New Front-End Initiatives at UW Health

- Ryan Klein, Sr. Director Patient Access & Financial Experience

UWHealth

Goals and Reminders

Ask Questions: We want this to be an open and interactive discussion

Collaborate: We want to hear from you and partner on this work

Informative: One of our goals today is to provide you insights into some unique and effective initiatives as well as background on where we have been and where we are headed

Move Around: We're here for a while so feel free to get up and move around as needed

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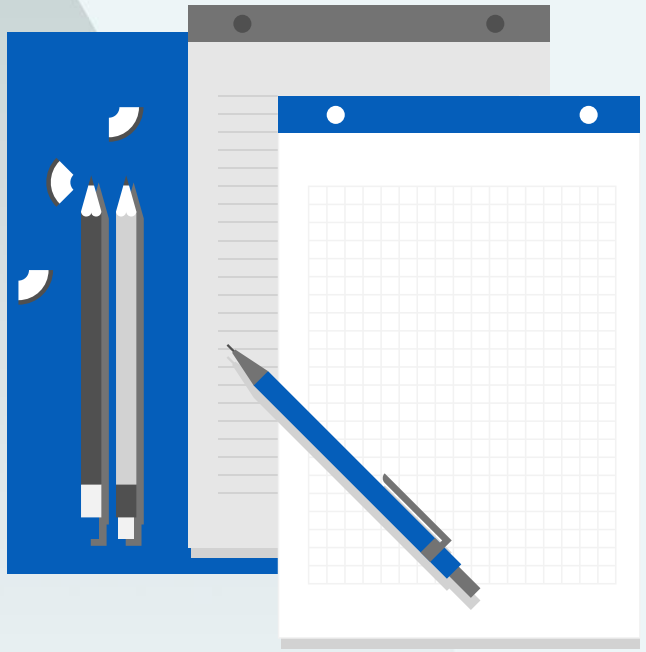
Agenda



- Medicaid Re-enrollment: H.R.1 Communication Plan
- Medicaid as a Secondary
- Automated OON Insurance Referral Reminders
- ABN Hard Stop
- Wrap Up & Questions

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About UW Health

UW Health is the integrated health system affiliated with the University of Wisconsin–Madison. We partner with the University of Wisconsin School of Medicine and Public Health to advance patient care, research, education and community service to patients from across the U.S. and around the world.

UWHealth

Care locations

- **6** main hospitals, **1** joint operating agreement hospital and **2** hospitals within main IL hospital
- **7** medical centers in WI and IL
- **105** primary and specialty outpatient locations in WI and IL

- **1,551** licensed beds
- **4** trauma centers in WI and IL ranging from level 1 to level IV
- **3** level IV and level III neonatal care units in WI and IL

Team

26,500+ employees
2,000+ physicians
1,200+ APPs
6,800+ RNs
800+ residents and fellows

Giving back

$415M
total community benefit

$46M
charity care

Financials

$6.3B
total system revenue*

**Total system joint operating agreement revenues*

Visits

867,000+ patients
85,500+ surgeries
4M+ outpatient visits
73,200+ inpatient admissions
245,000+ ED visits
258,300+ virtual visits

#1 hospital in Wisconsin, 14 years running
U.S. News & World Report

Medicaid Re-enrollment:
H.R.1 Communication Plan

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H.R.1 Background

Introduces federal Medicaid changes that are expected to **reduce enrollment in Medicaid over time**, primarily through new administrative and work-related requirements.

Key impacts include:

- **New work requirements (effective Dec. 31, 2026)** for adults ages 19–64 without dependents, requiring **80 hours per month** of work, training, or volunteering.
- **Shortened retroactive coverage** beginning **Jan. 1, 2027**, reducing coverage for medical care received prior to application (2 months for Non-Expansion States).
- **Overall enrollment decline** expected statewide, compounding post–public health emergency "unwinding" losses.

Bottom line: Wisconsin Medicaid enrollment is expected to decline under H.R. 1, driven largely by **administrative complexity and reporting requirements**. ***Keeping enrollee contact information current and providing advance notice will be critical to mitigate avoidable coverage loss.***

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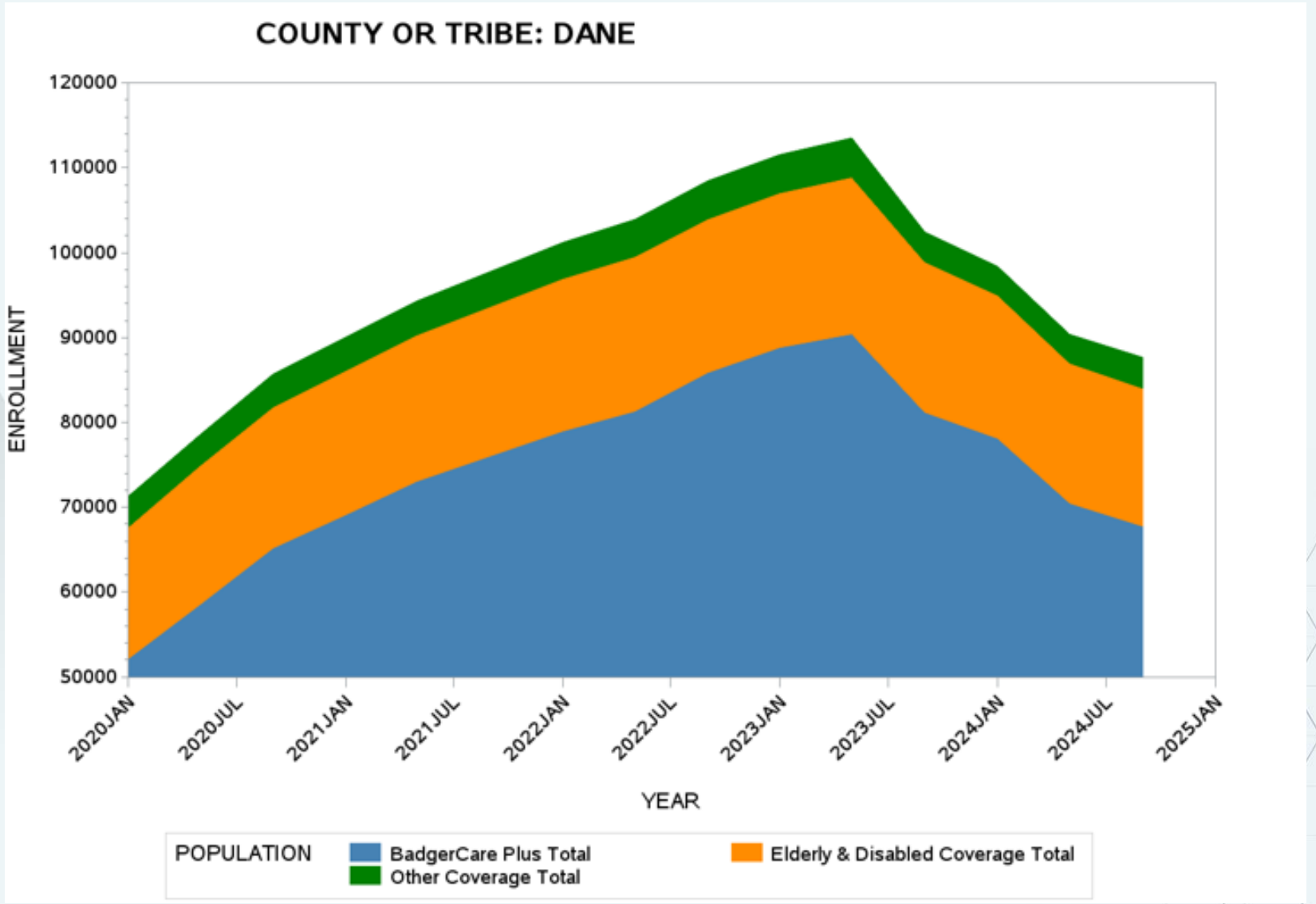
Decrease in Medicaid Enrollment – Dane County



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Healthcare Provider's Role

- **Federal Medicaid Changes**
  - HR 1 Phase One initiates compliance with federally mandated Medicaid work and engagement requirements starting in 2027.
- **Focus on Preparation**
  - *Primary goal is preparing Medicaid enrollees through clear communication before eligibility changes take effect.*
- **Update Contact Information Campaign**
  - *Effort to ensure Medicaid enrollees have current mailing addresses, phone numbers, and emails to receive notifications*.
    - SMS
    - Email
    - Patient Portal

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Phased Outreach Approach Moving Forward

- **Broad Public Education**
  - Summer 2026, communications start to educate public, normalize changes, and build trust to reduce misinformation.
  - Clear Messaging to Reduce Confusion
    - Messaging should clarify no immediate benefit changes and urges prompt response for continued coverage.
- **Targeted Individualized Outreach**
  - Late Fall/Early Winter 2026 shifts to direct, personalized notices with clear instructions to impacted individuals to ensure compliance.
  - Targeted communication to include work/volunteer requirements.
    ***State specific requirements yet to be determined.
  - Communication starts 20th of the month for future scheduled visits
- **Ongoing Support and Reinforcement**
  - Reminders in effort to prevent coverage loss among eligible customers.

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Outbound Communication Timeline

Summer 2026

Broad Public Outreach & Preparation

Communication to educate public emphasizing updating contact information

Late Fall/Early Winter 2026

Targeted 10-Day Notices

Individual notices to impacted members with required actions

January 2027+

Go-Live & Reinforcement

Reminders and ongoing outreach to keep members enrolled

June 2026 **2026** **2027+**

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Medicaid as a Secondary

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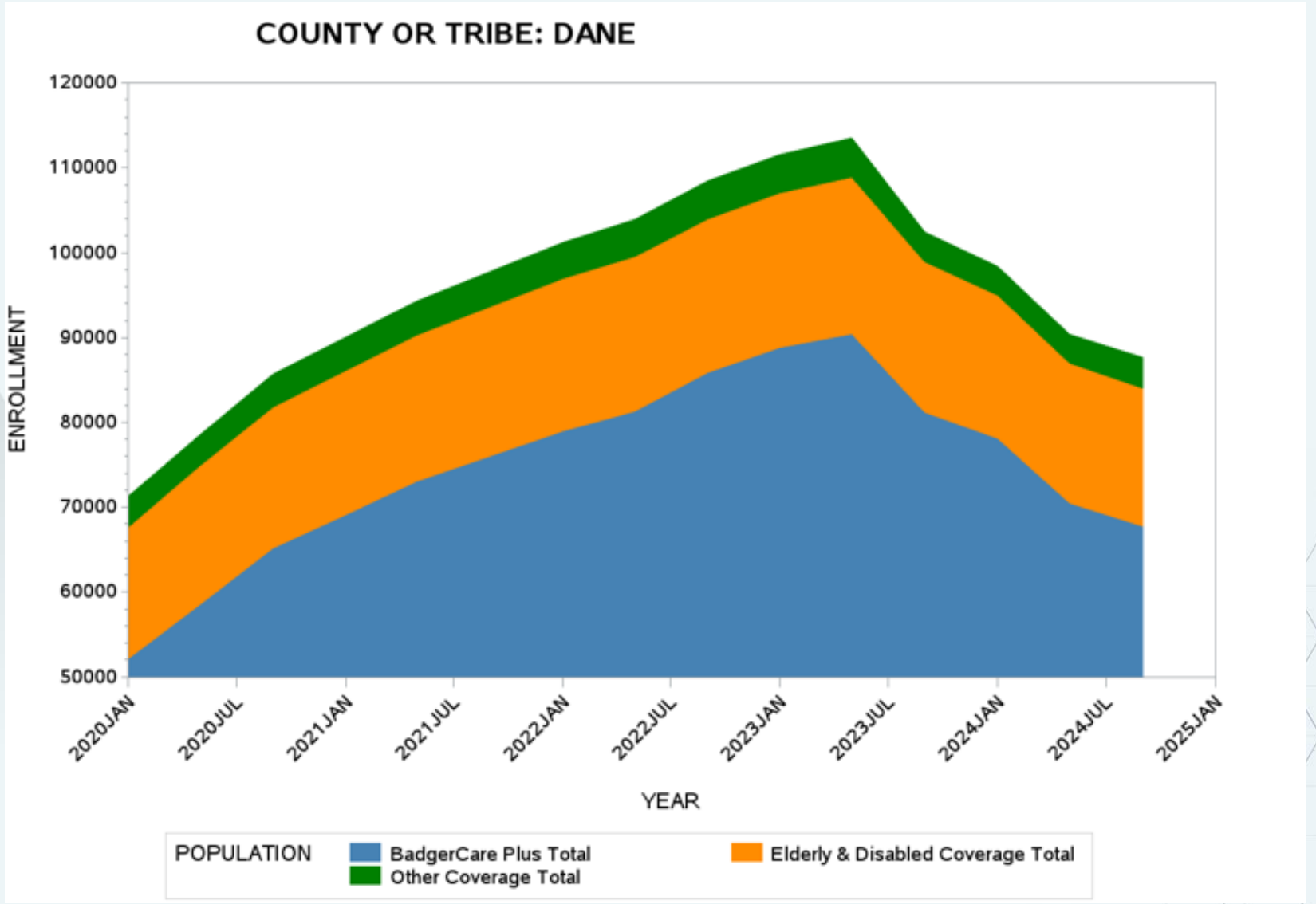
Decrease in Medicaid Enrollment – Dane County



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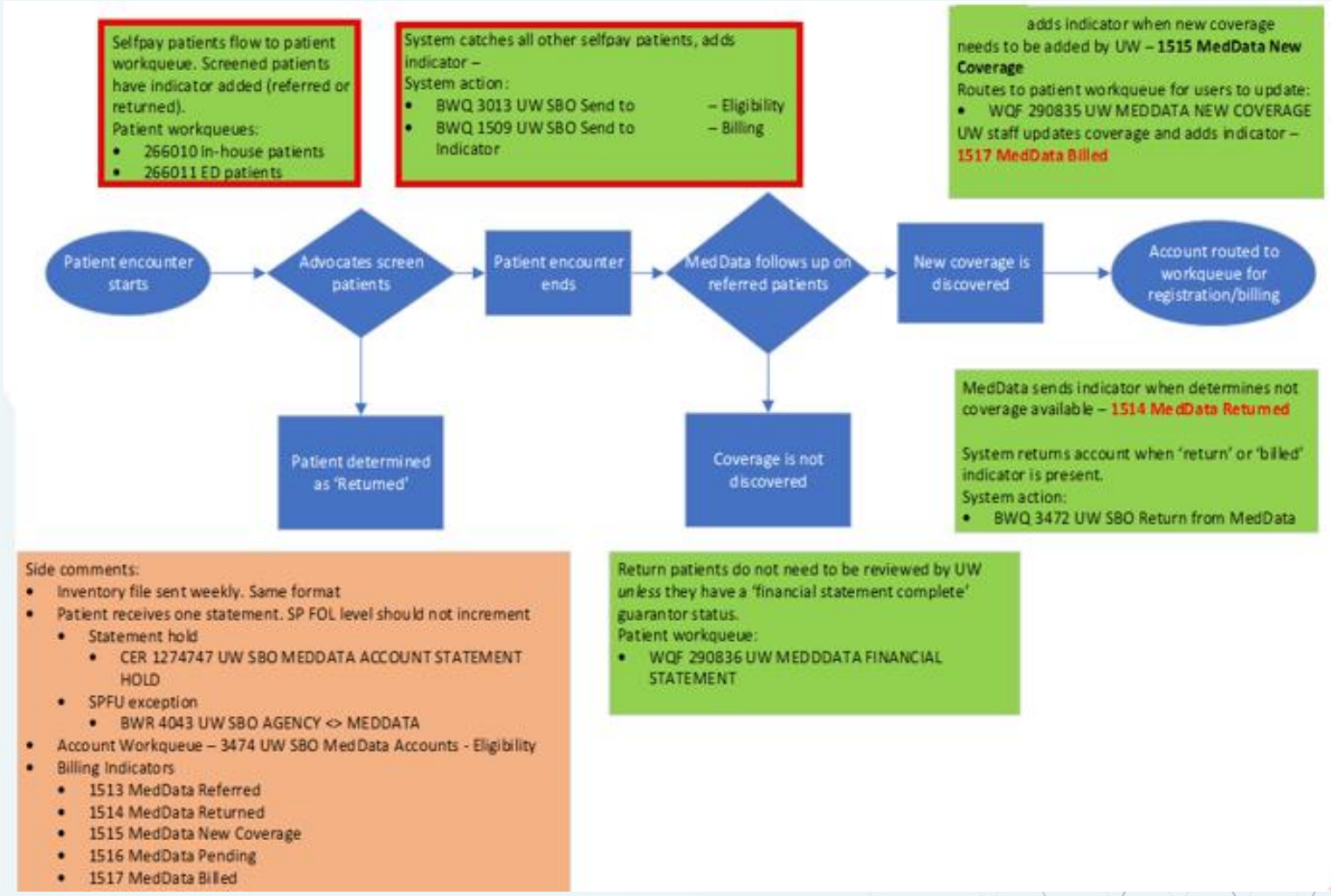
Historical Partnership and Scope

- **UW Health partners with a Medicaid Eligibility and Enrollment Vendor**
  - **Refer all self-pay IP, OP, and ED patients.**
  - **IP – Visit Daily onsite**
  - **OP and ED – Phone outreach.**



Current Workflow:

- **IP w/ NO Coverage**
  - Patients qualify, based on no insurance coverage on their account, for the Inpatient WQ. An Advocate reaches out to the patient either via an in room visit or by phone. They confirm that the patient has no insurance coverage and then screen for Medicaid eligibility.
- **IP Medicare (A & B and A only) w/ NO Secondary**
  - Patients qualify, based on Medicare only coverage on their account, for the Government Programs Inpatient WQ. Financial Counselor connects with patient or family to screen for Medicaid eligibility
- **OP w/ No Coverage**
  - Acct is assigned to an Advocate via batch job to identify coverage and/or Medicaid
- **ED w/ No Coverage**
  - Patients qualify, based on no insurance coverage on their account for the ED WQ. An Advocate attempts to connect with the patient while they are still in the ED to screen for Medicaid coverage. If they miss the patient, and patient is admitted, they will continue to try to connect with patient in house. If the pt is discharged they attempt to connect with them via phone.

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Increase in Out-of-Pocket Costs

"Out-of-pocket spending per person was *$115 in 1970 (or, adjusted for inflation, $703)*. By *2023, out-of-pocket spending had reached $1,514 per person*." – KFF (Kaiser Family Foundation)

At UW Health, we have seen a significant increase in Out-of-Pocket Patient Liability.

26% 

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340B

DRUG PRICING PROGRAM

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Medicare DSH Calculation

Disproportionate Patient Percentage (DPP) =

SSI% (Medicare SSI patient days ÷ Total Medicare patient days)

+

MA Eligible% (Medicaid Eligible patient days ÷ Total patient days)

Definitions:

Medicare SSI patient days = Inpatient days for patients entitled to Medicare Part A and SSI.

Total Medicare patient days = All inpatient days for patients entitled to Medicare Part A.

Medicaid Eligible patient days = Inpatient days for Medicaid patients not entitled to Medicare Part A.

Total patient days = All acute inpatient days in the period.

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How do we identify who may qualify for Medicaid as a secondary?

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Partner with our Presumptive Charity Care Vendor

- **Presumptive Charity Care**
  - Screen for Charity Care Eligibility when the account has completed the self-pay billing cycle
    - After statements, app push notifications, calls/texts
  - Eligibility for Presumptive Charity Care is based on the presumed Federal Poverty Level (FPL)
    - Presumed Household Income / Household Size

Family Size	Poverty Guideline	≤ 300% FPG	≤ 400% FPG	≤ 600% FPG
1	16,650	46,950	62,600	93,900
2	21,150	63,450	84,600	126,900
3	26,650	79,950	106,600	159,900
4	32,150	96,450	128,600	192,900
5	37,650	112,950	150,600	225,900
6	43,150	129,450	172,600	258,900
7	48,650	145,950	194,600	291,900
8	54,150	162,450	216,600	324,900

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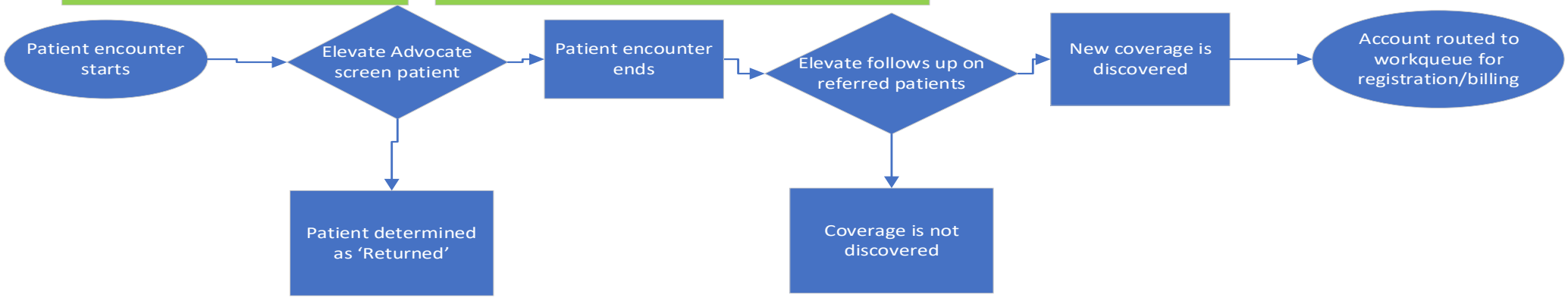
PILOT: Medicaid as a Secondary - Admitted Pts

Personal/Family Guarantors with Primary Payor
- Emergency
- Inpatient
- Outpatient Short Stay
- Observation
- Newborn

Patient Data
- Guarantor and Patient Data
- Pediatric Patients (≤17 Years)< 400% FPL
- Adult Patients (≥18 Years) <200 FPL

EXCLUDES:
- Self-Pay Patients
- Medicaid on HAR



Billing Indicators and Descriptions:

2215- Experian Pediatric Guarantor Qualified to

2216-Experian Adult Patient Qualified to

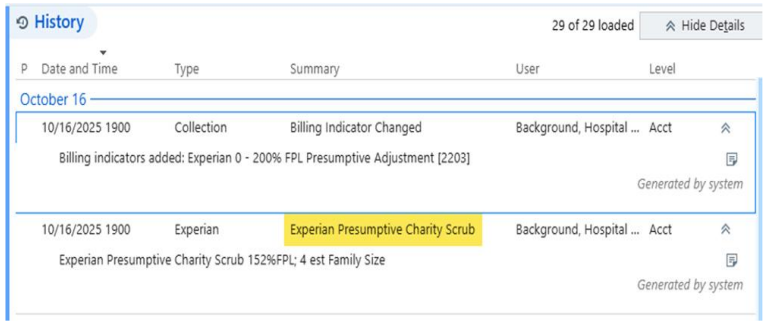
2217-Experian Screened Guarantor > FPL Threshold

2218-NULL (No results)

2219-Application Submitted

2220-Experian Not Medicaid Qualfied or Did Not Apply

Note Summary Example (History tab of HAR)



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PILOT: FPL Secondary Screenings

Trends in Screening Outcomes:

Of the Patients that have Responded

Wisconsin

Total referrals: 403

54% Over Income

36% Refusals

10% Application Filed or Approved

Illinois

Total referrals: 226

60% Over Income

21% Refusals

19% Application Filed or Approved

Campus	Screening Outcomes	Count of Screenings	Possible DSH Days
UWHealth Wisconsin	Referred - Active Outreach	3	
	Application Submitted	8	83
	Approved Application	30	463
	Screened Over Income	196	
	Discharged Unable to Locate	33	
	Refused Screening	133	
	Confident in primary coverage. Flyer left.	124	
	SW asked us not to speak with family	1	
	Interested in pursuing MCare not Mcaid	2	
	Has secondary Commercial payer	1	
	Have hit my deductible/copay	5	
UWHealth WI Totals		**403**	
UWHealth N. Illinois	Referred - Active Outreach	0	
	Application Submitted	21	180
	Approved Application	12	72
	Screened Over Income	102	
	Discharged Unable to Locate	56	
	Refused Screening	35	
	Confident in primary coverage. Flyer left.	31	
	Not interested in Govt Assistance	2	
	Newborn being added to guarantor primary	1	
	Refused due to recent approval for UW FA	1	
UWHealth N IL Totals		**226**	

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Medicaid Secondary 1-Pager

Are you worried about medical bills even though you have health insurance?

You may qualify for Medicaid as secondary coverage. This coverage can help pay for copays, deductibles, and other services not included in your primary insurance plan.

What Is Medicaid Secondary Coverage?

Medicaid helps pay for healthcare costs after your primary insurance has paid its share. This can include:

- Lower out-of-pocket costs
- Expanded services such as dental, vision, or pharmacy care
- Help navigating coverage options and avoiding surprise bills
- Care for children with special health needs even if your household is above the income limit

Applying for Medicaid? Let Us Help You!

UW Health has partnered Patient Financial Solutions® to help screen for eligibility programs, assist with applications, and answer questions related to the process.

Call 779-696-4822 or email

What You'll Need to Apply

- Proof of income and assets
- Household member details (Name, birth date, and Social Security Number)

General guidelines in the state of Illinois include the following income limits:

Household	Illinois Medicaid
Single	$1,800 a month/$21,600 a year
Married	$2,432 a month/ $29,187 a year
Household of 3	$3,065 a month/$36,777 a year
Household of 4	$3,697 a month/ $44,367 a year
+ additional	+$632 a month/ $7,584 a year

ElevatePFS® was founded to assist patients and their families with expediting the application process for the various state and local eligibility programs available to help pay for medical bills.

Our team of dedicated advocates and authorized representatives has in-depth knowledge and expertise working with these programs and is committed to helping you receive the assistance you deserve.

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Automated OON Insurance Referral Reminders

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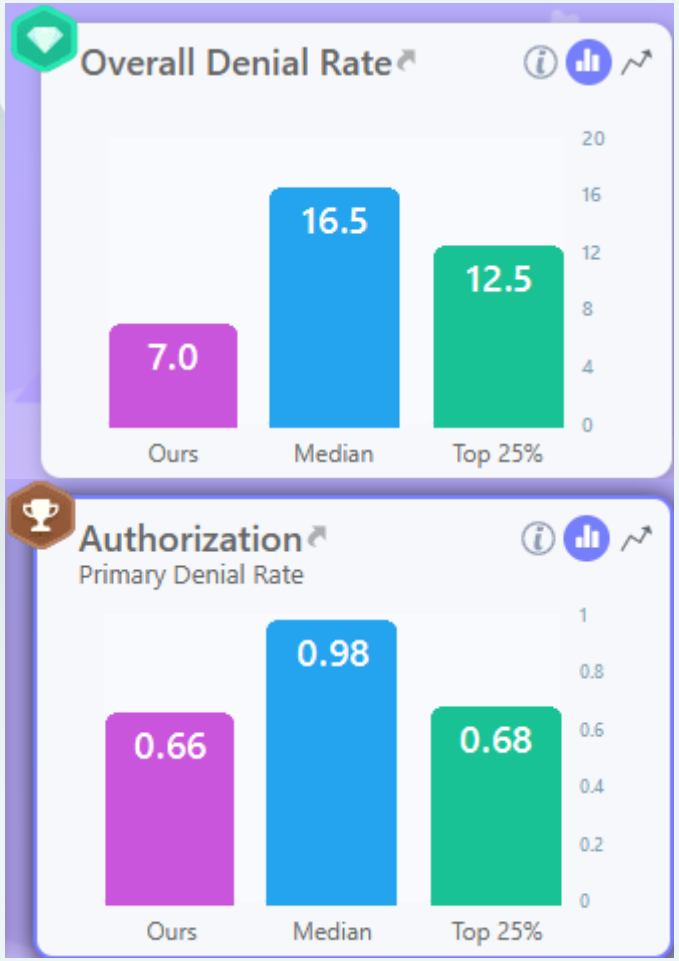
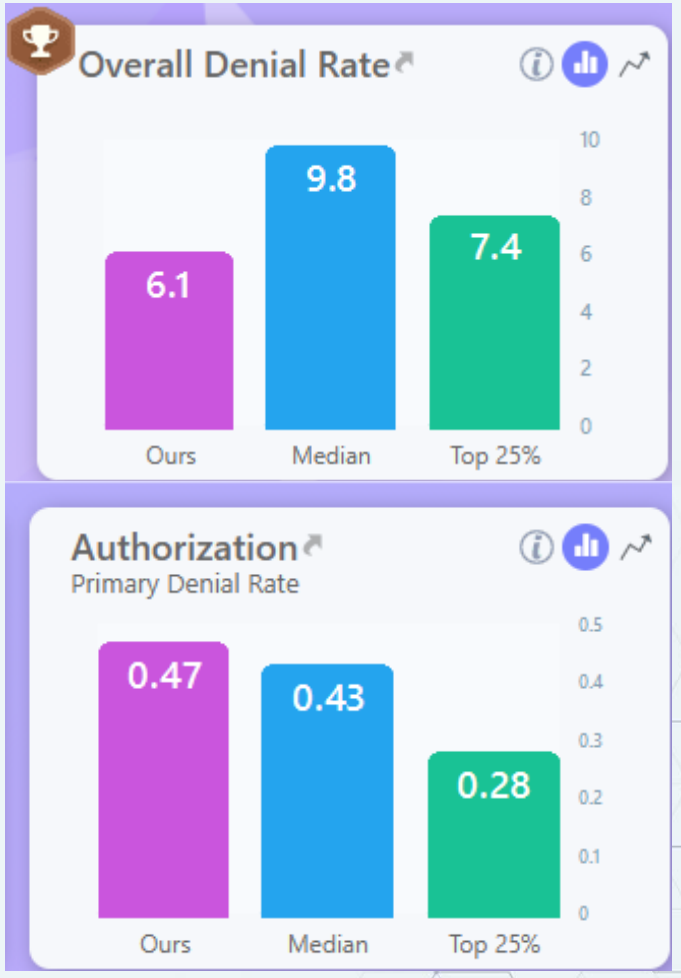
Denial Optimization

HB



PB



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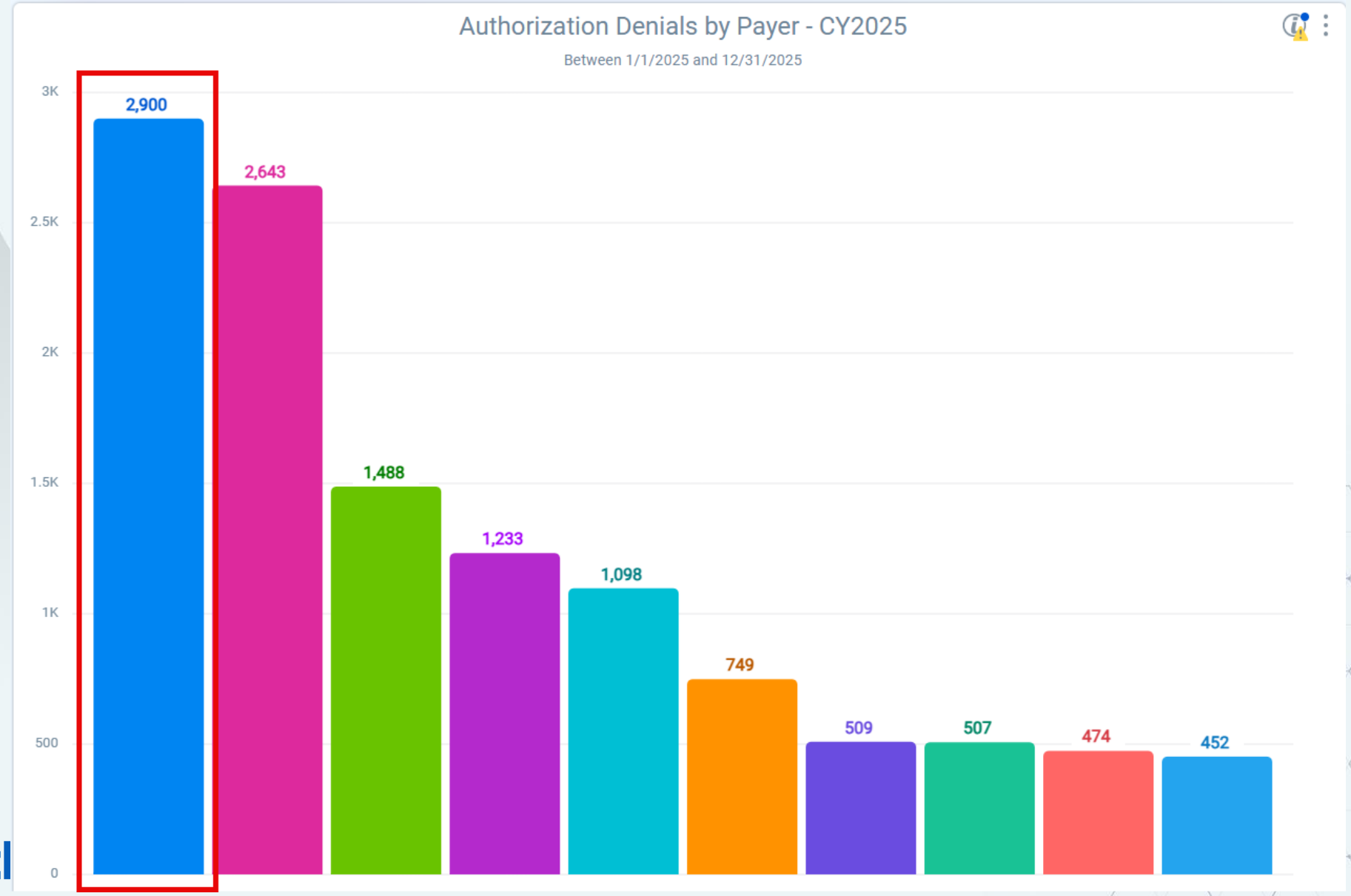
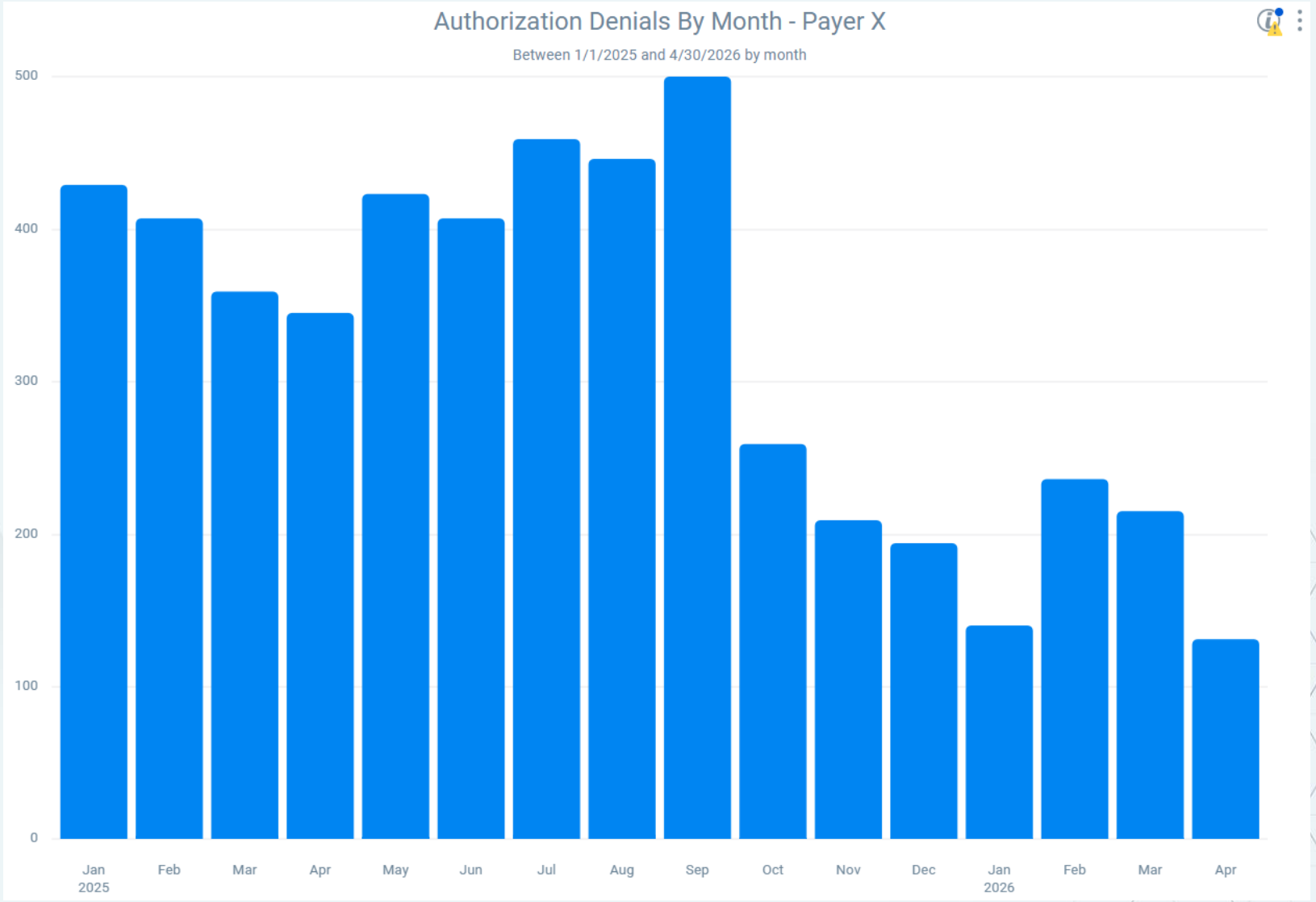
Auth Denials by Payer



Trending Auth Denials



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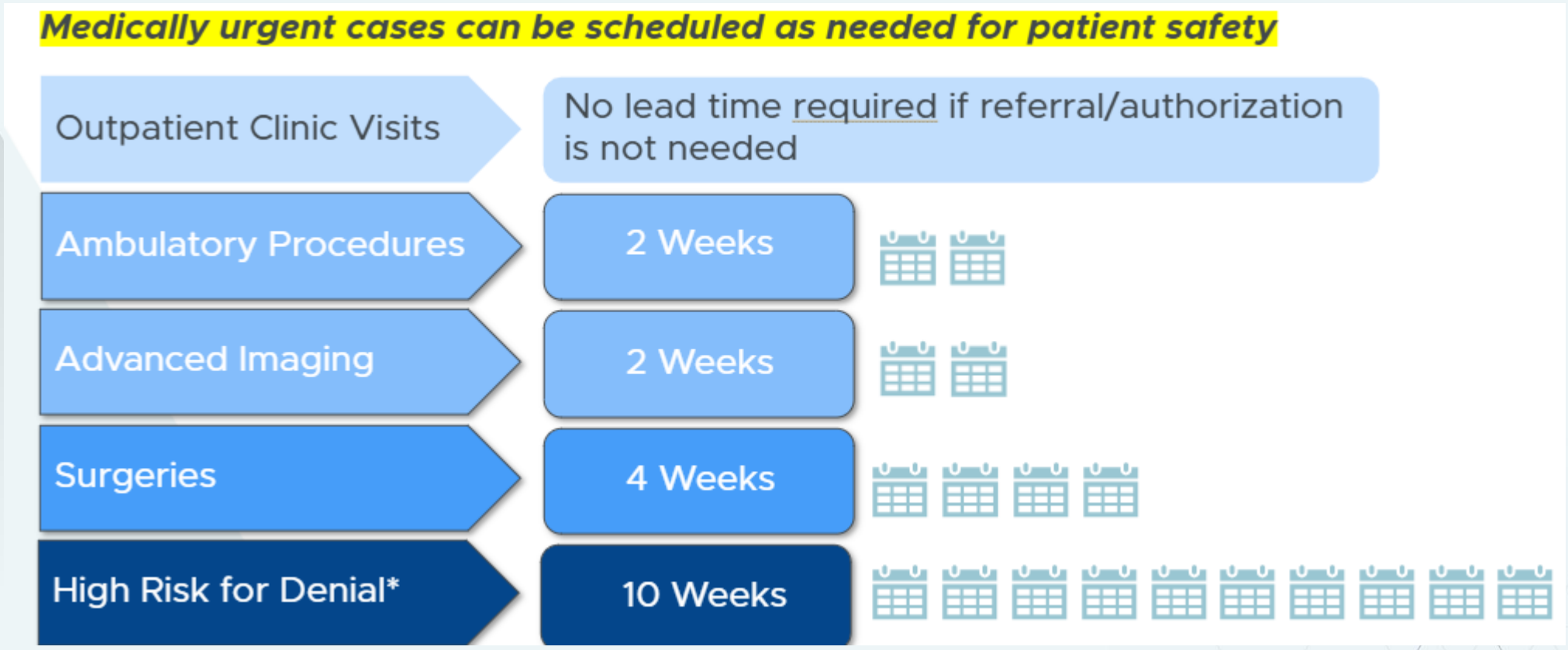
Scheduling Workflow:

*Payment Collection Policy



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Referral Workflow:

- **Once scheduled, the Appts fall to a "OON Appts Need Referral Reminder WQ"**
  - If a referral exists, Financial Clearance will document any outcomes on this referral
  - Referral does not exist; Fin Clearance will manually create a referral to document on
- **Checks on the payer website to see if an authorized insurance referral exists.**
  - If it exists, Financial Clearance documents on the appropriate referral, marks that it is authorized and attaches it to the scheduled appointment.
- ***Send referral request to patient and patient PCP via fax and/or phone***
  - Often multiple times
- **Check referral status frequently prior to DOS and update EHR.**

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Payment Collection Policy: Pre-Service Payment Expectations

Medically Urgent: **No pre-payment required** to proceed but must sign FRF and eligible to apply for financial assistance.

No Insurance Referral	Must sign Financial Responsibility Form (FRF) to proceed
No Prior Authorization	Cancel, reschedule, or pre-pay in full & sign FRF.
Non-covered Services	Cancel, reschedule, or pre-pay in full & sign FRF.

Medicare: Sign Advanced Beneficiary Notice (ABN) if required to proceed, no pre-payment required

Exceptions to the above: UW at fault for any of the above/we made a mistake etc.

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Referral Workflow:

- **Once scheduled, the Appts fall to a "OON Appts Need Referral Reminder WQ"**
  - If a referral exists, Financial Clearance will document any outcomes on this referral
  - Referral does not exist; Fin Clearance will manually create a referral to document on
- **Checks on the payer website to see if an authorized insurance referral exists.**
  - If it exists, Financial Clearance documents on the appropriate referral, marks that it is authorized and attaches it to the scheduled appointment.
- ***AUTOMATED sending referral request to patient and patient PCP via fax and/or phone***
  - Often multiple times
- **Check referral status frequently prior to DOS and update EHR.**

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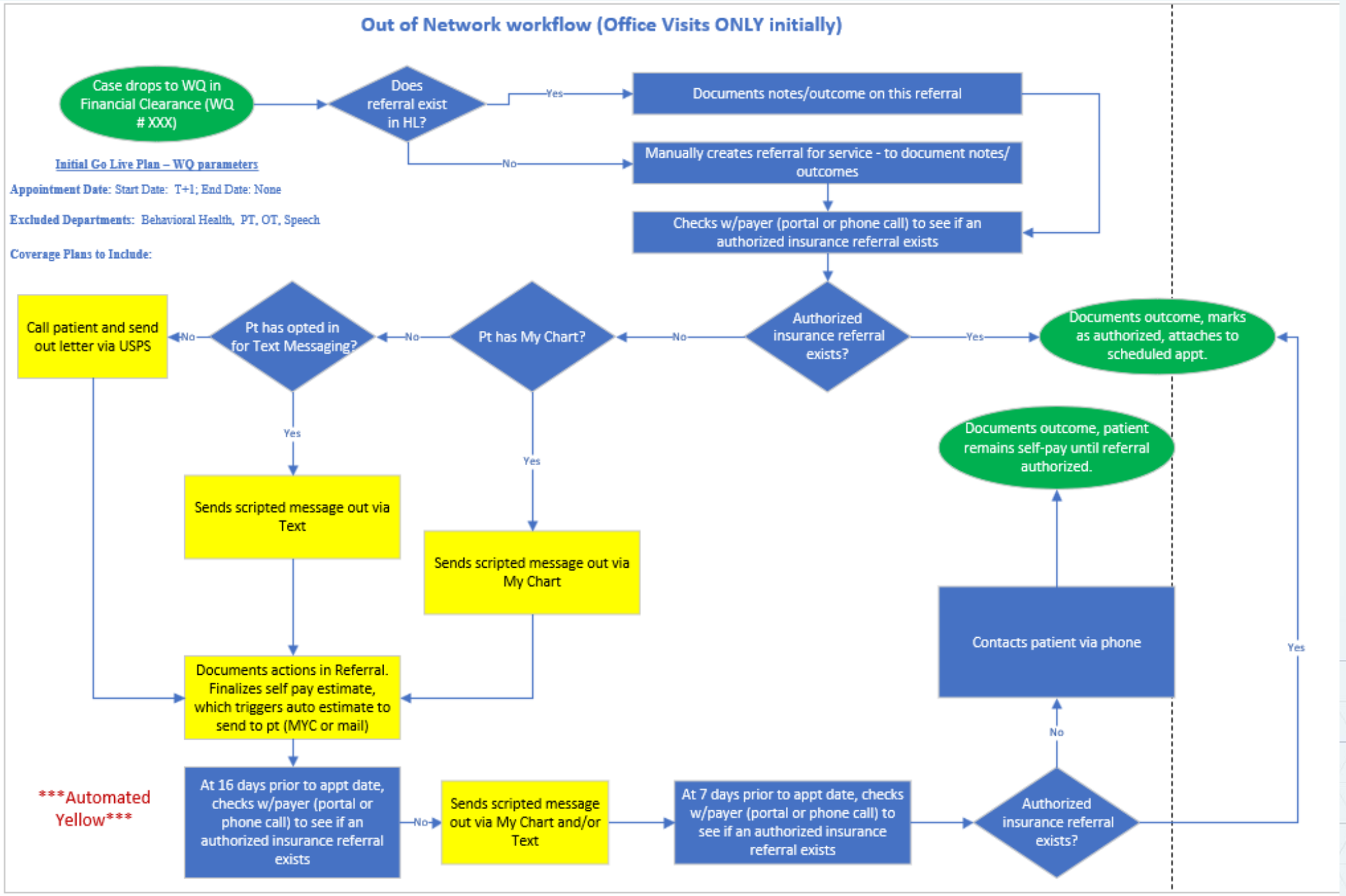
Out of Network workflow (Office Visits ONLY initially)



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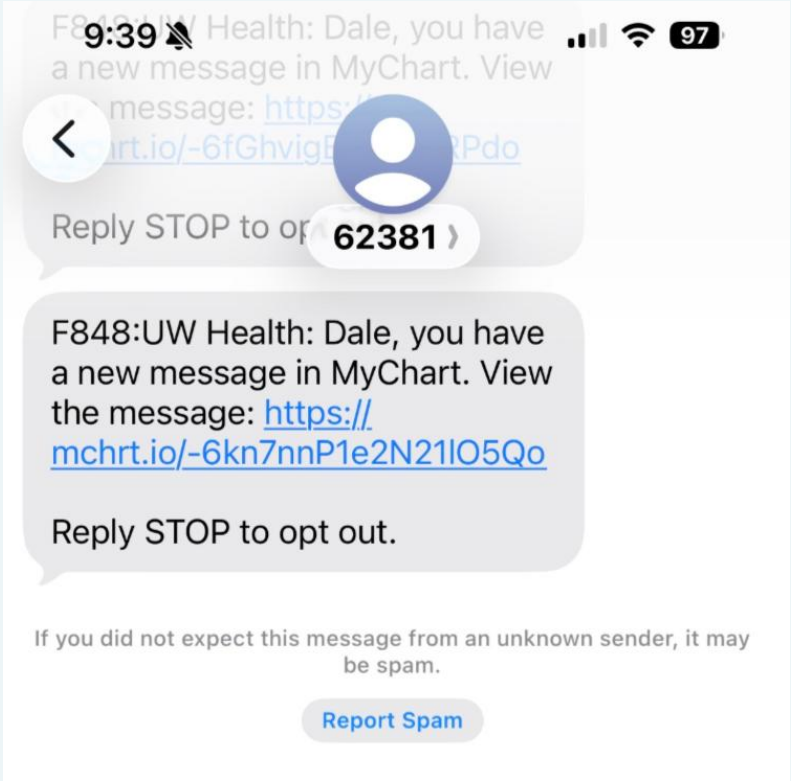
Text



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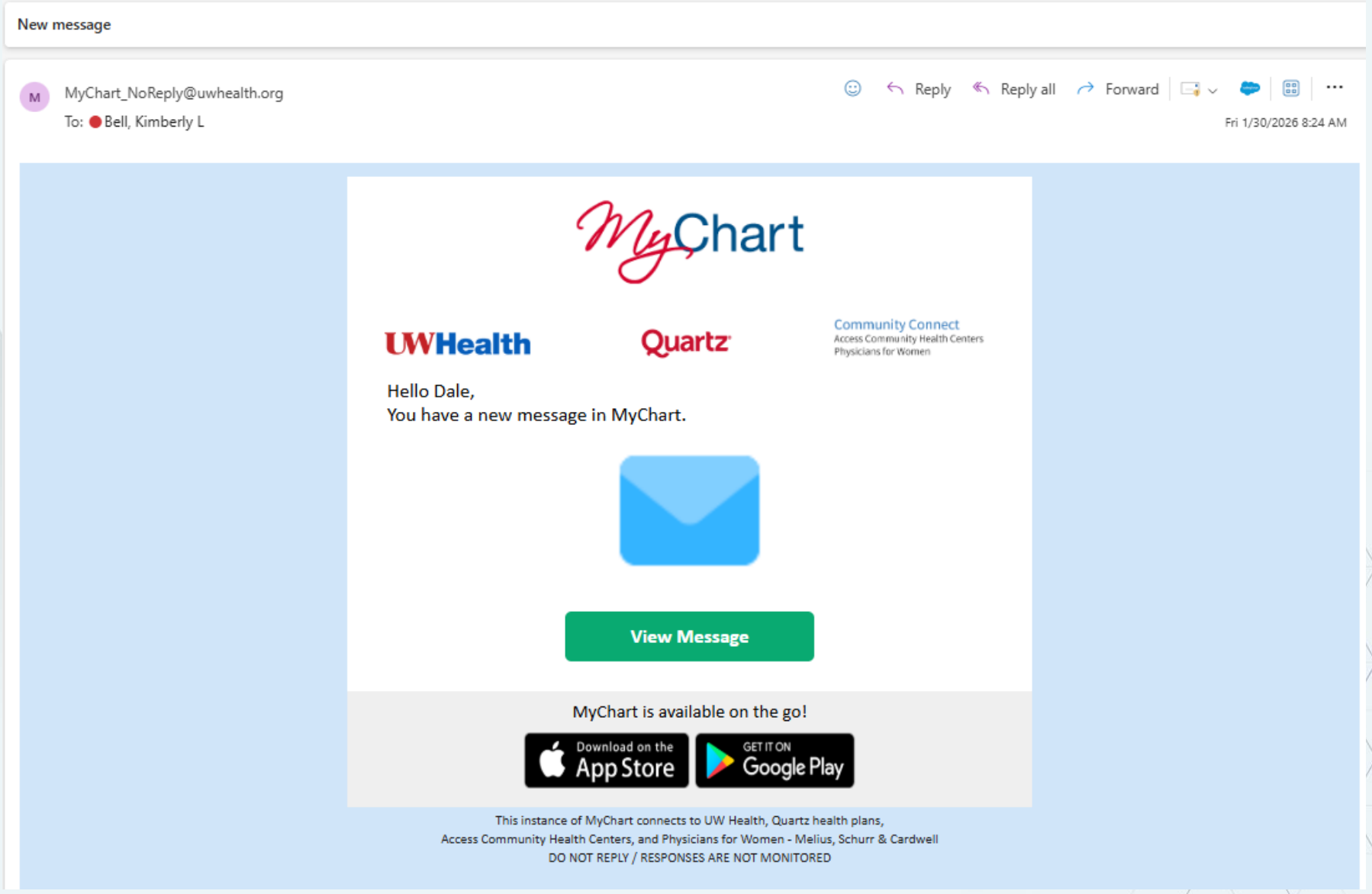
e-mail



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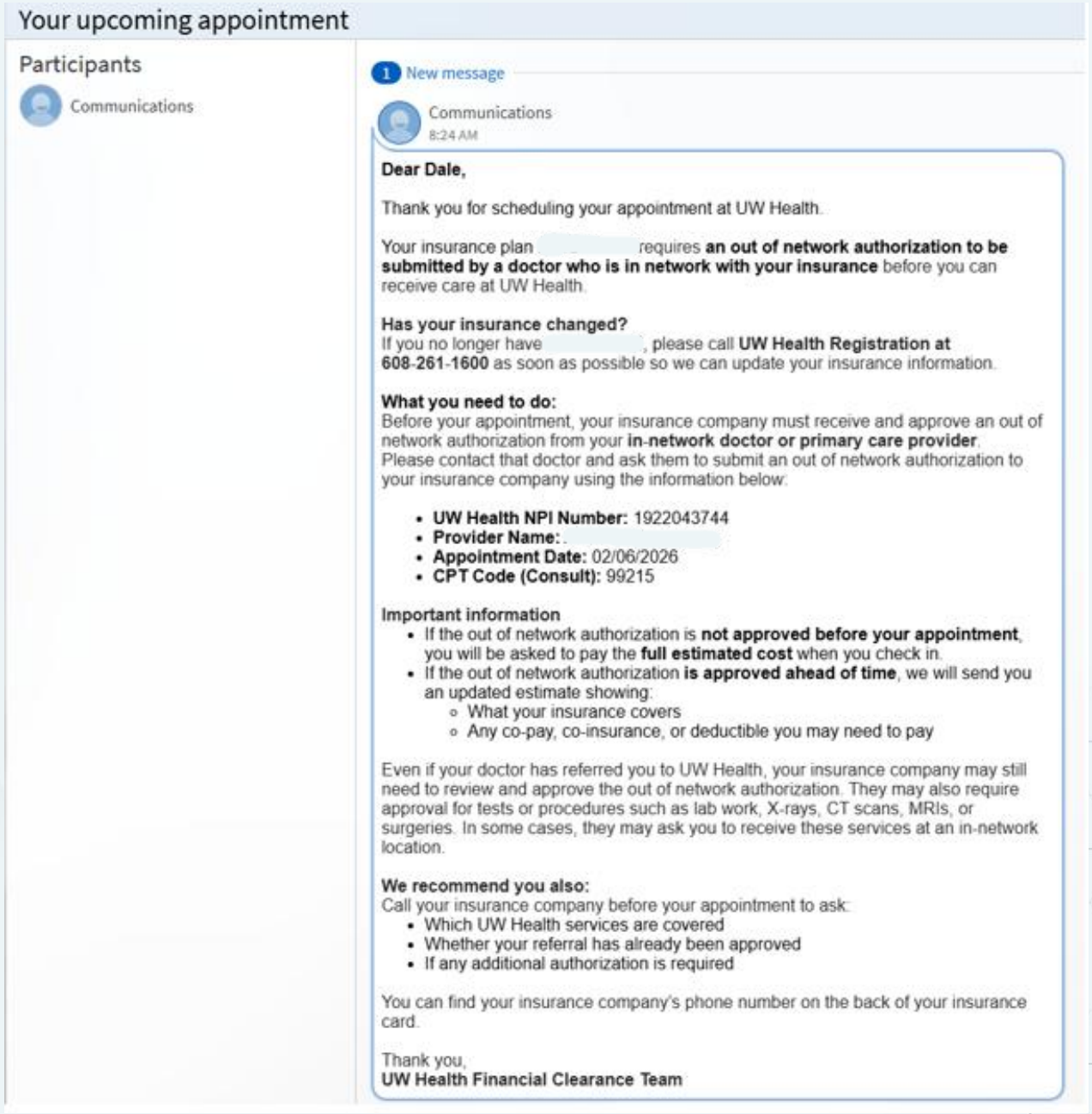
Detailed Message



Your upcoming appointment

Participants

Communications

1 New message

Communications
8:24 AM

Dear Dale,

Thank you for scheduling your appointment at UW Health.

Your insurance plan requires **an out of network authorization to be submitted by a doctor who is in network with your insurance** before you can receive care at UW Health.

Has your insurance changed?
If you no longer have , please call **UW Health Registration at 608-261-1600** as soon as possible so we can update your insurance information.

What you need to do:
Before your appointment, your insurance company must receive and approve an out of network authorization from your **in-network doctor or primary care provider**. Please contact that doctor and ask them to submit an out of network authorization to your insurance company using the information below:

- **UW Health NPI Number:** 1922043744
- **Provider Name:**
- **Appointment Date:** 02/06/2026
- **CPT Code (Consult):** 99215

Important information
- If the out of network authorization is **not approved before your appointment**, you will be asked to pay the **full estimated cost** when you check in.
- If the out of network authorization **is approved ahead of time**, we will send you an updated estimate showing:
  - What your insurance covers
  - Any co-pay, co-insurance, or deductible you may need to pay

Even if your doctor has referred you to UW Health, your insurance company may still need to review and approve the out of network authorization. They may also require approval for tests or procedures such as lab work, X-rays, CT scans, MRIs, or surgeries. In some cases, they may ask you to receive these services at an in-network location.

We recommend you also:
Call your insurance company before your appointment to ask:
- Which UW Health services are covered
- Whether your referral has already been approved
- If any additional authorization is required

You can find your insurance company's phone number on the back of your insurance card.

Thank you,
UW Health Financial Clearance Team

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Self-Pay Expectations

- **Appointment Date:** 02/06/2026
- **CPT Code (Consult):** 99215

Important information

- If the out of network authorization is **not approved before your appointment**, you will be asked to pay the **full estimated cost** when you check in.
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Even if your doctor has referred you to UW Health, your insurance company may still need to review and approve the out of network authorization. They may also require approval for tests or procedures such as lab work, X-rays, CT scans, MRIs, or

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Self-Pay Estimate if Referral NOT Authorized

UWHealth
PO Box 620993
Middleton, WI 53562-0993

Leah Zztestpa
4567 Looking Tr
SUN PRAIRIE WI 53590

Dear Leah Zztestpa,

Thank you for choosing UW Health. We strive to provide our patients with reliable information about their out-of-pocket costs as they make their health care decisions.

Because your health insurance plan is out of network and requires an authorized referral to cover services at UW Health, your next step will be to obtain a referral. To do that:

1. Contact your primary care provider to ask that they submit an insurance referral to your health insurance plan, asking for you to receive care at UW Health,
   - They may ask for UW Heath's Tax ID numbers; those can be found below.

2. Verify with your health insurance plan that they have received an insurance referral from your primary care provider. If approved, confirm the approval dates and services covered under the authorization.

Below are the Tax Identification number and National Provider Identification numbers of the facilities and providers involved in your care:

Provider NPI:
1598784555

Provider Tax ID:
391824445
391835630

Below you will find the estimated charge for services scheduled at UW HEALTH 1 S PARK ST MEDICAL CENTER.

Address of services to be provided:
1 S PARK ST, 1ST FLOOR
MADISON, WI 53715

Visit Estimate

Office Visit at UW Health 1 S Park St Medical Center
Orthopedics on 1/26/2026
CPT® 99215

Estimate ID #677
Prepared on 1/28/2026

Patient Name	Date of Birth	MRN	Patient Account	Insurance Coverage
Leah Zztestpa	02/24/1999	55143626	2001721	[redacted]

Summary

This section contains a summary of the estimated cost for Leah Zztestpa's upcoming visit on 1/26/2026.

You Pay	[redacted]
Not Covered	[redacted]
Discounts	

Details	[redacted]
Physician Fees	
Insurance Covers	
Discounts	
You Pay	

Charge Detail

This section contains the expected charges used to calculate your estimate. This is a good faith estimate based on similar past visits and the information we currently have available. Your final billed charges might be different from the expected charges listed here.

Diagnosis
—

Physician Charge Detail — Phone: 877-565-8855

Code	Description	Qty	Amount
99215	Office or Other Outpatient Visit, Est Patient, Level 5	1	[redacted]
	Discounts		
	Your responsibility for charges billed by your physician		

To proceed with services without an authorized referral, we require that you make your full estimated payment of $323.40 prior to or at the time of service.

This payment can be made:

- Calling 800-241-0309, Monday - Friday, 8am - 4:30pm
- Online through your MyChart account when completing eCheck-in

Please note that because of the personalized nature of healthcare, patient differences, and the potential for unforeseen complications we cannot provide an estimate guarantee. Therefore, this is only an ESTIMATE. Factors that may alter your estimated out of pocket costs include, but are not limited to the following:

- Variations to the services and codes listed above. For example, office visit fees vary based on complexity and time spent with your provider. We cannot predict the level of care you will need; therefore, office visit estimates are based on the most common visit level charged. Your final charge may be more or less depending on the specifics of your visit.
- Receiving additional services not listed above (i.e. additional labs, appointments, imaging, pathology)
- Unforeseen complications that may alter the course of treatment
- Receiving care at a different location

After your services are rendered, you will either be billed any remaining amount due or refunded any overpayment. If you have any patient balances for other dates of service, your overpayment will be applied to those balances.

Thank you again for choosing UW Health for your care.

Please take a few minutes to provide us feedback on these pre-service price estimates:
https://feedback.uwhealth.org/surveys/?s=W4JJK79NHF

Sincerely,

Angela
Financial Counselor

UW Health

You can now create your own estimate! Discover self service estimates for a number of common UW Health services: https://uwhealthmychart.org/mychart/guestestimates

Provider Based Billing and Facility/TelehealthSite Fees
UW Health has some hospital-owned clinics, also known as "provider-based clinics." These are considered an extension of the hospital. Therefore, the clinics must meet strict patient safety standards and follow regulatory requirements of the Centers for

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Self-Pay Estimate (more detail)

Thank you for choosing UW Health. We strive to provide our patients with reliable information about their out-of-pocket costs as they make their health care decisions.

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Provider Tax ID:
391824445
391835630

Summary

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You Pay	[redacted]
Not Covered	[redacted]
Discounts	

Details	[redacted]
Physician Fees	
Insurance Covers	
Discounts	
You Pay	

To proceed with services without an authorized referral, we require that you make your full estimated payment of $[redacted] prior to or at the time of service.

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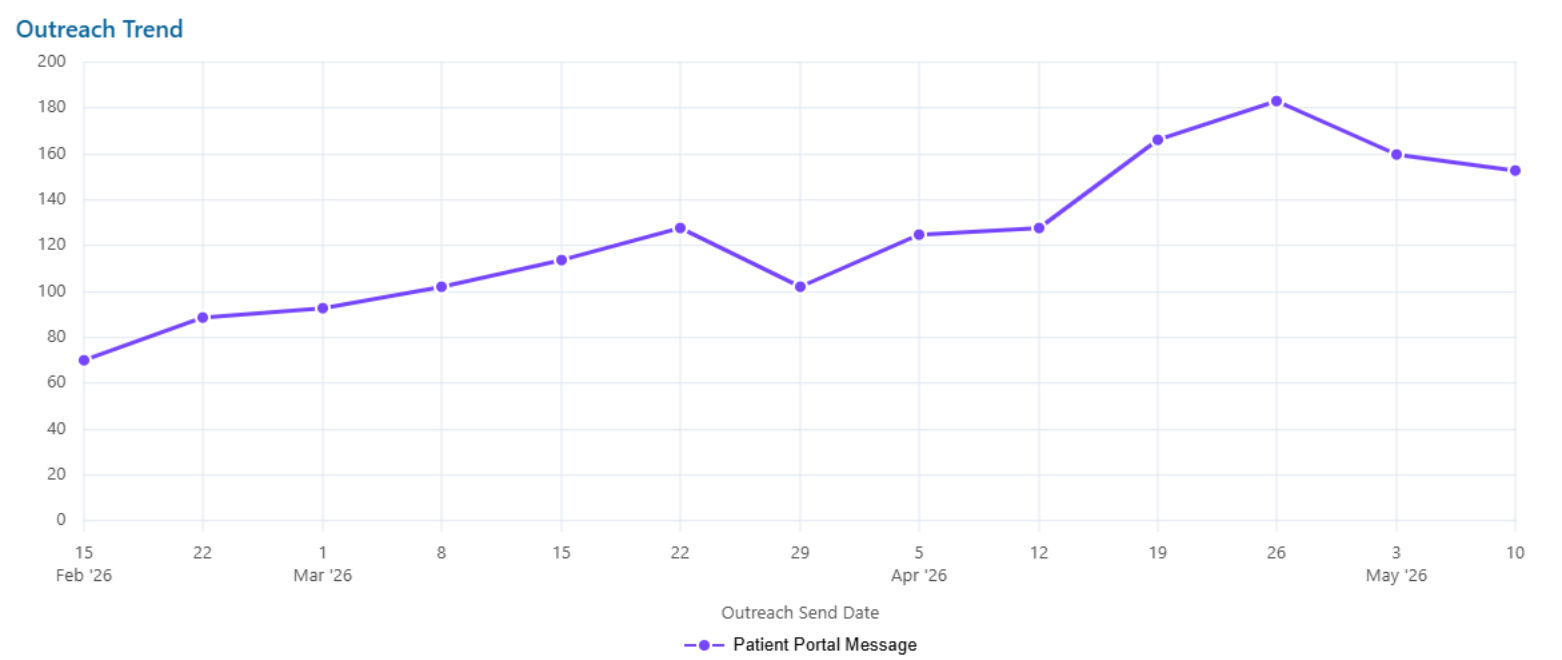
Results

- Since going live on Feb 18:
  - We have sent a total of **1,613 automated messages.**
    - **68.4% (1,103)** of messages were viewed in MyChart.
    - **40.7% (656)** of recipients' appointments were considered a success, meaning the referral was authorized, marked not needed, or they made a pre-payment on the estimate.



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Expansion

United Healthcare

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September 30, 2025

Referral requirements for Medicare Advantage HMO/HMO-POS plans

Update

Last modified: May 12, 2026

Most UnitedHealthcare Medicare Advantage HMO plans require referrals for specialty services, supporting a primary care-led model focused on coordinated, high-quality care. We've seen strong adoption of these requirements and appreciate the continued partnership of our primary care network.

As we refine our processes, we'll continue to defer adverse payment decisions related to referral requirements, extending the current grace period previously set to end April 30, 2026. We'll share additional details as updates are implemented, including advance notice before the grace period ends.

For an overview of Medicare Advantage referral requirements, including submission timing, exceptions, and state-specific guidance, visit the new **Medicare Advantage referrals web page**.

Providers should continue submitting referrals for services scheduled on or after Jan. 1, 2026.

Starting in 2026, most members enrolled in UnitedHealthcare Medicare Advantage HMO and HMO-POS plans are required to obtain a referral from their primary care provider (PCP) before accessing certain specialist services in outpatient, office or home settings. Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit. You can choose a start date of up to 5 calendar days prior to the entry date. Referrals are effective immediately upon submission.

The new referral requirements do NOT apply to services provided by a:

- Primary care provider
- Mental health provider
- Obstetrician/gynecologist
- Chiropractor
- Audiologist
- Oncologist
- Hematologist
- Nuclear medicine
- Neonatology
- Emergency medicine
- Nutritionist
- Podiatrist
- Optometrist
- Ophthalmologist
- Optician
- Radiologist
- Therapeutic radiologist
- Infectious disease specialist
- Urgent care

In addition, PCP referral is not required for these services:

- PT/OT/ST
- Cardiac rehabilitation services or pulmonary rehabilitation services
- Provision of anesthesiology (pain management services rendered by an anesthesiologist do require a referral)
- Home health agency services
- Services performed in an observation setting
- Any services from a pathologist or inpatient consulting physician, including hospitalists

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ABN Hard Stops

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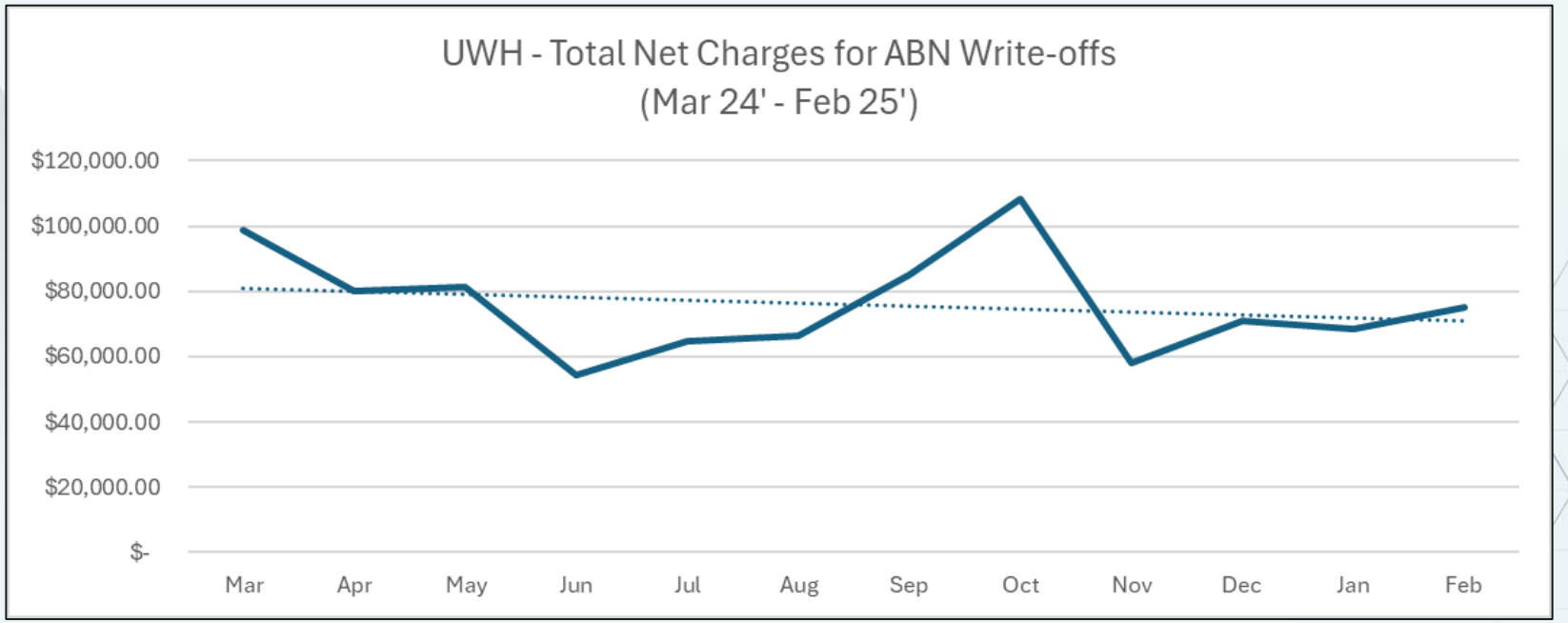
Why Work on ABN Write-Offs?

- **UW Health had greater than $1.38M in Net write-offs from Mar 24’ – Feb 25’**



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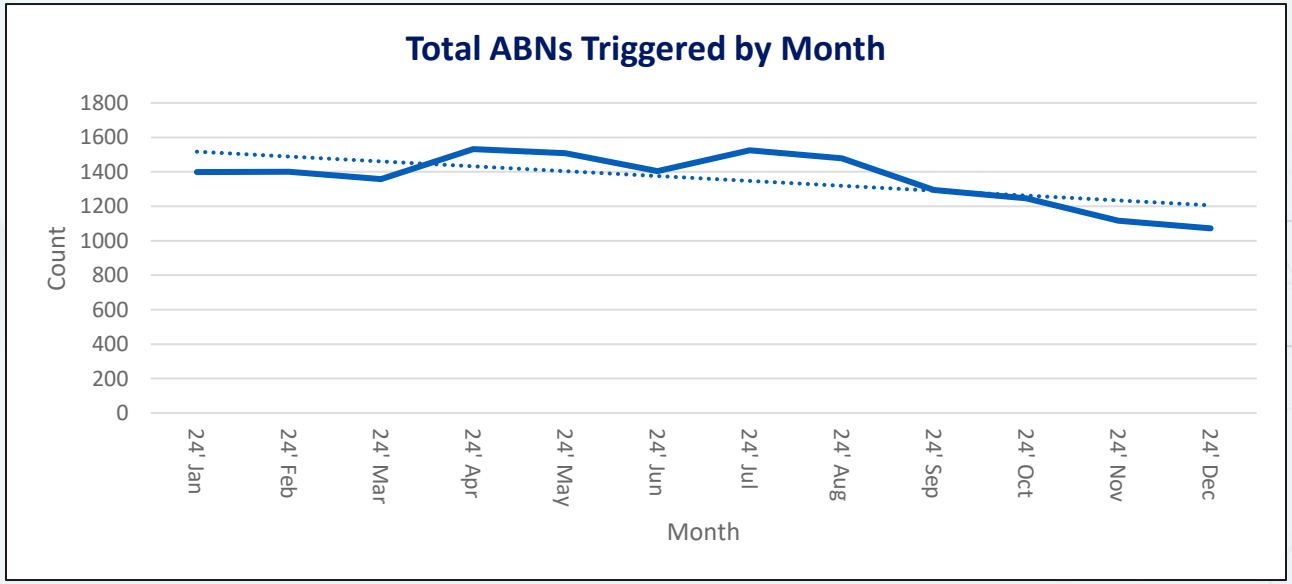
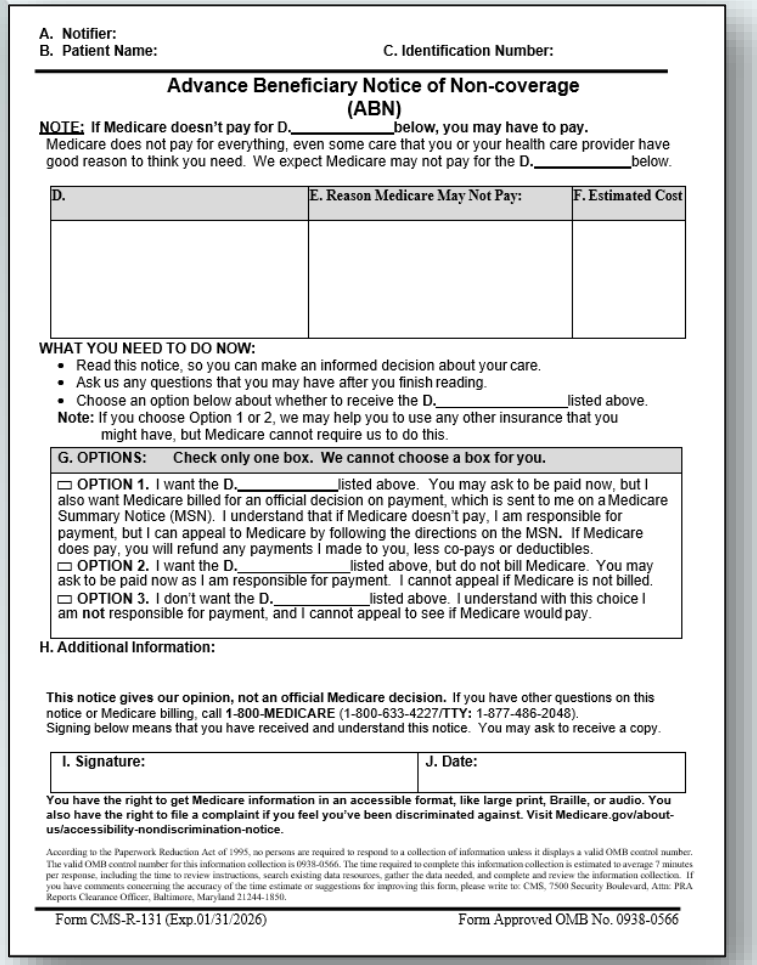
Why Work on ABN Write-Offs?

- **Over 16k ABNs trigger for ordering providers in CY2024**
- **Workflow Inefficiencies for ABNs without a Hard Stop**
  - Teams Impacted: Revenue Cycle, Clinic Staff, Schedulers
  - Keeping our work queues up to date
  - Following-up with Clinicians if a diagnosis is not covered to ensure appropriateness of ABNs, especially for high dollar procedures



MONTHLY AVE = 1,361

What is an ABN?



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

- The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers to beneficiaries in situations where Medicare payment is expected to be denied.
- The ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances.
- **Additional Resources:**
  - **ABN RULES:** Medicare Claims Processing Manual (100-4, Ch 30)
  - **ABN FORM:** ABN Form (CMS-R-131)

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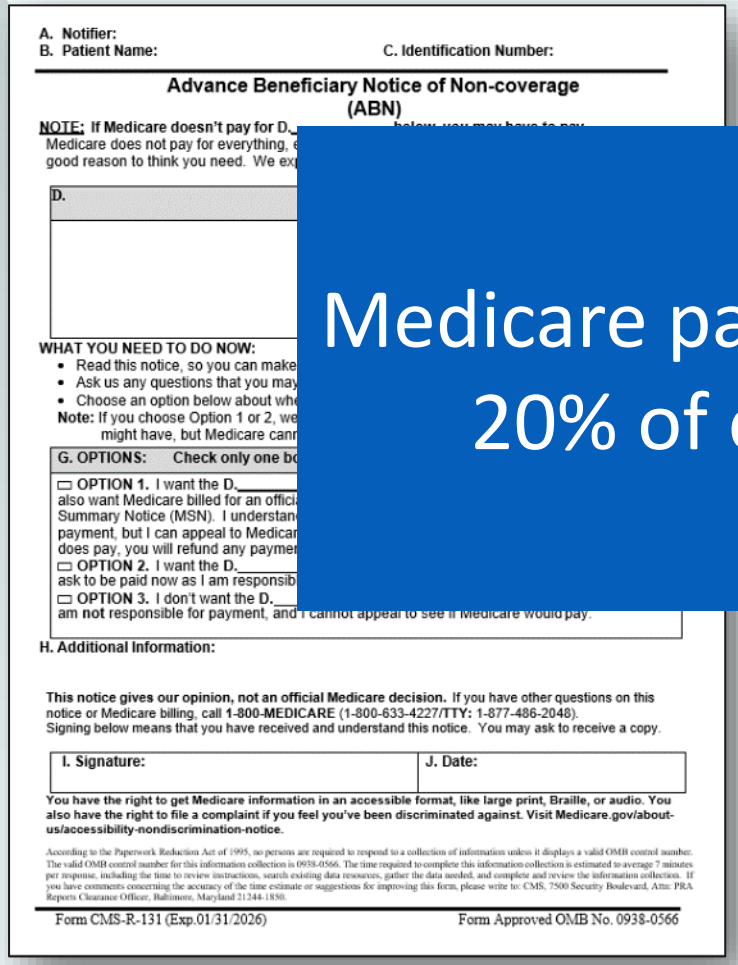
What is an ABN?



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to the

Ch 30)

Medicare patients account for greater than 20% of encounter volume in FY24!

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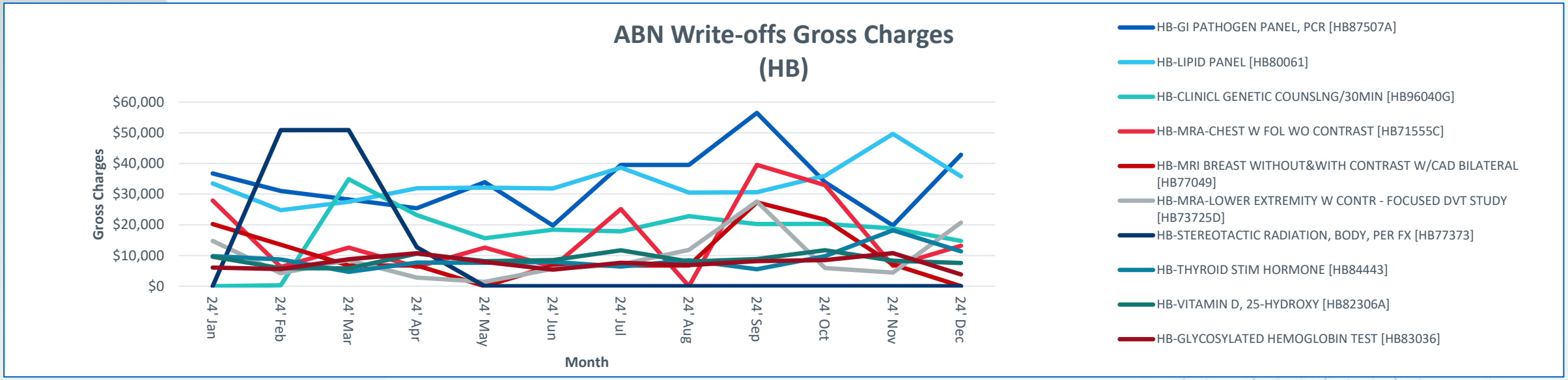
Top 10 ABN Write-offs ($)



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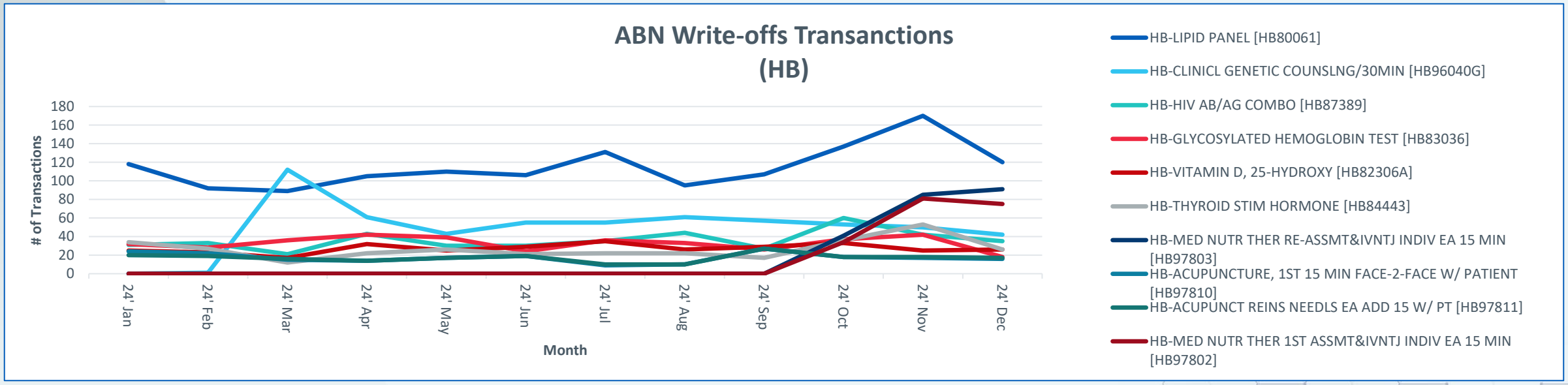
Top 10 ABN Write-offs (Volume)



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Top 10 Departments

#	DEPARTMENT	COUNT
1	Dept Of Family Medicine & Comm Health - Family Medicine General	1267
2	Dept Of Medicine - General Internal Medicine	1298
3	Dept Of Emergency Medicine - Emergency Medicine	258
4	Dept Of Medicine - Oncology	356
5	Dept Of Surgery - Oncology	34
6	Dept Of Medicine - Cardiology	80
7	Dept Of Medicine - Gastroenterology	126
8	Dept Of Medicine - Geriatrics	209
9	Dept Of Orthopedics And Rehab Medicine - Orthopedics	59
10	Dept Of Ob_Gyn - Oncology	77

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#1. DEPT OF FAMILY MEDICINE

Total Annual Count	1388
# of Procedures	54
Top 3 Costly Procedures would address this % of cost	62%
Top 3 County Procedures would address this % of counts	64%

TOP PROCEDURES	COUNT	COST
HB-LIPID PANEL [HB80061]	638	
HB-GI PATHOGEN PANEL, PCR [HB87507A]	38	
HB-VITAMIN D, 25-HYDROXY [HB82306A]	106	
HB-GLYCOSYLATED HEMOGLOBIN TEST [HB83036]	142	
HB-HIV AB/AG COMBO [HB87389]	56	
HB-THYROID STIM HORMONE [HB84443]	92	
Annual	1072	
Monthly	89	
	77%	77%

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#1. DEPT OF FAMILY MEDICINE

Total Annual Count	1388	
HB-HIV AB/AG COMBO [HB87389]	56	
HB-THYROID STIM HORMONE [HB84443]	92	
Annual	1072	
Monthly	89	
	77%	77%

Improving ABN capture of
6/54 studies would cover
>77% of our ABN losses

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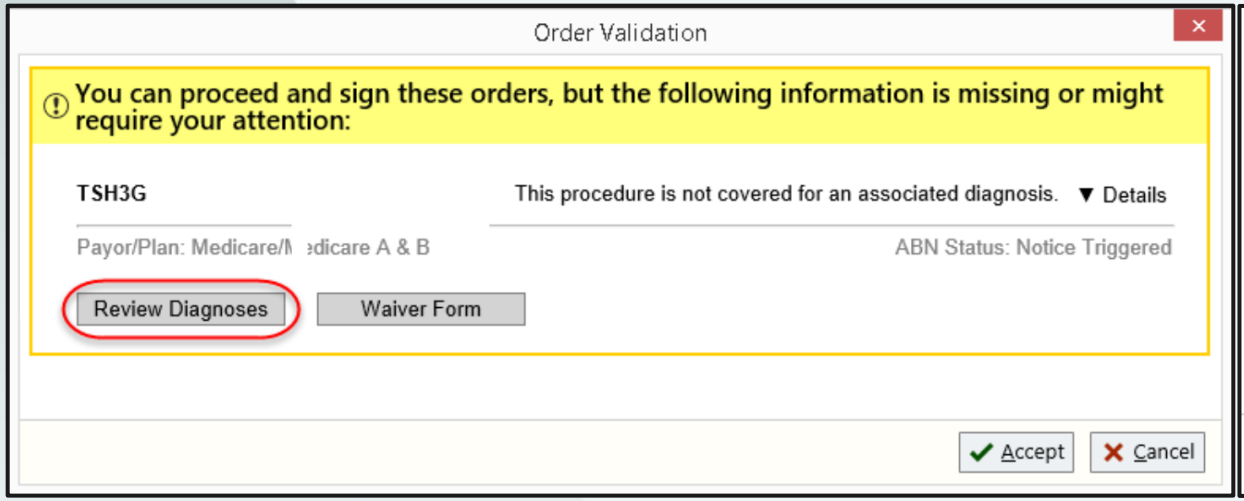
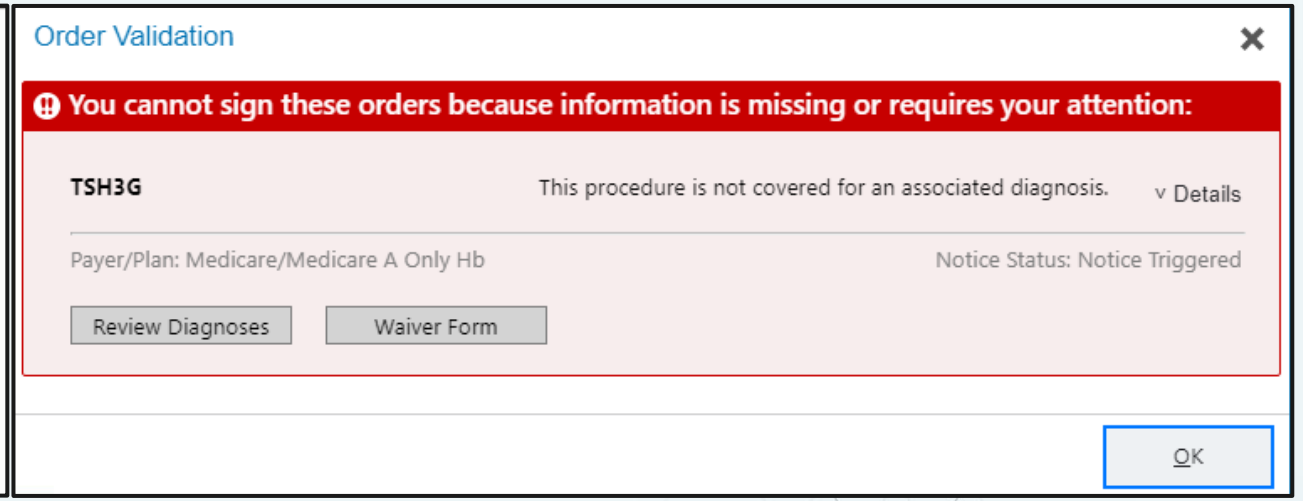
Implementing ABN Hard Stop Upon Order

CURRENT STATE: ABN ALERT



FUTURE STATE: ABN HARD STOP



This went to Senior Leadership Council:

1. Approving the ABN Hard Stop
2. ABN's must be signed by the patient to proceed with the service.

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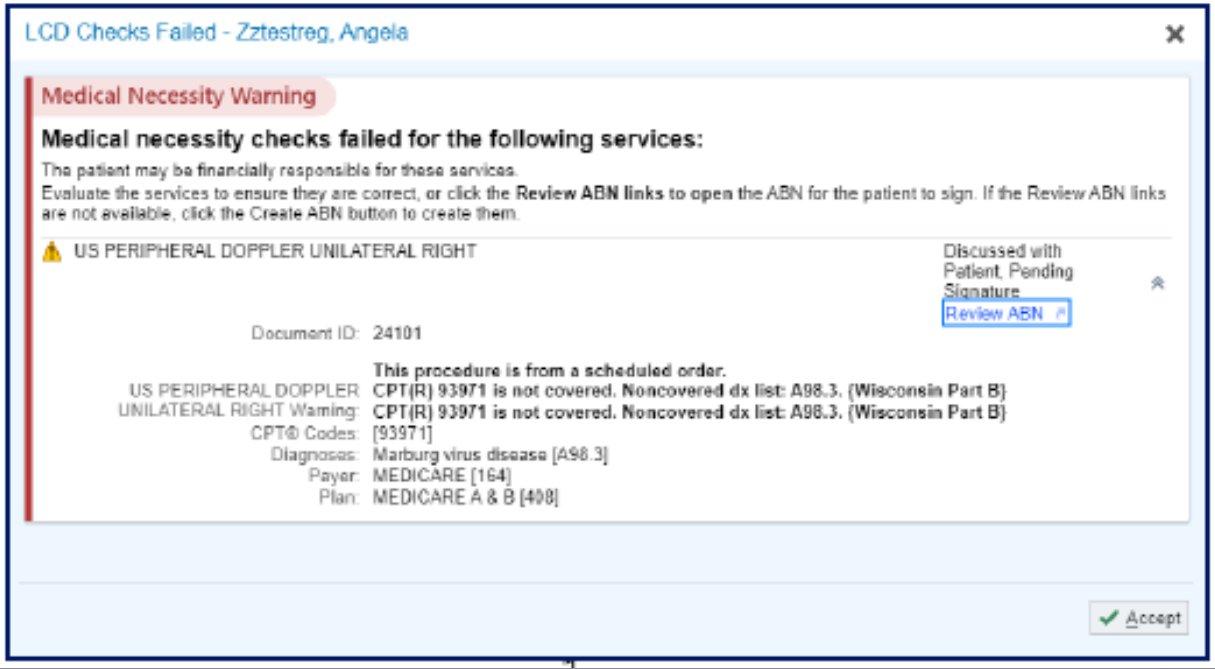
Implementing ABN Hard Stop Upon Arrival

Arrival Status	Msg	Patient	Phone	Provider/Resource	Appt Status	Type	Appt Notes	ABN NOT SIGNED
Unconfirmed		Zztestreg, Angela	Hm: 630-284-9256	US 1 ODANA RD	Sch	USPERIPHE...		

1. Attempt to check the patient in via the DAR, TPR or the Appt Desk.
2. If an **ABN** is required, you should receive a pop-up:



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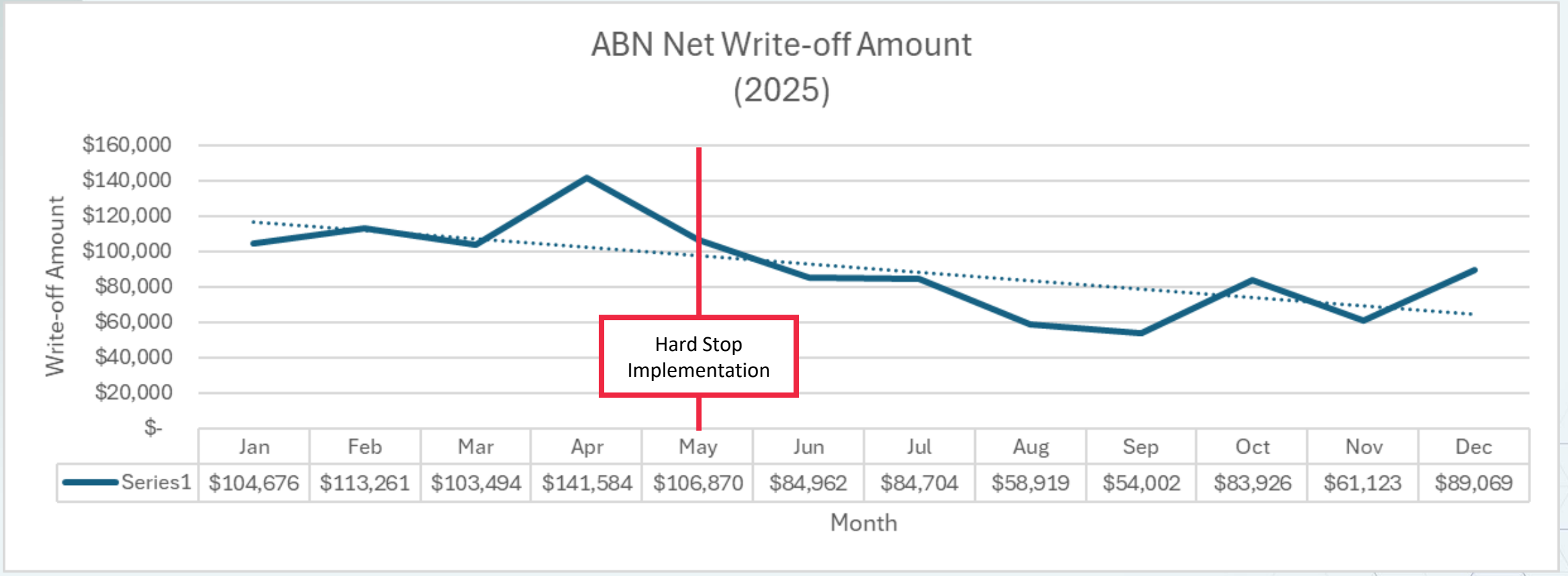
ABN Write-Off Data



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EXPANSION: Medicare Advantage Hard Stop Implementation

- The implementation of the Medicare Advantage Hard Stop prevents the ordering provider from bypassing a warning message alerting them that a more specific diagnosis is required to perform the procedure or service that otherwise may result in a UW Health write-off (same as Traditional Medicare ABN workflow)
- Strategic Alignment & Key Expected Benefits with a goal of $700,000 in savings.
- Immediate Benefits Realized
  - March & April 2026: *2000 orders* triggered a Medicare Advantage hard stop.
    - *1,175* (58%) – patient either signed ABN or order canceled/changed.
    - *813* (41%) - ordering provider entered in a new diagnosis code, eliminating a future write-off.
    - *12* (0.006%) patients refused to move forward with the order when informed they may be responsible for covering the cost of the service or procedure.

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Wrap Up & Questions

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