Statement for the Record

Submitted by Premier Inc.

"Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care"

Senate Budget Committee

May 8, 2024

Premier Inc. appreciates the opportunity to submit a statement for the record on the Senate Budget Committee hearing titled "*Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care*" on May 8, 2024. Premier shares the Committee's goal of addressing unnecessary, labor-intensive and costly processes that require healthcare professionals to take time away from caring for their patients. An urgent matter that demands immediate attention is the issue of delayed payments and denials of insurance claims by payers. These challenges not only hinder patients' access to care but also impose significant administrative burdens and additional costs on healthcare providers.

To bring evidence to the situation, Premier conducted a recent survey* of hospitals and health systems. As covered in more detail below, the survey revealed that nearly 15 percent of all claims submitted to payers for reimbursement were initially denied. More than 54 percent of claims rejected by private payers were ultimately overturned and the claims paid, but only after multiple rounds of provider appeals that cost providers nationwide roughly $19.7 billion a year.

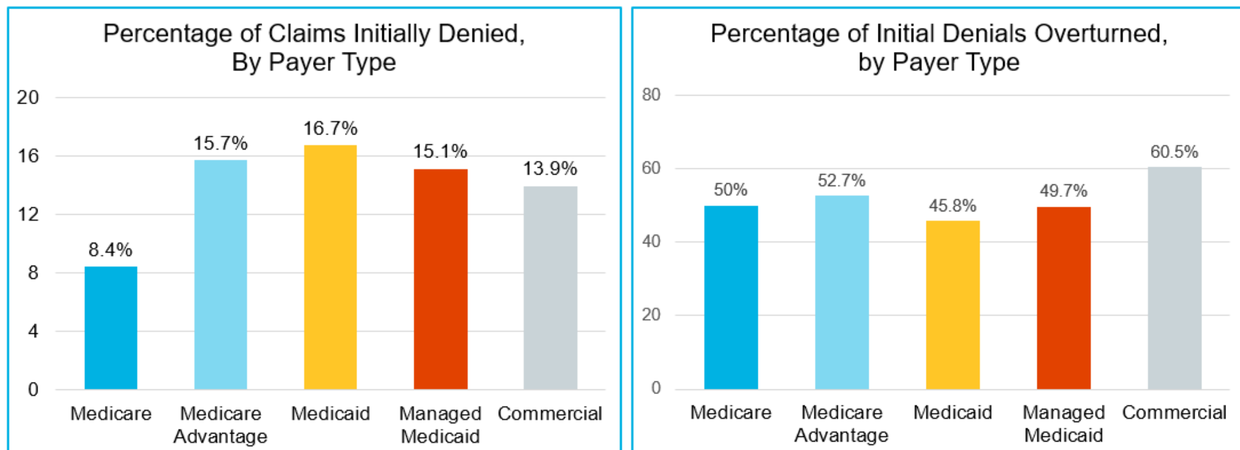
Premier and 118 of our member organizations, ranging from large health systems to independent physician offices, sent a letter to CMS highlighting these results and recommending policy solutions to prevent these payment delays and denials from impacting Medicare Advantage (MA) patients' timely access to healthcare. In April, the Centers for Medicare & Medicaid Services (CMS) replied to the letter and, as part of its response, outlined the scope and limitations of what CMS believes is its current statutory authority. This provides helpful direction on where Congressional action is needed and Premier plans to engage further with Congress to advance legislative levers to address rampant, unnecessary denials by MA plans.

I. Background on Premier Inc.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust standardized data gleaned from 45 percent of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. Survey Reveals Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims

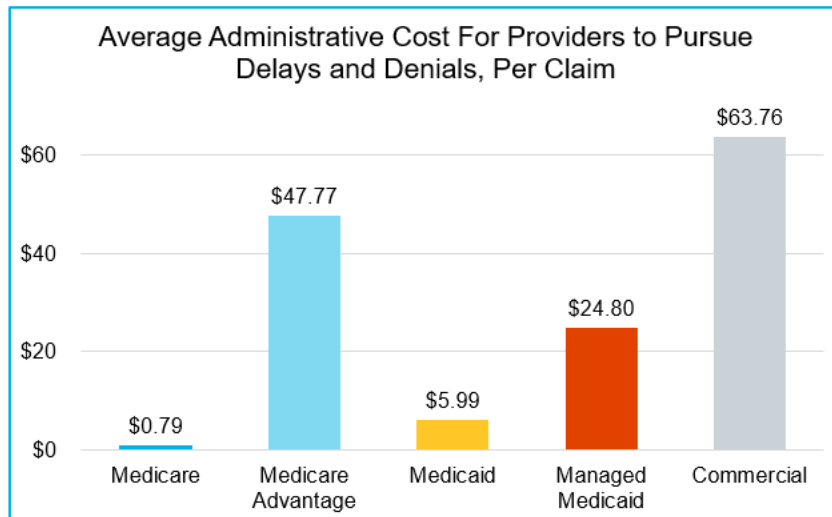
The results of a new Premier survey of hospitals and health systems found that more than 54 percent of claims rejected by private payers were ultimately overturned and the claims paid, but only after multiple rounds of provider appeals that cost providers nationwide roughly $19.7 billion a year. Nearly 15 percent of medical claims submitted to private payers for reimbursement are initially denied, according to the survey. An average of 3.2 percent of these claims included those that were pre-approved via the prior authorization process.



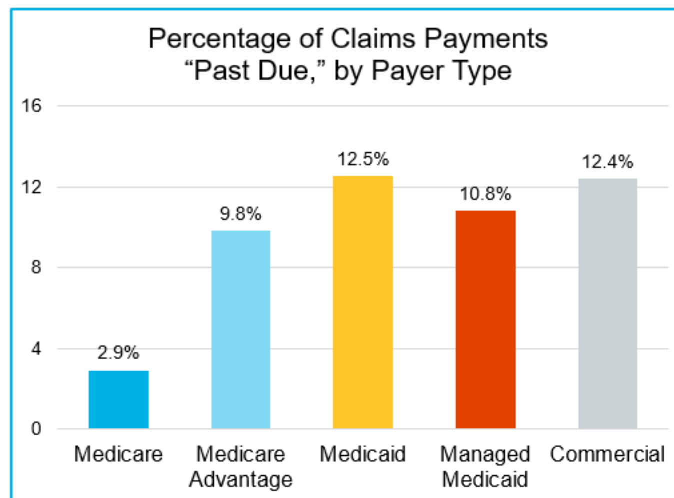
Unnecessary Insurer Denials Add Costs to the System and Compromise Hospital Financials

- Hospital and health system respondents that fought the denials did so at an average cost of $43.84 per claim. Considering that health insurers process about three billion medical claims each year, this means that providers spend about $19.7 billion a year in these reviews, more than half of which ($10.6 billion) was wasted arguing over claims that should have been paid at the time of submission.

- Importantly, this figure does not include the costs associated with added clinical labor, which the American Medical Association estimates adds $13.29 to the adjudication cost per claim for a general inpatient stay and $51.20 to the cost of inpatient surgery.

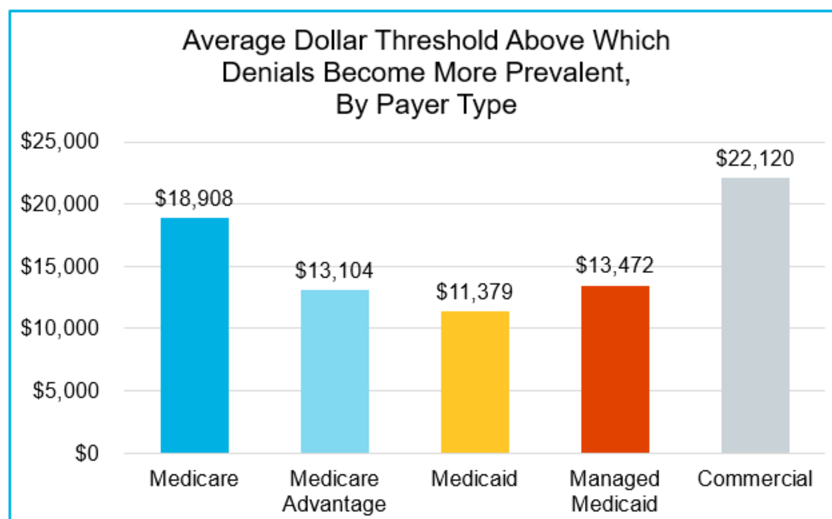


- Premier survey respondents reported conducting an average of three rounds of reviews with insurers, with each review cycle taking between 45 and 60 days. These delays resulted in nearly 14 percent (13.9) of all health system claims being past due for remittance, with providers often unable to recoup costs for up to six months after services were delivered.



Denials Are Also Costly for Patients and Threaten Timely Access to Care

- Patients whose bills are unpaid by their insurer may be liable for some or all of the ultimate costs of care. This is especially disconcerting considering denials tended to be more prevalent for higher-cost treatments, with the average denial pegged to charges of $14,000 and up.



- A lengthy period of limbo may also result in patients skipping or delaying necessary follow-up care until they can be certain that existing hospital bills will be paid.

- Respondents to Premier's survey reported that hospital discharges to post-acute care settings such as skilled nursing facilities (SNF) were particularly subject to initial denials, with more than 20 percent of all claims requesting discharge to a SNF for ongoing care and post-acute therapy denied by private insurers.

- This leads to longer than expected hospital stays, which adds expense and risk, as patients with longer stays have greater rates of secondary infections, falls and exposure to other contagious diseases.

- Payer denials also have downstream effects on care availability, as patients requiring a hospital admission may not have access to a bed until other patients are approved for discharge to the SNF setting of care.

III. POLICY RECOMMENDATIONS TO REDUCE PROVIDER BURDEN AND PROTECT MEDICARE ADVANTAGE PATIENTS' CONTINUITY OF CARE

As referenced above, Premier and 118 of our member organizations, ranging from large health systems to independent physician offices, sent a letter to CMS highlighting the results of the survey, expressing significant concerns about the potential impact of payment delays and denials on patients' timely access to healthcare. One area of concern is the Medicare MA program, where over a quarter of claims are subject to prior authorization, and nearly 20 percent of discharges to post-acute care settings are initially denied. The organizations called for policy changes to advance the needs of patients enrolled in the MA program by removing barriers to timely, high-quality, equitable care. Specifically, the organizations urge CMS to:

- Stringently monitor reporting of expenditures on direct patient care, particularly in the MA program:
- Collect data on payment denials and delays by MA plans;
- Return to its past policy of weighing patient experience and access measures more heavily in the MA Star Ratings methodology, empowering beneficiaries to hold their health plans financially accountable;

- Take enforcement action against MA plans that fail to abide by the coverage rules of Medicare;
- Work expeditiously to enforce its recent regulatory changes to streamline prior authorization requirements in the MA program; and
- Require coverage determination reviews to be conducted by physicians of the same specialty for the service being reviewed – not a cost-containment algorithm.

The letter also calls on policymakers to stipulate that claims approved under an electronic prior authorization may not be artificially delayed or denied and for Congress to ensure CMS has the statutory authority needed to enforce its regulations, including by holding oversight hearings to combat bad actors in this space.

In its April 24, 2024 response to the letter, Dr. Meena Seshamani, Deputy Administrator of CMS and Director of the Center for Medicare, outlines the current regulatory and enforcement protections currently available to MA beneficiaries and to providers to hold health plans accountable for covering Medicare benefits, including:

- CMS believes that the agency is generally prohibited from getting involved in contract negotiations or disputes between MA plans and network providers because of a statutory provision commonly known as the "non-interference clause," which may hamstring future efforts around data collection on payment delays and denials.
- The Contract Year 2024 MA rulemaking expressly prohibits MA organizations from denying coverage based on medical necessity or reopening its decision once a prior authorization is approved. The only exceptions are for "good cause" or if there is reliable evidence of fraud.
- CMS acknowledges that under current regulation, all amounts that an MA organization pays (including under capitation contracts) for covered services are included in the medical benefits portion of the plan's medical loss ratio (MLR) – we noted in our letter that current MLR regulations do not afford enough transparency for CMS or the public to recognize whether Medicare premium dollars are being paid to contracted network providers versus the health plan's own providers - or even retail - assets.
- CMS continues to consider ways to improve the prior authorization process for MA beneficiaries and providers but notes that even under current regulations, MA plans are supposed to notice beneficiaries of prior authorization decisions "*as expeditiously as the enrollee's health condition requires*," but no later than 72 hours from request receipt for urgent requests or 14 days for standard requests.

CMS' response is helpful for identifying the scope and limitations of what the agency believes is its current statutory authority, which Premier plans to use to refine our policy recommendations on these key issue areas - including advocating for statutory change where needed. Premier looks forward to working with Congress to put a stop to problematic payer practices that strain hospital resources, deplete cash reserves and hinder medically necessary care.

IV. Conclusion

In closing, Premier appreciates the opportunity to share these recommendations with the Committee and looks forward to working with Congress as it considers policies to root out unnecessary paperwork, costs and administrative burdens in our healthcare system. If you have any questions regarding our comments or need more information, please contact John Knapp at john_knapp@premierinc.com.

***Methodology**
Premier conducted a voluntary, national survey of member hospitals and health systems from October 10-December 31, 2023. Respondents represented 516 hospitals across 36 states, accounting for 52,123 acute care beds. Respondents were asked to consider all claims from January 1, 2022 to December 31, 2022. Findings are presented as averages, weighted by acute bed capacity of the respondent. Respondents ranged from a small 12-bed critical access hospital to large, multi-state health systems. A copy of the survey questions can be found here.

To calculate the costs associated with fighting payer denials, we multiplied the 3 billion claims processed each year by 0.15 (the average denial rate identified by the survey) to determine that 450 million claims were subjected to denials. We then multiplied that figure by $43.84 (the average cost incurred) to calculate $19.7 billion in costs. Considering that 54.3 percent of these claims were ultimately paid, we multiplied $19.7 billion by 54.3 percent to calculate the costs that were largely unnecessary.