



January 27, 2025

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

*Via electronic submission*

**RE: CMS-4208-P: Medicare and Medicaid Programs: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly**

Administrator Brooks-LaSure:

The Arkansas Hospital Association (AHA) represents over one hundred health care facilities and more than 45,000 employees across the state, all of whom are dedicated to delivering essential health care and community services to the people of Arkansas. On behalf of our member hospitals, we appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed update (CMS-4208-P).

Medicare Advantage (MA) plans were intended to serve as an alternative to supplement Traditional Medicare insurance, offering patients more choices and improving access to care. In Arkansas, nearly 43% of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan. However, in practice, many MA plans have failed to meet the expectations of their members, demonstrating instances of negligence and engaging in practices that, at times, erode patient trust and compromise care. This highlights the urgent need to strengthen oversight and regulation to ensure MA plans meet the standards of care and accountability that patients and providers rightfully expect.

## Ensuring Equitable Access to Health Care Services for Medicare Advantage Plans

### Ensuring Equitable Access to Behavioral Health Benefits

MA plans that do not align cost-sharing rates with Traditional Medicare Fee-for-Service (FFS) rates create significant challenges for hospitals, providers, and patients. This misalignment leads to financial strain for hospitals as they struggle to recoup adequate payment for health services, often operating at a loss. These financial pressures hinder hospitals' ability to maintain or expand behavioral health services, ultimately impacting patient access to care. This issue is further compounded by the increasing prevalence of MA plans, which now account for over 50% of Medicare enrollment nationally and 47% in Arkansas. Ensuring equitable cost-sharing rates is essential as MA adoption rises, allowing hospitals to sustain high-quality care and adequately serve their patients. Aligning cost-sharing rates with Traditional Medicare will help address these disparities and provide a more stable financial foundation for hospitals and providers.

We strongly support the proposal in CMS-4208-P to align behavioral health cost-sharing standards for MA and Cost Plans with Traditional Medicare for in-network providers. **To improve affordability for enrollees and minimize disruption to access and coverage options, we urge CMS to implement this policy beginning in 2026.** Delaying implementation to 2027 would prolong existing inequities and exacerbate financial challenges for hospitals, which are already navigating constrained resources. Behavioral health services are essential, and timely adoption of these standards is necessary for improving access and affordability for patients.

We also agree that a transition period is necessary for both payors and providers to adapt to the new reimbursement standards. A minimum transition period of six months, beginning with the contract year 2025 behavioral health cost-sharing standards would allow stakeholders to make the operational adjustments required to comply with the updated policy. This period would provide adequate time for training, contract modifications, and adjustments to benefit designs while ensuring continuity of care for enrollees. Additionally, we recommend that CMS monitor and evaluate the impact of these changes on MA plans' ability to satisfy existing actuarial equivalence requirements with Traditional Medicare cost-sharing. This evaluation will help address any unforeseen issues and ensure the long-term success of the proposed reforms. **By adopting these changes in 2026 with a structured transition period, CMS can better support hospitals, enhance patient access to equitable behavioral health benefits, and position the MA program to meet the needs of their enrollees.**

### Integrating Coverage for Dually Eligible Enrollees

The combination of benefits for dually eligible enrollees has the opportunity to improve patient access, efficiency, and care coordination. **We support the introduction of an integrated member ID card for both Medicare and Medicaid plans. A single ID card simplifies administrative processes for patients, providers, and CMS by reducing confusion and eliminating the need for multiple cards.** For patients, this enhances their experience by making it easier to navigate their coverage and access care. For providers, it streamlines eligibility verification and billing processes, reducing administrative burdens and improving workflow efficiency. For CMS, it facilitates better oversight and integration of data between Medicare and Medicaid programs, supporting efforts to improve outcomes for dually eligible populations.

**We also support conducting only one health risk assessment (HRA) for dually eligible enrollees unless a qualifying event necessitates a new one.** Reducing duplicative assessments offers significant cost and resource savings for health plans, providers, and the system as a whole. More importantly, it minimizes the burden on patients who might otherwise face repetitive assessments that can feel redundant or invasive.

Codifying timeframes for special needs plans to conduct HRAs and individualized care plans (ICPs) is another key improvement. Clear, consistent deadlines ensure that assessments and care plans are developed promptly, enabling early identification of health risks and faster implementation of interventions. **We urge CMS to emphasize enrollee involvement in the development of ICPs to ensure care plans are person-centered, responsive to individual preferences, and inclusive of cultural and social considerations.**

#### Guardrails for Artificial Intelligence (AI) in Medicare Advantage Plans

We strongly support the establishment of guardrails to ensure the responsible use of artificial intelligence (AI) in Medicare Advantage plans. While AI has the potential to enhance decision-making and streamline processes, it must not result in inequitable treatment or reduce access to necessary care. The application of AI in health care requires careful oversight to protect patients, ensure fairness, and maintain trust in the system.

Preventing AI from denying services without physician review must remain a key priority. Decisions affecting patient care must be informed by clinical expertise, with a qualified physician evaluating any denial of coverage. This safeguard ensures that patients receive appropriate care and that denials are made in consideration of the full clinical context. **Allowing AI to make final determinations without human oversight risks undermining patient safety and eroding confidence in the health care system.**

Additionally, we recommend that MA plans be required to describe the impact of AI on service denials, including an analysis of whether the model exhibits bias. Regular reporting on AI's influence on denied claims would allow CMS to monitor and address potential inequities. Transparent evaluation processes can ensure AI models are designed and deployed in ways that align with established standards of fairness and quality.

We also urge CMS to prohibit the use of iterative AI models that learn from their own information production. Such models, while potentially efficient, pose significant risks to validity and decision-making. Iterative learning can create a phenomenon where AI systems narrow their decision-making over time, moving away from evidence-based practices and introducing unintended biases. Instead, AI models should be rooted in human-based literature and continuously validated against reliable, up-to-date clinical data.

#### Aligning Internal Coverage Criteria for Medicare Advantage Plans

We support CMS's efforts to specify internal coverage criteria definitions for MA plans. Establishing clear, standardized definitions ensures consistency and transparency in coverage decisions, which is important for promoting equitable access to care. **Without these definitions, variations in the interpretation and application of criteria can lead to confusion among beneficiaries and disparities in access to benefits.**

We also recommend establishing policy guardrails to ensure access to benefits under MA plans. These guardrails should explicitly prohibit the use of overly restrictive criteria that could delay or deny access to necessary services. **Enrollees deserve confidence that their plan’s internal coverage decisions are made in alignment with Medicare FFS requirements and medical necessity, not solely based on cost considerations.** Clear policies that prioritize timely and appropriate access to benefits can improve health outcomes and reduce administrative disputes between plans and providers.

**Furthermore, we urge CMS to mandate that MA organizations publicly post their internal coverage criteria on their websites.** Providing this information transparently empowers beneficiaries to make informed decisions about their health care options and allows providers to better understand plan requirements for covered services. Additionally, internal coverage criteria content should be included in the enrollment process and explained by MA agents during beneficiary consultations. Enrollees must fully understand the implications of coverage criteria before selecting a plan, including how these criteria could impact their access to specific services or treatments. Agents should be required to attest to adequately describing these coverage policies prior to plan enrollment by the patient.

## **Integrating Traditional Medicare Standards into Medicare Advantage Plans**

### Promoting Community-Based Services and In-Home Provider Transparency

We support CMS’s proposal to enhance requirements for agents and brokers involved in the Medicare enrollment process. **Agents and brokers play a pivotal role in guiding beneficiaries through complex decisions, and it is essential that their interactions promote informed and equitable decision-making.** Requiring agents to provide information about the availability of low-income supports, such as the Part D Low-Income Subsidy (“Extra Help”) and Medicare Savings Programs, ensures that beneficiaries are aware of resources that can help them manage costs and access necessary care.

Additionally, agents should be required to explain general information about Medigap Federal guaranteed issue (GI) rights and the practical implications of switching from Traditional Medicare to Medicare Advantage. Beneficiaries must understand how Medigap GI rights work and how state laws may impact their ability to secure a Medigap policy. This is particularly important for agents licensed to sell in states with specific regulations, as it ensures that beneficiaries receive accurate, localized information.

To further enhance beneficiary protections, we recommend that agents pause during consultations to address any remaining questions the enrollee may have. This pause ensures beneficiaries have adequate time to process the information provided and seek clarification as needed. Agents should also be required to obtain a written or verbal attestation from clients, confirming that they were asked if they had any additional questions and that they had time to respond. Agents should likewise attest to having fulfilled this obligation, creating a clear record of the interaction. These measures promote transparency and accountability while helping beneficiaries make well-informed decisions.

### Enhancing Marketing and Communication Review Processes

We agree with CMS's efforts to strengthen the review process for Medicare Advantage marketing and communication materials. Ensuring promotional materials accurately represent plan benefits, benefit structures, premiums, cost-sharing requirements, and performance metrics like Star Ratings is essential to preventing beneficiary confusion. Any materials used to market or inform prospective or current enrollees should clearly explain rewards, incentives, and plan comparisons.

We recommend that CMS require all marketing and informational materials produced by Medicare Advantage plans be submitted for review prior to distribution. Shifting to an intent-to-market standard for review would risk the dissemination of misleading or incomplete information, potentially harming beneficiaries. **By maintaining and enhancing the pre-distribution review process, CMS can safeguard the accuracy and integrity of the information available to beneficiaries.**

### Strengthening Medicare Part D Network Pharmacy Agreements

We support CMS's proposal to require Part D sponsors to notify network pharmacies about in-network plans by October 1. Timely communication ensures that pharmacies can accurately advise beneficiaries about their coverage options and prevent disruptions in access to medications.

Additionally, we agree with the requirement that pharmacy networks be allowed to terminate without cause if the plan has a no-cause termination policy. Plans must also be required to report these changes to CMS within 30 days of termination. **These measures promote transparency and accountability in pharmacy-network arrangements, ensuring that beneficiaries are not unexpectedly impacted by changes in their pharmacy options.**

### Supporting Vaccine Cost-Sharing Changes

We support the proposed changes to vaccine cost-sharing under Medicare Part D, which would eliminate the application of the Part D deductible to vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Vaccines are one of the most effective tools for preventing disease, reducing health care costs, and improving population health. **Ensuring that cost is not a barrier to vaccine access is a critical step in encouraging higher vaccination rates among Medicare beneficiaries.**

### Insulin Cost-Sharing Changes

Diabetes remains a pressing public health issue in Arkansas, where over 300,000 residents are diagnosed, and an additional 18,000 new cases are reported annually. The financial burden of insulin can be a major barrier to effective diabetes management, leading to poor adherence and increased risks of complications. The Inflation Reduction Act's initial \$35 cap has already demonstrated its potential to alleviate this burden, and the proposed CY 2026 updates will ensure continued affordability and equitable access to this life-saving medication. As such, we support CMS's proposed updates to insulin cost-sharing policies under Medicare Part D, including the provision that insulin costs will not apply to the Part D deductible. The proposed changes, including

capping the monthly cost-sharing for insulin at \$35 and implementing a 25% cost-sharing requirement for certain insulin products beginning in 2026, represent a significant step forward in addressing the affordability challenges faced by beneficiaries with diabetes. **In order to protect providers, these caps should be imposed on the amount charged by pharmaceutical companies.**

#### Support for Prescription Payment Plans

We also agree with the proposal to cap monthly cost-sharing under prescription payment plans. This measure will allow beneficiaries to better manage their out-of-pocket expenses and avoid financial hardship, particularly for those on fixed incomes or managing multiple chronic conditions.

#### Expanding Coverage for Anti-Obesity Medications

We strongly support the inclusion of anti-obesity medications (AOMs) in Medicare Part D and urge CMS to extend this coverage to Medicaid. Obesity is a significant public health issue in Arkansas, where over 71% of the population is classified as overweight or obese. These statistics underscore the urgent need to address obesity as a chronic disease and provide access to evidence-based treatments, including AOMs.

Historically, Medicare Part D and Medicaid have excluded AOMs from coverage, limiting access to critical therapies. **Expanding coverage for AOMs reflects the growing recognition of obesity's impact on population health and health care systems. We recommend that CMS define obesity using a standardized metric, such as Body Mass Index (BMI), to ensure consistent eligibility criteria.**

#### Focus on 340B Underpayments

The Supreme Court's unanimous decision in *American Hospital Association v. Becerra* led to the Department of Health and Human Services (HHS) issuing a final rule in November to remedy the unlawful 340B payment cuts to certain hospitals. This ruling rightfully mandates lump sum repayments for the funds that were improperly withheld. While the Arkansas Hospital Association and our member hospitals are encouraged by this step, a major policy gap remains. MA plans that mirrored HHS's unlawful payment policy have not yet been held to the same standard, leaving hospitals with substantial underpayments.

Despite strong recommendations from stakeholders, including the American Hospital Association, HHS did not require MA plans to provide similar restitution. Instead, the issue was deemed "out of scope" of the final rule. The decision leaves hospitals vulnerable to ongoing financial losses, with billions of dollars still owed from MA plans for underpayments between 2018 and 2022. Since many MA plans align their reimbursement rates directly with Traditional Medicare, there is no valid rationale for allowing MA plans to avoid compliance with the repayment standard established for CMS. Consequently, the same regulatory actions that are now holding CMS accountable should be extended to MA plans.

The impact of HHS's earlier unlawful policy on 340B payments has placed undue financial stress on hospitals, exacerbated by the MA plans' lack of repayment. This situation not only undermines the

financial health of hospitals but also disrupts their ability to provide essential services to their communities. As CMS continues to enforce 340B repayment from Traditional Medicare, it must simultaneously mandate that MA plans make hospitals whole, ensuring that the substantial losses incurred are remedied. **We strongly urge CMS to prioritize measures that require MA plans to repay hospitals for underpayments related to 340B, upholding fairness and accountability across both Traditional Medicare and Medicare Advantage.**

## **Improving Information Transparency for Medicare Advantage Plans**

### Enhancing Oversight of Medical Loss Ratio (MLR)

We support aligning MA and Part D Medical Loss Ratio (MLR) reporting requirements with those of commercial and Medicaid plans to promote consistency, transparency, and accountability. Adding clinical and quality improvement standards for provider incentives and bonus arrangements to the MLR numerator will ensure that these programs prioritize patient outcomes and evidence-based care. At the same time, removing administrative costs from quality improvement activities will show the value of patient-centered initiatives.

Additionally, authorizing the release of Part C and Part D data and requiring detailed reporting on provider payment arrangements will improve transparency and enable policymakers to address concerns regarding vertical integration within MA and Part D programs. **This level of detail will allow for a better evaluation of how MLRs are calculated and whether funds are being appropriately allocated to improve quality, reduce costs, and support equitable access to care for beneficiaries.**

### Promoting Community-Based Services and In-Home Provider Transparency

We support requiring MA plans to submit provider directories to populate the Medicare Plan Finder (MPF), as this will improve the accuracy and usability of the platform for beneficiaries. MA plans should update their registries within 30 days of adding or removing a provider and attest to the accuracy of the directory within 30 days of each fiscal quarter to ensure beneficiaries are accessing the most current information. Adding a level of accountability will further ensure compliance and transparency. We also recommend that these data files be publicly available in machine-readable formats, such as .txt, .csv, or .xlsx, to allow researchers and stakeholders to analyze and utilize the data effectively.

We agree with the new requirements for supplemental benefits administered using debit cards and recommend additional measures to enhance transparency and protect beneficiary access to covered services. Specifically, MA plans should disclose when, how, and in what manner debit cards can be used by organizations and enrollees, including clear definitions of covered benefits linked to the cards. Supplemental benefit policies should require that debit cards are electronically linked to plan-covered items and services through a real-time identification mechanism to ensure appropriate utilization. Furthermore, additional rules should clarify acceptable over-the-counter (OTC) product categories, reducing the ambiguity of approved purchases. To protect beneficiaries, MA organizations should allow enrollees to access covered services through alternative processes if issues with the debit card arise. **Marketing of supplemental benefits should focus on their**

**functional value, avoiding emphasis on dollar amounts or benefit administration methods to ensure beneficiaries understand their practical application.**

We also support adding granularity to the Annual Health Equity Analysis of Utilization Management policies to assess the equitable distribution of services and benefits among different demographic groups including all in-home service contractors, community-based organizations (CBOs), and direct furnishing entities within the provider directory. Definitions of these entities should be codified, and MA plans should identify, within their provider directories, which providers meet the criteria for CBOs, in-home or at-home supplemental benefit providers, and direct furnishing entities. Plans should also distinguish hybrid providers offering both in-home and in-office services, either through a subset list within the directory or a separate list.

## **Conclusion**

We commend CMS for its ongoing commitment to aligning Medicare Advantage (MA) with the high standards of Traditional Medicare, ensuring equitable access to care and transparency across all areas. By addressing behavioral health cost-sharing, enhancing coverage for dually eligible enrollees, and implementing guardrails for AI to prevent inequities, CMS continues to prioritize patient health and well-being. Expanding Part D offerings, such as zero-cost vaccines and capped insulin prices, demonstrates a critical investment in improving affordability and outcomes for enrollees. We also appreciate the emphasis on promoting transparency, including updated provider directories, better oversight of supplemental benefits, and more rigorous Medical Loss Ratio reporting. These efforts collectively strengthen the Medicare program, fostering greater accountability, equity, and access.

Thank you, again, for the opportunity to comment on CMS-4208-P: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Please let me know how I can provide further information to you to help you as you move forward.

Sincerely,



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