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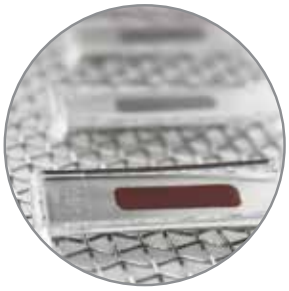

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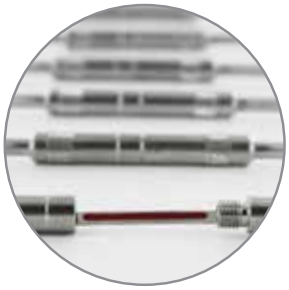

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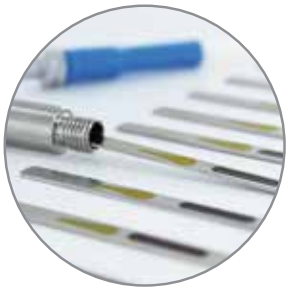

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Phone: 770/263-5262
FAX: 770/236-8023
e-mail: info@jhconline.com
www.jhconline.com

PUBLISHER
John Pritchard
jpritchard@sharemovingmedia.com

EDITOR
Graham Garrison
ggarrison@sharemovingmedia.com

ART DIRECTOR
Brent Cashman
bcashman@sharemovingmedia.com

DIRECTOR OF BUSINESS DEVELOPMENT
Anna McCormick
amccormick@sharemovingmedia.com

SENIOR EDITOR
Daniel Beaird
dbeaird@sharemovingmedia.com

CIRCULATION
Laura Gantert
lgantert@sharemovingmedia.com

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Scalable Strategies to Heart Health

New Mass General Brigham study finds ways to improve outcomes for heart failure patients.

BY PETE MERCER

A recent study conducted by Mass General Brigham, a Massachusetts-based integrated academic healthcare system, looked at a new approach to improve medical therapies to reduce the risk of worsening symptoms and extend the lives of patients with heart failure. A virtual care team of physicians and pharmacists was put in place to help guide treatment strategies for these patients, while looking for a scalable approach to help adopt these therapies into general practice.

IMPLEMENT-HF (Implementation of Medical Therapy in Hospitalized Patients with Heart with Reduced Ejection Fraction) started at Brigham Women's Hospital before expanding to include patients at Brigham and Women's Faulkner Hospital and Salem Hospital.

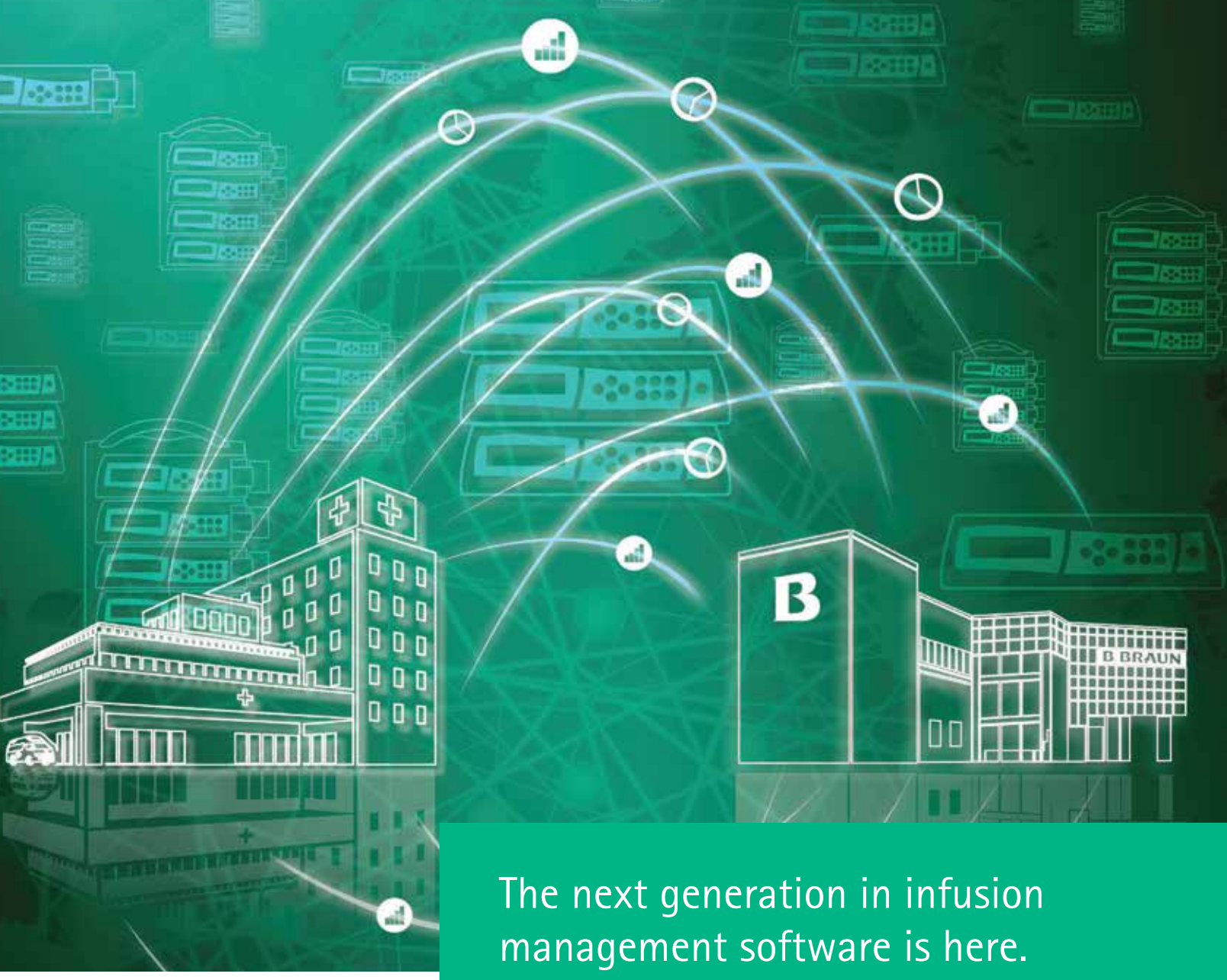
Dale Adler, MD, co-author of the study and executive vice chair of the BWH Department of Medicine and a specialist in Cardiovascular Medicine, said in a press release, "What we learned when we took this to the community hospitals was that cardiologists were eager to work with us to improve adoption of guideline-directed medical therapy to help their patients. Many physicians had read recent studies about therapy for heart failure and knew the ideal therapy combinations, but they hadn't had the chance to implement them with supervision. This study and the virtual care team we assembled gave them the opportunity to do so."

The patients included in the study were admitted to one of the hospitals between October 2021 and June 2022, whether they were admitted for a heart failure-related condition or not. The condition in question is heart failure with reduced ejection fraction, which is where the heart pumps less blood than the body needs. There were 198 unique patients and 252 clinical encounters across all three hospitals included in the study. Of this group, 145 encounters received usual care while the virtual care team provided guidance for 107 other patients.

That virtual team is a critical piece of the puzzle, consisting of a centralized physician, study staff and local pharmacist at each site where patient cases were evaluated daily to improve GDMT practices. They made 187 unique recommendations based on the patient data they were working with, which allowed for more patients to initiate new treatment or receive a more appropriate dosing of GDMT than before.

"We have been interested in identifying the most effective, safe, and scalable strategies to better implement medical advances in the treatment of heart failure and other cardiometabolic conditions," said lead author Ankeet S. Bhatt, MD, MBA, ScM, a former BWH Cardiovascular Medicine fellow who is now a cardiologist at Kaiser Permanente San Francisco Medical Center. "To see that a virtual care team could help improve guideline-concordant care across three diverse system hospitals and do so in a manner that was both safe and did not prolong hospitalization was a very encouraging finding."

Using this project as a foundation, the authors are looking scale up the study to see if they can reproduce with different variables like hospital type, geography, and population. ■



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Understanding the Evolving Laboratory Supply Chain

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Cardinal Health ™ Laboratory Products and Services distributes to more than 6,300 hospital labs, hospital-owned clinics, and reference laboratories. It leverages the scale of one of the largest dedicated lab distribution networks in the U.S. to deliver best-in-class laboratory products and logistics solutions.

"There's been an evolution during the pandemic on the importance of the laboratory supply chain and having a distribution partner who understands the laboratory from both a technical and logistics perspective," said Emily Berlin, Vice President Laboratory Marketing & Aero-Med Commercial Sales and Operations.

"We intensely focus our time from a product management and global sourcing perspective making sure our portfolios have the breadth and depth needed to support testing."


Emily Berlin

Berlin said Cardinal Health has added more products, product programs and additional service and/or cost options to its portfolio to make sure there is reliability on the supplies needed at the time the clinicians need them for testing, as planning has become paramount for health systems.

"Many health systems historically operated on a just-in-time approach, which was a standard practice until the pandemic," Berlin said. "But then weaknesses in this approach were identified. So, by partnering with a laboratory distributor, healthcare systems can create resiliency plans on the necessary products they need within their facilities to keep patient care and testing ongoing."

Enhanced partnerships, new programs

"Distribution has always been critical to a healthcare supply chain, but it is the recognition that a true partnership with transparent collaboration needs to occur between the distributor, customer and manufacturers," she said. "Everyone is coordinated and communicating to make sure information is flowing seamlessly."

The role supply chain plays in laboratory distribution

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To that end, Cardinal Health has offered some unique programs to its customers like the Cardinal Health Reserved Inventory Program, available for labs and health systems nationwide. It is individually tailored to participants and leverages data, such as historical utilization, to inform inventory needs more accurately.

This approach offers supply assurance for an often-unpredictable respiratory season further complicated by virus co-circulation.

"Exclusive programs like the Reserved Inventory Program, focus on maximizing the value of the program contract," Berlin said. "Making sure as much of the contracted lab supply is going through the distribution contract creates efficiencies and supply visibility from a workflow perspective for those participants."

Berlin adds there has been an overall greater focus on laboratory distribution adherence to standardization of formularies too. "This is really where supply chain professionals can collaborate with their clinical stakeholders to identify and implement product formularies across their network," she said.

"Patients are consuming healthcare like a product as testing continues to move closer to the home and more direct-to-consumer testing companies are providing services to patients. The services provided all originate with a laboratory test," Berlin said.

Collaboration is the key to success for organizations employing kitting services.

Specimen collection kitting services

With the acceleration of decentralized care and the growing focus on wellness and prevention, Cardinal Health has invested in its Lab Kitting Services business to meet demand.

Cardinal Health's new Aero-Med facility in East Hartford, Connecticut focuses on manufacturing and distributing customized and standardized specimen collection kits. The 110,000-square-foot facility replaced its previous 55,000-square-foot lab kitting space. It operates as one centralized warehouse, and both manufactures and distributes more than 50 million specimen collection kits annually to hospitals, reference labs and testing organizations.

Collaboration is the key to success for organizations employing kitting services. Dedicated Cardinal Health Kitting Specialists work with customers to help them understand their requirements, such as collection protocols, product usage and standardization, to simplify the kitting process. Customers can choose the components, including Cardinal Health ™ Brand Products, packaging, labeling, and shipping options that fit their needs. From design to distribution, Kitting Specialists manage the process to ensure regulatory compliance and customer satisfaction.

An investment in customer experience

Cardinal Health has made a significant investment focused on improving the customer experience and addressing supply chain resiliency and reliability. Investments have also been made in its quality procurement and planning systems and increased its inventory levels and days of inventory on hand within its network. One of the investments also includes a new, nearly 600,000 square foot distribution center opening in early 2023 in Central Ohio. Finally, there is a focus on broad access to components as a laboratory distributor, which is a differentiator for current customers connected to the Cardinal Health ™ Laboratory Products and Services part of the business.

"We view our role as enabling healthcare to be delivered; our customers count on us for our strategic partnership when it comes to reliability of laboratory supplies," Berlin said. "So, our commitment to the healthcare ecosystem is something that we take very seriously." ■

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— Mark Welch, Senior Vice President, Novant Health

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Addressing Burnout

The AAPA's Task Force seeks to provide education, support and research to mitigate the risks of burnout for PAs and other caregivers.

In 2019, the Board of Directors and House of Delegates of the American Academy of Physician Associates created a Joint Task Force on Burnout (JTF). Eric Tetzlaff, MHS, PA-C, DFAAPA, Chair, AAPA Task Force on Burnout, explained some of the reasons behind the formation of the Task Force: "The AAPA board of directors, the house of delegates and the PA community at large recognized the increasing and multidirectional demands on PA professionals with resultant detrimental impacts on professional well-being of PAs and the ability to provide high quality care to patients."

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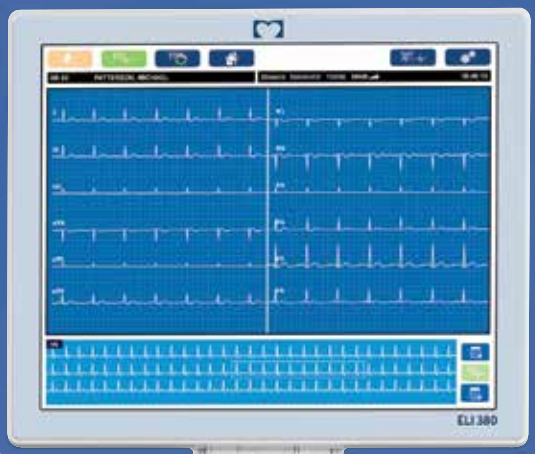

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ELI 280
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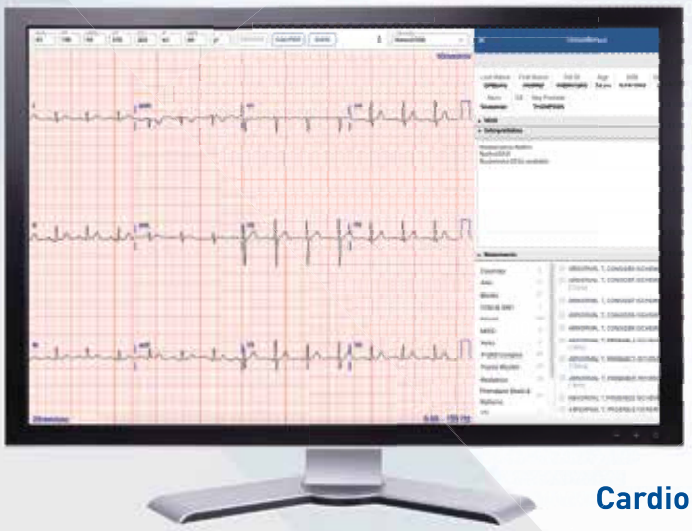

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The risk of professional burnout was not unique to PAs in healthcare as it is workplace syndrome suffered by all members of the healthcare team, Tetzlaff said, but there was an unmistakable unmet need to provide education, support and research on PA burnout to mitigate the risks of the burnout and help improve team-based care provided by PAs. "Although other organizations were addressing provider burnout, prior to the formation of the AAPA task force on PA burnout, there was no uniform and coordinated effort to address PA burnout."

In an interview with *The Journal of Healthcare Contracting*, Jennifer M. Orozco, DMSc, PA-C, DFAAPA, AAPA President and Chair of the Board, discussed burnout among today's healthcare workforce, how quality of care can be affected, and some initiatives the AAPA is undertaking to address the issue.

***The Journal of Healthcare Contracting*: Why are PAs particularly susceptible to burnout?**

Jennifer Orozco: Addressing burnout across healthcare professions has been a priority for the medical community for years, but the strain of COVID-19 on our healthcare system put a spotlight on how critical it is to foster clinician well-being as healthcare workers are quitting at alarmingly high rates.

AAPA has been proactively working to support PAs and fight burnout within our profession for many years. Prior to the pandemic, in 2019, AAPA established a taskforce to uncover the root causes of burnout in healthcare and identify meaningful, long-term solutions – not just treatments for the surface symptoms.

Though the task force's official work was completed in 2022, addressing PA well-being remains important to AAPA's work, and we continue to gather insights to inform the resources and support we provide to the profession.

AAPA's 2022 Salary Report found that while 46.3% of PAs reported experiencing some type of burnout, 79% of the PAs remain optimistic about the PA profession.

There are not enough providers to meet patient needs today, and the situation is expected to become even more dire in the coming years, creating a perfect storm.

***JHC*: What are some of the most demanding aspects of a PA's role within the care setting?**

Orozco: Across the country, PAs are experiencing the challenges of meeting patient needs with an ongoing healthcare workforce shortage. There are not enough providers to meet patient needs today, and the situation is expected to become even more dire in the coming years, creating a perfect storm. According to industry estimates, 99 million Americans lack adequate access to primary care, and 158 million Americans lack adequate access to mental health care.

One of the many learnings from the COVID pandemic is that the U.S. healthcare system has reached a tipping point – a "perfect storm." We are at the

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convergence of healthcare workforce shortages, a mental health crisis, a growing aging population, and a rise in chronic diseases like obesity and diabetes.

An analysis of EMSI data show there will be a shortage of up to 3.2 million healthcare workers by 2026. BLS data shows that 2% of the healthcare workforce quits every month.

Without modern, integrated, team-based healthcare, the U.S. healthcare system will simply not be able to meet these growing needs. We must remove outdated and burdensome requirements and laws that weigh down healthcare teams across the country. In many states, PAs are still required to be supervised by a physician, despite the ongoing and growing physician shortages. PAs are highly trained healthcare providers who should be allowed to practice to the full extent of their training and education. With more than 500 million patient visits annually, PAs are a crucial part of the solution to healthcare provider shortages. By removing unnecessary restrictions, PAs would be better able to meet patient needs where they are greatest.

***JHC*: How could this affect the quality of care?**

Orozco: Outdated healthcare laws directly impact a patient's ability to access high-quality and safe healthcare. For many patients, PAs are their primary care provider, and may be the only provider in town. Despite a growing healthcare workforce shortage, the PA profession is expected to continue growing rapidly. The BLS estimates the PA profession will grow 28% between 2021 and 2031, much faster than the 5% average growth rate for all professions. In fact, the PA profession is growing eight times faster than the physician profession. This is why AAPA continues advocating for legislation that ensures all providers are allowed to practice to the full extent of their training and education.

The BLS estimates the PA profession will grow 28% between 2021 and 2031, much faster than the 5% average growth rate for all professions.

***JHC*: What are some of the goals of the task force? Any initiatives or priorities in 2023?**

Orozco: When the task force was created by AAPA's House of Delegates in 2019, it was tasked with identifying and sharing strategies to reduce the impacts of burnout on PAs. The taskforce was responsible for identifying resources and strategies that lead to burnout, leading educational efforts on ways to prevent burnout, and raise awareness of the burnout issue impacting PAs nationwide. Three years later, the task force has met these calls to action, in part creating free CME models that are accessible to all PAs, launching an online burnout resource center, and leading a wellness symposium during AAPA's 2022 Conference in Indianapolis to educate PAs about burnout and ways to prevent it.

In 2023, AAPA will develop further continuing medical education (CME) on burnout and encourage dialogue to break the stigma surrounding mental health and treatment for mental health. In addition, AAPA is also providing funding to support the National Academy of Medicine's National Plan for Health Workforce Well-Being.

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Understanding the Differences

Why one supply chain leader believes knowledge of the unique needs and workflows in the non-acute space is a tremendous help in navigating supply chain disruptions.

Mona Clark, AVP, Ambulatory Quality, Lifepoint Health, is a nurse by trade with 25 years of experience who has practiced in both the acute and non-acute settings. Her role at Lifepoint is focused on leading strategic initiatives and quality for the organization's Physician Services team. Prior to March 2020, the primary focus of her position was on quality as it relates to value-based contracts, and her supply chain involvement was related to point of care testing in our practices.

However, when the pandemic hit, it was quickly identified that Lifepoint needed someone to lead its practices through all the supply chain issues they were experiencing at that time.

"The task was handed to me, and it was my first in-depth experience with supply chain management," Clark said. "Although the supply chain aspect of my role has transitioned out of crisis mode today, it has evolved into a more stable focus on compliance, standardization and optimization, and I have continued taking on the responsibility ever since."

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In the following interview, Clark discusses the benefits of having a dedicated non-acute supply chain team, planning for the unpredictable, and increasing diversity spend.

Why do you feel it is important for health systems to have a dedicated team that focuses on non-acute space?

There are significant differences between acute and non-acute spaces, and having someone dedicated to non-acute that understands the unique needs and workflows is a tremendous help in navigating supply chain disruptions.

On-site laboratory testing is a prime example of one of these specialized areas and is important in providing the best care to our patients. There are many unique challenges within non-acute settings that are not experienced in the acute space such as multiple locations and specialties being geographically spread out, as well as limited storage space within the practices.

How do you prepare and plan for the unpredictable?

The best way to prepare for the unpredictable is to partner with your distributor and leverage their insight into what they are hearing; conduct your own research into shortages and disruptions; and prepare to pivot quickly when needed. We have gained a significant amount of knowledge based on our experiences through the pandemic and need to take those lessons learned and apply them to everyday processes to be better prepared for uncertainties in the future.

Are you stockpiling through a private warehouse or distribution partner? Is this a priority?

We have stockpiled in the past and continue to monitor the situation. Throughout the pandemic, we relied on a centralized warehouse as we worked to keep our physician practices stocked with the needed supplies to keep both our staff and our patients healthy and safe. The warehouse is becoming less crucial than it once was at the height of the pandemic, but we are still utilizing it to purchase in bulk when we see possible shortages on the horizon to ensure our practices have what they need when they need it.

Is the risk of (expired product) worth taking?

You must have the resources to properly manage the stockpiled product as it relates to the expiration dates and clinic needs. We have worked closely with our distributor, vendor partners and the warehouse team to limit waste and utilize inventory prior to shelf-life expiration.

What actions are being taken with your health system as well as at site level to drive vendor diversity spend? How are you partnering with your supplier partners on DEI spend?

Diversity, equity and inclusion (DEI) is very important to Lifepoint. We are not only looking at expanding our vendor diversity spend, but we are also looking at the products available to make sure we are including options that are inclusive, such as bandages that come in multiple colors to match different skin tones. We are currently going through a formulary review, and during that time, each product is evaluated on several categories including diversification classification.

We feel it is very important to increase our diversity spend and are actively working to do so as we navigate the frequent supply chain issues. Since we are currently conducting a formulary review, it is easier to do both simultaneously.

We are not only looking at expanding our vendor diversity spend, but we are also looking at the products available to make sure we are including options that are inclusive, such as bandages that come in multiple colors to match different skin tones.

Is there any advice you would give someone who may be starting a role like yours in a health system that may have not had this role previously?

I highly recommend developing a strong partnership with your distributor and a close working relationship. Ask questions of those around you who have been in supply chain and rely on their wisdom until you learn the language and feel like you can start navigating it on your own. ■

The Public Health Emergency Ends

What it means for providers.

The federal Public Health Emergency (PHE) for COVID-19 expired this spring. Initially set to expire May 11, it was moved up to mid-April. "We are in a better place in our response than we were three years ago, and we can transition away from the emergency phase," declared the Department of Health and Human Services in February. The following are some of the changes likely to affect providers.

Telemedicine

"Telehealth has caused the most angst among our members," says Claire Ernst, director of government affairs, Medical Group Management Association.

During the PHE, individuals with Medicare had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply. The good news for the medical community is that Congress extended many PHE-related telehealth flexibilities through December 31, 2024, including:

- People with Medicare can access telehealth services in any geographic area in the United States, not just rural areas.
- People with Medicare can stay in their homes for telehealth visits rather than traveling to a healthcare facility.
- Audio-only visits will be offered to those who are unable to use both audio and video (e.g. smartphone or computer).

"Telehealth services became a game changer in both rural and urban areas throughout the country," says Kelly Ladd, CEO, Piedmont Internal Medicine, Atlanta. Prior to the PHE, only rural areas could provide and receive payment for these services. But that has changed, she says.

"Many of our senior citizens – including those in urban settings – do not feel comfortable going out in bad weather to go to the doctor. Telehealth allows them to engage with their provider for chronic care and even acute illnesses. It is especially helpful because it allows us to see the patient through video so we can make certain assessments. If the patient does not have video capabilities, we can still hear their voice, assess background noises, and have the personal engagement."

Many practices have taken the time and expense to incorporate telehealth into their workflow, and they are hoping their investment won't be cancelled with the expiration of COVID-era telehealth flexibilities, she says. "What CMS fails to realize is that providers must pay for the technology to provide these services and follow the same workflow as traditional office visits. We still must complete patient registration, review the patient chart, generate claims for payment and process those payments." In addition, practices have had to adjust their IT networks to add additional cybersecurity and adhere to HIPAA policies and procedures to ensure patient health information laws are followed.

An Illinois State Medical Society survey found that of the 81% of its physician members who reported using telemedicine, three-quarters had not done so prior to the start of the pandemic, says the Society's president-elect, Rodney S. Alford, M.D. "The flexibilities that were instituted at the federal and state level created a pathway for physicians to incorporate telemedicine into their practices."

Reimbursement an issue

Prior to the pandemic, among the most significant barriers to telemedicine was the fact that many payers, including Medicare, had restrictive reimbursement policies, says Dr. Alford. Illinois has already taken action to permanently retain many of the emergency flexibilities that applied to state-regulated health plans. Further, in-network healthcare professionals or facilities in the state must be reimbursed for telemedicine encounters at the same reimbursement rate that would apply to services delivered via an in-person encounter, at least through 2027.

'A top priority is to ensure patients have continuous healthcare coverage and ongoing access to comprehensive care once the PHE ends.'

Claire Ernst believes that eliminating payment parity for telemedicine and in-person visits, as CMS plans to do January 2024, could present challenges for MGMA's physician-practice members. "There's a large differential – as much as 30% – between tele visits and in-person visits, given the technology needed and workflow accommodations that must be made," she says. "We'll be looking at CMS's proposed Physician Fee Schedule, probably in July, to see if they address that."

Compliance with HIPAA rules presents another telemedicine challenge for practices. During the pandemic, HHS's Office for Civil Rights relaxed enforcement of some HIPAA-related requirements, including the use of HIPAA-compliant telemedicine platforms, she says. That will probably change in May. Smaller practices may be more adversely affected than big ones, as they conduct fewer telehealth visits and are less likely to use HIPAA-compliant platforms, she says.

Another telehealth-related issue to watch is interstate licensure for Medicare patients, says Ernst. During the pandemic, qualified clinicians were allowed to provide telemedicine services to patients in states other than their own, provided the other state did not object. That could change.

In addition, questions have been raised about reimbursement for audio-only telemedicine services. The American College of Physicians is pleased that CMS is extending coverage of audio-only E/M services until at least December 2024, says Shari Erickson, chief advocacy officer and senior vice president of governmental affairs and public policy. Researchers have begun to identify the positive impact on health equity of audio-only E/M services, she says.

But regardless of what Medicare does, not all private payers will necessarily follow suit. "Many have stopped payment for these services altogether over the past year, if they covered them at all during the worst of the pandemic," says

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Erickson. "And those that cover them may or may not be paying at the same rate as CMS. From a practice perspective, this makes for a very inconsistent experience and creates uncertainty as to if or how much physicians will be paid for offering audio-only services to their patients."

Remote patient monitoring

The end of the PHE also means changes for remote physiologic monitoring, or RPM. During the PHE, CMS permitted clinicians to bill for remote physiologic monitoring services furnished to both new and established patients, and to patients with both acute and chronic conditions. When the PHE ends, clinicians must once again have an established relationship with the patient prior to providing RPM services.

Piedmont Internal Medicine implemented remote patient monitoring and chronic care management services three years ago, says Kelly Ladd. "They have had a significant and positive impact on patient care" and have kept patients out of the Emergency Room, hospital admissions and readmissions. Blood pressure monitoring, pulse oximeter readings and glucometer-reading devices transmit information directly to software, which is monitored on a daily basis by nurses, she says. RPM facilitates patients' engagement between the patient and the physician's care RN/team on a regular basis, she adds.

COVID-19 vaccines

The end of the Public Health Emergency coincides with the U.S. government's plan to transition the provision of COVID-19 vaccines and treatments to the traditional healthcare marketplace. In a statement, the Department of Health and Human Services said the transition is not tied to the ending of the COVID-19 PHE, but rather reflects the fact that the federal government has not received additional funds from Congress to continue to purchase more vaccines and treatments.

When this transition occurs, many Americans will continue to get free COVID-19 vaccines, according to HHS. Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are a preventive health service for most private insurance plans and will be fully covered without a co-pay. Currently, COVID-19 vaccinations are covered under Medicare Part B without cost sharing, and this will continue. Medicaid will continue to cover all COVID-19 vaccinations without a co-pay or cost-sharing through September 30, 2024, and will cover ACIP-recommended vaccines for most beneficiaries thereafter.

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"A top priority for family physicians and the AAFP [American Academy of Family Physicians] is to ensure patients have continuous healthcare coverage and ongoing access to comprehensive care once the PHE ends," says Tochi Iroku-Malize, M.D., president of AAFP. "Transitioning COVID-19 vaccines to the commercial market may create financial and operational challenges for physician practices and could negatively impact access to and utilization of COVID-19 vaccines for patients.

"If the price of the vaccines is too high, physician practices may struggle to make the upfront investment in COVID-19 vaccines," she says. "Additionally, patients often prefer to receive vaccine counseling and administration from their usual source of primary care, such as their family physician. As the PHE unwinds, the administration and Congress must work to ensure appropriate COVID-19 vaccine prices and payment rates to enable trusted physicians to offer vaccines, promote vaccine confidence, and bolster vaccination rates."

Says Kelly Ladd, "Insurance carriers have not set their reimbursement fees, so we don't know how much we are going to be paid yet for the vaccine." And that amount will probably differ depending on the payer. What's more, payers tend to update their fee schedule quarterly, she says. "The problem is, we typically don't receive this information until the quarter is more than halfway through. We are not able to make an informed decision on which vaccine brand to choose."

Medicaid implications

Providers fear the end of the Public Health Emergency (PHE) will mean the loss of Medicaid coverage for millions of people. Through its "continuous enrollment provision," the federal government during the PHE required state Medicaid agencies to provide coverage even if an individual's eligibility changed. (Before the PHE, individuals could be cut from the program for failure to report a change in family status or income.) Consequently, enrollment for Medicaid and the Children's Health Insurance Program (CHIP) increased by 20.2 million people from enrollment in February 2020, the Kaiser Family Foundation found.

'From a clinician standpoint, it can be burdensome to review all arrangements entered under the Stark Law waiver. It is also unsettling that there is uncertainty as to whether CMS will audit and ask for proof of compliant documentation under the waiver."

Expiration of the continuous enrollment provision means that 17.4% of Medicaid and CHIP enrollees – approximately 15 million individuals – will probably lose Medicaid coverage, according to the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services. Children and young adults will be impacted disproportionately, with 5.3 million children and 4.7 million adults ages 18-34 predicted to lose Medicaid/CHIP coverage. Nearly one-third of those predicted to lose coverage are Latino (4.6 million) and 15% (2.2 million) are Black.

Certain states may be hit particularly hard. Nevada's enrollment in Medicaid and CHIP rose 47% during the pandemic, according to Kaiser Health News. Many signed up toward the start of the pandemic, when the state's unemployment rate spiked to nearly 30%.

Approximately 25% of Illinois citizens are enrolled in Medicaid under Illinois' current rules, says Rodney S. Alford, M.D., president-elect of the Illinois State Medical Society. "The continuous coverage provision has provided much-needed stability to patients who rely on the program to get healthcare services and has helped ensure that physicians who accept Medicaid patients can trust that their enrollment status is current. Illinois State Medical Society members are wary of the unavoidable disruption that will be caused when the redetermination process is resumed after more than three years of continuous eligibility."

The American College of Physicians supports additional options to prevent coverage gaps, including creating the option for Exchanges to adjust special enrollment periods for people who have Medicaid and Children's Health Insurance Plan coverage, says Shari Erickson, chief advocacy officer and senior vice president of governmental affairs and public policy. "We also have been urging CMS to encourage state Medicaid agencies to engage with Medicaid-

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2. Hollister data on file, ref-02883, May 2022
3. Hollister data on file, ref-02009, 2020. Financial estimates based on 2020 cost data

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participating physicians, particularly practices with an above-average share of Medicaid-enrolled patients, to help spread awareness of the post-Public Health Emergency coverage transition." ACP also supports enabling states to extend postpartum Medicaid coverage for a full year.

SNAP

People enrolled in the Supplemental Nutrition Assistance Program (SNAP) are already feeling the impact of the end of the PHE. The program provides nutrition benefits to supplement the food budgets of needy families. During the PHE, the federal government issued "Emergency Allotments" of $95/month or more to households getting SNAP benefits. But effective March 1, regular SNAP rules were reinstated. This could ultimately affect more than 41 million Americans, according to Axios.

"The American College of Physicians has called for SNAP benefit levels to be increased and the benefit calculation formula regularly adjusted to better reflect the rising costs of nutrient-dense food and other competing expenses," says Erickson. Many studies have found that SNAP significantly reduced food insecurity for participants, improved health outcomes, reduced healthcare expenditures, lowered nursing home and hospital admission rates, and lowered cost-related medication nonadherence compared with nonbeneficiaries, she says.

Stark Law

The physician self-referral law, also known as the "Stark Law," does two things: 1) It generally prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship; and 2) it prohibits the entity from filing claims with Medicare for any improperly referred designated health services. On March 30, 2020, CMS issued blanket waivers of certain provisions of the law so long as they were related to the COVID-19 emergency.

When the COVID-19 PHE ends, those waivers will terminate, and physicians and entities must immediately comply with all provisions of the Stark Law. That will entail some recordkeeping on their part.

'As the PHE unwinds, the administration and Congress must work to ensure appropriate COVID-19 vaccine prices and payment rates.'

"Clinicians who took advantage of the blanket waivers must make available to CMS, upon request, records relating to the use of the waivers," says Shari Erickson. "This means that clinicians should be maintaining separate documentation for their arrangements that justifies the purpose and scope of the arrangement. From a clinician standpoint, it can be burdensome to review all arrangements entered under the Stark Law waiver. It is also unsettling that there is uncertainty as to whether CMS will audit and ask for proof of compliant documentation under the waiver. This will distract physicians' focus from caring for what is most important – the patient."

As the government returns to a stricter approach to enforcing Stark, medical practices may experience some backlash from their patients. By law, providers are required to attempt to collect Medicare deductibles and co-insurance amounts from their patients, says Kelly Ladd, CEO, Piedmont Internal Medicine, Atlanta. Failure to do so could amount to enticement, a violation of Stark. During the pandemic, practices slowed down their collection efforts with little or no interference from CMS. But last July, CMS in a memo required physician practices to resume vigorous collection efforts. Piedmont complied, "but patients have been complaining because they had not received a bill before this past summer," says Ladd.

Supply chain

Providers have a few other issues to address as the PHE ends, according to those with whom *JHC* spoke. They include:

- Notification of shortages of critical devices.
- Issues surrounding physician prescribing of controlled substances.
- Staffing issues.

When the PHE ends, the U.S. Food and Drug Administration's ability to detect early shortages of critical devices related to COVID-19 could be limited, says HHS. During the PHE, manufacturers of certain devices related to the diagnosis and treatment of COVID-19 were required to notify the FDA of manufacturing discontinuances or interruptions.

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That requirement could end, though the FDA at press time was seeking congressional authorization to extend it.

Telemedicine and controlled substances

Throughout the PHE, the government waived provisions of the 2009 Ryan Haight Act, which requires a practitioner to have conducted at least one in-person medical evaluation of a patient before issuing a prescription for a controlled substance.

"The American Academy of Family Physicians has long urged Congress and the administration to remove barriers for physicians prescribing medication for opioid use disorder, and applauded SAMHSA [the Substance Abuse and Mental Health Services Administration of HHS] and DEA [Drug Enforcement Agency] for temporarily waiving certain restrictions during the PHE," says AAFP President Tochi Iroku-Malize, M.D.. At press time, AAFP was preparing comments on proposed rules regarding permanent telehealth flexibilities after the PHE ends. Those rules would create new limited options for telemedicine prescribing of controlled substances without a prior in-person exam.

"There is a lot of concern among MGMA members who started treating patients during the pandemic," says Claire Ernst, director of government affairs, Medical Group Management Association. "Now they are back to in-person visits. The proposed rules didn't go as far as we wanted. There are still a lot of roadblocks for people who need those medications and for prescribers."

Staffing issues

Healthcare providers throughout the country are still facing staffing shortages among physicians, mid-level providers RNs, medical assistants and front office and billing personnel says Ladd. "It has been very difficult to recruit, hire, and retain employees post-COVID shutdown."

Those issues are expected to continue after the PHE ends.

One question about staffing involves the supervision of residents. "Family physicians have emphasized that COVID flexibilities impacting the supervision of resident physicians have improved beneficiary access and medical training, particularly the expansion of the primary care exception," says Dr. Iroku-Malize. During the PHE, CMS expanded the codes that were billable under the primary care exception, meaning that residents could provide more services without the presence of a supervising physician during the visit if the supervising physician was overseeing the care and discussing it before and after visits. AAFP is advocating for the permanent expansion of the Medicare primary care exception, she says. ■

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Making the Switch

3 secrets your GPO isn't telling you.

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The following are 3 secrets your incumbent GPO won't tell you about making a switch:

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When was the last time your GPO examined every single contract to uncover opportunities to optimize pricing, fit into the overall portfolio and alignment with organizational goals? The process of switching GPOs shines a light on all facets of the supply chain by looking at everything.

By switching, many health systems see upwards of a **30% uptick** in contract compliance that the supply chain team didn't even know should be under contract and was missed by the incumbent GPO. Contract compliance is important now more than ever since supplies not covered under contract can see 250% higher inflation than those covered by your GPO contract.[1]

Unless your partner has the analytics, SMEs and field team to consistently identify opportunities and operationalize changes, you could slowly and imperceptibly lose that edge. Every hospital and health system would benefit from a systematic evaluation of its supplier contracts. The GPO is your number-one advocate for the best pricing, tier management, and value. And, through the evaluation, you'll get free consulting services to make the best decision no matter who you pick.

2 Switch and save

With the right partner, your pricing won't be disrupted during the switch. A grandfather clause will hold your pricing in line with where it is today while you explore savings opportunities amid all categories. Perhaps even more important, you won't lose any of your supply chain team's time, staff and capacity, nor that of your clinicians.

Your GPO partner should do the heavy lifting on the front and back end of the evaluation, reset and implementation process, freeing up internal staff for more value-add work. Once you establish key stakeholders within the organization and selection criteria, engage GPO partners in a 5-step comprehensive GPO assessment process, describe your goals, speak with or visit reference sites, and review the implementation plan to ensure that your team doesn't get stuck babysitting, filling gaps in contract coverage or having to join another regional aggregator to achieve the portfolio price you deserve.

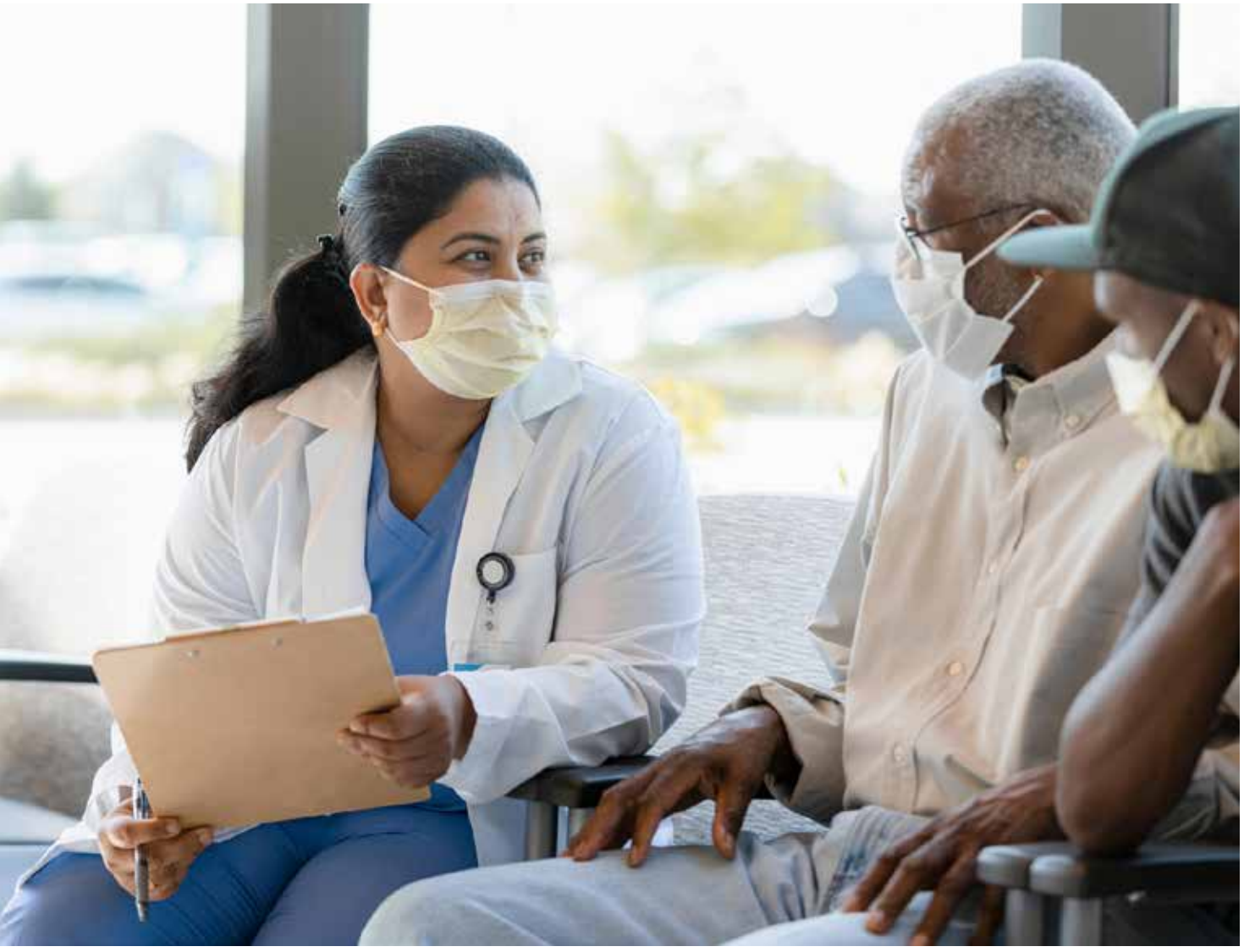
3 Create value beyond supplier contracts

Think beyond the market basket. While it is a useful quantitative tool, your GPO should be able to go far beyond the price point. Health systems don't need more solutions. They need a partner that will come alongside and demonstrate an understanding of your goals – a partner that can not only tell you what your score is but provide rapids insights and a support model to achieve your goals without a herculean lift internally.

Indeed, the right GPO partnership moves beyond fee share and into being a transformation engine for hospitals and health systems. The view is well worth the climb. Through this partnership, supply chain can become a chief driver of culture change, leading to better financial and clinical outcomes for patients and the organization. ■

[1] Inflation and Purchased Services, https://premierinc.com/newsroom/premier-in-the-news/inflation-and-purchased-services

Texas Health Expands Breeze Urgent Care Model



Texas Health Resources continues to expand its Breeze Urgent Care concept with the latest news of a new opening in Cedar Hill, Texas. Breeze Urgent Care aims to give patients quick, convenient and affordable access to health services.

According to Jamie Harraid, Texas Health Vice President of Ambulatory Services, "Breeze Urgent Care centers will be embedded in shopping and business centers so patients can access health services easily and quickly." The new urgent care business model is tailored to patients with an active lifestyle, allowing fast access to care every day of the year. Patients can expect to be "in and out within 30 minutes," according to Texas Health.

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Texas Health's urgent care model allows for a nuanced patient experience throughout the entire healthcare visit. According to Harraid, "patients are greeted by a personal clinical concierge, and are also seen by a Texas Health nurse practitioner or physician assistant." In this model, clinicians diagnose conditions, answer questions, and provide treatment options. The clinical concierge offers a personalized and compassionate patient experience, first guiding patients to their exam suite, offering hot tea, a blanket, or anything else needed for comfort. They are there for the entire appointment for support and to answer any questions.

For those without insurance, they offer a flat rate price of $185, which covers the cost of most expenses included in a visit.

Texas Health launched the Breeze Urgent Care model in 2020. There are currently 24 centers in North Texas, with new sites planned in Denton, Fort Worth, Arlington, Rockwall, Mansfield, and Richardson.

This redesigned urgent care system allows patients to get the care they need when they need it. The urgent care centers are open 8 a.m. to 8 p.m. to fit most busy schedules. The centers are additionally open seven days a week, 365 days of the year including holidays, recognizing that illness and injury can arise at any time.

Those seeking medical attention aged six months to seniors can receive care for a wide variety of common conditions and injuries including COVID-19, fevers, sprains and breaks, poison oak, UTIs, and more. Breeze Urgent care also provides additional services such as flu vaccinations, school and sports physicals, and X-ray imaging for injuries.

Texas Health's Breeze Urgent Care centers accept most insurance plans. For those without insurance, they offer a flat rate price of $185, which covers the cost of most expenses included in a visit. Expenses covered include an exam evaluation with a medical provider, in-clinic lab testing, and if needed, digital X-rays, medication, and prescription medications on-site.

Breeze Urgent Care keeps many common prescriptions on-site in a self-service kiosk, allowing patients to leave with their medication in hand, without a visit to the pharmacy. Patients can also choose to get medical care from the comfort of their own home online through virtual health services.

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