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Managed Care Contracting with Price Transparency

Summary, Challenges, and Best Practices

The Baker Tilly Team

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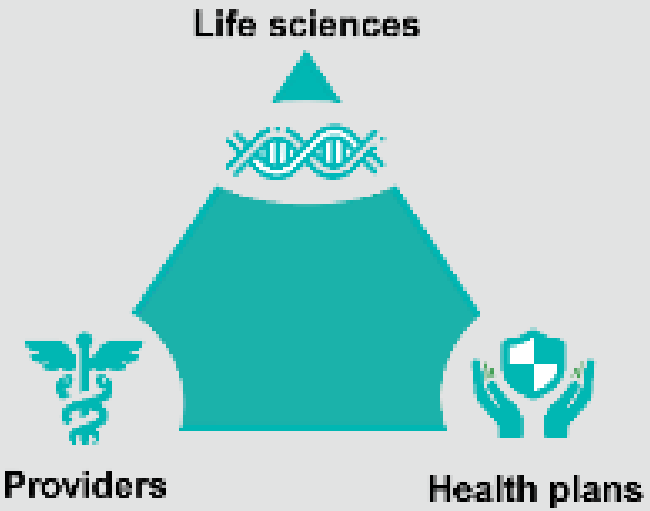
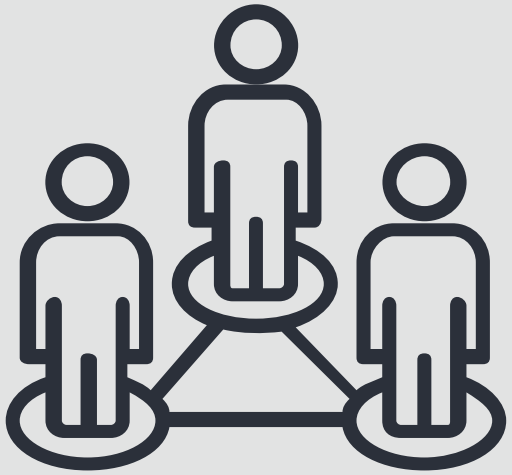
Baker Tilly – What we do / how we work

Dedicated service offerings and experienced team members focused on **all three major industry groups**



The Healthcare Consulting Team rated a ***Top 15*** *Healthcare Consulting Management firm* by Modern Healthcare in 2023



200+

Hospitals and Health systems serviced

Baker Tilly – What we do / how we work

Baker Tilly consulting service offerings at-a-glance

We dedicate ourselves to delivering efficiency, quality, creativity, innovation and forward-thinking solutions. We are passionate about enhancing and protecting our clients' value. Below are some key facts about our firm.

10th
largest advisory CPA firm in the U.S.

1,200+
consulting team members

130+
consulting partners

40%
of Baker Tilly's $1.3B in firm revenue

20+
years of consulting experience

60+
U.S. office locations

250+
workplace and culture awards

Providers	Life Sciences	Health Plans
• Serves 200+ hospitals and health systems • Serves 500+ CCRCs, skilled nursing, post-acute care and assisted living facilities • Enables strategic initiatives like delivery system transformation to perform within Value Based Care models • Focus areas include EHR implementation and optimization, interoperability, government reimbursement and managed care	• Serves 450+ clients at every stage of the life cycle • Industry sectors include medical device, pharmaceutical and biotechnology • Assists clients with gaining regulatory compliance, HCP engagement, strategic tax and other services	• Ranked 10th on A.M. Best's Top Health Audit Firms • Serves 200+ insurance companies across the United States • Assists clients with execution of critical initiatives through technology transformation, focused on Value Based Care, Network Management and core Administrative Systems (claims, others)

History of managed care contracting

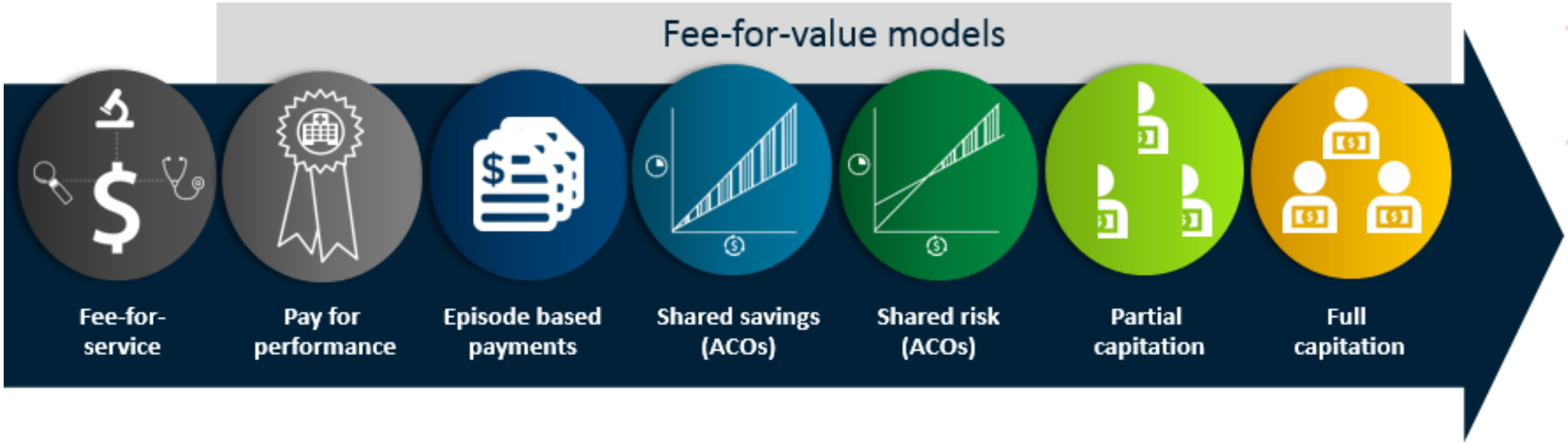
- A pathway to top line growth
  - Fee for service (FFS) payment methodologies continue to dominate reimbursement methodology structures under provider/payer agreements. Typical reimbursement structures include:
    - Percent of charge terms
    - Per diem rates
    - Case rates
    - Grouper rates
    - CPT/DRG specific rates
    - Percentage of Medicare terms
    - Fee schedule rates
  - These FFS payment methodologies are not value driven, but volume driven. Providers are paid on the volume of service provided versus payments driven by patient clinical outcomes

Payment risk spectrum

Small % financial risk

Moderate % of financial risk

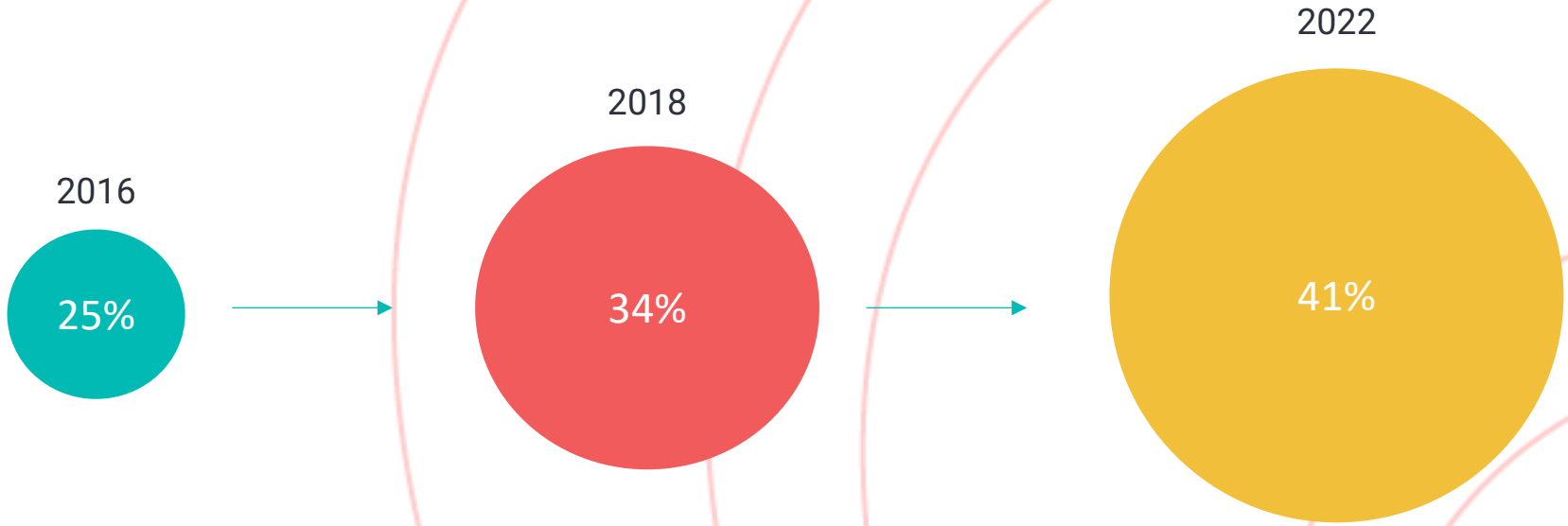
Large % of financial risk



Limited provider integration

More developed provider integration

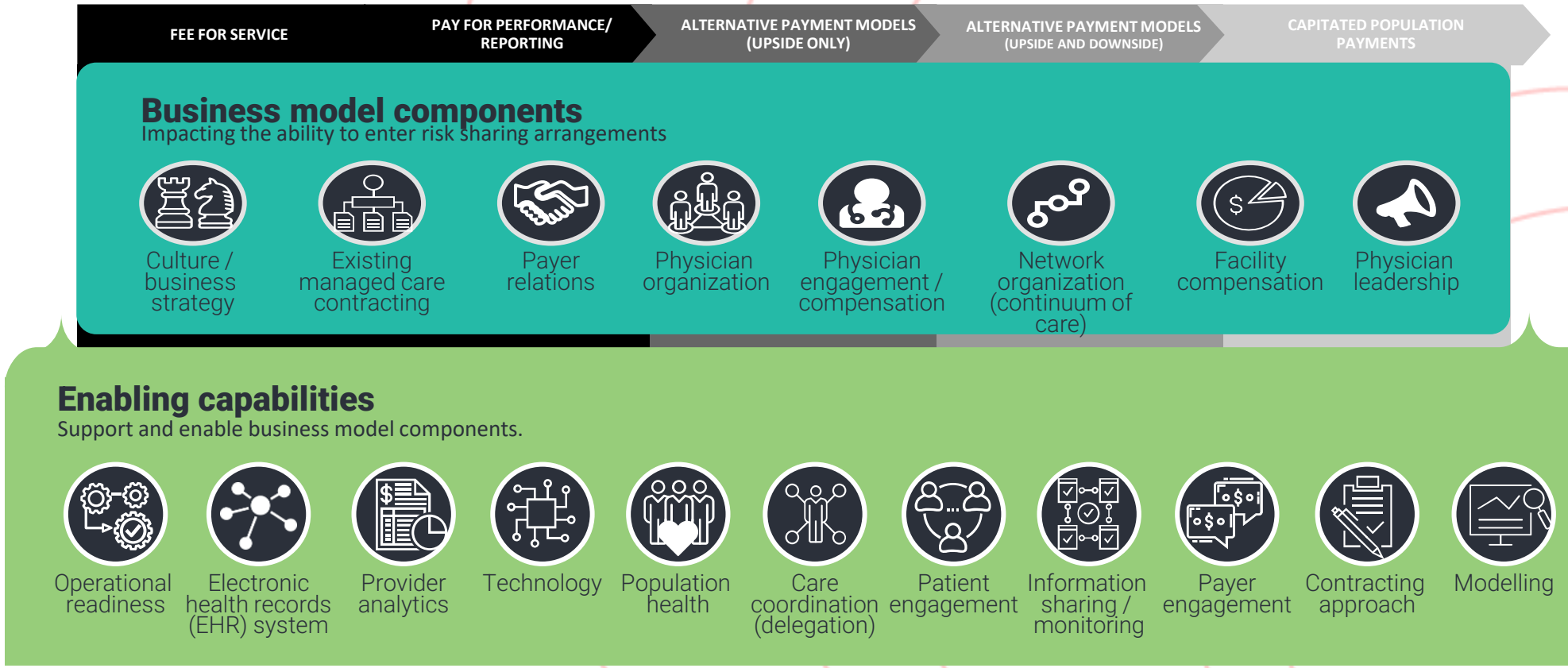
VBC continues to gain traction



- Value-based care models continues to gain traction, according to the Health Care Payment Learning & Action Network's (LAN) annual measurement of participation in alternative payment models, about 41% of health care payments in 2022 included some form of quality and value component
  - 19.6% represents two-sided risk
- LAN's 2030 goal is to have 50% of commercial payments represented by two-sided risk arrangements

Diverse skillsets required to operationalize FFS and FFV contracts

A framework for the adoption of Value Based Care programs in your organization



PRICE TRANSPARENCY

Price transparency overview

Price transparency is the ability of health care consumers to access information pricing of health care services, including out-of-pocket costs. CMS has finalized federal rulings for both hospitals (Hospital Price Transparency/HPT) and health plans (Transparency in Coverage/TiC) to help improve price transparency and encourage competitive rates.

Legislation Timeline

Jan 1, 2021: HPT #1 - *hospitals* required to publicly disclose the prices negotiated with insurers for common services and items
Jan 1, 2022: TiC #1 - *health plans* required to make available to the public three separate machine-readable files that include detailed pricing information
Jul 1, 2024: HPT #2 - *hospitals* must publish machine-readable files (MRF's) according to a new CMS standard format that includes new, more detailed data elements
Jan 1, 2025: HPT #3 - *hospitals* required to post average expected allowed amounts and Part B drug pricing.

Applicability

All *hospitals* and *health plans* must adhere to CMS guidelines to avoid facing penalties for noncompliance.
Note: standalone facilities, such as SNFs, are not subject to this ruling

Operational Impacts

- Requires hospitals and health plans make public their charges and reimbursement rates
- Enables consumers to access medical costs and pricing information to make more informed decisions
- Promotes competition among hospitals and health plans

65% of hospitals are estimated to be noncompliant due to failing to meet one or more price transparency requirements

3TB Estimated hospital data volume annually

The goals of price transparency in healthcare

- **Empowering Consumers:**
  - Clear, easy-to-find information about the costs of services enables consumers to make informed decisions
- **Addressing Asymmetry in Rate Information:**
  - Hospitals and health plans are both required to publish rates and provide portals for patients to estimate out-of-pocket expenses
- **Driving Competition and Lowering Prices:**
  - Hospital systems compete for market share which can drive prices down for consumers
- **Unlocking Gains in Affordability:**
  - Patients are interested in shopping for care which could unlock gains in affordability
- **Aligning Cost and Quality:**
  - Help address the disconnect between price and quality

Source: Price transparency: Will it boost your revenues? - IC System

The compliance landscape

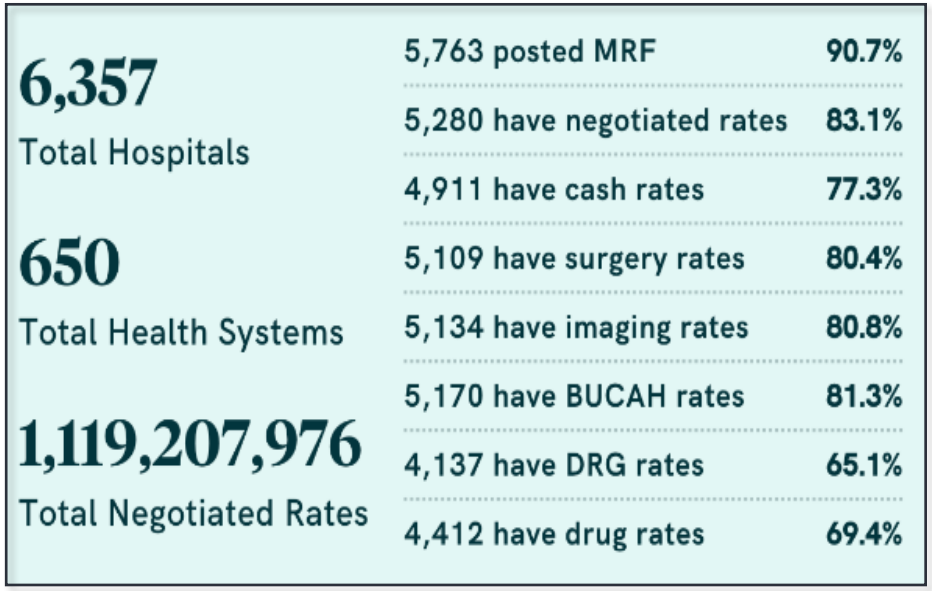
- **Industry reports vary when estimating HPT compliance**. CMS stated that other organizations had reported compliance rates ranging from approximately **5% to 85%**, depending on the organization's methodological approach.
  - Ex: in January 2024, Turquoise Health posted 90% of hospitals had posted pricing data, but analysts found that only 53% of hospitals were rated five stars as fully compliant with the rule.

- Hospitals are backsliding on compliance with HPT laws, according to a February analysis from nonprofit watchdog organization Patient Rights Advocate report. Of the 2,000 hospitals reviewed:
  - **1,311 hospitals (65.5%) were not in compliance with the rule.** The most common reason for noncompliance was missing or significantly incomplete pricing data
  - 87 hospitals (4.4%) did not post a usable standard charges file
  - 135 hospitals (6.8%) exhibited 'backsliding' with an assessment of *Noncompliant* in the current report after having been assessed as *Compliant* in a prior report

Table 1: Hospital Compliance

Report Date	Hospitals Reviewed	Compliant Hospitals	Percentage Compliant
Feb. 2024	**2,000**	**689**	**34.5%**
July 2023	2,000	721	36.0%
Feb. 2023	2,000	489	24.5%

Source: Patient Rights Advocate Sixth Semi-Annual Hospital Price Transparency Report



Source: Turquoise Health Hospital MRF Trends

Price transparency compliance matrix

	Hospitals	Health Plans / Payers	Professional Groups / Non-Hospitals
Most Recent Enforcement Deadline	**7/1/2024** (Updated MRF Guidance)	**7/1/2022**	**Not yet required**
MRF Refresh	**Annual**	**Monthly**	**NA**
Hospital Charges	**Yes**	**NA**	**NA**
Hospital Cash Rates	**Yes**	**NA**	**NA**
Commercial Facility Rates	**Yes**	**Yes**	**NA**
Commercial Professional Rates	**No** (does include hospitalists)	**Yes**	**NA**
Medicare Advantage	**Yes**	**No**	**NA**
Managed Medicaid	**Yes**	**No**	**NA**

Who's using this data?

Employers

Negotiate Costs: Revising health plan benefits and pushing for legislation to pressure hospitals to lower prices

Optimize Health Plan Benefits: Analyzing pricing data to tailor health plan benefits to better serve their employees.

Health Plans

Publishing Pricing Information: As of July 1, 2022, most group health plans and issuers are posting pricing information for covered items and services.

Empowering Consumers: Helps patients make informed decisions by providing estimates of out-of-pocket expenses.

Negotiate Reimbursement: Using data from other health plans to compare reimbursement rates at provider locations to support negotiations

Hospitals/Provider Groups

Negotiation Strategies: Hospitals/Provider groups can negotiate their insurance contracts by effectively utilizing competitor data.

Improving Cost-Quality Alignment: Address price dispersion and encourages patients to shop for care, potentially unlocking affordability gains for consumers.

Data Aggregators/ Innovators

Gather and Display Information: Platforms such Turquoise Health or Serif Health collect data to provide those rates to patients and help consumers understand price transparency data to make cost-conscious decisions when receiving care.

Patient Advocacy groups: Innovations, such as technology and analytics, empower patients to shop for care more than ever.

Benchmarking with price transparency: learnings

Corroborate multiple sources of reimbursement information

- Payer Machine Readable Files (“MRF”)
- Hospital Price Transparency (“HPT”) files
- Commercial reimbursement datasets for regional norms
- Medicare datasets

Careful interpretation of MRF data

- Identify and mitigate nuances of MRF and HPT data
- Build wholistic contract view to identify reimbursement terms for service codes not explicitly listed in the MRF
- Account for MRF incompleteness (e.g. missing implant add-ons, outlier terms, “lesser ofs”)

Normalize results for direct comparisons

- Express “per diem” based rates to fixed rates using average LOS
- Express Base DRG rates to Final DRG Case rates using applicable CMS DRG Weights
- Express “percent of charge” to fixed rates using standard charges

PRICE TRANSPARENCY

Corroborate transparency data

Hospital MRF data
"corroborates" Payer MRF data

		Hospital A		Hospital B	
Billing code description	**Billing code (DRG)**	**Payer Reported Rates (Source: Payer MRF)**	**Hospital Reported Rates (Source: Hospital MRF)**	**Payer Reported Rates (Source: Payer MRF)**	**Hospital Reported Rates (Source: Hospital MRF)**
Degenerative Nervous System Disorders w/o MCC	057	$12,008.76	$11,532.70	$14,617.62	$14,617.62
Intracranial Hemorrhage or Cerebral Infarction w MCC	064	$17,644.91	$17,474.05	$21,478.21	$21,478.21
Intracranial Hemorrhage or Cerebral Infarction w CC	065	$8,953.71	$9,006.40	$10,898.88	$10,898.88
Respiratory Infections & Inflammations w MCC	177	$14,943.99	$15,771.84	$18,190.53	$18,190.53
Pulmonary Edema & Respiratory Failure	189	$10,852.98	$10,695.32	$13,210.76	$13,210.76
Chronic Obstructive Pulmonary Disease w MCC	190	$9,707.78	$9,618.70	$11,816.77	$11,816.77
Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	470	$16,576.35	$19,661.59	$20,177.51	$20,177.51

Change in benchmarking capabilities over time

				A		B			C		
Hospital A 2023 Admissions				% of Medicare	Commercial Reimbursement (MSA)				Payer A MRF Rates		
DRG	DRG Description	Volume	Average Reimbursement	Hospital as a % of Medicare	AVG	25th %	50th %	75th %	Hospital A	Hospital B	Hospital C
All DRGs for Payer A		**225**	**$10,867**	**110-120%**	**$18,797**	**$12,794**	**$16,187**	**$21,488**			
795	NORMAL NEWBORN	30	**$1,813**	123%	$3,362	**$2,251**	$3,008	$4,059	$1,989	$2,594	$3,600
885	PSYCHOSES	27	**$10,446**	98%	$22,486	$8,935	**$12,404**	$21,563	$13,480	$17,577	$24,390
807	VAGINAL DELIVERY W/O STERILIZ	21	**$4,825**	118%	$10,326	**$7,734**	$9,361	$12,079	$6,455	$8,416	$11,679
788	CESAREAN SECTION W/O STERILIZ	18	**$5,551**	112%	$14,265	**$10,678**	$12,288	$15,844	**$8,435 Case Rate / $3,501 Per Diem**	$10,998	$15,261
193	SIMPLE PNEUMONIA AND PLEURISY	15	**$8,360**	118%	$16,835	**$14,331**	$17,293	$20,325	$13,088	$17,065	$23,679
897	ALCOHOL, DRUG ABUSE W/O REHABILITATION THERAPY	14	**$6,051**	107%	$13,213	**$7,036**	$10,732	$15,095	$7,347	$9,579	$13,292

REAL WORLD CASE STUDY

Benchmarking in the age of price transparency

Client Profile

A high performing comprehensive health care provider system in Western PA

- Pursuing regional and price managed care benchmarking for upcoming payer contract negotiations with four leading payers across 10 product lines

Key Requirements

- Review facility contract terms and language
- Collect local MSA geographical benchmarking data and price transparency information
- Analyze current payer contracted rates with competitor rates

Baker Tilly Solution

- Defined contract improvement recommendations into matrix for each payer
- Compared client claims data to regional market benchmarking rates to determine client position across top utilized services
- Utilized price transparency files to compare client's negotiated rates to local competitors
- Identified financial opportunities for client based upon current market position compared to MRF-based and Regional Marketplace Benchmarking

Customer Impact

Successfully identified facility rate opportunity and language improvements based on assessment of facility agreements

- Competitive position for negotiations
- Identified over $22 million in financial opportunity across commercial and Medicare advantage rates

REAL WORLD CASE STUDY

The best offense is a good defense

Client Profile

A hospital with a professional group within the Los Angeles geography looking to get a better understanding of reimbursement rates within the market

Key Requirements

- Review professional contract terms and language for top four payers
- Collect local MSA geographical benchmarking data and price transparency information
- Analyze current payer contracted rates with competitor rates

Baker Tilly Solution

- Utilized price transparency files to compare client's negotiated rates to local competitors
- Compared client contracted rates to regional market benchmarking rates to determine client position across top utilized services

Customer Impact

Identified that payer MRF data was not reported correctly for physician group and used that information to refute payer negotiation tactics when challenged on rate requests

Questions?

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