Premier is collecting data to inform our advocacy on behalf of members experiencing persistent payment denials and delays by health plans. We are interested in learning more about the financial and administrative burdens that providers face when appealing or pursuing denials/delays in claims payment. Understanding the severity of the issue amongst our members will help inform the development of a data-driven advocacy strategy in Washington DC.

For the purposes of the survey, please consider the time period from January 1, 2022 to December 31, 2022.

Please answer the following questions, to the best of your knowledge, by November 10, 2023. Upon completion, please email the completed PDF document to Mason Ingram at Mason_Ingram@premierinc.com. Should your organizational policies require that you submit this information in a different format, or via protected means, please contact Mason and we will gladly work with you to meet your organization's needs.

Ideally, the survey should be completed by the Finance or Revenue Cycle Management teams. Responses to the survey will be aggregated and anonymized.

Should you have any questions regarding the survey, please contact Mason Ingram at Mason_Ingram@premierinc.com.

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1. During the period from January 1, 2022 to December 31, 2022, what volume of your organization's claims were subject to pre-service approvals (e.g., prior authorization) by health plans? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	% of Claims Requiring Prior Auth
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

2. During the period from January 1, 2022 to December 31, 2022, what percentage of initial claims submitted to payers were denied? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	Initial Claim Denial %
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

3. Of the claims initially denied in Question 2, what percentage of denials were eventually overturned and the claims paid? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	Denial Overturn %
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

4. What proportion of claims that received a prior authorization were denied? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	Received prior auth, but still denied payment %
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

5. On average, how many rounds of payer review (including prior authorization, post-payment audits, etc.) does your organization undergo prior to receiving final claims payment? Please enter a number from 0-10 in the text boxes for each insurance type.

Insurance Product	Average # of rounds of audits prior to payment
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

6. Does your organization track the administrative cost of pursuing denials and/or delays in claims payments?

☐ a. Yes, my organization tracks this information

☐ b. No, my organization does not track this information

☐ c. Do not know

7. *If you responded "Yes" to Question 6 above,* what is the administrative cost of pursing denials and/or delays in claims payments? Please enter an average dollar amount per claim in the text boxes for each insurance type.

Insurance Product	Average admin cost per denied claim
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

8. What percentage of claims payments/remittances are "past due" to your organization based on the terms of your payer contracts? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	% of claims past due
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

9. Did claims denials and delays worsen during period from January 1, 2022 to December 31, 2022? Please select one response per insurance type.

Insurance Product	Worsened	Improved	No Change	Do Not Know
Medicare	☐	☐	☐	☐
Managed Medicare	☐	☐	☐	☐
Medicaid	☐	☐	☐	☐
Managed Medicaid	☐	☐	☐	☐
Managed Care and Other Commercial	☐	☐	☐	☐
Marketplace Exchanges	☐	☐	☐	☐

10. Based on your organization's experience, is there a dollar threshold above which denials and/or delays become more prevalent? If so, please indicate your best dollar estimate(s) below.

Insurance Product	Denial/Delay Threshold
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

11. Does your organization have a defined policy to determine at what point denials and/or delays count as unpaid or uncompensated care? If so, how has this affected your unpaid or uncompensated care estimates overall?

☐ a. Yes, my organization has a policy. [Free response for additional information]

☐ b. My organization does not have a specific policy.

☐ c. Do not know

12. Based on your organization's experience, what is the percentage of discharges to post-acute facilities (e.g., skilled nursing) that are initially denied? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	Initial Denial % for Discharge
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

13. Based on your organization's experience, how do delays/denials around coverage of discharges to post-acute care affect your care planning timelines? [Free response]

14. Based on your organization's experience, for what percentage of denied claims were you asked to downgrade the DRG, in order to receive claims payment? Please enter a percentage (0-100) in the text boxes for each insurance type.

Insurance Product	Initial Denial % for Discharge
Medicare	
Managed Medicare	
Medicaid	
Managed Medicaid	
Managed Care and Other Commercial	
Marketplace Exchanges	

15. With regard to patients who are covered by Medicare Advantage plans, who is responsible for managing the prior authorization process and ultimately securing authorization for a covered stay in a post-acute setting (e.g., SNF, home health)

    ☐ a. Acute facility (e.g., hospital case manager, discharge planner)

    ☐ b. Post-acute provider (e.g., SNF or home health agency staff)

    ☐ c. Other [free response text box]

16. Is there any additional information that you would like to share that might be helpful in our analysis? [Free response, optional field]

17. Name

18. Email address

19. In which states does your organization operate?

20. How many acute beds does your organization have?

21. If your organization operates across multiple states, is your experience consistent across all states?

- ☐ a. Our experience is consistent across all states in which our organization operates.
- ☐ b. No, we are more concerned about delays and/or denials in the following states: [Free response box]
- ☐ c. Do not know