



January 26, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-4212-P: Medicare Program; Contract Year 2027 Policy and Technical Changes to the MA Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Administrator Oz,

The Arkansas Hospital Association (AHA) represents more than one hundred health care facilities and over 45,000 employees across the state, all dedicated to providing essential medical care and community services to the people of Arkansas. On behalf of our member hospitals, we appreciate the opportunity to comment on the proposed Contract Year 2027 Policy and Technical Changes to the MA Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program.

Medicare Part D Benefit Redesign and Manufacturer Liability (IRA Implementation)

Medicare Part D Redesign

The Inflation Reduction Act (IRA) represents the most consequential restructuring of the Medicare Part D benefit since its inception, with a clear and necessary objective of reducing beneficiaries' exposure to high and often unpredictable out-of-pocket (OOP) prescription drug costs. By establishing a firm annual OOP cap, eliminating beneficiary cost sharing in the catastrophic phase, expanding low-income subsidies, and protecting access to essential therapies such as insulin and adult vaccines, the IRA directly addresses long-standing affordability challenges that have contributed to medication nonadherence among Medicare beneficiaries. Substantial evidence demonstrates that high-cost sharing is associated with delayed prescription fills, premature discontinuation, and higher total system costs. From this perspective, the IRA's focus on lowering patient cost burden is both economically and clinically sound, and its implementation holds meaningful promise for improving adherence, continuity of care, and population health outcomes. At the same time, while we are cautiously optimistic that these reforms will improve access for beneficiaries, their success will ultimately depend on whether corresponding safeguards are

sufficient to prevent unintended plan behaviors that could undermine access through indirect mechanisms.

Despite the IRA's strong beneficiary protections, the reallocation of financial risk within Part D creates incentives that may prompt insurance plans to adopt more aggressive utilization management strategies to control costs. Hospitals are particularly concerned that tighter formularies, expanded prior authorization requirements, increased step therapy protocols, and narrower specialty drug coverage could make it more difficult to initiate or continue clinically appropriate therapies, especially for medically complex patients transitioning from inpatient to outpatient care. These dynamics risk increasing administrative burden for hospital clinicians, delaying treatment initiation, and complicating discharge planning and care coordination. Moreover, enhanced plan leverage over formulary design may allow insurers to steer patients toward lower cost alternatives that, while technically permissible, may be less effective or less appropriate for individual patients based on clinical judgment. **Without additional guardrails, these indirect effects could shift decision-making authority away from providers and patients, undermine shared decision-making, and erode the intended access gains of the Part D redesign.**

At a minimum, the Centers for Medicare and Medicaid Services (CMS) should incorporate explicit guardrail language into the final rule to ensure that the Part D redesign achieves its intended purpose of reducing patient cost burden without undermining access to clinically appropriate care. First, CMS should require minimum formulary protections for high-cost, high-value therapeutic classes, including but not limited to oncology, immunology, transplantation, and complex chronic disease treatments, where therapeutic substitution may be clinically inappropriate or harmful for certain patients. CMS should also prohibit Part D plans from removing drugs mid-year in response to increased plan liability under the redesigned benefit. In addition, CMS should strengthen clinical appropriateness standards governing therapeutic substitution and step therapy to ensure that coverage decisions are driven by evidence-based medicine rather than cost containment alone. These protections are essential to preserving continuity of care and preventing disruptions in treatment for medically complex beneficiaries.

CMS should also establish minimum safeguards related to utilization management oversight and transparency. This includes placing clear limits on prior authorization and step therapy practices, particularly for specialty medications and therapies initiated in hospital settings, and requiring plans to demonstrate that such tools are clinically justified. In parallel, CMS should require enhanced transparency and reporting on utilization management practices, including denial rates, appeal outcomes, and time to therapy metrics. Public reporting and CMS oversight of these measures would allow regulators, providers, and beneficiaries to identify patterns of inappropriate access restrictions and ensure that utilization management is being used to support, rather than hinder, high-value care.

To protect patients during care transitions, CMS should further require temporary coverage or safe harbor periods for drugs initiated during hospitalization while coverage determinations and prior authorizations are finalized. Hospital clinicians often initiate time-sensitive therapies based on clinical necessity, and delays in post discharge access can lead to treatment interruptions, avoidable readmissions, and worse outcomes. A standardized transition of care protection would

reduce administrative burden on hospitals, promote adherence, and ensure that patients are not penalized for plan-level coverage determinations that occur after clinical decisions have been made.

Finally, CMS should commit to ongoing provider and hospital engagement as part of a long-term monitoring and evaluation strategy for the Part D redesign. Hospitals and frontline clinicians are uniquely positioned to identify access barriers and unintended consequences as they emerge, and their input should be systematically incorporated into CMS oversight frameworks. Over time, if plan behavior indicates that cost containment strategies are shifting financial and administrative burden downstream to providers or limiting access to clinically appropriate therapies, CMS should be prepared to tie insurer compliance with access to care, formulary methodology, and utilization management standards to the MA Star Ratings program or other accountability mechanisms. Doing so would reinforce the principle that the IRA's reforms are intended to reduce the cost of pharmaceuticals for patients, not to shift costs, delays, or clinical risk onto hospitals and providers. Together, these safeguards would help ensure that the redesigned Part D benefit fulfills its promise of improving affordability while preserving access and quality of care.

Special Enrollment Period

The AHA supports CMS's proposal to revise the special enrollment period for significant changes in the provider network by eliminating the requirement for a separate CMS or MA plan determination of whether a network change is significant. Allowing the special enrollment period to be triggered automatically when an enrollee is affected by a provider or facility termination is an important step toward ensuring beneficiaries have timely and meaningful options when continuity of care is disrupted. Requiring MA organizations to clearly notify affected enrollees of their special enrollment period rights in termination notices, including applicable timelines and related Medigap protections, will further improve transparency and awareness at a moment of heightened vulnerability.

However, to fully achieve the stated objective of preventing care disruptions, we urge CMS to strengthen this proposal by expanding the definition of affected enrollee to include beneficiaries who are scheduled to receive care from a provider or facility at the time they receive a termination notice. In many cases, it is the existence of a scheduled appointment, procedure, or course of treatment, not a retrospective lookback, that creates immediate clinical and logistical harm when a termination occurs. By excluding beneficiaries with scheduled care, CMS risks delaying surgeries, interrupting oncology treatment pathways, deferring essential diagnostics, and disrupting planned post-acute transitions to skilled nursing facilities, inpatient rehabilitation facilities, or home health services. These delays can result in prolonged hospital stays, avoidable functional decline, and increased readmission risk.

The current three-month lookback is intended to capture ongoing provider relationships, but it does not reliably identify beneficiaries facing imminent and time-sensitive care needs. Expanding the definition of affected enrollee to include scheduled care would better align the special enrollment period with CMS continuity of care goals and ensure that beneficiaries receive actionable enrollment options at the point when network disruptions pose the greatest clinical risk. Accordingly, we encourage CMS to finalize the proposed revisions and adopt this additional

safeguard so that the provider termination special enrollment period functions as a meaningful protection against care fragmentation rather than a narrowly applied administrative remedy.

MA and Part D Quality Measurement Updates

Updates to Star Ratings

The MA quality measurement and accountability framework plays an important role in promoting high-quality care, informing beneficiary choice, and aligning financial incentives with patient outcomes. CMS's proposed changes to the Star Ratings program, including the removal of certain measures related to appeals, grievances, and complaints, raise important questions about how quality oversight should capture both clinical performance and the operational practices that shape access to care. While we support efforts to streamline the Star Ratings program and focus on measures that reflect meaningful clinical outcomes and patient experience, we are concerned that eliminating measures tied to plan administration and beneficiary protections could weaken accountability for practices that directly affect access, delay care, and increase administrative burden for hospitals and clinicians. **Preserving a balanced quality framework is essential to ensuring that plans are rewarded not only for clinical outcomes, but also for responsible benefit administration and fair treatment of beneficiaries.**

Supplemental Requests for Information: Marketing Oversight, Regulatory Burden Reduction, and Program Integrity

Marketing Oversight and Agent/Broker Regulation

We strongly oppose CMS's proposed rollbacks of MA and Part D marketing oversight. CMS frames these changes as reducing friction, minimizing early call confusion, and lowering administrative burden, but that rationale ignores the very history that prompted CMS to adopt these protections in the first place. These guardrails were implemented because CMS and other oversight bodies repeatedly observed misleading sales practices, beneficiary confusion, and marketing that steered individuals into plans that did not match their clinical needs or stated preferences. If MA organizations, agents, and third-party marketing organizations consistently provided clear, complete, and unbiased information without overselling or manipulating vulnerable beneficiaries, these rules would not have been adopted. Medicare beneficiaries, particularly those with complex conditions and fixed incomes, are among the most fragile consumers in the health insurance market. CMS has an affirmative obligation to protect patients from high-pressure tactics, selective presentation of options, and enrollment decisions driven by sales incentives rather than patient needs. **Weakening these standards in the name of convenience is not prudent deregulation; it is an invitation to repeat the documented harms that led CMS to strengthen marketing oversight in 2022 and 2023.**

These rollbacks create predictable and significant risks for beneficiaries. Allowing marketing events to occur immediately following educational events in the same location, permitting scope of appointment collection at educational events, and removing the forty-eight-hour waiting period after scope of appointment completion increases the likelihood of high-pressure education to

enrollment conversions. Educational settings should be spaces where beneficiaries can learn without feeling targeted or pressured. The proposed framework blurs that line and enables sales conversion at the precise moment when beneficiaries are most susceptible to persuasive tactics. Eliminating the cooling-off period removes a practical safeguard that allowed beneficiaries time to consult caregivers, compare options, and reflect on network and formulary implications.

Retroactive remedies are not a substitute for front-end safeguards, particularly when plan changes can disrupt access, continuity of care, and financial stability.

CMS also proposed changes that weaken enforceability and reduce access to unbiased guidance. Shifting third-party marketing organization disclaimer timing from a bright-line first-minute requirement to a more subjective standard weakens compliance monitoring and enforcement. Removing state health insurance assistance programs from the disclaimer further reduces access to independent, community-based counseling resources that beneficiaries rely on to navigate complex coverage decisions.

The proposal also increases the risk of misleading advertising and reduces CMS's long-term investigatory capacity. Relaxing rules governing superlatives in marketing materials without requiring supporting documentation makes it easier for plans to make sweeping claims that beneficiaries cannot readily evaluate. Reducing call recording retention and considering alternatives such as transcripts or the elimination of recording entirely would further weaken oversight by limiting CMS's ability to identify patterns of misconduct and substantiate beneficiary complaints. These recordings are a foundational tool for program integrity, not an optional compliance burden.

Considering the previous concerns, these proposals shift power further toward insurers and their sales infrastructure at the expense of beneficiary protections. CMS should withdraw these proposed rollbacks and instead strengthen oversight mechanisms that ensure marketing and enrollment practices support informed decision making, transparency, and access to clinically appropriate care.

Regulatory Simplification and Reporting Burden Reduction

We strongly oppose CMS's proposal to eliminate the requirement that MA utilization management committees conduct annual data collection and analysis of prior authorization practices. Hospitals and clinicians consistently identify prior authorization as one of the most significant and harmful barriers to timely care in MA plans, contributing to dangerous delays in medically necessary services, clinician burnout, and substantial administrative costs. The proposed utilization management committee reporting would have provided essential baseline data on denial rates, appeal overturns, and authorization timelines. **Eliminating this requirement without establishing a clear and enforceable alternative would significantly weaken CMS's ability to hold MA plans accountable and undermine efforts to reform prior authorization practices.**

We also oppose efforts to weaken utilization management committee composition and responsibility requirements under the guise of reducing administrative burden. Clinically informed utilization management committees serve as an essential front-end safeguard by identifying inappropriate internal coverage criteria before they restrict access to care. This function is especially important given longstanding evidence that MA plans frequently apply internal coverage

criteria that are more restrictive than Traditional Medicare, as documented by the Department of Health and Human Services Office of Inspector General. Maintaining strong utilization management committee standards is, therefore, a necessary control that promotes parity between MA and Traditional Medicare and protects beneficiaries from inappropriate denials.

Network Adequacy

The Part D redesign and expanded utilization management authority heighten the need for strong and enforceable network adequacy standards across MA plans, particularly for post-acute care. Evidence comparing MA to Traditional Medicare and findings from federal investigations demonstrate that major MA plans disproportionately restrict access to inpatient rehabilitation facilities, long-term acute care hospitals, skilled nursing facilities, and home health agencies. These restrictions can harm patients by delaying clinically appropriate transitions out of acute care hospitals and keeping beneficiaries in higher cost settings when specialized post-acute care would better support recovery.

CMS should strengthen network adequacy oversight by adding key post-acute care facility types that are not currently subject to evaluation under 42 C.F.R. § 422.116(b)(2), including inpatient rehabilitation facilities, long-term acute care hospitals, and home health agencies. To address these failures, CMS should apply appropriate minimum standards for number, time, and distance where these providers are available. **These safeguards are essential to protect beneficiary access, support efficient care transitions, and ensure that cost containment efforts do not come at the expense of patient outcomes or hospital capacity.**

Medical Loss Ratio

Strong and modernized medical loss ratio reporting requirements are increasingly important as MA markets consolidate and vertically integrate. As insurers expand ownership across provider groups, pharmacies, pharmacy benefit managers, and other service entities, the risk increases that true medical spending will be obscured through related party transactions and internal cost allocations. Without consistent and detailed reporting, CMS cannot reliably assess whether premium dollars are being spent on patient care. CMS should strengthen and standardize medical loss ratio definitions and reporting to preserve transparency, accountability, and fair competition across the MA program.

Requests for Information on MA Enrollment and Program Direction

RFI: Future Directions in MA

As CMS considers the future of the MA program, it must reaffirm its fundamental responsibility to protect beneficiaries and safeguard program integrity. CMS has a duty to ensure that beneficiaries enrolled in MA receive access to health care services that are no more restrictive than those available under Traditional Medicare. Rolling back oversight and accountability mechanisms is deeply concerning, particularly considering repeated findings by the Department of Health and Human Services Office of Inspector General documenting harmful MA plan practices.

CMS must prevent MA plans from reclassifying coverage compliance issues as payment disputes to evade federal oversight. Once such strategies are adopted by one or two plans, they quickly become industry norms, undermining CMS authority and beneficiary protections. CMS must also modernize MA risk adjustment to curb gaming practices that reward aggressive coding without ensuring delivery of medically necessary care. Reforms must strengthen the link between payment and patient care while avoiding additional administrative burden on hospitals and clinicians.

CMS must collect more timely and meaningful data to identify harmful plan practices and intervene quickly when access barriers arise. Provider complaints, utilization management data, and claims information should be integrated to support targeted oversight. Finally, CMS must improve transparency so beneficiaries can understand provider access, network changes, and options when care is delayed or unavailable. **MA beneficiaries should not be treated differently from Traditional Medicare beneficiaries due to insurer practices branded as “cost containment strategies” that undermine access to care.**

Thank you again for the opportunity to comment on CMS-4212-P: Medicare Program: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, the Medicare Prescription Drug Benefit Program, and the Medicare Cost Plan Program. Please let us know if we can provide additional information as you move forward.

Sincerely,

A handwritten signature in black ink, appearing to read "Bo Ryall". The signature is fluid and cursive, with a large initial "B" and "R".

Bo Ryall
President & CEO
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