Crowe

Smart decisions. Lasting value.™

Crowe RCA Benchmarking Analysis

Who Gains From Medicare for All? Not Hospitals

July 2019

"Medicare for All" has dominated headlines since the 2016 presidential race and is gearing up to be another hot-button topic in the 2020 Democratic primary and presidential election. Much has been said about improved access to care, simplicity of administrative activities, and reduced spending in the American healthcare system that might be expected in a Medicare for All environment. What has not been fully discussed is the potential crippling impact to hospitals' top-line revenue, which hospitals rely on within an already razor-thin operating margin.

The Crowe Revenue Cycle Analytics (RCA) solution captures every patient transaction for more than 1,000 hospitals nationally for purposes of automating hindsight, accounts receivable valuation, and net revenue analyses. Within its benchmarking database, Crowe analyzed a portfolio spanning 45 states and comprising 605 hospitals within Medicaid expansion states and 409 hospitals in nonexpansion states, as of 2018. Crowe combines financial transaction information with 835/837 account-level data to produce comparative metrics. These metrics include accounts receivable (AR), denials, bad debt, credit balance, and cash to expected pay.

Crowe has used net revenue data to understand the impact of "Medicare-only" reimbursement.

Spoiler alert … this is not positive news for health system leaders.

It's no surprise to many health system finance professionals that a strong, well-negotiated managed care payer mix is critical to cover the revenue shortages from other payer groupings. The equalization of reimbursement to Medicare-only rates would eliminate the inequities of varying reimbursement for similar services but would lower the overall revenue per unit. Most dramatically, Crowe data indicates that average outpatient reimbursement would drop $143 (21.9%) per case for hospital-based services. However, the impact per case for inpatient reimbursement would be relatively flat at a less than 1% difference. Many hospitals still have robust outpatient managed care contracts, which would create a disproportionately negative effect in this new plan – whereas many others already have put infrastructure in place to manage "case rate" reimbursement (similar to Medicare's current diagnosis-related group reimbursement), and as such the impact might be muted.

Clearly, the payer mix of each hospital will drive the total impact of any change. To understand the proportion of hospitals likely affected, Crowe applied the Medicare-only reimbursement parameters to its database and determined that 90.2% of hospitals studied would experience a negative effect on net revenue. The largest impact (negative 53.5%) would be on a 246-bed facility with a nongovernment managed care payer mix of nearly 50%, and the most positive impact (a 24.0% increase in reimbursement) would be on a 97-bed facility with a government payer mix of nearly 90%. Across all U.S. hospitals, this proposed payment scheme appears to result in a more than $200 billion decrease in hospital reimbursement.

Many proponents of a simpler Medicare for All program point to administrative efficiencies as a balance to decreased reimbursement, and many positives exist with this proposed process. Revenue cycle key performance indicators (particularly those associated with cash flow) would be positively affected, as estimated here:

Revenue cycle key performance indicators

Metric	2018 baseline average	Estimated average Medicare for All metric
True AR days	53.5	37.6
True AR % > 90 days	33.9%	10.9%
Credit days	0.7	0.2

Average oupatient reimbursement
WOULD DROP
$143 per case
for hospital-based services

90%
of hospitals studied
would experience a
NEGATIVE EFFECT
on net revenue

LARGEST NEGATIVE IMPACT
-54%
would be on a
246-bed facility with a
NONGOVERNMENT
managed care payer mix
of nearly 50%

LARGEST POSITIVE IMPACT
24%
would be on a
97-bed facility with a
GOVERNMENT
payment mix
of nearly 90%

In addition, revenue cycle costs (also referred to as “cost to collect”) likely would decrease significantly as fewer variations in coverage, benefit plans, and payer interactions would require fewer personnel and unique technologies. It is estimated that cost to collect would decrease from approximately 3.5% of net revenue (on average) to approximately 2.0% or less. Patient experience – which often is challenged by confusing registration, authorization for services, denials, and benefit plan designs – also would improve. However, although elimination of administrative complexity is a common goal, the cost savings of simplicity do not appear to offset the net revenue decreases of a Medicare for All environment.

Take the lead

Many healthcare systems already have challenged their operators to determine how they can be successful within a Medicare-only reimbursement model. Unfortunately, the responses have not been optimistic to date, as the impacts are dramatic in a competitive healthcare system that requires increasing capital. Despite some political support for a broad one-size-fits-all approach, it is more likely that incremental change (more case rate reimbursement – outpatient, Medicaid reform with greater national influence, etc.) will continue to nip at the margins of health systems. To combat this, even competitive health systems could collaborate on creating the most efficient finance and revenue cycle operations, as the operating processes are very similar across the industry. Successful health systems often have taken the lead on turning political pressure into operating gains – before legislation has forced them to change.

Learn more

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

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

crowe.com/benchmarking

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

"Crowe" is the brand name under which the member firms of Crowe Global operate and provide professional services, and those firms together form the Crowe Global network of independent audit, tax, and consulting firms. "Crowe" may be used to refer to individual firms, to several such firms, or to all firms within the Crowe Global network. The Crowe Horwath Global Risk Consulting entities, Crowe Healthcare Risk Consulting LLC, and our affiliate in Grand Cayman are subsidiaries of Crowe LLP. Crowe LLP is an Indiana limited liability partnership and the U.S. member firm of Crowe Global. Services to clients are provided by the individual member firms of Crowe Global, but Crowe Global itself is a Swiss entity that does not provide services to clients. Each member firm is a separate legal entity responsible only for its own acts and omissions and not those of any other Crowe Global network firm or other party. Visit www.crowe.com/disclosure for more information about Crowe LLP, its subsidiaries, and Crowe Global.

The information in this document is not – and is not intended to be – audit, tax, accounting, advisory, risk, performance, consulting, business, financial, investment, legal, or other professional advice. Some firm services may not be available to attest clients. The information is general in nature, based on existing authorities, and is subject to change. The information is not a substitute for professional advice or services, and you should consult a qualified professional adviser before taking any action based on the information. Crowe is not responsible for any loss incurred by any person who relies on the information discussed in this document.
© 2019 Crowe LLP.

HC2003-003A