Redefining Revenue: Building Financial Resilience in an Era of Policy and Payment Change

Juan Montanez
Kristina Ramos-Callan
Jose Robles

Meet Our Experts

Kristina Ramos - Callan

Associate Principle
kramoscallan@healthmanagement.com

Health Management Associates

Juan Montanez

Managing Director
jmontanez@healthmanagement.com

Health Management Associates

Jose Robles

Senior Vice President
jrobles@healthmanagement.com

Health Management Associates

TODAY'S AGENDA

- Policy-Driven Revenue Volatility
- Mitigation Strategies
- Other Considerations
- Q&A

Policy-Driven Revenue Volatility

Planning For Volatility

Jose Robles
Senior Vice President

HMA
40 YEARS

WHAT'S INFLUENCING REVENUE VOLATILITY?

PRIMARY FACTORS

Coverage and Eligibility Policy

- OBBBA eligibility provisions, ACA tax credit expiration, and PRWORA expansion's impacts; 340B Program; Site Neutral Payments

Payment Policy

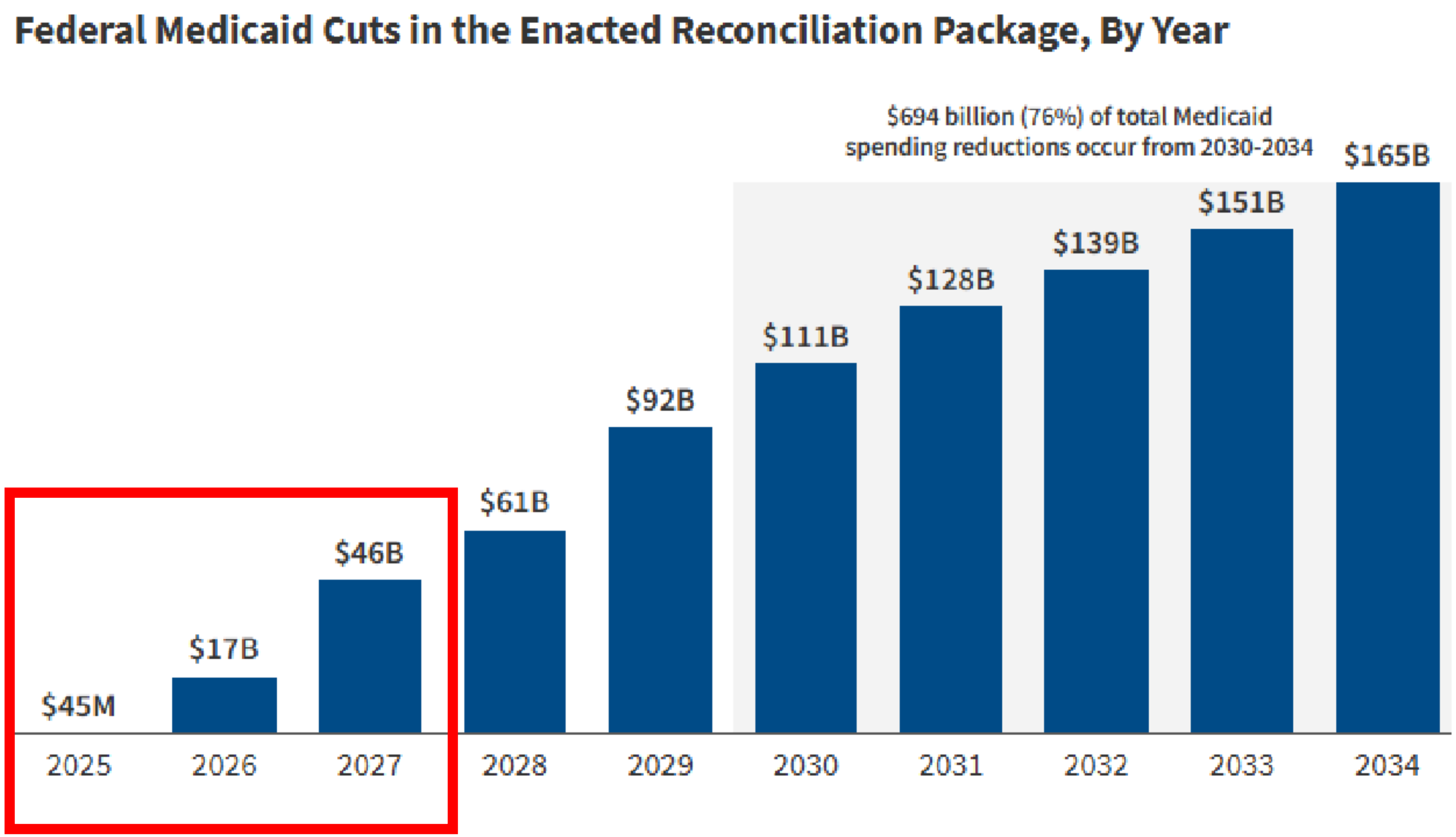
- Shift from Fee for Service to Value-Based Payment models; fraud, waste, and abuse initiatives
- Continued shift of care to outpatient settings

Other Considerations

- Workforce instability; rising cost of materials; others
- Net Entrants, AI Influence on care and care coverage &management

OBBBA IMPACT ON MEDICAID HAS A LONG TIMELINE

MORE THAN ¾ OF SPENDING REDUCTIONS HAPPEN 2030-34



Source: [Kaiser Family Foundation, (2025)](). "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package"

Short Term Impact

2025

- Essential Plan (NY & OR)
- Provider Tax freeze
- Planned Parenthood
- Nursing home staffing standards
- Rural Health Transformation Plans

2026

- Begin accessing Rural Health Transformation Fund
- Provider Tax cap
- Premium Tax credit
- Disenrollment of lawfully present immigrants from Essential Plan
- Emergency Medicaid reduction for immigrant eligibility (50%)

2027

- Community engagement (Medicaid expansion population)
- 6-month redetermination
- Narrowing of eligibility for lawfully present immigrants
- Medicaid address verification

OTHER POLICY THREATS ON HORIZON

Policy Threat	Brief Description	Financial Impact
Medicare Rate Compression	Updates lag inflation due to productivity adjustment	Margin erosion on IP/OP services
Medicaid Coverage & Supplemental Payments	States reassessing supplemental and directed payments	Lower net patient revenue
340B Program Restrictions	Manufacturer limits; contract-pharmacy constraints	Reduced outpatient drug margin
Site-Neutral Payment Expansion	Equalizing OPPS and physician-office rates	Large HOPD revenue reduction
MA & Commercial Prior Authorization/Denials	Increased denials and UM controls	Lower realized revenue; admin burden
MA Risk Adjustment Changes	Tighter coding intensity and oversight	Lower MA plan payments
Price Transparency & Rate Regulation	Enforcement + cost-growth caps	Downward commercial rate pressure
Billing Compliance & Audit	IP/OP, telehealth audits	Recoupments, penalties
Behavioral Health & Post-Acute Shifts	IMD waiver and reimbursement updates	Reduced psych/rehab/LTACH revenue

ACCESS TO 340B DRUG DISCOUNT PROGRAM

HEALTH SYSTEMS NEED TO MONITOR ABILITY TO CONTINUE TO ELIGIBLE FOR PROGRAM

Eligibility and Benefit

- Can qualify as DSH Hospital (11.75%) or RRC Hospital (8%)
- Programs allows providers to purchase drugs at discounted rates for covered outpatient drugs
- Cost savings range from 25% to 50% ($millions)

H.R. 1 Medicaid Caseload Change – Illinois

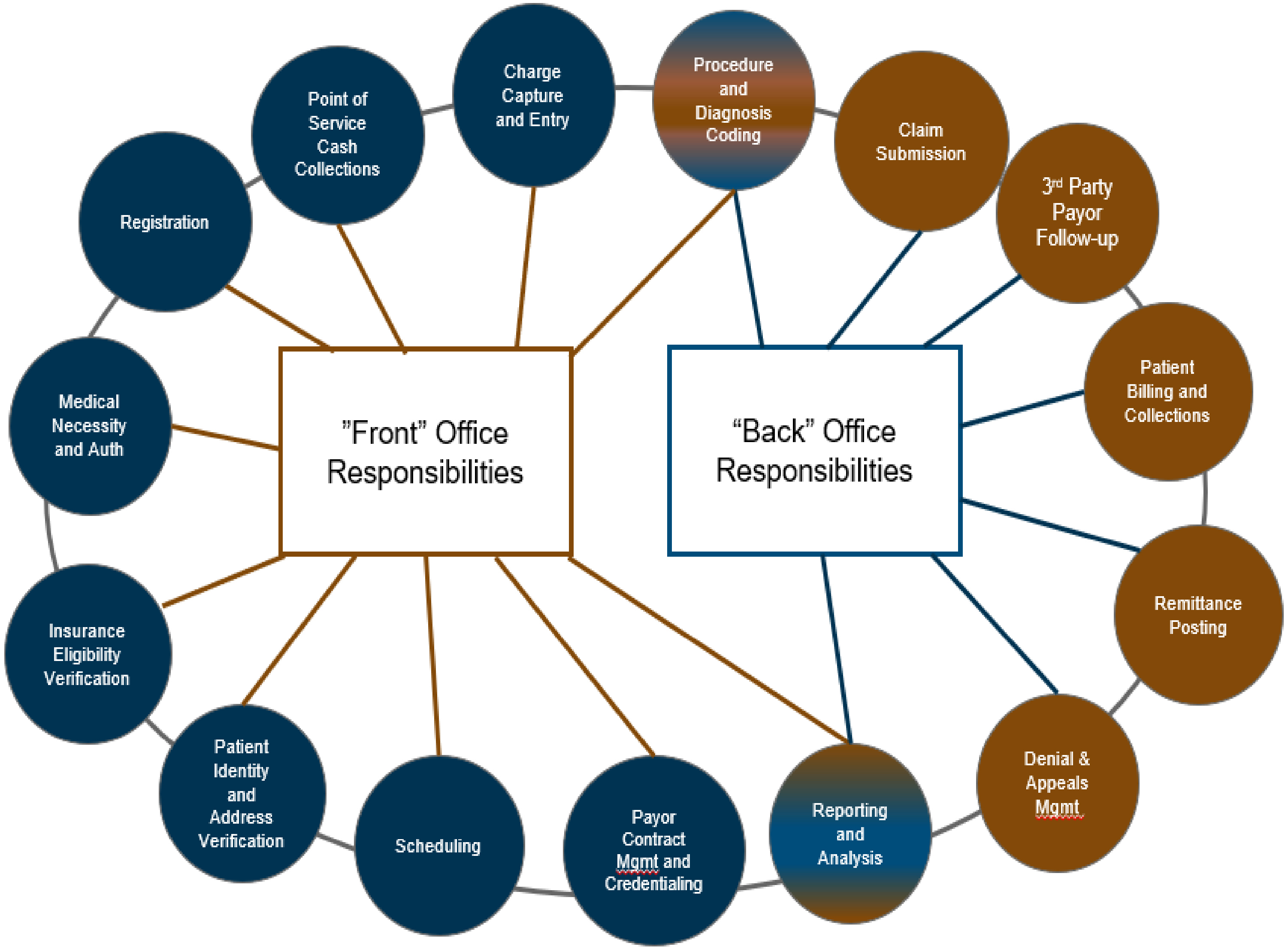
PROJECTED MEDICAID CASELOAD CHANGE (ALL GROUPS): 2026 – 2034

#	ADJUSTMENT	2025	2026		2027		2028		2029		2034	
PROJECTED MEDICAID CASELOAD CHANGE FROM BASE 2025 ENROLLMENT												
71107	Eligibility Redetermination Change		0	0%	(29,421)	-0.93%	(29,421)	-0.93%	(29,421)	-0.93%	(29,421)	-0.93%
71109	Alien Medicaid Eligibility		(3,551)	-0.11%	(3,551)	-0.11%	(3,551)	-0.11%	(3,551)	-0.11%	(3,551)	-0.11%
71112	Modify Retroactive Eligibility		0	0%	0	0.00%	(4,106)	-0.13%	(4,106)	-0.13%	(4,106)	-0.13%
71119	Community Engagement		0	0%	(91,493)	-2.89%	(124,763)	-3.94%	(195,461)	-6.17%	(220,414)	-6.95%
HR1	Indirect Caseload Impact		(8,333)	-0.26%	(9,137)	-0.29%	(9,941)	-0.31%	(12,427)	-0.39%	(41,488)	-1.31%
	Change from 2025 Base		(11,884)	**-0.37%**	(133,602)	**-4.22%**	(171,782)	**-5.42%**	(244,966)	**-7.73%**	(298,980)	**-9.43%**
	Total Enrollment	**3,169,500**	3,157,616		3,035,898		2,997,718		2,924,533		2,870,519	

Mitigation Strategies

MITIGATING IMPACT UNDERSTANDING REVENUE DRIVERS

REVENUE CYCLE AND RETROSPECTIVE PAYMENTS (COST REPORTS AND SUPPLEMENTAL PROGRAMS)



- Understand your key drivers and gaps in revenue cycle
- Understand your payor mix and related contracts
- What are the issues that will impact your process
- Pricing Strategy
- Claim Related vs Other
- Cost Reports
- Alternative Payment
- Risk & Quality Scores
- Supplemental Payments
- Service Line Strategy

MITIGATING RISK ACROSS REVENUE DRIVERS

MEDICARE/ MEDICAID REVENUE | CLAIMS & ADD-ON PAYMENTS

- Coding and Documentation
- Disproportionate Share Hospitals and Uncompensated Care
- Designations:
  - Critical Access Hospital (CAH), Rural Referral Center (RRC), Medicare Dependent Hospital (MDH) ,Sole Community Hospital (SCH), Rural Emergency Hospital (REH), etc.
  - Safety Net, Medicaid High Volume, High Outpatient Volume

MEDICARE/ MEDICAID REVENUE

- Wage Index
- Medical Education (Beds, Resident Counts, Affiliations)
- Readmissions and Present on Admission
- 340B Optimization
- Provider Alignment
- Cost/Charge Ratio
- Observation v Inpatient Status

CLAIMS & ADD-ON PAYMENTS

- State's Medicaid Financing Arrangement
- Policy Adjusters
- Per Diem/Per Discharge (rehab, psych, other)
- Provider Tax Program & Supplemental Payments
  - Move from static fixed payments to volume driven payments
  - Multipliers applied to claim payments
  - Supplemental Payment Pools
  - Directed Payment Programs

COVERAGE LOSSES

- Shifting Payor Mix
- Partnership to Manage Increased Emergency Department Volume
  - FQHC and other community partners
  - Behavioral Health Providers
- Increased severity of illness due to delayed care
  - Coding/outliers
  - Rate Negotiation
- Bed Management
  - Growth in low-acuity patients
  - Primary/Secondary care vs. Tertiary/Quaternary care
- Supplemental Payments and 340B Program Eligibility
  - Lower Medicaid % could disqualify you from supplemental pools/programs
- Workforce Investments

Operations and Technology Levers

Considerations for Providers

Juan Montanez
Managing Director
Information Management and Technology Advisory Services

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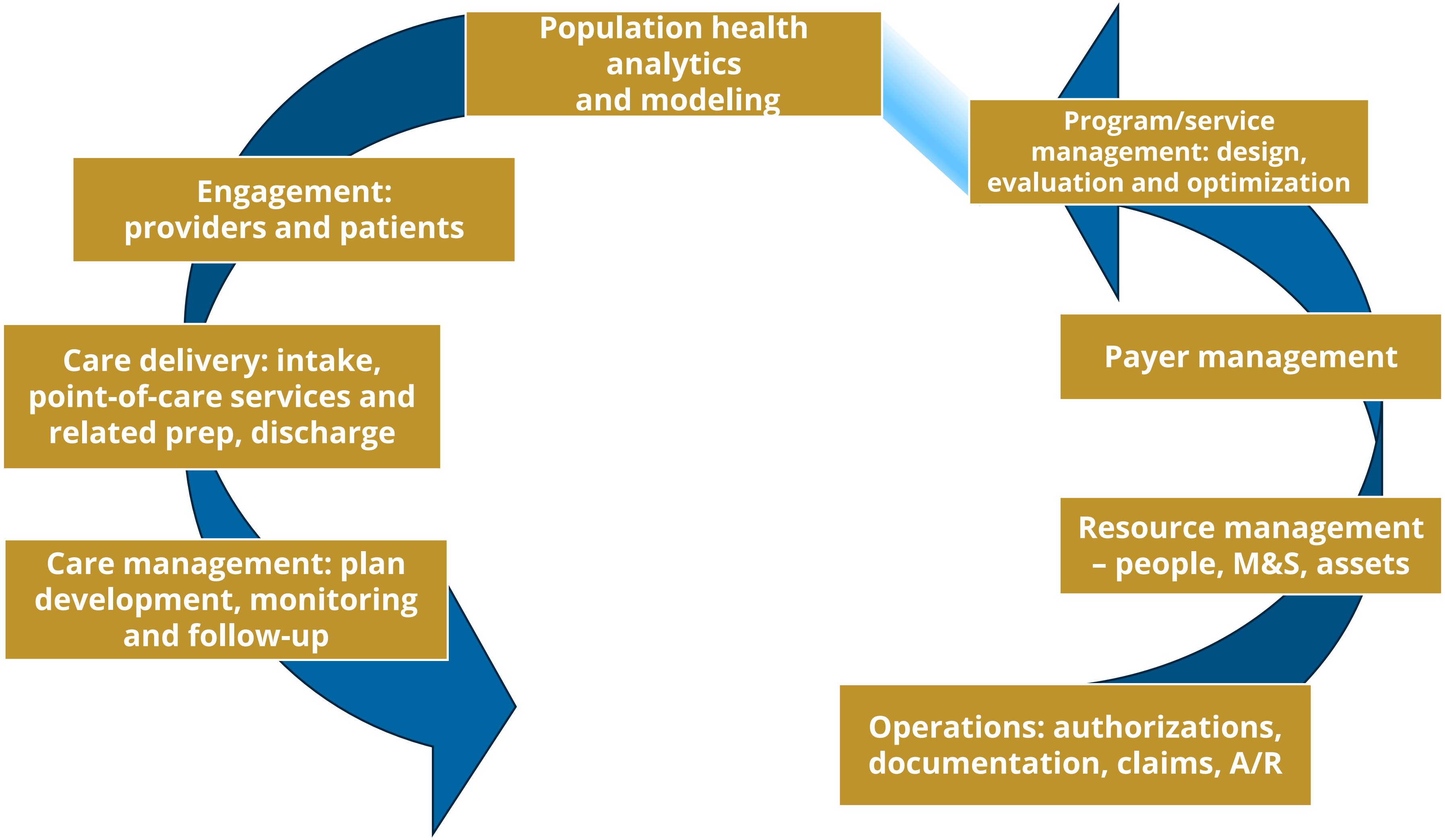
FRAMEWORK

Imperatives:

- Revenue augmentation
- Revenue preservation
- Resource use optimization
- Cost takeout



DRIVING REVENUE, RESOURCE USE & COST IMPROVEMENTS

	Population Health Analytics and Modeling	Engagement
Initiatives to consider	➢ Whole Person Data Warehouse ➢ Patient Profiling	➢ Members: omni-channel outreach and input ➢ Providers: collaboration platform
How technology can help	➢ Lower-cost data warehousing solutions ➢ AI-bolstered patient profiling and "big data" analytics	➢ AI-based outreach and self-help solutions ➢ IT platforms that complement EHRs and facilitate cross-disciplinary information exchange and collaboration

POPULATION HEALTH ANALYTICS AND MODELING

Identification

- ✓ IDs - multiple systems
- ✓ Cross-system indexing
- ✓ Identity validation

Location and Contact

- ✓ Physical address(es)
- ✓ Email address(es)
- ✓ Phone #(s)

Demographic Profile

- ✓ Age
- ✓ Sex
- ✓ Ethnicity
- ✓ Languages
- ✓ Family composition

Context

- ✓ Medical – including HSA/HRA and related findings
- ✓ Psychological/behavioural
- ✓ Social/environmental
- ✓ Employment
- ✓ Living arrangements
- ✓ Genetic profile
- ✓ Lifestyle and personality

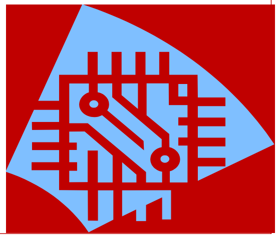
Service Involvement

- ✓ Eligibility categories
- ✓ Enrollment spans

- Health coverage
- Social services
- Other services

Service Utilization

- ✓ By category of service:
  - Dates, diagnoses (if applicable), services, providers, locations, costs



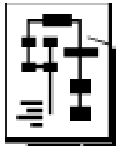
Collect
Profile
Model
Monitor
Analyze
Report

POPULATION TARGETING

PROGRAM DESIGN

PROGRAM IMPLEMENTATION PLANNING

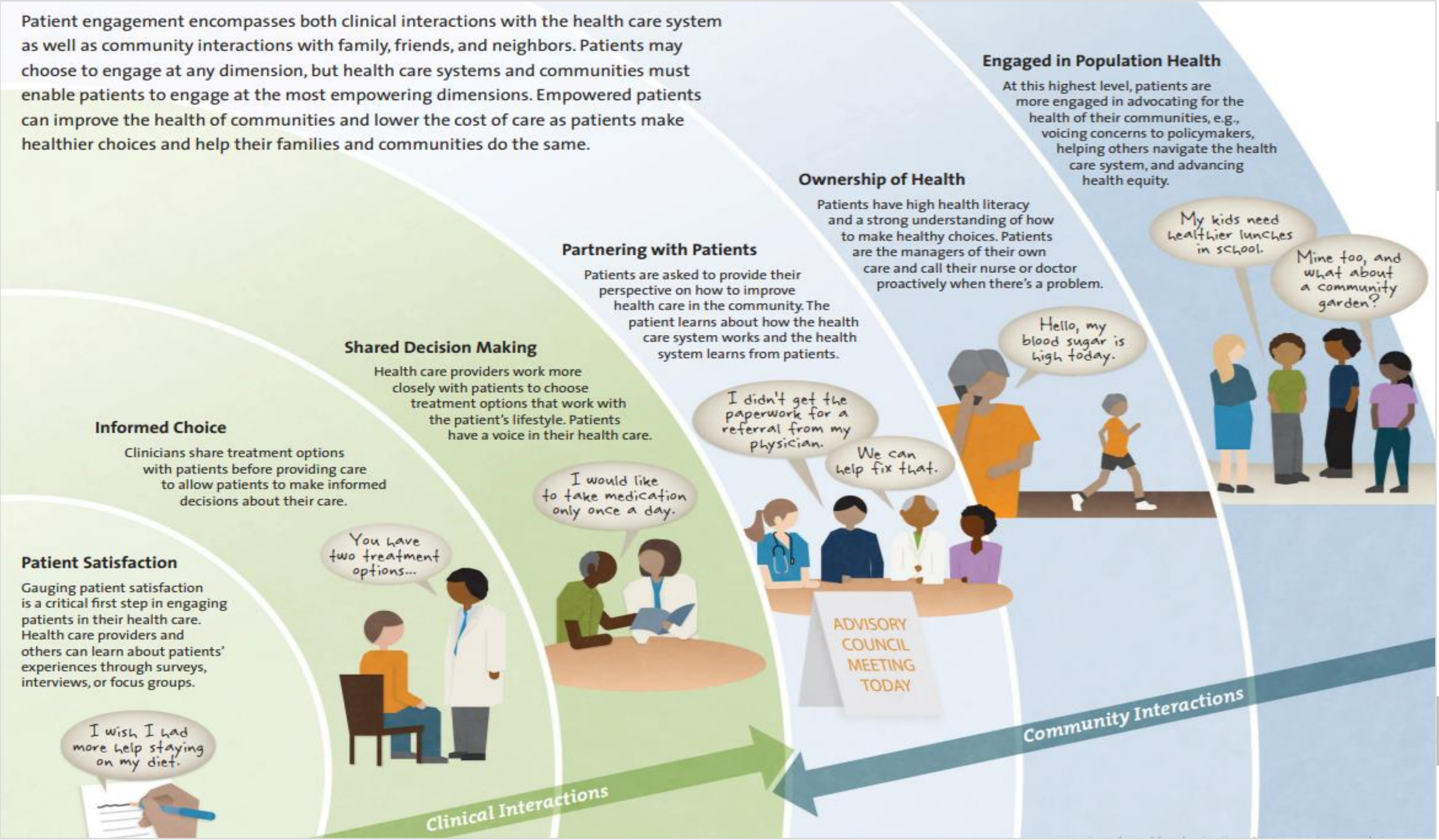
PROGRAM IMPLEMENTATION

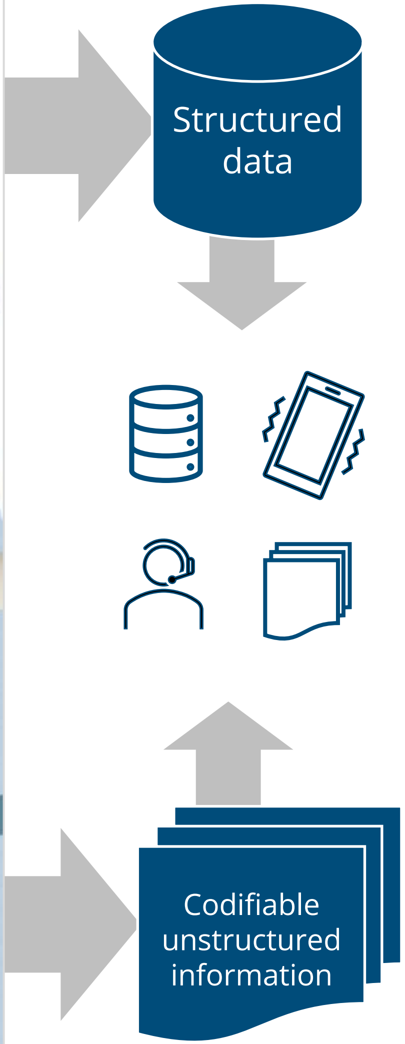


PROGRAM OPERATIONS

PROGRAM MONITORING AND EVALUATION

PATIENT ENGAGEMENT





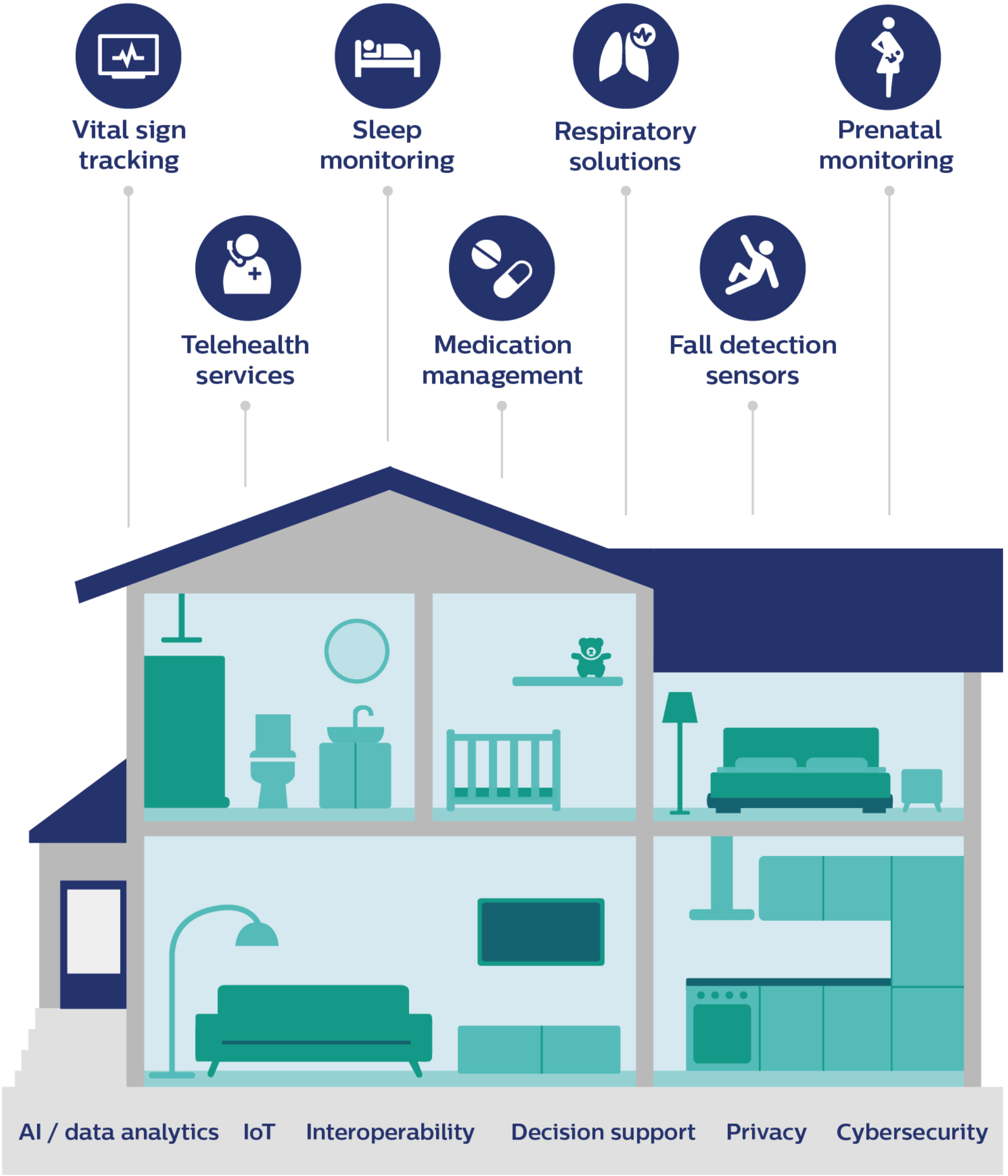
DRIVING REVENUE, RESOURCE USE & COST IMPROVEMENTS

	Care Delivery	Care Management
Initiatives to consider	➢ Care pathways ➢ E-consults ➢ Hospital at Home	➢ Multi-disciplinary care planning ➢ HRSN provider connections ➢ Closed-loop referrals
How technology can help	➢ AI-powered ambient documentation ➢ AI-augmented decision support ➢ Internet of Things/remote monitoring ➢ Ubiquitous, low-cost communications	➢ AI augmented care planning ➢ Community information exchange ➢ Closed -loop referral management systems

HOSPITAL-AT-HOME

- As hospitals reconsider how and where they deliver care to patients, many are seeing the hospital-at-home model as a promising approach.
- Hospital-at-home enables some patients who need acute-level care
  to receive care in their homes, rather than in a hospital

- This care delivery model has been shown to reduce readmissions and emergency room visits, reduce costs, improve outcomes and enhance
  the patient experience.
- Mt. Sinai (NYC, US): program participants had a 45 percent lower 30-day readmission rate, 55 percent lower 30-say ER visit rate, and almost 50 percent more patients expressed satisfaction with their care.
- The federal government has implemented a program that encourages adoption of this model.



DRIVING REVENUE, RESOURCE USE & COST IMPROVEMENTS

	Operations	Resource Management

Initiatives to consider	› Intelligent patient scheduling
	› Intelligent OR scheduling
	› Intelligent personnel scheduling
	› Contact center right-sizing and cost compression
	› RCM end-to-end tightening
	  › Front end: upfront cost-share collection
	  › Middle: airtight documentation
	  › Back end: error-less claiming
		› Incentive alignment in CBAs/ employment agreements
		› Supply chain optimization
		  › Inventory management automation
		  › Maximize joint purchasing
		› Facility redeployment

How technology can help	› AI-powered algorithms for scheduling optimization including no-show prediction › Cloud-based contact center platforms › Agentic AI for contact management › AI-enhanced tools for catching revenue leakage and optimizing coding	› Performance monitoring and analysis › Robotic process automation (RPA)

DRIVING REVENUE, RESOURCE USE & COST IMPROVEMENTS

Initiatives to consider

Payer Management	Program/Service Management
› Chargemaster optimization › Dynamic contract modeling › Incentive-based contracting	› Service lines/centers › Service location optimization › Alliances/joint operating agreements

How technology can help

- AI-bolstered analytics and modeling

CRITICAL SUCCESS FACTORS

KEYS TO AUGMENTING REVENUE, PRESERVING REVENUE, OPTIMIZING RESOURCE USE AND TAKING OUT COSTS

Innovation in services and support functions

- Shift from sick care to health promotion and preservation
- Particular focus on higher-cost, more impactable patients
- Greater adoption of "digital first" care models – leverage technology to the fullest in engagement, care delivery and management
- Includes innovations in how the **providers**, **employees** and **patients** interact and support each other

Information-intensive decision making and management

- Applications that turn vast amounts of data into usable, structured preventative, diagnostic, treatment and management information

Embrace of IT – especially AI – as a strategic asset

- IT can no longer be seen as a drag or a mere cost of doing business
- Need to elevate everyone's information system use comfort level and proficiency

Successful performance in value-based care arrangements

- Providers work together to assume responsibility for healthcare cost, quality, outcomes and overall status
- Historical obstacles:
  - Insufficient financial or competitive pressures
  - Status quo inertia
  - High fixed costs
  - Debt obligations
  - Challenge of managing "shared performance"
  - Inadequate management infrastructure
  - Lack of willing partners
  - Difficulty navigating the complexity of change

A WORD ABOUT AI

MAKING AI WORK IN YOUR ORGANIZATION

Transparency	Privacy and Security	Sophistication	Continuous Improvement
▪ Big push to ensure the use of AI is disclosed ▪ Big push to provide info on how AI algorithms/models are constructed and tested/ validated	▪ Always a critical consideration ▪ Address higher level of anxiety prompted by AI use	▪ Ensure bias is not "baked in" to AI models/algorithms ▪ Ensure AI models/algorithms are fed by all pertinent data ▪ Build appropriate parameters that prevent "hallucinations" ▪ Be selective – do not rush adoption	▪ Building confidence in AI-boosted applications will require CQI ▪ CQI efforts should incorporate input from multiple parties including outside/independent parties

Education

- Addressing anxiety and concerns about AI will require extensive education
- Education must be tailored to different stakeholders, beginning with leaders and policymakers

Other Programs and Policy Levers

Impact across the care continuum

Kristina Ramos-Callan
Associate Principal, New York

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OTHER POLICY FACTORS

SELECT REGULATORY POLICY AND PROGRAM INTERACTIONS WITH OBBBA

DIRECT POLICY ACTIONS

- Rural Health Transformation
- PRWORA
- SNAP – Reduces Enrollment by 3.2m Through 2034
- Health Related Social Needs Guidance Recission
- Designated State Health Program/Designated State Investment Programs
- Perinatal/Reproductive Healthcare Policy
- Economic Policy Factors (Tariffs, Inflation)
- HUD Changes to Continuum of Care
- Research Funding

INDIRECT IMPACTS

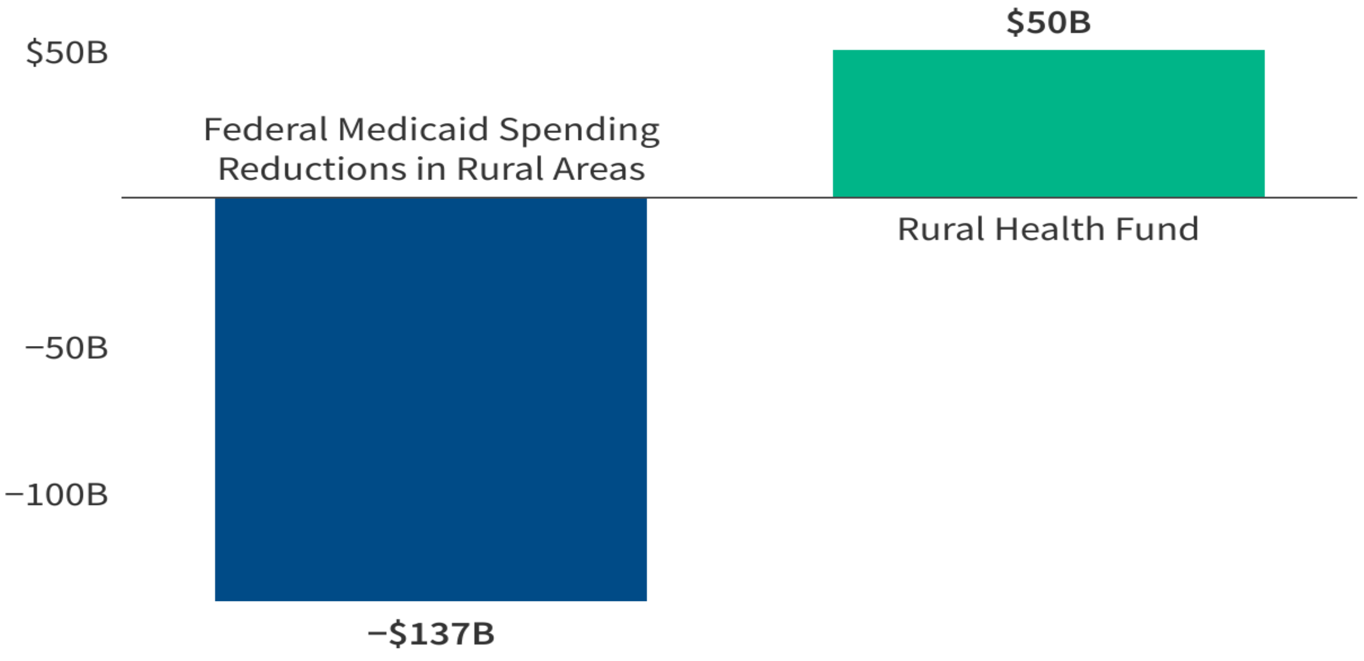
- Parental Coverage Loss Impact on Children
- Higher Insurance Premiums for Commercial Insured
- Reduced Economic Productivity

RURAL HEALTH TRANSFORMATION

Over half of the spending reductions are among 12 states with large rural populations and expanded Medicaid.

Figure 1

The Enacted Reconciliation Package Would Reduce Federal Medicaid Spending in Rural Areas by $137 Billion; the $50 Billion Rural Health Fund Would Partially Offset Reductions in Rural Areas



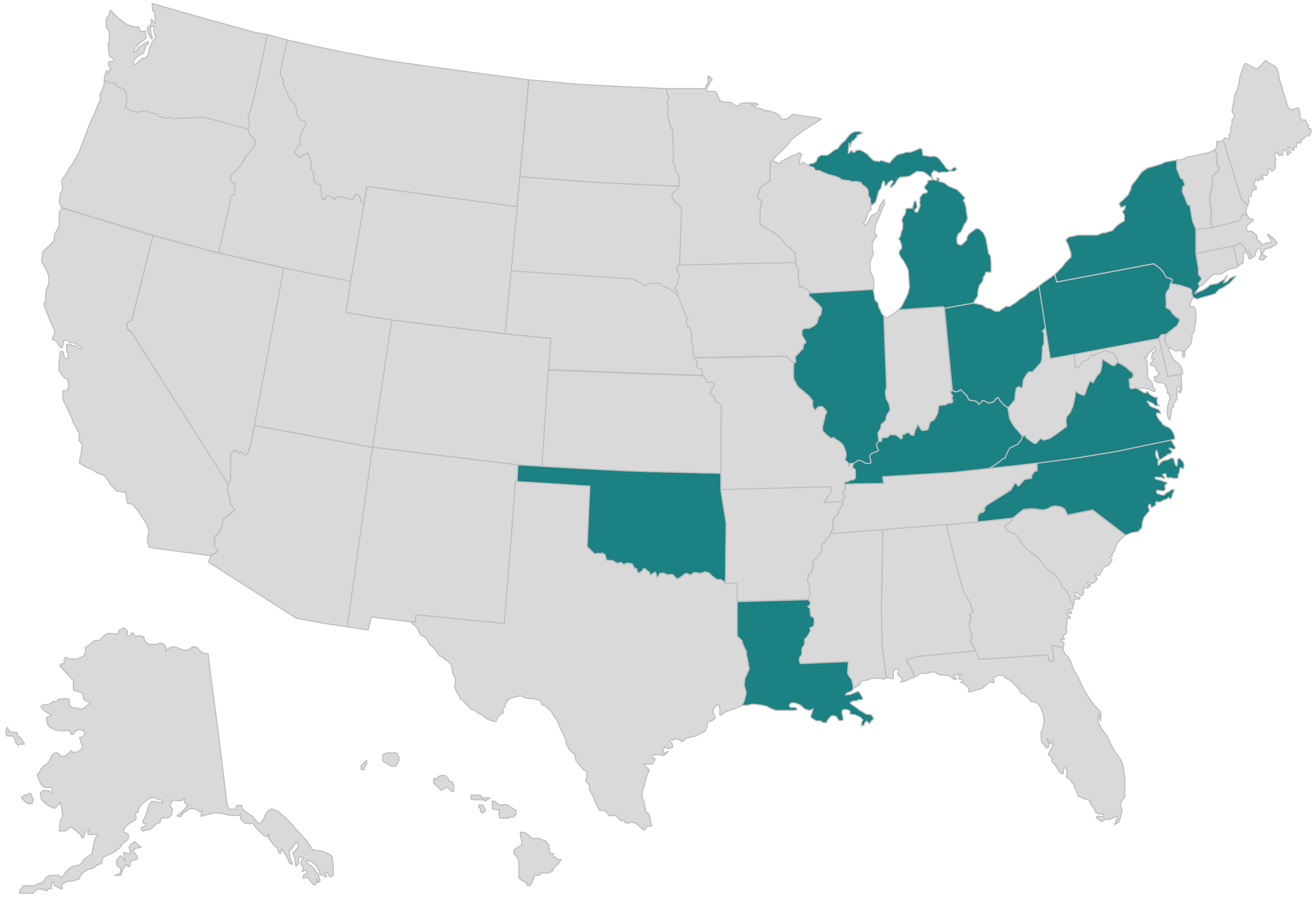
Note: The analysis uses T-MSIS data to estimate the percentage of Medicaid spending that paid for services used by rural enrollees. Those percentages were then applied to national estimated reductions in federal Medicaid spending from KFF's broader analysis of federal Medicaid spending reductions.

Source: Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States, and KFF analysis of the T-MSIS Research Identifiable Files, 2021

KFF

DISPARATE IMPACT ON EXPANSION STATES

10 ACA EXPANSION STATES MAY SEE RURAL FEDERAL MEDICAID REDUCTIONS >$5 BILLION THROUGH 2034



State	Reduction
KY	- $10.92
NY	- $ 6.37
IL	- $ 6.36
VA	- $ 5.95
NY	- $ 5.67
MI	- $ 5.63
OH	- $ 5.62
PA	- $ 5.5
OK	- $ 5.13
LA	- $ 5.02

WHY IS PRWORA IMPORTANT?

EDUCATION, HEALTH, SOCIAL SERVICES, WORKFORCE IMPACT

Education

- Head Start
- Workforce programs
  - Grants, scholarship, loans, loan repayment

Behavioral Health

- Certified Community Behavioral Health Clinica
- Community Mental Health Services Block Grants
- Other SAMHSA programs

Physical Health

- Health Center Programs (Community Health Centers/FQHCs)
- Title X Family Planning

- Academic Achievement
- Worker Training
- Education Affordability
- Long-term Economic Stability
- Better Personal Health
- Employee Absenteeism
- Long-Term Community Productivity

PRWORA Exclusions – Affected Populations

✓ QUALIFIED	× NON-QUALIFIED	
✓ Lawful permanent residents (LPRs) or people with green cards ✓ Refugees and people granted asylum ✓ People granted withholding of deportation/removal ✓ Conditional entrants ✓ People granted parole by DHS for a period of at least one year ✓ Cuban and Haitian entrants ✓ Certain abused immigrants, their children, and/or their parents ✓ Certain survivors of trafficking ✓ Individuals residing in the U.S. pursuant to a Compact of Free Association (COFA)	× People with Temporary Protected Status (TPS) × Applicants for adjustment to LPR status with approved visa petitions × Applicants for asylum or withholding of deportation/removal × People paroled for less than one year × People granted deferred enforced departure or deferred action × Special immigrant juveniles × U Visa holders × People with valid nonimmigrant status or nonimmigrant visas × Longtime residents	× People under an order of supervision who have employment authorization × People granted Family Unity × Applicants for cancellation of removal or suspension of deportation (with employment authorization) × Applicants for adjustment under the LIFE Act (with employment authorization) × Lawful temporary residents and applicants for legalization under IRCA (with employment authorization) × Applicants for registry (with employment authorization) × Undocumented immigrants

INTERDEPENDENT HEALTH AND SOCIAL NEEDS

Social factors influence health outcomes

- Lack of Health Insurance
- Community and Physical Environment
- Education and Work Status
- Housing
- Food Access
- Adverse Childhood Experiences
- Chronic Stress
- Financial Stability

Health Outcomes Influence Social Factors

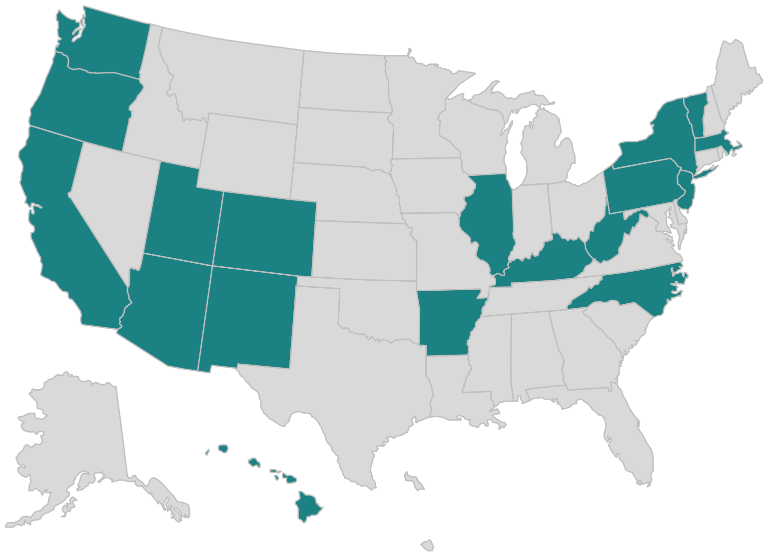
- Morbidity
- Physical Health Status
- Behavioral Health Status
- Functional Limitations and Disability
- Toxic Stress Syndrome
- Health Care Costs

CMS GUIDANCE INTERACTS WITH OBBBA

HRSN Guidance

Recission of Medicaid 1115 HRSN guidance: HRSN services will be considered for renewal on case-by-case basis. Affects:

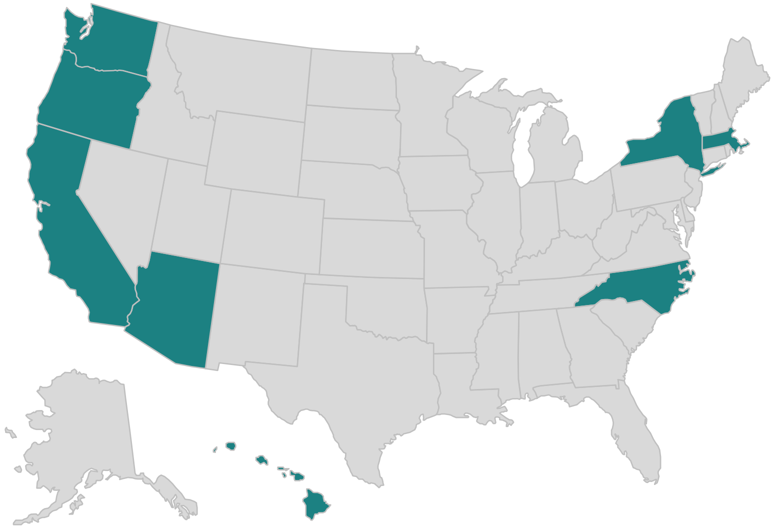
- Housing
- Nutrition
- Employment
- Medical Respite
- Infrastructure funding for delivery system



DSHP & DSIP Guidance

Rescinds authority to use Federal Match Funds for State Expenditures in such programs, introducing risk. Affects programs like

- HRSN services
- Youth with Special Health Care Needs
- Enhanced Care Management



Populations affected: people experiencing homelessness; or with low housing security; people with BH needs (SMI, SUD); low/no food security and high-risk pregnancy; post-partum; high utilizers; justice involved, etc

Potentially Affected States

Source: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations

DESIGNATED STATE HEALTH PROGRAM AND DESIGNATED STATE INVESTMENT PROGRAMS RECISSION

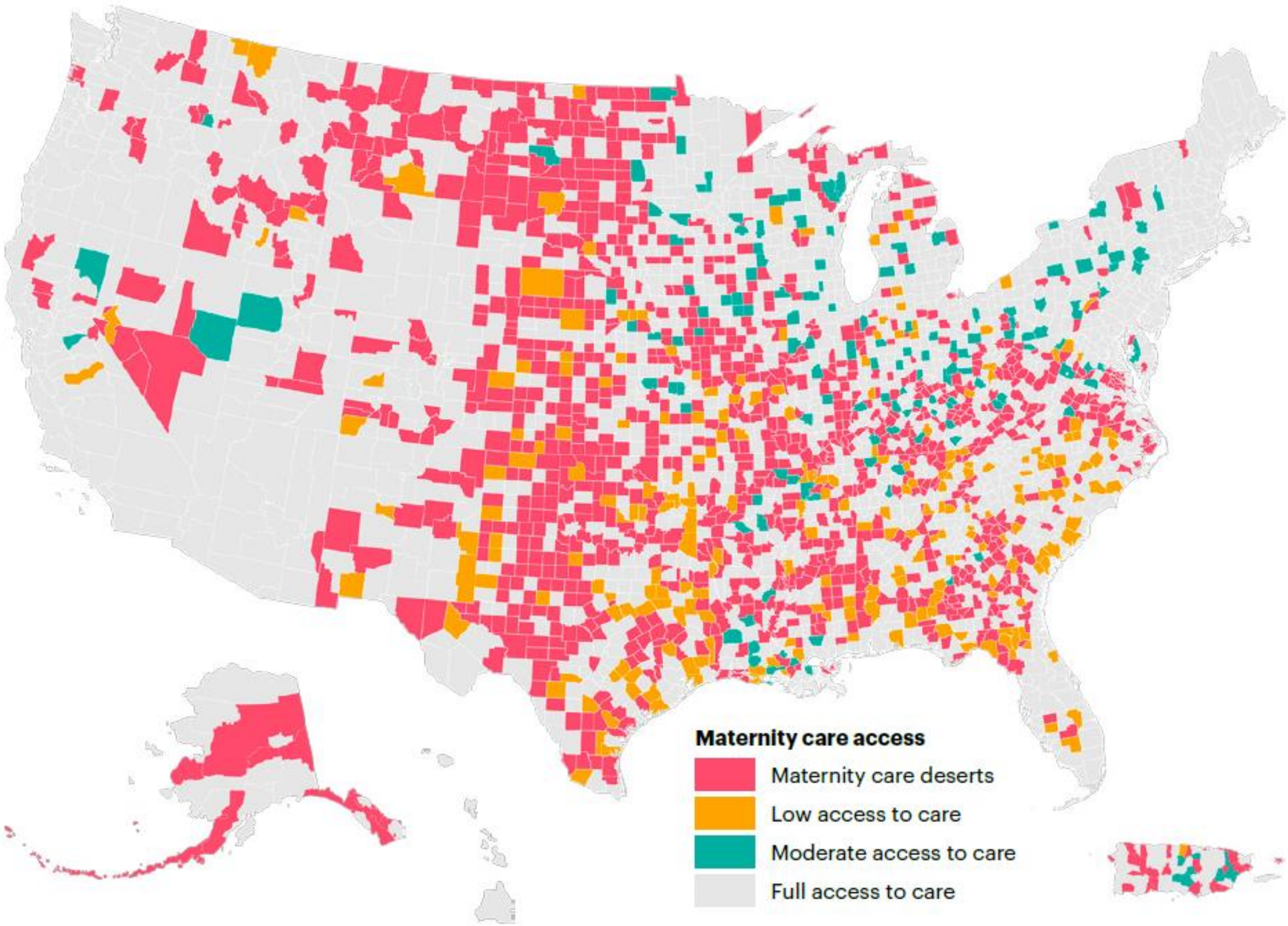
NEW YORK DEEP DIVE – PROGRAMS AT RISK OF REDUCED STATE FUNDING

Program	Funding
Newborn Screening (medical testing–mostly genetic–to identify disorders that without intervention have permanent impacts on children and families)	$20,549,336
Elderly Pharmaceutical Insurance Coverage (EPIC) (Medication costs for low-income individuals after Medicare Part D)	$204,407,520
Supportive Housing Initiative (Medicaid Supportive Housing)	$197,222,030
Nourish NY (Emergency food purchasing for pantries, food banks)	$200,000,000
Community Services for the Elderly (Supports aging in place for frail, low-income older adults)	$122,500,000
Rural Health programs (Supports formal partnerships between health and human services providers)	$30,283,930
Supplemental Support to Ryan White Programs (health care and supportive services for people w/ HIV who are low income or uninsured)	$72,992,020
Vital Access Providers Assurance Program (VAPAP) (financially distressed facilities)	$2,019,200,000
End of AIDS (range of services, data surveillance, medications for uninsured etc.)	$49,131,104
Expanded In-home Services for the Elderly (EISEP) (non-medical in-home services)	$240,700,000

PERINATAL CARE AND WOMEN'S HEALTHCARE ACCESS

Over 35% of US counties are maternity care deserts

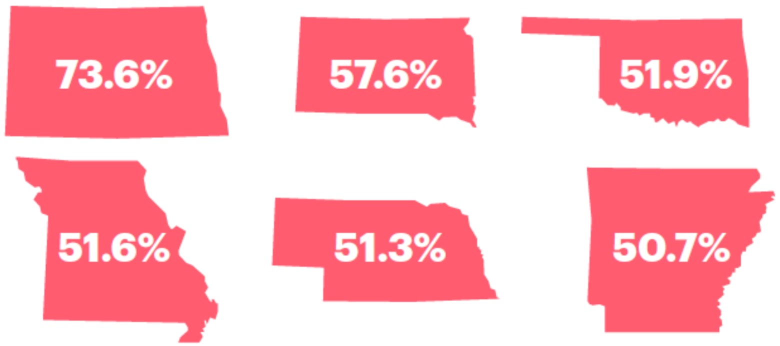
Figure 3. Maternity care access designation by county, US and Puerto Rico



Maternity care deserts are counties where there is a lack of maternity care resources:

- No hospitals or birth centers offering obstetric care
- No obstetric providers
- 2.2 million women of childbearing age live in maternity care deserts

States with the highest percent of maternity care deserts



Top Row: ND, SD, OK
Bottom Row: MO, NE, AR

Source: March of Dimes, 2024. *No Where to Go: Maternity Care Deserts Across the US.*

ECONOMIC AND OTHER POLICY FACTORS

Inflation

- Direct cost of supplies /cost of doing business
- Purchasing power of safety net benefits –
  - Increased hardship for families juggling multiple needs – food, transportation, medicine, housing and utilities

Tariffs

- Supply Chain
  - Pharmaceuticals (up to 100%; with expenses absorbed by Medicaid State plans, costs to safety net hospitals, The VA, and public health departments (PwC, 2025)
  - Cost of materials, Med Tech, Durable Medical Equipment, etc could raise hospital expenses by at least 15% (AHCRMM

Workforce Disruptions

- Changing eligibility to work
  - Direct service workers, subcontracted services, and Gig-Economy workers hit hardest
    - Certified nursing assistants, personal care attendants, CDPA, other paid caregivers,
    - Transportation, food delivery, pharmacy and grocery delivery
    - Subcontracted services (e.g. laundry; commissary services)
- Training and education funding cuts and policy changes
  - 4Health professions ineligible for government-backed student loans

BIG PICTURE

- Nothing happens in a vacuum
- Multiple regulations and programs interacting on access and revenue
- Other policy actions create conditions you can’t control
- Some changes create administrative burdens that are unfunded mandates
- Facilities reliant on high % public funding will need to diversify revenue and plan for resilience

NEXT STEPS FOR MITIGATING IMPACT

PROVIDER–LEVEL IMPACT	COMMUNITY-LEVEL IMPACT

› Project financial impact on your organization
› What supports care, quality, revenue goals?
› Identify technical assistance needs
  › Helping beneficiaries maintain coverage
  › Improved patient engagement and care continuity pathways
  › Facility designations and supplemental payment eligibility
› Identify operating support needs
  › Funding for health-related social needs and non-medical drivers of health to prevent adverse events
  › Bolster financial aid programs
› Consider any workforce investments
  › Social supports and outreach staff
  › Recruitment pipelines
  › Education cost offsets
	› Take proactive measures to address widespread decreased access to care
	› Leverage Community Benefit Funds to support health promotion and prevention
	› Support for community-based programs to keep people and communities healthy
	› Partner with organizations that can assist with navigating insurance coverage and health system access (redetermination, address verification, documenting community engagement)
	› Identify pathways to care for the uninsured and the uninsurable (as allowable by regulation)

WHERE ELSE CAN WE LOOK FOR LESSONS LEARNED?

- **How have health systems in other parts of the world responded to changes in health care financing?**
- **What do we know about future outcomes of populations with major disruptions in access to care and services?**
  - Surge management
  - Life disruptions
  - ACES impact on child development

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