March 21, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations, we appreciate the Administration's commitment to enabling access to high-quality, equitable care for Medicare beneficiaries enrolled in Medicare Advantage (MA) plans. In particular, we commend the Centers for Medicare and Medicaid Services (CMS) for recent regulatory efforts to improve transparency and competition, streamline burdensome prior authorization requirements and protect beneficiaries' access to medically necessary healthcare.

While these efforts will go a long way in strengthening the MA program, it is important that we bring to your attention a recent national survey of Premier's member hospitals and health systems that points to the need for additional policy change to advance the needs of patients enrolled in MA and the providers who care for them. The survey found that nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that are pre-approved through a prior authorization process. MA and Medicaid health plans denied initial claims submissions at higher-than-average rates of 15.7 percent and 16.7 percent, respectively. Denials tended to be more prevalent for higher-cost treatments, with the average denials across payer types pegged to charges of $14,000 or greater.

Despite significant rates of denials on initial claims submissions, the survey found that 52.7 percent of MA claims denials were eventually overturned, and the claims paid. However, hospital and health system survey respondents that fought the denials did so at an average administrative cost of $47.77 per claim for MA claims and $43.84 per claim on average across private insurance types. 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.

Costly Implications for Patients

Patients whose bills are unpaid by their insurer may also be liable for some or all of the ultimate costs of care – and a lengthy wait for coverage approval may result in patients' delaying necessary follow-up care until they can be certain that existing liabilities will be paid. According to The Commonwealth Fund, 46 percent of Americans report skipping or delaying necessary follow-up care because they worry about the costs, and another 49 percent say they would be unable to pay for an unexpected $1,000 medical bill within 30 days.

According to our survey data, hospital discharges to post-acute care settings such as skilled nursing facilities (SNF) have faced a particularly high level of coverage denials, particularly from MA plans. The survey found that more than 20 percent of MA claims requesting discharge to a SNF for ongoing care and post-acute therapy were initially denied.

Impact of Denials on Hospital Quality Ratings and Reimbursement

Research has shown that patients facing medical claim denials rate their satisfaction with their clinical care 8.2 points lower than patients who do not experience coverage denials, as assessed by the 100-point scale in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This finding holds true even when the claim is ultimately paid. Considering the 15 percent overall rate of denials found in our survey data, providers' overall quality scores may be significantly artificially depressed by these health plan behaviors. Poor quality scores have a host of compounding financial impacts for hospitals and health systems. For example, for providers participating in value-based payment models that tie payments to performance, lower quality scores may curb their ability to earn payment incentives or shared savings, and may even lead to payment penalties.

Providers' quality metrics are also often leveraged by private payers for ratesetting with network providers, reserving the highest payment rates for the highest performers. Under the current framework, payers may have a perverse incentive to *increase* denials, as it ultimately leads to poorer quality scores for providers, and which payers may use to reduce reimbursement rates.

Recommended Policy Solutions

To address these potentially dire impacts on Medicare beneficiaries and providers, ***we urge CMS to stringently monitor MA plans' reporting of expenditures on direct patient care***. It is imperative that CMS leverage its full authority to ensure that MA plans' medical loss ratio (MLR) requirements for revenue used for patient care are satisfied in alignment with the benefits to which Medicare beneficiaries are entitled.

We strongly encourage CMS to begin collecting data on payment delays and denials between MA plans and contracted providers to determine whether current health plan industry practices violate CMS' expectations around network adequacy. While MA plans may claim a contracted network of providers on paper, adequate payment to these networks is critical to continued access to care for Medicare beneficiaries. ***We also recommend that CMS begin collecting data on payment delays and denials between MA plans and out of network providers***, ensuring that CMS has sufficient data to fully evaluate Medicare beneficiaries' access to their entitled benefits. We will continue to work with Congress to help ensure CMS has the statutory authority needed to enforce its regulations, including urging Congress to hold oversight hearings to combat bad actors in this space. ***We specifically urge CMS to take enforcement action against MA plans that fail to abide by the coverage rules of Medicare***, which has included coverage of post-acute skilled nursing services since Congress created the Medicare program in 1965.

Additionally, we note that CMS has moved away from holding MA plans accountable for CAHPS and other patient experience measures in recent rulemaking by reducing the weighting of patient experience and access measures in the Star Ratings program. ***We recommend that CMS return to its past policy of weighting patient experience and access measures more heavily in the MA Star Ratings methodology, empowering beneficiaries to hold their health plans financially accountable***.

Finally, as CMS implements additional requirements for MA plans to utilize electronic prior authorization, we encourage going a step further to stipulate that claims approved under an electronic prior authorization may not be artificially delayed or denied. In essence, electronic prior authorization should serve as an agreement between the payer and provider to perform the requested service and remit timely payment for it. It is critical that federal regulators leverage the technology pathways that already exist to streamline prior authorization as soon as possible, rather than waiting years for health plans to catch up.

Conclusion

We sincerely appreciate your consideration of the above comments and our ongoing collaborative engagement with CMS. We would welcome the opportunity to discuss these challenges as well as opportunities for improvement with you and your team.

Sincerely,

Advanced Home Care Services West Inc.
AdventHealth
Advocate Health
Aesthetic Dermatology LLC
Alabama Spine and Pain
Alliant Holding LLC
Always Best Care Senior Services
AnMed
Ascension
Avera Health
Ballad Health
Baptist Health
Baton Rouge General Medical Center
Baystate Health
Bellin Health Partners
Bhawna Bahethi, MD, LLC
Billings Clinic
Bon Secours Mercy Health
Boone County Health Center
Breckinridge Health, Inc.
Bullock County Hospital
Butler County Health
Capstone Health Alliance
Carilion Clinic
Catholic Health System
Central Kentucky Diagnostic Center, LLC
Chesapeake Regional Healthcare
ChristianaCare
CommonSpirit Health
Community Memorial Healthcare
Cone Health
DHR Health
ECU Health
ExperienceCare Pharmacy LLC
Fairview
Firelands Health
FirstHealth of the Carolinas
Franciscan Healthcare
Freedom Medical and Mobility (dba Medi Mart)
Geritom Med, Inc.
Hamilton Healthcare System
Healthcare Purchasing Connection
Health Center Partners of Southern California
Health Enterprises Cooperative
Heritage Valley Health System
Highlands Internal Medicine
Howard County Medical Center

In House Senior Services
Independence Plus
Inwood Pharmacy
Iredell Health System
Iroquois Healthcare Association
Kuakini Health System
LAB Discount Drugs, Inc.
Lexington Medical Center
LifeBridge Health
Long Valley Pharmacy
Luminis Health
MaineHealth
Marshall Health Network
McLaren Health Care Corporation
McLeod Health Clarendon
Mercy Health Corporation
Meridian Medical Supply, Inc
Methodist Hospitals NW Indiana
MetroHealth Systems
Midwest Podiatry Centers
Moffitt Cancer Center
Mon Health System
Monument Health
Mosaic Life Care
Mountain Lakes Medical Center
Nathan Littauer Hospital and Nursing Home
North Oaks Health System
Northwestern Medicine
OSF HealthCare
Palmetto Infusion Services
Pandion Optimization Alliance
Patient Care Associates, Inc.
Pennington & Red Lake County Public Health & Home Care
Pharmarama LLC.
PharmaScript Inc.
Prairie Health Ventures
Premier Inc.
Providence
Remedi SeniorCare
Riverside Health System
Robert Beitman, MD, PA Gastroenterology (Cape May Court House, NJ)
Rochester Regional Health
RXD Medication Services
Saint Francis Health System
Saratoga Ophthalmology
Self Regional Healthcare
SLC Pharmacy INC
Smart Dental Designers
Southcoast Health System Inc
Specialty Sales & Service
Spectrum Infusion, Inc
Stony Brook University Hospital
St. Joseph's/Candler
St. Luke's University Health Network
Sterling Pharmacy

Summit Orthopedics, LTD
Texas Health Resources
Thayer County Health Services
The Center for Health Affairs & CHAMPS
The Healthcare Council/ShareSource
Tower Pharmacy
UnitedRx, LLC
Unity Pharmacy
UnityPoint Health
University Hospitals Cleveland
University of Tennessee Medical Center
VCU Health
WakeMed Health & Hospitals
Wellstar Health System
West 14 Apothecary
Wyckoff Heights Medical Center
Yankee Alliance, LLC.