NHA Revenue Cycle Residency Program: Session 4

March 4, 2025

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Introductions

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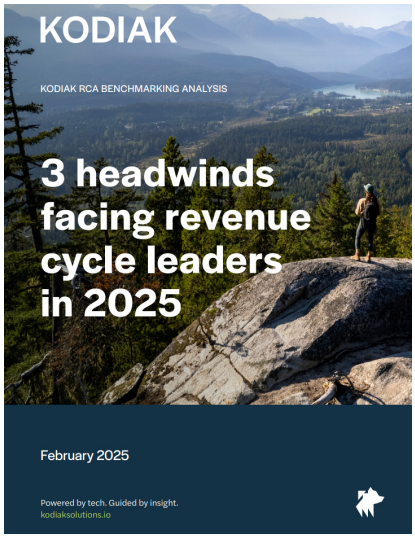
Agenda

1. Growing Headwinds
2. It's A New Administration
3. Executive Orders Impacting Healthcare
4. Trump Administration Health Policy Priorities
5. What Needs to Be on Your Website
6. Tackling Prior Authorizations: Open Discussion
7. Staffing Concerns and Succession Planning: Open Discussion
8. Final Presentations/Other Topics for May

1. Growing Headwinds



KPI	2023	2024	Change
True accounts receivable days	54.12	56.96	5.2%
True accounts receivable greater than 90 days	35.22%	35.95%	2.1%
Discharged not final billed days	9.16	9.56	4.4%
Initial denial rate	11.53%	11.81%	2.4%
Initial denial rate (prior authorization and precertification)	1.64%	1.52%	7.7%
Initial denial rate (medical necessity)	0.94%	0.98%	5.0%
Initial denial rate (request for information)	3.31%	3.49%	5.4%
Final denials as a percentage of net patient service revenue	2.75%	2.77%	0.4%
Six-month lagged cash to net revenue	94.15%	94.13%	0.0%
Bad debt as a percentage of gross patient service revenue	1.52%	1.44%	5.7%
Bad debt percentage of patient self pay after insurance	54.88%	55.49%	1.1%
Self pay after insurance collection rate for commercially insured patients	37.58%	34.46%	8.3%
Point-of-service cash collections as a percentage of total patient payments	18.03%	18.90%	4.8%

https://www.kodiaksolutions.io/internal/benchmarking_reports/kpi_benchmarking_february_quarterly

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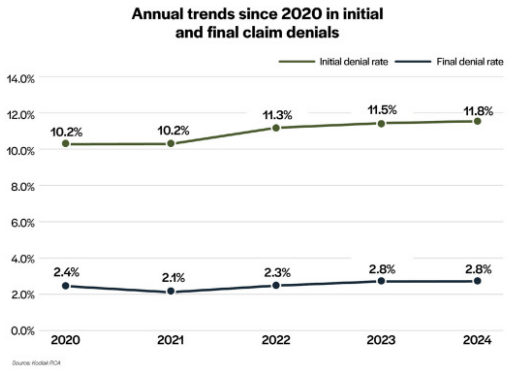
Growth In Initial and Final Denials



- Integrating their clinical departments into their revenue cycle operations.
- Escalating legal options against suspect payor behaviors.
- Automating low- or no-value patient accounts.
- Using better and advanced analytics to identify and mitigate root causes of denials.
- Deploying generative AI for claim denial appeal letters.
- Enhancing front-end revenue cycle processes.
- Setting up distinct and resourced task forces to deal specifically with claim denials.
- Focusing on DRG downgrades that deny claims or reduce claim payments.

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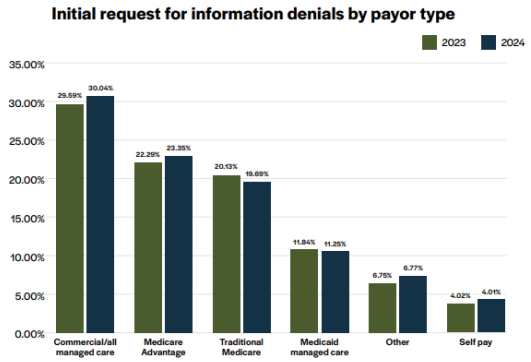
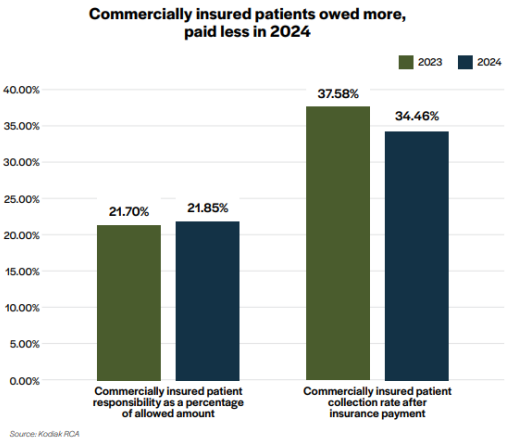
Growth In Medicare Advantage



- Developing stronger, more granular, and more precise payor scorecards to document inflated initial RFI denial rates.
- Creating data communities to share information on initial RFI denials by payor categories.
- Inserting stronger language in payor contracts and service-level agreements to limit pre-payment audits and denials.
- Escalating legal options against suspect payor behaviors.
- Terminating contracts with specific payors all together.

Growth In Patient Responsibility



Source: Kodiak RCA

- Improving patient education efforts on patients' health plan benefits designs.
- Enhancing communication with patients through their entire financial experience.
- Renewing their focus on POS collections.
- Working with advocacy groups to call attention to health plan benefits designs that fail to adequately cover patients' medical needs, often leading to patients being underinsured.
- Monitoring bad debt within their overall net revenue leakage tracking.

2. It's A New Administration

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What Happens to Biden Administration Regulations?

- Amend or repeal final rules through notice and comment rulemaking
  - Regulations considered "final" if published in *Federal Register* or released for public inspection even if delayed effective date
  - Likely targets: nursing home staffing levels, HIPAA reproductive rights, Section 1557
  - Exception: Under Congressional Review Act, new Congress can rescind regulations finalized after 8/1/24
- Place moratorium on effective date of final rules not yet in effect
  - Allows new administration time to review
  - Typically, not applied to rules required under statute or by judicial decision
- Amend or repeal guidance documents
  - Generally, does not require notice and comment rulemaking
- Stop, delay, or withdraw proposed rules
  - Issue moratorium on rules under development
  - Medicare Advantage/Part D proposed rule?
- Exercise enforcement discretion

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3. Executive Orders Impacting Healthcare

Initial Actions

- Immigration enforcement “sensitive location” policy rescinded
- Regulatory freeze
- Gender-affirming care for children
- Freeze on federal grants
- Artificial intelligence
- Drug pricing
- Strengthening Medicaid and the Affordable Care Act
- Provisions related to COVID-19 and pandemic preparedness
  - Reinstates service members discharged under DOD’s COVID vaccine mandate
- Withdrawing the US from WHO
- Enforcing the Hyde Amendment (federal funding for abortions)
- DOGE????

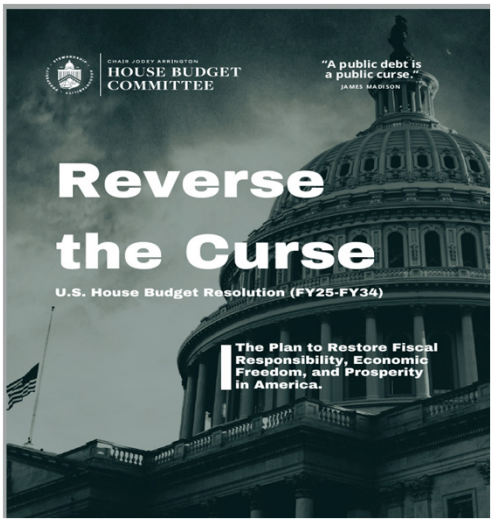
4. Trump Administration Health Policy Priorities

House Budget Resolution

- $4.5T in tax cuts
- Instructions to several committees that equal at least $1.5 trillion in cuts to mandatory spending
  - $880B cuts to Energy & Commerce (Medicaid), $230B cuts to Agriculture (SNAP)
  - Committees must submit legislation to House Budget Committee by **March 27**
- Mandate to find another $500 billion in spending reductions without specific committee instructions
- Any shortfall results in corresponding reduction in tax cuts (e.g., if only $1.7B in cuts, tax cuts reduced to $4.2T); any excess results in corresponding increase in tax cuts (e.g., if $2.3B in cuts, tax cuts increased to $4.8T)

Senate Budget Resolution

- $342B in new funding over four years divided between border security and national defense
- Committees charged with drafting implementing bill to determine funding source (spending cuts)
- Defer tax cut reauthorization to later time



https://budget.house.gov/imo/media/doc/reverse_the_curse_budget_blueprint_fy25-341.pdf

Creating Payment Parity for the Same Services:

Unnecessary costs in health care are not only breaking the budgets of working families, but they are bankrupting our country. Patients, providers, and taxpayers should pay the same amount for the same service, regardless of the setting. Currently, a hospital outpatient department is paid substantially more by Medicare compared to other delivery settings such as a physician office or ambulatory surgery center. This difference in reimbursement rates for the same services has created a financial incentive for hospital systems to acquire freestanding physician offices, fueling consolidation that reduces competition, drives up costs for patients and limits health care provider choices for patients. This includes payment for lower-complexity services such as office visits, imaging, and drug administration, which the Medicare Payment Advisory Commission (MedPAC) has noted are safe and effective to be delivered in a physician's office.

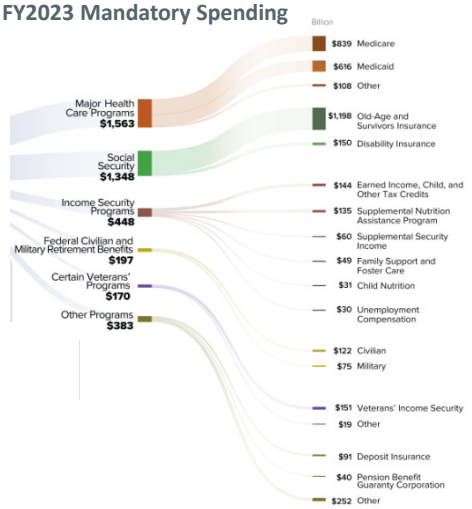
Because Medicare pays more, seniors also pay more in out-of-pocket cost sharing requirements, as well as Part B premiums and deductibles, which are indexed annually to a percentage of program costs. Accordingly, equalizing payments for certain outpatient services will decrease spending in Medicare and reduce costs for millions of seniors. Our budget supports equalizing Medicare payments for health care services that can be safely delivered in a physician's office. [31]

What Mandatory Spending Will Be Cut?

- Social Security benefits off the table
- Medicare benefits off the table
  - But not payments to providers
  - Top of the list: site neutral payment reforms ($146B)
  - Other options
    - Reduce 340B drug payments ($15.4B to $73.5B)
    - Reduce/eliminate bad debt coverage ($16.7B to $54.1B)
    - Consolidate/reduce GME payments ($94B to $103B)
    - Reform UCC payments ($229B)
    - Wage index geographic integrity ($10B)
    - Eliminate hospital dual classification ($10B)
    - Reform Medicare physician payments ($10B)

https://www.hfma.org/wp-content/uploads/2025/01/senate-finance-committee_budget-cuts-menu.pdf

FY2023 Mandatory Spending



https://www.cbo.gov/publication/59728

Potential Medicaid Funding Cuts

- Reduce or eliminate state-directed payments
  - First Trump administration proposed Medicaid Financial Accountability Regulation (MFAR)
  - Options now on the table: lower threshold from 6% to 5% ($48 billion), to 2.5% ($241 billion), or eliminate completely ($612 billion)
- Place caps on federal spending
  - Set annual maximum amount of federal funds to each state to operate Medicaid ($459 to $742 billion)
  - Set upper limit on federal payments per Medicaid enrollee in each eligibility group ($588 to $893 billion)
- Reduce federal matching rates
  - Standardize 50% match for all administrative services ($69 billion)
  - Remove 50% federal floor for non-ACA eligibility groups ($530 billion)
  - Reduce 90% federal match for ACA eligibility group ($561 billion)
- Expand work requirements
  - Reduce spending by reducing number of eligible beneficiaries (savings to state and federal government

Cuts in Payment to Medicare Advantage Plans

- Modify payments to MA plans for health risk
  - Increase coding intensity risk adjustment from 5.9% to 8% ($159 billion)
  - Increase from 5.9% to 20% ($1.049 trillion)
  - Adjust formula for calculating risk scores ($124 billion)
- Reduce MA benchmarks (currently tied to projected Medicare FFS spending for average beneficiary in same county)
  - Reduce by 10% ($489 billion)

Other Health-Related Cuts and Reforms

- Remote specified categories of non-citizens from eligibility for federal healthcare programs ($35 billion)
- Reduce Exchange subsidies ($102 billion)
- Permit employer defined benefit contributions towards Exchange plans
- Repeal ACA minimum coverage standards

5. What Needs to Be On Your Website

Required Postings: Federal

- Community Needs Assessment (26 CFR §1.501(r)-3(b)(7)(A))
- Notice of Non-Discrimination (45 CFR §92.8(f)(i)(ii)(iii))
- Charity Care/Financial Assistance (26 CFR §1.501(r)-4(b)(5))
- Hospital Price Transparency (45 CFR §180.50 and §180.60)
- Notice of Privacy Practices (45 CFR §164.520)
- Rights and Protections Against Surprise Medical Bills (45 CFR §149.430)
- Right to Receive a Good Faith Estimate (45 CFR §149.610)

6. Tackling Prior Authorizations: Open Discussion

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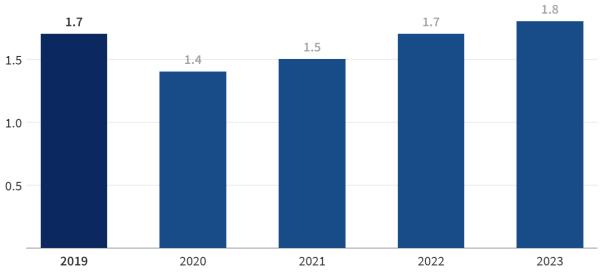
MA Prior Authorizations and Denials

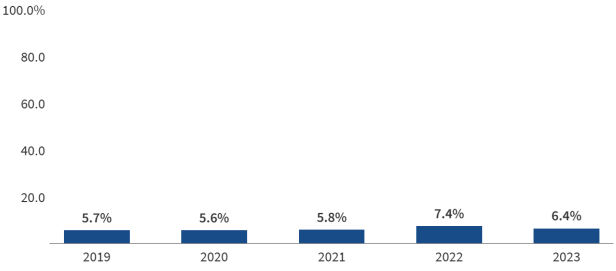
Prior Authorization Determinations per Medicare Advantage Enrollee in 2022 and 2023 Were Similar to Pre-Pandemic Levels

Number of prior authorization requests per enrollee, 2019 - 2023



Medicare Advantage Insurers Denied Fewer than 10% of Prior Authorization Requests in Recent Years

Adverse and partially favorable determinations as a share of all prior authorization determinations, 2019 - 2023



Source: Medicare Limited Data Set, Contract Years 2022 and 2023 Part C & D Reporting Requirements and Public Use File Contract Year 2019 - 2021 Part C & Part D Reporting Requirements

https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

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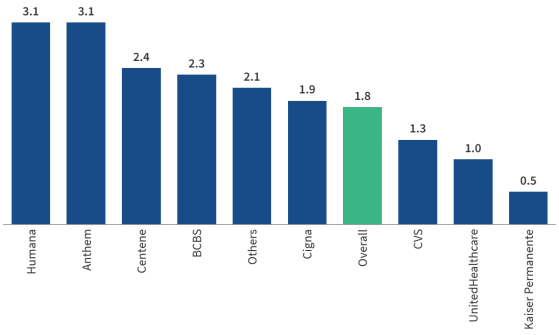
MA Prior Authorization – By Payer

Prior Authorization Determinations Are More Common Among Certain Medicare Advantage Firms

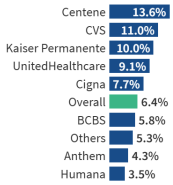
Requests for prior authorization of services per Medicare Advantage enrollee in 2023



: CMS, "Prior Authorization and Pre-Claim Review Program Stats," September 15, 2023 and "Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2023," January 17, 2025.

Firms Denied Between 4% and 14% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2023



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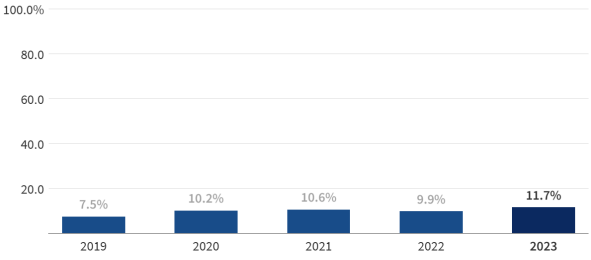
Appeal of Denied Prior Authorization

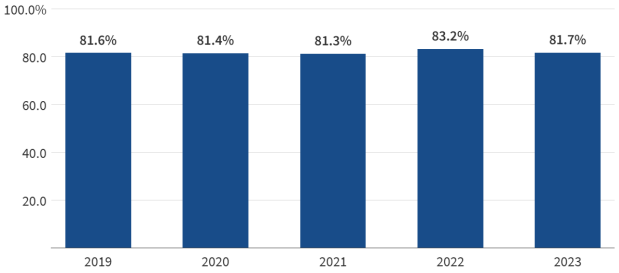
A Slightly Larger Share of Denied Prior Authorization Requests Was Appealed to Medicare Advantage Insurers in 2023 Than in Recent Years

Share of adverse and partially favorable prior authorization determinations that was reconsidered, 2019 - 2023



More Than 80% of Denied Prior Authorization Requests That Were Appealed Were Overturned

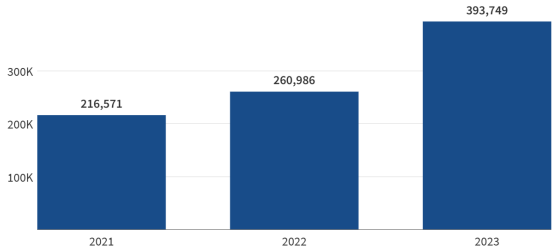
Share of reconsiderations that were fully or partially favorable, 2019 - 2023



Traditional Medicare - Prior Authorization

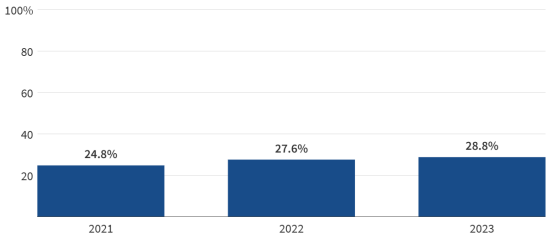
CMS Completed Just Under 400,000 Prior Authorization Reviews for Traditional Medicare in 2023

Reviews completed during the fiscal year



CMS Denied About One-Quarter of Prior Authorization Requests for Traditional Medicare

Share of reviews completed that were non-affirmed during the fiscal year



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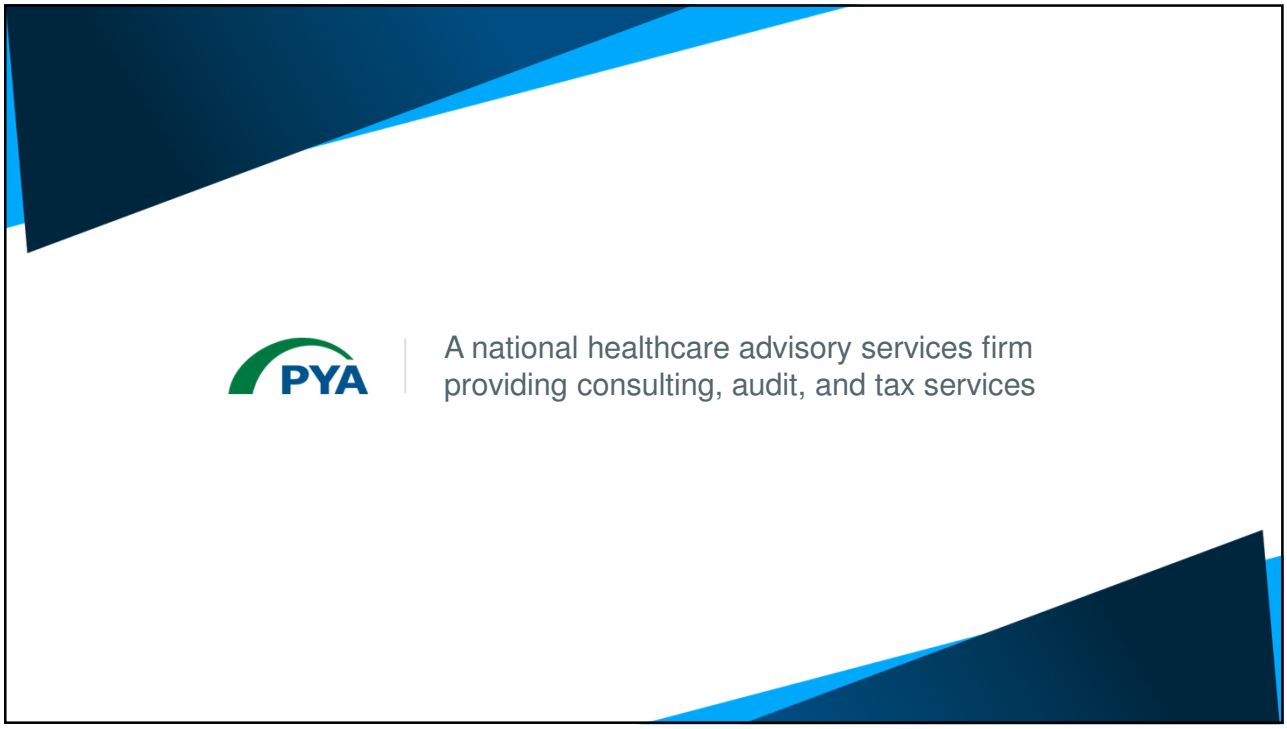
7. Staffing Concerns and Succession Planning: Open Discussion

8. Final Presentations/Other Topics for May

10-15 Minute Presentation (One Per Facility)

- How did you identify, define, and quantify issue to be addressed?
- What solutions did you consider?
- What solution did you elect to pursue?
- Who will be impacted?
- What resources will you require? (e.g., IT solution, staff training, physician buy-in)
- What challenges have you encountered and how will you address them?
- What is your implementation timeline?
- What are your key performance indicators (measures of success)?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