



January 26, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

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:

On behalf of nearly 400 hospitals and health systems, the California Hospital Association (CHA) provides the following comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the contract year (CY) 2027 Medicare Advantage (MA) program.

In California, where more than 56% of Medicare beneficiaries are enrolled in Medicare Advantage organizations (MAOs), it is critical that CMS policies prioritize continuity of care and maintain robust oversight mechanisms to protect beneficiaries from inappropriate plan practices. While CHA supports CMS' efforts to streamline administrative processes and protect patients during network disruptions, CMS should not weaken the Star Ratings system by removing vital transparency and insurer accountability measures.

Special Enrollment Period for Provider Termination

CHA supports CMS' proposal to revise and rename the existing special enrollment period (SEP) for significant changes in provider networks to the SEP for Provider Termination. CMS' clarifications will make it easier for MA enrollees to transition more seamlessly to different plans if there are mid-year changes to plan networks. This is an important strategy to improve and preserve consumer access to care when network disruptions occur.

Currently, the requirement for a determination of "significance" by CMS or an MA plan before a SEP is granted can create delays that disrupt a patient's continuity of care. By proposing that a determination of a "significant" network change is no longer necessary for an affected enrollee to be eligible for the SEP, CMS is taking a vital step toward protecting patients from disruptions caused by contractual issues between plans and providers.

CHA also supports the requirement that MA plans provide information about this SEP directly in the provider termination notice. This ensures that beneficiaries are aware of their timely options to select plans that meet their needs when network disruptions occur. Hospitals often play a key role in helping patients navigate these transitions, and these clarifications will reduce confusion for both providers and the older adults they serve.

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Opposition to the Removal of Star Ratings Oversight Measures

While CHA acknowledges CMS' objective to streamline the Star Ratings measure set, the removal of several measures that serve as essential oversight mechanisms for monitoring MAO behavior would dilute critical transparency and accountability protections for patients. Specifically, hospitals are concerned about the proposed removal of the following measures:

- Complaints about the Health/Drug Plan (CTM)
- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions (Maximus/IRE)
- Members Choosing to Leave the Plan (Part C and D)

Importance of the CTM

CMS proposes to remove the CTM measure, noting that complaint volume has decreased and that performance is "topped out" with high performance and minimal variation across contracts. CHA disagrees with this rationale and urges CMS to retain this measure, as it remains one of the few actionable oversight mechanisms available to providers within the MA program.

Unlike beneficiaries, who have multiple access-to-care and experience measures (such as the Consumer Assessment of Healthcare Providers and Systems), the CTM is effectively the only mechanism through which providers can have direct input into the Star Ratings system regarding plan performance. Removing this link diminishes the utility of the complaint pathway and removes a primary incentive for plans to promptly address provider grievances.

The low volume of complaints, CMS notes, reflects lack of provider awareness of the process — not a lack of challenges with plan performance or compliance with federal rules. The rationale that complaint volume has decreased should not be a basis for removal. CMS has not sufficiently educated the provider community on the location or proper use of the complaint submission process; providers have largely relied on word-of-mouth and provider association communications to navigate the system. As an alternative, CMS should offer education on the CTM to providers and monitor subsequent activity to better assess the prevalence of its use.

In addition, the CTM is a proven tool for enforcement. Hospitals report that the CTM process has directly resulted in positive outcomes that standard appeals alone could not achieve, including:

- **Overturing Adverse Decisions:** Hospitals have reported numerous instances where filing CTM complaints resulted in the overturning of improper adverse coverage decisions and the recovery of payments for medically necessary, covered services.
- **Behavior Correction:** The visibility of complaints has forced certain plans to discontinue non-compliant activities, such as conducting claim audits based on coverage criteria that were never publicly disclosed as required by 42 C.F.R. § 422.101(b)(6).
- **Deterrence:** The link between complaints and Star Ratings is a deterrent to the use of MAO practices that skirt federal rules and can be an effective tool to create dialogue between providers and plans in the context of CMS oversight. For example, some hospitals have reported that filing complaints promoted cooperative conversations with plans that had historically refused to engage in dialogue about delay or denial practices. In these cases, the complaint pathway effectively brought the parties to the table, and even deterred the continued use of problematic practices in some circumstances.

These experiences confirm that Star Ratings have the potential to influence plan behavior in positive ways. Removing the CTM measure would eliminate one of the few tools that successfully disincentivizes problematic plan tactics that delay or deny care or payment for Medicare-covered services.

Preserving Appeals Integrity and Maximus Oversight

CHA opposes the proposal to remove measures related to timely decisions and Independent Review Entity (Maximus/IRE) performance. CMS' claim that these measures are "topped out" ignores the reality of how certain MAOs handle reconsiderations. High performance scores on these particular measures are an illusion created when certain MAO plans selectively filter which appeals reach independent review, contrary to CMS rules, and thus these scores not an indicator of stable, high performance.

Data from the U.S. Health and Human Services Office of Inspector General (HHS-OIG) have identified that plans frequently overturn their own denials during the first level of appeal — historically overturning nearly 75% of cases.¹ In some cases, it appears this is done specifically to prevent indefensible denials from reaching the IRE. For cases MAOs refuse to overturn, certain plans utilize tactics to block independent review entirely, such as improperly relabeling valid patient appeals as "provider disputes" or "contractual payment decisions," or simply failing to issue the required Notice of Dismissal. By preventing these valid appeals from moving forward, plans make their denials virtually invisible to CMS oversight and in tandem artificially inflate their Star Ratings.

The Reviewing Appeals Decision measure provides a critical financial incentive for plans to overturn denials they cannot legally defend and helps ensure the IRE is playing a meaningful role as an independent, impartial, third-party reviewer of medical necessity decisions made by the plan. If this measure is removed, plans will face little penalty for upholding inappropriate denials and CMS will have no line of sight into this phenomenon. This may have the unintended consequence of emboldening plans to increase the volume of inappropriate denials, depriving enrollees of access to care and multiplying the administrative burden on patients and providers to access Medicare-covered services.

Further, in final CY 2026 rulemaking, CMS recently expanded enrollee appeal rights to ensure patients can appeal denials even after services are completed (post-service), closing a loophole plans previously used to block appeals for emergency or urgent care once the patient was discharged. Removal of the measures related to IRE forwarding and concurrence could stymie this important progress, leading plans to convert member appeals to provider appeals to avoid accountability through the IRE. Accordingly, retaining these measures is essential to ensure the new 2026 consumer protections actually result in increased access to care rather than increased administrative maneuvering by certain MAOs.

Finally, the claim that MAO IRE measure performance is high and stable is further contradicted by the high rate of Administrative Law Judge overturns reported by hospitals, particularly in the post-acute care space, where denials upheld by Maximus are frequently found to be incorrect upon further legal review. Removing these oversight measures when certain plans continue to game the IRE escalation process ignores the persistent, incorrect denials providers and beneficiaries face and decreases oversight at a time when more accountability is needed to ensure access to medically necessary care.

¹ <https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/>

Consumer Disenrollment Data is an Important Indicator of Beneficiary Access and Satisfaction

CHA urges CMS not to finalize the removal of the Members Choosing to Leave the Plan (Part C and Part D) measure. While CMS suggests this measure is difficult to interpret without knowing the specific reasons for disenrollment, this metric provides a crucial, high-level reflection of real-world beneficiary satisfaction that should not be discarded.

The fact that a member chooses to disenroll from an MA plan is a definitive signal of dissatisfaction or misalignment between the beneficiary's needs and the plan's offerings. CMS' inability to pinpoint the exact reason for every disenrollment does not diminish the value of the signal itself to prospective enrollees. Further, this metric works in tandem with the CTM measure; if a member is dissatisfied enough to leave the plan, the nature of that dissatisfaction is often captured in complaint data. Removing both measures — as CMS proposes — would obscure critical transparency regarding plan performance and deny prospective enrollees the ability to evaluate how incumbent members respond to plan policies and practices.

Conclusion

Rules alone are insufficient to achieve compliance; enforcement is critical to ensuring compliance with federal rules — and ultimately to ensure that Medicare Advantage beneficiaries receive the same level of, and access to, care as traditional Medicare beneficiaries, as intended. While deregulation efforts are helpful to reduce unnecessary burden and increase efficiency in the health care system, removing these particular Star Rating measures risks opening the MA program to further abuses, such as the inappropriate denial of medically necessary services and the blocking of member and provider appeal rights. CMS should maintain these measures to ensure that Star Ratings accurately reflect plan performance and behavior and provide meaningful transparency for beneficiaries and providers alike.

Thank you for your consideration. If you have any questions, please contact Michelle K. Millerick, vice president, policy, at mmillerick@calhospital.org.

Sincerely,

/s/

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California Hospital Association