THREE KEY THINGS IN HEALTH CARE

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- **Hospital providers should be planning now for potential impacts from the new 2021 Medicare Emergency Triage, Treat and Transport (“ET3”) model.**
  - The Centers for Medicare & Medicaid Services (“CMS”) recently announced that it will be implementing its new ET3 model on January 1, 2021, having delayed the initial May 2020 start date due to the COVID-19 pandemic.
  - This voluntary 5-year payment model seeks to reduce unnecessary emergency ambulance transports to high-cost hospital emergency department (“ED”) settings by offering Medicare reimbursement for treatment of beneficiaries in alternative lower cost settings as well as potential incentive payments to participating ambulance providers.
    - Participating ambulance providers will be paid for ambulance transports to alternative destination sites not currently covered by Medicare, such as urgent care clinics and primary care physician’s offices, and can also be paid for providing treatment in-place on the scene (including via telehealth).
    - Participating ambulance providers who achieve certain quality metrics may receive an upward adjustment of up to 5% to their payments for transport to alternative destination sites or treatment in-place beginning in the third year.
  - The ET3 model could be a significant disruptor to the traditional emergency transport model that relies almost exclusively on EDs, particularly if state Medicaid programs and commercial payors decide to participate in the model.
    - In February 2020, CMS selected 205 ambulance providers across 36 states and the District of Columbia (https://innovation.cms.gov/files/x/et3-selected-applicants.pdf) to participate in the new payment model – these providers account for more than 25% of Medicare ambulance transports in many regional markets and states.
    - CMS also plans to issue a Notice of Funding Opportunity in early 2021 for up to 40, two-year cooperative agreements, available to local governments or other entities that operate 911 dispatch systems in geographic locations with participating ambulance providers.
    - While ET3 is a Medicare payment model, CMS has made clear that the model will be most successful if implemented across multiple payor types and released an information bulletin providing guidance to state Medicaid programs on adopting the ET3 model.
  - The COVID-19 pandemic has jump-started this disruption to the traditional emergency transport model, with ED volumes continuing to trend well below pre-COVID levels.
    - CMS granted temporary waivers to expand the list of allowable destinations for ambulance transports during the pandemic – a precursor to the waivers that CMS will be granting to participating ambulance providers under the ET3 model.
    - Patients have adapted their healthcare utilization behavior to avoid EDs and will be more receptive to alternative treatment options under the ET3 model.
  - Utilization of alternative treatment options under the ET3 model could generate significant savings for Medicare and other payor programs by reducing avoidable visits to hospital EDs, which could have significant financial impacts on hospitals.

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        - CMS has estimated the potential savings for the Medicare program alone could be as much as $2 billion annually.
        - The corresponding negative impact on hospitals could be even greater to the extent that patients are being transported to receive alternative care in unaffiliated urgent care centers or physician offices.
    - **Key Takeaway**: Implementation of the ET3 model has the potential to benefit ambulance providers and reduce costs for the Medicare program, but hospital providers need to be aware of the potential significant impacts to their ED volumes and be thinking proactively about how to mitigate such impacts by offering alternative treatment site modalities to care for patients who will no longer be coming to the ED.

- **In a year fraught with challenges stemming from the COVID-19 pandemic, the Centers for Medicare & Medicaid Services ("CMS") announced 2019 performance year ("PY") results for the Medicare Shared Savings Program ("MSSP"), evidencing $1.19 billion in total net savings to the Medicare program.**
    - On September 14, 2020, CMS released MSSP financial and quality results for PY 2019, the first year in which accountable care organizations ("ACOs") could participate in a "Pathways to Success" option.
    - Established in 2012, the MSSP is a voluntary, value-based program that encourages health care providers (e.g., physicians, hospitals and others) to form and participate in ACOs, which in turn agree to be held accountable for the cost, quality, and experience of care for an assigned Medicare fee-for-service ("FFS") beneficiary population. Under the MSSP, ACOs that successfully meet quality and savings metrics are rewarded through sharing in a percentage of the achieved Medicare savings.
    - Notwithstanding increasing participation in the MSSP, ACOs have been slow to accept downside risk. As of January 2018, more than 80% of ACOs participated in Track 1, a shared-savings only model that did not expose ACOs to financial risk. CMS overhauled the MSSP in December 2018, issuing its "Pathways to Success" final rule to encourage faster transition to two-sided, risk-bearing models in which the ACOs are rewarded with shared savings *and* are accountable for repaying shared losses.
    - PY 2019 results reflect $1.19 billion in total net savings to Medicare – the largest annual savings for the MSSP since its inception – and suggest that CMS is on track to meet or exceed the $2.9 billion in federal savings over 10 years that it projected in its Pathways to Success final rule.
    - Importantly, the PY 2019 results demonstrate that ACOs participating under a Pathway to Success option generated more savings to the Medicare program than ACOs participating in a legacy track, generating net per-beneficiary savings of $169 per beneficiary as compared to $106 per beneficiary. In addition, ACOs that took on downside risk, whether through a legacy track or Pathways to Success option, performed better than their non-risk bearing counterparts, achieving net per beneficiary savings of $152 per beneficiary as compared to $107 per beneficiary. Nearly all ACOs continued to meet the quality performance standard and 92% of eligible ACOs earned quality improvement reward points.
    - Complete PY 2019 financial and quality results are available from CMS here.
    - **Key Takeaway:** As ACOs express concern about the impact of COVID-19 on continued participation in the MSSP and CMS takes steps to mitigate risk and encourage continued ACO

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participation, the PY 2019 results serve as a bright spot, confirming that two-sided risk bearing models – at least in a "normal" year – can be successful "win-wins" for participating ACOs and the Medicare program alike.

- **During the COVID-19 pandemic, the number of Americans who are uninsured due to job loss has skyrocketed, leaving patients responsible for paying a larger share of their health care expenses and providers facing questions about proper collection practices. In this climate, following best practices for resolution of medical accounts is more important than ever.**
  - A recent report published by the Healthcare Financial Management Association ("HFMA") and ACA International, "Best Practices for Resolution of Medical Accounts" (the "Report"), outlines "the current state of best practices related to the equitable resolution of the patient portion of medical bills." The goal of the report is "to document industrywide consistent patient education and engagement strategies – pre-service or post-service as the Emergency Medical Treatment and Active Labor Act (EMTALA) and circumstances dictate – and post-discharge account resolution practices to help resolve these challenges."
  - The Report sets forth the three elements of the best practices framework:
    - (1) *Patient-Friendly Billing*: Financial communications should be easy for patients to understand and written in clear language, allowing patients to easily determine the purpose of the communication. Medical bills should be concise and accurately reflect the patient's responsibility after the claim has been adjudicated and/or financial assistance or discounts have been applied. Furthermore, the needs of patients and family members should be considered when designing administrative processes.
    - (2) *Patient Communication*: Providers should attempt to engage in discussions with patients as early as possible, beginning before any financial obligation is incurred. Providers should discuss available account resolution options, such as coverage by third-party payers, financial assistance policies, and self-pay discount programs, which may provide either free or discounted care. In addition, providers should ensure written communications to patients are free of industry jargon and other confusing language.
    - (3) *Price Transparency*: Providers should provide patients with access to price estimates, as access to such information facilitates discussions regarding the patient's financial obligations, potential sources of coverage, financial assistance, and payment plans.
  - The Report also contains a checklist of steps providers should take before reporting patients to credit agencies, selling the debt to third-party collectors or filing lawsuits to collect unpaid bills. For example, the Report recommends that providers screen for primary and secondary coverage, including eligibility for public programs, and ensure reasonable communication efforts were made to provide patients with information regarding the availability of financial assistance, available discounts, financing options and payment plans.
  - The Report is particularly significant against the backdrop of reports over the years of health systems bringing hundreds, if not thousands of collection cases against patients.
  - **Key Takeaway**: The resolution of a patient's portion of medical bills can present challenges to both the patient and health care provider. To assist with these challenges and the added complexities caused by COVID-19, the establishment of best practices regarding the resolution of medical accounts, and dedication to maintaining such practices, is critical.

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