Kansas Hospital Association

January 25, 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 the Kansas Hospital Association (KHA), we appreciate the opportunity to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for policy and technical changes to the Medicare Advantage (MA) and Part D programs in contract year (CY) 2027. We appreciate CMS's continued efforts to update payment systems and improve quality and transparency, while recognizing the unique challenges hospitals face.

The Kansas Hospital Association appreciates CMS's decision to seek public feedback on the future direction of the Medicare Advantage program. Hospitals and health systems continue to experience persistent challenges with certain MA plans, including excessive and inconsistent prior authorization requirements—despite recent commitments to address them—along with inappropriate denials of medically necessary care covered under Original Medicare, restrictive and nontransparent coverage criteria, and inadequate provider networks.

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

MARKETING TACTICS

Kansas hospitals continue to encounter Medicare Advantage beneficiaries who report being misled when enrolling in an MA plan or subsequently denied medically necessary care. When these beneficiaries seek to return to Original Medicare, many find they are unable to obtain Medigap coverage due to pre-existing condition restrictions.

We respectfully request that Medigap plans be required to accept beneficiaries wishing to return to Original Medicare without pre-existing condition underwriting, ensuring continuity of care and protecting Medicare beneficiaries from unintended coverage barriers.

SPECIAL ENROLLMENT PERIOD FOR PROVIDER TERMINATIONS

CMS proposes to revise the Medicare Advantage special enrollment period (SEP) for provider network terminations by removing the requirement for CMS or MAO approval of whether a network change is "significant" and instead making the SEP available whenever an enrollee is affected by a provider or facility termination. The proposal would retain the current definition of an affected enrollee—those currently receiving or recently having received care—and require MAOs to clearly notify affected beneficiaries of their SEP and Medigap rights.

KHA strongly supports this change and urges CMS to further strengthen it by expanding the definition of "affected enrollee" to include beneficiaries with scheduled or time-sensitive care at the time of termination, ensuring the SEP truly protects continuity of care and prevents avoidable delays, disruptions, and adverse outcomes.

NETWORK ADEQUACY

Network adequacy is essential to meaningful access, informed Medicare Advantage plan selection, and fair competition, and CMS should strengthen network adequacy reporting and oversight while modernizing data submission to reduce administrative burden without sacrificing transparency.

While CMS has proposed a new "pattern of care" exception to network adequacy standards, KHA urges caution, as such an exception could weaken access requirements if not carefully defined, enforced, and limited with clear evidence standards, guardrails, and public accountability.

Finally, CMS should strengthen network adequacy standards for post-acute care by addressing MA barriers that delay discharges and restrict access, and by adding inpatient rehabilitation facilities, long-term acute care hospitals, and home health agencies to the facility types subject to time, distance, and minimum number requirements to ensure timely, clinically appropriate transitions of care.

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's proposal to streamline the Star Ratings program raises important questions about how best to align quality incentives with meaningful outcomes and beneficiary protections.

KHA is very concerned that removing measures tied to appeals and complaints could weaken accountability for operational practices that directly affect access to care, as well as adding substantial costs to the health care system.

APPEALS AND COMPLAINTS MEASURES

CMS proposes removing several Medicare Advantage Star Ratings measures related to appeals and complaints to refocus the program on clinical outcomes and patient experience, arguing that these measures are better suited for compliance monitoring.

KHA strongly disagrees, emphasizing that timely appeals decisions and complaint resolution are core quality measures that directly reflect beneficiary access to medically necessary care and due process protections, particularly when coverage for critical services is denied or delayed. Retaining these measures in Star Ratings is essential because the program's financial incentives and public transparency drive plan behavior; removing them would weaken accountability, increase administrative burdens on beneficiaries and providers, and risk greater reliance on retrospective audits rather than proactive safeguards that ensure timely access to care.

REDUCING REGULATORY BURDEN AND COSTS IN ACCORDANCE WITH EXECUTIVE ORDER 14192

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures[1]

Prior Authorization Reporting Removal - CMS proposes to eliminate Medicare Advantage utilization management committee requirements to collect and report detailed prior authorization data, citing a desire to reduce regulatory burden and pursue alternative data collection methods, such as interoperability.

KHA strongly cautions against removing this reporting without clear replacement mechanisms, as hospitals continue to experience harmful care delays, inappropriate denials, and significant administrative burden tied to MA prior authorization practices. KHA supports prior authorization reform but emphasizes that robust, transparent data collection—whether through UM committees or clearly defined alternatives—is essential to holding plans accountable and ensuring timely access to medically necessary care.

Kansas hospitals process approximately 19.6 million insurance remittances annually, associated with $59.1 billion in charges and $21.3 billion in allowable reimbursement. Insurer payment practices result in:

- ~2.2 million claims requiring rework or appeal.
- $65.9 million per year in avoidable administrative labor costs.
- $3.62 billion in revenue placed in dispute through full denials; and
- $4.55 billion in revenue reduced through partial denials.

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[1] 90 Fed. Reg. 54988

Total annual exposure: approximately $8.24 billion, before accounting for downcoding, observation reclassification, delayed-cash financing costs, or appeal write-offs.

Medicare Advantage plans account for a large majority of these dollars to the healthcare system and must be held accountable if we are to lower the cost of healthcare in America.

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.

CMS must hold Medicare Advantage plans accountable for complying with the rules they establish. The current UM Committee has not accomplished that. Too often, we see MA plans effectively circumvent new CMS requirements by altering internal policies or partially denying payment, actions that CMS later characterizes as "contracting issues" rather than noncompliance. This approach undermines the intent of CMS policy and allows plans to avoid accountability while providers and beneficiaries bear the consequences.

REQUEST FOR INFORMATION ON FUTURE DIRECTIONS IN MA

CMS is seeking stakeholder input on opportunities to modernize and strengthen the Medicare Advantage program to support competition and maximize value for beneficiaries and taxpayers. KHA supports this goal and emphasizes that achieving it depends on ensuring beneficiaries have timely access to high-quality, medically necessary care to which they are entitled.

Protecting the Integrity of the Medicare Advantage Program

As stated above, 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 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.[2]

[2] For example, one multi-state commercial insurer recently adopted a policy that effectively shifts a Original 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

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.[3] 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's authority to enforce standards, including established coverage criteria, but also fundamentally threaten CMS's 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's 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

KHA supports CMS's efforts to modernize the Medicare Advantage risk adjustment program, noting that the current system has enabled gaming, inflated program spending, and undermined competition.

KHA urges CMS to ensure reforms better align risk adjustment payments with the delivery of medically necessary care, discourage coding practices that inflate risk scores without improving access, and avoid shifting additional administrative burden onto hospitals and clinicians.

Strengthening the Program Through Data-driven Accountability and Transparency

The Kansas Hospital Association urges CMS to strengthen enforcement of existing Medicare Advantage requirements to ensure beneficiaries are not subjected to avoidable delays or inappropriate denials of Medicare-covered, medically necessary care, and that providers are not burdened with improper payment denials, delayed reimbursements, or excessive administrative requirements.

We support a risk-based, targeted approach to programmatic audits that focuses on MA plans and service areas with persistent indicators of access and compliance problems, particularly repeated inappropriate denials, administrative delays, and failures to adhere to coverage and medical necessity standards. Findings from the HHS Office of Inspector General, which documented denials occurring even when Medicare coverage criteria were met, highlight the need for proactive oversight to identify and correct systemic issues before beneficiaries are harmed.

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[3] 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.

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 first step in helping CMS trend and target oversight to recurring problem areas.

Improve Transparency so Beneficiaries Can Choose Plans Based on Real Access

Insurance agents who sell a Medicare Advantage plan to a beneficiary who becomes dissatisfied within the first 12 months should face financial penalties. Too many beneficiaries are being steered into MA plans that ultimately fail to provide the access to care they need, leaving them trapped in coverage that does not meet their medical needs. Stronger accountability for sales practices is necessary to better protect beneficiaries and ensure appropriate plan selection.

Thank you for the opportunity to comment on these important issues. Please do not hesitate to contact us if you have any questions. For additional information, you may reach Shannan Flach at sflach@kha-net.org or Jaron Caffrey at jcaffrey@kha-net.org

Sincerely,

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