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Insights from the Healing American Healthcare Coalition™

HEALING AMERICAN HEALTHCARE COALITION

From the Editor: With a solar eclipse between them, March Madness ended with South Carolina as the NCAA women's winner and UConn as the men's winner. This SPECIAL EDITION includes the entire Modern Healthcare op-ed from Chip Kahn and Dr. Bruce Siegel on the Change Healthcare cyberattack and Senate concerns about private equity. **TMR's** March Madness, a discounted subscription at $12.00/yr. for curated coverage of emerging healthcare issues two or three times each month, ends with this issue. Click here to subscribe.

Insurers' response to the Change breach failed providers, by Chip Kahn and Dr. Bruce Siegel, Modern Healthcare, 4/8/24

Chip Kahn, left, is president and CEO of the Federation of American Hospitals, and Dr. Bruce Siegel is president and CEO of America's Essential Hospitals.

It's been more than a month since an unprecedented cyberattack nearly brought down a large portion of American healthcare, severely limiting some patients and providers from completing the most basic tasks, such as scheduling appointments, approving medications and certifying insurance eligibility. The Feb. 21 attack on Change Healthcare, a subsidiary of UnitedHealth Group's Optum unit, severed the electronic ties that connect patients, providers and insurance companies. The attack robbed patients of the certainty they could seek and receive care, and it robbed physicians, pharmacists and hospitals of the resources necessary for patient care.

Despite their inability to get reimbursed, physicians saw patients, pharmacists continued to fill lifesaving prescriptions, and hospitals kept their doors open 24/7. Having no idea whether or for how long they could meet payroll, America's providers did what was necessary to continue caring for their patients. The Biden administration, too, made it clear that helping patients and providers needed to be a top priority, even as its authority over private insurance companies was limited.

Overlooked in this crisis, is that insurance companies failed to act decisively and collectively to protect patients and providers. While having a fiduciary obligation to spend premium dollars for patient care, insurance companies have instead generally sat on billions of dollars in their bank accounts — or even invested it and made millions on interest — while independent physicians take out personal lines of credit and hospitals serving large numbers of Medicaid beneficiaries, dually eligible patients and lower-income seniors on Medicare Advantage struggle to stay afloat, often taking out loans that cost them money in interest.

Here's what should have happened immediately when the threat facing patient care became painfully obvious.

First, meaningful advanced payments could have been offered to providers based on a historical average of their claims. This stopgap measure would have sent an immediate signal to providers — and the patients and communities they serve — that American businesses and livelihoods were not at risk of closure while the system was being fixed. This is not free money for providers. These are payments for services that will eventually be reconciled when all claims processing is restored.

To put this into perspective: Kodiak Solutions, a revenue cycle management firm, estimates that at least $2 billion per week in patient services could have been reimbursed to their client hospitals and systems by insurers in the first three weeks ($6 billion), but was held back. That represents just a fraction of total delayed payments. Industry-wide, an estimated $50 billion in patient services has

likely been affected since Feb. 21, according to Kodiak. That number dwarfs the $4.7 billion in payments United-Health Group said it has advanced to providers, according to its website April 5.

Instead, UnitedHealth offered laughably small loans or payments to providers at onerous terms, further increasing the stress heaped on our already overly burdened healthcare workforce. Other payers just pointed the finger at UnitedHealth and rejected requests for a financial lifeline. As a result, we continue to hear about providers taking out personal and business loans or liquidating savings accounts to keep their businesses afloat when that never needed to happen. Providers, many with slim margins, are losing dollars that could have been spent serving their communities.

Second, to help providers find workarounds to the situation, insurance companies should have suspended as many administrative hurdles as possible — such as prior authorization, filing deadlines and unique claim editing requirements that are now leading to excessive denials. But prior authorization requirements weren't waived, claims weren't paid and questions weren't answered. The fact is, six weeks out from the attack, we are nowhere near the end of this crisis. America's providers now face the next daunting phase of recovery.

Working through the backlog of claims will take months. Hospitals and provider groups are reallocating workers, assessing service cuts, moving around resources and signing contracts with new clearinghouses – each action costing them valuable resources that should be directed toward patient care.

Worse yet, as millions of backlogged claims and new claims are finally submitted, we expect many to be routinely rejected due to the hurdles that exist in switching to new vendors and the complexity required in filing these claims. Insurance companies assert that 90% or more of claims are *"flowing,"* yet among our member hospitals there are reports of submitted claims facing 25% to 40% rejection rates — triple the normal rate — because the new workarounds available to them typically don't include the thousands of insurer-specific details.

The coming months will be critical in helping physicians and hospitals recover as they work through the administrative nightmare that awaits them. We need to send a clear message to insurers that delays and denials are unacceptable in an era where we are all connected electronically and dependent on one another. The federal government needs to hold insurers accountable for ensuring that premium dollars go to patient care now – before their inaction drives providers to the brink.

Senate investigating whether ER care has been harmed by growing role of private-equity firms, by Gretchen Morgensen, NBC News, 4/1/24

TMR Topline – Led by its chairman, Sen. Gary Peters, D.-Mich., the inquiry by the Homeland Security and Governmental Affairs Committee centers on three of the nation's largest private-equity (PE) firms: Apollo Global Management, the Blackstone Group and KKR. Sen. Peters is concerned that emergency medicine staffing companies *"may be engaging in cost-saving measures at the expense of patient safety and care."* In recent years, PE firms have invested $1 trillion and are significant players in many sectors of the health care industry. NBC News has estimated that 40% of US ERs were overseen, staffed or managed by companies owned by PE firms.

Lawmakers target private equity in healthcare, citing 'rot', by Alex Kacik, Modern Healthcare, 4/4/24

TMR Topline – Citing the struggles of Steward Health Care's hospitals, Sens. Edward Markey (D-Mass.) and Elizabeth Warren (D-Mass.) are pushing for more oversight of PE investments in healthcare, stating that that stricter oversight of Steward transactions could have mitigated its financial decline. Cerberus Capital Management's exit process netted it a profit of about $800 million. Markey also released a discussion draft of the Health Over Wealth Act that would require PE firms that acquire healthcare companies to set aside funding to protect access to care, remove tax breaks that might incentivize investors to strip hospital assets and require PE firms to disclose their finances publicly and to HHS.

TMR's Take: American capitalism gone wild? Whether it's PE predators or oligopolistic insurers, profits take priority over patients and providers. US healthcare is in crisis. Bloomberg News states *"the existing system is undeniably failing,"* encouraging states to keep trying new approaches like Colorado's, and putting the Medicare-based public option back on the agenda. **TMR** agrees!