National Rural Health Association

January 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

RE: CMS-4208-P; Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan.

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the Contract Year (CY) 2027 Medicare Advantage (MA) Policy and Technical Changes proposed rule. As MA enrollment continues to grow in rural communities, it is important that program policies appropriately reflect rural care delivery patterns, administrative capacity, and beneficiary access considerations.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Background

The popularity of Medicare Advantage (MA) plans as an alternative to Traditional Medicare has grown significantly in recent years. Both rural and urban areas have seen MA enrollment become a larger fraction of total Medicare enrollment in the past decade, yet rural beneficiaries have increasingly chosen MA plans over Traditional Medicare with the recent rate of MA growth in nonmetropolitan counties higher than metropolitan counties.[1] Approximately 48% of all rural beneficiaries are enrolled in an MA plan and current trends point to MA plans enrolling a majority of rural beneficiaries in the next year.[2]

The growth of MA enrollment across the country underscores the importance of transparency, clarity, and consistency in MA for rural beneficiaries and providers. NRHA members have increasingly voiced their frustrations and concerns with MA plans and how these issues affect their beneficiaries' access to care. Rural beneficiaries already face access challenges given the unique characteristics of rural areas, and MA plan practices cannot continue to compound such barriers to care.

[1] Fred Ullrich & Keith Mueller, Medicare Advantage Enrollment Update 2024, RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health (Jan. 2025) https://rupri.org/2025/01/31/rupri-center-for-rural-health-policy-analysis-releases-medicare-advantage-enrollment-update-for-2024-january-2025.
[2] *Id.*

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II. Implementation of Certain Provisions of the Inflation Reduction Act of 2022.

A. Medicare Part D Redesign.

NRHA acknowledges CMS's proposal to codify Inflation Reduction Act–related changes to the Medicare Part D benefit, including updates to the deductible, elimination of the coverage gap, modifications to the annual out-of-pocket threshold, and transition to the Manufacturer Discount Program. Predictable and affordable prescription drug coverage is particularly important for rural beneficiaries, who may face additional barriers related to pharmacy access, income levers, transportation, and limited provider availability.

However, as these changes are implemented, NRHA encourages CMS to continue monitoring how Part D redesign interacts with MA utilization management practices. **Rural providers report that beneficiaries often lack clear understanding of coverage differences between Traditional Medicare and MA, particularly related to prior authorization requirements, cost-sharing obligations, and coverage limitations.** Improved transparency and beneficiary education may help mitigate confusion and administrative complexity at the point of care as new benefit structures take effect.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes)

A. Special Enrollment Period for Provider Terminations (§422.62(b)(23))

NRHA supports CMS's proposal to establish a Special Enrollment Period allowing beneficiaries to switch MA plans when a contracted provider leaves a plan's network, without requiring CMS to determine whether the network change is "significant." This policy is particularly relevant for rural beneficiaries, who may rely on a limited number of local providers or facilities. Allowing beneficiaries flexibility to respond to network changes may help mitigate access disruptions and support continuity of care.

NRHA notes, however, that network instability may be compounded by delayed payments, retrospective audits, and post-payment recoupments, which can discourage provider participation in MA networks. Greater clarity regarding payment timeliness standards and limitations on post-payment recoupment practices may help support network stability, particularly for critical access hospitals.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings).

B. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184).

NRHA recognizes CMS' ongoing efforts to ensure that MA plans provide high-quality care to enrollees and to maintain a quality measurement framework that supports beneficiary choice. Since the introduction of the MA Star Ratings system in 2006, CMS has expanded quality measurement to include clinical quality, administrative performance, and patient experience. Over time, Star Ratings performance may be influenced by measure inflation and temporary policy adjustments rather than

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sustained improvements in quality care.[3] Under flexibilities implemented during the COVID-19 public health emergency (PHE), CMS relaxed quality reporting requirements, resulting in an increase in the average MA Star Rating from 4.06 in 2021 to 4.37 in 2022.[1] Following the reversion to standard measurement rules, the average Star Rating declined to 3.95 in 2025, and the share of enrollees in 5-star plans fell from 27 percent in 2022 to 3 percent in 2025, returning closer to pre-PHE levels.[1]

Similarly, while a substantial share of MA contracts continues to receive quality bonuses, that share has declined in recent years. In 2025, 41 percent of rated MA contracts qualified for bonus status, down from 44 percent in 2024 and 51 percent in 2023, with 69 percent of MA enrollees enrolled in bonus-status contracts. [1] These trends highlight the importance of ongoing evaluation of measure selection, weighting, and reporting burden to ensure that Star Ratings remain meaningful, stable, and reflective of true performance differences.

NRHA supports CMS' proposal to remove low-variation administrative measures and refocus the Star Ratings system on clinical outcomes and patient experience. Continued refinement of this program may help improve interpretability for beneficiaries, reduce unnecessary reporting burden for plans and providers, and better align quality incentives with care delivery realities, including those in rural settings. NRHA also encourages continued consideration of how revised measures and weighting methodologies interact with rural delivery contexts, where access constraints, workforce shortages, and lower encounter frequency may influence performance on certain outcome-based measures.

NRHA further notes interest in whether **future modernization of quality measurement could better align incentives across value-based programs, including accountable care models, to reduce administrative complexity and promote consistency.**

Conversely, NRHA is **concerned about the proposed removal of the following Star Ratings measures:** Plan Makes Timely Decisions about Appeals; Complaints about Health/Drug Plan; Medicare Plan Finder Price Accuracy; Members Choosing to Leave the Plan; and Customer Service. **These measures are key indicators in the enrollee experience with the plan and are important factors both for consideration by individuals when selecting a health plan, as well as for CMS to ensure overall quality of plans being provided to our rural seniors.** In particular, our providers noted that "Members Choosing to Leave The Plan" is an important indicator for dissatisfaction with the plan or predatory enrollment by another plan. This measure can also demonstrate patient "churn", which can cause significant disruption and delays in patient care and provider reimbursement.

Additionally, our providers **have concerns about the removal of the following measures:** Diabetes Care – Eye Exam and Statin Therapy for Patients with Cardiovascular Disease. Providers stated that both of these measures are critical indicators for quality of care and quality of life for rural patients with chronic conditions.

[3] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Chapter 11: The Medicare Advantage Program—Status Report. Washington, DC: MedPAC; March 2025:370-371. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

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VII. Reducing Regulatory Burden and Costs in Accordance With Executive Order (E.O.) 14192.

F. Rescinding the Quality Improvement Program Health Disparities Requirement (§ 422.152(a)(5)).

NRHA acknowledges CMS's proposal to rescind the requirement that MA organizations incorporate at least one activity to reduce health and health care disparities within their Quality Improvement (QI) programs. CMS states that removing this requirement reduces administrative burden, maintains flexibility for MA organizations, and aligns QI program requirements with current statutory direction. NRHA recognizes CMS's intent to streamline regulatory requirements while preserving plan discretion. As this requirement is rescinded, NRHA **encourages continued monitoring to ensure that QI activities remain responsive to variation in health outcomes and access, including in rural communities** that experience persistent workforce and infrastructure constraints.

Requests for Information (RFIs):

Future Directions in Medicare Advantage.

1. Risk Adjustment, Payment Adequacy, and Rural Provider Sustainability

NRHA appreciates CMS's request for information on future directions in MA, including potential changes to risk adjustment, quality bonus payments, benefit design, and data transparency. Rural stakeholders have raised concerns that current risk adjustment methodologies may be overly sensitive to coding intensity rather than underlying health status, with downstream effects on payment accuracy and provider reimbursement.

Recent research raises important considerations regarding whether Hierarchical Condition Category (HCC) risk scores accurately reflect health status across rural and urban populations. A 2025 analysis found that rural Medicare fee-for-service beneficiaries consistently have lower HCC risk scores than their urban counterparts, despite experiencing higher mortality rates and a greater burden of chronic disease. The study attributes these differences not to better health among rural beneficiaries, but to structural factors such as reduced access to care, fewer evaluation and management encounters, and differences in coding intensity. As a result, **HCC scores may underrepresent the health complexity of rural beneficiaries, therefore NRHA encourages CMS to explore approaches that rely on adjudicated claims data rather than preliminary submissions for risk adjustments and to consider how rural-specific challenges and encounter frequency in rural areas may risk scores.** CMS should also consider alternative indicators, such as claims-based frailty indices or other measures of health complexity, that could help ensure that payment models more accurately reflect rural beneficiary needs and do not inadvertently disadvantage rural providers or plans serving high-need populations.

Additionally, much attention has been given to MA plans' "upcoding" practices, or coding more intensely, for plan payment purposes while applying downcoding, lower diagnosis-related groups, or restrictive medical necessity criteria when approving claims and reimbursing providers. Greater transparency regarding how risk adjustment interacts with provider payment methodologies and utilization management practices could support improved consistency, accountability, and program integrity across the MA program.

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2. Benefit Design and Cost-Sharing for Mental Health and Substance Use Disorder Services in Rural Communities

NRHA also urges CMS to consider benefit design reforms in relation to mental health (MH) and substance use disorder (SUD) cost-sharing as part of future MA policy development. Access to affordable MH and SUD services is essential to beneficiary wellbeing and chronic disease management. These services are especially critical in rural communities where provider availability is limited and disruptions in care can have significant downstream impacts on health outcomes.

As CMS noted in the CY 2026 MA proposed rule, beneficiaries in Traditional Medicare generally pay 20 percent coinsurance for services, with zero cost-sharing for opioid treatment program (OTP) services, while MA enrollees may face coinsurance of up to 50 percent for the same MH and SUD services. CMS data show that approximately one in four MA plans impose higher cost-sharing for MH specialty and psychiatric services than Traditional Medicare, and more than two in five MA plans impose higher cost-sharing for outpatient SUD services. These differences translate into meaningful financial burdens for rural beneficiaries and may discourage care initiation or continuity.

For rural beneficiaries, higher cost-sharing compounds existing access barriers, including longer travel distances, fewer in-network providers, and limited availability of specialty behavioral health services. NRHA is particularly concerned that elevated cost-sharing for SUD services, especially OTP services, which often require frequent or daily attendance, may effectively place treatment out of reach for rural beneficiaries. CMS has indicated that 71 percent of MA plans have higher cost-sharing for OTP services than Traditional Medicare, resulting in substantial out-of-pocket costs that can accumulate into thousands of dollars annually.

NRHA also calls attention to the fact that when rural Medicare beneficiaries with MH and SUD conditions seek services and treatment programs, they are often forced to weigh more affordable access to behavioral health services under Traditional Medicare against the supplemental benefits offered through MA plans. This tradeoff is especially problematic in rural areas, where continuity of MH and SUD care is critical and service disruptions can lead to avoidable hospitalizations, emergency department use, or worsening health outcomes. As CMS evaluates future MA benefit design, **NRHA encourages the agency to prioritize alignment of MA and Cost Plan cost-sharing for MH and SUD services with Traditional Medicare.**

3. Apply Substance Use Disorder and Mental Health Parity Protections to MA and Part D Plans and Remove Barriers to Treatment in Rural Communities

NRHA urges CMS to strengthen parity protections for SUD and MH services within MA and Part D, particularly given the persistent access barriers faced by rural Medicare beneficiaries. As demonstrated by stakeholder experience and available data, MA and Part D plan policies continue to disproportionately impede access to SUD and MH care relative to medical and surgical services.

Congress enacted the bipartisan Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 to prevent discriminatory benefit design and utilization management practices in private insurance. However, Medicare is not currently subject to MHPAEA, leaving many beneficiaries particularly those

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in rural and underserved communities without comparable protections. To the extent feasible under existing statutory authority, **NRHA encourages CMS to advance greater parity between SUD and MH coverage and medical/surgical coverage in MA and Part D, including with respect to cost-sharing, utilization management, and benefit design.**

Even absent congressional action, CMS has meaningful opportunity to improve access to SUD and MH care by removing unnecessary treatment limitations. **NRHA strongly encourages CMS to require MA and Part D plans to eliminate barriers such as cost-sharing, prior authorization, step therapy, and dosage or quantity limits for medications for opioid use disorder (MOUD).** These restrictions deter timely access to evidence-based treatment and are particularly harmful in rural areas, where provider shortages, limited pharmacy access, and transportation barriers already constrain care.

These utilization management practices contribute to persistently low rates of MOUD use among Medicare beneficiaries with opioid use disorder, with fewer than one in five receiving this gold-standard treatment. Rural providers report that repeated authorization requirements and restrictive dosing limits disrupt continuity of care and create administrative burdens that further limit treatment access. Removing these barriers would support CMS's goals of improving health outcomes, reducing preventable utilization, and ensuring more consistent access to SUD and MH care for rural Medicare beneficiaries.

NRHA strongly recommends that CMS take all available administrative and regulatory actions to remove barriers to MOUD and other SUD and MH treatments in MA and Part D, while continuing to work with Congress toward broader parity protections within the Medicare program.

4. Payment Adequacy and Financial Reconciliation Challenges for Rural Hospitals Participating in MA

NRHA notes stakeholders' concerns regarding payment adequacy and financial reconciliation for rural hospitals participating in MA. Rural providers, including critical access hospitals, report that they often accept MA payment rates comparable to Traditional Medicare in good faith. However, unlike Traditional Medicare, MA payment structures do not include cost report reconciliation mechanisms to account for rising operational costs. As a result, when costs increase, rural hospitals lack an avenue to reconcile underpayments for services already rendered. Providers further report an increase in unpaid beneficiary balances associated with MA plans, without access to Medicare bad debt reimbursement available under Traditional Medicare. Despite offering financial assistance as appropriate, rural hospitals are absorbing growing levels of uncompensated care related to MA cost-sharing obligations. These experiences suggest a need for **greater transparency regarding beneficiary fiscal responsibility under MA plans and consideration of how payment and benefit design interact with rural provider sustainability.**

Other common payment issues are timeliness and denials. Even when a rural provider receives payment equivalent to their Traditional Medicare rate, getting timely payments is difficult. For example, when a provider bills for a service, a plan may deny the claim after the beneficiary received the service despite previously receiving prior authorization which is used to determine medical necessity. NRHA members note that this happens most often for inpatient stays. In other cases, MA

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plans delay payment or make the process of getting paid the correct amount so time consuming and burdensome that rural providers do not have adequate staff, time, or resources to address every payment issue or to pursue timely and accurate payment. In extreme circumstances, NRHA members have noted up to $800,000 in delayed or denied payments. For rural hospitals that operate with thin or negative margins, delayed payments are a critical cash flow issue. Half of rural hospitals operate on negative margins, and they cannot absorb this level of untimely payments.[4] Furthermore, administrators are frustrated with untimely payments because it is difficult to operate and plan without predictable payments from a growing number of their patients.

Often rural providers disagree with the decision of the MA plan but have difficulty getting a peer-to-peer scheduled timely either because they do not receive a call back or because the MA plan says they have no availability for several days. Per CMS, rural providers cannot bill as "Observation" unless there is an "Observation" order so if they do not receive a level of care decision from the MA plan until the day of discharge or after. Rural providers are stuck not being able to bill as "Inpatient" or "Observation". In addition, this is having the MA plan to dictate care as opposed to the clinicians that lay hands on the patients.

As the ultimate payer of MA plans, **CMS must use its authority to ensure that MA plans are properly using federal funds when paying rural providers.** MA regulations state that contracts between CMS and MA plans must include a provision mandating that the plan will pay 95% of "clean claims" within 30 days of receipt.[5] MA regulations further provide the definition of a clean claim.[6] CMS must enforce this provision and investigate whether plans are meeting the 95% threshold and if they are determining correctly whether claims are clean. MA plans must not be permitted to delay and deny payments that are properly prepared with substantiating documentation by alleging that the claim is not "clean" and therefore cannot be paid within 30 days. **Traditional Medicare must pay providers within 30 days and MA plans must be held to the same standard. CMS should also mandate reporting by MA plans on the rate of timely payments to providers and make this information publicly available for providers.**

Even after payments are made to providers, plans will perform post-audits. NRHA members have experienced audits by MA plans that probe back as far as 4 years in an effort to recoup payments. MA plans should not have unmitigated authority to perform audits that go back years. Providers are subject to billing deadlines and similarly, MA plans should be subject to look back period restrictions for auditing payments.

Simplifying Network Adequacy Reviews.

NRHA supports CMS's interest in simplifying network adequacy reviews and reexamining time-and-distance standards, particularly as they apply to rural communities. Rural providers note that existing

[4] Michael Topchik, et al., Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory, Chartis (2024), 2, https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.
[5] 7§ 422.520(a)(1).
[6] § 422.500(b).

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standards, such as allowing travel distances of up to 60 miles, may not adequately reflect the role of rural hospitals as central access points for a broad range of services.
Network adequacy challenges are especially pronounced in behavioral health, where limited provider availability, inactive directory listings, and narrow networks can significantly restrict access. CMS's consideration of alternative approaches presents an opportunity to improve the accuracy of provider directories and ensure that network adequacy standards meaningfully reflect beneficiary access rather than nominal provider inclusion.

NRHA members are reporting that some MA beneficiaries do not realize that they are enrolled in an MA plan as opposed to Traditional Medicare. Oftentimes beneficiaries discover their new coverage by receiving an unexpected bill from the provider. In other instances, beneficiaries belatedly realize that they cannot see their usual provider because they are no longer in-network.

While MA plans may meet the health needs of some beneficiaries, **those who were inadvertently enrolled in an MA plan or enrolled without understanding the implications to their coverage should be able to transition back to Traditional Medicare.** It is possible for beneficiaries to change plans during open enrollment, but there are barriers to doing so. One major roadblock is cost. One typical reason that beneficiaries choose MA plans is because out-of-pocket costs are lower without having to buy a supplement, or Medigap, plan. MA plans typically cover premiums, but Traditional Medicare does not do so without the beneficiary purchasing a Medigap plan. Beneficiaries that want to switch to Traditional Medicare must be underwritten for a Medigap policy and beneficiaries may be denied a policy if they do not meet medical underwriting requirements.

Beneficiaries who enroll in MA plans, particularly those who switch from Traditional Medicare, may not realize that their provider access has shrunk. Beneficiaries in Traditional Medicare can see any provider and use any facility that accepts Medicare. One tradeoff for an MA plan is that beneficiaries can only see in-network providers. NRHA acknowledges the network adequacy parameters that MA plans must meet to ensure beneficiaries have access to providers within certain time and distance standards. The problem arises when beneficiaries must find new providers because their existing provider is now out-of-network in their new MA plan. Additionally, even though plans must contract with providers to meet network adequacy rules, this does not guarantee that rural beneficiaries are able to see their closest or local provider.

Increasingly, hospitals and health systems are considering dropping all contracts with MA plans because they can no longer deal with the complexities and administrative burden of MA plans. Unfortunately, this leads to restrictions on access to care for beneficiaries who cannot afford out-of-network services when their local hospital is no longer contracted with their MA plan. Rural MA beneficiaries face difficult choices of forgoing care, traveling further for care, or paying out-of-network costs.[7] For example, 21 hospitals in Kansas do not have any MA contracts, and a recent survey revealed that 31% of Kansas hospitals with contracts are considering dropping them. Qualitative results from this survey reveal a common theme across hospitals: Rural hospitals do not want to add new MA contracts due to unfavorable reimbursement and time-consuming administrative processes

[7] Gretchen Morgenson, 'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, says CEOs, NBC NEWS, Oct. 31, 2023, https://www.nbcnews.com/health/rejecting-claimsmedicare-advantage-rural-hospitals-rcna121012.

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(both related to prior authorization and payment) or are considering termination of existing contracts. Rural hospitals that are not considering termination feel stuck because they want to retain access to care for their communities, and penetration is too high not to contract with the plans. Hospitals also indicated that they had longstanding contracts with MA plans before enrollment grew substantially, and they did not face the prior authorization and payment issues that exist today before MA became a significant portion of the market.

Reducing Reporting Burden.

Rural providers report increasing requests for medical records and large-volume data submissions for audit or review purposes from MA organizations that may not directly support beneficiary care or program integrity. These requests require significant staff time, and providers may not always have clarity regarding which data submissions are mandatory versus discretionary. **Greater standardization and transparency regarding reporting expectations may help reduce unnecessary administrative burden while preserving CMS's oversight objectives.**

Benefit and Supplemental Benefit Usage and Utilization Data Reporting.

NRHA recognizes CMS's interest in benefit and supplemental benefit utilization data and notes particular stakeholder interest in nutrition-related benefits and preventive services. Rural providers observe that MA organizations frequently offer meal delivery and nutrition supports; however, verification of need, referral pathways, and reimbursement for associated care coordination services like social work involvement, remain inconsistent. Consideration of how supplemental benefits are operationalized and sustained in rural settings may help inform beneficiary plan selection and program effectiveness.

Providers noted that lack of transportation and lack of access to grocery stores and fresh foods remains a significant barrier in their communities. Our members noted that many rural facilities, especially rural hospitals, attempt to address these needs for the members of their communities, however, without reimbursement, these programs are often unable to meet the needs of population or are unsustainable long-term. **Direct reimbursement to facilities to support nutrition and transportation services would allow rural providers to establish sustainable programs.**

Special Needs Plans (SNPs): Model of Care and Enrollment Growth in C-SNPs and I-SNPs.

NRHA appreciates CMS's request for information on enrollment growth among dually eligible individuals in Chronic Condition SNPs (C-SNPs) and Institutional SNPs (I-SNPs), as well as requirements related to SNP Models of Care. In rural markets, enrollment patterns may reflect plan availability rather than beneficiary preference or clinical appropriateness. **Consideration of rural market dynamics and provider capacity may help inform future policy development related to care coordination and plan oversight.**

NRHA thanks CMS for the opportunity to submit comments on this proposed rule. We look forward to our continued work together. If you have any questions or would like to discuss our response further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,

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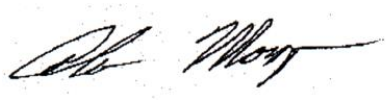

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