C+TAC
COALITION TO TRANSFORM ADVANCED CARE

January 26, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

Here are our comments on aspects of this proposed rule:

Special Enrollment Period for Provider Terminations

We support the proposal to change the eligibility criteria for the current special enrollment period (SEP) for Significant Change in Provider Network to reflect that such a determination by CMS or an MA organization is not necessary for an enrollee who is affected by the provider network change to be eligible for the SEP. MA network provider changes are challenging for

enrollees, especially those who may want to stay with their current provider if that provider is leaving the network. This proposal will allow those enrollees to change their coverage more easily, which will be a benefit to them and their providers.

Our only suggestion is that retaining the 3-month period of time in the current definition of an "affected enrollee", an enrollee who is assigned to, currently receiving care from, or has received care within the past 3 months from a provider or facility being terminated, is too short. Many patients only see their providers once or twice a year and so would not be able to change plans until their provider is, to them, long gone. For instance, a person being monitored for cancer care is often doing follow-up exams no more often than yearly. We therefore suggest at least 6, but ideally 12, months as the right interval to promote better continuity of care.

Adding Measure- Depression Screening and Follow-Up

We support the addition of this measure as we supported its consideration in previous rulemaking. It is unfortunate that, as the proposed rule notes, there are currently no measures specific to behavioral health care in the Part C and D Star Ratings, and so we agree that adding this measure would fill an important gap. We also appreciate that the measure incentivizes MA plans to provide any needed mental health services for enrollees who screen positive for depression. Screening, without the delivery of services, is of little benefit otherwise.

Removing the Health Equity Index (HEI) Reward from the Star Ratings Methodology

We do not support removing this health equity reward. The proposed rule provides no specific evidence to support its removal other than doing so "aligns with our focus on exploring ways to simplify and modify the Star Ratings methodology to further drive quality improvement." Simplicity should not be the key factor in performance measure selection. Are measures being chosen based on their ease of administration or on their value in improving health?

Further, health disparities do exist for the MA population that need to be overcome. A 2023 KFF literature review of MA enrollment by racial and ethnic group found higher MA enrollment rates among Black, Hispanic, and Asian and Pacific Islander beneficiaries than among White beneficiaries. Evidence from this review was less favorable for all these groups than White MA enrollees. These poor results will not go away unless MA plans are monitored and either rewarded for reducing or penalized for not addressing health care disparities. We urge the agency to develop the appropriate mechanisms to do so, especially given the growth in MA enrollment among these groups.

Passive Enrollment by CMS of the Dually-Eligible Population

We agree that the dually-eligible population benefits from more integrated care options and have long been in favor of allowing passive enrollment for full-benefit dually eligible enrollees from a non-renewing or terminating integrated D-SNP to another comparable integrated D-SNP. We therefore support the proposal to remove the requirement that the receiving integrated D-SNPs have substantially similar networks to the relinquishing integrated D-SNPs and, instead, require receiving integrated D-SNPs to provide continuity of care for all incoming enrollees for a minimum of 120 days. We agree that this amount of time should promote

continuity of care and appreciate that it allows for periods longer than 120 days. Our recommendation is that enrollees should be allowed to, and easily be able to, change plans should they choose so. Passive enrollment is only a benefit if they are placed in the plans they would have otherwise chosen for themselves. CMS might also allow persons affected by passive enrollment to move from integrated plans to traditional Medicare, rather than only to another integrated MA plan, as some may need to avoid MA's narrow networks.

Rescinding the Mid-Year Supplemental Benefits Notice

MEDPAC confirms that supplemental benefits offer significant value to enrollees with serious illnesses by addressing gaps in traditional Medicare coverage, particularly through enhanced support for chronic condition management and social determinants of health. The Special Supplemental Benefits for the Chronically Ill (SSBCI) like food allowances or home modifications are of particular value to those with serious illness and should be promoted to qualifying enrollees. We therefore are concerned about rescinding this mid-year notice. There is not enough evidence provided in the proposed rule to confirm that doing so is appropriate and, while its removal may be beneficial to MAOs, it may not be for enrollees. Please provide more information to confirm "that the frequency of utilization was higher than previously believed" and that this will not discourage use of these important benefits by enrollees with serious or chronic illness.

Rescinding the Annual Health Equity Analysis of Utilization Management (UM) Policies and Procedures

We acknowledge that there have been concerns about the UM Committee from the beginning, although we supported its addition in 2024 rulemaking. We therefore disagree with the consideration of its removal in this proposed rule and find the rationale provided inadequate. Neither the fact that "the CMS position on the health equity analysis requirement has changed" or that reducing "the regulatory burdens imposed by the UM Committee requirements implemented in the April 2024 final rule (is) consistent with the focus on streamlining regulations and reducing administrative burdens for those participating in the Medicare program" are appropriate justifications. They do not address the very real health disparities among the MA population noted earlier in this letter.

Therefore, we continue to support the UM Committee and, in response to the proposed rule's questions, do not feel that its composition requirements or responsibilities should be changed. Instead, we recommend proceeding with the UM Committee on a trial basis to see if and how effective it might be. If it is not effective, or it turns out that there are indeed "more effective ways to gain this information, including through robust interoperability efforts" as noted on page 318 of the proposed rule, then those could be substituted in future rulemaking.

Rescinding the Quality Improvement Program Health Disparities Requirement

Building on our previous health equity comments, we clearly disagree with "current administrative priorities" regarding diversity, equity, and inclusion. It would be wonderful if an executive order, in this case E.O. 14148, by eliminating federal policies to promote these important concepts could also somehow eliminate health disparities. But it can't. They are real

and while we agree that "some MA organizations were already addressing disparities in care for underserved populations through a variety of quality initiatives without the need for regulation" regulations exist to ensure that *all* enrollees regardless of race, ethnicity, socioeconomic status, etc. get the highest quality of care possible. Therefore, we do not support rescinding this requirement and urge the agency to either keep it or come up with an alternate way to ensure quality care for MA enrollees from underserved communities.

Request for Information (RFI) on Future Directions in Medicare Advantage (Risk
Here are our responses to select questions in this RFI:

- *Which diagnoses are most essential for CMS to include in its MA risk adjustment model? In certain instances, should CMS limit the use of diagnoses in risk adjustment based on a minimum threshold of disease severity or to patient encounters within specific settings? Should CMS require diagnoses to be substantiated by follow-up encounters or treatments? Similarly, should CMS exclude diagnoses from plan-initiated encounters that do not lead to follow-up care, such as those resulting from in-home health risk assessments, or diagnoses not linked to specific services furnished to an enrollee?*

  C-TAC recommends that diagnoses with high morbidity, a high mortality rate, or higher likelihood for hospitalization and complications related to underlying disease be identified as most essential in its MA risk adjustment model. Currently, this model primarily weights diagnoses based on the cost of the disease, but this does not consider the impact of the disease on the patient or the burden on their family caregiver. Those diseases with increasing severity should be weighed heavier in risk adjustment, with an effort to determine the severity of disease when ICD-10 codes do not account for this. For example, cancers do not have a stage of disease in the underlying ICD-10 code but are known to impact the patient and caregiver more heavily at later stages. CMS should require diagnoses to be substantiated by follow-up encounters or treatments to ensure that diagnoses are not inaccurately flagging or weighing diagnoses that are suspected but not yet validated by additional diagnostic testing or follow-up encounters. Similarly, CMS should exclude those encounters or diagnoses not linked to follow-up care or services furnished to an enrollee. Health plans and health systems are more often utilizing these risk adjustment models to proactively identify enrollees who would benefit from additional care coordination services, and excluding those enrollees with invalidated diagnoses from risk adjustment models would further improve these efforts.

- *Over what timeframes should CMS incorporate diagnostic data for risk adjustment purposes? How can CMS account for certain illnesses and injuries that are likely to persist but may not be captured within a given data year by a patient encounter? Similarly, how should CMS account for past conditions that are no longer active, but continue appearing as diagnoses?*

Chronic and serious illnesses can persist for some time depending on the trajectory of the disease and should be accounted for over multiple years. C-TAC suggests taking a population health approach to account for these illnesses or injuries that have long-lasting effects and flag these enrollees as part of risk adjustment in subsequent years from initial diagnosis. CMS could track persistency of the diagnosis and remove the enrollee only after the diagnosis is no longer linked to an enrollee receiving follow-up services. This can also help CMS account for past conditions that are no longer active but still remain in the medical record.

- *When incorporating diagnostic data from particular encounters, should CMS account for the payment status of the services associated with that encounter? For example, should the risk adjustment model include diagnoses from encounters where a payment was denied, or approved and later found to be improper?*

  Diagnosis of a disease or condition and the payment for services associated with that diagnosis can be separate issues. C-TAC recommends that CMS should not account for the payment status of the services associated with the encounter that diagnosed an enrollee with a particular disease or condition. For example, specialty palliative care providers often will submit bills for palliative care encounters not yet covered by Medicare. These claims have diagnoses of a serious illness that should be counted for risk adjustment purposes.

RFI on Well-Being and Nutrition

We support exploring tools and policies around the concept of well-being. It is the cornerstone of high-quality care for serious illness including the use of palliative care. Palliative care is holistic care that focuses on improving well-being and quality of life for the person and their family. The agency's focus on preventive care also supports the use of palliative care to promote well-being as it has been categorized a preventive service by CMS in its approval of the 2024 Hawaii Medicaid State Plan Amendment.

Our recommendation is to expand the concept of well-being to be more holistic and include not only mental and physical but social, emotional, spiritual, financial, and other quality of life domains. These domains are important for all MA enrollees but particularly for those living with a serious illness for whom disease prevention may no longer be possible. The concept of well-being should also include what matters to those enrollees and honors their goals and preferences

We also support nutrition as a concept. Good nutrition is important for all individual although it cannot keep people living disease-free all their lives until death. Even those on the best diets will develop illness and ultimately die. Therefore, a realistic nutrition concept should allow for the fact that some will have serious and life-limiting conditions, such as advanced cancer or irreversible heart or lung disease, where taking in less nutrition is part of a natural process in the disease's final stages. Along with the above well-being recommendation, we also suggest that any nutrition concept include the person's input, goals, and what is appropriate for them

nutritionally at their stage of life or illness. The benefits of focusing on nutrition must be balanced with any burdens to them and to their caregivers.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact me, Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

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