April 4, 2025

The Honorable Mehmet Oz, M.D.
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

Dear Administrator Oz:

On behalf of the undersigned organizations, we appreciate the Administration's commitment to improving the efficiency and effectiveness of healthcare. In support of this effort, it is important that we bring to your attention a recent national survey of hospitals and health systems that points to the need for additional policy changes to help protect patients and to reduce administrative burden and waste for both providers and payers in the claims adjudication process. 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.[1] Medicare Advantage (MA) and Medicaid health plans denied initial claims submissions at higher-than-average rates of 15 percent and 28.5 percent, respectively.

Despite significant rates of denials on initial claims submissions, the survey found that nearly 70 percent of these initial denials by private payers were eventually overturned and the claims paid. Overturn rates for initial denials were particularly high among MA (68.1 percent) and Medicaid managed care plans (65.7 percent). However, hospital and health system survey respondents that fought the denials did so at an average administrative cost of $80.16 per claim for MA claims and $57.23 per claim on average across private insurance types. Considering that health insurers process about three billion medical claims each year, one could extrapolate that providers spend about $25.7 billion a year in administrative costs on these denial appeals, more than half of which ($17.6 billion) was spent adjudicating claims that should have been paid at the time of initial claim submission.

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, 33 percent of Americans report skipping or delaying necessary follow-up care because they worry about the costs, and 40 percent of adults who delayed or skipped care reported that it led to worsening of their health problems.

According to the survey data, hospital discharges to post-acute care settings such as skilled nursing facilities (SNF) have faced especially high levels of coverage denials, particularly from MA plans. The survey found that more than 21 percent of MA claims requesting discharge to a SNF for ongoing care and post-acute therapy were initially denied. This delay results in patients remaining in a higher cost acute care setting longer and places them at risk for complications such as hospital acquired infections.

[1] Results from Premier Inc.'s National Survey on Payment Delays and Denials, published February 24, 2025 at https://premierinc.com/newsroom/blog/claims-adjudication-costs-providers-25-7-billion

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 nearly 15 percent overall rate of denials found in the 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 rate setting with network providers, reserving the highest payment rates for the highest performers. Under the current framework, payers are faced with 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.

Payers Face Challenges Issuing Payments for Incorrect or Incomplete Claims

For payers, each claim undergoes a review for accuracy, standardization and determination of payment amounts to serve as a backstop for patient safety and to avoid waste, fraud, abuse and other forms of improper payments. According to leading insurers, minor clerical and/or data errors are the top reason to deny claims approved via prior authorization. Small mistakes include misspelled names, missing information, documentation and coding mistakes, and inverted numbers (i.e., social security numbers, dates of birth and other vital information). These denials are particularly frustrating, since they should be largely avoidable with ironclad documentation and claim submissions processes.

The prior authorization process is also notoriously lengthy, requiring clinical and administrative reviews of complex and varying policies. As a result, the process can take several days or even months to complete. In these cases, some providers may opt to perform what they consider to be a medically necessary service before the prior authorization has been secured, which can (and does) ultimately lead to a claim denial.

Another problem with which payers must grapple is the need for complex and comprehensive patient records to determine the medical necessity of a given item or service. Clinical documentation often requires months of patient records, including clinical notes, diagnostic test results and evidence of conservative treatments pursued before recommending more advanced care. Many providers struggle to provide this level of detail, given that patients may have seen multiple providers in multiple states for the same condition, and the lack of portability in electronic health data. Absent a complete set of records, even claims for medically-necessary care may be subject to denials on the back end.

The Path Forward: Recommended Policy Solutions

The undersigned organizations have significant concerns about the negative effects that lengthy and cumbersome claims processes have on patients' access to care. We continue to support Congress and the Administration in the development of appropriate policy incentives to address the root causes of delays and inappropriate denials in claims processing, removing barriers to high-quality care.

Last year, similar data from 2022 was shared in a letter to the Centers for Medicare and Medicaid Services (CMS) signed by 119 organizations ranging from large health systems to independent physician offices. Due to our collective advocacy, CMS provided written guidance on what MA utilization management policies are – and are not – explicitly allowed by CMS, including specific regulatory citations to better equip providers to deal with the claims appeal and contract negotiation process with MA plans. In the agency's next MA rulemaking cycle, CMS incorporated several specific recommendations we raised, including

increasing transparency in medical loss ratio (MLR) reporting to help CMS and the public monitor potentially harmful impacts from payers' vertical integration practices.

While progress has been made, additional work remains, especially as the 2023 data indicates that MA plans continue to have disproportionately higher rates of prior authorization compared to other insurance types, as well as disproportionately higher rates of initial denials being overturned. Therefore, we urge CMS to do the following:

- 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.

- Finalize the agency's proposal in its Contract Year 2026 MA and Part D proposed rule that prohibits MA plans from reopening approved authorizations for acute care. If implemented, the regulatory change would improve patient experiences while minimizing additional regulatory burden.

- Collect and make public both:

    - (1) the percentage of payment denials and delays by CMS-regulated health plans that are generated by payer-owned and affiliated providers versus contracted providers; and

    - (2) the percentage of claims that are denied due to incomplete documentation by providers.

    Each of these data points is critical for healthcare consumers to fully understand the potential market failures that are driving the high prices they face – whether it be health insurance coverage from a vertically-integrated health plan or healthcare items and/or services from a provider who struggles with appropriate medical necessity documentation. Evidence-based policymaking is critical for designing the right solutions to the right problems in the least burdensome manner. As such, CMS has an opportunity to encourage payer transparency for healthcare consumers around reasons for denials. It is insufficient for payers to simply indicate that a prior authorization request was denied because it "does not meet medical necessity criteria," as this response does not help guide the patient or provider toward what the payer would deem as medically appropriate (and thus covered) care.

Additionally, it is critical for the Administration to work with private sector stakeholders to develop policy solutions that unleash innovation to technology-enable documentation, prior authorization and claims processing processes that are currently labor- and resource-intensive and highly susceptible to human error. The rise in tailor-made technology solutions that are integrated into providers' clinical workflows hold great promise for bridging the gap on appropriate documentation practices for providers. Further public-private partnership on identifying and fixing the broken components of the claims adjudication process, particularly for federally-supported health insurance programs, is the next step in getting patients the right care at the right time, improving outcomes and containing costs.

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 Neurology Associates
Advanced Pediatric Care, LLC

AdventHealth
Advocate Health
Ascension
Avera Health
Ballad Health
Baptist Health
Baton Rouge General Medical Center
BayCare Clinic, LLP
Baycare Health Partners
BayCare Health System
Bayhealth
Bellin Health Partners
Billings Clinic Logan Health
Bon Secours Mercy Health
Cape Fear Valley Health
Capstone Health Alliance
Carilion Clinic
Carle Health
ChristianaCare
Cone Health
DHR Health
ECU Health
El Centro Regional Medical Center
Fairview Health Services
Firelands Health
FirstHealth of the Carolinas
Greater Baltimore Medical Center
Gulfcoast Pharmaceutical Specialty, LLC
Health Center Partners of Southern California
HonorHealth
Inwood Pharmacy
Iroquois Healthcare Association
Kuakini Health System
Luminis Health
MaineHealth
Mary Greeley Medical Center
McLaren Health Care
Mercy Health Corporation
Methodist Hospitals
Methodist Le Bonheur Healthcare
MetroHealth
Monument Health
Mosaic Health
North Oaks Health System
Northwest Florida Community Hospital
Ophthalmic Surgeons & Physicians, LTD
OSF HealthCare
Palmetto Infusion Services
Pandion Optimization Alliance
PeaceHealth
PharmaScript Inc.
Prairie Health Ventures
Premier Inc.
Providence
Riverside Health

Saint Francis Health System
Southcoast Health System
St Luke’s University Health Network
St. Joseph's/Candler
St. Luke's University Health Network
Sterling Pharmacy
Stony Brook University Hospital
Summa Health
Tanner Health
Texas Health Resources
The Center for Health Affairs & CHAMPS GPO
The Healthcare Council/ShareSource
TriHealth, Inc.
Trinity Health
UnityPoint Health
University Hospitals
University of South Alabama (USA) Health
University of Tennessee Medical Center
Vandalia Health
VCU Health System
Vitruvian Health Care System
WakeMed Health & Hospitals
Wyckoff Heights Medical Center
Yankee Alliance