Fiduciary Check In

Getting Ready for the Era of Hospital Transparency: What does it mean for a Fiduciary?

April 26, 2022
Speakers

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Level Set: Timeline of hospital transparency and CAA.

- Dec 27, 2020: Hospital Price Transparency
- Jan 1, 2021: Consolidated Appropriations Act of 2021 (CAA)
- Jan 1, 2022: Transparency in Coverage (TICRA)
- Jan 1, 2023
- Jan 1, 2024
Pre CAA: Health Plan Components

- No Transparency
- Restrictive Legal Agreements
- Restrictive Data Use Agreements
- No Unit Cost transparency
- Complex RX pricing
- Hidden Third party fees

FIDUCIARIES unaware / unable to perform duties.
Post CAA: Health Plan Components: 39N

- Full Transparency
- Removal of Gag Clauses
- Full Access to your Data
- Full Unit cost Transparency
- Pass-Thru PBM
- Third Party Fee Transparency

EMPOWERED FIDUCIARIES become proactive purchasers.
CAA provides a great opportunity for Benefit Advisors & Plan Sponsors

The Goal of the CAA legislation is to improve transparency and empower fiduciaries

01 Removal of gag clauses from service provider contracts

02 Establish reporting requirements for pharmacy and prescription drug disclosures

03 Disclosure of direct & indirect compensation from all service providers

04 Required parity in substance abuse & mental health benefits

Potential Risks

- Government action for non-compliance
- Class action lawsuits against Plan Sponsor
Consolidated Appropriations Act (CAA) Compliance Made Easy

Our simple step-by-step plan will show you how to comply

- Understand your Fiduciary Obligations
- Connect with an HPfid Expert

Get Free Access To Our Educational Webinar
How Transparency and the CAA Empower You to Take Control of Health Plan Costs

The CAA is here...with defined fiduciary and attestation duties to be completed by health plan sponsors in 2022...but also with opportunities for significant health plan spend reductions!

HPfid is here to help you with an easy 3-step compliance process that puts plan sponsors on the road to compliance and in command of health spend.

Join compliance expert Tony Sorrentino to learn:
1. Your fiduciary responsibilities under CAA
2. Specific opportunities within CAA enabling data-driven benefit strategies
3. Your important Plan Sponsor Actions and Duties for 2022

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Hospital Price Transparency

April 5 – NASHP Hospital Reporting Tool
  • 8+ Year trend
  • Hospital Break Even By “Market”
  • % Medicare Break Even
  • Commercial Break Even

May 5 – Hospital Value Dashboard
  ▪ RAND 4.0 published April 2022
  ▪ NASHP Highlights
  ▪ Sample Turquoise Health Results
  ▪ CMS Star Ratings
  ▪ Sample Quantros Quality Ratings

July 1 – Plan Sponsor CAA Transparency Compliance

Employers Forum of Indiana
National Dashboard on Hospital Value
May 5 Conference

https://employersforumindiana.org/conference/
The Fiduciary Dilemma

- CAA requires fiduciaries to pay a fair price for services provided

- RAND and NASHP data suggest some health systems are charging well beyond “fair price,” driven largely by hospital costs

- Key contributors to hospital costs
  - Consolidation leading to less or no competition
  - Lack of transparency
  - Anti-competitive practices
Common Myths about Hospital Pricing

- Hospitals are doing their part to control costs
- Health insurance shields patients from financial loss
- Hospital consolidation leads to greater efficiency and lower costs
- Hospital consolidation leads to better patient outcomes
- Hospitals suffered huge losses during COVID-19
- Higher costs mean higher quality
- Hospitals are underpaid by Medicare and Medicaid
- Hospitals charge payers/plans sponsors prices that are reasonably higher than Medicare
- Higher hospital prices are needed when there is lower public health funding
- Higher hospital prices are needed when state public health ranking is lower, meaning patients are more unhealthy
- Nonprofit hospitals provide significant amounts of charity care, necessitating cost shifting

Getting to “Fair Price”

- MedPAC suggests a well-run hospital can manage close to Medicare on average.

- NASHP defines current break-even for a hospital as a percentage of Medicare (may reflect higher overhead spending).

Other considerations:
- Reasonable margins
- Existing margins and market share of Medicaid and Medicare
- Capital investments
- Market dynamics (e.g., nursing salaries, personnel shortages)
- Relative quality and safety metrics

Myth: The pandemic wiped out US hospital profitability.
Fact: Relatively efficient hospitals broke even in 2020.

Medicare payments and costs: Relatively efficient hospitals broke even in 2020

<table>
<thead>
<tr>
<th></th>
<th>Relatively efficient (15%)</th>
<th>Other (85%)</th>
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<tbody>
<tr>
<td>Performance in 2020</td>
<td></td>
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<tr>
<td>Share rating hospital a 9 or 10 (out of 10)</td>
<td>72%</td>
<td>69%</td>
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<tr>
<td>Risk-adjusted percent of national median</td>
<td></td>
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<tr>
<td>Mortality rate (30-day)</td>
<td>92</td>
<td>101</td>
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<tr>
<td>Readmission rate</td>
<td>96</td>
<td>102</td>
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<tr>
<td>Medicare costs per stay (standardized)</td>
<td>91</td>
<td>104</td>
</tr>
<tr>
<td>Median margin in 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Medicare margin</td>
<td>1</td>
<td>-6</td>
</tr>
<tr>
<td>All-payer total margin</td>
<td>7</td>
<td>5</td>
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Note: Relative values are the median for the group as a share of the median of all hospitals. Per stay costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer status, hospital type, hospital size, and hospital ownership and teaching status. Composite mortality was computed using the Elixhauser comorbidity index. Risk-adjusted mortality for all conditions. The reduced group is five-year MedPAC patient stays (the bottom 10 percent of hospitals) and hospitals in markets with high service use (Top 10 percent of hospitals). Due to concerns that Medicare payment and performance measures that reflect costs and risk-adjusted quality metrics.

Source: MedPAC analysis of cost report and claims-based quality data from CMS.

Results are preliminary and subject to change.
Appropriateness of current costs

Costs vary in response to financial pressure

- Low margins on Medicare patients can result from a high-cost structure that has developed in reaction to high private-payer rates.
- Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over payers.
- If private payers do not exert pressure, providers’ costs will increase and, all other things being equal, margins on Medicare patients will decrease.
- Providers under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure.

Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates.
Coalition/Purchaser Toolkit – Coming Soon!

*Employer Actions to Drive Fair Costs for Hospital Care*

- From Knowing to Doing
  - CAA and fiduciary rights and responsibilities
  - Understanding Market Dynamics
  - Evaluating Current Prices
  - Choosing your Strategy
  - Organizing for Action
    - Group purchasing
    - Policy advocacy

- RAND 4.0 and NASHP Highlights
- Responding to Myths with Facts
- Additional Resources
Questions?

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