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The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: Request for Information—Health Coverage That Works for Everyone

Dear Ranking Member Wyden:

On behalf of the Alliance of Safety-Net Hospitals, thank you for the opportunity to provide feedback on the Senate Finance Committee Minority Staff's Request for Information (RFI), *Health Coverage That Works for Everyone*.

The Alliance of Safety-Net Hospitals (ASH) is a nationwide coalition of like-minded safety-net hospitals that work together to advocate for responsible policy decisions within government health care programs, most notably Medicare and Medicaid. ASH member hospitals serve communities across the country and provide essential services to patients regardless of payer status or ability to pay. As safety-net providers, they see firsthand how federal coverage, payment, and insurer policies affect access to care in urban, rural, and underserved communities. Their experience underscores the importance of protecting Medicaid coverage, sustaining adequate provider funding, and ensuring that public and private health plans administer benefits fairly and efficiently.

ASH supports practical, consensus-driven reforms that make coverage affordable, dependable, and usable when patients need care. To achieve that goal, Congress should protect Medicaid coverage and provider funding, establish enforceable prior authorization standards, require timely payment of valid claims, and strengthen plan accountability. Coverage is meaningful only when patients can enroll and remain covered, obtain timely approval for medically necessary services, find an accessible in-network provider, and trust that their insurer will meet its payment obligations after care is delivered.

Our response focuses on reforms responsive to the RFI's questions concerning reversal of recent coverage and Medicaid financing reductions, prior authorization improvements, claims denials and appeals, insurer payment practices, and health plan accountability. We urge Congress to:

- protect coverage and state Medicaid financing capacity as the provisions of H.R. 1 take effect;
- establish clear, enforceable prior authorization standards that prevent delay and denial of medically necessary care;

- create a federal prompt-payment standard for Medicare Advantage and other federally regulated coverage; and
- strengthen claims-denial, appeal, and reporting requirements.

Reverse Coverage Losses and Preserve Provider Capacity

As the provisions of H.R. 1 begin to take effect, Congress should prevent avoidable coverage losses and preserve the provider capacity needed to serve people who rely on Medicaid coverage. H.R. 1 narrows states' Medicaid financing flexibility through new limits on provider-related taxes and state-directed payments (SDPs), while other provisions increase the frequency and complexity of eligibility reviews. Together, these policies will require eligible people to navigate more administrative steps to remain enrolled and will jeopardize provider payment rates. Congress can mitigate those effects by reducing paperwork-driven coverage disruptions and preserving adequate implementation flexibility—practical steps that promote continuity of care, personal responsibility, and responsible stewardship of public resources.

Restore and Safeguard Coverage

ASH urges Congress to restore the coverage protections reduced by H.R. 1 and, at minimum, give states sufficient implementation time and clear federal guidance for the new community engagement requirements. Medicaid eligibility policies should include robust notice and cure periods and accessible exemptions. Although CMS has proposed allowing individuals to attest to compliance for calendar year 2027, states remain uncertain about how to prepare for stricter compliance audits in 2028 and beyond. Safety-net hospitals work every day to help patients understand and maintain their Medicaid coverage, and ASH members will continue supporting patients amid uncertainty from CMS and state Medicaid programs. As 2028 approaches, the Committee should closely monitor state readiness and act as needed to protect eligible individuals from coverage losses. H.R. 1 was intended to prevent ineligible individuals from remaining enrolled, not to make it unreasonably difficult for eligible families to retain coverage.

Preserve State Medicaid Financing Tools

Congress should preserve state flexibility to finance Medicaid and support provider networks as it oversees implementation of H.R. 1. SDPs are federally reviewed tools that are tied to quality, access, and network adequacy. CMS recently proposed implementation policies that would extend Medicare-based limits beyond the four service types identified in the law, prohibit uniform rate increase SDPs, and impose new limits on fee-for-service provider payments. ASH [submitted comments](#) in response, urging CMS to:

- limit Medicare-based caps to the four service categories Congress identified in the law;
- preserve state flexibility to use uniform rate increases;
- reconsider its proposed hospital-specific Medicare payment limit methodology; and
- maintain grandfathered status for statutorily grandfathered payments even when they reach the Medicare cap.

The Committee can support these recommendations by asking CMS to remain within the statute's scope and preserve lawful state payment mechanisms that Congress did not restrict in H.R. 1.

As Medicaid managed care has expanded, states have fewer direct tools to address services and providers facing unusually high costs and inadequate base rates. SDPs have therefore become an important mechanism for supporting targeted provider initiatives, strengthening access, and advancing delivery-system reform. These arrangements are designed with fiscal safeguards and can improve care for Medicaid

beneficiaries. They also help states meet their statutory obligation to ensure that Medicaid payments are efficient, economical, quality-focused, and sufficient to maintain access comparable to that available to the broader population. Their widespread use—more than 350 proposals submitted by 41 states in 2024—demonstrates that SDPs are now an integral part of Medicaid’s financing framework.

Safety-Net Hospitals Are Most Vulnerable to Medicaid Changes

Safety-net hospitals maintain essential services regardless of payer mix, reimbursement adequacy, or the structure of a state’s Medicaid program. Because these hospitals generally have less capacity to offset Medicaid shortfalls through commercial payment or unrestricted reserves, SDPs allow states to direct additional support to providers serving a disproportionate share of Medicaid patients. As H.R. 1 is implemented, Congress should preserve sufficient flexibility for CMS and states to protect access, sustain high-volume Medicaid providers, and support the working families who depend on them.

SDPs allow states to target limited state support to providers that deliver the most care to Medicaid beneficiaries. When structured properly and approved by CMS under existing safeguards, SDPs are not open-ended spending mechanisms, but one of the few practical tools left for states to meet their obligation to Medicaid enrollees in managed care environments.

Set Enforceable Prior Authorization Standards

Prior authorization is designed as a targeted utilization-management tool, not a routine obstacle between a patient and medically-necessary care. ASH supports electronic prior authorization and interoperable application programming interfaces (APIs) that allow providers to identify coverage requirements, submit clinical information, and receive decisions through existing workflows. Technology alone, however, will not solve the problem unless Congress pairs it with enforceable standards for plan behavior. Reforms should preserve appropriate utilization oversight while ensuring that administrative processes support timely, evidence-based decisions by qualified clinicians.

Hold Payers Accountable to Clear Prior Authorization Standards

Congress should establish requirements that give patients and providers a fair, predictable process for obtaining medically necessary care. Those standards should include the following:

- require plans to make decisions within clear timeframes appropriate to the patient’s clinical circumstances, including shorter deadlines for expedited requests and transitions to post-acute care;
- automatically approve a request when a plan fails to issue a timely decision;
- require denial notices to identify the specific clinical criterion the patient did not meet and the information needed for reconsideration;
- limit repetitive or duplicative requests for records and documentation;
- require continuity of care when a patient changes plans, when a medication or service is already authorized, or when a patient is in an active course of treatment;
- use gold-carding and other exemptions for providers with high approval rates; and
- require public reporting of approval, denial, appeal, overturn, and timeliness data stratified by plan, service, and relevant patient characteristics.

Require Prompt Payment and Fair Claims Practices

The RFI appropriately asks how insurer practices affect patients’ ability to use their coverage and those practices extend beyond prior authorization. Even after care has been authorized and delivered, plans may

delay payment by repeatedly requesting records, placing claims in a pending status, or unilaterally asserting that a claim is not “clean.” Plans also deny claims and force providers into lengthy, costly appeals without meaningful independent oversight. According to the American Hospital Association, more than half of hospitals and health systems report over \$100 million in unpaid claims older than six months; across 700 hospitals, delayed or denied claims exceed \$6.4 billion. Safety-net hospitals are particularly challenged by these delays because they operate with limited financial flexibility while serving large numbers of Medicaid, Medicare, and uninsured patients. Predictable and timely payment is a basic expectation in any sustainable market. Resources devoted to chasing payment are resources that are not invested in staffing, new services, and community programs.

Medicare Advantage (MA) was intended to improve Medicare efficiency; however, MA plans delay and deny claims at five times the rate of traditional fee-for-service Medicare. To address these practices, Congress should establish a federal prompt-payment standard for MA and consider comparable protections across other federally regulated coverage. ASH supports the bipartisan Medicare Advantage Prompt Pay Act (S. 2879 and H.R. 5454) as a practical model. The bill would require MA plans to pay at least 95 percent of clean in-network claims within 14 days and out-of-network claims within 30 days, establish a uniform definition of “clean claim,” and require public compliance reporting and civil monetary penalties when plans miss those deadlines. A uniform definition would prevent plans from restarting the payment clock through unnecessary documentation requests. Interest on late payments and public compliance reporting would give health plans a clear incentive to process medically necessary claims supported by clinical documentation. Together, these reforms would place responsibility on the party controlling the payment process and reduce the waste created by repeated follow-up and appeals.

Ensure Health Plan Networks Deliver Meaningful Access

ASH agrees with the Minority Committee that consumers should be able to determine quickly whether a doctor or hospital participates in a plan’s network and remain confident that access will not change unexpectedly during the plan year. We support measurable, evidence-based access standards calibrated to market conditions. Benchmarks previously proposed by federal agencies—including 10 business days for routine outpatient mental health or substance use disorder care and 15 business days for primary care—may provide useful goals. However, any federal standard should account for comparable commercial-market performance, provider supply, geography, and the urgency of the service.

Standards must also account for persistent workforce shortages, particularly in rural and low-income communities where safety-net hospitals struggle to maintain providers. Rather than revisiting rigid appointment wait time standards as proposed by CMS previously, Congress can use its authority to pair access benchmarks with regional flexibilities, transparent reporting, and strategies that strengthen recruitment, retention, and sustainable provider participation. A plan could satisfy a wait-time requirement on paper by contracting with an available provider who is too distant or otherwise unable to meet a patient’s needs. Network oversight should evaluate whether patients can obtain timely care from appropriate providers within a reasonable distance, rather than relying on appointment availability alone.

Appointment standards must account for severe health care workforce shortages across insurance markets, especially in safety-net communities. These areas have long struggled to recruit primary care and behavioral health professionals, and many small community hospitals have discontinued OB/GYN services to maintain financial stability. Network accountability measures should therefore assess actual access and promote workable solutions, rather than penalizing plans or providers for shortages they cannot immediately remedy.

Strengthen Network Stability by Supporting Provider Participation

Network policy must also address the financial and administrative conditions that determine whether providers can remain in a plan's network. Delayed payment, repeated denials, and excessive administrative demands are especially difficult for small, rural, and safety-net providers to absorb. When providers terminate contracts or limit participation, patients lose choices even if a plan's directory appears adequate on paper. Policymakers should consider payment timeliness, denial practices, provider terminations, and closed panels as part of network oversight. Plans should be required to report material network changes and demonstrate a credible transition plan before a provider termination disrupts patient care.

Require Transparency and Accountability Across Coverage Programs

As the Minority Committee noted in the RFI, appeals processes, patient protections, and transparency requirements vary widely across private insurance markets. Congress should align reporting and enforcement requirements across MA plans, Medicaid managed care, marketplace plans, and other federally regulated coverage. A clear national standard will encourage greater consistency in the private market as well. Plans that administer public benefits or receive public funds should meet clear expectations for service, transparency, and responsible stewardship. Standardized public data should allow patients, employers, providers, states, and federal regulators to compare plan performance.

Oversight should focus on outcomes that matter: whether patients receive timely decisions, whether authorized care is paid correctly and on time, whether appeals reverse inappropriate denials, and whether networks provide meaningful access. Plans with persistent noncompliance should face corrective action, financial penalties, limits on enrollment growth, and other consequences proportionate to the harm, including measures modeled on the proposed Medicare Advantage Prompt Pay Act.

Advance Bipartisan Reforms That Make Coverage Work

ASH appreciates the Senate Finance Committee Minority Staff's comprehensive examination of whether health coverage works for patients, families, employers, and providers. Protecting coverage and provider capacity, limiting unnecessary prior authorization burdens, requiring fair claims administration, and ensuring meaningful networks are mutually reinforcing goals. Coverage cannot fulfill its promise if patients lose eligibility because of avoidable administrative barriers, cannot obtain authorization for necessary care, cannot find an available provider, or face financial consequences when an insurer refuses to pay for authorized services.

Thank you for the opportunity to provide feedback. ASH looks forward to working with the full Committee to advance bipartisan reforms that make coverage more affordable, reliable, and accountable for patients and providers. For more information about the views expressed in this letter, please contact us at info@safetynetalliance.org.

Sincerely,

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Executive Director
Alliance of Safety-Net Hospitals

