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pulse

Modernization for Medicare Proposed by CMS

Medicare could have a whole new look in the near future.

The Centers for Medicare & Medicaid Services' proposed changes for Medicare, available for public comment through Sept. 10, are expected to increase patient visit time with doctors and clinicians and reduce the paperwork burden for billing, CMS reports in a news release.

"The proposed rules would fundamentally improve the nation's health care system and help restore the doctor-patient relationship by empowering clinicians to use their electronic health records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes," CMS reports.

"Today's reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost," U.S. Department of Health and Human Services Secretary Alex Azar said in the news release. "Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS's proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork."

Under the proposals, Medicare payment policies would promote access to virtual care, ultimately saving beneficiaries time and money and improving their access to high-quality services in any location, according to the news release.

Clinicians and doctors are expected to see a significant rise in their productivity if the proposed changes are approved, which means better and more efficient care for patients.

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>
> – CMS Administrator Seema Verma

"Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care," said CMS Administrator Seema Verma. "This administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

Beneficiaries could connect with their doctor first using technology to evaluate if they need an in-person visit and the technology would also allow for, and encourage, information sharing among health care providers.

For example, lowering the paperwork burden associated with Medicare billing would save individual providers approximately 51 hours in time per year if 40 percent of their patients are enrolled in Medicare, according to CMS.

CMS is also focusing on advancing virtual care.

"CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals that will help beneficiaries' access high-quality services in a convenient manner," Verma said in the news release.

Virtual care will help Medicare beneficiaries in rural or urban areas who may face challenges getting to the doctor for routine visits. Innovative

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ANALYSIS

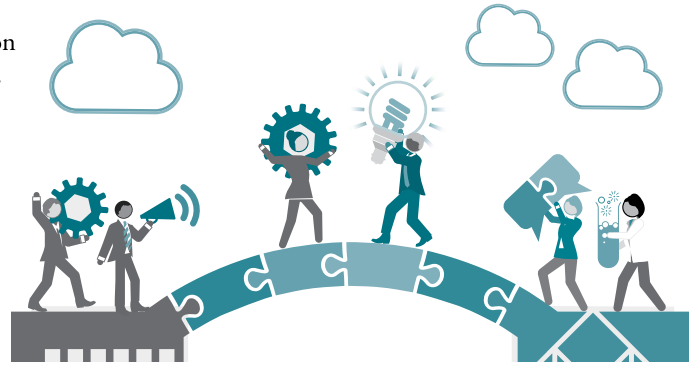
Health Care Merger and Acquisition Activity Builds Momentum

Merger and acquisition activity in the health care sector remains strong this year, particularly for not-for-profit hospitals and health systems, according to an analysis by Kaufman Hall.

The number of total transactions reached 50 in the first half of this year. In the second quarter alone, 16 of 21 transactions occurred among not-for-profit hospitals and health systems compared to five transactions among for-profit health care providers, according to the analysis (https://bit.ly/2LDRvKV). "When combined with first quarter results, more than 76 percent of deals announced in the first half of 2018 involve not-for-profit acquirers, while less than 24 percent involve for-profit acquirers."

"Not-for-profit hospital and health system leaders nationwide are moving aggressively to broaden their organizations' base and expand their presence, extending capabilities across larger geographies in order to address continued uncertainty in the industry," Anu Singh, managing director at Kaufman Hall, said in a news release.

Revenue cycle management vendors for the health care industry should take note of these trends, according to Corporate Advisory Solutions (CAS), which recently published its second quarter report on merger and acquisition activity (https://bit.ly/2mMr1ZO)



"This consolidation is positive for patients, increasing the quality of care to a larger population, but vendors will need to be larger and offer a wide breadth of service offerings to remain competitive," according to the report.

Overall, CAS reports the revenue cycle management (RCM) services sector bounced back to a "normal" volume of mergers and acquisitions after a quiet first quarter. There were five deals totaling a combined enterprise value of $987 million in the second quarter.

"The RCM industry continues to experience robust growth, which is expected to persist moving forward," CAS reports.

Hospital merger and acquisition activity also continues at a fast pace which, according to data from the Healthcare Financial Management Association, included 25 transactions in the first half of this year, CAS reports.

The industry is benefiting from growing health care expenditures which, CAS and the Altarum Institute report, are surpassing growth in the GDP. Year-over-year spending increased from 4.5 percent in December 2017 to 4.9 percent in February this year, according to the Altarum Institute.

"Within the industry, a push from local governments and advocacy groups for increased price transparency may positively re-shape how consumers make decisions about their health care [expenditures.] A less opaque structure will surely cause prices to drop across the board, strongly benefiting individuals," CAS reports.

Finally, advances in telehealth bolster consolidation of health care systems as patients have access to personalized care at home and break away from the traditional care model. Among other trends to watch, according to CAS, providers continue their move toward value-based care payment structures.

See Data Watch for a graph depicting the CAS findings on RCM mergers and acquisitions in the second quarter.

Modernization for Medicare *cont. from page 1*

technology that enables remote services can increase access to care and establish more opportunities for patients to access personalized care management as well as connect with their physicians quickly, according to CMS.

CMS is also advancing efforts to lower prescription drug and out-of-pocket costs.

"CMS is proposing a change in the payment amount for new drugs under Medicare Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective Jan. 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices," according to the news release.

Finally, CMS has issued a Request for Information on price transparency, specifically to determine if providers and suppliers can and should be mandated to inform patients about cost and payment requirements for health care and out-of-pocket expenses, the data elements that would be most helpful to encourage price shopping and what other updates are necessary to benefit health care consumers.

More information on all proposed changes from CMS: https://go.cms.gov/2vRLVho

STUDY

State Health Care Mandates Would Lower Uninsured Rate

Millions of U.S. consumers would gain access to health insurance while their premium expenses would decline if all states implemented their own health care mandates, according to a study from The Commonwealth Fund and Urban Institute.

Massachusetts and New Jersey have mandates and, if every state followed their lead, nearly four million consumers would have health insurance and premium costs would decline by an average of almost 12 percent, according to a news release from The Commonwealth Fund.

"These mandates would replace the Affordable Care Act's penalty for not having health insurance, a fee that Congress eliminated, effective 2019," it states.

Currently, the Affordable Care Act requires most Americans to have an insurance plan or face a financial penalty in an effort to "stabilize insurance markets by encouraging healthy people to purchase and stay enrolled in a health plan," The Commonwealth Fund reports.

The Congressional Budget Office expects premiums will rise and more consumers will lose their health insurance when the penalty is eliminated in January 2019.

However, according to The Commonwealth Fund and Urban Institute Study, if states take the reins and create their own mandates:

- Millions more consumers would have health insurance. In fact, enacting state individual mandates across the country in 2019, when the federal penalties are lifted, would lower the number of uninsured by 3.9 million—or 11.4 percent.
- If all states enacted their own mandate, health care premiums would decline an average of 11.8 percent. The impact on premium rates would differ across states based on how many healthy people sign up in the marketplaces again. In New Mexico, for example, premiums would decline by more than 20 percent and Colorado, the District of Columbia, Kentucky, Nevada, North Dakota, Washington, and West Virginia would see declines of more than 15 percent.

The study also shows uncompensated care costs for health care providers would significantly decline. "When patients are uninsured and can't pay their medical bills, state and federal governments, as well as physicians, hospitals and community health centers, absorb the costs of this uncompensated care," according to the news release. "As more people gain coverage mandates, demand for uncompensated care would fall by $11.4 billion nationally.

States can also enact comparable mandate penalties to those at the federal level to mitigate any negative effects of eliminating the penalties under the Affordable Care Act.

The study's authors, Linda Blumberg, Matthew Buettgens and John Holahan from the Urban Institute note that there are significant challenges to getting state-level mandates off the ground.

"Some states, for example, do not have state income taxes, and new financial structures would have to be developed to collect individual mandate penalties," they report. "Other state political environments are not conducive to enacting individual mandate legislation, even in states where governors and state policymakers generally support the [Affordable Care Act.]"

More information: https://bit.ly/2mKefe5

NEWS & NOTES

The Impact of Medical Bill Troubles

The Kaiser Family Foundation's June Health Tracking Poll of adults ages 18-64 shows nearly 60 percent of those reporting problems paying medical bills say it has a "major impact" on their family. A majority, 74 percent, say they cut back on other household expenses to pay their medical bills. Sixty-eight percent say they put off a vacation or major household purchases; 58 percent say they use up all or most of their savings; 51 percent say they take a second job or work more hours; while 41 percent say they take on more credit card debt. https://kaiserf.am/2AeWhKr

Register for Seminar on Health Care Collection Management

Explore the ways in which health care collections differ from other collection practices while you discover successful strategies for working with different types of accounts in a Sept. 18-20 seminar. ACA International will provide education on the life cycle of a health care account as it pertains to collections, strategies for working with self-pay and Medicare accounts and more. https://bit.ly/2LnaiL4

We Want To Hear From You

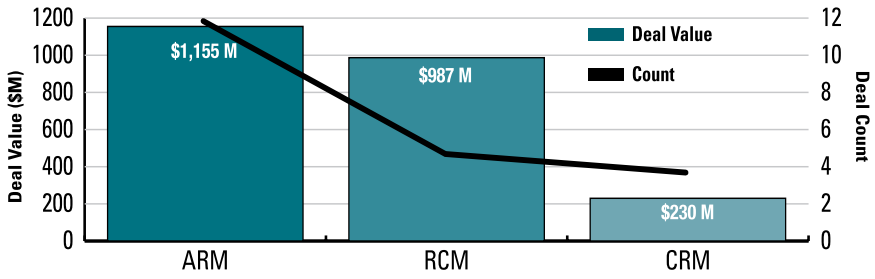
Pulse is published for ACA health care collection agencies to provide current industry information for health care providers. ACA International welcomes article ideas and submissions for consideration in *Pulse* to the Communications Department at comm@acainternational.org.

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse.

datawatch

How Revenue Cycle Management Deals Measure Up

Revenue cycle management deals in the second quarter 2018 reached $987 million, according to the Corporate Advisory Solutions second quarter report on merger and acquisition activity. There were five RCM deals in the second quarter. By comparison, there were 11 deals in the accounts receivable management sector for a combined enterprise value of $1.16 million and three deals in customer relationship management totaling $230 million.



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