PREMIER TRANSFORMING HEALTHCARE TOGETHER®

May 23, 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, S.W.
Washington, DC 20201

Submitted electronically to: http://www.regulations.gov

RE: Medicare Program; Request for Information on Medicare Advantage Data (RIN: 0938-ZB84)

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding its Request for Information (RFI) on Medicare Advantage (MA) data. Premier applauds the Administration's commitment to enabling access to high-quality, equitable care for Medicare beneficiaries enrolled in MA plans. In particular, we commend CMS for recent regulatory efforts to improve transparency and competition, streamline burdensome prior authorization requirements and protect beneficiaries' access to medically necessary healthcare. These ongoing federal efforts are critical to strengthening the MA program, yet CMS has the opportunity to take further action to make MA work better for beneficiaries, providers and taxpayers. In our comments, Premier specifically recommends that CMS consider the following:

- Collecting and publishing additional data on the flow of Medicare premium dollars through vertically-integrated health plans to create additional transparency;
- Collecting data on payment delays and denials between MA plans and their in-network contracted providers to determine whether current health plan industry practices violate CMS' expectations of network adequacy; and
- Collecting data on value-based payment arrangements that MA plans are entering into with providers.

Our recommendations are described in greater detail below.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 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 data gleaned from nearly half 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 1,400 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

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A Malcolm Baldrige National Quality Award recipient, 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. LEVERAGING DATA TO ENSURE MEDICAL LOSS RATIO COMPLIANCE AMONG VERTICALLY-INTEGRATED HEALTH PLANS

In this RFI, CMS specifically seeks feedback on data-related recommendations for evaluating the effects of vertical integration. Premier has significant concerns about the potential impact of health plan vertical integration on patients' access to care. Between 2016 and 2019 alone, the share of medical expenses sent to related businesses by large, national, vertically-integrated payers rose exponentially – increasing more than 500 percent for one of the largest MA plan sponsors in the country. While obtaining certain types of goods and services through related businesses could improve MA plans' efficiency and reduce overall spending, MA benchmarks and spending have continued to increase year-over-year despite accelerating vertical integration trends among payers.

Premier urges CMS to collect more granular data on health plan payments to owned versus contracted providers to more stringently monitor and enforce medical loss ratio (MLR) requirements in MA. Premier is concerned that vertical integration may weaken regulations aimed at reducing the potential for overpayment of MA plans. Current MLR regulations are intended to govern the percentage of MA plan spending on healthcare claims from its overall premium revenues. The Affordable Care Act required MA plans to maintain an MLR of at least 85 percent to improve alignment of medical benefit costs and payments. If a plan repeatedly uses less than 85 percent of premium revenues for health expenses (as opposed to administrative costs or profits), then the plan could be subject to sanctions. However, plan spending directed to owned or related businesses (such as physician groups and pharmacy benefit managers owned by the payer parent company) is currently counted solely as medical claims spending when calculating the MLR, even if some of that spending represents profits for the parent company.

The current MLR rules thus give rise to two types of incentives that could cause vertical integration to raise actual or reported MA claims spending. First, payer-owned related businesses (e.g., provider groups) not subject to MLR rules may set the "transfer prices" used to value transactions with MA plans in the same parent company above market-level prices as a means of relaxing the constraint on profits posed by MLR rules. This behavior would increase reported claims spending. Second, parent companies may direct their MA plans to purchase goods and services from related businesses to take advantage of this opportunity to circumvent the MLR rules. Shifting spurred solely by efforts to evade MLR rules would likely reduce efficiency and thus increase plans' spending. ***To address these concerns, Premier recommends that CMS require MA plans to be more transparent with reporting the amount of medical benefits spending that is paid to payer-owned related businesses versus contracted providers.***

III. HOLDING MA PLANS ACCOUNTABLE FOR MEDICARE COVERAGE REQUIREMENTS

A recent national survey of Premier's member hospitals and health systems 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 plans denied initial claims submissions at a higher-than-average rate of 15.7 percent. 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.

Additionally, 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 exceptionally 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.

Premier strongly encourages 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. ***Premier also recommends 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. ***Premier specifically urges 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.***

In response to Premier's previous recommendations for CMS to begin collecting data on payment delays and denials between MA plans and contracted providers, CMS noted that Section 1854(a)(6)(B)(iii) of the Social Security Act, commonly known as the "non-interference clause," prohibits CMS from requiring an organization to contract with a particular healthcare provider or to use a particular price structure for payment under such a contract. As a result, CMS is generally not involved in pricing or contract discussions and disputes between MA organizations and the providers participating in their plan networks. However, in its CY 2024 Medicare Advantage and Part D rulemaking, CMS posits that the Secretary has authority to require MA plans to follow the "two midnights" policy that exists under Medicare fee-for-service – a policy that exists solely to clarify for providers whether to bill Medicare Part A versus Part B in a bifurcated fee-for-service billing structure – without violating the non-interference rule. CMS explains in the final rule preamble that the "focus of this policy is not on how or how much MA organizations pay their contracted providers, but on ensuring that MA enrollees receive items and services for which benefits are available under Part A and Part B." The same logic applies for holding MA plans accountable for – or at the very least, collecting data on – paying their contracted network providers for covered services rendered to Medicare beneficiaries. When MA plans repeatedly delay or deny payment for services rendered, hospitals and health systems are forced to step away from those in-network contracts in order to remain financially viable, and fewer providers in MA networks may leave fewer care options for beneficiaries who stick with their plans.

Additionally, ***Premier strongly recommends that CMS make any data collected on health plan payment delays and denials publicly available so that beneficiaries and their families may have sufficient information to make informed choices about Medicare enrollment options***. CMS recently finalized requirements for MA and other CMS-regulated health plans to report certain metrics around prior authorization in their public websites to underscore "the importance of transparency and accountability in the health care system." Public reporting of rates of denials in particular is a powerful tool for incentivizing compliance with Medicare coverage rules.

IV. USING DATA TO INCENTIVIZE THE MOVEMENT TO VALUE-BASED CARE

In the CY 2023 Advance Notice, CMS expressed interest in developing a measure to capture value-based arrangements among MA organizations. Specifically, CMS sought feedback on how to structure a measure that focuses on the ways in which MA organizations contract with providers, what percentage of their providers have value-based contracts and what types of arrangements these contracts entail. Premier reiterates our support for CMS' interest in encouraging value-based arrangements in MA through the collection of this kind of data. While traditional Medicare alternative payment models have led the way, a significant amount of Medicare payment in MA remains in fee-for-service contracting arrangements. To empower providers to transform care, Premier believes that our healthcare system must move away from fee-for-service and ensure all payment systems are built on value.

Additionally, Premier believes that CMS should collect data that would help alleviate one of the biggest challenges in existing value-based arrangements in MA: data sharing. Premier's hospital and health system members frequently note that they do not have access to timely and/or comprehensive data on their patients in risk-based arrangements. Specifically, providers note that while they do receive some data from MA payers, the data reflects only a portion of the care received by beneficiaries in the value-based arrangements. ***Premier recommends that CMS collect data to examine whether MA plans share full, timely data with providers in value-based arrangements.*** Similarly, lack of alignment of value-based arrangements across MA payers creates significant burden on providers. Premier's members have noted poor alignment of measures and other requirements tied to payment across MA plans as an impediment to progress toward value. Premier believes that CMS could play a pivotal role in helping align value-based care models across MA payers and should begin collecting information from plans on the overall structure of their arrangements.

V. CONCLUSION

Premier appreciates the opportunity to comment on the CMS RFI on MA data. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues to the Administration in its policy development, please contact Mason Ingram, Director of Payer Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.

APPENDIX:
https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims