Mehmet Oz, M.D., M.B.A., Administrator
Department of Health and Human Services,
Attention: CMS-4212-P,
P.O. Box 8013,
Baltimore, MD 21244-8013

January 26, 2026

cc: Shruti Rajan, Deputy Director, Medicare Plan Payment Group
Vanessa Duran, Director of Medicare Drug Benefit and C&D Data Group

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

Dear Dr. Oz,

Better Medicare Alliance is pleased to submit the following comments on the proposed Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program ("Proposed Rule") on behalf of our Alliance and the more than 35 million beneficiaries enrolled in Medicare Advantage.[1] Better Medicare Alliance is a diverse coalition of over 200 Ally organizations and hundreds of thousands of beneficiaries who value Medicare Advantage. Together, our Alliance of community organizations, providers, health plans, aging service organizations, and beneficiary advocates share a deep commitment to ensuring Medicare Advantage remains a high-quality, affordable option for current and future Medicare beneficiaries. We are uniquely positioned to partner with CMS to advance shared goals of strengthening the Medicare Advantage program. Better Medicare Alliance's role as a trusted convener enables us to surface on-the-ground insights, facilitate collaboration across stakeholders, and support evidence-informed policymaking that protects beneficiary choice while promoting affordability, quality, and program integrity.

Medicare Advantage is now the primary form of Medicare coverage in the United States. Beneficiaries choose Medicare Advantage for high-quality, comprehensive care that costs them less on average than Original Medicare. In addition, Medicare Advantage serves a disproportionate share of lower-income beneficiaries, with more than one-third of enrollees reporting annual incomes below $25,000, compared with one-fifth of Original Medicare beneficiaries.[2]

Beneficiaries rely on Medicare Advantage for affordable health coverage, with average spending being $3,486 less per year in premiums and out-of-pocket costs compared to Original Medicare beneficiaries.[3] Seniors and individuals with disabilities choose and trust the affordable, quality, and innovative health care available in Medicare Advantage that

[1] Better Medicare Alliance. State of Medicare Advantage 2025. 2025. Available Here.
[2] AHIP. Medicare Advantage Demographics. 2025. Available Here.
[3] Better Medicare Alliance. State of Medicare Advantage 2025. 2025. Available Here.

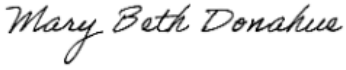
delivers better outcomes. For example, evidence shows Original Medicare readmissions were 3.8 times higher than those of Medicare Advantage beneficiaries in 2023.[4]

As the Medicare Advantage program continues to adjust to significant policy changes implemented in recent years, promoting stability for beneficiaries is critical. Millions of beneficiaries have experienced plan exits, higher costs, and reduced benefits in recent years.[5] A stable Medicare Advantage program enables consistent access to care and supplemental benefits, meaningful cost savings for beneficiaries, and high-quality, coordinated care that supports better health outcomes, including greater use of preventive services and fewer avoidable hospitalizations. We urge CMS to carefully consider the cumulative impact of policy changes and to prioritize thoughtful, phased implementation that minimizes disruption for beneficiaries.

While underscoring the importance of maintaining program stability, we strongly support CMS' efforts to modernize and strengthen the Medicare Advantage program to better serve beneficiaries for many years to come. We welcome the opportunity to partner with CMS to develop thoughtful modernization approaches and have outlined a range of policy recommendations across key areas, including payment modernization, risk adjustment, health risk assessments (HRAs), prior authorization and supplemental benefits. Better Medicare Alliance recognizes that collaboration and testing prior to implementation of policy changes is important for understanding the impacts on beneficiaries and the broader environment, minimizing unintended consequences and ultimately protecting beneficiaries. We are eager to engage with CMS as it moves forward with reforms.

Better Medicare Alliance is committed to preserving and strengthening Medicare Advantage as a critical choice for Medicare beneficiaries. We appreciate the opportunity to submit comments on the Proposed Rule and look forward to continued engagement with CMS to ensure stability and identify opportunities to strengthen the program for current and future beneficiaries.

Sincerely,



Mary Beth Donahue
President & CEO
Better Medicare Alliance

[4] AHIP. New Research: MA Enrollees Have Better Outcomes than People in Original Medicare. 2023. Available Here.
[5] Better Medicare Alliance. Analysis of the 2026 Medicare Advantage Plan Landscape. 2025. Available Here.

ATTACHMENT

Supplemental Benefits

CMS proposes to rescind the Mid-Year Supplemental Benefits Notice requirement included in the April 2024 Final Rule and to deregulate the § 422.102(e) pathway for certain Dual Eligible Special Needs Plans (D-SNPs) to offer supplemental benefits.

BMA Comments

Better Medicare Alliance supports CMS' proposal to rescind the Mid-Year Supplemental Benefits Notice requirement. We believe this requirement could unintentionally create confusion for beneficiaries due to lagged or incomplete data, variability in how benefits are delivered, and differences in vendor reporting capabilities. Rescinding this requirement aligns with the shared goal of improving beneficiary understanding while avoiding administrative processes that may not meaningfully enhance transparency.

Supplemental benefits are a defining feature of Medicare Advantage and play a critical role in supporting beneficiaries' medical, behavioral, and social needs. Flexibilities established during the first Trump Administration, such as the implementation of Special Supplemental Benefits for the Chronically Ill (SSBCI), have supported plan innovation and expanded benefit offerings that promote beneficiary wellness and address needs not met through traditional Original Medicare.

In 2026, most Medicare Advantage plans offer supplemental benefits that are widely valued by beneficiaries, including vision, dental, and hearing coverage. Specifically, 96% of Medicare Advantage plans offer dental benefits, 98% offer vision benefits, and 96% offer hearing benefits.[6] In addition, many plans offer a range of other supplemental benefits, such as fitness programs (91%), transportation (38%), meals 60%), and other services designed to support beneficiaries' health, functional needs, and overall well-being.[7]

As Medicare Advantage increasingly serves beneficiaries with complex medical and social needs, supplemental benefits remain a critical tool for addressing care gaps, supporting preventive services, and improving access to services that are not available in Original Medicare. Because Medicare Advantage beneficiaries are more likely to experience social risk factors that affect health outcomes, stable and predictable supplemental benefit policies are essential to ensuring these benefits can be sustained and effectively tailored to beneficiary needs.[8]

Stable payment policies, defined by predictability, transparency, and sufficient time for plans to adapt to changes, are foundational to sustaining and expanding supplemental benefits. Payment predictability enables plans to invest in benefit innovation, develop partnerships with community-based organizations, and support evidence development

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[6] Better Medicare Alliance. Analysis of the 2026 Medicare Advantage Plan Landscape. 2025. Available Here.
[7] Better Medicare Alliance. Analysis of the 2026 Medicare Advantage Plan Landscape. 2025. Available Here.
[8] Better Medicare Alliance. Social Risk Factors Are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage. 2020. Available Here.

over time. When payment policies are stable, plans are better positioned to maintain existing benefits, pilot innovative approaches, and invest in partnerships that address beneficiaries' medical and non-medical needs. We encourage CMS to continue supporting supplemental benefit innovation while fostering an environment that allows evidence to evolve and mature over time.

Marketing and Oversight

CMS proposes several updates to Medicare Advantage and Part D marketing and communications requirements, including streamlining and relaxing certain marketing rules, expanding flexibility around beneficiary outreach and scope of appointment (SOA) collection, enhancing transparency in marketing interactions, and updating oversight and definitions related to third-party marketing organizations (TPMOs).

BMA Comments

Better Medicare Alliance shares CMS' goal of ensuring beneficiaries receive clear, accurate, and non-misleading information when making Medicare coverage decisions. We are supportive of CMS' proposals to streamline marketing rules, improve transparency in marketing interactions, and strengthen oversight of marketing practices.

Better Medicare Alliance has long supported marketing guidance that supports beneficiaries in making informed choices. In our 2023 policy solutions, Better Medicare Alliance recommended the following proposals for CMS:[9]

- Enhance ongoing enforcement of misleading marketing practices
- Establish a code of conduct and/or best practices for TPMOs with continued oversight from health plans and CMS
- Prohibit TPMOs from distributing beneficiary contact information

Consistent with these longstanding positions, Better Medicare Alliance emphasizes the importance of clear and comprehensive oversight of TPMOs, given their significant and evolving role in beneficiary education and enrollment. Clear definitions and consistent application of marketing standards across all entities involved in beneficiary outreach remain critical to ensuring beneficiaries are fully informed and protected.

We commend CMS for recognizing the evolving marketing and communications landscape and for taking steps to enhance beneficiary protections while maintaining appropriate flexibility for outreach and education. As CMS refines marketing and TPMO oversight policies, it is important that requirements are appropriately targeted to address misleading practices, while avoiding unnecessary administrative burden or requirements that could inadvertently create confusion for beneficiaries. Oversight frameworks should prioritize clarity, consistency, and operational feasibility across plans, agents, and TPMOs.

Better Medicare Alliance also believes that Medicare Advantage and Part D plans should connect beneficiaries with access to translated materials and language assistance

[9] Better Medicare Alliance. Strengthening Medicare Advantage for Beneficiaries: Recommendations for Policymakers. 2023. Available Here.

services to support informed decision-making. At the same time, we encourage CMS to consider stakeholder concerns that existing translation threshold requirements may result in additional administrative burden and increased paper communications to beneficiaries.

As CMS finalizes these proposals, it will be important to maintain clear guardrails that prevent beneficiary confusion and to provide sufficient guidance to support consistent implementation. Ongoing oversight and evaluation will be essential to ensure these changes meaningfully advance beneficiary understanding and trust without unintended consequences.

Special Enrollment Period for Provider Terminations

CMS proposes revisions to the Special Enrollment Period related to provider network changes, including modifying eligibility criteria to make the SEP more accessible for beneficiaries, renaming the SEP to the "Special Enrollment Period for Provider Terminations," and updating required content in provider termination notices to improve beneficiary awareness and understanding of available coverage options.

BMA Comments

Better Medicare Alliance is generally supportive of CMS' proposal to revise and rename the Special Enrollment Period (SEP) related to provider network changes to improve beneficiary awareness and accessibility. Ensuring beneficiaries have timely information and meaningful options when experiencing provider terminations is an important safeguard.

At the same time, we encourage CMS to be mindful of potential unintended consequences if these changes are finalized. In particular, expanded SEP eligibility and additional notice requirements could contribute to overutilization of the SEP or an increased volume of notices, which may create confusion or lead to coverage changes that do not ultimately benefit beneficiaries.

Better Medicare Alliance also encourages CMS to retain a clear "significant change" standard for triggering this SEP, or, if modifications are made, to provide updated guidance clarifying what constitutes a significant versus insignificant provider network change. Clear standards and illustrative examples would support consistent application across plans, limit uncertainty, and help avoid unnecessary disruption for beneficiaries.

As CMS moves forward, we encourage careful monitoring of SEP utilization to ensure the policy functions as intended and is not subject to misuse. If finalized, ongoing monitoring and evaluation will be important to assess whether the SEP is being initiated consistently and appropriately, and whether it is improving beneficiary experience without introducing confusion or unnecessary churn. Medicare Advantage plans already provide continuity of care protections and SEP policies should be designed to complement these existing safeguards. Additionally, we encourage CMS to ensure required notices are clear, consistent, and operationally feasible so beneficiaries can understand their options without unnecessary complexity or confusion.

Additional Star Ratings Program Measures

CMS proposes updates to the Medicare Advantage Star Ratings Program, including the addition of a Depression Screening and Follow-Up measure beginning with the 2029 Star Ratings year.

BMA Comments

Better Medicare Alliance appreciates CMS' continued commitment to advancing high-quality care through the Star Ratings Program and supports the inclusion of outcome-focused measures, including the addition of preventive and behavioral health measures such as depression screening.

Preventive screenings and behavioral health assessments are foundational to improving population health and addressing care gaps, particularly as Medicare Advantage increasingly serves beneficiaries with complex medical and social needs. We encourage CMS to continue aligning quality measurement with outcomes that matter most to beneficiaries while ensuring changes to the Star Ratings Program are implemented in a predictable and transparent manner. Given the significant operational and cut point impact of these updates, clear guidance and thoughtful pacing will be important to support sustained quality improvement and maintain beneficiary confidence in the program.

Star Ratings Program - Request for Information

CMS issued an RFI seeking feedback on potential future refinements to the Star Ratings Program, including opportunities to streamline methodology, further incentivize quality and outcomes, and better align quality measurement with broader Medicare Advantage program goals.

BMA Comments

Better Medicare Alliance supports continued evolution of the Star Ratings Program toward outcome-based quality measurement that reflects the care experiences and health outcomes most meaningful to beneficiaries. The Star Ratings Program provides a stable and predictable quality framework that supports plans' ability to make sustained investments in care coordination, preventive services, and benefit designs that improve beneficiary experience and outcomes over time. Beneficiary enrollment patterns demonstrate the value of this framework as almost two in three beneficiaries enrolled in an MA-PD plan selected a plan with four or more stars in 2025.[10]

The Quality Bonus Program (QBP) is intended to encourage meaningful improvements in care by rewarding plans that perform well on key quality measures. Over time, the program creates strong incentives for plans to invest in improved clinical outcomes, enhanced member experience, and operational excellence.

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[10] Better Medicare Alliance. State of Medicare Advantage 2025. 2025. Available Here.

By linking financial bonuses to the Star Ratings program, CMS holds Medicare Advantage plans accountable for delivering high-quality, coordinated care. As scrutiny of Medicare Advantage plan performance continues to increase, Star Ratings offer a transparent and standardized mechanism for plans to demonstrate responsible operations and effective management of beneficiary care. Additionally, Star Ratings help align patient outcome goals across plans and providers. Any major changes to the program would therefore impact not only health plans, but also providers, many of whom have multi-year contracts tied to patient outcome performance under the program.

As CMS considers potential future refinements, it is important that changes to the Star Ratings Program be informed by a clear understanding of the cumulative impact of recent updates. Predictable implementation timelines and transparency will be critical to supporting long-term planning, sustained investment in quality improvement, and beneficiary confidence in the program. We encourage CMS to continue engaging stakeholders as it evaluates opportunities to refine the Star Ratings Program in ways that support high-quality, coordinated care.

Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs - Request for Information

CMS issued a RFI seeking feedback on the growth in enrollment of dually eligible individuals in Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs). CMS is exploring whether additional policies are needed to ensure these plans appropriately support care coordination and integration for dually eligible beneficiaries and align with federal and state efforts to improve the beneficiary experience for this high-need population.

BMA Comments

Better Medicare Alliance supports CMS' goal of improving care coordination and integration for beneficiaries enrolled in SNPs. Medicare Advantage SNPs serve some of the most medically and socially complex populations, and thoughtful integration can enhance continuity of care and beneficiary experience. Better Medicare Alliance and our allies share a strong commitment to delivering quality and patient-centered care to beneficiaries with diverse health needs. We are committed to serving the dually eligible population, those that are served via C-SNPs, D-SNPs, and I-SNPs.

Consistent with this commitment, Better Medicare Alliance offers the following recommendations:

- Protect beneficiary choice while upholding consistent national standards.
- Reduce administrative burden and promote a stable and competitive Advantage marketplace.
- Refrain from applying State Medicaid Agency Contract (SMAC) requirements to C-SNPs and I-SNPs. Better Medicare Alliance is opposed to requiring SMACs for C-SNPs and I-SNPs. We have found that there are several risks to beneficiary access, potential impact on market stability, and an increase of administrative burden.

- Preserve regulatory flexibility by avoiding disruptive measures, such as C-SNP look-alike thresholds. Better Medicare Alliance does not support look-alike thresholds for C-SNPs. If CMS implements look-alike thresholds for C-SNPs, Better Medicare Alliance recommends exemptions for partial duals and states without fully integrated D-SNPs.
- Maintain exemption for I-SNPs from additional requirements due to their distinct care model. Better Medicare Alliance encourages CMS to maintain exemptions for I-SNPs from additional requirements, given I-SNPs specialized role and small enrollment size.

Dually eligible beneficiaries enrolled in Medicare Advantage SNPs have significantly higher clinical complexity, with 72% reporting three or more chronic conditions. Despite this complexity, dual eligible SNP enrollees report better access to care, including a higher likelihood of having a usual source of care and fewer reported difficulties obtaining needed services compared to dually eligible beneficiaries in Original Medicare, underscoring the value of these plans designed for high-need populations.[11]

Better Medicare Alliance recommends continuing growth and standardization of care coordination requirements for C-SNPs that have over 1,000 full-dually eligible beneficiaries. This is inclusive of support for Medicaid appeals and sharing care coordination data with different states. As CMS considers updates to Special Need Plan policies, it is critical that plans have adequate time to implement changes in a way that prioritizes beneficiary stability and minimizes disruption. Rushed or fragmented implementation can unintentionally increase confusion, disrupt provider relationships, and undermine the very goals integration seeks to achieve. We encourage CMS to focus on phased approaches that allow plans, providers, and beneficiaries to adapt smoothly while maintaining continuity of care.

Future Directions in Medicare Advantage: Risk Adjustment, Quality Bonus Payments, and Data Sources - Request for Information

CMS issued an RFI seeking feedback on potential future directions for Medicare Advantage, including near-term and long-term changes to risk adjustment methodology and quality bonus payments. CMS requests input on the potential use of additional data sources and advances in technology, including artificial intelligence, and seeks feedback on how diagnoses and information from Health Risk Assessments (HRAs), encounter data, and chart reviews may be incorporated into risk adjustment approaches. CMS also seeks feedback on ways to achieve optimal nutrition for beneficiaries and improve preventative care in Medicare Advantage.

BMA Comments

[11] Better Medicare Alliance. Dual Eligible Beneficiaries Receive Better Access to Care And Cost Protections When Enrolled in Medicare Advantage. 2021. Available Here.

Better Medicare Alliance appreciates CMS' interest in modernizing the Medicare Advantage program to support competition, value, and beneficiary well-being. Given the significant policy changes implemented in recent years, we encourage CMS to pursue modernization thoughtfully and in phases, with particular care around payment-related policies.

Payment stability is foundational to beneficiary access, plan participation, and the continued availability of supplemental benefits. In addition, as CMS considers future directions for payment and quality policy, it is important to recognize the role the Star Ratings Program plays in providing a stable and predictable quality framework for Medicare Advantage. The Star Ratings Program supports plans' ability to make sustained investments in care coordination, preventive services, and benefit designs that improve beneficiary experience and outcomes. Alignment across payment policy, risk adjustment, and quality measurement helps ensure plans can continue making long-term investments in high-quality care and supplemental benefits that address beneficiaries' medical, behavioral, and social needs.

As CMS considers future directions for Medicare Advantage, Better Medicare Alliance offers the following goals to help guide thoughtful, phased modernization that strengthens the program for beneficiaries and the Medicare program more broadly:

- **Advancing Health Equity and Reducing Disparities**
    - Congress could:
        - Enable Medicare Advantage plans, through legislation, additional flexibility to target and tailor benefits to address social risk factors based on the health needs of beneficiaries with low socioeconomic status and/or specific subpopulations (e.g., people living with disabilities, who are LGBTQ+, who live in rural communities, and women).
        - Update entitlement to Medicare to align with entitlement to disability coverage.
    - CMS could:
        - Create alignment of data elements and definitions when developing data collection standards and guidelines for assessment tools and payer software (e.g., electronic health records).
        - Assess the impact of new policies focused on reducing disparities and advancing health equity finalized through rulemaking.
        - Foster partnerships between health plans, providers, and community-based organizations by providing guidelines and technical assistance (e.g., assisting community-based organizations seeking to partner with health plans to collect and share data).
    - Congress and CMS could:
        - Improve integration for dual eligible beneficiaries at both the state and federal level.
        - Pursue efforts that enhance and expand retention efforts that support a diverse health care workforce.

- **Enhancing Supplemental Benefit Data Collection and Evaluation**
    - CMS could:
        - Provide more detailed information about supplemental benefit offerings available on Plan Finder.
        - Standardize language and descriptions for supplemental benefits to support beneficiary decision-making.
        - Collect standardized data on utilization of supplemental benefits (e.g., by creating new procedure codes).
        - Evaluate supplemental benefit use and impact on social, emotional, and physical health outcomes and subsequently highlight any high-value benefits it identifies in public reports with the aim of incentivizing health plans to offer these benefits.
- **Strengthening the Value of In-Home HRAs**
    - CMS could:
        - Expand and codify in-home HRA best practices and assess whether health plans act in accordance with the best practices.
        - Encourage health plans to incorporate questions related to health equity into all HRAs.
- **Increasing Access to Mental and Behavioral Healthcare**
    - Congress could:
        - Support the retention and expansion of the mental and behavioral health workforce.
    - CMS could:
        - Add mental and behavioral health management measures to Star Ratings.
        - Facilitate behavioral health provider access to health information technology systems necessary for effective coordination.
    - Congress and CMS could:
        - Require health plans to offer robust mental and behavioral health services with low to no cost sharing.
        - Promote the integrations of mental and behavioral health care with primary health care services.
- **Improving Provider Directories and Accuracy of Information**
    - Congress could:
        - Require independent audits from health plans and CMS, with results posted publicly.
    - CMS could:
        - Require health plans to standardize their processes for requesting personnel changes from providers.
        - Increase accessibility-related information to provider directories.
        - Improve provider directory information by establishing shorter deadlines for directory updates.

        - Codify additional oversight and requirements for accuracy and timely updates to current Medicare Advantage provider directories, especially for mental and behavioral health.
        - Create a national provider directory to streamline reporting and beneficiary access.
- **Modernize and Streamline Utilization Management to Improve Patient Access**
    - Congress could:
        - Enact the Improving Seniors' Timely Access to Care Act, which would require Medicare Advantage plans to establish electronic prior authorization standards.
    - CMS could:
        - Require health plans to provide beneficiaries with clear, detailed, easily accessible information about coverage policies, criteria, and requirements via plan communication and enrollment tools.
        - Require health plans to collect and analyze data on electronic prior authorization adoption and integration.
- **Establish Marketing Guidance that Supports Beneficiaries in Making Informed Choices**
    - Congress could:
        - Enhance oversight of companies engaging in misleading marketing practices.
    - CMS could:
        - Enhance ongoing enforcement of misleading marketing practices.
        - Establish a code of conduct and/or best practices for TPMOs with continued oversight from health plans and CMS.
        - Prohibit TPMOs from distributing beneficiary contact information.

Risk Adjustment

Better Medicare Alliance supports gradual and transparent modernization of the risk adjustment model, including exploration of new data sources and advances in technology. At the same time, we emphasize the importance of payment stability and predictability as CMS considers potential updates.

Significant changes to risk adjustment or related methodologies should be tested prior to implementation to allow policymakers to evaluate impacts and avoid unintended consequences. Predictable implementation timelines will be essential to ensuring plans can continue to support beneficiaries effectively.

Specifically, Better Medicare Alliance suggests that CMS consider the following when making changes to risk adjustment:

- **Reflect the full spectrum of beneficiary needs and health status**: Risk adjustment must account for the wide range of physical, behavioral, functional, and social factors that affect health status and influence outcomes and costs. This includes all beneficiaries with complex chronic conditions, disabilities, dual

eligibility, and those from underserved communities. Risk adjustment should reduce, not reinforce, longstanding differences in care, access, and payment. Models must include adjustments for non-medical drivers of health, geography, and demographic factors to ensure communities and populations are not under-resourced.

- **Support fair and sustainable participation**: Risk adjustment should enable fair competition and participation for plans and providers of all sizes and capacities. Models must not disproportionately benefit those with greater administrative or technical resources and should avoid reinforcing existing access or outcome gaps.
- **Promote transparency and stakeholder engagement**: Changes to risk adjustment must follow transparent processes, including public notice, data availability, and meaningful opportunities for stakeholder input. Clear communication and collaborative development are essential to building confidence and ensuring informed implementation.
- **Test and phase-in model changes carefully**: Any significant update should be tested through demonstrations or "shadow models" that run alongside the current model before full implementation. This allows policymakers have adequate time to evaluate performance, understand impacts, and make adjustments without disrupting care or introducing unintended consequences.
- **Minimize administrative burden and focus on care**: Risk adjustment should be efficient and streamlined and reduce unnecessary administrative requirements, thus allowing providers and plans to prioritize high-quality, patient-centered care. Systems should reward accurate reflection of beneficiary needs.
- **Ensure integrity and guard against unintended incentives**: Models must be carefully designed to avoid incentivizing inappropriate coding practices, unnecessary utilization, or other strategies aimed at inflating risk scores. Risk adjustment should align payment with actual beneficiary needs and expected costs and not strategies to drive utilization and diagnostics.

Health Risk Assessments, Encounter Data, and Chart Reviews

Health Risk Assessments (HRAs) remain a critical clinical tool for identifying care gaps, chronic conditions, and unmet social needs. In-home HRAs, in particular, offer valuable insights that may not be captured in traditional clinical settings and can support more coordinated, patient-centered care. We support continued use of HRAs in ways that meaningfully inform care delivery, improve follow-up, and integrate information across providers and care teams. Better Medicare Alliance appreciates CMS's recognition of the importance of HRAs as an effective pathway for standardized collection and reporting of social risk factor data for beneficiaries enrolled in SNPs.

Better Medicare Alliance has compiled a set of policy recommendations designed to improve health outcomes, increase access, enhance program integrity and transparency, prevent misuse, and leverage HRAs to address chronic disease. These solutions are centered around three core themes based on opportunities to improve in-home health assessments:

- **Promote Enhanced Follow-Up Care Including With Existing Primary Care Physicians**
    - Enact a new statutory requirement designed to require Medicare Advantage plans to follow up with beneficiaries after an HRA visit has occurred based on evidence-based clinical guidelines. As appropriate to address clinical or non-medical needs, actions could include a best and reasonable attempt to initiate:
        - Follow-up actions based on the clinical assessment and as clinically indicated could include actions that would address chronic and often lifestyle-influenced behavior change and support and are particularly amenable to the flexibility of MA plans to complete them.
        - Some examples of actions that would qualify to meet the requirement (this is not an all-inclusive list): Weight management and support, mobility and fitness support, home safety modifications, dietician services, care management services, securing follow-up care with existing PCPs/Specialists, telehealth visits, connection to MA supplemental benefits (including community-based resources), online education, support groups, medication therapy management visit with a pharmacist, remote patient monitoring, fall prevention.
        - Member outreach tactics could include actions such as text messaging, phone calls, audio/visual communication via telemedicine, e-mail, mail, and application-based communication
            - Congress or CMS could set a required outreach minimum, e.g., 3 attempts unless a beneficiary opts out from communication.
        - Coordination with primary care providers (PCP):
            - Require Medicare Advantage plans to identify or find a PCP if there is not one assigned and attempt to schedule annual wellness visit or evaluation and management visit to address patients' condition(s).
            - Subject to consent of the beneficiary when required, provide the PCP with a summary of the visit information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources.
- **Strengthen Medicare Advantage Program Integrity & Oversight**
    - Mandate documentation of follow up: Require Medicare Advantage plans to document that either specific actions were taken or that specific attempts to initiate actions have been taken when clinically indicated.
    - Promote data integration: Require MA plans to integrate HRA data into health plan case management systems and that MA plans provide electronic data regarding the in-home visit to PCPs to the extent that PCPs have the capability of receiving it.

- Use evidence-based diagnostic criteria: When making diagnoses, require clinicians to use evidence-based clinical guidelines and established standards of care.
- Require data collection & transparency: In collaboration with stakeholders require CMS to develop, collect and publish key metrics such as:
  - Number of HRA encounters
  - Medication reviews conducted and adverse determinations identified and corrected.
  - Provider encounters 90-days after an in-home clinical visit.
  - Reports delivered to beneficiary's primary care provider (PCP).
  - Beneficiaries enrolled in disease or case management programs
  - Gaps closed, including quality measures and social determinants of health.
- Deploy HRA focused audits:
  - Upon finalization of rules standardizing CMS' 2016 in-home HRA best practices, include in the annual CMS program audit a review of and compliance with the regulation. This audit will examine if the MA plan is appropriately implementing CMS's best practices.
  - Require CMS to conduct a RADV audit with a targeted focus on in-home HRAs. This audit will examine the accuracy of the diagnoses being submitted.

- **Standardize HRA Requirements And Clinical Model**
  - Standardize the operating model of home health assessments to support holistic health care and chronic disease management: All HRAs should be required to meet CMS's 2016 in-home HRA best practices, including:
    - Performed by physicians, or qualified non-physician practitioners, specifically advanced practice registered nurses, nurse practitioners, physician assistants, or certified clinical nurse specialists;
    - All components of the Medicare Annual Wellness Visit, including a health assessment, such as the model health assessment developed by the Centers for Disease Control and Prevention;
    - Medication review and reconciliation.
    - Include a process to schedule appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources;
    - Conducting an environmental scan of the enrollee's home for safety risks, and need for adaptive equipment;
    - Include a process to verify that needed follow-up care is provided;
    - A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s);
    - Provision to the enrollee of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources; and

        - Enrollment of assessed enrollees into the plan's disease management/case management programs, as appropriate.
    - Ensure ongoing data analysis & evaluation:
        - Require CMS to examine whether select health conditions drive payments from in-home HRAs and HRA-linked chart reviews that may be more susceptible to misuse among MA companies.
        - Require MA plans to provide an annual report to CMS on what actions were attempted and completed by each plan
        - Require CMS to issue an annual report based on this information

We also support efforts to improve encounter data quality while cautioning against increased reliance on encounter data until accuracy and completeness are sufficiently improved. Similarly, appropriate use of chart reviews can help ensure beneficiary needs are accurately reflected, provided administrative complexity is minimized and processes remain focused on clinical accuracy. Better Medicare Alliance supports the use of linked chart reviews, supported by a specific medical event or encounter in the health record as a valuable tool to improve data accuracy, clinical validation, and care coordination.

Nutrition

Better Medicare Alliance recognizes the important role that nutrition and wellness play in supporting overall beneficiary health and well-being. In recent years, Medicare Advantage has increasingly prioritized the integration of supplemental benefits focused on nutrition and wellness, including access to healthy foods, fitness programs and meal delivery services. Better Medicare Alliance's allies have followed these trends by offering nutrition support alongside social services to better address beneficiaries' holistic needs.

We encourage CMS to continue promoting the value of nutrition and wellness and to provide stability and clarity around these programs so that plans can sustainably incorporate related supplemental benefits in future plan years. It is important to recognize that the Medicare population is broad and diverse, with varying health needs and definitions of "healthy food" and nutrition priorities. Better Medicare Alliance therefore urges CMS to work with stakeholders to develop a clear and inclusive framework for defining "well-being" that reflects the diversity of the Medicare beneficiary population.