



Payer Mix Shift Highlights Dramatic Reimbursement and Revenue Cycle Changes

Crowe RCA Benchmarking Analysis: 2014 in Review



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Executive Summary

The results are in and the data clearly depicts disparate behavior between providers in those states that have expanded Medicaid as compared to those that have not. While healthcare providers have experienced considerable change over the last several years, perhaps few years were as dramatic as 2014. Medicaid expansion and reform – core tenets of the *Affordable Care Act* – underscore a year of consistent progression toward a new delivery model.

Certainly, a sudden shift in the payer base will affect the reimbursement and revenue cycle strategies for any given provider. But how can healthcare providers better understand the “new normal”? Leveraging survey-based benchmarking may no longer be sufficient for performance monitoring against a national sample. Organizations increasingly need not only agile benchmarking methods to respond to market changes, but also more effective means of determining appropriate peer groups to compare to their market. Near real-time analytical tools and robust data warehouses create deeper opportunities for insightful metrics, allowing organizations to more accurately develop perspective in an ever-changing environment.

Using a daily feed of account-level transactional data with a monthly upload used to generate a variety of finance and revenue cycle metrics, the Crowe Horwath LLP Revenue Cycle Analytics (Crowe RCA) solution¹ generated benchmarking results for the following key performance indicators (KPIs) for 145 U.S. hospitals.

Medicaid Expansion Effects on Payer Mix

The Supreme Court ruled in 2012 that the federal government could not force Medicaid expansion on individual states. As a result, the healthcare coverage landscape around the nation has become varied based on whether a state has chosen to expand Medicaid. As of December 31 2014, 27 states and the District of Columbia have implemented expansion. Four of the 23 states (Indiana, Tennessee, Wyoming, and Utah) without expanded coverage were considering Medicaid expansion in some form.² Among states that have expanded Medicaid coverage, the implications became apparent immediately.

The RAND Corporation estimated a 9.3M net gain to the insured population with around two thirds of those due to increased Medicaid eligibility.³ From the end of 2013 to the end of 2014, Medicaid and Medicaid managed care organizations' revenue increased nearly 6 percent from 11.44 percent to 17.33 percent, offset in large part by the decrease in self-pay and commercial/managed care, 4.15 percent and 1.56 percent respectively. The impact of reform is evident to a much lesser extent in the nonexpansion states. Self-pay as a percentage of the entire population is down nearly 1.65 percent, nearly offset by the increase in commercial/managed care by 0.95 percent, driven by the individual mandate.

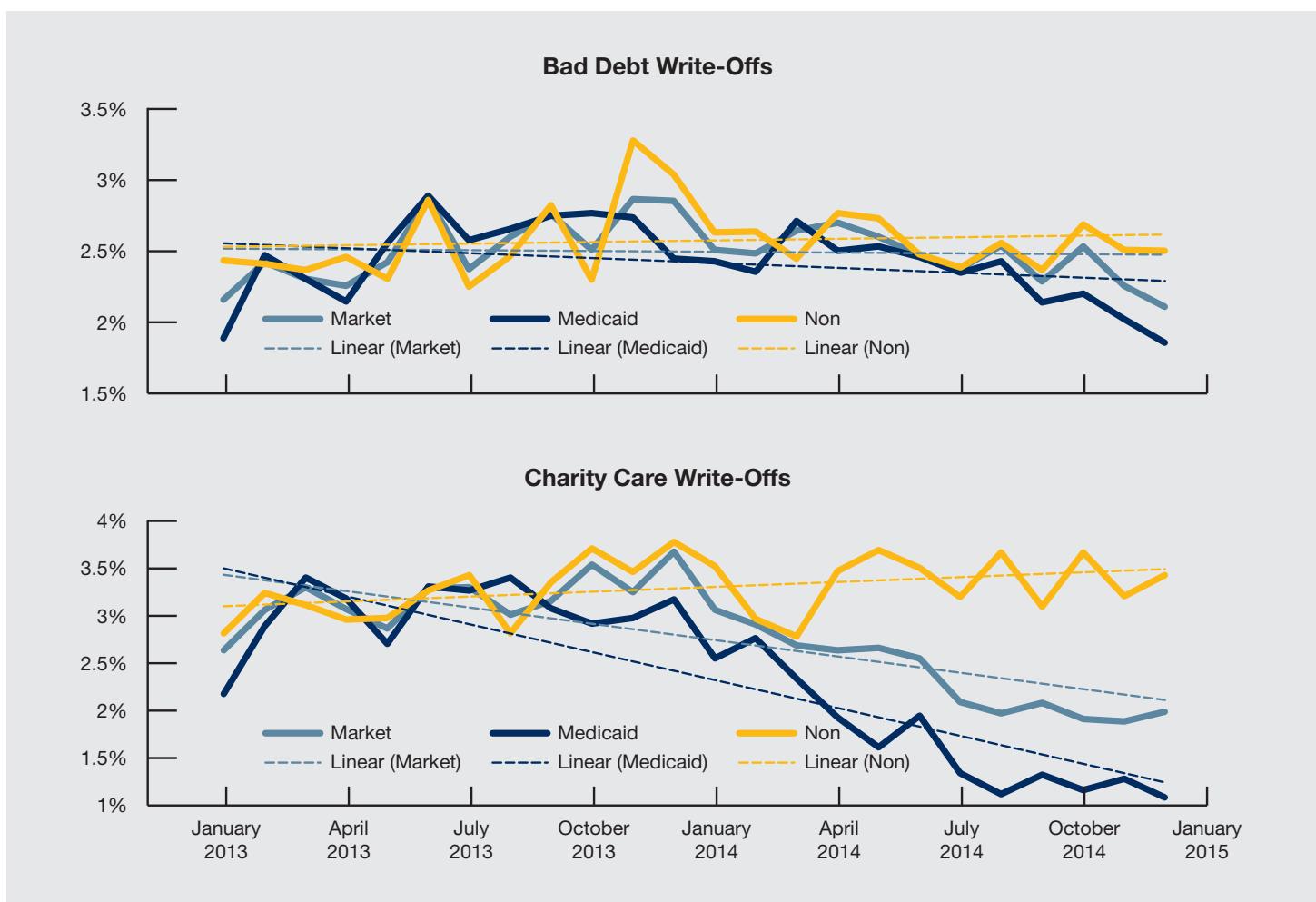
In Medicaid expansion states, Medicaid and Medicaid managed care claims increased nearly 6 percent of total gross patient service revenue from 2013 to 2014.

Payer Group	Medicaid Expansion			Nonexpansion		
	12/31/2013	12/31/2014	Change	12/31/2013	12/31/2014	Change
Commercial/Managed Care	32.33%	30.77%	-1.56%	33.23%	34.18%	0.95%
Medicaid – Managed Care	6.46%	11.45%	4.99%	8.48%	8.55%	0.07%
Medicaid – Traditional	4.98%	5.88%	0.90%	4.59%	4.75%	0.16%
Medicare – Managed Care	12.74%	13.85%	1.11%	8.68%	8.96%	0.28%
Medicare – Traditional	32.22%	31.57%	-0.65%	32.24%	31.97%	-0.27%
Other	3.46%	2.82%	-0.65%	2.44%	2.90%	0.46%
Self Pay	7.81%	3.66%	-4.15%	10.34%	8.69%	-1.65%
Total	100.00%	100.00%		100.00%	100.00%	

Medicaid Expansion Effects on Uncompensated Care

Furthermore, Medicaid expansion has considerable impact on uncompensated care. In this changing landscape, providers must benchmark their current performance against the appropriate peer groups in order to establish appropriate definitions of success and to outline opportunities for improvement. When assessing uncompensated care between 2013 and 2014, a large variance exists between providers in expansion states and those in nonexpansion states.

The national market benchmark at the end of 2013 for bad debt and charity write-offs was 2.5 percent and 3.2 percent, respectively. By the end of 2014, bad debt and charity write-offs in nonexpansion states remained flat at 2.6 percent and 3.3 percent, respectively. In expansion states, bad debt write-offs decreased subtly to 2.3 percent while charity write-offs decreased quite dramatically to 1.7 percent.



Nonexpansion Effects in the Marketplace

Outside of Medicaid expansion, the healthcare industry has been affected by a variety of other factors in recent years. With the continued adoption of high-deductible health plans (HDHPs), patient responsibility from the insured has risen steadily. The Kaiser Family Foundation⁴ has found that the number of these plans has increased by approximately 50 percent from 2011 to 2014. In 2014, HDHPs represented 18 percent of employer-sponsored health plans. This trend has caused providers to take a closer look at improving return on investment related to self-pay after insurance collections and has increased the need for solutions related to patient collections and point-of-service collections.

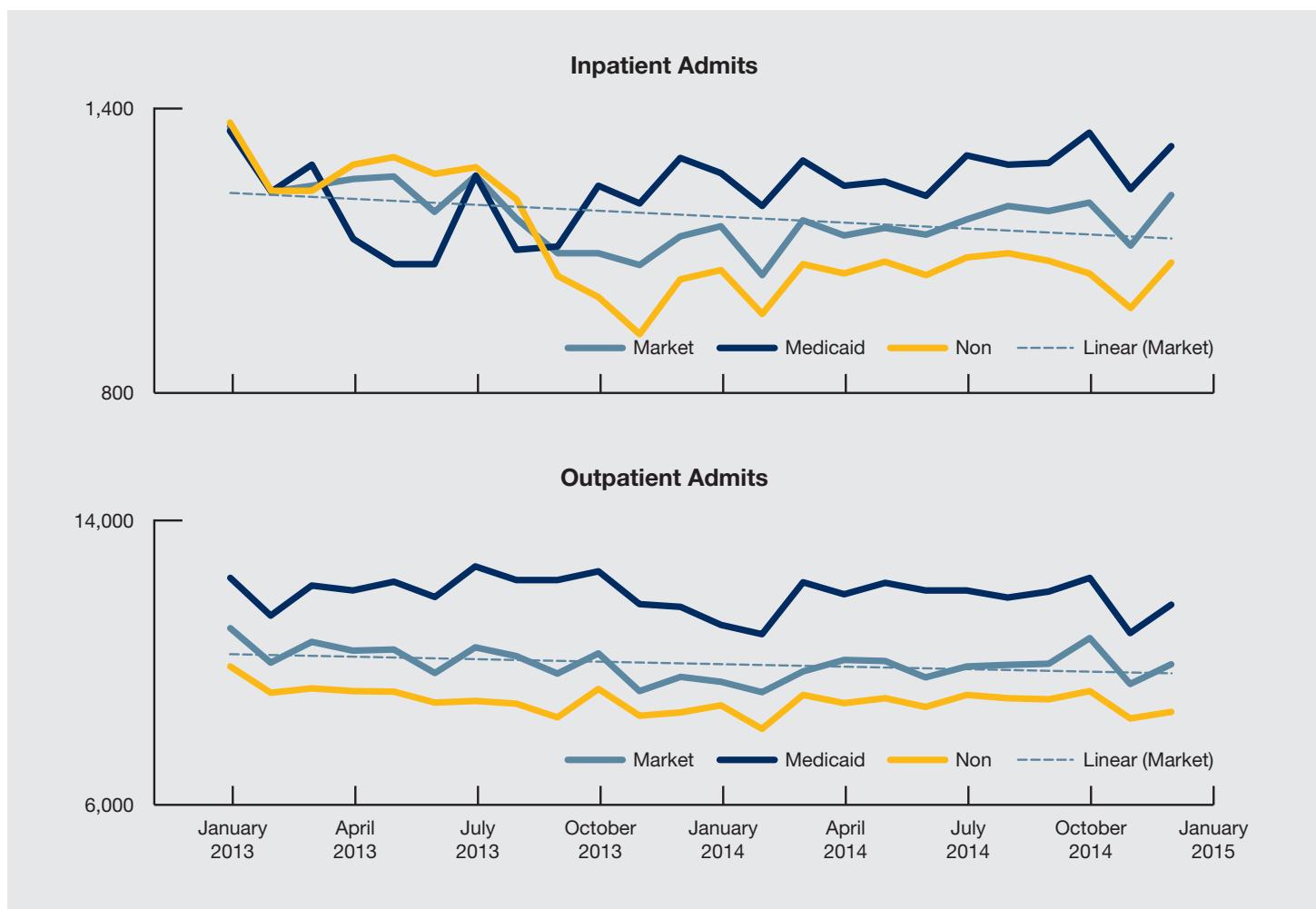
Another key development has been the providers' integration of the Centers for Medicare & Medicaid Services (CMS) Two-Midnight Rule into operations. This has caused a shift of short-term inpatient (IP) stays into outpatient (OP) observation statuses. Declining inpatient admission trends occurred in 2013 and 2014. In addition, this trend also may increase net revenue per case on inpatient stays because of a higher concentration of long-term and more complex inpatient cases.

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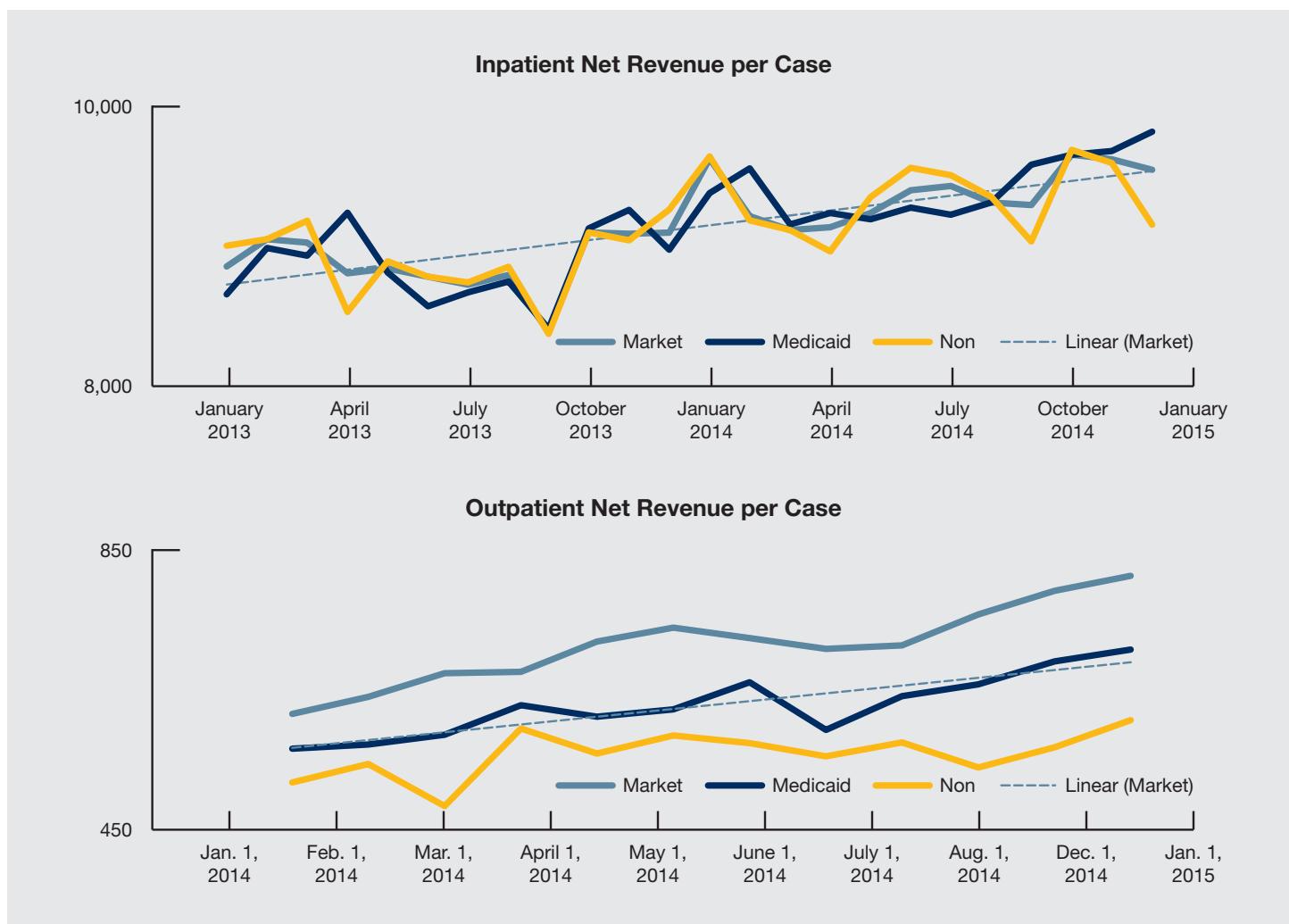
Market Trends – Volume

- Overall inpatient admits decreased by 4 percent from 2013 to 2014. While Medicaid expansion states increased inpatient admissions from 2013 to 2014 by 7.4 percent, inpatient admissions among nonexpansion states conversely declined by 12.9 percent.
- Outpatient admissions also decreased from 2013 to 2014 by 3.5 percent. Medicaid expansion and nonexpansion states decreased 3.4 percent and 2.7 percent, respectively.



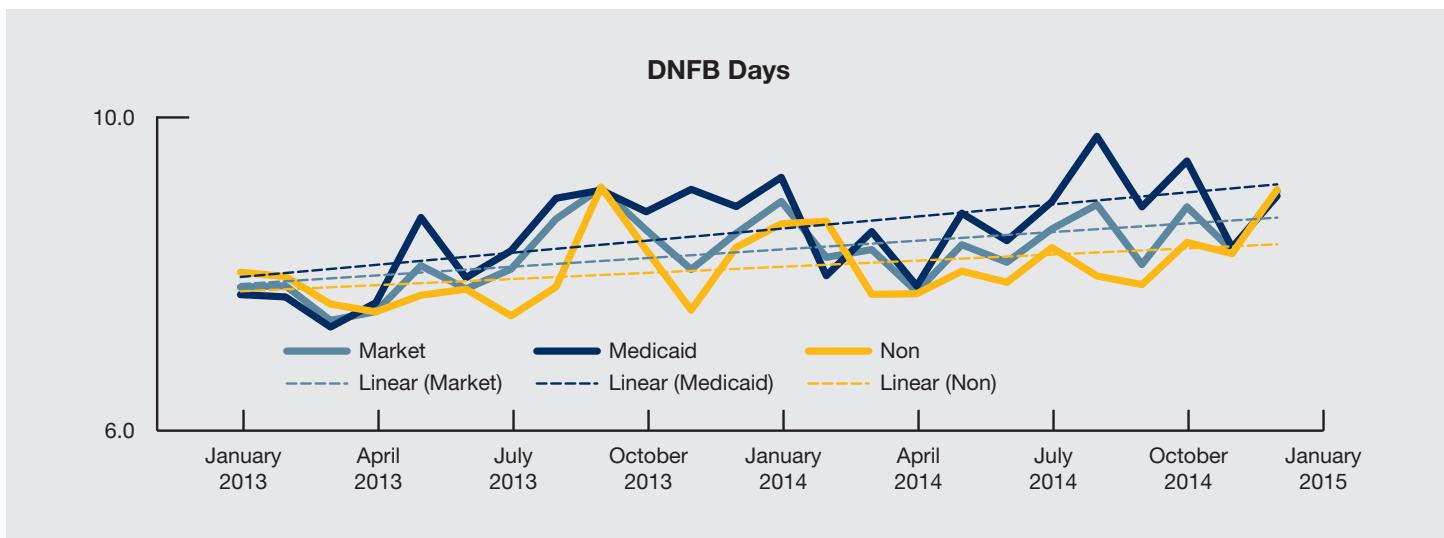
Market Trends – Net Revenue per Case

- As lower-cost cases move from inpatient to outpatient status, driven in large part by the Two-Midnight Rule, inpatient net revenue per case increased by 5.7 percent from 2013 to 2014.
- Inpatient net revenue per case in Medicaid expansion states increased slightly more than in nonexpansion states – a 6.3 percent increase and 5.0 percent increase, respectively. There has been a larger increase among Medicaid expansion states because of the conversion from self-pay to Medicaid.
- As lower-cost cases move from inpatient to outpatient, outpatient net revenue per case increased by 6.7 percent from 2013 to 2014 because lower-cost inpatient claims are now performed in an outpatient setting.
- Based on the stratification of net revenue per account, lower-cost outpatient visits have decreased – potentially moving out of hospitals and into ancillary service providers.
- Net revenue per case in Medicaid expansion states has increased slightly more than in nonexpansion states – an 10.8 percent increase and 2.2 percent increase, respectively. The larger increase among Medicaid expansion states is because of the conversion from self-pay to Medicaid.



Market Trends – A/R Days, DNFB Days, A/R > 90, and Takebacks

- Although gross days in accounts receivable (A/R) have varied moderately over the past 24 months, the 2013 average days decreased only one day in 2014.
- Discharge not final billed (DNFB) days trended upward throughout the market. Medicaid expansion states increased 0.4 days from 2013 to 2014, while non-Medicaid expansion states increased 0.3 days from 2013 to 2014. This trend is most likely a sign that points toward longer periods of bill holds while individuals are being qualified for Medicaid.
- A/R over 90 days as a percent of total A/R (27 percent) and net credit days (0.65%) were comparable over the past year. In addition, few material changes occurred in recoveries on bad debt and inactive accounts (2.1 percent) as a percent of total A/R over the past 24 months.
- Over the past two years, takebacks have decreased significantly, with large declines occurring in the last two quarters of 2014. Historically, takebacks averaged 2.0 percent of debit A/R from January 2013 to June 2014. However, in the following six months, takebacks declined to 1.4 percent of debit A/R on average. The suspension of Medicare Recovery Audit Contractors (RAC) audits earlier in 2014 may be the largest factor in this decline.



Crowe analysis

Conclusion

While some metrics have changed little over the past two years, it is clear that market factors related to the *Affordable Care Act*, Medicaid expansion, and the Two-Midnight Rule – as well as the increased popularity of high-deductible health plans – have caused providers to take a closer look at some KPIs. As the market continues to evolve, providers will need to be able to evaluate volume and revenue trends against the appropriate peer groups to act decisively in strategic decision-making. With the added complexity and impact of additional insured patient liabilities, providers also will need dynamic benchmarking solutions to properly assess performance and ROI of tools used to assist in collection and uninsured conversion to coverage. Dynamic benchmarking solutions that can evolve in real time with the organizations that use the solutions will allow executives, decision-makers, and other stakeholders to provide greater transparency while navigating the continued evolution of healthcare.

Methodology Overview

The Crowe RCA benchmarking initiative includes 326 distinct hospitals in the database. Of those, 229 are classified as acute-care facilities, 62 are classified as critical-access facilities, and the remaining 35 are classified as rehabilitation, psychiatric, and cardiovascular clinics. Seventy-three have a bed count of under 25; 124 have between 26-150 beds; 64 have between 151-300 beds; and 65 have more than 300 beds. For the market-level analysis presented in this report, we considered 145 facilities – 65 in expansion states and 80 in nonexpansion states. All had more than 125 beds. The hospitals with less than 125 beds contained a significant number of highly specialized facilities that introduced an undesirable level of inconsistencies in the data distribution.

The database includes information from hospitals in 35 states. The following states included 25 or more facilities: Florida, Indiana, Kansas, Kentucky, Nebraska, South Dakota, and Texas. Of the sample, 131 of the hospitals are in states that expanded Medicaid, while 195 are located in states that did not. The database also has fields in which Crowe can customize specific peer groups in order to analyze hospitals in the most meaningful segments – including but not limited to geographic region, urban vs. rural, academic hospitals only, outsourced revenue cycle functions vs. internal revenue cycle functions, and patient accounting system. Our system uses daily feeds of account transaction information and is supplemented by a monthly upload that is used for generating a variety of finance and revenue cycle metrics.



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- ¹ The Crowe® Revenue Cycle Analytics (Crowe RCA) solution was invented by Derek Bang of Crowe Horwath LLP. The Crowe RCA solution is covered by U.S. Patent number 8,301,519.
- ² On January 25, 2015, the Health and Human Services administration approved Indiana's plan for Medicaid expansion making it the 28th state to implement expansion.
- ³ Changes in Health Insurance Enrollment Since 2013" report, April 2014, RAND Corporation and authors Katherine Grace Carman and Christine Eibner, http://www.rand.org/pubs/research_reports/RR656.html
- ⁴ "Yes, You Are Paying a Lot More for Your Employer Health Plan Than You Used To," Jason Millman, The Washington Post, Sept. 10, 2014, <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/09/10/yes-you-are-paying-a-lot-more-for-your-employer-health-plan-than-you-used-to/>