NATIONAL HEALTH COUNCIL

January 26, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P)

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment in response to the Contract Year (CY) 2027 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program (Part D), and Medicare Cost Plan Program.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of nearly 200 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.

General Comments and Priority Recommendations

MA and Medicare Part D are central to the care and coverage experience of beneficiaries with complex and ongoing health needs.[1] As MA enrollment continues to grow and the Part D benefit is implemented as redesigned under the Inflation Reduction Act (IRA), CMS' regulatory and operational decisions will play a determinative role in

[1] Kangyeon Lee and Wendy Yi Xu, "Treatment Burdens in Traditional Medicare and Medicare Advantage," *The American Journal of Managed Care* 31, no. 12 (December 2025), https://www.ajmc.com/view/treatment-burdens-in-traditional-medicare-and-medicare-advantage.

shaping beneficiary affordability, access to medically necessary care, patient safety, program integrity, plan incentives, and overall trust in the Medicare program.[2]

The CY 2027 proposed rule addresses a broad set of policy areas, including implementation of statutory Part D redesign elements, updates to the Star Ratings program, modifications to marketing and communications requirements, and requests for information related to special needs plans (SNPs) and potential future changes to MA payment design. CMS has articulated an interest in regulatory simplification and burden reduction, and the NHC supports modernization efforts that improve beneficiary experience while reducing unnecessary administrative complexity. Such efforts, however, should be assessed against a patient-centered standard that examines whether beneficiaries can reasonably understand their coverage, anticipate costs, and obtain timely access to needed medications and services without avoidable administrative burden.

Beneficiaries experience MA and Part D through a set of operational processes that directly affect access to care, including enrollment and plan selection, point-of-sale pharmacy adjudication, coverage determinations (including prior authorization where applicable), provider network access, and appeals and grievance pathways.[3] In these contexts, policy changes that may appear technical or administrative can have substantial downstream effects, particularly for individuals with chronic disease, disability, cognitive impairment, or high-cost medication needs.[4] The NHC encourages CMS to evaluate final policy decisions not only in terms of administrative efficiency, but also with respect to their practical implications for continuity of care, transparency, and access to clinically appropriate treatment.

Throughout the CY 2027 proposed rule, the NHC urges CMS to anchor its final policies in the following priorities:

1. **Ensure beneficiary comprehension and transparency in implementing the Part D redesign.** Implementation should promote clear, consistent, beneficiary-facing explanations of the redesigned benefit and reduce confusion regarding cost sharing, true out-of-pocket (TrOOP) accounting, manufacturer discounts, and reinsurance. The NHC urges CMS to ensure that plan communications enable beneficiaries and caregivers to understand how costs accrue over the plan year, what payments count toward the annual out-of-pocket threshold, and what to expect at the pharmacy counter across benefit phases.

2. **Ensure Manufacturer Discount Program accountability and point-of-sale protections.** The transition from the Coverage Gap Discount Program to the

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[2] Centers for Medicare & Medicaid Services (CMS), "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," January 10, 2025, https://www.cms.gov/files/document/2026-advance-notice.pdf.

[3] Center for Medicare Advocacy, "Comments on Proposed Rule for Medicare Parts C & D (CY 2026)," January 2025, https://medicareadvocacy.org/center-comments-on-proposed-rule-for-medicare-parts-c-d/.

[4] Kirsten Stryker Blasch, Robin Duddy-Tenbrunsel, and Mark Newsom, "Policy Changes to Expect for Medicare Advantage in 2027," Avalere Health, September 23, 2025, https://advisory.avalerehealth.com/insights/policy-changes-to-expect-for-medicare-advantage-for-2027.

Manufacturer Discount Program alters financial flows and operational processes. From the patient perspective, the key test is whether required discounts are applied accurately and consistently at the point of sale without delays, disputes, or administrative friction that could increase beneficiary costs or disrupt medication access. The NHC urges CMS to reinforce clear sponsor accountability and timely enforcement pathways to ensure that operational failures are not borne by beneficiaries.

3. **Preserve patient-relevant quality signals while refining Star Ratings methodology.** The NHC urges CMS to ensure that changes to the Star Ratings measure set and methodology retain meaningful indicators of access, care coordination, medication adherence, and beneficiary experience, particularly for beneficiaries with complex or ongoing needs. The NHC urges CMS to assess and mitigate downstream effects on supplemental benefits, service delivery, and care continuity for populations that rely on stable, coordinated models of care.

4. **Maintain marketing, communications, and Third-Party Marketing Organization (TPMO) safeguards that prevent beneficiary harm.** The NHC urges CMS to ensure that any burden-reduction changes are paired with clear accountability for downstream marketing entities and enforcement mechanisms capable of preventing misleading marketing and inappropriate enrollment in real time. These protections are particularly important for beneficiaries who may be more vulnerable to confusing or aggressive marketing practices, including individuals with cognitive impairment, serious illness, or limited capacity to evaluate complex coverage tradeoffs.

5. **Ground SNP policy development in beneficiary understanding and effective integration.** The NHC encourages CMS to evaluate whether growth in SNP enrollment reflects improved care coordination and clinically meaningful targeting, or whether it reflects product proliferation and beneficiary confusion that fragments care. Future policy development should prioritize integration across Medicare and Medicaid where applicable, clear beneficiary- and caregiver-facing explanations of plan types and coordination responsibilities, and safeguards against inappropriate steering.

6. **Exercise caution and transparency in RFIs addressing structural MA payment changes.** Potential reforms to risk adjustment and quality bonus payments could reshape plan incentives and, in turn, beneficiary access. The NHC urges CMS to approach these issues with transparency, data-driven analysis, and appropriate testing where warranted. The NHC urges CMS to explicitly assess implications for beneficiaries with chronic disease and disability, including effects on provider networks, utilization management practices, program integrity, and access to specialized services.

The NHC provides detailed comments below to support CMS in achieving its stated objectives while ensuring beneficiary experience remains a core consideration. As CMS finalizes policies, the agency should monitor indicators that can signal unintended consequences early, including complaint and grievance patterns, pharmacy access

disruptions, prior authorization and appeal outcomes, and evidence of network-related access barriers.

Medicare Part D Redesign and Codification of IRA Provisions

The NHC supports CMS' proposal to codify, through regulation, the statutory changes to the Medicare Part D benefit enacted under section 11201 of the IRA. Codification provides necessary regulatory clarity and appropriately reflects that the redesigned Part D benefit is now a permanent feature of the Medicare program rather than a transitional or interim policy framework. Clear regulatory articulation is essential to ensuring consistent implementation across sponsors and to supporting beneficiary understanding as the redesigned benefit is fully operationalized.

For beneficiaries and caregivers, the Part D redesign has altered not only annual cost exposure, but also the day-to-day experience of obtaining prescription drugs.[5] In practice, beneficiaries experience the redesigned benefit through interactions with Part D sponsors, pharmacy benefit managers, specialty pharmacies, and point-of-sale adjudication systems that determine whether medications can be accessed in a timely and predictable manner.[6] Beneficiary experience is shaped by how cost sharing is calculated, whether required discounts are applied accurately in real time, how benefit phase transitions are communicated, and how quickly adjudication errors or coverage disputes are resolved. CMS' regulatory and operational implementation choices will therefore be determinative in assessing whether the redesigned benefit improves predictability and access or instead introduces new sources of confusion and administrative friction.

The NHC further notes that beneficiaries have experienced multiple significant changes to the Part D benefit over a relatively short period, including staged implementation across successive plan years. Even when changes are intended to improve affordability, repeated redesign can make it more difficult for beneficiaries to anticipate costs, compare plan options, and feel confident in coverage decisions. This challenge is particularly acute for beneficiaries with complex and ongoing medication needs, who interact with the Part D benefit primarily through frequent pharmacy encounters rather than annual plan materials.[7] Recent changes to the Part D benefit have also been accompanied by measurable shifts in formulary design, including reductions in coverage for certain branded drugs in competitive classes, which may further complicate beneficiary decision-making and continuity of therapy across plan years.[8] The NHC

[5] CMS, "Medicare Prescription Payment Plan: Steps for Implementation and Beneficiary Impact," January 15, 2025, https://www.cms.gov/newsroom/fact-sheets/medicare-prescription-payment-plan-2025.

[6] Stacie B. Dusetzina et al., "Medicare Part D Redesign Savings May Be Lower For Beneficiaries With Spending Below The Out-Of-Pocket Cap," *Health Affairs* 44, no. 1 (January 2025): 45–53.

[7] Nathan Hodson and Wändi Bruine de Bruin, "Why Do Few Medicare Beneficiaries Switch Their Part D Prescription Drug Plans? Insights from Behavioral Sciences," *Journal of Public Health Policy* (December 2025), https://doi.org/10.1057/s41271-025-00618-1.

[8] Hanke Zheng and Jon Campbell, *Impacts of the Inflation Reduction Act on 2025 Formulary Coverage in Medicare Part D Plans*, poster presented at ISPOR 2025, Montréal, QC, Canada, May 2025, Value in

encourages CMS to promote continuity and clarity by clearly distinguishing what elements of the benefit have changed, what has remained consistent, and how the redesigned benefit operates across the plan year from a beneficiary perspective, while closely monitoring formulary trends and access outcomes to ensure that implementation of the redesigned benefit does not inadvertently undermine meaningful choice or continuity of care for beneficiaries who rely on stable access to prescription therapies.

Beneficiary Understanding of Cost Sharing and TrOOP Accumulation

The elimination of the coverage gap and the establishment of a capped annual out-of-pocket threshold represent meaningful improvements for Part D beneficiaries. However, many enrollees continue to experience difficulty understanding how costs accrue toward the annual threshold, including which payments count toward TrOOP costs and how manufacturer discounts, plan payments, and other contributions are treated.[9] In practice, beneficiaries often learn how the redesigned benefit functions through points of friction, such as unexpected cost-sharing amounts at the pharmacy counter, rejected claims, or inconsistent explanations from plans, pharmacies, and customer service representatives.[10] For beneficiaries who rely on high-cost therapies or specialty drugs, uncertainty regarding TrOOP accumulation and benefit phase transitions can undermine adherence and contribute to avoidable delays in treatment initiation or continuation.[11] These challenges are especially concerning for individuals managing progressive conditions, rare diseases, or complex treatment regimens, where interruptions in therapy may result in irreversible harm.[12]

The NHC urges CMS to require greater standardization in how Part D sponsors present TrOOP information and cost-sharing explanations to beneficiaries. Sponsors should be expected to clearly explain how plan payments, manufacturer discounts, and other contributions affect progress toward the annual out-of-pocket threshold. CMS-developed model language or standardized templates could reduce variation across plans, improve beneficiary comprehension, and support pharmacists, counselors, and caregivers who are frequently asked to interpret plan rules in real time.

Beneficiary communications should move beyond disclosure of cumulative TrOOP totals and explain what those figures mean for expected point-of-sale cost sharing and future benefit phase transitions. Beneficiaries should be able to determine whether they are approaching the annual threshold, what they are likely to pay at the pharmacy

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Health 28, suppl. 1 (2025), HPR47, https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans.

[9] Sayed B. A. et al., *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act: Inflation Reduction Act Research Series: Research Report* (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, July 7, 2023), https://www.ncbi.nlm.nih.gov/books/NBK616489/.

[10] Hodson and Bruine de Bruin, "Why Do Few Beneficiaries Switch?"

[11] Dusetzina et al., "Part D Redesign Savings."

[12] Geoffrey Joyce et al., "Medicare Part D Plans Greatly Increased Utilization Restrictions On Prescription Drugs, 2011–20," *Health Affairs* 43, no. 3 (2024): 391–397.

counter, and how costs will change once the threshold is reached. These explanations should be integrated into routinely used beneficiary-facing materials, including the Evidence of Coverage, Explanation of Benefits, and mid-year notices related to cost sharing.

The NHC encourages CMS to recognize that many beneficiaries rely on caregivers to manage medications and plan interactions.[13] Communications that assume high health literacy, strong numeracy, or sustained administrative capacity do not reflect the realities faced by many Medicare beneficiaries.[14] Codification of the Part D redesign should therefore encourage sponsor communications that are structured around common beneficiary questions and that facilitate shared decision-making rather than placing the burden of interpretation on patients and families.

Manufacturer Discount Program and Point-of-Sale Protections

The Manufacturer Discount Program is a central component of the redesigned Part D benefit and significantly alters the flow of payments among manufacturers, plans, and Medicare. While the NHC supports CMS' efforts to codify the program consistent with statutory requirements, the program's effectiveness from a beneficiary perspective depends on consistent and accurate application of required discounts at the point of sale.

The redesigned benefit relies on coordinated operational processes among manufacturers, plans, pharmacy benefit managers, and pharmacies to ensure that discounts are calculated and applied correctly. Even modest inconsistencies or delays can result in incorrect cost-sharing amounts, unexpected charges, or disruptions in medication access. These risks are particularly acute for beneficiaries who rely on high-cost therapies, transition between benefit phases early in the plan year, or obtain medications through specialty pharmacy channels where administrative processes are often more complex.[15]

The NHC urges CMS to establish clear regulatory expectations that beneficiaries should be held harmless from operational or reconciliation issues among involved entities related to discount eligibility, timing, reconciliation, or classification. Such issues should not result in delayed access to medications or retroactive adjustments that shift financial burden onto beneficiaries. The NHC urges CMS to reinforce sponsor responsibility for ensuring uninterrupted access and accurate point-of-sale cost sharing, with reconciliation handled between entities without beneficiary involvement.

The NHC urges CMS to clarify enforcement pathways that are meaningful from a beneficiary perspective. When discount application failures occur, beneficiaries require rapid correction and access to clear remedies. The NHC urges CMS to assess whether

[13] Rachel O'Conor et al., "Caregiver Involvement in Managing Medications among Older Adults with Multiple Chronic Conditions," *Journal of the American Geriatrics Society* 69, no. 10 (2021): 2916–2922, https://doi.org/10.1111/jgs.17337.

[14] Lee and Xu, "Treatment Burdens."

[15] Dusetzina et al., "Part D Redesign Savings."

sponsors are subject to sufficiently clear obligations to resolve point-of-sale discount problems within defined timeframes and whether escalation pathways for pharmacies and prescribers are adequately supported. Discounts that are eventually reconciled do not protect beneficiaries if access is denied or delayed at the moment care is needed.

Reinsurance Changes and Plan Incentives

The revised reinsurance structure under the redesigned Part D benefit shifts a greater share of financial liability to plans and manufacturers. While these changes are intended to improve incentives and reduce federal spending, the NHC encourages CMS to remain attentive to how plans respond to these shifts in practice.

The NHC urges CMS to monitor whether changes in plan liability are associated with modifications to formulary design, utilization management practices, or pharmacy network structures. For beneficiaries with complex or rare conditions, such changes may be experienced as delays in treatment initiation, interruptions in stable therapy regimens, or increased administrative burden for prescribers and caregivers.[16] Monitoring should include trends in formulary placement, prior authorization and step therapy requirements, exception and appeal outcomes, pharmacy network design, and beneficiary complaints related to medication access. The NHC urges CMS to ensure that monitoring is sufficiently granular to detect issues affecting particular drug classes, benefit phases, or patient populations and be prepared to provide guidance or take corrective action where patterns of concern emerge.

The NHC encourages CMS to consider whether aggregated reporting of relevant access indicators could support accountability and stakeholder assessment of Part D redesign implementation. Transparency regarding access trends would help ensure that the affordability improvements envisioned by the IRA are realized in practice.

Operational Implementation and the Pharmacy Counter Experience

Codification of the Part D redesign presents an opportunity for CMS to promote greater operational consistency across plan administration and beneficiary-facing materials. Variation in plan communications, customer service scripts, and pharmacy adjudication practices increases the risk of misunderstanding and inconsistent application of benefit rules. Beneficiary complaints frequently arise not because statutory requirements are unclear, but because operational execution produces inconsistent cost-sharing results or delays at the point of care.[17] The NHC encourages CMS to use complaint data, pharmacy access issues, and sponsor performance metrics to identify whether beneficiaries are experiencing systematic friction related to discount application or benefit phase transitions. Where recurring operational problems are identified, timely technical guidance and corrective action will be essential. Beneficiaries should not bear

[16] Adina Lasser, "Drug Price Negotiation Requires Oversight to Protect Older Americans," *Health Affairs Forefront*, January 14, 2025, https://doi.org/10.1377/forefront.20250113.791945.

[17] National Council for Prescription Drug Programs (NCPDP), “Recommendations for Medicare Part D Post Point-of-Sale Claim Adjustments,” version 1.1 (June 2025), https://www.ncpdp.org/NCPDP/media/pdf/WhitePaper/MedicarePartDPostPoint-of-SaleClaimAdjustments.pdf.

the burden of resolving systemic implementation failures through repeated customer service interactions, appeals, or delayed therapy. Clear escalation pathways and enforceable accountability mechanisms are critical to ensuring that the redesigned Part D benefit operates reliably and predictably at the pharmacy counter.

Updates to the Star Ratings Program

The MA and Part D Star Ratings program plays a central role in shaping both beneficiary plan selection and plan behavior. For many beneficiaries, Star Ratings are among the most visible and accessible indicators of plan quality and performance during open enrollment.[18] Star Ratings also drive quality bonus payments and rebate levels that materially affect plan resources, benefit design, and investment in care coordination and beneficiary support services.[19] From a beneficiary perspective, changes to the Star Ratings measure set, scoring methodology, or reward structure can therefore influence access to providers, availability of supplemental benefits, utilization management practices, and continuity of care.

The NHC urges CMS to evaluate proposed Star Ratings changes for both methodological soundness and their real-world implications for beneficiary experience and access, particularly for individuals with chronic disease, disability, or complex care needs. The NHC supports CMS' goals of simplification, stability, and focus within the Star Ratings program. However, simplification should not come at the expense of patient-relevant quality signals or undermine incentives for plans to invest in services and infrastructure that support beneficiaries with higher levels of need.

Measure Set Simplification and Preservation of Patient-Relevant Quality Signals

The NHC recognizes CMS' intent to streamline the Star Ratings measure set and reduce unnecessary complexity but emphasizes that any efforts to simplify measurement should be accompanied by robust accountability to ensure continued plan oversight and effective enforcement. Over time, expansion of the measure set has increased administrative burden for plans and created challenges related to overlap, redundancy, and interpretability.[20] Streamlining may improve clarity and focus only where it preserves patient-relevant quality signals and does not diminish CMS' ability to monitor plan performance in areas that directly affect beneficiary access and experience.

The NHC encourages CMS to carefully evaluate whether the removal or consolidation of measures diminishes visibility into domains that directly affect beneficiary experience, including access to care, care coordination, medication adherence, management of

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[18] CMS, "2025 Medicare Advantage and Part D Star Ratings," October 10, 2024, https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings.

[19] Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, *Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025* (San Francisco: KFF, June 12, 2025), https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/.

[20] Eric P. Borrelli et al., "Relationship Between Medication Adherence and Other Medicare Star Rating Measures," *The American Journal of Managed Care* 31, no. 11 (November 2025): 689, https://doi.org/10.37765/ajmc.2025.89820.

chronic conditions, and responsiveness to beneficiary needs.[21] Beneficiaries with complex medical conditions often experience quality through timeliness, continuity, and administrative navigation rather than through discrete clinical outcomes alone.[22] Measure set changes that obscure these dimensions risk overstating plan performance while masking access barriers that materially affect outcomes and limiting CMS' ability to identify and address problematic plan practices through oversight and enforcement.[23]

The NHC urges CMS to ensure that any measure set changes maintain the Star Ratings program's ability to reflect how plans perform for beneficiaries who rely most heavily on Medicare services and to support effective regulatory oversight. Simplification should not disproportionately remove measures that capture beneficiary experience or administrative access challenges, particularly where such measures provide insight into how plans function for individuals with complex and ongoing needs. The NHC recommends that CMS assess whether proposed changes have differential effects across plan types or beneficiary populations, including plans serving individuals with multiple chronic conditions or higher levels of medical complexity, and ensure that simplification does not inadvertently weaken incentives to invest in patient support services critical to these populations or reduce CMS' capacity to identify access-related concerns through quality measurement.

Decision Not to Implement the Health Equity Index Reward

CMS proposes not to move forward with implementation of the Health Equity Index reward and to retain the historical reward factor in the Star Ratings methodology. While the NHC understands the administrative and methodological challenges associated with introducing new reward structures, particularly those that rely on stratified performance measures and complex attribution methodologies, it remains important that quality measurement reflect meaningful variation in beneficiary experience and outcomes.[24]

Beneficiaries with chronic disease, disability, and complex care needs may face access challenges and care experiences that are not fully captured by aggregate performance measures.[25] The NHC encourages CMS to continue evaluating whether the Star Ratings program sufficiently reflects meaningful differences in beneficiary experience and access for these populations. Any future proposals in this area should be supported by a clear policy rationale, transparent methodology, and robust stakeholder engagement. The NHC encourages CMS to clearly articulate how new approaches

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[21] Better Medicare Alliance, *Improving Medicare Advantage Quality Measurement*, white paper, October 24, 2018, https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_StarRatings_WhitePaper_2018_10_24.pdf.

[22] CMS, "Medicare 2025 Part C & D Star Ratings Technical Notes" (updated October 3, 2024), https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf.

[23] CMS, *2026 Star Ratings Measures and Weights* (Baltimore: CMS, April 7, 2025), https://www.cms.gov/files/document/2026-star-ratings-measures.pdf.

[24] Lee and Xu, "Treatment Burdens."

[25] David T. Eton et al., "Building a Measurement Framework of Burden of Treatment in Complex Patients with Chronic Conditions: A Qualitative Study," *Patient Related Outcome Measures* 3 (2012): 39–49, https://doi.org/10.2147/PROM.S34681.

would interact with existing quality incentives and assess whether they would introduce additional compliance burdens or unintended effects on plan participation, particularly among plans serving higher-need populations.

Star Ratings Volatility, Methodological Change, and Beneficiary Communication

Year-to-year volatility in Star Ratings scores remains a significant concern from a beneficiary perspective, particularly because beneficiaries may reasonably interpret substantial score changes as reflecting meaningful differences in plan quality and performance.[26] When fluctuations are driven primarily by methodological recalibration or technical adjustments rather than changes in underlying plan performance, this disconnect can undermine the utility of Star Ratings as a reliable decision-making tool.[27]

The NHC urges CMS to strengthen beneficiary-facing explanations when methodological changes occur so that beneficiaries can distinguish between score changes driven by performance and those resulting from technical or methodological updates. Without clear and accessible explanation, volatility may erode confidence in Star Ratings and contribute to unnecessary plan switching that disrupts continuity of care without improving access or outcomes.[28] The NHC encourages CMS to consider whether Plan Finder tools and other beneficiary-facing materials could incorporate clearer contextual explanations of year-over-year score changes. Even limited, plain-language explanations could support more informed plan selection, particularly for beneficiaries managing ongoing care relationships or complex treatment regimens.

Implications for Quality Bonus Payments and Beneficiary Access

Quality bonus payments associated with Star Ratings materially influence plan resources and strategic decisions, including premium affordability, supplemental benefit offerings, and plans' capacity to invest in care coordination, beneficiary outreach, and provider network development. For beneficiaries with chronic disease and complex care needs, supplemental benefits supported by quality bonuses may include services that directly facilitate access and continuity, such as transportation, care management, medication adherence support, and other non-medical services that address barriers to care. Changes to Star Ratings scoring or bonus eligibility may therefore have indirect but significant implications for beneficiary access, even when core benefits remain unchanged.

The NHC encourages CMS to assess how proposed Star Ratings changes may influence plan decisions related to benefit design, provider networks, and utilization management. The NHC urges CMS to monitor whether modifications correlate with

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[26] Andrew Anderson and Mark K. Meiselbach, "Fluctuating Star Ratings and Medicare Advantage Bonuses," *JAMA Health Forum* 6, no. 10 (October 3, 2025): e254398, https://doi.org/10.1001/jamahealthforum.2025.4398.

[27] Eric Levine, Holden Corcoran, and Haley Payne, *Refining MA Stars: Policy Considerations and Discussion*, white paper (Washington, DC: Avalere Health, June 10, 2025), https://advisory.avalerehealth.com/wp-content/uploads/2025/06/Refining-MA-Stars-Policy-Considerations-and-Discussion.pdf.

[28] Anderson and Meiselbach, "Fluctuating Star Ratings"

reductions in supplemental benefits, increased administrative barriers, or narrower networks that disproportionately affect beneficiaries who rely on coordinated and ongoing care.

Implications for Plans Serving High-Need Populations

Changes to Star Ratings methodology and bonus structures can have disproportionate effects on plans that serve higher concentrations of beneficiaries with chronic disease, disability, or other complex needs.[29] These plans may face unique challenges related to care coordination, medication management, and beneficiary engagement that are not fully reflected in simplified measure sets.[30]

The NHC recommends that CMS assess the distributional impacts of proposed Star Ratings changes and consider whether additional safeguards are necessary to avoid penalizing plans that serve high-need populations. Maintaining stable incentives for plans to continue serving these beneficiaries is essential to preserving access and continuity of care, particularly in markets with limited plan options. The NHC encourages CMS to consider how Star Ratings policies interact with other program features, including risk adjustment, utilization management oversight, and marketing rules. Quality measurement does not operate in isolation, and combined policy effects may shape plan behavior in ways that are not apparent when changes are evaluated individually.[31]

Preserving Trust in the Star Ratings Program

The NHC urges CMS to prioritize beneficiary trust as a core objective of the Star Ratings program. Beneficiaries should be able to understand what ratings mean, how they are calculated, and how they relate to access and care quality. When ratings appear disconnected from lived experience, beneficiaries may discount the program entirely, undermining its value as both a consumer information tool and a policy lever. As CMS finalizes Star Ratings policies for CY 2027, the NHC encourages the agency to maintain stability where possible, provide adequate transition periods for methodological changes, and engage stakeholders early to identify potential unintended consequences. Predictability and transparency in quality measurement support long-term plan investment in care coordination and reduce the risk that short-term rating fluctuations drive reactive changes that negatively affect beneficiary access.

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[29] David J. Meyers, Amal N. Trivedi, and Andrew M. Ryan, “Flaws in the Medicare Advantage Star Ratings,” *JAMA Health Forum* 6, no. 1 (January 24, 2025): e244802, https://doi.org/10.1001/jamahealthforum.2024.4802.

[30] Amal N. Trivedi, “Understanding Seniors’ Choices in Medicare Advantage,” *Journal of General Internal Medicine* 31, no. 2 (February 2016): 151–52, https://doi.org/10.1007/s11606-015-3511-3.

[31] Medicare Payment Advisory Commission (MedPAC), “Chapter 11: The Medicare Advantage Program: Status Report,” in *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2025).

RFI on Future Directions in MA (Risk Adjustment and Quality Bonus Payments)

The NHC appreciates CMS' decision to seek stakeholder input on the future direction of the MA program, particularly with respect to risk adjustment and quality bonus payments. These payment mechanisms are foundational to plan participation and behavior and have material implications for beneficiary access, benefit design, and care coordination. Given their central role in shaping plan incentives and beneficiary experience, any reforms in this area should be pursued deliberately, transparently, and with sustained attention to patient impact.

Risk adjustment and quality bonus payments influence which beneficiaries plans are willing to serve, how resources are allocated across benefits and services, and whether plans invest in infrastructure that supports individuals with complex medical needs.[32] Changes to these mechanisms therefore affect not only plan finances, but also beneficiary experience, particularly for individuals with chronic disease, disability, or high-cost conditions.[33] The NHC urges CMS to evaluate potential reforms with an explicit focus on how changes may alter plan behavior in ways that affect access, continuity of care, and service delivery for high-need populations.

Risk Adjustment Policy Considerations

Risk adjustment is intended to compensate plans for the expected costs of serving beneficiaries with varying health needs and to reduce incentives for favorable risk selection. The accuracy, stability, and predictability of risk adjustment methodology are essential to ensuring that plans remain willing to enroll and adequately serve beneficiaries with complex or costly conditions.

As CMS considers potential future reforms, the NHC urges the agency to assess whether proposed changes improve predictive accuracy without introducing instability or unintended access barriers. Reforms that reduce the adequacy of risk adjustment for certain conditions or populations may lead plans to respond through narrower provider networks, increased utilization management, or reduced investment in care coordination services that support high-need beneficiaries.[34]

The NHC encourages CMS to consider the cumulative effects of recent and ongoing changes to risk adjustment, including coding intensity adjustments and model updates. Beneficiaries and plans alike benefit from predictability, and frequent or substantial methodological changes can create uncertainty that undermines long-term planning and sustained investment in patient-centered care models.[35] Evaluation of future reforms should therefore account not only for individual policy changes in isolation, but also for the combined effects of successive adjustments over time.

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[32] MedPAC, "Medicare Advantage Program Status Report."

[33] Meyers, Trivedi, and Ryan, "Flaws in MA Stars."

[34] Meyers, Trivedi, and Ryan, "Flaws in MA Stars."

[35] Levine, Corcoran, and Payne. "Refining MA Stars"

The NHC further encourages CMS to assess whether current and proposed risk adjustment models adequately capture the needs of beneficiaries with multiple chronic conditions, functional limitations, or complex medication regimens. The NHC encourages CMS to evaluate whether existing methodologies sufficiently reflect the costs associated with care coordination, social supports, and other services that are critical to maintaining health and preventing avoidable utilization among high-need populations.

Quality Bonus Payments and Plan Incentives

Quality bonus payments tied to Star Ratings significantly influence plan resources, benefit offerings, and strategic priorities. Bonus payments and rebates support supplemental benefits, reduced premiums, and investments in care management and beneficiary engagement. As a result, changes to bonus payment structures can have downstream effects on beneficiary access even when core benefits remain unchanged.[36]

The NHC urges CMS to evaluate how potential reforms to quality bonus payments may affect plan incentives to serve beneficiaries with complex needs. Increased volatility or reduced predictability in bonus eligibility or payment levels may discourage sustained investment in services that support care coordination, medication adherence, and non-medical supports that are particularly valuable to beneficiaries managing chronic conditions.[37]

The NHC encourages CMS to consider whether proposed reforms appropriately balance incentives for quality improvement with the need for stability. Sudden or sweeping changes may encourage short-term plan responses that prioritize rating optimization over sustained investment in patient-centered care.[38] The NHC encourages CMS to assess whether bonus payment structures interact with risk adjustment in ways that amplify or mitigate access risks for high-need populations.

Data Transparency and Stakeholder Engagement

Transparency is essential as CMS evaluates potential reforms to MA payment policy. Stakeholders should be able to understand the rationale for proposed changes, the data supporting them, and the expected implications for plans and beneficiaries. Clear communication is particularly important given the complexity of risk adjustment and quality bonus payment mechanisms and their indirect effects on beneficiary experience.

The NHC encourages CMS to provide detailed analyses of how potential reforms would impact different plan types, markets, and beneficiary populations, including whether changes may disproportionately affect plans serving higher concentrations of

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[36] Biniek, Damico, and Neuman, *Medicare Advantage Quality Bonus Payments*.

[37] MedPAC, “Chapter 2: Supplemental Benefits in Medicare Advantage,” in *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2025), https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch2_MedPAC_Report_To_Congress_SEC.pdf.

[38] Anderson and Meiselbach, "Fluctuating Star Ratings."

beneficiaries with chronic disease, disability, or socioeconomic vulnerability, and to engage patient organizations, providers, states, and plans early and consistently as it explores future policy directions. Such engagement can help identify unintended consequences and inform refinements that support beneficiary access while advancing program integrity and sustainability.

Testing, Phased Implementation, and Monitoring

Given the foundational role of risk adjustment and quality bonus payments in the MA program, the NHC recommends that CMS avoid implementing major structural changes without adequate testing and evaluation. Where appropriate, the NHC encourages CMS to consider phased implementation, targeted pilots, or demonstration models to assess real-world effects before applying reforms broadly.

The NHC encourages CMS to establish clear monitoring frameworks to evaluate the impact of any changes on beneficiary access, utilization management practices, network adequacy, and care coordination. Monitoring should include both quantitative indicators and qualitative feedback to capture how reforms are experienced by beneficiaries and caregivers.

The NHC supports CMS' evaluation of the future direction of MA payment policy and encourages the agency to ensure that any reforms reinforce access, stability, and patient-centered care for beneficiaries with complex and ongoing health needs. These incentive structures are particularly consequential for beneficiaries with complex needs, including dually eligible individuals, and CMS' concurrent RFI on SNP enrollment growth is therefore timely.

RFI on Dually Eligible Individual Enrollment Growth in Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs)

The NHC appreciates CMS' decision to solicit input on enrollment growth among dually eligible individuals in C-SNPs and I-SNPs. Enrollment trends among high-need populations can provide important insight into whether plan structures are supporting meaningful care coordination or contributing to increased complexity and beneficiary confusion. Dually eligible individuals represent one of the most medically and socially complex populations served by Medicare, and enrollment patterns within special needs plans have significant implications for care coordination, access to services, and beneficiary experience across both Medicare and Medicaid.[39]

Growth in dually eligible enrollment within SNPs warrants careful evaluation to determine whether it reflects improved alignment between beneficiary needs and plan design or whether it signals increasing complexity within the MA program that may be difficult for beneficiaries and caregivers to navigate. Because eligibility criteria, enrollment pathways, and benefit structures differ across SNP types, beneficiaries may enroll in C-SNPs or I-SNPs without fully understanding how benefits are coordinated,

[39] Rebekah I. Stein et al., "Growth of Chronic Condition Special Needs Plans among Dual-Eligible Beneficiaries, 2011–24," *Health Affairs* 44, no. 3 (2025): 304–312, https://doi.org/10.1377/hlthaff.2024.00651.

how provider networks are structured, or how coverage responsibilities are divided between Medicare and Medicaid.[40]

Beneficiary Understanding and Enrollment Decision-Making

From a beneficiary perspective, distinctions among C-SNPs, I-SNPs, and dual eligible special needs plans (D-SNPs) are often unclear.[41] Eligibility criteria, enrollment triggers, and benefit structures can be difficult to interpret, particularly for individuals managing multiple chronic conditions, functional limitations, or cognitive impairment. As a result, beneficiaries frequently rely on marketing materials, brokers, or plan representatives when making enrollment decisions, increasing the importance of clear, accurate, and standardized communication regarding SNP design and integration.[42]

As CMS evaluates SNP enrollment growth, the NHC emphasizes the importance of prioritizing beneficiary understanding. Clear and consistent explanations of SNP types, eligibility pathways, levels of Medicare–Medicaid integration, and beneficiary rights could support more informed plan selection. The NHC encourages CMS to assess whether existing beneficiary-facing materials adequately explain how SNP enrollment affects access to providers, prescription drugs, long-term services and supports, and cost-sharing obligations across programs.

The NHC encourages CMS to evaluate whether beneficiaries enrolled in C-SNPs or I-SNPs have a clear understanding of how care coordination is expected to function in practice. Enrollment alone does not ensure meaningful integration, and beneficiaries may reasonably assume that SNP participation provides a level of coordination that is not consistently realized. The NHC encourages CMS to assess whether plan communications and operational practices align with beneficiary expectations and with statutory and regulatory intent.

Care Coordination and Integration Across Medicare and Medicaid

The central policy rationale for SNPs serving dually eligible individuals is improved coordination of care across Medicare and Medicaid. Effective integration has the potential to reduce fragmentation, improve continuity of care, and better address the complex medical and social needs of beneficiaries who rely on services across multiple delivery systems.[43]

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[40] MedPAC, “Institutional Special Needs Plans,” in *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Tab-I-I-SNPs-Mar-2025.pdf.

[41] Joan F. Brazier et al., “Expansion and Marketing of Medicare Advantage to Persons with End-Stage Kidney Disease,” *JAMA Network Open* 8, no. 6 (June 2, 2025): e2516359, https://doi.org/10.1001/jamanetworkopen.2025.16359.

[42] Brazier et al., "Expansion and Marketing."

[43] Eric T. Roberts et al., “Integrating Medicare and Medicaid Coverage for Dual Eligibles—Recommendations for Reform,” *JAMA* 330, no. 5 (2023): 409–410, https://doi.org/10.1001/jama.2023.8879.

As CMS evaluates enrollment growth in C-SNPs and I-SNPs, the NHC urges the agency to assess whether increased enrollment is associated with measurable improvements in care coordination and beneficiary outcomes. Evaluation should include the effects of SNP enrollment on transitions between care settings, access to primary and specialty care, medication management, and coordination of long-term services and supports.

The NHC also encourages CMS to examine how federal SNP policies interact with state Medicaid contracting and oversight authority. States play a central role in designing and implementing integration models for dually eligible individuals, and federal policies should reinforce, rather than undermine, state efforts to promote aligned enrollment and coordinated care. The NHC encourages CMS to assess whether current federal requirements create incentives that are misaligned with state integration goals or contribute to fragmented enrollment across plan types.

Marketing, Steering, and Appropriate Plan Placement

Enrollment growth among dually eligible individuals in C-SNPs and I-SNPs also raises questions regarding marketing practices and potential beneficiary steering. Beneficiaries may be directed toward plans based primarily on eligibility criteria without sufficient consideration of whether a particular SNP type is the most appropriate option given their medical, functional, and social needs.[44]

The NHC urges CMS to evaluate whether existing marketing and enrollment safeguards are sufficient to support appropriate plan placement for dually eligible individuals. This evaluation should include whether beneficiaries receive clear explanations of alternative plan options, including D-SNPs, and whether enrollment decisions reflect informed choice rather than default pathways or marketing incentives.

The NHC encourages CMS to consider whether additional guardrails or clarifications are warranted to prevent inappropriate steering, particularly in markets where enrollment growth appears concentrated and beneficiary counseling resources may be limited.

Oversight, Data, and Future Policy Development

Any future changes to SNP eligibility, enrollment rules, or oversight mechanisms should be informed by beneficiary experience, access outcomes, and evidence regarding the effectiveness of care coordination. The NHC encourages CMS to leverage available data, including complaints, appeals, disenrollment patterns, and service utilization, to assess whether SNP enrollment growth is associated with improved or diminished beneficiary experience.

Early and sustained engagement with states, patient organizations, and other stakeholders can help inform whether policy adjustments are warranted and support a more complete understanding of how SNP enrollment trends manifest across diverse

[44] Stein et al., "Growth of Chronic Condition SNPs."

markets and delivery systems. Such engagement is also critical to identifying unintended consequences that may not be apparent from enrollment data alone.

The NHC supports CMS' continued evaluation of SNP enrollment trends and encourages the agency to ensure that future policy development advances integration, clarity, and beneficiary-centered care for dually eligible individuals.

Marketing, Communications, and TPMO Requirements

The NHC welcomes efforts to ensure that MA and Part D marketing and communications requirements promote clarity, accuracy, and beneficiary understanding. Effective communication is foundational to informed enrollment decisions and to beneficiaries' ability to navigate coverage options in programs that are inherently complex.[45] CMS has articulated an interest in modernizing and streamlining marketing requirements, and the NHC recognizes the potential value of regulatory updates that reduce unnecessary administrative burden while maintaining clear consumer protections.

Changes to marketing and communications standards warrant careful scrutiny given their direct implications for beneficiary understanding and enrollment decisions.[46] CMS' enforcement history reflects the need for ongoing oversight of marketing practices within MA and Part D to address beneficiary confusion and ensure adherence to applicable program standards.[47] Any reduction in existing safeguards should therefore be evaluated with particular attention to how such changes may affect beneficiaries who rely heavily on intermediaries to interpret plan options, enrollment rules, and coverage implications.

Marketing and communications requirements serve a core consumer protection function within MA and Part D. Beneficiaries frequently depend on agents, brokers, and third-party marketing entities to navigate plan selection, understand benefit design, and assess cost-sharing obligations.[48] For beneficiaries living with chronic disease, cognitive impairment, functional limitations, or limited health literacy, the accuracy and clarity of marketing materials can directly influence access to medically necessary care,

[45] Medicare Rights Center, "Beneficiary Experiences with Medicare Advantage Marketing," December 3, 2025, https://www.medicarerights.org/policy-documents/beneficiary-experiences-with-medicare-advantage-marketing.

[46] U.S. Senate Committee on Finance, "Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen," March 24, 2025, https://www.finance.senate.gov/imo/media/doc/pushing_medicare_advantage_on_seniors_unraveling_the_complex_network_of_marketing_middlemen_-_32425docx.pdf.

[47] Jakob Emerson, "OIG Warns of Risky Medicare Advantage Marketing Schemes," *Becker's Payer*, December 16, 2024, https://www.beckerspayer.com/payer/oig-warns-of-risky-medicare-advantage-marketing-schemes/.

[48] Laura Skopec, Judy Feder, and Stephen Zuckerman, *Challenges of Choice in Medicare: The Role of Agents and Brokers in a Public Program* (Washington, DC: Urban Institute, September 19, 2025), https://www.urban.org/sites/default/files/2025-09/Challenges%20of%20Choice%20in%20Medicare.pdf.

continuity of provider relationships, and financial stability.[49] Regulatory changes in this area should be assessed not only for administrative efficiency, but for their real-world implications for beneficiary experience and access.

Modifications to TPMO Definitions and Plan Accountability

CMS proposes to revisit and potentially refine the definition of third-party marketing organizations under sections 422.2260 and 423.2260. The NHC agrees that additional clarity regarding the scope and roles of marketing entities may be appropriate, particularly as marketing practices evolve and increasingly rely on digital platforms, lead generators, and subcontracted arrangements.[50]

However, any modification to TPMO definitions must preserve clear and enforceable accountability. MA organizations and Part D sponsors should remain responsible for the actions of downstream entities that materially influence beneficiary decision-making, regardless of organizational structure, compensation model, or technological format.[51] Revisions to definitional scope should not weaken CMS' ability to hold plans accountable for marketing practices conducted on their behalf.

From a beneficiary perspective, distinctions among plans, agents, and marketing intermediaries are often unclear and largely irrelevant.[52] Beneficiaries reasonably expect that entities presenting plan information are subject to consistent standards and oversight. The NHC urges CMS to ensure that any revised definitions continue to capture entities that meaningfully shape enrollment decisions and that plans retain responsibility for compliance across all marketing channels.

Elimination of Outbound Enrollment Verification and Related Safeguards

The NHC is concerned about CMS' proposal to eliminate outbound enrollment verification— which has functioned as an important safeguard against unauthorized or inappropriate enrollments, particularly in contexts involving aggressive, misleading, or high-pressure marketing practices—as part of its broader effort to reduce regulatory burden.[53] Before finalizing the removal of this requirement, the NHC urges CMS to demonstrate that alternative protections are sufficient to prevent beneficiary harm. The absence of outbound verification may disproportionately affect beneficiaries with limited capacity to independently confirm enrollment decisions or to identify and resolve

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[49] Abby Sachar et al., *A Closer Look at the Growing Role of Special Needs Plans in Medicare Advantage* (San Francisco: KFF, September 25, 2025), https://www.kff.org/medicare/a-closer-look-at-the-growing-role-of-special-needs-plans-in-medicare-advantage/.

[50] Senate Committee on Finance, "Pushing Medicare Advantage."

[51] Skopec, Feder, and Zuckerman, *Challenges of Choice in Medicare*.

[52] Medicare Rights Center, "Beneficiary Experiences."

[53] Government Accountability Office, "Medicare Advantage: Explosive Growth in Unauthorized Plan Switches," preliminary report, December 3, 2025, summarized by House Committee on Ways and Means, accessed January 26, 2026, https://waysandmeans.house.gov/2025/12/03/watchdog-finds-consumer-harm-and-billions-of-taxpayer-dollars-wasted-in-health-care-fraud-in-affordable-care-act-plans/

enrollment errors after they occur. Improper enrollment can result in coverage disruptions, provider access issues, and delays in care that are difficult to remedy retroactively.

If CMS proceeds with eliminating outbound enrollment verification, the agency should clearly articulate how beneficiaries will be protected from unauthorized enrollments and how CMS will identify and address problematic enrollment patterns in a timely manner. Any reduction in front-end safeguards should be paired with responsive oversight and enforcement mechanisms capable of preventing harm rather than primarily responding after beneficiaries have already experienced adverse effects.

Testimonial Requirements, Translation Thresholds, and Use of Medicare Branding

The proposed modifications to testimonial requirements, translation thresholds, and standards governing the use of Medicare branding, including the Medicare card image, raise additional concerns regarding beneficiary confusion and misperception. Testimonials, if not carefully regulated, may create unrealistic expectations or obscure material coverage limitations.[54] Reductions in translation requirements may disproportionately affect beneficiaries with limited English proficiency, increasing the risk that individuals misunderstand benefits, cost-sharing obligations, or network restrictions.[55]

The NHC urges CMS to evaluate these proposals through a beneficiary-impact lens and assess whether reduced requirements compromise access to accurate, culturally appropriate information. Regulatory streamlining should not increase the likelihood that beneficiaries misunderstand coverage options or make enrollment decisions based on incomplete or misleading information. The NHC emphasizes the need for CMS to continue enforcing clear standards governing the use of Medicare branding to prevent beneficiaries from mistaking plan marketing materials for official CMS communications or endorsements.

Oversight, Data, and Enforcement

If CMS proceeds with modifications to marketing, communications, or TPMO requirements, enhanced data-driven oversight and timely enforcement will be essential. The NHC encourages CMS to leverage complaint data, enrollment and disenrollment patterns, and other available indicators to monitor the effects of regulatory changes and to identify emerging risks promptly, while clearly communicating plan accountability expectations and enforcement approaches under any revised framework. Effective oversight requires mechanisms that operate quickly enough to prevent or mitigate beneficiary harm, rather than solely addressing violations after coverage disruptions have occurred. The NHC supports modernization of marketing requirements where

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[54] Emerson, "OIG Warns."

[55] Alisha Rao, Drishti Pillai, and Samantha Artiga, *Designating English as the Official Language of the United States Could Impact Millions with Limited English Proficiency* (San Francisco: KFF, October 10, 2025), https://www.kff.org/racial-equity-and-health-policy/designating-english-as-the-official-language-of-the-united-states-could-impact-millions-with-limited-english-proficiency/.

such changes demonstrably improve beneficiary understanding and reduce unnecessary administrative burden; however, regulatory updates should not weaken protections that are essential to ensuring that beneficiaries can make informed enrollment decisions and maintain stable access to care.

Utilization Management, Prior Authorization, and Internal Coverage Criteria

Utilization management practices, including prior authorization requirements and internal coverage criteria, play an established and appropriate role in MA, including supporting clinically appropriate care, program integrity, patient safety, and efforts to address fraud, waste, and inappropriate utilization. The NHC recognizes that only a subset of services is subject to prior authorization and that the majority of prior authorization requests are ultimately approved.[56] We also acknowledge ongoing industry initiatives to streamline prior authorization processes, expand electronic prior authorization, and improve continuity of care.[57] At the same time, utilization management remains one of the primary ways beneficiaries experience MA coverage in practice. Patient organizations report that, for some beneficiaries, particularly those with ongoing, urgent, or complex care needs, delays in authorization, lack of clarity regarding applicable standards, or repeated administrative requirements may disrupt care even when services are ultimately approved.[58,59,60] The NHC encourages CMS to continue monitoring utilization management practices as part of its broader oversight of MA plan administration, with a balanced focus on program integrity, patient safety, and beneficiary protection. Oversight should emphasize transparency, consistency, and timeliness in coverage determinations, particularly for beneficiaries with complex and ongoing health needs.

Where MA plans apply internal coverage criteria as part of utilization management, clear disclosure and consistent application are essential to beneficiary understanding, timely care delivery, and safe continuity of treatment. The NHC urges CMS to continue reinforcing expectations that internal coverage criteria are evidence-based, publicly disclosed, and applied consistently, and that coverage determinations do not rely on undisclosed or inconsistently applied standards that could delay or impede access to

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[56] AHIP, *Improving Prior Authorization for Patients & Providers: 2024 Survey Results* (Washington, DC: AHIP, 2024), https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization-final.pdf.

[57] U.S. Department of Health and Human Services, "HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System," press release, June 23, 2025, accessed January 26, 2026, https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html.

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

[59] NHC, *Exploring the Burden of Prior Authorization.*

[60] 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.

medically necessary care. Targeted oversight is particularly important where internal criteria affect services that are urgent, ongoing, or central to patient safety.

Transparency and Disclosure of Coverage Standards and Internal Criteria

Transparency regarding internal coverage criteria is an important component of beneficiary understanding and confidence in the MA program. Clear communication regarding the basis for coverage determinations supports informed decision-making and appropriate use of appeal rights.[61] The NHC encourages CMS to continue emphasizing clear, accessible disclosure of internal coverage criteria where such criteria are used in coverage determinations, with particular attention to beneficiary-facing communications and denial notices. Denial notices should clearly indicate whether internal coverage criteria were applied and provide sufficient explanation to support timely resolution or appeal where appropriate.

Prior Authorization Processes, Timeliness of Care, and Continuity of Care

While prior authorization affects a limited portion of services within MA and is often resolved without impact, for some beneficiaries delays may affect care timelines, particularly those with urgent or ongoing care needs, even when approval is ultimately granted.[62,63,64] The NHC encourages CMS to continue monitoring patterns of repeated prior authorization requests for ongoing or maintenance therapies and assess whether existing safeguards sufficiently support continuity of care while addressing appropriate utilization concerns.

For beneficiaries with chronic and complex conditions, the cumulative effect of repeated authorization requirements may shape overall access to care over time.[65] The NHC encourages CMS to continue evaluating utilization management policies through a cumulative impact lens to ensure that existing safeguards appropriately protect high-need populations, in coordination with other beneficiary protections.

Appeals, Grievances, and Access to Remedies

Appeals and grievance processes are critical for beneficiaries, particularly after an initial denial of medically necessary care. Their value lies in both their formal availability and if they are accessible, understandable, and capable of producing timely resolution. When procedures are complex, notices are unclear, or standards are applied inconsistently,

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[61] NHC. *Exploring the Burden of Prior Authorization.*

[62] Jeannie Fuglesten Biniek et al., "The Use of Prior Authorization in Medicare Advantage, 2021–2023" (paper presented at the AcademyHealth Annual Research Meeting, 2025).

[63] NHC. *Exploring the Burden of Prior Authorization.*

[64] Tanya Henry, “Prior Authorization Delays Care and Increases Health Care Costs,” American Medical Association, accessed January 26, 2026, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.

[65] Pamela Johnson et al., “Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes: A Systematic Review,” (October 2025), https://pubmed.ncbi.nlm.nih.gov/40912445/.

some beneficiaries may be discouraged from pursuing appeals, even when denials are later overturned.[66] For individuals with serious or progressive conditions, delays associated with appeals can result in deterioration of health status, interruption of treatment, or avoidable utilization that cannot be remedied retroactively.[67]

Clarity and Accessibility of Denial Notices

Clear, accurate, and accessible denial notices are foundational to meaningful access to appeals. Beneficiaries must be able to understand why a service or medication was denied, what standards were applied, and what options are available to challenge the decision. Patient organizations report that, in some cases, denial notices are written in technical or legal language that is difficult for beneficiaries and caregivers to interpret, particularly for individuals with limited health literacy, cognitive impairment, or serious illness.[68] The NHC supports CMS' continued assessment of whether additional standardization of denial notices would improve consistency and comprehension across plans. Excessive variation in notice structure and content can contribute to confusion and unequal access to remedies, even when formal appeal rights exist.

Appeals Outcomes and Beneficiary Experience

High appeal overturn rates raise important questions about the appropriateness and consistency of initial coverage determinations.[69] While appeals serve an essential corrective function, reliance on appeals can place administrative and emotional burden on beneficiaries and caregivers.[70] Many beneficiaries do not pursue appeals due to lack of awareness, limited capacity, health status, or concern about navigating complex processes.[71] From a patient-centered perspective, overturns may indicate opportunities to improve the clarity and consistency of initial coverage determinations. The NHC urges CMS to continue examining whether plans with high denial or overturn rates are applying overly restrictive criteria or inconsistent standards that undermine timely access to care. The NHC also encourages CMS to assess whether certain beneficiary populations are less likely to pursue appeals despite experiencing denials, and whether disparities exist in appeal utilization or outcomes. Ensuring equitable access to remedies requires not only formal appeal rights, but practical accessibility for all beneficiaries. Effective use of these remedies depends on beneficiary awareness and access to support

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[66] Biniek, Damico, and Neuman, *Medicare Advantage Quality Bonus Payments*.

[67] Johnson et al., "Adverse Effects."

[68] Miranda Yaver, "Rationing by Inconvenience: How Insurance Denials Induce Administrative Burdens," *Journal of Health Politics, Policy and Law* 49, no. 4 (August 2024): 539–565, https://doi.org/10.1215/03616878-11186111.

[69] Biniek, Damico, and Neuman, *Medicare Advantage Quality Bonus Payments*.

[70] Margaret A. Kyle and Austin B. Frakt, "Patient Administrative Burden in the US Health Care System," *Health Services Research* 56, no. 5 (October 2021): 758, https://doi.org/10.1111/1475-6773.13861.

[71] Yaver, "Rationing by Inconvenience."

Grievances, Appeals, and Beneficiary Support as Early Indicators of Systemic Issues

Grievance and appeals processes serve complementary roles in identifying beneficiary experience and potential systemic issues within MA and Part D.[72] While appeals focus on coverage determinations, grievances capture beneficiary concerns related to service quality, communication, access barriers, and plan conduct that may not rise to the level of a formal denial. As such, grievance data often provide early signals of emerging issues that warrant regulatory attention before they result in widespread harm. The NHC encourages CMS to continue treating grievance and appeals data as core components of program oversight and to ensure that reporting and analysis are sufficiently granular to support identification of recurring issues at the plan or service-category level. Patterns of grievances related to pharmacy access, network adequacy, customer service, care coordination, or marketing practices, as well as repeated denials or high overturn rates, may indicate underlying issues that merit further review.

Effective use of these remedies depends on beneficiary awareness and access to support. Navigating appeals and grievance processes often requires sustained administrative capacity, familiarity with plan rules, and, for beneficiaries with complex medical needs, assistance from caregivers, advocates, or counselors.[73,74] The NHC encourages CMS to continue supporting efforts to ensure that beneficiaries have access to meaningful assistance when pursuing appeals or grievances and to assess whether beneficiaries are aware of these processes and feel comfortable using them. Clear communication regarding grievance rights, protections against retaliation, and available assistance is essential to enabling beneficiaries to raise concerns without fear of adverse consequences and to ensuring that appeals and grievance activity informs CMS' broader oversight and enforcement framework rather than functioning as isolated compliance metrics.

Preserving Trust Through Effective Remedies

Appeals and grievance systems play a central role in maintaining beneficiary trust in the MA and Part D programs.[75] When beneficiaries believe that denials can be fairly and promptly reviewed, and that concerns will be addressed without retaliation or undue burden, confidence in the program is strengthened.[76] As CMS finalizes policies for CY 2027, the NHC encourages the agency to continue prioritizing accessibility, timeliness, and transparency in appeals and grievance processes. Effective remedies are essential

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[72] Skopec, Feder, and Zuckerman, *Challenges of Choice in Medicare*.

[73] Kyle and Frakt, "Patient Administrative Burden."

[74] Mark Schlesinger et al., "Voices Unheard: Barriers to Expressing Dissatisfaction to Health Plans," *The Milbank Quarterly* 80, no. 4 (2002): 709–755, https://doi.org/10.1111/1468-0009.00029.

[75] Justin Lo et al., *Claims Denials and Appeals in ACA Marketplace Plans in 2023* (San Francisco: KFF, 2025), https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/.

[76] Pamela Herd and Donald Moynihan, "Health Care Administrative Burdens: Centering Patient Experiences," *Health Services Research* 56, no. 5 (2021): 751–754, https://doi.org/10.1111/1475-6773.13858.

to ensuring that MA and Part D operate in a manner that is not only compliant with statutory requirements, but responsive to the needs of beneficiaries.

Network Adequacy, Specialty Access, and Continuity of Care

For beneficiaries with chronic disease, disability, rare conditions, or complex treatment needs, access to appropriate specialists and experienced care teams is often central to health outcomes and continuity of care.[77] Network adequacy therefore functions as a core beneficiary protection that directly affects access to medically necessary care.[78] The NHC encourages CMS to continue treating network adequacy as a patient-centered access issue, with oversight that extends beyond compliance with numerical standards. A network that satisfies numerical standards may fail to meet beneficiary needs if it lacks sufficient specialty depth, geographic accessibility, or continuity with established providers. CMS' oversight should continue to focus on whether networks function effectively in real-world care delivery, particularly for beneficiaries with complex or high-intensity care needs.

Accuracy of Provider Directories

Accurate provider directory information is foundational to meaningful beneficiary choice and continuity of care.[79] Beneficiaries rely on directories when selecting plans, confirming access to specialists, and making decisions during periods of acute or evolving health needs.[80] Inaccurate or outdated directory information can lead to delayed care, unexpected out-of-network charges, and disruptions to established provider relationships, and can undermine beneficiary trust in both plans and the Medicare program when representations made during enrollment and marketing do not align with actual network participation.[81] The NHC supports continued CMS attention to provider directory accuracy as a beneficiary protection concern and urges CMS to continue monitoring directory accuracy and taking corrective action, particularly when inaccuracies affect access to high-demand specialties or specialized care settings.

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[77] Matthew Bolz-Johnson et al., "Enhancing the Value of Clinical Networks for Rare Diseases," *Rare Disease and Orphan Drugs Journal* 1, no. 9 (2022), http://dx.doi.org/10.20517/rdodj.2022.01.

[78] American Medical Association, "Prior Authorization Delays Care and Increases Health Care Costs," accessed January 26, 2026, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.

[79] CMS, "Online Provider Directory Review Report," January 19, 2018, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

[80] Michael S. Adelberg et al., "Improving the Accuracy of Health Plan Provider Directories," *Health Affairs* 38, no. 6 (June 2019), https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories.

[81] CMS, "Online Provider Directory Review Report."

Specialty Access for Beneficiaries with Complex and Rare Conditions

For beneficiaries with rare diseases, cancer, and other serious or complex conditions, meaningful access to specialized providers and centers of excellence is often essential to appropriate care delivery.[82,83,84] The NHC encourages CMS to continue evaluating whether existing network adequacy standards appropriately account for specialty access needs, particularly for services disproportionately used by beneficiaries with complex conditions. The NHC also calls on CMS to assess whether plans meet minimum access thresholds and also if networks support timely access to clinically appropriate specialty care and continuity with experienced providers.

Continuity of Care and Mid-Year Network Changes

Continuity of care is a critical concern for beneficiaries who experience changes in health status, provider availability, or plan enrollment. Disruptions in established care relationships can result in delayed treatment, medication interruptions, and increased risk of adverse outcomes. For beneficiaries managing progressive or complex conditions, continuity with familiar providers is often essential to maintaining stability and avoiding avoidable complications.[85]

The NHC encourages CMS to continue emphasizing continuity of care protections as an important component of beneficiary safeguards. These protections should apply when providers exit networks and when plans modify coverage policies, internal criteria, or utilization management requirements in ways that affect ongoing treatment. Beneficiaries should receive clear, timely, and plain-language explanations of continuity protections, including the duration of transitional coverage and any steps required to maintain access to existing providers. The NHC encourages CMS to continue evaluating and strengthening safeguards for mid-year network changes, including notice requirements, continuity of care protections, and access to out-of-network care when necessary to maintain ongoing treatment, and to monitor such changes to identify patterns that may affect beneficiary stability. Clear, timely, and plain language communication regarding continuity protections, including the duration of transitional coverage and steps required to maintain access to existing providers, will remain essential to beneficiary understanding and confidence.

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[82] Meghan C. Halley et al., "Rare Disease, Advocacy and Justice: Intersecting Disparities in Research and Clinical Care," *The American Journal of Bioethics* 23, no. 7 (2023): 18, https://doi.org/10.1080/15265161.2023.2207500.

[83] Halley et al., "Rare Disease, Advocacy and Justice."

[84] Adelberg et al., "Improving the Accuracy."

[85] Gina Koch et al., "Barriers and Facilitators to Managing Multiple Chronic Conditions: A Systematic Literature Review," *Western Journal of Nursing Research* 37, no. 4 (2015): 498–516, https://doi.org/10.1177/0193945914549058.

Interaction Between Network Design and Utilization Management

Network adequacy and utilization management policies often interact in ways that compound access barriers.[86] Even when providers are in network, prior authorization requirements, referral pathways, or administrative processes may affect the timing of access to care.[87] Beneficiaries experience these policies cumulatively, rather than as separate regulatory categories.[88] The NHC encourages CMS to continue evaluating network adequacy within an integrated access framework that considers utilization management practices and beneficiary communications together. The NHC encourages CMS to assess whether plans with narrower networks also exhibit higher denial rates, longer authorization timelines, or increased reliance on post-service denials, and whether such patterns are associated with increased appeals, grievances, or care disruptions.

Oversight, Monitoring, and Beneficiary Trust

Effective oversight of network adequacy and continuity of care relies on timely, actionable data. The NHC supports CMS in continuing to leverage complaint data, appeals outcomes, and access indicators to proactively identify and address emerging access issues, alongside periodic compliance review where appropriate. Beneficiary trust depends on stable provider networks and oversight that prevents, rather than merely documents, access disruptions.[89] As CMS finalizes CY 2027 policies, the NHC encourages continued prioritization of network adequacy, specialty access, and continuity of care as core components of beneficiary protection, particularly for beneficiaries with complex and ongoing health care needs.

Mid-Year Coverage Changes, Formularies, and Beneficiary Stability

Coverage stability is central to meaningful access to care for MA and Part D beneficiaries.[90] Beneficiaries select plans during open enrollment based on representations regarding covered services, formularies, provider access, and utilization

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[86] William C. Chen et al., “Integrating Prior Authorization into Clinical Workflows for Care Access and Practitioner Experience,” *JAMA Network Open* 8, no. 12 (December 22, 2025): e2549093, https://doi.org/10.1001/jamanetworkopen.2025.49093.

[87] Ani Turner, George Miller, and Samantha Clark, *Impacts of Prior Authorization on Health Care Costs and Quality* (Washington, DC: National Institute for Health Care Reform, 2019, updated November 2024), https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

[88] Kyle and Frakt, "Patient Administrative Burden."

[89] Better Medicare Alliance, “Sustaining and Strengthening Medicare Advantage,” updated 2024, https://bettermedicarealliance.org/wp-content/uploads/2022/12/BMA-Sustaining-and-Strengthening-Medicare-Advantage-2022.pdf.

[90] Medicare Payment Advisory Commission, “Medicare Advantage,” in *MedPAC Data Book* (Washington, DC: MedPAC, July 2025), sec. 9, https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_Sec9_SEC.pdf.

management requirements.[91] When coverage policies change mid-year, those representations, in certain circumstances, no longer align with beneficiaries' actual access to care, creating confusion, disruption, or financial uncertainty.[92]

For beneficiaries managing chronic disease, disability, rare conditions, or complex treatment regimens, mid-year changes may interrupt established care plans, delay treatment, or require clinically inappropriate substitutions.[93] CMS' oversight should therefore focus on whether mid-year changes preserve continuity of care and protect beneficiary reliance interests, rather than solely on whether procedural requirements are met.

Formulary Changes and Continuity of Medication Access

Mid-year formulary changes present particular risks for Part D beneficiaries who rely on uninterrupted access to medications.[94] Beneficiaries stabilized on specific therapies may face new utilization management requirements, tier changes, increased cost sharing, or removal of drugs from preferred coverage categories after enrollment.[95] Even when alternatives are available, switching therapies mid-course may not be clinically appropriate for certain beneficiaries and can introduce avoidable clinical risk.[96]

The NHC supports CMS' longstanding safeguards governing mid-year formulary changes and encourages continued evaluation of how existing protections operate in practice. Transition fill requirements are an important mitigation tool, but patient organizations report that some beneficiaries experience confusion regarding the duration of transition periods, documentation requirements, and the likelihood of continued approval. The NHC recommends that CMS ensure consistent application of transition policies across plans and require timely, actionable notices explaining how formulary changes affect beneficiaries' medications, available options, and continuity protections, in a manner that allows beneficiaries to act before access is disrupted.

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[91] Mark N. Rood et al., "The Effect of Insurance-Driven Medication Changes on Patient Care," *The Journal of Family Practice* 61, no. 7 (2012): E1–E7.

[92] Connecticut General Assembly, "State of Connecticut Report on Mid-year Formulary Changes," 2017, https://www.cga.ct.gov/2017/insdata/tmy/2017HB-07123-R000302-Cook%20,%20Michelle,%20State%20Representative-TMY.PDF.

[93] Thomas Delate and Rochelle Henderson, "Effect of Patient Notification of Formulary Change on Formulary Adherence," *Journal of Managed Care Pharmacy* 11, no. 6 (2005): 493–498, https://doi.org/10.18553/jmcp.2005.11.6.493.

[94] Christopher L. Cai et al., "Changes in Medicare Part D Plan Designs After the Inflation Reduction Act," *JAMA Internal Medicine* 185, no. 10 (2025): 1266, https://doi.org/10.1001/jamainternmed.2025.4003.

[95] Joyce et al., "Medicare Part D Plans"

[96] Erin Nguyen et al., "Impact of Non-medical Switching on Clinical and Economic Outcomes, Resource Utilization and Medication-Taking Behavior: A Systematic Literature Review," *Current Medical Research and Opinion* 32, no. 7 (2016): 1281–1290, https://doi.org/10.1185/03007995.2016.1170673.

Mid-Year Utilization Management and Coverage Policy Changes

Mid-year changes are not limited to formularies and may include new or expanded prior authorization requirements, step therapy protocols, or updates to internal coverage criteria implemented after enrollment. Such changes can alter the conditions under which beneficiaries receive care they reasonably expected to be covered and, for beneficiaries with ongoing or high-intensity needs, may result in treatment delays, increased administrative burden, or interruptions in care.[97,98] The NHC urges CMS to ensure that mid-year policy changes preserve continuity of care and are not experienced by beneficiaries as unexpected or disruptive restrictions on access. Oversight should assess whether existing limitations on mid-year utilization management changes adequately protect continuity of care and beneficiary expectations, particularly when revised internal criteria are applied to services or treatments that were previously covered or reasonably expected to be covered.

The NHC encourages CMS to ensure that changes to internal coverage criteria during the plan year are communicated clearly, applied prospectively, and accompanied by appropriate continuity protections where applicable. The NHC further encourages CMS to continue evaluating whether existing safeguards are sufficient to prevent mid-year policy updates from being applied retroactively or in ways that undermine reliance on coverage representations made during enrollment.

Beneficiary Communication, Monitoring, and Coverage Stability

Clear, timely, and plain-language communication is essential to mitigating the impact of mid-year coverage changes.[99] Beneficiaries cannot meaningfully respond to changes if notices are delayed, overly technical, or fail to explain practical consequences. Patient organizations report that some beneficiaries and caregivers receive notices that do not clearly describe how a change affects care or what steps are required to preserve access, undermining continuity of care and beneficiary confidence.

The NHC is concerned that, unlike prior CY rules and guidance, the CY 2027 proposed rule does not meaningfully address the Medicare Prescription Payment Plan (MPPP), despite the program's central role in the Part D redesign and persistently low beneficiary awareness and enrollment. Limited uptake indicates that many beneficiaries remain

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[97] Chronic Care Alliance, "Utilization Management: Prior Authorization, Step Therapy and Non-Medical Switching," 2024, https://chroniccarealliance.org/priority-issues/step-therapy/.

[98] Ji-Yoon Shin et al., "Insurance Denials and Patient Treatment in a Large Academic Radiation Oncology Center," *JAMA Network Open* 7, no. 6 (2024): e2416359, https://doi.org/10.1001/jamanetworkopen.2024.16359.

[99] National Governors Association, "Using Plain Language for Effective Health Communication," January 22, 2025, https://www.nga.org/news/commentary/using-plain-language-for-effective-health-communication/.

unaware of the program or do not understand how to enroll or use it effectively.[100,101,102] The NHC urges CMS to use the annual rulemaking process as a key vehicle to reinforce beneficiary awareness of the MPPP and to redouble education and outreach efforts, particularly at points of care where beneficiaries are making real-time decisions about prescription access and affordability. The NHC also encourages CMS to evaluate whether additional steps are needed to reduce administrative friction and ensure the program functions as intended for beneficiaries most likely to benefit, including options to simplify enrollment, enhance accessibility, and improve the clarity and usability of beneficiary-facing communications, with appropriate safeguards for beneficiary choice.

Effective oversight of mid-year coverage changes depends on CMS' broader data integration and monitoring infrastructure, as discussed below. Within that framework, the NHC encourages CMS to continue leveraging complaint data, appeal outcomes, and utilization trends to identify whether mid-year changes are producing unintended barriers to care. Where patterns of frequent or disruptive changes result in beneficiary confusion or access disruption, the NHC urges CMS to consider targeted guidance, corrective action, or enforcement as appropriate. Public transparency, where feasible, can further support accountability and trust. While plans require some flexibility to respond to evolving clinical evidence and operational considerations, that flexibility must be balanced against the need for predictability and continuity of care. As CMS finalizes policies for CY 2027, the NHC encourages the agency to continue prioritizing coverage stability as a core component of beneficiary protection.

Data, Technology, and Program Oversight as Cross-Cutting Beneficiary Protections

Across the CY 2027 proposed rule, CMS emphasizes modernization, operational efficiency, and burden reduction. From a beneficiary perspective, the success of these efforts will depend less on the technical precision of individual provisions than on how effectively CMS monitors implementation, identifies emerging access risks, and intervenes when policy interactions produce unintended harm. Data integration, analytic capacity, and oversight posture therefore function as cross-cutting beneficiary protections that determine whether regulatory objectives are realized in practice.

Some of the concerns raised throughout these comments, including pharmacy access disruptions under Part D redesign, utilization management challenges, marketing-related enrollment issues, network instability, and mid-year coverage changes, may reflect patterns that can emerge when multiple program features interact and when

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[100] PAN Foundation, *Medicare 2025 Open Enrollment Research Among Medicare Beneficiaries*, prepared by The Harris Poll (Washington, DC: PAN Foundation, August 2025), https://www.panfoundation.org/wp-content/uploads/2025/09/PAN-Medicare-Open-Enrollment-Research-Sept-2025.pdf.

[101] Jeff Thiesen and Sarah Markiewicz, *M3P in 2025: Early Insights on Benefits and Uptake* (Parsippany, NJ: IQVIA, August 14, 2025), https://www.iqvia.com/locations/united-states/blogs/2025/08/m3p-in-2025-early-insights-on-benefits-and-uptake.

[102] Mark Gooding et al., *Early Enrollment Data Indicates More Beneficiaries Could Benefit from the Medicare Prescription Payment Plan (MPPP)* (Washington, DC: Avalere Health, April 23, 2025), https://advisory.avalerehealth.com/insights/early-enrollment-data-indicates-more-beneficiaries-could-benefit-from-mppp.

operational incentives shift faster than oversight mechanisms adapt. CMS' ability to detect and respond to these patterns in near real time is essential to preserving beneficiary access, continuity of care, and trust in the Medicare program.

CMS has access to a wide array of data sources that, when integrated and analyzed proactively, can function as early warning indicators of beneficiary harm. Complaint and grievance data, appeals and overturn rates, pharmacy access reports, enrollment and disenrollment patterns, network adequacy indicators, and utilization management metrics each provide partial insight into beneficiary experience. When viewed collectively, these data can help identify emerging issues before they become widespread or entrenched.

The NHC encourages CMS to continue strengthening its use of integrated analytics to identify patterns that may warrant timely intervention. For example, spikes in pharmacy-related complaints following benefit phase transitions, sustained increases—if observed—in prior authorization denials for specific services or drug classes, or clustering of grievances tied to marketing practices or enrollment pathways may warrant targeted review and corrective action.

CMS and plans increasingly rely on data-driven and technology-enabled tools, including automation and artificial intelligence, to manage utilization, adjudicate claims, and support program integrity across MA and Part D. While these tools can improve efficiency and consistency, they also raise important considerations related to transparency, explainability, accountability, and beneficiary access. From a beneficiary perspective, oversight mechanisms protect access only when they are sufficiently governed, understandable, and capable of producing timely corrective action when problems arise.

The NHC encourages CMS to ensure that technology-enabled oversight and plan operations remain anchored in clear accountability frameworks, including meaningful transparency into how automated tools are used in coverage determinations and utilization management. Beneficiaries should receive understandable explanations of coverage decisions and retain meaningful access to human review, particularly in complex or high-risk cases. Ongoing visibility into the use and impact of automated tools is especially important where reliance on such tools may correlate with higher denial rates, delayed care, or increased appeals activity.

Data collection and monitoring are only effective if they translate into timely and visible action. Beneficiaries experience harm not when a policy is imperfect, but when identified problems persist without correction. The NHC urges CMS to continue clarifying how patterns of concern identified through complaints, appeals, utilization data, or other indicators will trigger intervention, including issuance of technical guidance, targeted audits, corrective action plans, or enforcement where appropriate. Predictable and transparent oversight pathways support both plan compliance and beneficiary confidence by encouraging proactive correction rather than reactive compliance.

Finally, CMS' use of data, technology, and oversight tools should support beneficiary-facing transparency where feasible. Aggregated reporting on access-related indicators, appeals outcomes, or identified systemic issues can enhance accountability and inform

stakeholder engagement without imposing undue administrative burden. Transparency reinforces trust by demonstrating that beneficiary experiences are actively monitored and addressed as a core component of program administration. Across MA and Part D, beneficiaries with chronic disease, disability, and complex care needs are particularly sensitive to operational failures and delays; ensuring that oversight mechanisms are sufficiently responsive to protect these populations is essential to maintaining confidence in the Medicare program as it evolves.

Conclusion

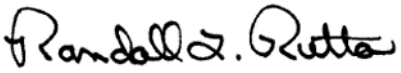
The NHC appreciates CMS' continued efforts to strengthen the MA and Part D programs through thoughtful rulemaking and stakeholder engagement. The CY 2027 proposed rule addresses a wide range of issues central to beneficiary access, affordability, and trust in the Medicare program. The NHC supports CMS' focus on codifying statutory Part D redesign elements and refining program oversight, while urging CMS to remain attentive to the practical ways in which regulatory changes are experienced by beneficiaries with chronic disease, disability, and complex medical needs.

As CMS finalizes this rule, the NHC urges CMS to prioritize patient-centered implementation, transparency, and accountability across all policy areas. Simplification and deregulatory efforts should be balanced against the need to preserve meaningful protections for beneficiaries, particularly where past experience has demonstrated risk of misleading marketing, inappropriate utilization management, or access disruptions related to plan administration and benefit design. In the Part D context, the NHC urges CMS to ensure that codification advances beneficiary understanding and point-of-sale reliability, and that manufacturer discount requirements operate predictably and without friction for patients. In the MA context, the NHC urges CMS to ensure that quality measurement and payment incentives remain aligned with beneficiary-relevant outcomes and do not create incentives for restrictive access strategies that disproportionately affect high-need populations.

The NHC stands ready to continue working with CMS to ensure that MA and Part D remain responsive to patient needs and aligned with the program's foundational goals. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs at kbeer@nhcouncil.org or Shion Chang, Senior Director, Policy & Regulatory Affairs at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

We appreciate the opportunity to provide these comments and look forward to ongoing collaboration.

Sincerely,



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