Summer 2019

CAHoots Newsletter is funded through the IN FLEX State Office of Rural Health (SORH).

Drug Take-Back Boxes Available at IU Health Blackford and Jay Hospitals

IU Health Blackford and Jay are happy to announce that a Drug Take-Back Box has recently been installed in each hospital. The Take-Back Boxes will allow members of the community to clean out their medications and dispose them in a safe way.

"We are excited to offer a safe and secure option for community members to dispose of expired and unused medication," said Jerry Carlson, RPh, IU Health Blackford Outpatient Pharmacy Manager, "This is a positive for both our team members and the communities we serve."

Cheri Knapke, PharmD. RPh, Pharmacy Operations Manager at IU Health Jay agrees, "This is an extremely valuable service for our community, as we have had many questions surrounding the topic of unwanted medications and what to do with them for a long time now. The drug take back box provides a safe, secure avenue for disposal of medication to avoid possible accidental poisonings, misuse and overdoses in our community. We are excited to see the drug take-back program in operation here in the hospital, a convenient area for community access."

The best way to safely dispose of unused pills and other over-the-counter or prescription medication is to take them to a designated collection site. Safe drug disposal prevents substance abuse and accidental poisoning, and reduces the risk of water or land contamination.

The boxes at both locations accept expired and discontinued medications. It has both written and pictorial instructions for customers as to what goes into the box, and what should not (i.e. needles, liquids, inhalers, lotions, and mercury thermometers should not be placed in the box). It is acceptable to dispose prescription bottles with their contents, as any patient information is kept confidential and cannot be accessed by others.

Clean out your medicine cabinet the SAFE way!

Help prevent prescription drug abuse, accidental poisoning and water contamination by depositing your expired or unused drugs in the disposal container provided here.

What you CAN dispose of here:	What we DON'T accept:
• Over-the-counter medications • Prescription drugs • Controlled prescription drugs (Schedule II through Schedule V)	• Flammable liquids • Illegal drugs (e.g., heroin, cocaine, ecstasy, marijuana) • Medical waste • Medical equipment • Mercury thermometers • Inhalers • Sharps (e.g., needles, syringes, scalpels, lancets)

Please keep your medications in their original containers.

"IU Health as a system is committed to improving the health and wellness of all Hoosiers," said Dave Hyatt, President of IU Health East Central Region Critical Access Hospitals, "Providing a safe and effective way for our community to dispose medications is another way to support that commitment and help fight the state-wide drug epidemic. I encourage our communities to utilize this valuable service."

The Drug Take-Back box at IU Health Blackford is located in the Retail Pharmacy at 410 Pilgrim Blvd Hartford City IN 47348 during normal business hours of Monday-Friday, 8am-6pm. For more information, please call 765-348-4989.

The Drug Take-Back box at IU Health Jay is located in the main hospital lobby. It is available 24 hours a day, 7 days a week for medication disposal. For more information, call 260.726.1931.

EHR Use Plays Key Role in Boosting Patient Experience Among Execs

By Kate Monica
12 July 2019 via *EHR Intelligence*

A recent survey of healthcare industry executives found 90 percent of respondents leverage EHR use to improve the patient experience

About 90 percent of healthcare industry executives in a recent survey reported leveraging EHR use as a key aspect of their initiatives to improve the patient experience.

As part of the **Sage Growth Partners (SGP) survey** commissioned by Docent Health, researchers surveyed 100 healthcare executives including CEOs, COOs, chief quality officers, chief transformation officers, and other members of healthcare organization leadership. About half of respondents headed up community hospitals, while 20 percent were from short-term acute care settings.

Other executives came from specialty hospitals, children's hospitals, rehabilitation centers, and psychiatric hospitals.

Overall, researchers found 69 percent of respondents rank **improving the patient experience** as their first or second-highest priority in 2019.

“Across the industry, provider organizations are seeing that in order to remain competitive, they need to deliver more patient-centered experiences to their consumers,” said Docent Health CEO Paul Roscoe. “While the survey findings show that most respondents recognize how critical this is, it was surprising to see that a significant portion haven't taken programmatic action.”

Ninety-three percent of respondents are still using phone calls as a way to engage consumers, while 83 percent promote the use of patient portals. Seventy percent of survey respondents stated they have implemented additional staff and physician training to improve their interactions with patients.

“Provider organizations will need to adopt enterprise-wide initiatives like patient navigation programs and relationship management technology in order to effectively support personalized outreach for consumers throughout the continuum of care,” Roscoe added.

Thirty-five percent of respondents reported having a centralized customer relationship management (CRM) platform, and 39 percent reported using text messaging to communicate with patients.

Survey respondents who reported having effective CRMs integrated the technology directly with their EHR systems.

EHR-integrated CRMs have the ability to send automated patient communication reminders for patient navigators and staff. Additionally, executives with EHR-integrated CRMs reported receiving analytics insights directly through their clinical workflows.

Healthcare executives utilizing CRMs were more likely to report positive outcomes related to patient experience. Sixty-nine percent of users reported higher patient retention rates, compared to 39 percent of healthcare executives without a CRM in place.

Additionally, 52 percent of executives with a CRM reported reduced unnecessary emergency department visits, compared to 46 percent of executives without CRMs.

Engaging patients using EHR technology has been a challenge for healthcare providers since the advent of the health IT systems.

As recently as 2017, less than 40 percent of hospitals allowed patients to access their EHR data through application programming interfaces (APIs.)

This finding came in a **2019 ONC data brief** detailing patient engagement capabilities in hospital EHR systems across the country.

Nearly all hospitals included in the data provided patients with the capability to view and download their personal health information by 2017. However, significantly fewer critical access hospitals (CAHs) enabled patients to view and download their EHR data than non-CAHs.

Furthermore, less than ten percent of hospitals reported that most of their patients had activated their patient portals.

“On average, four in 10 hospitals reported that 0 to 9 percent of patients activated their patient portal,” said ONC.

“Hospitals’ rates of patients accessing their patient portal also varied by hospital type. For example, compared to CAHs (33 percent), non-CAHs (38 percent) were more likely to report 0-9% of patients activated access to their patient portal,” ONC continued.

These low rates of patients engaging with their portals online were not specific to hospital size. ONC found no significant difference in the percent of patients accessing their portals between small and medium-to-large hospitals.

Hospitals are continuing to work to increase the number of patients accessing and viewing their EHR data online as health IT plays a more critical role in care delivery.

Greene County General Hospital Welcomes General Surgeon, Dr. Lucio Palanca

Greene County General Hospital is thrilled to welcome board-certified general surgeon, Lucio Giovanni “LG” Palanca, MD to the GCGH family. As a general surgeon with over 20 years of experience, Dr. Palanca will perform a broad range of surgical procedures and consultations exclusively at GCGH. Starting in September, his office will be located on the second floor of the Hospital in the Outpatient Clinic area.

His recent departure from Putnam County Hospital, where he served as the main “go to” surgeon for over 12 years, is indeed a benefit that the Greene county community welcomes. In addition to his many responsibilities, he also served as the cancer surgeon liaison for the American College of Surgeons in his capacity as staff surgeon of the Cancer center of the hospital. His broad-based knowledge and skill has allowed him to provide surgical services mainly but not exclusively in the form of surgery for breast cancer, skin cancer, colon cancer and other forms of gastrointestinal and genitourinary malignancies. He also provides all forms of laparoscopic, endoscopic and urologic procedures from basic laparoscopic gall bladder removals, colon cancer surgery, and advanced hernia surgery as well as colonoscopies and upper endoscopy. These are just a few of the offerings from his vast repertoire of expertise.

Originally hailing from the Philippines, he has made Indiana his home for over 20 years and enjoys hunting and photography. As a physician, he has received training in Urology with over 6 years at the National Kidney and Transplant Institute in the Philippines. In the US, he served as a research fellow in Urology at the University of Louisville, Kentucky and completed a surgery residency in Indiana University. He is board certified and a fellow of the American College of Surgeons.

Greene County General Hospital welcomes his arrival as part of the expansion of services to provide surgical access for our patients and the community as a whole, Brenda Reetz, GCGH CEO explains.

Patients are benefiting from GCGH’s growth. In the past year, GCGH has expanded its surgical service line to include orthopedic and sports medicine surgery. Other surgical offerings at GCGH include general and

laparoscopic surgery, podiatry, dentistry, pediatric dentistry, endoscopy, obstetrics, and gynecological procedures. GCGH is currently booking appointments for Dr. Palanca.

9 Statistics on Hospital Revenue Cycle Performance Award Winners

By Kelly Gooch
30 July 2019 via *Becker's Hospital Review*

https://www.beckershospitalreview.com/finance/9-statistics-on-hospital-revenue-cycle-performance-award-winners.html
"The Healthcare Financial Management Association recently shared data on the integrated delivery systems, health systems, individual hospitals and critical access hospital that received the association's 2019 MAP Award for high performance in revenue cycle."

Rural Hospitals Struggle in States That Declined Obamacare

By Michael Braga, Jennifer Borresen, Dak Le and Jonathan Riley
28 July 2019 via *JDNews*

More than half of all rural hospitals in Mississippi, South Carolina, Georgia and Oklahoma lost money from 2011 through 2017.

In Kansas, the bloodletting was even more widespread.

Two out of three rural hospitals in the state operated in the red during the seven year period.

What these states also have in common is that legislators voted against expanding Medicaid under the Affordable Care Act, which would have provided coverage for hundreds of thousands of uninsured residents and bolstered rural hospital bottom lines.

Fiercely conservative and inherently distrustful of the federal government, state politicians balked at picking up 10 percent of the Medicaid expansion tab and repeatedly expressed fears that Washington bureaucrats would renege on generous Obamacare funding, leaving states to cover an ever increasing share of the healthcare burden.

That hasn't happened yet.

In the meantime, residents of deep red rural America — farmers and farm workers, small business owners and their employees, the old and irfirmed — are seeing their hospitals founder and close.

"The irony to me," said John Henderson, who heads The Texas Organization of Rural & Community Hospitals and supports Medicaid expansion, "is that we're paying federal income taxes to expand coverage in other states. We're exporting our coverage and leaving billions of dollars on the table."

While experts agree embracing Obamacare is not a cure-all for rural hospitals and would not have saved many of those that closed, few believe it was wise to turn the money down.

The crisis facing rural America has been raging for decades and the carnage is not expected to end any time soon.

High rates of poverty in rural areas, combined with higher than average unemployment, aging populations, lack of health insurance and competition from other struggling institutions will make it difficult for some rural hospitals to survive regardless of what government policies are implemented.

For some, there's no point in trying. They believe the widespread closures are the result of the free market economy doing its job and a continued shakeout would be helpful. But no rural community wants that shakeout to happen in its backyard.

"A hospital closure is a frightening thing for a small town," said Patti Davis, president of the Oklahoma Hospital Association. "It places lives in jeopardy and has a domino effect on the community. Healthcare professionals

leave, pharmacies can't stay open, nursing homes have to close and residents are forced to rely on ambulances to take them to the next closest facility in their most vulnerable hours."

Origins of the Crisis

The nation's current system of rural hospitals dates back to the 1940s and the belief that every town deserves a modern facility.

But with the rapid development of healthcare technology, the supply and demand for healthcare services shifted to urban areas.

"Most of what we knew how to do in the 1970s and 1980s could be done reasonably well in small towns," said Dr. Nancy Dickey, president of the Rural and Community Health Institute at Texas A&M. "But scientific developments and advances in neurosurgery, microscopic surgery and the like required a great deal more technology and a bigger population to support the array of technology specialists."

The number of services rural hospitals could provide consequently shrunk, and hospitals didn't need as many beds, Dickey said. At the same time, rural populations began to decline as jobs dried up and younger folks moved away.

That left rural communities with older, poorer populations and a greater number of uninsured — financially challenging demographics that forced more than 180 rural hospitals to shut down in the 1990s alone.

Alarmed by the closures, politicians responded by passing legislation that included the creation of the Critical Access Hospital designation, ensuring that a select group of rural hospitals would have all of their costs covered for Medicare patients.

The new laws contributed to a significant drop in closures during the first decade of the 21st century. But when the Great Recession hit, many rural hospitals found themselves in another deep financial hole. Closures began rising again — a trend that has not relented despite the economic rebound.

"If you don't take the expansion," said Dickey, the Texas A&M professor, "it's a challenge to make sure you have enough paying patients coming through the door."

Lack of Coherent Policies

Looking at the data, it's hard not to conclude that hospitals in non-expansion states are suffering far worse that those that embraced Obamacare.

They account for 77 of the 106 closures over the past decade. They also are home to a greater percentage of money losing facilities and lower profit margins.

But for most of these states, refusing Medicaid is not their only problem.

Most have higher poverty rates and more hospitals concentrated in adjacent geographical areas. Many also lack coherent statewide policies to address the crisis.

Texas, for instance, experienced 17 closures since 2010 — the most in the country, according to the Sheps Center for Health Services Research at the University of North Carolina in Chapel Hill. But practically all of them were located in the eastern and southeastern parts of the state.

These are small agricultural communities, explained Henderson, who heads The Texas Organization of Rural & Community Hospitals. The population is generally poorer and the hospitals are closer to each other.

By comparison, hospitals in West Texas are further apart. They have less competition, and they are often supported by property taxes connected to the oil and gas industry. When oil prices are up, hospitals in these communities have access to more resources, Henderson said.

Like Texas, the fate of rural hospitals in Kansas often depends on what local resources they have to draw on.

"Because many of our hospitals are affiliated with local governments, each locality might take a different approach," said Kari Bruffett, the Kansas Health Institute's vice president for policy.

It's clear those approaches aren't working.

Not only have five Kansas hospitals shut down since 2010, but seven more are counted among the 20 worst performing rural hospitals in the country. They include Kiowa County Memorial Hospital in Greensburg and Morton County Hospital in Elkhart, which both lost more than $17 million between 2011 and 2017.

For some academic researchers and politicians in conservative states, there are good reasons for the failure of rural hospitals and the free market should be left to decide the winners and losers.

Navigant, a Chicago-based healthcare consulting firm, recently published a report stating that 153 of the 430 unstable rural hospitals in the United States are "not essential." If they went down, their communities would find other ways of meeting residents' needs.

That conclusion is supported by a 2015 Harvard University study that looked at 195 hospital closures between 2003 and 2011 and found that, while patients had to travel further after a shutdown, death rates and other key indicators of quality healthcare did not worsen.

But George Pink, deputy director of the North Carolina Rural Health Research Program, isn't convinced the free market is the best model for rural America.

"Healthcare has shown itself many times over to be a market that regularly fails," Pink said. "If you think of a small, rural community, miles from anywhere else, you wouldn't expect the market to jump in and provide solutions. Think about the high percentages of poor, chronically ill, elderly, and disabled in these towns. These are not people with a lot of political power."

Urban and Rural Working Together

While hospitals in most states that declined to expand Medicaid are struggling, Utah provides a notable exception.

"Twenty years ago, we instituted a policy where we would take a little money from urban hospitals and give it to rural hospitals," said Dave Gessel, executive vice president of the Utah Hospital Association. "That's provided a base for all our hospitals."

Utah also has a diversified and growing economy, a low poverty rate and a tradition of donating generously to charity, Gessel said, and rural hospitals have been successful in attracting experienced executives from bigger markets.

He added that the Mormon church provides a unifying influence.

"Rural Utah is pretty heavily Mormon," Gessel said. "Because of those connections, those ties, local residents realized if they didn't come together, things could get really bad."

As a result, only three rural hospitals in Utah reported losses from 2011 through 2017, and collectively its 21 hospitals logged the highest profit margin in the country.

Pink, the professor at UNC's Sheps Center, said several other states have taken novel approaches to addressing the crisis. Louisiana recently passed the Rural Hospital Preservation Act that supports rural hospitals with wrap around funding, and North Carolina is about to follow its lead.

"These are useful initiatives," Pink said. "But I don't know of any hospital that's opposed to Medicaid expansion. It's good from a financial standpoint. But more importantly, it provides access to healthcare for vulnerable people."

Governor Holcomb Directs Actions Aimed at Reducing Indiana's Smoking Rate

ISDH, FSSA take immediate steps to make available tobacco cessation tools; changes will enhance state's infant and maternal mortality efforts

The Indiana State Department of Health and Indiana Family and Social Services Administration acted on direction from Governor Eric J. Holcomb to improve access to and the affordability of tobacco cessation products for Hoosiers wanting to quit smoking or using tobacco.

On July 15 at Eskenazi Health Center West, 38th Street, State Health Commissioner Kris Box, M.D., FACOG, issued a standing order effective Aug. 1 allowing Hoosiers to purchase tobacco cessation products at Indiana pharmacies without having to obtain an individual prescription. Indiana becomes only the 12th state with a policy or standing order allowing pharmacists to prescribe tobacco cessation products, eliminating financial and time barriers for individuals considering quitting smoking.

Dr. Jennifer Walthall, M.D., MPH, Secretary of Indiana Family and Social Services Administration, also announced Indiana Medicaid will follow Gov. Holcomb's directive to reimburse health care providers offering tobacco cessation counseling for expectant mothers. She also announced that Indiana Medicaid will remove copayments for tobacco cessation products for pregnant women or members up to one year postpartum.

"One of our main priorities is reducing the smoking rate of our expectant moms, and we know they will respond positively," said Dr. Box. "Studies show that women are more likely to quit smoking during pregnancy because they want to give their baby the best possible start in life. Quitting tobacco will improve maternal health and send us farther down the path to achieving Governor Holcomb's goal of being best in the Midwest in infant mortality by 2024."

Women who smoke are at least twice as likely to have a preterm birth, which is the leading cause of infant mortality in Indiana. Indiana has the 7th highest infant mortality rate in the nation and is 3rd in the U.S. for maternal mortality. Gov. Holcomb has made reducing Indiana's infant and maternal mortality a top health priority of the state, and smoking is one of the most important modifiable causes of poor pregnancy outcomes. Studies show that smoking during pregnancy increases the risk of stillbirth by almost 50 percent and neonatal death by over 20 percent.

"According to statistics tracked by ISDH, nearly 25 percent of expectant Indiana mothers on Medicaid smoke during pregnancy compared to approximately 8 percent of all expectant mothers nationwide," Dr. Walthall said. "Increasing access to smoking cessation products and further reducing barriers to success will help improve both maternal and infant health."

Training will continue for health care professionals, such as medical assistants and community health workers, to connect them with pregnant women seeking tobacco cessation counseling.

Commentary: We Need to Measure Hospital Rates of Minimally Invasive Surgery

By Ira Leeds and Martin Makary
30 July 2019 via *US News*

THE BIGGEST ADVANCEMENT in the field of surgery over the last 30 years has been the advent of minimally invasive surgery. Using minimally invasive surgery, operations such as removing a lung tumor, uterus or tail

of the pancreas can often be performed with far fewer wound infections and far fewer or no opioids needed, among other well-established benefits to the patient. So why do some hospitals have low rates of minimally invasive surgery for candidate patients?

Some surgeons simply prefer to cut patients open in a more-invasive, traditional approach. "It's just how I like to do it," is a frequent justification within the surgical community.

Sure, there are always patients who need the open surgery approach -- patients who had complicated past operations or have a tumor necessitating a wide excision (those who require certain complex procedures), but these exceptions have become an over-stated reason as to why some doctors avoid using the state-of-the-art minimally invasive approach. From a quality-measurement standpoint, many common, standard operations can be compared in a like-to-like fashion among similar hospitals to calculate a meaningful utilization rate – and it's not always the academic giants or the large health systems that sponsor NFL teams that have the highest adoption rates. Researchers have found that utilization rates are essentially randomly distributed.

So given the wide variation in hospital use of minimally invasive surgery, it would make sense for consumers to be able to consider overall utilization rates for standardized common procedures when evaluating hospitals. The biggest difference between Hospital A and Hospital B may be that one of them routinely performs an operation minimally invasively and the other does not.

Important considerations should be made when benchmarking hospitals in this way. Comparisons should only be performed for the subset of operations where the evidence supports clinical superiority (e.g., colon cancer surgery, hysterectomy), and comparisons should be made by procedure type (e.g. non-cancer hysterectomy rates). Critical access hospitals and rural medical centers where workforce issues are reaching crisis levels should be exempt; many surgeons in these areas are unfairly expected to have a broad mastery of surgical skills across many specialties, which is radically different from how surgery is practiced in more populated areas where surgeons are better resourced and more specialized. When physicians seek surgery for ourselves, we often seek the surgeons who embrace and have mastered the minimally invasive approach. Now that this data is measurable and the evidence is clear, don't we have a moral obligation to make the data available to people comparing hospitals when seeking care?

Consider the case of laparoscopy for removal of the appendix. A 2018 Cochrane Collaboration meta-analysis of 67 randomized clinical trials comparing laparoscopic with open appendectomy demonstrated that the laparoscopic approach was associated with reduced rates of postoperative wound infection, reduced postoperative pain, reduced lengths of hospital stay, and faster return to work.

The presentation of appendicitis is relatively randomly distributed in the population. Yet, a minority of surgeons routinely perform all appendectomy operations through an open laparotomy, while most others perform nearly all through the laparoscopic approach. Given this variation, would you want to know how most appendix surgery is performed at a particular hospital? Do they perform 90%, 50%, or 0% of appendix removals using the minimally invasive approach?

Similar to the appendectomy example, standard, elective colon surgery is another example where the superiority of minimally invasive surgery is clear. Numerous studies have demonstrated that the short-term benefits of laparoscopic colon surgery include reduced overall complication rates, improved physiologic function following surgery, faster recovery and hospital discharge, and improved 30-day quality of life measures. Importantly, meta-analyses performed in colorectal cancer populations have suggested equally good long-term outcomes with no difference in cancer recurrence or cancer-related mortality.

A risk-adjustment based on both patient factors and institutional referral factors could be applied to ensure that hospital-to-hospital comparisons are fair. In addition, rather than ranking or rewarding hospitals on small differences in utilization rates (e.g., 93% laparoscopic versus 87% laparoscopic), it would be better and more interpretable to present inlier versus extreme outlier practice patterns (e.g., hospitals below a consensus-derived utilization rate). In conjunction with both complication and safety rates, adoption rates of minimally invasive surgery represent a tremendous opportunity to create a more patient-centered metric of quality.

The field of quality science is currently lacking measures that capture the appropriateness of the surgical approach. Differences in approach are well established to impact outcomes. The metric, rate of minimally invasive utilization, would begin to address this gap by creating an incentive to address surgeons who have rejected minimally invasive surgery purely as a matter of practice style. With evidence that laparoscopic

surgery is superior for a select group of standardized operations, we propose that the proportion of cases performed laparoscopically at an institution be factored into the ranking of U.S. hospitals.

Rush Memorial News

RMH recently added Vapotherm technology.

RMH Golf Outing on July 12 was an overwhelming success with over 36 teams… pictured (R-L) is RMH CEO Brad Smith; HR VP, Brian Bane and teammates. Close to 25k was raised for scholarships!

RMH welcomes Spine Surgeon Dr. Barrett Boody, from the Indiana Spine Group.

Rush Memorial Hospital is pleased to welcome pulmonologists Dr. Ryan Schroeder and Dr. Emily Cochard.

CMS Eyes Smaller 340B Hospital Pay Cuts in Case of Court Loss

By Susannah Luthi
30 July 2019 via *Modern Healthcare*

The Trump administration hasn't given up on its 340B hospital reimbursement cuts, but officials have also come up with a smaller, alternative pay cut in case the CMS loses its ongoing court battle over the original plan.

In the CMS' newly proposed outpatient prospective-payment system, or OPPS, rule released late Monday, the administration walked a careful line. The steep Medicare Part B cuts to 340B hospitals will continue for now, even though a federal judge has blocked them and demanded a government remedy to providers that saw the cuts.

But stakeholders have also been asked to weigh in about a new potential payment rate for 340B hospitals that would almost undo the challenged 22.5% cut. Instead of getting reimbursed at a drug's average sales price, or ASP, plus a 6% administration fee, the 340B providers could get the average sales price plus 3%.

"We are soliciting public comments on the appropriate OPPS payment rate for 340B-acquired drugs, including whether a rate of ASP plus 3% could be an appropriate payment amount for these drugs, both for (calendar year) 2020 and for purposes of determining the remedy for CYs 2018 and 2019," the proposed rule said.

A federal judge demanded the "remedy" the CMS referenced earlier this summer. U.S. District Judge Rudolph Contreras halted the cuts for both 2018 — when they first went into effect — and in 2019.
Instead of granting the permanent injunction against the cuts that the hospitals and hospital groups had wanted, Contreras asked HHS to take "first crack" at devising a remedy.

The CMS made it clear in the proposed rule that the Trump administration will appeal the decision. And one hospital group—the Federation of American Hospitals, which represents investor-owned hospitals—supports the original cuts and plans to file an amicus brief in the appeal. The group filed a brief in the lawsuit earlier this side, but didn't take a side.

The group's CEO, Chip Kahn, said the CMS' original cut is an equity issue for hospitals that aren't eligible for the steep 340B discounts because they're for-profit.

"There's a set of issues here," Kahn said. "On the one hand Medicare patients receive full payment, and the whole point of 340B is to help hospitals for their uncompensated-care patients."

Crucially for the 340B hospitals in question, the CMS has asked for responses on whether the remedy should be retrospective or prospective through increases to future 340B claims, "and whether there is some other mechanism that could produce a result equitable to hospitals that do not acquire drugs through the 340B program while respecting the budget-neutrality mandate."

Hospitals don't want a remedy that makes up for past losses elsewhere. This is a major issue for Kahn and the for-profit hospitals that don't want to see a cut to any future payment as a result of the push on 340B hospitals.

"Our position is that for remedies going forward we just want to make sure we're not required to dig back in any payment — which means going forward we believe they shouldn't make an adjustment to affect us because of a court decision," Kahn said.

American Hospital Association General Counsel Melinda Hatton reiterated this position as well. She said the AHA doesn't deem the proposed remedy "appropriate," and referenced the group's court pleadings where the AHA argued "the government should be required to propose and implement a solution to make those hospitals that were adversely impacted whole and hold others harmless."

If the CMS loses its appeal of the hospital lawsuit, the agency said it would likely propose the specific remedy for 2018 and 2019 and, potentially, 2020 through the 2021 outpatient prospective-payment system rulemaking process. Stakeholder comments would inform those proposals.

The American Hospital Association, America's Essential Hospitals and the Association of American Medical Colleges each blasted the administration for trying to preserve the existing cuts.

"With its proposed rule, the Centers for Medicare & Medicaid Services (CMS) ignores a federal court's unequivocal and explicit finding that the agency acted unlawfully when it imposed deeply damaging cuts to hospitals in the 340B drug pricing program," America's Essential Hospitals CEO Bruce Siegel said in a statement.

The group wouldn't comment on the suggested remedy, citing ongoing litigation.

The AHA and AAMC took a similar tack in emphasizing the court decision.

"Now that the court has ruled that those cuts are illegal and exceeded the administration's authority, we urge CMS to refrain from doing more damage to impacted hospitals with another year of illegal cuts," AHA CEO Rick Pollack said. "Instead, as a remedy, CMS should be offering a plan to promptly restore funds to those affected by the illegal cuts."

Ivy Baer, AAMC's senior director and regulatory counsel, also expressed disappointment "in light of our strong win in the District Court."

Hospitals eligible for 340B include critical-access hospitals, large disproportionate-share hospitals like academic medical centers, rural referral centers, free-standing cancer hospitals and sole community hospitals.

Hospital pay from Medicare Part B also came up last week in the Senate Finance Committee's massive proposal to lower drug costs. One provision targeted the 6% administrative fee for hospitals that both the Obama and Trump administrations have wanted to curb. Under the Senate bill, this fee would be capped at $1,000 per drug per day.

Additionally, the off-campus hospital outpatient departments that have had their higher Part B reimbursements "grandfathered" in would lose their special status.

About the *All of Us* Research Program

The ***All of Us* Research Program** began national enrollment on May 6, 2018, inviting people ages 18 and older, regardless of health status, to join this momentous effort to advance individualized prevention, treatment and care for people of all backgrounds. Part of the National Institutes of Health, *All of Us* is expected to be the largest and most diverse longitudinal health research program ever developed.

Participants are asked to share different types of health and lifestyle information, including through online surveys and electronic health records, which will continue to be collected over the course of the program. Those who join will have access to study information and data about themselves, with choices about how much or little they want to receive.

Data that are collected will be broadly accessible to researchers of all kinds, including citizen scientists, to support thousands of studies across a wide range of different health topics. By doing so, they are hoping to discover how to more precisely prevent and treat other health conditions. Knowledge gained from this research could help researchers improve health for generations to come.

Why *All of Us* is Important for Patients

Health care is often “one size fits all” and is not able to fully consider differences in individuals’ lifestyles, environments, or biological makeup. This is because we have limited data from past research studies about how those elements interact. The average patient is often prescribed drugs and treatments as if they are all the same. Learning more about the differences between individuals can help researchers develop tailored treatments and care for all people.

How *All of Us* Benefits Health Care Providers

Today there are too few conditions with evidence and options for individualized care. Too often, patients from underserved communities have not been included in clinical research, and our ability to care for diverse populations is diminished as a result. More data, discoveries, and tools can help providers to give their patients customized care more easily, especially for those communities that are disproportionately impacted by health issues.

Why Diversity Matters

Historically, many segments of the U.S. population have been left behind in medical research, including people of color, sexual/gender minorities, those with lower socioeconomic and educational status, rural communities, and other groups. The result is significant health disparities. The *All of Us* Research Program seeks to help fill in the gaps of information about those communities that previously have not been well represented.

How to Join the *All of Us* Research Program

The program is seeking one million or more people from all walks of life to participate in this historic endeavor. Those interested in joining the program can do so by visiting, www.JoinAllofUs.org. Enrollment is open to all eligible adults who live in the United States.