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Advancing Health in America

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January 26, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Dear Administrator Oz:

On behalf of our nearly 5,000 hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for policy and technical changes to the Medicare Advantage (MA) and Part D programs in contract year (CY) 2027.

The AHA commends CMS for seeking comprehensive public feedback regarding the future direction of the MA program. With MA enrollment now approximately 54% of eligible beneficiaries, federal oversight must be further strengthened to ensure beneficiary access to care, program integrity and the financial stability of Medicare overall. Furthermore, the scale and complexity of MA make the modernization of program rules and oversight mechanisms critical for beneficiaries, providers and taxpayers alike.

Hospitals and health systems continue to encounter persistent challenges with certain MA plans, including excessive and inconsistent prior authorization requirements (despite recent commitments to address these issues), inappropriate denials for medically necessary care covered under Original Medicare, restrictive and nontransparent coverage criteria, and inadequate provider networks. We again commend the administration for providing stakeholders with an opportunity to inform your work, ensuring the MA program remains a high-quality option for beneficiaries and does not compromise the quality or financial stability of Medicare coverage. Below, we

provide our perspectives on certain proposals contained within the CY 2027 proposed rule, as well as other aspects of the MA program or certain plan actions that we believe warrant consideration.

SPECIAL ENROLLMENT PERIOD FOR PROVIDER TERMINATIONS

CMS proposes to revise the existing special enrollment period (SEP) for Significant Change in Provider Network at 42 C.F.R. § 422.62(b)(23) by changing the eligibility criteria. The change would remove the requirement for a CMS or Medicare Advantage organization (MAO) determination that a provider network change was significant enough for an affected enrollee to be eligible for the SEP. Instead, CMS proposes to make the SEP available whenever an enrollee is affected by a provider or facility termination. CMS proposes to retain the definition of "affected enrollee" in 42 C.F.R. § 422.62(b)(23)(ii), meaning an enrollee who is assigned to, and currently receiving care from, or has received care within the past three months from a provider or facility being terminated. CMS also proposes requiring MAOs to notify affected enrollees of their SEP rights in the provider termination notice, including the SEP's start and end dates and related Medigap guaranteed issue rights.

The AHA strongly supports this SEP change and believes it is an important step toward ensuring beneficiaries have timely and meaningful options when their continuity of care is at risk due to network disruptions.

The AHA also seeks clarity from CMS regarding the provider termination SEP proposed in the rule. Specifically, whether it would apply not only when an MA organization initiates the termination of a provider from its network, but also when a contracted provider terminates network participation. As currently drafted, the regulatory text could be interpreted as limiting SEP eligibility to plan-initiated terminations, which would leave beneficiaries without comparable protection when a network disruption occurs due to a provider's decision to exit a plan's network. If the purpose of this policy is to safeguard beneficiary access and promote continuity of care, then MA enrollees should be eligible for the SEP regardless of whether the MA plan or the provider initiates the network change, because the impact on the patient, loss of in-network access to a trusted clinician or facility, is the same.

In addition, we recommend that CMS strengthen the proposal by expanding the definition of "affected enrollee" to include an enrollee who is scheduled to receive care from a provider or facility at the time the enrollee received the provider termination notice. A scheduled appointment, procedure or course of treatment is often the point at which a termination creates immediate hardship, such as delayed surgeries, missed post-discharge follow-ups essential to preventing complications, interruptions in oncology care scheduled as part of a defined treatment pathway, and deferred diagnostics where timing affects downstream clinical decisions. Moreover, terminations can derail time-sensitive post-acute transitions — such as a planned discharge to a skilled nursing facility, inpatient rehabilitation facility or home health provider — which

can lead to prolonged hospital stays, avoidable functional decline and increased readmission risk.

The existing three-month lookback is intended to capture ongoing relationships, but it can overlook beneficiaries who have scheduled time-sensitive care and are therefore especially vulnerable to delay. Expanding the definition would better align the SEP trigger with CMS' stated policy objective: reducing the lag between a termination event and a beneficiary's awareness of their rights and enrollment options by eliminating a separate "significant change" determination and ensuring clear, actionable information is included in the termination notice. If the goal is to prevent care disruptions, excluding beneficiaries with scheduled care would undermine the core purpose of the provider termination SEP. Therefore**, the AHA encourages CMS to finalize the proposed revisions to this SEP and expand the definition of "affected enrollee" to include beneficiaries with scheduled care at the time they receive a termination notice**, so that the SEP functions as a true continuity-of-care safeguard.

REPORTING PROCESSES AND DATA COLLECTIONS

CMS seeks comments on current network adequacy and medical loss ratio (MLR) reporting processes and data collection efforts to identify specific areas where requirements can be simplified, consolidated or eliminated while maintaining program integrity and beneficiary protections.[1]

CMS' efforts to review reporting and data collection requirements present a critical opportunity to modernize the MA program. Accurate, timely and transparent data are the foundation of meaningful oversight and informed beneficiary choice. While we support CMS' goal of reducing unnecessary administrative burden, streamlining must not come at the expense of accountability. As outlined below, **the AHA recommends CMS simplify the reporting processes through automation and standardization while preserving and strengthening the integrity of MLR and network adequacy reporting requirements and data collection.**

Medical Loss Ratio Reporting

The AHA supports strong MLR reporting requirements for health insurers. These requirements are necessary to hold insurers accountable for spending a minimum amount of the premium dollars on patient care, therefore preventing excessive administrative costs or plan profits.[2] MLR reporting requirements are essential to the oversight of insurer practices and improve transparency on plan performance for the

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[1] 90 Fed. Reg. 54897

[2] Commercial plans have issued approximately $13 billion in consumer rebates while altering plan behavior considerably since MLR requirements were implemented in 2012. See KFF, "2024 Medical Loss Ratio Rebates" (June 5, 2024), https://www.kiff.org/private-insurance/medical-loss-ratio-rebates/.

public. The importance of these requirements is heightened as vertically integrated arrangements may allow corporate commercial insurers to hide true medical spending, create incentives to shift reporting through related-party entities and complicate fair comparisons of value across plans. While such vertical integration is not inherently problematic, without consistent and detailed MLR reporting, CMS cannot credibly assess whether spending on services within the same family of companies is appropriate or not, undermining the value proposition of capitated payment.

The AHA supports updating MLR reporting requirements to guard against abuse by vertically integrated insurers.[3] CMS should consider focusing on improving the clarity and consistency of MLR reporting. This can be achieved through better standardization of categories and clearer treatment of intercompany eliminations and administrative allocations, rather than reducing the scope of reporting. Such improvements would ensure fairer competition and strengthen the integrity of the MA program by preventing large, multi-market insurers with vertically integrated affiliates from leveraging their scale and structure to inhibit genuine competition with smaller, regional MA plans.[4]

Network Adequacy

Network adequacy is foundational to access to care, and data on provider networks is necessary for beneficiary plan selection and meaningful competition. Beneficiaries cannot compare plans in a competitive marketplace if they cannot reliably determine which hospitals, physicians, post-acute providers and other facilities are in-network and accessible. As such, CMS should strengthen network adequacy reporting and oversight requirements, while modernizing the submission process to reduce administrative burden without reducing transparency.

To simplify the exception request process, CMS raises the idea of creating a separate pattern of care exception under 42 C.F.R. § 422.116(f)(1), that could be used where the pattern of care in an area is unique, and the organization believes its contracted network is consistent with or better than Original Medicare's pattern of care. We caution CMS in proceeding with such an exception, as it could inadvertently weaken network adequacy standards and reduce access by relying on utilization patterns that reflect existing access barriers, especially after provider terminations or in markets with known access constraints. It may create a risk that MA plans will treat the exception as an

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[3] American Hospital Association, *Comments on FTC Request for Information Regarding Reducing Anti-Competitive Regulatory Barriers* (May 23, 2025), PDF, https://www.aha.org/system/files/media/file/2025/05/AHA-Comments-on-FTC-Anticompetitive-Deregulations-RFI.pdf (accessed Jan. 9, 2026).

[4] Daniel R. Arnold and Brent D. Fulton, "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers," Health Affairs 44, no. 11 (2025): 1395–1403, https://doi.org/10.1377/hlthaff.2025.00155 (finding UnitedHealthcare paid Optum-affiliated providers ~17% more than non-Optum providers, on average).

alternate pathway to approval without making the investments needed to meet time/distance and minimum number standards in 42 C.F.R. § 422.116. If CMS moves forward with such an exception meant to address unusual market conditions, it should establish clear, enforceable parameters, including: (1) minimum evidence standards (i.e., what data sources, what time window, what service lines), (2) a clear definition of "unique pattern of care" and what constitutes "consistent with or better than" Original Medicare, and (3) guardrails to prevent the exception from masking access issues (including public reporting of approved exceptions, time-limited approvals with renewal only upon updated evidence and automatic re-review after provider network terminations or access complaints).

Finally, CMS should strengthen network adequacy standards to ensure beneficiaries can transition promptly to the next clinically appropriate site of care. This is particularly important when a patient needs access to medically necessary post-acute care (PAC) services. Hospitals and clinicians continue to report that MA administrative barriers, particularly those affecting PAC, delay discharges and impede access to covered services. As we have highlighted in the past, delays associated with PAC access have been linked to substantially longer inpatient stays for MA beneficiaries compared with Original Medicare and an investigation has documented that major MA plans disproportionately restrict access to inpatient rehabilitation facilities (IRFs), long term acute care hospitals (LTCHs), skilled nursing facilities (SNFs) and home health agencies (HHAs).[5] These restrictions can harm patients and undermine program value by keeping beneficiaries in acute care settings when a clinically appropriate transition to PAC is indicated. Timely transition to PAC would ensure patients receive care from interdisciplinary teams with specialized clinical training and treatment programs meant to achieve patients' rehabilitation and recovery goals.

To help address these failures, CMS should add key post-acute care facility types not currently included in the list of facility types subject to network adequacy evaluation under 42 C.F.R. § 422.116(b)(2), including IRFs, LTCHs and HHAs, and apply the corresponding minimum number and time and distance standards where these facility types are available.

MA QUALITY RATING SYSTEM

The MA quality rating system (Star Ratings) program is an important tool to measure the quality of health plans, reward high-performing plans and help beneficiaries make informed coverage choices. CMS' proposal to streamline the measures in the Star Ratings program raises important questions about how best to align quality incentives

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[5] U.S. Senate, Committee on Homeland Security and Governmental Affairs, Permanent Subcommittee on Investigations, Majority Staff Report, Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care (Oct. 17, 2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf (accessed Jan. 9, 2026).

with meaningful outcomes and beneficiary protections. While the AHA supports CMS' goal of streamlining reporting while prioritizing measures of clinical care and patient experience, we are concerned that removing the measures tied to appeals and complaints could weaken accountability for operational practices that directly affect access to care, as well as add substantial costs to the health care system.

Appeals and Complaints Measures

CMS proposes to simplify and refocus the measures in the Part C Star Rating program set on clinical care, outcomes and patient experience of care measures, where CMS says performance is not "topped out" and there is more variation across contracts.[6] As part of the realignment, CMS proposes to remove the following measures, among others:

- Plan Makes Timely Decisions About Appeals (Part C).
- Reviewing Appeals Decisions (Part C).
- Complaints About the Health/Drug Plan (Part C and Part D).

CMS suggests these measures would be better suited to monitor plan performance and compliance, rather than as quality measures within the Star Ratings program.
The AHA respectfully disagrees with the premise that measures must serve one function or the other. Oversight and quality incentives are not mutually exclusive. Indeed, oversight and quality incentives operate through distinct but complementary mechanisms that are both necessary to sustain accountability in MA. Furthermore, timeliness has long been considered one of the six aims of health care quality, and the measures CMS proposes to remove reflect whether MA plans are addressing beneficiary access issues in a timely fashion. In short, the three measures proposed for removal are indeed measures that directly reflect the quality of health plans.

Importantly, the appeals and complaint processes are often the final recourse for beneficiaries when coverage is denied for critical treatments, including inpatient hospital stays, post-acute services or other medically necessary care. These measures are not mere "administrative process" indicators; they are essential beneficiary protection measures that reflect whether MAOs are administering benefits in a manner that safeguards timely access to medically necessary care and preserves due process. CMS itself underscored that the "measures have been invaluable to CMS' efforts to monitor and improve plan performance and compliance in critical operational areas."[7] Patients experience consequences when MA plans delay appeal decisions or fail to appropriately handle complaints, including delayed discharges, disrupted transitions or treatment, and avoidable administrative burdens on clinicians and care teams. These

[6] 90 Fed. Reg. 54965
[7] 90 Fed. Reg. 54965

downstream impacts are particularly acute for medically complex patients and those who rely on time-sensitive coverage decisions.

Even if the average performance is relatively high and variation among plans is limited, retaining these measures is important because of the financial incentives and public transparency associated with the Star Ratings program. Removing these measures would weaken a key incentive for MA plans to maintain adequate staffing, systems and operational capacity to process appeals promptly and to resolve complaints effectively. MA plans are unlikely to prioritize these functions absent clear, ongoing incentives, especially in an environment where MA plans face competing demands and naturally focus resources on the measures that most directly affect Star Ratings and revenue. We are already seeing a concerning trend of MA plans eliminating peer-to-peer discussions, a voluntary process that is a critical safeguard helping to resolve disputes efficiently and avoid unnecessary formal appeals.

The AHA believes that eliminating these measures could unintentionally increase burdens on beneficiaries, providers and CMS alike. When the Star Ratings program no longer reinforces these accountability expectations, MA plans will be less likely to take proactive actions to avoid inappropriate denials, delay tactics, and administrative friction that force beneficiaries and providers into the appeals and complaints process in the first place. CMS would be left to rely more heavily on resource-intensive compliance activities, including programmatic audits, to detect and correct problems after harm has occurred. By contrast, maintaining these measures within Star Ratings provides an additional prospective accountability lever that can help sustain high performance, deter backsliding and reduce demand on CMS' limited enforcement and oversight capacity.

Similarly, the AHA does not believe Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures alone can serve as an adequate backstop for monitoring access and administrative harm arising from delays and denials. CAHPS is an important patient-experience instrument, but it is necessarily high-level and lagged, and it does not provide the operational specificity needed to identify and correct discrete plan practices that impede access to care in real time, such as delayed reconsiderations, improper dismissals or complaints that reflect breakdowns in coverage administration. By contrast, the appeals and complaints measures capture operational performance signals tied directly to beneficiary protections and access to care, using administrative data sources that CMS already maintains and updates through formal processes. These measures, therefore, complement, not duplicate, CMS' compliance tools and CAHPS results. Moreover, they provide a clearer, more actionable line of sight into whether plans are administering benefits in a manner consistent with Medicare coverage rules and due process expectations.

Therefore, we urge CMS to retain these measures in the Star Ratings program as an essential component of ensuring MA plan accountability, beneficiary protection and access to timely, medically necessary care.

REDUCING REGULATORY BURDEN AND COSTS IN ACCORDANCE WITH EXECUTIVE ORDER 14192

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures[8]

Prior Authorization Data Reporting Requirements. In the proposed rule, CMS seeks to eliminate requirements that health plan Utilization Management (UM) Committees conduct an annual data collection and analysis of plan prior authorization requirements established under the 2025 MA final rule and subsequently revised under the 2026 MA final rule. This analysis would have required plans to report baseline data on specific prior authorization metrics, including denial rates, the percentage of denials overturned on appeal and the average amount of time that it took for plans to complete prior authorization requests. CMS indicates that this removal would be consistent with the administration's goals of reducing regulatory burden. The agency states that this analysis is not the best vehicle to obtain baseline data on prior authorization use, believing that there are more effective ways to gain this information, such as through interoperability efforts. The agency commits to continuing to explore ways to collect data regarding prior authorization use in a manner that best represents all MA enrollees.

As we have stated previously, our members consistently report MA plan prior authorization requirements as persistent and pressing areas in need of reform. Hospitals and health systems have expressed concern that many MAOs apply prior authorization requirements in ways that can create dangerous delays in care, contribute to clinician burnout and increase costs for the health care system by requiring substantial financial investments in staff and technology systems. Specifically, providers report that plans frequently deny medically necessary care that should have been approved under CMS coverage criteria, cite significant care delays created by drawn-out plan decisions and indicate an enormous amount of administrative burden created by inefficient and improperly administered MAO prior authorization protocols, especially when errors are made, and the provider must appeal an inappropriate denial. The AHA supports CMS' efforts to reform prior authorization, and we believe that robust data collection is essential to sufficiently hold plans accountable and effectuate reform goals. We believe that the UM Committee's collection and reporting of this data would greatly support this task, though we remain open to other methods of collecting baseline data, including through interoperability, as the proposed rule notes. We urge CMS to specifically detail alternative methods of collecting information on overturn rates, inappropriate use of internal coverage criteria to deny coverage and the average time it takes for plans to adjudicate authorization requests before eliminating existing mechanisms.

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[8] 90 Fed. Reg. 54988

UM Committee — Composition and Responsibilities. CMS requests comments on how to reduce administrative burdens associated with UM Committee requirements for consideration in future rulemaking, including requirements that UM Committees represent various clinical specialties and the UM Committee's role in the implementation of internal coverage criteria.

The AHA appreciates the agency's effort to explore policy solutions that reduce unnecessary requirements, minimize duplicative processes, and reduce financial burdens. We believe that the existing UM requirements promote this same concept by establishing a front-end review of coverage policies. Specifically, a well-informed UM Committee, comprised of experts in the impacted specialties, can validate the appropriateness of coverage rules before they impact patient access to care. This is a much less administratively burdensome process than requiring CMS to audit plans to verify compliance. Additionally, this saves plans, providers and patients from having to navigate resource-intensive appeals processes otherwise needed to protect patient care access against improper policies.

Additionally, we believe that the UM Committee's proactive approval of internal coverage criteria is an important control to ensure parity in access to care for beneficiaries enrolled in MA and Original Medicare. Under CMS regulations and MAO requirements, plans may not use internal coverage criteria that are more restrictive than Original Medicare coverage rules for a procedure. Plans have consistently failed to uphold this requirement, as elucidated by the April 2022 Health and Human Services Office of the Inspector General (HHS OIG) report.[9] Sufficient guardrails and oversight are necessary to ensure that plans comply with CMS internal coverage criteria rules, and thereby protect patients from inappropriate obstacles to medically necessary care. The AHA believes that the UM Committee responsibilities significantly supplement CMS oversight roles and protect patients more efficiently.

REQUEST FOR INFORMATION ON FUTURE DIRECTIONS IN MA

CMS seeks stakeholder comments through several requests for information, including one on opportunities for modernizing and strengthening the program with the aim of supporting competition and maximizing the value of the program for beneficiaries and taxpayers.[10] The AHA supports CMS' desire to enhance the value of MA for both beneficiaries and taxpayers. Achieving this objective depends on ensuring that beneficiaries can promptly access high-quality, medically necessary care they need and to which they are entitled.

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[9] U.S. Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OEI-09-18-00260 (April 27, 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf (accessed Jan. 9, 2026).
[10] 90 Fed. Reg. 54991

Protecting the Integrity of the Medicare Advantage Program

It is important that CMS ensures MA plans do not circumvent CMS oversight by reclassifying coverage issues as mere payment disputes, thereby invoking the non-interference clause as a shield against federal intervention meant to protect patients and taxpayers from harmful insurer policies and practices. We have observed that certain MA plans treat what are fundamentally compliance matters under federal regulations as contractual price disputes, including implementing policies to standardize their downgrading or denial practices.[11]

We have seen over the years that once one or two MA plans put a policy in place, others follow suit until those policies become fundamental business practices of the MA plans.[12] Allowing an MA plan to implement a policy that reclassifies a coverage issue as a payment dispute creates a roadmap for other MA plans to do the same. These actions are deeply troubling not only because they undermine CMS' authority to enforce standards, including established coverage criteria, but also they fundamentally threaten CMS' ability to protect the integrity of the MA program and safeguard beneficiary access and the efficient use of taxpayer funds. Along with the effort to modernize the MA program to maximize its value, CMS' action to prevent MA plan attempts to circumvent oversight would send a clear signal about the agency's commitment to ensuring a strong, viable MA program that serves the interests of beneficiaries and taxpayers.

MA Risk Adjustment Program

The AHA supports CMS' commitment to modernizing the risk adjustment program. While well-intended, the existing approach to risk adjustment has led to inappropriate gaming of the system that has advantaged the largest legacy MA plans at the expense of smaller, regional plans and potential new entrants. This has resulted in excessive, unwarranted spending in the program and the destabilization of competition.

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[11] For example, one multi-state commercial insurer recently adopted a policy that effectively shifts a traditional coverage determination into a payment dispute. Under the longstanding approach, plans assess whether an inpatient stay is appropriately covered as inpatient or should be reclassified to outpatient observation consistent with the Two-Midnight Rule. Under the new policy, however, the plan approves the inpatient claim but then unilaterally reduces reimbursement to an observation-like rate, attempting to treat what is fundamentally a coverage issue as a contractual payment matter and thereby avoid CMS oversight under the non-interference clause.

[12] In recent years, insurers, including most of the large, multi-state commercial insurers, have increasingly implemented "E/M downcoding programs," often using automated edits, to unilaterally reduce reimbursement for higher-level evaluation and management visits unless providers submit additional documentation and pursue appeals. Kenzi Abou-Sabe, "'Guilty until proven innocent': Inside the fight between doctors and insurance companies over 'downcoding,'" NBC News, Oct. 9, 2025, https://www.nbcnews.com/health/health-care/guilty-proven-innocent-fight-doctors-insurance-companies-downcoding-rcna230714.

As CMS considers options to modernize the MA risk adjustment to strengthen competition and deliver value for beneficiaries and taxpayers, we urge the agency to ensure that any changes strengthen the link between these additional payments and beneficiaries receiving medically necessary care. In other words, certain plans cannot continue to be rewarded for coding strategies that inflate risk scores while also being some of the most problematic in terms of beneficiary access to care. Not only will this help align incentives to ensure beneficiaries are receiving the care they need, but also it should help reduce any incentives for insurers to acquire certain physician practices for the primary objective of influencing diagnosis capture for risk scoring purposes.

Equally important, we urge CMS to consider how any changes could impact plans' network providers and avoid shifting administrative workload onto hospitals, physicians and other clinicians who already face substantial insurer-related burden. Risk adjustment reforms that rely on after-the-fact documentation requests and manual record submission would worsen administrative friction and divert clinical resources.

Strengthening the Program Through Data-driven Accountability and Transparency

The AHA urges CMS to strengthen enforcement of existing MA requirements so that beneficiaries are not subjected to avoidable delays or inappropriate denials of Medicare-covered, medically necessary care, and providers are not subjected to inappropriate payment delays and denials or excessive administrative burden.

We support a risk-based, targeted approach to programmatic audits that prioritizes MA plans and service categories with persistent indicators of access problems, particularly those with patterns of inappropriate denials, repeated administrative delays and noncompliance with coverage and medical necessity standards. The HHS OIG has documented that some MA denials occurred even when requests met Medicare coverage rules, underscoring the need for proactive oversight that identifies systemic problems before they harm beneficiaries.

Use Existing Data and "On-the-ground" Intelligence to Find Problems Faster

Timely, accurate information on MA plan compliance is essential to ensure MA enrollees have coverage that is no more restrictive than Original Medicare. CMS can strengthen oversight by drawing on multiple data sources, including plan-reported UM and appeals data, encounter/claims information, and complaints and grievance trends, to identify outliers and intervene quickly when access barriers emerge. Provider complaints are a particularly important source of direct, on-the-ground intelligence about plan behavior, and CMS' move to route provider complaints into the Health Plan Management System Complaints Tracking Module through an online intake process is a positive first step in helping CMS trend and target oversight to recurring problem areas.

Modernize Oversight Tools to Scale Enforcement

CMS recently outlined an "enhance and accelerate" strategy for Risk Adjustment Data Validation audits that includes technology-enabled review and scaled audit capacity.[13] CMS should consider applying similar operational discipline to access-related oversight by using enhanced technology to collect, standardize and monitor meaningful plan performance indicators and to direct limited oversight resources to the highest-risk plans and practices.

Improve Transparency so Beneficiaries Can Choose Plans Based on Real Access

Finally, we believe CMS should consider pairing stronger oversight with plan-level transparency that helps beneficiaries evaluate the real-world accessibility of services under each coverage option. We recommend CMS consider reporting plan-level metrics that reflect access and compliance, such as coverage denial rates, appeal outcomes, grievance/complaint trends and measures of care delays attributable to administrative processes, and incorporate these indicators into consumer tools, such as the Medicare Plan Finder, to support informed plan selection.

We thank you for the opportunity to comment on these important topics. Please contact me if you have any questions, or feel free to have a member of your team contract Noah Isserman, AHA's director of health insurance and coverage policy, at nisserman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

[13] https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits.