
CorroHealth

A Hospital's Game Plan for Overcoming Payer Denials

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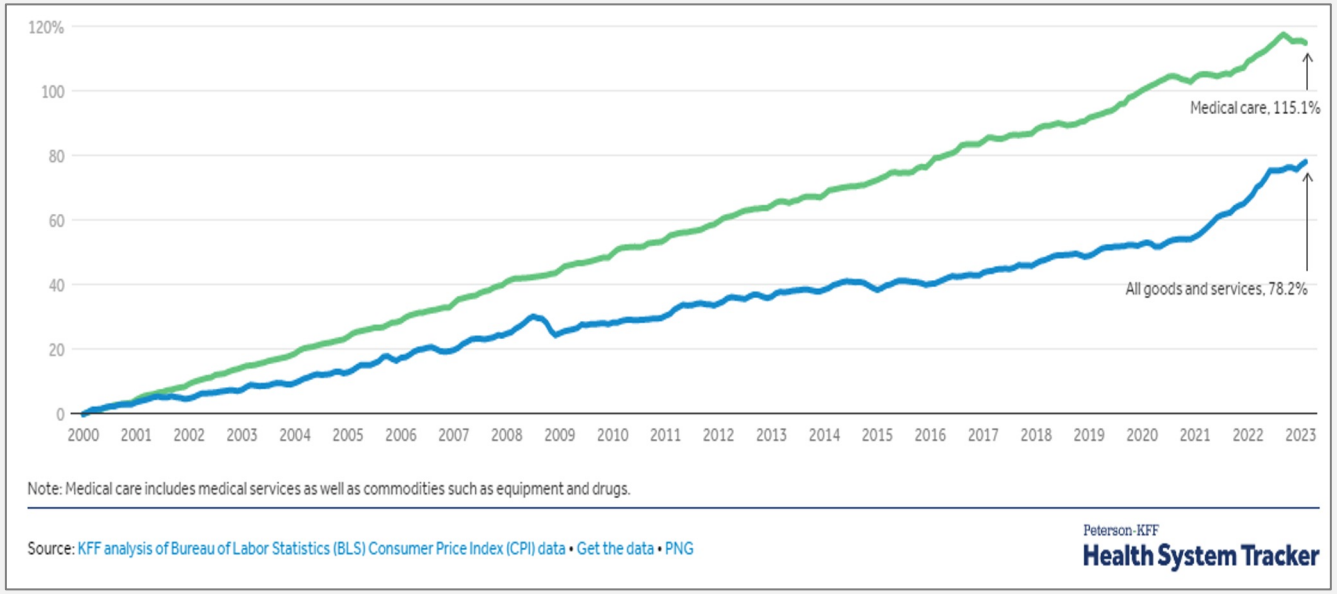
Healthcare Macros & Payers
Relentless Pursuit of Profit Margin

Cost of Labor, Goods, Services & Technology Continue to Rise

- The cost of healthcare labor and goods has grown faster than the overall cost of consumer goods and services.
- Increasing operating expenses, staffing shortages, rising interest rates and investment losses are expected to continue.
- Analysts estimate that the annual US national health expenditure is likely to be $370 billion higher by 2027 due to the impact of inflation compared with pre pandemic projections.

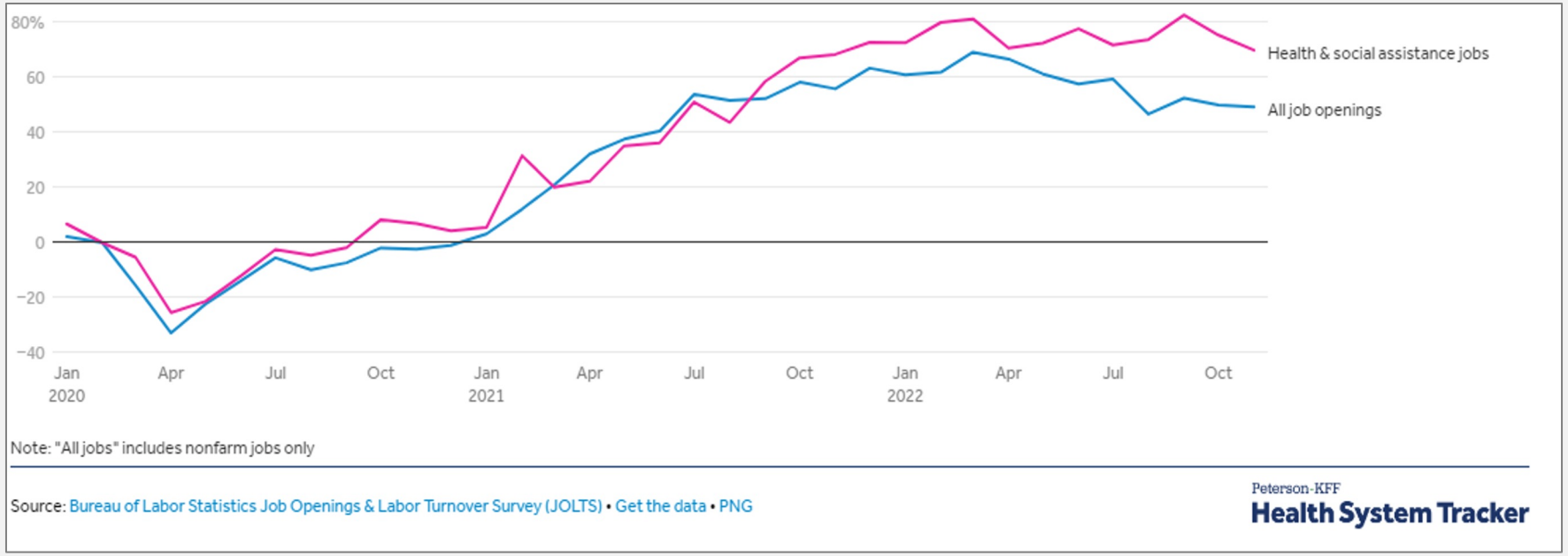
Cumulative % change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care and for all goods and services, 1/2000 – 2/2023



Source: Kaiser Family Foundation. https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy

Persistent Clinical Workforce Shortages Drive Increased Labor Expense

Cumulative % change in job openings, 2/2020 – 11/2022, health & social assistance jobs compared to all jobs



Source: Kaiser Family Foundation. https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment

- Job openings in the health sector are higher than all job sectors and higher than pre-pandemic levels, especially for clinical RN and ancillary specialty roles. By 2025, there is an expected gap of 200,000 to 450,000 (10-20%) registered nurses.
- A combination of increasing demand, increasing utilization, and decreasing supply will drive the shortage.
- Projected shortages will drive increased healthcare labor costs and outpace inflation. However, expect layoffs of executives, administrative staff, management, and other non-clinical staff to mitigate margin declines.
- Recruitment and retention remain a strategic focus of organizations.

What Are the Controllables?

With structural cost headwinds continuing through 2024, the strategic imperative to aggressively and responsibly manage revenue is of utmost importance to achieve sustainable financial performance.

So…

What are the macro pressures on revenue/reimbursement, and what can we as providers do to optimize performance?

Know Your Opponent

“The best defense is a good offense.”

Military Strategists/George Washington/Bill Belichick

Know your Opponent: **Understand The Payer "Home Team Advantage"**

Macro Drivers of Hospital Revenue & Cash Pressure

Patient Mix Shifts

Providers are experiencing patient mix-driven revenue and cost pressures as Medicare beneficiaries increasingly opt for Medicare Advantage plans

- Increased Medicare Advantage enrollment results in Hospital cost pressure due to burdensome payer authorization / denials processes.
- The mix shift also results in revenue compression driven by higher OBS% and payment shortfalls in Medicare Advantage as compared to Medicare FFS.

Expansion of Risk Arrangements

MAOs have expanded at-risk arrangements, creating incentives for physicians to status and document in ways that reduce reimbursement to hospitals

- In 2022, there were ~100,000+ Optum Physicians employed or affiliated. Risk-sharing arrangements continue to increase as MAOs publicly promote "value-based" arrangements as "containing healthcare cost" strategies.
- Antiquated contract terms provide limited or no recourse for the facilities to combat payer influence.

Increased Payer Denials

Payers have aggressively elevated denial activity to offset erosion of record-breaking profits driven by return to pre-pandemic hospital visit volumes

- Broader provider market has experienced 15-35% increases in payer denial rates with highest increases in payers who have gone unchecked by payer escalation / defense strategies.
- Archaic appeal contract language creates unsustainable cash gaps as hospitals are forced to choose between exercising their contractual rights and realizing timely cash collections.

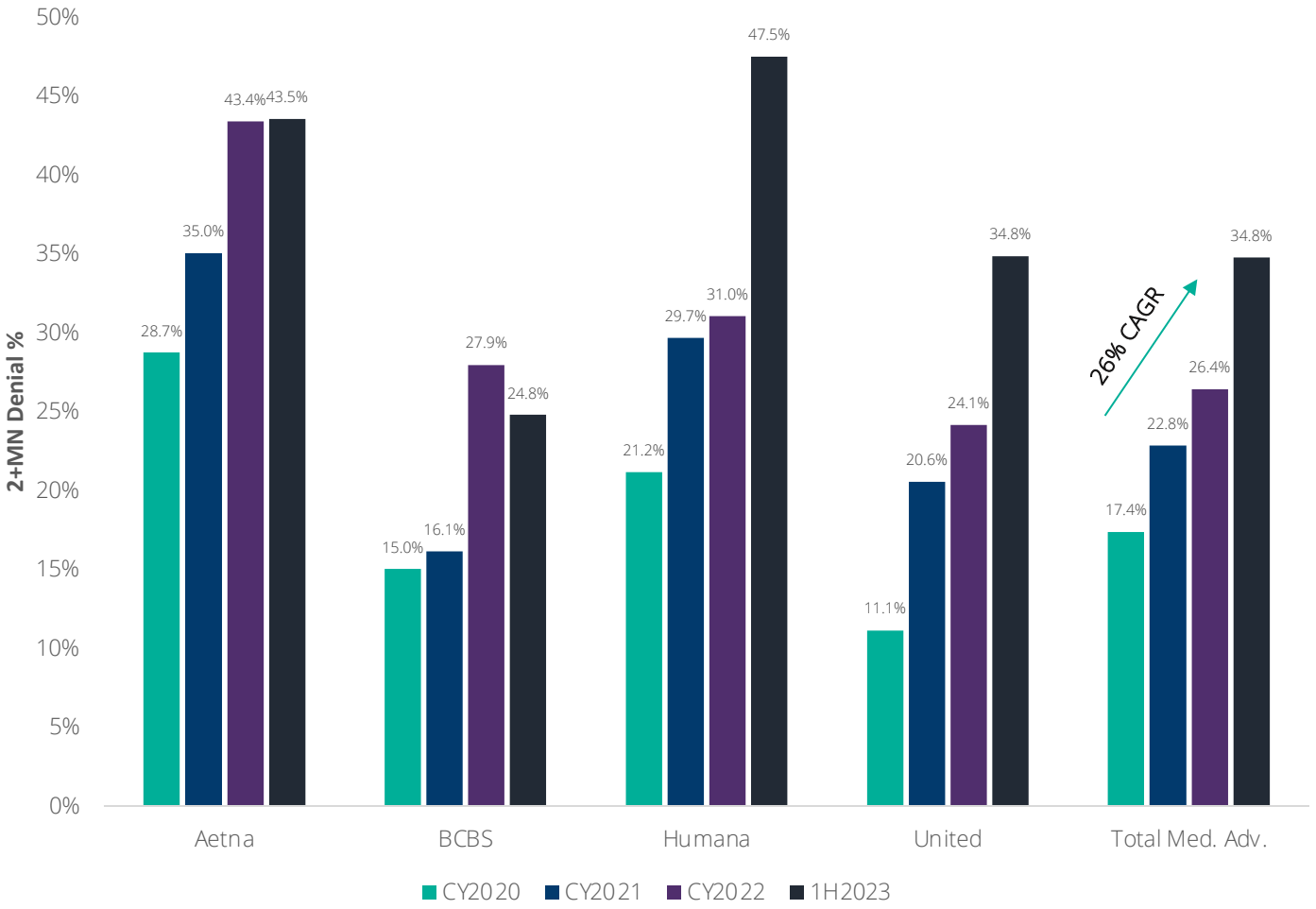
Increased DRG Downgrades

DRG downgrades have increased as payers continue to push revenue erosion tactics to the mid/back-end revenue cycle and through post-payment audits

- Payers have created alternate methods of defining diseases / categorizing patients and may promote these methods as more accurate than the CMS-defined methodologies.
- For example, many MAOs encourage providers to embrace the Sepsis-3 definition and disregard the CMS approved Sepsis-2 methodology.

Know Your Opponent: **National Payer Denial Activity**

Medicare Advantage 2+MN Denial Rates[1]: CY2020 to 1H2023 (National Trends)



- All major Medicare Advantage payers have escalated aggression towards health systems and increased denial rates since 2021 - 2+MN Denial % CAGR of 26% between 2020 and 1H CY2023.
- While Aetna has historically driven the highest denial rates (~43% in 2022 to 1H2023!) on 2+MN cases, Humana recently overtook Aetna as the most aggressive denier of Inpatient cases with a 47.5% 2+MN Denial % in 1H 2023!
    - *Humana's recent spike in Medicare Advantage denial activity coincides with their initiative to exit their Commercial products and anchor their offerings in the Medicare Advantage business[2].*
- United and BCBS have also driven double-digit increases in denial rates 2023 vs 2020.
- The overall National Medicare Advantage denial rate on 2+MN cases was 34.8% in the first half of CY2023, a 31.5% increase vs CY2022 rates (26.4%).

[1] Denial rates on cases with LOS of 2+MN and for hospitals achieving 2+MN Observation rates of <10%
[2] https://press.humana.com/news/news-details/2023/Humana-to-Exit-Employer-Group-Commercial-Medical-Products-Business

Know your Team’s Strengths and Weaknesses

Be Proactive Not Reactive

Know Your Team: **Drivers of Revenue Loss from High OBS Rates**

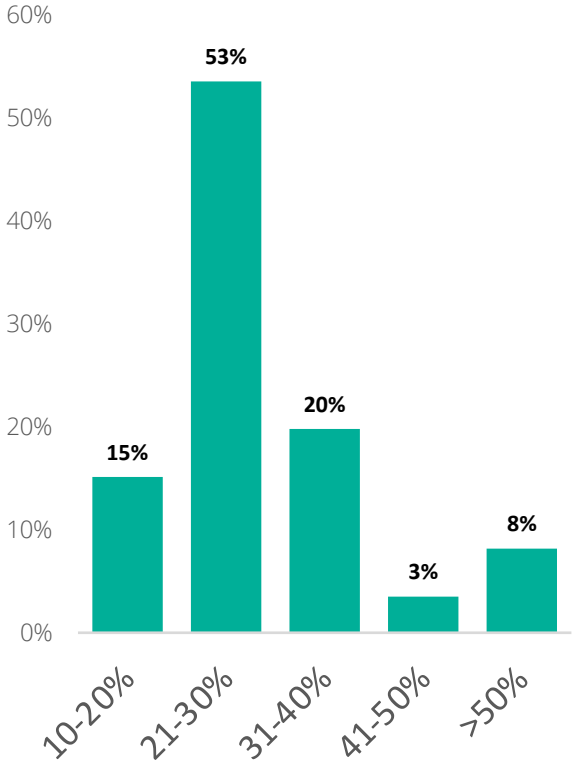
Observation-related revenue loss has myriad causes, but it can be improved by addressing each of the individual factors that contribute to it.

- Process for Case Reviews: Which cases get reviewed and when? Which cases are “high priority?”
- Review Standards/Criteria: Are they applying InterQual? MCG? or the 2-Midnight rule?
- Physician Advisor (“PA”) Training and Staffing: Do you have the right number of PAs? Are they clear in the process and standard of review?
- UR Staff: Do you have the right number of Case Managers? Are they following the process?
- Treating Physician Education: Does the attending staff understand the CMS definition of IP vs OBS? Do they know what’s required of them?
- Process Accountability: Did every “high priority” case receive the right review at the right time? Did the UM staff, PAs, and treating physician follow the process and review standards?
- Payer Influences: Are aggressive denials encouraging UM to leave patients statused as OBS?
- Payer Hospitalists: Payer-affiliated hospitalists are more likely to leave 2, 3, and 4+ Midnight cases as Observation compared to truly independent physicians. Is this happening at your facility?
- KPIs to Measure Outcomes: What is your Denial rate? Total OBS rate? “Net Inpatient Realization?”
- Managed Care Contract Language: What is the definition of Inpatient vs OBS, start/stop of service, process, etc.

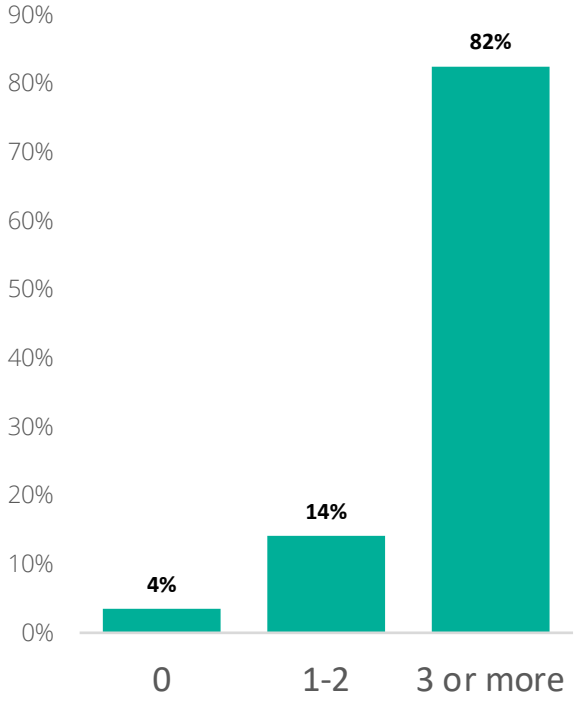
Know Your Team: **Nationwide Payer Denials & Escalation Efforts**

CorroHealth webinar hosted by American Hospital Association on November 2nd, 2023 to discuss the "Net Impact of Payer Denial Tactics on Hospital Performance." Attendees included 341 health system executives who were asked the following questions:

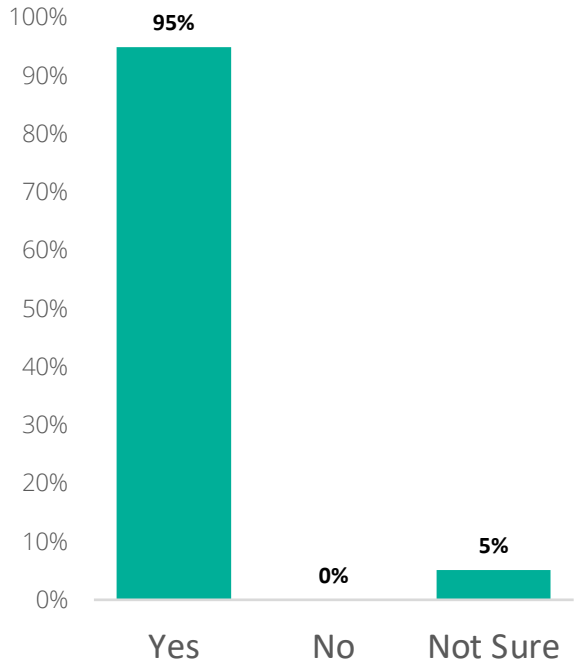
What Is Your Medicare Advantage Denial Rate?



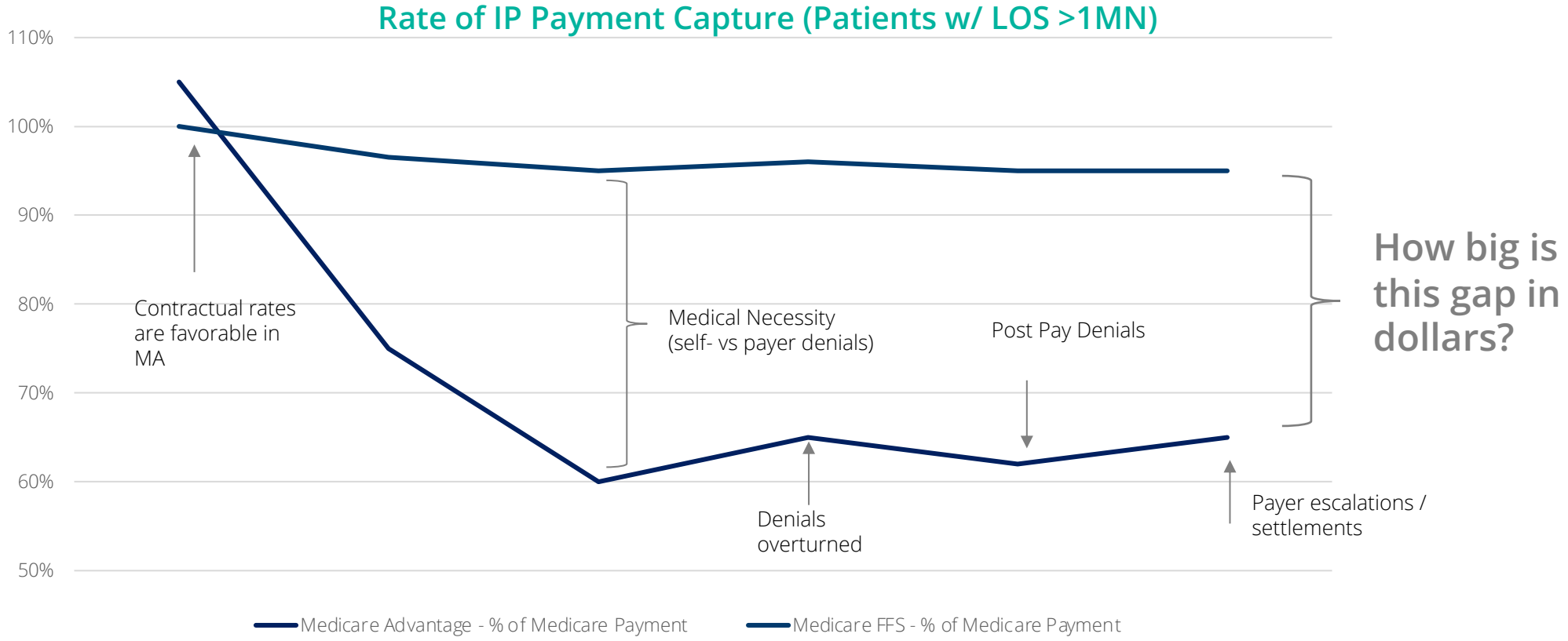
How Many Payer Escalations Have You Conducted Over the Past Year?



Do You Plan on Conducting More Payer Escalations This Upcoming Year Than Last Year?



Know Your Team: **Payment Erosion in Medicare Advantage**



Combatting Payment Erosion

- **Framing & Sizing:** Understanding financial impact at the individual case level
- **Root Cause Analysis:** Tying financial impact to specific payer behaviors
- **Addressing Internal Opportunities:** Is our patient statusing process consistent with Medicare FFS? Are we appealing the right denials?
- **Escalation Strategy:** Do we have the right information and strategy to escalate remaining payment gaps?

Know Your Team: **Payment Performance Assessment**

A Strategic Approach

Combining data, case reviews, team insights, and workflow processes, clarifies performance improvement opportunities and identifies the primary drivers.

Data Evaluation: Baseline assessment to quantify and validate the payment performance opportunity leveraging customized benchmarks.

Departmental Interviews: Questionnaires and interviews informed by data findings to understand team structures and workflows.

Process Mapping and Evaluation: Workflows are documented from patient status determinations, through appeal process and payment collection.

Targeted Case Reviews: Data Evaluation selects targeted cases for clinical documentation review. Chart review will audit clinical documentation and supportability in appeal/escalation.

Strategy

The Gameplan

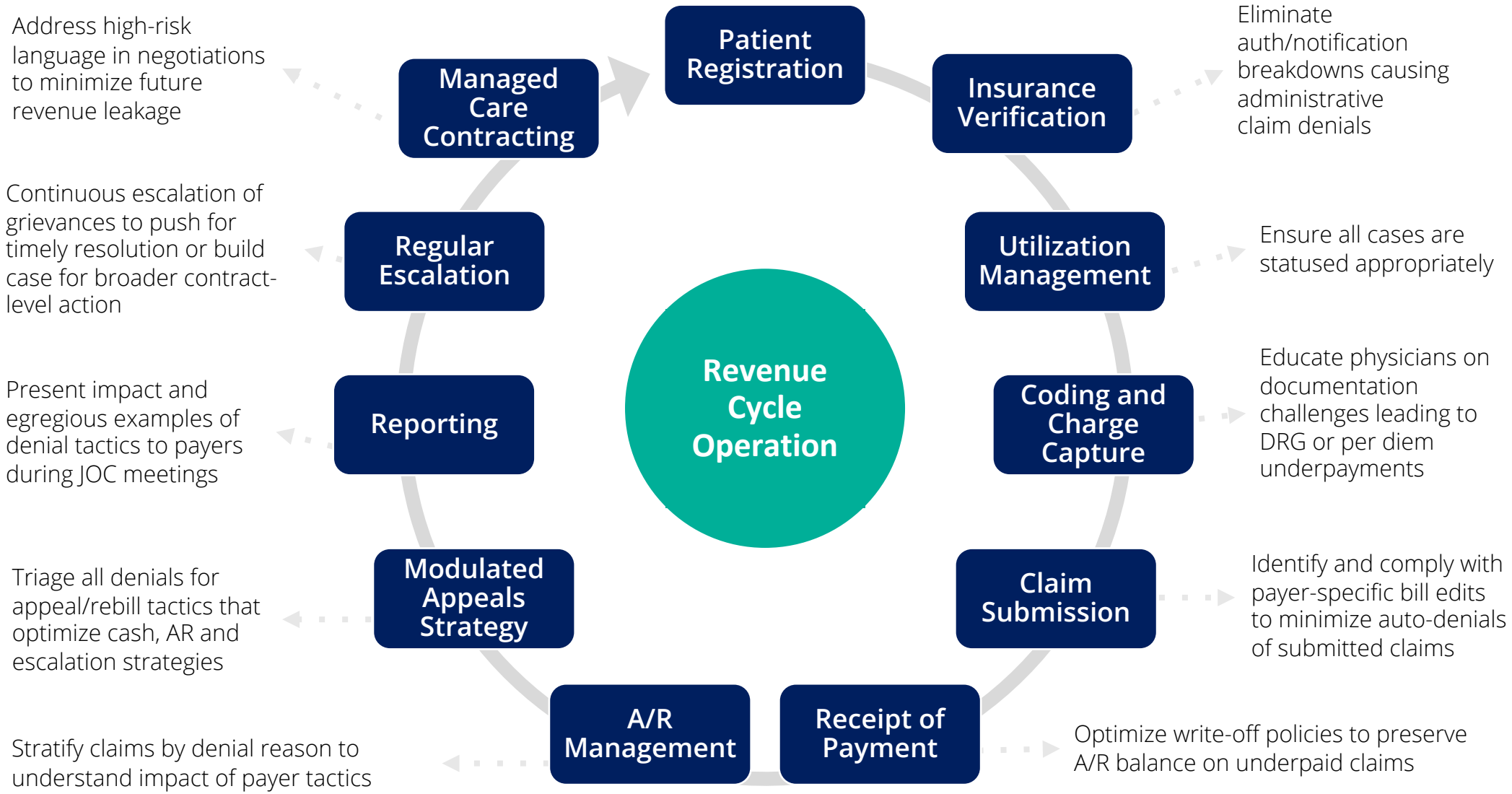
Optimizing Appeals & Payer Escalation Initiatives

Enterprise Strategy & Approach to Denials/Appeals Management

Low Denials/Manage AR → Maximize Revenue

	Scenario 1: Unsustainable Long-Term	★ Scenario 2: Healthy Balance of Revenue/AR Optimization	Scenario 3: Can Create Widening AR/Cash Gaps
HEALTH SYSTEM PROFILE	• Not-for-Profit, low/no margin, conservative hospital (with evergreen endowment or effective fundraising)	• For-Profit or Not-for-Profit, Aggressive, Optimize Revenue	• For-Profit or Not-for-Profit, Aggressive, Maximize Revenue
STRATEGY	• Minimize denials, write-offs, manage to industry metrics such as write-off <2% of revenue • Bill very conservatively; very high OBS Rate, low CMI, Sepsis 3 only, minimize appeals • "Cordial" relationship with payers to protect standard YoY rate increases	• Appropriate billing • Aggressive appealing • Hold payers accountable through consistent, aggressive, widespread escalations, driving strong contract terms and yearly cash infusions	• Aggressive billing • Aggressive appealing • Unmodulated appeals strategy

Re-Think The Revenue Cycle: Ensure Each Area Is Optimized To Fully Realize Compliant Revenue



Establish Clear Roles for Key Stakeholders

Executive Leadership

- Drive the overall business strategy
  - When to trigger a litigation type of escalation; Which payer / market combinations to pursue and why?
  - What are the goals for the escalation? What trade-offs is the organization willing to make?
  - Proceed /Not Proceed / Adjust / Settle based on input provided by the escalation team (legal opinion, business opinion, etc.)

Managed Care

- Traditionally, Managed Care can be reluctant to pursue escalations because they feel that these will jeopardize the relationships that they have worked hard to cultivate, and often these processes feel too aggressive and abrupt
- Manage payer contract negotiations, on-going venues for escalation; requires process/others to pave the way for more significant resolutions
- Informed by data, understand the most important contract terms for each negotiation, as terms have different impact for each contract

Local Market / Facility Executives

- Help executive leadership determine: priority, escalation trade-off choices, proceed/not-proceed choices, settlement choices
- Assist counsel on business priorities and business content necessary for legal discussions as they unfold
- Maintain solid tracking of denials and appeal activity to inform escalation priorities and accurately quantify magnitude of these grievances

Rev Cycle Leadership

- On-going analytics to quantify grievances for key payers for each market.
- Make recommendations about escalation priorities and goals
- Recommend key contract protections based on operational impact analysis
- Assist counsel on business priorities and business content necessary for legal discussions as they unfold
- Detailed case review and expert participation in escalation meetings

Tactical Options to Modulate Appeals Strategy: Third Quarter

1	**Pre-Bill Downgrade**	Downgrade IP cases to OBS that have a high probability of being denied and not overturned on appeal. Generally recommended for targeted 0-1 midnight cases not part of broader escalation.	• *Goal:* Reducing write-offs to ensure OP revenue is booked. • *Downside:* Losing downstream IP revenue. ***Note**: With a 45%-55% probability of approval on P2P, this option should never be considered pre-P2P. The P2P should always be pursued.*
2	Immediate Rebill of Low Impact Denials	Immediately rebill as OP cases with very low probability of overturn and not part of a broader appeal strategy.	• *Goal:* Reducing unnecessary AR and Billing Office time by avoiding appeals with very low overall benefit. • *Downside:* Losing downstream IP revenue of cases that would win on appeal, even if infrequent.
3	Limited Appeals	Low-cost appeals (e.g., form letters, limited clinical review) for non-high-dollar cases with a low probability of overturn (e.g., stop after L1 appeal).	• *Goal:* Reducing time and effort spent on appeals with limited value to the full pursuit, reducing AR and Billing Office time while still registering an appeal with the payer. • *Downside:* AR time may still be long if all levels pursued. Potential impact to efficacy.
4	Full Appeals	Maximize appeal success (Physician/Clinical letters, pursue all levels) for cases with reasonable probability of success and high impact.	• *Goal:* Maximize probability of appeal success to minimize upheld denials. • *Downside:* AR time and resources.

Create Analytical Infrastructure to Measure Denial Behavior, Impact of Payer Grievances, and Calibrate Appeal Strategy

Payer Performance Dashboard – XYZ Health System

Data for Period Jan X1 to Dec X2

Medicare Advantage Payer Performance Dashboard

Payer	Inpatient Contract Revenue	Inpatient Revenue Realization			Grievance Category: Medical Necessity		Technical / Administrative		DRG Downgrades		Readmission		Audit		Unknown / Unmapped					
		Exp. vs Actual Variance $	Underpaid Cases	% Pymt Var	Total Gap $	Total Cases	Total Gap $	Total Cases	Total Gap $	Total Cases	Total Gap $	Total Cases	Total Gap $	Total Cases	Not Paid Gap $	Not Paid Open AR	Not Paid Cases	Underpaid Gap $	Underpaid Open AR	Underpaid Cases
Payer 1	$91,351,849	**$13,744,172**	**1,511**	15.0%	$6,922,777	695	$91,147	55	$1,156,257	121	$4,072,122	431	$496,640	87	$269,559	$122,295	38	$735,670	$555,356	84
Payer 2	$73,076,201	**$13,437,475**	**1,105**	18.4%	$5,487,719	487	$1,338,155	103	$3,772,297	314	$254,090	24	$598,089	56	$163,204	$80,106	15	$1,823,921	$328,245	106
Payer 3	$44,100,748	**$5,547,606**	**431**	12.6%	$2,539,387	225	$332,561	19	$20,622	2	$1,275,354	119	$0	0	$57,134	$4,237	5	$1,322,547	$17,285	61
Payer 4	$45,505,370	**$8,189,061**	**772**	18.0%	$4,196,252	397	$1,020,874	96	$1,464,766	137	$268,657	25	$422,542	40	$112,242	$77,008	11	$703,728	$195,997	66
Payer 5	$25,384,979	**$3,632,041**	**345**	14.3%	$1,656,979	155	$906,278	89	$337,774	32	$16,811	2	$336,024	31	$29,953	$20,922	3	$348,223	$82,477	33
Payer 6	$51,877,962	**$2,712,798**	**238**	5.2%	$1,096,035	103	$36,393	2	$1,324,205	115	$36,934	3	$55,674	5	$55,842	$37,356	5	$107,715	$66,111	5
Payer 7	$45,769,941	**$1,065,597**	**114**	2.3%	$86,273	10	$117,938	15	$263,222	25	$511,093	55	$36,688	5	$14,230	$3,378	1	$36,154	$20,129	3
Payer 8	$24,671,934	**$2,656,765**	**256**	10.8%	$755,659	77	$1,394,650	132	$45,442	3	$241,692	23	$64,700	6	$42,410	$21,692	4	$112,212	$79,161	11
Total	$401,738,986	$50,985,515	4,772	12.7%	$22,741,081	2,149	$5,237,996	511	$8,384,583	749	$6,676,752	682	$2,010,357	230	$744,575	$366,994	82	$5,190,170	$1,344,760	369

Which payers should be prioritized → What current tactics are they using to erode payments → Data drill down & validation → Payer escalation
- JOC
- Contract terms discussion
- Arbitration

Fourth Quarter

Payer Escalation

4th Quarter Payer Escalation: Strategic Goals & Tactics

Goals

- Alter the dynamics of key payer-provider relationships as increasingly aggressive payer tactics accelerate provider revenue erosion.
- Recover lost revenue for services appropriately rendered to patients.
- Establish standard channels to address future conflicts and grievances.

Escalation Tactics

Arbitration / Litigation	Contract Guardrails	JOCs / Tactical Mtgs	Grievance Reconciliation
As needed based on payer	Ongoing AND Recurring		

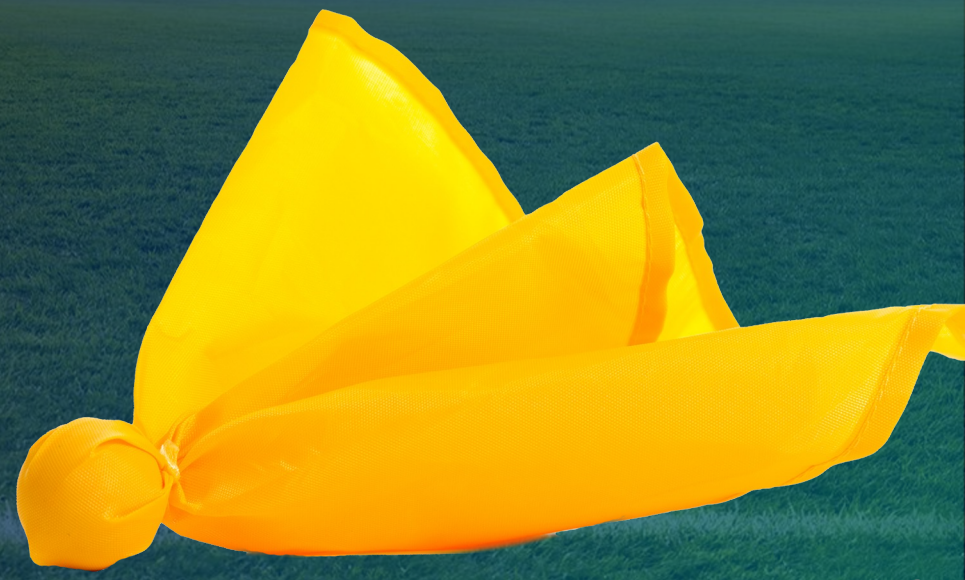
• Aggressive efforts to:
  ○ Force retro compensation
  ○ Catalyze shift in payer-provider power dynamic
  ○ Enable and strengthen ongoing contract terms / tactics
• Recurring litigation may not always be necessary for payers willing to resolve via abbreviated methods
	• Processes designed to contain and neutralize payers' revenue erosion tactics on an ongoing basis
	• Initialized or enhanced through upfront litigation efforts necessary to catalyze the payer to bring the appropriate decision makers prepared to resolve grievances
	• Recover lost revenue and protect future revenue to which the system is rightfully entitled
	• Continuous on-going pressure in the form of regular "abbreviated" grievance escalations that bypass full litigation, but some payers may need recurring litigation		

Payer Escalation Continuum: Fourth Quarter Power Play

Ad Hoc Payer Relations Meetings	Tactical discussion (nothing strategic); no decision-makers present; often no clear agenda or deadline-driven action items.
Coordinated, Structured, Recurring JOCs	Clear agenda (both tactical & strategic items) set by provider; topics/grievances backed by data; decision makers at table.
Executive-Driven Grievance Escalation	Executive team aligned around preparation of "escalation package," which often includes demand letter (outlining the issues), data, and case examples.
Pre-Arbitration	If payer fails to respond meaningfully to escalation, notify payer of intentions.
Arbitration	Contract typically includes arbitration clause. Might include threat of termination.
Litigation	Consider outside counsel with expertise in grievance areas.

Enforce Regulations and Hold Payers Accountable

Flag On The Play!



Addressing Medicare Advantage Plans' Egregious Behavior

Inappropriately applying **more restrictive UM and payment criteria than traditional Medicare**, is a violation of Medicare rules. *[SSA Section 1852(d)(4)(A)] and [42 CFR §417, 422, and 423 (F.R. 2020- 11342)]*

High Level Process

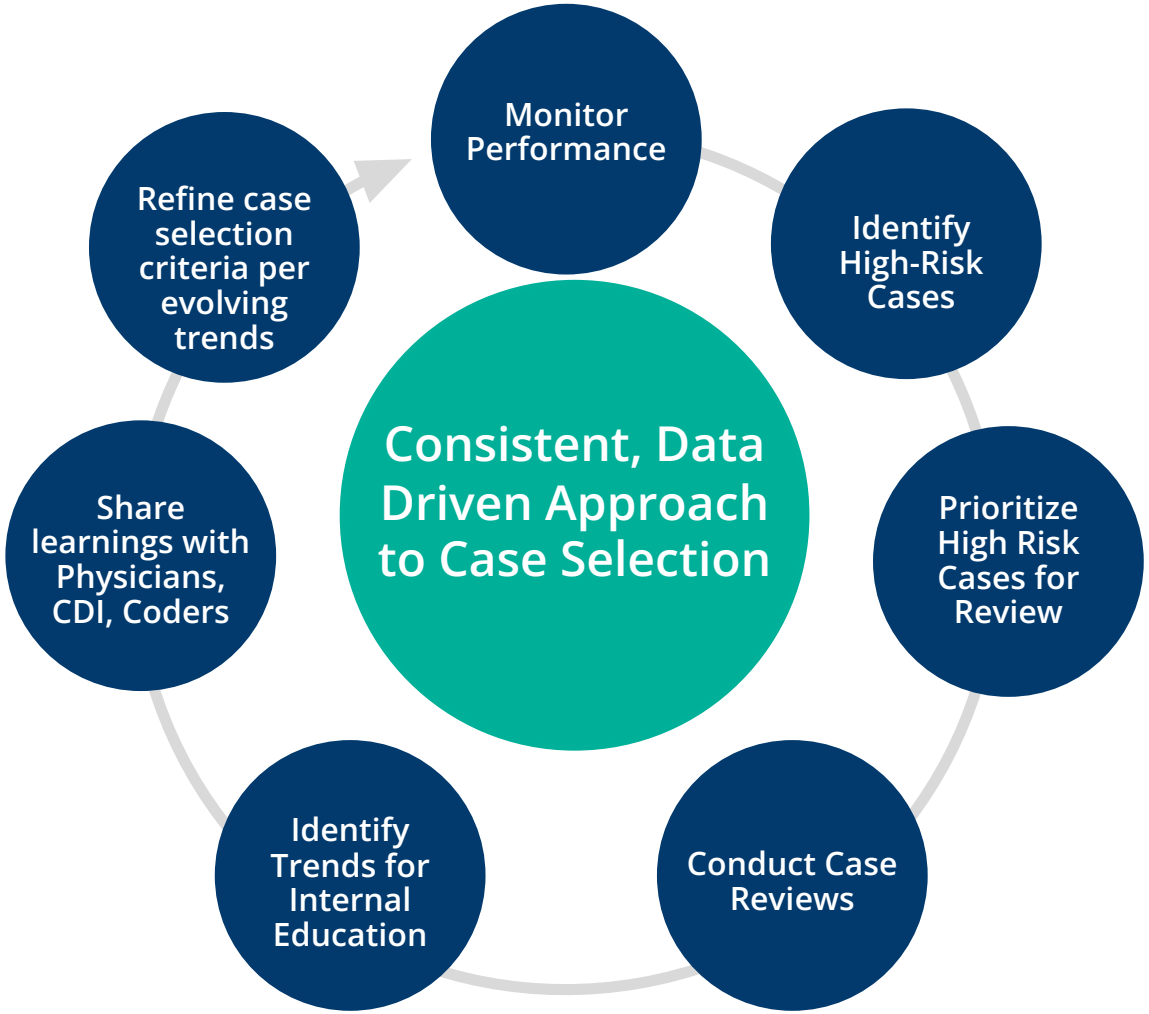
1. **Define goals and desired outcomes for specific grievances**
2. **Align strategy, core processes, and accountabilities**
3. **Monitor, report, and iterate on approaches to achieve goals**

Tactical Workflow

Highest impact strategies leverage cross-functional coordination
Utilization Review, Clinicians, Revenue Cycle, Coding, Managed Care, Finance, etc

A feedback loop allows the team to share learnings and become more targeted over time.

Measurable results will enable the team to quantify progress made as well as adapt to new information & pivot toward new opportunity areas



Consistent case selection criteria will enable the team to stay targeted and highly efficient with their time and efforts

A forum or platform for sharing feedback & learnings across the organization is a key component of developing an effective team

Over time, developing a method of prioritization will enable the team to spend their limited time on only the most impactful cases

Leveraging the Power of Partnership

The strength of the team is the player, the strength of the player is the team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