Federation of American Hospitals

January 26, 2026

**Via electronic submission at** http://www.regulations.gov

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

**RE:** *Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program;* 90 *Fed. Reg.* 54,894 (Nov. 28, 2025).

Dear Dr. Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced Proposed Rule on *Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program* published in the Federal Register (90 Fed. Reg. 54,894) on November 28, 2025. FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's hospitals. We commend CMS for its ongoing commitment to protecting the quality and integrity of the coverage and care provided to the millions of seniors who choose to access their Medicare benefits through private Medicare Advantage (MA) plans.

FAH members increasingly care for more seniors enrolled in MA as compared to those in Traditional Medicare fee-for-service, and both FAH and our members strongly support the program's ability to offer greater flexibility beyond the structure of Traditional Medicare. Despite this support, we remain deeply concerned about the troubling and harmful practices by some MA plans that undermine patient access to medically necessary care. These plans too often inappropriately deny, restrict or delay services, forcing providers to divert critical time and resources toward navigating denials and delays—rather than focusing on their core mission of delivering high-quality patient care.

As enrollment in Medicare Advantage grows, so too must oversight to ensure plans are meeting their obligations under the Medicare statute and CMS regulations. Without effective oversight and accountability, harmful plan practices risk becoming normalized—eroding beneficiary protections, increasing administrative burdens on providers and undermining the long-term integrity of the program and the Medicare Trust Fund. In reviewing the Proposed Rule, we encourage CMS to:

- **Preserve accountability for plan behavior**
  - FAH supports CMS's recognition that some existing Star Ratings measures are topped out or exhibit limited variation, but urges CMS to retain a core subset of measures (e.g., appeals timeliness, appeals review and complaints measures) that promote transparency and hold plans accountable for operational behaviors with direct clinical and access consequences. These tools are essential to monitoring how plans function in practice and highlighting how beneficiaries access and experience care.
- **Incorporate FAH Level 1 Upheld Denials measure into Star Ratings**
  - FAH urges CMS to adopt the FAH-developed Level 1 Upheld Denials measure, which captures plan decision-making at the initial point of denial, demonstrates meaningful variation across plans and addresses known limitations of downstream appeals measures that systematically underrepresent inappropriate denials.
- **Protect beneficiary access and choice**
  - FAH supports CMS's proposal to establish a special enrollment period when provider networks change and efforts to improve alignment for dually eligible beneficiaries. Simultaneously, we caution against policies such as passive enrollment that could disrupt continuity of care or obscure true network adequacy through sub-networking practices.
- **Strengthen network adequacy oversight and transparency**
  - FAH urges CMS to strengthen post-acute network adequacy requirements to address chronically thin networks that delay hospital discharges and disrupt medically necessary transitions of care.
  - FAH supports applying network adequacy requirements at the sub-network level, where downstream organizations often function as enrollees' de facto provider networks. Without transparency and oversight, sub-networks can restrict access to preferred providers and fail to meet CMS adequacy standards. FAH recommends CMS evaluate networks at the level beneficiaries experience care and strengthen audit and enforcement tools.
- **Strengthen MA program integrity and competition**
  - FAH strongly supports CMS's focus on risk adjustment reform and data transparency, while urging safeguards to prevent payment distortions, manipulation and inclusion of unpaid claims. We also emphasize the need for clearer oversight of vertically integrated payment arrangements that can undermine medical loss ratio accountability without delivering beneficiary value.

Additional detail and supporting analysis on these recommendations are provided in the comments below.

## Improving Beneficiary Access to Care and Coverage While Ensuring MA Plans Provide Value: Response to Supplemental RFIs (Part I.D.)

FAH generally supports the appropriate simplification, consolidation or elimination of reporting processes and data collections to address unnecessary burdens in Medicare programs through the use of automated data sharing or other initiatives that decrease reliance on manual processes. These efforts, however, must not undermine important transparency objectives or oversight to ensure program integrity, beneficiary access and coverage of critical benefits. The supplemental RFI focuses on ideas for streamlining data collection processes for network adequacy, medical loss ratio (MLR) reporting, benefit usage and utilization data and requirements related to the special needs plan model of care.

FAH strongly urges that CMS identify opportunities to improve the effectiveness of data collections in these areas to address known problems encountered by MA enrollees and the providers that care for them.

***Network Adequacy.*** FAH supports efforts to improve oversight and effectiveness of Medicare Advantage Organization (MAO or MA Plan) network adequacy. Network adequacy reviews are critical for ensuring that MAOs fulfill their statutory obligation under section 1852(d)(1)(A) of the Social Security Act to make

covered benefits are "available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits." At present, however, FAH has continuing concerns about the unmonitored and non-transparent use of sub-networks in ways that impede beneficiary access to MAOs' reported provider networks and deficiencies in MA post-acute networks. FAH therefore urges CMS to take action to ensure that network adequacy requirements and reviews address sub-networks and post-acute networks.

*Sub-Networks.* FAH supports the adoption of network adequacy requirements specific to each sub-network used by an MAO to ensure that covered benefits remain available and accessible to each enrollee in the service area. MAO "sub-networks"—downstream organizations that provide administrative and health care services to beneficiaries—are often affiliated with their own contracted or employed physician or provider groups. MAOs' sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees' *de facto* provider network notwithstanding the MAO's presentation of its full network in the provider directory and the Health Service Delivery (HSD) tables used in network adequacy reviews. This practice creates confusion among MA enrollees who may have reviewed the plan's network information in an effort to ensure in-network access to their preferred physicians, hospitals and other providers, only to realize later that a downstream organization will discourage them from accessing particular providers, rendering network access to those providers illusory. Moreover, the downstream organization's sub-network itself may not satisfy the network adequacy standards established by CMS and the requirements in section 1852(d)(1) of the Social Security Act.

**FAH recommends that CMS evaluate networks at the level at which beneficiaries actually have access to care, taking into account the MAO's sub-network structures. We further recommend CMS take action to foster MAO network transparency to protect MA beneficiary's access to care by implementing audit protocols to identify and review the adequacy of these downstream organizations' provider networks and taking appropriate network enforcement actions for noncompliance with network adequacy standards.**

*Timely Access to Post-Acute Providers.* FAH also urges CMS to evaluate and update network adequacy requirements to ensure the sufficiency of MAOs' post-acute provider networks. MAOs' networks are often thin on post-acute providers, which creates challenges for hospitals seeking a medically appropriate post-acute provider that is willing and able to accept a timely patient transfer. A recent study found patients enrolled in Medicare Advantage plans are more likely to experience longer hospital stays and are less likely to be discharged to the right setting for their follow-up care than those on Traditional Medicare. Among the most striking findings: **Medicare Advantage patients had hospital stays that were 40% longer on average than those with Traditional Medicare. This translates to a full seven days in the hospital on average for MA patients versus five for traditional Medicare patients**.[1]

At present, the minimum number requirement under 42 CFR § 422.116(e)(2)(iii) can be satisfied with a single in-network skilled nursing facility (SNF) or an ambulatory surgical center, creating little incentive for MA plans to develop robust post-acute networks. **We urge CMS to establish minimum network adequacy requirements for long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), in addition to SNFs, in recognition of the fact that these providers serve distinct, critical roles under the umbrella of post-acute care.** FAH members report that the dearth of in-network post-acute providers results in inappropriately prolonged inpatient hospital stays for MA enrollees in need of post-acute care, delaying and disrupting the patient's transition to medically necessary post-acute care (including care at LTCHs, IRFs and SNFs). In addition, this practice has adverse impacts on acute care capacity as acute care beds are deployed for MA enrollees in need of post-acute care. The absence of robust network adequacy requirements for post-acute providers is further compounded by the financial incentives for MA plans. Because a delayed discharge to post-acute care often reduces payment to the

[1] NORC at the University of Chicago. *Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries.* June 2025. Accessed January 24, 2026. Available at https://strengthenhealthcare.org/wp-content/uploads/2025/06/PAC-Analysis-Findings.pdf

post-acute provider without increasing the hospital's per-discharge payment amount, MA plans have neither a regulatory nor a financial incentive to remedy gaps in their post-acute networks.

**FAH therefore urges CMS to clarify that in-network post-acute care is unavailable or inadequate to meet an enrollees' needs under 42 CFR § 422.112(a)(1)(iii) when such care has been ordered and satisfies coverage criteria but is not immediately available.** In such a case, the enrollee should be permitted to access out-of-network post-acute care at in-network cost sharing and/or the MA plan should be required to provide additional payment to the hospital in the amount that would have been paid to the post-acute provider for that day of care. These approaches would provide an appropriate counterbalance to the MA plan's existing incentives and refocus efforts around ensuring the enrollee's access to timely and appropriate care. **In addition, FAH urges CMS to scrutinize MA plans' networks for inclusion of post-acute care providers by raising the minimum number requirement for post-acute facilities and monitoring enrollee wait times for discharge to these facilities.**

*Transparency Around Network Quality.* **To generally support transparency around network adequacy issues, CMS should include a standard in the Star Ratings Program that highlights both the adequacy and the stability of an MA plan's network.** Specifically, CMS should design a measure to ensure that beneficiaries are aware of problems that any MA plan has had both with the initial adequacy of its networks and the changes an MA plan has made during the course of a plan year that affect its networks. In addition, to further promote quality-oriented competition among MAOs and empower Medicare beneficiaries to make informed choices during open enrollment, CMS should revise the provider network directory requirements to ensure that the use and composition of any sub-networks is fully disclosed.

***Medical Loss Ratio (MLR).*** A robust and transparent MLR program is critical in safeguarding the financial integrity of the MA program, and ultimately, ensuring that it provides enrollees with high-value coverage. Pursuant to section 1857(e)(4) of the Act, MAOs are required to return excess MA funds if they fail to achieve an MLR of at least 85 percent. Meaningful MLR requirements thus provide MA enrollees and taxpayers with assurances that the MA program is using Medicare Trust Fund dollars and premiums to provide real value, rather than diverting funds to inefficient administrative expenses and profits. FAH thus generally supports regulatory actions that improve the effectiveness of the MA MLR to promote value within the MA program.

In the decade following the initial development of MLR reporting, we have seen a significant increase in vertical integration among MAOs, with MAOs acquiring and controlling a growing number of providers. These market trends threaten to jeopardize the utility of the MLR and the public confidence it inspires in the MA program insofar as the MLR requirements are not modernized to address vertical integration and transfers between related entities. In particular, FAH is concerned that transfers from MAOs to related parties might obscure actual spending on profits and administrative expenses by the integrated system as a whole. **This concern is compounded by the ability of vertically integrated entities to classify certain administrative functions, overhead, and internal transfers as "quality improvement activities," thereby masking true administrative costs and undermining the transparency the MLR is intended to provide. Without clearer standards and enhanced oversight, these classifications risk diluting the integrity of MLR reporting and limiting CMS's ability to assess whether Medicare dollars are being spent as Congress intended.**

With increased vertical integration, MAOs may be incentivized to make claims payments to providers under common ownership or control that exceed fair market value or incentive and bonus payments to related parties that exceed appropriate incentives for high-value care. Unchecked, these related party payments and transfers may improperly reduce or eliminate MLR rebate obligations, and in so doing, they may misuse Medicare Trust Fund dollars, diminish public faith in the MA program, reduce competition from unintegrated MAOs and jeopardize financial stability in the MA market. **To address these issues, FAH supports transparency and accountability with respect to MAO payments to related providers in vertically integrated systems and MLR reforms that distinguish between *bona fide* claims payments**

**to related providers and related party transfers that reduce MLR rebate payments without providing programmatic value.**

***MA Benefit Usage and Utilization Data.*** As noted elsewhere in the Proposed Rule, the MA program extensively uses encounter data for both payment purposes (risk adjustment payments) and oversight. This data, however, obscures the actual benefits provided by MAOs by often including items and services for which the MAO partially or fully denied payment. An MA plan provides coverage for basic benefits "by furnishing, arranging for, or making payment for all services that are covered by Part A and Part B of Medicare." 42 CFR § 422.101(a). Thus, when an MA plan denies payment, it likewise denies coverage for the claimed service, and payment data in remittance advices (form 835) is essential to ensuring adequate MA oversight. **Along these lines, as discussed in response to the RFI on future directions in Medicare Advantage further below, FAH urges CMS to exclude data from unpaid claims in risk adjustment data reporting and payments.**

### Special Enrollment Period for Provider Terminations (Part IV.A., § 422.62(b)(23))

FAH supports CMS's proposal to empower Medicare beneficiaries to exercise freedom of choice in the event of certain changes in their MA plan's provider network. Midyear network changes frequently occur after beneficiaries' enrollment options have closed, effectively allowing plans to narrow or restrict networks once beneficiaries are locked into coverage. We agree that the beneficiary should have the discretion to determine whether a particular change in their MA plan's provider network warrants disenrollment or enrollment in a new MA plan, **and we support the proposal to make the special enrollment period available to any beneficiary who is assigned to, currently receiving care from or has received care in the past three months from a provider or facility being terminated from the plan's provider network.**

Beneficiaries are in the best position to determine whether a particular plan will continue to serve their needs after a provider network change, and this special enrollment period should be available without the need for CMS to determine first that the change in the plan's provider network is significant or for the beneficiary to seek a special enrollment period for exceptional circumstances. By putting this decision in the hands of the beneficiary, this change will improve the beneficiary experience while eliminating an unnecessary government review to assess whether a network change warrants a special enrollment period.

### Use and Release of Risk Adjustment Data (Part IV.B, § 422.310(f))

**In line with FAH's broad support for improved transparency in the MA program, FAH supports CMS's proposal to revise § 422.310(f) to allow for the use and release of risk adjustment data in ways that are better aligned with the use and release of fee-for-service claims data and other MA data.** In addition, as discussed in connection with RFIs in the Proposed Rule, risk adjustment payments should reflect MAO coverage rather than potentially unpaid provider encounters and oversight on MA benefit utilization should likewise focus on those services for which the MAO provided coverage (*i.e.*, payment). **Therefore, CMS should require submission by the MAOs of both 837 claims data and associated 835 remittance data, which together provide the complete context necessary for accurate analysis and oversight.**

### Beneficiary Marketing and Communication (Part IV.F, §§ 422.2264, 423.2264, 422.2274, 423.2274)

**While generally supporting actions to alleviate unnecessary regulatory burdens, FAH urges CMS to retain without modification the various standards involving time and manner of beneficiary outreach as appropriate to the effective and prudent operation of the MA program.** These procedural protections—including the 12-hour delay requirement between educational and marketing events, the 48-hour rule for Scope of Appointment (SOA) forms, and the restriction on collecting SOA forms at educational events—promote informed beneficiary choice with respect to coverage options and improve the quality of

educational events. Although FAH shares CMS's desire to eliminate barriers to access to information and resources for Medicare beneficiaries, the "cooling-off periods" contained in 42 CFR §§ 422.2264, 423.2264, 422.2274 and 423.2274 already strike the appropriate balance by reducing the likelihood that beneficiaries will be subject to undue pressure and giving beneficiaries the opportunity to consider their options fully before making key decisions. The other safeguards identified in the Proposed Rule, such as the potential availability of assistance from family and the availability of special enrollment periods in the event of certain marketing or enrollment improprieties, are inadequate on their own to ensure beneficiaries have the opportunity to engage in well-informed decision-making during enrollment.

## Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)

**MA Part C & D Prescription Drug Plan Quality Rating System**

CMS proposes a set of changes to the Medicare Advantage and Part D Star Ratings (Star Ratings) System intended to simplify and refocus the program by modifying the measure set used to determine plan performance. As part of this effort, CMS proposes to remove several administrative and operational measures from the Part C and Part D Star Ratings. CMS explains that these measures largely assess plan processes and compliance activities, such as operational timeliness, customer service functions and administrative handling of appeals or complaints, rather than clinical quality or health outcomes.

CMS states that its rationale for removing these administrative and operational measures is driven by several factors. First, CMS notes that performance on many of these measures is consistently high across plans, resulting in limited variation and reduced ability to meaningfully distinguish plan performance. CMS further asserts that some of these measures may be better suited for ongoing program oversight and compliance monitoring rather than inclusion in a quality rating system designed to reward improvements in care and outcomes. Finally, CMS indicates that removing these measures would simplify the Star Ratings framework and allow greater emphasis on outcome-focused measures, which CMS believes more directly reflect the quality-of-care beneficiaries receive and better align with program goals.

FAH acknowledges CMS's proposal to remove certain administrative and operational measures from the MA Star Ratings program, including measures related to appeals timeliness, appeals review, beneficiary complaints, customer service, call center performance and enrollment stability. Specifically, CMS proposes to remove the following measures: Plan Makes Timely Decisions About Appeals (Part C); Reviewing Appeals Decisions (Part C); Appeals Auto-Forward (Part D); Complaints About the Health Plan (Part C); Complaints About the Drug Plan (Part D); Members Choosing to Leave the Plan (Part C); Customer Service (Part C and Part D); Call Center – Foreign Language Interpreter and TTY Availability (Part C and Part D); Call Center – Hold Time (Part C and Part D); Call Center – Call Abandonment (Part C and Part D); and Appeals Timeliness (Part D).

FAH agrees with CMS that, when reviewed individually, several of these measures exhibit limited variation in plan performance and, in some cases, appear topped out, reducing their ability to meaningfully discriminate among plans. FAH also recognizes CMS's view that some of these measures may be better suited for program oversight and compliance monitoring than for inclusion in a quality rating system focused on outcomes. However, FAH believes that this conclusion, while accurate at the individual-measure level, does not negate the continued policy value of retaining a core subset of these measures as accountability drivers within the Star Ratings framework.

In particular, measures such as Plan Makes Timely Decisions About Appeals (Part C), Reviewing Appeals Decisions (Part C) and Complaints About the Health/Drug Plan (Part C and Part D), play a critical role in promoting transparency and holding plans accountable for operational behaviors that directly affect beneficiary access to care and provider burden. These measures capture whether plans are administering benefits fairly, responding to beneficiary concerns in a timely manner, and making appropriate coverage determinations at key decision points in the care continuum.

The Complaints About the Health/Drug Plan measures are especially important because they provide a formal mechanism through which both beneficiaries and providers can surface patterns of problematic plan behavior that warrant CMS attention and corrective action. Providers frequently serve as the first point of contact when beneficiaries experience inappropriate denials, excessive delays or administrative barriers to medically necessary care, and these measures help translate those frontline concerns into actionable signals for CMS.

When these measures are attached to an insurer's Star Ratings, they create meaningful incentives for plans to improve utilization management practices, customer service responsiveness and fairness in appeals processes, areas that are central to beneficiaries' real-world experience of quality, even if they are not strictly clinical outcome measures. Removing these measures risks creating a transparency and accountability gap at precisely the point in the program where beneficiaries, providers and policymakers need it most.

FAH has long supported CMS's efforts to refine and improve the Star Ratings program so that it meaningfully differentiates plan performance, promotes beneficiary access to high-quality care, and aligns payment adjustments with true improvements in care delivery and patient experience. In prior comment letters, FAH has consistently emphasized that the strength of the Star Ratings program depends not on simplification for its own sake, but on the inclusion of measures that reflect how MA plans operate in practice and how their operational decisions affect beneficiaries and providers in real time.

**Against that backdrop, FAH is deeply concerned that the proposal to remove administrative and operational measures would weaken the Star Ratings program at a moment when greater, not less, accountability for plan behavior is needed.**

Administrative and operational functions such as utilization management, prior authorization and claims adjudication are not ancillary to quality. They are core mechanisms through which MA plans shape access to care, influence clinical decision making, and determine whether beneficiaries receive medically necessary services in a timely manner. This is also a critical area in which MA continues to lag behind traditional Medicare. Unlike beneficiaries in the fee-for-service program, MA enrollees are routinely subject to utilization management practices, coverage restrictions and administrative barriers that can delay or block access to services that would otherwise be covered under Original Medicare. These so-called "administrative and operational" functions have direct clinical consequences. Delayed or inappropriate denials can result in postponed treatment, clinical deterioration, unnecessary appeals and avoidable administrative burden on providers and patients alike.[2]

In prior MA Star Ratings comments, FAH has cautioned against separating clinical quality from operational performance, noting that beneficiaries do not experience quality in silos. A plan's ability to achieve high scores on process measures or patient experience surveys does not offset harm caused by inappropriate utilization management practices. Removing administrative and operational measures risks conveying that these aspects of plan performance are less central to quality, when in fact they are often the primary drivers of beneficiary and provider dissatisfaction.

FAH has consistently urged CMS to strengthen the Star Ratings program by incorporating measures that capture plan behavior earlier in the care continuum. FAH reiterates its strong support for the inclusion of FAH Level 1 Upheld Denials measure in the MA Star Ratings program.[3]

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[2] Medicare Payment Advisory Commission. 2023. Report to the Congress: Medicare and the Health Care Delivery System. Washington, DC.; Office of Inspector General, U.S. Department of Health and Human Services. 2022. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.*

[3] Battelle. National Consensus Development and Strategic Planning for 2023 Pre-Rulemaking Measure Review (PRMR): Preliminary Assessment Report—Clinician Committee: Health Care Quality Measurement. Prepared for the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. Columbus, OH: Battelle, December 2023. Contract No. 75FCMC23C0010.

Unlike existing Level 2 appeals measures, which reflect a small and self-selected subset of denials that are appealed and overturned, the Level 1 Upheld Denials measure assesses plan decision-making at the point where the vast majority of utilization management determinations occur. It captures whether plans are making appropriate coverage decisions in the first instance, rather than after beneficiaries and providers have navigated complex and resource-intensive appeals processes, a limitation that CMS and federal oversight bodies have previously acknowledged.

Field testing and independent analyses demonstrate that the Level 1 Upheld Denials measure exhibits meaningful variation across Medicare Advantage plans, even when Level 2 measures are capped. The measure has shown strong reliability and stability over time, as well as clear clinical and policy relevance. Importantly, empirical analyses indicate that performance on the Level 1 measure is not redundant with existing appeals-based measures. In fact, evidence shows that some plans that perform well on Level 2 appeals measures perform poorly on the Level 1 measure, and vice versa. This divergence underscores the inadequacy of relying on downstream appeals data as a proxy for appropriate plan behavior.

FAH also has noted in prior comments that certain quality measures currently included in the Star Ratings program demonstrate a positive correlation with the Level 1 Denials Upheld measure. This relationship reinforces the construct validity of the measure and supports the conclusion that it captures meaningful aspects of plan performance, including access, appropriateness of care and beneficiary experience.

FAH is particularly concerned that removing administrative and operational measures without incorporating the Level 1 Upheld Denials measure would leave a significant accountability gap in the Star Ratings program. Such an outcome would undermine beneficiary protections, reduce transparency for plan selection and weaken incentives for plans to improve utilization management practices.

Many beneficiaries do not appeal denials due to unawareness that appealing is an option, complexity, time constraints or health status, and many providers absorb administrative costs rather than pursuing appeals. As a result, the Level 2 appeals measures systematically underrepresent the prevalence and impact of inappropriate denials. Eliminating operational measures without addressing this gap risks further insulating plans from accountability.

FAH urges CMS to reconsider the proposed removal of administrative and operational measures from the Star Ratings program. At a minimum, these measures should be retained until more sensitive and behaviorally meaningful alternatives are implemented. More importantly, CMS should seize this opportunity to strengthen the Star Ratings framework by incorporating empirically validated measures, such as FAH Level 1 Upheld Denials measure, that more accurately reflect how plans operate and how their decisions affect beneficiaries in practice.

In prior MA Star Ratings comment letters, FAH has emphasized that the credibility and legitimacy of the Star Ratings program depend on its ability to reflect the realities of care delivery. The program should hold plans accountable not only for outcomes on paper, but for the day-to-day decisions that determine whether care is delivered appropriately and without unnecessary delay. Removing administrative and operational measures without replacing them with stronger tools runs counter to that expectation.

**FAH supports thoughtful refinement of the MA Star Ratings program but believes the proposal to remove administrative and operational measures would represent a step backward for beneficiary protection, transparency, and program integrity. CMS should instead focus on modernizing and strengthening the measures set to address known limitations in variability and discriminatory power, including by incorporating the Level 1 Upheld Denials measure. Doing so would better align the Star Ratings program with CMS's stated goals of improving quality, promoting access and ensuring that quality bonus payments reflect genuine differences in plan performance.**

### Special Needs Plans—Passive Enrollment by CMS (Part VI.B., § 422.60)

FAH applauds CMS's continued efforts to improve the experience for dually eligible beneficiaries and decrease the burden of securing coverage for their care, including by promoting aligned enrollment. We also appreciate CMS's attention to the practical challenges created by seeking a D-SNP with a substantially similar provider network for purposes of effectuating a passive enrollment process described in 42 CFR § 422.60(g), but believe that the proposed continuity of care protections would be inadequate to ensure that the beneficiary's choice of a facility network at initial enrollment is respected during passive enrollment. The MA program is designed to facilitate and prioritize consumer choice, and automatic enrollment in a health plan the beneficiary did not select is atypical. Although FAH, like CMS, finds value in the concept of allowing passive enrollment for full-benefit dually eligible enrollees from a non-renewing or terminating integrated D-SNP to another comparable integrated D-SNP, we believe that the value of passive enrollments does not outweigh the value of beneficiary access to the facility network they chose and that enrollee choice should be maximized during any passive enrollment. The proposed continuity of care requirement would address active treatment issues but would be inadequate to preserve the beneficiary's choice with respect to the facility network they will rely on should they need acute hospital care and post-acute care. Moreover, FAH believes that a facility-focused substantial similarity requirement for passive enrollment would not preclude passive enrollment in appropriate circumstances as there is less variability in MA facility networks as compared to physician networks. **FAH therefore recommends that CMS maintain the requirement that the receiving D-SNP have a *facility* provider network that is substantially similar to that of the non-renewing integrated D-SNP.**

### Utilization Management Policies and Procedures (Part VII.E, § 422.137)

FAH appreciates the opportunity to comment on the proper role of MAOs' utilization management (UM) committees, particularly with respect to the UM Committees' responsibilities with respect to the implementation of internal coverage criteria.[4] As a general matter, FAH strongly supports UM Committee requirements that are appropriately focused on ensuring adequate review and internal oversight of MAO UM policies and procedures so that MAO enrollees can be assured of appropriate access to their Medicare benefits. To this end, CMS's regulations at 42 CFR § 422.137(d)(2) properly require UM Committees to ensure that the coverage criteria in the MAO's UM policies and procedures comply with the requirements and standards set forth in 42 CFR § 422.101(b). This requirement efficiently ensures that MAO UM policies and procedures comply with regulatory requirements. In addition, the requirement is not duplicative of any other regulatory process, does not generate redundant reports and is central to ensuring that UM policies and procedures do not unlawfully deviate from Medicare coverage criteria for basic benefits or impermissibly deprive MA enrollees of their basic benefits.

**In fact, FAH urges CMS to take decisive action to further address the inefficiencies and financial burdens created by MAOs' unlawful application of coverage criteria that deviate from established Medicare coverage criteria or that otherwise impermissibly interfere with MA enrollees' coverage for their basic benefits.** FAH and its members have observed repeated issues with MAOs announcing and applying internal coverage criteria that impermissibly add to fully established Medicare coverage criteria, replace or contradict Medicare coverage criteria, are not based on current evidence in widely used treatment guidelines or clinical literature, do not address clinical harms, including from delayed or decreased access to items or services, and otherwise fail to comply with 42 CFR § 422.101(b)(6). These instances of non-compliance by MAOs jeopardize program integrity, directly harm beneficiaries whose care is denied or delayed, and burden beneficiaries and their providers with the inefficiency and financial burden of appeals to secure coverage for their basic benefits.

**To appropriately target these inefficiencies and burdens, FAH urges pragmatic transparency initiatives that will reduce the erroneous and improper approval of internal coverage criteria by UM**

[4] 90 Fed. Reg. at 54,989 (seeking "policy solutions that eliminate redundant reporting, reduce unnecessary requirements, and minimize duplicative processes to address inefficiencies and reduce financial burdens").

**Committees.** In particular, UM Committees should review and approve internal coverage criteria through a process that mirrors the process used by Medicare Administrative Contractors (MACs) to develop local coverage determinations (LCDs). As described in chapter 13 of the Medicare Program Integrity Manual, LCDs are adopted through a process consisting of consultation, publication of the proposed LCD, open meeting concerning the proposed policy, opportunity for public comment in writing, publication of a final LCD that includes a response to public comments received and public notice of the new policy at least 45 days in advance of the effective date. This process offers critical safeguards, including ensuring that LCDs do not conflict with Medicare statutes, rulings, regulations, and national coverage, payment, and coding policies and are appropriately informed by stakeholder perspectives and current evidence.

Mirroring this process in the MAO context would offer similar benefits, allowing key stakeholders—including impacted patients and providers—to raise issues during the internal coverage criteria development process that either preclude the adoption of the proposed internal coverage criteria altogether (*e.g.*, the Medicare coverage criteria are fully established or current evidence in widely used treatment guidelines or clinical literature do not support the proposed criteria) or support modification of the policy (*e.g.*, to better reflect current evidence or appropriately address clinical harms). Informed by these perspectives, UM Committees would be better able to ensure that each UM policy and procedure uses coverage criteria that comply with 42 CFR § 422.101(b), thereby reducing delayed and denied care and burdensome appeals.

### RFI on Future Directions in Medicare Advantage—Risk Adjustment (Part VIII.B.)

FAH strongly supports CMS's evaluation of the Part C Risk Adjustment Program with an eye to advancing competition, reducing manipulability, ensuring accurate payments and mitigating unintended consequences. In past comments, FAH has expressed its longstanding concern that MA plans use encounter data from denied, pended, and underpaid claims in their risk adjustment submissions, and we continue to urge CMS to limit MA encounter data to data derived exclusively from paid claims where the provider is not fully capitated. Pursuant to section 1853(a)(3)(A), the risk adjustment program is required to "account for variations in per capita costs based on health status." The use of encounter data that is disconnected from or overstates the MA plans' costs because the MA plan has denied, pended or underpaid the claim distorts MA risk adjustment payments, undermining the fiscal integrity of the program and distorting competition among MA plans. Permitting MA plans to benefit from the inclusion of denied, pended and underpaid claims through the Part C Risk Adjustment Program is particularly problematic when MA plans deny claims at significantly higher rates than commercial insurance carriers and self-funded group health plans.

To put it simply, MA plans should not be able to increase their revenue through the Part C Risk Adjustment Program based on data contained in claims that the MA plan has failed to pay. **FAH applauds CMS's evaluation of the Part C Risk Adjustment Program and urges CMS to promptly act to exclude data associated with denied, pended or underpaid claims from risk adjustment submissions and payments. As part of this realignment of MA risk adjustment payments with the statutory focus on variations in per capita *costs* based on health status, FAH supports the collection of 835 remittance data alongside the encounter data to ensure that risk adjustment payments are not inflated by health status information that is unconnected with MAO costs.**

FAH appreciates this opportunity to offer comments on the CY 2027 Medicare Advantage Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact Alyssa Keefe, SVP, Head of Policy at akeefe@fah.org.

Sincerely,
/s/
Charlene MacDonald
President and CEO