January 26, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

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 Plan Program

Dear Administrator Oz,

LeadingAge appreciates the opportunity to comment on the Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P), (which will be referred to in this letter as "proposed rule"). We appreciate CMS' continued commitment to clarify expectations for Medicare Advantage (MA) and Special Needs Plans (SNP) as well as seeking stakeholder feedback on critical issues to ensure beneficiaries receive the medically necessary Medicare benefits for which they are eligible while also reducing administrative burdens on providers and plans.

To provide some context for our comments, let us share a little about LeadingAge. We represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our comments reflect the perspective and experiences of providers of post-acute care, long-term services and supports, and home and community-based services who contract with MA and SNPs to provide services. In addition, we also have providers who lead MA plans, SNPs and PACE programs. Our comments will focus on issues that impact their ability to effectively deliver services and be paid for those services.

We offer our support for the following proposals:

- **Special Election Period (SEP) for Provider Terminations from Network.** This revised special enrollment period allowing enrollees to make mid-year coverage changes when one or more of their providers will no longer be in their plan provider network is a welcome addition to the list of SEPs. We are seeing increasing provider network shifts in MA plans and enrollees can be significantly and negatively impacted when one key, trusted provider is no longer covered.

- **Use and Release of Risk Adjustment Data.** LeadingAge agrees with CMS that there are a variety of uses for risk adjustment data that can be used to evaluate and improve the MA program. As CMS changes what entities can access this data and how it is used, we would ask that CMS ensure that the revised language would permit CMS to share these data in their entirety, including specific provider payment information with the Medicare Payment Advisory Commission (MedPAC) for the purposes of evaluating plan payment adequacy to providers. As MA enrollment grows, it becomes increasingly important to monitor provider payment adequacy in both traditional Medicare and the MA program, as it is directly tied to beneficiary access to care. Therefore, we wish to ensure that the proposed revisions to the rule would not prevent MedPAC from accessing all reported data for the purposes of assessing the adequacy of payments to providers paid by MA plans. We are not suggesting that MedPAC would be permitted to publish granular payment information by plan or service but instead could report aggregate trends or ranges regarding plan payments to providers by type of plans (e.g., MA vs. SNP, large national vs. regional, for profit vs. not for profit).

On the proposals below, we offer some issues for CMS to consider before finalizing these sections and ideas for further improvement to achieve beneficiary access to eligible Medicare benefits and clarity on how the proposals apply.

Strengthening Current Medicare Advantage Program Policies

Medicare Advantage/Part C Quality Rating System & Quality Bonus Program

LeadingAge agrees that the Medicare Advantage (MA) Star Ratings program warrants examination and reform to better incentivize meaningful quality improvement. CMS's 2025 MA and Part D Star Ratings Fact Sheet shows a concerning trend: average MA plan performance has declined steadily since 2022, falling from 4.37 stars to 3.92 stars. This downward trajectory underscores the need to strengthen—not weaken—the program's ability to hold plans accountable for access, compliance, and enrollee experience.

We offer the following recommendations focused on outcomes, prevention, and transparency. While improved data collection and alignment across plans remain essential—and LeadingAge has submitted extensive comments on these issues in prior years—we have intentionally grounded our recommendations in measures and data elements that are already available today.

Retention of Complaint-Related Measures. CMS's 2025 Fact Sheet shows declining performance since 2022 on the measures "Complaints About the Plan," "Customer Service," and "Members Choosing to Leave the Plan." These trends suggest the need for continued focus on beneficiary experience and plan accountability. While we understand CMS's desire to streamline the Star Ratings system and remove measures that are considered topped out, the recent performance data does not support eliminating these measures at this time.

Indeed, removal of complaint-related measures would be particularly ill-advised given the Senate Finance Committee's findings that marketing complaints have more than doubled in the past year, along with widespread concerns regarding inappropriate care denials. These measures remain highly relevant and valuable to both beneficiaries and providers, and CMS should postpone their removal until complaint trends show sustained improvement.

To further enhance transparency and accountability, LeadingAge recommends that CMS annually publish in the Medicare Plan Finder the total number of complaints each MA plan receives, categorized by type (e.g., marketing, access to care and denials, network adequacy). Making this information publicly available would better inform consumer choice and appropriately reward plans that avoid deceptive marketing practices, maintain accurate networks, and ensure access to covered care.

Retention of Appeals Measures. KFF reports that in 2023 MA organizations made nearly 50 million prior authorization decisions. Although only 11.7 percent of denials were appealed, more than 80 percent of those appeals were successful. Despite this, the CY 2027 MA rule proposes eliminating the Star Ratings measures "Plan Makes Timely Decisions About Appeals" and "Reviewing Appeals Decisions," based on average performance trends between 2015 and 2025.

However, CMS's own 2025 Fact Sheet shows that recent performance on these measures has declined. These trends indicate it is premature to remove them. While sometimes characterized as process measures, appeals performance directly affects beneficiaries' ability to access medically necessary care and to continue ongoing services critical to maintaining function and quality of life. These measures are fundamental indicators of whether a plan is meeting its core obligation to provide Medicare-covered benefits.

These measures should therefore remain part of the MA Star Ratings program and be publicly reported. Consumers have limited comparative information when deciding between traditional Medicare and MA plans. Unlike MA, traditional Medicare has minimal use of prior authorization for skilled nursing and home health services and is only beginning to pilot prior authorization for select Part B items. Transparency around prior authorization and appeals processes is essential for beneficiaries to understand how access to care may differ between traditional Medicare and MA, and among MA plans themselves. Until additional data demonstrate stronger plan compliance, these measures should not be removed.

Provider Satisfaction and Complaint System. While LeadingAge recommends retaining appeals measures, we recognize CMS's interest in incorporating more direct indicators of plan compliance. Prior authorization delays and denials are among the most common complaints against MA plans; however, until December 2025, the CMS Complaint Tracking Module (CTM) primarily captured complaints from beneficiaries and their families.

Providers—who are on the front lines of care delivery and deeply familiar with Medicare coverage rules—offer a critical and complementary perspective. The appeals process has served as a primary compliance check, yet it captures only a small fraction of inappropriate denials. As noted above, fewer

than 12 percent of denials are appealed, in part because beneficiaries face financial risk, administrative burden, and low confidence in navigating complex Medicare rules. Pursuing an appeal places undue burden on families with limited means because if they appeal a decision that is further denied by the plan, they are then on the hook financially to pay for the uncovered services received while awaiting an appeal decision. Therefore, information on appeals alone is an incomplete measure of plan compliance.

For several years, LeadingAge has urged CMS to establish a confidential process for providers to report MA plan noncompliance through the CTM. We appreciate CMS's December 2025 announcement of a new provider complaint module. This tool has the potential to identify systemic patterns of noncompliance in closer to real time and to provide a more complete picture of plan behavior. Our members continue to report cases in which MA plans wrongfully terminate skilled care, refuse to continue services when a patient's condition plateaus (contrary to the Jimmo Settlement), or assert lack of documentation despite clear evidence that information was submitted.

We believe data from this new provider complaint module will offer a stronger indicator of plan compliance than appeals data alone. Because providers understand Medicare coverage rules and plan contracting requirements, their reports are especially well suited to identifying barriers to access. CMS should incorporate this information into the Star Ratings program and/or Medicare plan finder to better inform consumers and to differentiate plans that consistently comply with Medicare rules.

Aligning Plan Readmission Measures with Post-acute Care (PAC) Settings. LeadingAge also recommends strengthening plan accountability for care transitions by aligning MA readmission measures with post-acute care (PAC) settings. Currently, MA plans report an All-Cause Readmissions measure that is displayed as star ratings rather than as percentages, limiting its usefulness to consumers and policymakers. Moreover, this aggregate measure provides little insight into whether plan coverage decisions—such as denials or early terminations of PAC services—contribute to avoidable rehospitalizations.

By contrast, skilled nursing and home health providers publicly report 30-day rehospitalization rates and Discharge to Community measures on Care Compare. These measures capture whether beneficiaries successfully return to the community without unplanned rehospitalization or death within 31 days of discharge. PAC providers play a critical role in safe transitions out of the hospital, yet MA plans frequently restrict networks or limit access to these services to control costs.

To better align incentives and promote high-quality transitions of care, LeadingAge recommends that CMS:

- Update the Plan All-Cause Readmissions measure to report the percentage of MA enrollees readmitted within 30 days following PAC services; and
- Add the Discharge to Community measure to the MA Star Ratings program to allow beneficiaries to assess plans' access to and performance in post-acute care.

Together, these changes would improve transparency, foster stronger plan-provider collaboration, and reduce costly and preventable hospital readmissions—benefiting beneficiaries and the Medicare program alike.

Request for Information on Future Directions in Medicare Advantage: Save Money by Restructuring MA Quality Bonus Payments to Mirror Provider Value-Based Payment Programs

LeadingAge is well acquainted with quality-based payment structures. Skilled nursing facilities and home health agencies participate in Medicare value-based payment (VBP) programs that function as quality incentive systems. In the SNF VBP, CMS withholds a portion of base payments and allows providers to earn it back—and in some cases more—by improving performance on defined quality measures. Many Medicare Advantage (MA) plans already apply similar VBP approaches in their contracts with providers.

We believe the MA Quality Bonus Payment (QBP) program should be restructured to follow this same model. Doing so would better align incentives, improve accountability, and reduce unnecessary spending in the MA program.

LeadingAge supports MedPAC's recommendation to replace the current add-on bonus structure with a withhold-and-earn-back approach. Specifically, CMS should shift away from paying quality bonuses on top of MA plans' per member per month (PMPM) benchmarks and instead apply:

1. a rate penalty of at least 2% for inadequate reporting of encounter data and other critical data elements; and
2. a payment withhold that MA plans can earn back based on performance on outcomes and compliance-focused measures.

This approach is directly analogous to the quality reporting and value-based payment programs that post-acute care providers operate under today. It would also reduce MA spending and ease pressure on the Medicare Trust Fund, which is currently financing these bonuses. As CMS increasingly relies on encounter data to establish risk scores, the persistence of incomplete or inaccurate reporting is concerning. A reporting-related rate penalty would meaningfully incentivize plans to improve the completeness and accuracy of their data submissions. Additionally, payment penalties are current policy with all Medicare provider-based quality reporting programs.

More broadly, we urge CMS to transition MA quality incentives from a bonus-financed system to a value-based payment model built around a withhold. MedPAC concluded in June 2020 that the current MA QBP is costly and does not reliably distinguish high-quality care, concerns echoed by the Urban Institute. MedPAC recommended replacing the QBP with a Medicare Advantage Value Incentive Program (MA-VIP), under which rewards and penalties would be financed by plans themselves and distributed at the local market level. Comparing plans against peers in the same service area—rather than at the contract level—would yield a more accurate and meaningful assessment of plan performance.

This structure closely mirrors how Medicare provider VBP programs operate: a portion of payment is withheld, pooled, and redistributed based on performance, with some funds returning to the Medicare Trust Fund. For example, under the Skilled Nursing Facility VBP program, CMS withholds 2 percent of SNF fee-for-service Medicare payments. CMS is required to redistribute 50–70 percent of the withhold as incentive payments based on performance on measures such as rehospitalizations and infections, while the remaining funds are retained in the Medicare Trust Fund.

In contrast, MA plans today receive quality bonuses layered on top of the PMPM payments they already receive to furnish Medicare Parts A and B benefits. Notably, the Office of Inspector General (OIG) has documented instances in which MA plans have failed to meet basic program obligations, including inappropriate denials and service terminations. In this context, it is unclear why plans receive bonus payments beyond their base rates for benefits they are already required to provide. A value-based incentive structured as a withhold could instead serve as a meaningful compliance tool.

For instance, earned-back payments could be tied to metrics such as rates of improper prior authorization denials or inappropriate service terminations. This would incentivize plans to strengthen regulatory compliance, improve beneficiaries' timely access to medically necessary care, and reduce avoidable administrative burden throughout the system. When plans deny or terminate services inappropriately, costs are shifted to providers through increased administrative work and to beneficiaries through stress, delays in care, and potential out-of-pocket expenses during appeals.

A restructured MA-VIP-style program could address both compliance and fiscal stewardship. Allowing plans to earn back withheld funds only when they meet established benchmarks would encourage more careful initial prior authorization reviews and earlier collaboration with providers to resolve missing information—rather than pushing errors into the appeals process. Plans that fail to meet performance or compliance standards would forfeit withheld funds, which should be returned to the Medicare Trust Fund, extending its solvency.

As an association of nonprofit, mission-driven aging services providers, LeadingAge believes strongly in responsible stewardship of Medicare dollars. We can no longer support quality bonuses financed by the Medicare Trust Fund when MA plans are consistently non-compliant with fundamental program requirements. The MA program was intended to generate savings for Medicare; instead, spending on quality bonuses has grown substantially since their introduction in 2015.

Restructuring MA quality incentives around a withhold-and-earn-back model would create clearer accountability, better align incentives with patient outcomes and compliance, and provide CMS with a mechanism to rein in costs while safeguarding the Medicare program for current and future beneficiaries.

Reducing Regulatory Burden and Costs

Additional Medicare Advantage Regulatory Burden Reduction: We would like to call CMS' attention to other regulatory barriers impacting providers who contract with MA plans. In our 2025 comments on CMS' regulatory burden reduction RFI we made the following topline recommendations:

- Streamline claims payment processes in MA by waiving or modifying current requirements that allow each MA plan to maintain its own administrative infrastructure.
- Implement a single, standardized prior authorization (PA) portal/form and process across all MA plans. Such a system would reduce administrative cost and complexity, centralize PA and concurrent reviews (CR) data collection increasing transparency and compliance, prevent records and decisions from being lost, and improve timely care delivery while aligning with CMS's regulatory goals.
- Adopt a presumptive eligibility model for PAC services. Under this approach, when a physician certifies the need for PAC, providers would be allowed to initiate services without an initial PA for a defined period tailored to each PAC setting.
- MA PAs should authorize the service, not the provider. Once medical necessity is confirmed, patients should be able to use the PA with any eligible provider (e.g., in-network for HMOs, any provider for PPOs). This could expedite patient access to PAC services, so they are not in the hospital longer than is necessary.
- Shorten MA claims processing timelines to align with original Medicare, enforce stricter oversight of denial practices as recommended by the OIG, and require real-time cost sharing transparency. These steps would reduce unnecessary costs and support the financial viability of PAC providers.
- Limit MA plans to conducting an audit of only a limited sample of provider claims. If the provider sample shows they are largely compliant and appropriate payments, no further action should be taken unless there is evidence of fraud. If there is a pattern of errors, then further review would be appropriate. Some plans are currently auditing nearly every claim without evidence of fraud, and it just creates unnecessary, time consuming work for providers to prove a second time that they were indeed owed the money.

LeadingAge as part of the Post-Acute Care (PAC) Medicare Advantage Coalition in November 2025 submitted the following detailed recommendations for how CMS could improve the PA process to increase the chances of PA requests being accurate and complete upon initial request and in turn, speeding up the timeline to a coverage decision and patient access to care.

- Standardize all PA requests across MA plans; and
- Reclassify all PAC-related PA requests and concurrent reviews as expedited and subject to a maximum 24-hour response time for coverage determination.

The detailed recommendations can be found in this solutions paper.

Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42)). In our comments on the Contract Year 2025 Proposed Rule, LeadingAge strongly supported efforts to help beneficiaries better understand what supplemental benefits are available to them under offered MA/SNP plans

through mid-year notifications about unused benefits. We know many beneficiaries sign up for a particular plan because of these enticing supplemental benefits. We want to see utilization of these benefits that are designed to improve the health of the individual. Currently, it is unclear if beneficiaries aren't accessing the supplemental benefits because they are unsure how to do so or have forgotten they are available, or if instead, associated cost sharing may pose a barrier. While the research presented by CMS does find that nearly 70% of beneficiaries have used at least one of their supplemental benefits, the survey also found 24% of beneficiaries did not know what benefits their plan offers.

We understand plans have struggled to figure out how to implement this requirement and thus, CMS has delayed its implementation; however, we continue to believe this is important information for beneficiaries and reinforces transparency. To that end, we recommend CMS instead delay the implementation of this provision to 2027 and take the intervening time to develop a revised approach to implementing this notice that provides important information to beneficiaries and an executable approach for plans. Taxpayers are paying for these services and if they are not utilized, the unspent dollars merely revert to the plan bottom line with no benefit to the enrollee. Additionally, we ask that CMS publish a report as soon as possible, with the data collected thus far from MA and SNP plans on supplemental benefits offered and utilized per its February 21, 2024, memo on "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records." This would provide important transparency for beneficiaries and policymakers regarding the true value of supplemental benefits until the notice can be implemented.

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7)). In the absence of robust alternative data reporting and transparency regarding plan coverage of and beneficiary access to core Medicare Part A and Part B services, LeadingAge strongly opposes CMS's proposal to rescind the requirement for Medicare Advantage organizations (MAOs) to conduct and report an annual health equity analysis of their utilization management (UM) policies and procedures.

Additional transparency into MAO utilization management practices remains critically important. Proposals to reduce reporting requirements are particularly concerning given recent federal oversight findings—including the 2024 U.S. Senate Permanent Subcommittee on Investigations' Refusal of Recovery report and the 2022 OIG report on MA denials—which demonstrate that MA enrollees are experiencing disproportionate denials and barriers to accessing post-acute care services. These concerns are especially acute for disadvantaged populations, including dually eligible beneficiaries, who already face systemic barriers to care and who are more likely to require post-acute and long-term services and supports.

As of January 1, 2025, MAOs' utilization management committees are required to analyze the impact of prior authorization policies across different populations. When CMS initially proposed this requirement, LeadingAge supported the policy objective but urged CMS to go further by requiring more granular, service- or item-level reporting, given the wide variability in prior authorization practices across services and provider types. That variability—and its consequences for beneficiary access—was clearly documented in the 2024 Senate report. Eliminating the reporting requirement altogether, without replacing it with a more meaningful transparency framework, would represent a step backward in CMS's ability to oversee beneficiary access to Medicare-covered services.

LeadingAge remains deeply concerned that some MAOs are failing to ensure that enrollees receive all medically necessary Medicare Part A and B services. Our nursing home members continue to report situations in which long-stay residents —who are typically dual eligible and receive custodial assistance with activities of daily living—are being denied medically necessary post-acute SNF care following a hospitalization**.** In these cases, MAOs have asserted that skilled care can be "substituted" by services provided in the long-term care setting. This is inconsistent with Medicare coverage rules.

While nursing homes may provide both custodial and skilled services, these services are not interchangeable**,** and skilled nursing care following a qualifying hospitalization is a Medicare-covered benefit. Under traditional Medicare, long-stay nursing home residents are eligible for SNF coverage following a minimum three-day inpatient hospital stay. MAOs are required to meet at least that coverage standard. Denials of SNF care in these circumstances strongly suggest that MAOs are relying on internal coverage criteria that are more restrictive than traditional Medicare—contrary to statutory and regulatory requirements.

Further, LeadingAge notes that in September 2025, the Office of Management and Budget approved CMS-10905, the Service-Level Data Collection for Initial Determinations and Appeals, and that CMS proposed in December 2025 to initially implement this requirement as a pilot. LeadingAge strongly urges CMS to expedite the pilot and move toward full implementation for all MA plans no later than CY2027**.** This service-level data collection holds promise for providing CMS with the actionable, beneficiary-focused information necessary to assess whether MAOs are appropriately covering all Medicare services and ensuring meaningful access to care.

If CMS proceeds with rescinding the annual health equity analysis of utilization management policies, it is imperative that CMS fully implement CMS-10905 on an accelerated timeline to avoid a significant oversight gap. Without either requirement in place, CMS would lack essential tools to evaluate whether utilization management practices are contributing to inequitable access to Medicare-covered services—particularly for dually eligible individuals and other high-need populations.

LeadingAge urges CMS to reconsider its proposal and retain the annual health equity utilization management analysis requirement until service-level determination and appeal data are fully operational and available for oversight, monitoring, and enforcement purposes.

Additional PACE Regulatory Burden Reductions. We would also like to call CMS's attention to other regulatory barriers impacting PACE programs. In our 2025 comments on CMS's regulatory burden reduction RFI we made the following recommendations:

- To ensure timely access to care, eliminate the current limitation of participant enrollment on the first day of the month to allow for anytime enrollment in PACE.
- To support capacity for serving more people, streamline the PACE provider application process (e.g., allow POs to have multiple service area expansion applications under simultaneous review and increase the frequency with which CMS accepts applications for new and expanding POs).

Improvements for Special Needs Plans

LeadingAge appreciates CMS's continued focus on improving care integration for dually eligible beneficiaries and shares the agency's goal of ensuring that individuals with complex health and social needs receive coordinated, high-quality care. We have historically supported CMS's efforts to address non-integrated "D-SNP look-alike" plans—particularly when those plans attract high proportions of dually eligible beneficiaries without meaningfully integrating Medicare and Medicaid benefits.

We understand CMS's concern that similar enrollment patterns could emerge within Institutional Special Needs Plans (I-SNPs) and Chronic Condition Special Needs Plans (C-SNPs). While LeadingAge agrees that CMS should continue to monitor enrollment trends and integration outcomes across all SNP types, we strongly oppose applying a 60-percent D-SNP look-alike threshold to I-SNPs or C-SNPs. Such an approach would misunderstand the populations these plans are designed to serve and would risk undermining beneficiary choice, provider-led care models, and plan viability—without guaranteeing improved integration.

High Dual Enrollment in I-SNPs and C-SNPs Is Expected and Appropriate

There are clear and legitimate reasons why I-SNPs and C-SNPs enroll a high proportion of dually eligible individuals.

I-SNPs, by definition, serve individuals who require institutional-level care. Nationally, approximately 60 percent of nursing home residents are dually eligible for Medicare and Medicaid. Likewise, individuals with multiple chronic conditions—which C-SNPs are specifically designed to serve—are disproportionately likely to be dually eligible. According to the National Institutes of Health, nearly three-quarters of adults aged 65 and older have multiple chronic conditions, and health care spending for these individuals is significantly higher than for those without chronic conditions. It therefore follows that both I-SNP and C-SNP enrollment will naturally include a majority of dually eligible beneficiaries.

High dual enrollment in these plan types should not be interpreted as an attempt to circumvent integration requirements, but rather as a reflection of demographic reality and appropriate plan specialization.

Applying D-SNP Look-Alike Thresholds Would Be Counterproductive

While LeadingAge agrees that dual eligible populations deserve better integration—and that integration can improve outcomes and reduce unnecessary costs—we do not believe extending D-SNP look-alike thresholds to I-SNPs or C-SNPs would advance those goals.

Notably, the majority of existing D-SNP enrollment is in coordination-only D-SNPs, which represent the *lowest* level of integration precisely because they do not cover any Medicaid services. Applying a blunt enrollment-based threshold to I-SNPs and C-SNPs risks restricting access to plans that may actually offer more tailored clinical models and stronger day-to-day care coordination for their enrollees than many large, minimally integrated D-SNPs.

Unlike general MA plans, all SNPs are required to operate under an approved Model of Care that is specifically designed to meet the needs of their target population. Beneficiaries should continue to be

able to choose among different SNP options—particularly when an I-SNP or C-SNP may better align with their clinical, functional, or residential needs.

A More Appropriate Path: Voluntary, State-Driven Integration Options
Rather than restricting enrollment or mandating D-SNP-style requirements, LeadingAge encourages CMS to allow states the flexibility to pursue voluntary integration strategies with I-SNPs and C-SNPs, where states determine such approaches are appropriate for specific populations.

We do not support requiring I-SNPs or C-SNPs to enter into State Medicaid Agency Contracts (SMACs). For many states and provider-led plans, the administrative burden would be significant and, in some cases, prohibitive. Many LeadingAge member-led I-SNPs and C-SNPs operate with relatively small enrollment and limited administrative capacity, making mandatory SMAC requirements cost-prohibitive—despite these plans' strong clinical integration and holistic approach to care.

A voluntary framework would allow states that are ready and willing to collaborate with I-SNPs or C-SNPs to pursue deeper integration without destabilizing plans that are effectively serving highly specialized populations.

Unique Considerations for Facility-Based I-SNPs
Facility-based I-SNPs warrant particular consideration due to their distinct care delivery model. These plans serve individuals in a fixed residential setting where care is delivered primarily on-site. Enrollees receive most of their medical, personal, and supportive services within the facility they call home, with off-site care coordination and transportation arranged when specialized services are required.

Members operating facility-based I-SNPs report that additional regulatory or contracting requirements—particularly in states implementing highly integrated D-SNP models—could further disadvantage these plans. I-SNPs already have the lowest enrollment of any SNP type, making it difficult to compete with large national plans on provider contracting and administrative scale. Many beneficiaries enrolled in large D-SNPs do not receive the same level of continuous, on-site care coordination that facility-based I-SNPs provide.

Critically, I-SNP enrollees are not simply plan members; they are residents. Policies that threaten the viability of these plans—by forcing unsustainable contracting arrangements or triggering plan exits—risk disrupting beneficiaries' homes and stability. CMS should carefully weigh the downstream consequences of any policy changes on residential continuity and access to care.

C-SNP Considerations
LeadingAge similarly opposes applying a D-SNP look-alike threshold to C-SNPs that appropriately enroll high proportions of dually eligible individuals. C-SNPs are designed around specialized benefit structures and care models for particular chronic conditions, many of which disproportionately affect dual eligible populations. Eliminating or discouraging access to these plans solely because they exceed an arbitrary enrollment threshold would unnecessarily limit beneficiary choice and undermine tailored care.

We support CMS giving states the option to develop and oversee SMAC arrangements with C-SNPs where appropriate. However, we caution against making such arrangements mandatory, as doing so could create additional administrative burden for states and divert resources away from strengthening integration through D-SNPs where that remains the primary policy objective.

In conclusion, each SNP type—D-SNPs, C-SNPs, and I-SNPs—serves a distinct role within the MA program and responds to different beneficiary needs, care settings, and clinical profiles. CMS policy should reflect these differences and avoid one-size-fits-all thresholds that could undermine effective, provider-led models of care.

LeadingAge appreciates CMS's ongoing evaluation of SNP performance, enrollee experience, and outcomes across plan types, and we support state efforts to protect beneficiaries transitioning from highly integrated models such as PACE while maintaining continuity of care. We urge CMS to preserve beneficiary choice and plan diversity by allowing voluntary, state-driven pathways to integration for I-SNPs and C-SNPs rather than extending D-SNP look-alike restrictions that were not designed with these plans in mind.

Supplemental Requests for Information

Modernizing Marketing and Oversight: LeadingAge has supported CMS's continued efforts to curb deceptive marketing practices and the distribution of misleading information by MA plans and their agents. This has been a great concern for our members, as they are the ones who often must explain to the person in their care that they are enrolled in an MA plan (not a Medigap plan) and that the plan determines from which providers they can receive care and how much care they receive. Therefore, we oppose efforts to scale back key beneficiary protections.

- **Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements.** LeadingAge opposes CMS's proposal to remove language describing the State Health Insurance Assistance Programs (SHIPs) in standard language that marketing organizations are required to use when speaking with potential enrollees. TPMOs repeatedly demonstrate that they are misleading, misinforming and often not acting in the best interests of beneficiaries. SHIPs provide an important counterbalance to these actions with unbiased counseling services to aid beneficiaries in evaluating their Medicare and Medicaid issues and options. Additionally, SHIPs can unveil additional benefits that a recipient was not aware they were eligible for. Therefore, language regarding SHIPs should be retained in the communications from the TPMOs.

- **Limiting Protections Against Pressure to Enroll in a Medicare Advantage Plan.** LeadingAge members have reported troubling instances of broker and agent misconduct. These include situations in which brokers aggressively pursued beneficiaries on a provider campus in an effort to pressure them to disenroll from a PACE program and instead enroll in a MA plan that lacks care integration, solely to promote the availability of a flexible benefit card. Members have also reported misleading communications that falsely suggest beneficiaries must sign a document to retain their existing benefits, when in fact the paperwork enrolls them in an MA plan. The 2022 U.S. Senate Finance Committee report on "Deceptive Marketing Practices Flourish in Medicare Advantage,"

underscored how these issues persist and why regulations to restrain these practices are necessary. For these reasons, we do not believe now is the time to back off the protections that have been put in place to protect Medicare beneficiaries.

In Section VI.F on page 58, entitled "Removing Rules on Time and Manner of Beneficiary Outreach", CMS proposes allowing marketing events to occur after educational events in the same location. While we understand the efficiency this presents for plan representatives, we think the proximity of these events may inappropriately blur the lines for beneficiaries making them more susceptible to pressure to enroll. Not all beneficiaries have a caregiver to assist them in evaluating their Medicare options making them most vulnerable to pressure to make a decision following an educational event. Additionally, while a special enrollment period is available for beneficiaries who have been misled, many are unaware of this option or how to invoke it and prove the deception. Providing distance between an educational event and signing up an enrollee gives the beneficiary time to do their own research and consult their family to make a fully informed decision.

- **Oppose removing the requirement for our approval of plan use of the Medicare Card image found in §§ 422.2262(a)(1)(xix) and 423.2262(a)(1)(xviii).** LeadingAge understands the desire to remove the requirement that CMS approve MA plan use of the Medicare Card image as this uses CMS resources. However, we suggest that CMS retain §§ 422.2262(a)(1)(xix) and in 423.2262 (a)(1)(xviii) but repeal the last line of the clause, "Use of the Medicare card image is permitted only with an authorization from CMS." The other components of §§ 422.2262(a)(1)(xix) should be retained. To prevent beneficiary confusion, it is important to continue to prohibit plan use of the Medicare name, CMS logo and Medicare card image. The use of this image by plans leads to more confusion for beneficiaries. Our providers have seen beneficiaries misled into signing up for MA plans because they see the Medicare card image or reference to CMS on a letter and they believe they are just signing up for or renewing their Medicare coverage. Therefore, an outright prohibition of the use of the Medicare Card image and the other references to CMS and Medicare could eliminate any confusion and free up current CMS resources used for these approvals.

- **Oppose Eliminating the Outbound Enrollment Verification found in §§ 422.2272(b) and 423.2272(b).** LeadingAge members continue to encounter situations where the older adults they serve are surprised to find they are enrolled in an MA plan (not a Medigap plan or their PACE program) or find they've been enrolled in a plan that does not serve their best interests (e.g. their providers in network, dual eligible in a non-integrated plan, etc.) Therefore, we oppose CMS's proposal to eliminate outbound enrollment verification.

  Further we think protections should be enhanced. LeadingAge and our partner the National PACE Association provided CMS with detailed comments to protect PACE participants who are particularly vulnerable to aggressive marketing practices. We respectfully request that CMS include additional protections to promote beneficiary choice and ensure informed decision-making. Specifically, we call on CMS to:

- Require MA plans to explain all out-of-pocket costs and network/coverage limitations clearly and fully, based on standardized language, to prospective enrollees prior to their enrollment in an MA plan.
- Stipulate additional measures during the PACE participant voluntary disenrollment process (42 CFR § 460.1624) – e.g., requiring written revocation of PACE coverage analogous to the Medicare hospice benefit – to ensure the authenticity and intentionality of the participant's voluntary disenrollment. One aspect of the revocation process should include why the disenrollment occurred that would allow tracking of the number of revocations occurring for this reason.
- Permit mid-month enrollment in PACE for former PACE participants to re-enroll in PACE if beneficiary wants to return to PACE following their disenrollment from a MA plan. Although beneficiaries can disenroll from a MA plan or Part D plan to enroll in PACE at any time, pursuant to current requirements, the beneficiary may face a significant coverage gap given that a participant's enrollment in PACE is not effective until the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement (42 CFR § 460.1585). Participants who elect to re-enroll in PACE within two months of disenrollment should be allowed to enroll mid-month. The PACE organization should receive a prorated reimbursement for that month to help support a smooth transition of care.
- Clarify that when MA brokers inform beneficiaries of the comparative benefits of their current coverage (e.g., PACE) to an alternate MA plan that the broker inform them, in plain language, if they would be enrolling in a plan that does not cover or coordinate their Medicaid benefits; and any benefits the individual would "lose" under the new plan (e.g., transportation to groceries). These measures, along with potentially other mitigation efforts, are vital to prevent PACE participants from experiencing a detrimental break in their PACE or Medicaid coverage including potential disruptions in the receipt of care and, for PACE organizations, from foregoing typically a month or more in lost Medicare or Medicaid revenue (i.e., the time until PACE coverage is reinstated).

Artificial Intelligence (AI). We continue to believe that AI demonstrates considerable potential for all of us in health care to work more efficiently. However, AI is only as good as its inputs so when the inputs are misaligned with what the law requires related to Medicare beneficiaries access to eligible benefits, then we think it is important to ensure someone who knows the rules reviews coverage determinations including prior authorizations and concurrent reviews to ensure there are no unnecessary delays or errors that prevent someone from accessing needed care for which they are eligible. Therefore, LeadingAge has supported prior CMS proposals to refine the definition of "automated systems" to include "artificial intelligence" and the addition of a definition of "patient decision support tool" as these are becoming predominant elements of health care coverage decision making. To the degree that these mechanisms are used in MA plan service or coverage determinations, we think it is important to ensure AI does not serve as a barrier to medically necessary services. Regrettably, we've heard of situations where individuals who live in long-stay nursing homes receiving assistance with their activities of daily living are told by MA plans that they cannot receive Medicare-level skilled nursing care following a

hospitalization. This would be an example of a plan not following 42 CFR 422.110 (a). CMS did not finalize this proposal but indicated it would issue additional AI guidance in the future. We would like to see CMS outline appropriate guardrails and safeguards for AI use in making decisions about care to ensure that beneficiaries continue to have timely access to medically necessary Medicare Part A and B services.

CMS has also expressed interest in using AI to make certain tasks in health care easier. LeadingAge believes one such opportunity CMS could explore is developing a CMS-operated, unbiased AI decision-support tool within Medicare.gov to guide beneficiaries in choosing among traditional Medicare (along with possible Accountable Care Organization benefits), Medigap, PACE and Part D and MA plans that best align with their care needs. Such a tool could offset potentially misleading information provided by some brokers/agents or support them in their work with beneficiaries. LeadingAge is uniquely positioned to help CMS ensure that post-acute access, care transitions, and real-world service availability are reflected in plan recommendations. LeadingAge welcomes the opportunity to meet with CMS to discuss inclusion of post-acute access metrics (such as authorization timeliness, denial and appeal patterns and network capacity), strong transparency and accountability standards and safeguards to prevent any future AI tools from reinforcing utilization avoidance or inequities. With appropriate guardrails, a CMS-developed AI agent could significantly improve beneficiary choice while reducing downstream harm for older adults and the aging services providers who care for them.

Streamlining Data Collection for Credentialing: LeadingAge supports CMS's efforts to improve and simplify the provider and facility network review process overall, including the submission process, the exception request process, and the timing and frequency of the reviews. We would like to take this opportunity reiterate our support for establishing a single National Directory of Health Care Providers and Services (NDH) that could serve as a "centralized data hub" for healthcare provider, facility and entity directory information nationwide. This would help reduce the administrative burden that our aging service providers as well as MA plans incur related to the number of places they must report or update organizational data. CMS could take this effort a step further and allow the provider to electronically transfer their data from the national provider directory to the plan when they sign a contract. This may require regulatory changes to the expectations for plans to credential providers.

LeadingAge recommends CMS re-examine the efficiency and burden reduction of developing a national health care and services provider directory that could be used by private plans and federal agencies and coordinated with state data on current licensure and certification status. We have articulated the many advantages of such an initiative in our comment letter on an CMS request for information on establishing a National Directory of Health Care Providers and Services (CMS-0058-NC). By creating a single source of truth for provider information, we could eliminate the duplicative data collection across plans, providers and government agencies, ensure more consistent and accurate data regarding provider service locations, and reduce providers' administrative burden by only requiring a single portal to report and update their data that could then populate federal and state government databases and also be accessible for plans to download for their files. It could also make it easier for the federal government to track fraudulent providers. This could also reduce the number of people responsible for collecting and updating this data within the federal government.

Exceptions for Network Adequacy: LeadingAge acknowledges that patterns of care often cross county lines or sometimes geographic barriers such as rivers can impact from which providers beneficiaries seek

care and should be recognized. However, we are concerned about the proposal to offer plans an additional exception for plan network adequacy requirements beyond current exceptions. Should such an exception be pursued, we would want to ensure important safeguards are in place for any such proposal to prevent plans from invoking such an exception merely because providers are refusing to contract with them due to insufficient rates or excessive administrative burden. As we noted in our response to the CMS Request for Information on Medicare Advantage in August 2022, inadequate post-acute care provider payment rates and excessive administrative burden on network providers will lead to access to care issues for beneficiaries. We are hearing increasingly from members that they are unable to find a home health agency who will admit certain MA enrollees for services. We have heard hospital frustration that MA enrollees are sitting in their beds with no place to discharge them to because PAC providers are either full, don't have adequate staffing to take more admissions, and/or they can't afford to take an MA enrollee and lose hundreds of dollars a day to provide their care. We supported CMS's previous interpretation of the statutory and regulatory requirements that would require plans to arrange for any medically necessary covered benefits with out of network providers, when in network providers or services are unavailable or inadequate to meet an enrollees need and that these services should be provided at the in-network cost sharing rates. If an exception is created CMS is empowering plans to continue to pay providers inadequately. This impacts not just Medicare beneficiaries but the entire healthcare system and could have serious long-term consequences to service access.

Additionally, plans should have to continue to demonstrate that they have attempted to contract with providers who are within time and distance standards. If such an exception were to be adopted, we would expect the standard of proof would go beyond the plan having a "belief" that their network is at least as good as Original Medicare. They should have to prove such a claim. CMS should require plans to make a concerted effort to contract with all available providers and for those who are not contracted, pay out of network providers the Medicare fee-for-service rates for their services not a discounted rate.

Improving Plan Issuance of Notice of Medicare Non-Coverage. As we have noted in prior comment letters to CMS, there is a clear opportunity to strengthen the Notice of Medicare Non-Coverage (NOMNC) process to ensure that MA enrollees receive protections equivalent to those afforded under traditional Medicare when plans decide to terminate coverage for PAC services. Coverage determinations and notification processes must support safe, appropriate discharges and reflect beneficiaries' ongoing or evolving medical and functional needs**,** rather than relying on narrow utilization criteria.

SNFs are required to ensure safe discharges for all individuals in their care. In traditional Medicare, this obligation is more readily fulfilled because SNFs determine discharge timing as part of the interdisciplinary care planning process, in consultation with the beneficiary and family, and consistent with Medicare coverage requirements. Under MA, however, plans—not providers—make coverage termination decisions and issue the NOMNC. This dynamic places SNFs in a significantly more challenging position, particularly when plan determinations do not fully account for the real-world barriers beneficiaries face upon returning home.

SNF providers report that MA plan coverage termination decisions often fail to consider critical discharge-related factors, such as environmental barriers (for example, a beneficiary must navigate multiple steps to enter the home but can safely manage only one), the availability and capacity of informal caregivers (such as a frail spouse or geographically distant family members), and the beneficiary's ability to access food, medications, and follow-up care. When these factors are overlooked, beneficiaries are placed at risk of unsafe discharges, avoidable rehospitalizations, and adverse health outcomes.

Timing of NOMNC issuance further compounds these risks. It is not uncommon for enrollees to receive a NOMNC late on a Friday afternoon or evening, resulting in a required discharge as early as Sunday morning. In effect, this offers roughly one day for families to prepare for a discharge or an appeal. Weekend or holiday discharges are often impractical and unsafe. Many beneficiaries require home-based services following discharge, such as home health care, which necessitates identifying an appropriate provider, confirming capacity, and completing intake processes—steps that frequently cannot be accomplished over a weekend. In addition, many MA enrollees require durable medical equipment (DME), such as hospital beds or oxygen equipment, which often requires prior authorization. Plans frequently do not process prior authorizations for these items outside of regular business days, further delaying safe discharge planning.

Notification challenges also undermine beneficiaries' appeal rights. When family members or representatives cannot be reached by phone, providers must mail the NOMNC. However, the U.S. Postal Service does not deliver mail on Sundays or federal holidays, and first-class mail delivery times have lengthened. These delays can prevent beneficiaries from receiving timely notice, compress the window for filing an appeal, and leaving families with insufficient time to prepare for a safe transition home.

For these reasons, the current NOMNC notice requirements are insufficient to ensure beneficiary protections. We urge CMS to adopt the following changes:

- **Extend the NOMNC notice period from two calendar days to three calendar days.** The current two-calendar-day requirement counts the day the notice is issued—even when delivered late in the day—and does not ensure a full 48-hour notice period. Extending the requirement to three calendar days would provide beneficiaries, families, care coordinators, and SNF staff with meaningful time to arrange necessary services, secure equipment, address discharge barriers, or pursue an appeal. This change would better align notice requirements with the realities of care transitions and promote safer discharges.

- **Codify existing CMS appeals guidance regarding subsequent NOMNCs following a successful appeal.** CMS updated Medicare Advantage appeals guidance effective January 1, 2025, instructing plans that when an enrollee has previously received a favorable NOMNC appeal decision during the same episode of care, the plan must "detail the specific change(s) in the enrollee's condition since the previous appeal that provide the basis for this decision to terminate services." We strongly urge CMS to codify this guidance in regulation. Beneficiaries should not be forced to repeatedly appeal coverage termination decisions when there has been

no material change in clinical status or circumstances. Codifying this requirement would reduce unnecessary appeals, administrative burden, and disruption for beneficiaries, providers, and plans alike, while reinforcing program integrity and beneficiary protections.

Medical Loss Ratio (MLR) Reporting: In general, LeadingAge has supported CMS's efforts to align MLR calculations across MA, Medicaid and Commercial insurance. However, we believe some of the previous proposals lacked adequate definitions which could have unintended impacts on any data collection efforts.

- **Defining Incentives and Bonus Payments in MLR Numerator:** Plan flexibility is a key aspect of the MA program that allows plans to deliver care and services differently, to innovate, and to reduce unnecessary cost. While we favor greater transparency within the program, we are concerned that CMS's proposal to only permit plans to include incentive and bonus payments in the MLR numerator if they "are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers" may inadvertently exclude payment arrangements (e.g. shared savings) that are indirectly tied to quality outcomes or the delivery of quality care and largely championed by policymakers. For example, some of our provider-led MA/SNP plans enter into shared savings arrangements with providers. In these situations, the shared savings payment received by the provider may not be tied directly to a specific quality measure, such as reduced hospitalizations per 1000 lives. Nonetheless the plan is unlikely to achieve these savings without a provider making efforts to improve upon this metric. LeadingAge encourages CMS to revise the definitions to include a broader array of payment arrangements that either directly or indirectly tie to quality.

- **Defining Quality Improvement Activities in the MLR Numerator.** Previous proposals have suggested excluding administrative costs for quality improving activities from the MLR numerator, but we were concerned that it would inadvertently exclude activities such as investments to support primary care medical homes, help providers initiate telehealth services, nurse call lines, provider and participant education, case conferences between the interdisciplinary team members. All of these investments can improve the experience of care and outcomes for the enrollee. In any future data collection on MLR, definitions will be critical to consistent collection of data. We urge CMS to clarify the definition of "administrative" costs related to quality improvement activities to ensure that investments detailed above are not excluded them from the MLR numerator. Excluding these activities from the MLR numerator may disincentivize these desired investments and activities.

- **Reporting on Provider Payment Arrangements for MLR:** CMS also previously proposed requiring MAOs to report aggregate expenditures by provider payment arrangement type in MA as part of the MLR report in three categories ordered from lowest to highest financial accountability for providers: fee-for-service (FFS), Alternative Payment Models (APMs), and population-based payments. We agree that collecting this information further supports transparency and oversight activities related to these payment arrangements. However, we would note that many of these provider arrangements are already included in Part C reporting requirements and as part of plan bids. CMS should evaluate why the existing information collected under the Part C reporting requirements and

as part of plan bids is inadequate, and if necessary, revise the Part C reporting to reflect the missing information, instead of creating an additional and potentially duplicative reporting requirement.

- **Vertical Integration MLR Reporting.** We understand policymakers are grappling with ways to address concerns about MAOs that are vertically integrated with providers, pharmacies and other related health care entities and how premium dollars flow among these entities. In the past, we encouraged CMS to methodically approach how to address these concerns by clearly identifying the specific issues they are trying to correct related to vertically integrated entities and the characteristics of those entities that they believe to be acting inappropriately before implementing any further policies. Additional data collection on the relationship between vertically integrated MAOs could help CMS better craft policies that address concerns such as are vertically integrated MAOs only making favorable payments to their related entities and not other contracted providers?

Thank you again for the opportunity to share our perspective on your proposals for CY2027 MA policy changes. We appreciate your willingness to listen to our concerns, as well as our suggestions for improving the Medicare Advantage program. Please reach out if we can answer any questions related to our comments.

Sincerely,

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About LeadingAge: We represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.