January 26, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
ATTN: (CMS-4212-P)

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)

Dear Administrator Oz:

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in the United States with our committed 326,000 primary care workforce, and the 52 million patients we serve. For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services at over 17,000 locations across rural and nonrural communities. This includes 1 in 3 rural residents and 1 in 2 in poverty. As our nation's largest primary care system, there is strong evidence, including from the Congressional Budget Office, that our work saves lives and also saves Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.[1] Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.[2]

The number of CHC Medicare patients has increased significantly over the past ten years, from 1.5 million in 2010 to over 3.6 million in 2024. Medicare patients currently make up 11% of the patients CHCs serve.[3] CHCs play an integral role in helping lower Medicare patients' out-of-pocket costs. Costs for CHC Medicare patients ($2,370) are 10% lower than those for physician office patients ($2,667) and 30% lower than those for outpatient clinics.[4] This can be attributed to the CHC model of care, which strives to provide Medicare patients with affordable and high-quality care.

NACHC appreciates CMS' efforts to enhance plan quality and collect stakeholder feedback on improving the Medicare Advantage and Part D programs. Medicare patients are the fastest-growing population served by CHCs.[5] With increased enrollments in Medicare Advantage (MA), we are eager to share our feedback on the proposals, focusing on the areas that can be improved to benefit CHCs entering into MA agreements and the patients utilizing MA coverage. Our comment letter is broken down in six sections: I. Special

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[1] Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. BMC Pediatr. 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548.
[2] https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf
[3] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)
[4] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)
[5] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)

Enrollment Period for Provider Terminations; II. Star Ratings - Adding, Updating, and Removing Measures; III. Request for Information on Future Directions in Medicare Advantage; IV. Request for Information on Well-Being and Nutrition Policy Changes; V. MA Marketing Oversight; and VI. Supplemental Requests for Information.

I. Special Enrollment Period for Provider Terminations

NACHC supports and appreciates CMS's proposal at § 422.62(b)(23) to remove barriers for enrollees who seek to change plans when their provider exits the plan network. Simplifying the process for enrollees to qualify for a Special Enrollment Period (SEP) by eliminating the requirement that CMS or the MA plan verify whether a provider leaving the network counts as a "significant" change is crucial to preserving beneficiary choice. The revision would allow any beneficiary who is currently receiving care from, or has been treated by, an impacted provider or facility within the last three months to qualify for a SEP. This proposal promotes continuity of care and preserves patient choice to seek another provider, ensuring their health-related needs are met.

II. Star Ratings - Adding, Updating, and Removing Measures

NACHC is concerned that CMS's proposal to remove measures assessing beneficiary experience with MA plan operations will reduce MA plan oversight to ensure enrollees are receiving timely and quality access to their respective benefits and coverage. Specific customer experience measures are necessary to confirm that a plan's administrative and/or operational policies—and the way they are communicated to beneficiaries—do not create barriers to accessing care that ultimately harm beneficiary outcomes.

Specifically, CMS proposes to remove the following measures that focus exclusively on a beneficiary's experience with plan operations and policy: Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C), Reviewing Appeals Decisions, Special Needs Plan (SNP) Care Management. Call Center – Foreign Language Interpreter Availability, Complaints about the Health/Drug Plan, and Customer Service. CMS suggests that there is little performance variability between contracts when justifying the removal of these measures. Instead of removing them entirely, we recommend that CMS consider opportunities to better measure these customer service metrics, thereby showcasing the true enrollee experience. For example, the Medicare Payment Advisory Commission (MedPAC) has previously recommended collecting, calculating, and reporting measures at the geographic level to increase transparency regarding plan performance, as opposed to the contract level.[6] This stratified reporting approach would also make Star Rating data more helpful for beneficiaries, allowing them to view data specific to the plan they are choosing, rather than comparing an average score across all plans in a given contract.[7] It is imperative that these measures are not lost so that our nation's seniors have sufficient information when deciding which plan to enroll in.

This is especially important for the dual-eligible population, which is more likely to be sicker and have more complex care needs compared to patients with only Medicare.[8] A larger share of dual-eligible beneficiaries are enrolled in Medicare Advantage plans versus original Medicare. CMS data show that from 2012 to 2021, the proportion of dually eligible individuals doubled, from 22 percent to 51 percent, in Medicare Advantage plans.[9] CHCs, given their specialty in being patient-centered medical homes that

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[6] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf
[7] https://medicare.chir.georgetown.edu/implications-of-measuring-medicare-advantage-quality-at-the-contract-level-what-that-means-for-beneficiary-choices-and-plan-payments/
[8] https://www.kff.org/medicare/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/
[9] https://www.cms.gov/files/document/managedcareenrollmenttrendsdatabrief2012-2021.pdf

provide care coordination and integrated care, serve a growing percentage of these patients. In 2023, CHCs served 1.35 million dually-eligible patients.[10] It is crucial to have transparency on these measures to ensure that this medically complex and financially insecure population is not disadvantaged.

CMS also proposes adding a Depression Screening and Follow-Up measure to Star Ratings. While we applaud CMS's interest in improving behavioral health, screening for depression and connecting patients to follow-up resources typically occur through physicians or auxiliary personnel, such as Community Health Workers. One tool that CHCs use to do this is the Protocol for Responding and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.[11] NACHC helped create this tool to enable CHCs and other providers to collect the data they need to better understand and address their patients' risk factors and needs. If this measure were finalized, the onus for performance would likely be placed on physicians who contract with MA organizations. Consistently high screening rates would translate into a higher Star Rating and a financial bonus. Still, MA organizations would have no requirement and no oversight to ensure that the MA plans provide support or resources that would pass down the financial benefits of strong performance, despite the crucial role clinicians play in boosting the rating. While NACHC supports this measure for the benefit of our patients, CMS should do more to ensure MA organizations provide the necessary support to resource-strapped CHCs whose providers would shoulder the responsibility of this measure.

NACHC supports improving patient access to behavioral health services, given the strong integration of behavioral health into primary care at CHCs. CHCs offer a wide range of integrated mental and behavioral health services for children and adults, including comprehensive individual or group counseling, intensive outpatient services, addiction and recovery services, Medication-Assisted Treatment (MAT), school-based therapy, and crisis services. However, adoption of this measure without alignment of cost-sharing for behavioral health services between MA and traditional Medicare would put undue onus on providers. Additionally, this parity would significantly help decrease the cost barriers patients may face and ensure that patients have more equal access to behavioral health, regardless of their type of Medicare coverage. Unfortunately, CMS opted not to adopt this proposal for CY 2025.[12] **Before CMS adopts this measure, NACHC recommends implementing the previously proposed mental health parity cost-sharing requirements and monitoring behavioral health network adequacy to ensure sufficient patient access before adopting this measure.**

Streamlining Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures

CMS seeks suggestions for new measures that would promote prevention and wellness. Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits.[13] Nationally, only 4.7% of health care spending in the U.S. goes towards primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4%.[14] CHCs serve 10% of the U.S. population, but represent only 1% of health care spending in the U.S.

[10] https://geigergibson.publichealth.gwu.edu/community-health-centers-are-increasingly-important-medicare-beneficiaries#_edn3
[11] https://prapare.org/
[12] https://www.federalregister.gov/d/2024-27939/p-611
[13] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.
[14] https://doi.org/10.1599/mmf.2025.0218

By keeping people healthy, primary care not only saves lives but also saves money. Studies estimate that in 2023, primary care at CHCs saved Medicaid an estimated $38.6 billion by keeping patients healthy, preventing ER visits and hospitalizations, and reducing the use of costly specialty services.[15] Promoting prevention and wellness requires reallocating existing resources toward primary care. With additional investment, CHCs can address gaps in primary care and reverse the nation's chronic disease and mental health crises in communities that need it the most. As a starting point for increasing primary care spending, payers could be required to track and publicly disclose how much they spend on primary care services. **NACHC suggests that CMS consider new measures or requirements that require MA plans to track and report data on their primary care spending to encourage plan prioritization of prevention and wellness.**

NACHC additionally recommends that the Administration strengthen health plan accountability for physician satisfaction. In the United States, more than two in five primary care doctors feel burned out, which is higher than in nearly every other country.[16] Just like the rest of the healthcare system, CHC doctors experience burnout due to several factors. Measures that assess general health plan support of physicians and clinicians, such as efficient, timely, comprehensive data exchange and feedback mechanisms, utilization management criteria, prior authorization denial rates and/or timeliness, payment policies, claims denials, prompt pay compliance, and customer service, would all be excellent additions to the quality program.

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7))

NACHC urges CMS to reconsider the proposal to remove the annual analysis of utilization management (UM) policies and procedures on populations with limited access to health care. While we appreciate CMS's efforts to balance regulatory burden with data collection on prior authorization use by MA plans, requirements for plans to report and compare metrics on the use and outcomes of prior authorization processes across different beneficiary populations add transparency, helping hold plans accountable and protecting beneficiary access. The collection of these data enables stakeholders to better understand the effects of UM on patient care and provides insight into documented differences among beneficiary groups. This information promotes transparency, accountability, and fair outcomes for all Medicare beneficiaries. NACHC would support alternative plans to report similar data if CMS determines that the current assessment is too burdensome.

Improving prior authorization reporting is crucial to enhancing access to medically necessary services for patients and alleviating the administrative burden on CHC staff. Nearly all MA enrollees are required to obtain prior approval, or authorization, for coverage of certain treatments or services, which is generally not required in Original Medicare. NACHC requests further progress to ensure that 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, CHC patients aged 65 and older are the fastest-growing age group and are growing increasingly complex, with higher rates of chronic conditions. For this group of CHC patients, denials can lead to worsening health outcomes, increased pain and discomfort, unnecessary hospitalizations, and a decreased quality of life. In 2022, MA insurers fully or partially denied 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 to 5.6% in 2020, 5.8% in 2021, and 7.4% in 2022.[17] Improper denials can

[15] Capital Link. The Value and Impact of the National Health Center Program. 2025.
[16] https://www.commonwealthfund.org/publications/surveys/2025/nov/causes-impacts-burnout-primary-care-physicians-10-countries
[17] https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/

delay or prevent beneficiaries from accessing medically necessary care, lead to beneficiaries paying out of pocket for services that Medicare covers, or create an administrative burden for beneficiaries or their providers who choose to appeal the denial.[18] 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 CHC patients reporting that they suffer from a chronic condition.[19] We strongly encourage the agency 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.

III. Request for Information on Future Directions in Medicare Advantage

Clarifying MA Wrap Around Payments: **NACHC urges CMS to develop standardized template language for Medicare Advantage and CHC contracting and to provide technical assistance to states to adapt these templates based on input from CHCs. NACHC would welcome the opportunity to partner with CMS to develop and refine these templates.** Standardized contract terms and more explicit guidance on wrap-around services and care coordination payments would reduce administrative burden for CHC billing staff, improve claims consistency, and support timely payment. Per 42 CFR 422.316, CHCs must be made "whole" by Medicare through supplemental payments to cover the difference, if any, between the payment received by the CHC for treating MA enrollees and the payment to which the CHC is entitled.[20] The intent behind the statute involving wrap-around payments for CHCs is to ensure that they are paid for services that MA patients are entitled to receive. However, we have heard several concerns regarding the processing of CHC payments by Medicare Administrative Contractors (MACs).

CHCs have reported having to submit separate claims to MACs for medical and behavioral health services, which they would typically submit on a single claim to ensure payment processing. Additionally, many MACs are not transparent about their preferred process for wrap payments, and there is no uniform guidance for CHCs and MACs to rely on. These complications with timely wraparound payments further exacerbate CHCs' existing financial challenges and burden their staff with additional administrative work. Allowing standardized, CMS-approved, state-developed contract language, paired with clear and uniform wrap-around billing guidance, would help align expectations across Medicare Advantage plans, Medicare Administrative Contractors, and CHCs, promote timely payments, and reduce unnecessary administrative burdens.

Improving Prior Authorization: **NACHC urges CMS to make great efforts to improve prior authorization processes for CHC patients and providers**. Improving prior authorization reporting and oversight is critical to increasing patients' access to medically necessary services and reducing the administrative burden on CHC staff. Nearly all Medicare Advantage enrollees are required to obtain prior approval, or authorization, for coverage of certain treatments or services, a requirement that generally does not apply under Original Medicare. **NACHC requests continued progress to ensure MA patients are not improperly denied needed care and urges CMS to prioritize oversight of prior authorizations with MA plans to ensure patients receive fair and timely access to services.** These issues are particularly concerning for CHC patients ages 65 and older, who represent the fastest-growing patient population served by CHCs and are increasingly medically complex, with higher rates of chronic conditions. In 2022, Medicare Advantage insurers fully or partially denied 3.4 million (7.4%) prior authorization requests. This

[18] https://oig.hhs.gov/oei/reports/oei-09-18-00260.asp
[19] https://content.naic.org/sites/default/files/national_meeting/Final-CR-Report-AI-and-Health-Insurance-11.14.24.pdf
[20] 42 U.S.C. §1395w-23(a)(4)(A)

denial rate has steadily increased from 5.7% in 2019 to 5.6% in 2020 and 5.8% in 2021.[21] Improper denials can delay or prevent access to medically necessary care, force beneficiaries to pay out of pocket for services covered by Medicare, or create an administrative burden for beneficiaries or their providers who choose to appeal the denial.[22]

For CHC patients, interruptions in care can exacerbate chronic conditions, potentially resulting in disease progression, increased symptom severity, and a higher risk of complications. In fact, CHC patients are growing increasingly complex, with nearly 32% of CHC patients reporting that they suffer from a chronic condition.[23] **NACHC supports efforts to enhance data reporting and transparency around prior authorization and looks forward to working with CMS to ensure prior authorization policies do not adversely affect CHC patients or undermine access to medically necessary care.**

Streamlining Provider Enrollment: **NACHC urges CMS to streamline provider enrollment and credentialing requirements for CHCs and to evaluate options for a single, standardized credential recognition for CHC providers across MA plans.** Currently, Medicare Advantage participation requires CHC organizations to enroll with CMS while individual practitioners undergo separate credentialing with each MA plan. This process is distinct from Medicare fee-for-service enrollment and often involves duplicative documentation, repeated license verification, and plan-specific approval requirements tied to billing and member assignment. These inefficiencies increase administrative burden, delay network onboarding, and disproportionately affect smaller and rural CHCs with limited administrative capacity.

CHCs have consistently raised concerns that Medicare provider enrollment requirements are cumbersome and add unnecessary complexity in an already resource-constrained environment. Minor technical issues, such as mismatched addresses across Medicare enrollment forms and HRSA records, can delay provider approval and payment. Additionally, the 2026 Medicare provider enrollment fee of $730 represents a high cost for CHCs operating on tight margins. In some states, CHCs must also obtain Medicaid site approval before receiving Medicare provider status, further delaying participation.

NACHC recommends that CMS streamline Medicare provider enrollment requirements to ensure the process remains robust while being more accessible and efficient for providers. NACHC also urges CMS to collaborate with the Health Resources and Services Administration (HRSA) to simplify the Medicare site registration process for CHCs under § 424.510. The current site registration process is overly complex and varies across states and MACs, creating significant administrative and financial burdens. A more coordinated and standardized CMS-HRSA approach would help CHCs expand access to high-quality, affordable care for Medicare beneficiaries while maintaining appropriate program oversight.

Developing Stronger CMMI Models: **NACHC urges CMS to explore and develop new payment and service delivery models through the CMS Innovation Center (CMMI) that encourage shared savings or capitated arrangements between Medicare Advantage plans and CHCs.** As you are aware, the Innovation Center develops and tests models designed to enhance patient care, reduce costs, and align payment systems to promote patient-centered practices.[24] These models provide a valuable platform for testing alternatives to traditional fee-for-service reimbursement, including arrangements that align financial incentives around prevention and chronic disease management. For example, the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model represents a voluntary 10-year Innovation Center payment model that will test outcome-aligned payments for managing chronic conditions such as

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[21] https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/
[22] https://oig.hhs.gov/oei/reports/oei-09-18-00260.asp
[23] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf
[24] https://www.cms.gov/priorities/innovation/models

hypertension, diabetes, and depression.[25] ACCESS is designed to shift payment focus toward measurable health outcomes and continuous care improvements rather than discrete services, demonstrating how alternative payment structures can enable better chronic care delivery. Expanding similar model frameworks to the MA program could promote payment arrangements that share savings or offer capitated incentives between MA plans and CHCs, leading to more sustainable CHC financing and better alignment around prevention and long-term care goals.

To ensure these models achieve their intended impact, NACHC also urges CMS to align patient attribution requirements and processes among payers in the same insurance program and work with CMMI to streamline attribution strategies across payers.[26] Patient attribution identifies the healthcare relationship between a patient and provider. It is a key component of value-based care arrangements, enabling providers to be accountable for quality and cost outcomes. However, CHCs have reported ongoing challenges with patient attribution under MA, including delayed or inaccurate attribution data that hinder access to crucial information and care coordination efforts, such as scheduling Annual Wellness Visits (AWVs), and complicate participation in shared savings or capitated arrangements. Improving attribution accuracy and requiring MA plans to provide timely, transparent access to updated patient attribution lists via plan portals would strengthen payer-provider alignment, reduce administrative burden, and enhance the effectiveness of shared savings and capitated models intended to improve outcomes for Medicare beneficiaries served by CHCs. Such improvements would help ensure that CMMI models and value-based care initiatives function as intended, improving care quality and financial sustainability for providers serving high-need populations.

Telehealth: **NACHC urges CMS to encourage Medicare Advantage plans to simplify and standardize their telehealth coverage rules for CHC patients.** While MA plans have the flexibility to offer telehealth benefits beyond what is available under Original Medicare, CHCs have reported that telehealth rules vary by plan, ultimately creating confusion, billing challenges, and administrative burdens for providers and patients. **Ensuring parity of telehealth coverage across MA plans is critical so CHC patients can reliably access clinically appropriate services regardless of plan selection, without facing inconsistent benefits or gaps in care.** Greater parity would also help prevent disruptions in ongoing treatment and promote equitable access to telehealth for medically underserved populations. CMS has previously affirmed that MA plans may cover clinically appropriate telehealth services and may treat them as basic benefits when they meet access and network adequacy requirements. This clarity would lead to more consistent telehealth policies, including coverage of telehealth services provided by CHCs, and improve access to care while reducing unnecessary operational complexity.

IV. Request for Information on Well-Being and Nutrition Policy Changes

CHCs serve some of the most medically and socially vulnerable populations in the country, playing a critical role in addressing chronic diseases and unmet health needs. Nearly 18 percent of CHC patients are uninsured, and many face higher rates of chronic conditions such as diabetes, heart disease, hypertension, asthma, and obesity, with prevalence increasing in recent years.[27] As evidence continues to show that poor nutrition contributes to the development and progression of these conditions and drives higher health care costs, CHCs have increasingly focused on addressing nutrition and food access as part of comprehensive, preventive care.[28]

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[25] https://www.cms.gov/priorities/innovation/innovation-models/access
[26] https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf.
[27] National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)
[28]https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00585?utm_campaign=april+2025+issue&utm_medium=email&_hsenc=p2ANqtz-_jWvS1Nxnidt5qoCGVoM2w7uStqWiILDOrv-ComvmMPPPjBJaA-pVkh_-

CHCs have long addressed health beyond the exam room through enabling services that integrate nutrition into care delivery, including diet and nutrition counseling, education, and peer support for families, as well as community-based food initiatives. While research shows that nutrition is often overlooked in primary care settings nationwide, CHCs have demonstrated scalable, community-driven Food for Health approaches that improve outcomes and reduce costs.[29] NACHC strongly supports expanding and strengthening nutrition-focused and Food for Health programs across all CHCs, recognizing their unique capacity to support healthier communities. We have outlined several ideas for CMS to consider to advance nutrition policies.

NACHC urges CMS to coordinate with other agencies within the Department of Health and Human Services (HHS) to convene a Food as Health Advisory Committee that includes representation from CHCs, food banks, small farmers, food retailers, and community-based organizations to develop federal, state, and local policy strategies to scale and sustain Food for Health programs nationwide. Food for Health interventions, including produce prescription programs, medically tailored meals, and medically tailored groceries, are designed to prevent and treat diet-related chronic diseases by integrating nutrition into clinical care and addressing food insecurity, which disproportionately affects underserved communities. These interventions have demonstrated promise in improving health outcomes and reducing healthcare costs. Currently, most Food for Health programs continue to be supported primarily through private and public grants, as well as Medicaid Section 1115 demonstration waivers, which vary significantly by state in terms of scope, benefits, and eligibility criteria. As of April 2025, 12 states have approved 1115 waivers that include nutrition and Food for Health components,[30] reflecting significant but inconsistent state-level activity. A federal advisory committee can help identify best practices, inform the development of sustainable reimbursement and implementation strategies, and ensure consistent, evidence-based policy frameworks across jurisdictions.

To support broader implementation of Food as Health initiatives, NACHC recommends that CMS allow CHCs to receive reimbursement for upstream non-clinical factors of health screenings outside of the annual wellness visit context. CHCs routinely screen patients for non-clinical factors, including food insecurity, as part of initial risk assessments and regular check-ins. These screenings often inform critical follow-up care planning. Embedding reimbursement for such services across care settings would better align payment with clinical practice, enabling CHCs to intervene earlier and more consistently.

Furthermore, CMS should support new or expanded federal grants, in collaboration with HRSA, that explicitly recognize CHCs as eligible entities for Food as Health funding opportunities, including the establishment of community kitchens and food pharmacies. Programs such as HRSA Service Expansion Grants have proven useful in expanding services to underserved patients. Federal nutrition incentive programs, including the Gus Schumacher Nutrition Incentive Program (GusNIP)[31] and SNAP-Ed, offer funding mechanisms that align with Food for Health goals[32]; explicitly highlighting CHCs as eligible partners in these initiatives would foster uptake, strengthen community-based nutrition efforts, and support data collection to inform outcomes and best practices. **CMS and HRSA should provide flexibility**

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[29] https://odphp.health.gov/foodismedicine/promising-practices-and-tools/promising-practices/promising-practices-food-medicine-interventions-summary-listening-sessions-health-centers.

[30] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

[31] https://nutritionincentivehub.org/about/gusnip

[32] https://www.nutritionincentivehub.org/media/3zyhmj1l/snap-ed-and-gusnip-combining-nutrition-education-and-incentives-for-greater-impact.pdf.

within medically tailored meal grant opportunities to support greater involvement of CHCs, which many operate broad, community-based nutrition programs responsive to local needs. Expanding access to more flexible grant models would allow CHCs to implement a range of evidence-based nutrition interventions, including medically tailored meals, produce prescriptions, and other whole-food approaches. This flexibility would align with the Administration's Real Food initiative[33] and acknowledge the unique role CHCs play in bridging gaps in access to healthy, whole-food meals for underserved communities.

Additionally, NACHC encourages CMS to expand data collection efforts on Food as Health interventions and to promote private sector partnerships that share data with HHS. Improved federal data on the types, duration, and outcomes of Food for Health programs, including impacts on health outcomes and healthcare utilization, will support evidence generation and inform cost-effective program design. Collaboration with private and corporate partners that fund or implement Food for Health projects is essential to capturing real-world data at scale, informing policy development, and identifying replicable models that enhance nutrition security and reduce disparities for historically underserved communities.

V. MA Marketing Oversight

NACHC cautions CMS from implementing the proposed changes to Third-Party Marketing Organization (TPMO) disclaimer requirements at §§ 422.2267 and 423.2267. This change could increase reliance on potentially biased marketing entities and weaken protections intended to support informed plan selection. Given the greater financial vulnerability and lower health literacy rates among many older adults served by CHCs, it is imperative that these disclaimers be clear, explicit, and consistently presented to ensure beneficiaries fully understand their coverage options and available consumer protections. CHCs continue to see the effects of deceptive marketing practices by MA plans and brokers, particularly given that roughly one-third of MA enrollees rely on brokers to select coverage.[34] While MA plans often advertise comprehensive, low-cost coverage and supplemental benefits, they frequently fail to clearly explain significant limitations, including restricted provider networks, prior authorization requirements, denials of care, and significant cost sharing for certain services. For example, one of the primary benefits marketers present to beneficiaries about MA is the inclusion of dental, hearing, and vision benefits that are not available 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.[35] 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.[36] Removing the explicit reference to State Health Insurance Assistance Programs and relaxing the timing of the disclaimer risks reducing beneficiary awareness of neutral resources.

NACHC also opposes the proposal to eliminate the 48-hour Scope of Appointment waiting period at §§ 422.2264(c)(3)(i) and 423.2264(c)(3)(i). The waiting period was designed to protect beneficiaries from high-pressure sales tactics and provide time for them to consult with family or caregivers before making enrollment decisions. CHCs routinely assist patients who later discover high-cost sharing, restrictive networks, or prior authorization barriers, with no recourse until the next enrollment period.[37] Removing

[33] https://www.hhs.gov/press-room/fact-sheet-historic-reset-federal-nutrition-policy.html
[34] https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose
[35] 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.
[36] 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/.
[37] https://cepr.net/publications/medicare-advantage-and-deceptive-marketing/#easy-footnote-bottom-19-167551

this safeguard increases the risk of rushed and uninformed enrollments, further undermining trust in the Medicare enrollment process. We encourage CMS to take more intentional action in ensuring that enrollees are properly informed of their coverage options and maintain the right to change their minds within a given time period.

Finally, NACHC strongly opposes removing the ban on superlative language in MA and Part D marketing materials at §§ 422.2262(a)(1)(ii) and 423.2262(a)(1)(ii). Allowing terms such as "best" or "top-rated," even if not overtly misleading, invites subjective claims that are difficult for beneficiaries to verify and complicates meaningful plan comparison based on coverage. CHCs frequently hear from patients who are confused or disappointed after enrolling in plans heavily marketed around supplemental benefits that are limited by high coinsurance or narrow coverage.[38] Retaining clear restrictions on superlative language is more effective than after-the-fact enforcement and remains critical to protecting beneficiaries from misleading marketing practices.

VI. Supplemental Requests for Information

a. Modernizing MA Marketing Oversight

NACHC appreciates CMS's request for feedback on modifying the definition of Third-Party Marketing Organizations (TPMOs) under §§ 422.2260 and 423.2260 to clearly delineate the roles and requirements that apply to different types of TPMOs. Greater clarity on which entities fall within the TPMO definition and the specific obligations that attach to them could reduce operational ambiguity for CHCs and their outreach and enrollment staff. These distinctions may also enhance the beneficiary experience by ensuring that marketing and enrollment assistance are subject to appropriate and consistent oversight, while allowing CHCs to continue providing trusted, patient-centered assistance without unnecessary compliance uncertainty.

At the same time, NACHC urges caution regarding potential changes to the 5 percent translation requirement at §§ 422.2267 and 423.2267. CHCs serve a disproportionate share of patients with limited English proficiency, and standardized, translated Medicare Advantage materials are essential to ensuring meaningful access to information and informed decision-making. Any reduction or modification to translation requirements risks decreasing the availability of materials in languages spoken by smaller or emerging language groups, further exacerbating barriers to understanding Medicare options. **NACHC encourages CMS to maintain strong translation standards to ensure fair access for non-English-speaking beneficiaries and to avoid shifting additional interpretation and education burdens onto already resource-constrained CHCs.**

NACHC appreciates CMS's request for input on strategies to hold bad actors accountable, align incentives in the agent and broker space, and distinguish between good-faith errors and patterns of noncompliance. We have consistently supported strong CMS oversight of deceptive Medicare Advantage marketing practices and robust consumer protections from dishonest agents and brokers.[39] Enhanced accountability is crucial given the reliance many beneficiaries place on third-party marketing organizations when selecting coverage and the lasting consequences of misinformed enrollment decisions.

We encourage CMS to focus on data-driven oversight approaches, including targeted monitoring, audits, and corrective action plans for MA plans and TPMOs that demonstrate repeated or systemic noncompliance. CMS should differentiate between isolated good-faith errors and ongoing violations that harm beneficiaries, while reserving stronger enforcement actions for entities that fail to correct problematic

[38] https://cepr.net/publications/medicare-advantage-and-deceptive-marketing/#easy-footnote-bottom-19-167551
[39] https://www.nachc.org/wp-content/uploads/2025/05/Medicare-Advantage-and-Part-D-Rule-Comment-Letter.pdf.

behavior. Similar to CMS's oversight of Marketplace brokers,[40] a graduated enforcement framework that emphasizes transparency, remediation, and meaningful penalties for repeat offenders would help protect beneficiaries, promote compliance, and reinforce trust in the Medicare Advantage enrollment process. We look forward to continuing to support the Administration's efforts to reduce mistrust and protect beneficiaries from deceptive MA marketing practices.

b. Enhancing Decision Support Tools

NACHC appreciates the opportunity to discuss how technology, particularly artificial intelligence (AI), can be leveraged to enhance decision-support tools used by CHCs and their patients. CHCs are committed to empowering patients to make informed decisions about their care and identifying innovative approaches to advance whole-person care. However, significant resource constraints impact these efforts. CHCs operate on consistently thin financial margins while serving some of the nation's most low-income populations. CHC patients are four times more likely to have incomes at or below the Federal Poverty Level (FPL) and twice as likely to have income under 200 percent of FPL compared to the overall U.S. population.[41]

NACHC urges the Administration to ensure that patients at CHCs have the same access to technologies as other Medicare patients. In addition to providing affordable, high-quality healthcare to all patients regardless of their financial status, CHCs offer enabling services, such as patient education on technological tools. From providing tech support to offering more advanced guidance through digital health literacy training, CHCs help patients understand and effectively utilize tools such as telehealth, remote monitoring, and other innovative digital technologies that support informed decision-making and improved health outcomes.[42]

NACHC recommends continued investment in Health Center-Controlled Networks (HCCNs), which can help advance technology and AI usage for CHCs and patients. CHCs are already advancing access to technology, especially through HCCNs. HCCNs are groups of health centers collaborating to utilize health information technology (HIT) to enhance operational and clinical practices. HCCNs help CHCs leverage health IT to increase participation in value-based care by improving the patient and provider experience, advancing interoperability, and using data to enhance value. They provide specialized training and technical assistance that leverage economies of scale, including group purchasing power, shared training resources, and data analytics capabilities. For example, a CHC serving San Diego and Riverside Counties identified low levels of digital literacy and limited access to technology among its patient population. Through a partnership with an HCCN, the CHC implemented a digital literacy initiative that included digital health ambassadors and enhanced support for video visits. As a result, the CHC experienced increased adoption of MyChart and higher rates of self-scheduled visits, along with qualitative reports indicating that patients felt more confident and comfortable using digital health tools.[43] In 2021, approximately 83% of federally funded CHCs participated in an HCCN, an increase from approximately 73% over the past 3 years.[44] Participation is likely to continue to grow if there is continued support and investment. HCCNs are crucial to improving how technology is leveraged to enhance decision-support tools for beneficiaries and their caregivers.

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[40] https://www.cms.gov/newsroom/press-releases/cms-statement-agent-and-broker-marketplace-activity.
[41] 2025 UDA Data, HRSA. (hrsa.gov)
[42] https://www.nachc.org/wp-content/uploads/2024/06/CHC-of-the-Future.pdf
[43] https://ochin.org/member-spotlights/improving-patient-health-well-being-digital-literacy/
[44] https://jhmhp.amegroups.org/article/view/8389/html#:~:text=The%20number%20of%20FQHCs%20participating,HCCNs%20(6%2C7)

Additionally, to enhance the use of these tools and positive outcomes, NACHC recommends that the Administration fund CHC-led pilots and research on AI. We request that CMS support multi-site demonstration projects that allow CHCs to co-develop, test, and refine AI tools with academic and industry partners using representative populations and outcomes.[45] Use of AI tools in healthcare settings and training on a wide array of representative datasets enables greater adoption and better outcomes for MA beneficiaries and their caregivers. To remain competitive and keep up with ever-changing technology, CHCs welcome opportunities to partner with agencies in the AI space. Pilot projects could be developed for CHCs along a continuum with different approaches for those that are advanced in their use and understanding of AI and those that are just beginning to use AI to bolster patient care. Numerous documented success stories exist of CHCs utilizing AI. For example, two community health centers in Chicago and New York used an AI chatbot to educate patients about preventive services like cancer screenings, remote blood pressure screenings, and well-child visits. The six-month pilot AI project successfully improved workflows and improved health literacy and motivation for patients.[46]

Aside from investment, NACHC urges the Administration to develop frameworks or guidance that maintain transparency and explainability when using any type of AI for decision-support interventions. The Assistant Secretary for Technology Policy (ASTP), in the 2024 HTI-1 Final Rule,[47] established new "Algorithm Transparency" requirements[48] for AI and other predictive algorithms that are mandatory for all healthcare providers using certified electronic health record (EHR) technology (CEHRT) in delivering patient care. The Final Rule also established a regulatory approach requiring transparency in the training data used for decision-support interventions (DSI) models. This promotes responsible AI and enables clinical users to access a consistent baseline set of information about the algorithms and models they use for clinical decision-making and to assess them for bias, fairness, appropriateness, validity, effectiveness, and safety. ONC-certified health IT supports the care delivered by more than 96% of hospitals and 78% of office-based physicians around the country.[49] The changes will improve interoperability through more modern standards and newer versions of existing standards; assist partner agencies such as CMS and the Centers for Disease Control and Prevention (CDC) in fulfilling their missions through certified health IT; improve care delivery for clinicians and care experience for individuals by improving access to more interoperable data – consistently and reliably – for patient care and individual access; require greater transparency regarding the decision support interventions included in certified health IT.

NACHC recommends that the Administration promote the development of affordable and accessible AI technologies, including those that can operate in low-bandwidth environments and on low-cost devices. Many CHC patients live in rural areas – CHCs serve one in three rural residents across the country[50] – and many of those residents may not have access to high-speed Internet or Wi-Fi. Having access to high-speed internet means that a patient can use their remote monitoring device to track their chronic disease, consult with their doctor during a telehealth appointment, or view their lab results through their electronic health records.[51] This access meaningfully improves a patient's health and care journey. Households in rural areas were less likely to use high-speed internet services, and costs can make internet

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[45] https://muse.jhu.edu/article/975574
[46] https://www.nachc.org/leveraging-chatbots-to-improve-preventive-care/
[47] https://www.federalregister.gov/documents/2024/01/09/2023-28857/health-data-technology-and-interoperability-certification-program-updates-algorithm-transparency-and
[48] https://www.healthit.gov/sites/default/files/page/2023-12/HTI-1_Gen-Overview_factsheet_508.pdf
[49] https://www.healthit.gov/topic/laws-regulation-and-policy/health-data-technology-and-interoperability-certification-program
[50] 2025 UDA Data, HRSA. (hrsa.gov)
[51] https://www.commonwealthfund.org/publications/podcast/2025/may/in-rural-america-weak-signal-can-mean-worse-health

access unaffordable for individuals with lower household incomes. Limited access to reliable technology (e.g., internet and computers), as well as low health and digital literacy, may restrict a patient's ability to engage meaningfully at a CHC.[52] CHCs serve one in three people in poverty, who are also impacted by a lack of reliable, stable internet access.[53] The American Health Information Management Association Foundation found that "while over 8 in 10 households with incomes above $100,000 used wired high-speed internet service at home,[54] only about 5 in 10 households with incomes below $25,000 did in 2021."[55]

c. Improving Network Adequacy

NACHC recommends that CMS create a similar requirement for MA plans, mirroring the Essential Community Provider provision for Qualified Health Plans (QHPs), to encourage more contracting opportunities between CHCs and MA plans. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)[56] to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, including CHCs, HIV/AIDS clinics, and family planning clinics. CHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations nationwide. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs. Currently, QHPs are required by § 156.235 to contract with 35% of CHCs in their service area. If CMS created a similar provision for MA Plans, it would ensure that families have adequate access to affordable, quality care provided by CHCs in their own communities.

NACHC recommends that CMS revisit the current MA network adequacy standards, specifically the time and distance standards outlined at § 422.116, to enhance access to care, particularly for specialist providers. A significant difference between Medicare Advantage and Original Medicare is that MA plans have a limited provider network for their enrollees to visit. While we appreciate that CMS recently updated these network adequacy standards in 2023 to help ensure adequate access, recent feedback from CHCs suggests that these standards are not creating sufficient access for CHC patients to providers, especially specialists. Because CHCs are required to be located in medically underserved areas, the lack of in-network providers in those areas presents a significant challenge for patient access, especially for older adults who experience chronic conditions, resulting in frequent appointments with specialists.[57] Thus, CMS should exercise increased oversight to improve access to care for older Americans residing in regions facing affordability challenges and to ensure they have access to comprehensive healthcare services.

CHCs across the country have reported a general shortage of providers, particularly in rural areas. For instance, a CHC in rural northern California reported that many specialists in their area do not contract with Medicare Advantage plans. While the CHC itself chooses not to contract with MA plans, even if it did, there would be no in-network specialists nearby to send its MA patients. Furthermore, a rural Missouri CHC shared that there is only one in-network primary care provider with the MA plan in the area. Older CHC patients may experience mobility issues, making it difficult to travel long distances to seek specialist care. CHCs are strategically placed based on the needs of the community – they must be located in or serve a community with a medically underserved population or a community that has a shortage of healthcare

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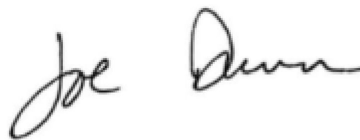
[52] https://www.samhsa.gov/blog/digital-access-super-determinant-health#4
[53] 2025 UDA Data, HRSA. (hrsa.gov)
[54] https://www.ntia.doc.gov/data/explorer#sel=wiredHighSpeedAtHome&demo=income&pc=prop&disp=chart
[55] https://www.ahimafoundation.org/understanding-the-issues/health-equity-and-broadband-internet-access/
[56] Section 1311(c)(1)(C)
[57] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5486481/

providers.[58] Ensuring adequate access to providers in communities that are already medically underserved is paramount to promoting healthcare for all, regardless of where patients live. Health centers try to bridge the primary care gap but face limitations when referring their patients for specialty care under MA coverage.

Additionally, we understand that current regulations direct MA plans to "arrange for and cover any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs," per 422.112(a)(1)(iii). However, given the general lack of education MA plans provide to enrollees about these benefits and their quickness to deny proper prior authorization requests, better time and distance standards can help alleviate barriers to accessing timely, quality care within MA plans, especially for patients in rural areas. We urge CMS to adjust MA network adequacy standards, particularly the time and distance requirements, to enhance patients' access to care.

Thank you for the opportunity to comment on these proposals. We look forward to continuing our collaboration with CMS to advance the health and well-being of Medicare Advantage patients. If you have any questions about our comments, please contact Elizabeth Linderbaum, Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer

[58] https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers