OBBBA Tuesdays

Improving Revenue Cycle & Managed Care Performance for Hospitals

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OBBBA Tuesdays

Scan to register and listen to archives, as they are available.

08.26
Overview & Implications

09.09
Understanding & Communicating Financial Impact

09.23
Improving Revenue Cycle & Managed Care

10.07
Identifying Aligned Growth Opportunities

10.21
Mitigating Regulatory Impacts – DSH & 340B

11.04
Mitigating Regulatory Impacts State-Directed Payments

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Agenda

1. Updates and Medicaid Work Requirements (Community Partnerships)
2. Revenue Cycle Opportunities
3. Revenue Cycle – Operational and Eligibility Impact
4. Revenue Cycle – Policy Review
5. Managed Care Landscape
6. Price Transparency & Commercial Rate Benchmarking
7. Medicare Advantage

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01

Updates and Medicaid Work Requirements

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SDP Questions – Partial Clarity

CMS issued preliminary guidance through a letter dated September 9, 2025

Grandfathered Guidance & Definitions

- Certain SDPs in rating periods occurring within 180 days before or 180 days after July 4, 2025 are eligible for grandfathering period
- Good faith effort – defined to be synonymous with a “completed preprint.”
- Completed preprint – equivalent to the definition described on page 6 of the CMCS Information Bulleting published November 7, 2023
  - “[a] complete State directed payment preprint submission requires a State directed payments preprint form as well as the preprint addendum tables in an Excel workbook, as necessary….The preprint must be completed in full, and all information must be provided only in the fillable sections of the preprint and the addendum tables”
- Total dollar amount of a grandfathered SDP cannot increase through the beginning of the phasedown period (January 1, 2028)
- CMS will permit the higher total for SDPs grandfathered under more than one rating period

https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

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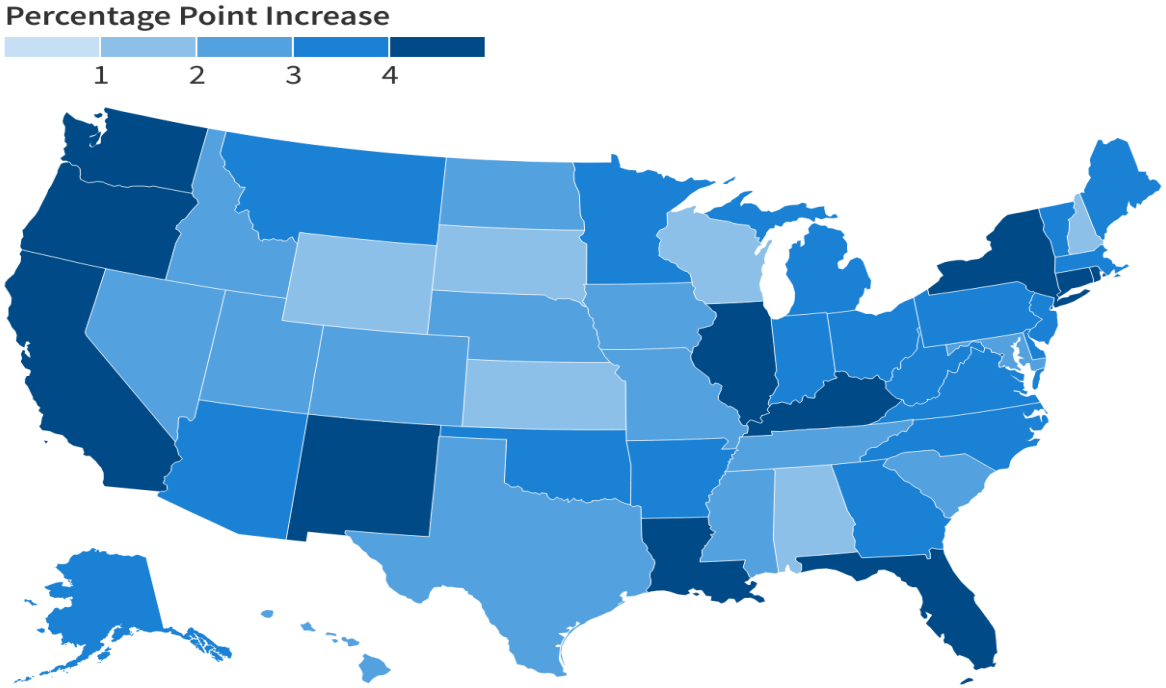
OBBBA: Coverage Impact

Changes to Medicaid and Exchange eligibility are projected to increase the uninsured by 10 million.

2034 Projected Uninsured Increase

OBBBA Medicaid & Exchange Provisions



Note: This map takes into account the effects on the uninsured population of passing the One Big Beautiful Bill Act. See methods for details.

Source: KFF analysis of population data from Weldon Cooper Center for Public Service; estimates of uninsured population growth by policy change from CBO, and KFF estimates of how the uninsured increase would be allocated across states (see Methods for additional sources and details).

KFF

Source: https://www.kff.org/affordable-care-act/issue-brief/how-will-the-2025-reconciliation-bill-affect-the-uninsured-rate-in-each-state-allocating-cbos-estimates-of-coverage-loss/

Medicaid

- Work requirements for select individuals ($326B)
- Increased redeterminations for expansion population ($62B)
- Reduced retroactive eligibility ($4.2B)

Exchange

- Increased income verification requirements ($37B)
- Limits premium tax credit eligibility for certain SEPs ($39B)
- Restricts premium tax credit eligibility for non-citizens ($120B)

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OBBBA: Medicaid Work Requirements

States must implement work requirements no later than January 1, 2027. Temporary compliance exemptions may be granted through December 31, 2028.

General

- Impacts adults aged 19 to 64 covered under Medicaid expansion
- 80 hours per month of qualifying activities:
  - Paid employment
  - Workforce training
  - Community Service
  - Half-time enrollment in education

Administrative

- Applicants must show compliance for 1-3 months *prior* to applying
- Must be verified at lease once every six months
- May verify as often as every month
- Exemptions for certain individuals included
- Reduces 3-month retroactive coverage

State Impact

- Outreach must begin 4 months before implementation
- Written notices of non-compliance with a 30-day response window
- Increased data matching
- Disenrollment of deceased individuals
- Interim Final Rule must be issued by June 1, 2026

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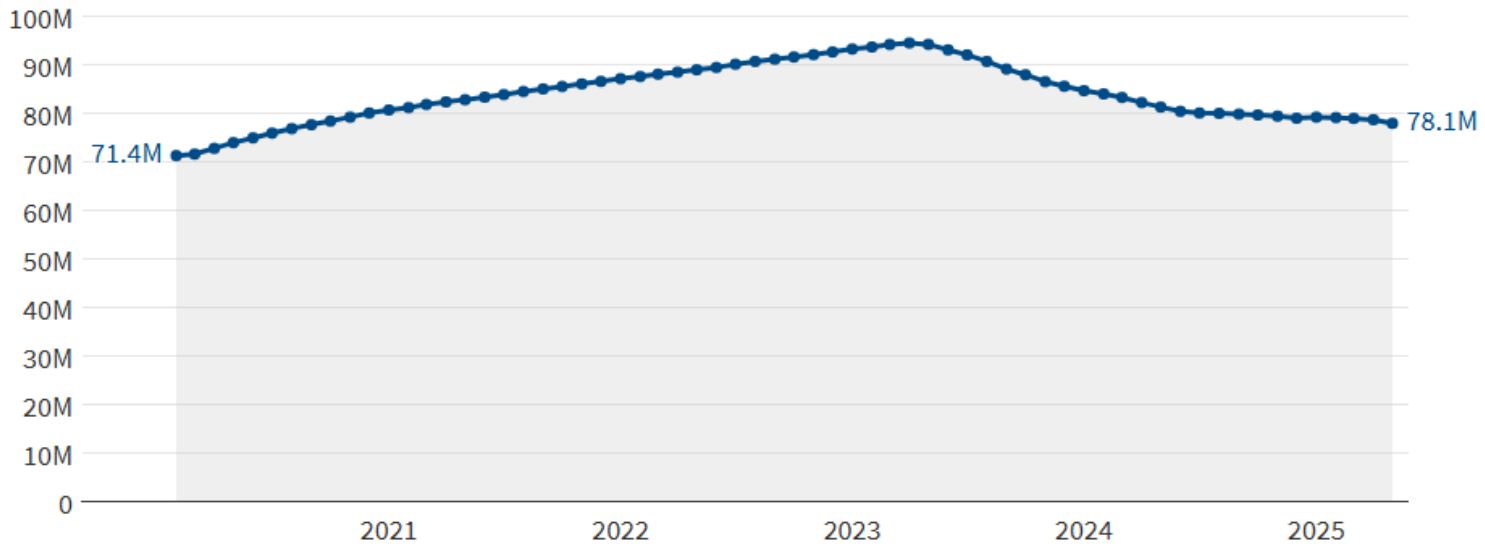
Medicaid Enrollment History

National Enrollment in Medicaid / CHIP, 2020 - 2025



Note: M = Millions. May 2025 data are preliminary and are subject to change in subsequent enrollment reports; all other months are based on updated enrollment reports. Rhode Island did not report data for December 2024 due to technical issues.

Source: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, last updated August 29, 2025. • Get the data • Download PNG

KFF

- Providers have been dealing with declining Medicaid coverage
- Post-pandemic unwinding has led to a decline of 17.5% nationwide since pandemic-era highs
- Future changes will only turbo charge these declines
- There is time to prepare

Source: https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/

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Community Partnerships

With declines in Medicaid coverage, providers need to think through different channels on how to care for the same population and guide these vulnerable patients through the administrative complexities that are the American health care system

Non-clinical

- Community centers
- Food pantries
- Housing support
- Faith-based organizations
- Libraries

Clinical

- Joint ventures
- FQHCs
- Mobile units
- Value-based care

Public Health

- Community facing and public trust
- Pooling of resources to reduce administrative costs
- Duplication of services
- Leveraging data

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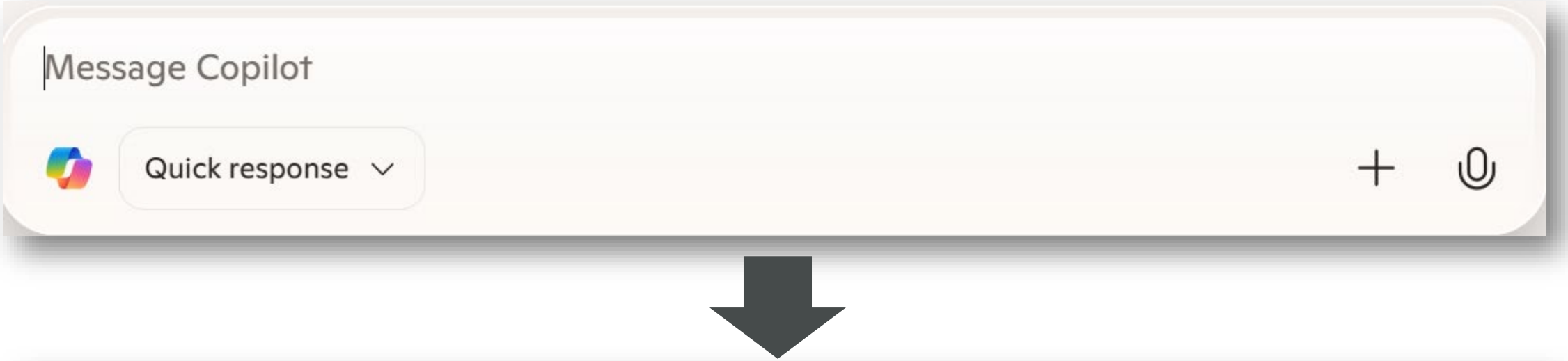
02

Revenue Cycle Opportunities

OBBBA Impacts and Preparation

”Copilot, how should for profit health systems better prepare for the impact of OBBBA?”



1. Revenue Cycle & Managed Care Optimization

- For-profit systems are encouraged to:
  - Improve front-end revenue cycle operations to connect uninsured patients with coverage.
  - Use benchmarking data to renegotiate managed care contracts.
  - Partner with community groups to maintain coverage continuity [4].

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OBBBA Preparation and Planning

Revenue Cycle Impact Overview

Front-end Revenue Cycle

Strategic Preparation	Coverage Discovery	Financial Assistance Policy	Regulatory Considerations
Communicate Internally	Eligibility	Policy Review	No Surprises Act
Establish Communication Pathways	Redundancy in Coverage Discovery	Self-pay Discounts	501R
Community outreach	Enrollment Options	Charity Care Presumptive Eligibility	State Directed Payments
Care Coordination	“Make or Buy”	Staffing Considerations	Worksheet S10

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03

Revenue Cycle – Operational and Eligibility Impact

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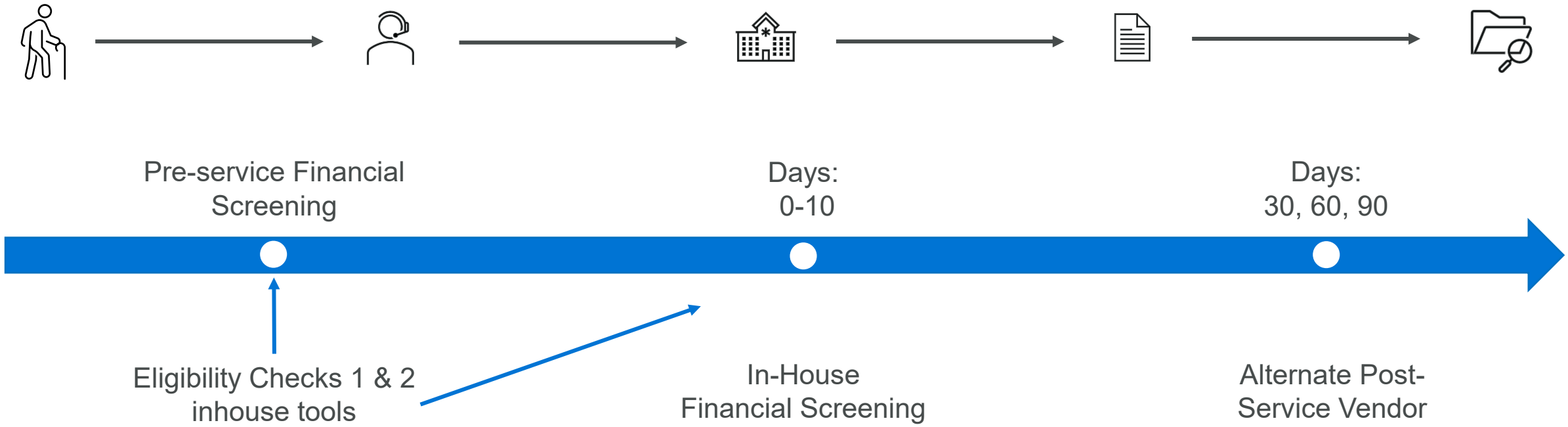
Pre-service and Post Service Eligibility

Build Redundancy in Coverage Discovery

Recommended automated eligibility workflows for non-covered patients



Opportunities:

- Increased **automation** to minimize manual workflows and touches
- **Leverage use of multiple tools/vendors** to support coverage discovery processes

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Self-Pay Financial Clearance Decision Tree

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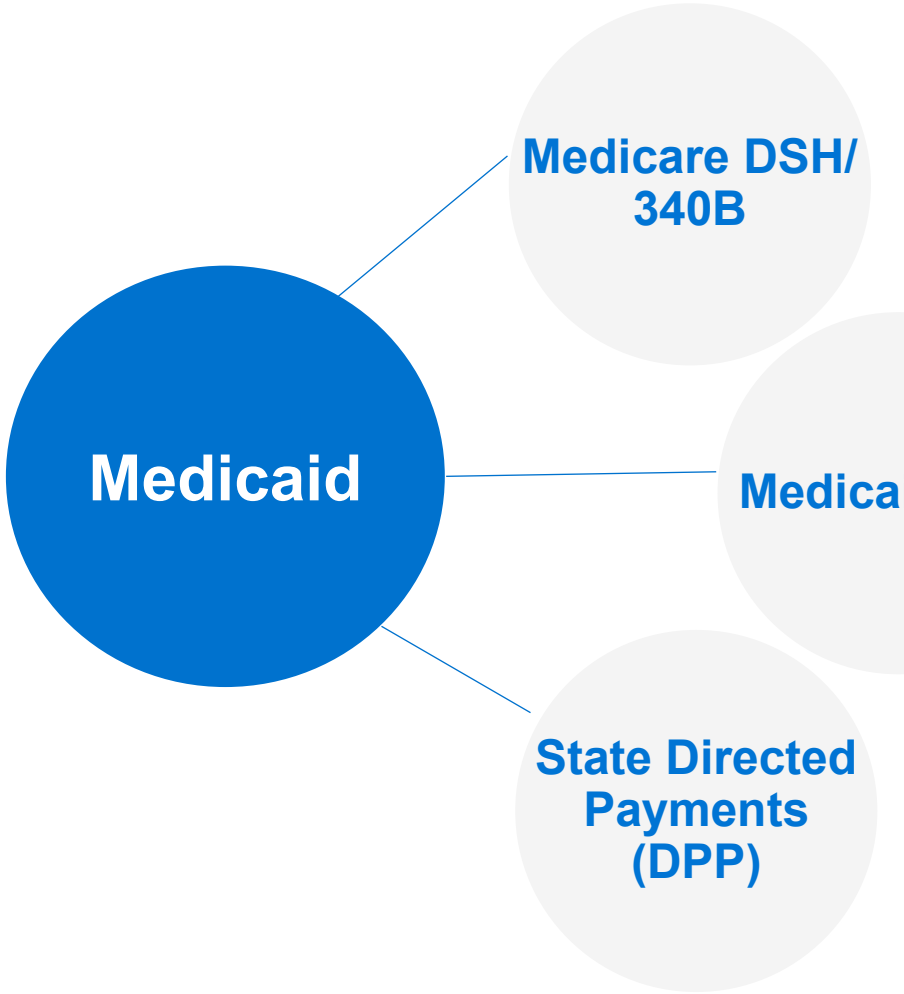
Scenario: patient insurance coverage not identified at time of referral or admission

		Action Items and Steps:	Eligibility Found:	Eligibility Not Found:
Step I	Coverage Discovery	Launch Coverage Discovery to search for active coverage	Insurance found and verified. Update patient account	Insurance not found. Flag account as Self Pay. Proceed to Step II
Step II	Medicaid Eligibility	Financial Counseling intake to screen for Medicaid/SSI eligibility	Eligible for Medicaid or SSI. Assist with application and document retrieval	Not eligible. Update patient account notes. Proceed to Step III
Step III	Financial Assistance Eligibility	Financial Counseling intake to screen for financial assistance / charity eligibility	Determine charity assistance level and assist with application and document retrieval	Proceed to run Self-Pay estimate and collect discounted patient responsibility

Improving Medicaid Eligibility

Reimbursement Considerations



Medicaid Eligible Days, Medicare/SSI Days, Total Days

Cost of Uncompensated Care (Medicaid & Uninsured)

Administered through Medicaid MCO's, multiple approaches, state-specific

Purpose: To assist hospitals treating a disproportionate share of low-income patients.

Key Strategies for Improving SSI/Medicaid Eligibility Internally

1. Start the SSI/Medicaid eligibility process earlier for better outcomes
2. Focus on **ED, Inpatient, and high-cost scheduled services** for screening eligible patients
3. Prioritize patient education on SSI/Medicaid eligibility criteria
4. Utilize trained staff to assist patients throughout the application process
5. Ensure consistent follow-up on application statuses to support patients

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Medicaid Eligibility Teams

Develop a Staffing Plan

Internal

Screening goals

- 95% inpatients screened
- 80% outpatients screened
- **40-50 outpatients screened a day per FTE**
- **10-12 inpatients screened a day per FTE**

Staffing

- FTEs determined on patient volumes
- Application follow up processes
- Training program with regular updates
- Track conversion rates

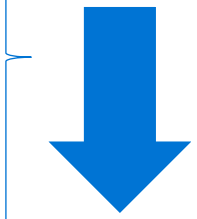
External

Higher volume screening capabilities

- Inpatient – 2500+ accounts a year
- Outpatient – 30,000+ accounts a year

Traditional Example Benchmarks

- Inpatient
  - 40% (variable) acceptance rate for accounts referred
  - 70% approval rate (variable)
- Outpatient
  - 3-7% acceptance rate
  - 40% approval rate



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04

Revenue Cycle – Policy Review

Policy Review

Financial Assistance and Self-pay Policies

Great opportunity to internally assess and update key policies for critical attributes and **STAFFING**

Financial Assistance Policy

- ✓Purpose & Scope– what entities are covered?
- ✓Definitions
  - Charity Care / Discounts and sliding scale
- ✓Eligibility and qualifications
  - Federal poverty level (FPL)
- ✓Application process
- ✓Communication & Publication
- ✓Presumptive charity eligibility
- ✓Fair patient billing and collections practices

Self-Pay Policy

- ✓Purpose & Scope
- ✓Automated discounts
  - Amounts Generally Billed (AGB)
- ✓Patient estimates and minimum deposits
- ✓Bad debt treatment
- ✓Payment plans / loan options

<u>Other operational self-pay considerations:</u>

- ✓Propensity to pay & patient treatment
- ✓Staff scheduling expectations for deferral/escalation

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FAP Policy Best Practices

Anatomy of the Ideal FAP

Key features and explanations of an ideal FAP

Policy Scope

Who is this covering? Hospital? Clinic? Specific providers?

Policy Purpose

What is the reason for the policy?

Policy Definitions

Clear definitions of terms mentioned throughout policy

Policy Examples

SCOPE:
The scope of this policy encompasses hospital, clinic, etc.
Changes reflected in this Charity Care and Financial Assistance Policy are a formalization of procedures which have been followed to qualify a patient for charity care or financial assistance.

PURPOSE:
Hospital provides inpatient, outpatient, emergency, ambulance, and Physician Services.
Hospital may provide charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for government programs, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Hospital strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

DEFINITIONS:
For the purpose of this policy, the terms below are defined as follows:

Charity Care: Discounted care provided to patients who are uninsured for the relevant medically necessary service, ineligible for government or other charity care benefit, and unable to pay.
Hospital maintains two types of charity care for the purposes of this policy, Financially Indigent and Medically Indigent.

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FAP Policy Best Practices

Anatomy of the Ideal FAP

Key features and explanations of an ideal FAP

Policy Overview

Summarize key sections of the policy and any disclaimers and expectations

Policy Examples

***POLICY*:**

Overview

This written policy:

- Includes eligibility criteria for financial assistance –full or partially discounted care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how Hospital my publicize the policy within the community served by Hospital
- Limits the amount Hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed to commercially or Medicare insured patients.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Hospital's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability

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FAP Policy Best Practices

Anatomy of the Ideal FAP

Key features and explanations of an ideal FAP

Eligibility Criteria

Clearly defined eligibility considerations used to determine level of financial need

Amounts Charged to Patients

Basis and calculations used to determine the amount charged to qualifying financial assistance patients

Policy Examples

Eligibility Criteria and Amounts Charged to Patients

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity may be based on an individualized determination of financial need, and shall not take Into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts Hospital will charge patients qualifying for financial assistance is as follows, but not limited to:

1. Patients who are uninsured and whose family income is at or below 300% of the FPG are eligible to receive care at a fully discounted rate.

2. Patients who are uninsured or underinsured and whose family income is above 300% but not more than 500% of the FPG are eligible to receive services at discounted rates no greater than the amounts generally billed to commercially insured or Medicare patients.

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FAP Policy Best Practices

Anatomy of the Ideal FAP

Key features and explanations of an ideal FAP

Application Procedures

Explains methodology used to assess the financial need of a patient

FAP Communication

How are you making the FAP policy known to all patients and the community served?

Policy Examples

***PROCEDURE*:**

Method by Which Patients May Apply for Charity Care

1. Financial need may be determined in accordance with procedures that involve an individual assessment of financial need and may include but not limited to:

   a. An application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need

Communication of the Charity Program to Patients and Within the Community

Notification about charity care available from Hospital shall be disseminated by Hospital by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the Conditions of Admission form, at admitting and registration departments, and patient financial services offices that are located on the Hospital's campuses, and at other public places as Hospital may elect. Hospital may also provide a summary of this charity care policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital as

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FAP Policy Best Practices

Anatomy of the Ideal FAP

Key features and explanations of an ideal FAP

Presumptive Charity Eligibility

Clearly defines life circumstances that could qualify an individual for free care, such as homelessness or participation in government programs such as food stamps or WIC

Policy Examples

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, Hospital could use outside agencies in determining estimate of income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include, but are not limited to:

1. State-funded prescription programs
2. Homeless or received care from a homeless clinic
3. Participation in Women, Infants and Children programs (WIC)
4. Food stamp eligibility
5. Subsidized school lunch program eligibility
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)

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Financial Assistance Program (FAP) Overview

501r Requirements & Best Practice

501r Requirements

Written Financial Assistance Policy (FAP)

- Must apply to all emergency and medically necessary care
- Must include eligibility criteria, basis for calculating amounts charged, and application methodology
- Must describe the process for determining FAP eligibility
- Must describe actions in the event of non-payment

Publicizing the FAP

- Must be publicized on hospital website and in public locations within hospital
- Must provide paper copies (i.e. Plain Language Summary)

Translation for Limited English Proficiency Populations

- Must translate FAP documents into primary languages spoken by significant populations served in community

Billing and Collections

- Do not engage in extraordinary collection actions prior to making FAP available

No Surprises Act

No Surprises Act

- Dictates financial treatment for non-covered and out-of-network patients
  - Emergency Care
  - Out of network providers at an in-network facility
- Good faith estimates for self-pay/uninsured patients
  - Examine current state processes
  - Assess for potential volume increases

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Source: IRS.gov

05

Managed Care Landscape

Provider Pressures

- Labor shortages & increased costs
- Continued inflation
- Margins remain lower than pre-COVID levels
- OBBBA: increasing uninsured population

Figure 1. Labor constitutes largest percentage of hospital expenses.

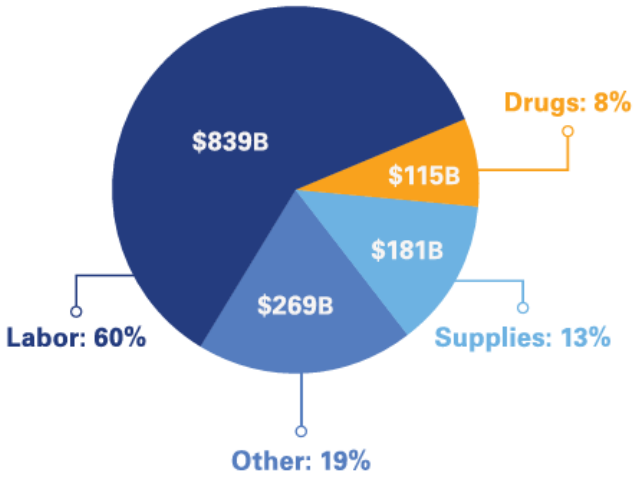


Figure 2. Inflation growth was more than double the growth in IPPS reimbursement, 2021 - 2023

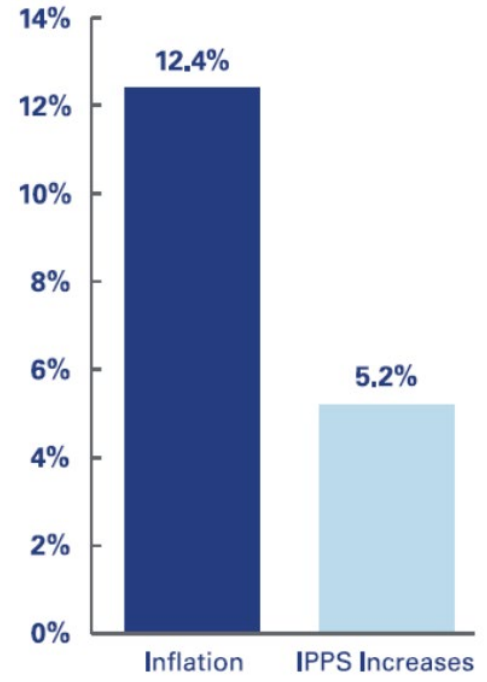


Figure 4. Hospital payments do not cover the costs of providing vital inpatient services

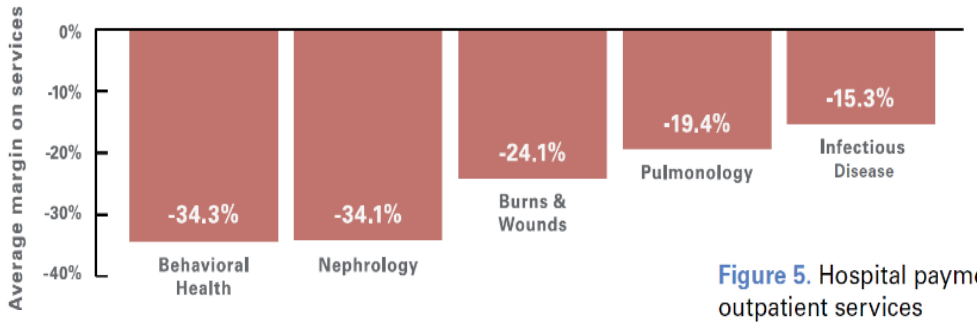
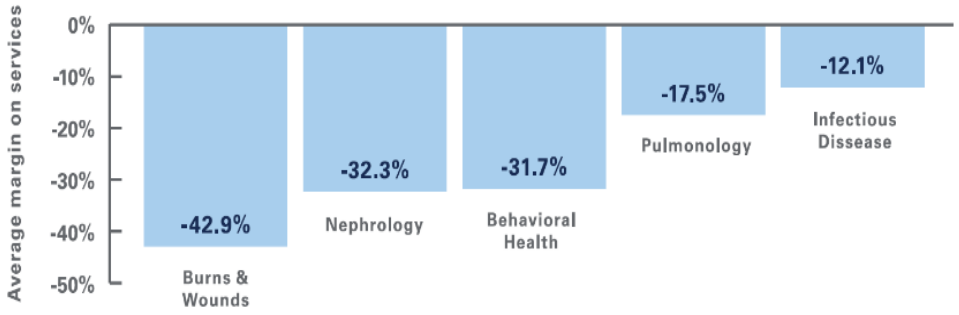


Figure 5. Hospital payments also fail to cover the costs of providing essential outpatient services



Source: America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities, aha.org

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Focus on Cost, Quality, and Accessibility

Pressure to Control Increasing Costs

- Employers
- Payors
- Providers
- Consumers
- Governmental

Focus on Value & Quality

- Care management programs
- Steerage efforts increase focus on defensible pricing
- Growth in population health programs & value-based care

Site-of-Service Shifts

- Inpatient to outpatient
- Ambulatory & freestanding providers
- In-person care vs. virtual

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Provider-Payor Challenges

One of the **largest** insurers has become one of the **largest** employers of doctors. In 2023, UnitedHealthcare with Optum **increased** the number of employed or affiliated physicians to **90,000** & has plans to **continue expansion**.

The **largest** health systems are **10x smaller** than the **largest payors,** creating an **imbalance** in negotiations. Negotiated rates are **one portion** of payor trends that are shifting.

The combination of **Medicare & Medicaid** is now **larger** than commercial payor sources, creating a larger **rate differential**.

Medicare rates are **not** increasing at substantial levels amid **large** cost increases. These lower increases are **not** offsetting the cost increases seen by health systems.

Source: Becker Hospital Review

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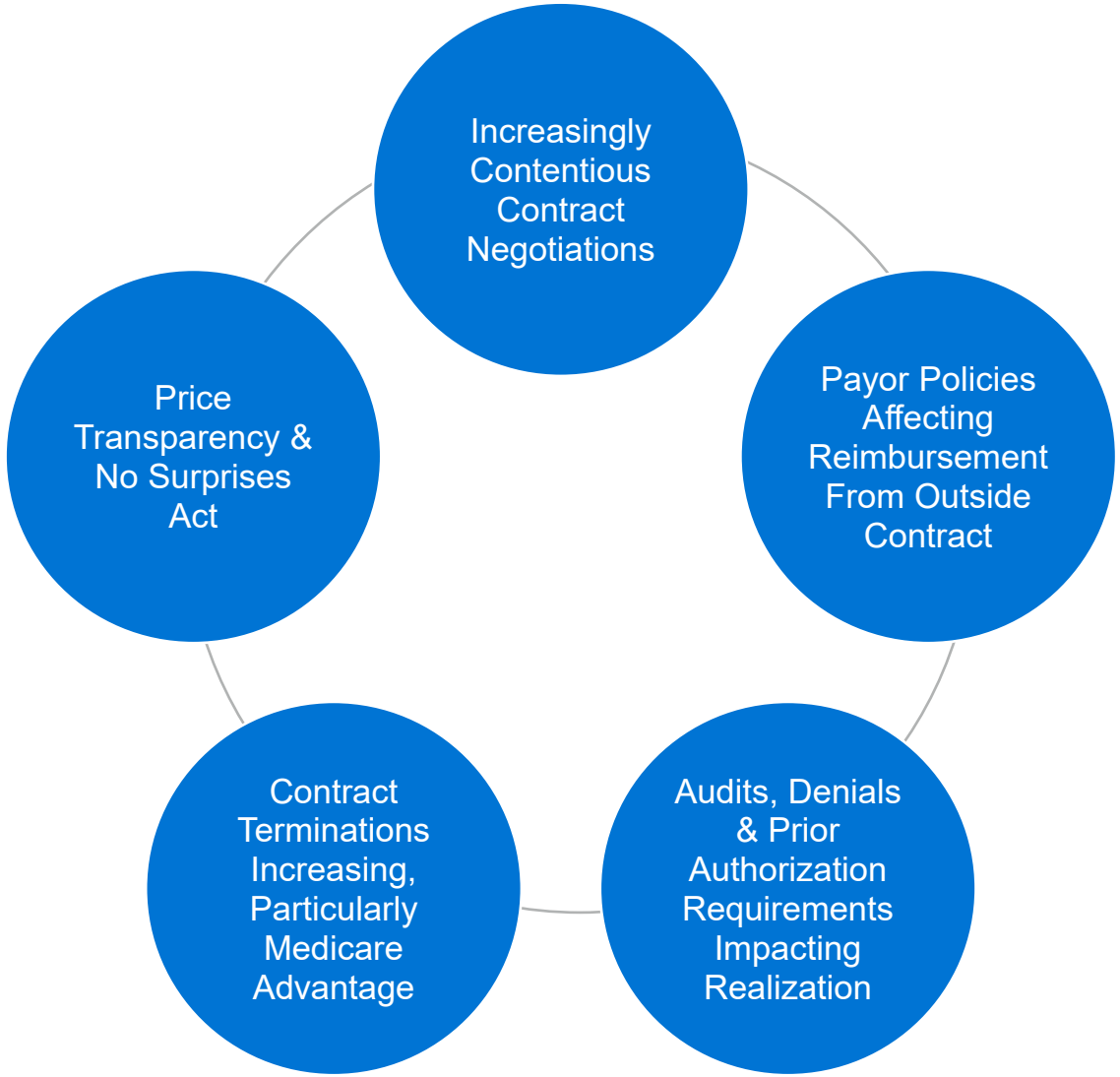
Provider-Payor Relationships



HEALTH

Medicare

Hospitals, doctors drop private Medicare plans over payment disputes

Ken Alltucker
USA TODAY

Published 3:52 p.m. ET Oct. 27, 2023 | **Updated 4:30 p.m. ET Oct. 27, 2023**

HOSPITALS, MEDCITY INFLUENCERS, PAYERS

Payer Negotiations Are Getting Ugly

As margins at health systems continue to contract, and insurance company profits continue to surge, contract negotiations are becoming increasingly contentious. With billions of dollars potentially at stake, you need to be prepared and aligned well in advance.

REIMBURSEMENT NEWS

Private payers initially deny nearly 15% of medical claims

Financial Management

15 health systems dropping Medicare Advantage plans | 2024

Image sources: USA Today, MedCity News, TechTarget, Becker's Hospital Review

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06

Price Transparency & Commercial Rate Benchmarking

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CMS Transparency in Coverage Ruling

Effective January 1, 2021, **hospitals** were required to publish negotiated rates with all payors.

- Historically confidential information
- Limited services provided in a consumer-friendly format; “machine-readable file” (MRF) of all services

Effective July 1, 2022, **payors** were required to publish negotiated rates for all provider types.

- Hospitals plus physicians, ASCs, post-acute facilities, etc.
- Phased rollout; all services now required to be published

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Payor Price Transparency Data

Forvis Mazars utilizes a platform for exploration of payor price transparency MRFs:

- Server able to digest payor files, which can be terabytes in size
- Reduction of ghost rates & irrelevant plans; enriches data for easier discovery
- Analytical consolidation of data across payors, markets, & other meaningful data points
- Forvis Mazars overlays knowledge & expertise to develop business-ready insights

Lifting the Veil

The availability of Price Transparency data is intended to unveil previously proprietary pricing between providers and payors. The data will create internal and external market disruption:

Health Plans/Payors will utilize the published pricing to ascertain whether the rates they have with providers are in line with rates negotiated with other insurers.

Providers will utilize the published pricing to compare themselves to their peers and among each of the health plans to drive their strategic pricing initiatives and approach to managed care.

Employers armed with competitive pricing from hospitals and payors may elect to develop steerage mechanisms to encourage employees to utilize lower-cost hospitals.

Informed consumers will have the ability to shop rates among hospitals and health plans.

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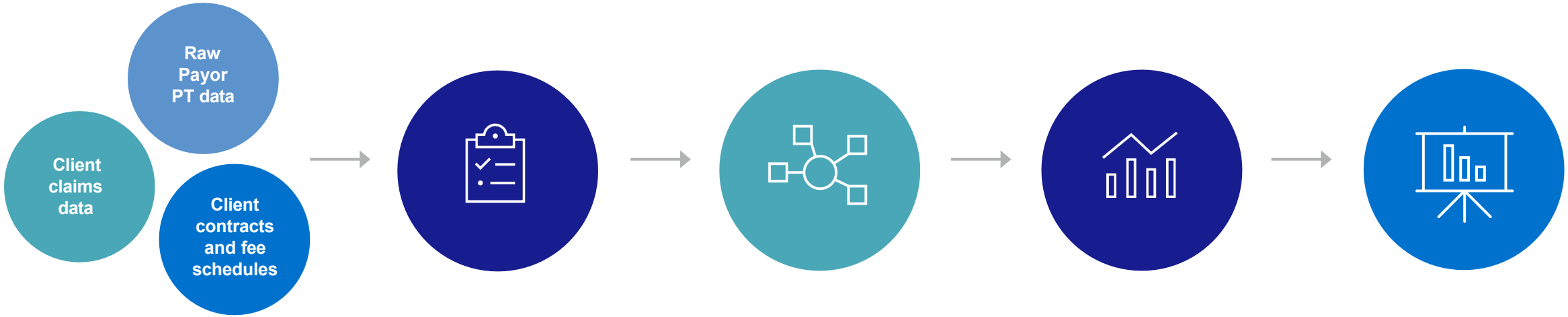
Rate Benchmarking
Methodology



Source
Access raw data from Payor Price Transparency files, client commercial claims data for top payors, & current contracts & fee schedules

Validate
Summarize key data statistics, *e.g.*, payor mix, case mix, and validate receipt of all necessary elements from client

Normalize
Standardize service line mapping, identify focus areas, refine Payerset data, define benchmark parameters, & identify any assumptions & limitations

Benchmark
Identify pricing tenets for comparison, create & apply benchmarks, & aggregate results by payor & service line

Summarize
Summarize observations that will inform recommendations

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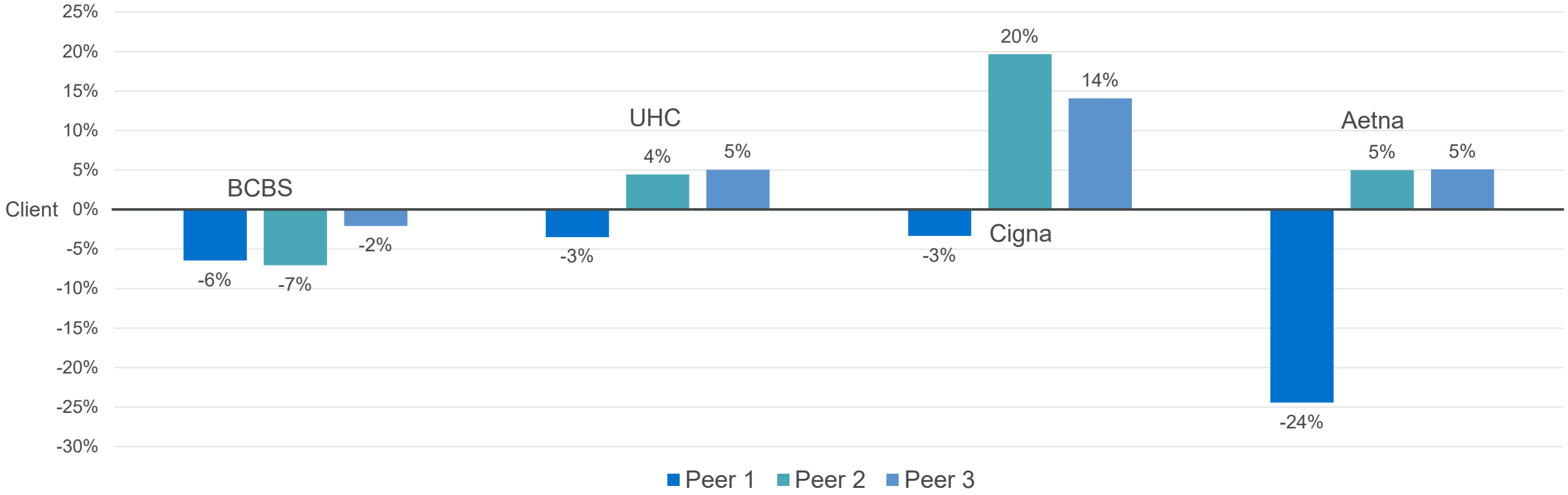
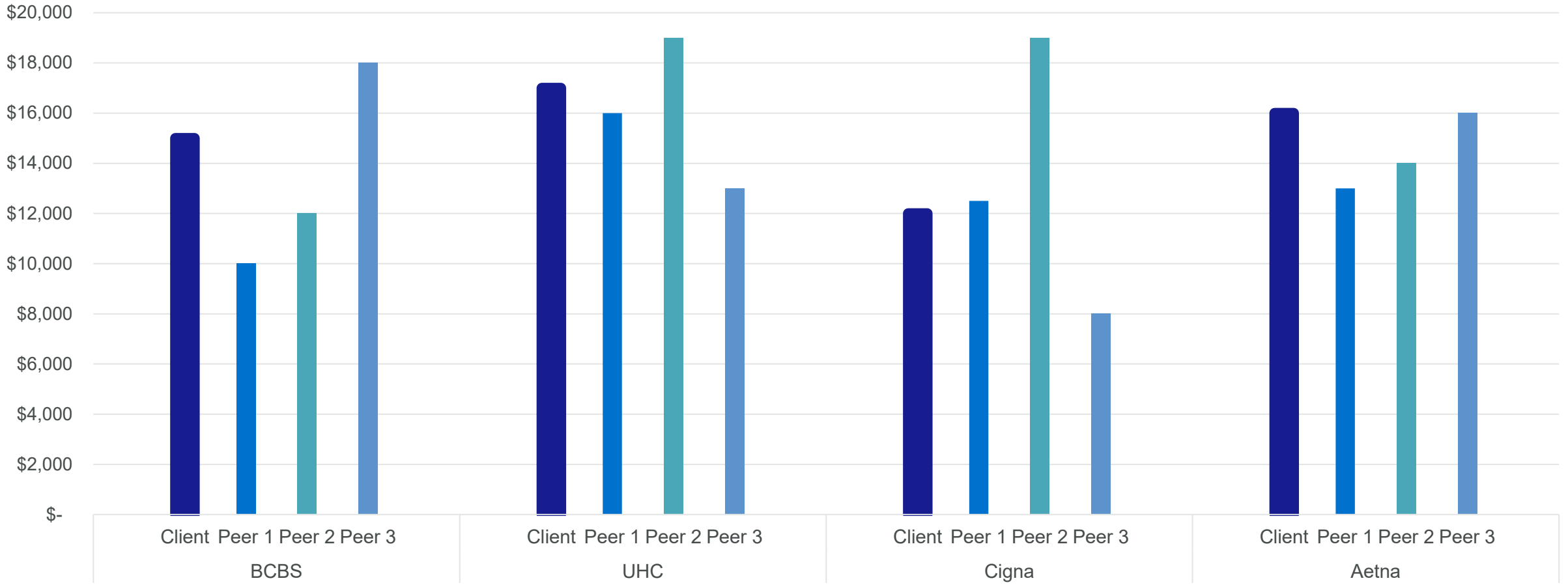
Overall Hospital Rates by Payor

This chart is inclusive of the aggregate service lines benchmarked in this report and represents the weighted average dollar variance of each peer from Client based on their specific contract rates, billed charges, and using Client's utilization. Client is represented by 0% on the horizontal axis, and the differential from each peer is shown as a percent variance; a negative variance indicates that Client's contracted rates are higher than the identified peer, and a positive variance indicates that Client's contracted are lower than the identified peer.



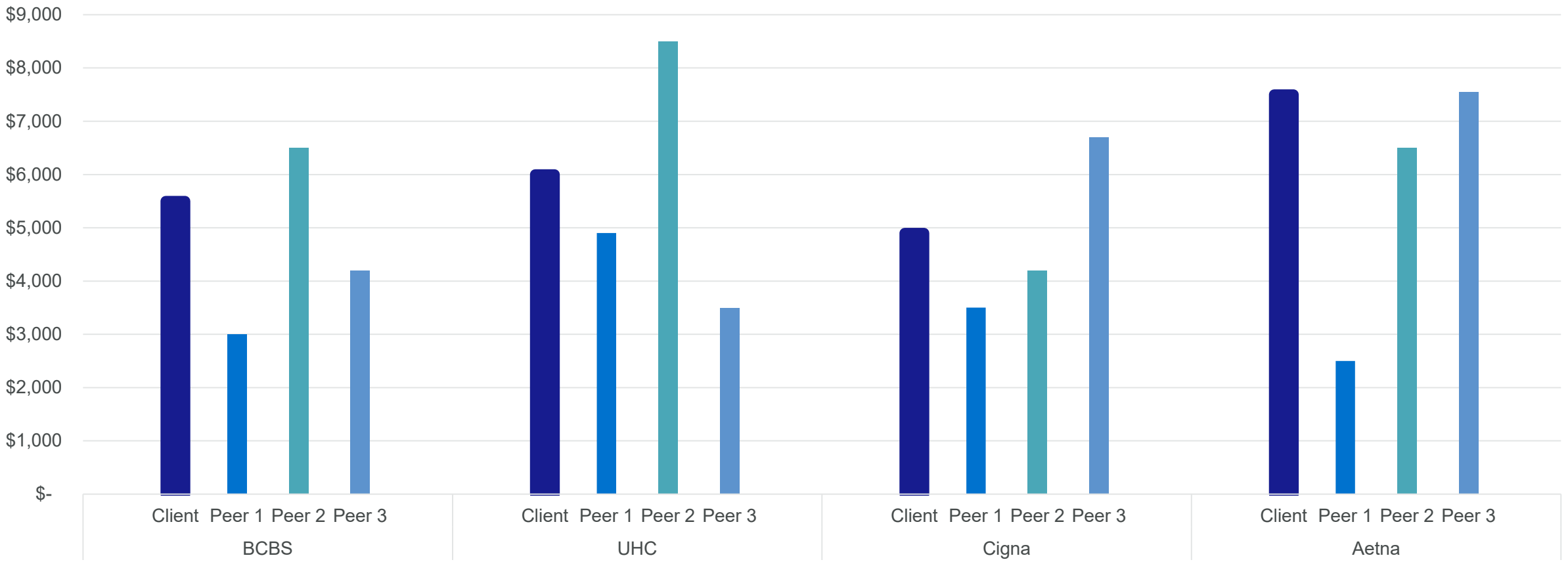
Inpatient

The graph below shows a client's payor-specific rates relative to peers for inpatient services, shown here as weighted average case rates.



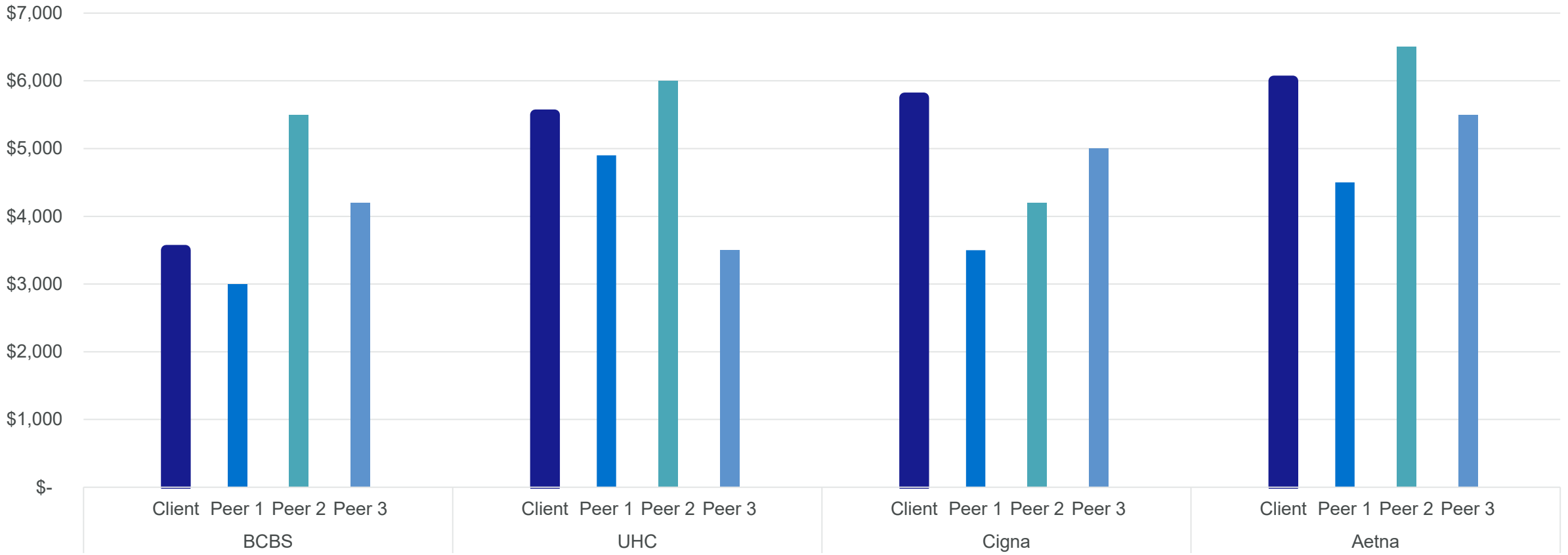
HOPD Surgery

The graph below shows a client's payor-specific rates relative to peers for HOPD Surgery services, shown here as weighted average case rates.



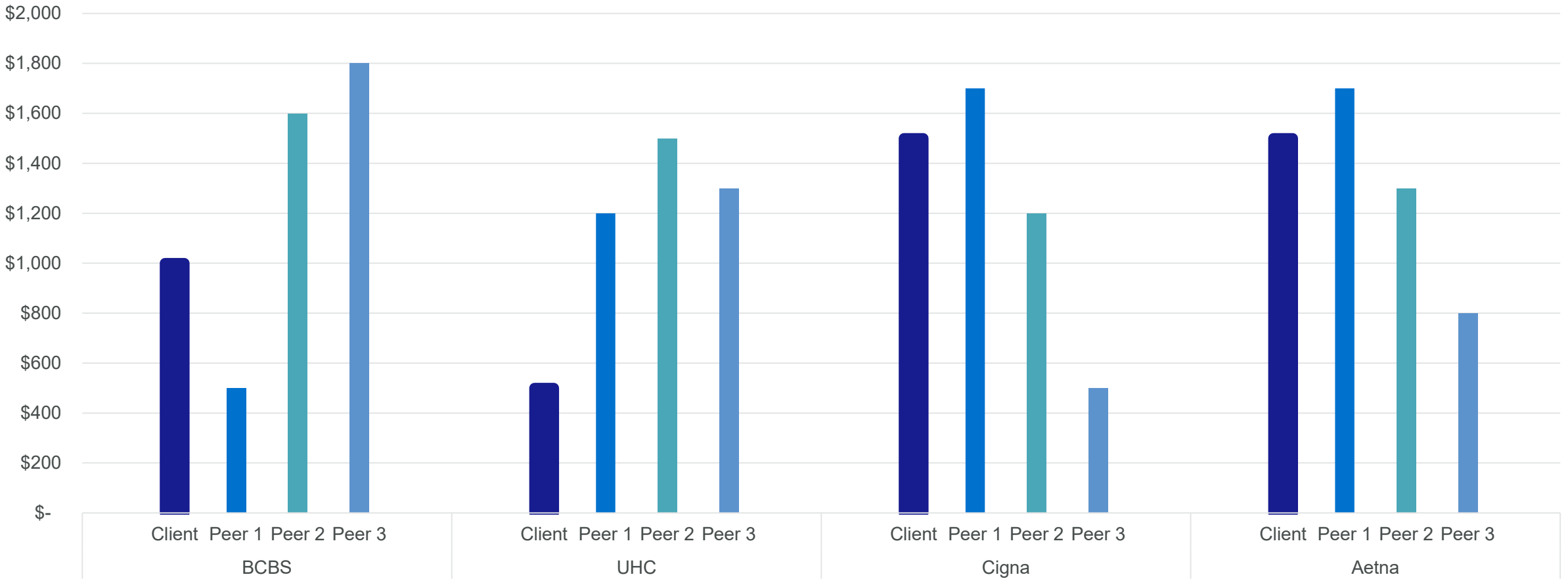
Emergency Department

The graph below shows a client's payor-specific rates relative to peers for Emergency Department services, shown here as weighted average case rates. The market average by payor has also been graphed.



Imaging

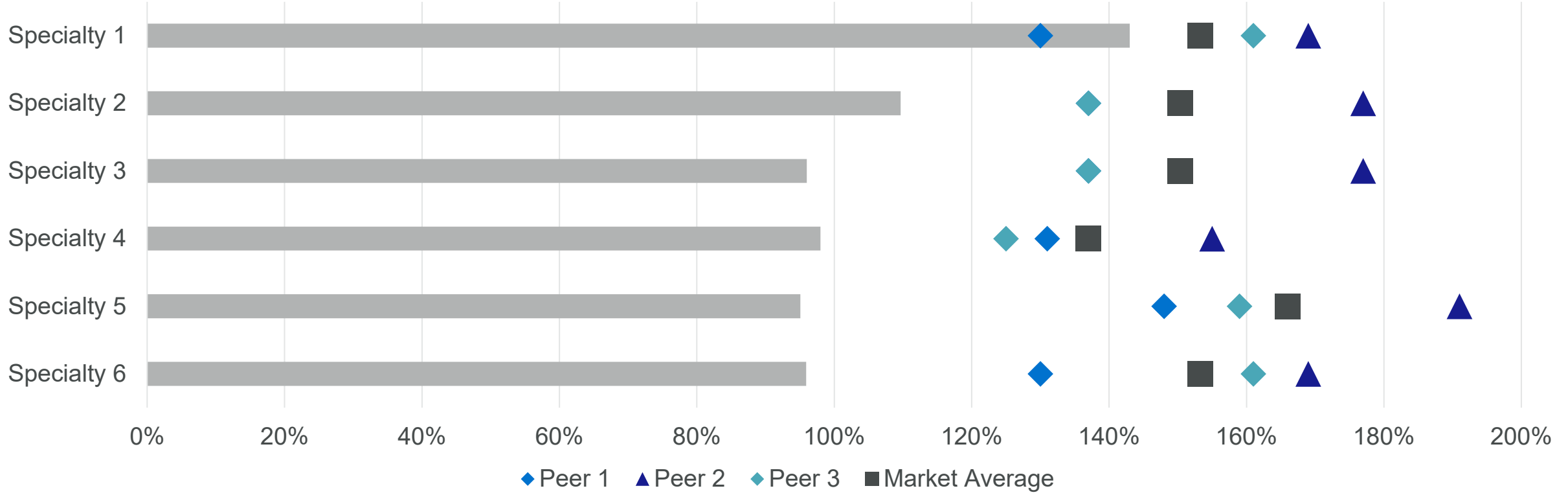
The graph below shows a client's payor-specific rates relative to peers for imaging services, shown here as weighted average case rates. The market average by payor has also been graphed.



Physician Benchmarking

BCBS

The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, *e.g.*, primary care, orthopedics, etc.



Financial Projections

Target increases for upcoming negotiation cycles have been developed using the peer reimbursement ranges for services evaluated in this report. Estimated net revenue impact is based on historical claims payments. While there is additional opportunity to align with the market in some cases, it is typically difficult to achieve rate increases greater than 9% in Year 1. To continue to close the gap with the market, additional increases in Years 2 & 3 should target 4-8%.

Payor	Entity	Annual Net Revenue	Target Increase	Est. NR Impact (Year 1)
BCBS	Hospital	$ 130,000,000	7%	$ 9,100,000
BCBS	Physicians	$ 20,000,000	5%	$ 1,000,000
UHC	Hospital	$ 34,000,000	9%	$ 3,000,000
UHC	Physicians	$ 6,000,000	9%	$ 540,000
Cigna	Hospital	$ 43,000,000	9%	$ 3,870,000
Cigna	Physicians	$ 7,000,000	9%	$ 630,000
Aetna	Hospital	$ 31,000,000	9%	$ 2,800,000
Aetna	Physicians	$ 6,000,000	9%	$ 540,000
Total				**$ 21,480,000**

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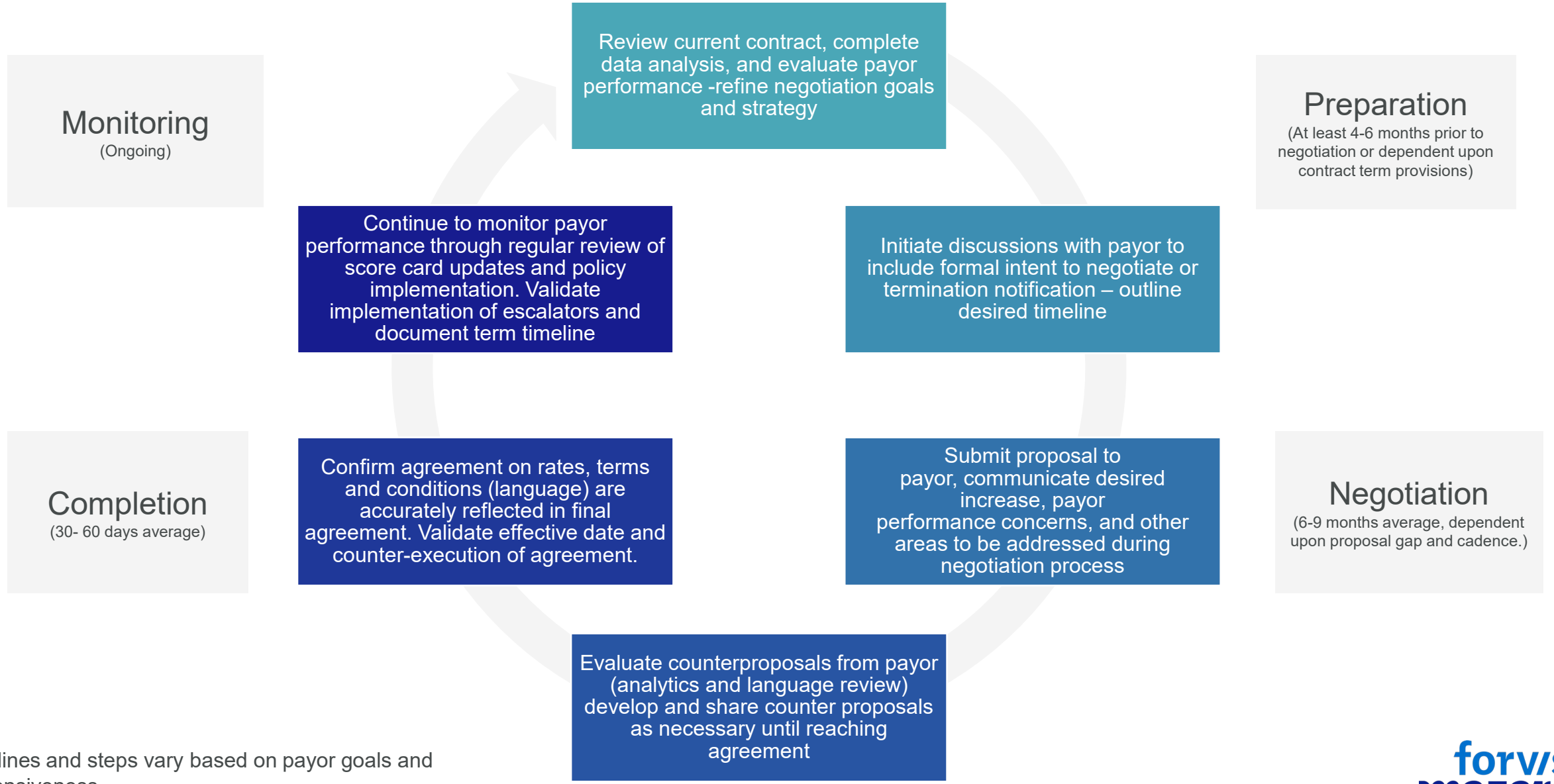
Negotiation Lifecycle



Timelines and steps vary based on payor goals and responsiveness.

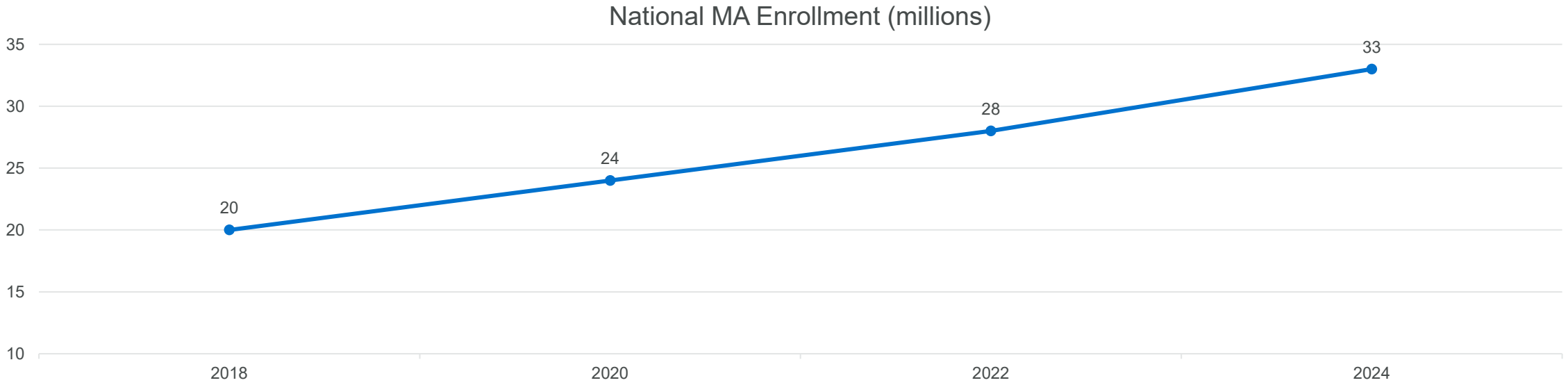
07

Medicare Advantage

Medicare Advantage Landscape

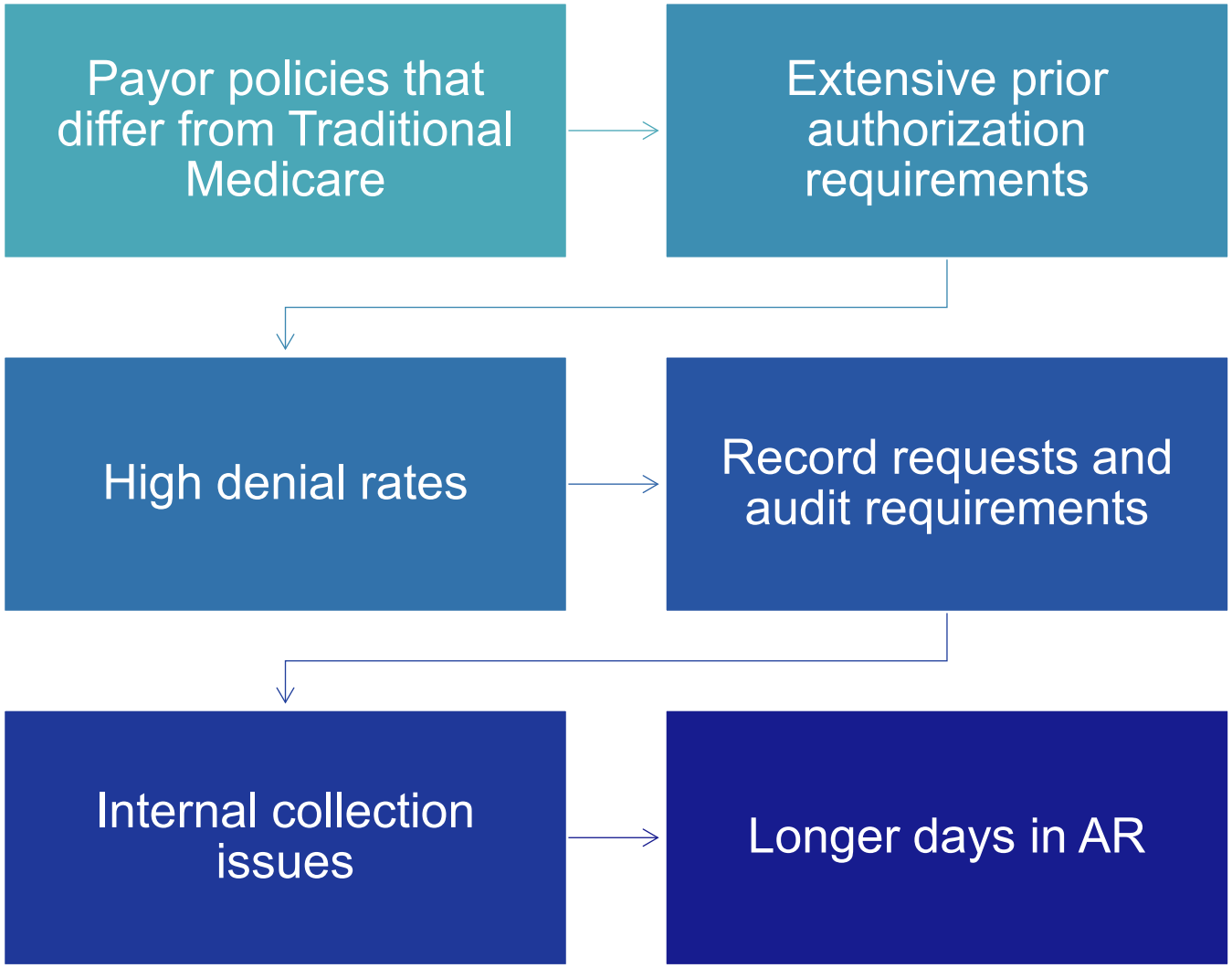
$462 Billion Medicare Payments to MA Plans in 2024

61% by 2030 Projected MA Enrollment



Source: KFF.org Medicare Advantage in 2024 enrollment update and key trends

Administrative Challenges



Recent public contract disputes and terminations include:

- Wake Med (NC) and Humana
- Genesis Healthcare System (OH) and Anthem, Humana
- Southeast Georgia Health System (GA) and WellCare (Centene)
- Baptist Health Medical Group (KY) and Humana, UHC, and WellCare

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Contractual Challenges

Exclusion of Add-ons

Health plans excluding DSH and other add-ons payment, if eligible, from reimbursement calculation

Payor Policies

Growing number of policies through Provider Manuals and Utilization Management guidelines embedded in contract language and limits reimbursement

340B

Contracts do not adequately address 340B Pricing

Sequestration

Cuts passed on to hospitals

Bad Debt

Agreements do not allow for Bad Debt Recovery

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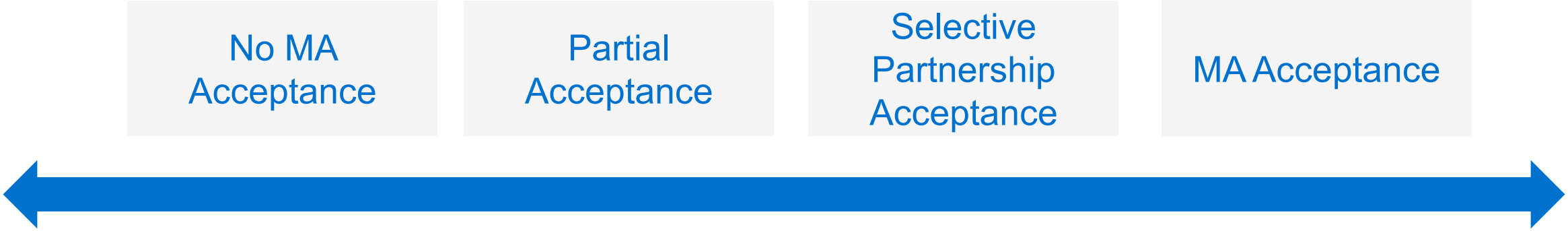
Contracting Strategies



No MA Acceptance	Partial Acceptance	Selective Partnership Acceptance	MA Acceptance
Terminate all existing MA agreements and accept only traditional Medicare	Terminate plans specific plans based on unfavorable reimbursement rates and/ or excessive administrative burdens	Select only high performing MA plan(s) to build key partnerships or choose one plan for an exclusive partnership	Accept all MA plans to drive patient accessibility

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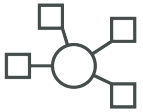
Considering Termination



Organizational Alignment

- Does the MA Plan align with current organizational goals? Does it support the mission and vision?
- Can internal administrative workflows, clinical pathways, and revenue integrity monitoring improve performance of existing contract?
- Does a quality program exist? If so, how does that contribute to revenue and how do the goals align with internal quality metrics?

Financial Considerations

- Does the cost of administering the plan, including staff and other resources, result in financial losses?
- If financial and operational concessions are made by plan, would there be consideration of termination recension through process? What would those need to be?
- Would movement from terminated MA plan to other MA plans or traditional Medicare result in improved financial and operational position?

Access to Care

- How does termination of MA plan impact physician panels, volume, access and productivity?
- How will terminating the plan impact access for current patients and the community? How will continuity of care be impacted?

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Exit Strategy

Timing

- Consider alignment with open enrollment
- Ensure alignment with organizational goals
  - **Now:** puts pressure on payor, but may limit communication internally/externally
  - **Future Contract Year:** provides ample time to implement communication plan

Communication Plan

- Prepare marketing plan focused on internal and external stakeholders: Board, physicians, administrative staff, members, community, brokers
  - Include communications once termination is issued, mid-point of discussions (if applicable), and post termination
- Provide internal staff with clear talking points
- Place organizational position and FAQs on website

MA Sales Campaigns Begin

No later than 9/15, notify all stakeholders of potential or active terminations with MA payors (brokers, patients, physicians)

Medicare Annual Enrollment Period (AEP) Oct. 15 through Dec. 7

Provide updates (using preferred methodology) to stakeholders monthly until resolved or enrollment period ends

MA Open Enrollment Period

By 1/1, provide updates to stakeholders outlining list of payors, plans being accepted along with updates on ongoing negotiations.

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MA Contracting Best Practices

Language Considerations

- Material policy protections
- Validation of how add-ons, sequestration, etc. are to be addressed
- Clear alignment with CMS coding and methodologies when mentioned (e.g. two-midnight rule)

Reimbursement Terms

- Ensure net reimbursement from potential MA partners is not disadvantaged to traditional CMS
- Fee for service rates should have contracted reimbursement no lower than 100% CMS and should align with CMS % preferred/ defined yield expectation
- Where possible, sequestration should not be passed through to provider or should be offset with premium to CMS pricing
- All CMS add-ons should be included or accounted for with equitable percent increase (DSH, etc.)

Performance Monitoring

- Quantify Denial rates, payment delays, and preauthorization issues
- The ability to quantify impact of these administrative challenges is crucial to successfully negotiating financial terms with MA payors; or identifying payor partnership(s) for participation considerations

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Polling Question

Would you like Forvis Mazars to follow up with you on this topic?

A Yes

B No

OBBBA Tuesdays

Scan to register and listen to archives, as they are available.

08.26
Overview & Implications

09.09
Understanding & Communicating Financial Impact

09.23
Improving Revenue Cycle & Managed Care

10.07
Identifying Aligned Growth Opportunities

10.21
Mitigating Regulatory Impacts – DSH & 340B

11.04
Mitigating Regulatory Impacts State-Directed Payments

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Questions?

Achieving Health

What We Believe

Healthcare organizations must commit to collaboration, prioritizing resources for continual improvement, and developing core capabilities.

What is to gain from Achieving Health?

1. Enhanced competitive advantage
2. A growing public reputation
3. Improved partnership opportunities
4. Risk mitigation
5. Increased access to resources
6. Better outcomes delivered more efficiently

Achieving Health
Core Capabilities

Healthcare organizations should develop and continually improve upon five core capabilities as a prerequisite to Achieving Health for individuals, communities, and their enterprises.

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