2023 Mid America Summer Institute Aug. 7-9 • Minneapolis

Igniting the Spark

FOR HEALTHCARE TRANSFORMATION

HFMA Region 8

GREATER HEARTLAND • IOWA • MINNESOTA • NEBRASKA
NORTH DAKOTA • SOUTH DAKOTA • SUNFLOWER

> Hospitals are difficult institutions to manage efficiently. They must juggle often-conflicting goals: delivering high volumes of care, providing a diverse range of services, attracting patients from competitors, upgrading equipment, keeping costs under control, avoiding medical errors, and financing uncompensated care. In doing so, they are often constrained by a web of commitments to patients, staff, capital projects, and community partners."

https://www.nationalaffairs.com/publications/detail/the-cost-of-hospital-protectionism

Market Drivers: Tailwinds and Headwinds

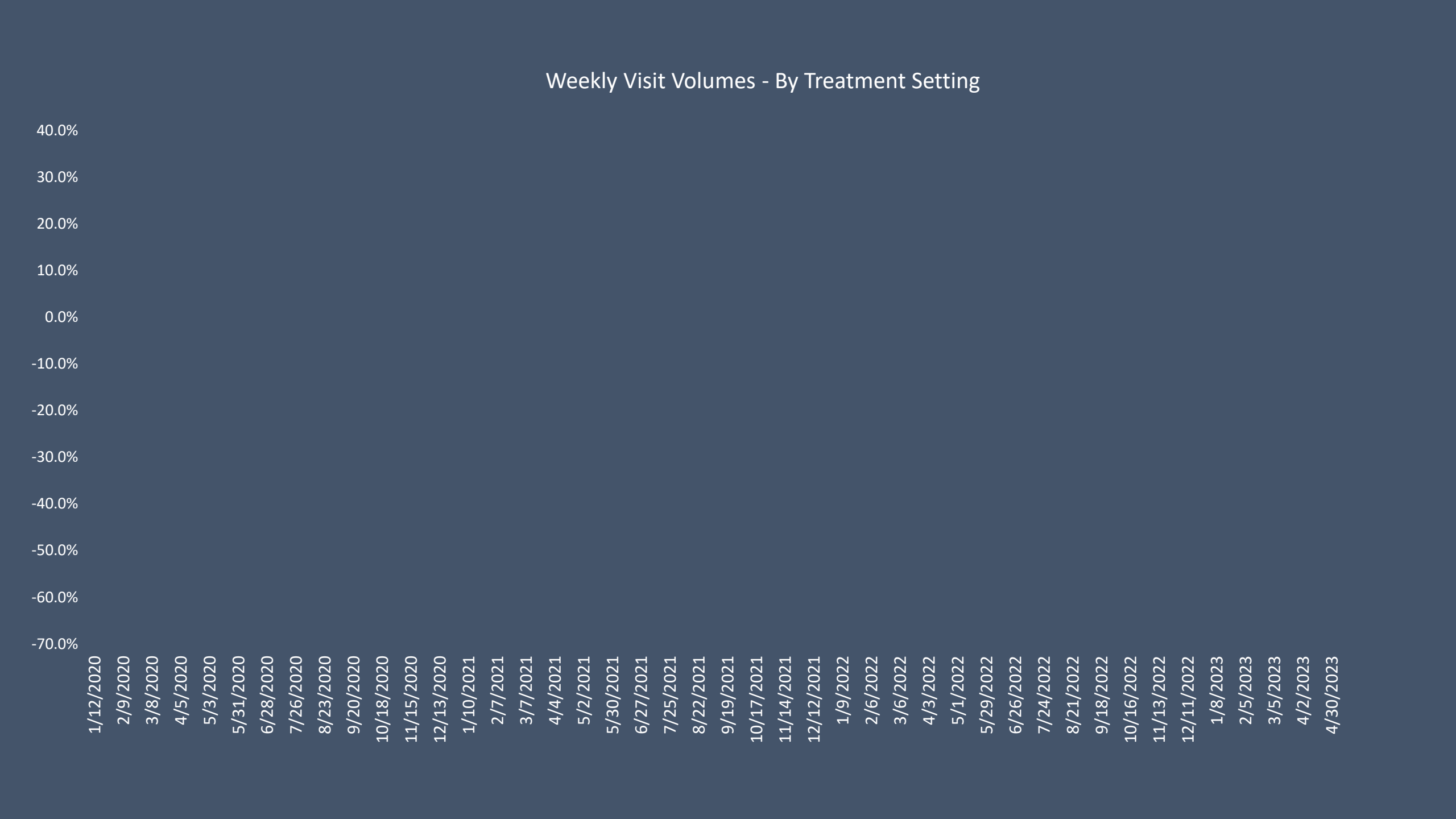
Tailwinds

- **Demographics** – aging population and pandemic related care deficits are stabilizing
- **Technology** – EHR based RCM is inferior to third-party solutions–hospitals know it – they must accelerate cash faster than the EHR can and investing in technology
- **Respect** – Consumers and policymakers know that health systems are a critical piece to the economy

Headwinds

- **Margins challenges** – shortfalls in volume and cash have created a deficit
- **Expenses** – Labor and supply costs have stabilized, but the debt is there – will take some time to fully stabilize
- **Cash** – Bond covenants and declining payer relations have drained cash and difficult to rebound at same rate

https://institutes.kpmg.us/healthcare-life-sciences/articles/2023/hcls-investment-outlook.html


Weekly Visit Volumes - By Treatment Setting
40.0%
30.0%
20.0%
10.0%
0.0%
-10.0%
-20.0%
-30.0%
-40.0%
-50.0%
-60.0%
-70.0%
1/12/2020
2/9/2020
3/8/2020
4/5/2020
5/3/2020
5/31/2020
6/28/2020
7/26/2020
8/23/2020
9/20/2020
10/18/2020
11/15/2020
12/13/2020
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9/18/2022
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11/13/2022
12/11/2022
1/8/2023
2/5/2023
3/5/2023
4/2/2023
4/30/2023

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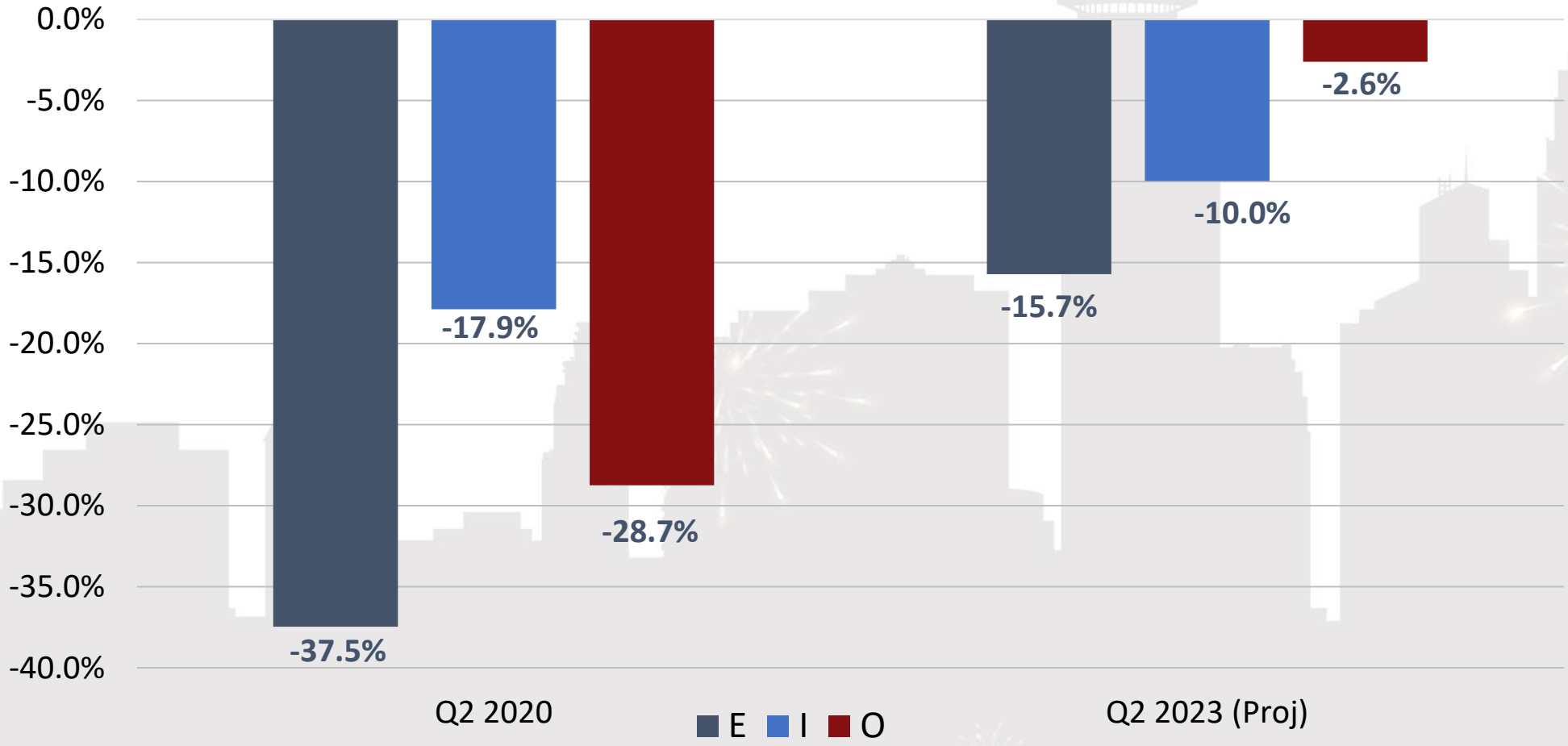
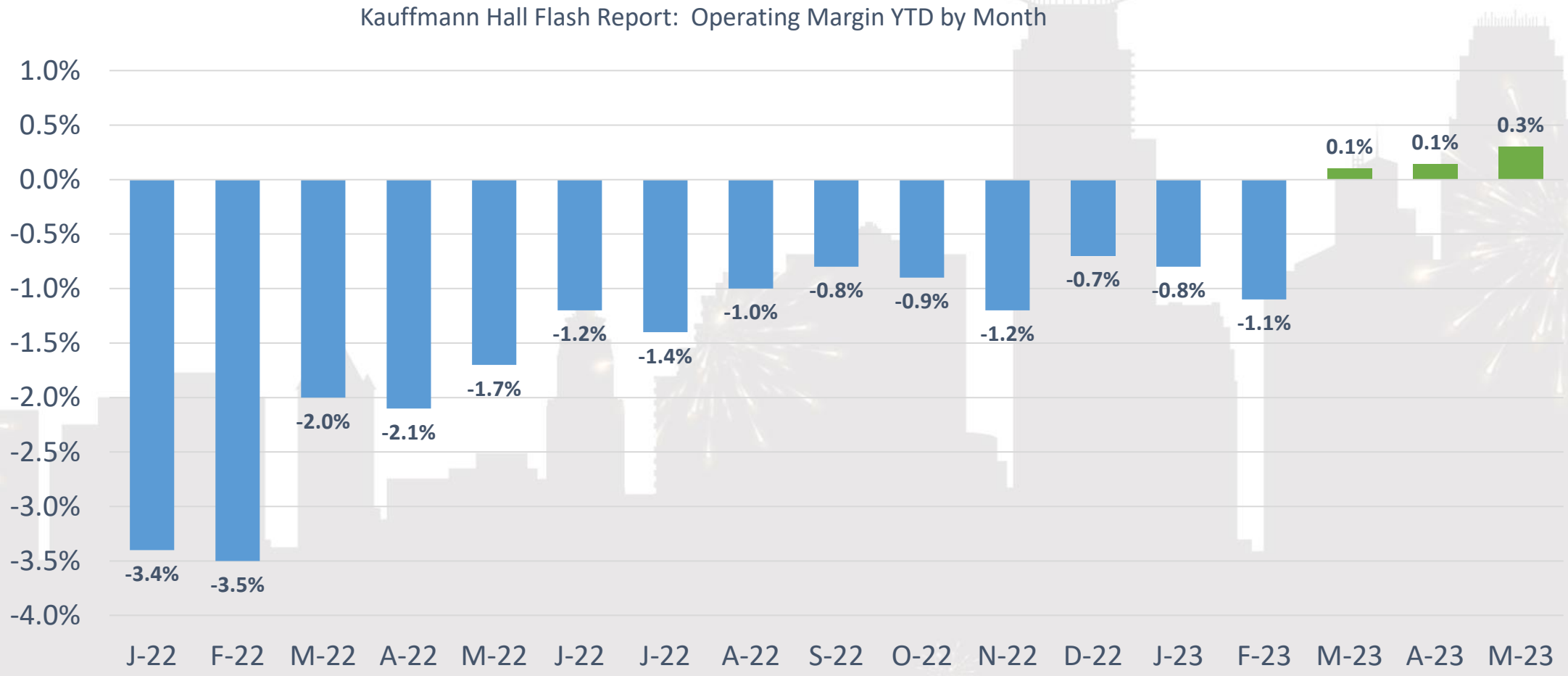
Significant recovery in Q2 2023 volumes as compared to 2020

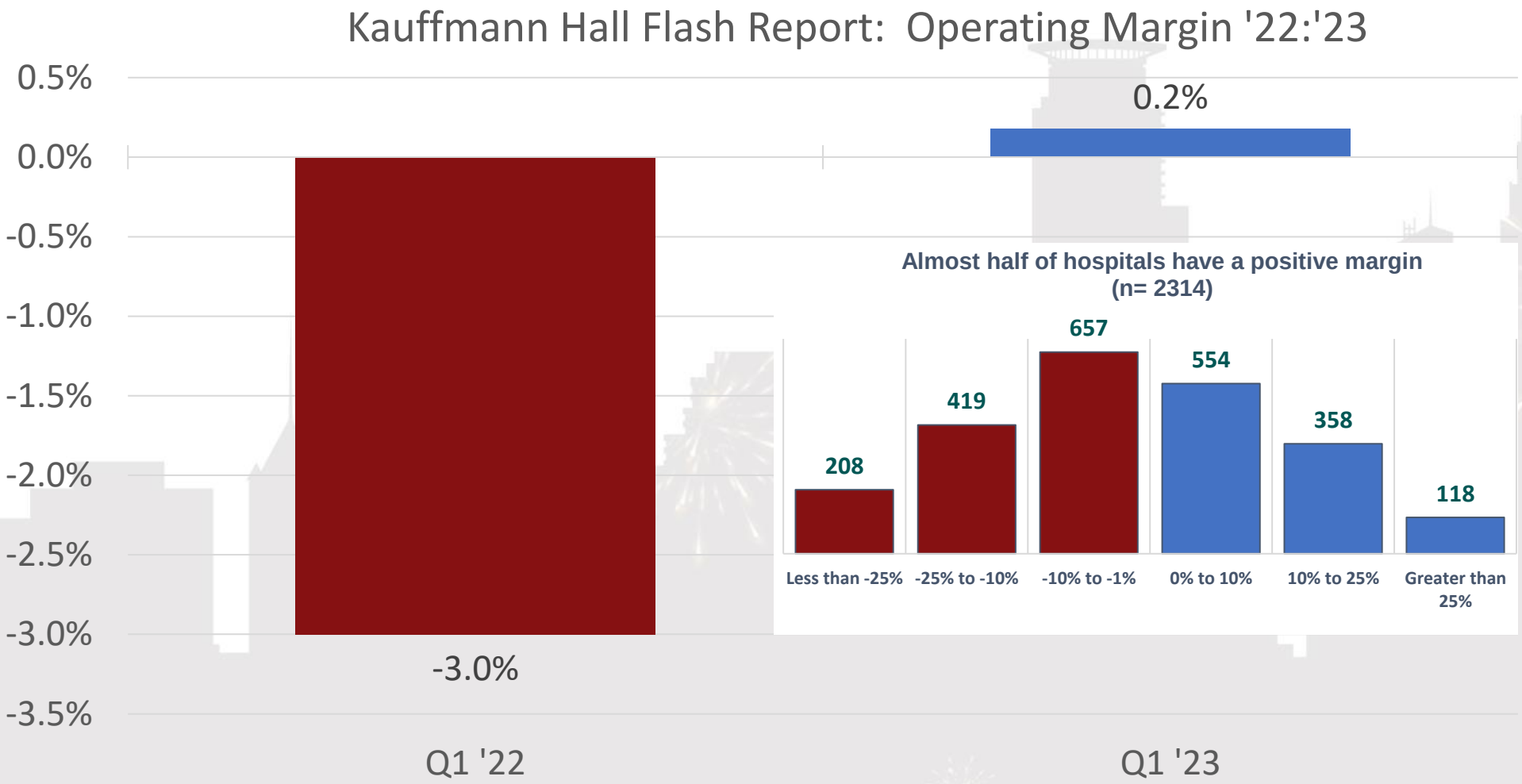


Hospitals had a challenging 2022 … an entire year in red … but recovering in 2023



https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2023

2023 margins are vastly improved



https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-may-2023

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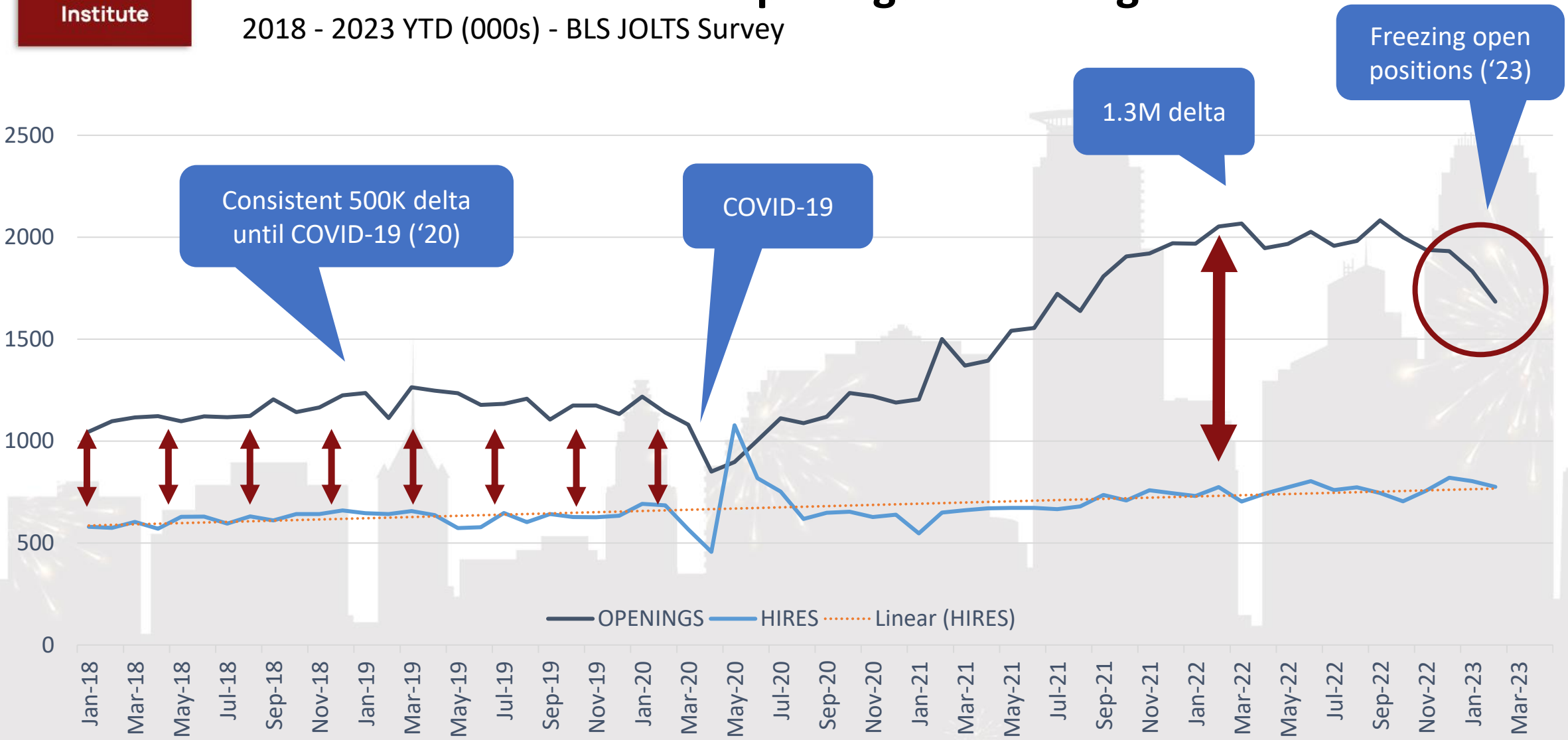
US Healthcare Position Openings and Hirings

2018 - 2023 YTD (000s) - BLS JOLTS Survey



SOURCE: BLS. https://www.bls.gov/jlt/data.htm

Shortage of RCM Labor Dramatically Impacts Revenue

- **48%** — **patient billing errors**
- **45%** — **long hold times** for scheduling and customer service calls
- **44%** — **cancellations and rescheduling** due to staff shortages
- **29%** — **issues with price transparency compliance**
- **20%** — **operational deficiencies** due to the labor shortage

https://www.hcinnovationgroup.com/finance-revenue-cycle/revenue-cycle-management/news/21272867/survey-cfos-rcm-vps-facing-severe-cost-staffingshortage-challenges

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Fitch – 2023 recovery; slow and "good performance" the exception, not the rule

"… **labor pressures** and generationally elevated **inflation**, **compressing margins** for virtually all providers

…became **highly pronounced in a very short period of time**

…compounded **by investment losses**

…2023 not expected to show a rapid operational recovery

…A select few health systems continue to enjoy **strong operating margins**, which is a **mark of distinction** in the current sector landscape…"

https://www.beckershospitalreview.com/finance/hospitals-faced-worst-operating-year-ever-in-2022-fitch.html

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Challenges

Payers:

- Automated claims clearinghouse
- Changing rules – DENIALS!
- Sophisticated actuarial analytics
- No urgency to pay claim
- Lots of tools, missing clinical “story”

Providers:

- Fixed resources
- Inventory mixed
- Wasteful claim touches
- Lack of analytics/insight
- Need revenue ASAP
- Have clinical data

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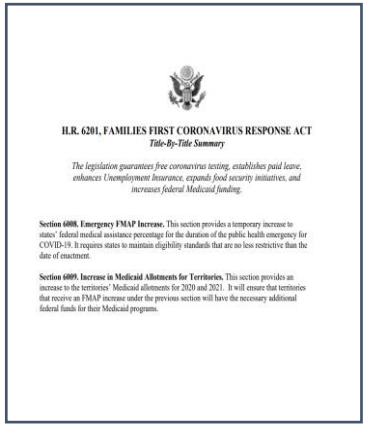
Medicaid redeterminations and the PHE

Pre-Covid-19

State agencies and providers redetermine Medicaid eligibility **month-to-month**

Covid-19 / Public Health Emergency (PHE) / Family First Coronavirus Response Act (FFCRA)



H.R. 6201, FAMILIES FIRST CORONAVIRUS RESPONSE ACT

Title-By-Title Summary

The legislation guarantees free coronavirus testing, establishes paid leave, enhances Unemployment Insurance, expands food security initiatives, and increases federal Medicaid funding.

Section 6008. Emergency FMAP Increase. This section provides a temporary increase to states' federal medical assistance percentage for the duration of the public health emergency for COVID-19. It requires states to maintain eligibility standards that are no less restrictive than the date of enactment.

Section 6009. Increase in Medicaid Allotments for Territories. This section provides an increase to the territories' Medicaid allotments for 2020 and 2021. It will ensure that territories that receive an FMAP increase under the previous section will have the necessary additional federal funds for their Medicaid programs.

"States must apply Medicaid eligibility standards, methodologies, and procedures that are **no more restrictive** than those in effect on January 1, 2020….and must provide **continuous eligibility through the end of the month in which the PHE ends**"

April 1, 2023 – April 2024

State agencies and providers perform **redeterminations month-to-month with cascading FMAP**

Medicaid enrollment and disenrollment (based on income)

Continuous enrollment requirement (CER) in place during PHE. States ease enrollment MOEs. **Medicaid grows** and **redeterminations frozen** with additional funding (FMAP)

Phased Medicaid enrollment and disenrollment (based on income)

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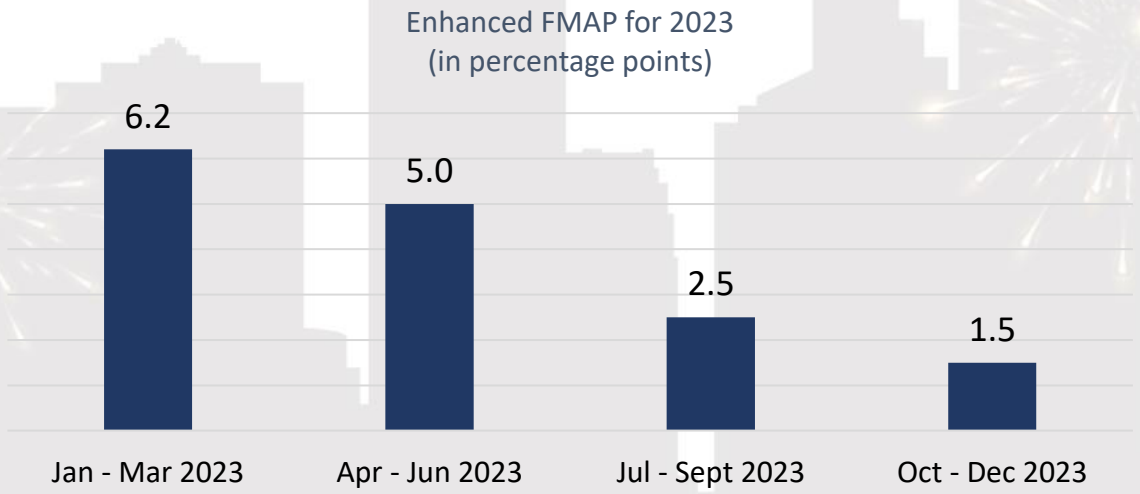
New Framework For End of Continuous Coverage

Continuous Coverage De-Linked from PHE

- Beginning April 1, 2023, states may begin disenrolling Medicaid enrollees who are no longer eligible after conducting a fresh and complete renewal
- Current maintenance of eligibility (MOE) requirements continue to apply through March ‘23
- New MOE requirements starting April 1, 2023

Enhanced FMAP Phases Down

- States that comply with applicable MOE requirements will receive:



https://ccf.georgetown.edu/2021/08/02/webinar-series-unwinding-the-covid-19-medicaid-continuous-eligibility-provision/

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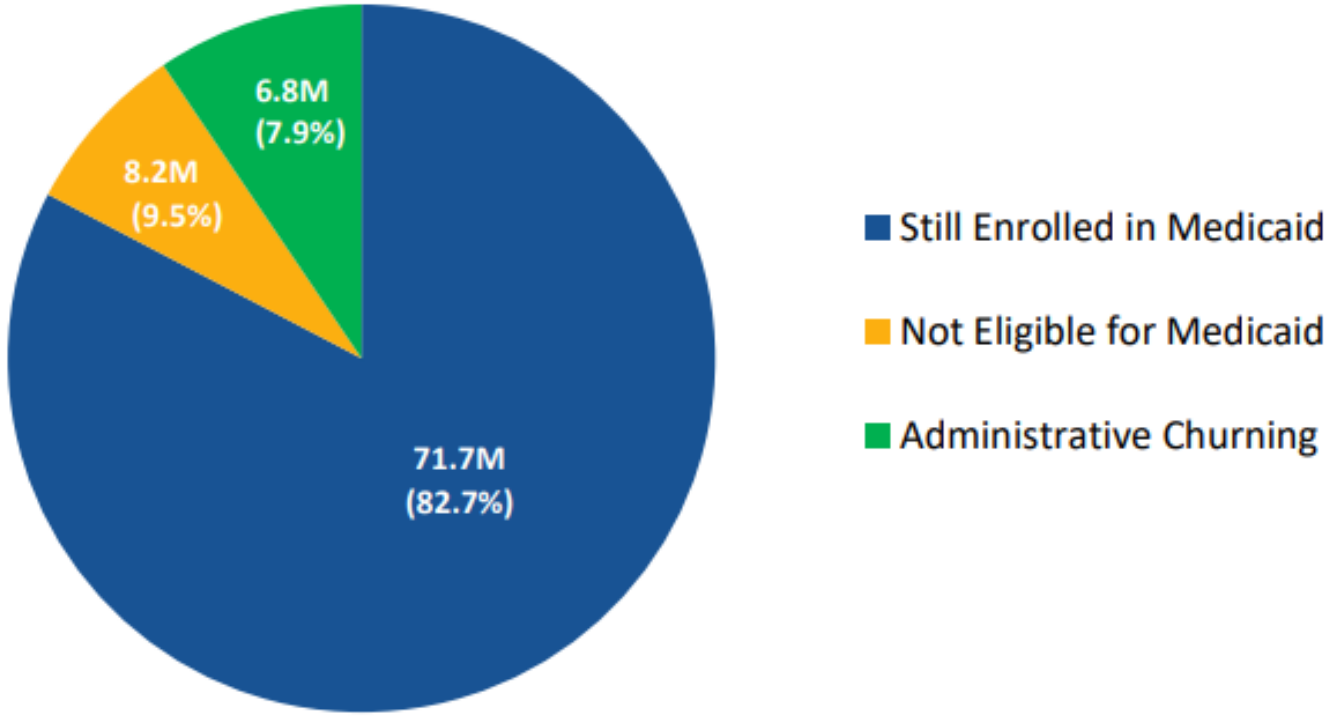
15M Medicaid enrollees lose coverage with PHE expiration

Predicted Eligibility, Ineligibility, and Administrative Churn Among Medicaid Enrollees at End of PHE



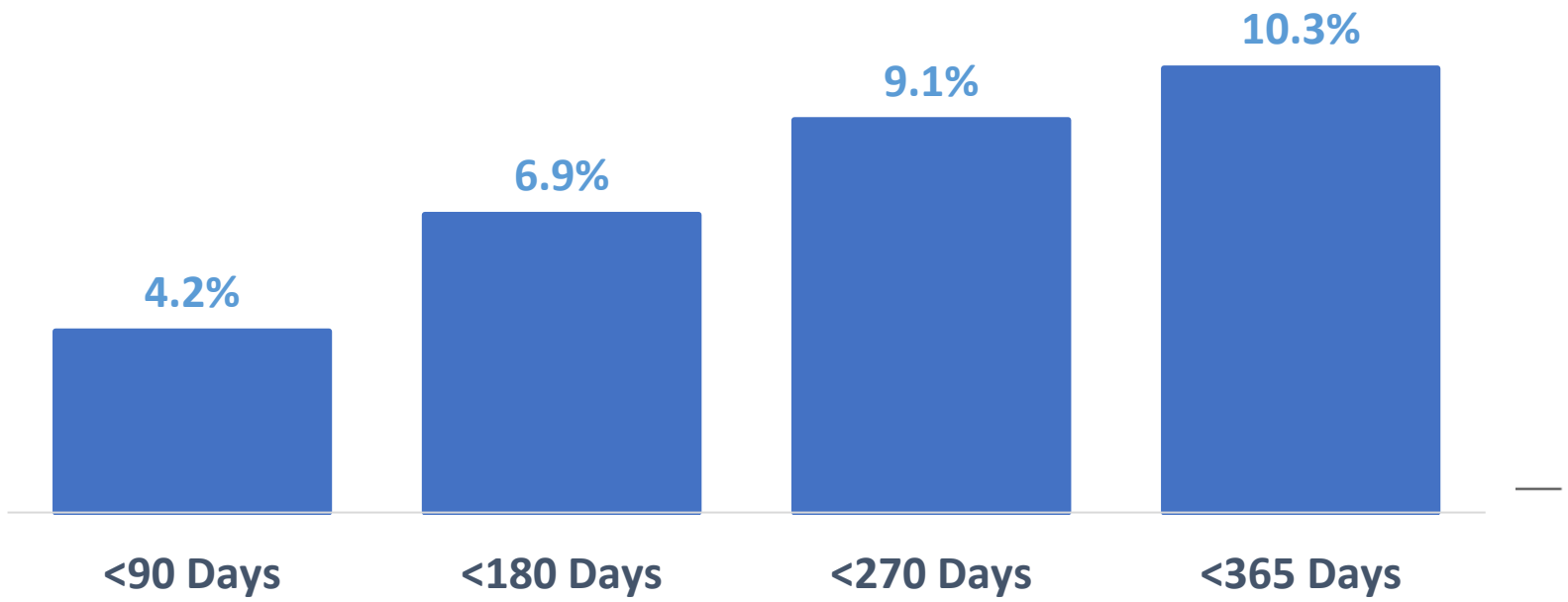
* Administrative churning refers to the loss of Medicaid coverage despite ongoing eligibility, which can occur if enrollees have difficulty navigating the renewal process, states are unable to contact enrollees due to a change of address, or other administrative hurdles. The risk of administrative churning may be particularly high after the PHE due to the volume of redeterminations states must conduct and the time since Medicaid agencies last communicated with many beneficiaries.

https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

“Churn” has real implications in 2023-2024

Share of Medicaid Enrollees Who Disenrolled Then Re-Enrolled In Less Than One Year

Percent of full-benefit Medicaid/CHIP enrollees who disenrolled and then re-enrolled within varying time periods, 2018



SOURCE: KFF analysis of the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files (RIF).

KFF

Hospitals:

- revenue stream is **volatile**
- operations, supply and labor **costs are high**

MAJOR focus on

“expense management”

- RCM vendor performance has been **difficult** to measure, **expensive** to maintain, and **duplicative** in offerings

- Hospitals are closely evaluating third party relationships – looking to **consolidate** or **eliminate**

RCM market has had rapid growth with mixed results

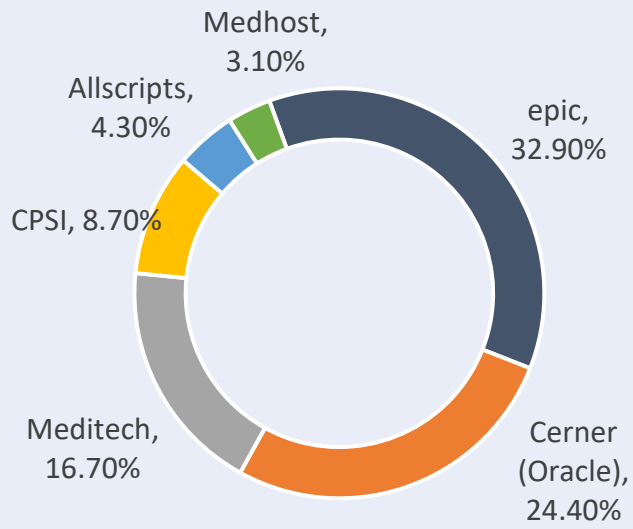
Majority of hospitals have an EHR, and 70%+ use 3rd party RCM vendors

Third party RCM software by type 2022:2021

RCM Function	2022	2021	+ / - YOY
Charge capture	80%	85%	-5%
Claims management	100%	90%	10%
Clinical Documentation Improvement	87%	78%	9%
Denial management	70%	68%	2%
Medicaid eligibility	84%	76%	8%
Patient engagement	86%	89%	-3%
Patient financing	79%	68%	11%
Prior Auth	68%	86%	-18%
Presumptive charity	73%	68%	5%
Estimation	82%	100%	-18%
Propensity to pay	56%	68%	-12%
Eligibility / Discovery	91%	90%	1%

EHR technology is widely adopted but falling short in RCM performance

EHR Market Prevalence



https://klasresearch.com/report/us-hospital-market-share-2022-strong-purchasing-energy-across-large-small-and-standalone-hospitals/1935

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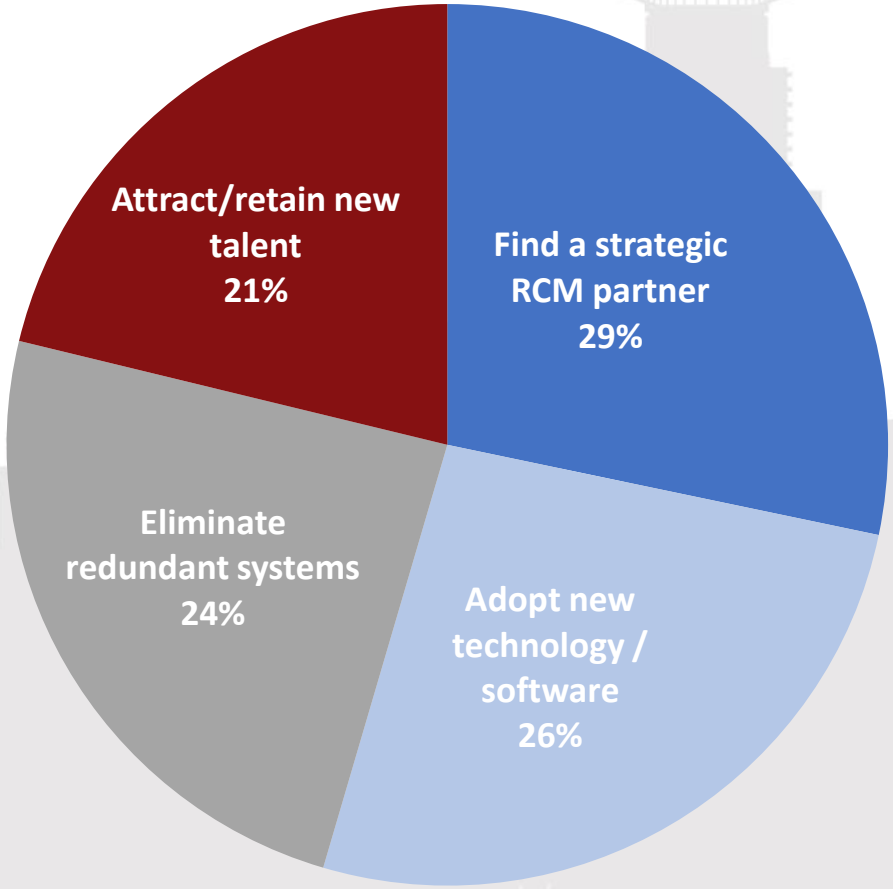
Varying Approaches to Navigating the Staffing Crisis in Revenue Management

Strategic focus for remaining 2022

n = 205 CFOs and vice presidents of revenue cycle



https://akasa.com/press/filling-the-gaps/https://www.hcinnovationgroup.com/finance-revenue-cycle/revenue-cycle-management/news/21272867/survey-cfos-rcm-vps-facing-severe-cost-staffingshortage-challenges

Unlocking a Mass Migration in Revenue Management

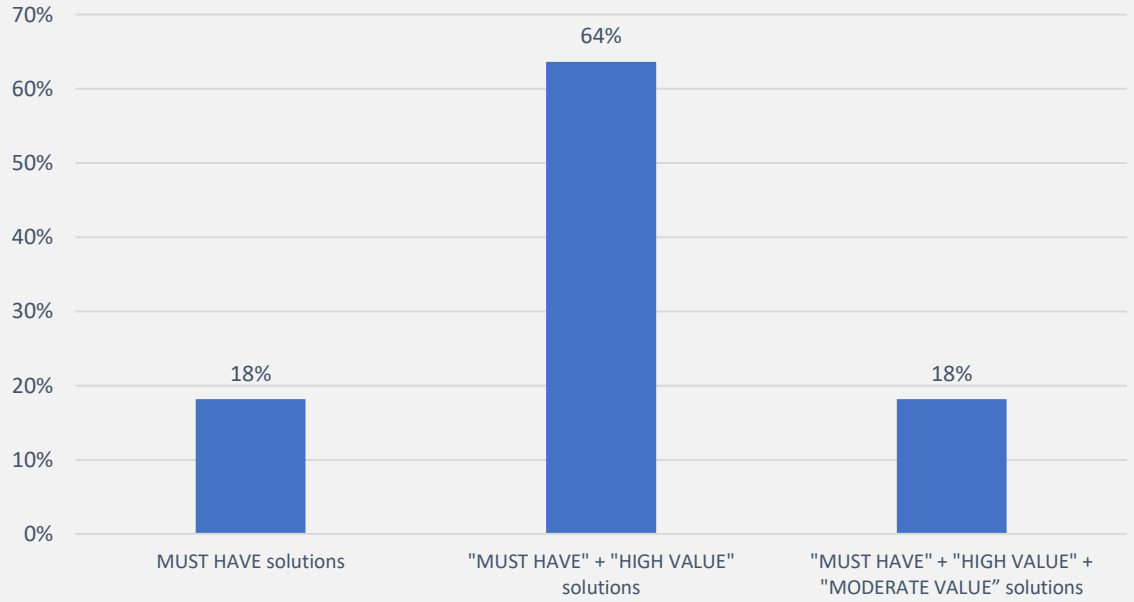
A majority of healthcare financial leaders will migrate to a single vendor revenue management platform when robust functionality is available.

Early Adopters
18 percent of respondents will begin their migration when all “must have” functionality is available in an end-to-end platform.

Middle Majority
64 percent of respondents will migrate when all “must have” and all “high value” functionality is available in an end-to-end platform.

Laggards
The remaining **18 percent** of respondents will migrate when all “must have”, “high value”, and “moderate value” functionality is available in an end-to-end platform.

From a functionality standpoint, under what conditions would your organization migrate away from its current RCM strategy to a single-vendor RCM platform?



Source: FinThrive AlphaSights CFO Survey, 2022

Rethinking revenue management in the healthcare ecosystem

Less complexity by consolidating vendors

Reduced level of IT work

Improved data security

Improved cost-efficiencies

Higher ROI from solution synergy

Best-in-breed solutions

Vision for Future State Payer-Provider Collaboration

Unite the provider and payer onto a common technology to reduce friction, improve operational efficiency and eliminate unnecessary costs

Healthcare Revenue Cycle

- Eligibility Request
- Prior Authorization Request
- Deductible Request
- Encounter / Claim Submission
- Annual Contract Modeling
- Claims Payment Remit Acceptance
- Patient Statement

Payer / Health Plan

- Eligibility Determination
- Prior Authorization Determination
- Deductible Confirmation
- Encounter / Claim Acceptance
- Annual Contract Modeling
- Claims Payment (Remittance)
- Explanation of Benefits / Explanation of Services

What does “good” look like?

REVENUE MANAGEMENT KPIS (Q2 2023)

ITEM	KPI	DESCRIPTION	BENCHMARK	VALENCE	SOURCE(s)
1	A/R Days (days)	Measure of revenue cycle efficiency. Measurement of the length of time it takes receive and post payments for medical services after discharge. Common measurement for performance of all functions of revenue cycle management. CALCULATION*: A/R days = A/R balance/average daily charge amount. Gross	**43.3**	↓	HBI
2	Denials (% of NPR)	Denial write-offs as a percent of net patient revenue (NPR). Refusal of an insurance carrier to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional. Goal is to minimize claim touches and maximize first pass yield on clean claims. CALCULATION*: Total dollar amount of claims denied by payers divided by the total dollar amount of claims submitted. Gross	**2.0%**	↓	HBI
3	Cost to Collect (%)	Indicator of operational performance, measures the efficiency and productivity of revenue cycle process. Includes labor, software and any services involved in collecting patient and payer revenue. CALCULATION*: Total revenue cycle cost divided by total revenue collected within a given period. Net	**2.5%**	↓	HBI
4	Bad Debt (% NPR)	Indicates organization's ability to collect on accounts and identify payer sources for those who cannot meet financial obligations. Can point towards missed opportunities in classifying patients into payment or charity buckets, as well as compliance with payer rules. CALCULATION*: Divide the amount of bad debt by the total accounts receivable for a period. Gross	**2.3%**	↓	HBI
5	POS Collections (% NPR)	Patient payments prior to or at time of service and up to seven days after discharge and/or patient cash collected on prior service(s) at the time of a new service. Accelerates cash collections and can reduce collection costs. CALCULATION*: POS cash collected divided by total cash collected during a given period. Net	**0.9%**	↑	HBI
6	Charity Care Adjustments (% NPR)	Trending indicator of the performance the provider's financial assistance policy. Indicates services provided under the provider's financial assistance policy for the under or uninsured. CALCULATION*: Dollars of accounts qualifying for charity care divided by total account dollars. Bad debt, shortpayments and charity care make up total uncompensated care. Gross	**1.3%**	↓	HBI
7	% A/R > 90 days	Total insurance AR aged greater than 90 days from discharge as percent of all discharged AR that is not in DNFB, BD or in credit status. Net	**24.0%**	↓	HBI
8	Clean Claim Rate	Total clean claims number divided by total number of clean claims	**90.0%**	↑	HBI
9	Operating Margin (%)	Indicator of the income derived from patient care operations. Profitability indicators measure the extent to which the organization is using its financial and physical assets to generate a profit. CALCULATION*: (Total operating revenue – total operating expenses) ÷ total operating revenue. Net	**0.7%**	↑	BECKERS
10	Days Cash on Hand	Represents the amount of money it takes to pay all of the hospital's expenses for that number of days. CALCULATION*: Dividing unrestricted cash and cash equivalents by the system's average daily cost of operations, excluding depreciation (annual operating expenses, excluding depreciation, divided by 365). Net	**221.0**	↑	BECKERS

We are rethinking revenue management (R2M)

KPI-based approach to move the needle for holistic revenue improvement

Metric (KPI)	25th percentile	50th percentile	75th (Goal) percentile
Denial adjustment	2.1% NPR ($7M)	1.3% NPR ($5M)	1.0% NPR ($4M)
Bad Debt	8.1% NPR ($28M)	5.3% NPR ($19M)	2.6% NPR ($9M)
Cost to Collect	3.4% NPR ($12M)	3.3% NPR ($12M)	2.9% NPR ($10M)
Contract Yield	6.2% NPR ($22M)	4.5% NPR ($16M)	2.8% NPR ($10M)

Financial Opportunity	Value ($)	Improvement (%)
25th to 50th	**$18.3M**	+ 7.7
50th to 75th	**$17.9M**	+7.6
75th to 90th	**$13.4M**	+6.3

Financial Model Impact

- 350 bed standalone
- $350M net patient revenue
- 2.5% Operating margin

Adapted from Advisory Board

Summary

“This is like changing a tire on a race car going around the track;

near-term versus long-term

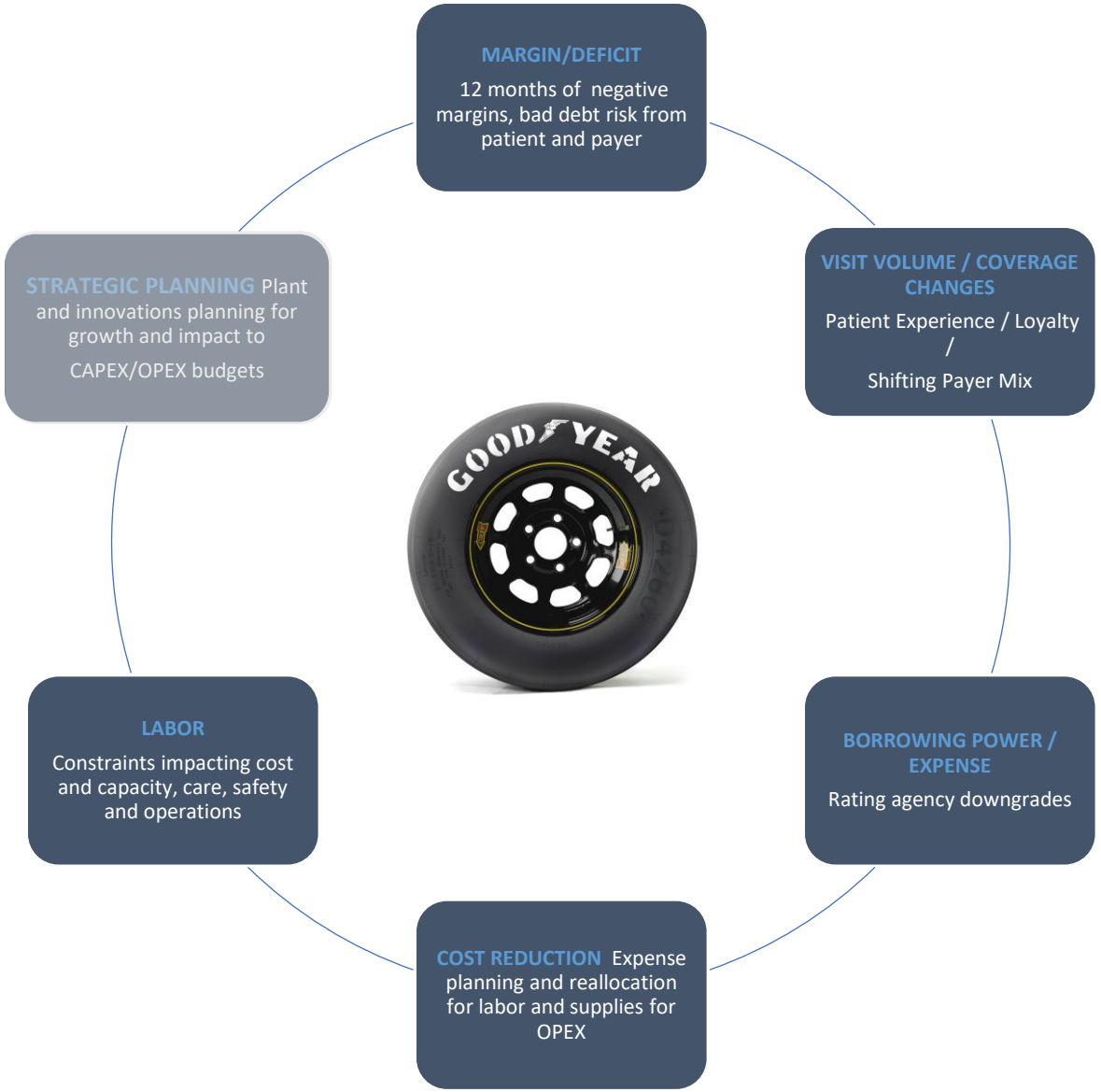
…things are moving very fast…”

Lisa Goldstein, senior vice president at Kaufman Hall

https://www.fiercehealthcare.com/providers/2023-forecast-7-immediate-and-long-term-priorities-hospital-leaders

Pressure and priorities

Will 2023 be a "good year" for health systems and hospitals?



Summary

- Market headwinds forecast of year of recovery for hospitals
- Cash is “king” from patient and payers
- Optimizing people, process, and technology can automate your revenue management to offset labor constraints
- Having a foundational revenue management strategy leads to best-in-class performance

If we are to ensure that healthcare remains affordable and widely available for future generations, we need to **radically rethink** how we provide and manage it - in collaboration with key health system partners - and apply the technology that can help achieve these changes.

Frans van Houten
CEO, Phillips

Questions?

Thank you!

Jonathan G Wiik MHA MBA FHFMA

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