Crowe RCA benchmarking analysis

Time for a commercial break

Commercial payors might provide higher reimbursement rates to providers for care to their members, but getting commercial payors to pay is another story

May 2023

The consensus of many healthcare industry financial prognosticators in late 2022 and early 2023 was that hospitals and health systems should fare well in 2023 as they bounce back from the unprecedented and lingering pandemic-induced financial challenges of 2022.

There was a general sense that things couldn't get worse. There was nowhere to go but up. Profit margins would improve. Revenue would be stable or increase. Operational challenges would subside.

But data at the end of the first quarter of the 2023 calendar year suggests that the expectations for 2023 were, in fact, too optimistic. Crowe research, based on its proprietary Crowe Revenue Cycle Analytics net revenue software platform, reveals a further deterioration in financial performance as indicated by many critical financial key performance indicators (KPIs).

Notably, hospitals and health systems themselves are not at fault for the deterioration in their financial performance. In fact, providers are doing anything and everything just to survive. Unfortunately, some of those survival tactics – aggressive but fair collection actions, reducing or eliminating poor-performing service lines, and staff reductions – have shoved hospitals and health systems into a negative media light.

Our hope at Crowe is that this latest edition of our quarterly KPI benchmarking report will illustrate just how challenging an environment providers face this year and how, for the most part, the challenges are coming from external forces largely out of their control.

Bloom is off the commercial payor rose

More than 1,800 hospitals and 200,000 physicians use the Crowe Revenue Cycle Analytics platform to manage their net revenue performance. Based on our analysis of providers' de-identified Crowe RCA data, about 45% of a typical hospital's patient population has health insurance through a commercial carrier. These patients have a nongovernmental health plan of some type – traditional, preferred provider organization, health maintenance organization, high-deductible health plan (HDHP), and so on – through their employer or purchased directly from a state or federal health insurance exchange or an insurance carrier itself.

Conventional wisdom has been that treating more patients with commercial, or private, health insurance was seen as a good thing from a net revenue point of view – the more privately insured patients the better. Why? Hospitals and health systems could negotiate prices with commercial payors, commercial payors typically paid higher rates than public or government payors like Medicare and Medicaid, and commercial payors usually paid claims faster than public payors because there was less red tape.

If you ask hospitals and health systems to pick which type of payor they'd prefer to have more of in their payor mix, the answer still likely would be commercial. Crowe RCA data shows that commercial payors reimburse providers at a higher amount on a per-case basis compared with Medicare:

- $18,156.50 is paid by commercial payors compared with $14,887.10 paid by Medicare in average net revenue per inpatient case.
- $1,606.86 is paid by commercial payors compared with $707.30 paid by Medicare in average net revenue per outpatient case.

It's true that commercial payors might generate more net revenue than public payors on a per-case basis. But at what cost?

The comprehensive Crowe RCA database tracks all aspects of payor performance, and the performance across commercial and public payors varies widely. In fact, commercial payors take the longest to pay, require providers to jump through more administrative hoops to get paid, and delay payments to providers via claim denials at a higher frequency than government payors.

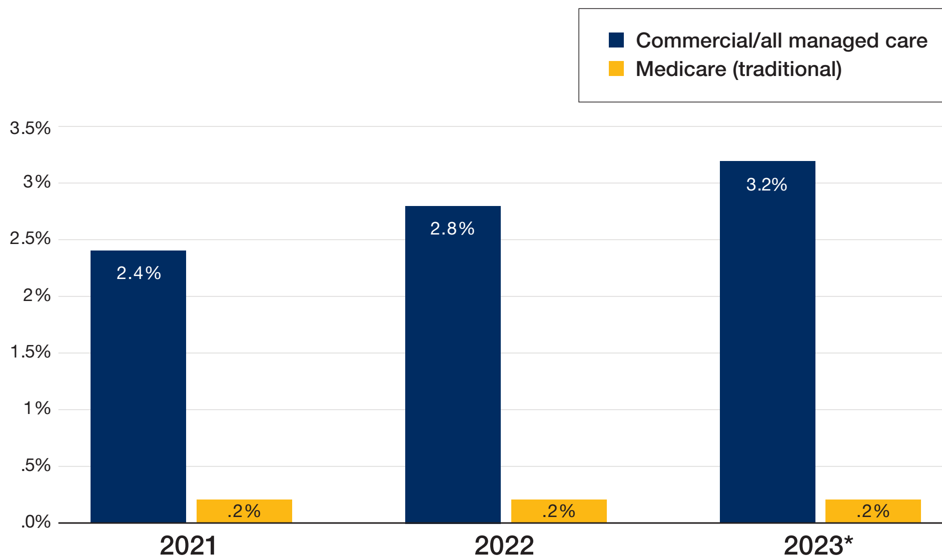
So much for conventional wisdom.

Prior authorization and precertification denials: Commercial payors versus Medicare

In a typical claim cycle, a significant metric is prior authorization and precertification denials. These are claim denials from payors based on the payor's decision that a provider did not get prior approval for care before it was rendered or that the care provided wasn't necessary based on the patient's medical diagnosis and prior approval from the payor was required. For example, the payor might say inpatient care should instead have been provided on an outpatient or observational basis. Collectively, these types of denials are referred to as "medical necessity" denials.

The rate of medical necessity denials has been rising for several years, and that trend continued in the first quarter of 2023.

Percentage of medical necessity inpatient claim denials by payor category



* Through first three months of 2023
Source: Crowe RCA

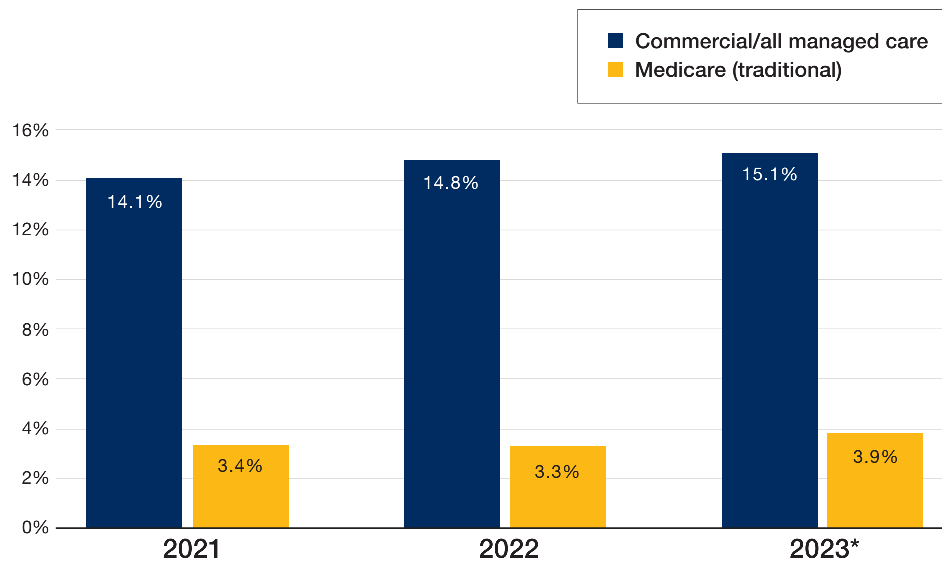
In 2022, the initial prior authorization/precertification denial rate for inpatient claims for commercial payors was 2.8%, up from 2.4% in 2021. We're seeing more of the same again this year with the rate at more than 3% through the first three months of the year. By comparison, the denial rate for traditional Medicare was 0.2% through the first quarter of 2023.

While a single-digit denial rate might seem minor, a prior authorization/precertification denial can trigger a major fight to get paid. A provider that disagrees with the denial faces a labor-intensive appeals process that might involve utilization management, nursing staff, physicians, and possibly the patient. This effort can be significant, costly, time-consuming, and difficult. And it often doesn't end with the payor making the full and appropriate payment to the provider for the services that the patient received.

Initial denials: Commercial payors versus Medicare

The prior authorization/precertification denial category is a subset of a larger, broader metric of initial denials. The initial denial rate metric captures initial claim denials by payors for any reason. Once again, commercial payors don't look any better when compared with Medicare.

Percentage of inpatient and outpatient claims initially denied for any reasons by payor category



* Through first three months of 2023
Source: Crowe RCA

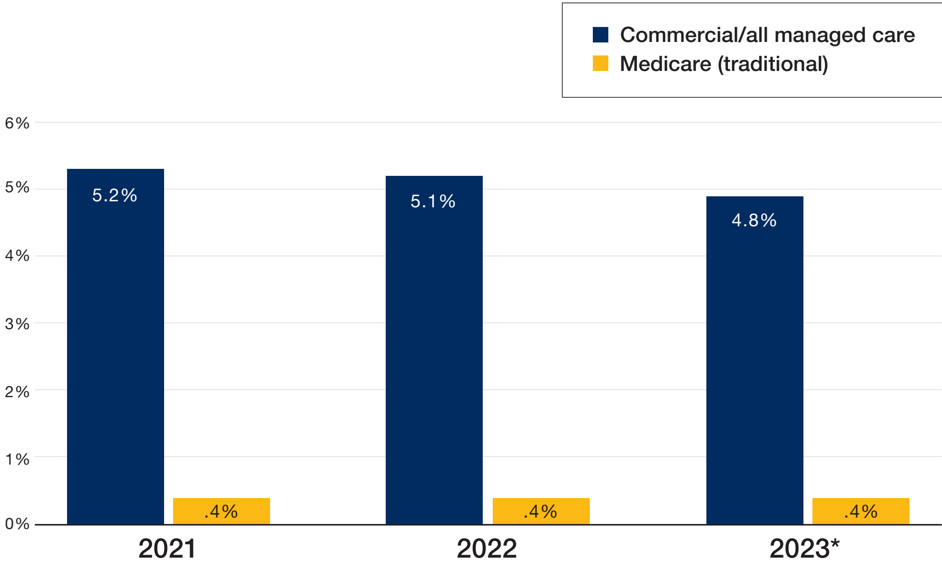
Through the first quarter of 2023, commercial payors initially denied 15.1% of inpatient and outpatient claims for any reason compared with 3.9% for Medicare over the same period.

Although most initially denied claims become paid claims, the administrative effort to bring an initial denial to positive resolution is very costly for the provider. It requires some form of action on the part of the provider in order to receive payment for services rendered.

Request for information denials: Commercial payors versus Medicare

Another claim denial category that contributes to delays in payment from commercial payors is the request for information (RFI). RFI denials occur when a payor decides not to process a claim because some type of required documentation – an attachment, a signature, a copy of the medical record – is missing from the claim. Here, commercial payors have 12 times the denial rate compared with Medicare.

Percentage of inpatient and outpatient claims initially denied by payor who requested more information by payor category



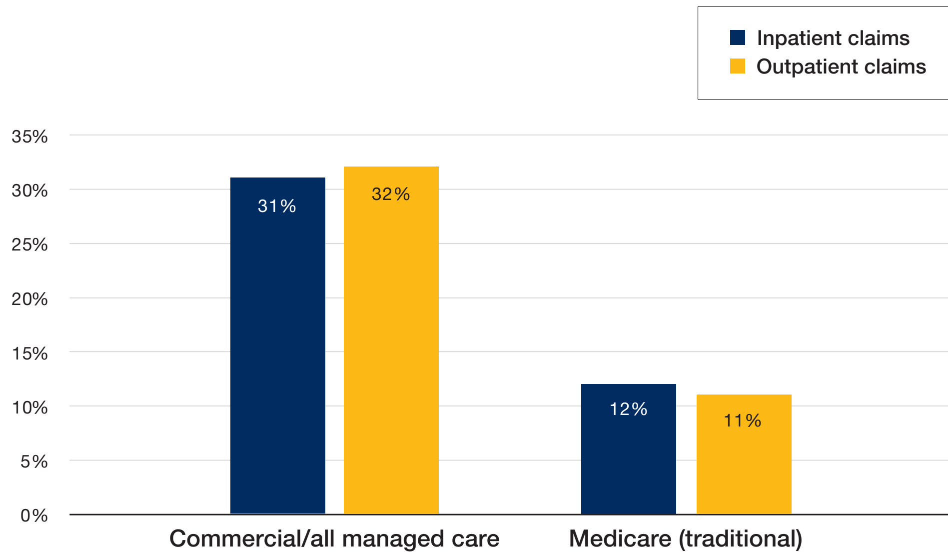
* Through first three months of 2023
Source: Crowe RCA

The RFI denial rate through the first quarter of 2023 for inpatient and outpatient claims submitted by providers to commercial payors was 4.8%. It was 0.4% for traditional Medicare. When you consider that, based on our data an RFI, denial delays payment by at least 45 days, such denials by a provider's best payors can wreak havoc on cash flow and accounts receivable performance.

Accounts receivable

Prior authorization/precertification denials, initial denials, and RFI denials all affect the timeliness to payment metric, commonly known as the accounts receivable (AR) metric. AR over 90 days are claims submitted three months prior that have not yet been paid.

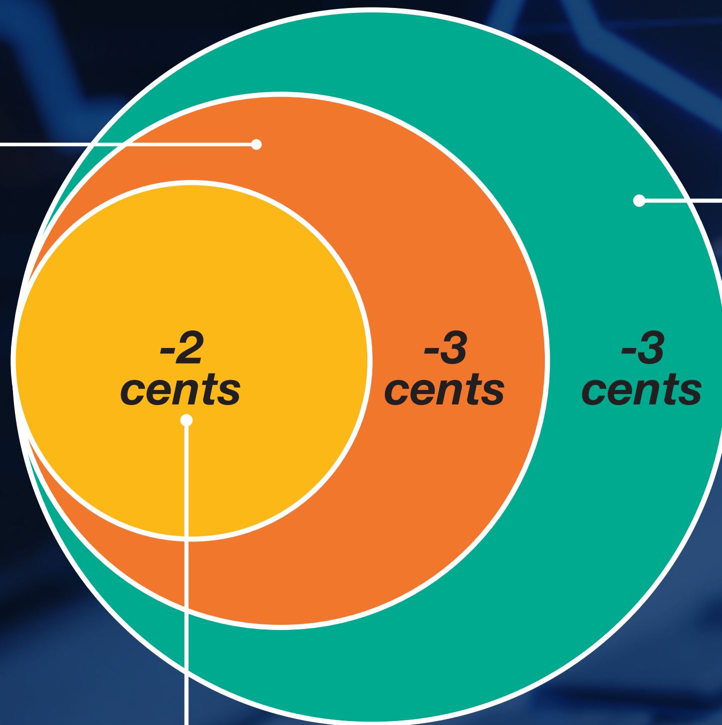
Percentage of 2023 claims by payor category for inpatient and outpatient claims not paid after 90 days*



* Through first three months of 2023
Source: Crowe RCA

About a third of inpatient and outpatient claims submitted by providers to commercial payors weren't paid for more than three months during the first quarter of 2023. The percentage is less than half that for inpatient and outpatient claims submitted to Medicare. It's hard for hospitals rebound from the pandemic-induced downturn when their best payors are holding onto a third of their claims payments for more than 90 days.

Threat metrics: Bad debt, final denials, and takebacks



Final denials

The value of final denials as a percentage of gross patient services revenue from commercial payors was 2.8%.

Takebacks

Commercial payor takebacks as a percentage of net patient revenues from commercial payors through the first quarter of 2023 is 3.2%.

Bad debt

Bad debt as a percentage of gross patient services revenue from commercial payors was 1.9%.

Prior authorization/precertification denials, initial denials, and RFI denials also shed light on the percentage of payments threatened altogether – not just delayed payment as seen in the AR greater than 90 days metric.

The first of these nonpayment threat metrics is bad debt – revenue that a provider expected to receive from patients but didn't. In the past several years, many commercial health plans have moved to an HDHP structure, requiring patients to pay the first $2,000, $5,000, or more out of pocket for their care before their health plan payments kick in. Patients with HDHPs know they have that financial responsibility, but many don't pay because they either can't afford it or choose not to pay it. Those unpaid amounts become bad debt.

Through the first quarter of 2023, bad debt as a percentage of gross patient services revenue from commercial payors was 1.9%, according to Crowe RCA data. That means about 2 cents is shaved off of each dollar that providers collect from commercial payors. By comparison, that percentage is 0.3% for patients with traditional Medicare coverage who are responsible for any coinsurance payments or deductibles.

The second of these threat metrics is final denials. A final denial happens when a provider exhausts all attempts to get paid from a payor, and the payor will not pay the claim. Final denial rate also varies significantly by payor category.

Through the first quarter of 2023, the value of final denials as a percentage of gross patient services revenue from commercial payors was 2.8%, according to Crowe RCA data. That means another 3 cents comes off of each dollar providers collect from commercial payors. By comparison, traditional Medicare has denied 1.6% of costs at the same point in 2023.

The third threat metric is payor takebacks. A takeback occurs when a payor pays a provider for services rendered but then determines that the payment wasn't warranted and takes back the payment from the provider. Many commercial payors use third-party vendors to review paid claims in search of justification for a takeback. Common reasons cited in a takeback are diagnosis-related group misclassifications and payment for an inpatient stay when an outpatient or observation visit was warranted. Administratively, takebacks are burdensome for providers as payors often give little notice to providers of a takeback and simply apply the offset to a future remittance file with little or no chance for the provider to refute or challenge the payor's unilateral decision.

Commercial payor takebacks as a percentage of net patient revenues from commercial payors through the first quarter of 2023 is 3.2%, meaning another three pennies taken from each commercial payor dollar collected. By comparison, the takeback percentage for traditional Medicare is only about 1%.

Providers’ financial survival will take a village

In an environment where hospitals and health systems face challenges by regulators, patient advocacy groups, and media about their collection, service line, and staffing practices yet still face unprecedented and unwavering financial pressures, it’s important to continually evaluate and understand the contributing factors behind why providers have to make the hard decisions that draw such scrutiny.

Providers expect 15% of every dollar billed to be challenged and scrutinized and to expend labor-intensive and costly procedures to ultimately get paid. Eight cents of every dollar providers bill to commercial payors will never be received or will be taken back once received. One-third of the AR that is aging over three months is from the payor category that providers rely on most to drive their financial performance. This is the bleak reality from 45% of a typical hospital’s business. How could any business survive in this scenario?

Hospitals and health systems have been dealing with significant headwinds over the past several years, all of which challenge the very existence of many providers. Most organizations are not thriving. They’re only doing what they must do to survive. Hospitals and health systems deserve to be paid for care that they provide to patients, regardless of the patients’ health insurance coverage.

Contrary to popular belief, it’s significantly easier to get paid by Medicare than by commercial payors. True, commercial payors help to offset the payment shortfalls from Medicare and Medicaid – when they pay. But given the effort required to get paid, is it worth it? Why does it have to be so hard?

With the first quarter of 2023 revealing continued financial pressures on hospitals and health systems, providers should verify that commercial payors are adhering to contract terms, fight for every dollar that they’re entitled to receive, and hold commercial payors accountable.

Hospitals and health systems should be able to deliver on their missions without the fear of nonpayment, delayed payment, partial payment, or payment takebacks. When providers make difficult decisions that ensure they capture all the dollars they can, they should be able to make those decisions without fear of the media shining a negative light on their business practices. Providers cannot survive alone. It takes an entire healthcare industry village.

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 Consulting
+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

"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. © 2023 Crowe LLP.

CHC2403-002B