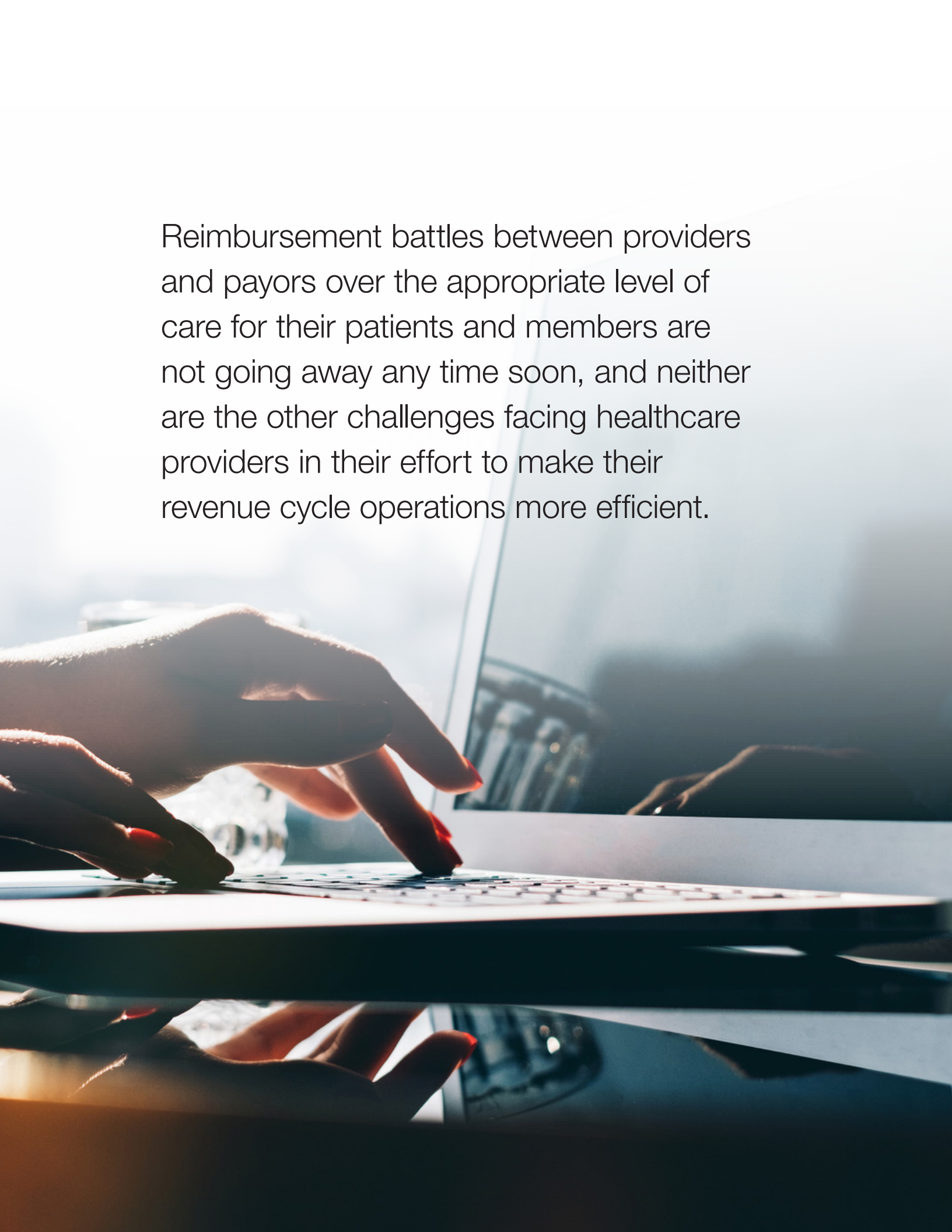
Crowe RCA benchmarking analysis

Who's picking up the check?

Payors increasingly are forcing providers to defend the level of care that they assign to patients

February 2023

Reimbursement battles between providers and payors over the appropriate level of care for their patients and members are not going away any time soon, and neither are the other challenges facing healthcare providers in their effort to make their revenue cycle operations more efficient.



Having a loved one in the hospital for any period of time can be one of the most stressful life experiences for any family. During the episode of care, providers and families typically are in alignment when it comes to the goal of doing what is best clinically to help the patient recover and regain health. Patients and families rely on the clinical opinions of the trained professionals to make determinations about care. Unfortunately, post-discharge is often when the reliance and alignment end.

What many do not see is that the end of the hospital stay is often just the beginning of a time-consuming and expensive battle to be fought by the hospital against the patient's health insurer to defend the level of care that it provided to the patient and to get accurately and appropriately reimbursed in a timely manner for that care.

This battle often starts with a debate about whether the patient should be held for observation and then sent home after the condition stabilizes or should be admitted to the hospital for inpatient care. This observation versus admission decision has been a murky and contentious dispute between providers and payors for many years.

For example, often the provider and the payor are basing their observation versus admission decisions on different medical necessity criteria. That makes coming to a consensus a challenge. Imagine trying to order food through a drive-thru, but the prices and menu items on the placard outside don't match up with what employees can see on their screens. The customer has no idea what will be coming through that window or what the final price will be. That's not a great recipe for a positive customer experience no matter how hungry the person or how good the food.

So why does it matter whether a patient was in an observation or inpatient status?

1. The status can affect the eventual out-of-pocket costs for the patient related to the services provided.
2. The administrative burden placed on providers to defend the level of care given adds to the overall cost of healthcare.
3. The financial burden of lost revenue associated with these battles makes it harder for healthcare providers to invest in their true mission of caring for their communities.

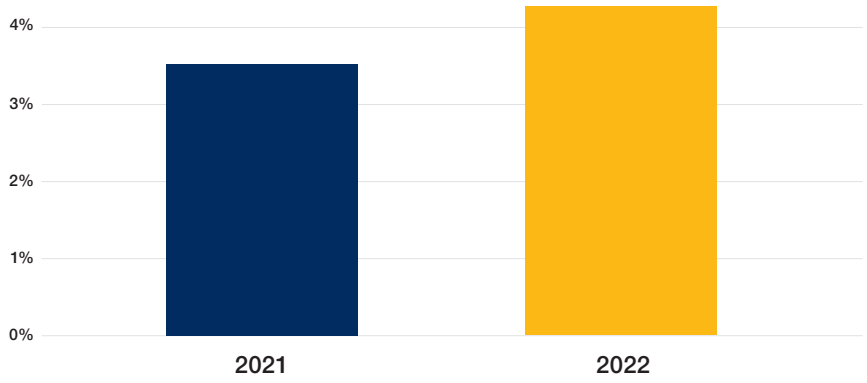
Crowe research, based on its proprietary Crowe Revenue Cycle Analytics (Crowe RCA) net revenue software platform, shows that these level-of-care battles are increasing in frequency and ratcheting up financial pressure on providers who already are dealing with higher expenses and increased resource constraints. The Crowe RCA solution monitors every patient transaction every day from more than 1,700 hospitals and more than 200,000 physicians to highlight the challenges faced by providers in today's landscape.

Initial clinical denial rates are on the rise

Payors are denying a higher proportion of inpatient claims filed by providers. Through November 2022, the dollar value of initial clinical denials by payors represented 4.2% of billed inpatient dollars. That percentage is 18.5% higher than in 2021.

Many of these denials require skilled employees with clinical expertise to prepare, file, and manage appeals through a payor's defined process. A larger inflow of these denials coupled with existing nursing shortages have strained providers' ability to manage the added workload. To add fuel to the fire, once a payor denies a claim, the provider has only a predetermined amount of time to appeal the payor's decision before the payor deems the denied or reduced claim "final," placing the revenue at even greater risk.

Inpatient initial clinical denial rate



Navigating a more complex payor environment

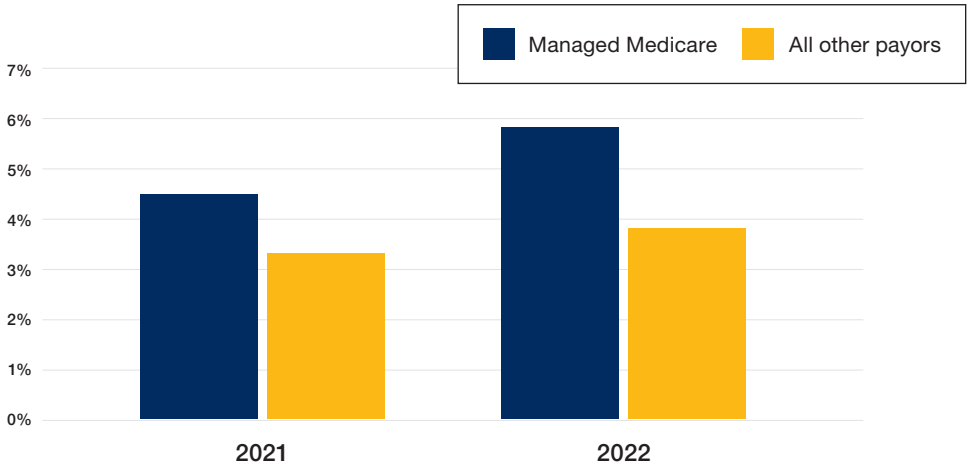
One of the most straightforward payor categories when it comes to assigning the appropriate level of care is traditional Medicare. Medicare adopted its two-midnight rule in October 2013, providing guidance to providers on how they should decide whether to send a patient to observation or admit the patient to the hospital. Under the rule, if a physician believes that the patient requires inpatient-level care and that care is likely to span at least two midnights, the patient should be admitted as an inpatient.

Medicare Advantage (MA) plans, though, are different from traditional Medicare. Medicare Advantage is a capitated program for providing Medicare benefits in the United States where Medicare pays a private-sector health insurer a fixed payment to then cover the healthcare expenses of its covered patient. Medicare Advantage plans are one of the fastest growing payor categories with about 30.8 million members as of January, according to the latest monthly enrollment report from CMS. That's up 6.1% from January 2022, per CMS data. Unfortunately for providers, many of these plans have adopted restrictive level-of-care criteria more in line with those used by commercial health insurance carriers than in line with traditional Medicare.

In fact, when comparing denial rates, Medicare Advantage plans show a higher denial rate than all other payor categories. Through November of 2022, the initial inpatient level-of-care claim denial rate for MA plans was 5.8% compared with 3.7% for all other payor categories.

As the percentage of Medicare beneficiaries enrolled in MA plans goes up, providers will have to adjust their clinical operations and admission criteria to deal with the corresponding increase in clinical denials by MA plans for their members.

Inpatient denial rate by payor grouping

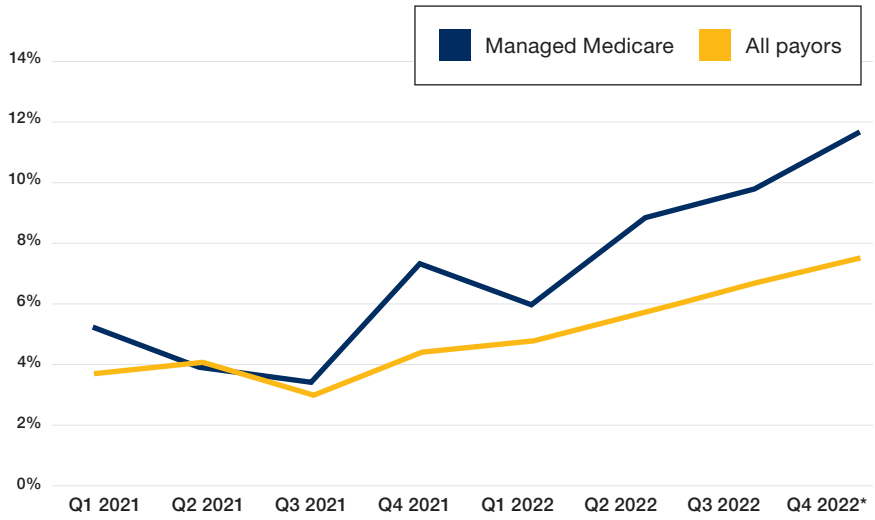


Revenue loss within the inpatient population mounts

As denials have increased and as the payor landscape continues to evolve, Crowe research also has uncovered that these level-of-care issues are having a material impact on providers' bottom lines.

One metric Crowe uses to monitor this impact is the value of final denials as a proportion of a provider's net revenue. In 2021, providers wrote off 3.6% of their inpatient revenue as uncollectible. Through November 2022, that number jumped to 5.9% – a 64% increase. When isolating just the payors within the MA plan population, the performance is even worse. Write-offs through November 2022 were at 8.5% compared with 4.7% in 2021. With performance at these levels, providers should take action to address inpatient denials as quickly as possible.

Inpatient final denial value as a percentage of net revenue



* Q4 2022 is through November.
Note: Graph displays quarterly figures, but percentages in body copy represent an annual average.

Charting a path forward

It's clear that these reimbursement battles between providers and payors over the appropriate level of care for their patients and members are not going away any time soon, and neither are the other challenges facing healthcare providers in their effort to make their revenue cycle operations more efficient. However, providers can take a few concrete steps to improve their net revenue performance and reduce the financial impact of these issues.

- **Focus on efficiency**. Create alignment between revenue cycle teams and utilization management and case management teams to create a consensus on which denials to focus on to reduce as much wasted effort as possible.
- **Focus on prevention**. Implement a physician adviser program to verify patient status is correct and allow for peer-to-peer reviews to be completed when payors offer them.
- **Focus on impact**. Use internal data and available external benchmark data to identify the payors that are having the greatest impact on revenue and share the data with the payors to help resolve any ongoing issues.
- **Engage the patient**. Often these appeals can take months, which can leave patients in the dark awaiting their bill. Informing patients of the status helps to build a positive patient experience.

For more on how to successfully navigate these trends and maintain and improve the revenue cycle performance of your hospital or health system, please contact the dedicated and experienced revenue cycle team at Crowe.

Learn more

For more information on the Crowe RCA benchmarking program, please visit crowe.com/benchmarking or contact:

Colleen Hall
Managing Principal, Healthcare
+1 615 515 3813
colleen.hall@crowe.com

Ken Ruiz
Principal, Healthcare Consulting
+1 317 706 2765
ken.ruiz@crowe.com

Matt Szaflarski
Senior Manager, Healthcare Consulting
+1 630 586 5229
matt.szaflarski@crowe.com

The Crowe Revenue Cycle Analytics (Crowe RCA) solution was invented by Derek Bang of Crowe.
The Crowe RCA solution is covered by U.S. Patent number 8,301,519.

crowe.com

CHC2305-001D