MARKET UPDATES
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New CMS Enforcement on ER Physician Standby Costs Could Threaten CAHs

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- CMS has recently begun to enforce a provision of Provider Reimbursement Manual §2109 indicating that in order for physician availability services costs to be allowable, **the provider must demonstrate that it explored alternative methods for obtaining physician coverage but was unable to do so**
- In order to claim Emergency Room Availability costs, the provider must have certain specific documentation, including **evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services**
  - For example, advertisements for emergency room physicians to be compensated on a fee-for-service basis placed in appropriate professional publications
- CMS Auditors are enforcing this regulation in 2015 desk reviews
- **UPDATE: May 17th 2018 Correspondence between CMS and CAH**
  - **Noridian Health Care Solutions Guidance:**
    - **CMS has indicated that if the Criteria of "Evidence that CAH explored alternative methods of obtaining ER coverage" is the only criteria not met, the MAC should not disallow the availability cost**
  - **CMS Correspondence: The guidance provided by Noridian accurately reflects the CMS expectations**
    - **New Guidance to be issued during Q2 2018 by CMS**

2019 ACA Final Rule – 4/9/18

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- 2019 Final Rule on the ACA intended to "promote health care choice and competition and decrease costs."
- Key impacts of the Final Rule include the following:
  - ✓ **Allows states to choose their own Essential Health Benefits.** Starting in 2020, states will be able to either adopt another state's 2017 benchmark plan; replace one or more of its benefit categories with that of another state's; or completely build a new essential benefits package as long as the plan is in line with a "typical employer plan." *Plans will still have to offer the 10 essential health benefits required by the Affordable Care Act.*
  - ✓ **State regulators will only review rate hikes of 15% or more.** The CMS is upping the rate increase threshold that triggers a review by state regulators to premium hikes of at least 15% for 2019.
  - ✓ **Fewer people will pay the individual mandate tax penalty.** The CMS is allowing insurance exchanges to extend exemptions to the penalty based on a lack of affordable coverage available in an area.
  - ✓ **Eliminates standardized options.** The CMS eliminated standardized options from the federal marketplace in 2019.
    - ✓ Standardized options share cost-sharing structures and benefit designs, and were initially proposed as a way to simplify shopping for consumers.
  - ✓ **Relaxes rules around the medical loss ratio (MLR).** In 2019, states will be able to request changes to the minimum individual market MLR that insurers must meet if states can demonstrate that a lower MLR would help stabilize their markets.

Sources: CMS press release 4/9/2018, *CMS issues final 2019 Payment Notice Rule to increase access to affordable health plans for Americans suffering from high Obamacare premiums,* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-09.html; Modern Healthcare, *5 takeaways from CMS' final 2019 ACA marketplace rule,* Shelby Livingston, 4/10/2018 http://www.modernhealthcare.com/article/20180410/NEWS/180419990

DOJ Refuses to Defend the ACA (6/8/2018)

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- The U.S. Justice Department refused to defend the ACA against a lawsuit filed by 20 Republican state attorneys general, and reinforced state litigators' arguments that major provisions of the law were invalidated automatically in 2017 when the individual mandate was repealed.
  - In *Texas v. Azar*, a case brought in February by Texas and 19 other Republican-led states, Texas asked the court to deem the Individual Mandate unconstitutional arguing that a previous Supreme Court ruling had upheld the Individual Mandate as a tax penalty only
    - Thus, when the 2017 Tax Cut and Jobs Act eliminated the tax penalty, the individual responsibility became unconstitutional; therefore
    - Since the law cannot function without the mandate, the entire ACA must invalidated.
- **Citing the legal question of the ACA provisions' "severability," Administration argued that the ACA's guaranteed issue and community rating requirements can only work together with the individual mandate, so must be repealed**.
  - **Per the DOJ interpretation, repealing the individual mandate means the pre-existing conditions and community rating provisions must also go.**
- Industry experts dispute the DOJ's position, arguing that the individual mandate is clearly severable from the ACA, and argued that a legal ruling otherwise would devastate hospitals and patients.
  - On June 7, Democratic attorneys filed a response to the preliminary injunction motion strongly defending the ACA and its provisions. The case is likely headed to the Supreme Court.
- 52M Americans with preexisting conditions could face higher premiums or lose insurance coverage.

Sources: ModernHealthcare, *Uncertainty could spook insurance markets as DOJ decides not to defend ACA,* Susannah Luthi, June 8 2018 http://www.modernhealthcare.com/article/20180608/NEWS/180609919/uncertainty-could-spook-insurance-markets-as-doj-decides-not-to; The Commonwealth Fund, *Trump Administration Court Filing Threatens Coverage for Preexisting Conditions,* Timothy S. Jost, 6/8/18 http://www.commonwealthfund.org/publications/blog/2018/jun/trump-administration-preexisting-conditions#/utm_source=Trump%20Administration%20Preexisting%20Conditions&utm_campaign=Health%20Coverage&utm_medium=Twitter

2019 IPPS Proposed Rule (4/24/18) - Summary

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CMS released its 2019 Medicare Inpatient Prospective Payment System proposed rule, which is intended to increase **price transparency for patients, reduce administrative burden on providers and emphasize interoperability**

Key takeaways from the proposed rule include:

- Acute care hospitals participating in CMS' quality programs will receive a 1.75 percent operating payment rate increase
- The rule requires hospitals to publish a list of their standard charges online
- The proposed rule slashes measures deemed duplicative, excessively burdensome or "topped out"
- The rule will also ease documentation requirements
- The rule would update the Hospital Inpatient Quality Reporting Program to stratify measure rates by dual-eligible Medicare-Medicaid patients
- The rule aims to overhaul meaningful use to put a new focus on interoperability and flexibility

Sources: Becker's Hospital CFO Report, *CMS releases 2019 IPPS proposed rule: 10 things to know,* Emily Rappleye, 4/25/18 https://www.beckershospitalreview.com/finance/cms-releases-2019-ipps-proposed-rule-10-things-to-know.html; HFMA, *Online Posting of Charges Among New Medicare Rules Proposals,* Rich Daly, 4/25/18

2019 IPPS Proposed Rule (4/24/18) – Payment

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- The proposed rule also would **increase IPPS payment rates by 1.75 percent**, and the base rate for long-term care hospitals (LTCHs) by 1.15 percent

Factor	Percent Change
FY 2019 Market Basket	2.8
Multifactor productivity adjustment	-0.8
ACA Adjustment	-0.75
Subtotal	1.25
MACRA Documentation and Coding Adjustment	+0.5
Net increase before application of budget neutrality factors	1.75

  - Breakout of increase among hospital categories:

Hospital Type	All Proposed Rule Changes
All Hospitals	2.1%
Large Urban	2.1%
Other Urban	2.1%
Rural	1.1%
Major Teaching	2.6%

- The rule would implement the second of a three-year transition to using Worksheet S-10 data to determine uncompensated care payments
- Disproportionate Share Hospital (DSH) payments would increase by $1.5 billion in FY19 due in part to an increase in the share of uninsured patients.

Sources: *2019 IPPS proposed rule things to know,* Emily Rappleye, 4/25/18 https://www.beckershospitalreview.com/finance/cms-releases-2019-ipps-proposed-rule-10-things-to-know.html; CMS Fact Sheet 4/24/18 *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

2019 IPPS Proposed Rule (4/24/18) – Payment (cont.)

- Extends the Medicare-Dependent Hospital Program through FY2022
- Extends the ACA expansion of the Low-Volume Hospital (LVH) payment adjustment for FY 2018
  - Broadens qualifying rules for FY 2019-FY20-22 to hospitals with fewer than 3,800 total discharges

Sources: *2019 IPPS proposed rule things to know,* Emily Rappleye, 4/25/18 https://www.beckershospitalreview.com/finance/cms-releases-2019-ipps-proposed-rule-10-things-to-know.html; CMS Fact Sheet 4/24/18 *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

2019 IPPS Proposed Rule (4/24/18) – Price Transparency

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- To increase price transparency, hospitals would be **required to post their "standard charges" online** "via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate."
- CMS also sought comment on the following:
  - A requirement that providers inform patients of their out-of-pocket costs for a service before the service is furnished
  - Surprise out-of-network bills from physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and on unexpected facility fees and physician fees for emergency department visits
  - A requirement to publicize any "hospital non-compliance" with its transparency requirements, as well as undertaking "additional enforcement mechanisms."

"We are seeking information from the public regarding barriers preventing providers from informing patients of their out of pocket costs; what changes are needed to support greater transparency around patient obligations for their out of pocket costs; what can be done to better inform patients of these obligations; and what role providers should play in this initiative,"
- CMS fact sheet

Sources: HFMA, *Online Posting of Charges Among New Medicare Rules Proposals,* Rich Daly, 4/25/18; CMS Fact Sheet 4/24/18 *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

2019 IPPS Proposed Rule (4/25/18) - Policy Changes

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The proposal would remove from the inpatient quality-reporting program 18 measures that are "topped out" or no longer relevant, or for which the burden of data collection outweighs the value

CMS proposed updating the scoring approach for the hospital-acquired conditions, readmissions, and value-based purchasing programs

The EHR Incentive Programs **(which include CAHs)** would be renamed the "Promoting Interoperability Programs." CMS also proposed a more flexible, performance-based approach to determining whether a hospital has met the EHR requirements to avoid a payment penalty under Medicare.

The rule included a request for information (RFI) to invite EHR interoperability ideas

CMS proposed that hospitals be required to report only four electronic clinical quality measures for one quarter and that the number of eligible measures be reduced. A new scoring mechanism would allow hospitals to receive points on measures under four objectives: e-prescribing, health information exchange, provider-to-patient exchange, and public health and clinical data exchange.

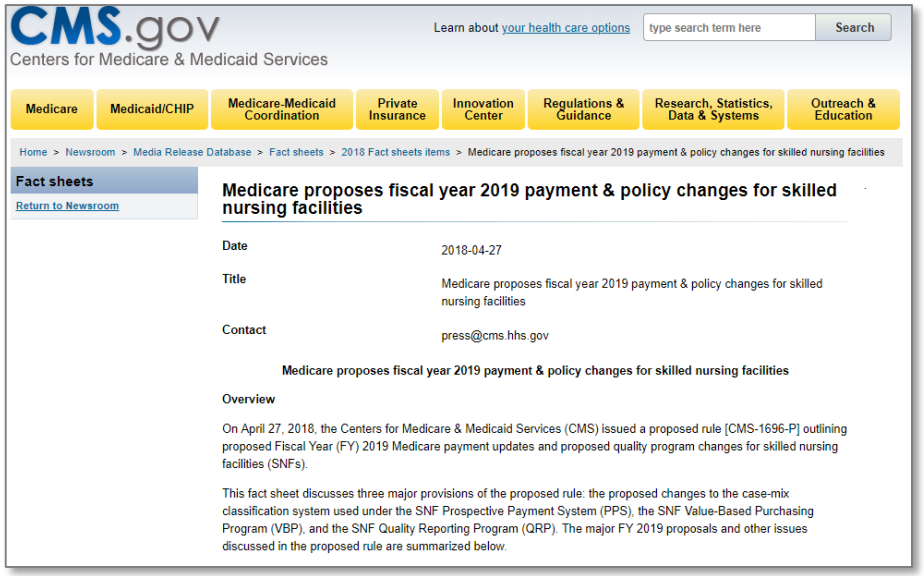
CMS would modify some measures in Stage 3 of Meaningful Use and remove six measures

The agency also proposed to add two measures related to opioid treatment

Sources: Becker's Hospital CFO Report, *CMS releases 2019 IPPS proposed rule: 10 things to know,* Emily Rappleye, 4/25/18 https://www.beckershospitalreview.com/finance/cms-releases-2019-ipps-proposed-rule-10-things-to-know.html

Proposed FY2019 Payment/Policy Changes for SNFs (4/27/2018)

- The proposed rule has three major provisions:
  - SNF Prospective Payment System (PPS)
  - SNF Value-Based Purchasing Program (VBP)
  - SNF Quality Reporting Program (QRP)
- The proposed changes continue a commitment to shift Medicare payments from volume to value, with continued implementation of the SNF VBP and SNF QRP
- CMS also proposes a new case-mix model that focuses on the patient's condition and resulting care needs rather than on the amount of care provided
- CMS estimates an increase of $850 million in Medicare payments to SNFs, resulting from the FY 2019 SNF market basket update required to be 2.4 percent by the Bipartisan Budget Act of 2018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Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities

Date 2018-04-27

Title Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities

Contact press@cms.hhs.gov

Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities

Overview

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [CMS-1696-P] outlining proposed Fiscal Year (FY) 2019 Medicare payment updates and proposed quality program changes for skilled nursing facilities (SNFs).

This fact sheet discusses three major provisions of the proposed rule: the proposed changes to the case-mix classification system used under the SNF Prospective Payment System (PPS), the SNF Value-Based Purchasing Program (VBP), and the SNF Quality Reporting Program (QRP). The major FY 2019 proposals and other issues discussed in the proposed rule are summarized below.

Source: cms.gov Fact Sheet 4/18/27 Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html

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Modernizing the SNF PPS Case-mix Classification System

- The RCS-I case mix model will now be called the SNF Patient-Driven Payment Model (PDPM) and be implemented by 10/1/2019
- The proposed new case-mix model, PDPM, would focus on clinically relevant factors, rather than volume-based service for determining Medicare payment
  - PDPM would adjust Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs)
  - It would further adjust the SNF per diem payments to reflect varying costs throughout the stay and incorporate safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals.
- SNF PDPM would reflect an approximately 80% reduction in the number of payment group combinations compared to the RCS-I,
- PDPM would also make greater use of certain standardized items for payment calculations, such as in using function items also used for the SNF QRP
- PDPM would simplify complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years)

Source: cms.gov Fact Sheet 4/18/27 Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html

Medicare's Proposed FY2019 Payment and Policy Changes for SNFs

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SNF Quality Reporting Program (QRP)

- The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and swing-bed rural hospitals *except for critical access hospitals.*
  - SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the annual market basket percentage update
- CMS proposes to:
  - Publicly display the four SNF QRP assessment-based quality measures, and increase the number of years of data used to display two claims-based SNF QRP measures, Discharge to the Community and Medicare Spending per Beneficiary, from 1 year to 2 years
  - Codify policies that have been finalized under the SNF QRP

SNF Value-Based Purchasing Program (VBP)

- Beginning 10/1/18, the SNF VBP Program will apply either positive or negative incentive payments to SNFs based on their performance on the program's readmissions measure
- The FY 2019 proposed rule proposes updates to policies, including the performance and baseline periods for the FY 2021 SNF VBP Program year, an adjustment to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception (ECE) policy

Source: cms.gov Fact Sheet 4/18/27 Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html

Azar Lays Out Agenda for Value-Based Care (3-6-2018)

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*"**There is no turning back to an unsustainable system that pays for procedures rather than value.** In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us. This administration and this President are not interested in incremental steps. We are unafraid of disrupting existing arrangements simply because they're backed by powerful special interests."*

- In an address to the Federation of American Hospitals on March 5, Secretary Azar laid out his four priorities for value-based care transformation

Give consumers control over their health information through improved HIT. Azar advocated for "putting the technology into the hands of the patients themselves," stressing the importance of empowering consumers.

Increase transparency. Azar stated that boosting transparency of services will help patients better shop for care, citing personal experience. He believes that Americans have the right to know what healthcare services and pharmaceuticals will cost.

Use of MACRA and CMS Innovation Center. The secretary cited the importance of Medicare and Medicaid in value-based transformation and cost control. He advocated for tools such as MACRA and the CMMI's ACOs that are already in place and asserted that "we will use these tools to drive real change in our system."

Reduce government burdens. Azar referred to regulatory burdens such as certain Medicare and Medicaid price reporting rules, restrictions in some FDA communication policies, and current interpretations of various well-meaning anti-fraud protections.

Sources: HHS.gov https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html; Politico.com, *What Alex Azar wants on value-based care (and how it resembles Obama's goals),* Dan Diamond 3/6/2018 https://www.politico.com/newsletters/politico-pulse/2018/03/06/what-alex-azar-wants-on-value-based-care-and-how-it-resembles-obamas-goals-123351

Senate Considers Global Budgets for Rural Providers (5/24/2018)

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- Senate Finance Committee rethinking Medicare payment policy for rural hospitals, honing in on global budget demonstrations
- Global budgets aim to give rural hospitals resources to test ways to build up population health, addressing rural hospitals' dependency on fee for service payments by Medicare and Medicaid
- In Pennsylvania's global payment model demo, hospitals receive a fixed sum for inpatient and outpatient services by all payers including Medicare
- Leaders of a rural hospital system and small insurance plans whose networks focus on rural areas offered testimony to the Committee and called for different Medicare payment models that give critical access hospitals room to change their operating model to limit inpatient beds, stressing how hard it is for rural hospitals to recruit and keep physicians

Source: Modern Healthcare, *Senate committee eyes global budgets for rural Providers,* Susannah Luthi, May 24, 2018 http://www.modernhealthcare.com/article/20180524/NEWS/180529959

CMS Rural Strategy 2018: Summary (5/10/2018)

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After a series of listening sessions with rural stakeholders and consumers, CMS has developed a rural health strategy that focuses on five objectives:

- Apply a rural lens to CMS programs and policies
- Improve access to care through provider engagement and support
- Advance telehealth and telemedicine
- Empower patients in rural communities to make decisions about their health care
- Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

Source: cms.gov, CMS Rural Strategy https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

CMS Rural Strategy 2018: Activities

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- The activities CMS plans to undertake to support this strategy are as follows.

Apply a Rural Lens to CMS Programs and Policies

- Utilize the "Optimizing CMS Policies and Programs for Health Equity Checklist" to review relevant policies, procedures, and initiatives for possible impacts on rural health insurance plans, providers, or communities
- Identify and accelerate diffusion of promising, evidence-based practices to improve access to services and providers in rural communities

Improve Access to Care Through Provider Engagement and Support

- **Scope of Practice:** Explore options to increase the number of trained and licensed allied health professionals able to provide health care in rural communities.
- **Meaningful Measures:** Implement a new approach to quality measurement that focuses on value rather than volume. Review and revise current quality measures, and align quality measurement activities with other industry measurement.
- **Technical Assistance:** Provide technical assistance to providers to help them comply with policies, and implement CMS policies and initiatives to develop or transform their practice. Provide technical assistance on quality measure reporting to rural providers in support of quality improvement. Leverage CMS contractors and others to foster quality improvement efforts by rural providers through the submission of quality measures, data analysis, and provider engagement and outreach.
- **Transportation:** Explore opportunities within existing CMMI fraud and abuse waivers that could cover certain transportation services. Include transportation and telehealth flexibilities within new CMMI models where appropriate.

Source: cms.gov, CMS Rural Strategy https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

CMS Rural Strategy 2018: Activities, cont.

- The activities CMS plans to undertake to support this strategy are as follows.

Advance Telehealth and Telemedicine

- Explore options for modernizing and expanding telehealth through CMMI models and demonstrations, such as the Next Generation Accountable Care Organization Model, Frontier Community Health Integration Project Demonstration, and Bundled Payments for Care Initiative advanced model

Empower Patients in Rural Communities to Make Decisions About Their Health Care

- Collaborate with rural communication networks to develop and disseminate easy-to-understand materials to help rural patients navigate the health care system
- Foster the empowerment and engagement of rural patients in their health care through targeted outreach efforts

Leverage Partnerships to Achieve the Goals of the CMS Rural Health Strategy

- Explore opportunities with the Office of the National Coordinator for Health Information Technology and other federal partners to promote interoperability and increase utilization of electronic health records for quality improvement in rural areas
- Work with federal and state partners such as the Federal Office of Rural Health Policy, to understand and evaluate the impacts of CMS programs on rural communities, and develop recommendations as appropriate
- Convene CMS and health plan representatives to discuss challenges and strategies to increase participation of health plans in rural areas
- In coordination with the Centers for Disease Control and Prevention and other federal partners, increase the focus on maternal health, behavioral health, substance use disorders, and the integration of behavioral health and primary care

Source: cms.gov, CMS Rural Strategy https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

Blueprint to Reduce Prescription Drug Prices (5/11/2018)

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- Administration released the policy plan to reduce prescription drug prices, "American Patients First"
- The plan focuses on four central goals:

Increasing competition, including:

- Steps to prevent manufacturer gaming of regulatory processes such as Risk Evaluation and Management Strategies (REMS)
- Measures to promote innovation and competition for biologics
- Developing proposals to stop Medicaid and Affordable Care Act programs from raising prices in the private market

Easing negotiation, including:

- Experimenting with value-based purchasing in federal programs
- Allowing more substitution in Medicare Part D to address price increases for single-source generics
- Reforming Medicare Part D to give plan sponsors significantly more power when negotiating with manufacturers
- Leveraging the Competitive Acquisition Program in Part B.
- Working across the Administration to assess the problem of foreign free-riding

Creating incentives to lower prices, including:

- FDA evaluation of requiring manufacturers to include list prices in advertising
- Updating Medicare's drug-pricing dashboard to make price increases and generic competition more transparent
- Reforms to the 340B Drug Discount Program

Lowering out-of-pocket spending on drugs, including:

- Prohibiting Part D contracts from preventing pharmacists' telling patients when they could pay less out-of-pocket by not using insurance
- Improving the usefulness of the Part D Explanation of Benefits statement by including information about drug price increases and lower cost alternatives

Source: HealthLeadersMedia, *What's in Trump's 'American Patients First' Plan?,* HealthLeaders Media Staff, May 11, 2018
http://www.healthleadersmedia.com/leadership/whats-trumps-american-patients-first-plan?page=0%2C1

Blueprint Targets 340B Program, Threatening Rural Hospitals

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- Proposed strategies to reduce prescription drug prices are cuts to the 340B Drug Pricing Program
  - This proposed action follows CMS 340B cuts that began in January 2018 and reduced Medicare payment for 340B program drugs from the average sales price (ASP) plus 6 percent to ASP minus 22.5 percent.
- **The 340B policy changes proposed in the new report, many of which would require legislative approval, would ensure hospitals paid under Medicare Part B deliver more than one percent of their patient costs in charity care in order to receive the discounts available in the program.** Specific changes included:
  - ✓ Changing the definition of patient
  - ✓ Changing the requirements governing covered entities that contract with pharmacies or registering off-site outpatient facilities
  - ✓ Revisiting current mechanisms for identifying and preventing duplicate discounts
  - ✓ Bolstering oversight or claims standards to prevent duplicate discounts in Medicaid and other programs
- Those ideas followed recommendations in the proposed FY19 budget, which suggested mandating that 340B benefits be shown to help patients
- *As savings from the 340B program provide a lifeline for struggling rural hospitals, hospital leaders and members of Congress have expressed deep concern that the proposed cuts could have a drastic negative impact on rural hospital finances and patient access to care*

Sources: hfma.com, *340B Targeted in Trump Administration Drug Push,* Rich Daly, 5/15/18; HHS.gov, *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs,* May 2018; revcycleintelligence.com, *Pres Trump Eyes 340B Drug Reforms to Lower Prescription Drug Costs,* Jacqueline LaPointe, May 11, 2018 https://revcycleintelligence.com/news/pres-trump-eyes-340b-drug-reforms-to-lower-prescription-drug-costs

Walmart-Humana Strong Sign of Healthcare Industry Consolidation Trend (4-11-2018)

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- Per The Wall Street Journal, Walmart plans to purchase Humana for $69 billion, the biggest acquisition so far for Walmart
- This acquisition is just one in a disruptive trend as the healthcare industry rapidly merges with the retail world. Other examples include
  - Cigna's purchase of Express Scripts
  - CVS Health deal to buy Aetna
  - Lyft's deal with AllScripts
- Per David Friend, MD, chief transformation officer and managing director of the Center for Healthcare Excellence & Innovation with the consulting firm BDO, "Medicare Advantage (MA) is the future of healthcare…Humana is a key player in the MA market. So together, Walmart and Humana stand to rule the future healthcare world."

"Walmart-Humana signifies the beginning of the avalanche that will cause the entire healthcare system to converge…Traditional healthcare, retail, and technology companies will unite behind a singular goal—survival."
-David Friend, MD

Source: HealthLeadersMedia, *Walmart-Humana 'Signifies the Beginning of the Avalanche' in Healthcare,* Gregory A. Freeman, 4/11/18
http://www.healthleadersmedia.com/health-plans/walmart-humana-signifies-beginning-avalanche-healthcare

Substitution

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Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care

By NICK WINGFIELD, KATIE THOMAS and REED ABELSON JAN. 30, 2018

- Partnership to provide healthcare to organizations' employees and eventually expanded to benefit all Americans
- "Free from profit-making incentives and constraints" (Jamie Diamond, CEO JPMorgan Chase)
- "Reducing health care's costs and burden on the economy while improving outcomes would be worth the effort" (Jeff Bezos, CEO Amazon)

Source: New York Times, January 30, 2018

Value of Primary Care Providers

RELATED CONTENT

UnitedHealth's Optum to buy DaVita Medical Group for $4.9 billion

By Erica Teichert | December 6, 2017

UnitedHealth Group has agreed to buy dialysis provider DaVita's medical unit for $4.9 billion in cash to expand the national insurer's outpatient care services, the company said Wednesday.

- UnitedHealth Group will become one of the largest physician employers in the US
  - OptumCare will employ or be affiliated with 30,000 physicians and expand 30-market operation to 75 markets
  - Shielding itself from hospitals and steering patients to lower priced care outside the hospital

Source: Modern Healthcare, December 6, 2017

Insurers' Disruptive Growth Strategies Pose Threat to Hospitals

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Per Moody's, health insurers are engaging in new, disruptive growth strategies aimed at lowering healthcare spending that threaten the credit quality of not-for-profit hospitals

- **Hospitals will be vulnerable to direct competition as insurers purchase providers.** The purchase of these providers (the CVS-Aetna merger is a prime example) move care away from higher-cost hospital settings.
- **Health insurers are moving to value-based payment models that emphasize quality over quantity of care, leaving hospitals with less volume.** By owning physicians, insurers can take greater control of premiums and expenses, including those related to hospital care.
- **Hospital revenues and margins will come under additional pressure as insurers gain negotiating power**. When negotiating contracts, insurers will benefit from increased scale. At the same time, hospitals are becoming increasingly reliant on commercial payments to cover operating costs as governmental payors reduce rates. As insurers impose more restrictions on what types of care they will provide coverage for, hospitals will be vulnerable to rising bad debt levels and fewer emergency room visits.

Source: Moody's Investors Service, *Sector in-Depth: Not-for-profit and public healthcare – US. Hospitals face new threat from health insurers' disruptive growth strategies*