With no buyer, Intermountain Health shutters physician group

Average annual healthcare cost in all 50 states

HCR 9

The Legislative Council is authorized to establish a task force to undertake and complete a study of Medicaid managed care programs, including comparison of the costs and benefits of Medicaid managed care services and value-based services, and to make recommendations regarding a comprehensive Medicaid managed care program in Idaho, with the goal of reducing costs, achieving a predictable and transparent Medicaid budget, improving health care access and outcomes, and ensuring network adequacy for Medicaid participants. The Legislative Council shall determine the number of legislators and membership from each house appointed to the task force and shall authorize the task force to receive input, advice, and assistance from interested and affected parties who are not members of the Legislature

HB 162

The legislation expands the ability of Idaho citizens in rural and underserved areas to access health care from providers who are not physically present in a patient’s geographical area. The legislation updates the Idaho Telehealth Access Care Act in Title 54, Chapter 57, Idaho Code by changing the term “telehealth” to “virtual care,” and clarifies virtual care practice requirements. This legislation also provides a permanent solution to lessons learned through COVID-19 related to technology limitations and best practice interstate licensure exemptions for qualified provider’s licensed and in good standing in another state to provide continuity of patient care

HB 369

This is the FY 2024 original appropriation bill for the Department of Health and Welfare’s Division of Medicaid. It appropriates a total of $4,539,917,000 and caps the number of authorized full-time equivalent positions at 213.00. Other actions were taken for the Division of Medicaid, and the table below reflects all of the othersupplementals contained in other bills. H323 of 2023 contained supplemental 1 for the Public Health Emergency; supplemental 4 for Early and Periodic Screening Assessment; supplemental 5 for Receipt Authority; and supplemental 6 for Upper Payment Limit Increase. S1195 of 2023 contained supplemental 3 for MMIS Procurement. This bill contains one supplemental, supplemental 7 for a onetime Provider Rate Increase for the last quarter of FY 2023.

Additionally, this bill funds twelve line items, which provide: funding for the Behavioral Health Plan; funding for the Ground Emergency Medical Transportation (GEMT) waiver as approved in S1283 of 2022; funding which moves the Homes with Adult Residential Treatment (HART) to this division; funding for a quality improvement organization contract; funding for a review of managed care compliance; funding for a contractor to implement the budget model as a result of the KW Lawsuit; removes General Fund and adds federal funds for the impacts of the stepped down enhanced FMAP; adds dedicated funds for the state's share of the upper payment limit (UPL); provides for a provider rate increase for six home and community based provider types; implements the Millennium Fund Committee recommendation to make Millennium Income Fund dollars onetime in the Division of Medicaid; removes funding for disenrollment from Medicaid due to unwinding; and provides additional funding as a trailer appropriation to HCR9.

HB 201

Over a third of women in Idaho do not have health insurance prior to pregnancy and do not have access to health coverage beyond 60 days postpartum. This legislation will improve health access for pregnant/postpartum women and infants and ensure 12 months postpartum health coverage for women.

HB 366

This legislation requires that several program integrity and cost-saving measures be implemented in Medicaid as a condition for the continued expansion of eligibility to able-bodied adults under the Affordable Care Act. These conditions include a work requirement and enrollment caps for able-bodied adults and a requirement that the improper payment rate in Medicaid be reduced to 5 percent or less.

HB 215

Amends existing law to provide for enforcement of provisions applicable to pharmacy benefit managers.

HB 291

The purpose of this legislation is to establish minimum and uniform standards and criteria for the audit of pharmacy records by or on behalf of pharmacy benefit managers and other authorized entities.

Healthcare Consolidation Q4 2022: Cross-Market Mergers Continue Apace

2022 has been an active year in healthcare consolidation as well as for merger challenges and enforcement. As we approach the year end, healthcare deals continued as many entities seek to close the transactions before the new year. Increasingly, as seen in the 4th quarter, healthcare deals are shifting to cross-market transactions, making review and enforcement efforts more challenging. In case you missed it, this final Litigation and Enforcement Highlights of the year will help you catch up on some of the cross-market deals in Q4 2022 that caught our attention.

Advocate Aurora and Atrium Health

One of the most scrutinized healthcare mergers this year received regulatory approval and was completed earlier this month. Announced in May, the megamerger of Advocate Aurora, headquartered in Wisconsin and Illinois, and Atrium Health of North Carolina, combines 67 hospitals across Alabama, Georgia, Illinois, North Carolina, South Carolina, and Wisconsin. The new regional health system is named Advocate Health and is now the fifth largest nonprofit health system in the country. The merger was initially paused when the Illinois Health Facilities and Services Review Board denied the transaction for lack of details on the controlling interests of the merged entity. The issue was resolved when the parties provided more information per the board's request. Notably, while North Carolina Attorney General Josh Stein expressed concerns about the merger's effect on healthcare access in North Carolina, neither the state attorneys general nor the Federal Trade

Commission challenged the merger, likely due to the difficulty in proving competitive harms from a cross-market merger spanning different states.

Despite the fact that antitrust enforcers did not bring a merger challenge, the merger may impact price and competition. Both parties to this merger have been the subject of antitrust lawsuits arising from their respective market power. Advocate Aurora is the product of a 2018 merger between Advocate Health and Aurora Health and the resulting market power from that merger has already raised alarms in the Wisconsin area. Also in May, a private lawsuit was filed in Wisconsin federal court alleging the health system leveraged its substantial market power forced insurers to enter all-or-nothing and anti-tiering and anti-steering contract terms, and used referral restraints, noncompetes and gag clauses to suppress competition from other healthcare providers and demand higher prices for its services. Coincidentally, Atrium Health was also the target of similar allegations in the landmark case brought by the Department of Justice and North Carolina AG over its use of anticompetitive contracting terms. That case settled in 2019 with terms that prohibits Atrium from enforcing the anticompetitive clauses in contracts with insurers. What will the combination of these two hospital systems bring? Antitrust experts and economists are no doubt watching with great interest.

Deaconess Health System and Quorum Health

Another cross-market transaction involving Illinois hospitals received approval this month from the Illinois Health Facilities and Services Review Board. Deaconess Health System is set to acquire four hospitals in southern Illinois from Quorum Health for $146 million. Based in Indiana, Deaconess is a nonprofit health system that operates 12 hospitals in Illinois, Indiana, and Kentucky. Quorum Health, on the other

hand, is a for-profit health system based in Tennessee with 21 hospitals across 13 states. Due to its financial struggles in recent years, Quorum had been selling off many of its hospitals to pay for its debts, including the ones being sold to Deaconess, with others to come. Given the cross-market nature of the transaction and the issue of solvency of the entity involved, this deal likely will not be challenged by antitrust enforcers and is expected to close by the end of the year.

Sanford Health and Fairview Health Services

In November, another cross-market merger was announced between Sanford Health and Fairview Health Services. Sanford operates 47 hospitals in South Dakota, North Dakota, and Minnesota. Fairview is based in Minnesota, where it operates 11 hospitals. The proposed merger will integrate the two nonprofit systems in the Midwest region under the Sanford Health brand. In this transaction, the two entities seemingly do not have overlapping service areas, and it remains to be seen whether the deal would be challenged by either federal or state regulators.

Notably, this is the third time Sanford Health has attempted at a cross-market merger deal in the past three years. In 2019, the proposed merger with UnityPoint in Iowa was called off in the negotiation stage. The following year, the deal with Intermountain Healthcare of Utah also fell through. Intermountain Healthcare, however, found its own cross-market deal with SCL Health, which closed earlier in April this year. Intermountain is a nonprofit system that operates in Utah, Idaho, and Nevada, while SCL Health is a Catholic health system with significant market shares in Colorado and Montana, as well as operations in Wyoming and Kansas. The combination of Intermountain and SCL Health formed a 33-hospital rural health system in the Rocky Mountain region and is now the 11th

largest nonprofit system in the country. While that merger received extensive review from Colorado enforcers, it did not face regulatory hurdles given the lack of geographic overlap in the markets.

While the FTC and DOJ have successfully challenged and blocked several mergers this year, cross-market mergers have largely proceeded under the radar. Nonetheless, the rise of cross-market transactions in recent years warrant greater scrutiny on the market effects of these mergers. The Source researchers partnered with economists at the UC Berkeley Petris Center to study this growing trend and its potential impact on competition. As recently published in *Health Affairs*, the study found that more than half of all hospital acquisitions between 2010 and 2019 qualified as cross-market, namely involving hospitals in a different geographic market. Additionally, there is increasing evidence that cross-market mergers may have potential anticompetitive effects because they enable health systems to tie their hospitals across markets and demand higher prices from insurers. Such anticompetitive behavior are the exact allegations in the antitrust lawsuits filed against Advocate Aurora and Atrium Health. More research and studies will come in the coming year as we dive deeper on the topic and examine the price and quality effects and how to address the cross-market phenomenon. In the meantime, be sure to check out the Cross-Market Systems interactive key issue page on The Source for additional resources and the latest developments.