HOUSE HEALTH SUBCOMMITTEE ON HEALTH CARE FACILITIES

INFORMATIONAL MEETING ON HOSPITAL CONSOLIDATION AND CLOSURE

Wednesday, February 28th, 2024

10:00 am

Room 60 East Wing

Harrisburg, PA

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1. Call to Order
2. Attendance

Panel 1 Payment models and support for rural hospitals

Janice Walters, Executive Director, Rural Health Redesign Center Authority

Panel 2 Innovation to support independent hospitals

Joe Gribik , Chief Executive Officer, Pennsylvania Mountain Health Alliance (PHMA)

Mike Makosky, CEO of Fulton County Medical Center and Board Chair of PMHA

Jack Sisk, President of Punxsutawney Area Hospital and Board Treasurer of PMHA

Nicole Clawson, VP of Finance/Revenue Cycle for PMHA

Panel 3 Data to promote health system advancement

Craig Behm, Chief Executive Officer, CRISP Shared Services

3. Adjournment

RURAL HEALTH REDESIGN CENTER

Written Testimony Submitted by:
Janice Walters, MSHA, CHFP
Executive Director. Rural Health Redesign Center

Thank you to the House Health Committee for hosting this subcommittee informational meeting on bolstering rural and independent hospitals. Thank you to Chair Frankle and Republican Chair Rapp for understanding the importance of our rural hospitals and their significance in not only ensuring access to healthcare in rural communities, but to the economic impact these hospitals have in their communities. I am honored to have been asked to provide testimony at this hearing and represent the significant work the Commonwealth has accomplished collectively in advancing rural health payment reform and the lessons we have learned in our journey together these past 6 years. It has been a privilege to lead the innovative efforts of the Pennsylvania Rural Health Model (PARHM), and support the creation of the Rural Health Redesign Center (RHRC) as its chief operating officer, and more recently its executive director.

Background – The RHRC and the PARHM

Through the legislative Act 108 of 2019, and subsequently Act 15 of 2023, the Rural Health Redesign Center Authority (RHRCA) was created to advance the mission of ensuring access to high-quality healthcare remains in rural Pennsylvania. The RHRCA has a governing board of directors comprised of hospitals, payers, government officials, and national rural health experts. The RHRCA was officially formed in May of 2020 and has been governing the Pennsylvania Rural Health Model (PARHM) since its inception. In addition to the Rural Health Redesign Center Authority (RHRCA), a supporting not-for-profit organization was also created, the Rural Health Redesign Center Organization (RHRCO), with the overall vision of supporting the RHRCA and becoming a long-standing resource to rural healthcare leaders and institutions. These two organizations, the RHRCA and RHRCO, are collectively known as the Rural Health Redesign Center (RHRC).

The PARHM was the first of its kind innovative demonstration program that is being administrated in partnership with the Centers for Medicare and Medicaid Innovation (CMMI) that is testing an alternative payment model specifically designed for rural hospitals. The PARHM was a seven-year demonstration program, beginning in 2018 with a pre-implementation year, followed by 6 performance years, 2019-2024. We are currently in the final program year.

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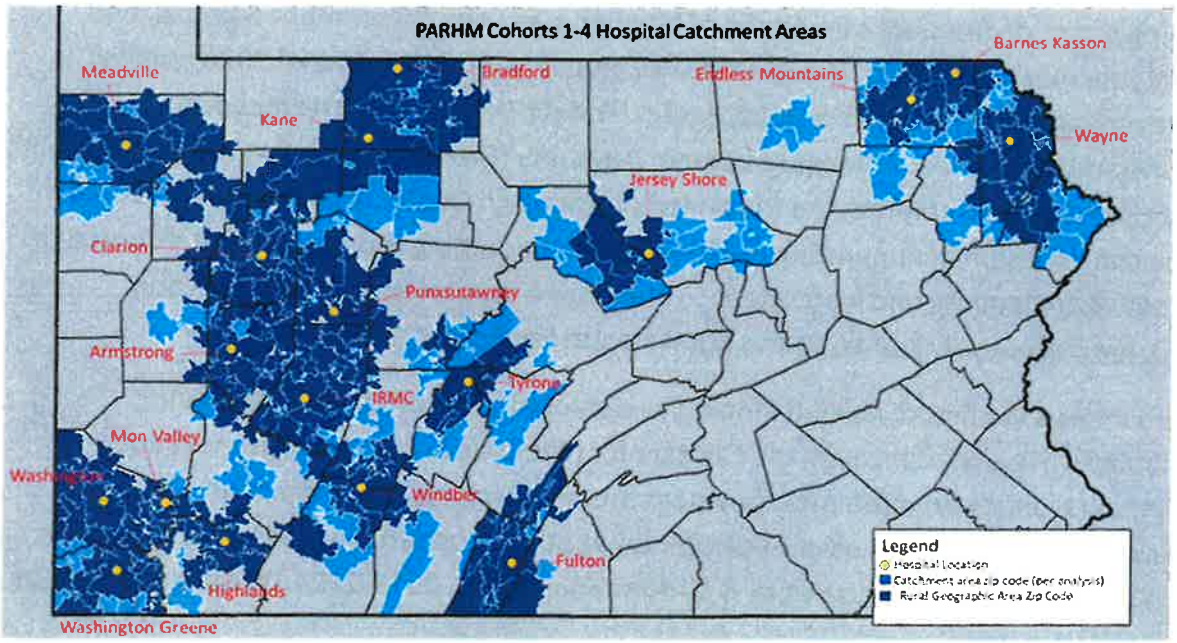
The overarching goals of the program were to test the following: 1) if we fundamentally change how hospitals are paid (i.e., moving them to a global budget framework) can we improve their financial viability, 2) by stabilizing the revenue, can hospitals improve the health of the populations served within these communities, and 3) through a redesigned payment structure, can we reduce the total cost of care growth rate over time.

The RHRC has data that shows it is achieving the overarching objectives of the PAHRM. While the program is certainly not perfect, it has proven to be a robust learning laboratory for what works as well as what does not work well within rural health payment reform. Despite its imperfections, seventeen of the eighteen participant hospitals have improved operating margins during the program period, and quality indicators show improvement against national rural averages. In addition, RHRC data shows that the program is managing within its Total Cost of Care (TCOC) growth guardrails.

Through the first 4 performance years of the program (2019-2022), an additional $188M of revenue was paid to our participant hospitals by the participant payers. Participants in this program include eighteen hospitals as well as the predominant 3rd party payers in the Commonwealth. The payers included Highmark, University of Pittsburg Medical Center, Geisinger Health Plan, Aetna, and CMS / Medicare. The payers remain the source of payment of the global budgets to the participant hospitals which span across fifteen rural counties. The map below shows the footprint of this program.



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The participant hospitals include thirteen PPS hospitals including UPMC Kane, Bradford (Kaleida), Meadville, Independence Health Clarion, Punxsutawney, Armstrong, Indiana Regional, Washington (UPMC), Washington Greene (UPMC), Penn Highlands Monongahela Valley, Penn Highlands Connellsville (Highlands Hospital), Windber, and Wayne Memorial; and five critical access hospitals Endless Mountains, Barnes-Kasson (Wayne Memorial), Geisinger Jersey Shore, Fulton County, and Penn Highlands Tyrone. Participants are a mix of independent and system-owned hospitals. Seven of the eighteen hospitals were independent upon entry into the program but have either been subsequently acquired by a larger organization or are currently in the process of being acquired. This statistic alone would indicate that while there is data to support that the PARHM provided stability and improved operating margins for the participant rural hospitals over the course of the program, it was not enough to sustain these organizations as independent rural entities.

The work of the RHRC

The role of the RHRC specific to the PAHRM is to support both participant hospitals and payers within the program. This support includes providing the necessary technical assistance and infrastructure to facilitate both the global budgeting process, as well as the transformation planning and implementation process for hospitals. This includes activities such as developing shared learning platforms to advance population health initiatives and transformation planning, grant-writing research support, financial modeling for service line changes, and program reporting and monitoring. The RHRC's cost of providing robust technical support services for the PARHM is approximately $2.5MM per year, and to date has been funded by federal CMS dollars and private grant funds. Current funding for the RHRC's PARHM work is expected to expire by the end of calendar year 2024. However, it is believed that given its work to date, the RHRC remains ideally situated to continue to provide needed infrastructure to rural communities to advance payment reform, population health improvement, and improved efficiencies to rural and other safety net providers in need of assistance.

In addition to supporting the hospitals and payers within the PARHM, the RHRC also works with other distressed hospitals and offers a host of rural relevant expertise to rural healthcare providers beyond those listed above. In addition to the services mentioned already, services include rural relevant strategic planning including implementation and accountability processes, financial and data analysis, grant-writing services, compliance and regulatory support, performance improvement services, educational platforms, leadership development resources, organization culture assessments, project

management training, revenue cycle evaluations, and overall C-suite leadership support. These services are provided through RHRC staff as well as partnerships with other organizations with rural relevant expertise.

Key Lessons Learned

As mentioned, the PARHM created a robust opportunity to identify what works well with rural health payment reform and what did not work so well. To frame what worked, what didn't, and other key lessons, I will highlight several in each category for reference.

Things that worked well were:

1. The all-payer nature of the program: the predominance of hospital revenue as paid to our participant hospitals through the global budget included the majority of its revenue from all prominent payers in the state.
2. The level of technical assistance provided to the hospitals: Given the level of competing priorities and resource limitations of rural hospitals, leaders have stated that if it wasn't for the support the RHRC provided, they could not have participated in the program.
3. The RHRC's creation, and its subsequent governing board: Both payers and hospitals felt it essential to have an independent entity, outside of the governor's direct jurisdiction, governing the program to insulate it from the election cycle and subsequent priorities. All felt this work was too important to be tied to a specific administration's priorities. The work is governed by the key stakeholders, which has been essential for its success.
4. The commitment of the participants to stick with the program: This program was only successful because of the commitment of the parties to stick with it, even when the outcomes may not have been in the best interest of each individual entity. There was a level of commitment to the journey that is noteworthy, and deserves to be recognized for all participants, hospitals and payers alike.
5. The patience of the participants to be flexible during the PHE: When this program was launched, no one knew that there was going to be a global crisis a little more than a year into the performance years. As a reminder, the RHRC was created in May of 2020, and the commitment of the board members and their organizations to be patient to allow data to drive decisions was equally remarkable.
6. The transformation planning process: The RHRC built infrastructure to support hospitals in moving from volume to value strategies. This work required hospitals to think differently, and the RHRC built tools and frameworks to guide hospitals through this process.

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Things that did worked well:

1. The lack of data infrastructure: In order to administrate a program of this nature, robust data is needed. The work was stifled due to a lack of data infrastructure and data sharing within the program. In the absence of all-claims or other infrastructure, program administration had to rely on summary level data as individually submitted by the payers to administrate the program.
2. The methodology as developed was complicated: While the goal was to develop a fairly simple global budget framework, it became very complicated in order to meet the demands of the various stakeholders. As a result, we have a complicated methodology that is difficult for hospitals to understand and is resource intense to manage. The current program requires a lot of trust on the part of hospitals as they don't understand the "black box" calculations that occur within the frameworks and rely heavily on the RHRC to manage the budgets on their behalf.
3. The methodology as currently developed isn't as predictable for hospitals or payers as originally hoped: Due to the methodology as mentioned above, the global budget is not overly predictable due to some of the adjustments included within it. This creates challenges for both hospitals and payers each year as it relates to financial statement preparation.
4. The lack of timely, actionable data by which to advance population health initiatives: Data sharing is not as robust as it could be, or should be, to improve population health. If rural health care providers are being asked to manage within fixed payment arrangements, data sharing on the parts of all payers should be a requirement to ensure the providers can be successful.
5. Lack of RHRC funding in later performance years: As mentioned, the funding for the current PAHRM is reaching its end, and as a result the RHRC is having to cut back its support to the participant hospitals. There is more the RHRC could do with adequate funding.

Other Key Lesson:

Lesson 1: Change of this nature is hard, and it takes different skillsets and mindsets to be successful. There is a continued need to remind stakeholders of why we are doing this work together. It is easy to revert to the old way of thinking.
Lesson 2: Even when rural health leaders and payers know change is needed, often competing priorities and lack of resources do not allow them to adopt change.
Lesson 3: There is an element of fear that accompanies change. Recognizing this fear, understanding it, and mitigating it are fundamental keys to success.
Lesson 4: Trust is the essential element in order to make all of this work. Stakeholders must trust that there is aligned purpose to the work, and that everyone is working to achieve that desired outcome of ensuring access to care remains in rural communities.

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Lesson 5: Robust data infrastructure will be essential for a successful next generation program.

As we collectively begin to put pen to paper for a next generation strategy, considering all of the lessons learned will be part of that work.

Path Forward

It estimated that 1.3MM individuals reside within the Commonwealth communities that the RHRC currently supports. By keeping these hospitals open, as well as other providers that are in need of new strategies and solutions, we not only retain access to essential healthcare solutions, but also employment and broader economic benefit. We know that the hospitals the RHRC already works with accounts for approximately 18K jobs and $2.6B of economic benefit for their communities and the Commonwealth.

The current PARHM program is in its final performance year. For the traditional CMS Medicare portion of the program, the hospitals within the program have a two-year transition period which will allow them to continue to receive global budget through 2026 if the hospital chooses to do so. However, for the PA-based aspects of the program (commercial, Medicaid Managed, and Medicare Managed), the current program will terminate as of December 31, 2024.

Given the imminent need for a replacement program, and with the support and direction from the Shapiro Administration in follow-up to the Rural Health Roundtable held on January 18th, 2024, the RHRC has been tasked with leading the development of a next-generation replacement program proposal. The RHRC will be leading efforts in the coming months to develop a proposal with the goal of having this solution drafted by the end of 2024 for inclusion in the 2025 Governor's budget cycle. This timeline was identified by the Governor in his address at the January 18th Round Table. Development of this program will include broad stakeholder engagement across the Commonwealth, including hospitals, payers, Commonwealth agencies such as DOH, DHS, PID, the State Office of Rural Health, the Hospital and Health System Association of PA, and other partner organization. The collective goal is to not abandon our rural hospital participants but develop better and more refined methodologies using lessons learned from the current program.

There are many thoughts and ideas regarding what the next solution should contain, including what services are essential to rural communities, the funding strategies to be utilized to ensure rural healthcare remains viable, the infrastructure required for success,

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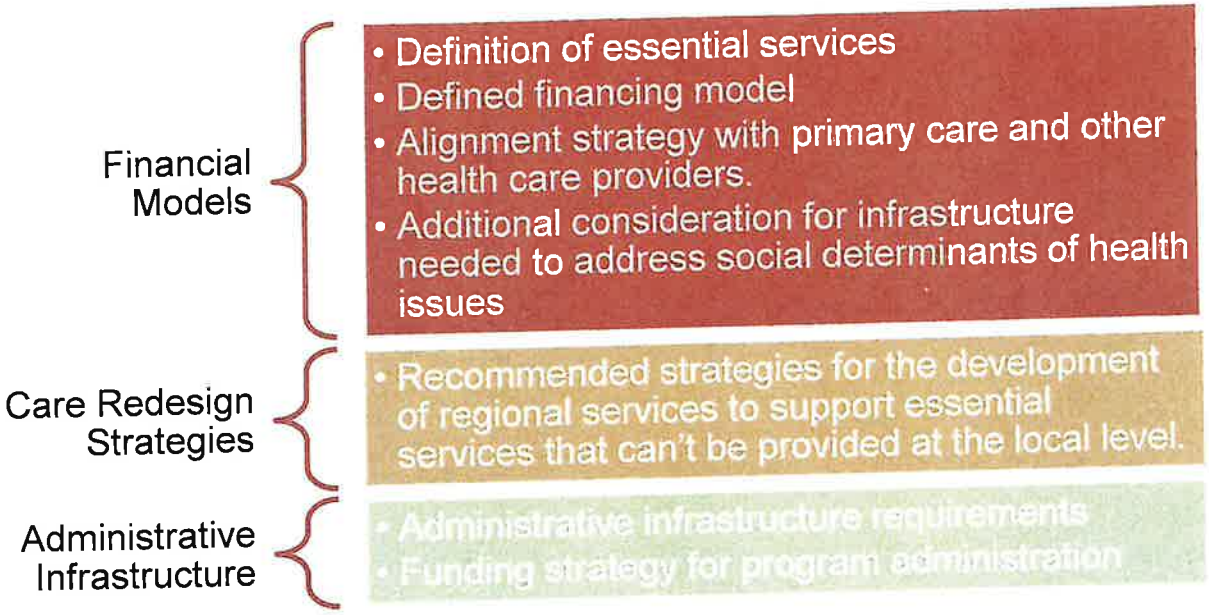
and Commonwealth budgetary considerations that may be needed to ensure a sustainable long-term solution. The work of the RHRC, in partnership with the Shapiro administration and the legislature, will be to develop a strategy that can be adopted as a Pennsylvania rural health solution. This next generation solution will be developed through robust stakeholder engagement over the course of the next several months. Our collective goal also includes ongoing dialogue with our federal partners at CMS / CMMI to determine what the federal replacement program will be in 2027 upon completion of the transition period. A summary of key objectives to be identified within the planning work are summarized in the diagram below:



Closing Remarks

The RHRC appreciates the ongoing interest in, and support of, the current Pennsylvania Rural Health Model as well as your interest and support for what comes next. The creation of a successful next generation strategy will require the ongoing support of all of you. The country has learned so much from our journey together and it continues to look to the Commonwealth to help inform and influence rural health policy in response to the ever-increasing rural health crisis. I look forward to the continued partnership with the legislature as we continue to advance innovative solutions to ensure access to care remains in our vulnerable communities. I firmly believe we have the knowledge as well as the fortitude within the Commonwealth to solve the challenging problems before us, and I look forward to the continued partnership as we move forward together.

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Thank you again to this committee and to the Chairman for this opportunity to provide testimony on this very important subject matter, and I look forward to continued conversation.

Respectfully submitted: *Janice Walters, Executive Director, RHRC*

February 28, 2024
Subcommittee on Health Care Facilities
Hospital consolidation and closure
East Wing - Room 60

Panel 2 – Innovation to support independent hospitals

Joe Gribik
Chief Executive Officer
Pennsylvania Mountain Health Alliance

Written Testimony transcript from:

Michael Makosky, President and CEO
Fulton County Medical Center
McConnellsburg, PA

My name is Michael Makosky and was appointed the President and CEO of Fulton County Medical Center in June 2018. Prior to that, I was CEO of small, rural hospitals in New Mexico and West Virginia for corporate-owned, for-profit hospitals and not-for-profit community hospitals. FCMC is a 21-bed Critical Access Hospital with a 67-bed nursing home. We are 1 of 16 CAHs in PA and of those 16, 4 are independent. When I was hired, my marching orders from the Board of Directors were, and still are, to remain independent as long as possible. Since then, rural hospitals have endured many headwinds, including declining payments, increased administrative burdens, lack of timely EMS transfer to a higher level of care, provider and clinical staff recruitment, and recovery from the Covid pandemic. These issues impact all hospitals, but other factors affect independent hospitals more than hospitals that are part of a larger system, including increased pressure to improve computer EMR connectivity with other facilities, cybersecurity, securing telemedicine and other clinical partnerships, and providing competitive, yet cost-effective health insurance and other benefits to recruit and retain our employees, to name a few.

When times get tough and hospitals are facing adversity or unfavorable financial situations, hospital board members and Executive Teams typically huddle and ask "Who are we going to affiliate with". At FCMC, when facing issues that threaten our viability, we roll our sleeves up and say, "OK how are we going to pull ourselves out of this one." We are, however, realists facing real-life struggles to survive in this challenging healthcare environment and my Board realizes that affiliation is inevitable at some point in the future. Affiliating is a solution, but as my Board Chair put it, "Affiliation is plan Z, only until we have gone through Plan A, B thru Y will we consider affiliation". We will not wait until we are in dire straits and financially strapped, we will affiliate when our board feels the time is right. Until then, we will fight to remain independent. The most important aspect for us to remain independent is to keep the decision-making for the medical center local. The board feels this will:

1) Preserve jobs in our community
   a) One of the practical results of consolidation is achieving economies of scale, which make for a more efficient operation, but will result in job losses locally

2) Preserve services in our community
   a) The fear is that affiliation with another entity will result in cutting underutilized and low-utilization/high-cost services, which has been, and continues to be, the experience with OB services in rural communities
      i) This also feeds the job-loss fear
   b) Also, when clinical services are cut, a greater number of patients will need to be transported to a larger hospital
      i) EMS transportation is already in crisis – adding extra transfers will over-tax an already strained EMS system

3) Preserve hospital operations in our community
   a) Oftentimes, systems will push policies, procedures, and protocols down to the small, rural hospitals. Those protocols may work well in a larger hospital, but make no sense in a CAH.

4) Preserve healthcare in our community
   a) when larger systems become financially challenged, they typically look first at the smaller affiliate hospitals to make cuts before they consider cuts at their more well-established hospitals

5) Preserve healthcare resources in our community
   a) capital purchases and other equipment purchases are typically prioritized with larger hospitals receiving priority for those capital dollars over smaller, lower-volume affiliate hospitals

Of course, when done properly with the right partner, and using technology such as telemedicine, affiliations benefit small hospitals and communities, especially when affiliating with the larger, more well-established systems that commit to the community.

The topic of this panel is – ***Innovation to support independent hospitals***. The PA Rural Health Model put reimbursement on a global payment model designed to smooth payments to hospitals over the year to help hospitals make payroll and meet other expenses during the lower-volume times. Any money saved by the hospitals was to be reinvested back into the community through a Transformation Plan. This model seems great in theory, but practically, the model basically pays hospitals the same amount only in a different format. In many cases the Model paid more than it should have, resulting in significant overpayments that put cash-strapped hospitals into more trouble. Fulton County Medical Center's payback liability is greater than $3M, with more on the horizon. Innovating new payment models is key to solving

the rural health crisis. Hospital billing is super complicated, and insurance companies do not make it easy. Medical insurance companies really serve as the judge, jury, and executioner when it comes to making payments to hospitals. It is also a fact that health plans want to keep people out of hospitals. It is a goal of the Rural Health Model to decrease emergency room utilization and readmissions to inpatient care. Other payment models, including Value-Based Purchasing goals also are geared towards, and offer incentives, to keep patients out of the hospital. These are great initiatives and I too want the people in my community to be healthy, but as hospital utilization decreases because of these initiatives, so does the hospital's financial viability. If the goal is for hospitals to be constantly ready to take care of all the patients that come through the Emergency Room doors, which we did during the pandemic, then medical payment plans, governmental payors and insurance companies must be ready and willing to make up the financial difference during times of lower patient census to keep hospitals financially viable. If the payors would simply pay hospitals fairly and eliminate the denial and certification games, and regulations were streamlined and updated to reduce the administrative burdens, ALL hospitals would have a fighting chance.

Health Subcommittee on Health Facilities

February 28, 2024

Jack Sisk, President Punxsutawney Area Hospital

Good morning. My name is Jack Sisk and I currently serve as president of Punxsutawney Area Hospital and have done so for about a year and a half. I've been employed by PAH for 38 years --- over three decades as the CFO. We are part of the two-hospital system Pennsylvania Mountains Care Network along with Indiana Regional Medical Center to our south.

During the 2010's we recognized that we should not go it alone and expanded existing partnerships with Indiana Regional Medical Center that culminated in 2020 with a full asset merger. Our belief was that we should partner with another like minded hospital while our balance sheet was strong. We trusted each other and had common goals that focused on maintaining local healthcare decision making.

Unlike what is often seen in mergers where the smaller facility sees service and revenue decline as patients are redirected for services to the main facility, PAH has experienced the opposite. We have seen our net patient revenues grow from $38,000,000 in FY 2020 to a projected $56,000,000 in FY 2024. Our parent, PMCN has assisted us in expanding services offered in Punxsutawney and bringing new specialists to our market.

The rural hospital struggle is nothing new. Over my 38 years there is always a different challenge to overcome. Our relationship with PMHA gives us small independent facilities the leverage and scale to compete. I couldn't imagine trying to manage the revenue cycle process without Nicole Clawson and her team. PMHA provides PAH access to top-notch talent at a fraction of the price.

The Pennsylvania Rural Health Model has been a program that has significantly benefited PAH and our patients. This creative program with the cooperation of the State and the Centers for Medicare and Medicaid Services has gone a long way to support rural hospitals. The Rural Health Model needs to continue in some form to support rural access in Pennsylvania. Janice Walters and her team need your support and financial commitment. It allows us to find unique ways to transform health outcomes in our rural community without the downside of lower volume resulting in losses at the hospital. We are all incentivized to keep our communities healthier.

I appreciate the opportunity to dialog with you today and provide any insight into improving rural healthcare in Pennsylvania.

Innovation to Support Independent Hospitals

HEALTH Subcommittee on Health Facilities

Testimony Submitted by:

Nicole L. Clawson, Vice President of Finance/Revenue Cycle

Pennsylvania Mountains Healthcare Alliance

February 28, 2024

Good morning, I would like to thank the committee for inviting me to testify in front of you all today on innovation to support independent hospitals in our state of Pennsylvania. I will focus on the revenue cycle and reimbursement issues our member hospitals are facing and potential solutions to assist with this.

To accompany this testimony, I have submitted supplemental slides that consist of publicly reportable data on the effects of Medicare Advantage plans nationally, within the state of Pennsylvania, and within our member hospitals.

My name is Nicole Clawson, and I am the Vice President of Finance and Revenue Cycle for Pennsylvania Mountains Healthcare Alliance (PMHA). I have been with PMHA for almost 3 years serving in this capacity and worked with another Pennsylvania based hospital for 10 years prior. Before coming to PMHA, I was part of a hospital system where a larger organization came in for affiliation. While I was happy in my role there, my passion was within the independent rural community hospital and decided to continue my path with PMHA who had a similar vision and focus.

Reimbursement is important however, to be able to continue to provide access to quality healthcare to the patients within the rural communities of Pennsylvania we need help in terms of payment reform. Our member hospitals look to sustain and grow services within the communities, yet reimbursement delays, cuts and unnecessary denials are counterproductive to this. The administrative burden is extensive not only on the front end of the patient care but then again on the back end with trying to collect, manage denials, and get proper reimbursement for the services provided. The administrative teams that are needed to be assembled for these unexpected or unnecessary pitfalls are large.

Today I would like to focus on a government plan within many commercial payers, Medicare Advantage.

From our level at PMHA, Medicare Advantage plans come in at the highest group of payers that constitutes delays in collection, denials, and overall nonpayment. With those accounts sitting on our accounts receivable greater than 90 days, Medicare Advantage plans continue to be our top payers for reimbursement issues such as:

- Authorizations
- Medical necessity
- Documentation requests
- Emergency room downgrades
- Bundled payments

- Inclusive payments
- Non covered services
- Proprietary policy usage in addition to CMS NCD policy restrictions
- Inpatient downgrades to observation

I have compiled data to show the magnitude using current information from one organization within a 3-week period:

- This data is for denied Claims for Medicare Advantage plans only
- Time period of January 21, 2024 thru February 11, 2024
- Medicare Advantage plans denied 2,800 claims with the gross charge amount of $534,000
- All denied for reasons I just described
- That is 2,800 patient service visits that had to be re-worked due to payer denials.

We have processes and systems within the hospitals to capture the preservice work that needs done administratively, yet we continue to see these plans delaying and denying payment after the fact. The denials and issues continue to grow even with all the processes in place to avoid this. This creates unnecessary back end administrative burden which is what occurs with the example I've described, this burden hits the facility as well as potentially the patient in the form of either higher patient liability or the assumption since they did not receive a bill "timely" that it was due to a negative action on the hospitals part.

I have provided slides with additional data showing both nationwide and within our state of Pennsylvania.

Slide 2- Shows the increase in Medicare Advantage plans, making up most Medicare enrollees.

The next slide shows the overturn rate in 2021 of those that denied for lack of authorization demonstrating the administrative burden, having denials overturned, thus having payment received after rework with figures as high at 94%

Slide 4 & 5 is an MGMA report from May 2023 showing the continued increase in burdensome Medicare Advantage prior authorization denials.

We are seeing physician fee schedule cuts, new policies come out with targeted dates of 2026 on authorizations from the CMS level but with the fear of it being a shell game with the payers moving the from a denial of no authorization to result in potential hospitals or patients taking the hit.

In looking at solutions and partnerships on how we could reform, on slide 6-7 I see potential solutions being:

- State level false claim and fraud investigation into government health insurance plans that are found to routinely deny payment to health care providers
- State level support the 2024 Medicare Advantage Prior Authorization Rule
- Publishing a regulatory overload report
    - State level study and/or survey assessing regulatory burden
- Reviewing and using the Pennsylvania Insurer Prompt Pay Statute

The remaining slides show additional backing for the Medicare Advantage issues, with the last being a sample of hospitals that called it quits with these plans in other states, which does not help our patients access to care.

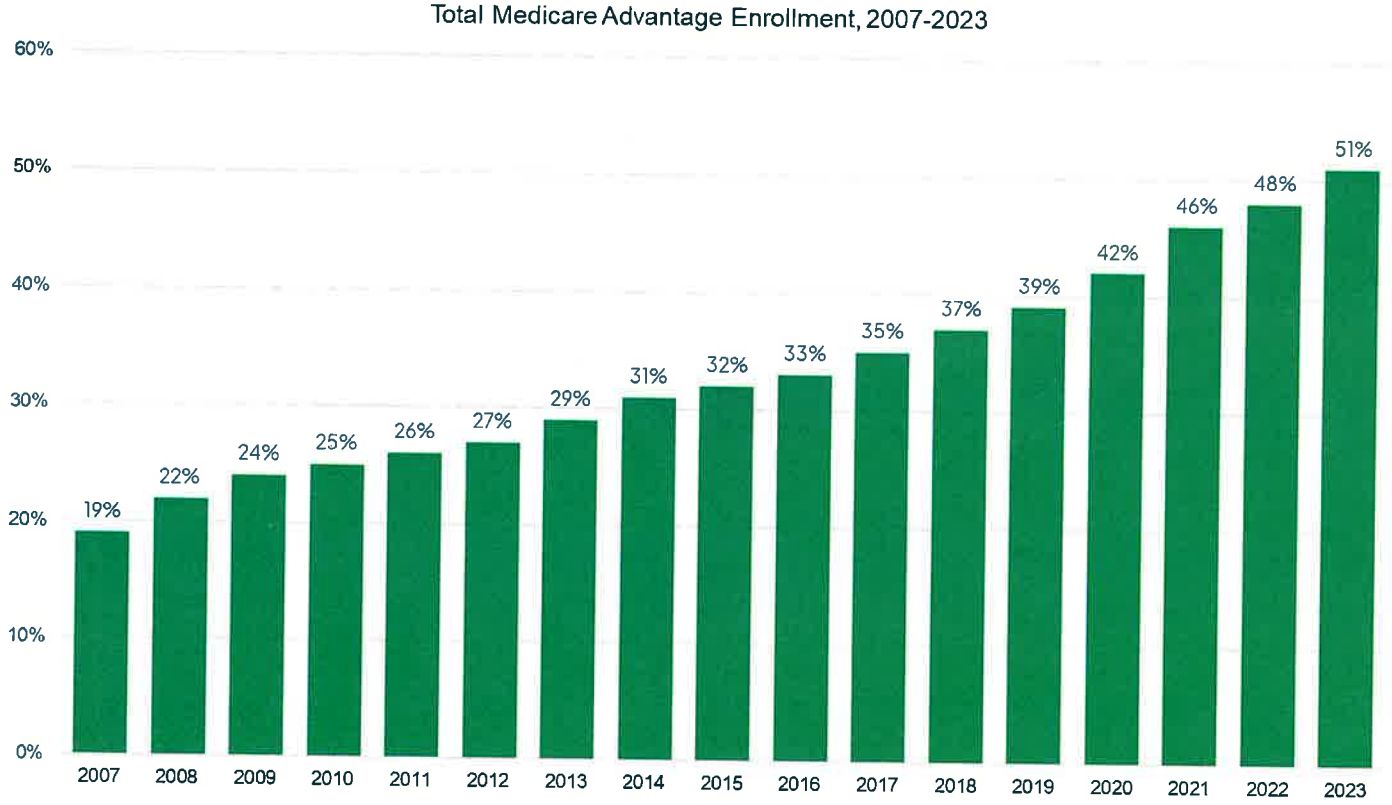
Together understanding the struggles rural community hospitals are having and thus working together to find innovative solid solutions to keep the access to quality care available to our rural communities for years to come is a common goal. I thank you for allowing me to speak to all of you today and allowing me to be part of the solution.

MEDICARE ADVANTAGE

National and Pennsylvania Perspectives

February 28, 2024
Nicole L. Clawson
Vice President Finance/Revenue Cycle
Pennsylvania Mountains Healthcare Alliance
www.pmhalliance.org

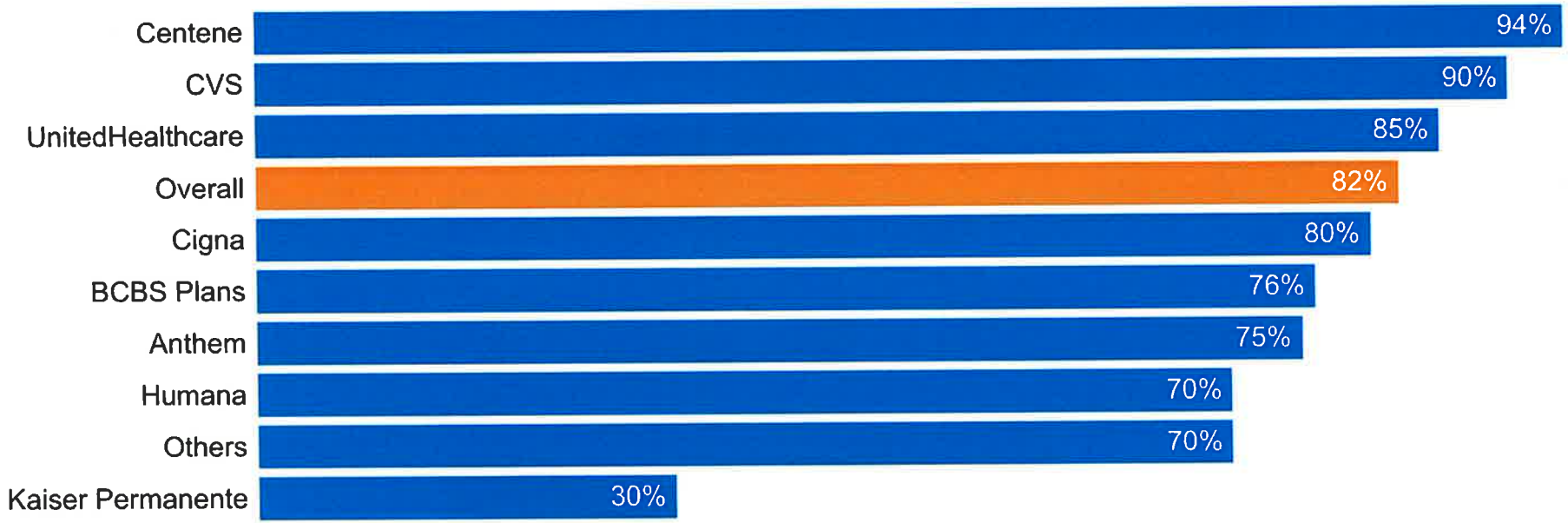
In 2023, Medicare Advantage makes up majority of Medicare enrollees



https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/#:~:text=Medicare%20Advantage%20enrollment%20as%20a,in%202023%20(Figure%201)

Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2021



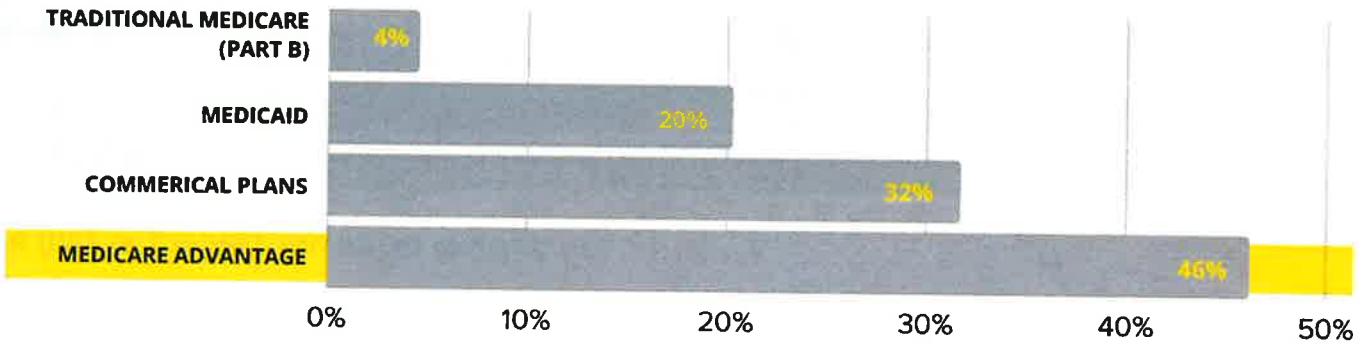
NOTE: Includes reconsiderations that were fully or partially favorable. Anthem BCBS plans are not included due to data quality issues.
SOURCE: Technical Specifications Public Use File of Contract Year 2021 Part C and D Reporting Requirements Data

KFF

MGMA Report

PRIOR AUTHORIZATION BURDENS ARE INCREASING AS MEDICAL GROUPS SEE MORE MEDICARE ADVANTAGE PATIENTS. The uptake of MA plans was reflected among practices surveyed; 95% treat patients that are covered by MA, and 75% report they are seeing an increasing number of MA patients. Practices ranked MA as the most burdensome as it pertains to obtaining prior authorization when compared to commercial plans, traditional Medicare, and Medicaid.

MOST BURDENSOME FOR OBTAINING PRIOR AUTHORIZATION:



https://www.mgma.com/getmedia/788a1890-8773-4642-9c22-b224923e4948/05-03-2023_PA-in-MA_FINAL.pdf.aspx?ext=.pdf

MGMA Report

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUESTS RESULT IN DANGEROUS DELAYS AND DENIALS IN NECESSARY MEDICAL CARE — REFORM IS CRITICALLY NEEDED. With an increase in utilization of prior authorization across both commercial payers and MA, practices are struggling to ensure patients continue to maintain access to medically necessary care. Prior authorization processes can vary greatly across payers, resulting in a convoluted and overly burdensome process.

97% of medical groups report their **patients experienced delays or denials for medically necessary care (e.g., prescription medicine, diagnostic tests, or medical services) due to prior authorization requirements**

FOR PRIOR AUTHORIZATIONS THAT REQUIRE A PEER-TO-PEER (PRACTICE CLINICIAN TO HEALTH PLAN CLINICIAN) DISCUSSION, IS THE HEALTH PLAN CLINICIAN GENERALLY FROM A RELEVANT SPECIALTY TO THE TREATMENT OR DISEASE IN QUESTION?

72% SAY NO

https://www.mgma.com/getmedia/788a1890-8773-4642-9c22-b224923e4948/05-03-2023_PA-in-MA_FINAL.pdf.aspx?ext=.pdf

Supporting Hospitals Administrative Burden Reduction through:

- Requesting false claim and fraud investigations for MCOs
- Supporting the 2024 MA Prior Auth rule
- Publishing a regulatory overload report

https://www.aha.org/lettercomment/2022-05-19-aha-department-justice-re-false-claims-act-investigations
https://www.aha.org/news/blog/2024-02-15-prior-authorization-final-rule-will-improve-patient-access-alleviate-hospital-administrative-burdens
https://www.aha.org/press-releases/2024-01-17-aha-statement-cms-final-rule-prior-authorization
https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report

Penn. Insurer Prompt Pay Statute

Pennsylvania Statutes Title 40 P.S. Insurance
991.2166.
Prompt payment of claims

(a) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

(b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000299.asp

OIG case file reviews determined that MAOs:

- Delayed or denied Medicare Advantage beneficiaries' access to services
- Denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules
- Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers
- Avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.
- Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and post-acute facility stays (e.g., inpatient rehabilitation).
- Among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules; in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service
- Some prior authorization requests did not have enough documentation to support approval, yet our reviewers found that the existing beneficiary medical records were sufficient to support the medical necessity of the services.
- Payment requests - 18 percent of the requests met Medicare coverage rules and MAO billing rules. Most of these payment denials in our sample were caused by human error during manual claims processing reviews

Hospitals calling it quits with MA Plans:

- Mayo Clinic (MN)
- Scripps (CA)
- WakeMed (NC)
- Vanderbilt (TN)
- Cameron Regional (MO)
- Baptist Health (KY)
- Stillwater (OK)
- Brookings (SD)
- St. Charles (OR)

(not an exhaustive list)

https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html

BECKER'S
Hospital CFO Report

Financial Management

Hospitals take aim at Medicare Advantage

Jakob Emerson - Wednesday, August 16th, 2023

Medicare Advantage may now provide health coverage to more than half of the nation's seniors, but that is not stopping health systems from pushing back against the growing and controversial program.

Hospitals have been dropping Medicare Advantage plans over high claim or prior authorization denial rates since at least 2018, but it was an uncommon move until recently. Some systems have noted that most MA carriers have faced allegations of billing fraud from the federal government and are being probed by lawmakers over high denial rates.

Rochester, Minn.-based Mayo Clinic warned Medicare-eligible patients in Florida and Arizona in October that it does not accept most Medicare Advantage plans, and Vanderbilt University Medical Center in Nashville, Tenn., was preparing to drop Humana and Centene MA plans before reaching contract agreements in March.

Cameron (Mo.) Regional Medical Center stopped accepting Cigna's MA plans in 2023 and plans to drop Aetna and Humana in 2024. It plans to continue Medicare Advantage contracts with UnitedHealthcare and BCBS. the *St. Joseph News-Press* reported in May. Cameron Regional CEO Joe Abrutz previously told the newspaper the decision stemmed from delayed reimbursements.

Stillwater (Okla.) Medical Center ended all in-network contracts with Medicare Advantage plans amid financial challenges at the 117-bed hospital. Humana and BCBS of Oklahoma were notified that their MA members would no longer receive in-network coverage after Jan. 1, 2023. The hospital said it made the decision after facing rising operating costs and a 22 percent prior authorization denial rate for Medicare Advantage plans, compared to a 1 percent denial rate for traditional Medicare.

Brookings (S.D.) Health System will no longer be in network with any Medicare Advantage plans in 2024, the *Brookings Register* reported. The 49-bed, municipally owned hospital said the decision was made to protect the financial sustainability of the organization.

Bend, Ore.-based St. Charles Health System has taken it a step further and is not only considering dropping all Medicare Advantage plans, but is also encouraging its senior patients not to enroll in the private Medicare plans during the next open enrollment period.

The health system's president and CEO, CFO, and chief clinical officer cited higher rates of denials, longer hospital stays and overall administrative burden for clinicians.

"We recognize changing insurance options may create a temporary burden for Central Oregonians who are currently on a Medicare Advantage plan, but we ultimately believe it is the right move for patients and for our health system to be sustainable into the future to encourage patients to move away from Medicare Advantage plans as they currently exist," St. Charles Health CFO Matt Swafford said.

Thank you!

Nicole L. Clawson, MBA RHIA CPC
Vice President, Finance/Revenue Cycle
PENNSYLVANIA MOUNTAINS HEALTHCARE ALLIANCE

CRISP

Maryland's State-Designated Health Information Exchange

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Enabling Legislation

Vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration

Health Information Exchange (HIE)

- State-designated independent non-profit serving Maryland, and in affiliation with the HIEs in West Virginia, the District of Columbia, Connecticut, Virginia, and Alaska through CRISP Shared Services

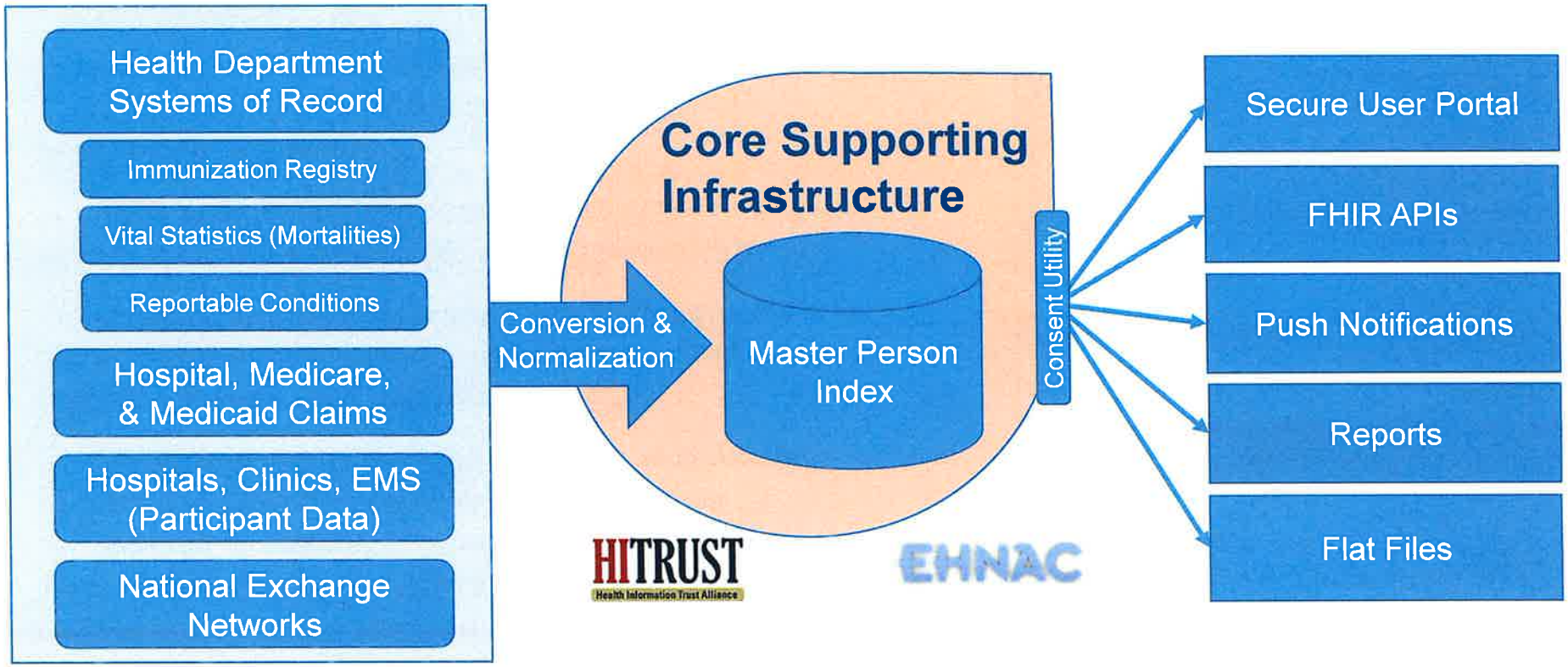
https://mgaleg.maryland.gov/2009rs/bills/hb/hb0706t.pdf

Health Data Utility (HDU)

- HB1127 required the State-Designated HIE to operate as an HDU, advancing equity and wellness by linking data across the public health system and enabling secure, appropriate access beyond traditional health information users.

https://mgaleg.maryland.gov/2022RS/bills/hb/hb1127T.pdf

Technology Components



CRISP Services

1. POINT OF CARE: **Clinical Query Portal & InContext Information**
   - Search for your patients' prior health records (e.g. labs, radiology reports, etc.)
   - Determine other members of your patient's care team
   - View external records in a SMART on FHIR app inside your EHR
2. CARE COORDINATION: **Event Notification Delivery**
   - Be notified when your patient is hospitalized in any regional hospital
   - Enhance workflows across multiple care settings and teams
3. POPULATION HEALTH REPORTS: **CRISP Reporting Services (CRS)**
   - Use administrative and clinical data to design and measure interventions
4. PROGRAM ADMINISTRATION:
   - Making policy discussions more transparent and informed
   - Disseminating evidence-based best practices and technology
5. HEALTH DATA UTILITY:
   - Deploying services in partnership with health officials
   - Providing information and reports to state and local health departments
   - Linking, analyzing, and sharing data across the continuum

Service	Typical Week
Portal Queries	75,000
EHR Application Launches	150,000
Automated API Calls	1.5 mil
Outbound Event Notifications	3.5 mil
Inbound ADTs	3.0 mil
Inbound ORUs	1.7 mil
Participating Organizations	2,200
Active Users	27,000

Key Pillars of a Health Data Utility

Services

- **Enrich Data**
  - Link disparate data sets
  - Use multiple sources to fill gaps
  - Improve data feeds
  - Surface key insights
- **Distribute Information**
  - Create visualizations
  - Control access levels
  - Push individual clinical records
  - Share analytic files
- **Enable Interventions**
  - Flag patients at the point of care
  - Notify appropriate end users
  - Share relationships between organizations

Value

All data becomes more useful when it is linked, normalized, deduplicated, and cleansed within a single analytics engine

User experience is enhanced and usage increases when a single entity is responsible for governance and distribution

Alignment between population level reports and actionable individual experiences is more likely to result in positive change

Broad Alignment for Payment Model Activities

Care Coordination Tools	Population Health Reports	Program Performance Reports
• Pertinent treatment information at the point of care (clinical, SDOH, care alerts) • Notifications to allow timely follow up after discharge and transitional care • Close loop referrals • Patient identification for care management interventions	• Key trends and descriptive statistics for patient population • Study of directional data for specific populations and geographies • Patient identification for care management interventions • Intervention tracking	• Key metrics for programs such as MDPCP, MPA, EQIP, CTI, ECIP • Results and opportunities for quality improvement related to HSCRC payment methodologies
Program Administration	**Quality Reporting**	**Learning System**
• Support participants with program enrollment and related requirements • Technical assistance for providers • Promote policy transparency and coordination with stakeholders	• Annual MDPCP eCQM reporting • Hospital Quarterly eCQM collection in partnership with HSCRC • Ambulatory eCQM data collection in partnership with MDPCP	• Educational webinars • White papers • Learning collaboratives • Website resources • Annual summit

National Trends in Data Exchange

- Multi-regional providers, payers, and the federal government have been pushing for "national networks"
- TEFCA (Trusted Exchange Framework and Common Agreement) is the voluntary national network and legal flow downs created by the Office of the National Coordinator as directed in the 21st Century Cures Act
- Federal solutions enable basic exchange, but do not address certain key issues:
  - Patient matching, identity verification, and consent
  - Compliance with regional laws and regulations
  - Push notifications and bulk data delivery
  - Providers, particularly those serving vulnerable populations, not using optimal EHRs
- Many states, including Pennsylvania (P3N) and Maryland (CRISP), have reciprocal data sharing for each others' residents who cross borders for care

CRISP Shared Services Model: Scale technology while enabling local data use and control

- Leveraging a shared asset gives citizens better, more efficient, less expensive care and services
- Patient data should freely flow for all permitted uses to all interested parties
- Each state has unique policies, regulations, priorities, demographics, and needs
- Consumers require consent over how their data is used
- Data should not be owned by any group and instead be governed by an accountable, non-profit organization
- Technology infrastructure scales as a utility and can be reused for many stakeholders without duplicating costs

Resources

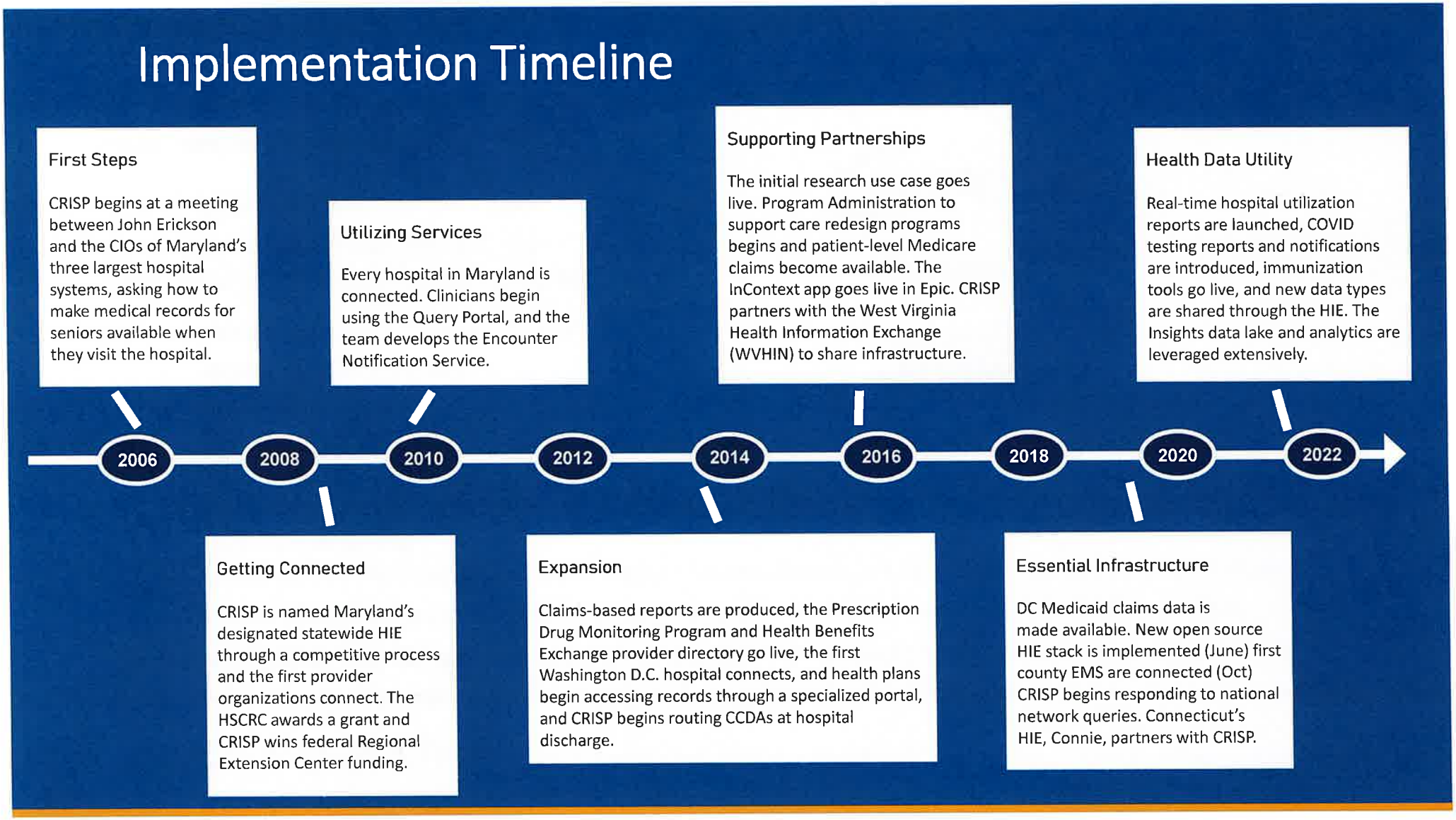
Training materials, recorded webinars, and patient education flyers can be found at: https://crisphealth.org/

Information about CRISP Shared Services is available at: https://crispsharedservices.org

Craig Behm, President & CEO
craig.behm@crisphealth.org

Appendix

Implementation Timeline



Privacy & Security

Opt-out model gives patients the right to block electronic access to their information shared through the HIE

- All participating providers must update Notice of Privacy Practices and make patient education materials available
- If a patient opts out, no information will be available through the portal and notifications about hospitalizations for this patient will be blocked
- EXCEPTION: By Maryland law, opt-outs do not apply to PDMP and this data will still be visible in a patient's record

Annual audits and reports as required by State Designation Agreement, regulations, and best practices

- SOC 2 Type 2
- HIPAA & COMAR Compliance
- Cybersecurity & Social Engineering Testing

Adhering to industry best security standards

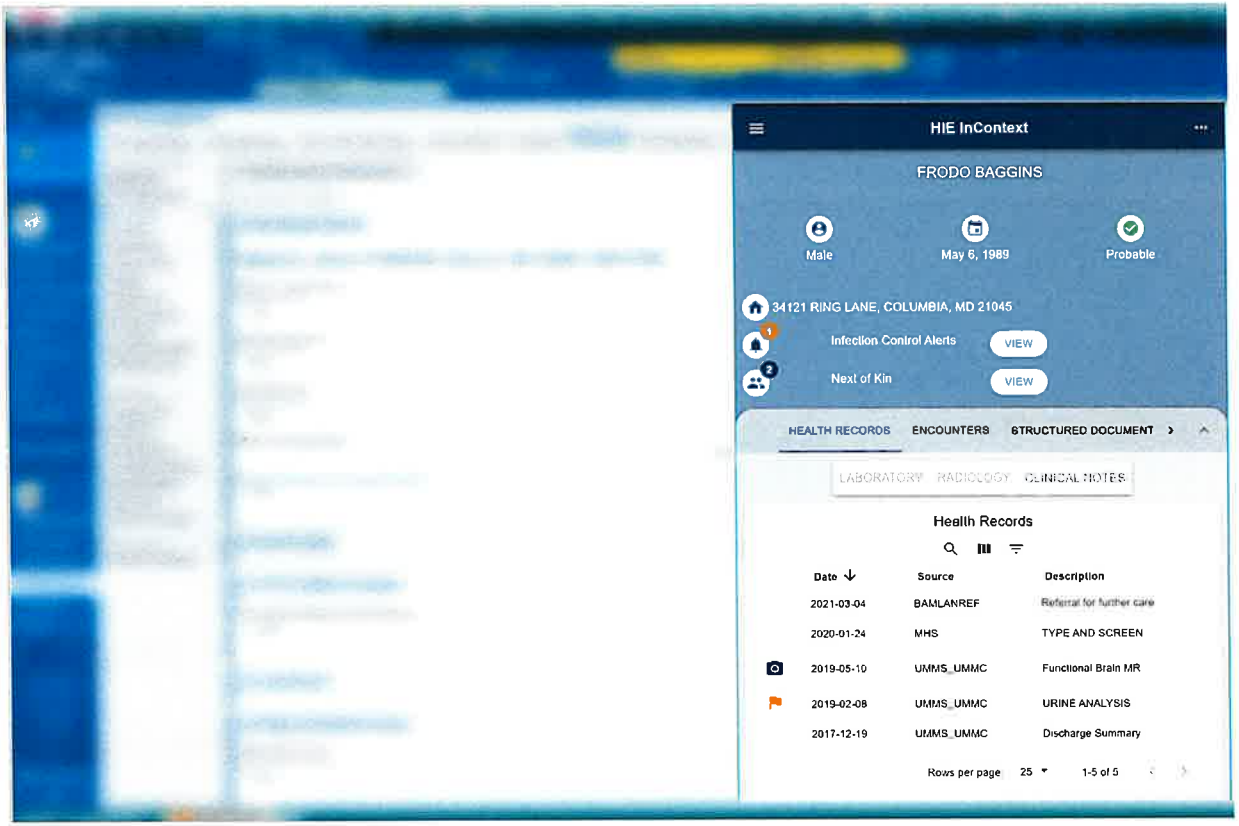
- EHNAC HIE accredited since Feb. 2017
- HITRUST certificated since Nov. 2017

Continuous privacy monitoring

- Protenus software monitors query activity to identify potentially suspicious activity outside of a permitted use case

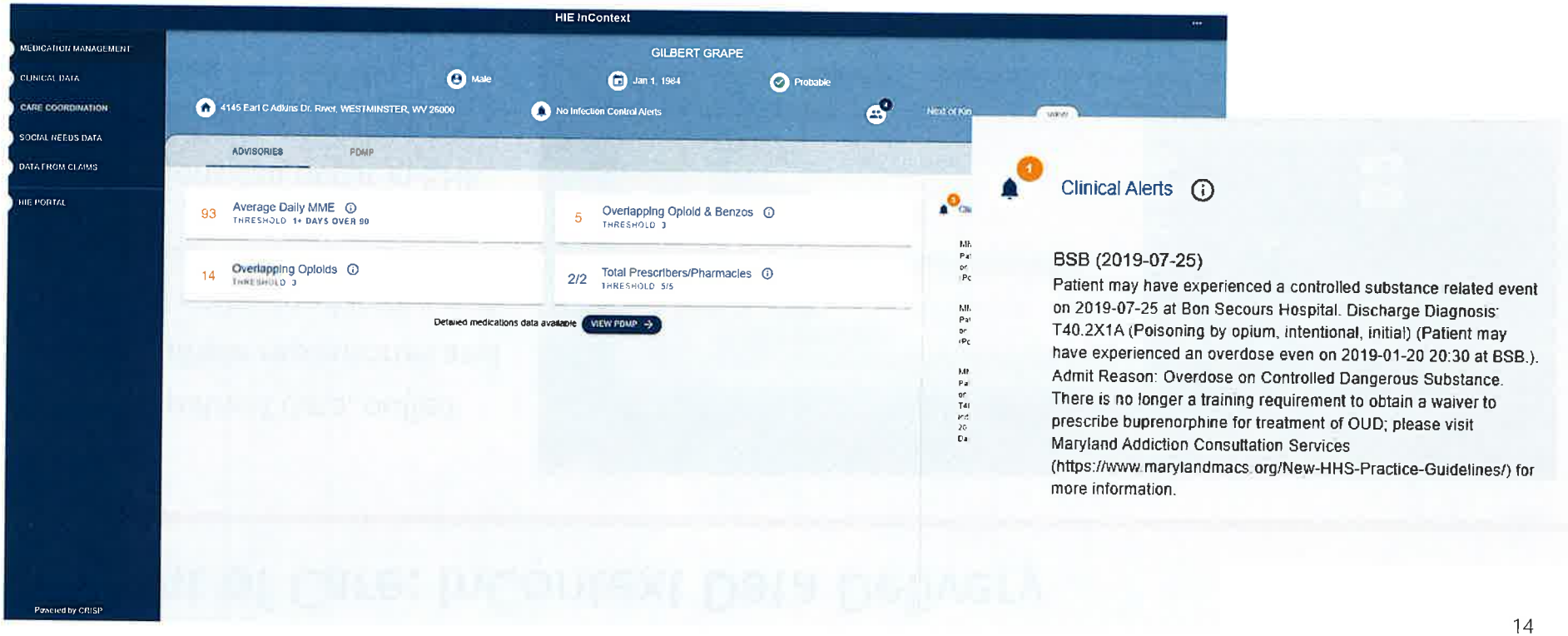
Point of Care: InContext Data Delivery

- View of patient data, pulled from multiple repositories and sources, embedded in the end user's EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP is FHIR compliant and moving to USCDI+ and TEFCA



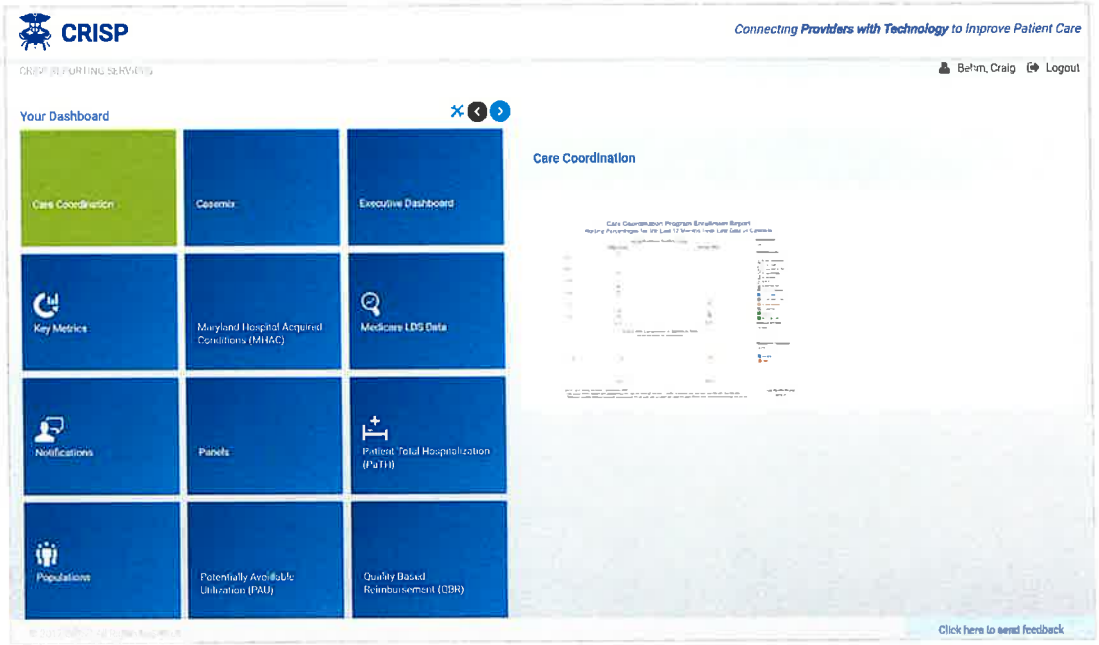
Important Additional Data

- Data is combined across sources to reveal critical information



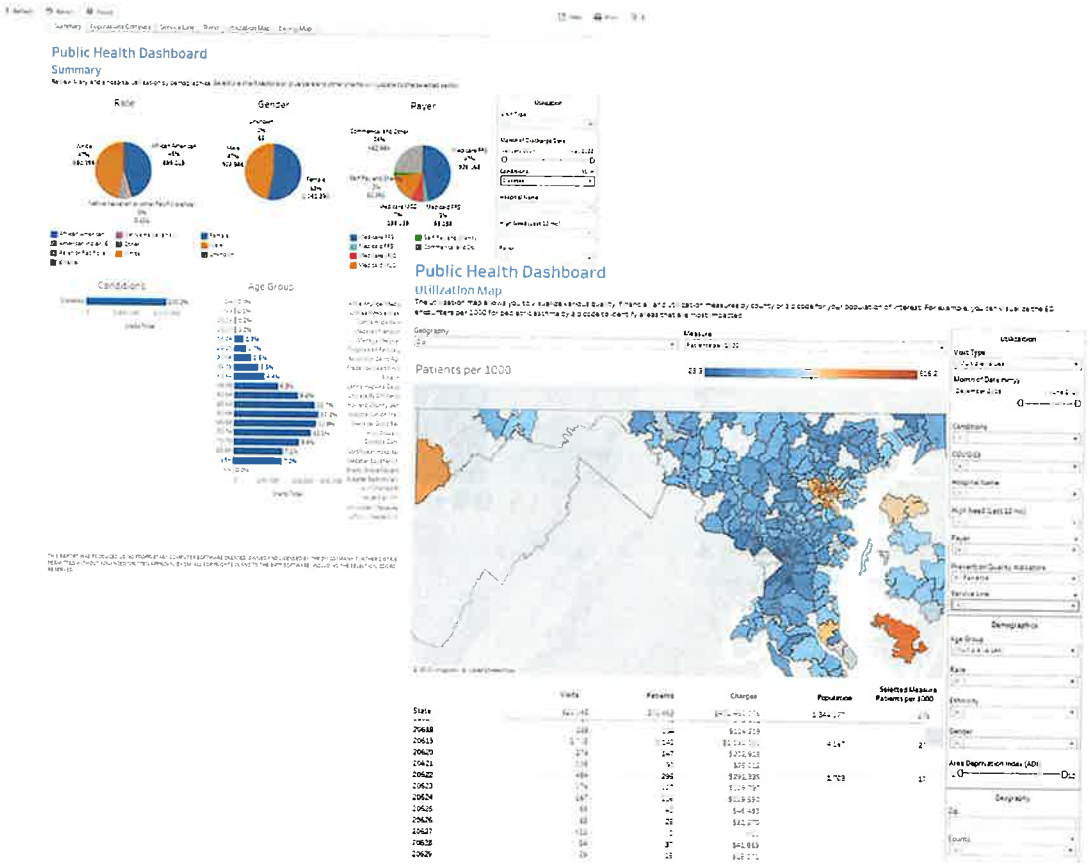
Population Health: CRISP Reporting Services

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
- There are over **600 active users** viewing **85 reports** over **2,000 times per month**



Public Health Dashboard

- Designed for individuals working on population health and public health, who want a deeper understanding of their community's health
- Users can define a population of interest that will persist through the report to better understand that population's characteristics
- The dashboard hosts interactive maps of Maryland to drill down into utilization by county or zip code and view areas of excess



Maryland Model Program Participants

Episode Care Improvement Program (ECIP):
15 Hospitals participated in ECIP for CY2023, and the unduplicated count of care partners was **4,764** individual clinicians & **9** facilities.
The total amount of hospital incentives awarded since program inception is **$9,025,347.**

Episode Quality Improvement Program (EQIP):
CRISP supports specialty practice and other provider participation in bundled care arrangements. In CY2023, there were **2,733** care partners participating across **64** EQIP entities

Care Transformation Initiatives (CTIs):
All but 2 MD Hospitals are participating in at least one CTI, and in total, **107** participant elected CTIs cover **263,907** episodes. CRISP Care Transformation Profiler allows hospitals to view all CTIs statewide and to monitor progress.

MD Primary Care Program (MDPCP):
48 practices joined in 2023, and 154 practices graduated to Track 3. Currently there are more than 500 primary care practices participating in the program

HIE – MDH Collaboration Success Stories

School Immunizations

- Sent bulk immunizations to 2 county school systems, adding efficiencies to a process that required manual, individual querying to confirm student immunization records. One school system reported decrease in staffing needs from 10 to 2 FTE.

Cancer Registry

- The MD Cancer Registry is required to send tumor abstracts for all cancer cases who died to CDC. CRISP was able to send encounter information for folks the Registry was missing, and they were able to reach out to those providers to get missing information. Using CRISP supplied data, the team was able to reduce the rate of missing in half, from 3% to 1%

Cryptosporidium

- On 9/28, Baltimore City announced that levels of a microscopic parasite (Cryptosporidium) was found in reservoir. MDH requested data to help assess their baseline data. On 10/3, CRISP provided positive labs data and total tests to MDH to compare against their numbers. MDH reported that there were no additional cases identified by CRISP that were missing from their eLR feeds, providing additional confidence in required reporting.

Pregnancy and HIV

- MDH had concerns they weren't identifying all HIV positive pregnancies and infants as soon as they could be. CRISP sends pregnancy indicator in HIV positive individuals to MDH for outreach and checking. We were able to identify 4 infants exposed to HIV that were previously unknown to MDH.

Data Quality

In January 2024, we transformed 16.6M inbound ADTs for analytics in Azure with the following completeness by data element:

- Race = 95%
- Ethnicity = 93%
- Gender = 100%
- Address = 99%
- PCP = 70%
- Diagnosis = 38%

Category	1/14/2024	1/7/2024
ADT-based Metrics		
Admit Reason	64 %	62 %
Diagnosis	33 %	34 %
Diagnosis Timeliness	95 %	92 %
Diagnosis Description	34 %	34 %
Discharge Summary Timeliness	68 %	65 %
PCP NPI	52 %	52 %
Next of Kin	60 %	60 %
Address	99 %	99 %

Data Quality Dashboard

Date 12/1/2023 – 12/31/2023 | All

Source Code	Facility	ADTs	Admit Reason	PCP NPI	Next of Kin	Race	Ethnicity	Language	Address	Phone	Encounters	Dx Codes	Dx
MMC	Meritus Medical Center	1,795,474	39 %	84 %	42 %	95 %	98 %	100 %	99 %	99 %	122,090	80 %	
JHH	Johns Hopkins Hospital	1,711,482	93 %	59 %	65 %	98 %	95 %	100 %	99 %	99 %	84,902	97 %	
CCHS	Christiana Care Health System	1,241,430	80 %	61 %	71 %	95 %	96 %	100 %	99 %	99 %	175,276	57 %	
MS_MPP	Medstar Physician Partners	1,058,394	54 %	0 %	50 %	92 %	50 %	100 %	100 %	100 %	453,089	0 %	
AAMC	Luminis Health - Anne Arundel Medical Center	888,047	44 %	63 %	62 %	96 %	92 %	100 %	99 %	98 %	106,890	55 %	
ENS_PRIVIA	Privia Health	886,440	0 %	3 %	62 %	94 %	94 %	100 %	100 %	100 %	644,705	0 %	
JHCPA	Johns Hopkins Home Care Group - RPM	681,893	76 %	74 %	61 %	93 %	88 %	100 %	97 %	97 %	165,645	99 %	
MHS	Mercy Medical Center (No Auditable Contacts or Assets)	745,962	36 %	83 %	47 %	99 %	99 %	100 %	99 %	99 %	336,796	38 %	
WMHS	UPMC - Western Maryland	622,451	98 %	75 %	98 %	99 %	93 %	100 %	100 %	99 %	26,038	10 %	
JHH_BVIEW	Johns Hopkins Bayview Medical Center	584,103	93 %	62 %	68 %	99 %	96 %	100 %	100 %	100 %	31,704	95 %	
MEDSTAR_FSH	Medstar Franklin Square Medical Center	408,641	100 %	39 %	91 %	99 %	94 %	100 %	100 %	98 %	33,874	21 %	
JHH_HH	Johns Hopkins Home Health	396,081	5 %	57 %	57 %	85 %	77 %	100 %	92 %	92 %	1,990	84 %	
HCGH	Johns Hopkins Howard County Medical Center	374,645	91 %	69 %	75 %	96 %	93 %	100 %	99 %	99 %	16,972	95 %	
HCH	Holy Cross Health Center - Silver Spring	345,858	86 %	36 %	83 %	83 %	62 %	100 %	96 %	96 %	17,497	85 %	
GBMC	Greater Baltimore Medical Center	334,945	70 %	69 %	48 %	83 %	82 %	100 %	97 %	87 %	57,567	26 %	
FMH_ID	Frederick Health	334,587	93 %	0 %	89 %	98 %	94 %	99 %	98 %	99 %	26,186	98 %	
AGH	Atlantic General Hospital	320,716	97 %	77 %	5 %	98 %	94 %	100 %	100 %	98 %	16,825	0 %	