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arkansas chapter

HFMA Arkansas Chapter Payor & Reimbursement Summit

A Comprehensive Guide to Avoiding Denials, Increasing Reimbursement, and Managing Patient Throughput and Length of Stay

October 30th, 2025

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Agenda & learning objectives

How can hospitals navigate recent industry and payor challenges and improve performance through enhanced practices and management in the areas of utilization Management, status assignment, denials prevention, Physician Advisor practices, medical necessity documentation, length of stay, and patient throughput.

Objectives:

- Understand where the gaps in your organization might be related to UM, status determination and OBS management, denials prevention, and length of stay
- Enhance your ability to recognize trends and how to measure areas of opportunity and success
- Understanding the importance of patient throughput and length of stay management as it affects emergency department holds and backfill

National trends & industry shifts

Revenue Cycle & denial prevention (Middle Revenue Cycle & Medical Necessity)

Case studies and closing thoughts

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Today's Presenters

Brian Pisarsky, RN, MHA
Managing Director, Kaufman Hall

Dan Burke, CHFP, CRCR
Vice President, Kaufman Hall

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vizient + KaufmanHall + SG2 health care intelligence leveraging our combined strengths

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National trends & industry shifts

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Polling Question #1

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"The intensity of headwinds in 2025 is significantly more severe than they were ten years ago…

…some issues are still the same; however, labor shortages, the changing landscape of relationships with payers, and the cost of inputs are more intense… and that means we must be more strategic in our planning."

RICHARD J. LIEKWEG
Chief Executive Officer, BJC Health System

Key Market Fundamentals (2015 vs. 2025)

More Reliance on Government Payers
THEN 40% | NOW 45%
of individuals insured by Medicare and Medicaid

Compressed Operating Margins
THEN 3.4% | NOW 2.5%
median health system operating margin

Shifting Care Settings
THEN 108 | NOW 100
inpatient admissions per 1,000 individuals

Rising Health Care Burden
THEN 149M | NOW 164M
people with a chronic medical condition (est.)

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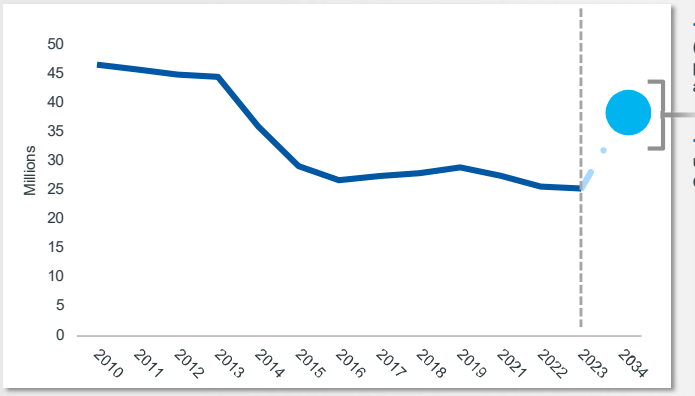
Managing a larger uninsured population may be familiar, but the landscape is different now

U.S. Number of Uninsured Among 0-64 Age Group 2010-2023, with Estimated OBBBA Additional Uninsured 2034



+~15M (if enhanced premium tax credits are not extended)

+~10M uninsured from OBBBA

Today's Market Complexities

- Fragile post-pandemic financial stabilization
- Payers grappling with new margin pressures
- Employer premiums outpacing inflation
- Costs to provide care +50% since 2010
- Workforce challenges and shortages

New Market Opportunity

- Acceleration of AI and advanced analytical tools

Source: (1) Kaufman Hall National Hospital Flash Report: June 2025 Data; (2) https://www.usinflationcalculator.com/inflation/health-care-inflation-in-the-united-states/

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Exact impact on health systems will vary, requiring tailored analysis and modeling

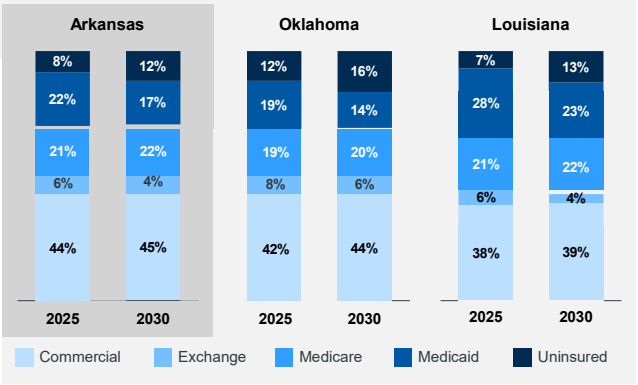
State policies
Impacts will differ by state based on existing policies, demographics, and legislative responses

Payer mix
Health systems that see more Medicaid and Exchange patients will be more exposed to OBBBAA impacts

Local demographics
Specific factors, like a greater share of recent immigrants, will have significant impacts on local insurance enrollment

Insurance Mix Forecast by State

Includes underlying demographic trends, baseline policy, and OBBBAA



Sources: Sg2 2024 Insurance Coverage Forecast, Kaufman Hall analysis of OBBBAA

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A rising payer focus on denials

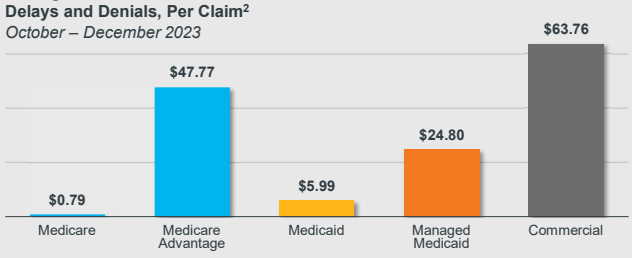
- Payers are using more advanced processes to perform automated reviews, more complex criteria for claims submission and medical necessity, and more variables and technical specifications in contracts – all of which leads to an increase in denied claims[1]
- Commercial payers take the longest to pay[3]
- Half of hospitals reported more than $110M in unpaid or delayed claims that are at least 6 months old[1]
- 55% have a MA claim at least 6 years old[1]
- Claims adjudication cost healthcare providers more than $25 billion in 2023[2]

Sources: (1) Healthcare Financial Management Association March 2023; (2) Premier, 2023-2025; (3) Association of Clinical Documentation Integrity Specialists June 2023 (4) Kodiak Solutions report, May 2025

What We Are Seeing Today…

- *Inadequate payer reimbursements*
- *Inpatient to observation downgrades*
- *Managed care denials continue to rise*
- *Decreased payer collaboration*

Average Administrative Cost For Providers to Pursue Delays and Denials, Per Claim[2]
October – December 2023



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Polling Question #2

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AI can transform revenue cycle and improve financial performance

As healthcare continues to face increasing financial pressure, staffing shortages and payer complexity, AI and automation are becoming essential tools in modernizing revenue cycle operations, especially in denials prevention

AI Maturity Level	MODERATE	LOW	MODERATE	HIGH	MODERATE	MODERATE	LOW
Opportunity	**Scheduling and Registration**	**Eligibility and Utilization Review**	**Charge Capture and CDI**	**Claims Processing**	**Denial Management**	**AR Follow-Up**	**Payment Collections**
	• **Intake Chatbots**: Handles patient requests and communication in the EHR • **Benefit Estimation**: Calculates the patient's portion based on visit type and insurance data	• **Eligibility Verification**: Automates eligibility checks against payer records • **Prior-Authorization**: Confirms prior-authorization requirements and submits requests	• **Charge Identification and Suggestions**: Scans documentation and EHR data to uncover additional billing opportunities • **Clinical Documentation Review**: Reads notes to spot missing data and improve specificity	• **Claims Scrubbing**: Catches and edits preventable errors before claim submission, reducing denials • **Claims Status**: Utilizes robotic process automation to pull claims status updates directly from payer portals	**Appeals Generation**: Auto-generates appeal letters using denial codes and supporting medical records **Predictive Editing** Proactively flags errors and missing data before claim submission, reducing denials	• **Correspondence Generation**: Develops follow-up emails to payers based on common information and processes	• **Payment Reconciliation**: Aligns payments across lockboxes and bank deposits to post more efficiently

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How can you optimize your revenue cycle to get paid for the work you do?

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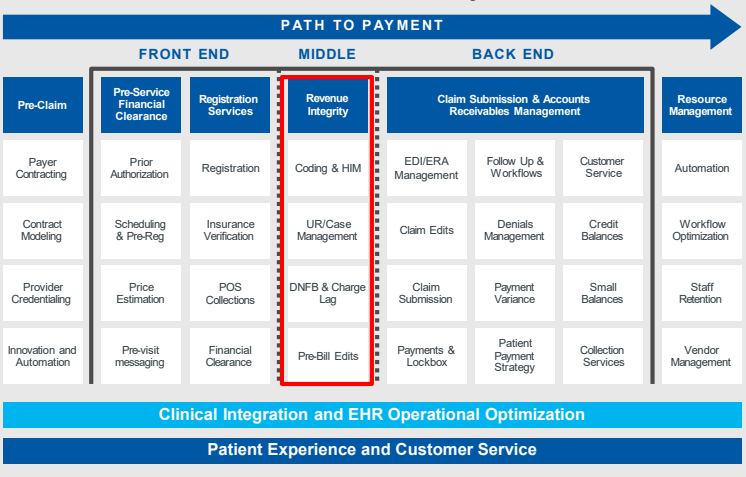
The path to payment is complex

End-to-End Revenue Cycle



Key Pain Points in Typical Organizations

1	Revenue Cycle Operational Standardization and Integration
2	Patient Access Pre-Service Financial Clearance Optimization
3	Clinical Documentation & Level of Care
5	Denial Prevention and Management
6	Payer Delays and Challenges Driving Payer Escalation

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Three pillars of denials prevention

Multi-Disciplinary Denial Prevention Committee and Strategies

Denial Awareness and Communication

Integration, Technology and Denial Predictive Analysis

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Roles and responsibilities for teams coordinating Care

Centralized Utilization Management

Position	Care Management	Utilization Management	Social Work	Physician Advisors	Non-Clinical Support
Responsibilities	• Lead clinical care coordination and apply risk-assessment tools • Complete initial discharge planning assessments • Coordinate with patients and families on care plans • Participate in multidisciplinary rounds and address operational barriers • Address and mitigate delays to progression of care	• Complete initial admission/status reviews • Own medical necessity reviews across the continuum of care and conduct medical necessity outreach with providers • Manage concurrent denials and post-bill level of care denials and appeals • Provide consistent UR coverage 7 days/week	• Drive ongoing discharge planning and psychosocial evaluations • Coordinate referrals (hemodialysis, behavioral health, post-acute) • Manage complex care challenges, discharge barriers and link community resources • Provide family support and address social determinants of health • Screen for and intervene in cases of abuse or neglect	• Review New Admissions • Perform Utilization Mgt. (UM) Activities • Continued Stay Review • Care Coordination • Maintain an Active Role in Denial Prevention • Escalation • Regulatory Compliance • Misc.	• Coordinate daily workflows • Monitor and track authorization requests, payor communications, and peer-to-peer escalations • Maintain and update UM reporting tools • Assist with preparation and submission of payor documentation • Coordinate schedules and document case discussions • Generate regular reports for leadership review

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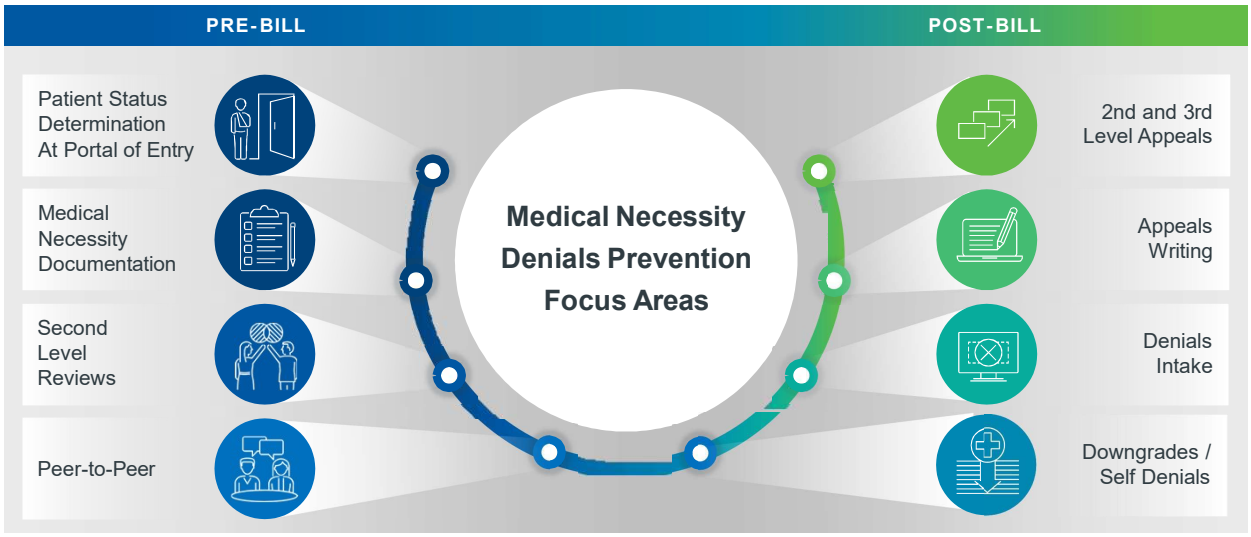
Life cycle of a medical necessity denial



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What is observation status?

Observation is an outpatient designation that allows physicians to place a patient in an acute care setting to monitor if there is a need for an inpatient admission

Patients are commonly discharged from observation or admitted as an inpatient within 24-48 hours

Common symptoms that could end up with a patient placed in observation for further testing include chest pain, shortness of breath, nausea/vomiting/stomach pain and fever, among other reasons

There are financial impacts for the hospital and the patient

Hospital Reimbursement

- Significantly lower payments compared to inpatient ($6.5K vs. $2K) which is a good all payor assumption

Patient Liability

- Since observation status is an outpatient service, a Medicare patient pays 20% for coinsurance
- However, whether a patient pays a greater amount depends on various factors including whether their deductible has been met and the amount of charges incurred

The use and rate at which this patient status is used varies by region and even unique system

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CMS Final Rule (2023) & The Two Midnight Rule

The CMS Final Rule for 2023, which is effective beginning in 2024 will:

- Require MA plans to comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare laws;
- Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria in a way that differs from requirements under Traditional Medicare;
- Establish restrictions on when and how a plan may create internal coverage criteria in specific instances where coverage criteria are not fully established under Traditional Medicare;
- Clarify that the CMS inpatient-only list applies to MA plans;
- Limit MA plans' ability to apply site-of-service restrictions not found in Traditional Medicare;
- Clarify the circumstances under which MA plans may use prior authorizations;
- **Direct MA plans to adhere to the two-midnight rule for coverage of inpatient admissions**

Two Midnight Rule by CMS for Medicare patients implemented in 2014 states that:

- **Inpatient admissions payable under Part A - if admitting practitioner expects the patient to require a hospital stay that will cross two midnights and the medical record supports that reasonable expectation**
- **Clinical documentation supports acute care medical necessity**

Physician Expectation	Actual Duration of Hospital Stay	
	< 2MN	> 2 MN
> 2 MN	Admission	Admission
< 2 MN	Observation	Consider Admission

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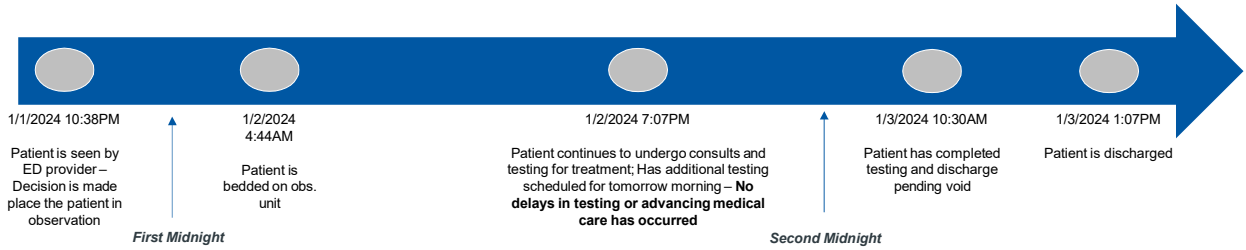
Two Midnight Rule Application

- **Variation between insurance providers on when the clock starts**
- **The 2 MN Rule requires an expectation the "Episode of Care" will extend beyond 2 midnights**
  - An "episode of care" includes time spent in the ED, Observation, and Inpatient
  - 2 MNs is not 48 hours; Observation should realistically be considered a 24-hour decision point
- **Delays in testing or advancing medical care does not count as "medically necessary". The continued care cannot be for the convenience of the patient or the doctor**



This patient's episode of care is now expected to exceed 2 MNs – should be converted to IP

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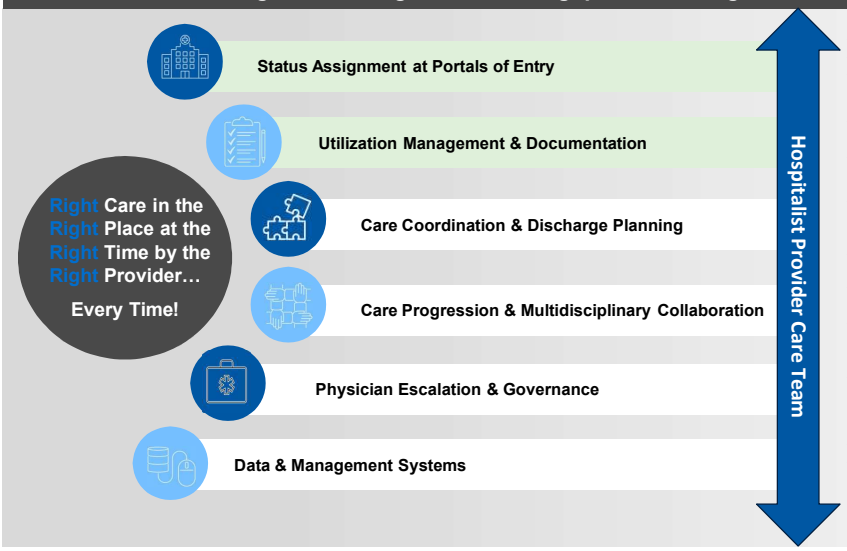
Clinical Efficiency Leading Practice Pillars

Characteristics of a High Performing Patient Throughput & LOS Organization



- Does discharge planning start on admission?
- Is the patient's status and level-of-care assignment accurate?
- Is Emergency Department patient arrival and care progression pathway efficient and appropriate to minimize operational delays?
- How are you managing observation patients throughout the hospital?
- Are you performing reviews for medical necessity and reacting appropriately to support revenue cycle integrity?
- Does the case management department have the right staffing and skill mix to collaboratively manage the patient's case and plan for discharge?
- Are you proactively meeting to discuss discharge barriers?
- Are multidisciplinary rounds concise and effective in communicating the medical plan, discharge milestones and barriers?
- Is there a physician escalation process to timely resolve identified barriers?
- Do processes and culture support physician-to-physician discussions on patient cases based on medical necessity and documentation?
- Are you tracking the appropriate KPIs to drive changes?
- How are you communicating results and improvements to your teams?

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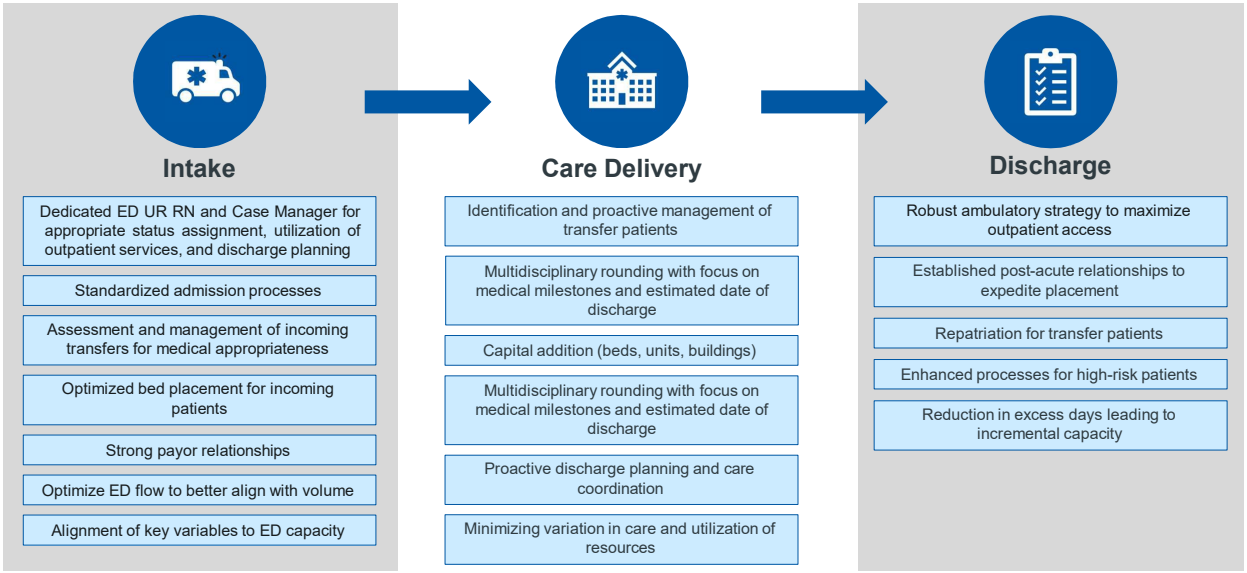
Multi-levered Comprehensive Capacity Strategies



Intake

- Dedicated ED UR RN and Case Manager for appropriate status assignment, utilization of outpatient services, and discharge planning
- Standardized admission processes
- Assessment and management of incoming transfers for medical appropriateness
- Optimized bed placement for incoming patients
- Strong payor relationships
- Optimize ED flow to better align with volume
- Alignment of key variables to ED capacity

Care Delivery

- Identification and proactive management of transfer patients
- Multidisciplinary rounding with focus on medical milestones and estimated date of discharge
- Capital addition (beds, units, buildings)
- Multidisciplinary rounding with focus on medical milestones and estimated date of discharge
- Proactive discharge planning and care coordination
- Minimizing variation in care and utilization of resources

Discharge

- Robust ambulatory strategy to maximize outpatient access
- Established post-acute relationships to expedite placement
- Repatriation for transfer patients
- Enhanced processes for high-risk patients
- Reduction in excess days leading to incremental capacity

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Measuring Success

Physician Advisor & UR Executive Scorecard

	Metric	Best Practice	Region					
			Hospital 1		Hospital 2		Hospital 3	
			FY 2023	FY 2024 YTD	FY 2023	FY 2024 YTD	FY 2023	FY 2024 YTD
OBS Rates	**Observation % - All Payor**	**<= 25% ***	**30.1%**	**27.1%**	**23.2%**	**24.0%**	**20.1%**	**18.8%**
	Observation % - Traditional Medicare	<= 15% *	19.4%	18.1%	12.7%	13.3%	12.2%	10.1%
	Observation % - Managed Medicare	<= 25% *	33.4%	28.6%	26.7%	28.6%	21.7%	22.4%
	Observation % - All Other Payor	<= 30% *	34.8%	36.5%	29.6%	26.6%	26.3%	27.4%
Peer-to-peer Data	P2P Completed - All Payor	-	64	83	26	23	33	39
	P2P - Denial Overturned	-	46	57	16	12	20	22
	P2P - Denial Upheld	-	17	25	8	10	13	14
	P2P - Move to Next Level Appeal	-	11	8	N/A	N/A	N/A	N/A
	Percentage OBS Accepted for Concurrent Denials	<= 35%	27%	29%	50%	56%	53%	57%
	Percentage P2P Completed	**>= 65%**	**73%**	**71%**	**50%**	**44%**	**47%**	**43%**
	Percentage P2P Overturned	**>= 70%**	**71%**	**69%**	**64%**	**51%**	**59%**	**57%**

Legend
Improvement
Monitor
Area of Focus

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Case Studies & Closing Thoughts

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Key takeaways

- Create an adaptable organization designed to recognize gaps and support change management
- Utilize tools to proactively measure opportunities and the impact of change in your organization
- Promote collaboration and accountability across the enterprise to strengthen denial prevention, UM processes, and length of stay
- Ensure accessibility to data to enable timely, action-oriented interventions

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CASE STUDY

1,500+ Bed Six-Hospital System in Southeast

CHALLENGE
aimed to optimize the patient status determination process and reduce patient length of stay. The system was struggling with rising Observation rates and some of the facilities were capacity constrained

RESULTS
The team's efforts reduced 18,000 excess days and reduced the observation rate by over 10% at most of the facilities

Benefit achieved to date is over $40 million

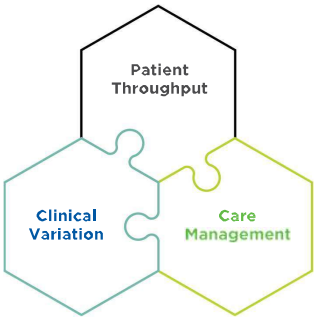
Solution

Kaufman Hall partnered with a major hospital system to improve financial and operational performance, which included:

- Reviewing patient status processes, patient throughput constraints, and clinical variation
- Care management redesign focusing on patient status at the point of entry, discharge planning and organizational structure
- Implement Clinical Consensus Teams across multiple diagnosis areas
- Multi-disciplinary rounds across the organization
- Defining and tracking of process metrics (leading indicators)
- Physician Advisor program

Benefits realized

- Reduced LOS and Observation rates



Results

18,000
Reduction in excess day for the system

$40.0M+
Total benefit for system

Abbreviations: AMC = academic medical center; LOS = length of stay.

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CASE STUDY

3-Hospital Regional Health System in Upper Midwest

CHALLENGE
The health system sought top-decile LOS performance against peers

RESULTS
Improvement in capacity and throughput led to a 0.49-day reduction in length of stay

AMC LOS index improved from 1.05 to 0.90

Solution

Vizient partnered with three-hospital system and leaders to improve operational processes including multidisciplinary care coordination:

- Optimization of multidisciplinary rounds
- Managing to a target discharge date
- Implementation of LOS visual management boards on nursing units
- Defining and tracking of process metrics (leading indicators)
- Implementation of visual daily management systems for long-term sustainability
- Execution and coaching of Gemba walks and Leader Standard Work
- Physician Advisor integration into LOS

Benefits realized

- Reduced LOS for inpatient units
- Leadership Accountability System for sustainment and continuous improvement

Critical success factors

- Partnership and collaboration with hospital physicians and clinical leaders
- Support from case management and utilization review leaders
- Commitment to facilitate long-lasting change through cross-channel collaboration
- Standard Work to guide discussions around patients' discharge

Results

0.49-day
Reduction in LOS for three-hospital system

$44.3M
Total savings for system

Abbreviations: AMC = academic medical center; LOS = length of stay.

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Questions?

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Qualifications, Assumptions and Limiting Conditions (01.30.24):

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