HLX RECAP + RESOURCES

2024 Healthcare Leadership Exchange

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HEALTH PARTNERS

"This event is not just an opportunity to network, but a platform to share insights, explore innovative solutions and forge partnerships that will drive meaningful change in healthcare."

Judson Ivy, Founder, President + CEO, Ensemble

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2024 HEALTHCARE LEADERSHIP EXCHANGE

Executive Insights

We brought together more than 50 healthcare executives and industry leaders for meaningful dialogue about the economy, healthcare policy and changing payer-provider dynamics. The following is a summary of the ideas and insights shared.

What's Inside

What to Expect with the Next Administration

As an unpredictable election cycle unfolds, healthcare remains surprisingly absent from the campaign spotlight. Yet, behind the scenes, significant policy shifts are transforming the healthcare landscape and experts predict many changes will persist regardless of the election outcome.

Quick hits

> There will be more regulatory uncertainty and administrative burden.

> Enforcement will remain focused on antitrust, whistleblowing and fraud.

> Rationalizing and right-sizing will guide policy efforts for the next decade.

> Both payers and providers will be fighting to extend ACA subsidies.

There will be more regulatory uncertainty and administrative burden across the industry.

"The Supreme Court really dropped a bunch of meteors onto the government in 2024," explained Eric Hargan, former Deputy Secretary of HHS, citing three key rulings that are poised to redefine how regulations are established and challenged.

> [The Corner Post decision] may mean that [HHS] is in the business now of defending all its old regulations perpetually.
>
> Eric Hargan

The Chevron decision has garnered significant media attention, even outside of the legal community, as it overturned the way administrative law has been practiced for more than 40 years. Instead of deferring to the administrative agencies to interpret laws, courts now have the authority to interpret laws themselves.

Eric Hargan, former Deputy Secretary of HHS, discussed recent legislation that could increase administrative burden and uncertainty for providers and government agencies.

Corner Post v. Board of Governors: The court held that the statute of limitations starts when an injured party first experiences that injury, rather than when the regulation is first published, which opens the path to legal action against a wide variety of longstanding regulations which have historically been difficult to challenge, explained Hargan. "This may mean that the department is in the business now of defending all of its old regulations perpetually, in different forms all over the place."

SEC v. Jarkesy: This ruling mandates that the SEC must prosecute securities fraud cases in federal court, granting defendants the right to a jury trial, calling into question the legality of many agency-originated civil penalties. The shift from administrative proceedings to federal courts could increase the administrative burden on hospitals, requiring more resources for legal compliance and defense.

Kirk Ogrosky, former Deputy Chief of Healthcare Fraud, DOJ
Greg Demske, former Chief Counsel, OIG
Justin Bernick, antitrust defense attorney, Hogan Lovells

Enforcement efforts will remain focused on antitrust, whistleblowing and fraud.

Matt Tormey, Ensemble's Chief Compliance Officer, was joined by Kirk Ogrosky, the former Deputy Chief of Healthcare Fraud at the DOJ, Greg Demske, former Chief Counsel at the OIG and Justin Bernick, Partner at Hogan Lovells in global regulatory, to discuss key focus areas for enforcement in the current and future administration.

> ## Antitrust is having a moment unlike anything we've seen in modern history.
>
> Justin Bernick

Antitrust: Antitrust enforcement is experiencing heightened scrutiny, particularly in the healthcare sector. The Biden administration has prioritized antitrust issues, leading to increased enforcement actions by the FTC and DOJ, which our panelists believe will continue regardless of the next administration. New guidelines are making it easier for the government to challenge transactions that could reduce competition.

Even without pending acquisition targets, CEOs should anticipate antitrust issues that might arise. Bernick recommends thoroughly reviewing payer contract provisions, especially when they're up for renewal, to make sure there's nothing that's going to "raise antitrust tripwires, especially if you have relatively high market share in your geographic area."

Whistleblowing: The DOJ has introduced a pilot program to encourage whistleblowers to report fraud, particularly in commercial insurance and Medicare Advantage plans. Whistleblowers can receive significant financial rewards, which incentivizes reporting of suspected fraud and will likely lead to an increase in criminal cases.

Ogrosky suggested organizations conduct thorough investigations of any reported concerns and have great employment lawyers on hand to support any reported issues.

Medicare Advantage Fraud: The DOJ is aggressively pursuing cases involving Medicare Advantage risk adjustment fraud and other fraudulent activities by providers and payers. Hospitals must be prepared for audits and investigations into their Medicare billing practices and provide continual compliance training to staff.

Download this tip sheet: How to respond to DOJ civil investigative demands

Rationalizing and right-sizing will guide policy efforts for the next decade.

Hargan was joined by Molly Smith, Group Vice President of Public Policy at the American Hospital Association, and Andrew Donahue, Director of Healthcare Finance Policy at HFMA, to discuss policy trends heading into the next administration. They predict that the first 100 days, regardless of party, will be focused on finding ways to pay for government funding and tax cuts, which will lead to more concerted efforts to cut healthcare spending.

"A lot of what we're talking about with health policy right now is increasingly a financial story…a lack of tax revenue to pay for these glorious benefits we've committed over decades for this very large generation," explained Donahue.

> Cuts are going to be coming. What we need to do is be very careful about directing cuts to where it's not going to impact access, quality or coverage.
>
> Molly Smith

The panel agreed that either administration is likely to take an incremental approach to cost cutting, focusing on **expanding site neutral payments, scaling back 340B** and continuing to evaluate ways to eliminate **administrative waste and consumer friction** from the healthcare system.

"Especially with the status of the Medicare trust fund, cuts are going to be coming. What we need to do is be very careful about directing cuts to where it's not going to impact access, quality or coverage," Smith said.

**Molly Smith,** Group VP, Public Policy, AHA

How to Take Action

One major theme was a concern for the lack of awareness policymakers and the public have about the financial pressure hospitals are under. Our panel urged the audience to take action through advocacy and education:

#1 Amplify your voice: Get active in your state hospital association. Share data and stories with the American Hospital Association so they can advocate on your behalf.

#2 Activate your community: Leverage the power of social media to compel state and federal representatives to visit your facilities. Encourage employees to vote and give them time off to do so.

#3 Streamline your message: Combine compelling data with relatable anecdotes to help educate your board and policymakers about the financial implications and community impact of bad payer behavior and inequitable policies.

Brad Gingerich, VP, Payer Strategy, Ensemble
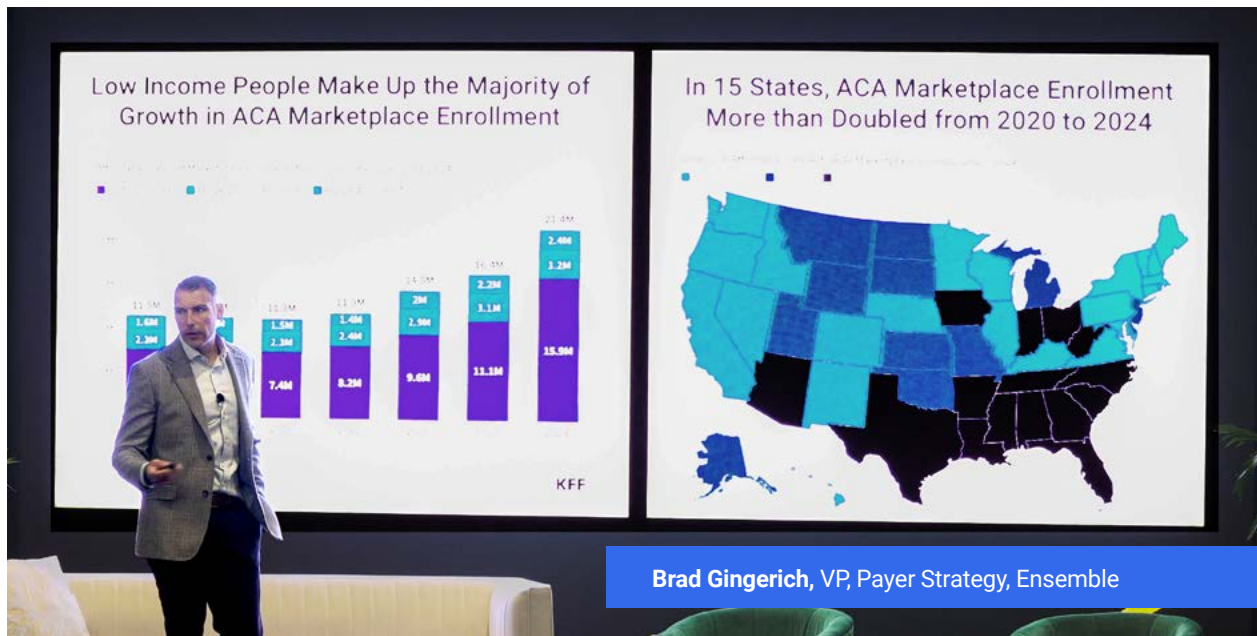
Both payers and providers will be fighting to extend ACA subsidies.

In addition to the need to address a concerning decline in children's coverage, Smith stressed the importance of fighting for the renewal of ACA subsidies that are set to expire in 2025.

> Making sure that we can preserve coverage is going to be very, very important for most hospitals and health systems.
>
> Molly Smith

ACA subsidies have made health insurance more affordable, with the added benefit of bringing favorable commercial reimbursement rates and contracting leverage to providers.

"We're seeing a conversion from uninsured or Medicaid over to a commercial product which traditionally pays 2 to 3 times Medicaid," explained Brad Gingerich, Vice President of Payer Strategy for Ensemble.

He expects to see an increase in lobbying efforts from payers and providers, noting that renewing ACA subsidies "may be a rare topic that payers and providers are aligned on."

Failing to extend the subsidies for ACA plans poses significant risks:

Millions could lose coverage, which could lead to increased uninsured rates. Lower-income enrollees would experience the steepest premium increases if subsidies expire.

Self-funded employer costs will increase if employees move back to their employer plans once lower-cost ACA options disappear.

Providers could face significant revenue loss if patients move from commercially insured to Medicaid or uninsured populations.

How to take action

Gingerich explained how to leverage ACA plan membership growth during negotiations:

#1 Educate consumers during open enrollment

#2 Ensure contracted rates are equivalent to commercial rates

#3 Support lobbying efforts to renew subsidies

Read more about the opportunities presented by ACA plans.
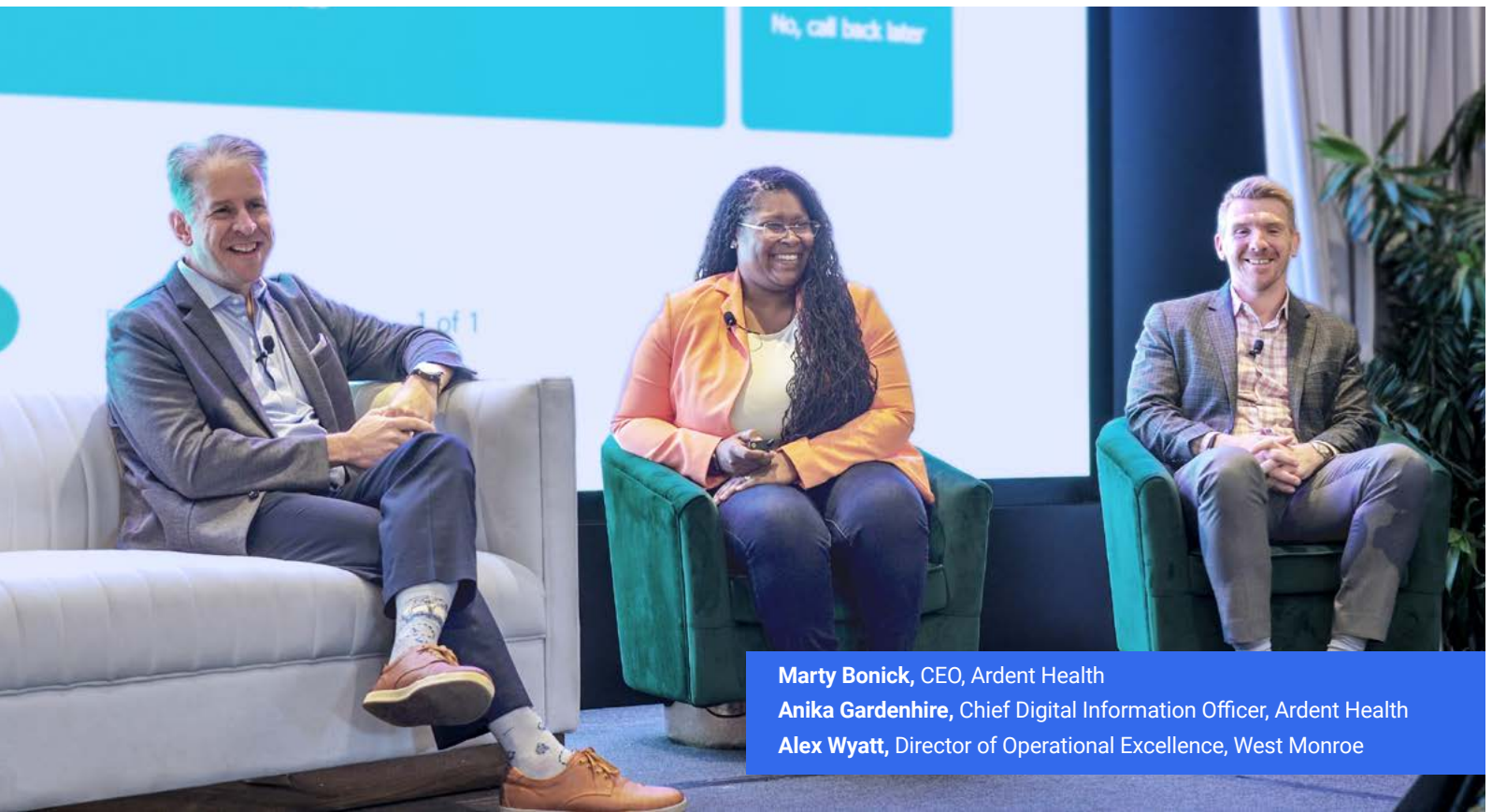
Marty Bonick, CEO, Ardent Health
Anika Gardenhire, Chief Digital Information Officer, Ardent Health
Alex Wyatt, Director of Operational Excellence, West Monroe

Actionable Insights

We've distilled key insights from HLX discussions into tangible takeaways your organization can immediately put into action.

Quick hits

> How to prepare for rapid recovery from a cyber attack

> How to succeed with AI initiatives

> How to go toe to toe with payers and win

How to Prepare for Rapid Recovery From a Cyber Attack

Ardent Health CEO Marty Bonick and Chief Digital Information Officer Anika Gardenhire shared their harrowing experience of managing a ransomware attack that struck on Thanksgiving Day, underscoring the critical importance of preparedness, rapid response and effective communication during such crises.

> When you think of hacking, don't think 'kid in a hoodie' like in the movies. Think Ocean's Eleven.
>
> Anika Gardenhire

Don't underestimate how sophisticated cyber attacks can be.

Gardenhire explained that the common portrayal of hackers in movies — a kid in a hoodie behind a screen clicking for 15 seconds — could not be farther from reality.

"Think Ocean's Eleven and lots of detailed planning. Think contractors and subcontractors. ...There's an entire industry [in the background] making this happen. ...We have to fight this as an industry as well," said Gardenhire.

Establish clear decision-making authority.

Within hours of seeing ransomware notification pop up on screens, Ardent's leadership made the difficult decision to turn off the internet to contain the threat and prevent further damage.

"We put the entire healthcare system in airplane mode," explained Bonick.

Gardenhire emphasized how critical clear decision-making authority is when time is of the essence. She shared that a CIO of another organization recently impacted by a cyber attack was "very vocal about the amount of time wasted figuring out who could make what decisions."

Practice extended downtime procedures without internet connectivity.

Being able to implement downtime procedures and transition to divert status effectively is critical, but many organizations don't practice downtime with the entire internet going down.

"It's amazing the number of things that actually run on the internet backbone today," said Bonick. "Just take your phone, put it in airplane mode and go, okay, how functional is this device? You can still use some of the apps, but they don't talk to each other."

Transitioning to manual process was a significant hurdle, especially with staff who've never had to use a paper-based process before. Gardenhire also expressed how critical access to basic supplies like paper is during internet downtime.

"You've got [crash] packs meant to last you a day or two days, but what happens on day three and four and five?" she asked.

Questions to ask yourself

> **How long can we survive** without dropping a bill or collecting money?

> **How much cash on-hand do we have** to pay staff and vendors without a working payroll system?

> **How much insurance do we have** for cyber and business interruption?

> **How will we communicate updates** to staff, physicians, business partners and our board?

> **How will we reassure the community** of our ability to safely care for patients?

Questions to ask your teams

> Do we have **proper monitoring** in place to identify if a bad actor is in our system?

> Are our **backups secure** and could we restore them if needed? How long would it take?

> Do we have **on-call resources** for negotiation assistance, extraction and restoration?

> Do we have a **phone tree** that outlines the notification process for leaders and teams?

> Who would stand up the **hospital incident command system** (HICS)? How would we run the HICS if phone systems were compromised?

Common pitfalls to avoid

> **Overconfidence** in disaster recovery solutions or the organization's ability to "figure it out on the fly'"

> **Misalignment** that business continuity is an IT-owned activity

> **Lack of detailed procedures** and supporting provisions for maintaining critical processes during a disruption

> **Lack of testing** or operational readiness to respond to a disruption

Tools + templates

Alex Wyatt, the Director of Operational Excellence at West Monroe, emphasized the importance of proper business continuity planning and provided the following resources:

Business Continuity Policy: This helps establish organizational expectations and responsibilities.

Business Impact Analysis: This helps establish critical processes, define IT recovery requirements and identify areas of risk.

Critical Process Business Continuity Plans: These define the actions the business should take to maintain critical operations during a disruption.

Click on the links above to download business continuity templates provided by West Monroe.

How to Get Started with Generative AI

[Manish Goyal](#), Operating Partner at Berkshire Partners, shared valuable insights on how organizations can successfully leverage generative AI. He noted that projections of its economic impact range from $7 trillion to $20 trillion, but the gap between potential and realized value is still significant.

"Everybody's talking about it. Everybody says they're doing a ton of pilots. And yet when you really peel behind the covers, not too many people are getting a lot of value out of this," he explained. This dichotomy underscores the importance of focusing on practical applications that deliver tangible benefits.

Here are the key steps Goyal recommends organizations take to start harnessing the full potential of this transformative technology.

Leverage differentiated data.

One of the key steps for success is leveraging proprietary data to develop effective use cases. Goyal noted payers like United Healthcare and Aetna are already making significant investments in this space. He cited a recent McKinsey report that estimates payers will see $1 billion of impact from AI initiatives on every $10 billion in revenue.

"There's a lot of upside for the payers and they're working aggressively on it," he explained. "And they have a substantial advantage because the data they're looking at is much broader than most of us have in this room."

> ## The biggest mistake I see companies make is not getting started. You can, and should, get started.
>
> Manish Goyal

Prioritize strategic use cases.

Not all AI projects will yield immediate results, so it's essential to focus on those that align with business goals and have a high potential for impact.

"This is an evolving technology. There will be misses," he said. "So as you're thinking about use cases, really think about where the tech applies. Is it an important enough business problem? And can I do this in a way where I'm accessing data that I previously couldn't?"

These use cases can range from productivity enhancements, like automating tasks and improving processes, to product innovation, which involves using AI to improve and refine customer offerings.

Examples Goyal is seeing across the Berkshire portfolio include copilots to support coding and staff education, natural language processing, document classification, predictive logistics in manufacturing, customer service agents and operational enablers like the [AI-enabled appeal letters Ensemble is piloting](#).

Manish Goyal, Operating Partner, Berkshire Partners
Grant Veazey, Chief Technology Officer, Ensemble
Andrew Ray, SVP, Operational Excellence, Ensemble

Solve the last mile problem.

Successful implementation and adoption requires alignment between business and technology teams, rapid evaluation and a unified tech stack to avoid fragmentation and ensure scalability.

> ## Every business person has to be a technologist and vice versa.
>
> Manish Goyal

When working with probabilistic models instead of deterministic models, deciding how you will evaluate success is critical. Create the right metrics to measure different parts of the pipeline, including quality of ingestion, retrieval of information, generation of final response or agent actions.

Invest in the right infrastructure.

Successful AI projects require significant investment in skilled professionals and robust data platforms, but starting small with manageable projects can demonstrate quick wins to help build confidence and momentum.

Goyal shared examples from the Berkshire portfolio of companies who have started their AI journeys. The smallest company has two people working on a document extraction use case part time. One of the largest efforts is at Ensemble with nearly 300 data scientists and engineers working on multiple use cases in execution and development.

"What's most important to me is that these companies actually got started," said Goyal.

AI in action: See how Ensemble is helping clients increase revenue yield and improve the patient experience with generative AI for clinical appeals and customer service.

>

How to Go Toe to Toe with Payers + Win

[Brad Gingerich](#), Vice President of Payer Strategy at Ensemble, sat down with [Billie Jean Mounts](#), Chief Revenue Officer at Bon Secours Mercy Health, [Paul Hiltz](#), CEO of NCH, and [Teddy Scherpenberg](#), CFO of The Christ Hospital Health Network, to discuss actionable strategies and lessons learned from successfully going toe to toe with payers.

Here are practical strategies that health system CEOs and CFOs can implement to shift from defense to offense in the fight against bad payer behavior:

Get comfortable being a squeaky wheel.

Don't let fear of uncertainty paralyze you from action. Demand letters are part of the business, explained Gingerich. "Our partners who have the best relationships with the most challenging payers are those that are the squeaky wheel."

"Specific to 340B, we have sent demand letters to every single MA payer," Mounts explained. "And the responses have been emphatic. No. They don't think CMS has the authority to get involved in that."

As the AHA has recommended, Mounts is vetting various law firms to support her efforts in challenging the payers on this topic and others.

Make your voice heard: If you suspect a possible violation of the Medicare Advantage CY2024 Rule, [submit this form to CMS.](#)

> ## You cannot delay getting demands on record to start the litigation process. This needs to be the approach with all payers on all payment issues.
>
> Billie Jean Mounts

"Unfortunately, payers only respond to two things: termination and litigation. So those are the tactics. And we've got to be very diligent," she explained. "These are things we're going to have to stay on top of. You cannot delay getting demands on record to start the litigation process. This needs to be the approach with payers on all payment issues."

Mounts shared her excitement about leveraging generative AI to amplify efforts. "Right now the process is to go through all your AR, batch it all up and send them a big letter for [millions of dollars]. Can you imagine just sending out individual appeal letters? They have to respond to every single correspondence. ...It's time to turn the tables on them and put the administrative burden back on the payer."

"We've quantified what it costs for keeping a patient in the hospital waiting for a [skilled nursing facility] authorization and I'm sending a demand letter. They owe us that reimbursement," she said.

Rally everyone around your efforts.

Getting in front of the story is key, explained Scherpenberg. He suggested taking time to explain to the public that the relationship with the payer isn't equitable, describe the macroeconomic conditions within healthcare and underscore why these rates increases are so important.

> I think messaging to the community long before you get into the negotiations was the biggest learning.
>
> Teddy Scherpenberg

During NCH's recent public renegotiation, Florida Blue representatives reached out to NCH's board, local employers and elected officials trying to control the narrative.

"We've had to sharpen up our story," he said, noting that drawing attention to specific payer performance issues can help educate stakeholders. "I was surprised when I got real involved in this is that Florida Blue's initial denial rate is like four times higher than any of the other commercial payers."

Scherpenberg reinforced how critical it was for his organization to engage the community, including large employer groups, when they went through a similar termination negotiation. "I think building that trust and building those relationships is going to set us up for the next time, because I'm sure there will be a next time," he said.

"We still enjoy great sentiment in the community. The payers are not the good guys in the public opinion," Hiltz added. "So it's important to remind the public why you need fair compensation."

Ad from NCH's campaign during Florida Blue negotiation

He shared that NCH's clinical staff has been very supportive during their recent public negotiation with Florida Blue. "They come up and say, 'why didn't you do this 10 years ago? It's about time we stand up for what we deserve.'"

Plan ahead + stay the course.

Planning ahead, gaining early alignment across the organization and establishing strong communication with stakeholders is critical during payer disputes, Mount explained. "You've got to gear up for this. You can't do it in 30 days."

Mounts shared her lessons learned with NCH to help them prepare for the public renegotiation with Florida Blue. "There is a playbook the payers follow and you've got to be patient and take emotion out of the process," she explained.

"You kind of have to take it to the line, and ultimately they want to see if you're willing to," Hiltz said. "They don't negotiate. They don't really respond. ...It's just been no, no, no."

"They don't start wheeling and dealing until they have to," Gingerich added. "And that's the 25th hour or so, from their perspective."

Post-conference progress: September 30 was the termination date for NCH's Florida Blue contract, and an agreement was finally reached on that date.

Brad Gingerich, VP, Payer Strategy, Ensemble
Billie Jean Mounts, Chief Revenue Officer, BSMH

Hold payers accountable.

The hard work is not over once the contract negotiation is done. Favorable terms are only as good as your ability to enforce them and hold payers accountable.

Scherpenberg cited a recent Ohio Hospital Association survey that estimated more than $400 million is spent across Ohio by providers fighting egregious denials and appeals.

> You've got to gear up for this. You can't do it in 30 days.
>
> Billie Jean Mounts

"You do all that work to get that contract in place, and still the payers look for ways to deny claims and put you through all this administrative burden," Mounts said. "They're going to keep picking at you if you don't fight them."

She shared her strategy for holding payers more accountable — an automatic process to review payments, flag egregious behavior and issue demand letters.

"I want a portfolio of demand letters and disputes on record so that when I go into my next set of negotiations, I have already done all of these challenges," she said.

Mounts shared another example of having to push back against a payer during a settlement because they wanted to reprocess old claims without considering the patient impact.

She told the payer they can reprocess the claims if the patient liability is zero, explaining the harm in having patients get bills and statements a year or two after having services rendered. "The payer's attitude was that the patients are used to getting that all the time, you know, they're accustomed to it. And I said 'that is a terrible patient experience.' ... I think that's just a good synopsis of their mentality."

Payer strategy resources

Learn more about how Ensemble can support your payer strategy as well as lessons we've learned from hundreds of contract negotiations and payer disputes.

Ensemble's Payer Scorecard

Tips for Going Out of Network

Making ICHRA Plans Work for You and Your Patients

Strategies for Successful Contract Negotiations

The Ensemble Difference

We go beyond traditional revenue cycle operations to drive value for our clients. AI innovation and payer strategy support are two examples of how we're focusing on eliminating friction across the revenue cycle.

Quick hits

> AI in Action: How Ensemble Is Putting Innovation to Work for Clients

> Holding Payers Accountable for Your Revenue: Ensemble's Payer Strategy

AI in Action: How Ensemble Is Putting Innovation to Work For Clients

Our approach

With a team of more than 270 data scientists and engineers, we're continuing to maximize the power of our collective data to drive insights and innovation that will improve interoperability with payers and eliminate administrative waste across the revenue cycle. We launched our first machine learning model in 2017 for DRG validation and have since gained 10 patents for AI-enabled technology.

We've invested more than $100 million over the past decade to build a data infrastructure to enable our AI capabilities. Grant Veazey, Ensemble's Chief Technology Officer, explains that compiling data is just the first step: "The ability to then structure that data and harmonize it is what makes it meaningful."

> There's a lot of infrastructure that goes in the back end of making 'sexy tech' work.
>
> Grant Veazey

Ensemble's AI-infused decisioning engine, EIQ®, transforms data into actionable revenue cycle intelligence to guide operator actions, automate complex workflows and prevent errors before they occur.

Our focus

We're testing and deploying AI use cases across three main categories to drive maximum value for clients:

Accelerating revenue and improving yield for clients with ML-driven account prioritization, DRG validation, automated technical appeals and policy copilots for associates.

Meeting modern patient demands with virtual customer service agent, patient scoring and segmentation and tailored engagement.

Replicating clinical intelligence with generative AI clinical appeals, AI-assisted authorizations, autonomous medical coding and peer-to-peer review support.

> It's really important to understand what makes good gen AI use cases and where you can be successful.
>
> Grant Veazey

How can I help?
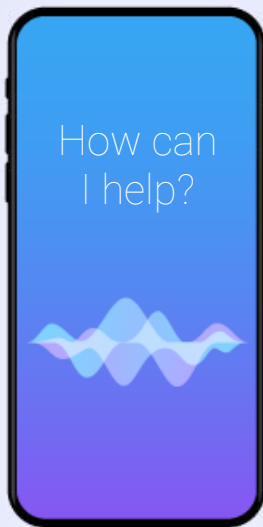
Phased pilots will launch across our clients during the first half of 2025.

Solution Spotlight:
Virtual Customer Service Agent

Problem: Patients are only willing to wait on hold for one minute before getting frustrated. Considering 36% of patients would consider switching providers due to a poor billing experience, providing convenient customer service capabilities is critical.

Solution: Ensemble's virtual agent provides an omni-channel, self-service option to address patient inquiries with conversational interactions. Through intelligent information gathering, the agent can seamlessly transition calls to humans when needed and create an interaction summary with recommended next steps after each call.

24/7 omni-channel coverage

Greater than 25% improvement in one-touch resolution

Greater than 50% improved patient engagement

Appeal

Refined Gen AI generated appeal letter

Phased pilots will launch across our clients during the first half of 2025.

See it in action.

Hear from our experts about our vision for clinical alignment.

Solution Spotlight:
AI for Clinical Alignment

Problem: Investments in payment integrity AI are enabling payers to review and deny claims faster, overwhelming providers, constricting cash flow and decreasing revenue.

Solution: Ensemble's generative AI for clinical alignment synthesizes and analyzes disparate data sources, including EMRs, clinical guidelines, payer criteria and peer-to-peer recordings to create compelling clinical arguments at scale, designed to pass the most rigorous payer scrutiny.

Improve denial overturn rate

Improve clinical arguments

Decrease patient denials

> Payers are heavily invested and so are we. We're leveling the playing field to give our clients a fighting chance.
>
> Grant Veazey

Our 2024 product snapshot + 2025 roadmap

Account prioritization | Live
Machine learning models trained on thousands of account variables to score and route accounts for efficient resolution

Policy copilot | Live
Generative AI to analyze and extract insights from unstructured data like payer policies to assist operations

Clinical + technical appeal generation | Launching Q4 2024
Generative AI appeals to minimize lost revenue and accelerate reimbursement

Virtual customer service agent | Launching Q4 2024
Natural language engine to address patient inquiries in a convenient, conversational and compliant way

Autonomous medical coding | Launching Q1 2025
Generative AI coding to alleviate administrative burden and improve billing accuracy

Holding Payers Accountable for Your Revenue: Ensemble's Payer Strategy Support

Leveraging Ensemble's collective purchasing power of $35 billion in net patient revenue, we empower our clients' managed care departments with the data, scale and approach needed to successfully resolve payer performance issues and negotiate equitable contracts.

"We're a value-added service to augment and support your existing departments. … We want to come in and provide value and help you achieve outsized results that you may not have otherwise been able to do," explained Brad Gingerich, Vice President of Payer Strategy at Ensemble.

Here's a summary of the value-add capabilities available to all our end-to-end clients:

Issue escalation + resolution

Our payer strategy team issues more than 10 demand letters each week on average to payers on behalf of our clients. "That's how you start the process. You're not going to hurt feelings on the payer side," Gingerich explained. "As soon as we start to see systemic issues, that's where we escalate. We try to resolve them en masse."

Our issue resolution capabilities include:

> Demand letter, mediation + arbitration support in conjunction with client counsel

> Joint operating committee meeting facilitation to review + resolve issues impacting revenue

> The size, the scale, the resources that [Ensemble] brings to bear on behalf of their clients is incredible. And the investments in technology that they're making to go to war with the technological investments the payers are making are really important as we think about the future.

Teddy Scherpenberg

> State + federal advocacy efforts in partnership with hospital associations to support lobbying efforts on behalf of providers

Contract negotiation support

We provide full turnkey contract negotiation support, including:

> Contract language review + recommendations to align with best practice terms

> Contract modeling to assess the impact of price changes + various payment methodologies

> Out-of-network strategy support to maximize leverage + prepare provider organizations for the impact of contract termination

Annual Revenue by Payor | **Payment to Charge Ratio** | **Patient Cost Share** | **Revenue Protection**

# Accounts	Total Charges	Total Payments	PCR Ratio (Net)
19.9M	$119.2bn	$23.7bn	19.9%

Summary by Payor Category

Payor Category	PCR Ratio (Net)	Accounts with Charges (#)	Total Payments
Blue Cross	29.9%	3,840.0K	$5,520.8M
Medicare	16.6%	4,112.5K	$5,279.8M
United Healthcare	24.2%	1,568.3K	$1,041.6M
Managed Medicare	14.3%	1,463.0K	$1,584.3M
Managed Care	30.0%	656.6K	$1,302.0M
Aetna	23.1%	1,109.4K	$1,371.2M
Commercial	32.1%	733.6K	$1,335.5M
Managed Medicaid	13.7%	1,661.7K	$1,310.0M
Humana	15.1%	891.6K	$853.8M
Medicaid	10.7%	596.5K	$718.7M
Cigna	39.6%	357.5K	$589.6M
Veterans Administration	17.9%	119.7K	$254.5M
Medical Mutual	31.8%	185.7K	$248.9M
Other Government	14.7%	86.1K	$177.5M
Total	19.9%	19,863.9K	$23,748.8M

Total Accounts and PCR by Discharge Month

● Total Accounts ● Payment to Charge Ratio (Net)

(Jul 2023 – May 2024) Total Accounts: 1.6M, 1.8M, 1.7M, 1.8M, 1.6M, 1.7M, 1.6M, 1.7M, 1.5M
PCR (Net): 19.9%, 20.0%, 20.3%, 20.1%, 21.0%, 19.1%, 19.5%, 19.6%, 19.6%, 19.9%

PCR by Payor Sub Category

Sub Category	PCR
International	40.9%
Managed Care	37.4%
Transplant	36.4%
Commercial	35.1%
TPL	34.2%
Workers Comp	32.9%
Unmapped	17.7%
Medicare	16.6%
Other Government	10.2%
Managed Medicaid	15.9%
Managed Medicare	15.1%
Client Billing	12.4%

PCR by Client

Client	PCR
Redacted	38.4%
Redacted	36.5%
Redacted	33.9%
Redacted	29.5%
Redacted	28.0%
Redacted	28.3%
Redacted	27.3%
Redacted	27.2%
Redacted	20.0%
Redacted	25.3%
Redacted	24.6%
Redacted	24.6%

Ensemble's Payer Scorecard: We normalize data across thousands of payer plans to provide an apples-to-apples comparison of payer performance from the national level down to the account level to identify trends and opportunities for improvement across each of our clients.

Performance + pricing optimization

We've made significant investments to benchmark payer behavior across all of our clients. The ability to compare apples to apples and drill down to the account level helps us hold payers accountable and move from issue identification to actual resolution quickly. Our performance and pricing optimization capabilities include:

> Payer scorecard to monitor + compare performance across payers

> Payer price transparency analysis to benchmark negotiated rates across providers

> CDM review to identify charge increase allowances and "lesser of" opportunities

> If we identify something, we can easily export the data, put in a demand letter and give it to the payer. In three weeks, we're sitting across the table and we're resolving those claims with the payer.

Brad Gingerich

Connect with our Payer Strategy team to learn more about how we're putting the payer scorecard to work for you.
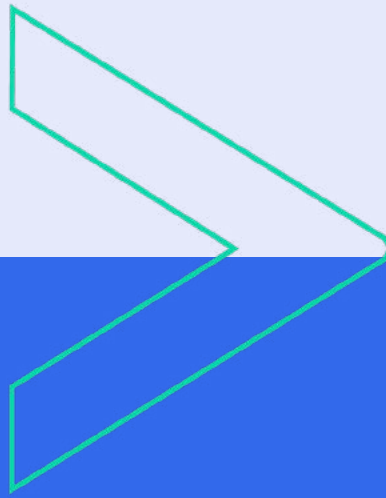
I firmly believe that as we navigate the complexities of our industry, it is through collaboration and shared vision that we can achieve our goals.

The best is ahead.

Judson Ivy, Founder, President + CEO, Ensemble

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