Avoidable claim denials and the impact on Medicaid providers.

A call for transparency and a more collaborative process

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Optum

Claims that are unnecessarily complex and cause denials that are avoidable are key contributors to lost revenue, diminished satisfaction and reduced enrollment among Medicaid providers. The technology now exists for States to adopt more efficient payment processes, create more transparency and alleviate the administrative burden on Medicaid providers and managed care organizations (MCOs) so they can focus on serving Medicaid recipients.

In this piece, the term "avoidable claims denial" assumes there is no fraud, waste or abuse involved; the claim was simply improperly denied.

A lack of transparency and complexity contribute to costly waste

The American health care system is generally considered one of the best in the world. But it comes at great cost and with considerable waste. Health care spending in the U.S. now totals $4.7 trillion.[1] The estimated annual administrative cost of health care eclipses $1.1 trillion,2 and nearly 25 percent of that administrative cost is associated with clinical and administrative waste—estimated at a staggering $273 billion.[3]

$4.7T
in health care spending

$1.1T
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$273B
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Why so much clinical and administrative waste?

This paper explores how lack of transparency and claims complexity are key drivers in improper claims denial. Transparency is lacking between payers and providers across a variety of functions:

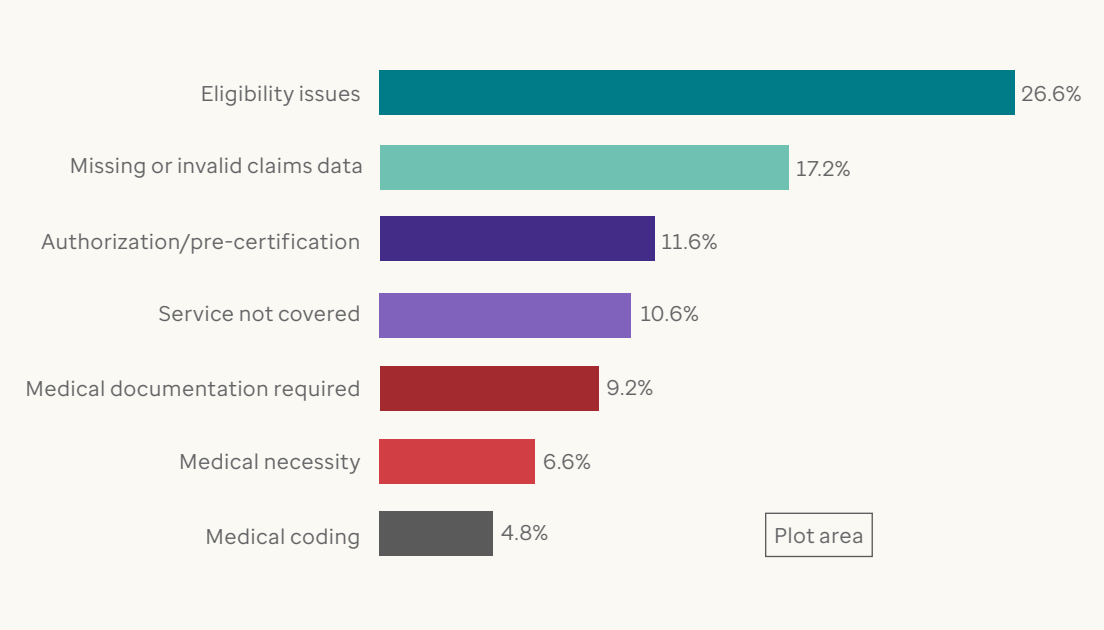
- Varying clinical guidelines
- Complex and confusing preauthorization processes
- Manual processes for exchanging data
- Disconnect between claims and clinical data
- Siloed policies, business rules and systems among payers and providers

Ultimately, this lack of transparency results in:

- Unnecessary complexity
- Less than optimal clinical outcomes
- Cost associated with administrative rework and improper claims denials

Denials have increased, but the reasons remain the same

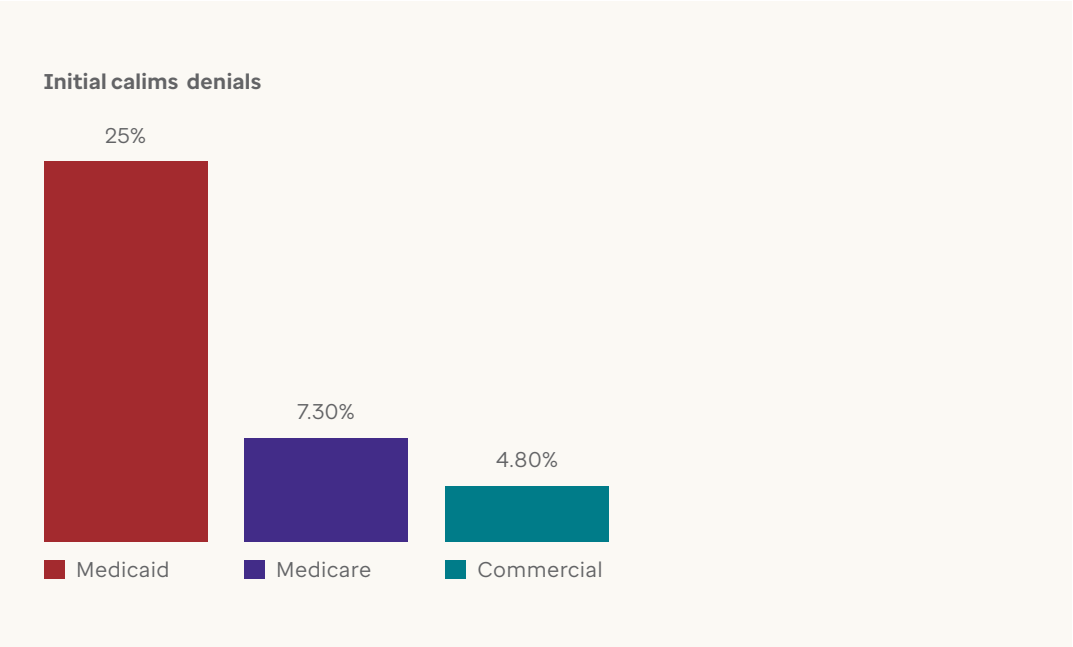
Nationally, denials have increased almost 25 percent between 2016 and 2020.[4] However, the reasons for denials have remained mostly consistent as shown in the chart below.



Research by Change Healthcare reveals that 86 percent of denials are potentially avoidable and are due to the lack of clarity between payer rules and providers' understanding of those rules.[4]

An outsized impact on Medicaid providers

In comparison to Medicare and Commercial providers, Medicaid providers experience an outsized impact of denied claims due to much lower reimbursement rates than other insurers. Documentation required by Medica.



Approximately 25 percent of all Medicaid claims are returned to the provider with at least one denied line.[5] This is across all national measures and includes fee for service and managed care claims. In contrast, Medicare and Commercial are initially denied at significantly lower rates of 7.3 percent and 4.8 percent, respectively.[5]

Assuming providers bill their claims based on their knowledge of the payers' policies and rules, then it can be inferred that the complexity of Medicaid claims is generally higher than that of Medicare and Commercial claims, and to some degree drives increased denial rates.

Improper denials are a tax on provider revenue

Whether operating under a fee for service or MCO model, payment friction is a serious issue for States because a direct and causal link can be established between claim denial rates, subsequent costs and Medicaid provider enrollment.

If a provider feels a claim is improperly denied, there are two ways forward:

Option 1: Accept the result and write off the denied claim

Option 2: Initiate a generally costly back-and-forth negotiation with the payer to resubmit or appeal

The first option has an obvious cost. The second option, however, also presents a considerable cost as detailed below.

	Medicaid	Medicare	Commercial
Claim denial rate	**25%**	**7.3%**	**4.8%**
Submitted claim amount	$98.57	$136.05	$179.40
Initial denial amount	$19.26	$9.38	$8.80
Final denied amount	$14.25	$5.48	$4.81
Final paid amount	$84.32	$130.57	$174.59
Revenue % of submitted amount	85.5%	95.9%	97.3%

Chart A: Financial impact of denied claims

Medicaid providers have an average **Submitted Claim Amount** of $98.57 per claim.[5] Compare that to the average Submitted Claim Amounts for Medicare and Commercial lines of business and a stark reality is revealed: On average, Medicaid is the lowest payer, Commercial is the highest, and Medicare is somewhere in between.

For Medicaid, the **Initial Denied Amount** is on average $19.26 per claim while Medicare and Commercial are $9.38 and $8.80, respectively.[5] Clearly, a significant percentage of the expected payment amount is being denied for Medicaid.

The **Final Denied Amount** assumes the provider has not written off the claim and is pursuing a resubmittal and appeal process. (This is Option 2 in the section above.)

- For Medicaid, the final denied amount is $14.25 compared to Medicare at $5.48 and Commercial at $4.81.5
- The delta between the Initial Denied Amount and the Final Denied Amount is important to consider. With Medicaid, the Final Denied Amount represents a 25 percent reduction; Medicare 42 percent; and Commercial 45 percent.[5]

This makes the decision for a provider to pursue an appeal process for a Commercial or Medicare claim much easier than a Medicaid claim. The Medicaid provider must decide if the 25 percent reduction in denial is worth the effort.

Lastly, the **Final Paid Amounts** for Medicaid at $84.32 is a bit misleading. As Chart B below will show, the provider incurs an average administrative cost of $14.70 to resubmit the claim in order to collect the $84.32.5 When the average administrative cost is deducted from the $84.32, the Final Paid Amount is further reduced to $69.62 for services rendered–just a little over 70 percent of what the provider expected to receive.

The **Revenue Percent of Submitted Amount** for Medicaid is 85.5 percent for Medicaid claims, 95.5 percent for Medicare and 97.3 percent for Commercial.[5] These figures reinforce the hypothesis that providers have a greater understanding of Medicare and Commercial claims when producing their billing and charge entry than they do Medicaid, despite having the available resources at their disposal.

Medicaid providers ask: Is it worth the time and effort to resubmit the claim?

University of Chicago research included evaluating denial reason codes within five categories listed in the chart below. The cost to the provider in each of the five categories across the three lines of business–Medicaid, Medicare and Commercial–is based on the complexity of the work the provider must perform.

	Administrative	Contractual	Coverage	Duplicate	Information	Avg. admin cost for claim resubmission
Medicaid	25.1% $15.39	29.7% $9.19	25.1% $14.66	4.1% $21.00	16.0% $13.24	**$14.70**
Medicare	25.1% $15.39	40.6% $7.43	23.1% $12.14	10.2% $11.40	9.8% $10.49	**$10.29**
Commercial	25.1% $15.39	55.0% $8.40	12.7% $18.33	8.7% $20.62	9.7% $17.36	**$17.18**

Chart B: Cause for claim denials

For example, for a Medicaid claim denied for Contractual reasons, the provider incurs an average cost of $9.19 to perform the research required to resubmit the claim.[5] A Duplicate claim, however, costs the same provider $21.5 A Medicaid provider, therefore, is more likely to pursue a Contractual claim than a Duplicate claim. The provider may make a different decision with a Medicare claim based on the level of effort they must expend.

Medicaid providers spend on average $14.70 to resubmit claims that were erroneously denied.[5] When evaluating the claim denial response from a payer, the provider has to make a decision: Is it worth my time and effort to pursue the resubmittal of this claim?

In Chart C, the Expected Claim Value: write off is the average write off amount. As was established in Chart B, providers incur $14.70 for every single line resubmittal they pursue.[5] If a claim is for $10.10, it would be a losing proposition to pursue the claim. Conversely, the Expected Claim Value: Resubmit line represents the average resubmittal amount, and it exceeds $14.70.5. Therefore, it would be valuable for the provider to pursue the resubmittal.

The next two lines in Chart C reflect the average resubmittal cost when adding denied lines to a claim. The costs go up rapidly starting with $14 for one line, $33 for three lines and so on.[5]

Finally, administrative costs coupled with reduced reimbursement amounts after resubmittal or appeals result in Medicaid providers losing on average 17.4 percent of revenue whereas Medicare and Commercial lose just 5 percent and 2.8 percent, respectively.[5] That's a significant difference.

Providers are billing Medicaid, Medicare, and Commercial payers simultaneously. When coding and evaluating responses from payers, they experience the Medicaid billing complexities as well as the financial impact and, naturally, draw distinctions between the three lines of business.

	Medicaid	Medicare	Commercial
Expected claim value: write-off	$10.10	$12.94	$12.21
Expected claim value: resubmit	$21.43	$20.88	$34.90
Admin cost of resubmission (1 line)	$14.00	$10.00	$17.00
Admin cost of resubmission (3 line)	$33.00	$26.00	$37.00
Lost revenue due to claims denials	$9.36	$2.59	$1.81
Lost claim value due to denials	17.4%	5.0%	2.8%

Chart C: Financial impact of denied claim resubmissions

Interoperability and time value have an impact

There are additional factors that compound the impact of claims denials on Medicaid providers.

The Interoperability and Patient Access Final Rule (CMS-9115-F) makes claims data more accessible to members. While this is a positive change, members will increasingly see claims they assumed were covered having been denied. This is likely to generate calls to providers and to member hotlines inquiring about claims status and if the member will have to pay for services out of pocket. Providers will need to spend additional time managing patient administrative burden. Members who are aware and concerned about coverage have a higher likelihood of contacting patient representative organizations and/or legislative members or panels. Both of these types of contact require program resources to respond and mitigate.

Members who incorrectly assume they will be responsible for the payment of an erroneously denied claim may be reluctant to seek services for conditions that should be covered under program guidelines, ultimately compromising their quality of life.

The time value of money also must be considered. Many providers operate on tight margins and interruptions in cash flow can be detrimental to daily operations. Delays in payment negatively impact the value of money to providers by decreasing the value of a dollar over time. For example, consider a six-month resolution window and a year-over-year inflation rate of 9.1 percent. If a provider expects to be paid $1,000 in June and it takes six months to resolve the denied claim, the purchasing power of the $1,000 is reduced by 4.43 percent. At six months, the provider would need to be paid $1,046.37 to be made whole, unlike if their claim had not been erroneously denied and they'd been paid on time.

$$FV = PV(1 + \frac{r}{n})^{nt}$$

$$1046.37 = 1000(1 + \frac{.091}{12})^{12*0.5}$$

Providers pay attention to reimbursement rates

A direct and causal link can be established between claim denial rates, subsequent costs, and Medicaid provider enrollment.

For an accurate estimate of net revenue, providers need to factor in costs of write-offs and denied claims collections processes.

When providers forego 17.4 percent of their anticipated, but already low, revenue, they're less motivated to continue servicing Medicaid beneficiaries. Many providers will assess the opportunity cost of remaining in the Medicaid program versus leaving to create more capacity to service non-Medicaid patients.

From the provider's perspective, a 5 percent increase in revenue has the same impact regardless of where it comes from—an increase in reimbursement rates or a reduction in administrative costs. Providers pay attention to their reimbursement rates and costs and make corresponding decisions.

Providers who move to states with higher Medicaid reimbursement rates (one standard deviation higher) are 1.2 percent more likely to accept Medicaid patients.

When administrative costs increase by one standard deviation, there's a 1.2 percent reduction in provider participation.

The way forward

States with fee for service or MCO models can adopt the latest strategies and technologies to reduce Medicaid claim complexity and improper claims denials.

Deploy efficient provider communication and engagement solutions
Provider confusion regarding program billing processes and procedures contributes to errors in claims that could be otherwise avoided. Deploying an engagement platform that delivers advanced and efficient communications can help mitigate this issue by giving providers easy access to clear and concise billing documentation to guide them as they code claims. An engagement platform can help keep providers current on changing reimbursement policies and procedures and align policies to the date service was rendered.

Embed advanced clinical editing solutions
Disconnects between published reimbursement policy and what is occurring during the adjudication process can cause provider abrasion and increased costs for providers and payers alike as claims are appealed due to improper denial. Many adjudication systems could benefit from software solutions that deliver modern, rules-based, clinical editing and keep them current with policy changes at industry, national, and state-specific levels. Such solutions can improve provider satisfaction and help reduce overall costs resulting in higher auto-adjudication rates and fewer appealed claims.

Use the EDI stream to identify claims that are likely to be denied and instruct providers on coding steps that may resolve the issue

The EDI stream is a fertile source of claim information that can identify claims that are likely to be denied. By evaluating these claims, providers can get advance notice of that likelihood and learn how to adjust the claim so it aligns with reimbursement policy. At the speed of EDI, providers can receive detailed instructions on claim correction steps, far surpassing the traditional CARC & RARC process. Such a solution integrates with existing software and systems and is non-disruptive to payer and provider.

Leverage near real-time visibility into claims data for greater efficiency, collaboration and accountability

Lack of transparency between States, providers and MCOs can erode trust. Providers may say claims are late or not being paid while MCOs say claims are not submitted in a timely or correct manner. Before they can look into these issues, State agency leaders must wait weeks or months for claim data to process through the EDW. Tools within the EDI stream now can offer in near real-time a 360-degree view of pre-adjudicated claims data, revealing the reasons behind claims denials and ejections; the performance of each MCO; and insight into the types of claims being processed, rejected and denied—stratified by program and provider. Data is received on a daily and weekly basis. With greater insight and accountability, payments are more timely, provider challenges are resolved faster and relationships between providers, MCOs, State leaders (including Legislators) improve.

Engage with providers' coding solutions to identify and correct claims that will deny prior to submittal

Innovative and advanced technologies engage directly with the provider community at the point of care or charge entry. Solutions move reimbursement rules and logic from provider manuals and adjudication systems into providers' practice management systems. When these are integrated, changes to reimbursement logic applied in the adjudication system are immediately available to the providers as they code their claims. This type of solution has the potential to eliminate virtually all claim denials while improving provider satisfaction.

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Prior to joining Optum he served as a Director with the State of Utah's Medicaid program, leading technical systems management of their legacy Medicaid system and oversaw the technical implementation of the states' new MMIS. `

John started his career as a database administrator and worked across several industries including supply chain management, financial services, contact center management, and pharmaceuticals.

Start the conversation

Interested in reducing improper Medicaid claims denials and provider abrasion? Contact us to start the conversation at optum.com/stategovcontact

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CMS Medicare Data on Provider Practice and Specialty

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