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January 26, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically: www.regulations.gov

RE: CMS-4212-P: Contract Year 2027 Policy and Technical Changes to Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the proposed changes to the Medicare Advantage and Part D programs for contract year 2027.

HANYS appreciates CMS' efforts to improve care quality and access for people enrolled in these programs by updating the Star Ratings and streamlining enrollment processes. In addition, we appreciate CMS' efforts to engage stakeholders in the MA policy development and implementation process to increase the value of the MA program for beneficiaries and taxpayers.

Participation in MA plans continues to grow. In 2025, 21.2 million Medicare beneficiaries (62%) were enrolled in an MA plan. This is more than what it was ten years ago, when 15 million beneficiaries were enrolled. In New York, 54% of beneficiaries were covered by an MA plan in 2025.

This growth trend shows no signs of slowing down; the Congressional Budget Office projects total MA enrollment will reach 64% of all Medicare beneficiaries by 2033.

HANYS and our members have long supported consumer choice and innovation within a strong health insurance market. However, while the MA program offers some advantages to beneficiaries, it also comes with unintended limitations that are inconsistent with Medicare fee-for-service policy. This causes confusion for beneficiaries who may not understand the differences between FFS and MA.

Furthermore, in practice, many MA plans have failed to meet the expectations of their members, demonstrating instances of negligence and engaging in practices that, at times, erode patient trust and compromise care. For example, the use of prior authorization by MA plan has significantly increased in the past five years.

Consumer protection

A U.S. Senate Majority Staff Report found that the share of MA beneficiaries enrolled in an MA plan that requires prior authorization grew from 72.6% in 2019 to 99% by 2023. This increase has created significant friction for both patients and providers, and in some cases has led to patients abandoning treatment. MA plans' use of prior authorization and other utilization management policies erodes access to quality care for patients and unnecessarily lengthens their time in acute care settings. This not only drives concerns regarding patient safety but also avoidable costs in acute hospital settings.

Another area of concern is the payments made to MA plans. Congress' Medicare Payment Advisory Commission estimates that MA payments in 2025 were 20% above traditional Medicare — a difference that amounts to $84 billion in annual spending. This overpayment gives MA plans a significant financial incentive to restrict care once individudals are enrolled, as MA plans receive a fixed payment for each member, regardless of the services delivered.

We support CMS' continued efforts to improve the MA program and advance important consumer and beneficiary protections. However, we caution against any erosion to those protections and ask that CMS stand behind its statement in its fact sheet that the proposed rule "aims to improve quality and access to care for people enrolled" in the MA program.

HANYS shares this perspective and we urge CMS to further strengthen its oversight to ensure MA plans do not impede patient access to care or continue to impose administrative and financial burdens on providers.

Updates to Star Ratings

CMS proposes significant changes to the Star Ratings system, aiming to further support Medicare beneficiaries by helping them compare Part C and Part D quality measures, while streamlining administrative processes for the plans.

HANYS supports CMS adding a new Part C Depression Screening and Follow-up measure to address gaps in behavioral healthcare. CMS' focus on improving behavioral health outcomes and aligning measures across programs is timely and essential, as depression is highly prevalent among MA beneficiaries and historically has been undertreated.

However, HANYS has concerns regarding some of CMS' other proposals. While it is important to modernize the Star Ratings system and reduce unnecessary administrative burdens, this should not come at the cost of meaningful oversight. CMS is responsible for ensuring MA plans deliver safe, reliable, high-quality products.

HANYS is disappointed that CMS proposes removing the Excellent Health Outcomes for All reward (previously called the Health Equity Index reward). This reward was intended to target enrollees who are at higher risk for poor health outcomes, including those who are dually eligible for both Medicare and Medicaid, low-income subsidy recipients and disabled beneficiaries. Removing explicit equity requirements risks weakening oversight at a time when Medicare's population is becoming increasingly diverse and disparities in care access are well documented.

HANYS and our members are committed to systematically and intentionally addressing social determinants of health and closing healthcare gaps in every New York community. HANYS believes

that closing these gaps will enable every individual to achieve optimal health through the delivery of equitable health services.

CMS proposes streamlining and refocusing the measure set by removing 12 measures focused on administrative processes. HANYS is concerned that CMS plans to remove the "Plan Makes Timely Decisions about Appeals" and "Reviewing Appeals Decisions" measures. These measures focus on how fast a plan sends information for an independent review and how often an independent reviewer finds the health plan's decision to deny coverage to be reasonable.

Eliminating these measures would remove any accountability for MA plans to address timely appeals decisions and provider appeals on inappropriately denied claims. Both are important measures to track and have a direct impact on an MA plan's overall Star Rating. A *Health Affairs* study found that MA plans denied 17% of their initial claim submissions and that 57% of all claim denials were overturned. Though the appeal process creates an administrative and financial burden for providers, it is an important opportunity to support their patients and the care they provide. If the measure is removed, there is nothing in place to hold MA plans accountable for their actions.

While we support adding a measure to address behavioral health gaps, HANYS urges CMS to not adopt its proposals to remove the "Excellent Health Outcomes for All" reward and the "Plan Makes Timely Decisions about Appeals" and "Reviewing Appeals Decisions" measures.

Special enrollment periods

CMS proposes two provisions focused on streamlining and improving the beneficiary enrollment experience. One proposal would modify an SEP for enrollees to change MA plans when one or more of their providers leaves their plan's network. It would remove the limitation on the existing SEP that requires both the MA plan and CMS to deem the network change "significant." The second provision would codify existing CMS policy that certain SEPs require prior CMS approval.

HANYS strongly supports and applauds these proposals. Allowing enrollees to change their MA plan when one or more of their providers goes out of network will reduce coverage gaps for beneficiaries and support continuity of care. This will improve not only beneficiaries' experience, but more importantly ensure they continue receiving the care they need.

In addition, codifying existing policies to ensure SEPs are only changed through rulemaking would boost the stability of the MA plans and reduce uncertainty around plan changes. Formal rulemaking would support our members in better understanding the SEP process for MA plans and reduce any confusion related to sub-regulatory guidance.

Requesting feedback on MA program improvements

HANYS appreciates the opportunity to provide feedback to CMS on how to strengthen the MA program by reducing unnecessary administrative burdens for hospitals and health systems and advancing important consumer and beneficiary protections. Our recommendations for MA program improvements follow.

Risk-adjustment changes

Risk adjustment is used to modify capitated MA plan payments based on their enrollees' characteristics and health conditions, particularly those that are likely to affect their healthcare spending. For an MA plan, a higher risk score means higher payment from CMS. Therefore, MA plans

have a financial incentive to thoroughly document enrollees' diagnoses. This frequently results in MA enrollees appearing to have more health conditions than similar individuals enrolled in Medicare FFS, thus driving up plan payments.

A recent report issued by Sen. Charles E. Grassley shows that UnitedHealth Group's MA program engaged in aggressive coding strategies to maximize its risk-adjustment scores. Furthermore, UnitedHealth Group developed diagnostic coding guidelines for use by other MA plans — creating new standards for diagnoses and diagnoses codes.

In addition, a 2024 Office of Inspecter General report found that most of the $7.5 billion in additional payments to MA plans resulted from questionable patient diagnoses based on in-home health risk assessments and medical chart reviews done as part of those assessments.

While we appreciate CMS' recent efforts to strengthen the agency's audit capabilities to target risk adjustment overpayments to MA plans, **we strongly urge CMS to conduct additional audits targeting MA plans' use of HRAs and HRA-linked chart reviews**. CMS must validate diagnoses reported only on in-home HRAs and HRA-linked chart reviews to ensure that MA plans are not wrongfully "upcoding."

Cost of care

The MA program is costing the federal government an estimated $76 billion more than what would have been spent for traditional Medicare, per a recent MedPAC report. The increased spending to support MA rebates and MA plan coding issues is becoming costly for taxpayers. This additional funding benefits the MA plan rather than beneficiaries, particularly since payments to MA plans are fixed per enrollee regardless of what the MA plan pays out to hospitals and health systems for services. This model incentivizes MA plans to impose restrictions on services and make utilization management challenging for hospitals and health systems.

HANYS urges CMS to review the excessive cost of supporting MA plans and to continue to address the restrictions that MA plans impose on care for beneficiaries.

Medicare FFS coding policies

Similar to the variations in coverage policies between Medicare FFS and MA plans, MA plans have unilaterally created separate coding and diagnosis grouping standards that are contrary to Medicare FFS. A key example relates to sepsis: MA plans follow Sepsis-3 criteria for determining provider reimbursement.

The Sepsis-3 criteria, formulated by the Sepsis Definitions Task Force, are not consistent with the Sepsis-2 criteria that otherwise have been universally adopted, most notably by CMS and New York state. This results in MA plans denying payment for early sepsis interventions. The use of Sepsis-3 by MA plans in New York also harms reimbursement for hospitals and health systems that are required to follow the Sepsis-2 criteria.

HANYS strongly urges CMS to align Medicare FFS and MA coding policies to ensure consistent use of Current Procedural Terminology coding practices and Diagnosis Related Group assignments.

Post-acute care

Institutional PAC providers, including inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals and home health agencies, play a vital role for recovering Medicare beneficiaries — whether in FFS or MA. Inadequate MA plan networks of PAC providers create significant challenges for patients needing this specialized care. It is critical that providers that deliver basic benefits covered by Medicare be appropriately represented in MA plan networks.

HANYS recommends that CMS explicitly add PAC providers to the MA network adequacy requirements.

In addition to the network adequacy challenges for PAC providers, MA plans' prior authorization processes play an extensive role in delaying care transitions. Hospitals are serving as a long-term destination rather than a way station for those who, once their acute care needs are met, are better served in a non-hospital setting. Despite CMS' welcomed PAC changes in the CY 2024 final rule, inappropriate denials for PAC through prior authorization have relentlessly continued.

Keeping patients in an inpatient bed while waiting for the MA plan's decision is not in the patient's best interest. These delays often result in missed clinical opportunities for patients to access the more specialized care typically provided in PAC settings.

A report by the American Hospital Association found MA patients stay nearly 10% longer in rural hospitals before being discharged to medically necessary PAC settings, compared to Medicare FFS patients.

Extended patient stays result in financial and administrative burdens on hospitals and health systems. This is particularly challenging for rural hospitals and MA beneficiaries from rural areas. Reducing PAC admission barriers would improve care quality for beneficiaries and decrease the financial and workforce strain on hospitals, particularly those in rural communities.

In addition, we have serious concerns about the behavior of some MA plans that approve prior authorization requests for PAC but later issue retrospective denials for the same services. This has been a longstanding problem for many of our PAC providers.

HANYS recommends that CMS conduct more frequent and targeted audits of MA delays and denials for PAC services, including the criteria being applied to evaluate admissions for facility-based PAC services and the rationale for denials. CMS must also ensure that IRFs, SNF, LTCHs and HHAs are explicitly added to MA network adequacy requirements and that standards are adopted to ensure there are a sufficient number and type of each PAC facility in MA networks.

Prior authorization and utilization management parameters

With over 21 million people enrolled in MA plans, the current flawed prior authorization process needs to be reevaluated. Inappropriate and excessive denials for prior authorization are pervasive among MA plans.

The process of requesting prior authorization is burdensome and frequently results in clinical delays. As MA plans apply a more stringent medical necessity criteria than traditional Medicare. A recent survey of patients found that 62% reported they had medical care delayed because of their insurance provider. The inefficient prior authorization process across MA plans results in financial burden for stakeholders and poor-quality healthcare for consumers.

HANYS strongly urges CMS to review the strict utilization management and prior authorization processes MA plans have set in place and align them with traditional Medicare.

Two-midnight rule

Although the CY 2024 final rule codified that MA plans are required to adhere to the "two-midnight" benchmark, it did not require MA plans to follow the two-midnight presumption, which refers to the directive to Medicare FFS reviewers to presume that inpatient stays that extend over two midnights are appropriate for inpatient care. Despite CMS' directive that MA plans follow the two-midnight rule, MA plans continue to downgrade inpatient hospital stays to observation status with practices and policies that are more restrictive than Medicare FFS and are inconsistent with the two-midnight benchmark.

The two-midnight rule clearly states that if the admitting physician expects the patient to require hospital care that spans at least two midnights, it is an inpatient hospital admission. We applaud CMS for extending the two-midnight presumption to MA plans, however, a number of MA plans have started to find their way around the two-midnight benchmark rule. Not only does this impact patient care, it also muddies the water for hospital reimbursement. MA plans are calling these new policies "contractual" changes or labeling them as "level of severity" policies. At their core, these policies do not align with the two-midnight rule, as they downgrade care determinations that clearly meet the two-midnight benchmark.

HANYS recommends that CMS collect data on MA plan level of care determinations that downgrade care from inpatient to observation status, including the rationale. We also urge the agency to collect and monitor additional MA and Medicare FFS data on length of stay for observation cases and denials of inpatient cases exceeding two days at the plan level. This additional level of data collection will help provide insight into MA plans' compliance with the two-midnight benchmark.

Network inadequacy

Although CMS has network adequacy standards for MA contracts that consist of minimum numbers of providers, maximum travel time and distance to providers, and maximum wait times, MA plans routinely develop narrow networks that barely meet the mimimum standards. As a result, they often steer patients away from hospitals and hospital-based providers for a variety of speciality services.

One example is National Cancer Institute-designated hospitals. Although all Medicare FFS beneficiaries have access to NCI-designated hospitals, a signficant percentage of MA plans do not have any NCI-designated hospitals in their networks (depending on the study, it is anywhere from 40% to 60%). The current network adequacy definition relies on the number of board-certified oncologists within a certain number of miles. This is insufficient, as patients need access to any combination of surgical, medical and radiation oncologists specializing in their given cancer.

Strong network adequacy standards for MA plans are critical for ensuring beneficiaries have timely, convenient and quality access to medically necessary care, preventing care gaps, limiting out-of-pocket costs and safeguarding access to care.

HANYS strongly urges CMS to continue to fully audit MA plans' provider networks and further strengthen the requirements.

Other areas for consideration

Readmissions

Another area where MA plans significantly deviate from Medicare FFS is inpatient hospital readmissions. MA plans frequently claim to be following CMS rules, but instead establish readmissions policies that are more restrictive and often based on timeframes that differ from CMS, such as 14 or 21 days. Some MA plans will not cover readmissions within a health system and others deny coverage for an inpatient "readmission" for services completely unrelated to the original admission.

HANYS asks CMS to clarify that MA plans' inpatient hospital readmissions policies cannot be more restrictive than Medicare FFS.

Claims payments and processing

Hospitals and other providers regularly struggle with MA plans that delay processing and paying claims for medically necessary care. Unlike Medicare FFS, where claims must be paid within 14 days, there are no prompt payment standards that require MA plans to provide timely payment to contracted provider. MA regulations allow up to 30 days for contracted providers — if an MA plan does not pay within 30 days, it is supposed to pay interest on the claim when the claim is ultimately paid. Unfortunately, there is no recourse or process for providers when MA plans do not adhere to the regulations.

HANYS urges CMS to impose stronger prompt pay timelines with meaningful penalties when plans miss the deadline for prompt payment.

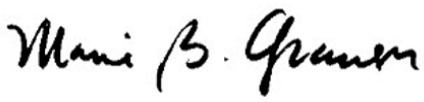
Enforcement and oversight

CMS needs to provide greater oversight of MA plan behavior. Without proper oversight and enforcement, MA plans have no incentive to change their behavior and comply with CMS rules.

HANYS strongly urges CMS to establish stiffer enforcement mechanisms and meaningful penalties for MA plan non-compliance.

If you have questions, please contact me at bgrause@hanys.org or 518.431.7765, or Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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