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25th Annual Revenue Cycle Conference
Tailgates, Touchdowns, & Revenue Cycle Championships!
It's time……to Reignite!

ACCELERATING THE TRANSITION TO A PATIENT-CENTRIC REVENUE CYCLE

Erica Napolitano & Richard Riter

January 26, 2024

SPEAKER INTRO

Erica Napolitano

Former healthcare leader with more than 20 years of hospital operations experience.

- Patient Access
- Revenue Cycle
- Financial Counseling & Navigation
- Oncology, Surgery and Imaging Operations

Richard Riter

Leader of Moss Adams Revenue Cycle Consulting practice, background includes:

- Working in large, multi-state health systems and AMCs
- All areas of revenue cycle

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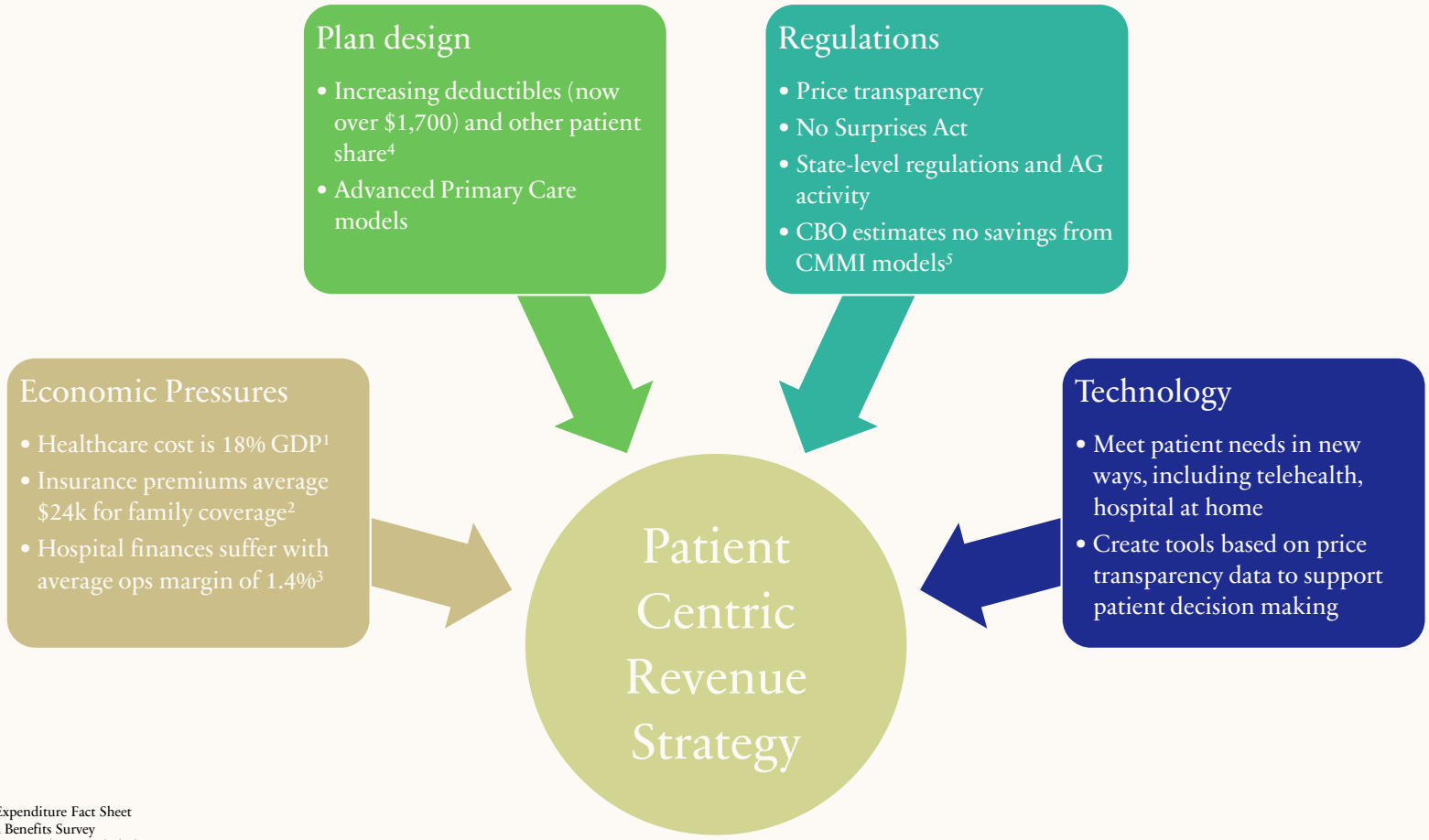
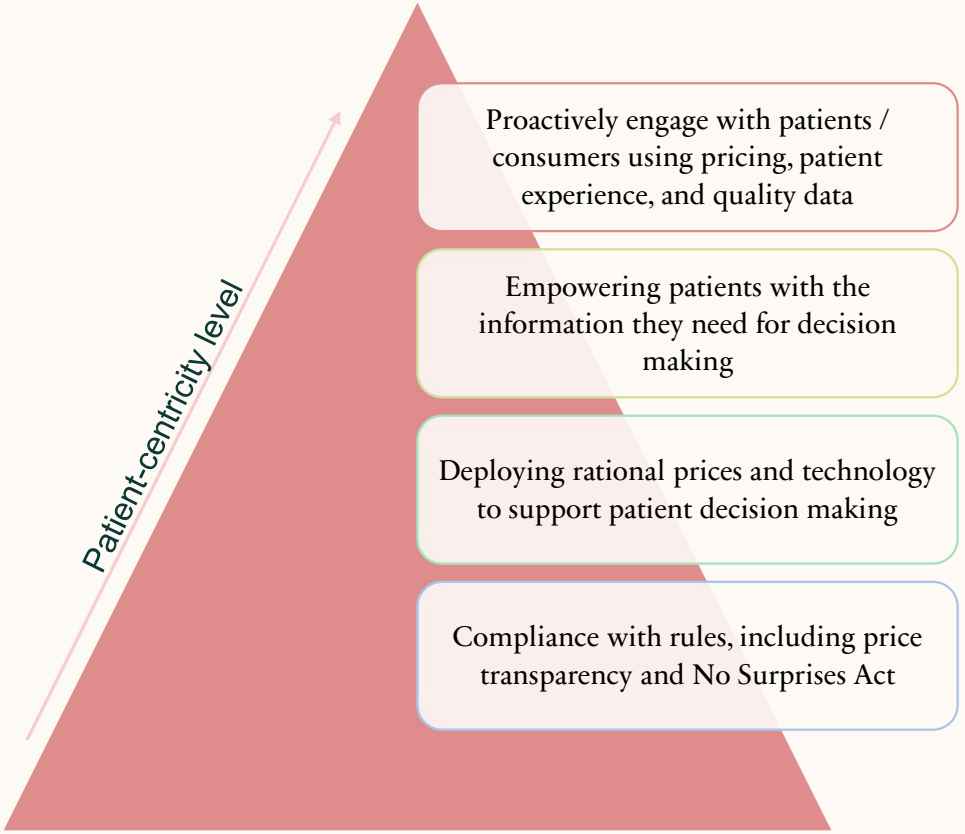
PURSUING A PATIENT CENTRIC REVENUE STRATEGY IS BECOMING CENTRAL TO PROVIDER SUCCESS



Data Sources:
[1] CMS 2023 National Health Expenditure Fact Sheet
[2, 4] 2023 KFF Employer Health Benefits Survey
[3] October 2023 Kaufman Hall National Hospital Flash Report
[5] CBO September 2023 report on Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation

PROVIDERS ARE AT VARYING STAGES IN DEPLOYING PATIENT-CENTRIC STRATEGIES

Many **traditional providers** are still **struggling with compliance**, while **non-traditional players** are making in-roads with **patient-centric strategies** that capture the most financially advantageous patient populations.



REV CYCLE IS KEY TO HEALTH SYSTEMS' PATIENT CENTRICITY STRATEGIES

Quality

- Patient outcomes
- Patient perception of quality

Cost

- **Pricing / cost transparency**
- Value-Based Care

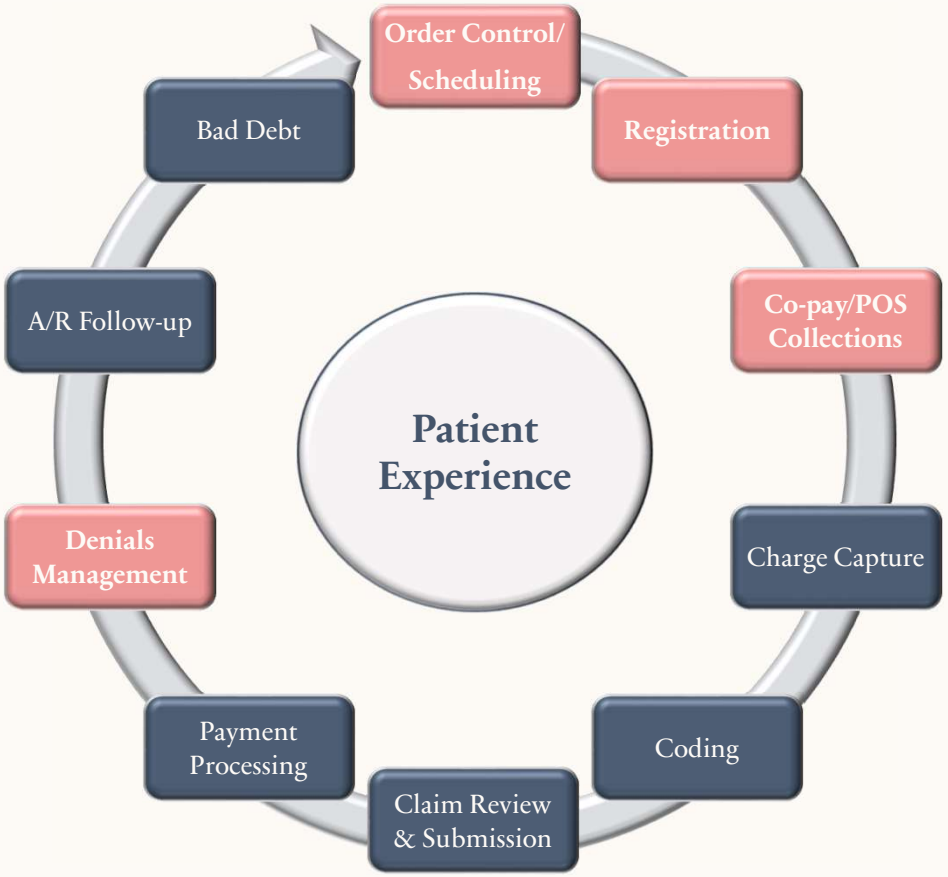
Patient Experience

- Communication
- **Clinical and financial patient navigation assistance**
- Patient access / scheduling
- Venues of care based on patient need: urgent care, physician offices, hospital at home
- Digitally enabled services, including tele-health and asynchronous care

CLINICAL & FINANCIAL PATIENT NAVIGATION ASSISTANCE

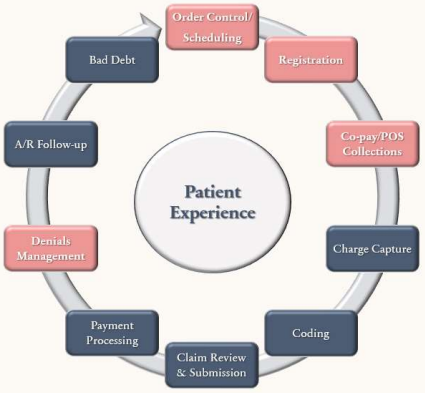
Reducing Financial Toxicity

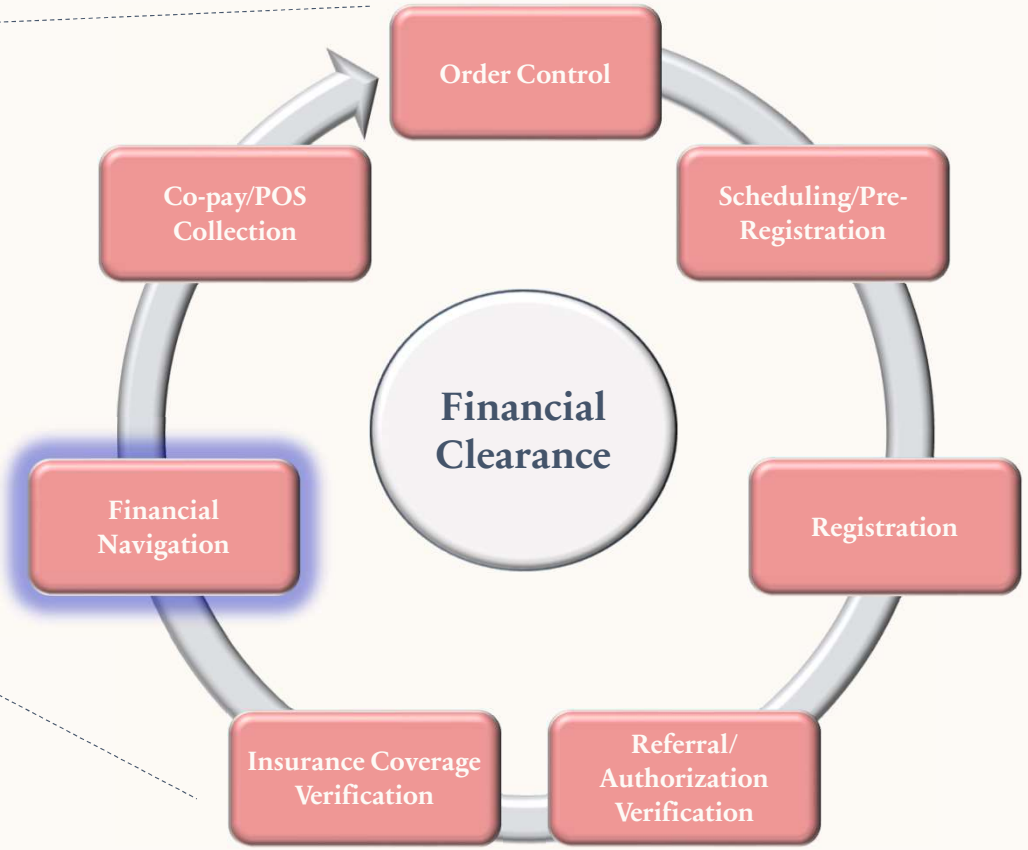
IT STARTS WITH FINANCIAL CLEARANCE



Financial Clearance Responsibilities

INCORPORATE FINANCIAL NAVIGATION





NEW HAMPSHIRE HOSPITAL CASE STUDY

Norm's Story

BACKGROUND

- Diagnosed with an aggressive stage 4 cancer
- Insurance would not cover prescribed immunotherapy
- Treatment regime deemed 'off-label'
- Estimated out-of-pocket cost over $20,000 per treatment
- Patient could not afford treatment costs and declines care
- Meets with Financial Navigator and wishes for "one more Christmas" with his family

Norm's Story *continued…*

OUTCOME

- Financial Navigator immediately looked into ways to help the patient
- Co-pay assistance not applicable for off-label
- Drug replacement was new and took some time to get approved
- The patient got his wish and had several more holidays with his family

"The Financial Navigator worked with us, so Norm was able to get the drug. And now, two years later, he's still alive to celebrate another holiday season with us!"
-Pat

ADDRESSING THE COST OF CARE

Financial Toxicity

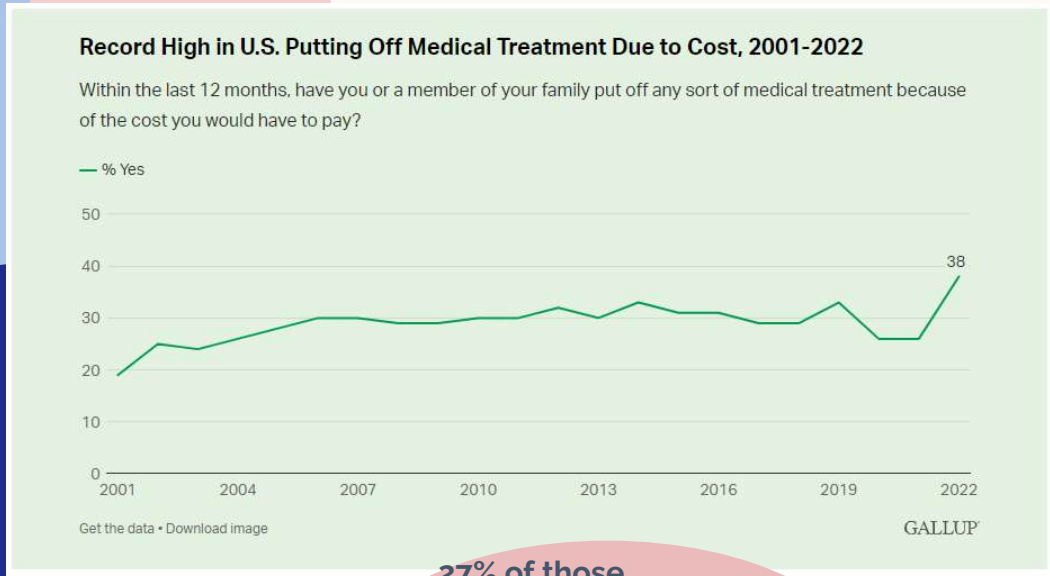
- A term used to describe the financial impact of care/treatment
- Applicable to any patient with a chronic high-cost disease or illness
- Driven by a combination of factors including:
  - High out-of-pocket treatment/drug costs, including high co-pays and deductibles
  - Reduced income due to not being able to work
  - Being underinsured or uninsured

IMPACT OF THE COST OF CARE ON PATIENTS

- Patients under extreme financial distress have a reduced quality of life
- A recent study correlated financial hardship in cancer patients to increased mortality rates[1]
  - Among cancer patients ages 18-64, 30% reported medical financial hardships
  - Of those 30%, there was a 17% excess mortality rate
  - More research is needed for other disease types
- Extends beyond the patient to their family members and loved ones
- Patients will have less ability to pay out-of-pocket costs owed to their Provider

Data Sources:
[1] Journal of National Cancer Institute; Association of Medical Financial Hardship and Mortality Among Cancer Survivors in the United States
[2] https://news.gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx?utm_source=linkedinbutton&utm_medium=linkedin&utm_campaign=sharing

WHY DOES THIS MATTER?



27% of those Americans also reported that the treatment delayed was for a very or somewhat serious condition[2]

SIGNS OF FINANCIAL TOXICITY

- Missing doctor visits or treatments
- Skipping prescription refills or taking less than prescribed to prolong the time between refills
- Reduced spending on necessities such as food, clothing, or utilities
- Inability to pay bills
- Maxed out credit cards
- Increased stress, anxiety and depression

PATIENT EXPERIENCE MATTERS

Better patient health outcomes

Happy patients are loyal patients

Loyal patients will refer family and friends

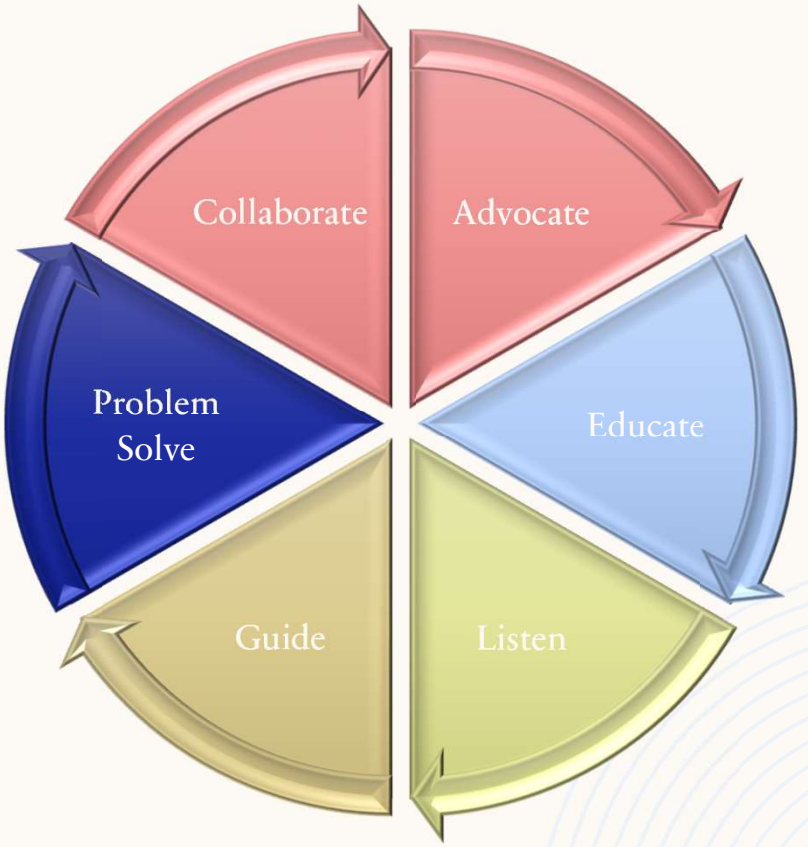
Informed patients are better positioned to pay out-of-pocket costs

Consumerism in healthcare is growing

Increases employee satisfaction

FINANCIAL NAVIGATION PROGRAM

- Financial Conversations
- Benefits Investigation
- Insurance Coverage Optimization
- Prior Authorization Obtainment/Verification
- Patient Education
- Identification of Assistance Programs
- Facilitation of Insurance/Billing Issue Resolution



BENEFITS OF IMPLEMENTING CLINICAL & FINANCIAL NAVIGATION PROGRAMS

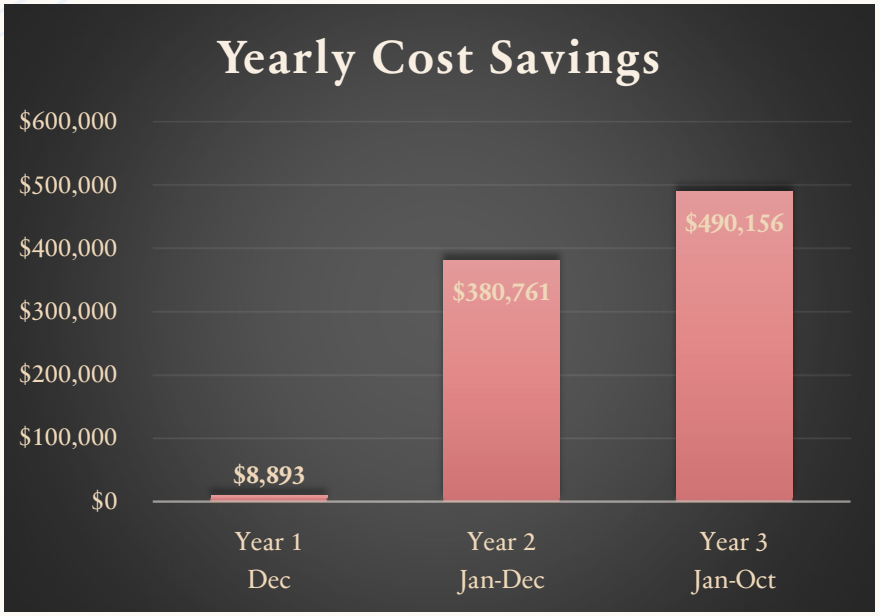
Increased patient satisfaction

Medication and treatment adherence

Improved quality of life

Patient retention within the health system

FINANCIAL IMPACT



WHAT HEALTHCARE PROVIDERS CAN DO

Offer more complex patients financial navigation services
(cancer, cardiovascular disease, autoimmune diseases, neurological diseases)

Provide estimates for all scheduled services

Knowing the costs up front, versus after the fact, empowers patients in decision making

Keep a list of resources available to support patients

Include financial navigators as part of the multi-disciplinary care team

PRICING / COST TRANSPARENCY

Move Beyond Compliance

NO SURPRISES ACT AND PRICE TRANSPARENCY SIGNIFICANTLY CHANGE PAYER/PROVIDER DYNAMICS

No Surprises Act

- Establish IDR process to resolve out-of-network disputes
- Require good faith estimates for uninsured / self pay individuals
- Establish patient-provider dispute process for uninsured / self pay individuals
- Provide a way to appeal certain health plan decisions
- Incentivize some providers to re-evaluate relationship with hospitals

Combined Impact

- Full pricing information disclosed, which allows payers to pressure providers for the most advantageous peer payer's rates
- Establishes a default price if no agreement, while still being litigated, may be beneficial to payers
- Removes patients from the middle of payer / provider disputes as there is not risk of balance billing
- The cost and friction of submitting a claim for IDR reduces the value for the initiating party, generally the provider
- Network adequacy requirements remain important, and may become more important in the future

Price Transparency

- Publish all payer rates
- Provide patients with rate information via either shoppable service list or patient estimator tool
- Supports creation of aggregation of pricing information for app development and advocacy

CMS HAS IMPOSED CIVIL MONETARY PENALTIES ON FOURTEEN HOSPITALS THROUGH 9/30/2023

Enforcement actions publicized by CMS, as of 9/30/2023

Date Action Taken	Hospital Name	CMP Amount	Effective Date
2022-06-07	Northside Hospital Atlanta	$883,180	2021-09-02
2022-06-07	Northside Hospital Cherokee	$214,320	2021-09-09
2023-04-19	Frisbie Memorial Hospital	$102,660	2022-10-24
2023-04-19	Kell West Regional Hospital - Under Review	$117,260	2022-07-08
2023-07-20	Falls Community Hospital & Clinic	$70,560	2023-01-06
2023-07-20	Fulton County Hospital – Under Review	$63,900	2022-12-22
2023-07-24	Community First Medical Center – Under Review	$847,740	2022-06-22
2023-08-22	Hospital General Castaner	$101,400	2022-09-19
2023-08-22	Samaritan Hospital - Albany Memorial Campus – Under Review	$56,940	2023-06-06
2023-08-22	Doctors' Center Hospital Bayamón	$102,200	2023-06-14
2023-08-23	Betsy Johnson Hospital	$99,540	2023-06-06
2023-08-23	UF Health North – Under Review	$979,000	2023-02-27
2023-09-05	Holy Cross Hospital – Under Review	$325,710	2023-06-21
2023-09-27	West Covina Medical Center	$59,100	2023-03-15

CMP Notice letters are made public with detail of violations. For example, Northside Atlanta's letter states the following timeline:

3/24/21: CMS initially reviewed website

4/19/21: Initial warning notice

9/2/21: CMS reviewed their website again

9/30/21: Request for CAP

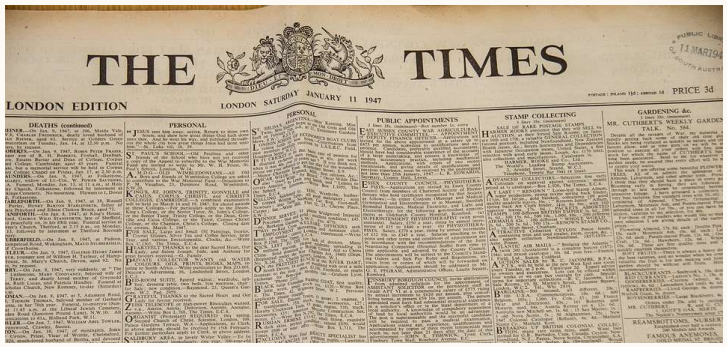
11/15/21: Northside responded by email, stating in part that potential patients were to "request specific price estimate quotes by either calling the Price Estimate Line..." or emailing

12/20/21: Request for revised CAP, due 1/4/22

1/11/22: CMS conducted a technical assistance call. Northside confirmed the previous violations had not been corrected and that the hospital had removed all previously posted pricing files.

1/24/22: Requested a revised CAP within 10 days

THE FINAL RULE WILL DRAMATICALLY INCREASE MRF DATA CONSISTENCY AND USABILITY


THE TIMES

LONDON EDITION

LONDON SATURDAY JANUARY 11 1947

PRICE 3d

collection of values to contextualized, actionable

MRF changes

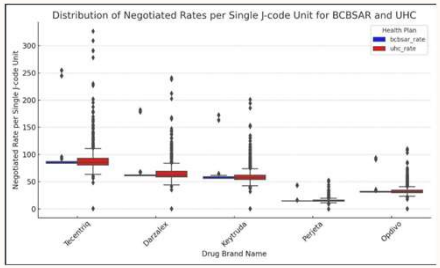
- Standard format for MRFs – beginning January 2024, with a subset of fields
- Encode general data elements (hosp name, lic num, location name, address, file version, date of update) – July 2024
- Hospitals affirm that file is complete and accurate – July 2024
- Validation tool available to hospitals - now

Proposed MRF expanded fields

- Require that data must be at payer and plan name level
- Specify type of contracting method used – July 2024
- Indicate if the "standard charge" should be interpreted as a dollar amount, percentage, or algorithm; if percentage or algorithm, specify calculation factors and expected payment – July 2024
- Description of item or service that corresponds to standard charge, if item or service is provided with inpatient admission or outpatient department visit; and for drugs, the drug unit and type of measurement
- Modifiers – January 2025
- Consumer-friendly expected allowed amount – January 2025

AN ECOSYSTEM IS BEGINNING TO FORM, AND IT MAY HAVE SIGNIFICANT IMPACT ON PROVIDERS

Provider Price Files



Source: Bright Spot Insights

Data aggregators / tool developers

Payer Price Files

Employers	• Negotiate self insured rates with employers • Negotiate directly with employers
Payers	• Negotiate rates with providers • NSA / contracting strategies
Providers	• Understand rates vis a vis market • Incorporate into patient-centric strategy
Patients / Consumers	• Evaluate cost vs quality • Health insurance decisions (co-insurance, deductible) • Plan upcoming care
Advocates / regulators / lawmakers	• Evaluate drivers of rate variation • Assess impact of provider consolidation • Advocate for rate controls to control healthcare cost increases

Possible outcomes

- Employer pressure to reduce self insured rates
- Commercial rates facing a possible “race to the bottom”
- Accelerate shift to outpatient / ASC and payment parity
- Patient pressure for more rational and simple rates
- Changing patient expectations about availability and firmness of price estimates
- Pressure for more linkage between price and quality / outcomes
- Advocate / regulator work toward narrowing gap between commercial and gov’t payers

NO SURPRISES ACT REGULATIONS CONTINUE TO BE LITIGATED

- The No Surprises Act was passed by Congress to shield patients from large, unexpected bills from providers who weren't contracted with their payer.
- This legislation, and associated regulations, have produced many impacts to the relationships between providers and payers that were not widely anticipated.
- The backlog to hear the cases and activity in the courts have meant that much uncertainty remains in the final impact.

Case	Area Challenged
TMA I	Arbitration approach where offer closest to the QPA was presumed to be the appropriate out-of-network rate
TMA II	Requirement that arbitrators give outsize weight to the QPA
TMA III	Inclusion of "ghost rates" in calculation of median for use in QPA (rates contracted by payers with providers who do not provide the services in question) Ability of self-insured plans to opt in to a lower QPA by using rates of other self-insured plans
TMA IV	Increase in arbitration fees and method for batching of cases

WHAT PROVIDERS SHOULD DO NOW

Patient-Centric Pricing

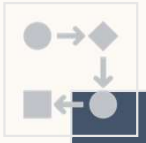
- Review cost information to make sure you're setting yourself up for sustainability
- Evaluate position in market including: 1) outcome & patient experience, and 2) traditional & non-traditional market participants
- Begin pricing rationalization, including: 1) chargemaster, 2) rates within payer contract, 3) among payers, and 4) among venues of care
- Analyze scenarios of future commercial pricing levels and shifts to outpatient / ASC to incorporate into strategic planning

Regulatory Compliance

- Validate 1/1/24 updated requirements are reflected
- Prepare for 7/1/24 and 1/1/25 updated requirements
- Be careful that you don't end up in violation of 12-month update requirement as you're preparing for the next set of updates
- Have internal audit or an external party review compliance with all rules
- Formally define internal roles, including designating an "authorized official" to prepare for future regulatory inquiries

No Surprises Act – Payer Contracting

- Because payers are using QPA as a ceiling for negotiation in some cases, providers should model QPA impact of NSA outcome scenarios to inform payer contracting strategy
- Cultivate multi-dimensional, collaborative relationships with key payors, including value-based elements
- For providers with significant out-of-network volume, evaluate possibility of contractual relationships with a limited set of payers
- Monitor impact on viability of hospital-based independent physician groups



No Surprises Act – Operations

- Design processes that can adapt to changing bundling approaches
- Develop a process to identify eligible cases that may enter the IDR process
- Assess staffing levels, technology, and training needs
- Create cross-functional teams to navigate uncertainty that include representatives from legal, compliance, billing, finance, operations, managed care contracting, and information technology

THE BOTTOM LINE

Implementing patient centric programs will benefit your organization financially, in addition to improving relationships with your patients

Establishes your organization in the market	Creates happy, empowered patients	Improves payer contracting position
Protects valuable revenue	Reduces denials	Reduces bad debt & charity care

THANK YOU

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