Dext Capital Quarterly Industry Update 2Q2022

Inflation, recession, supply chain, oh my!

Hospitals and healthcare systems face unprecedented challenges as rising drug, labor, and supply costs eat away at thin operating margins. At the same time, the proposed Medicare Hospital Inpatient Prospective Payment System (IPPS) is deemed inadequate by providers.

Proposed Changes to Payment Rates under IPPS The proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is projected to be 3.2%. This reflects an FY 2023 projected hospital market basket update of 3.1%, reduced by a projected 0.4 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by statute.

Hospitals may be subject to other payment adjustments under the IPPS, including:

• Payment reductions for excess readmissions under the Hospital Readmissions Reduction Program;

• Payment reduction (1 percent) for the worst-performing quartile under the Hospital-Acquired Condition Reduction Program;

• Upward and downward adjustments under the Hospital Value-Based Purchasing Program.

The proposed increase in operating and capital IPPS payment rates, partially offset by decreases in outlier payments for extraordinarily costly cases, will generally increase hospital payments in FY 2023 by $1.6 billion. In addition, CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments combined will decrease in FY 2023 by approximately $0.8 billion. Subject to determinations on applications for additional payments for inpatient cases involving new medical technologies following a review of public comments on the proposed rule, CMS also estimates that these payments will decrease by $0.8 billion in FY 2023. Under current law, additional payments for Medicare Dependent Hospitals and the temporary change in payments for low-volume hospitals are set to expire in FY 2023. In the past, these payments have been extended by

legislation, but if they were to expire, CMS estimates that payments to these hospitals would decrease by $0.6 billion.

AHA Lobbies Congress to Call on CMS to Increase IPPS

The American Hospital Association (AHA) urged Congress to call on the Centers for Medicare & Medicaid Services (CMS) to make changes to the hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2023 in order to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care to patients and communities.

The current inflationary economy combined with the COVID-19 pandemic has put unprecedented pressure on America's hospitals and health systems. They remain on the front lines continuing to care for COVID-19 patients, as well as all other patients that walk through their doors. Historic inflation has extended and heightened the already severe economic instability brought on by the pandemic resulting in razor-thin operating margins from massive surges in input costs, including a struggling workforce, drug costs, supplies and equipment. Even slight increases in expenses have dramatically negatively affected many hospitals' operating margins, jeopardizing their ability to care for patients. On top of these unprecedented challenges, hospitals and health systems are now facing additional financial pressures from CMS. It is imperative for CMS to make meaningful changes to the IPPS proposed rule for FY 2023 to ensure hospitals are accurately paid for the care they provide to their communities. CMS' proposed market basket update of 3.2% for FY 2023 as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the current unprecedented inflationary environment. Since the market basket and associated productivity update use historical data to forecast the future, the current rising inflation and massive growth in expenses facing hospitals and health systems were not adequately considered in the estimates. More recent data shows the market basket for FY 2022 is trending toward 4.0%, well above the 2.7% CMS actually implemented last year.

Congress should urge CMS to implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022. In addition, Congress should urge CMS to eliminate the productivity cut for FY 2023. These two critical changes to the

IPPS proposed rule would help to more accurately reflect the cost of providing health care and provide hospitals and health systems with some of the resources needed to continue to help their patients and communities. We look forward to working with you to make certain these improvements are implemented in the final IPPS rule.

Hospital Labor, Drug, and Supply Costs

America's hospitals and health systems continue to face unprecedented financial pressures due to the ongoing effects of the COVID-19 pandemic and the current inflationary economy. Historic inflation has extended and heightened the already severe economic instability brought on by the pandemic resulting in razor-thin operating margins from massive surges in input costs, including a struggling workforce, drug costs, supplies, and equipment. Even slight increases in expenses have dramatically negatively affected many hospitals' operating margins, jeopardizing their ability to care for patients and communities. Taken together, these shifts, even after accounting for changes in volume that occurred during the pandemic, hospital expenses per patient increased significantly from pre-pandemic levels. By the end of the calendar year (CY) 2021, total hospital expenses per adjusted discharge were up 20.1% compared to pre-pandemic levels in 2019. Further exacerbating the problem for hospitals are Medicare sequestration cuts and payment rates that are well below cost increases. These levels of increased expenses and operating margin declines are not sustainable. Additional support and resources are needed to protect patients' access to care.

On top of these extraordinary challenges, hospitals and health systems are now facing additional, unnecessary financial pressures from the Centers for Medicare & Medicaid Services (CMS) proposed hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2023. The rule's proposed payment updates and policy changes would result in a net decrease in payments to IPPS hospitals in FY 2023 compared to FY 2022. CMS estimates were produced using historical data that in a steady-state economy may predict the anticipated rate of cost increases with some accuracy to determine provider reimbursements. The end of CY 2021 into CY 2022 should not, in any sense, be considered a steady-state economic environment representative of past trends. As a result, the proposed market basket and productivity update will inadequately reimburse hospitals and health systems.

Cost Plus Drugs Formulary in the Works

A formulary is in the works, and potential clients have a "very strong interest" in a pharmacy benefit manager from Mark Cuban's generic drug company, Cost Plus Drug Co. "We are open to conversations with all stakeholders, whether manufacturer, distributor, insurer, etc., that furthers our goal of being the low-cost provider," Mr. Cuban told Becker's.

Though no launch date for the PBM has been publicly announced, Cost Plus CEO Alex Oshmyansky, MD, Ph.D., told The Wall Street Journal in October that 2023 is the goal. Once the formulary is where they "need it to be," the new company will be able to begin sharing drug costs, markups, and pass-through fees, with the ultimate goal of creating more savings for consumers, according to Mr. Cuban.

"The supply chain for distributing pharmaceuticals to patients is so cumbersome and broken," Dr. Oshmyansky told the Journal. "We decided the only way to get our drugs to the people who need them is to build a parallel supply chain where we have control of all the intermediary players and ensure the same level of transparency at every level."

Cost Plus launched in January 2021 with the objective of producing affordable versions of expensive generic drugs and transparency around the costs to manufacture, distribute and market those drugs to pharmacies. With no middlemen or rebates for payers, the company adds a 15 percent margin for wholesale prices and overall profit. With about 100 drugs in its arsenal from launch, the drug company has since upgraded to sell more than 700 medications, ranging from pain relief and allergy pills to heart health and cancer drugs, according to its website.

A recent study found that if Medicare employed the same prices as Cost Plus for generic medications, the program could have saved Medicare recipients up to $3.6 billion in 2020 alone. Mr. Cuban tweeted the results and told President Joe Biden to "have your people call my people and let's get this done." But for Cost Plus to take a bigger step into the industry, it needs a PBM that isn't structured like those owned by major payers, which Mr. Cuban likens to club bouncers. "They're the ones who say, 'Hey, I'm controlling access to all the big insurance companies. If you want this insurance company to sell your drug, you've got to pay the cover charge,'" he told NPR in February. "All these drugs pay the cover charge to these PBMs through rebates, and because they're paying the cover charges, the prices are jacked

up. We said we're going to create our own PBM, we're going to work directly with the manufacturers, and we're not going to charge the cover charge."

Though nearly 80 percent of the nation's PBM market is controlled by just three payers — and 97 percent by the largest six — Mr. Cuban said his PBM can compete and be profitable, all while sharing operating cost details and passing on 100 percent of rebates to clients.

"If you make money on drugs, you're in conflict with the intrinsic interest of the patient," Mr. Blackley said. "Things that should come out of new market entrants like ourselves or Mark Cuban's are the competition, the education of the market, and the recognition by employers and health plans that there are alternatives that can meet their needs."

It's a conflict that has garnered a lot of national attention as of late. Since May, bipartisan legislation has been introduced in Congress to create more regulations around the drug middlemen, which is currently awaiting a vote on the Senate floor. The Federal Trade Commission also launched an inquiry into the six largest PBMs and has put the industry on notice about a new enforcement policy against illegal bribes and rebate schemes. But starting alternative PBMs is challenging. It can take at least a year to build a national pharmacy network that offers both ample geographic coverage and an enticing value proposition for pharmacies, according to Mr. Blackley. At a minimum, that network should consist of one national pharmacy to anchor the network (such as CVS or Walgreens), one grocery or regional chain, and independent pharmacies, which make up a third of the U.S. pharmacy market.

Justice Department Charges Dozens for $1.2 Billion in Health Care Fraud

The Department of Justice today announced criminal charges against 36 defendants in 13 federal districts across the United States for more than $1.2 billion in alleged fraudulent telemedicine, cardiovascular and cancer genetic testing, and durable medical equipment (DME) schemes.

Additionally, the Centers for Medicare & Medicaid Services (CMS) and Center for Program Integrity (CPI) announced today that they took adverse administrative actions against 52 providers involved in similar schemes. The department seized over $8 million in cash, luxury vehicles, and other fraud proceeds in connection with the enforcement action.

The coordinated federal investigations announced today primarily targeted alleged schemes involving the payment of illegal kickbacks and bribes by laboratory owners and operators in exchange for the referral of patients by medical professionals working with fraudulent telemedicine and digital medical technology companies. Telemedicine schemes account for more than $1 billion of the total alleged intended losses associated with today's enforcement action. These charges include some of the first prosecutions in the nation related to fraudulent cardiovascular genetic testing, a burgeoning scheme. As alleged in court documents, medical professionals made referrals for expensive and medically unnecessary cardiovascular and cancer genetic tests, as well as durable medical equipment. For example, cardiovascular genetic testing was not a method of diagnosing whether an individual presently had a cardiac condition and was not approved by Medicare for use as a general screening test for indicating an increased risk of developing cardiovascular conditions in the future.

Some of the defendants charged in this enforcement action allegedly controlled a domestic and overseas telemarketing network that lured thousands of elderly and/or disabled patients into a criminal scheme. The owners of marketing organizations allegedly had telemarketers use deceptive techniques to induce Medicare beneficiaries to agree to cardiovascular genetic testing and other genetic testing and equipment.

The charges announced today allege that the telemedicine companies arranged for medical professionals to order these expensive genetic tests and durable medical equipment regardless of whether the patients needed them and that they were ordered without any patient interaction or with only a brief telephonic conversation. Often, these test results or durable medical equipment were not provided to the patients or were worthless to their primary care doctors. Prior to the charges announced as part of today's nationwide enforcement action and since its inception in March 2007, the Health Care Fraud Strike Force, which maintains 16 strike forces operating in 27 districts, has charged more than 5,000 defendants who collectively billed federal health care programs and private insurers approximately $24.7 billion.

Physician Payment Rule 2023

CMS released its annual proposed changes to the physician fee schedule for 2023 on July 7, which includes a proposed $1.53 conversion factor decrease.

Seven things to know:

1. The proposed physician fee schedule conversion factor for 2023 is $33.08, down from $34.61 in 2022. The proposal considers a statutory requirement that the conversion factor for 2023 remains flat as well due to the expiration of the 3 percent increase in physician fee schedule reimbursement payments in 2022 that was required in the Protecting Medicare and American Farmers From Sequester Cuts Act.

2. To help address the shortage of behavioral health practitioners, CMS proposes allowing licensed professional counselors, marriage and family therapists, and other behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. CMS is proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team.

3. CMS is proposing to bundle certain chronic pain management and treatment services into new monthly payments to improve patient access to team-based comprehensive chronic pain treatment. CMS is also proposing covering opioid treatment and recovery services from mobile units to increase access for homeless people or those living in rural areas.

4. CMS is proposing to incorporate advance shared savings payments to certain new Medicare shared savings program ACOs. This would be one of the first times traditional Medicare payments would be permitted for such uses, and CMS said it is expected to be an opportunity for providers in rural and other underserved areas to make investments needed to become an ACO. CMS is proposing that smaller ACOs have more time to transition to downside risk.

5. CMS is proposing a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations. It is also proposing benchmark adjustments to encourage more ACOs to participate and succeed. The goal is to have all traditional Medicare recipients in an accountable care relationship with a healthcare provider by 2030.

6. CMS is proposing to pay for dental services, such as dental examination and treatment, preceding an organ transplant. CMS is seeking comment on

other medical conditions where Medicare should pay for dental services, such as for cancer treatment or joint replacement surgeries.

7. The 60-day comment period closes on Sept. 6.

Rural Hospital Update

Out of 2,176 rural hospitals, 441 faces three or more risk factors, putting them at risk of service reduction or closure, according to a May 4 Bipartisan Policy Center report.

Eight things to know:

1. There were 116 rural hospital closures between 2010 and 2019.

2. Federal relief over the past two years helped stabilize facilities, and the pace of closures slowed.

3. That assistance was temporary; however, rural hospitals continue to struggle financially and have had difficulty recruiting nurses and other healthcare employees.

4. Financial risk factors rural hospitals face include negative total operating margin, negative operating margin on patient services alone, negative current net assets, and negative total net assets.

5. Rural hospital closures can significantly reduce access to healthcare services and affect healthcare workers' availability.

6. The Bipartisan Policy Center recommends providing rural hospitals across-the-board Medicare spending reductions until two years after the federal COVID-19 public health emergency ends.

7. It recommends permanently authorizing the Medicare Dependent Hospital program and making rural low-volume payment adjustments permanent.

8. It recommends updating or rebasing Sole Community Hospital and Medicare Dependent Hospital payment structures to ensure reimbursements are in line with current costs.

Other Items:

• Amazon.com Inc said it would buy primary care firm One Medical for $3.49 billion, adding brick-and-mortar doctors' offices to its arsenal as the e-commerce giant pushes deeper into healthcare. The all-cash deal heralds a dramatic expansion of Amazon's healthcare ambitions, having piloted virtual

care visits for Amazon employees in Seattle in 2019 before offering such services to other employers and in other cities under the Amazon Care brand. "We think healthcare is high on the list of experiences that need reinvention," said Neil Lindsay, senior vice president of Amazon Health Services. In One Medical, Amazon is aiming to acquire a company with brand-name customers such as Airbnb Inc and Alphabet Inc's Google, according to its website. One Medical is a primary care provider that offers both telehealth services and options to meet doctors in person at its 182 offices scattered across 25 markets in the United States.

• It's been more than a year since Alice Walton announced her plans for a national medical school in northwest Arkansas. New details about the facility and its goals are available. Ms. Walton, the only daughter of Walmart founder Sam Walton, shared plans to finance and build a four-year medical school in Bentonville, Ark., in March 2021, with construction set to begin in 2022. The institution was first named the Whole Health School of Medicine and Health Sciences. On June 29, its board of directors unanimously approved the change in name to The Alice L. Walton School of Medicine. Arkansas-based architecture firm Polk Stanley Wilcox is leading the building of the Alice L. Walton School of Medicine, with design currently in the development phase and construction of the 154,000-square-foot building to begin in spring 2023. The school aims to welcome its first class in fall 2025, pending accreditation. Ms. Walton is founding the school with modern interpretations of medicine and health in mind. "Building on evidence-based approaches to teaching, the curriculum will include rigorous training in whole health, humanities, integrative health approaches, research methods, and cutting-edge technologies, with a unique focus on interprofessional collaboration, mental health, social determinants of health and nutrition," a news release from the school states. "Equity, diversity, and inclusion will be high-priority areas. The school will support students, faculty, and staff, learning about self-care and emphasizing it in their own lives."

• On July 8, Los Angeles Mayor Eric Garcetti signed an ordinance establishing a $25 minimum hourly wage for workers at eligible privately owned healthcare facilities, according to a post on his Twitter account. The signing came after the Los Angeles City Council voted unanimously on June 29 in favor of raising the minimum wage. Mr. Garcetti called the minimum wage increase "a deserved pay raise to our heroes, who for the past few years have taken on an unimaginable burden for all of us." "It's time we put

them first," he said. The ordinance will affect workers in a range of roles at certain privately owned healthcare facilities in the city, such as acute care hospitals, affiliated clinics, and skilled nursing facilities. Affected roles include clinicians, nurses, aides, technicians, maintenance workers, janitorial or housekeeping staff, groundskeepers, guards, food service workers, pharmacists, and administrative or clerical workers. The increase excludes managers and supervisors. The office estimates that the minimum wage increase will affect about 20,000 healthcare workers.

• California is the first state to challenge the pharmaceutical industry after Gov. Gavin Newsom allotted $100 million to launch CalRx, the state's insulin brand. Half of the budget will go toward product development, and the other $50 million is set aside for "a California-based insulin manufacturing facility that will provide new, high-paying jobs and a stronger supply chain for the drug," Mr. Newsom said. About a million state residents who have diabetes can't afford the insulin they need, and across the nation, 1.2 million people "experienced catastrophic spending" after the treatment's prices hiked more than 200 percent from 2008 to 2017. "We know people should not go into debt to receive life-saving medication," Mr. Newsom said. The budget allows California to manufacture "insulin at a cheaper price, close to at cost, and to make it available to all." The governor did not specify how much insulin would cost.

Things I’m monitoring during 2Q22:

• CMS IPPS Rates

• Rising interest rates

• Cost containment

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