PREMIER

September 17, 2025

Michael Chernew, PhD
Chairman
Medicare Payment Advisory Commission
425 I Street NW
Suite 701
Washington, DC 20001

Submitted electronically to: meetingcomments@medpac.gov

Dear Chairman Chernew:

Premier Inc. appreciates the opportunity to submit comments to the Medicare Payment Advisory Commission (MedPAC) regarding the initial analysis of Medicare Advantage's (MA) impacts on hospital finances that was shared at MedPAC's September public meeting. Premier is encouraged by MedPAC's willingness to continue to examine this increasingly significant issue for hospitals, non-acute providers and the patients they serve. Considering the limitations of the current analysis noted by MedPAC staff – specifically, issues with generalizability due to heterogeneity among hospitals and geographic regions – Premier offers several recommendations to strengthen MedPAC's future analysis, including:

- Clarifying that the lack of statistical significance in the relationship between MA growth and net revenues for hospitals paid under Medicare's Inpatient Prospective Payment System (IPPS) is the result of statistical analysis of "profit" as a variable, rather than the mathematical consequence of reductions to both revenues and operating expenses;
- Examining regional variation in the impacts of MA growth on providers, segmenting data beyond whether a hospital is paid under IPPS or under the critical access hospital (CAH) payment methodology;
- Expanding analysis beyond impact on hospitals to include the finances of providers across the continuum of care;
- Separately analyzing the impacts of MA plans that are owned and operated by large, national health insurance companies versus smaller, regional plans;
- Analyzing the impacts of the growth of MA plans that include dually-eligible beneficiaries compared to Medicare-only MA plans;
- Examining whether the impacts of MA growth on provider finances varies based on whether there is a low, moderate or high level of MA penetration in a given market; and
- Pursuing additional analysis of the impact of MA growth on uncompensated care, as suggested by staff during the public meeting.

Our recommendations are discussed 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 325,000 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.

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 healthcare is delivered nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. ADDRESSING GEOGRAPHIC VARIATION AMONG HOSPITALS

As noted during the staff presentation, MA enrollment has grown exponentially over the past decade, and more than half of Medicare beneficiaries are currently covered by an MA plan. In the most recent analysis presented during the September public meeting, MedPAC staff sought to examine the relationship between county-level MA penetration and changes in hospital finances, noting that MA plans have both the incentives and the mechanisms to reduce payments to providers. Among hospitals paid through the Medicare IPPS, MedPAC staff found that, on average, a 10-percentage point increase in MA penetration is associated with a 1.3 percent decrease in the hospital's all-payer revenues and a 1.2 percent decrease in the hospital's all-payer costs. However, the current analysis did not establish a statistically significant association between MA growth and overall net hospital revenues, potentially due to the noted limitations of the study. Additionally, as noted in past discussions, staff analysis has not identified a statistically significant relationship between MA enrollment changes and hospital finances among CAHs. MedPAC staff notes, however, that cost-based reimbursement for CAHs could explain this finding since their payment methodology could mitigate reductions in volume.

Premier encourages MedPAC to continue its analysis of the impacts of MA growth on providers by first addressing the acknowledged limitations of the initial research. To improve the likelihood of definitively establishing statistical significance, Premier recommends additional sub-analyses of MedPAC results out of a concern that average national results could mask significant geographic variation. Specifically, Premier recommends that MedPAC:

- Clarify that the lack of statistical significance in the relationship between MA growth and net revenues (referred to in the analysis as "profits") among IPPS hospitals is the result of statistical analysis of profit as a variable, rather than an extrapolation based on the mathematical "netting out" of reduced revenues and reduced costs.
- Comprehensively analyze variation among different geographic areas, such as metropolitan and rural areas, to look for regional variation among the impacts of MA on hospital finances. Moreover, geographic analysis should include all hospitals (and ultimately, all providers) within a geographically rural region, rather than simply comparing rural hospitals to urban hospitals. There is heterogeneity even within rural regions and not all hospitals are necessarily classified as rural or a CAH. Including all hospitals within a geographic area provides a more complete picture.
- Expand analysis to outpatient settings and additional provider types to examine the impact of MA growth across the continuum of care.
- Analyze impacts of MA growth on uncompensated care, as suggested by staff as a topic for further exploration.

III. ADDRESSING VARIATION AMONG MA PLANS AND MA

In its current analysis, MedPAC compares relative impacts of MA enrollment changes on hospitals that are and are not integrated with an MA plan. It is important to note that this analysis only includes one variable to address the significant heterogeneity among MA plan structures. Premier offers additional variables to consider in the analysis of MA growth, including:

- Separately analyzing the effect of MA plans run by large, national payers compared to plans run by smaller, regional plans on hospital finances. For example, this could be accomplished in part by constructing a binary variable that indicates whether an MA plan is operating under the ownership structure of a large-scale health insurance company.
- Separately analyzing the effect of dual-MA plans compared to non-dual plans on hospital finances.
- Stratifying the results of original findings by "levels" of MA penetration (e.g., quartiles) to more closely examine any variation in impacts between high-penetration counties and low-penetration counties.

IV. CONSIDERATIONS FOR FUTURE RESEARCH: SAFEGAURDING MA NETWORK ADEQUACY

As MedPAC considers its future research agenda, Premier notes that it has come to our attention that MA plans may be systematically excluding CAHs from their provider networks, potentially compromising rural Medicare beneficiaries' access to care. Premier understands that one of the reasons that MA plans may be reluctant to contract with CAHs is that these providers are generally paid at higher Medicare rates than hospitals paid under the IPPS and Outpatient Prospective Payment System. By statute, Medicare pays CAHs 101 percent of their costs, and MA plan reimbursement must mirror fee-for-service (FFS) Medicare reimbursement. Given the low volume at many CAHs, this can result in higher per-case payments for FFS Medicare and MA plans. However, if an MA plan removes a CAH from its network prior to the start of a new plan year, then the plan benefits from higher risk adjustment associated with CAH patients during the bid process without having to pay the subsequent costs for those patients during the contract year. For two years after an MA plan terms a CAH contract, the MA plan benefits from the additional cost of the CAH in its benchmark rate due to the two-year lag in baseline data.

Premier asks MedPAC to examine these scenarios to help drive evidence-based policymaking. Premier is concerned that this alleged action on the part of MA plans is counterproductive to ongoing efforts to preserve access to these hospitals through special reimbursement arrangements made available to them through the CAH designation.

V. CONCLUSION

Premier appreciates the opportunity to comment on MedPAC's ongoing research into the impacts of MA on hospitals, non-acute providers and patients. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues, please contact Mason Ingram, Senior Director of Government Affairs, at Mason_Ingram@premierinc.com or Somaieh McMullan, Senior Director of Payment Policy, at Somaieh_McMullan@premierinc.com.

Sincerely,

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Senior Vice President of Government Affairs
Premier Inc.