

EXECUTIVE REFERENCE BRIEF

THE DENIAL ECONOMY EVIDENCE FILE

The research behind The Denial Numbers Are Public. Read the Overturn Rate.

Seven source groups. Clear scope. The limitation that should travel with every number.

VERSION 1.0

APPROVED EDITION

EVIDENCE VERIFIED SEPTEMBER 8, 2026

INSIDE

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PUBLIC SIGNAL

CMS and first reports

02

OVERTURN

Appeal and OIG evidence

03

ACCOUNTABILITY

Human, law, and vendor



What the public numbers can and cannot decide.

Three conclusions remain useful when the years, markets, populations, and evidence types stay separate.

01

TRANSPARENCY IS ACTIONABLE

CMS has made performance visible enough to investigate. The files remain too inconsistent for a complete hospital revenue decision.

02

OVERTURN IS NOT CASH

A favorable appeal is a signal. It does not establish eligibility, root cause, cost, collectability, or the value of the unappealed pool.

03

THE DECISION LAYER IS LOCAL

Combine external payer signals with appeal eligibility, expected overturn, collection, cost, cycle time, and root cause.

HOW TO READ THE EVIDENCE LABELS

Federal reporting requirement
Current official CMS requirements and implementation materials.

Independent policy analysis
KFF analysis bounded by its sample, market, year, and method.

Federal oversight review
OIG findings limited to the service, organizations, and period examined.

Physician survey
Self-report from surveyed physicians, not an audit or causal adjudication.

Dated legal landscape
A time-bounded state-law review; requirements differ by jurisdiction.

Vendor case study
A named customer result published by the vendor and requiring buyer diligence.

ALHQ operating interpretation: the public data are an external signal. The Denial Yield Review supplies the local decision layer.

Transparency created a usable signal.

CMS establishes the reporting floor; KFF shows what the first public files reveal and where comparability stops.

1

CMS prior-authorization metrics reporting requirements

FEDERAL REPORTING REQUIREMENT

FAQ MODIFIED SEPTEMBER 1, 2026 | TEMPLATE JULY 2026

- Impacted Medicare Advantage, Medicaid, CHIP, and federally facilitated Marketplace payers must publish annual prior-authorization metrics for medical items and services other than drugs.
- Calendar-year 2025 was the first reporting year, with publication due by March 31, 2026.

WHAT IT DOES NOT PROVE

The rule does not cover every commercial or employer-sponsored plan. Some count and expedited-appeal fields are optional, and one standard template is recommended rather than required.

ROLE: REPORTING FOUNDATION

[CMS FAQ](#)

[CMS TEMPLATE](#)

[CMS-0057-F](#)

2

KFF analysis of the first 2025 public payer reports

INDEPENDENT POLICY ANALYSIS

AUGUST 13, 2026

- Across the markets examined, standard-request denial rates were 12% in Medicare Advantage, 14% in Medicaid managed care, and 18% in the federally facilitated Marketplace.
- Of appealed standard denials, 67%, 47%, and 43%, respectively, were overturned.

WHAT IT DOES NOT PROVE

KFF analyzed 14 major insurers, not every payer. Market and service differences make raw rankings unsafe, and overturn percentages describe appealed cases, not all denied requests.

ROLE: CURRENT PUBLIC-MARKET SIGNAL

[OPEN KFF ANALYSIS](#)

High overturn deserves investigation.

Keep the 2024 Medicare Advantage data separate from the scoped OIG review and from the 2025 public reports.

3

KFF analysis of 2024 Medicare Advantage determinations

INDEPENDENT ADMINISTRATIVE-DATA ANALYSIS

2026 ANALYSIS OF 2024 CMS PART C DATA

- Medicare Advantage insurers made nearly 53 million prior-authorization determinations in 2024 and denied about 4.1 million.
- Only 11.5% of denials were appealed; 80.7% of appealed denials were overturned.

WHAT IT DOES NOT PROVE

This 2024 Medicare Advantage dataset is separate from the 2025 public reports. The unappealed pool is not automatically improper, appeal-eligible, collectible, or worth pursuing.

ROLE: APPEAL-RATE AND OVERTURN SIGNAL

[OPEN KFF ANALYSIS](#)

4

HHS OIG review of Medicare Advantage SNF admission denials

FEDERAL OVERSIGHT REVIEW

2026 REVIEW OF JUNE 2024 REQUESTS

- Across 19 Medicare Advantage organizations, 12% of reviewed SNF admission requests were denied, 18% of those denials were appealed, and 95% of appealed denials were overturned.
- OIG also reported a concentrated contractor pattern that warrants direct attribution and oversight attention.

WHAT IT DOES NOT PROVE

One service, one month, and 19 organizations do not establish an all-service national rate. Do not imply the contractor alone made every final denial decision.

ROLE: SCOPED OVERSIGHT SIGNAL

[OPEN OIG REPORT](#)

Accountability must survive the automation.

Survey, legal-landscape, and vendor evidence answer different questions and should never be merged into one proof claim.

5

AMA survey of practicing physicians

PHYSICIAN SURVEY

MAY 18, 2026 | 2025 SURVEY

- Among 1,000 practicing physicians, 24% agreed that medical-necessity denials were reviewed by a licensed and qualified physician.
- Twenty-six percent reported that prior authorization had led to a serious adverse event for a patient in their care.

WHAT IT DOES NOT PROVE

Self-reported perceptions and experiences are not an audit of payer files or adjudicated causal evidence.

ROLE: HUMAN-REVIEW AND CLINICAL-STAKES SIGNAL

[OPEN AMA SOURCE](#)

6

KFF review of state AI rules for prior authorization

DATED LEGAL LANDSCAPE REVIEW

MAY 6, 2026 | CURRENT APRIL 28, 2026

- KFF identified nine states with enacted laws addressing AI in prior authorization or claims review.
- Themes include licensed human review, individualized clinical circumstances, disclosure, and periodic outcome assessment.

WHAT IT DOES NOT PROVE

State requirements differ, and some laws apply only to prior authorization. This is not one uniform national rule or legal advice.

ROLE: AI ACCOUNTABILITY CONTEXT

[OPEN KFF REVIEW](#)

7

Janus Health case study with Carle Health

NAMED VENDOR CASE STUDY

ACCESSED SEPTEMBER 8, 2026

- Janus reports a 20% reduction in authorization-related outpatient write-offs, \$2.4 million annual net revenue impact, time equivalent to 6.4 FTEs, and 63% touchless auto-approval in scope.
- The named health system and financial, labor, and workflow measures make the claim inspectable.

WHAT IT DOES NOT PROVE

Vendor-published evidence still requires the baseline, denominator, period, scope, cost, attribution method, and proof that the result persisted.

ROLE: BUYER DILIGENCE CASE

[OPEN VENDOR CASE](#)

Use the signal without outrunning the evidence.

The brief stays credible only when each number retains its year, denominator, population, and evidence label.

CLAIM-BOUNDARY MATRIX

EVIDENCE TYPE	SAFE USE	DO NOT INFER
CMS requirement	Who reports and which measures	Every payer is covered or files are standardized
2025 public reports	Market-specific denial and appeal outcomes	A complete payer ranking or share of all denials recovered
2024 MA data	Appeal activity and overturn in that dataset	A metric interchangeable with the 2025 reports
OIG review	A scoped SNF oversight signal	An all-service national denial rate
Physician survey	Reported experience and trust concerns	Audited payer behavior or adjudicated causation
State-law review	Dated themes and jurisdictional variation	One national legal standard
Vendor case	A named result worth diligence	Transferable ROI or independently validated causation

SOURCE HANDLING AND FRESHNESS

- All source groups were verified through direct sources on September 8, 2026.
- September 16 is inside the approved 14-day freshness window.
- Recheck material claims only if publication occurs after September 22 or a material claim changes.

THE LOCAL DECISION LAYER

Expected net appeal yield = appeal-eligible denied amount x expected overturn probability x collection probability - appeal cost

Define the hospital data source, time horizon, allowed-amount basis, cycle time, and root cause. The Denial Yield Review is the companion operating workbook.

USE NOTE

This Evidence File supports ALHQ Issue #3, The Denial Numbers Are Public. Read the Overturn Rate. It is an executive reference brief, not legal, clinical, coding, contractual, or regulatory guidance. Local facts and applicable requirements should determine the final decision.