American Hospital Association™
Advancing Health in America

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October 3, 2025

Michael Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission
425 I Street NW, Suite 701
Washington, D.C. 20001

Re: American Hospital Association Comments on September 2025 Meeting

Dear Chairman Chernew,

On behalf of our nearly 5,000 member hospitals, health systems and other affiliated health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is grateful for the opportunity to provide comments on the Medicare Payment Advisory Commission's (MedPAC's) preliminary analysis of the association between Medicare Advantage (MA) enrollment changes and hospital finances shared during the September public meeting. With MA having emerged as the predominant form of Medicare coverage, understanding the effects of the MA program on beneficiaries and the providers who care for them is essential.[1]

We appreciate that the Commission recognizes the importance of studying the financial impacts of high and growing rates of MA enrollment on hospitals. As MedPAC staff noted in their September presentation, hospital leaders consistently report that certain MA plans often impose administrative and coverage barriers to patients' access to timely care in appropriate settings. These concerns are well-founded.

Indeed, evidence continues to mount that certain MA plans create barriers to patient access to care and provider payment. For example:

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[1] Medicare Payment Advisory Commission. 2025. A data book: Health care spending and the Medicare program. Washington, DC: MEDPAC.

- From 2022 to 2023, hospitals and health systems report that MA claim denials rose by 55.7%, adding substantial administrative workload on clinicians and delaying payment for medically necessary care.[2]
- MA plans imposed nearly 50 million prior-authorization determinations in 2023 — an upstream requirement that consumes significant staff time regardless of whether a claim is ultimately denied.
- The vast majority – 81.7% – of appealed cases are at least partially overturned, demonstrating that the plans are introducing inappropriate barriers to access to care and payment for services.[3]
- Delays in care due to health plan administrative requirements have resulted in MA beneficiaries experiencing roughly 40% longer inpatient stays prior to discharge to post-acute care compared to traditional Medicare beneficiaries.[4]
- Further, the Senate Permanent Subcommittee on Investigations documented that major MA insurers use prior authorization to restrict transfers to skilled nursing, inpatient rehabilitation and long-term acute care hospitals at much higher rates than other types of care, corroborating concerns about delayed care transitions.[5]

Taken together, these data validate the Commission's focus on the impact of the MA program on hospitals and confirm — through both our analyses and external evidence — that MA is imposing materially greater, and inappropriate, administrative burdens on hospitals as compared to traditional Medicare.

Against this backdrop, the Commission's preliminary county-level finding — that increases in MA enrollment are not statistically associated, on average, with changes to hospital "profit margins" (all payer margins) — is difficult to reconcile.[6] Based on our understanding of the analysis, we have identified several data and methodological limitations. First, the underlying data may be ill-suited to capture the administrative intensity (e.g., denials, prior authorization churn and delayed post-acute transfers) that rarely appears cleanly in cost-report aggregates. Second, averaging effects across all hospitals obscures substantial heterogeneity by market, payer mix, geography and hospital type (with rural, safety-net and high-MA-penetration systems most exposed).

Furthermore, relying solely on all-payer margin as a measure of hospital financial health risks overlooking how MA penetration uniquely affects hospitals. Organizations that track hospital financial performance, such as credit rating agencies, routinely

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[2] https://www.aha.org/guidesreports/2024-09-10-skyrocketing-hospital-administrative-costs-burdensome-commercial-insurer-policies-are-impacting
[3] https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/
[4] https://strengthenhealthcare.org/wp-content/uploads/2025/06/PAC-Analysis-Findings.pdf
[5] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
[6] https://www.medpac.gov/wp-content/uploads/2025/09/Tab-G-MA-effect-on-hospitals-Sept-2025-SEC.pdf

supplement margin analysis with metrics including days cash on hand and debt service coverage, recognizing that hospital resilience depends on more than operating margin. More importantly, however, focusing on all-payer profit margin as an aggregate metric can obscure the financial pressures imposed by MA plans' administrative practices and reimbursement structures, particularly in hospitals with high or growing MA enrollment. A more accurate picture requires examining payment-to-cost ratios and payer-specific margins, especially for MA compared to traditional Medicare and commercial payers. For example, these burdens fall especially hard on rural providers: recent AHA analyses show that many rural hospitals are reimbursed by MA at 90.6% of traditional Medicare on a cost basis, with MA patients experiencing 9.6% longer inpatient stays before post-acute transfer and majorities of rural clinicians reporting quality impacts and rising administrative load.[7]

Given the importance of understanding the impact of the MA program on the health care system, we encourage the Commission to continue this analysis. However, as the Commission advances its work, we urge it to refine the analytic approach to address these concerns. In the absence of appropriate data or mechanisms, which we acknowledge can be incredibly complicated and nuanced, we encourage MedPAC to explore alternative approaches to better understanding these dynamics. This could include seeking focused information from plans on their authorization and appeals processes, linking existing hospital financial data with available MA utilization information, and running analyses that account for differences across markets and hospital types. We also recommend pairing the numbers with on-the-ground perspectives through hospital site visits and case studies, as well as convening a small technical advisory group (hospitals, plans, Centers for Medicare & Medicaid Services and researchers) to validate measures and ensure transparency.

In addition, although MedPAC noted that the findings represent correlation rather than causation, the AHA is concerned that external audiences may misinterpret MedPAC's preliminary findings or take them out of context. There is a risk that policymakers, the media and the public could use these initial results to draw broad conclusions about the program's effectiveness without considering critical nuances.[8] Such misinterpretations could lead to policy decisions that overlook major systemic issues within the MA program, including transparency gaps, barriers to care for beneficiaries, underpayment, excessive administrative burdens and inadequate oversight.

We appreciate MedPAC's leadership in exploring this complex topic given the substantial implications of MA enrollment growth for Medicare beneficiaries and the overall stability of the health care system in many communities. As such, it is essential to exercise caution in drawing conclusions based on the study findings to date. More granular data, methodological adjustments and careful consideration of the unique

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[7] https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america
[8] https://www.healthcaredive.com/news/medicare-advantage-hospital-finances-MedPAC/759535/

realities individual hospitals face are critical to ensure that policymakers have the information they need to develop appropriate solutions to the challenges created by certain MA plans. The AHA is ready to partner with MedPAC to advance this work and ensure that policymakers have the clearest possible picture of how MA affects patients and hospitals.

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Noah Isserman, AHA's director of health insurance and coverage policy, at nisserman@aha.org or 202-626-2333.

Sincerely,

/s/

Molly Smith
Group Vice President
Public Policy

Cc: Paul Masi, M.P.P.
MedPAC Commissioners