Kansas Hospital Association Updates
September 2025

Kansas Hospital ASSOCIATION

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AGENDA

- KHA Strategy Recap
- Creating an Environment Where Hospitals are Financially Healthy
  1. Clinically Integrated Networks
  2. Financial Awareness Campaign & Impact of Commercial Payers on Kansas Hospitals
- Hold Payers Accountable for Inequitable Policies & Practices
  1. KHA Payer Scorecard
  2. Medicare Advantage Open Enrollment
  3. Payer Pulse Newsletter
- Advance State & Federal Programs that Support Hospitals
  1. Provider Assessment Program & the OBBBA
  2. Managing Medicare Advantage & Filing Complaints
  3. Credentialing & Provider Enrollment Initiative

Kansas Hospital ASSOCIATION

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Vision
Optimal health for Kansans and Kansas hospitals.

Mission
To be the leading advocate and resource for members.

Values
Excellence – Exceeding Expectations
Collaboration – Building and Fostering Partnerships
Integrity – Upholding Respect and Trust
Knowledge – Pursuing Innovation and Developing Expertise

Strategic Aim
Improve Kansas' statewide health ranking with a focus on preventive health services.

Strategic Priorities
Advocacy and Regulations
Finance and Reimbursement
Health Care Workforce
Quality and Safety

3

Advocacy and Regulations
- Advocate for and initiate policies to maintain and expand access to health care with a focus on workforce and financial viability.
- Collaborate with partners to showcase the importance of health care to the state economy.
- Advance and initiate policies that reduce the administrative burden in health care.
- Increase the number of hospital advocates engaging on health care issues.

Finance and Reimbursement
- Create an environment where hospitals are financially healthy.
- Hold payers accountable for inequitable policies and practices.
- Advance state and federal programs that support hospitals.
- Foster new models and technology to improve financial sustainability.

Health Care Workforce
- Promote hospital and health care careers.
- Develop and share tools to enhance hospital recruitment and retention efforts.
- Collaborate with stakeholders to optimize the number of health care graduates who stay in Kansas.
- Identify and communicate innovative and emerging trends and technologies.

Quality and Safety
- Provide and promote data, tools and technologies to reduce disparities in care.
- Foster innovation and partnerships to improve health care quality and safety.
- Engage with stakeholders to support health equity and community health improvement.
- Focus on preventive services and engage partners to address Kansas health rankings.

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- **Create an environment where hospitals are financially healthy**

  1. Research and evaluate opportunities that may permit collective payer relationships.
  2. By May 2025, create and implement a public awareness campaign that focuses on the economic impact of hospitals, financial challenges, and the barriers with the reimbursement sectors.
  3. By August 2025, develop and distribute resources for members to assist them in communicating about the multitude of financial strains on Kansas hospitals.

- **Hold payers accountable for inequitable policies and practices**

  1. Utilize the data gathered through the All-Payers Scorecard to initiate meaningful payer conversations.
  2. Provide resources for the membership to assist them in educating their community about the Medicare Advantage program, including hosting three community education programs.
  3. Review key payer policies, provide potential financial impacts to hospitals and engage in payer conversations.

- **Advance state and federal programs that support hospitals**

  1. Leverage the provider assessment program to maximize Medicaid reimbursement for member hospitals.
  2. Advocate for prior authorization reform by generating two resources that highlight the challenges prior authorization creates in the delivery of health care.
  3. Collaborate with KDHE, KanCare MCOs, and other stakeholders to reduce the administrative burdens on providers, including standardizing policies within the KanCare program.

- **Foster new models and technology to improve financial sustainability**

  1. Provide education and assistance to members on new models of reimbursement, including the TEAM model and Rural Community Hospital demonstration program.

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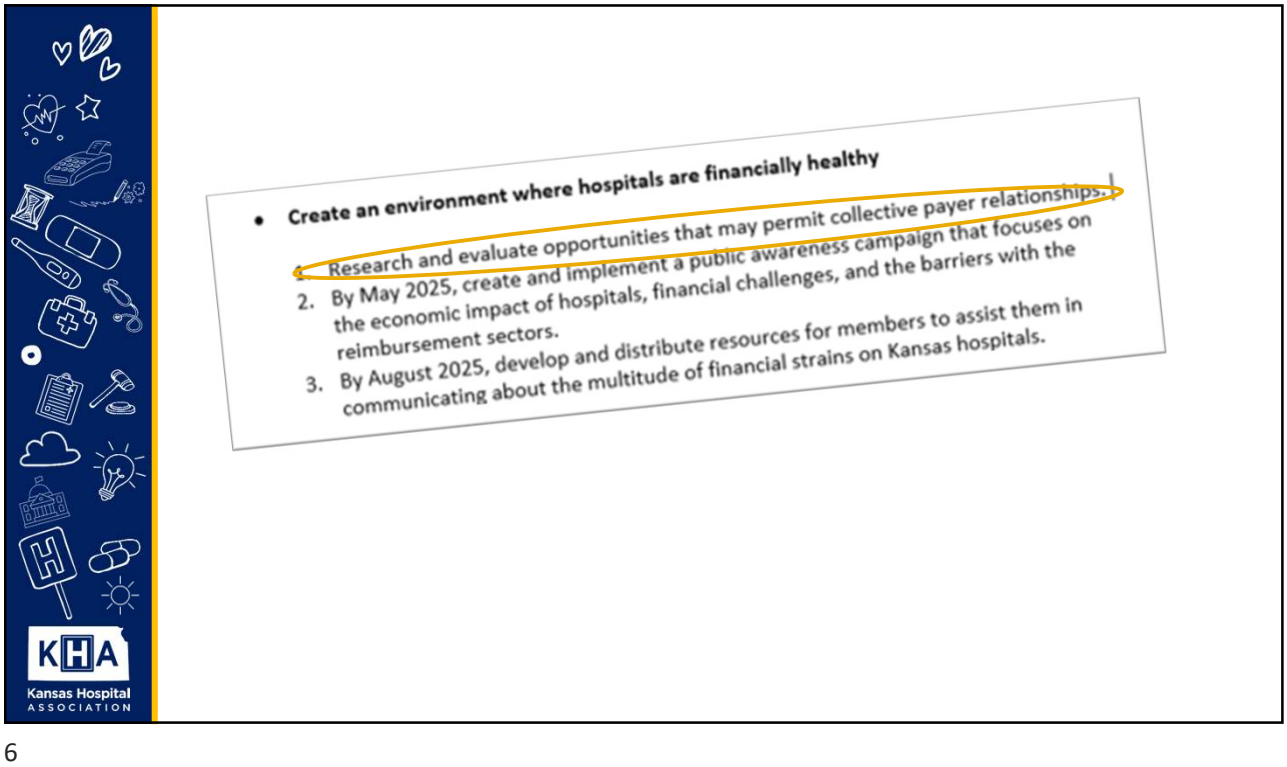

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What is a Clinically Integrated Network?

An organization of healthcare providers that collaborate to improve patient care quality and efficiency by sharing data, implementing clinical protocols, and coordinating care across the continuum of services. The primary goals are to enhance patient outcomes, reduce healthcare costs, and enable providers to contract with payers for better reimbursement, all while ensuring coordination and communication among affiliated caregivers.

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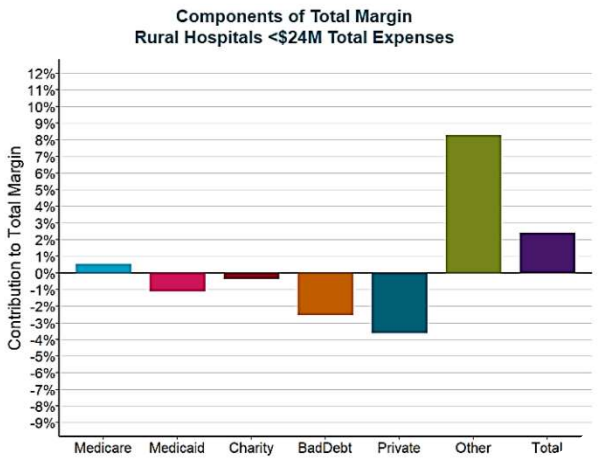
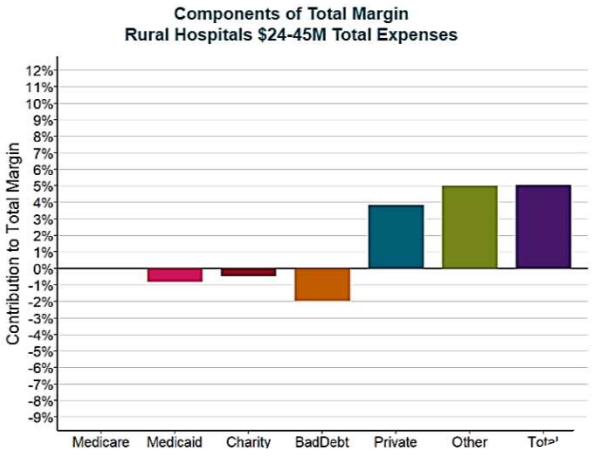
Smallest Hospitals Lose Money on Commercial Contracts





https://ruralhospitals.chqpr.org/Problems.html#revenue_sources

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Rural Hospital Challenges	Clinically Integrated Network Solutions
Loss of operational control through health system affiliations	Maintaining control through interdependence with peers
Patient and service volumes lack critical mass for value-based contracting	Combining patients through a clinically integrated network allows single signature contracting
Too few covered lives impedes positive value-based performance	Aggregating High-Value Networks (HVN) covered lives provides necessary scale for managing value-based risk
Payer-designed value-based programs that are not practical in the rural setting	Designing health plan products designed to recognize and reward rural strengths
Lack of purchasing power and inefficient resource utilization	HVN shared services builds group purchasing strength and efficient resource utilization
Underdeveloped clinical and financial data systems	Implementing a Population Health Platform for real time sharing of cost and quality data
Difficult providing isolated physicians with peer-to-peer support	Supporting physicians with clinical integration committees composed of their peers
Inadequate training and support for leaders and managers	Sharing learning among leaders and managers through roundtables/competency committees

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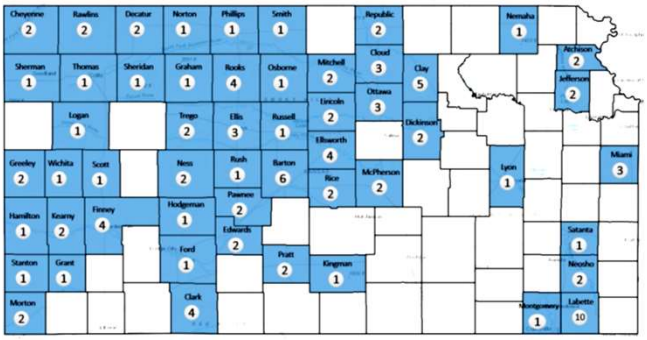
Kansas Clinical Improvement Collaborative



- Founded by University of Kansas Health System in 2014 under a CMS Innovation Award
- Initial focus on evidence-based practice for heart attack and stroke, chronic condition management
  - Expanded clinical conditions, quality measurement
  - Expanded centralized services
  - AHRQ-listed Patient Safety Organization
- Participated in MSSP/ACO REACH since 2017

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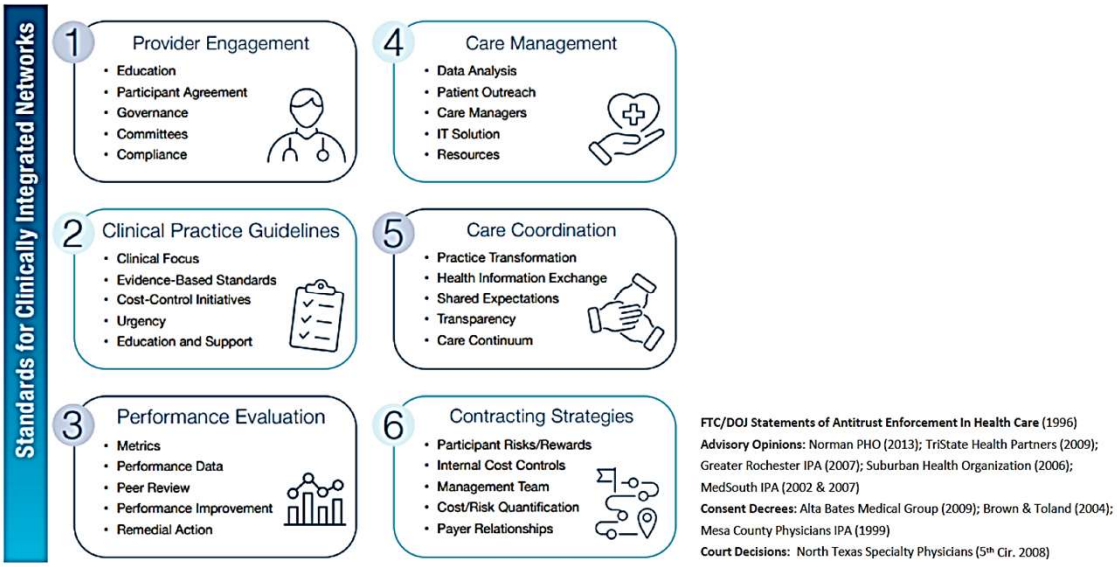
CIN Evaluative Criteria



FTC/DOJ Statements of Antitrust Enforcement In Health Care (1996)
Advisory Opinions: Norman PHO (2013); TriState Health Partners (2009); Greater Rochester IPA (2007); Suburban Health Organization (2006); MedSouth IPA (2002 & 2007)
Consent Decrees: Alta Bates Medical Group (2009); Brown & Toland (2004); Mesa County Physicians IPA (1999)
Court Decisions: North Texas Specialty Physicians (5th Cir. 2008)

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KHA EDUCATIONAL WEBINAR ON CLINICALLY INTEGRATED NETWORKS COMING IN OCTOBER

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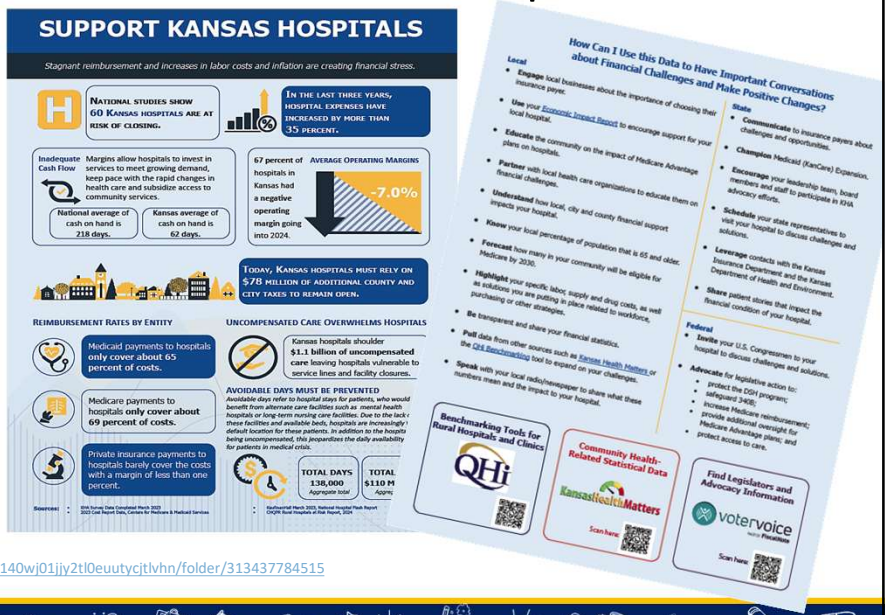
Overall Financial Health of Hospitals

- January 2025
- Infographic
- How to for Members
- Social Posts



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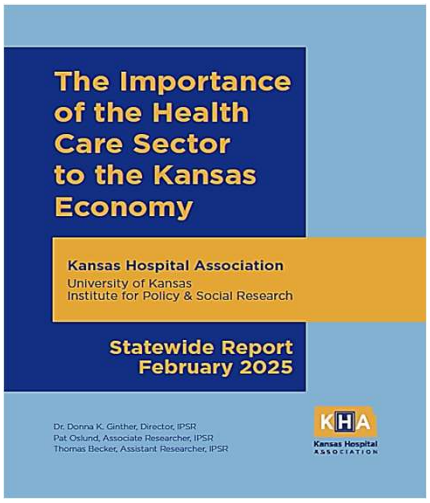
Economic Impact of Hospitals

- February 2025
- Media Release
- Social Posts
- Targeted social media posts around Kansas Capital



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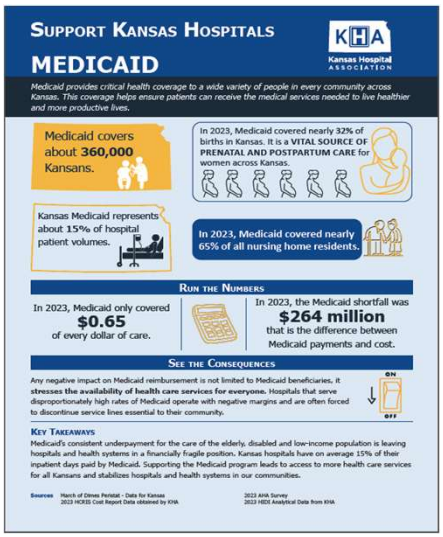
Medicaid in Kansas

- March 2025
- Infographic
- Social Posts
- Box.com toolkit



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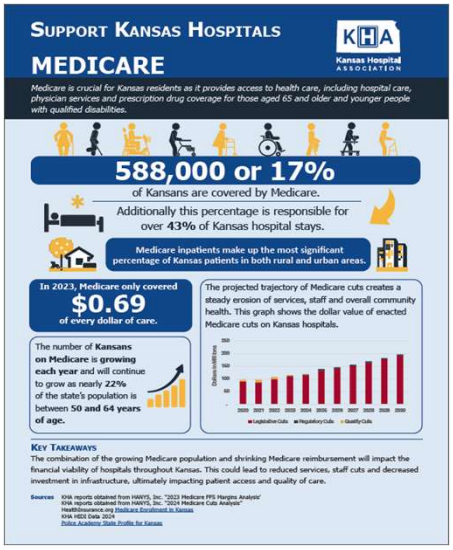
Medicare in Kansas

- April 2025
- Infographic
- Social Posts
- Box.com toolkit



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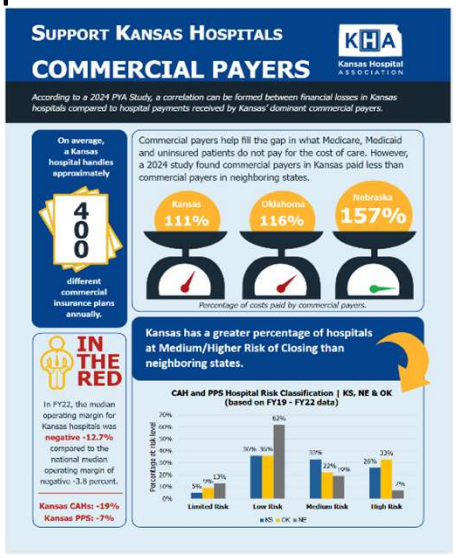
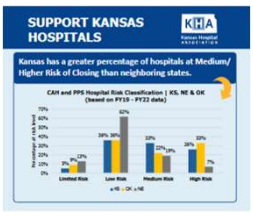
Impact of Commercial Payers

- May 2025
- Infographic
- PYA Study
- Media Release/Interviews
- Social Media





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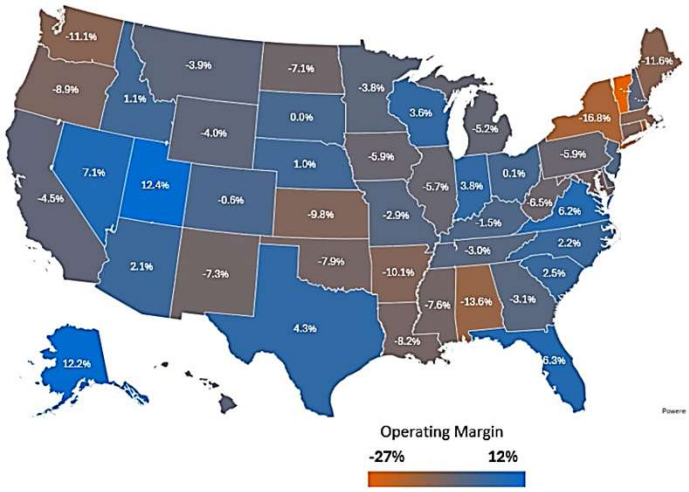
The Average Hospital

Median Operating Margin by State (PPS)



Top 5		
State	Rank	Operating Margin
Utah	1	12.4%
Alaska	2	12.2%
Nevada	3	7.1%
Florida	4	6.3%
Virginia	5	6.2%

Bottom 5		
State	Rank	Operating Margin
Maine	46	-11.6%
Alabama	47	-13.6%
Rhode Island	48	-16.1%
New York	49	-16.8%
Vermont	50	-27.2%

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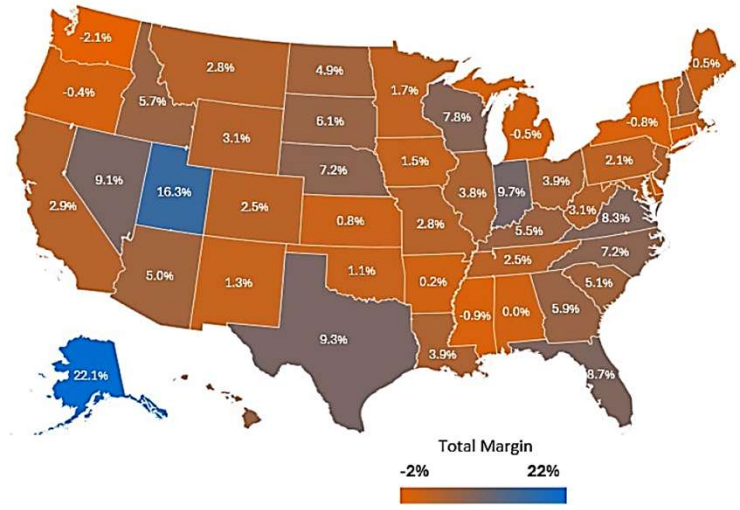
The Average Hospital

Total Margin by State (PPS)



Top 5		
State	Rank	Total Margin
Alaska*	1	22.1%
Utah*	2	16.3%
Indiana	3	9.7%
Texas	4	9.3%
Nevada*	5	9.1%

Bottom 5		
State	Rank	Total Margin
New York*	46	-0.8%
Mississippi	47	-0.9%
Delaware	48	-1.2%
Connecticut	49	-1.4%
Washington	50	-2.1%

*Also listed as a Top/Bottom 5 state for Operating Margin.

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DEEP DIVE ANALYSIS INTO KANSAS HOSPITALS

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Assessing Hospitals' Financial Risk Profile

- PYA evaluated financial metrics of CAHs and PPS hospitals in State 1, State 2, and State 3 to assess the financial health of each state's hospitals.
- Specifically, we performed the following work steps:

1. Obtained financial statement data from 2023 Medicare Cost Reports
2. For each hospital, evaluated the financial metrics to assign a risk classification
3. Assigned a weight to each metric's risk score
4. Based on its overall risk score, each hospital was assigned to one of four risk classifications: limited risk, low risk, medium risk, and high risk

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Risk Profile Score Methodology

2023 financial metrics were assigned a risk score based on:

1) Industry benchmarks
2) PYA's professional judgment

Assigned weight to each metric's risk score

Metric	Metric Weight
Total Margin	15%
Operating Margin	15%
Return on Equity	10%
Current Ratio	10%
Net Days in Patient A/R	10%
Equity Financing Ratio	20%
Cash Flow to Total Liabilities	10%
Average Age of Plant	5%
Occupancy Rate	5%
	100%

Each hospital assigned to one of 4 risk classifications based on its cumulative score

Hospital Risk Classification
Limited Risk
Lower Risk
Medium Risk
Higher Risk

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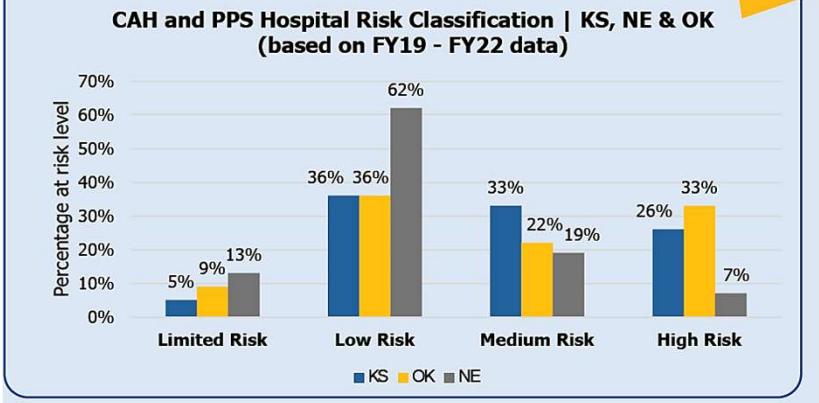
Kansas has a greater percentage of hospitals at Medium/Higher Risk of Closing than neighboring states.



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What Key Factors Impacted Hospital Financial Results?

- PYA selected 3 hospitals in State 1 for an in-depth financial evaluation:
  - **One PPS Hospital**
  - **Two CAHs**
- Key data collected for 3 selected hospitals:
  - **Billing and Collections Data** – to analyze reimbursement differences among major payers, including value-based arrangement incentives
  - **Audited Financial Statements** – to assess the overall financial strength of each facility fiscal 2022 and 2023 as available by each hospital
  - **Medicare Cost Reports** – to evaluate Medicare reimbursement rates as a percent of billed charges by type of service from the most recent period available

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Key Factors Influencing Hospital Operating Margin

PYA analyzed key factors impacting operating margin:

Key services and variables impacting operating margin (in millions)

	PPS 1	CAH 1	CAH 2
Services (Professional, Clinic, Other)	16.1	-0.8	-1.0
Payer reimbursement	4.7	-2.7	-0.3
Other (340B, Uncompensated care, etc.)	-4.6	0.7	-0.2
Operating Margin $	($16.1)	($2.8)	($1.5)
Operating Margin %	-7.3%	-14.5%	-5.8%

Losses Impacted By Several Factors

- Investment (losses) on professional/clinic services and other nonhospital services such as home health care. Losses due in part to continued investment in providers and reimbursement that does not cover the cost of these services.
- Commercial payer reimbursement rates for hospital services in some cases less than Medicare allowable cost.
- Reimbursement rates (actual payments) for Medicare Advantage Plans lower than traditional Medicare and lower than cost.
- Low reimbursement rates for a growing volume of Medicaid services compared to cost.
- High levels of uncompensated care.

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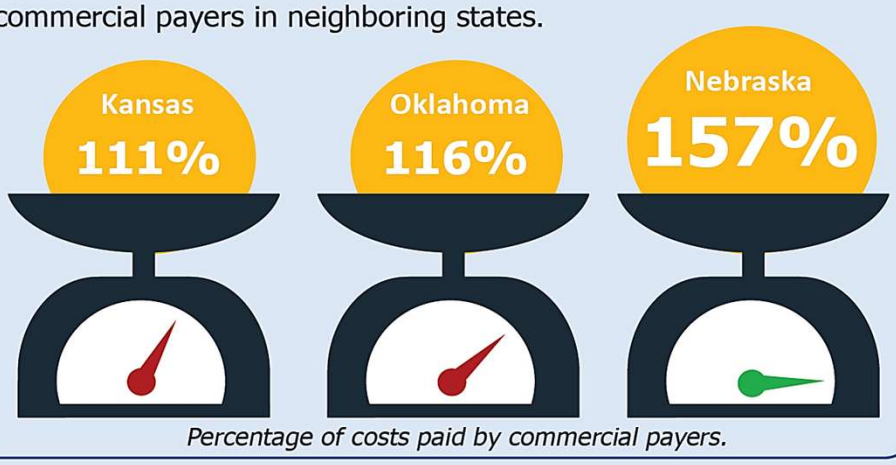
Commercial payers help fill the gap in what Medicare, Medicaid and uninsured patients do not pay for the cost of care. However, a 2024 study found commercial payers in Kansas paid less than commercial payers in neighboring states.



Percentage of costs paid by commercial payers.

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HOW ARE THE DOMINANT COMMERCIAL INSURANCE COMPANIES DOING IN KANSAS?

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Commercial Insurer Market Share

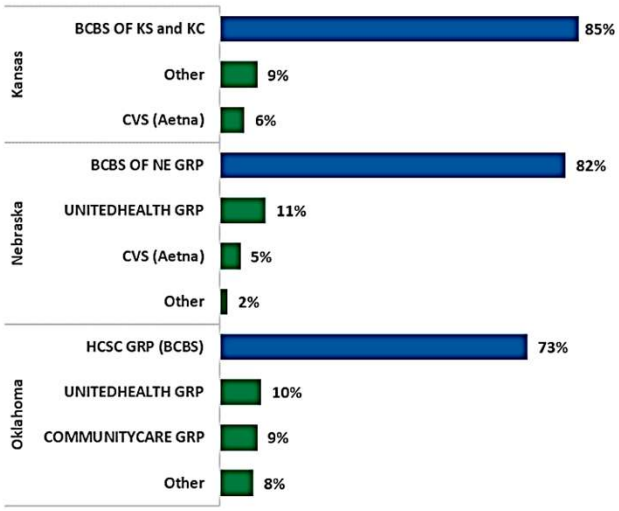
Market Share of Three Largest Processors
Large Group Market

Blue Cross Blue Shield (BCBS) holds a dominant market share in the 3 states evaluated:

Kansas – 85%

Nebraska – 82%

Oklahoma – 73%



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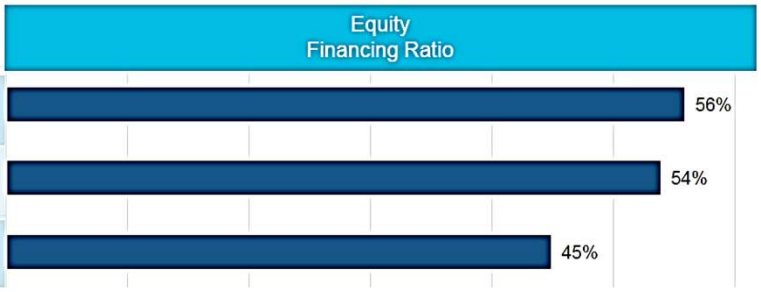
Commercial Insurer Financial Snapshot

Asset Size Rank	Equity Financing Rank	
2	1	BCBS of Kansas
1	2	United Healthcare Group Total
3	3	BCBS of Kansas City Total



- Top commercial insurers in Kansas reflected **strong equity financing ratios**, indicating a substantial amount of assets generated from operations and other activities available to operate their health insurance businesses.
- Blue Cross and Blue Shield of Kansas posted a –5.4% operating margin and a $130 million loss in 2022, **yet equity grew by $101 million on the strength of $231 million in investment and asset-valuation gains.**

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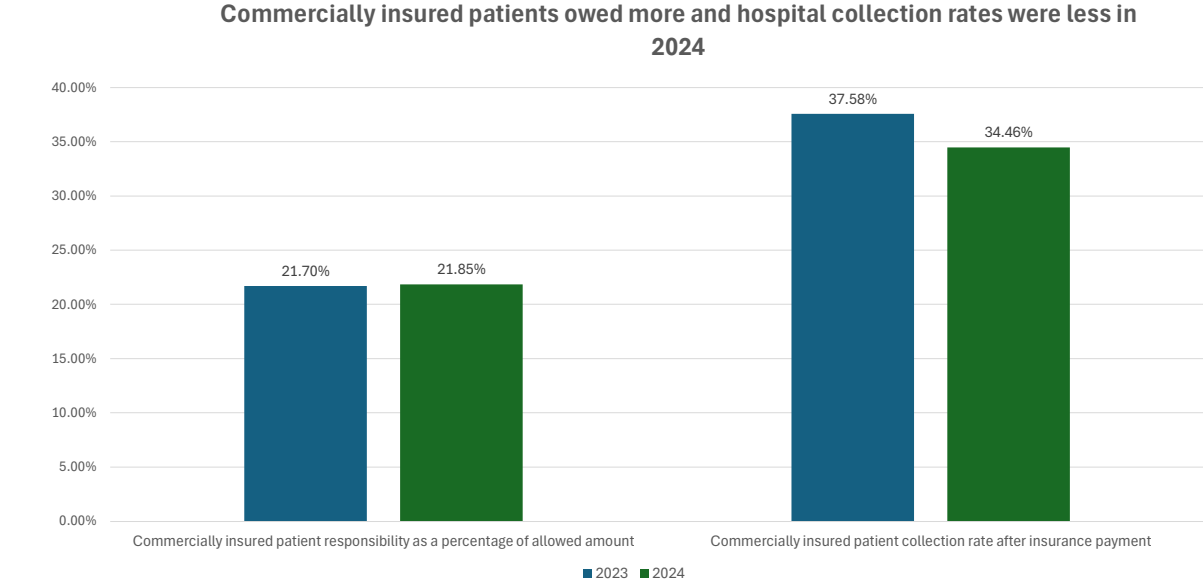

https://www.businesswire.com/news/home/20250227049715/en/Healthcare-Providers-Facing-Stiff-Headwinds-on-Revenue-Cycle-Performance-Kodiak-Solutions-Data-Show

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Bottom line: An Imbalance Hurting Patients and Hospitals

Data demonstrates that insured patients in Kansas are responsible for an ever-increasing share of the cost of their care. For many individuals, even though they have insurance, this cost is unaffordable, and hospitals are left with the bill. Additionally, reimbursement rates from Kansas commercial payers to hospitals keep trending down. Hospitals are left with less money to fill the gap in what Medicare, Medicaid, underinsured and uninsured patients do not pay for the cost of their care. Modest rate increases to hospitals from commercial payers would help this disparity and should not increase employer premium costs because commercial payers have benefited from federally funded programs that maintain local access to care. In addition, the scale of investment portfolios for insurance companies appears disproportionate relative to their underwriting exposure, liquidity needs and regulatory capital requirements. This growth imbalance has grown to a level that may exceed what is prudent and needed. It is reasonable to expect commercial payers (not their customers) to bear their fair share of the cost of maintaining network adequacy.

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If you want to learn more about the KHA All-Payer Scorecard, please visit https://payerscorecard.com/ and reach out to Shannan Flach at sflach@kha-net.org.

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Average Patient Responsibility ($)

National Average Commercial Payers	$175
Kansas Average Commercial Payers	$190
Kansas BCBSKS	$261

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Observation Rate (%)

National Average – All Payers	17.1%
Kansas Average – All Payers	23.9%
National Medicare Advantage	27.3%
Kansas – Medicare Advantage	35.6%

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Full Denial Value (%)

National Average – All Payers	7.0%
Kansas Average – All Payers	5.7%
National Medicare Advantage	8.6%
Kansas Medicare Advantage	17.9%
National Managed Medicaid	9.9%
Kansas Managed Medicaid	9.9%

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Common Denial and Downcoding Areas

Kansas' Largest Payers by # of Claims (excluding Tradtional Medicare)
Blue Cross Blue Shield of Kansas Commercial
UnitedHealthcare Medicare Advantage
United Healthcare Commercial
United Healthcare Medicaid
Aetna Medicare Advantage
Ambetter Medicaid
Aetna Commercial
Humana Medicare Advantage

Medicare Advantage	
UHC Inpatient Full Denial %	33%
UHC Observation Partial Denial %	45%
UHC ED Full Denial %	27%
UHC Outpatient Full Denial %	23%
Aetna Observation Partial Denial %	54%
Aetna Inpatient Full Denial %	22%
Humana MA ED Downcoding	21%
Commercial	
UHC & BCBS Observation Partial Denial %	30%
Aetna Observation Partial Denial %	40%
UHC Inpatient Full Denial %	19%
Medicaid	
UHC Outpatient Partial Denial %	65%
UHC ED Partial Denial %	73%
UHC Observation Partial Denial %	87%
UHC Inpatient Full Denial %	20%

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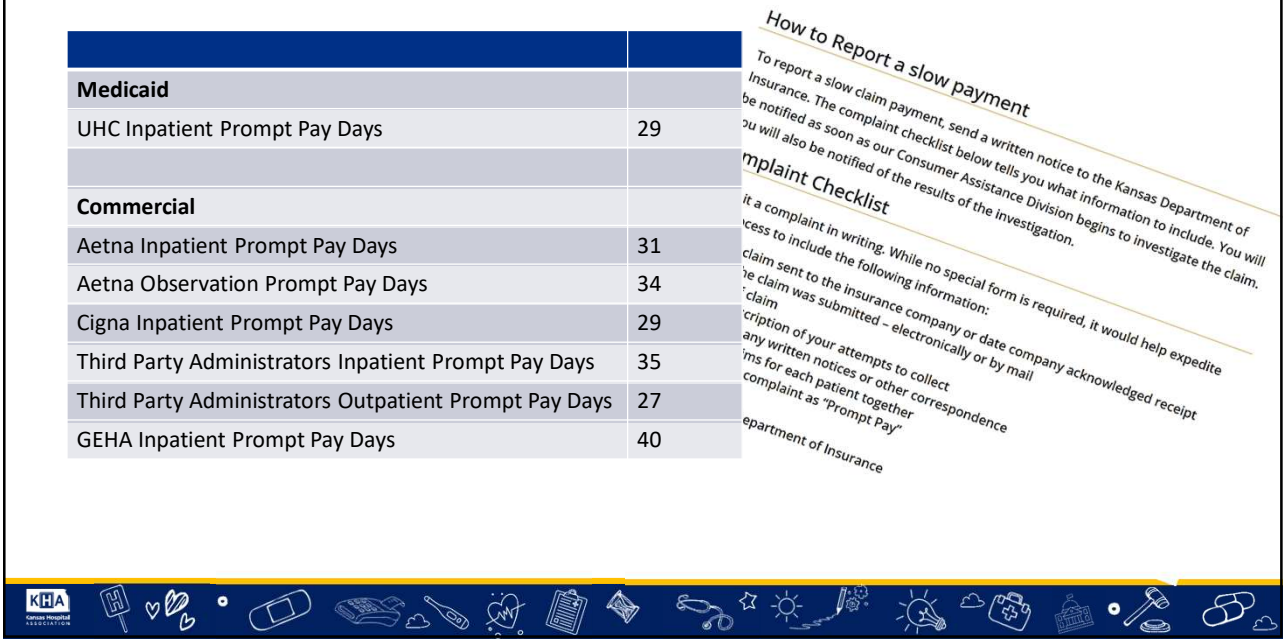
Be Aware of Prompt Pay Days!

Medicaid	
UHC Inpatient Prompt Pay Days	29
Commercial	
Aetna Inpatient Prompt Pay Days	31
Aetna Observation Prompt Pay Days	34
Cigna Inpatient Prompt Pay Days	29
Third Party Administrators Inpatient Prompt Pay Days	35
Third Party Administrators Outpatient Prompt Pay Days	27
GEHA Inpatient Prompt Pay Days	40


How to Report a slow payment

To report a slow claim payment, send a written notice to the Kansas Department of Insurance. The complaint checklist below tells you what information to include. You will be notified as soon as our Consumer Assistance Division begins to investigate the claim. You will also be notified of the results of the investigation.

mplaint Checklist

it a complaint in writing. While no special form is required, it would help expedite cess to include the following information:

claim sent to the insurance company or date company acknowledged receipt e claim was submitted – electronically or by mail claim cription of your attempts to collect any written notices or other correspondence ms for each patient together complaint as "Prompt Pay"

epartment of Insurance

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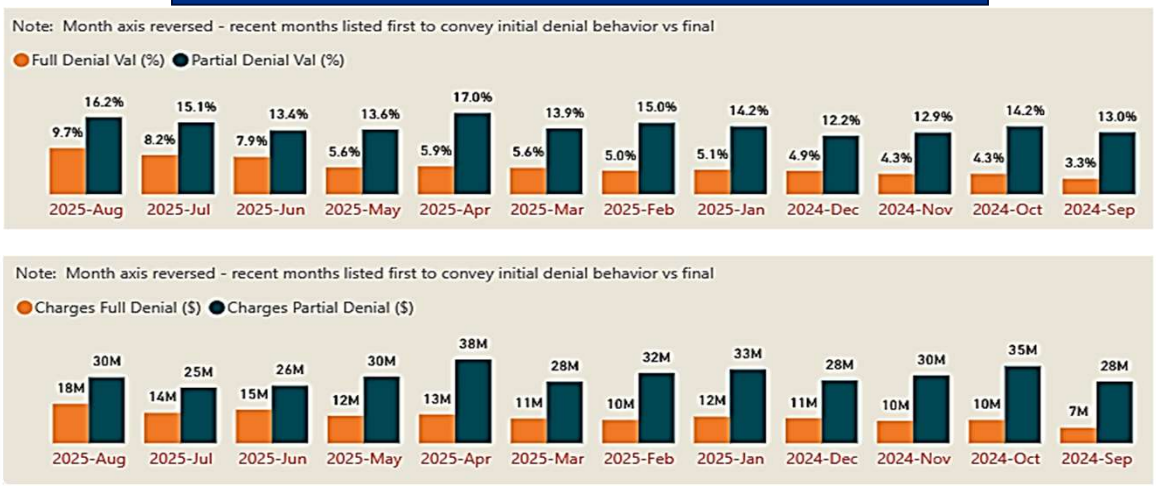
Full Denial (%) in KS

5.7%

Although the percentage of denials in Kansas is below the national average, the financial impact remains significant—totaling $506 million annually for the hospitals included in this analysis. Importantly, this figure represents only a portion of Kansas hospitals. When KHA aggregates the impact across all hospitals statewide, the estimated annual cost of denials rises to $1.6 billion.

Partial Denial (%) in KS

14.2%



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KHA Kansas Hospital ASSOCIATION

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Medicare Advantage Open Enrollment Resources Available

- Social Media Posts
- Know Your Facts Series
- Postcard Examples
- Poster Examples
- Talking Points
- Box.com

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  3. Review key payer policies, provide potential financial impacts to hospitals and engage in payer conversations.

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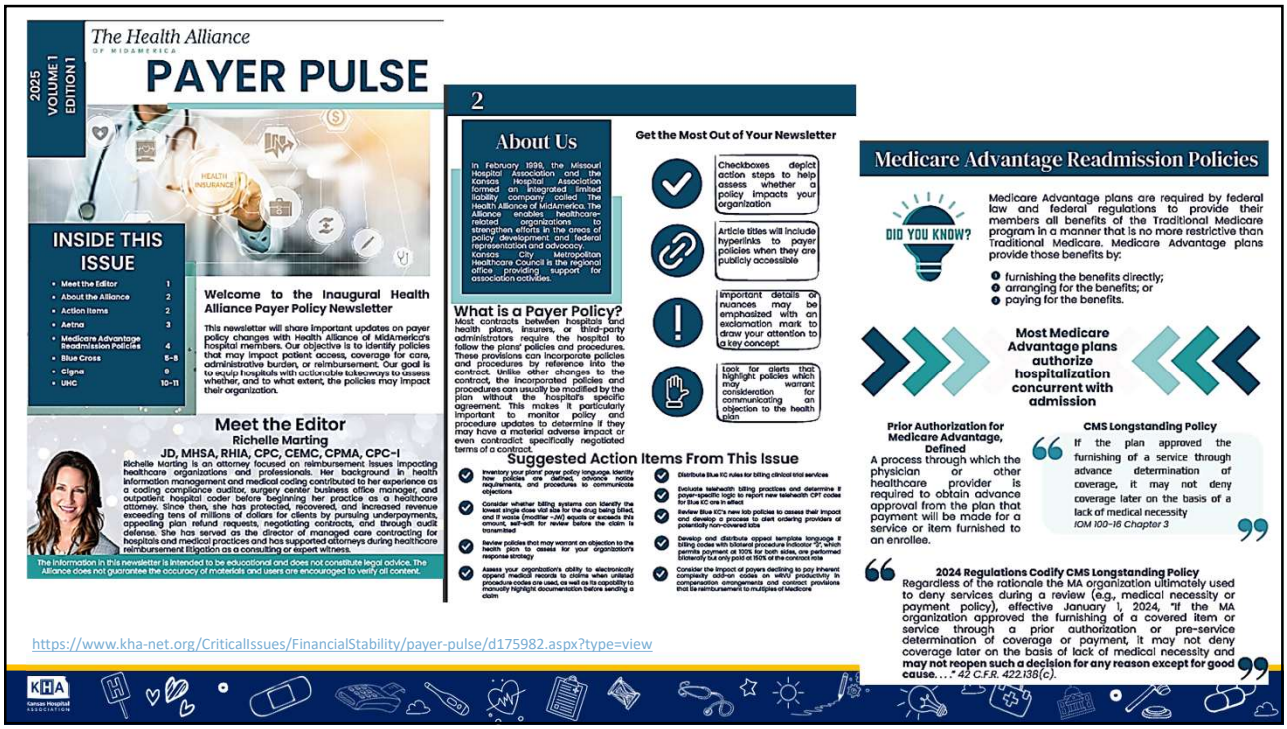

The Health Alliance OF MIDAMERICA

2025 VOLUME 1 EDITION 1

PAYER PULSE

INSIDE THIS ISSUE

Welcome to the Inaugural Health Alliance Payer Policy Newsletter

This newsletter will share important updates on payer policy changes with Health Alliance of MidAmerica's hospital members. Our objective is to identify policies that may impact patient access, coverage for care, administrative burden, or reimbursement. Our goal is to equip hospitals with actionable takeaways to assess whether, and to what extent, the policies may impact their organization.

Meet the Editor

Richelle Marting

JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I

Richelle Marting is an attorney focused on reimbursement issues impacting healthcare organizations and professionals. Her background in health information management and medical coding contributed to her experience as a coding compliance auditor, surgery center business office manager, and outpatient hospital coder before beginning her practice as a healthcare attorney. Since then, she has protected, recovered, and increased revenue exceeding tens of millions of dollars for clients by pursuing underpayments, appealing plan refund requests, negotiating contracts, and through audit defense. She has served as the director of managed care contracting for hospitals and medical practices and has supported attorneys during healthcare reimbursement litigation as a consulting or expert witness.

About Us

In February 1996, the Missouri Hospital Association and the Kansas Hospital Association formed an integrated limited liability company called The Health Alliance of MidAmerica. The Alliance enables healthcare-related organizations to strengthen efforts in the areas of policy development and federal representation and advocacy. Kansas City Metropolitan Healthcare Council is the regional office providing support for association activities.

Get the Most Out of Your Newsletter

- Checkboxes depict action steps to help assess whether a policy impacts your organization
- Article titles will include hyperlinks to payer policies when they are publicly accessible
- Important details or nuances may be emphasized with an exclamation mark to draw your attention to a key concept
- Look for alerts that highlight policies which may warrant consideration for communicating an objection to the health plan

What is a Payer Policy?

Most contracts between hospitals and health plans, insurers, or third-party administrators require the hospital to follow the plans' policies and procedures. These provisions can incorporate policies and procedures by reference into the contract. Unlike other changes to the contract, the incorporated policies and procedures can usually be modified by the plan without the hospital's specific agreement. This makes it particularly important to monitor policy and procedure updates to determine if they may have a material adverse impact or even contradict specifically negotiated terms of a contract.

Suggested Action Items From This Issue

- Inventory your plans' payer policy language, identify how policies are defined, advance notice requirements, and procedures to communicate objections
- Consider whether billing systems can identify the lowest single dose vial size for the drug being billed, and if waste (modifier -JW) equals or exceeds this amount, set-edit for review before the claim is transmitted
- Review policies that may warrant an objection to the health plan to assess for your organization's response strategy
- Assess your organization's ability to electronically append medical records to claims when unlisted procedure codes are used, as well as its capability to manually highlight documentation before sending a claim
- Distribute Blue KC rules for billing clinical trial services
- Evaluate telehealth billing practices and determine if payer-specific logic to report new telehealth CPT codes for Blue KC are in effect
- Review Blue KC's new lab policies to assess their impact and develop a process to alert ordering providers of potentially non-covered labs
- Develop and distribute appeal template language if billing codes with bilateral procedure indicator "2", which permits payment at 100% for both sides, are performed bilaterally but only paid at 150% of the contract rate
- Consider the impact of payers declining to pay inherent complexity add-on codes on wRVU productivity in compensation arrangements and contract provisions that tie reimbursement to multiples of Medicare

Medicare Advantage Readmission Policies

DID YOU KNOW?

Medicare Advantage plans are required by federal law and federal regulations to provide their members all benefits of the Traditional Medicare program in a manner that is no more restrictive than Traditional Medicare. Medicare Advantage plans provide those benefits by:

1. furnishing the benefits directly;
2. arranging for the benefits; or
3. paying for the benefits.

Most Medicare Advantage plans authorize hospitalization concurrent with admission

Prior Authorization for Medicare Advantage, Defined

A process through which the physician or other healthcare provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee.

CMS Longstanding Policy

"If the plan approved the furnishing of a service through advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity"
IOM 100-16 Chapter 3

2024 Regulations Codify CMS Longstanding Policy

Regardless of the rationale the MA organization ultimately used to deny services during a review (e.g., medical necessity or payment policy), effective January 1, 2024, "If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and **may not reopen such a decision for any reason except for good cause**. . . ." *42 C.F.R. 422.138(c).*

https://www.kha-net.org/CriticalIssues/FinancialStability/payer-pulse/d175982.aspx?type=view

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Plan Compliance?

August 2025

This month's reminders

We regularly review and adjust our clinical, payment and coding policies. Review our policies and claim edits on our provider portal on Availity®.* Just go to **Payer Space > Resources > Expanded Claim Edits.**

90-day notices

Level of severity inpatient payment policy

This policy applies to all participating Medicare facilities that have a Medicare allowable payment methodology and that participate in Aetna Medicare Advantage and/or

Our goal is simple: We want to help you get reimbursed faster for inpatient admissions that are initially denied. You'll receive faster payment and still be allowed to appeal for a higher payment.

Effective November 15, 2025, we'll adopt a new reimbursement approach for hospital stays of 1+ midnight in cases where a member is urgently or emergently admitted to a hospital and the provider has submitted an inpatient order.

- We'll approve the inpatient stay without a medical necessity review and pay the claim at a lower level of severity rate that's comparable to your rate for observation services.**
- If the inpatient stay meets MCG (Aetna

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Coming Soon!

- **Medicaid Program Advocacy**

  Initiate the formation of the next RFP proactively by monitoring opportunities and request language in Medicaid RFPs from 2027 to 2029.

- **Education Sessions and Workshops**

  Quarterly webinars focused on hospital contracting and revenue cycle changes. These education workshops will drill down to the most critical elements of trending topics affecting the revenue cycles.

- **Kansas Medicaid Managed Care Contract Amendment**

  Creation of a contractual amendment, outside of rate provisions, to clearly memorialize the MCO's obligations to the State

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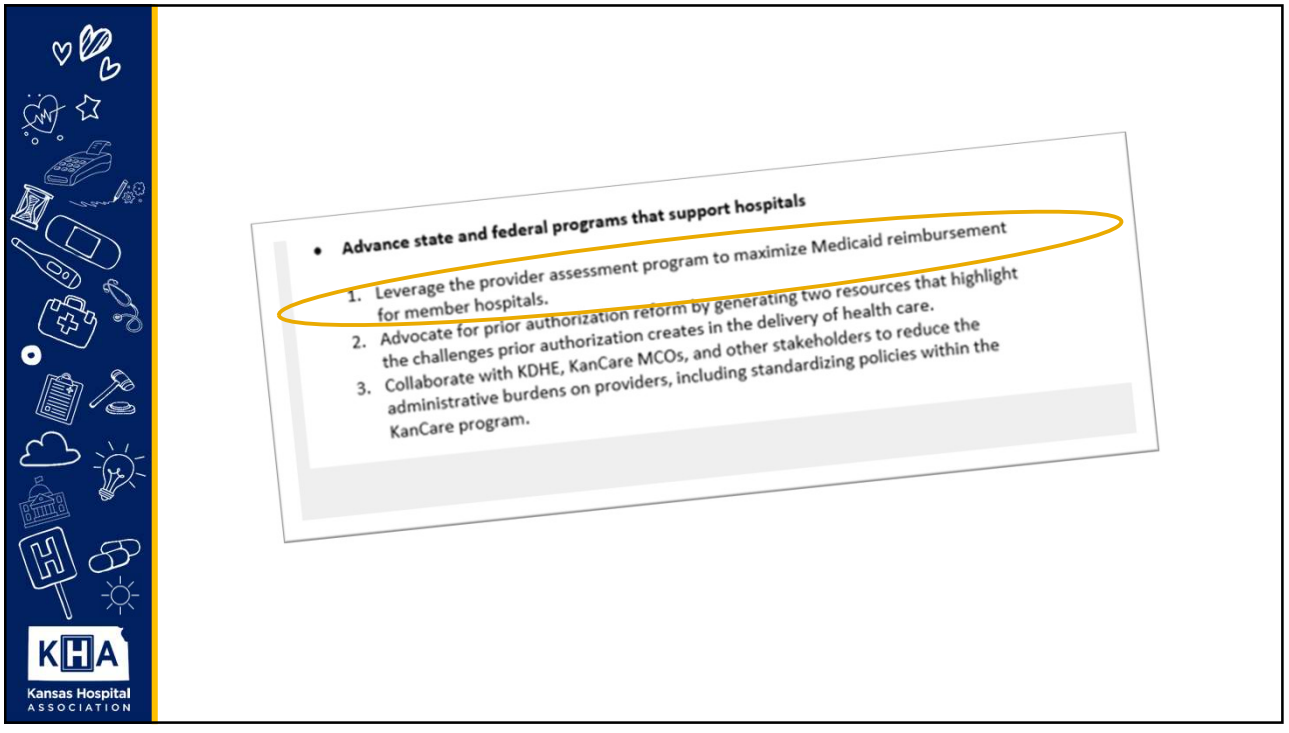

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2025 Provider Assessment has been approved!

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Recap:

1) The tax rate for PPS hospitals will increase from 3% to 6% net inpatient and outpatient revenue except for the Children's Mercy outpatient tax, which will go from 2.85% to 5.85%

This slight difference allows Kansas to pass the qualification tests related to the provider tax.

2) The percentage of the hospital pool that goes to CAH/REHs will increase from 3.0% to 4.3%.

3) Quarterly Enhancement Payments will be distributed to hospitals based on your hospital's Medicaid claims data

4) Since we just received approval in September, Kansas needs to catch up on payments for the 1st Two Quarters

5) KDHE has distributed the dollar amounts to the Medicaid MCOs for the 1st Quarter, and they should be distributed to hospitals in the next few weeks

6) KDHE is working to capture the 2nd quarter data, and the goal is to have those payments distributed by the end of October, when the PPS hospitals are required to make the first tax payment

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Impact on Medicaid DSH

New Provider Tax Program implemented in 2022 negatively impacted Medicaid DSH for some PPS hospitals.

Medicaid Uncompensated Care (listed on S-10 cost report) changed drastically resulting in hospitals with little to no Kansas Medicaid shortfall

As the provider tax program moves to a 6% tax program, more hospitals will lose Medicaid DSH dollars

******PLEASE do not assume that you will no longer qualify for Medicaid DSH and not complete the DSH application. Depending on your annual Medicaid mix and Uncompensated Care, there may be a possibility to receive some DSH compensation.**

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2026 Provider Assessment (*not approved yet)*

- Program will add the Critical Access Hospitals to the 6% Tax Payment Program that will then provide an additional net $135 million in quarterly enhancement payments to Critical Access Hospitals. If this is approved, the first tax payment from the CAHs will be due on May 31, 2026.

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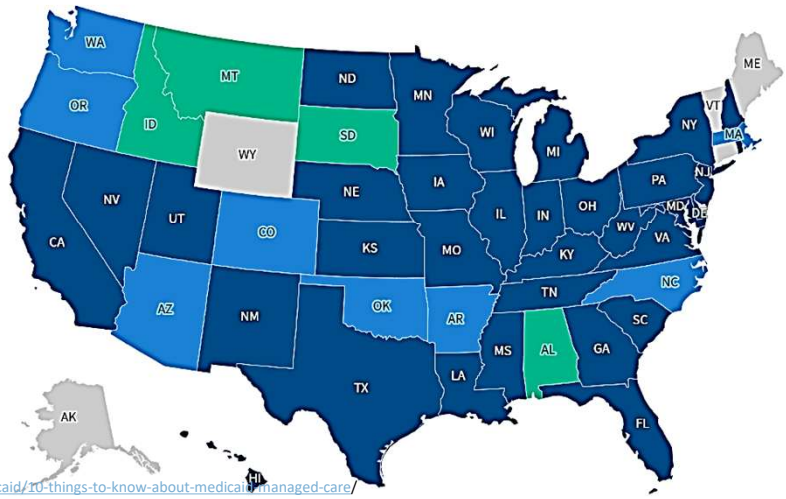
ONE BIG BEAUTIFUL BILL ACT (OBBBA)

51

As of July 2024, 42 States Used Capitated Managed Care Models to Deliver Services in Medicaid.

MCO only (34 states including DC) MCO and PCCM (8 states) PCCM only (4 states) No comprehensive MMC (5 states)



https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/

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OBBBA: STATE DIRECTED PAYMENTS

- New spending caps
  - New SDPs:
    - Must not exceed 100% of Medicare payment rates in expansion states
    - Must not exceed 110% of Medicare payment rates in non-expansion states
  - Existing SDPs:
    - Include SDPs submitted before July 4, 2025, for rural hospitals and prior to May 1, 2025, for all other providers
    - Existing SDPs subject to an annual phase-down of 10 percentage points beginning January 1, 2028, until reaching the applicable Medicare-based cap
- Definition of "Medicare payment rates"
  - There are different methods for proxying Medicare payment rates
    - Examples include PPS MS-DRG/APC equivalents or Medicaid fee-for-service Upper Payment Limit (UPL) calculations

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OBBBA: RURAL TRANSFORMATION FUND

- Total *federal* funding of $50 billion, distributed at $10 billion per year from 2026 to 2030
  - 50 percent of funds distributed evenly across states with approved applications
    - Application deadline: December 31, 2025
    - Application guidance in early September
  - Remaining 50 percent distributed based on CMS discretion with consideration to the following factors:
    - Share of state's population in rural parts of metropolitan areas
    - State's relative share of rural health facilities
    - Needs of hospitals serving a disproportionate number of low-income patients with special needs
- States have flexibility around the use of awarded funds
  - Non-hospital providers may be eligible (rural health clinics, federally qualified health centers, opioid treatment centers, etc.)
  - Up to 10% of each state's allotted funds may be used for administrative purposes
  - Broad definition of "rural" hospital under OBBA, but states have flexibility to narrow the scope of eligible hospitals

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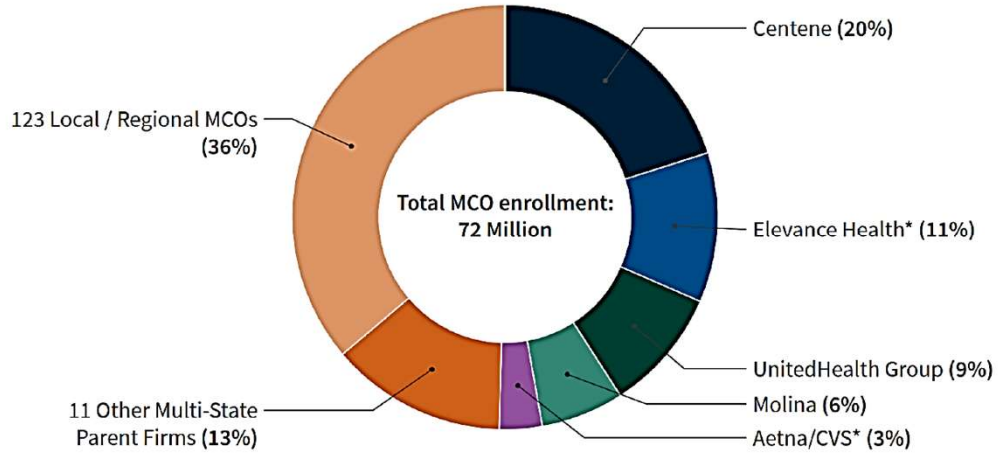
Five Fortune 500 Companies Have Half of the Medicaid MCO Market.

Share of total comprehensive Medicaid MCO enrollment as of July 1, 2022:



https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/

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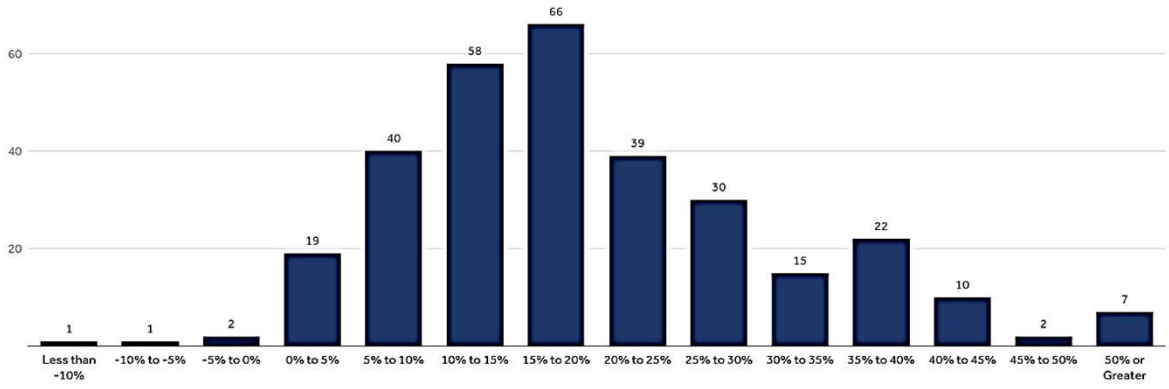
Distribution of proposed 2026 rate changes among 312 ACA Marketplace insurers



Note: The median increase is about 18%.

Source KFF analysis of data from ratereview.healthcare.gov, California Department of Managed Health Care and insurer rate filings • Get the data • PNG

Peterson-KFF Health System Tracker

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- **Advance state and federal programs that support hospitals**

1. Leverage the provider assessment program to maximize Medicaid reimbursement for member hospitals.
2. Advocate for prior authorization reform by generating two resources that highlight the challenges prior authorization creates in the delivery of health care.
3. Collaborate with KDHE, KanCare MCOs, and other stakeholders to reduce the administrative burdens on providers, including standardizing policies within the KanCare program.

Kansas Hospital ASSOCIATION

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Managing Medicare Advantage

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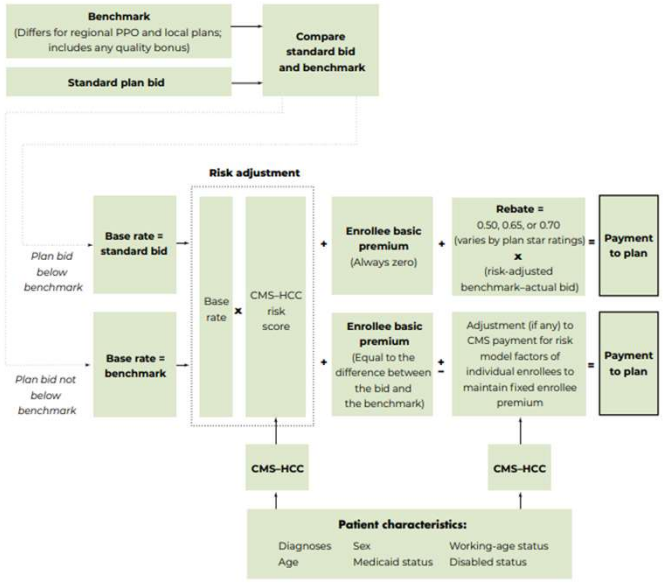
Medicare Advantage Payment System



https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_MA_FINAL_SEC.pdf

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Star Rating Basics

- Intended to promote quality of care, ensure public accountability
- Star rating categories
  - Staying healthy: addresses preventive services (e.g., screenings, physical exams, vaccinations)
  - Managing chronic conditions: frequency of tests and treatments for long-term health issues
  - Members experience: member rating of their experience, including getting care from their doctor and getting prescription medications
  - **Member complaints and performance: how often members found problems with plan and how performance improved year over year**
  - Customer service: use of foreign language interpreters and TTY services; processing appeals and new enrollments timely
- 2026 MA and Part D Proposed Rule included changes to categories and criteria, but not finalized

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Impact of Star Ratings

- Plans with 4 or more stars receive 5% quality bonus payments
  - Bonus payments used to finance supplemental benefits and zero-premium plans
- Upper and lower thresholds for each measure
  - Approximately 40 measures, scored 1-5
- Plans with 5 stars can enroll members year around
- Plans with low ratings often restricted from expanding geographically/not renewed

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Submitting Provider Complaints to CMS

- New Centralized Process for Provider Complaints against Medicare Advantage Plans
  - Provider appeal complaint – plan failed to follow applicable appeals process
  - Claims payment dispute – e.g., plan's decision to partially approve, downcode, or bundle services or approve service at lower level of care
- Provider must complete Appeal/Claim Payment Dispute Cover Sheet* for each complaint (i.e., one cover sheet for each beneficiary case)
  - Send in password-protected file to MedicarePartCDQuestions@cms.hhs.gov and part_c_part_d_audit@cms.hhs.gov
  - CMS will not process complaint unless provider previously communicated with plan
- CMS will facilitate plan-provider communication, track and trend types of complaints – but not resolve specific disputes
  - Input complaint into CMS Complaint Tracking Module (Star Rating measure = # of CTM complaints/1000 members)

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Provider Complaint Submission Form

- Each file must be password protected
  - Submit a second email with the password to the file
- Information Required for All Complaints

Date of Submission to CMS
Submitting Entity (If the case is submitted by an organization *representing* a Medicare provider, submit evidence of the contractual relationship between the provider and the representative organization that documents the organization's authority to investigate the case on the provider's behalf. Likewise, if the submitting entity is representing a beneficiary(ies), submit an Appointment of Representative (AOR) form demonstrating the authority to investigate the case(s) on the beneficiary(ies) behalf.)
Complainant's Name, E-mail Address, Telephone Number
Beneficiary Name
Beneficiary HICN/MBN (Medicare Beneficiary Number)
Provider Name, Telephone number, E-mail address
Medicare Advantage Organization Name
Claim Number
Date(s) of Service

- Link to form and Instructions

https://calhospital.org/wp-content/uploads/2024/08/instructions-for-organizations-representing-providers-to-submit-provider-complaints-related-to-medicare-advantage-organizatio.pdf

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Medicare Advantage Plans Received 50 Million Prior Authorization Requests in 2023

- 99% of Medicare Advantage enrollees in plan that requires prior authorization
  - Skilled nursing services – 99%
  - Part B drugs – 98%
  - Acute inpatient hospital stay – 98%
  - Psychiatric hospital stay – 93%
  - Outpatient psychiatric services – 82%
- In the same year, there were only 400,000 Prior Authorization Requests in Traditional Medicare
  - CMS denied slightly less than 30%

https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

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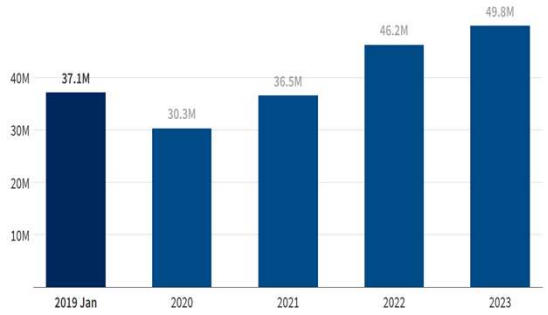
2023 Prior Authorization Requests and Denials - Overall

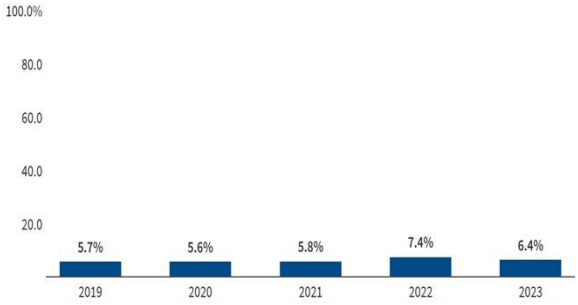
Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023

Total number of prior authorization determinations, 2019 - 2023



Medicare Advantage Insurers Denied Fewer than 10% of Prior Authorization Requests in Recent Years

Adverse and partially favorable determinations as a share of all prior authorization determinations, 2019 - 2023



https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

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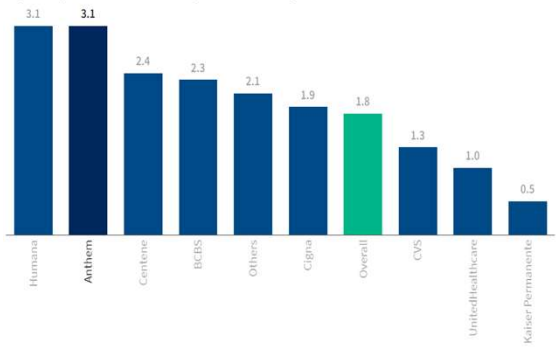
2023 Prior Authorization Requests & Denials – By Payer

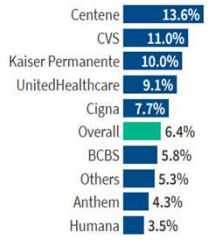
Prior Authorization Determinations Are More Common Among Certain Medicare Advantage Firms

Requests for prior authorization of services per Medicare Advantage enrollee in 2023



Firms Denied Between 4% and 14% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2023



https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

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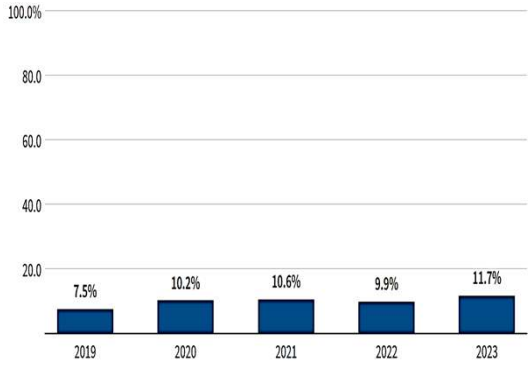
2023 Appeals of Prior Authorization Requests

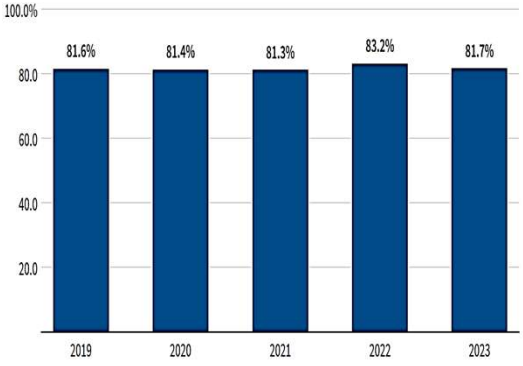
A Slightly Larger Share of Denied Prior Authorization Requests Was Appealed to Medicare Advantage Insurers in 2023 Than in Recent Years

Share of adverse and partially favorable prior authorization determinations that was reconsidered, 2019 - 2023



More Than 80% of Denied Prior Authorization Requests That Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable, 2019 - 2023



https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

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New Medicare Advantage Rules Coming Into Enforcement in 2026

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January 2024 Prior Authorization Final Rule

- By 1/1/2026, must send PA decisions within 72 hours (urgent) and 7 calendar days (standard)
  - For MA plans, current rule is 14 calendar days for standard requests
  - For MA plans, shorter time periods for Part B drugs (24/72 hours) will remain
- By 1/1/2026, must furnish provider with written explanation for PA decision
  - For MA plans, current rule requires for post-claim audits
- By 3/31/2026, must post PA metrics on website
  - Percent of PA requests approved, denied, approved after appeal
  - Average time between submission and decision
- By 1/1/2027, must implement APIs to facilitate electronic PA process
  - Identify items/services requiring PA (excluding drugs) and specify documentation requirements

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CY2026 Policy and Technical Changes

- Cannot deny coverage for lack of medical necessity if:
  - Gave prior authorization
  - Pre-service determination of coverage/payment
  - Concurrent determination during enrollee's receipt of inpatient/outpatient service absent good cause/reliable evidence of fraud
- Cannot use clinical information obtained after initial organizational determination to establish good cause for reopening approved inpatient hospital admission
  - *"…we are finalizing our proposal to restrict plans' ability to use information gathered after the inpatient admission has taken place when reviewing the appropriateness of the admission itself"*
  - Allows for exceptions –
    - When patient is not actually enrolled in the plan on the day of admission
    - When hospital withheld material information that would have impacted the plan's decision

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Rules Already In Enforcement

71

CY2024 MA & Part D Final Rule

1. Must comply with traditional Medicare NCDs, applicable LCDs, and general coverage and benefit conditions
   - Including coverage criteria for inpatient, IRF, and SNF admissions and HHA services
     - Including inpatient only list and admissions meeting two midnight benchmark
2. If (and only if) coverage criteria not fully defined by above, may establish internal coverage criteria
   - Must be based on current evidence in widely used treatment guidelines or clinical literature
   - Must be publicly accessible on plan website (including summary of evidence)
   - Must demonstrate additional criteria provide clinical benefits highly likely to outweigh any harm (including delayed/decreased access to care)

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2024 MA & Part D Final Rule

3. Must establish Utilization Management Committee led by Medical Director to review PA policies annually
   - Includes awareness of current LCDs, NCDs, and other Traditional Medicare coverage policies
   - 2025 MA & Part D Final Rule (released 04/04/2024) added new requirements
     - At least one committee member must have expertise in health equity
     - Committee must conduct annual plan-level health equity analysis of PA policies
4. PA approval must remain valid for as long as medically necessary to avoid disruptions in care; must provide minimum 90-day transition period when enrollee undergoing treatment changes coverage

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A Review of the Two-Midnight Rule: 42 CFR 412.3

- Requirements for **coverage**:
  - The admitting physician expects the patient to require hospital care that crosses two midnights
  - The planned service is a surgical procedure specified by Medicare as inpatient only, regardless of the expected duration of care
  - Where the admitting physician expects the patient to require hospital care for only a limited period of time that does not cross 2 midnights, admission may be appropriate based on the clinical judgment of the admitting physician and medical record support for that determination
    - The physician's decision should be based on such complex medical factors such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.
- *"…we confirm that the criteria listed at 412.3(a)-(d) apply to MA."* (4/12/23 *Federal Register)*

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Two Midnights – Benchmark vs. Presumption

- Not required to follow two midnight presumption (CMS medical review instruction)
  - Any claim that crosses two midnights following inpatient admission order are presumed appropriate for payment
- MA plan may evaluate whether admitting physician's expectation was *reasonable* based on complex medical factors documented in medical record
- **InterQual and Milliman Care Guidelines are not substitutes for the law!!**
  - *"…MA plans may not use InterQual or MCG criteria, or similar products, to change coverage or payment criteria already established under Traditional Medicare laws."*
  - Can be used to assist in creating internal coverage criteria (when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD)
    - *Federal Register* April 12, 2023, page 22194-22195

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The April 2023 Final Rule is Nothing New

Medicare Advantage plans always have had to comply with the Two-Midnight Rule, aka the Two-Midnight Benchmark. This isn't new

Medicare Advantage plans can avoid the Two-Midnight Presumption; but this just refers to what claims it selects to review. They still must follow the rule.

InterQual and MCG are not substitutes for the Two-Midnight Rule.

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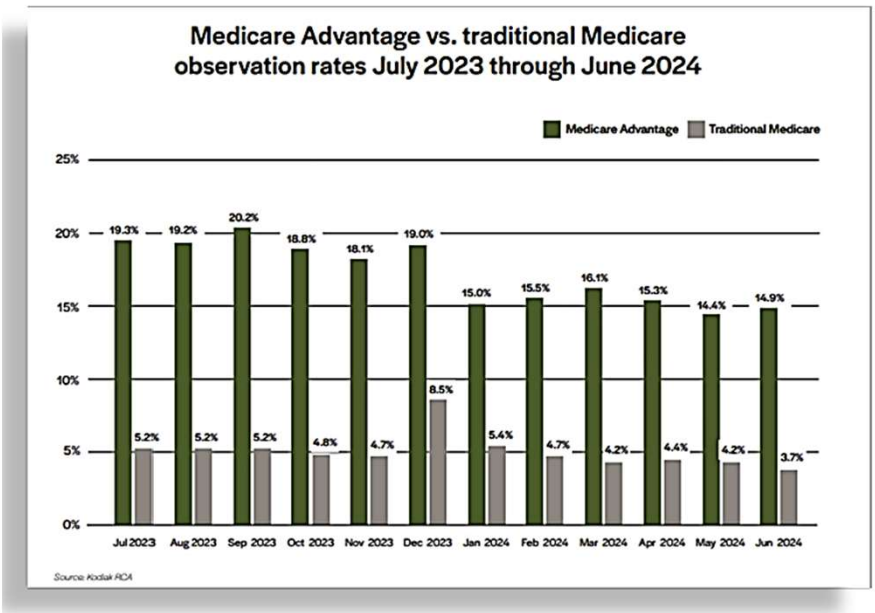

https://kodiaksolutions.io/internal/benchmarking_reports/kpi_benchmarking_november_quarterly

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Tips To Reduce Inpatient Denials

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Ways To Reduce Dispute and Avoid Improper Denials

- Educate doctors to document their expectations when admitting
- Design your physician admitting systems accordingly
  - Consider check boxes and free text fields that quote from the language in Section 412.3(d)

Section 412.3(d) – The physician's decision should be based on such complex medical factors such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

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Tips To Reduce DRG Downcoding

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Payer Tactics:

- Payers often implement blanket initiatives or polcies for prepay review and records requests that target higher weighted DRGs or particular DRGs vulnerable to validation such as sepsis

-or-

- Payers target claims carrying secondary diagnosis of one chronic condition/major chronic condition which can be removed/downgraded to result in lower-weighted DRG. For example, respiratory failure, renal failure, malnutrition
- Payers use software driven claim edits based on algorithms that conclude coded items do not support DRG without medical record review.
- Payers give vague denial reasons
- Utilize outside vendors who are not knowledgeable about the clinical issues or cannot competently review a medical record.

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Ways To Reduce Dispute and Avoid Downgrading

- Start with the contract. Helpful language includes requirements that payers pay the claim as billed but may allow post-payment audits that permit DRG review and payment corrections where there is joint agreement in the change to the DRG.
- Coordinate with EHRs or Vendors to track and review downgraded claims to dissect targeted claims. These are most likely higher-level E/M, complex claims with modifiers, and higher-weighted DRGs and chronic conditions
- Identify denial codes used by payers
  - 'documentation does not support level of service'
  - 'payment based on appropriate level of care'
  - 'level of care adjustment'
- Track payments to identify silent downcoding
- Identify and challenge problematic policies
- **Consistently** appeal improperly downcoded claims
- Educate clinical personnel on strong documentation
- Conduct regular internal coding audits

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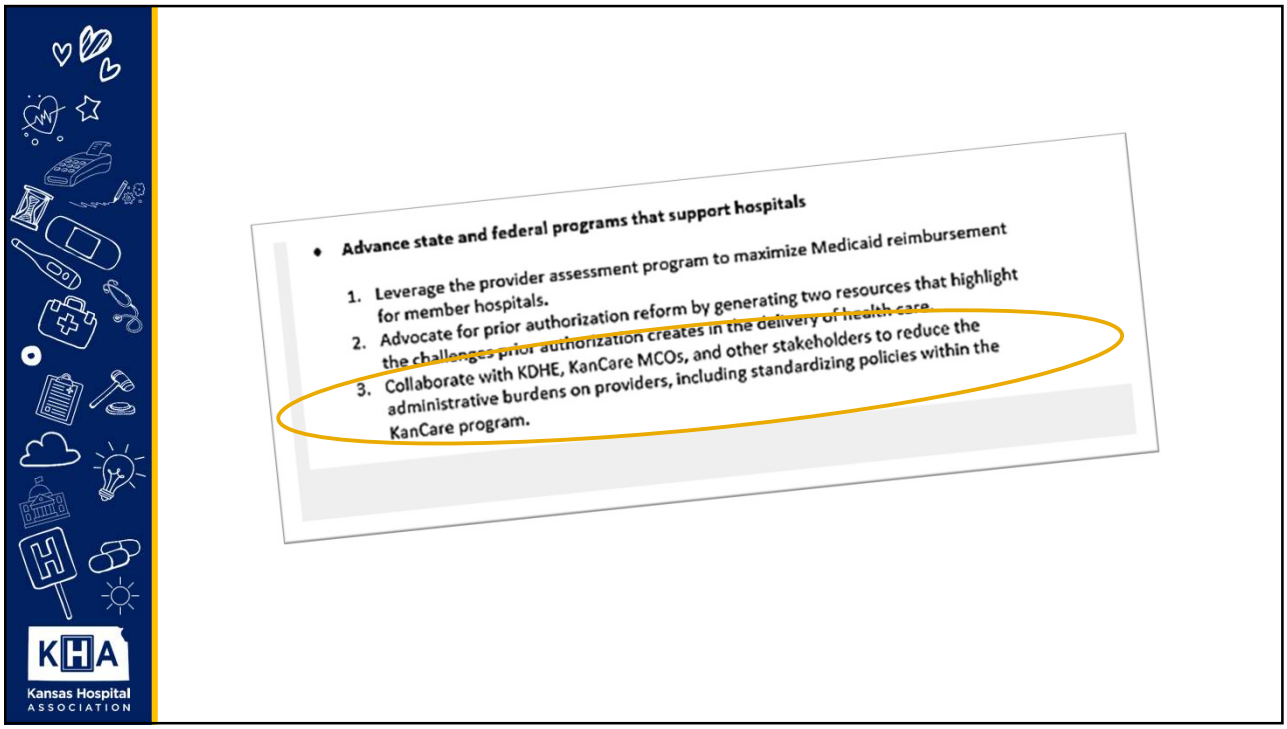

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Credentialing & Provider Enrollment Collaborative Committee

Key Findings:

Participants highlighted the following ongoing questions:

- How do we resolve ongoing issues with KMAP revalidations going to incorrect email addresses?
- How can redundant processes across credentialing steps be reduced?
- What strategies can shorten credentialing timelines for the benefit of the healthcare system?
- Are stakeholders willing to centralize or collaborate more extensively on credentialing processes?
- Some participants are still digesting the information and had no immediate questions.

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Potential Future Topics to Address Barriers and Duplication

Participants suggested several areas for future discussion:

- **Process Streamlining:** Explore ways to eliminate repeated steps across credentialing.
- **Centralized Systems:** Consider a statewide or multi-entity approved process to reduce duplication (similar to CAQH/NCQA).
- **Standardized Credentialing Application:** Develop an agreed-upon credentialing application utilized and accepted by all insurance payers.
- **Universal Roster:** Develop a standardized format for roster submission to Medicaid payers.
- **Use of CAQH/NCQA:** Further explore CAQH utilization to reduce administrative burden.
- **Uniform Background Checks:** Discuss creating a universal background check process that can be shared.
- **Simultaneous Processing:** Identify steps that can run concurrently to reduce delays.
- **Understand Payor Timelines:** Examine why payor processing takes as long as it does and seek clarification.

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