Federal Issues

CMS Finalizes Alternative Payment Models for Specialty Care
The Centers for Medicare & Medicaid Services is transitioning more specialty care to value-based reimbursement with two new alternative payment models for end-stage renal disease and cancer care.

A final rule released late last week unveiled the finalized End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model and its partner Kidney Care Choices Model, as well as the mandatory Radiation Oncology (RO) Model.

All three models alter how specialists in Medicare get paid by tying reimbursement to quality metrics and the rate of kidney transplantation in the case of the ETC Model. The model will also use monthly capitation payments to incent ESRD facilities and managing clinicians in certain areas to deliver dialysis in patient homes versus expensive dialysis facilities.

The ETC Model is part of the White House’s push to advance kidney care from last year, which, among other items, directed HHS to create a new payment model in Medicare and increase reimbursement rates for new renal dialysis drugs and biological products as

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well as the development of innovative equipment and supplies for dialysis treatments.

The model’s payment adjustments will begin in January and run through June 30, 2027.

Meanwhile, CMS issued a final rule setting forth a five-year bundled payment model for radiation oncology, which will be mandatory in certain areas of the country beginning January 1, 2021, and is estimated to save Medicare $230 million over five years, according to CMS. CMS projects the Model to cover approximately 30 percent of all eligible Medicare fee-for-service radiotherapy episodes nationally.

Under the rule, participants will receive a bundled payment for 90-day episodes of radiation therapy for 16 disease sites, including breast, lung, prostate and colorectal cancer. The RO Model will leverage bundled payments to see if Medicare providers and suppliers will deliver more radiotherapy versus more visits or deliver radiotherapy services in one setting over another (e.g., hospital outpatient department or freestanding radiation therapy center).

The bundled payment will replace their regular Medicare fee-for-service payments for these services. Participants will keep any savings if spending is less than the bundled payment, subject to quality and patient experience measures, but also be responsible for any spending above the payment amount. The model is site-neutral, meaning CMS will calculate the bundled payment amount similarly regardless of whether the provider is a physician, hospital outpatient department or non-hospital setting.

Industry position: Reaction from hospitals, physicians and advocacy groups are mixed. “CMS’s decision to start this model in January will be extremely challenging for hospitals,” said Joanna Hiatt Kim, American Hospital Association’s vice president for payment policy and analysis.

- Physician groups have also expressed concern noting requiring practices to participate and then forcing them to start the model on January 1, 2021, is untenable for practices already enduring staff shortages and other challenges due to the COVID-19 pandemic.
- The transition to value-based payment will require significant practice changes and investments to comply with the model’s requirements and various groups are urging CMS to delay the start date.
Why this matters: Both of these models will significantly impact current delivery care models and test ways to further CMS’ goals of reducing Medicare expenditures while preserving or enhancing the quality of care furnished to beneficiaries.

CMS Releases Applications and Additional Information for New Rural Health Model
Eligible organizations can apply for up to $5 million each to serve as lead organizations for the Community Transformation Track in the Centers for Medicare & Medicaid Services’ Community Health Access and Rural Transformation Model.

The organizations will recruit and partner with participating hospitals and other stakeholders in a rural area to develop and implement a health care delivery system redesign strategy. Letters of intent to apply for the funding are due Jan. 18.

CMS expects to award funding to up to 15 lead organizations, which will serve over a seven-year period, including a pre-implementation period beginning July 1, 2021. The two-track CHART model, announced last month, seeks to provide up-front funding and predictable payments that are less dependent on service volume, and reduce regulatory burden and increase flexibilities for model participants.

Background: In August, the Trump Administration announced a new demonstration model, the Community Health Access and Rural Transformation (CHART) Model, which aims to improve rural health by leveraging innovative financial arrangements, along with operational and regulatory flexibilities. This announcement last month responds to the Aug. 3 White House Executive Order that directed the launch of a new payment model “to ensure that rural healthcare providers are able to provide the necessary level and quality of care.”

The CHART Model seeks to support rural health care access by:
- increasing rural providers’ financial stability by providing up-front funding and predictable payments that are less dependent on service volume; and
- relaxing certain requirements via waiver to reduce regulatory burden and increase flexibilities for model participants

Through the model, CMS is directly providing a pool of $75 million in upfront, seed funding, with 15 rural communities applying for up to $5 million to develop local transformation plans. With this upfront seed funding, CMS is also providing regulatory and operational flexibility for updated service delivery models as well as changing how participating hospitals in these communities are paid, from a system based on volume to stable, monthly payments.

In addition to supporting these 15 rural communities, CMS is also looking for 20 rural Accountable Care Organizations to participate in the model, paying shared savings upfront so that ACOs have infrastructure funding to be successful on the move towards achieving better outcomes. Taken together, these are substantial and tangible actions to support health care in rural communities.

More information on the model can be found at the CMS Innovation Center website.

Why this matters: The approximately 57 million Americans living in rural communities, including millions of Medicare and Medicaid beneficiaries, face unique challenges when seeking health care services, such as limited transportation options, shortages of health care services, and an inability to fully benefit from technological and care-delivery innovations. Current regulations and volume-based payment structures...
perpetuate these challenges, with unsustainable financial models leading to over 130 rural hospitals closing since 2010. Options to restructure and transform the rural health care delivery system are critical to maintaining viable access to services for these communities.

**CMS Emergency Care Model to Begin Jan. 1**
The Emergency Triage, Treat, and Transport Model will begin January 1, the Centers for Medicare & Medicaid Services announced. CMS postponed the original May 1 start date in April as model participants worked to respond to the needs of the COVID-19 emergency. CMS in February selected 205 ambulance service providers or suppliers to participate in the five-year payment model. Selected applicants will receive a revised participation agreement in mid-October.

The agency plans early next year to release a funding opportunity notice for cooperative agreements with entities that operate or oversee 911 dispatches in areas where ambulance providers are participating.

**Background:** Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 911 call. Under the ET3 model, CMS will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination partner (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care partner, either on the scene or connected using telehealth.

For more on the five-year payment model, announced last year, visit the [CMS Innovation Center](https://innovation.cms.gov/initiatives/et3).

**Why this matters:** The model will allow beneficiaries to access the most appropriate emergency services at the right time and place. The model will also encourage local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches to promote successful model implementation by establishing a medical triage line for low-acuity 911 calls. As a result, the ET3 model aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.

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**HRSA Final Rule Expands Reimbursable Expenses for Living Organ Donors**
The Health Resources and Services Administration released a [final rule](https://www.hrsa.gov/health-center/financeanswers/financeanswers.html#final-rule) and [notice](https://www.hrsa.gov/health-center/financeanswers/financeanswers.html#notice) expanding the types of expenses the National Living Donor Assistance Center will reimburse to include lost wages and child- and elder-care expenses for living donors who lack other forms of financial support.

The program previously reimbursed only travel, lodging, meals and incidental expenses related to living organ donation.

The rule takes effect on October 22, 2020.

**Why this matters:** Every 10 minutes, another person is added to the national organ transplant waiting list, and approximately 20 people die every day while waiting for a transplant. The current approach to acquiring organs for transplantation relies on the altruism of deceased donors and their families and the voluntarism and altruism of living organ donors. Living organ donation offers a viable transplant option,
primarily for kidney and liver transplant candidates, and helps to reduce the overall number of individuals on the national organ transplant waiting list, thus improving the transplantation system overall.

In response to these challenges, President Trump directed the agency to develop revisions the rule in July to help remove financial barriers to living organ donation. Transplants using organs from living donors last year accounted for 19% of the nation's 39,719 transplants.

Federal COVID-19 Policy Guidance and Other Developments

**Testing:** The Centers for Disease Control and Prevention (CDC) made clarifications to the *summary of considerations and current CDC recommendations* regarding SARS-CoV-2 testing. The update amends guidance published on August 24, now clarifying the need to test individuals who are asymptomatic but have had close contact with someone known to have a SARS-CoV-2 infection.

**Vaccine News:** The Department of Health and Human Services (HHS) and the Department of Defense (DoD) released a plan for delivering millions of doses of a future COVID-19 vaccine to Americans at no cost. The documents, developed by HHS in coordination with DoD and the Centers for Disease Control and Prevention (CDC), provide a strategic *distribution overview* along with an *interim playbook* for state, tribal, territorial, and local public health programs and their partners on how to plan and operationalize a vaccination response to COVID-19 within their respective jurisdictions.

**CDC Study Suggests COVID-19 Mitigation Efforts Could Reduce Impact of Flu:** A new *Centers for Disease Control and Prevention study* suggests that social distancing and other measures to stop the spread of SARS-CoV-2 could help reduce the impact of flu this fall and winter in the United States if widely practiced.

U.S. flu activity declined sharply within two weeks of the COVID-19 emergency declaration and widespread implementation of community mitigation measures, including school closures, social distancing and mask wearing, the study found.

“Influenza vaccination for all persons aged 6 months remains the best method for influenza prevention and is especially important this season when SARS-CoV-2 and influenza virus might cocirculate.”

**FDA Approves New Option Amid COVID-19-spurred Sedation Drug Shortages:** The Food and Drug Administration approved [dexmedetomidine hydrochloride in 0.9% sodium chloride injection](https://www.fda.gov) for the sedation of initially intubated and mechanically ventilated patients in an intensive-care setting and of non-intubated patients prior to and/or during surgical and other procedures.

The drug helps address short supplies of sedation options due to the COVID-19 public health emergency. Side effects of the drug include low blood pressure, slow heart rate and dry mouth.

**ASPR Releases Latest Batch of COVID-19 Resources:** The Department of Health and Human Services’ Office of the Assistant Secretary for Preparedness and Response recently posted new and updated COVID-19 resources at its [Technical Resources, Assistance Center, and Information Exchange](https://www.hhs.gov). They include:
• Critical Care Load-Balancing Operational Template and Considerations for Assessing Regional Patient Load-Balancing Effects during COVID-19 to help manage COVID-19 patient surge;
• COVID-19 Considerations for Long-Term Care Facilities toolkit compiling consideration based on lessons learned during the pandemic’s early months; and
• an interagency Behavioral Health Compendium to help regional emergency coordinators and federal and state planners support stakeholders in various areas of COVID-19 response and recovery.

FDA Clarifies Emergency Authorization for Abbott Point-of-care Test: The Food and Drug Administration reissued its emergency use authorization for the Abbott ID NOW COVID-19 test to indicate that the product is intended for specimens collected “from individuals who are suspected of COVID-19 by their health care provider within the first seven days of the onset of symptoms.”

The revised EUA also clarifies that the test is authorized for emergency use by laboratories certified under the Clinical Laboratory Improvement Amendments that meet the requirements to perform high, moderate or waived complexity tests; and that U.S. testing facilities must report all results to the appropriate public health authorities.

Fed Updates FAQs for Main Street Lending Program: The Federal Reserve Board updated its FAQs on the Main Street Lending Program to clarify its expectations for nonprofit and other facilities regarding lender underwriting. The revised FAQs emphasize that lender underwriting should look back to the borrower’s pre-pandemic condition and forward to their post-pandemic prospects, and clarify supervisory expectations for lenders originating Main Street loans.

The board said the changes provide guidance on completing and submitting Main Street legal documents and entering data into the portal for multi-borrower loans; and clarify the application of the direct loan restrictions on loans between Main Street borrowers and their owners, employees and officers. The FAQs also include details regarding co-borrower loans.

FDA Approves New Anesthetic/Sedation Drug Option: The Food and Drug Administration approved a new drug application for propofol injectable emulsion, an intravenous general anesthetic and sedation drug in short supply.

“The agency recognizes there is increased demand for certain products, such as propofol injectable emulsion, during the novel coronavirus pandemic, and remains committed to facilitating access to safe and effective medical products to help address critical needs of the American public,” the agency said.


Test developers are required to assess their test’s performance against a reference panel of viral samples to receive emergency use authorization. In the data, a lower product LoD (limit of detection) indicates a test’s ability to detect a smaller amount of viral material in a given sample, signaling a more sensitive test. FDA plans to update the data as it receives additional results to help inform laboratories, health care providers and patients about the relative performance of available tests.

The FDA also awarded a research contract to the University of Liverpool and global partners to sequence and analyze SARS-CoV-2 and other coronavirus samples to help inform the real-time performance of molecular-based diagnostics.
HHS Unveils COVID-19 Vaccine Distribution Strategy: The Department of Health and Human Services released its strategy for the public distribution of a COVID-19 vaccine. HHS said that it developed the strategy in coordination with the Department of Defense and the Centers for Disease Control and Prevention.

It provides a strategic distribution overview along with an interim playbook for state, tribal, territorial and local public health programs and their partners on how to plan and operationalize COVID-19 vaccination response within respective jurisdictions.

NIH Study Links SUDs with COVID-19 Susceptibility: People recently diagnosed with substance use disorders were more likely to develop COVID-19 and be hospitalized or die from the virus, according to a National Institutes of Health-funded study recently released.

Using millions of non-identifiable electronic health records, the study’s authors found that while patients with a SUD make up 10.3% of the U.S. population, SUD patients represent 15.6% of the nation’s COVID-19 cases; they say this underscores the need for SUD screening and treatment as part of pandemic control. The study indicates that the strongest adverse COVID-19 effects were seen in those with opioid or tobacco use disorders.

“The lungs and cardiovascular system are often compromised in people with SUD, which may partially explain their heightened susceptibility to COVID-19,” said study co-author and Director of the National Institute on Drug Abuse Nora Volkow, M.D. “Another contributing factor is the marginalization of people with addiction, which makes it harder for them to access health care services. It is incumbent upon clinicians to meet the unique challenges of caring for this vulnerable population, just as they would any other high-risk group.”

CMS Issues CY 2022 Advance Notice for the CMS-HCC Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) issued for comment the Advance Notice for Calendar Year 2022 Changes to the CMS-HCC Risk Adjustment Model. CMS explains it is publishing the 2022 Advance Notice in two parts because the 21st Century Cures Act mandates a 60-day comment period for certain risk model changes.

Under the proposal, CMS would fully transition to the risk adjustment model first adopted in the CY 2020 Rate Announcement. Specifically, CMS proposes to:

- Complete phase-in of the updated risk adjustment model by calculating risk scores using 100% of the risk score calculated with the 2020 CMS-HCC model;

- End the blending of encounter data- based and RAPS- based risk scores, so that 100% of the risk score will be based on diagnoses from encounter data and fee-for-service (FFS) claims for the 2022 payment year. In 2021, CMS will determine risk scores based on 75% of encounter data system (EDS) data and FFS claims, and 25% from the legacy Risk Adjustment Processing System (RAPS) system and FFS claims; and
- Discontinue use of inpatient diagnoses to supplement EDS data. Since 2019, CMS has supplemented EDS-based risk scores with data derived from RAPS inpatient diagnoses in an effort to minimize the impact of operational challenges related to EDS data submission.

Notably, the agency also states they “are considering publishing the Rate Announcement in January 2021 in light of the challenges for MA organizations, PACE organizations, and Part D sponsors posed by the uncertainty associated with the COVID-19 pandemic.” If CMS proceeds with that approach, they would publish Part II of the Advance Notice in the Fall of 2020 and establish final 2022 rates and payment policies roughly three months earlier than normal.

Comments on the Advance Notice are due to CMS by 6:00 p.m. ET November 13.

State Issues

Delaware
Legislative

Delaware Federal and State Primary Election Results

State Results
Delaware was among the last to hold their statewide primary, and Republican Party endorsed attorney Julianne Murray scored a 41-35 percent win over state Sen. Colin Bonini (R-Magnolia) in the gubernatorial nomination election. Ms. Murray will now challenge first-term Gov. John Carney (D) who is a heavy favorite to win re-election in November. Mr. Carney was re-nominated in the Democratic primary with 85% of the vote. Insurance Commissioner Trinidad Navarro won his primary election with 64 percent of the vote.

The most unexpected outcome in last week’s primary was the defeat of Senate President Pro Tem David McBride by Marie Pinkney. Senator McBride has been a member of the Delaware legislature since 1978 and had not had an opponent since 1984. Ms. Pinkney won with 52.37 percent of the vote and will face Republican Alexander Homich in the general election.

In the state House of Representatives, three incumbent Democrats lost their primaries. Veteran legislator and former House majority whip John Viola lost to Madinah Wilson-Anton. Ms. Wilson-Anton won 42.6 percent of the vote to Viola’s 41.2 percent. She will face Republican Timothy Conrad. Ms. Wilson-Anton, a former House staffer and current staffer with the Biden Institute at the University of Delaware would be the first person of the Muslim faith to serve in the Delaware General Assembly.

One-term Representative Ray Siegfried lost to Larry Lambert in the 7th Representative District Democratic primary. Mr. Lambert won a convincing 59 percent of the tally. Mr. Lambert will face Republican James Haubrich and Libertarian Scott Gesty in November.

Federal Results
In the US Senate race, conservative activist Lauren Witzke was a 57 percent winner in the Republican primary and she now advances into a general election contest opposite Sen. Chris Coons (D), who runs for a second full term after serving the balance of former Vice President Joe Biden’s last US Senate term. Teacher and actor Lee Murphy is now the Republican nominee against sophomore Rep. Lisa Blunt Rochester (D-Wilmington). Both Sen. Coons and Rep. Blunt Rochester are prohibitive favorites in November.

To view the full primary election results, visit this website: [2020 Delaware primary election results](#).

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**State Issues**

**Pennsylvania**

**Legislative**

**Joint State Government Commission Issues Behavioral Health Care Capacity Study**

Late this summer, the Joint State Government Commission (JSGC) issued a report titled “Behavioral Health Care System Capacity in Pennsylvania and its Impact on Hospital Emergency Departments and Patient Health.” The report was the result of [House Resolution 268 of 2019](#), which directed the JSGC to appoint an advisory committee to conduct an assessment of the commonwealth’s current behavioral health needs and the impact that the behavioral health care system’s capacity has on hospital emergency departments (ED) and patient health.

The advisory committee consisted of experts across the spectrum of behavioral health care, and included physicians, public health authorities, behavioral health professionals, hospital administrators, and patient advocates.

The 148-page report included a comprehensive set of recommendations, as well as an analysis of system capacity, factors that contribute to the problem, and successful emergency response models. While the report does not include an evaluation of the length and extent of discharge delays experienced by hospitals throughout the commonwealth, it does include a series of recommendations and findings.

For example, the report:

- Strongly validated that ED boarding is a serious problem for patients and hospitals, and that it results from underfunded and fragmented behavioral health and substance abuse delivery systems
- Recommends policy actions to promote integrated physical health and behavior health services and crisis intervention services to take pressure off of—and reduce admissions to—EDs
- Explains that low payment rates for behavioral health/substance abuse services are a problem, and that reimbursement for rural and safety net hospitals needs attention. The report also identifies the threat and implications of looming disproportionate share hospital payment cuts, and highlights alternative payment models for hospitals (such as the Pennsylvania Rural Health Model)
- Acknowledges the importance of behavioral health payment parity enforcement, and explains that insured patients experience shorter delays in finding care following an ED discharge than uninsured patients—highlighting the importance of insurance coverage expansions
- Encourages several steps to strengthen and grow the behavioral health workforce and address provider shortages in rural counties
• Strongly supports the expansion of the use of telepsychiatry—as well as payment parity—and emphasizes the need for broadband coverage expansions and participation in the interstate licensing compact to promote this treatment modality.

• Recommends the development of new programs—such as regional psychiatric EDs, alternative treatment programs in hospitals, and rural capacity development—and provides a compendium of successful programs adopted by providers and governments in other states.

Other recommendations in the report—such as the adoption of bed registries—are at odds with hospital priorities.

Lastly, the report also describes the significant impact of the opioid crisis on hospital EDs and emergency medical services personnel.

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**Dental Direct Payment Bill Stalls in House of Representatives**

An effort to bring House Bill 564 up for a floor vote failed this week in the House of Representatives. The current version of the legislation, sponsored House Appropriations Committee Chairman Stan Saylor (R-York), requires health insurers to directly pay non-participating dentists and all other non-participating network providers, and permits them to balance bill patients any difference between the insurer’s payment and the provider’s charge—a practice also known as “surprise” balance billing. A number of members expressed concern about this provision, particularly at a time when individuals are being negatively impacted by the coronavirus pandemic and action is underway at the federal level to end this anti-consumer practice.

The health and dental insurance community opposed House Bill 564. However, they did support amendments proposing to prohibit the practice of balance billing.

**Why this matters:** If enacted, House Bill 564 would:

• Increase patient out of pocket costs during this time of economic uncertainty;

• Add complexity and confusion to the consumer health care experience, encouraging the practice of “surprise” balance billing; and

• Provide an unfair advantage to any provider deciding not to contract with insurers, eliminating the quality standards and cost saving protections of health insurer networks.

Although the number of legislative session days is dwindling, House Bill 564 could still receive consideration.

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**Interstate Compact, Optometric Practice Measures Receive Consideration in the House**

Several bills addressing the practice of medicine across state lines and the modernization of optometric medicine received consideration this week in the House of Representatives:

• **House Bill 862** – Authorizes Pennsylvanians to join the Physical Therapy Licensure Compact in order to facilitate the interstate practice of physical therapy.

• **House Bill 2561** – Updates the Optometric Practice and Licensure Act to address the use of certain drugs approved by the Food and Drug Administration, optometric student education practices and treatment protocols.
• **House Bill 2584** – Would address concerns raised by the Federal Bureau of Investigations (FBI) to allow information to be shared regarding background checks in accordance with the Interstate Medical Licensure Compact Act (IMLC). The proposal was amended by the House to place it in Act 112 of 2016, which is the IMLC and that it would only apply to physicians who want to participate in the IMLC.

The bills have been placed on the House voting calendar for consideration.

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**House Health Committee Votes in Favor of Several Health Care Measures**

The House Health Committee voted to advance several health care measures earlier this week.

• **House Bill 2103** – Amends the Patient Test Result Information Act of 2018 to clarify and simplify how and when a patient is to receive test results. While hospitals and physicians worked closely on the underlying bill to ensure all patients received information about how and when to obtain test results, the bill was unsatisfactorily amended, including patient notification requirements, revised definitions, and Department of Health responsibilities.

• **House Bill 2792** – Directs the Department of Health (DOH), in consultation with the Department of Human Services (DHH), to create a registry of medical directors in all personal care homes, long-term care facilities, and assisted living residences.

• **House Bill 2779** – Ensures that the transition is a gradual return to health care practices for both the provider and the patient by extending waivers and administrative flexibilities for 90 days passed the end of the emergency declaration. The bill was amended to shorten the extension from one year to 90 days, add additional members to the advisory committee, and ensure that a waiver that was terminated prior to the end of the executive order would not be valid during the extension period. Additional amendments are likely to be proposed.

• **House Bill 2861** – Amends the Health Care Facilities Act to require the Department of Health (DOH) to develop a process to designate an essential caregiver during an Emergency Disaster Declaration for a resident of a long-term care nursing facility, or allow an individual with decision-making authority for the resident to designate an essential caregiver.

The bills have been placed on the House voting calendar for consideration.

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**Industry Trends**

Policy / Market Trends

**CQMC Updates Core Measure Sets to Improve Care, Reduce Burden, Eliminate Redundancy**

The Core Quality Measures Collaborative (CQMC) released four updated core measure sets covering specific clinical areas as part of its mission to provide useful quality metrics as the nation’s health care system moves from one that pays based on volume of services to one that pays for value. CQMC’s core measure sets promote better patient outcomes, aligning measures across public and private payers, and reduce the burden of measurement by eliminating low-value metrics and redundancies.
Why this matters: The CQMC is a diverse coalition of health care leaders representing over 75 consumer groups, medical associations, health insurance providers, purchasers and other quality stakeholders, all working together to develop and recommend core sets of measures by clinical area to assess and improve the quality of health care in America. The CQMC was convened in 2015 by AHIP and the Centers for Medicare & Medicaid Services (CMS) and is housed at the National Quality Forum (NQF).

Industry Trends
Provider / Delivery System Trends

Hospital Price Transparency Study Released; AHA Raises Concerns about Study’s Validity
Last Friday, the RAND Corporation issued its third National Hospital Price Transparency Study, an employer-led initiative intended to measure and report the prices paid for care at the hospital and service-line levels. After an initial review of the findings, the American Hospital Association (AHA) said the study continues to inaccurately suggest that Medicare payments should be used as a benchmark for private insurers (despite reimbursing below the cost of care) and uses a limited sample size and outdated data.

A recent blog from the AHA outlines a more complete picture of hospital pricing based on comprehensive data, noting that hospital prices remain in check and the danger of pulling resources from providers.

Key findings:
• During 2018, across all hospital inpatient and outpatient services, employers and private insurers included in the report paid 247 percent of what Medicare would have paid for the same services at the same facilities. This difference increased from 224 percent of Medicare during 2016 and 230 percent during 2017
• From 2016 to 2018, the overall relative price for hospitals (including inpatient and outpatient care) increased from 224 to 247 percent, a compounded annual rate of increase of 5.1 percent
• Some states (Arkansas, Michigan, and Rhode Island) had relative prices under 200 percent of Medicare; others (Florida, West Virginia, and South Carolina) had relative prices that approached 350 percent of Medicare
• In at least some parts of the country, employers have options for high-value facilities that offer high quality at lower prices, but there is no clear link between hospital price and quality or safety

Why this matters: Last year, RAND issued a similar study that made broad claims about the prices that private insurers pay hospitals. The hospital pushed back that the study relied on severely limited data and lacked the level of reliability that could make it useful to inform serious policy discussions or decisions and has shared findings from economists that cite multiple concerns with the methodology of this and another similar study.
Interested in reviewing a copy of a bill(s)? Access the following web sites:

Pennsylvania Legislation: [www.legis.state.pa.us](http://www.legis.state.pa.us).
West Virginia Legislation: [http://www.legis.state.wv.us/](http://www.legis.state.wv.us/).
For copies of congressional bills, access the Thomas website – [http://thomas.loc.gov/](http://thomas.loc.gov/).
If you have any questions about a DE, PA, WV or congressional bill, contact the Government Affairs Department at (717).302.3978.

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