McFaul - Regardless of the final strategy for Medicare to dramatically reduce its spiraling expenses, current “experiments” will lead into a form of completive bidding between providers for Medicare and Medicaid enrollees based on costs for covered lives. The initiative will focus on prevention and value-based reductions in current treatment strategies.

Timing for transitioning to retail primary care (e.g. CVS, Walmart, Walgreen models) based on competitive bidding is also inevitable.

With the loss of 50+% of all patients to CMS bid winners and retail primary care centers, the industry will become acute care inpatient and surgical entities that will also be forced to compete based in a TBD covered life formulae.

Summary

Provider leadership at nearly all systems and networks has had the ability to increase top line revenue through fee-for-service activity. Bottom line margins have depended upon performance improvement companies with their revenue derived from “Safe Harbor” legislation that allows for rebates and fees (legal kick-back processes).

Over the past six months, the costs associated with middlemen have surfaced as a problem that a factor for healthcare expenses being 18+% of GDP. Refer to the following for discussion purposes:

http://www.mcfip.net/upload/GPO%20Money%20Flow.pdf

The healthcare delivery industry is already in the stage of disruption (aka Clayton Christensen’s theories for innovators dilemma).

Historic paths for top line and bottom line fiscal opportunities are obviously not sustainable. Innovative system and network leaders are starting to follow the example of Haven (the Amazon initiative that is

focused on the reduction of self-insured healthcare expenses for their 1.2 million employees as the means of enhancing their bottom line).

Theories for how Haven is likely to morph into retail primary care service centers as a means of increasing top line revenue can be discussed with interested parties.

The specific strategies for fiscal survival of systems and networks are coming into focus. Current options can vary but the common factor is the ability to prevent or cost effectively treat chronic diseases based on comparative effectiveness for cost/quality that will be driven by business strategies that utilize competition.

https://www.hpnonline.com/regulatory/article/21073977/new-navigant-analysis-paints-three-whatif-scenarios-in-the-face-of-medicare-expansion

New Navigant analysis paints three "what-if" scenarios in the face of Medicare expansion

MARCH 29, 2019

In a new paper by Navigant, the organization considers three different hypothetical financial outcomes that hospitals would face if Medication (sp Medicare) expansion were to happen. The researchers point out that hospitals already receive a lot less reimbursement from Medicare than they do from private payors and that an expansion would stress hospital revenues even further, particularly in a time when increasing numbers of aging baby boomers are enrolling in the government program. In 2016, hospitals lost almost $50 billion treating Medicare patients because of the disparity between the delivered cost of care and Medicare's current payment rates.

In their analysis, the authors created a hypothetical medium-sized regional, non-profit multi-hospital system called "Excelsior Health System" which has 1,000 beds across five hospitals, annual combined patient revenues of about $1.2 billion, and a current operating margin of 2.3 percent. Its commercial insurance contracts pay about 200

percent of Medicare rates, and represent approximately 25 of patient volume by charges.

Here is a snapshot of the three hypothetical policy scenarios (minus Medicare Advantage plans) Excelsior could face during a Medicare expansion:

· **Voluntary Medicare buy in after age 50:** In this scenario, the researchers suggest the financial impact to Excelsior would be minimal. Self-pay patient write-offs would be reduced but offset by fewer payments for the people who would be shifting off of the exchange/commercial plans to the Medicare rate. These shifts could, hypothetically, result in a $9.6 million reduction in revenues, leaving the system with a 2 percent positive operating margin. However, what if half of the employer-insured 50+ population shifts to the new plan? Then, suggests the analysis, Excelsior's revenues would drop by $97 million and reduce the operating margin from +2.3% to -5.1%.

· **Medicare as a public option:** In the public option scenario the suggested negative margin impacts are worse. Assuming Medicare rates remain at current levels (i.e., 100 percent Medicare rate), hospital revenues could, hypothetically, drop approximately $153 million and margins would drop -6.3%. But if Medicare rates increase 10 percent hospital revenues would then drop to $97 million, with a new margin of -5.7%.

· **Medicare as a single-payer (excluding Medicaid):** This last hypothetical scenario is the most discouraging, as expected, and "eviscerates Excelsior's operating margins, reducing revenues by approximately $330 million and leaving a new margin of -22," the analysts wrote. However, if Medicare were to raise payment to 120 percent of the current Medicare rates (something the authors said could happen for political reasons), "Excelsior loses 'only' about $158 million in revenue, resulting in a new margin of -14 percent."

Access the full paper for supporting details.