February 25, 2026

The Honorable Mehmet Oz

Administrator

Centers for Medicare and Medicaid Services

200 Independence Avenue SW

Washington, DC 20201

Dear Administrator Oz,

LeadingAge appreciates the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (CMS-2026-0034), which will be referred to in this letter as "Advance Notice").

To provide context for our comments, let us share a little about LeadingAge. Our mission is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. 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 our providers' ability to effectively deliver services and be paid for those services.

The Centers for Medicare and Medicaid Services (CMS) is proposing a nearly flat rate increase of 0.09% for MA plans in 2027, despite projecting a 4.04% growth percentage for the 2027 MA non-ESRD rates and 5.10% in FFS.

Broadly, LeadingAge believes annual rate adjustments should appropriately reflect rising costs faced by both providers and plans. However, our experience has shown that when MA plans receive annual increases in payment rates, these increases are not often passed on to the providers who deliver care to their enrollees. Currently, our provider members report that MA organizations (MAOs) typically offer contract rates significantly below what traditional Medicare pays for the same services. At the same time, these MAOs impose additional administrative burdens, raising the overall cost of delivering care to MA enrollees. In some instances, MAOs have offered our provider members payment rates as low as Medicaid payment rates, amounting to roughly 50% of Medicare reimbursement to providers, despite the more complex and resource-intensive skilled care required under Medicare.

If CMS finalize CY2027 MA rates at the proposed 0.09% rate, we anticipate our providers will be offered contracts with even lower rates as a consequence. Current law offers no safeguards to ensure that providers receive adequate payment rates from MAOs. With MA penetration exceeding 50% in more

than 45% of U.S. counties in 2026, providers find it increasingly challenging to decline unfavorable MA contracts, as doing so may require them to withdraw from delivering Medicare services altogether due to the declining volume of traditional Medicare business. A low rate increase for MA plans could also impact plans that normally pay providers more comparably to Medicare, potentially forcing them to also reduce their contracted provider payment rates to accommodate the limited increase from CMS. Ultimately, the current structure leaves providers vulnerable to inadequate compensation for the complex care they deliver to Medicare beneficiaries and has the potential to further negatively impact beneficiaries' access to Medicare services.

We understand MA rates also reflect other factors such as adjustments made to how risk scores are calculated. LeadingAge supports the CMS proposal to exclude unlinked chart review records from the HCC score calculations. We particularly like the fact that this change not only will limit risk scores being determined based upon care and services a beneficiary receives, but also that CMS expects this change to level the playing field across plans making smaller and/or more regional plans more competitive.

Further, we support the update to the CY2027 blended rate calculation for PACE organizations as part of the transition to the CMS-HCC payment model. Although we expressed initial concerns last year about this change and whether our PACE organizations were ready, those concerns appear unwarranted. Our PACE members have been preparing for this transition and at this point believe the proposed earlier shift to a 50-50 blended rate in CY2027 should be manageable. We ask CMS to continue to monitor this transition to ensure it continues to go smoothly.

The Advance Notice appears also proposes additional adjustments to the MA Star Rating measures beyond those proposed in the CY2027 MA and Part D policy and technical proposed rule (CMS-4212-P).

We support revising the definition of All Cause Readmissions (Part C) to include denied claims. Our providers frequently face denials due to documentation or system errors, many of which are later resolved. Regardless of payment status, readmissions should be counted because they occurred. Excluding denied claims encourages plans to avoid accountability for actions that contribute to readmissions, such as early termination of or lack of approval for necessary post acute care (PAC) services.

We also encourage CMS and NCQA to explore adding a measure examining all cause readmission rates following receipt of post acute care (PAC). We think this information could be collected via encounter claims data and should not pose additional burden. Additionally, this data could provide meaningful insight into the effects of plan coverage decisions on enrollee's health when they return to their homes. Our skilled nursing facilities report decisions to shorten or terminate PAC services, and to fail to ensure safe care transitions by ensuring those needing home health services and durable medical equipment are received timely.

We believe that the addition of an All Cause Readmission 30 days after PAC services could be captured through claims data and should not increase administrative burden on the MA plans. On the Transitions of Care (Part C) measure, LeadingAge supports the proposal to reduce the patient engagement post-discharge timeframe to 14 days. Our provider members increasingly observe Medicare Advantage

(MA) enrollees being discharged to home without essential services, such as home health, in place prior to discharge. To better assess whether beneficiaries are safely transitioned home, we recommend that NCQA and CMS consider adding an indicator to track all-cause readmissions within 30 days following post-acute care (PAC) services.

Under Medicare regulations, skilled nursing facilities (SNFs) are responsible for ensuring safe care transitions; however, this is more challenging to accomplish when the decision to terminate care is made by the MA plan. This causes a quandary when the SNF disagrees with the plan decision and yet must ensure a safe discharge. Some plans rely on algorithms to determine the duration of care and rarely deviate from these determinations, even when an enrollee's condition changes or continued skilled care is clinically indicated. Appeals of these decisions are not consistently pursued, as beneficiaries may be concerned about potential financial liability if an appeal is unsuccessful. As a result, appeal rates are not a reliable indicator of inappropriate care duration, coverage decisions or unsafe transitions.

Tracking readmissions following PAC services could help identify instances in which transitions occur too quickly or where care coordination is insufficient to ensure timely access to in-home supports, whether through a home health agency or a capable family caregiver. Ensuring safe transitions and assisting enrollees in establishing needed services and durable medical equipment (DME) should be core components of an MA plan's care coordination responsibilities. When timely access to in-home services or equipment cannot be secured, discharge may be premature. Difficulty in securing a home health agency may also reflect inadequate plan payment rates that do not cover providers' costs.

We believe that adding an all-cause readmission measure for the 30 days following PAC services—captured through claims data—would provide meaningful insight into care transition quality without increasing administrative burden for MA plans.

We appreciate the opportunity to provide input into these proposals and share our perspective on the impacts. We look forward to continuing to work with you to improve the Medicare Advantage program to ensure beneficiaries have access to medically necessary care for which they are eligible and plans pay providers adequately for the services they deliver to MA enrollees.

Sincerely,

Nicole O. Fallon

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LeadingAge

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