the US Dept of Veterans Affairs. ++
- “There is a dangerous gap between the demand and supply of affordable prescription drugs. “
- Formation of a new not-for-profit generic drug company will work with 1000+ hospitals.
- About a year to get rolling/expect 1st Q of 2019. ‘Healthcare systems are in the best position to fix the problems.”

- “Amazon, JP Morgan, Berkshire form new company to tackle healthcare costs.” 1-18 (Now called Haven)
- Forming indpt company to address healthcare needs of their US employees/500,000 ‘free from profit-making incentives and constraints.”
- Focus will be technology solutions first.
- New CEO: Dr Atul Gawande. 3 focus areas: *Data tracking/treatments; continuing pre-existing coverage; end of life care.* 6-18
- ***2-18 35% would use Amazon ins plan***
- ***8-18 Setting up own employee clinics/Seattle.***

National – Why Apple should buy Epic? 1-19

- Apple will open medical clinics for its employees this spring. 2-18. Announces positions 8-18
- Created website acwellness.com to announce to employees. CA -2 clinic
- Called: **AC Wellness** – network of clinics "as multiple, stunning state-of-art medical centers." Announced openings for all levels of care givers.
- Will leverage its medical clinics as a way to test its health services and advance its "Apple Watch" studies.
- Tells investors: 'Wants to be more than just apps and devices."

- Jim Cramer- opinion
- 63% of Apple's revenue comes from iPhone.
- Epic and its competitors often engage in info 'blocking" or the refusal to share data between networks which can lead to issues with patients and providers' ability to access health records.
- Apple launched its Health Records service last year, which allows iPhone users to access their own medical records from participating hospitals.
- Apple can act as the middleman between providers and hospitals with different EHRs.
- If Apple wants to become a universal EHR provider, to be handshake between, say the Apple watch data and the EHR system, they are going to need to break into this market big and the best way to do that is to acquire the best: EPIC.
- Epic does not plan to go public.

The Healthcare Nation at a Glance

- Apple opening its iPhone-based health records feature to developers and researchers to they can create apps that use health record data to help users better manage medications, nutrition plans and dx.
- Google is developing its own prescription for US healthcare costs: Smarter Artificial Intelligence.
- HealthPopuli: **US Worker's say Healthcare is the most critical issue facing the nation. 1-18**
- Geisinger, Dignity Health among first hospitals to pilot Apple's medical records system. 1-18
  - Apple announced its intent to integrate patient health records into its Health app to make it easier for consumers to review their medical data. While providers offer 'portals' for access, Apple aims to embed patient data from multiple providers into the iPhone main system. Download 11.3Beta version.
  - Others in pilot: Rush University Medical Center, LA Cedars-Sinai, Philly Penn Medicine.

National – 35% of employers are implementing alternative payment and delivery models. 8-18

- Sources of health insurance coverage:

Employer	43.7%
Pd in full by self	20.2%
No insurance	14.8%
Medicaid	8.8%
Medicare	7.5%
Something else	4.5%
VA	4.3%
A union	2.9%

(Gallup 1-25-18)

*Employers usually pay 50% of the monthly employee premiums.

- Gallup: % of uninsured US Adults as of 4th Q 2017:

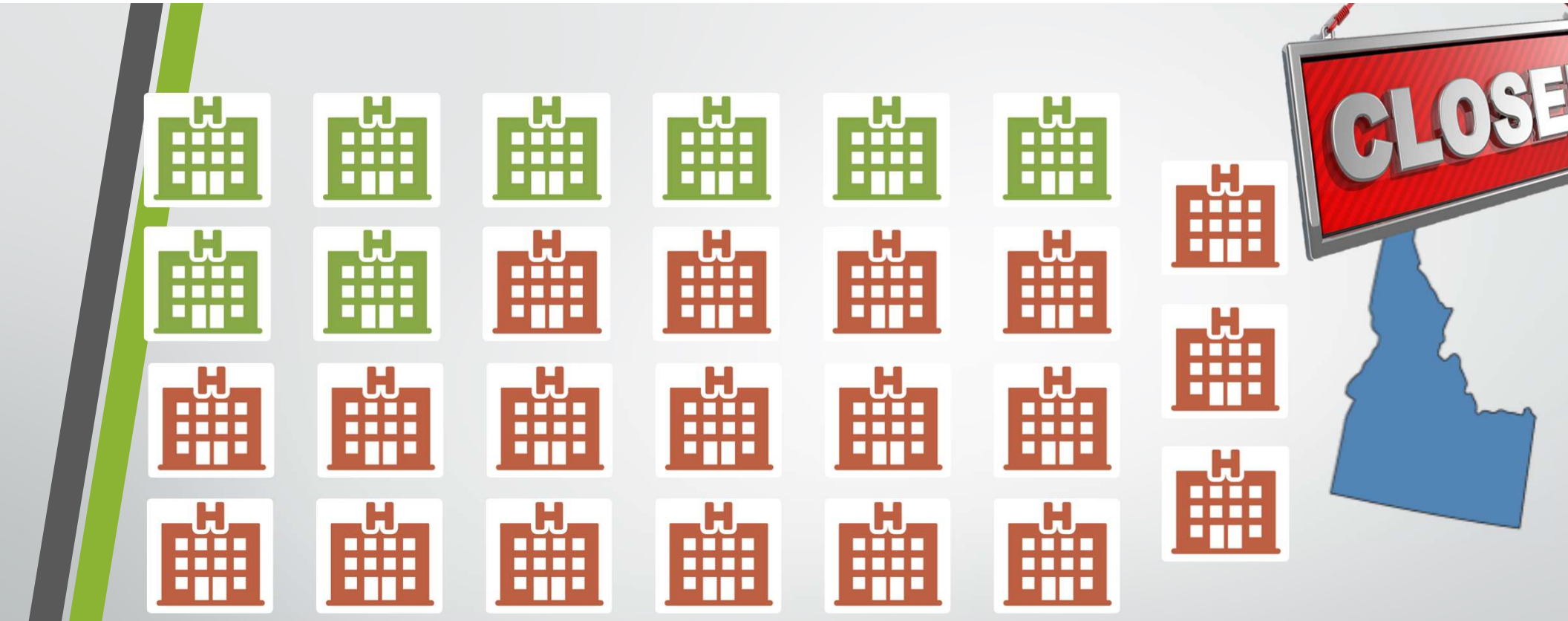
Ages 18-25	16.7%
Ages 26-34	20.1%
Ages 35-64	12.8%
Ages 65 +	2.1%

*Exchange/state is an option for any adult who works for a company with less than 50 employees, self employed, early/gap retirement, entrepreneurs, small businesses, start up companies, etc.

Think 'individual' when thinking less than 50 employee companies.

The Healthcare Nation at a Glance

- CMS/Medicare will cancel major bundle payment initiatives – Cardiac
- LA hospital to close, laying off 638 employees
- At **least 26 non-profit hospitals** at risk of bankruptcy.
- Tenet/for profit to close 232-bed Phoenix hospital
- 450 Hospitals at risk of closure. 15% have weak financials. Morgan Stanley 8-18
- CHI's operating loss swells to $585M in FY 2017
- Hospital operating margins dropped 39% in 3 yrs. Expenses grew by 3% more than income.
- 20 bed critical access hospitals in NC to close Dec 31, 2017
- **Healthcare bankruptcies more than TRIPLE in 2017**
- 89 RURAL hospitals close in 2018 –so far.
- CA hospital files for bankruptcy after missing payroll.
- **How well are the hospitals educating their public on REAL financial challenges??**



Idaho's Rural Community Hospitals

8 of 27 hospitals are financially viable, per IHA, 2018

The Rural Healthcare Story

- "Rural areas face challenges with transportation, a shortage of healthcare professionals, & impractical funding.
- About 46M live in rural areas. More likely to have heart disease, cancer, unintentional injuries, chronic lower-respiratory disease and stroke than urban areas.
- Rates of obesity, tobacco use and suicide are also usually higher.
- *THINK TELEHEALTH – CMS is exploring as well as commercial payers.. Who is paying for it?*
- Nationwide rural areas are home to 19% of the population but cover 97% of U.S. land area.
- Transportation limitation is exacerbated as the population ages.
- Critical access hospitals/less than 25 beds –need flexibility to meet need.
- Telemedicine is another promising solution to help with shortages –but does relay on speed and quality of broadband in the area."

(US News, 1-18)

An Idaho Story – One of Shortages and Growth "Physician Access Index" Merritt Hawkins, 2017

- Cumulative scores/metrix from 1-50 in all 31 categories: **Idaho is ranked 38th out of the 50 states.**
- Hot spots: higher #, negative finding
  - Primary care providers per 100,000 - 70
  Ranked 46th
  - Physicians per 100,000 – 173
  Ranked 49th
  - Medical residents per 100,000 – 4
  Ranked 48th *but 7th In retaining residents*
  - % of population without insurance – 13.6%
  Ranked 38th
  - % of population on Medicare – 15.2%
  Ranked 37th
  - % of population on Medicaid – 17%
  Ranked 37th

- Metrix data continued:
  - Nurse practioners per 100,000 – 53
  Ranked 43rd
  - Physician Assistants per 100,000 – 46
  Ranked 16th
  - % of physicians 60 or older – 24.6
  Ranked 7th (ID has fewer physicians over 60 than 43 other states)
  - % of physicians planning to retire 1-3 yrs-21%
  Ranked 50th *****

Mental health: 38th in shortage per capita
22nd in % of mental health needs met
51st in Mental Health Inpatient beds****

Idaho is a booming economy! Yep…and where will the providers come from to address the growth?

Thanks for Joining Us in this Educational Journey…

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Thanks for being a part of the dynamic Region 8 HFMA conference. Love it!