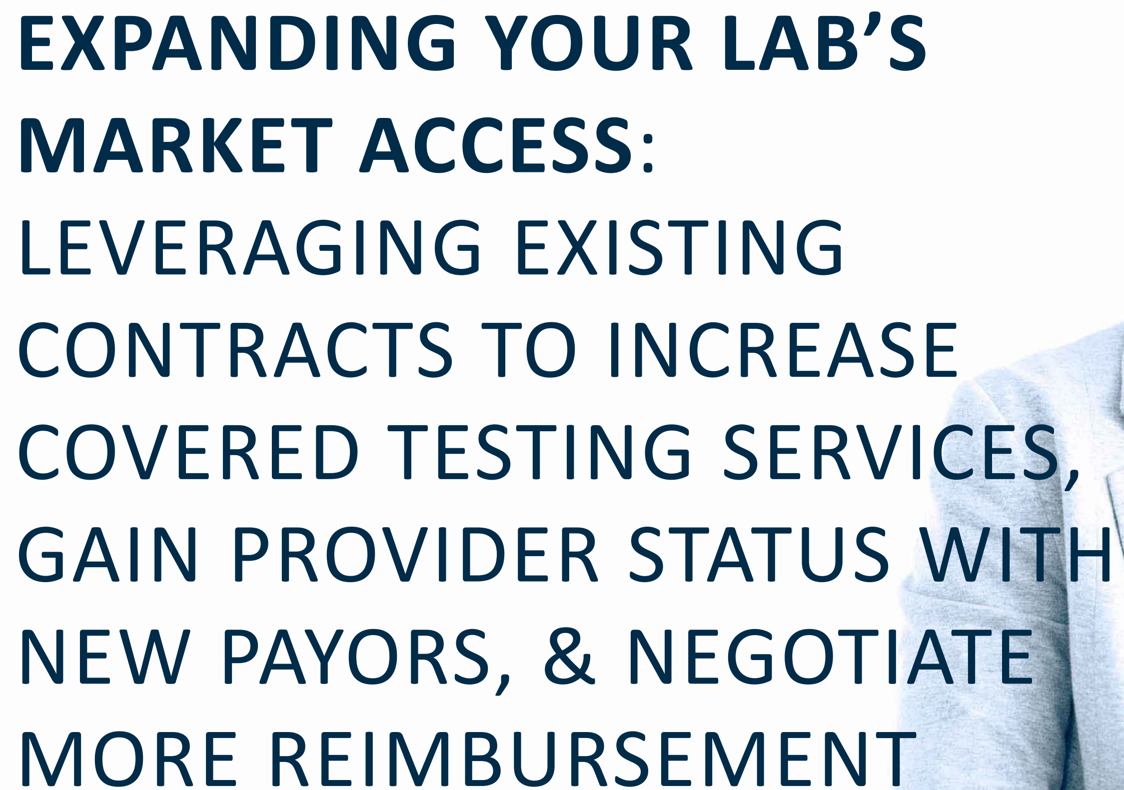

EXPANDING YOUR LAB'S MARKET ACCESS: LEVERAGING EXISTING CONTRACTS TO INCREASE COVERED TESTING SERVICES, GAIN PROVIDER STATUS WITH NEW PAYORS, & NEGOTIATE MORE REIMBURSEMENT

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Speakers

Heather Agostinelli
Vice President and Head of Specialty RCM
XiFin, Inc.

Heather Agostinelli, VP and Head of Specialty RCM at XiFin, brings 29+ years of healthcare expertise. Proficient in RCM best practices, she collaborates with top laboratory executive teams, sharing her proficiency and leading her team to manage RCM processes effectively, ensuring operational excellence.

Clarisa Blattner
Senior Director of Revenue and Payor Optimizations
XiFin, Inc.

Clarisa Blattner, the Sr. Director of Revenue and Payor Optimization at XiFin, Inc., is a renowned subject matter expert in revenue cycle management (RCM). With a keen focus on operational efficiency and revenue maximization, she brings over 20 years of invaluable experience in the healthcare sector.

Debbie Windsor
Vice President of Market Access

Debbie Windsor, VP of Market Access, is a seasoned healthcare executive with over two decades of experience. Her expertise in market access, strategic initiatives, and patient-centered care has consistently driven positive change and improved outcomes in the healthcare industry.

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Agenda

- Why investing in Market Access is crucial to success
- Why your Market Access team and RCM team need to be in lock-step
- Tools to solidify market access and payor coverage
- How your RCM solution/outsourced services provider can help
- XiFin-Recommended Best Practices for Market Access
- Q & A

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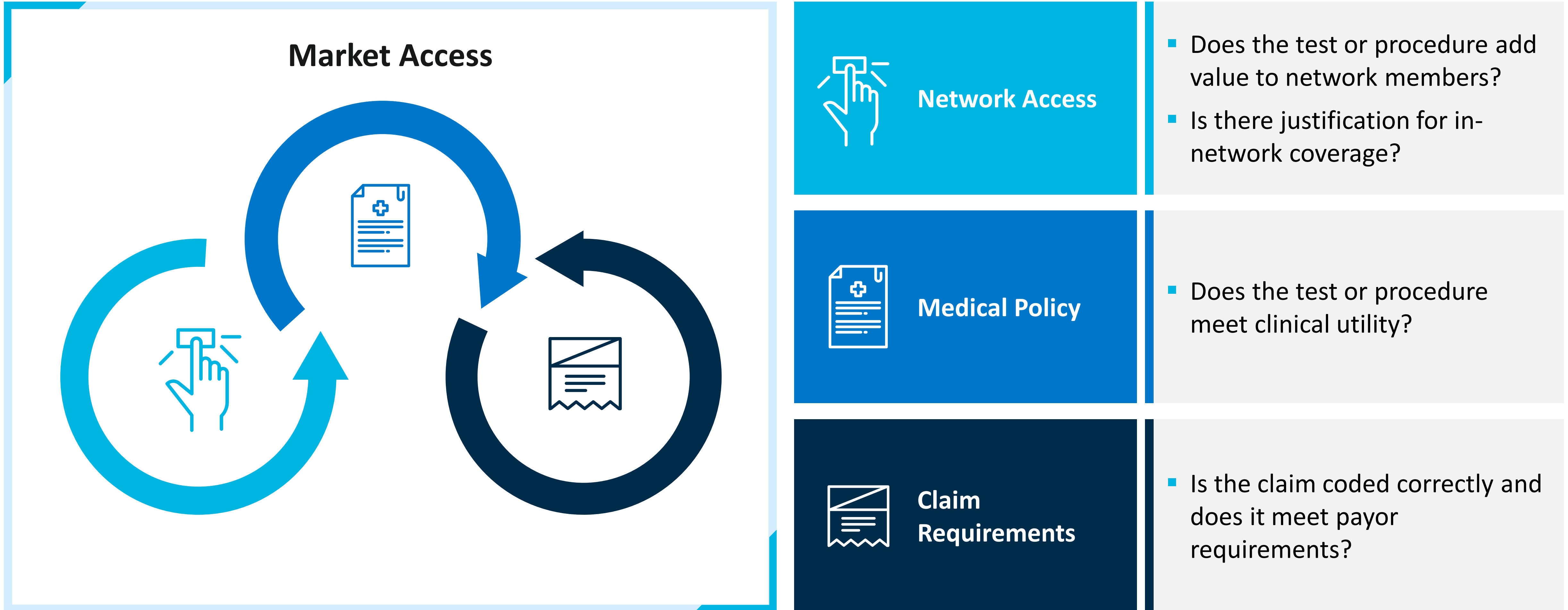
The Three Core Pillars of Market Access



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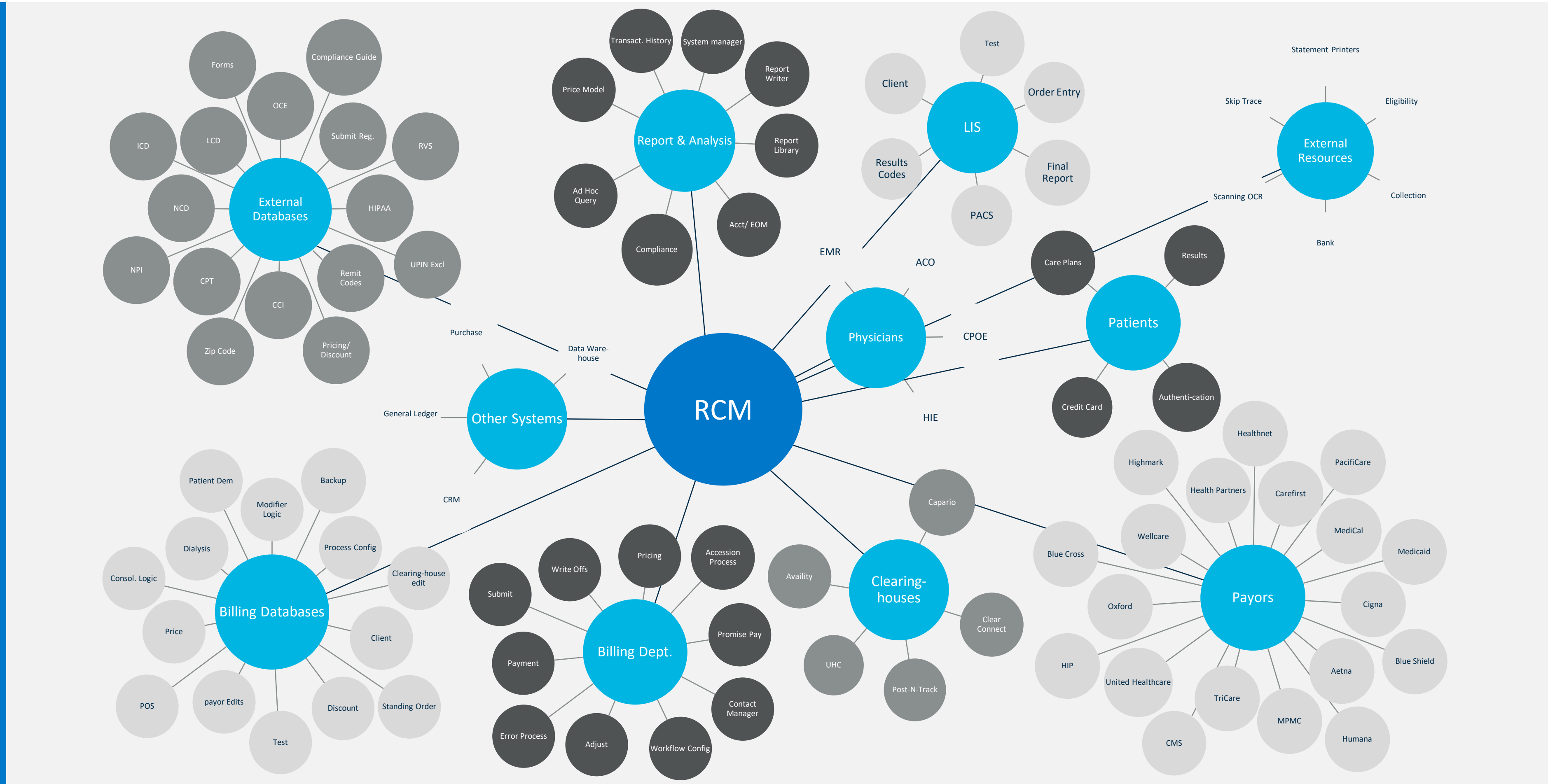
Diagnostic Billing Continues to Grow in Complexity

Connecting & Automating Your Ecosystem



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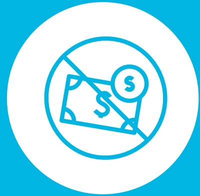
Common Challenges for Diagnostic Providers Across Specialties



Claims

- 35% of diagnostic procedures have errors that need correction from referring provider before they can be reimbursed
- 65% of denied claims never corrected & resubmitted up

3rd Party Payors

- Proliferation of rules
- Coding changes
- Increase in prior authorizations
- Increasing portion of reimbursements becoming patient responsibility

Labor Costs

- Billing and insurance-related costs ranged from $20 to $215 representing 3% to 25% of professional revenue*
- 62% of healthcare system administrative costs are attributed to billing and insurance-related activities**

Regulatory

- PAMA
- FASB
- EKRA
- False Claims Act
- No Surprises Act
- Hospital Price Transparency

Reiner, G., "Healthcare Financial Management Association [HFMA],"Success in Proactive Denials Management and Prevention" May 2021
*** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5839285/*

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Market Access

A Collaborative Approach is Essential

The Market Access team cannot operate effectively as an island. It must take a strategic, cross-departmental approach.

Market Access	▪ Payors must be seen as customers ▪ Payors must see tests & procedures as value-added services ▪ Gaining and expanding in-network coverage is a primary objective ▪ Requires clarity on medical policy
Commercial (Sales & Client Service)	▪ Growth-focused: Increasing order volume and achieving higher reimbursement ▪ Market access plays important role in commercial/GTM strategy ▪ Client experience is a core value
RCM	▪ Understanding of payor-specific requirements ▪ Develop coding expertise ▪ Measure outcomes by payor, service, and referring client ▪ High-efficiency processing through AI-powered workflow automation
Finance	▪ Deep understanding of cost per test/procedure (COGS) ▪ Client profitability analysis ▪ Need near-time insight into reimbursement changes to understand impact on revenue forecast

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Investing in Market Access is Crucial to Success

Market Access's role is to achieve consistent coverage across major payors.

Teams must be able to navigate complex reimbursement policies and coverage negotiations.

Establishing strong relationships with payors fosters trust and credibility, paving the way for expanded coverage and sustained growth.

Investing in Market Access team members with contracting and negotiating experience is vital to attain and broaden coverage.

The right team can streamline reimbursement, mitigate barriers to access, and enhance affordability for patients.

A seasoned Market Access team is indispensable to maximize impact and reach.

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Common Market Access Challenges

Organizations that offer complex or proprietary diagnostics or remote monitoring services often share four common, frustrating challenges:

1. Achieving payor coverage

2. Understanding coding requirements

3. Securing reimbursement Securing the right reimbursement.

4. Staying compliant with evolving payor policies

The best way to overcome these hurdles and achieve financial stability and sustainability is through collaboration between the market access, commercial (i.e., sales), and revenue cycle management (RCM) teams.

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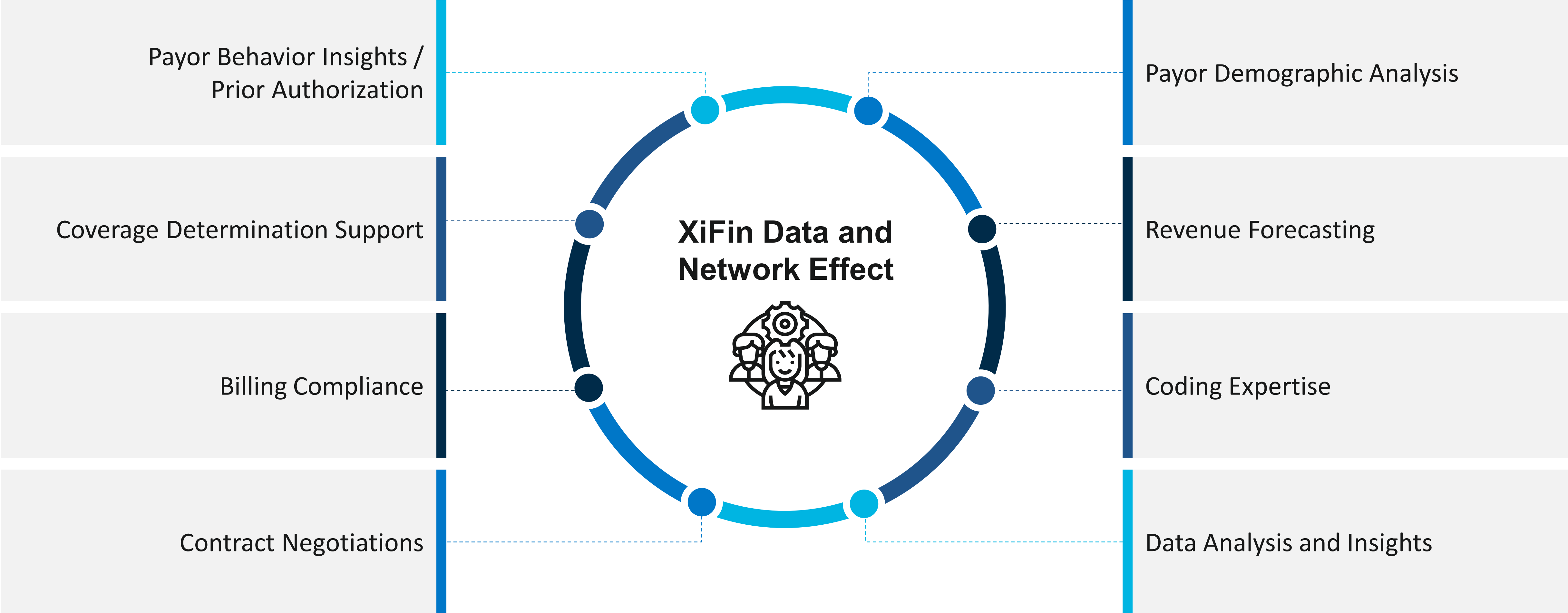
RCM Data and Expertise Supports Access and Coverage



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Payor Behavior Insights: Discrepancy Reporting

The Expect Discrepancy Analysis compares the previous 90 days of third-party payor reimbursement with current expect price tables.

The Discrepancy Detail illustrates each distinct allowed amount compared against the established expect price and its statistical weight in the sample.

The Discrepancy Impact describes the total financial impact of the discrepancies over the specified time period.

Payor ID	Procedure Code	Modifi	Fee Schedule	Allowe	Effective Price	Value of Impact	Confiden	Claim Populati	Varian	Customer Impact	% Varian	Payor group	Payor Name
XXXXXXX-A	XXXX1		MCNJ-XX-ZZ	$2.94	$8.83	$149,959.40	99%	25,671	$5.89	$151,202.19	-200%	Medicare	MEDICARE - NEW JERSEY
XXXXXXX-B	XXXX2		WCNATIONALXXXX	$5.85	$4.75	$5,606.70	75%	6,761	($1.10)	($7,437.10)	19%	Medicare Advantage Contracted	WELLCARE NY MEDICARE
XXXXXXX-C	XXXX3		MOLINANYMCD-XX	$4.75	$10.00	$29,442.00	100%	5,612	$5.25	$29,463.00	-111%	Medicaid MCO Contracted	MOLINA HEALTHCARE OF NEW YORK
XXXXXXX-D	XXXX4		AETNAYYYY	$8.49	$7.81	$3,752.92	100%	5,529	($0.68)	($3,759.72)	8%	Medicare Advantage Contracted	AETNA MEDICARE ADVANTAGE
XXXXXXX-B	XXXX5		WCNATIONALMCR20	$4.30	$3.50	$3,268.00	77%	5,339	($0.80)	($4,271.20)	19%	Medicare Advantage Contracted	WELLCARE NY MEDICARE
XXXXXXX-E	XXXX6		METROMCD-ZZZZ	$20.15	$0.30	$99,408.80	100%	5,015	($19.85)	($99,547.75)	99%	Medicaid MCO Contracted	METRO PLUS HEALTH PLAN MEDICAID
XXXXXXX-B	XXXX7		WCNATIONALMXXXX	$5.38	$4.37	$3,094.64	77%	3,980	($1.01)	($4,019.80)	19%	Medicare Advantage Contracted	WELLCARE NY MEDICARE
XXXXXXX-C	XXXX8		MOLINANYMCD-XX	$7.56	$9.00	$5,126.40	100%	3,560	$1.44	$5,126.40	-19%	Medicaid MCO Contracted	MOLINA HEALTHCARE OF NEW YORK
XXXXXXX-B	XXXX9		WCNATIONALMXXXX	$9.31	$7.56	$4,660.25	75%	3,528	($1.75)	($6,174.00)	19%	Medicare Advantage Contracted	WELLCARE NY MEDICARE
XXXXXXX-C	XXX10		MOLINANYMCD-XX	$4.37	$9.71	$17,408.40	100%	3,262	$5.34	$17,419.08	-122%	Medicaid MCO Contracted	MOLINA HEALTHCARE OF NEW YORK
YYYYYYY	XXX11		FIDELISAAAA	$18.47	$51.31	$99,505.20	100%	3,032	$32.84	$99,570.88	-178%	Medicaid MCO Contracted	FIDELIS CARE OF NEW YORK MEDICAID MC
XXXXXXX-B	XXX12		WCNATIONALXXXX	$3.21	$2.60	$1,216.34	78%	2,550	($0.61)	($1,555.50)	19%	Medicare Advantage Contracted	WELLCARE NY MEDICARE
XXXXXXX-E	XXX13		METROMCD-ZZZZ	$3.00	$0.30	$6,777.00	100%	2,510	($2.70)	($6,777.00)	90%	Medicaid MCO Contracted	METRO PLUS HEALTH PLAN MEDICAID
ZZZZZZZ	XXX14		SUNSHINESTATEDD	$5.03	$7.04	$4,765.71	100%	2,371	$2.01	$4,765.71	-40%	Medicaid MCO Contracted	SUNSHINE STATE HEALTH PLAN
XXXXXXX-D	XXX15		AETNAYYYY	$10.96	$10.08	$1,805.76	100%	2,056	($0.88)	($1,809.28)	8%	Medicare Advantage Contracted	AETNA MEDICARE ADVANTAGE
XXXXXXX-D	XXX16		AETNAYYYY	$7.03	$6.47	$1,145.76	100%	2,050	($0.56)	($1,148.00)	8%	Medicare Advantage Contracted	AETNA MEDICARE ADVANTAGE
VVVVVVV	XXX17		HEALTHFIRSTJJJJ	$20.01	$33.35	$27,266.96	100%	2,044	$13.34	$27,266.96	-67%	Medicaid MCO Contracted	HEALTHFIRST NY & NJ
XXXXXXX-C	XXX18		MOLINANYMCD-XX	$13.32	$29.60	$33,178.64	100%	2,040	$16.28	$33,211.20	-122%	Medicaid MCO Contracted	MOLINA HEALTHCARE OF NEW YORK
XXXXXXX-C	XXX19		MOLINANYMCD-XX	$6.79	$12.50	$6,983.33	100%	1,225	$5.71	$6,994.75	-84%	Medicaid MCO Contracted	MOLINA HEALTHCARE OF NEW YORK
XXXXXXX-D	XXX42	TC	AETNAYYYY	$63.16	$58.11	$484.80	100%	96	($5.05)	($484.80)	8%	Medicare Advantage Contracted	AETNA MEDICARE ADVANTAGE
XXXXXXX-A	XXX81	26	MCNJ-XX-ZZ	$23.70	$24.58	$51.04	91%	64	$0.88	$56.32	-4%	Medicare	MEDICARE - NEW JERSEY

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Understanding Payor Behavior

Payor Trend Analysis

Payor reimbursement behavior is complicated and constantly changing:

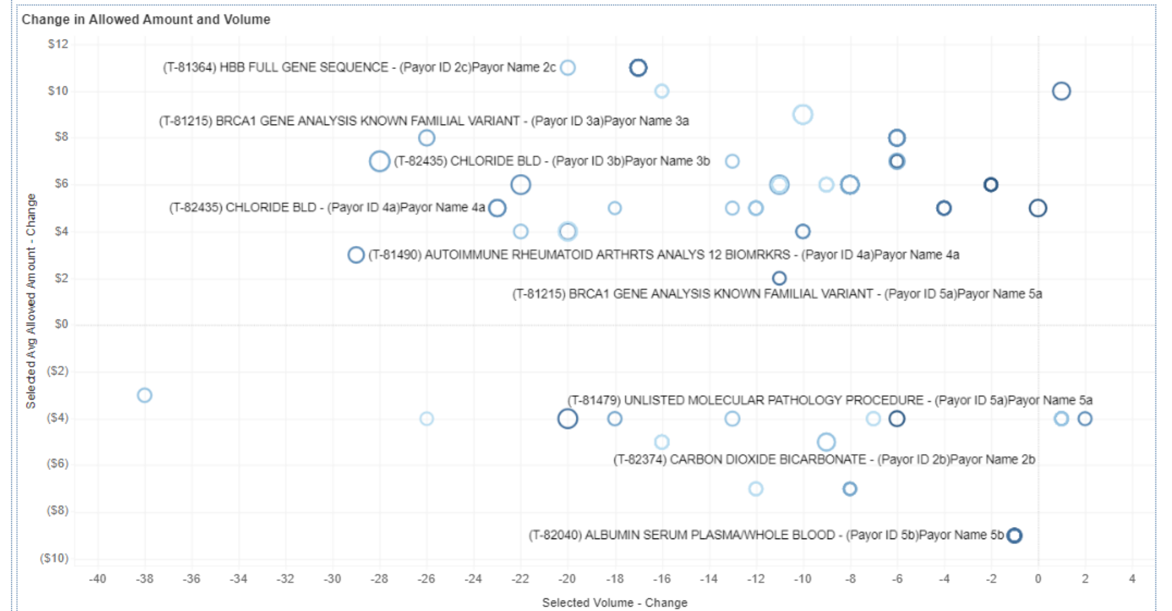
- New products and plans
- In and out-of-network providers
- Policy evolution
- Service-level limited coverages

These changes manifest in billing as:

- New denials
- Changes in denial rate
- Change in % reimbursement
- Change in time to payment

Failure to quickly recognize and adapt workflow to payor reimbursement changes can result in:

- Costly appeals projects
- Bulk write-offs
- Patient billing – audit prevention



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Understanding Top Denial Reasons

CO151

Payment adjusted because the payor deems the information submitted does not support this many/ frequency of services

CO252

Claim will be reconsidered when additional claim information is received

CO96

Non-covered charges

CO50

Non-covered services because this is not deemed a 'medical necessity' by the payor

CO55

Experimental/ Investigational, when a procedure code is billed with an incompatible diagnosis for payment purposes, and the ICD-10 code(s) submitted is/are not covered under an LCD or NCD

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Example: Understanding Medical Record Documentation Requirements

Who?
Ordering/referring provider

What?
What service(s)/test(s) is/are being ordered?

Where?
Where is the specimen being sent?

When?
Date service was provided

Why?
Patient’s signs/symptoms or what prompted the test to be ordered

How?
How are the test results being used to manage the patient’s medical condition?

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Prior Authorization

Programmatic Approach is Essential

Market Access

- Monitoring on payor policy by plan and service
- Successful coverage tied to appeals strategy
- Gold Card status
- Negotiate away requirements

Commercial

- Educated and engaged sales team
- Referring entity's existing PA process (potential to leverage)
- Drive adoption of portals/other methods of info collection
- Client education program

RCM

- Visibility to payor plan/service-specific requirements
- Measure outcomes by payor, service, and referring client
- Cross-departmental feedback loop – Market Access, Commercial, and Finance
- Potential for genetic counseling

Finance

- Continuous process improvement
- Client profitability analysis
- Overall strategic decisions

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Gold Card Approach to Prior Authorization

Gold Card Act of 2022
H.R. 7955

Exempts physicians from prior authorization requirements if 90% of the physicians' requests were approved in the preceding 12 months

States that have introduced the "Gold Card" legislation

- Colorado
- Indiana
- Kentucky
- Mississippi
- New York
- Texas
- West Virginia

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Increasing Burden of Audits

Healthcare providers are experiencing an increase in pre-adjudication and post-adjudication audits.

New requirements from payors to submit correspondence, medical records, and/or medical necessity documentation before adjudication.

RCM partners can support by:

- Collaborating to better understand payor requirements.
- Identifying opportunities to streamline processes through electronic communication of data to payors.
- Leveraging payor relationships to resolve audits more quickly; ensuring correct information is submitted with the initial claim.

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How Your RCM Partner Can Help

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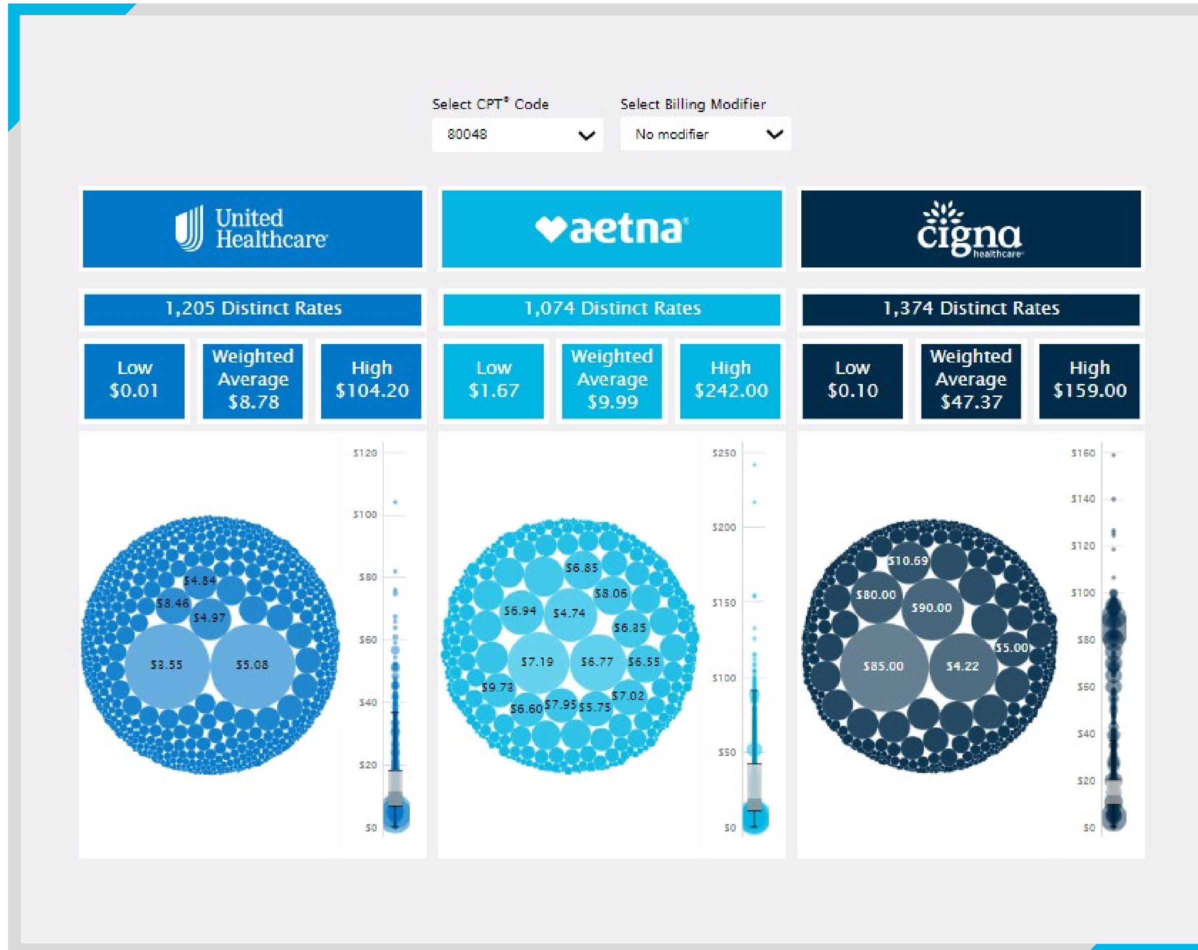
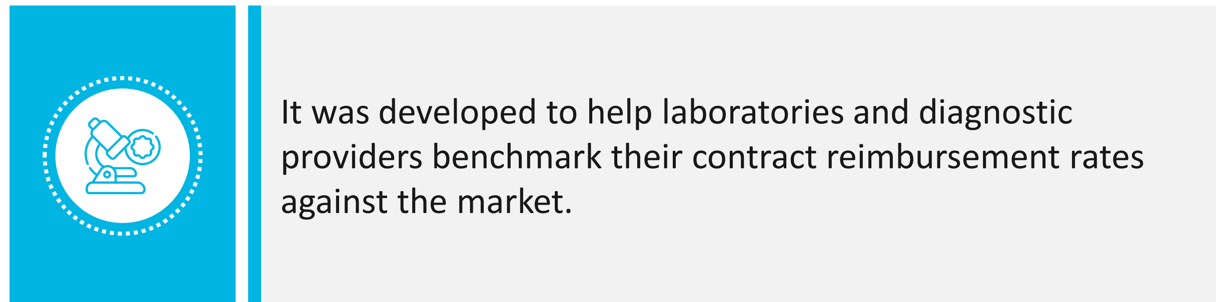
Payor Rate Transparency Monitor

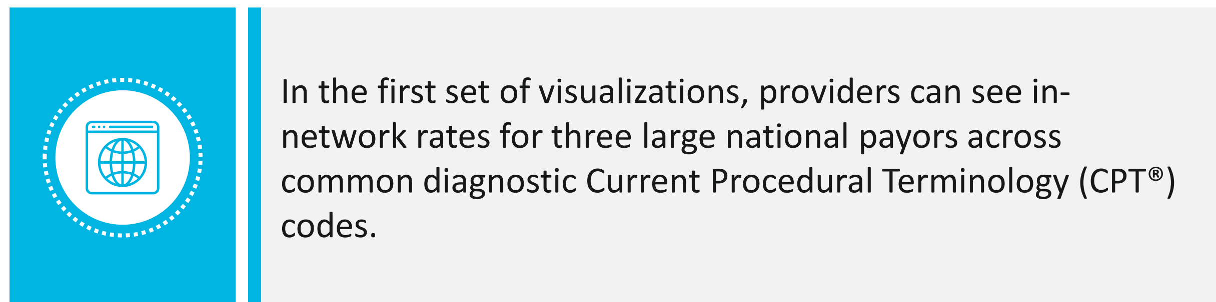
Health plan contracted pricing comparison by CPT



The Payor Rate Transparency Monitor was introduced in December 2023.



It was developed to help laboratories and diagnostic providers benchmark their contract reimbursement rates against the market.



In the first set of visualizations, providers can see in-network rates for three large national payors across common diagnostic Current Procedural Terminology (CPT®) codes.

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XiFin-Recommended Best Practices for Market Access

Analyze your payor mix

Understand the relevant medical policies

- For Medicare or Medicaid billing, are there local coverage determinations (LCDs) or national coverage determinations (NCDs) that impact your services?

Know your prior authorization (PA) requirements

Work with your RCM partner to leverage their data resources and contacts

- Your RCM partner can query their cross-customer data to understand average reimbursement for similar services, top denial reasons, and denial trends
- Leverage your RCM partner's contacts and relationships with payors and policy advisors

Meet regularly across teams to share data and trends to prioritize efforts

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Questions

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Thank you