STATE of the STATE

2018 ARIZONA WINTER

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State of the State

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THE HERTEL REPORT

STATE OF THE STATE 2018

January 2018

Dear Friends and Colleagues:

Welcome to the 36th edition of the Winter State of the State brought to you by The Hertel Report. For more than 20 years, Arizona healthcare professionals have turned to The Hertel Report for accurate, impartial, timely and solutions-focused news, data and information about our managed care market.

One of the many ways that we deliver information and data is through these biannual breakfast meetings where we bring subject matter experts to deliver insight and share experiences about critical developments across the Arizona healthcare landscape.

This morning, you'll meet Jim Whitfill, an expert in ACO development and operations, health information technology and strategic planning, Lisa Mead, an expert in healthcare quality reporting, leadership and empowering women leaders; and Marcus Johnson, an expert in Arizona public policy and the grass-roots efforts to enroll citizens into coverage.

With more than 35 years experience as a professional in the Arizona managed care marketplace, I see repeating trends. When I came out of college 1985, the hot word was HMO, health maintenance organization. The objectives of these organizations were to connect members to primary care physicians and encourage wellness and prevention. Then there were IPAs and PHOs and integrated delivery systems. All were focused on putting the providers in the driver's seat for delivering efficient health care to health plan members. The 2010 passing of the Affordable Care Act (ACA) put renewed focus on this paradigm with accountable care organizations (ACOs). CMS has arrangements with ACOs to track quality and cost for traditional Medicare patients. These and other organizations aggregate providers into networks focused on delivering improved quality of care and controlling costs.

Value in healthcare is defined as Quality/Cost over time. And these organizations are accountable for quality care and sharing or taking risk for the costs of such care. The term we're using now for this paradigm is "value-based". The Hertel Report is calling these organizations, in the aggregate, value-based networks (VBNs). Today, we will share with State of the State attendees the latest about the progress of VBNs Arizona.

I would like to thank all of the ACOs and VBNs that participated in our data query about the size and scope of the Arizona value-based scene. Their commitment to transparency and collegiality is precisely the objective of The Hertel Report. We are all in this together. Learning from each other and sharing our experiences strengthens our Arizona healthcare community, to which we are all connected.

Please be sure to share your experiences about the 2018 Winter State of the State by participating in our survey at www.surveymonkey.com/r/WSOS2018.

Thank you for attending the 2018 Winter State of the State,

Jim
Jim Hammond
Publisher

P.S. If you are not already a member of The Hertel Report, please consider joining today.

AGENDA

THE HERTEL REPORT

2018 Winter State of the State Agenda

7 AM
NETWORKING BEGINS
7:30 AM
BREAKFAST
8 AM
PROGRAM BEGINS

- WELCOME, INTRODUCTIONS
- LEGISLATIVE UPDATE WITH PELE FISCHER
- HEADLINE NEWS
- MEDICARE ADVANTAGE
- AHCCCS
- ACA COVERAGE UPDATE WITH MARCUS JOHNSON
- VALUE-BASED NETWORKS WITH JIM WHITFILL
- QUALITY AS A BUSINESS STRATEGY WITH LISA MEAD
- DISCUSSION

GUEST SPEAKERS

PELE FISCHER, JD
VICE PRESIDENT, POLICY AND POLITICAL AFFAIRS
ARIZONA MEDICAL ASSOCIATION

MARCUS JOHNSON
DIRECTOR, STATE HEALTH POLICY AND ADVOCACY
VITALYST HEALTH FOUNDATION

JIM WHITFILL, MD
PRESIDENT, LUMETIS, LLC
CHIEF MEDICAL OFFICER, INNOVATION CARE PARTNERS

LISA MEAD, RN
PRESIDENT, CROWNE HEALTHCARE CONSULTING
FOUNDER, ARIZONA WOMEN IN HEALTHCARE

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Arizona Foundation is an independent, not-for-profit Preferred Provider Organization. Originally established by physicians in 1969 as an alternative to health maintenance organizations, we have grown into Arizona's largest statewide, independent network by providing highly-accessible, quality care.

We work directly with brokers, consultants, general agents, third party administrators, and insurance companies to provide the freedom of choice by offering and/or endorsing a variety of healthcare solutions.

Our Workers' Compensation Plan, Foundation Comp, was designed for self-funded employers and workers' compensation carriers. Foundation Comp offers its clients aggressive discounts and the largest, most accessible network of hospitals, occupational health medical centers, urgent care centers, physical therapy centers, and outpatient surgery centers, as well as a comprehensive network of physicians.

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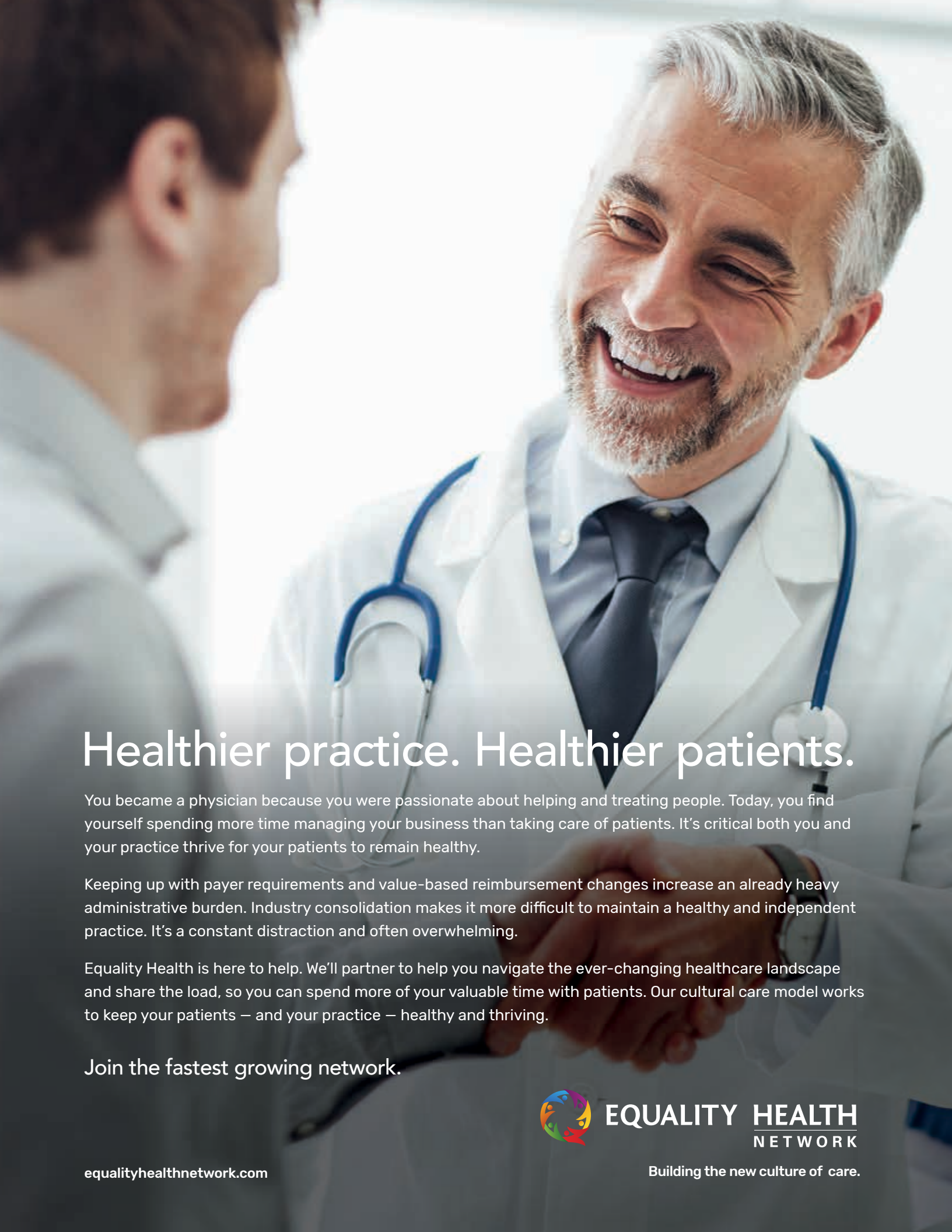

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Keeping up with payer requirements and value-based reimbursement changes increase an already heavy administrative burden. Industry consolidation makes it more difficult to maintain a healthy and independent practice. It's a constant distraction and often overwhelming.

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THE HERTEL REPORT

2018 Arizona Winter State-of-the-State

January 2018

Introduction

- **Jim Hammond**
  - Publisher & CEO of The Hertel Report
  - Managing Consultant, Professional Healthcare Solutions
  - State-wide Healthplan & Provider Relations Expert
  - Conference Speaker & Resource to: AzHHA, AHE, MCMS, HFMA - AZ, CBIZ, ASPA, AMN, HCAA, CMSA, Sonora Quest, Humana, Dignity Health, U of A, CNBC, Money Radio, *Wall Street Journal*, NPR, *Modern Healthcare*, *Phoenix Business Journal*, *Arizona Daily Star*, Vitalyst Health Foundation, Web AZ, and more
  - Former AZ HFMA President

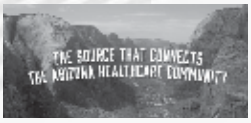
Guest Speakers

- Pele Fisher
  - Vice President, Policy and Political Affairs, Arizona Medical Association
- Marcus Johnson
  - Director, State Health Policy and Advocacy, Vitalyst Health Foundation
- Jim Whitfill, MD
  - President, Lumetis, LLC.
  - Chief Medical Officer, Innovation Care Partners
- Lisa Mead, RN
  - President, Crown Healthcare Consulting
  - Founder, Arizona Women in Healthcare

Agenda

- Welcome, Introductions
- Legislative Update with Pele Fisher
- Headline News
- Medicare Advantage
- AHCCCS
- ACA Coverage Update with Marcus Johnson
- Value-based Networks with Jim Whitfill
- Quality as a Business Strategy with Lisa Mead
- Discussion

The Hertel Report



- Trusted & Respected
- Impartial & Timely
- Solutions Focused
- Locally Owned
- Weekly News
- Monthly Newsletter
- Quarterly Data
- Networking & Conferences

The Hertel Report Community

- 15 Founding Sponsors
- 50 Corporate Members
- 10 Community Partners
- 1000+ Individual Members
- 11 Newsletters
- 4 Data Editions
- 4+ State of the State Meetings
- More.....

The Source that Connects the Arizona Healthcare Community

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ARIZONA MEDICAL ASSOCIATION

The Arizona Medical Association is a voluntary membership organization for all Arizona medical and osteopathic physicians.

Mission:

Promote and provide leadership in the art and science of medicine;

Preserve and improve the health of all Arizonans;

Represent Arizona physicians in the public forum;

Defend Arizona physicians' freedom and ability to practice medicine in the best interests of your patients.

CURRENT POLITICAL CLIMATE

- Arizona Politics are in flux like never before …
- Unique dynamics …
  - Tense Political Climate
  - New Legislators
  - Statewide elections
  - Term limits impacts
  - High profile issues and debates

2018 Legislative Overview

- Leadership
  - Senate President: Steve Yarbrough (Chandler)
  - Minority Leader: Katie Hobbs (Phoenix)
  - House Speaker: J.D. Mesnard (Chandler)
  - Minority Leader: Rebecca Rios (Phoenix)
- Health Committees
  - House Health Chair: Rep. Heather Carter (North Phoenix - Cave Creek)
  - Senate Health Chair: Senator Nancy Barto (North Phoenix)
- Medical Expertise?!?!

2018 Legislative Forecast - Health

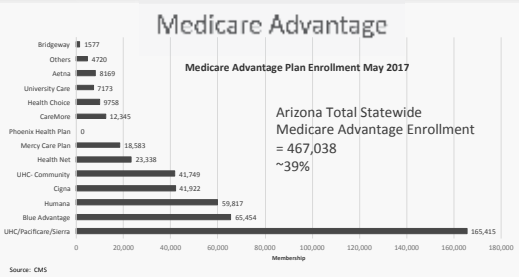
- Combatting the Opioid Epidemic
  - During his State of the State address, Governor Ducey called for a special session to pass legislation related to combating the opioid crisis.
- Regulation
  - Certification Community Health Workers
  - Licensure of Dental Therapists
- AHCCCS
  - Federal Waiver – implement caps and work requirements
  - Chiropractic Coverage for Adults
  - Oral Health Coverage for Pregnant Women

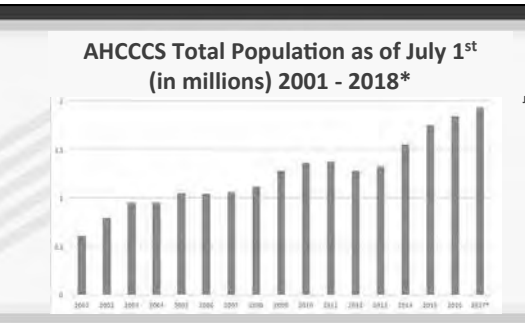
2018 Legislative Forecast - Health

- Behavioral Health
  - Peace Officer Transport
  - Hospital Boarding of psych patients
- Public Health
  - Tobacco 21
  - Prohibit indoor tanning for persons under 18 years of age
- Administration
  - Credentialing Improvements and Efficiencies
- More to Come ….

WAYS TO GET INVOLVED

- VOTE! And Vote Early!
  - Primaries are critical
- Join associations that are advocating for the issues that are important to YOU!
- Support Candidates
- Donate to a PAC
- Attend a fundraiser
- Get to know your legislators!





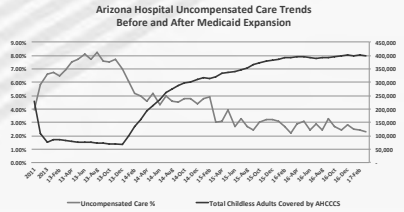
Restoration and Expansion by the numbers

- 400,000 • Expansion Adults
- 82,000 • Mental Health Service
- 47,000 • Substance Use Disorder
- 26,700 • Cancer Treatment
- 31% each • 20-29 YO and >50 TO
- 11,563 • Individuals with SMI
- 17.3% to 11.1% • Uninsured 2013-2015

AHCCCS

Reaching across Arizona to provide comprehensive quality health care for those in need

Uncompensated Care Trends



Source: Arizona Hospital and Healthcare Association

ALTCS Award for 10-1-17 Start

- North – United
- Central (Maricopa, Pinal, Gila)
  - University – Mercy Care – United
- South
  - University
  - Mercy Care (Pima)
- Roughly 9,000 members transitioned
- Bridgeway (Centene) out

AHCCCS Committed to Integration

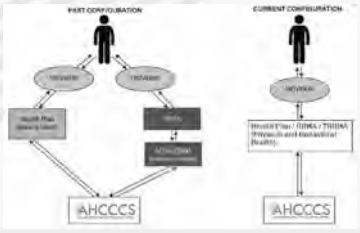
A Case for Integrating Physical and Behavioral Health Services:

1. Ease navigation of health care services;
2. Single point of accountability;
3. Align incentives to improve a person's whole health; *and*
4. Streamline care coordination to get to better outcomes.

AHCCCS Acute Plan Enrollment Shift January 2017 to 2018

HEALTH PLAN	MEMBERSHIP	YOY CHANGE
United Healthcare	507,409	15%
Mercy Care Plan	368,137	1%
Health Choice AZ	248,971	-1%
Care 1st AZ	146,386	31%
University Family Care	131,948	-4%
Health Net Access	58,567	1%

Vision - Integration at all 3 Levels



Integrated Acute Care Bid
AHCCCS Complete Care

- RFP out November 2, 2017
- Integrated Physical and Behavioral Care
- For all Adults without Serious Mental Illness
- And All children except CMDP (foster kids)
- Crisis Services responsibility of RBHA
- Move to GSA's like ALTCS
- PROPOSALS DUE JAN 25!

Anticipated Procurement Timeline — **Contract/RFP No. YH19-0001**

Date	Activity
November 02, 2017	Issue Request for Proposal
November 08, 2017	Pre-Proposal Prospective Offerors' Conference and Technical Interface Meeting
November 14, 2017	Prospective Offerors' First Set of Technical Assistance and RFP Questions Due by 5:00 p.m. Arizona Time
November 30, 2017	First RFP Amendment Including Responses to RFP Questions Issued
December 08, 2017	Prospective Offerors' Second Set of Technical Assistance and RFP Questions Due by 5:00 p.m. Arizona Time
December 20, 2017	Second RFP Amendment Including Responses to RFP Questions Issued
December 28, 2017	Prospective Offerors' Third Set of Technical Assistance and RFP Questions Due by 5:00 p.m. Arizona Time
January 08, 2018	Third RFP Amendment Including Responses to RFP Questions Issued
January 25, 2018	**Proposals Due by 3:00 p.m. Arizona Time**
March 08, 2018	Contracts Awarded/Transition Services Begin On or Before
October 01, 2018	Program and Medical Service Implementation On or After

Note: *Dates are subject to change*

Integrated Contractor Geographic Service Areas

Additional zip code exceptions may be considered to allow for further alignment with certain tribal lands.

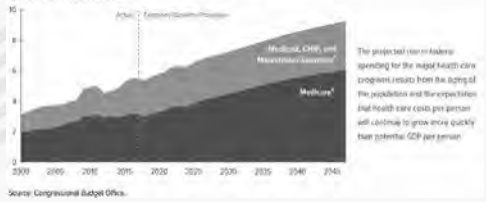
AHCCCS

ACA Coverage Updates

Marcus Johnson
Director, State Health Policy & Advocacy
Vitalyst Health Foundation

Federal Spending on the Major Health Care Programs, by Category

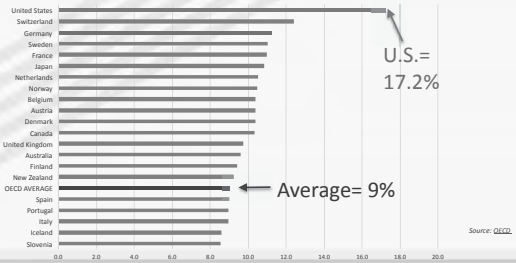
Percentage of Gross Domestic Product



Source: Congressional Budget Office.

Source: Congressional Budget Office

Health Spend by **% GDP** (2016)

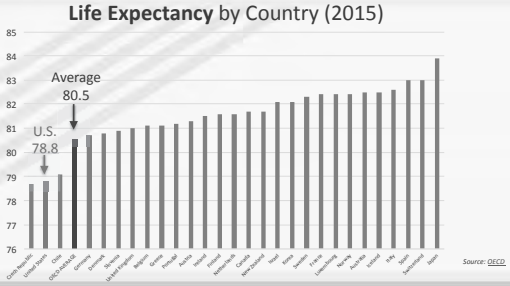


U.S.= 17.2%

Average= 9%

Source: OECD

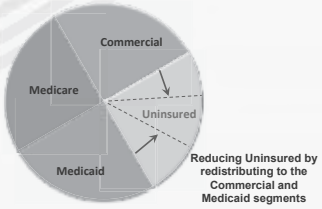
Life Expectancy by Country (2015)



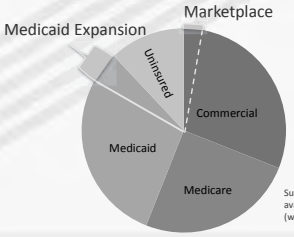
Objectives of The Affordable Care Act

- Reduce Uninsured
  - Mandate and Exchanges
  - Medicaid Expansion
- Bend the Cost/Quality Curve
  - Squeeze out the fat (Insurance Co. & Provider)
  - ACOs/Value-Based Networks/Care Coordination
  - Provider Accountability

REDUCE THE UNINSURED

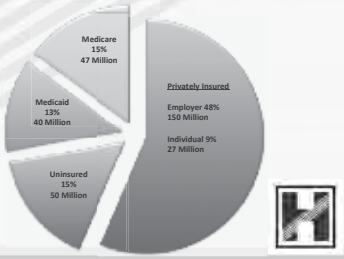


UNINSURED MIGRATION

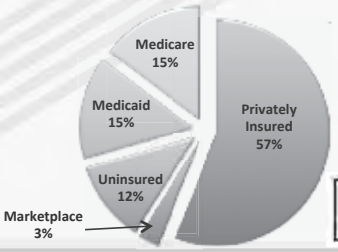


Subsides for low-income citizens ONLY available through Marketplace (www.healthcare.gov)

Uninsured Pre-ACA

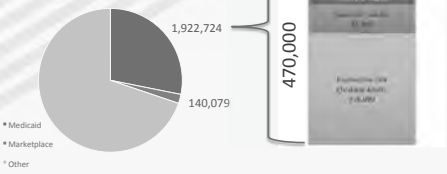


ACA Squeezing out the Uninsured



Who's **Covering** Arizona?

Health Insurance Coverage of the Total Population - Arizona 2017



** Marketplace enrollment reflects effectuated #s from 2/17. Total enrollment = 196,291.*

Source: AHCCCS
Source: CMS

Change is Coming

"The primary driver of our national debt is our healthcare programs. There's no one magic bullet– like pass this and it's fixed– but, save the healthcare system and you're saving the country from its debt crisis."

Paul Ryan
Speaker of the House

Modern Healthcare

The Summer of Repeal and Replace

- AHCA
- BCRA
- Skinny Repeal
- Graham-Cassidy
- Bipartisan Efforts
- Executive Orders
- Regulatory Levers

The Show Must Go On

- Health care facilities moving toward value
- Insurance companies planning for market shifts (Marketplace Open Enrollment and Medicaid Integrated Contract)
- AHCCCS calculating Fed impact on 1115 Waiver submittal
- Consumers deciphering what this actually means

2018 ACA Open Enrollment

- Enrollment period cut in half (November 1-December 15, 2017)
- Less Support for Navigators (~40% cut, nationally)
- Much Less Advertising (~90% cut, nationally)
- Tax Bill Zeroes-Out Individual Mandate Penalty
- Increased uncertainty amongst industry and consumers
- Cost Sharing Reductions unfunded, unsupported by White House

Cost Sharing Reduction Payments Still Uncertain

- **2014: U.S. House Filed Suit**
  - **Argument:** Cost-Sharing Payments Illegal – No Congressional Appropriation
- **2016: District Court Provides Favorable Ruling to House**
  - Decision Stayed by Judge – Revisit Decision Post Election
- **2017: Trump Administration does not defend lawsuits, stops funding**
- **2018: Susan Collins (R) ME still bargaining with Senate to fund CSR's**

Cost-Sharing Reductions were available for beneficiaries at or below 250% FPL or $29,700 for a single person

With Cost Sharing Reductions:

Without Cost Sharing Reductions:

Average Premiums for Arizona Marketplace Enrollees

	2016	2017	% Change
Total Premium **Sticker Price**	$324	$611	↑88.6%
Consumer Cost **after Subsidies** ***(among those receiving subsidies)***	$120	$104	↓13.3%

Sources: CMS, CMS

Number of Insurers in Arizona's Marketplace

2014	2015	2016	2017	2018
8	11	8	2	2

Source: Kaiser Family Foundation

Marketplace Premium Variation (Pre-Subsidy)

AZ particularly vulnerable to market disruption.

Disproportionately high Marketplace premium prices in AZ.

Fortunately, subsidies buffer most enrollees from high premium costs.

BUT…enrollees >400%FPL exposed to full cost of coverage

Map based on 40-yr old, non-smoker, selecting 2nd lowest cost silver plan in 2017
Source: National Academy of State Health Policy

HIM Arizona Plans 2018 Final Lineup

Maricopa and Pima Counties

ambetter.

Health Net A Better Decision

[Average premium increase 1.8%]

All Rural Counties

BlueCross BlueShield of Arizona

[Average premium decrease 0.8%]

2018 Marketplace Costs
(39 year-old, Maricopa County)

Income	Silver Premium (Gross)	Silver Premium (Post-Subsidy)	Bronze Premium (Post-Subsidy)
$18,090 (150%FPL)	$506.62	$62.78	$1.60 ☆
$27,135 (225%FPL)	$506.62	$165.29	$59.78

Source: Credit to Arizona Alliance of Community Health Centers

2018 Marketplace Costs
(39 year-old, Pima County)

Income	Silver Premium (Gross)	Silver Premium (Post-Subsidy)	Bronze Premium (Post-Subsidy)
$18,090 (150%FPL)	$357.40	$62.18	$1.00 ☆
$27,135 (225%FPL)	$357.40	$164.53	$98.54

Source: Credit to Arizona Alliance of Community Health Centers

2018 Marketplace Costs
(39 year-old, Yuma County)

Income	Silver Premium (Gross)	Silver Premium (Post-Subsidy)	Bronze Premium (Post-Subsidy)
$18,090 (150%FPL)	$713.51	$0.00 ☆	$0.00 ☆
$27,135 (225%FPL)	$713.51	$39.95	$0.00 ☆
$30,150 (250%FPL)	$713.51	$80.20	$0.00 ☆

Source: Credit to Arizona Alliance of Community Health Centers

2017-2018 HIM Enrollment Statistics

	2017	2018
U.S.	• 12.2 million enrollments (9.2M on healthcare.gov platform) • 69% renewal / 31% new • 83% of all enrollments received financial assistance • 36% of enrollment is under age 35 • 12% earn incomes outside of subsidy range	• 8.7 million FFM enrollments • 72% renewal / 28% new
AZ	• 196,291 enrollments (140,079 effectuated) • 74% renewal / 26% new enrollment • 84% of all enrollments received financial assistance • 41% of enrollment is under age 35 • 18% earn incomes outside of subsidy range	• 165,758 enrollments • **Detailed 2018 enrollment data not yet made available**

Source: CMS

Arizona's Marketplace

Who's Benefiting
- Arizonans earning up to 400%FPL, receiving subsidies
- Largely protected from price fluctuations, due to subsidy formula.

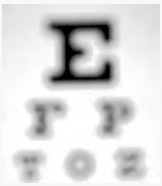
Who's Hurting
- Arizonans earning above 400%FPL, who don't have…
  - Employer Insurance
  - AHCCCS or CHIP
  - Medicare
  - VA

Family Size	100%	133%	138%	250%	350%	400%
1	$11,880	$15,800	$16,400	$29,700	$41,580	$47,550
2	$16,020	$21,300	$22,100	$40,050	$56,070	$64,100
3	$20,160	$26,800	$33,600	$50,400	$70,560	$84,650
4	$28,440	$37,850	$39,250	$60,750	$85,050	$97,200
5	$28,410	$37,785	$39,205	$71,100	$89,210	$113,800

"This year CMS took a more cost effective outreach approach, spending just over $1 per enrollee on outreach and education for Exchange coverage compared to nearly $11 per enrollee last year." – Seema Verma

Coverage Policy Outlook

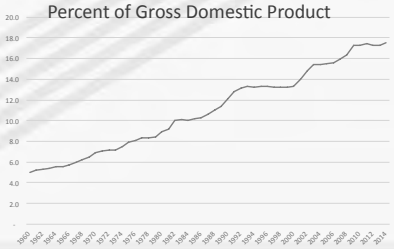
- Impact of individual mandate repeal?
- Alexander-Murray, Collins-Nelson?
  - CSR Funding
  - Reinsurance Funding
  - Outreach and Enrollment Funding
- Association Plans?
- Short-Term Medical Plans?
- Medicaid Buy-In?
- Medicaid Per-Capita Caps?
- Medicaid Block Payments?
- KidsCare Funding?



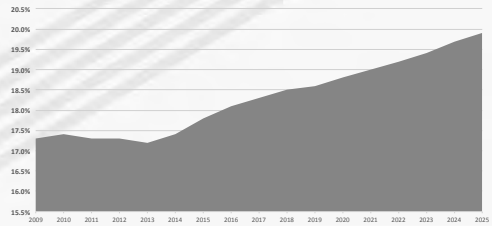
Value-Based Care
How to Get From Here to There

With Jim Whitfill

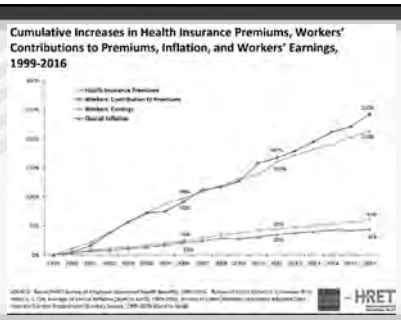
National Health Expenditures as a Percent of Gross Domestic Product



Healthcare as % GDP Projected

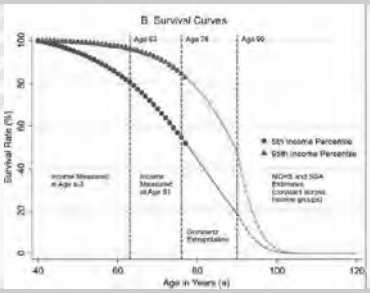


Employer and Employee Costs Rising



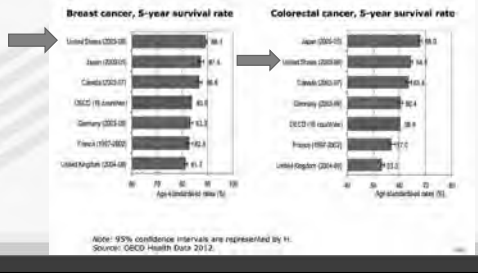
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits

US Life Expectancy Tied to Income

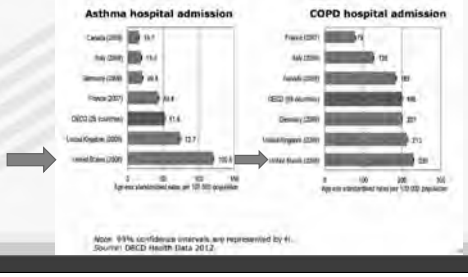


JAMA. 2016 Apr 26; 315(16): 1750–1766. doi: 10.1001/jama.2016.4226

Cancer system is generally performing well

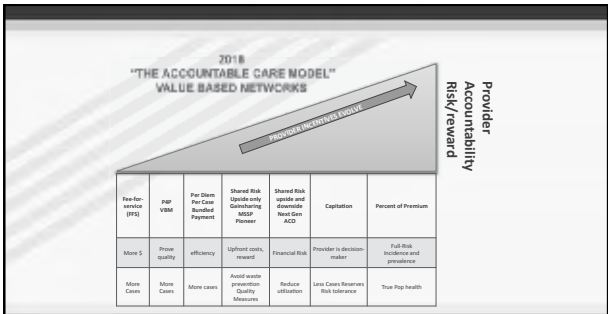


Primary care sector is not performing so well



How Do We Address Increasing Costs with Inconsistent Outcomes?

It's the Value Based Network Stupid



Let's talk about Nomenclature

- Accountable Care Organizations – ACO's are funded by the ACA and specifically address traditional Medicare
- Clinically Integrated Networks
- Physician Hospital Organizations
- Independent Physicians Associations
  - Primary Care
  - Multispecialty
- Single TIN Groups

All can be Value-Based Networks

Indicators of Value-Based Networks

- Contract with health plans with rewards tied to triple aim
- Connect electronically
- Track and report quality data
- Track and report utilization data
- Upside risk agreements (MSSP Track 1, Commercial ACO deals)
- Upside and downside risk (MSSP Track 2-3, Next Gen)
- PMPM Targets
- Percent of Premium

How Do They Get Paid?

- Still Fee-for Service
  - Patient Centered Medical Home - Increased rate, extra fees for meeting targets
  - "Transactional Services" - new codes and non-coded services
- Shared Savings
  - PMPM spending targets, with quality standards Pass/Fail
  - Other variations
- PMPM Revenue
  - Division of Financial Responsibilities
  - Specialty or Services specific (CPT-code ranges, etc.)
  - Network adequacy
- Percent of Premium
  - All medical spend
  - PCP or Specialty, Ancillary

"Transactional Services"

- Health Risk Assessments
- Gaps in care
- Medication reconciliation
- Attestations
- CCM
  - 99490, 99487, 99489
- TCM
  - 99495, 99496

=

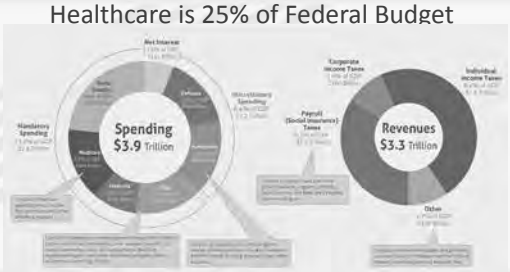
- Better relationship between patient and provider
- Can uncover multiple conditions leading to better care
- Potential to reduce ER Visits and avoidable admissions
- Potential to reduce cost of care
  - Right Services, Right Place, Right Time
- Increased Revenue Potential for Risk Entity (Appropriate RAF scoring)
- Increased Revenue Opportunity for Providers

WIN for the Patient, Win for the Provider, Win for the Payor
Targets the triple aim: Better Care, Better Patient Experience, Lowers the Cost of Care

Transition to Value Based Care Can Be A Spectrum

- Early Phase: added revenue for services missed in a FFS model
  - Pay for performance
  - Transactional payment for coordination services
- Middle Phase: Added revenue for managing cost of care
  - MSSP Track 1
  - More transactional revenue for HRA's, case management, interventions
  - Commercial shared savings agreements
- Late Phase: Management of Financial and Clinical Risk
  - Percent of premium
  - Bundled specialty episodes
  - Capitation

Healthcare is 25% of Federal Budget



CMS and the Push for Value

Three *Distinct* Quality Reporting Programs Impacting Hospitals

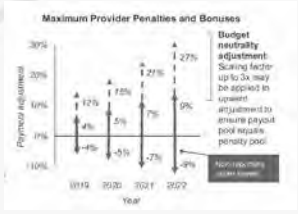
Program	Data	Financial Impact
Value Based Purchasing	Patient satisfaction, core measures, mortality, cost reductions	1.5 % withhold, can lose the 1.5 %, get some back or even receive > 1.5 % for excellent performance 2 % withhold in FY 2017
Readmissions Reduction Program	Medicare readmissions within 30 days	Up to 3% of Medicare revenues if trigger on measured conditions
Hospital-Acquired Condition (HAC) Reduction Program	Claims and NHSN reporting	1% of Medicare revenues if in bottom 25% of hospitals

Medicare Access & CHIP Reauthorization Act of 2015 (passed April 2015)

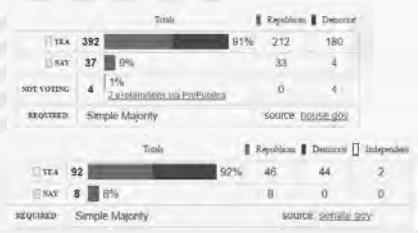
- Repeals the SGR Formula
- Ties Part B Fee Schedule to cuts or increases based on cost & quality
- Combines three quality reporting systems into one (with 3 parts…)
- Incentivizes providers into Advanced Alternative Payment Models (AAPMs) –i.e. taking downside risk

MIPS brings threats of fee schedule cuts and incentives based on MIPS scores

- *All providers are required to participate in MIPS in 2017,* proposed rule
- First reporting period 1/1/2017 to 12/31/2017
- Payments adjusted in 2019 based on performance in the 2017 period
- MIPS is budget neutral so any incentives are paid for via cuts to other providers
- However there is a budget exempt $500 million dollars for "exceptional" performance in the first 5 years



MACRA Passed Overwhelmingly in Bipartisan Vote



MIPS Score: Components

Clinical Practice Improvement Activities Category
15% of score in year 1

Quality Category
60% of score in year 1; replaces the Physician Quality Reporting System

Cost Category*
10% of score in year 2; replaces the Value Modifier Program, also known as Resource Use)

Advancing Care Information Category*
25% **of score in year 1;** formerly Meaningful Use

*For clinicians who do not meet these category requirements, CMS proposes reweighting the score to 0 and recalculating the other categories.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slides-2017.pdf

CMS Estimates of MACRA Impacts

Provider Type	# of Physicians / Clinicians	Allowed Charges (mil)	% with Negative Payment Adjustments	% with Positive Payment Adjustments
All specialties	761,342	$72606	45.5%	54.1%

- Solo Providers: 87% will suffer falling reimbursement rates
- 2-9 Providers: 70% will experience falling reimbursement rates
- 25-99 Providers: 55% will experience a rise in reimbursement
- >100 Providers: 81% projected to see a rise in reimbursement

https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

MIPS Participant Exemptions

Are newly enrolled in Medicare;

Have ≤ $90,000 in Medicare billings OR have ≤ 200 Medicare patients;

Are significantly participating in an AAPM.

Has MACRA Been Neutered?

- Slowing of implementation under Obama has continued under Trump
- 40% of providers now exempt from MACRA
- MIPS score of 3 will prevent cuts in 2019
- Mean FFS increase will be 0.9%
- Cost to report MIPS nationally is greater than the additional payment by CMS for best performers

MedPAC Recommends Scrapping MIPS

- MIPS is "burdensome and inequitable"
  - $1 Billion in reporting costs
- "Reported measures not meaningful"
  - Not measuring outcomes
- MIPS will not improve care for beneficiaries nor move Medicare…towards high-value care"
- Recommends new "Voluntary Value Program"
  - Encourage movement to AAPM
  - Remove clinician reporting measures
  - Clinicians form voluntary groups for reporting
  - Use claims and patient surveys for metrics

MSSP Tracks

Track *1*
Upside Risk only (2012 -)
- APM under MACRA
- Retrospective attribution
- Max sharing rate 50%
- Payment limit 10%
- MSR: 2-4% set by CMS

Track *1+*
Upside and Downside Risk (2018 -)
- AAPM under MACRA
- Prospective attribution
- Max sharing rate 50%
- Max loss rate of 4% of benchmark
- Payment limit 10%
- MSR: 0-2% & chosen by ACO

Track 2- *Upside and Downside Risk; 2012-*
- AAPM under MACRA
- Retrospective attribution
- Max sharing rate 60%
- Payment limit 15%
- Lower MSR and now with choice in MSR/MLR levels
- Loss limit 5%|7.5%|10%

Track 3 *Upside and Downside Risk; 2015-*
- AAPM under MACRA
- Prospective Attribution
- Max sharing rate 75%
- Payment limit 20%
- More waivers
- Loss limit 15%

Qualifying Advanced APMs for 2017

- *Advanced Alternative Payment Models* vs *Alternative Payment Models* : only the former will count for incentives and MIPS exemption
  - Shared Savings Program - Track 2
  - Shared Savings Program - Track 3
  - Next Generation ACO Model
  - Comprehensive ESRD Care (CEC) - Two-Sided Risk
  - Comprehensive Primary Care Plus (CPC+)
  - Oncology Care Model (OCM) - Two-Sided Risk
  - Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
  - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Future Arizona ACO Tracks

ACO Name	2017 Track	2018 Track
Banner Health Network	MSSP Track 3	MSSP Track 3
Arizona Connected Care	MSSP Track 1	MSSP Track 1
Arizona Care Network	MSSP Track 1 and Next Generation	MSSP Track 1 and Next Generation
Commonwealth PCACO	MSSP Track 1	MSSP Track 1
John C. Lincoln ACO	MSSP Track 1	MSSP Track 1
Scottsdale Health Partners	MSSP Track 1	MSSP Track 2
ASPA Connected Community	MSSP Track 1	MSSP Track 1
North Central Arizona AC	MSSP Track 1	Track 1+
Abacus ACO	MSSP Track 1	MSSP Track 1
Optum ACO	Next Generation	Next Generation
PathfinderHealth	N/A	Track 1+

Have ACOs Been Successful?

- CBO scored MSSP to save $4.9 Billion through 2019
- OIG reported MSSPs have saved CMS $1.7 Billion through 2016
- Quality scores have risen in more mature ACOs
  - Better care vs better reporting

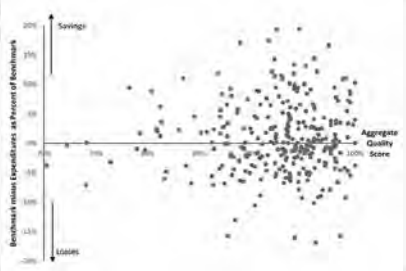
http://thehealthcareblog.com/blog/2017/12/18/fixing-macra-should-mean-fixing-the-apm-pathway/

National MSSP Results To Date

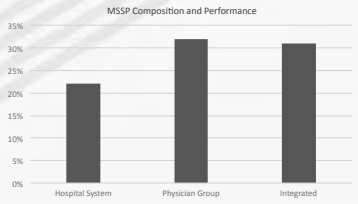
MSSP Results	2012	2013	2014	2015	2016
Earned Shared Savings	29	55	92	125	134
Reduced spending, below threshold	25	60	89	83	107
Increased spending, below threshold	60	88	223	184	187
Owed money back to CMS	0	1	0	0	4
Total	114	204	404	392	432

2018
- 561 ACOs
- 101 downside risk
- 21 with no experience

Cost vs Quality in MSSPs



Physician Engagement via Ownership Matters in MSSP



Arizona ACO 2016 Results

https://www.thehertelreport.com/mssp-aco-2016-arizona-results-scottsdale-health-partners-earns-nearly-9m-in-earned-shared-savings/

ACO Movement/News

- PathfinderHealth leaves NCAAC and starts MSSP Track 1+
- Summit (NEAR network) Joins NCAAC
- Banner Health Network moves from Pioneer to Track 3
- ACN Running MSSP Track 1 and Next Generation
- Scottsdale Health partners goes to MSSP Track 2

- CMMI will be going in a "new direction"
- Too much healthcare consolidation
- "We must shift away from a fee-for-service system that reimburses only on volume and move toward a system that holds providers accountable for outcomes and allows them to innovate"
- "Consumers need more control over the allocation of health-care resources. "

2017: A Pivot from APM to Medicare Advantage?

- No new APMs introduced
- Several cancelations
  - Part B drug demonstration project
  - Cardiac bundles
- Rejected Payment Model Technical Advisory Recommendations
  - Two APMs
- Scaling back previous efforts
  - CJR

Other Value-Based Networks

- Iora Health
- P3 Healthcare Partners
- Summit Medical Group
- Cigna Medical Group

VBN's – What do they do?

- Aggregate Providers
- Seek actionable clinical intelligence
  - Meaningful data, Analytics, Workflows
  - Care Management – primary care, social, community, education
- Deliver Measured Quality
  - BP, Cholesterol, depression, diabetes, fall risks, BMI, Meds, Med-Rec, tobacco, vaccines, preventive exams, wellness visits, Care Management

Quality as a Business Strategy

Value = Quality/Cost
(Over Time)

Lisa Mead, RN, MS, CPHQ

QUALITY

Enhancing Culture
Working in Teams
Training
Planning
Partnering with Suppliers &Customers

Removing Barriers
Voice of the Customers
Reward & Recognition
Benchmarking
Outcomes
Data

The New Paradigm for Quality Improvement

- Aimed at continuous improvement
- Data Driven
- Avoids Blame
- Create systems that prevent errors
- Encourages "thinking outside the box"

Six Improvement Aims from IOM:

The process of improving the lives of patients, the health of communities, and the joy of the healthcare workforce involves focusing on an ambitious set of goals adapted from the Institute of Medicine's six improvement aims for healthcare systems:

- Safety
- Effectiveness
- Patient-Centeredness
- Timeliness
- Efficiency
- Equity

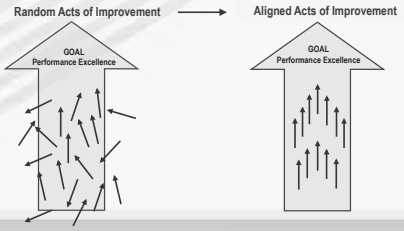
Quality care is also coordinated, compassionate, and innovative.
(Roper, IOM 2006)

The Platform for Improvement

- Will, Hope, and Optimism
- Transparency: All Teach – All Learn
- Safe and Just Environment
- Innovation and Improvement Science
- Integrated, Results-Oriented Teams
- Designing Care with the Patient Involved
- Courageous and Adaptive Leadership

Institute Healthcare Improvement

How Far Along is Your Company in the Quality & Process Improvement Journey?



How to Drive Excellence

- Implement methods to build and maintain performance excellence in your health care organization.
- Execute strategies to enhance accountability and achieve quality and patient safety objectives.
- Utilize measurement tools to track clinical and organizational progress toward meeting performance expectations.

Role of Leadership

- Champion of an environment that "enables" performance excellence
  - Builds relationships
  - Helps to achieve results
  - Leads people
  - Leads strategic change
  - Allocates talent and resources

The Leadership System

Questions to Consider:

- What would you like to improve?
- What about your organization could be made:
  - Safer
  - Timelier
  - More Efficient
  - More Effective
  - More Patient Centered
  - More Equitable

Getting Started

- Engage your leaders
- Define/Review the vision, values, mission, culture
- Teach Quality PI principles
- Set priorities for Quality Plan Development
- Develop policy and procedures
- Develop a "scorecard" or "dashboard"
- Gather data
- Analyze the data
- Develop improvement plans
- Implementation and follow through

Why Value-Based Payment Isn't Working, and How to Fix It

Creating a Patient-Centered Payment System to Support Higher-Quality, More Affordable Health Care

Harold D. Miller

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

Failures of Existing Payment Models

http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

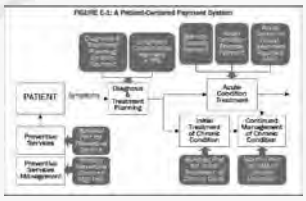
Shared Savings Model Failures

- Do not ensure high quality care is delivered
- Do not align payments with cost of care
- May not support services not covered under FFS
- Incentives to not do things may not align with patients
- Risk adjustment not enough to encourage serving high need patients
- Provider payment not under control of the provider
- Retrospective payment design leads to provider uncertainty

http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

Patient Centered Payment System

- Preventative Care
  - CMF and bundles
- Diagnosis and Treatment Planning
  - Bundles
- Acute Condition Treatment
  - Bundles
- Managing Chronic Conditions
  - Bundle and CMF



http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf

Final Thoughts

- ACA Not Dead Yet
- Medicaid is Evolving
- CMMI Call-out for Innovation
- Push to Value-Based Care Models Continue
- Traditional Utilization and Payment Decisions Shifting to VBN's
  - Transparency
  - The in-crowd has to earn it!
  - Essentially the Triple Aim → ↑ Quality ↓ Cost ↑ Satisfaction

THE HERTEL REPORT

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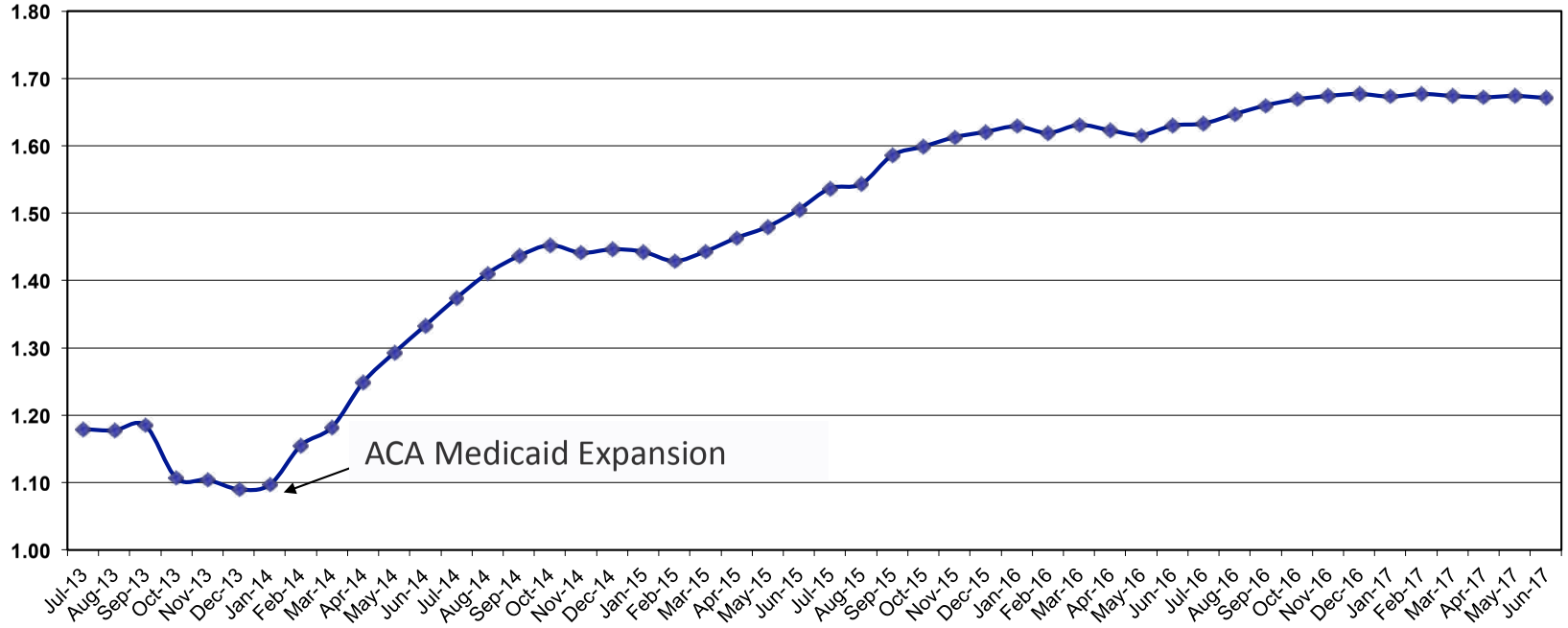
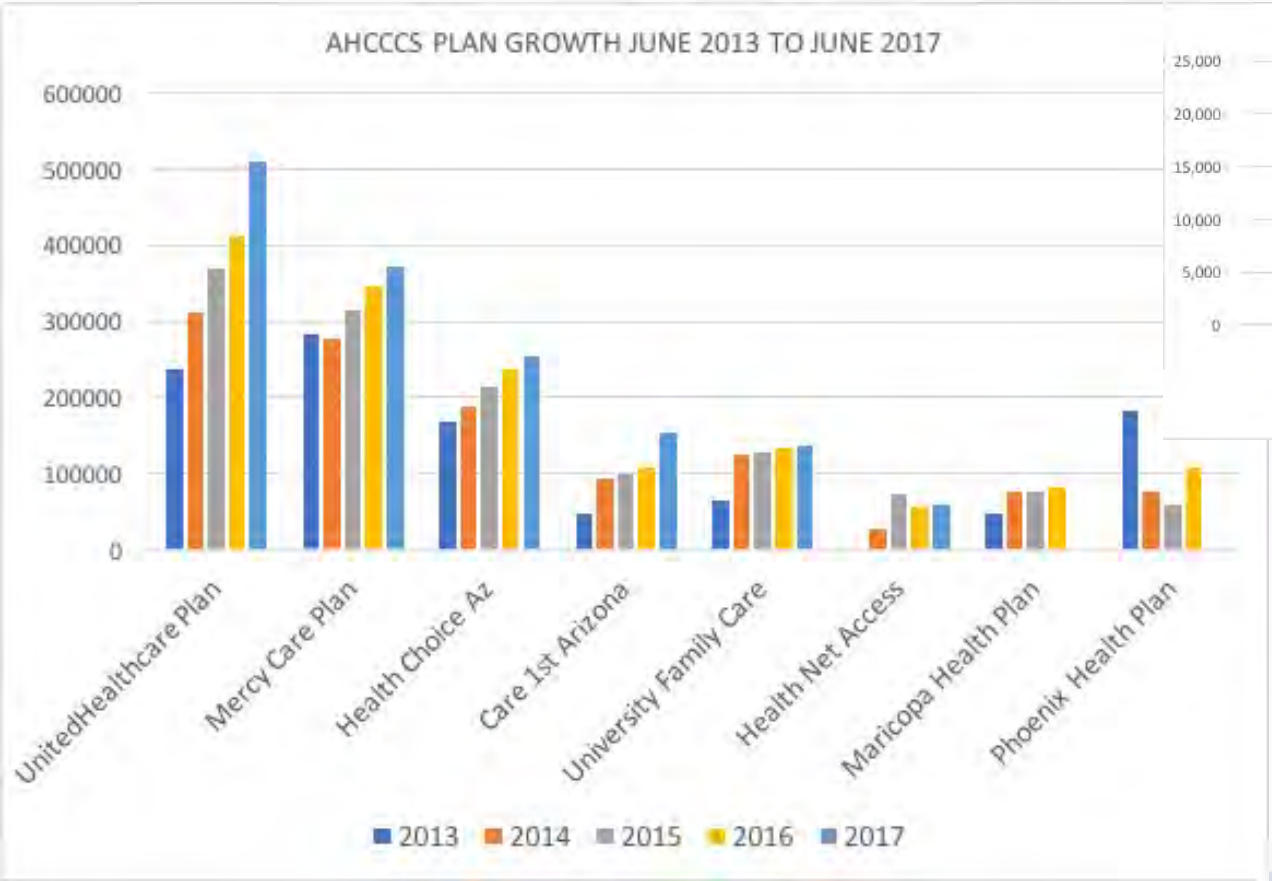
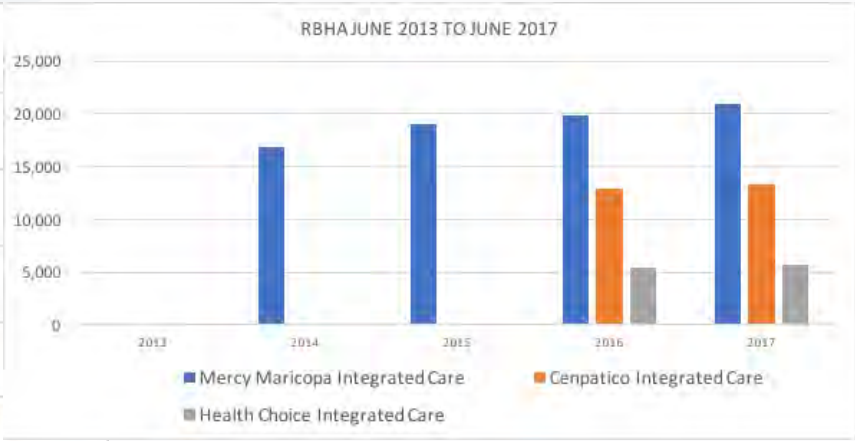
AHCCCS Population (in Millions)
Acute Population
July 2013 to January 2018

January 1, 2018 AHCCCS
Acute population 1,638,422







AHCCCS ENROLLMENT BY CONTRACTOR JUNE 2013 TO JUNE 2017

Arizona Medicare ACOs 2018

ACO	Start Date	Ownership/Structure Service Area	PCP's	Attributed members/ #Beneficiaries
Banner Health Network[1]	1/1/2012	Banner Health Network Maricopa and Pinal Counties	1020	50,737
Arizona Connected Care	4/1/2012	Community Providers, TMC Southern Arizona	195	8,318
Arizona Care Network[2]	1/1/2013	Dignity Health & Abrazo Health Arizona	634	33,000
Commonwealth PCACO	1/1/2013	Independent PCP's Arizona, New Mexico	100	16,000
JC Lincoln ACO	7/1/2013	Honor Health Maricopa County	126	16,400
Scottsdale Health Partners[3]	1/1/2014	Honor Health Maricopa County	150	23.500
ASPA-Connected Community	1/1/2015	Independent Physicians (ASPA) Arizona, New Mexico	50	6,200
North Central AZ Accountable Care[5]	1/1/2015	Yavapai RMC with Summit Affiliates Gila, Coconino, Navajo, Yavapai	145	14,500
Abacus ACO	1/1/2016	Arizona Community Physicians Southern Arizona	131	28,000
Optum ACO[4]	1/1/2016	Optum Medical Network Maricopa County	175	37,000
PathfinderHealth[5]	1/1/2018	Northern Arizona Healthcare Coconini and Yavapai Counties	78	9,843

[1]MSSP Track 3 [2] Next Gen and MSSP Track 1 [3] MSSP Track 2 [4] Next Gen [5] MSSP Track 1+ All others MSSP Track 1

VBN's

*All of the attributed lives in the Medicare column are through the MSSP or Next Generation programs.
**PCPs is total MD/DO and midlevel practitioners

This table illustrates attributed lives for many Value-based Networks in Arizona. While this list is comprehensive, we know there are other VBN's in Arizona not accounted for in this report and table.

The data was aggregated by The Hertel Report, sourced from responses directly from the VBN's.

Value-Based Networks - Estimated Covered Lives Report 2018

Organization Name	Medicare*	Medicare Advantage	Commercial	Medicaid	Estimated Total Lives	Estimated Number of PCP's**
Abacus ACO	28,000	23,200	30,000	7,100	88,300	131
Arizona Care Network	33,000	1,500	105,000	111,000	250,500	1,069
Arizona Connected Care	8,318	5,819	14,021	0	28,158	195
Arizona Priority Care	N/A	11,005	0	0	11,005	322
ASPA Connected Community	6,200	0	0	0	6,200	50
Banner Health Network	50,737	90,381	288,644	13,200	442,962	1,032
Commonwealth ACO	16,000		24,000	5,000	42,200	97
District Medical Group	N/A	0	0	91,500	91,500	60
Equality Health Network	N/A	0	0	77,255	77,255	290
Health Choice Preferred	N/A	6,000	1,000	31,000	38,000	125
Innovation Care Partners	N/A	17,000	20,000	0	37,000	300
John C. Lincoln ACO	16,400	N/A	N/A	N/A	16,400	140
MIHS	N/A	0	0	91,500	91,500	60
NCAAC	14,500	0	0	0	14,500	145
Optum ACO	37,000	65,000	0	0	102,000	600
PathFinder ACO	9,843	0	6,056	0	15,899	78
Scottsdale Health Partners	23,500	N/A	N/A	N/A	23,500	150
TOTAL	243,498	219,905	488,721	336,055	1,288,179	4,784
	18.9%	17.1%	37.9%	26.1%		

N/A: Not Applicable

THE HERTEL REPORT

Volume XX, No. 11/November 29, 2017

The Source that Connects the Arizona Healthcare Community

GOP SENATE TAX BILL HEALTHCARE IMPACT

As the U.S. Senate's $1.5 trillion tax plan takes shape this week, Republican lawmakers are bending over backwards to flip members concerned the bill includes a repeal of the individual mandate.

On Tuesday, the Senate Budget Committee approved in a party-line vote (12-11) to send its tax bill to the floor for debate and amendments. If Senate GOP legislators convince a simple majority (51) to pass their tax bill this week, House leaders may move to adopt the Senate version or move into "conference" to reconcile both tax proposals to ready it for passage before year's end.

The Congressional Budget Office (CBO) analysis concluded repealing the individual mandate would reduce the number of Americans with health insurance by 4 million in 2019 and 13 million in 2027. The repeal also cuts the federal budget by $338 billion between 2018 and 2027.

GOP leaders, including President Trump, have reportedly stepped up the pressure by throwing their support behind proposed legislation advocating for a short-term federal reinsurance program and another that extends cost-sharing reduction payments to insurers for two years, to win over pivotal Republican votes.

The reinsurance bill, sponsored by Senator Susan Collins (R-ME) and Bill Nelson (D-FL), directs $2.5 billion to states to establish "invisible high risk pool or reinsurance programs." The proposed legislation provides an 80 percent reimbursement rate to insurers for claims between $50,000 and $500,000 from 2018 to 2020 and in 2021 for claims between $100,000 and $500,000.

Designed to stabilize the individual market and combat expected double-digit premium spikes resulting from an appeal, the measure may mean reduced insurance costs for middle class consumers.

Continued Page 3

AHCCCS IMD WAIVER MORE TREATMENT OPTIONS

Arizona is one of seven states requesting amendments to the section 1115 Research and Demonstration waiver to remove certain statutory hurdles guarding Medicaid dollars from funding institutions of mental disease (IMD) for substance abuse treatment. After a year of waiting, West Virginia was the first to receive approval under the new administration; it leads in per capita deaths for opioid overdose.

By allowing psychiatric facilities larger than 16 beds to provide reimbursable services for stays longer than 15 days, IMD waivers overturn old facility exclusions in order that Medicaid beneficiaries with substance use disorder (SUD) have more treatment options.

"CMS spoke with us informally about this and it became clear that there is a path forward for the substance use disorder stays to get an exemption from the 15-day limit for those stays and that's what we need to focus on, so that has been the direction that we've gone," said Elizabeth Lorenz, assistant director of intergovernmental relations at AHCCCS.

With President Trump's recent declaration of the opioid crisis as a "national public health emergency" under federal law, the focus has again turned to ensure victims of the epidemic and anyone with mental health or substance abuse disorders are getting proper treatment.

In his speech, the president mentioned emergency response efforts concerning the IMD waiver exclusion requests, yet approvals are still pending: "we will announce a new policy to overcome a restrictive 1970s-era rule that prevents states from providing care at certain treatment facilities with more than 16 beds for those suffering from drug addiction."

There are risks that come with a full repeal of the exclusion, such as expenses; and Congress may be hesitant to encourage or incentivize institutionalization when outpatient services may be better suited for a beneficiary.

Continued Page 2

ARIZONA'S KIDSCARE THE FIGHT FOR FUNDING

As Congress debates funding, more than 23,000 Arizona children face losing their health coverage under the Children's Health Insurance Program (CHIP), known in Arizona as KidsCare.

Funding for the $15 billion CHIP program, typically a bipartisan issue, is now caught in the cross-hairs of the ongoing healthcare debate in Washington. Siman Qassim, Director of Health Policy for Arizona's Children Action Alliance said, "Healthcare has become radioactive. Congress is creating so much uncertainty for families."

Created in 1997, CHIP helps children in families who don't qualify for Medicaid but cannot afford private health insurance. It provides health and dental care for children in families earning up to twice the federal poverty level (FPL), or about $40,840 a year for a family of three. CHIP families pay $10 to $50 a month for one child and no more than $70 a month for multiple children, based on income.

CMS stepped in using unspent dollars from the budget year to keep the program going after federal funding ran out for CHIP at the end of the fiscal year, September 30. Those new funds are expected to run out mid-December. Failure to approve the $15 billion annual appropriation puts the healthcare of Arizona children who rely on KidsCare at risk.

Qassim says passing the bill to fund CHIP is a "no-brainer" and gives credit to Governor Doug Ducey, who she believes understands how critical the Kids Care program is for Arizona families.

Ducey recently negotiated a contingency plan with the Arizona Health Care Cost Containment System (AHCCCS) to continue funding KidsCare in the hope Congress will act before the end of the year. Any plan the Governor suggests would need legislative approval.

Continued Page 2

340B DRUG DISCOUNT PROGRAM PROGRESS

The 340B drug discount program was originally established to aid hospitals and other "covered entities" to provide the nation's low-income patient population with necessary outpatient drugs at significantly reduced prices. Critics of the system say hospitals have found loopholes allowing them to abuse the program for profit.

The loophole is found in the law itself; the program requires pharmaceutical manufacturers to enter a pricing agreement with the Department of Health and Human Services (HHS) to allow front-end discounts on medications purchased by eligible providers. Although providers have access to this discount, the 340B program never specifically required hospitals to share it. Experts are concerned that instead of using the rebates for patient care, many pocket the difference of those discounts for profit.

Early this year, to tackle the war on price gouging by drug companies, the Health Resources and Services Administration (HRSA) established a final rule to set a $5,000 penalty every time a drug company intentionally overcharges a 340B hospital. The effective date of this final rule has been delayed to July 1, 2018 to allow for "necessary time to fully consider the substantial questions of fact, law, and policy raised by the rule," HHS stated.

"Hospitals use the 340B benefits in many different ways, we have worked with our hospitals to articulate that to members of Congress, I mean sometimes it is done through patient discounts that are mathematically calculated, other times it is done through other community benefits programs."

Debbie Johnston
Senior Vice President of Policy Development
Arizona Hospital and Healthcare Association

"There is no statutory requirement for covered entities to document how they use revenue from the program,"

Medicare Payment Advisory Commission
Report to Congress

Johnston insists big pharma's 340B price gouging is only a small part of the issue, "the pharmaceutical industry may not like the 340B program but once again that is a small piece of drug prices and I think we all need to step back and look at the system in general,

Continued Page 3

AHCCCS IMD Waiver Cont'd From Page 1

In a presentation given by the Arizona Department of Health Services to address the state's response to the opioid crisis, removal of the IMD exclusion to "allow facilities to receive reimbursement for substance abuse treatment," was advised as a recommendation in the fight against this epidemic.

As Arizona and other states inch toward integration between behavioral health providers and acute providers, Dr. Charlton Wilson, chief medical officer for Mercy Care Plan says the waiver won't have an impact on the industry's move toward value-based contracting.

"I think that the value-based opportunities will continue regardless of what the waiver status is because it is our best opportunity to make sure the state is giving the highest value for its Medicaid dollars and also making sure that our patients, our members get the very best quality and experience," he said.

Dr. Wilson also highlighted he importance of value-based arrangements with proprietors across the continuum of care services and ensuring that these arrangements "drive better quality and an improved provider experience and an improved patient experience."

Arizona KidsCare Cont'd From Page 1

Ducey already discussed tapping into the state's $460 million "rainy day" fund, which was formerly known as the Budget Stabilization Fund (BSF). The account safeguards revenue set aside during times of above-trend economic growth and can be used during times of below-trend growth.

Christina Corieri, the Governor's Health and Human Services Policy advisor said the state could move all children in households earning 100 to 138 percent of Federal Poverty Level from KidsCare to AHCCCS. She indicated that when Congress does eventually refinance the CHIP program it is likely to approve "backfill" dollars to reimburse the state for any funds it spent providing care in the interim.

In 2010, Arizona ended KidsCare during the Great Recession even though the state was reportedly ranked with the third highest rate of uninsured children in the nation, according to a Georgetown center study.

After Medicaid expansion, the uninsured rate dropped from 11.9 to 10 percent. Before KidsCare was reinstated last year, Arizona was the only state in the nation without a CHIP. Arizona legislators supported resurrecting KidsCare in part because it would rely completely on federal funding and no state monies would be used to support the program.

Michal Goforth, executive director for the Pima Community Access Program is concerned some Arizona children are going to go without the healthcare they need should lawmakers lack a solution to fund chip.

"When they last froze KidsCare, families moved to insurers with higher premiums," said Goforth and unfortunately, "The networks in those plans were not strong with pediatricians."

WATCHING CHIP

Congress has seen two CHIP bills. Both extend CHIP for school-aged children for five years and keep higher funding going for two years: The Senate bill is strictly for CHIP funding and needs 60 votes to pass.

The House bill has off-sets as it's combined with the Champion Act which renews community healthcare funding. Recently 171 Democrats voted against the House bill which would retain the ACA temporary 23 percentage point increase in the federal CHIP matching rate through end of September 2019. Without this protection, states would face up to $3.5 million in cuts in federal support for CHIP the next fiscal year. It then provides states a one-year transition with an 11.5 percentage point increase in the matching rate in 2020, then returns the matching rate to regular levels (approximately 70 percent) in 2021. The House bill continues the ACA's maintenance-of-eligibility requirement that prohibits states from cutting children's eligibility for Medicaid and CHIP through 2019. That requirement would be extended through 2022 for those with incomes below 300 percent FPL.

NOTE: *Inside Health Policy* is reporting that action on CHIP may be more likely included in the year-end omnibus bill, when federal lawmakers must pass legislation to raise the debt ceiling and keep the government open for business.

340B Drug Discount Program Cont'd Page 2

where the expenditures are actually occurring, where they are graded and drilling down as to why—340B is not a reason why drug costs are so expensive," she said.

A group of democratic senators are strongly urging the Trump administration to stop delaying the implementation of a rule to punish drug manufacturers for raising prices. Like many presidents before him, Trump has deemed drug prices "outrageous," but politics complicate efforts; drug manufacturers are historically generous patrons to political campaigns.

Led by Sen. Gary Peters of Michigan, 11 senators wrote to acting HHS secretary Eric Hargan and HRSA Administrator George Sigounas about the delaying a decision on the 340B program stating:

> "Currently, HHS has limited authority to penalize pharmaceutical companies that overcharge 340B health care providers despite significant evidence that these companies frequently and impermissibly overprice their products. Further delays or changes the implementation of this rule contradict President Trump's repeated promises to crack down on unfair drug pricing and allows bad actors to continue enriching themselves at the expense of the American public."
>
> Letter to HHS from 11 U.S. Senators

Lori Reilly, Executive VP at PhRMA, commented on the absence of representation for hospitals at the Senate Health Panel meeting in October, saying: "One important part of the supply chain that is not with us here today is the hospital sector. Just this morning we released a paper that looked at the—20 of the most commonly prescribed expensive medicines in hospital outpatient settings and found that on average hospitals increase and are reimbursed 2.5 times the acquisition cost in which they purchase medicines in this country. They are an important part of the supply chain and I hope we talk about them more today."

In the Hospital Outpatient Prospective Payment System (OPPS) final rule released Nov. 1, CMS reduced the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Program.

THE SEQUOIA PROJECT

In 2012, the Office of the National Coordinator for Health IT (HHS) transitioned its eHealth Exchange management to the private sector. The Sequoia Project, a non-profit organization, took over to advance the implementation and utilization of interoperability within healthcare data exchange across the nation.

Essentially, interoperability is the communication and connection of various databases, systems and software that allow an accurate and efficient exchange of information to flow through those platforms. This exchange makes health data easily accessible for payers, hospitals, physicians and other providers.

Chris Masci, Vice President of Operations in the United States for Dedalus, said that interoperability is absolutely necessary in delivering the quality of care patients need in today's digital age, "As a doctor, you cannot rely on a patient for information…especially now with how often the payer process is being altered, you're not even going to get information from the payers sometimes because people are changing health plans," he said.

Imagine a person is rushed to the hospital with injuries and the doctor is going to administer certain medication but hospital staff learns the man is allergic to that particular medicine through the health information exchange (HIE) system. Even when patients are incapacitated, HIE data can be life saving.

Nationwide, HIEs face interoperability challenges as records are shared across systems. The problem, said Masci, is that "in the American healthcare system, when you're talking about sharing information… there are so many barriers put up, it's not lucrative for the organization."

Masci argues there should be incentives for the use of this coordination—especially for private organizations to participate—without forcing a tremendous change on work flow.

Currently, the Sequoia Project is the largest health information exchange network in the country, but Masci claims that the flaws are in the HIE business models that, "were built from the top down when they should've been built from the bottom up," and while he believes interoperability is possible at a state level, it still has too many unanswered questions.

GOP Senate Tax Bill Healthcare Impact

The Center on Budget and Policy (CBP) countered that while the reinsurance bill is a "sensible standalone measure" it wouldn't undo the damage of the repeal and "will not meaningfully reduce the risk that insurers will leave the market."

"Reversing the coverage losses and other harmful consequences of mandate repeal would require dedicating that amount, or significantly more, to that purpose; $3.5 billion in reinsurance funding wouldn't come close," CBP stated Tuesday.

By teaming the new reinsurance bill with The Bipartisan Health Care Stabilization Act (BHCSA) which guarantees insurers two years of funding for cost-sharing reductions, Republicans hope to downplay the impact of repealing the individual mandate as they tick off final votes for the tax plan. Endorsed by more than 200 health and business groups, the bill also invites states to customize insurance options through innovation waivers and expands consumer access to lower-premium Copper plans by making them available to consumers of all ages, not just those under age 30, as in current law.

Trump ended the cost-sharing payments in October, characterizing them as a bailout for insurance companies, but insurers receive CSR payments to lower co-pays and deductibles for Americans earning between 139 and 250 percent of the federal poverty level.

On Wednesday, the CBO dashed the GOPs hope that BHCSA would soften the impact of the tax bill's repeal of the individual mandate by concluding it wouldn't. Summarily, the agency stands by its earlier predictions: Repealing the mandate will reduces the federal deficit $338 billion between 2018 and 2027 and will result in 4 million without health insurance in 2019 and 13 million in 2027 with premiums in the non-group increasing about 10 percent each year for the next decade.

DEEP CUTS EXPECTED FOR MEDICARE CLINICAL LAB TESTS

Beginning in January 2018, The Clinical Laboratory Fee Schedule (CLFS) rates released November 20, 2017 become effective as required by the Protecting Access to Medicare Act (PAMA) of 2014.

The new CLFS rates are based for the first time on weighted median private payor rates reported by labs between January 1 and June 30, 2016. CMS contends the use of market data to establish rates will ensure the agency is paying appropriately for services and saving taxpayers. The agency estimates the new rates will reduce Medicare spending by $670 million in 2018.

In 2016, Medicare paid $6.8 billion under Part B for lab tests for about 28 million beneficiaries; 25 such tests cost Medicare $4.3 billion or 60 percent of the agency's total lab spend. The same year, one percent of labs received 54 percent of all Medicare payments for those top 25 lab tests; the average payment that went to each lab: $8.2 million

Prior to setting the new CLFS schedule, CMS received data from nearly 2,000 laboratories, most were physician office labs (57 percent), independent labs (34 percent), urgent care centers, hospital inpatient and federally qualified health centers (8 percent) with just one percent returned from hospital labs.

Critics warn that because most hospital-based labs were not eligible to report private payment rates because most lack their own national provider identifier (NPI), the lack of hospital lab data from private insurers will skew the new Medicare lab rates lower leaving hospitals, especially those in communities with few commercial labs, with reduced profit margins.

> "The end result is that the largest independent laboratories – which already have pricing that is much lower than hospital-based laboratories, and which in some cases have private health plan contracts based on a percentage of Medicare CLFS- will drive the rates that are used for CMS's new fee schedule..."
>
> Lale White, CEO of XIFIN

Independent laboratories, which have been identified by the Office of Inspector General (OIG) as being at risk for noncompliance with Medicare billing requirements, crushed competitors, returning 90 percent of reports used to develop the new fee schedule.

Lab Price Jumps

From 2015 to 2016, a new category of tests, multianalyte assays with algorithmic analysis (MAAAs) stood out jumping 665 percent. These tests, which include a colorectal screening test, combine multiple test results with other patient information to create a predictive risk score. Such tests are typically proprietary and are exclusively offered by the developing lab. In 2016, Medicare paid $890 per MAAA test – the biggest, per-test bill from labs.

ASPA CHOOSES EXCELICARE FOR PHM

The Arizona accountable care organization, ASPA Connected Community, moves to Excelicare for its population health management, cloud-based technology. Promoted as a "multi-dimensional clinical data repository" with "superior interoperability capabilities" Excelicare is in the business of supporting coordinated care across sectors specialties and disciplines. It also handles MIPS reporting.

> "Principal among the capabilities that ASPA Connected Community expects to leverage is Excelicare's exceptional ability to aggregate and normalize data from EHRs, clinical labs, imaging facilities, health information exchanges, claims data and other sources."
>
> Connie Richardson, executive director ASPA

To support its population health management approach, ASPA Connected Community expects to benefit from the platform's workflow tools, dashboards and analytics as well as risk stratification, the cornerstone of the approach. By identifying and dividing patients by health status, lifestyle and medical history, providers and healthcare organizations can begin segmenting patients by risk, identifying care gaps and coordinating patient care, especially for those with chronic disease.

Excelicare will also be used by the Arizona State Physician Association ASPA, an independent physician association and ASPA Empowered Healthcare Services, a clinical support services provider associated with ASPA.

COMINGS & GOINGS

Summit Health Management: **Keith Dines** is now senior strategic advisor, **Blue Beckham** is now the VP of business development and network management and **Trina Foster** is now director of operations.

Jill Bernard was promoted to area VP of health and government markets at VSP Vision Care.

Saul Blair has left IPC Healthcare (now Team Health) and started his own company, BHG Consulting.

Karl Fry left Arizona Business Bank and has joined Arizona Healthcare Realty Group.

Blue Cross Blue Shield of Arizona CEO **Sandy Gibson** has announced her retirement at the end of January 2018.

Chad Jans Is now health information specialist at Health Service Advisory Group, he was previously a project manager of value-based reporting at Maricopa Integrated Health System.

Dr. Vishu Jhaveri announced his retirement January 1st as chief medical officer for Blue Cross Blue Shield of Arizona

Justin Orsini was promoted to director of business development for Healthcare Financial Resources, Inc.

Lisa Stevens Anderson joined Equality Health and is now the COO of Q Point. She was formerly the CEO of Banner Health Network.

Mitchell Zack is now VP of contracting and payer relations for Providence St. Joseph Health. Zack was former VP of network management for Cigna.

The Hertel Report
29455 N. Cave Creek Road
Suite 118 Box 453
Cave Creek, AZ 85331
602-679-4322

Publisher: Jim Hammond
Managing Editor: Paula Blankenship
Contributors: Veronica Graff and Rhonda Montgomery

NOTES

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JIM HAMMOND, PUBLISHER

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jim@thehertelreport.com
602.679.4322

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Arizona healthcare leaders know that when employees stay informed and feel connected, they become more invested in finding solutions in today's complex and rapidly changing healthcare environment.

Corporate members receive multiple individual memberships for their employees, as well as the coordinating benefits listed to the left. In addition, corporate memberships also include:

- **INCREASED VISIBILITY WITHIN THE ARIZONA HEALTHCARE COMMUNITY, INCLUDING:** BUSINESS DIRECTORY LISTING, CORPORATE PROFILE, LOGO, DESCRIPTION & MEMBER LISTING
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- **PRE-PAID & DISCOUNT ADMISSION(S) TO THE STATE OF THE STATE**

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