NATIONAL HEALTH COUNCIL

January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Contract Year 2026 Policy and Technical Changes to Medicare Advantage, Medicare Prescription Drug Benefit, Medicare Cost Plan, and PACE Programs (CMS-4208-P)

Submitted electronically via regulations.gov

Dear Acting Administrator Wu,

The National Health Council (NHC) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for *Contract Year 2026 Policy and Technical Changes to Medicare Advantage (MA), Medicare Prescription Drug Benefit (Part D), Medicare Cost Plan, and Programs of All-Inclusive Care for the Elderly (PACE)*. We commend CMS for its commitment to enhancing access, equity, and transparency in these critical programs.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

Overarching Comments and Recommendations

The NHC supports CMS' efforts to address systemic challenges in MA and Part D programs, particularly in areas like prior authorization, behavioral health access, access to innovative treatments, and patient protections against misleading marketing practices. These proposals, if implemented effectively, have the potential to significantly improve the experiences of beneficiaries with chronic diseases and disabilities.

However, the scope and complexity of the proposed rule may present implementation challenges. To facilitate a smooth transition, we urge CMS to:

- Provide clear, stakeholder-specific guidance tailored to plans, providers, and patient organizations.
- Host targeted educational sessions to ensure stakeholders understand the operational and clinical implications of the proposed changes.
- Phase in particularly complex provisions to allow adequate time for implementation and monitoring of their impact on beneficiaries.

While addressing specific issues, the success of these reforms also requires a consistent emphasis on robust education, outreach, and monitoring. Ensuring all stakeholders have the tools, knowledge, and feedback mechanisms to adapt effectively will be key to realizing the full potential of these changes. Below, we provide detailed comments and recommendations on key provisions of the proposed rule.

Coverage of Anti-Obesity Medications (AOMs)

The NHC applauds CMS for aligning with the medical community and proposing to recognize obesity as a chronic disease and allow Medicare Part D coverage for AOMs. This reinterpretation of the statutory exclusion of weight-loss agents represents a pivotal shift in health care policy, aligning with the growing medical consensus that obesity is a chronic disease requiring treatment.[1] Obesity is a multifaceted condition influenced by biological, environmental, and social determinants of health.[2] Effective management requires a comprehensive approach. AOMs are already covered under various other insurance programs, including the Federal Employees Health Benefits Program, Medicaid, the Department of Veterans Affairs, TRICARE, commercial insurance plans, and state employee health plans. Expanding Medicare coverage would align it with these existing standards and address a critical gap in care by creating a pathway for millions of Medicare beneficiaries to access evidence-based treatments that can significantly improve health outcomes, reduce comorbidities, and enhance overall quality of life.[3,4, 5]

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[1] Theodore K. Kyle et al., "Regarding Obesity as a Disease: Evolving Policies and Their Implications," *Endocrinology and Metabolism Clinics of North America* 45, no. 3 (2016): 511–520, published in final edited form September 2016, https://doi.org/10.1016/j.ecl.2016.04.004.

[2] Andrew S. Baez et al., "Social Determinants of Health, Health Disparities, and Adiposity," *Progress in Cardiovascular Diseases* 78 (2023): 17–26, published in final edited form May 11, 2023, https://doi.org/10.1016/j.pcad.2023.04.011.

[3] National Health Council. Weight Management and Health for People Living with Chronic Conditions. Research Series Issue 4. October 2023. https://nationalhealthcouncil.org/research-briefs/weight-management-and-health-for-people-living-with-chronic-conditions/

[4] MAPRx. Clinical Evidence Driving Patient Access in Medicare Part D: Case Study for Improving Obesity Coverage. 2022. https://maprx.info/wp-content/uploads/2022/09/MAPRx-Clinical-Evidence-Driving-Patient-Access-Obesity.pdf.

As such, the NHC supports CMS' proposal to ensure that Part D sponsors cover AOMs for obesity with clinical criteria that is not more restrictive than the FDA labeling for each AOM. We also encourage CMS to refer to clinical practice guidelines to inform review of Part D plan-submitted prior authorization criteria for clinical appropriateness and protect against inappropriate access limitations for Part D beneficiaries.

To strengthen the proposal, the NHC recommends that CMS avoid implementing rigid definitions of "overweight" and "obese." Instead, CMS should review Part D plan prior authorization criteria to ensure that plan definitions align with treatment guidelines and ICD-10 diagnosis codes, promoting consistency and alignment among providers and payers. While the NHC does not endorse specific numerical thresholds, aligning with these guidelines would help ensure that prior authorization processes evolve with the latest evidence and clinical best practices, supporting fair, effective implementation and enabling stakeholders to navigate this important policy change with confidence.

The NHC recognizes that Medicare already covers AOMs for patients who are overweight and have comorbid conditions such as diabetes or cardiovascular disease. However, we urge CMS to consider broadening eligibility criteria to include individuals who are overweight but have not yet developed these conditions. Expanding coverage to at-risk populations aligns with preventive care principles, helps reduce the progression of obesity-related conditions, and alleviates the long-term burden on the health care system.[6] Such an expansion would also address disparities in access to care, particularly among vulnerable populations that face systemic barriers to treatment.[7]

The success of this policy hinges on robust education and outreach efforts to ensure awareness among both patients and providers. The NHC encourages CMS to develop accessible, culturally competent educational materials tailored to diverse beneficiary populations. These materials should emphasize the importance of AOMs as part of a comprehensive, multidisciplinary approach to obesity management, including lifestyle interventions. Additionally, education should highlight the interactions between obesity and other diseases, ensuring that providers consider multiple contributing factors rather than solely attributing health issues to obesity.[8] Equally important is provider education to combat the stigma often associated with obesity and equip health care professionals

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[5] Centers for Disease Control and Prevention. "Consequences of Obesity," last reviewed May 15, 2023, https://www.cdc.gov/obesity/basics/consequences.html

[6] Libbi Green and Patty Taddei-Allen, "Shifting Paradigms: Reframing Coverage of Antiobesity Medications for Plan Sponsors," Journal of Managed Care & Specialty Pharmacy 29, no. 5 (May 2023): 564, https://doi.org/10.18553/jmcp.2023.29.5.564.

[7] Tiffani Bell Washington et al., "Disparities in Access and Quality of Obesity Care," Gastroenterology Clinics of North America 52, no. 2 (April 7, 2023): 429–41, https://doi.org/10.1016/j.gtc.2023.02.003.

[8] National Health Council, *Weight Management and Health*

with tools to have compassionate, informed conversations with their patients about treatment options. Addressing stigma is critical to fostering a supportive care environment that encourages patients to seek and adhere to treatment.[9]

To ensure accountability and continuous improvement, the NHC recommends that CMS establish patient-centric metrics to evaluate the impact of expanded AOM coverage. Key indicators of successful implementation could include reductions in obesity-related comorbidities, improvements in quality of life, medication adherence rates, and health care cost savings in addition to other patient-reported outcomes. Analysis of these metrics can provide valuable data to guide future refinements of the policy and demonstrate its long-term effectiveness.

Additionally, the NHC underscores the importance of leveraging findings from health care economic evaluations as a tool to help validate the cost-effectiveness of AOMs. For example, one U.S.-based organization – the Institute for Clinical and Economic Review (ICER) – recently recognized AOMs as cost-effective and reasonably priced.[10] This recognition represents a pivotal step in the broader acceptance of AOMs among the health economics community. CMS' proposal aligns with this growing evidence base, which is a first step in demonstrating a commitment to patient-centered policy that supports equitable access to proven treatments.

Lastly, the NHC recommends that CMS carefully evaluate the regulatory and financial implications of expanding AOM coverage, with a focus on avoiding any unintended consequences that could impede patient access. While we strongly support expanding coverage to improve access to critical treatments, it is crucial to ensure the policy is implemented in a way that does not create disparities between Medicare and Medicaid beneficiaries. A timely and comprehensive evaluation of both programs will help ensure that the expansion is financially sustainable, minimizes inefficiencies, and maintains consistent access, all while enabling beneficiaries to promptly access the treatments they need.

By adopting these recommendations, CMS can amplify the transformative potential of its proposal, ensuring that Medicare beneficiaries living with obesity have equitable access to life-changing treatments. The NHC applauds CMS for taking this bold and necessary step to address one of the nation's most pressing health challenges. Through expanded eligibility, robust education initiatives, and data-driven evaluation, this policy can serve as a catalyst for better health outcomes, reduced disparities, and a higher quality of life for millions of Americans living with obesity.

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[9] Susannah Westbury et al., "Obesity Stigma: Causes, Consequences, and Potential Solutions," Current Obesity Reports 12, no. 1 (February 14, 2023): 10–23, https://doi.org/10.1007/s13679-023-00495-3.

[10] Institute for Clinical and Economic Review, *Assessment of Barriers to Fair Access Report*, 2024, https://icer.org/wp-content/uploads/2024/12/2024-Barriers-to-Fair-Access-Final-Report-121924.pdf.

Prior Authorization and Utilization Management

The NHC appreciates recent regulatory changes implemented by CMS to enhance prior authorization processes and increase transparency in utilization management. While prior authorization has proven effective for managing costs by ensuring medical necessity and reducing overutilization of unnecessary care, when inappropriately implemented, it can lead to delays in care and additional burdens for patients and providers, which in turn may increase overall health care expenses.[11,12,13,14] The NHC values CMS' continued efforts to refine these processes; by addressing these challenges and ensuring that prior authorization is appropriately implemented, CMS is taking important steps toward promoting patient-centered care that maintains the balance between cost control and timely access to necessary treatments.

The NHC welcomes CMS' proposal to clarify the application of internal coverage criteria by requiring alignment with Traditional Medicare when no other criteria exist. This reform is essential for reducing inconsistencies in coverage determinations, ensuring equitable access to care regardless of the plan a beneficiary is enrolled in. The NHC and its member organizations have long advocated for consistent standards across MA and Traditional Medicare to reduce confusion for patients and providers. CMS' action aligns with these priorities and represents a meaningful step toward uniformity in coverage decisions.[15]

The requirement for MA plans to publicly disclose their internal coverage policies is another significant advancement. Transparency empowers patients and providers with the information needed to navigate prior authorization processes more effectively, reducing frustration and inefficiencies. This proposal reflects the NHC's longstanding position that patients must have access to clear, understandable, and actionable information about their health benefits to make informed decisions about their care.[16]

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[11] American Medical Association, *2022 AMA Prior Authorization (PA) Physician Survey* (2023), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[12] Mark Kyle and Natalie Keating, "Prior Authorization and Association with Delayed or Discontinued Prescription Fills," *Journal of Clinical Oncology* 42, no. 8 (2023), https://doi.org/10.1200/JCO.23.01693.

[13] American Medical Association, "Prior Authorization Delays Care and Increases Health Care Costs," accessed January 2, 2025, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.

[14] National Health Council. *NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease.* November 2023. https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf.

[15] National Health Council*, NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease.*

Additionally, the NHC supports CMS' proposal to require MA plans to notify enrollees of their appeal rights and address after-the-fact overturns that create payment issues for providers and patients. Historically, lack of awareness about appeal rights has left many patients without recourse when their care was delayed or denied.[17] Ensuring that enrollees are informed of their rights and that plans are held accountable for their coverage decisions is essential to safeguarding patient access and promoting trust in the system.

The introduction of enhanced data collection to monitor decision rationales and appeals at the plan level is a critical step toward fostering continuous improvement in utilization management practices. These data will enable stakeholders to identify systemic issues and advocate for reforms that address persistent barriers to care. The NHC has consistently called for greater accountability and transparency in the collection and reporting of data related to health care access, as such efforts can illuminate inequities and inefficiencies in the system.[18]

While these proposed changes represent significant progress, the NHC urges CMS to adopt additional measures to further strengthen these reforms. First, CMS should mandate real-time decision-making for urgent services to minimize delays in patient care. Delays in urgent care can lead to adverse outcomes, particularly for individuals with chronic diseases and disabilities—a concern repeatedly raised by NHC member organizations.[19,20,21,22] Similarly, CMS should accelerate the adoption of electronic prior authorization systems and other technological solutions to streamline decision-making

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[16] National Health Council. NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease. November 2023. https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf.

[17] Tanya Albert Henry, "Over 80% of Prior Auth Appeals Succeed. Why Aren't There More?" *American Medical Association*, October 3, 2024, https://www.ama-assn.org/practice-management/prior-authorization/over-80-prior-auth-appeals-succeed-why-aren-t-there-more.

[18] National Health Council. Policy Recommendations for Reducing Health Care Costs. September 2021. https://nationalhealthcouncil.org/wp-content/uploads/2021/09/NHC-Health-Care-Costs-2021-Recommendations.pdf.

[19] National Health Council, *National Health Council 2024 Public Policy Issue Areas Survey* (internal survey, Policy & Government Affairs, 2023).

[20] National Health Council, *National Health Council 2023 Public Policy Issue Areas Survey* (internal survey, Policy & Government Affairs, 2022).

[21] National Health Council, *National Health Council 2022 Public Policy Issue Areas Survey* (internal survey, Policy & Government Affairs, 2021).

[22] National Health Council, *National Health Council 2021 Public Policy Issue Areas Survey* (internal survey, Policy & Government Affairs, 2020).

for critical but not urgent cases. Faster resolution of these cases can reduce administrative burden, improve patient outcomes, and foster greater trust in the prior authorization process.[23]

Second, the NHC encourages CMS to establish robust oversight and enforcement mechanisms to ensure compliance with the new transparency and prior authorization requirements. Without consistent enforcement, these reforms risk becoming ineffective in practice, leaving patients and providers vulnerable to continued administrative challenges.

Lastly, the NHC recommends that CMS publish data on appeals, overturns, and prior authorization outcomes on a regular basis. Publicly available data will enable stakeholders to assess system performance, identify trends, and recommend further improvements. Transparency in these areas is crucial for driving accountability and fostering a learning health system that continuously evolves to meet the needs of patients.

The NHC believes these enhancements will amplify the impact of CMS' proposed reforms, reducing administrative burdens, promoting equity, and ensuring that Medicare beneficiaries receive the care they need when they need it. By adopting these additional measures, CMS can further solidify its commitment to patient-centered care and systemic improvement.

Artificial Intelligence (AI) Guardrails

The NHC applauds CMS for its proactive efforts to ensure equitable and unbiased application of AI in MA plans. As AI technologies increasingly permeate the health care landscape, safeguarding against unintended consequences and promoting equity, transparency, and patient-centricity is essential.[24,25,26]

AI holds immense potential to transform care delivery by improving diagnostic accuracy and streamlining administrative functions. Recognizing both the opportunities and challenges posed by AI, the NHC is currently developing Principles on Health AI

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[23] Kaushik Bhaumik et al., "How Electronic Prior Authorizations Can Benefit Stakeholders," EY, March 23, 2023, https://www.ey.com/en_us/health/how-electronic-prior-authorizations-can-benefit-stakeholders.

[24] Daniel Yang, "AI in Health Care: 7 Principles of Responsible Use." Kaiser Permanente, August 19, 2024. https://about.kaiserpermanente.org/news/ai-in-health-care-7-principles-of-responsible-use.

[25] Laura Adams et al., *Artificial Intelligence in Health, Health Care, and Biomedical Science: An AI Code of Conduct Framework Principles and Commitments Discussion Draft, NAM Perspectives* (Washington, DC: National Academy of Medicine, 2024).

[26] The Light Collective, Digital Public, and Experts and Community Leaders. *Collective AI Rights for Patients* (2024), https://lightcollective.org/wp-content/uploads/2024/06/Collective-AI-Rights-For-Patients-v_2.0.pdf.

through its Special Committee on AI—a coalition of patient advocates, health care leaders, and experts committed to advancing patient-centered health solutions. This collaborative effort draws from diverse perspectives across the health care spectrum, ensuring AI technologies are designed, implemented, and continually refined with transparency, equity, and safety at the forefront. These principles aim to foster trust, empower patients, and align the rapid evolution of AI in health care with the needs and priorities of patients and their caregivers.

CMS' proposed requirements for MA plans to ensure that AI systems comply with existing nondiscrimination standards and provide equitable access to care are significant steps in the right direction.

To build on these efforts, the NHC urges CMS to adopt additional measures aligned with the principles that are beginning to take shape in the NHC's evolving framework on Health AI:

- **Human Oversight of AI Outcomes:** It is critical that AI-driven decisions in clinical and administrative settings are subject to human review, particularly for high-stakes outcomes affecting access to care or treatment plans. Incorporating human oversight ensures that nuanced, patient-specific factors that may not be captured by AI systems are considered. A hybrid model that combines AI's efficiency with human judgment will help safeguard against errors and biases while fostering trust in AI applications.
- **Comprehensive Transparency:** AI applications should be fully disclosed, explainable, and accessible to patients and providers in layperson terms. This includes clear communication about how AI tools are used in clinical and administrative decisions. Transparency fosters trust and empowers patients and providers to actively participate in care decisions.
- **Bias Mitigation and Equity:** AI systems must draw on representative, reliable data to minimize bias and avoid perpetuating existing health disparities. The NHC supports continuous monitoring and reporting on the performance of AI tools, particularly their impact on populations at risk of health inequities, as outlined in the principles of Equity and Accessibility and Bias Mitigation.
- **Patient-Centered Design:** Early and ongoing patient input should guide the development and implementation of AI systems to ensure they meet diverse patient needs. This aligns with the principle of Patient-Centered and Informed Design, emphasizing the importance of engaging patients at every stage of AI integration.
- **Accountability:** CMS should ensure that developers and operators of AI tools are accountable for their outcomes, including addressing errors, biases, or harmful effects associated with AI applications. This principle of Accountability reinforces the need for clear oversight mechanisms.
- **Continuous Improvement:** AI technologies must undergo rigorous testing, validation, and iterative improvement to adapt to emerging challenges and ensure their safety and effectiveness in real-world health care settings.

By integrating these principles into its framework, CMS can ensure that AI technologies advance health equity, protect patient rights, and enhance the quality of care for

Medicare beneficiaries. The NHC is committed to supporting these efforts and emphasizes the importance of collaboration among all stakeholders to ensure the responsible and ethical deployment of AI in health care.

Ensuring Equitable Access to Behavioral Health Benefits

The NHC welcomes CMS' proposal to align behavioral health cost-sharing requirements in MA with those in Traditional Medicare. This alignment represents a significant advancement in reducing financial barriers that disproportionately affect access to mental health and substance use disorder services. Behavioral health services are critical for managing chronic conditions and improving overall quality of life for Medicare beneficiaries, particularly for those with complex medical and social needs.[27]

The NHC has consistently emphasized the importance of behavioral health care in achieving equitable health outcomes. Mental health is an integral component of overall health, and insufficient access to behavioral health services exacerbates existing health disparities among vulnerable populations, including those with multiple chronic conditions.[28] Aligning cost-sharing requirements across MA and Traditional Medicare ensures that all beneficiaries can access essential services, such as psychiatric care, substance use treatment, and opioid use disorder programs, without undue financial burden.

To strengthen CMS' proposals, the NHC recommends expediting the implementation timeline to address the urgent need for equitable access to behavioral health services. Timely implementation is particularly critical for beneficiaries requiring immediate mental health or substance use treatment, where delays can lead to worsening health outcomes, increased hospitalization rates, and preventable mortality.[29]

Additionally, the NHC urges CMS to provide detailed and actionable guidance to MA plans on implementing these cost-sharing changes without compromising coverage or increasing cost-sharing for other essential services. This guidance should include best practices for balancing actuarial soundness with patient affordability and strategies to minimize disruption to beneficiaries during the transition. Plans should be equipped with tools and resources to manage these changes effectively, ensuring beneficiaries can access a comprehensive range of services without financial strain.

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[27] Arlene S. Bierman et al., "Transforming Care for People with Multiple Chronic Conditions: Agency for Healthcare Research and Quality's Research Agenda," *Health Services Research* 56, Suppl 1 (2021): 973–979, https://doi.org/10.1111/1475-6773.13863.

[28] Judy Ng et al., "Racial and Ethnic Disparities in Mental Health Among Diverse Groups of Medicare Advantage Beneficiaries," CMS Data Highlight no. 11, December 2017, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-Vol11-Dec-2017.pdf.

[29] Julia C. Prentice and Steven D. Pizer, "Delayed Access to Health Care and Mortality," Health Services Research 42, no. 2 (April 2007): 644–662, https://doi.org/10.1111/j.1475-6773.2006.00626.x.

The NHC also encourages CMS to incorporate broader behavioral health equity goals into its implementation strategy. Behavioral health services must be accessible across diverse geographic regions, including rural and underserved areas where access is historically limited. Ensuring that MA plans maintain robust behavioral health networks and provide culturally and linguistically appropriate care is essential to achieving meaningful progress in behavioral health equity.[30]

To support the long-term sustainability of these reforms, CMS should monitor the impact of the aligned cost-sharing requirements on beneficiary access and health outcomes. Regular data collection and stakeholder engagement, including feedback from patient organizations, providers, and health plans, will help identify and address any unintended consequences.

By adopting these recommendations, CMS can amplify the positive impact of its behavioral health cost-sharing reforms, ensuring that Medicare beneficiaries have equitable access to critical mental health and substance use disorder services. These changes will not only improve health outcomes for individuals but also contribute to broader efforts to achieve health equity and reduce systemic barriers to care. The NHC remains committed to supporting CMS in advancing these vital reforms and fostering a health care system that prioritizes comprehensive and accessible behavioral health care.

Marketing and Communications Oversight

The NHC supports CMS' expanded oversight of marketing materials and practices, particularly its efforts to address misleading information and enhance transparency. Misleading advertisements can have serious consequences for Medicare beneficiaries, especially those who have limited health literacy and are managing chronic conditions or complex health needs.[31] Such advertisements may lead beneficiaries to make uninformed decisions about their coverage, potentially resulting in disrupted care or financial harm.[32] CMS' proposals to broaden the definition of "marketing" to include general advertisements that influence enrollment decisions and to require additional topics to be discussed during agent and broker interactions are critical steps toward

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[30] Francesca Mongelli et al., "Challenges and Opportunities to Meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States," *Focus: Journal of Life Long Learning in Psychiatry* 18, no. 1 (2020): 16–24, https://doi.org/10.1176/appi.focus.20190028.

[31] U.S. Senate Committee on Finance, *Deceptive Marketing Practices Flourish in Medicare Advantage: A Report by the Majority Staff* (Washington, DC: U.S. Government Publishing Office, November 2, 2022), https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

[32] U.S. Senate Committee on Finance, *Deceptive Marketing Practices Flourish in Medicare Advantage*, https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

mitigating these risks and ensuring beneficiaries receive accurate and comprehensive information.

To further strengthen these efforts, the NHC recommends that CMS expand penalties for non-compliance with its marketing rules. Substantial and enforceable penalties will deter repeat offenders and reinforce the importance of adhering to CMS standards. This approach will promote accountability among all stakeholders and help ensure that the welfare of beneficiaries remains a top priority in marketing practices.[33]

The NHC also urges CMS to standardize templates for marketing materials. Providing clear, consistent formats for materials will make it easier for beneficiaries to compare plans and understand the options available to them. Standardized templates can help eliminate ambiguities, ensuring that all essential information is presented in an accessible and user-friendly manner. Such consistency is especially important for beneficiaries who may already face challenges navigating the complexities of Medicare coverage.[34]

Finally, the NHC emphasizes the importance of empowering beneficiaries through education. CMS should invest in initiatives to teach beneficiaries how to identify and report misleading advertising. This could include developing easy-to-understand guides, creating public service announcements, or offering online resources that explain what constitutes deceptive practices and how beneficiaries can protect themselves. Partnering with patients and patient organizations to develop and review these educational materials will ensure they are understandable, actionable, and relevant to beneficiaries' needs. Such collaboration can help enhance the materials' usefulness and effectiveness, ultimately promoting better outcomes. Educating beneficiaries not only enhances their ability to make informed decisions but also helps to hold plans accountable for adhering to ethical and regulatory standards. By implementing these recommendations, CMS can further its goal of protecting Medicare beneficiaries from misleading marketing practices. These measures will enhance transparency, build trust in the Medicare program, and ensure that beneficiaries have the necessary information to select the plans that best meet their health care needs.

Enhancing Transparency in Provider Directories

The NHC supports CMS' proposals to improve the accessibility and accuracy of provider directories by requiring MA plans to submit directory data for inclusion in the Medicare Plan Finder and mandating regular updates to ensure beneficiaries have access to real-time information. These changes are vital for empowering beneficiaries to

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[33] U.S. Senate Committee on Finance, *Deceptive Marketing Practices Flourish in Medicare Advantage*, https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

[34] Sungchul Park and Jim P. Stimpson, "Unmet Need for Medical Care Among Medicare Beneficiaries by Health Insurance Literacy and Disability," *Disability and Health Journal* 17, no. 2 (April 2024): 101548, https://doi.org/10.1016/j.dhjo.2023.101548.

make informed choices about their health care coverage and ensuring equitable access to care across diverse populations.

The NHC recommends that CMS expand the scope of information available in the Medicare Plan Finder by including additional provider attributes such as language proficiencies, specialized training in serving diverse populations, and accessibility for individuals with disabilities. These attributes will enable beneficiaries to identify providers who are equipped to address their specific needs, fostering personalized care and improving the overall patient experience. Addressing these factors is particularly important for beneficiaries from underserved or diverse communities who may face unique barriers to accessing appropriate care.[35]

To ensure the accuracy and reliability of provider directories, the NHC urges CMS to implement robust mechanisms for real-time updates and regular audits. Inaccurate or outdated information can create significant barriers to care, especially for individuals seeking new providers or managing complex health needs. Clear accountability measures should be established to maintain the integrity of directory data and prevent disruptions in care access.[36]

By enhancing the usability and dependability of provider directories, CMS' proposals, combined with these recommendations, will significantly improve the beneficiary experience, facilitate informed decision-making, and advance equitable access to high-quality health care services. These changes represent a critical step in modernizing health care infrastructure to better serve the diverse needs of Medicare beneficiaries.

Medicare Prescription Payment Plan

The NHC applauds CMS for codifying and expanding the Medicare Prescription Payment Plan (MPPP), a vital program that allows Medicare beneficiaries to spread out-of-pocket costs for Part D drugs over time. By providing beneficiaries with the flexibility to manage high-cost prescription expenses more effectively, the MPPP enhances financial stability for individuals managing chronic and complex health conditions. This approach is particularly beneficial for those who might otherwise delay or forego necessary medications due to cost concerns, ensuring that patients can access life-sustaining treatments when they need them.

To maximize the impact of this program, the NHC recommends that CMS implement safeguards to ensure beneficiaries are fully informed about their enrollment options and have a clear understanding of how the MPPP operates. It is crucial that information about the program is accessible, transparent, and easy to comprehend, particularly for populations with varying levels of health literacy. Beneficiaries should receive detailed

[35] Wändi Bruine de Bruin et al., "Medicare Part D Beneficiaries' Self-Reported Barriers to Switching Plans and Making Plan Comparisons at All," *Health Affairs Scholar* 2, no. 11 (November 2024): qxae141, https://doi.org/10.1093/haschl/qxae141.

[36] Abigail Burman, "Combatting Deceptive Health Plan Provider Directories," *Yale Law & Policy Review* 40, no. 2 (2021): 78–148, https://yalelawandpolicy.org/sites/default/files/YLPR/2_burman_pe.12.2_78-148.pdf.

guidance about how spreading costs over time could affect their overall financial planning, as well as clear instructions on how to enroll in and navigate the program.

The NHC also recommends that CMS monitor enrollment trends closely to identify any barriers to participation, particularly among underserved populations. Targeted strategies should be developed to address these challenges, ensuring equitable access to the program across diverse demographics, including those with lower income levels or limited access to information about Medicare programs.

The NHC supports CMS' proposal to implement an automatic renewal process for MPPP enrollment, provided beneficiaries retain the ability to opt out if they choose. This automatic renewal feature has the potential to simplify administrative processes for beneficiaries who wish to remain enrolled while reducing the risk of lapses in coverage. However, CMS should carefully evaluate the operational and cost implications of this proposal to ensure that it does not create undue burdens on beneficiaries or inadvertently disrupt access to care, as well as assess the long-term sustainability of the automatic renewal feature to avoid any unintended consequences for patient access and system efficiency. CMS should also issue clear guidance emphasizing that beneficiaries maintain full control over their financial decisions and can opt out at any time. This transparency is essential to ensuring that beneficiaries feel empowered and that their participation in the program remains voluntary and informed.

The success of the MPPP will depend heavily on robust education and outreach efforts. The NHC urges CMS to strengthen these initiatives by integrating enrollment options into the Medicare Plan Finder, a key resource for beneficiaries exploring their coverage options. Providing an intuitive, user-friendly pathway for MPPP enrollment within this tool can significantly increase program visibility and accessibility. Additionally, CMS should leverage pharmacies as a strategic point of outreach, offering targeted information about the program at the point of care. Pharmacists often serve as trusted health care advisors for beneficiaries, making them an ideal partner in raising awareness of the MPPP and its benefits.

To further enhance the MPPP, CMS must accelerate progress toward enabling real-time enrollment at the point of sale (POS), beyond the proposed plan-facilitated approach, and explore additional innovative enrollment options to ensure seamless access for beneficiaries. A robust POS enrollment system would allow beneficiaries to seamlessly access the program when and where they fill prescriptions, minimizing delays and simplifying the process. CMS should prioritize the development and implementation of this functionality, as it has the potential to significantly expand access and ease the administrative burden for beneficiaries and providers alike.

Additionally, CMS should explore other innovative enrollment pathways, such as providing enrollment support through community organizations, trusted health care settings, or mobile platforms. These strategies can help bridge persistent gaps for beneficiaries who face logistical, technological, or informational barriers. Equipping trusted community partners and health care providers with the tools to assist beneficiaries will enhance program reach and equity.

Engaging stakeholders, including patient organizations, is critical to the program's success. CMS should collaborate with these groups to co-develop and review educational materials to ensure they are understandable, actionable, and culturally appropriate for the diverse Medicare population. CMS should also work with these organizations to disseminate the information and share it with beneficiaries. This engagement with patient organizations, which beneficiaries see as a trusted source of information, will enable them to receive clear guidance on how to enroll, navigate the program, and understand its implications for their financial planning.

By accelerating progress on POS enrollment and other innovative pathways, and by fostering collaboration with key stakeholders, CMS can ensure that the MPPP becomes a cornerstone of equitable and patient-centered care. These measures are essential to overcoming persistent access challenges and maximizing the program's impact on improving medication adherence, reducing financial stress, and enhancing overall health outcomes for Medicare beneficiaries.

By adopting these recommendations, CMS can ensure that the Medicare Prescription Payment Plan achieves its full potential in reducing financial barriers to prescription drugs and improving access to essential medications for Medicare beneficiaries. These measures will not only enhance affordability but also promote adherence to prescribed treatments, ultimately leading to better health outcomes and improved quality of life for Medicare beneficiaries. The NHC remains committed to supporting CMS in advancing this critical program and fostering a health care system that prioritizes affordability, equity, and patient-centered care.

Promoting Transparency for Pharmacies and Protecting Beneficiaries from Disruptions

The NHC supports CMS' proposals to enhance transparency in pharmacy network contracts and protect beneficiaries from potential disruptions caused by network changes. These measures, which include requiring pharmacies to receive advance information about their network status before open enrollment and allowing pharmacies to terminate contracts without cause under the same terms as sponsors, represent significant strides toward ensuring stability and fairness in the pharmacy network landscape.

To further safeguard beneficiaries, the NHC recommends that CMS require Part D sponsors to proactively notify beneficiaries of any significant changes in pharmacy network composition during open enrollment periods. Timely notification will empower beneficiaries to make informed decisions about their plan options, ensuring continuity of care and access to necessary medications.

The NHC also welcomes CMS' emphasis on establishing parity in contract termination rights between pharmacies and sponsors. This balance helps maintain a robust pharmacy network, ensuring consistent and reliable access to medications for beneficiaries.

Additionally, the NHC urges CMS to implement robust monitoring mechanisms to assess pharmacy network stability and identify systemic barriers that may limit patient access. Regular oversight and data collection will enable CMS to address potential challenges proactively, minimizing disruptions and fostering a more resilient pharmacy network.

By adopting these proposals alongside the recommended enhancements, CMS can establish a transparent and equitable pharmacy network system that prioritizes patient access, supports provider sustainability, and ensures care continuity for Medicare beneficiaries.

Formulary Inclusion and Placement of Generics and Biosimilars

The NHC supports CMS' proposals to improve formulary practices by prioritizing access to generics, biosimilars, and other cost-effective medications in the Medicare Part D program. These provisions represent a critical advancement in reducing out-of-pocket costs for patients, enhancing equity, and ensuring that beneficiaries have access to affordable treatments essential for managing their health. By mandating compliance with statutory obligations to promote generics and biosimilars, CMS is taking an essential step toward addressing medication affordability and improving health outcomes for Medicare beneficiaries.

To further strengthen these efforts, the NHC recommends that CMS adopt additional measures to ensure broad access to generics, biosimilars, and other cost-effective treatments. First, CMS should enhance enforcement mechanisms to ensure that Part D sponsors and pharmacy benefit managers (PBMs) fully comply with requirements for cost-effective drug utilization management. Currently, reliance on high-cost non-preferred tiers creates significant financial barriers for patients needing lower-cost medications, which undermines the intent of formulary policies.[37] Strengthened enforcement will ensure that beneficiaries consistently have access to affordable medications without undue financial strain.

Additionally, CMS should require plans to provide clear justification for their formulary placement decisions, particularly when higher-cost drugs are prioritized over generics or biosimilars. Making this information public would increase accountability and address downstream impacts, such as increased burdens on providers and higher taxpayer costs. Increased transparency will ensure that formulary practices align with broader goals of affordability and patient access.[38] Furthermore, CMS should include manufacturer rebates in the definition of "negotiated price." This change would allow beneficiaries to directly experience cost savings at the point of sale.

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[37] Tasmina Hydery and Vimal Reddy, "Tiered Formulary Structures and Their Impact on Medication Access," *Journal of Managed Care & Specialty Pharmacy* 30, no. 2 (2024): 206–214, https://www.jmcp.org/doi/epdf/10.18553/jmcp.2024.30.2.206.

[38] American Medical Association. *Issue Brief: Improving Prescription Drug Price and Cost Transparency*. Accessed January 2, 2025. https://www.ama-assn.org/system/files/issue-brief-improving-drug-price-cost-transparency.pdf.

The NHC also recommends that CMS revisit its tier composition policies, including prohibiting Part D plans from placing generics on brand tiers and reconsidering "preferred" specialty tier policies for generics. These revisions would reduce confusion and ensure equitable cost-sharing, fostering greater use of affordable medications. To promote accountability, CMS should also publicize formulary designs and utilization management practices that fail to meet broad access requirements. Highlighting non-compliant practices would encourage plans to prioritize adherence to CMS standards and equitable access for beneficiaries.[39]

To further empower beneficiaries, CMS should increase transparency regarding utilization management and coverage limitations for generics in the Medicare Plan Finder. Providing clear descriptions of these restrictions would enable beneficiaries to make more informed decisions about their coverage options. Additionally, systemic incentives that inadvertently reward plans for prioritizing higher-cost medications over generics and biosimilars must be addressed. These misaligned incentives undermine efforts to promote the use of cost-effective treatments and lead to higher costs across the health care system. CMS should eliminate such incentives to ensure that formularies align with patient-centered goals.[40,41]

However, while the NHC supports the use of generics and biosimilars as a means to improve care and reduce costs for many Medicare beneficiaries, it also cautions CMS to recognize that there are situations where switching to a generic may not be appropriate for certain patients. For example, individuals with epilepsy may experience uncontrolled seizures if switched from a brand-name medication to a generic. Similarly, patients with other chronic conditions, such as Parkinson's disease or rheumatoid arthritis, may require consistent medication formulations to effectively manage their symptoms. The NHC recommends that CMS ensure that Part D plans have a clear, efficient process for beneficiaries to request formulary exceptions, allowing them to remain on brand-name medications when medically necessary. This will ensure that efforts to expand access to cost-effective medications do not unintentionally compromise patient care.

Finally, the NHC urges CMS to collect and publicly share data on formulary composition and utilization trends, particularly regarding access to generics and biosimilars. Greater transparency in these areas will enable stakeholders to assess the effectiveness of

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[39] Patient Access Network Foundation. "Key Findings from the 2023 PAN Foundation Patient Access Survey." Accessed January 9, 2025. https://www.panfoundation.org/insights/key-findings-from-the-2023-patient-access-survey/.

[40] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System.* Chapter 5, "Improving the Medicare Part D Program." Washington, DC, June 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch5_reporttocongress_sec.pdf.

[41] Sophia Lopez et al., "Study: 57 Percent of Covered Generic Drugs Not on Part D Generic Tiers in 2025," *Insights & Analysis Coverage and Payment,* December 9, 2024, https://avalere.com/insights/57-of-covered-generic-drugs-not-on-part-d-generic-tiers-in-2025.

formulary policies and identify areas for improvement. These efforts will ensure that Medicare beneficiaries fully benefit from policies designed to enhance access to affordable medications.

By adopting these recommendations, CMS can build on its strong foundation and further advance a formulary system that prioritizes affordability, equity, and access. These measures will ultimately improve health outcomes and enhance the quality of life for millions of Medicare beneficiaries.

Administration of Supplemental Benefits Coverage Through Debit Cards

The NHC welcomes CMS' efforts to enhance the transparency and functionality of supplemental benefits administered via debit cards in MA. By clarifying allowable purchases, providing guidance on coverage, and requiring alternative access processes when card issues arise, CMS is taking important steps to ensure beneficiaries can utilize their supplemental benefits effectively and without undue administrative challenges. These proposals reflect a commitment to improving the beneficiary experience, particularly for those who rely on these benefits to address critical health needs.

To further strengthen these efforts, the NHC recommends that CMS require MA plans to provide real-time support for beneficiaries encountering issues with their debit cards. Prompt assistance is vital to prevent interruptions in access to essential supplemental benefits, especially for populations with urgent needs or limited alternative resources. Real-time support services will help ensure beneficiaries can continue accessing covered items and services without delays.

The NHC also underscores the importance of standardized disclosures about the scope and limitations of debit card coverage. Beneficiaries need clear, consistent, and accessible information about what their debit cards can and cannot be used for. This transparency will reduce confusion, empower beneficiaries to make informed decisions, and enhance the overall utility of the cards in delivering supplemental benefits.

Additionally, the NHC encourages CMS to explore innovative enhancements to debit card functionality by integrating their use with mobile applications. Features such as real-time balance tracking, purchase history, and notifications can help beneficiaries manage their benefits more effectively and with greater confidence. Mobile integration would also allow beneficiaries to access support and additional resources conveniently, further improving their experience with supplemental benefits.

By adopting these recommendations, CMS can ensure that debit cards are not only a practical tool for delivering supplemental benefits but also a dependable and transparent resource. These measures will enhance beneficiaries' ability to utilize their supplemental benefits efficiently and equitably, ultimately supporting better health outcomes and increased satisfaction with the MA program.

Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors

The NHC supports CMS' proposals to enhance transparency and safety in the provision of community-based and in-home services under MA. By formally defining community-based organizations (CBOs) and in-home service providers, and requiring these entities to be listed in MA provider directories with clear identification of their roles and qualifications, CMS is addressing significant concerns about patient safety, service quality, and equitable access to care. These measures are critical to fostering trust between beneficiaries and service providers, as well as promoting informed decision-making for beneficiaries seeking these services.

To maximize the effectiveness of these proposals, the NHC recommends requiring MA plans to prominently display comprehensive information about in-home service providers in their directories. This information should include providers' qualifications, certifications, and any established ties to the communities they serve. Including this level of detail will empower beneficiaries to make informed and confident decisions about their care while fostering a greater sense of trust in the services offered under MA.

Additionally, the NHC highlights the importance of establishing standardized training and credentialing requirements for in-home service providers. Uniform standards across MA plans will ensure consistent quality of care and promote beneficiary confidence in the safety and reliability of these services. Beneficiaries need the assurance that individuals entering their homes to deliver care meet rigorous standards of professionalism, competency, and ethical conduct. The NHC further emphasizes the need for transparency in the process for reporting issues and real-time resolution of problems such as provider no-shows, delays, or lapses in service quality. CMS should require MA plans to establish easily accessible mechanisms for beneficiaries to report concerns and to ensure swift responses to these reports. Clear guidelines and expectations for addressing such issues will not only enhance trust in these services but also ensure uninterrupted and high-quality care for beneficiaries.

The NHC also urges CMS to develop and implement robust outreach and education initiatives to inform beneficiaries about their rights and the safeguards in place to protect their personal information and health data. Clear communication regarding privacy protections and data security will not only address beneficiary concerns but also strengthen trust in the broader MA program. These efforts should include accessible educational materials and targeted outreach strategies to ensure that beneficiaries across diverse communities understand their protections and options.

Finally, the NHC encourages CMS to engage with stakeholders, including patient organizations, providers, and CBOs, to continuously evaluate and refine these policies. Regular feedback will ensure that the implementation of these measures remains responsive to beneficiary needs and supports the highest standards of care.

By adopting these recommendations, CMS can build on its strong foundation to enhance patient safety, improve the quality of in-home and community-based care, and

ensure equitable access for all MA beneficiaries. These efforts will go a long way in promoting trust and confidence in the MA program while addressing the evolving needs of its diverse beneficiary population.

Part D Medication Therapy Management (MTM) Program Eligibility Criteria

The NHC welcomes CMS' proposal to expand eligibility criteria for the Medicare Part D MTM program to include beneficiaries with other forms of dementia in addition to Alzheimer's disease. This inclusive and patient-centered approach reflects an understanding of the broader population living with chronic conditions and acknowledges the importance of providing timely and comprehensive interventions to optimize therapeutic outcomes. Expanding eligibility criteria represents a significant step forward in addressing the needs of vulnerable beneficiaries, promoting equitable access to the support required to improve their quality of life and health outcomes.

The NHC encourages CMS to work with Part D sponsors to adopt and implement these expanded eligibility criteria as soon as possible. Swift action is essential to ensuring that newly eligible beneficiaries gain timely access to the MTM program's vital services. Delays in implementation risk leaving this vulnerable population without the resources they need to manage their health effectively.

To facilitate prompt and successful adoption, CMS should collaborate with plans to provide clear and practical guidance on implementing the expanded eligibility criteria. This partnership will ensure that plans are equipped to integrate the updated requirements efficiently while maintaining the program's high standards.

The NHC emphasizes the importance of robust education and outreach initiatives to maximize the effectiveness of the expanded MTM program. CMS should prioritize the development and dissemination of targeted educational resources aimed at providers, beneficiaries, and caregivers to raise awareness about the updated eligibility criteria. Providers play a critical role in identifying and referring eligible patients, so clear communication is essential to help them understand how these updates will impact their practice and patient interactions. Educating beneficiaries on their eligibility and the benefits of the MTM program is equally important, as it will empower them to fully utilize the available services. In addition, outreach to caregivers—who are often essential in managing the health of beneficiaries with conditions such as dementia, Alzheimer's disease, chronic kidney disease, Parkinson's disease, and other chronic or cognitive impairments—is vital. Ensuring that caregivers are well-informed will help them better support beneficiaries who may need assistance in navigating the health care system and accessing the MTM services.

Educational resources should be accessible, culturally appropriate, and tailored to the unique needs of diverse beneficiary populations. By prioritizing communication and outreach, CMS can help bridge gaps in knowledge, promote enrollment, and ensure that the program reaches those who would benefit most.

To ensure the long-term success of the MTM program, CMS should establish mechanisms for monitoring the impact of these changes on patient outcomes. Regular evaluations will provide valuable insights into the effectiveness of the expanded

eligibility criteria in improving health outcomes for beneficiaries with dementia. These assessments should also consider the experiences of beneficiaries, caregivers, and providers to identify areas for improvement and inform future policy updates.

Based on the results of these evaluations, CMS should explore opportunities to further expand eligibility to other high-risk populations who may benefit from MTM services. This iterative approach will allow the program to evolve in response to the diverse and changing needs of Medicare beneficiaries, ensuring that it continues to serve as a vital tool for optimizing medication use and improving health outcomes.

The NHC applauds CMS for taking this significant step to broaden the scope of the MTM program, making it more inclusive and impactful for beneficiaries living with dementia and other chronic conditions. By prioritizing prompt implementation, targeted education, and continuous evaluation, CMS can ensure that the program achieves its full potential in supporting Medicare beneficiaries. The NHC remains committed to collaborating with CMS to enhance the MTM program and advance policies that promote equitable, patient-centered care.

Improving Experiences for Dually Eligible Enrollees

The NHC supports CMS' proposed measures to improve the experience of dual-eligible beneficiaries by integrating health risk assessments (HRAs) and member identification (ID) cards. These reforms represent a meaningful step toward streamlining administrative processes, reducing redundancy, and promoting equitable, patient-centered care for a particularly vulnerable population. Dual-eligible beneficiaries, who often have complex medical and social needs, face significant challenges in navigating fragmented care systems.[42] CMS' proposals have the potential to address these barriers and improve care coordination and outcomes for this group.

The NHC has long recognized the importance of tailored, coordinated care for dual-eligible beneficiaries.[43] Integrated HRAs have the potential to provide a more comprehensive understanding of an individual's needs by combining Medicare and Medicaid assessments. This approach reduces duplication, minimizes administrative burden, and ensures that care plans reflect the full spectrum of beneficiaries' health and social needs. Similarly, the implementation of integrated ID cards will simplify access to services, reduce confusion among beneficiaries, and improve the efficiency of care delivery.[44]

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[42] Maria T. Peña et al., *The Landscape of Medicare and Medicaid Coverage Arrangements for Dual-Eligible Individuals Across States* (Kaiser Family Foundation, October 24, 2024), https://www.kff.org/medicare/issue-brief/the-landscape-of-medicare-and-medicaid-coverage-arrangements-for-dual-eligible-individuals-across-states/.

[43] National Health Council, *NHC Response to Duals RFI*, letter to Senator Bill Cassidy, January 13, 2023. https://nationalhealthcouncil.org/letters-comments/nhc-response-to-duals-rfi/.

To maximize the effectiveness of these reforms, the NHC recommends that CMS ensure the integrated health risk assessment process includes patient-centered metrics that address the specific needs of dually eligible populations. These metrics should account for the unique challenges faced by this group, such as higher rates of chronic conditions, greater social vulnerabilities, and limited access to resources. Incorporating these metrics will enable care teams to develop more personalized and actionable care plans, ultimately improving health outcomes and beneficiary satisfaction.

The NHC urges CMS to provide robust technical assistance and training to MA and Medicaid plans to facilitate the seamless implementation of integrated ID cards and HRAs. This support is essential to ensure that plans adopt these changes effectively without compromising care quality. Training should include best practices for data integration, strategies for maintaining patient confidentiality, and approaches to engaging beneficiaries in the HRA process. By equipping plans with the necessary tools and knowledge, CMS can foster a smoother transition and maintain continuity of care for dual-eligible beneficiaries.

To ensure the long-term success of these reforms, the NHC recommends that CMS actively monitor their impact on care coordination, beneficiary satisfaction, and overall health outcomes. Data collection and analysis will be critical to identifying best practices, addressing any implementation challenges, and refining the approach over time. CMS should engage stakeholders, including patient organizations, providers, and health plans, in this process to ensure that reforms remain responsive to the needs of dual-eligible beneficiaries.

Additionally, CMS should consider collecting feedback directly from beneficiaries through surveys or focus groups to better understand their experiences with the integrated ID cards and HRAs. This input will provide valuable insights into the real-world impact of these changes and help CMS make data-driven adjustments to further enhance care coordination and accessibility.

By implementing these recommendations, CMS can amplify the positive impact of its proposals to improve the experience of dual-eligible beneficiaries. These reforms have the potential to create a more seamless, patient-centered care experience, ensuring that dual-eligible individuals receive the coordinated, high-quality care they deserve. The NHC is committed to supporting CMS in advancing these critical reforms and fostering a health care system that prioritizes equitable and efficient care for all beneficiaries.

Medical Loss Ratio (MLR) Reporting Enhancements

The NHC supports CMS' proposed updates to MLR reporting requirements, which aim to enhance transparency and accountability within MA and Part D plans. These updates

[44] Bipartisan Policy Center, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, July 2020, https://bipartisanpolicy.org/wp-content/uploads/2020/07/BPC_Health_Integration_of_Care_V3.pdf.

represent a critical advancement toward ensuring that resources are allocated effectively to improve patient outcomes and maintain the integrity of these programs.

To maximize the impact of these proposals, the NHC recommends that CMS require detailed reporting on how plans allocate resources to quality improvement activities, with a specific emphasis on initiatives that directly benefit patients. Such granularity will provide greater transparency into how funds are utilized to enhance care delivery, allowing stakeholders to evaluate whether plans are prioritizing activities that improve health outcomes and patient experiences.[45]

The NHC supports CMS' efforts to establish clear standards for audits and compliance within the MLR reporting framework. Regular audits and consistent enforcement are essential for ensuring accuracy, accountability, and transparency in the MA and Part D programs.

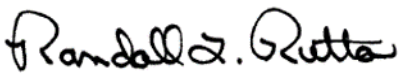
Furthermore, the NHC encourages CMS to actively solicit feedback from stakeholders, including patient organizations, on the MLR reporting process. Regular engagement with stakeholders will provide valuable insights into areas for refinement, ensuring that the MLR framework evolves to address emerging challenges and remains aligned with patient-centered goals.

By incorporating these recommendations, CMS can further enhance the effectiveness of the MLR reporting requirements, ensuring that resources are utilized in a transparent, accountable, and patient-focused manner. This will ultimately support meaningful improvements in care delivery and health outcomes for Medicare beneficiaries.

Conclusion

The NHC applauds CMS for its commitment to advancing patient-centered reforms in MA and Part D programs. By adopting the recommendations outlined in this letter, CMS can ensure that the proposed changes maximize their potential to improve patient care, equity, and outcomes. We welcome the opportunity to work with CMS to advance these goals and provide further input as needed. Please do not hesitate to contact Jennifer Dexter, Vice President of Policy and Government Affairs, at jdexter@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer

[45] Georgetown University Health Policy Institute Center for Children and Families, "Transparency in Medicaid Managed Care: CMS Posts Annual MLR Reports," November 15, 2024, https://ccf.georgetown.edu/2024/11/15/transparency-in-medicaid-managed-care-cms-posts-annual-mlr-reports/.