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January 27, 2025

Acting Administrator Jeff Wu
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted electronically: www.regulations.gov

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

Dear Acting Administrator Wu:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the proposed changes to the Medicare Advantage and Part D programs for contract year 2026.

HANYS is thankful for CMS' efforts to strengthen beneficiary protections, promote access to behavioral health providers, advance coverage equity and increase oversight of prior authorization and utilization management tools.

Participation in MA plans continues to grow. In 2024, more than 32 million Medicare beneficiaries were enrolled in an MA plan — more than half of all Medicare beneficiaries. This is more than double what it was ten years ago, when 15 million beneficiaries were enrolled. In New York, 56% of beneficiaries were covered by an MA plan in 2024.

This trend shows no signs of slowing down, as the Congressional Budget Office projects total MA enrollment will reach 64% of all Medicare beneficiaries by 2033.

HANYS and our members have long supported consumer choice and innovation within a strong health insurance market. However, while the MA program offers some apparent advantages to beneficiaries, it also comes with unintended limitations that are inconsistent with Medicare fee-for-service policy. This causes confusion for beneficiaries who may not understand the differences between FFS and MA.

Furthermore, 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. For example, the use of prior authorization by MA plan has significantly increased in the past five years.

A Senate Majority Staff Report found that the share of MA beneficiaries enrolled in an MA plan requiring prior authorization grew from 72.6% in 2019 to 99% by 2023. This increase has created significant friction for both patients and providers, and in some cases has led to patients abandoning treatment. MA plans' use of prior authorization and other utilization management policies erodes access to quality care for patients and unnecessarily lengthens their time in acute care settings. This not only drives concerns regarding patients' safety but also avoidable financial expenditure within acute hospital settings.

Another area of concern relates directly to the payments made to MA plans. Congress' Medicare Payment Advisory Commission estimates that MA payments in 2024 were 22% above traditional Medicare — a difference that amounts to $83 billion in annual spending. This overpayment gives MA plans a significant financial incentive to restrict care once individudals are enrolled, as MA plans receive a fixed payment for each member, regardless of the services delivered.

We support CMS' continued efforts to improve the MA program and advance important consumer and beneficiary protections; however, as CMS notes in its own fact sheet, "CMS remains concerned about barriers accessing care and high burden on the system."

HANYS shares those concerns and we urge CMS to further strengthen its oversight to ensure MA plans do not impede patient access to care or continue to impose administrative and financial burdens on providers.

Strengthening prior authorization and utilization management guardrails

CMS proposes to clarify and strengthen existing provisions that limit MA plan use of internal coverage criteria for medical necessity determinations. To achieve this, CMS-4208-P defines the term "internal coverage criteria" and establishes additional guardrails designed to promote transparency and consistency in the criteria used to make medical necessity determinations. HANYS fully supports these efforts, as MA plans continue to interpret the meaning of "internal coverage criteria" differently since the implementation of the calendar year 2024 MA final rule.

In addition, CMS proposes a series of additional guardrails and clarifications regarding the limited set of circumstances in which MA plans may create their internal coverage criteria, including:

- clarifying that internal coverage criteria may only be used to supplement or interpret already existing content with the Medicare coverage and benefit rules;
- requiring MA plans to identify the *plain language* describing the applicable Medicare coverage and benefit criteria they are interpreting or supplementing when it is impermissible to adopt internal coverage criteria — and make such plain language explanation available in publicly accessible materials;
- prohibiting using an MA plan internal criterion that does not provide clinical benefit to the patient and only exists to reduce utilization of the item or service; and
- prohibiting using internal criteria to automatically deny coverage of basic benefits without the MA organization making an individual medical necessity determination based on the patient's individual circumstances and medical condition.

HANYS strongly supports limiting MA plans from adopting more restrictive rules than Medicare FFS, as these divergent policies result in significant inequities in coverage between FFS and MA and impose substantial burdens on providers. **HANYS recommends CMS further increase its audit and enforcement action to ensure compliance.**

CMS has yet to address another area where MA plans significantly deviate from Medicare FFS: inpatient hospital readmission policies. The CMS Hospital Readmissions Reduction Program focuses on a specific set of conditions or procedures for a 30-day period. MA plans claim to be following CMS rules; however, they have established their own readmissions policies that are more restrictive, based on different timeframes than CMS and are used as technical denials rather than clinical decisions. In addition, MA plans frequently deny coverage for readmissions at different hospitals within a health system, while others deny coverage for an inpatient "readmission" for services completely unrelated to the original admission.

HANYS asks CMS to clarify that MA plans' inpatient hospital readmissions policies cannot be more restrictive than Medicare FFS and that MA plans cannot use these policies for technical denials that leave no appeals rights or recourses for providers.

Organization determinations and appeal rights

CMS proposes several modifications to strengthen existing regulations regarding MA coverage and responsibility, including prohibiting MA plans from reopening approved authorizations for inpatient hospital admissions.

HANYS strongly supports these proposals, especially the prohibition on retrospective denials of authorized services. Prior authorization should be a guarantee of payment (absent materially false or fraudulent information); CMS should not allow MA plans to approve medically necessary services and then rescind their approvals after the services have been provided to beneficiaries.

Cost sharing for behavioral health services

MA beneficiaries endure higher out-of-pocket costs for behavioral health services than FFS beneficiaries do. As a result, they are significantly less likely to use those services than FFS beneficiaries. CMS data show that while 28% of MA enrollees live with a mental illness, on average, only 3% received treatment from a behavioral health provider in 2023. Therefore, CMS proposes to improve access to services by ensuring that the in-network cost sharing for behavioral health services is no greater than the cost-sharing limits in FFS.

Specifically, CMS proposes the following standards:

- 20% coinsurance or an actuarially equivalent copayment limit for mental health specialty services, psychiatric services, partial hospitalization/intensive outpatient services, and outpatient substance abuse services (current standard: 30% to 50% coinsurance or actuarially equivalent copayment, based on the plan's maximum out-of-pocket).
- Zero cost sharing for opioid treatment program services (current standard: 50% coinsurance or actuarially equivalent copayment for all MOOP types).
- 100% of estimated Medicare FFS cost sharing for inpatient hospital psychiatric services (current standard: 100% to 125% of estimated Medicare FFS cost sharing, based on the plan's MOOP type).

HANYS strongly supports these efforts to improve access to behavioral health services for MA enrollees and urges CMS to finalize them for CY 2026.
Maintaining a robust and stable healthcare workforce is the cornerstone of providing quality care. However, significant behavioral health workforce shortages may challenge in-network access to

behavioral health providers. **We urge CMS and Congress to invest resources to support behavioral health workforce development.**

Medical loss ratio reporting

CMS proposes several changes to the MLR requirements for MA and Part D plans to improve oversight and better align agency reporting requirements for MA with commercial and Medicaid requirements. Among the proposals is to exclude administrative costs from quality-improving activities in the MA and Part D MLR numerators. In addition, to ensure that reported provider bonus payments are properly based on QIAs, the rule proposes that only those provider incentives and bonuses tied to clearly defined, objectively measurable and well-documented clinical or quality improvement standards may be included in the MLR numerator.

Taken together, these proposals are meant to prevent MA plans from artificially inflating MLRs by including inappropriate activities in the QIA calculation. **HANYS supports these efforts to improve market transparency, beneficiary choice and oversight; and increase reporting on plans' profit and spending.**

Guardrails for artificial intelligence

CMS highlights the increased use of AI in healthcare and warns of the potential for these technologies to exacerbate biases and inequities if left unchecked. The proposed rule seeks to ensure that MA plans continue to provide equitable access to services by clarifying that MA plan use of AI or automated systems must comply with existing laws and regulations that prohibit discrimination against beneficiaries based on any factor that is related to health status or condition.

HANYS and our members are committed to systematically and intentionally addressing social determinants of health and closing healthcare gaps in every New York community. HANYS believes that closing these gaps will enable every individual to achieve optimal health through the delivery of equitable health services — this includes ensuring AI tools do not discriminate against patients. **We urge CMS to finalize this proposal.**

To ensure that MA plans comply with Medicare's rules and do not inappropriately create barriers to care, we urge CMS to implement the following measures:

- require MA plans to report prior authorization data including reason for denial, by type of service, beneficiary characteristics and timeliness of prior authorization decisions;
- require MA plans to disclose information to providers about the use of AI-based algorithms in their utilization review process;
- prohibit MA plans from making any decision regarding coverage of, including payment for, patient care based solely on the results derived from the use or application of AI;
- require MA plans to establish an ongoing quality assurance testing process based on criteria established by CMS; and
- mandate that final adverse determinations shall only be made by a clinical peer reviewer in the exercise of their individual professional judgment and adhering to evidence-based clinical guidelines, after a review of the enrollee's or insured's circumstances and relevant medical documentation.

Provider directory requirements and inclusion in the Medicare Plan Finder

CMS proposes to require MA plans to report provider directory data to CMS for incorporation into the agency's Medicare Plan Finder platform and attest to the accuracy of their provider directory information. **HANYS supports these proposals and recommends CMS finalize them.**

Additional areas for consideration and comment

Medicare FFS coding policies

Similar to the variations in coverage policies between Medicare FFS and MA plans, MA plans have unilaterally created separate coding and diagnosis grouping standards that are contrary to Medicare FFS. A key example of this relates to sepsis. MA plans follow Sepsis-3 criteria for determining provider reimbursement.

The Sepsis-3 criteria formulated by the Sepsis Definitions Task Force are not consistent with the Sepsis-2 criteria that otherwise have been universally adopted, most notably by CMS and New York state. This results in MA plans denying payment for early sepsis interventions. The use of Sepsis-3 by MA plans in New York also harms reimbursement for hospitals and health systems that are required to follow the Sepsis-2 criteria.

HANYS strongly urges CMS to align Medicare FFS and MA coding policies to ensure consistent use of Current Procedural Terminology coding practices and Diagnosis Related Group assignments.

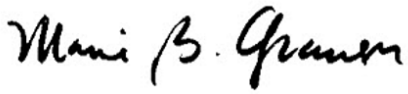
Enforcement and oversight

HANYS believes that CMS needs to provide greater oversight of MA plan behavior. Throughout this proposed rule, CMS has responsively addressed many stakeholder concerns regarding the MA program and plan policies and practices that delay or restrict access to care. Without proper oversight and enforcement, MA plans have no incentive to change their behavior and comply with CMS rules.

HANYS strongly urges CMS to create a meaningful mechanism for providers and other stakeholders to identify and report suspected violations. We also ask CMS to establish meaningful penalties for MA plan non-compliance.

If you have questions, please contact me at bgrause@hanys.org or 518.431.7765, or Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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