January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4208-P
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)

Dear Acting Administrator Wu:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of an equitable health care system, free from disparities.

Community Health Centers are the best, most diverse, most innovative, and most resilient part of our nation's health system. For sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, mountain, frontier, and island communities. Today, health centers serve nearly 32.5 million patients, or 1 in 10 individuals, at over 16,000 locations. This includes nearly 10 million or 1 in 5 rural residents, more than 29 million or 1 in 3 in poverty, and more than 5 million or 1 in 5 uninsured people. The number of Medicare patients seeking care at health centers is skyrocketing, mirroring the demographic shift towards an older population. Patients 65 plus are the fastest-growing patient population for health centers, and over 11% of health centers' patients are Medicare beneficiaries.[1]

In addition to medical services, health centers provide dental, behavioral health, pharmacy services, and other "enabling" or support services that facilitate access to care for individuals and families in medically underserved communities, regardless of insurance status or ability to pay. NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities. The collective mission and mandate of NACHC and the 1,496 health centers nationwide is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

NACHC appreciates CMS' goal to enhance protections in the Medicare Advantage and Part D programs and collect stakeholder feedback on what types of data the agency should collect to improve understanding of how MA impacts its beneficiaries. Medicare patients are the fastest-growing patient population in health centers.[1] With increased enrollment in Medicare Advantage, we applaud CMS' diligence in crafting proposals to ensure adequate access to care and supplemental benefits. We are eager to share our feedback

[1] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)

on the proposals, focusing on the health center perspective on areas where proposals in which Medicare Advantage can be improved to benefit health centers entering into MA agreements and the patients utilizing MA coverage. Our comment letter is broken down into four sections: I. Improving Patient Access; II. Bolstering Protections; and III. Miscellaneous Comments.

I. Improving Patient Access

Enhancing Rules on Internal Coverage Criteria § 422.101

NACHC supports CMS's proposals to define "internal coverage criteria," require that such criteria only supplement or interpret the plain language of Original Medicare criteria, establish policy guardrails, and require MA plans to post their internal coverage criteria on their websites publicly. We appreciate CMS' ongoing efforts to decrease the opacity that has surrounded internal coverage through previous final rules and FAQs.[2]

NACHC appreciates the agency's broader approach to defining internal coverage criteria, including criteria used for medical necessity determinations and criteria that are used by MA plans.[3] We also strongly support CMS's proposed policy guardrails that would prohibit the use of any criterion that does not have any clinical benefit and, therefore, exist solely to reduce utilization of the item or service, and to prohibit the use of any criterion used to automatically deny coverage of basic benefits without the MA organization making an individualized medical necessity determinations.[4] We further commend CMS for ensuring these internal coverage criteria are displayed prominently on the MA plan's website and readily available to the public without barriers.[5] Through these collective actions, there will be an enhanced understanding of MA plans' decision-making on coverage as well as further parity with coverage within Original Medicare.

Ensuring Equitable Access—Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137)

NACHC supports CMS' proposal to direct MA organizations to include disaggregated data on each item or service of prior authorization metrics on their websites. Having metrics available, such as the percentage of approvals and denials for both standard and expedited requests, could reduce the items and services subject to prior authorization. Additionally, publishing the average time elapsed between submission and the decision of prior authorization will also help payers remain accountable to the standards in place when these regulations are finalized. It will also help unearth trends that will lead to actions to decrease inequities.

Improving prior authorization reporting is key to increasing access to medically necessary services for patients and reducing the administrative burden on health center staff. Nearly all Medicare Advantage enrollees are required to obtain prior approval, or authorization, for coverage of some treatments or services — something generally not required in Original Medicare. NACHC requests further progress be made to ensure MA patients are not being improperly denied care. NACHC urges CMS to prioritize oversight of prior authorizations with MA plans to ensure patients receive fair and timely access to the care they deserve. As previously mentioned, health center patients ages 65 and older are the fastest-growing age group and are growing increasingly complex, with higher rates of chronic conditions. For this group of health center patients, denials can result in worsening health outcomes, increased pain and discomfort, unnecessary hospitalizations, and decreased quality of life. In 2022, MA insurers fully or partially denied

[2] https://www.ahcancal.org/Reimbursement/Medicare/Documents/CMS%20Memo%20FAQ%20on%202024%20MA%20Final%20Rule%202.6.24.pdf
[3] § 422.101(b)(6)(iii)
[4] §§ 422.101(b)(6)(iv)(A) and (B)
[5] § 422.101(b)(6)(ii).

3.4 million (7.4%) prior authorization requests. This percentage has continued to grow over the past few years; the share of all requests that were denied increased from 5.7% in 2019, 5.6% in 2020 and 5.8% in 2021 to 7.4% in 2022.[6] Improper denials can delay or prevent beneficiary access to medically necessary care, lead beneficiaries to pay out of pocket for services that are covered by Medicare or create an administrative burden for beneficiaries or their providers who choose to appeal the denial.[7] Furthermore, interruptions can exacerbate chronic conditions, potentially resulting in disease progression, increased symptom severity, and a higher risk of complications. In fact, health center patients are growing increasingly complex, with nearly 32% of health center patients reporting that they suffer from a chronic condition.[8] We strongly support the agency's proposal to enhance the data reported around prior authorization and look forward to working with the Administration to ensure prior authorization does not adversely affect patients.

NACHC supports CMS's proposal to ensure that any use of artificial intelligence (AI) and automated systems by MA plans preserves equitable access to MA services. Health insurance plans regularly use AI and automated systems to conduct utilization management activities, which can lead to unintended harm,[9] especially when no live person makes or reviews an individualized medical necessity determination. Health center patients are particularly vulnerable, as many are low-income and experience more adverse social drivers of health. Faulty AI systems denying crucial care could have a detrimental impact on patient health.

Recent research has uncovered how some commercial insurers, including those that operate MA plans and D-SNPs, are using AI to deny routine therapy services in at least 18 states.[10] We believe CMS' proposal is a strong first step in curbing the harmful use of AI in MA plans, and we encourage CMS to evaluate and build upon state activity. We also note that many health insurers are using third-party AI systems and programs, and we encourage CMS to clarify in these regulations that third-party development and use of AI should also be subject to the requirements for preserving equitable access to MA services.

We recommend CMS continue to enforce guidelines to ensure that insurers consider relevant factors for each patient when making coverage decisions through artificial intelligence (AI) to better benefit MA patients. While we appreciate that CMS' Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule provides MA patients with certain protections regarding coverage denials based on the use of AI and algorithms, the rule still permits MAOs to use algorithms, AI, and related technologies to assist in making coverage determinations if certain factors are considered for each patient.[11] These include all medical necessity determination requirements[12] and circumstances based on the specific individual, including the patient's medical history, physician recommendations, and clinical notes. It is unclear whether these factors were ever taken into consideration or if they will be in the future. For this reason, since MAOs are permitted to use AI algorithms, NACHC requests that CMS take additional steps to ensure insurers consider the relevant patient-specific factors outlined above when making coverage determinations.

NACHC supports CMS's proposals at § 422.137 to add an executive summary of the results of the analysis of the utilization management policies and strongly supports CMS's suggestion to add having

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[6] https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/

[7] https://oig.hhs.gov/oei/reports/oei-09-18-00260.asp

[8] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf

[9] https://content.naic.org/sites/default/files/national_meeting/Final-CR-Report-AI-and-Health-Insurance-11.14.24.pdf.

[10] https://www.propublica.org/article/unitedhealth-mental-health-care-denied-illegal-algorithm.

[11] https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf

[12] 42 CFR § 422.101(c)

an MH or SUD diagnosis as a social risk factor for this analysis. Recent claims and encounter data research by RTI International found exceptionally high MA denial rates for SUD treatment. In 2020, MA plans denied 45.3% of claims for inpatient hospital treatment with a primary diagnosis of SUD, compared to 3.3% in Original Medicare. MA plans denied 10.9% of hospital outpatient treatment claims with a primary diagnosis of SUD, compared to 2.2% in Original Medicare.[13] As health centers continue to provide high-quality behavioral health care services through Intensive Outpatient Programs, or some CHCs being dually-certified as Certified Community Behavioral Health Clinics, it is important to try and bridge the gap to address this disparity. The inclusion of having an MH or SUD diagnosis as a social risk factor for this analysis would help rectify this inequality and fill one of the many critical gaps presented by Medicare's lack of protections under the *Mental Health Parity and Addiction Equity Act (MHPAEA).* We urge CMS to work with Congress to apply MHPAEA to Medicare, including MA and Part D plans. In the meantime, it is critical that all MA plans evaluate data on how their utilization management policies and procedures may disproportionately affect access to MH and SUD services and items and take the necessary steps to reduce such barriers. We believe that this is something that MA plans would be able to operationalize through the claims data.

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

NACHC supports CMS' proposal to define community-based organizations in Medicare Advantage regulation at (§422.2) and asks CMS to clarify that health centers meet the CBO definition to ensure we are listed in MA provider directories. Based on the definition that CMS seeks to codify, CBOs are ''public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health and social needs of those populations;" health centers seem to fit into this definition. Besides offering healthcare services, directed by Section 330,[14] they provide enabling services such as outreach and enrollment, translation and interpretation, and transportation.[15] Furthermore, CMS' motivations in codifying this CBO definition are to "ensure individuals know which providers are deeply rooted within the communities they serve." Community is rooted within their name; the board of every community health center directly reflects who they serve. Fifty-one percent of a health center's board must be made up of that center's patients, and they must represent patients who the health center serves, given demographic factors like race, ethnicity, and gender.[16] Health centers are seen as community hubs that offer myriad resources in addition to healthcare services. In keeping with CMS's intent behind codifying the definition of CBOs and enhancing patient knowledge and awareness of health centers' offered services, we urge CMS to clarify that health centers, by definition, are CBOs, so they are included in MA directories.

Part D Coverage of Anti-Obesity Medications and Application to the Medicaid Program

While NACHC supports the CMS's proposal at (§423.100) to cover Anti-Obesity Medications (AOMs) under Part D and in the Medicaid program, we are concerned about the cost-sharing burden under Part D for health center patients. Obesity is a chronic disease affecting an increasing number of children, teens, adults, and older Americans. Health centers have seen a steady increase in the number of patients diagnosed with obesity. CHCs treated almost 9 million patients with obesity in 2023, which is a

[13] https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf.
[14] https://www.nachc.org/wp-content/uploads/2023/02/Section-330-statute-as-of-March-2018-Clean.pdf
[15] https://www.nachc.org/nachc-content/uploads/2023/07/Health-Center-Enabling-Services_NACHC_July2023_2021UDS.pdf
[16] https://bphc.hrsa.gov/compliance/compliance-manual/chapter20

1.1% increase from the prior year.[17] The longer a person is obese, the more significant obesity-related conditions such as diabetes, high blood pressure, and heart disease become over time.[18] Given the chronic diseases and conditions associated with obesity and the fact that obesity is hard to treat, AOMs can be an essential tool in improving a patient's health.

With more than 50% of health center patients enrolled in Medicaid[19], NACHC believes this proposal is an important move toward low-income patients accessing medications that can drastically improve their overall health. However, many health center patients, despite having incomes under 200% of the Federal Poverty Line (FPL), face high prescription co-pays due to high deductible plans. To make essential medications more affordable, CHCs utilize the sliding fee scale to reduce costs wherever possible. While co-pays for Medicare Part D patients may be waived in certain situations, it is not automatic and depends on specific circumstances.[20] For instance, co-pays may be waived only for certain medications and the patient must demonstrate financial need to qualify for the discount. Because Medicare Part D patients still need access to medications, pharmacy staff can typically work with medical providers to find alternative, covered medications[21], but that may be challenging with AOMs due to high demand and limited alternatives available.

<u>Medicare Advantage Network Adequacy & Promoting Informed Choice – Format Provider Directories for Medicare Plan Finder</u>

NACHC supports CMS's proposal at §422.111(m) to require Medicare Advantage provider directory data be submitted for use in the Medicare Plan Finder (MPF) for the 2026 Annual Enrollment Period. NACHC believes these proposals will improve beneficiaries' access to care and ensure they have accurate information about MA plans' networks to make informed decisions when selecting coverage, enhance access to care, and prevent surprise bills. Nearly 70% of health center patients live under 100% FPL, and 91% live under 200% FPL.[22] As health centers serve some of the nation's most vulnerable patients, it is critical that enrollees have dependable information about their in-network providers. MA plans must cover all medically necessary services that Original Medicare covers.[23]

Additionally, MA plans must cover all medically necessary services that Original Medicare does not cover – like certain vision, hearing, and dental services. This is partially why MA enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2024 to 60% by the end of the decade.[24] However, health center patients frequently enroll in MA plans without being fully informed of the limitations of their network, made by private insurance companies. If a provider is in-network, the MA plan will cover medically necessary services for a small co-pay. Still, an out-of-network provider can leave patients with significant out-of-pocket costs, impacting their access to care. This situation is especially devastating for health center patients who experience several types of social drivers of health (SDOH), such

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[17] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6A&year=2023 (14a); https://www.nachc.org/nachc-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf (Figure 3-7: Health Center Patients are Increasingly Complex).
[18] https://www.hopkinsmedicine.org/health/conditions-and-diseases/obesity/preventing-obesity#:~:text=Earlier%20onset%20of%20type%202,Encourage%20physical%20activity.
[19] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2023 (Line 8)
[20] https://www.nachc.org/nachc-content/uploads/2023/03/A-primer-on-health-Center-Phamracy-Operations.pdf
[21] Ibid.
[22] https://www.kff.org/report-section/community-health-centers-growing-importance-in-a-changing-health-care-system-issue-brief/
[23] https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf
[24] https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/

as employment, food security, and transportation issues. Without appropriate coverage, these patients have cost-sharing responsibilities that create detrimental financial situations.

MA plans are required to publish directories to enable beneficiaries to make informed choices. However, the accuracy of provider directories has been a significant problem for some Medicare Advantage plans. A 2018 CMS report found that 52% of physicians listed in MA provider directories contained at least one inaccuracy.[25] Typical errors include wrong phone numbers, incorrectly listing in-network providers as accepting new patients when they are not and omitting in-network providers from plan directories. There have also been several cases reported where health center patients enrolled in an MA plan believing their physician was in-network. However, upon attempting to schedule appointments, they were informed by the insurance billing office that their physician was not covered by their MA plan[26]:

- A health center in California said that, for MA plans, when patients look up their provider, the directory will show their doctor as an in-network.
- Another health center in North Carolina shared an incident where a patient relied on the MA plan's website to verify their provider's network status. Despite the website indicating the provider was in-network, the patient discovered after enrolling that this was not the case.

These instances highlight the critical need for greater transparency and accuracy in MA provider networks to prevent patients from facing such misleading and frustrating situations.

NACHC supports the requirement at §422.116(a)(1)(i) for MA organizations to attest that their provider directory information is accurate, consistent, and in compliance with CMS' MA network adequacy requirements. As mentioned earlier, health centers have reported being inaccurately listed in MA provider directories, which impacts their existing patients' access to certain services due to lack of coverage. This can also create a high level of demand for patients seeking care from a limited selection of in-network providers.

MA organizations rely on various practices to maintain provider directories. These include credentialing services, vendor support, and even provider responses, all of which CMS considers unreliable practices.[27] It is unfair to penalize health center patients who enroll in an MA plan based on false information but then are expected to pay for the plan's mistake, not seek essential health care, or risk being uninsured altogether. When health center patients discover that their provider is not in their plan's network, providers are left with a choice: send the patient home without care, ask the patient to pay for the service under out-of-network costs, or be prepared to provide the service for free. For example, some health center workers have stated that when a patient is out-of-network, the health center offers either a sliding fee scale or provides the service at no cost.

To ensure compliance with the proposed adequacy standards, NACHC urges CMS to perform secret shopper surveys of plan compliance with the accuracy of MA provider directories. Like the provision finalized in the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F)[28] this proposal would streamline the beneficiary experience regardless of the insurance they enroll in. These secret shopper surveys would be a direct test of compliance, helping inform CMS about network adequacy across MA plans and better ensure patients' access to care. NACHC

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[25] https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf
[26] https://www.pbs.org/newshour/economy/physician-isnt-medicare-advantage-network-can
[27] https://blogs.lexisnexis.com/healthcare/provider-data/provider-directories-still-falling-behind/
[28] https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

also recommends requiring the results of the secret shopper surveys to be posted online, enabling enrollees, advocates, and providers to track plan performance and hold MA plans accountable by implementing remedial measures to address any inaccuracies. We encourage CMS to consider compiling these reports and publishing them in one place on its Medicare.gov website to make it easier to find and compare the reports of different states or to evaluate the performance of an MA organization.

NACHC also encourages CMS to require that MA plans demonstrate the adequacy of their networks through providers that are submitting claims and, therefore, actively participating in the plan rather than relying on the inaccurate and unavailable providers currently listed in MA plan provider directories. If a health plan does not have accurate providers listed in their directories, health center patients seeking care will struggle to find a provider. A recent report from the U.S. Senate Finance Committee found that more than 80% of the identified listings for Medicare Advantage mental health providers were inaccurate or unavailable.[29] CMS should increase its oversight efforts to regularly audit health plan directories to hold MA plans accountable for the quality of their provider directories and for accurately documenting their networks. Adding an enforcement measure to this proposal will enhance access for enrollees and alleviate the burden on health center patients from needing to call multiple providers to inquire if they are accepting new patients or searching for updated contact information for their providers. NACHC supports the attestation proposal from CMS and will continue to support efforts to improve transparency and accountability for accurate provider directories.

Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and MA Cost Sharing Limits (§§ 417.454 and 422.100)

Community Health Centers have long been at the forefront of treating mental and behavioral health in America because they are accessible, community-based, and comprehensive. Since 2010, the number of patients receiving behavioral health services at health centers has grown by almost 63%. In 2023, health centers provided more than 26 million mental health visits to patients; this is 3.2 million more visits than in 2020.[1]

NACHC applauds CMS for proposing to align MA and Cost Plan in-network cost-sharing with Traditional Medicare for intensive outpatient (IOP) services, mental health specialty services, opioid treatment program (OTP) services, outpatient SUD services, partial hospitalization (PHP), psychiatric services, and inpatient hospital psychiatric services. NACHC has continuously advocated for policies to support health centers' ability to fully integrate behavioral health services with primary care settings. The mental health services provided by health centers can vary based on the needs of the community where facility sites reside. Since 2020, health centers increased screening for depression and follow-up by 7%.[1] Health centers offer a wide range of integrated mental and behavioral health services, including comprehensive individual or group counseling, intensive outpatient services, addiction and recovery services, Medication-Assisted Treatment (MAT), and crisis services. Proposing cost-sharing thresholds to align with traditional Medicare increases access and delivery time for Medicare beneficiaries in most need of mental health services.

CHC mental health services are patient-centered and often delivered while working harmoniously with community partners (hospitals, counselors, pharmacies, and others) to support the full range of patients' health needs. Health centers utilize interdisciplinary teams to coordinate care and offer case management to diagnose, treat, and care for individuals with trauma, sleep disorders, abuse, depression, anxiety, or

[29] Senate Committee on Finance, "Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks," (May 3, 2023)
https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.

alcohol or drug use, among other mental health conditions. CHCs are effectively positioned to provide integrated mental health and primary health care services in a community-based setting. Additionally, NACHC encourages CMS to consider additional strategies related to integrating care that prioritizes mental health and leverages the ability of the largest primary care network of CHCs to improve the quality and availability of care.

II. Bolstering Enrollee Protections

NACHC supports the proposal to expand agent and broker requirements regarding Medicare Savings Programs (MSP), Extra Help, and Medigap (§§ 422.2274 and 423.2274). NACHC is aware of the deceptive marketing practices used by Medicare Advantage plans and the brokers who sell MA plans. By requiring agents and brokers to discuss the availability of low-income supports, informing Medigap eligible beneficiaries about their Federal guaranteed issue rights when enrolling in an MA plan, and requiring agents to pause to address remaining questions before finalizing a beneficiary's enrollment, CMS is taking intentional action towards ensuring enrollees are properly informed of their coverage options and able to receive resources for additional support. While some health center outreach and enrollment staff do help beneficiaries enroll in MA plans, a large amount (one-third) of MA plan enrollees enlist brokers to help them choose their coverage.[30] When a patient finds out they must pay high co-pays for services or that their doctor is out-of-network, there is, unfortunately, no recourse other than waiting to switch to another plan once open enrollment begins. Health centers try to step in and help make services more affordable for patients in these instances, yet this does not address the larger misinformation issue.

Many patients have expressed confusion and regret about choosing a particular Medicare Advantage plan. This proposal may help decrease instances where patients sign up for MA plans, enticed by the free or low premiums but are unaware of the copays and cannot afford coverage. By adding these additional broker requirements, enrollees will have added protection from intentional or unintentional misinformation about their health insurance and can sign up for the coverage they are eligible to receive.

These stronger requirements are essential for holding agents and brokers accountable for ensuring they provide enrollees with accurate plan information. It is crucial for brokers to educate individuals before making enrollment choices. Many health center patients are eligible for additional coverage options, especially the low-income subsidy (LIS). Unfortunately, they are not always aware of or given the information to determine if they are eligible for these savings programs. They typically choose a health insurance plan without additional coverage. Patients see the advertisements or benefits for Medicare Advantage plans and typically enroll without being made aware of other opportunities they are eligible for to save money, like Medicare Savings Programs (MSP) and the LIS. In 2021, over 1.1 million people were both enrolled in LIS and eligible for MSP but ultimately not enrolled in this essential financial assistance program.[31] The same patients could have greatly benefited from resources informing them of their eligibility. Although many patients at health centers can receive help with enrollment from the health center's outreach and enrollment staff, providing better oversight, guidance, and enforcement will ultimately protect patients and increase their confidence when receiving assistance from a broker. NACHC supports these additional requirements and urges CMS to continue safeguarding enrollees by informing them about their coverage options and the available support for accessing additional benefits.

NACHC is also supportive of the proposal to broaden the marketing definition in §§422.2260 and 423.2260 to improve CMS oversight of MA and Part D advertising materials and rely on the intent

[30] https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose
[31] https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/

standard to determine appropriate communications materials and marketing activities. NACHC has previously raised concerns about misleading marketing tactics used by Medicare Advantage plans and brokers, which have consistently caused confusion among enrollees when choosing a plan. As we mentioned earlier, while MA plans advertise comprehensive, inexpensive coverage, they often fail to explain the drawbacks, such as restricted networks, prior authorizations and denials of care, and high costs for supplemental benefits.[32] Medicare beneficiaries deserve to choose the best plan for them without getting misled by deceptive, fraudulent advertisements by marketers on behalf of MA plans. For example, one of the primary benefits marketers present to beneficiaries about MA is the inclusion of dental, hearing, and vision benefits that don't exist in Original Medicare. While around 96% of MA enrollees are in a plan that offers some dental coverage, these enrollees do not utilize dental services more than those in Original Medicare.[33] This reality is likely due to high costs as many plans have very high coinsurance rates outside of routine check-up and cleaning appointments, along with cost sharing for preventative care.[34] While many health center patients can turn to assistance from health center outreach and enrollment staff, the enhanced oversight of MA marketing materials and enforcement will protect patients and make them feel more confident about their plan choice.

Administration of Supplemental Benefits Coverage Through Debit Cards §§422.2, 422.102, 422.102, 422.111, and 422.2263

NACHC supports the proposed guardrails on supplemental benefits covered by plan-administered debit cards. Community health centers utilize the sliding fee discount program to adjust the cost of healthcare services based on a patient's income level, meaning those with lower incomes pay less, allowing for affordable access to healthcare. Unfortunately, this discount does not cover supplemental benefits, like over the counter (OTC) products, eye care, and healthcare devices that can greatly improve a patient's overall health. These debit cards are another form of access for Medicare Advantage enrollees to pay for plan-covered items and services broadly recognized as important tools to promote healthy behaviors and increase visits for primary and preventive services.

NACHC recommends CMS update the Medicare Claims Processing Manual guidance on supplemental benefits to ensure health center patients can properly utilize supplemental benefits. The current language in Chapter 9, Section 60.4 of the Claims Processing Manual, gives the impression that information from the CHC cost report is used to develop the MA supplemental payment amount for services renders to Medicare Advantage enrollees[35] and that the incurred costs in serving MA enrollees are considered in the year-end cost report reconciliation. Unfortunately, this is not true. While the CHC cost report does include fields for identifying payments from MA plans and the number of visits with MA enrollees, those items are "for informational purposes only." They are not used in the cost report reconciliation. In practice, the per-visits amount of the supplemental payments that Medicare makes for services CHCs render to MA enrollees is based on information submitted by the CHC to each Medicare Administrative Contractor (MAC) on a per-contract basis, not information from the cost report.[36] Currently, every MAC has discretion as to how they calculate these supplemental payments, without regulation or federal guidance. NACHC believes this language was never updated after the implementation of the

[32] https://cepr.net/publications/medicare-advantage-and-deceptive-marketing/#easy-footnote-bottom-19-167551

[33] Lisa Simon, Zirui Song, and Michael L. Barnett, "Dental Services Use: Medicare Beneficiaries Experience Immediate And Long-Term Reductions After Enrollment: Study Examines Dental Services Use by Medicare Beneficiaries.," Health Affairs 42, no. 2 (February 1, 2023): 286–95, https://doi.org/10.1377/hlthaff.2021.01899.

[34] Meredith Freed et al., "Medicare and Dental Coverage: A Closer Look," Kaiser Family Foundation, July 28, 2021, https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/.

[35] Social Security Act 1833(b)(3)(B) and 42 CFR 405.2469

[36] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf see Section 60.4, pages 27-28.

Medicare CHC PPS and encourages CMS to review its guidance on the issue to ensure more uniformity in how supplemental payments are calculated.

NACHC also supports CMS's proposal for a robust alternative process to be made readily available to enrollees and providers. In one instance, a health center reported that several patients attempted to use plan provided debit cards to cover dental services that were furnished at the same location as their medical center. The debit cards were denied, and after multiple calls between the patients, the CHC, and the plan, it was determined that the debit card had "deemed" the dental care as ineligible because the plan had tied the CHC's dental practice to the medical center, even though the services were not related to their medical benefits. The plan was unable to rectify the issue, and the patients were ultimately unable to use their debit cards for eligible services covered under their plan. NACHC encourages CMS to require MA plans to better inform beneficiaries of their alternative options for payment of these benefits and ensure their debit cards are being used for the services they should cover, regardless of the location at which they were furnished. If patients are unable to pay for these essential health services, they are less likely to seek the proper health care they need.

NACHC encourages CMS to clarify that high-value food/nutrition, housing/living environment, and transportation supplemental benefits – which have been demonstrated to prevent/treat illness and/or reduce avoidable emergency/healthcare utilization – are "primarily health related." This would increase patient choice and reduce administrative complexity by clarifying that high-priority supplemental benefits addressing food/nutrition, housing/living environment, and transportation are "primarily health related," based on existing evidence that these benefits enable the prevention/treatment of illness and/or reduction of avoidable emergency/healthcare utilization.

We note that CMS has long prioritized a select set of high-value SDOH domains[37] – including food/nutrition – across numerous federal programs,[38] citing extensive evidence linking these to worse health outcomes[39], increased utilization[40], higher annual healthcare expenditures[41], and poorer mental health.[42] In its Value-Based Insurance Design (VBID) model, CMS identified food/nutrition, housing/living environments, and transportation as "priority" domains with a "high impact" and "substantial evidence base." CMS selected these "based on high prevalence in the MA population, existing evidence on their effect on costs and health outcomes, and alignment to existing CMS efforts."[43]
Via VBID, CMS made it easier for high-risk MA enrollees to access this small set of high-value evidence-based benefits via waivers allowing participating MAOs[44] "the ability to offer non-primarily health related supplemental benefits to targeted enrollees, beyond the statutorily-defined 'chronically ill enrollee,' provided that such benefits have a reasonable expectation of improving or maintaining the health or overall function of the targeted enrollee." By terminating VBID, CMS eliminated this flexibility from the MA program, because non-primarily health related supplemental benefits are only allowed for those enrollees who meet the complicated three-part statutorily-defined criteria for a chronically ill enrollee. Acknowledging this challenge, CMS stated[45] that "…limited access to healthy foods and transportation

[37] https://www.govinfo.gov/content/pkg/FR-2022-08-10/pdf/2022-16472.pdf
[38] https://www.commonwealthfund.org/blog/2023/lets-get-it-right-consistent-measurement-drivers-health
[39] Ibid.
[40] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0645?journalCode=hlthaff
[41] https://pmc.ncbi.nlm.nih.gov/articles/PMC6426124/
[42] https://aspe.hhs.gov/reports/mental-health-consequences-covid-19-role-social-determinants-health-research-brief
[43] https://www.cms.gov/files/document/vbid-cy25-rfa.pdf
[44] Ibid.
[45] https://www.cms.gov/blog/medicare-advantage-value-based-insurance-design-vbid-model-end-after-calendar-year-2025-excess-costs

and/or unmanaged chronic health conditions, can prevent patients from seeking health care. MA plans aim to address these challenges, ***but current rules make it hard to reach certain patients***."[46]

CMS could issue a non-exhaustive list of examples of acceptable benefits in the food/nutrition, housing/living environments, and transportation domains – just as it provided such a list of permissible primarily health-related OTC items in the 2026 MA Proposed Rule (99289). Health centers have long screened for and extended access to different types of benefits like these to our members, as health centers have been at the forefront of bridging the gap with social drivers of health. Furthermore, growing literature recognizing the importance of combining GLP-1 drugs and "food is medicine" interventions for greatest efficacy.[47] CMS's clarification that high-priority supplemental benefits (including those addressing food/nutrition) are "primarily health related" would be an important complement to its provision for Part D coverage of anti-obesity medications to reduce excess body weight or maintain weight reduction long-term in the 2026 MA Proposed Rule (99375).

III. Miscellaneous

Medicare Transaction Facilitator Requirements for Network Pharmacy Agreements

NACHC supports amending §423.505 to require that Part D sponsors' network contracts with pharmacies require such pharmacies to be enrolled in the Medicare Drug Price Negotiation Program's ("Negotiation Program") Medicare Transaction Facilitator Data Module ("MTF DM") but reiterates our concerns about the MTF-DM collection of sensitive financial information.

Instead of the MTF collecting banking information, NACHC recommends CMS revisit a suggestion on employing existing structures used to issue discounts and rebates. The rebates could be handled through the wholesaler rebate process, similar to chargeback or credit/rebills already in place with the 340B program. The wholesaler purchases the medication at the full wholesale acquisition cost (WAC) on the front end of the transaction. Depending on the inventory account where a purchase is made, the appropriate pricing is extended by the wholesaler prospectively (in this case, the MFP), and the manufacturer, through the chargeback process, credits the wholesaler the difference between the WAC and MFP. In the chargeback model, the dispensers can purchase prospectively at the MFP and would not, as the smallest players in the system, bear the financial burden of sustaining the discounts for Medicare until they are made "whole" by a rebate. The credit/rebill process is also well established in the pharmacy industry, allowing a drug sold by a wholesaler on one account to be credited and reassigned to another account, for example, credit a WAC purchase and reassigning (rebill) as an MFP purchase.

Additionally, 340B covered entities are used to mass repayment models from manufacturers to covered entity purchasers facilitated by the 340B Prime Vendor. In this instance, the Health Resources and Services Administration (HRSA) requires manufacturers to refund covered entities on all drug overcharges and urges them to work in good faith with covered entities for repayments. HRSA expects repayment procedures to follow similar processes that align with standard business practice and be documented in the manufacturer's policies and procedures.[48] Facilitated by the 340B vendor, these rebates primarily take the form of credits to the wholesaler accounts where the purchases were made or checks sent directly to the entity, neither requiring the housing of entity banking information. On the other hand, a model exists to facilitate entity repayments directly to manufacturers within the 340B program for 340B over-purchases, also facilitated by

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[46] https://www.cms.gov/priorities/innovation/innovation-models/vbid#:~:text=A%20variety%20of%20factors%20including,it%20%E2%80%94%20to%20manage%20their%20health. (emphasis added above)
[47] https://jamanetwork.com/journals/jama/article-abstract/2815919
[48] https://www.hhs.gov/guidance/document/340b-drug-pricing-program-frequently-asked-questions

Apexus.[49] In this, the covered entity's over-purchased amount is paid back to the drug manufacturer, facilitated by Apexus. CMS could consider these well-established processes for the reconciliation of payments to run smoothly between covered entities and manufacturers while simultaneously protecting sensitive banking information from falling prey to bad cyber actors.

We understand that section 40.4.2.2 of the final guidance does include the collecting and sharing of banking information from dispensing entities to Primary Manufacturers via the MTF but remain concerned about cyber security and sharing this sensitive information across numerous manufacturers. In 2024 alone, 677 healthcare data breaches were reported to the Department of Health and Human Services (HHS) Office of Civil Rights, which resulted in more than 182.4 million people being impacted.[50] In early 2024, a massive cyberattack was launched against Change Healthcare/Optum, subsidiaries of United Health Group, which impacted around 1 in 3 Americans' sensitive health information.[51] This attack had long-term, significant repercussions for health centers and our patients; 77% of health centers reported that the cybersecurity breach negatively impacted them. Over 60% of health centers had patients who were impacted by a delay in access to care due to the inability to obtain prior authorization, service interruption, or going without needed medications. Seventy-two percent of health centers report that access to discounted medication or health care services has been affected, and one in five health centers have had over half of their revenue impacted by the breach. An average of 75% of health center patients have been directly affected by the breach.[52] We are concerned about the MTF's ability to protect this highly sensitive financial information given the realities of cyberattacks against the healthcare sector. Furthermore, as the number of manufacturers participating increases each year, an increased number of manufacturers will be accessing this highly sensitive financial information.

Promoting Transparency for Pharmacies and Protecting Beneficiaries from Disruptions

NACHC supports the proposal at §423.505(i) to require Part D sponsors to notify network pharmacies which plans the pharmacies will be in-network for a given plan year by October 1. Many health centers offer pharmacy services through an on-site, entity-owned pharmacy or a contract pharmacy. Most health centers also participate in the 340B Drug Discount Pricing Program, enabling them to provide more accessible pharmacy services and reasonably priced medications to their patients. These proposed changes will allow pharmacies to better inform beneficiaries of potential disruptions of care in the new year, which is already a hectic time for pharmacy operations with new formulary and benefits changes. The advanced notice would also help pharmacies prepare patients for upcoming cost changes and allow them to educate patients about alternative options based on the patient's financial and medication needs.

NACHC supports CMS's proposal to require sponsors to provide pharmacies with a list of in-network plans. However, we urge CMS to consider making the information more readily available, not just upon request. Access to this information is incredibly useful for pharmacies to inform beneficiaries of any upcoming changes. To limit the administrative burden placed on pharmacy staff, making this list more readily available on October 1 would improve transparency and limit beneficiary disruption of care.

NACHC also supports CMS's proposed 'no cause' clause to allow Part D sponsors or pharmacies to terminate contracts without cause after providing notice to the other party. Allowing pharmacies to back out of binding poor financial reimbursement commitments would create an equitable field between smaller network pharmacies and Part D sponsors, as these agreements historically favor the sponsor. Additionally, the clause would allow pharmacies more flexibility with contracting. NACHC supports this

[49] https://www.apexus.com/apexus-refund-services/covered-entity-refund-service
[50] https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf
[51] https://energycommerce.house.gov/posts/what-we-learned-change-healthcare-cyber-attack
[52] https://www.nachc.org/wp-content/uploads/2024/04/NACHC-Change-Healthcare-Cybersecurity-Breach.pdf

proposal as it provides some financial protection for network pharmacies from bad reimbursement rates, direct and indirect remuneration (DIR) fees, or unfavorable addendums that are presented after the contract is signed.

Improving Experiences for Dually Eligible Enrollees

In 2017, health centers served 1.03 million dually eligible patients, growing to 1.35 million in 2023.[2] As CHCs are required to adapt and tend to the needs of the population they serve, health centers can provide targeted service and program offerings that can avoid more costly care such as End-Stage Renal Disease, heart disease, diabetes, or obesity. As CMS has described the challenges of service fragmentation, this dual population includes intense users of health services that are often, on average, more costly than other healthcare populations. As the central primary care provider for medically underserved populations and communities, integration efforts must consider streamlining administrative processes in addition to innovative care models. **NACHC strongly supports CMS's efforts to improve the experiences for dually eligible enrollees through one integrated member identification (ID) card, one integrated health risk assessment (HRA) with updates to timeliness standards and prioritization of the involvement of the enrollee in the development of individualized care plans (ICPs.)** Health centers are a key partner to support dual eligible Medicare and Medicaid individuals. The lack of alignment between Medicare and Medicaid penalizes health centers and undermines a patient's access to respectable and comprehensive patient centered care and services.

Health centers serve more Medicare and Medicaid dual eligible patients than other ambulatory care providers. Health centers serve 39% of Medicare patients who are dually eligible patients[53] compared to emergency departments treating 21% and private physician offices caring for 6% of this population. CHCs have experience coordinating between public and privately funded care management and care coordination services for this population. Health centers provide each patient with an individual assessment to determine their eligibility for health insurance, striving to connect medically vulnerable and underserved patients with the most affordable and comprehensive coverage they qualify for. One member ID card for a patient enrolled in both an MA and a Medicaid managed care plan would reduce the administrative burden on health centers when checking coverage and potential out-of-pocket costs. This upfront clarity supports health centers in managing their care plans for these patients and will help to improve patient outcomes and overall health care spending.

The dual eligible population has a higher rate of chronic conditions that require extensive care coordination and case management. This can include tracking referrals, working with the pharmacy to manage a patient's medication use, and aligning treatment plans when there are several health issues. Health centers use these strategies to manage and control high-risk patients through the full range of their care needs, which leads to better health outcomes. Health centers are experts in conducting patient assessments of community needs and linking patients to care. CMS' proposal requiring D–SNPs to conduct a single comprehensive, integrated HRA, that meets both Medicare and Medicaid requirements reduces duplicity and unity of care plans and services. Health centers may only bill for one risk assessment annually; one integrated assessment reduces confusion in determining which program to bill. Additionally, efficiencies in assessments positions health centers to align with value-based care arrangements.

With the growing shift towards keeping individuals in their homes and community as they age and receive care, NACHC anticipates that health centers will become critical health care providers for more dually eligible patients. All efforts to address the inconsistencies between both programs for dual eligible beneficiaries will help ensure timeliness to care ultimately improving health outcomes and reducing administrative costs.

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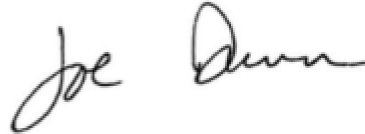
[53] https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf

The provisions in this proposed rule will positively impact health center patients' access to high-quality, affordable health coverage and care through enhanced enrollee protections and assurances in Medicare Advantage and Part D programs. We greatly appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer