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January 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

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

Submitted electronically at https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program

Dear Administrator Dr. Oz,

Thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2027 proposed changes to the Medicare Advantage (MA) and Medicare Prescription Drug (Part D) programs (CMS-4212-P). The Legal Action Center (LAC) is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunity for individuals with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC leads the Medicare Addiction Parity Project, which works to comprehensively and equitably improve coverage of and access to substance use disorder (SUD) care for older adults and people with disabilities.

We commend CMS for its work over the past decade to strengthen Medicare's SUD coverage. We appreciate the opportunity to continue to work with you to close the remaining gaps,[1] and to ensure all older adults and people with disabilities enrolled in MA and Part D plans have the opportunities and resources to manage their SUDs and to achieve the greatest possible health and wellbeing. We offer the following recommendations, with detailed comments following:

1. Align MA cost-sharing for mental health (MH) and SUD services with Traditional Medicare to improve wellbeing for MA enrollees, as previously proposed by CMS (MA RFI);
2. Require MA plans to contract with third party entities to perform secret shopper surveys, consistent with the requirements for other CMS-regulated plans, to ensure meaningful access to timely care (MA RFI);

[1] "Medicare's Expanded Coverage of Substance Use Disorder Treatment: Important Progress and Recommendations to Fill Remaining Gaps," Legal Action Center (2024), https://www.lac.org/assets/files/2024-MAPP-Updates-Issue-Brief-share_Updated.pdf.

3. Require MA and Part D plans – especially those serving dually eligible individuals – to comply with MH/SUD parity protections and remove unnecessary treatment limitations (MA RFI and C-SNP/I-SNP Dually Eligible RFI);
4. Add the Initiation and Engagement in SUD Treatment (IET) measure to Part C, in addition to the proposed Depression Screening and Follow-Up Star measure, and adopt other measures that promote access and remove barriers to SUD and MH treatment;
5. Withdraw the various proposals that would reduce access to culturally and linguistically appropriate care;
6. Finalize the proposal to change the Special Enrollment Period for provider terminations; and
7. Withdraw the proposal to update third-party marketing organizations disclaimer requirements.

A. Request for Information: Future Directions in Medicare Advantage

1. Align MA and Cost Plan Cost-Sharing for MH and SUD Services with Traditional Medicare to Improve Wellbeing for MA Enrollees

LAC appreciates the opportunity to comment on wellbeing policy changes that CMS should consider in future years for the MA program. One such policy that would "improve overall health, happiness, and satisfaction in life that could include aspects of emotional wellbeing, social connections, purpose, and fulfillment" is to **align MA and Cost Plan cost-sharing for MH and SUD services with Traditional Medicare fee-for-service cost-sharing**, as CMS proposed in the CY26 MA proposed rule.[2] Access to affordable MH and SUD treatment is vital for overall health and emotional wellbeing, and we strongly urge CMS to adopt this policy.

As CMS noted in that proposed rule, beneficiaries in Traditional Medicare pay only 20% coinsurance for all services (with zero cost sharing for opioid treatment program (OTP) services), while MA enrollees may be charged up to 50% coinsurance for the same MH and SUD services. CMS's data shows that approximately one in four MA plans have higher cost-sharing for MH specialty and psychiatric services than Traditional Medicare, and individuals in these plans would save an average of $7 per visit under the proposed change. The potential impact for access to SUD services is even greater: more than two in five MA plans have higher cost-sharing for outpatient SUD services than Traditional Medicare, and individuals in these plans would save an average of $30 per day under the proposed change. This means an individual enrolled in MA receiving outpatient SUD treatment just once a week would save over $1500 annually, and we know many individuals receive treatment even more frequently than that.

Notably, 71% of MA plans have higher cost-sharing for OTP services than Traditional Medicare, and individuals in these plans would save an average of $47 per visit. These costs add up quickly for individuals who attend treatment daily, as required for many participants, and these numbers show that many MA enrollees with SUD are currently spending thousands of dollars out-of-pocket annually to access this lifesaving SUD treatment.

[2] 89 Fed. Reg. 99340, 99401 (proposed Dec. 10, 2024).

While these additional costs would be minimal for MA and Cost Plans, these savings would be life-changing for Medicare beneficiaries with SUD and MH conditions. Among Medicare beneficiaries with SUD, one of the most commonly reported reasons for not receiving treatment was financial barriers.[3] Additionally, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) found that Medicare beneficiaries with opioid use disorder (OUD) who receive the low-income subsidy are almost three times more likely (26% compared to 9%) to receive medications to treat their OUD than beneficiaries without the subsidy, identifying the high Part D cost-sharing (averaging $268/annually for those without the subsidy, compared to $19/annually for those with the subsidy) as a potential explanation for this disparity.[4] We have heard from many treatment providers and advocates that Medicare beneficiaries with SUDs feel like they have to choose between their SUD treatment – which is currently more affordable through Traditional Medicare – and the other benefits that they might be able to receive through MA plans, like vision, hearing, and dental. No one should be forced into this position, and we believe this policy will help ensure that those who choose to enroll in MA plans do not have to sacrifice their wellbeing or their SUD and MH care needs.

Accordingly, we strongly encourage CMS to adopt this policy to align MA and Cost Plan in-network cost-sharing with Traditional Medicare for SUD and MH services, consistent with CMS's goals to improve wellbeing and to better prevent and manage chronic diseases.

2. Require MA plans to Contract with Third Party Entities to Perform Secret Shopper Surveys to Ensure Meaningful Access to Timely Care

Another policy that would improve overall health and wellbeing for MA enrollees would be a **requirement for MA plans to contract with third party entities to perform secret shopper surveys on their network directories, consistent with the requirements for other CMS-regulated plans**. In this proposed rule alone, CMS makes reference to its own use of secret shopper surveys (i.e., for contacting SHIPs posed as dually eligible beneficiaries), reinforcing that this method is the industry standard for collecting valuable data on access to information and care.

LAC is concerned with the HHS OIG's findings that MA provider networks – especially those for MH and SUD ("behavioral health" in the report) – are overly narrow and have many inactive providers, which prevents beneficiaries from getting the care they need.[5] Some of these findings included:

- Three-quarters of MA plans had less than 25% of the counties' behavioral health workforce in their networks;

[3] William J. Parish et al., "Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers," American Journal of Preventative Medicine 63(2), (Aug. 2022), https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040.
[4] U.S. Department of Health & Human Services Office of Inspector General, "The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern," (Dec. 2023), https://oig.hhs.gov/oei/reports/OEI-02-23-00250.pdf.
[5] U.S. Department of Health & Human Services Office of Inspector General, "Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers," (Oct. 2025), https://oig.hhs.gov/documents/evaluation/11233/OEI-02-23-00540.pdf.

- In more than half of MA plans, at least 1/3 of the providers listed in their network were inactive (did not provide a single service to enrollees that year); and
- On average, 55% of the behavioral health providers listed in MA plan network directories were inactive.

These findings are deeply troubling, and suggest that stronger policies are needed to ensure MA plans are maintaining adequate networks and updating their directories to ensure beneficiaries can access timely MH and SUD care to achieve optimal health and wellbeing. To improve MA beneficiary disease prevention and health promotion, LAC encourages CMS to adopt secret shopper survey requirements consistent with those for the qualified health plans (QHPs) on the federally-facilitated marketplace (FFM) and Medicaid managed care organizations (MCOs). CMS can leverage the existing technical guidance that it has already developed for QHPs, and then should ensure the results are made publicly available and incorporated into quality metrics, as described further below.

3. Apply SUD & MH Parity Protections to MA and Part D Plans and Remove Barriers to Treatment, Including Those for Medications for Opioid Use Disorder

Both of the above examples – as well as various other data[6] – demonstrate that MA and Part D plans are consistently and disproportionately failing Medicare beneficiaries who need SUD and MH care. Congress passed the bipartisan Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 to prevent these types of discrimination in health insurance, but tens of millions of Americans across the country are deprived of these consumer protections when they become eligible for Medicare, since it is not currently subject to this law. To the extent feasible, **we urge CMS to adopt policies and practices that facilitate greater parity between SUD and MH coverage and medical/surgical coverage**.

Even if full parity cannot be applied without Congressional action, we encourage CMS to **continue to improve access to SUD and MH services and medications by removing unnecessary treatment limitations**. For example, CMS should require all MA and Part D plans to remove cost sharing, prior authorization, step therapy, and dosage caps/quantity limits for medications for opioid use disorder (MOUD). These types of barriers all deter access to treatment, contributing to the disproportionately low rate at which Medicare beneficiaries with OUD access this gold standard of care – fewer than one in five.[7] Accordingly, we strongly recommend CMS remove barriers to MOUD and other types of SUD and MH treatment as it continues to work with Congress towards parity.

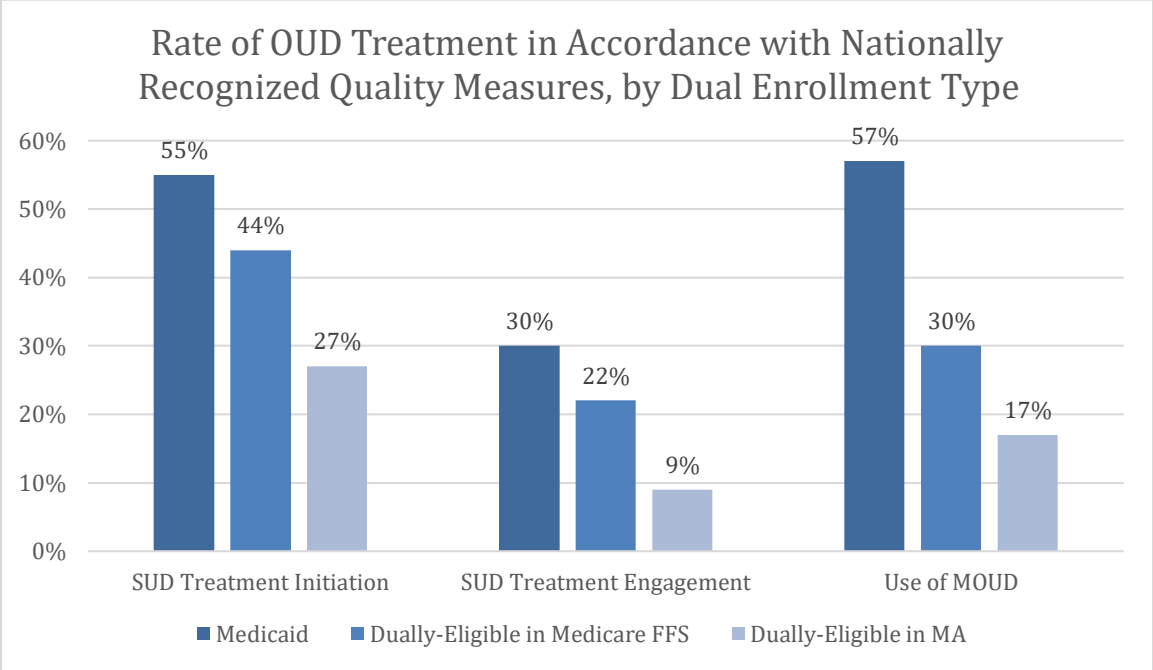
<u>B. Request for Information: C-SNP and I-SNP Growth and Dually Eligible Individuals – Improving Access to MH and SUD Treatment</u>

We thank CMS for continuing to monitor and seek information on improving access to care for

[6] "Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020," Legal Action Center (Oct. 2024), https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf.
[7] U.S. Department of Health & Human Services Office of Inspector General, "Fewer than One in Five Medicare Beneficiaries Received Medication to Treat Their Opioid Use Disorder," (Apr. 2025), https://oig.hhs.gov/documents/evaluation/10253/OEI-02-24-00430.pdf.

dually eligible individuals. LAC shares CMS's interest in supporting improved access to treatment and care coordination for individuals with MH conditions and/or SUDs, including those with serious mental illness (SMI). We appreciate the opportunity to comment on how special needs plans (SNPs) are serving this population and what improvements could be made to ensure individuals with these conditions are connected to appropriate services, especially given the higher rate of SUD in this population.[8] Specifically, we recommend CMS require plans that serve a majority of dually eligible individuals be required to comply with MHPAEA.

We are particularly concerned with recent research that shows **dually eligible individuals enrolled in MA plans are receiving lower quality OUD care than those enrolled in Medicare fee-for-service (FFS), as well as compared to individuals who have Medicaid only**.[9] For example, dually eligible individuals in MA plans only initiated SUD treatment 27% of the time, compared to 44% of dually eligible individuals in Medicare FFS and 55% of Medicaid beneficiaries. Similarly, a staggering 9% of dually eligible individuals in MA plans engaged in (continued) SUD treatment, compared to 22% of dually eligible individuals in Medicare FFS and 30% of Medicaid beneficiaries. Finally, the rate at which individuals with OUD access medications for OUD (MOUD) – the gold standard of treatment for this condition – is also far worse for this population: only 17% of dually eligible individuals in MA plans, compared to 30% of dually eligible individuals in Medicare FFS and 57% of Medicaid beneficiaries. The following chart illustrates these findings.



[8] "Two Plans are Not Always Better Than One: Barriers to Substance Use Disorder Treatment for Dual-Eligible Individuals," Legal Action Center (Jan. 2024), https://www.lac.org/assets/files/Duals-Issue-Brief-2024.01.19_MAPP-Branded.pdf.

[9] Tami L. Mark et al., The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs 44(9), 1086-1091 (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.

We recognize that a significant part of the problem here is Medicare's insufficient coverage of SUD treatment. Nonetheless, these MA plans are providing poor quality OUD treatment to the dually eligible population at a rate that is very concerning in the midst of the ongoing opioid public health emergency.[10]

As described in the prior section, MA and Part D plans – including plans that serve dually eligible individuals – are not subject to MHPAEA. This is particularly problematic for dually eligible individuals though, because this population *would* have parity protections if they were enrolled in Medicaid managed care plans, rather than these Medicare plans. The lack of this anti-discrimination law's protections may explain some of the disparities in the quality outcomes described above, since MA and Part D plans continue to impose disproportionate treatment limitations on SUD and MH care. As such, **to improve access to SUD and MH care – and overall health and wellbeing – for dually eligible individuals, we urge CMS to require plans that serve a majority of dually eligible individuals (D-SNPs and D-SNP look-alikes) to comply with MHPAEA**, as well as the other protections that promote care coordination and integration with Medicaid.

C. Adding, Updating, and Removing Star Ratings Measures

1. Adding Measures: Add the Initiation and Engagement of SUD Treatment (IET) measure to Part C, in addition to the proposed Depression Screening and Follow-Up Star Ratings Measure

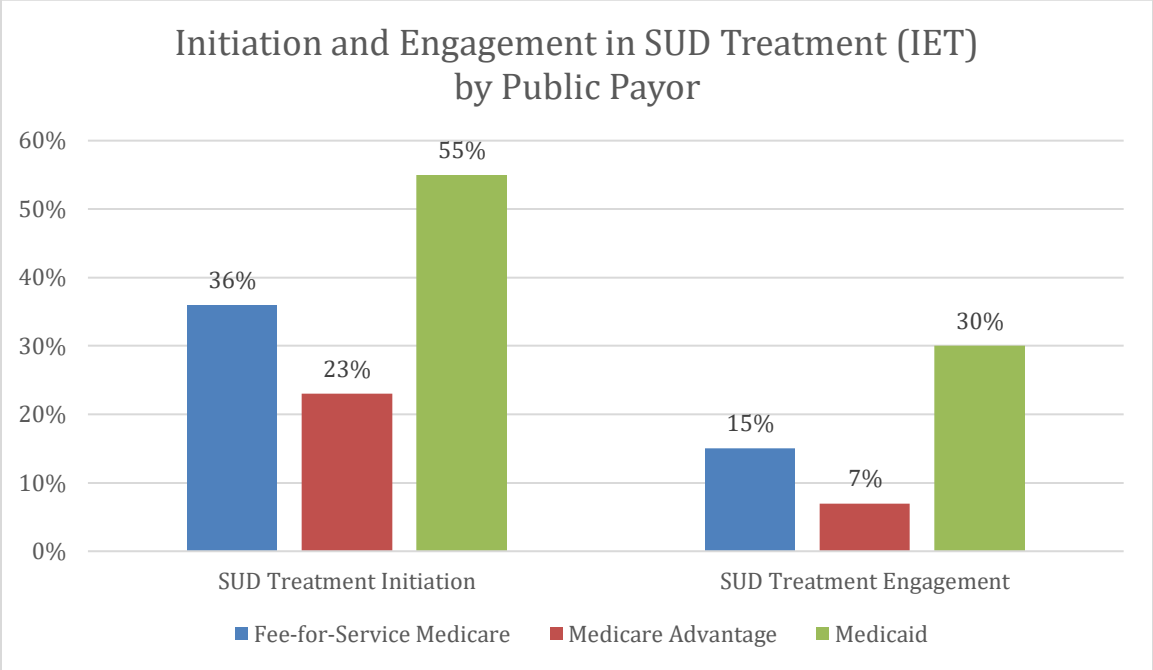
We commend CMS for continuing to improve the Part C and Part D Star Ratings system by focusing on improving clinical and other health outcomes. **LAC supports CMS's proposal to add "Depression Screening and Follow-Up" as a new MA Star measure**. Suicide rates are higher and rising in older adults than in any other age group,[11] and it is vital that depression and other mental illnesses be timely identified so Medicare beneficiaries can be connected to appropriate care. Given the significant role MH and substance use have in an individual's health and wellbeing, we believe adding this measure will be consistent with CMS's goal of preventing and managing chronic disease and ensuring that MA enrollees have access to quality care.

Relatedly, **we strongly encourage CMS to add the "Initiation and Engagement of SUD Treatment" (IET) Star measure to Part C**. Just like the Depression Screening and Follow-Up measure, IET is nationally endorsed and in alignment with the private sector, and would provide an appropriate SUD counterpart to the currently proposed MH measure. In fact, CMS proposed adding this composite SUD measure in the CY26 MA proposed rule,[12] and it is even more important now that MA plans be transparent in their provision of SUD care as the opioid public

[10] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," ASPR (Dec. 15, 2025), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-15Dec2025.aspx.
[11] Chloe Zilkha, Vani Agarwal, & Richard G. Frank, "Suicide Rates Are High And Rising Among Older Adults in the US," Health Affairs Forefront (Mar. 4, 2024), https://www.healthaffairs.org/content/forefront/suicide-rates-high-and-rising-among-older-adults-us.
[12] 89 Fed. Reg. 99340, 99474 (proposed Dec. 10, 2024).

health emergency continues.[13] As CMS noted at the time, MA contracts have been collecting this data for over ten years, so adding this to the Star Ratings will not increase the burden or cost for plans.

At the same time, adopting this measure will ensure that MA plans are appropriately investing in access and removing barriers to SUD treatment. Recent research shows that MA plans are currently performing significantly worse than FFS Medicare – and much worse than Medicaid – on these two measures: only 23% of MA enrollees initiated SUD treatment as compared to 36% in Medicare FFS; and only 7% of MA enrollees engaged in (continued) treatment, as compared to 15% in Medicare FFS.[14] The following chart illustrates these findings.



Consistent with CMS's goal, modifying the Star Ratings to include IET would drive improved quality of care. Moreover, as CMS noted in the CY26 Physician Fee Schedule (PFS) proposed rule, several risk factors related to poorer prevention and management of chronic disease include substance use.[15] Therefore, adding this Star Ratings measure would also incentivize MA plans to better prevent and manage chronic conditions, including SUDs as well as the many diseases that are caused and/or exacerbated by substance use, consistent with this Administration's current priorities.

[13] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," ASPR (Dec. 15, 2025), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-15Dec2025.aspx.
[14] Tami L. Mark et al., The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs 44(9), 1086-1091 (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.
[15] 90 Fed. Reg. 32352, 32507 (proposed July 16, 2025).

2. Additional Recommendations to Improve the Star Ratings System: Network Adequacy Measure

As discussed earlier in our comments, LAC strongly recommends CMS require MA plans to conduct secret shopper surveys, consistent with the requirements for QHPs on the FFM and Medicaid MCOs. We further believe **CMS should adopt a quality measure for the Star Ratings system that includes the results of these surveys, including a composite measure of (1) ability to make an appointment and (2) ghost networks** – that is, the extent to which the network directory is accurate. Similar to the QHP and Medicaid MCO requirements, CMS could start by requiring these surveys to be conducted for SUD and MH providers as well as for primary care providers. We believe this type of network adequacy measure would fill a critical gap in the current Star Ratings system and also better enable beneficiaries to make informed decisions when choosing plans about whether their plan will be able to meet their health care needs and whether they will have timely access to care.

3. Removing and Modifying Measures

We agree that significant revisions are needed for the Star Ratings system to be more effective. Reducing the number of measures is certainly an important step. However, we are concerned that CMS has proposed to remove a number of measures that provide valuable information for consumers and should continue to be a source of accountability for plans.

LAC opposes CMS's proposal to remove the Health Equity Index (HEI) reward and replace it with the historical reward factor, and urges CMS to withdraw this proposal. Research consistently shows that the Star Ratings system does not improve quality of care for Medicare beneficiaries. Rather, it seems to embed disparate quality standards into the MA and Part D system, insofar as more resourced and healthier populations continue to have access to higher quality plans. However, the HEI reward did not do that – it provided an appropriate incentive for plan sponsors to level the playing field and invest in quality improvements for dually eligible, low-income, and disabled beneficiaries. By contrast, the historical reward factor has no bearing on improving clinical care, outcomes, or patient experience, as CMS contends. There is ample evidence that these plans are consistently denying patients needed care, both directly and indirectly.[16] It seems counterintuitive that these plans should be rewarded for doing so, at the same time that CMS suggests that the quality system needs to be dramatically modified because it is failing to achieve its purpose. As such, we urge CMS to withdraw this proposal, and allow plans to continue to move forward with the HEI investments they have been making over the past several years in preparation for this reward system to go into effect.

LAC also opposes CMS's proposal to remove the Parts C and D measure for "Members Choosing to Leave the Plan," and urges CMS to withdraw this proposal. Almost half of all MA enrollees leave their MA plan within just a few years after they initially enroll, and enrollees with more substantial health and health care needs are more likely to dis-enroll compared to

[16] "Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020," Legal Action Center (Oct. 2024), https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf.

healthier enrollees.[17] We frequently hear stories of MA and Part D enrollees leaving their plans due to narrow networks and unaffordability of the care they need, particularly for OTP services and MOUD, as described earlier in our comments. These plans should be held accountable for failure to provide reasonable and necessary care for their enrollees.[18] Rather than remove this measure, we believe this is one that CMS should strengthen by requiring additional information about the reasons(s) for disenrollment so that this data can be used to guide future policy.

D. Access to Culturally and Linguistically Appropriate Services

LAC has concerns about CMS's overall approach in this proposed rule to remove protections ensuring culturally and linguistically appropriate services, as well as the means by which CMS can meaningfully collect data about the quality of care that different populations are receiving. For example, the annual health equity analysis of utilization management policies and procedures is not only important for addressing quality differences, but also for transparency related to prior authorization, which CMS has worked for several years now to try to improve and streamline. Publishing this data is also consistent with the President's recent proposal to hold big insurance companies accountable by requiring them to post the rates at which they deny care.[19] Transparency, anti-discrimination rules, language assistance services, and quality improvement programs *protect* access to care for Americans, including those with SUD and MH conditions. Accordingly, **LAC does not support the following proposals, and encourages CMS to withdraw**:

- Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7))
- Revisions to Ensuring Equitable Access to Medicare Advantage (MA) Services (§ 422.112(a)(8))
- Rescinding the Requirement for the Notice of Availability (§§ 422.2267(e)(31) and 423.2267(e)(33))
- Rescinding the Quality Improvement Program Health Disparities Requirement (§ 422.152(a)(5))

E. Special Enrollment Period for Provider Terminations (§ 422.62(b)(23))

LAC supports CMS's recommended changes from the current special enrollment period (SEP) for Significant Change in Provider Network to an SEP for Provider Terminations. As CMS appropriately notes in the proposal, not all provider changes may rise to the level of "significant" for the majority of beneficiaries, but they may be significant for the individual,

[17] Government Accountability Office, "GAO-17-393; Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight" (April 28, 2017), https://www.gao.gov/products/gao-17-393; Government Accountability Office, "GAO-21-482: Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending" (June 28, 2021), https://www.gao.gov/products/gao-21-482.

[18] *See* David J Meyers, *et al.*, "Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020," JAMA Network (August 25, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808747.

[19] The White House, "Fact Sheet: President Donald J. Trump Calls on Congress to Enact the Great Healthcare Plan," (Jan. 15, 2026), https://www.whitehouse.gov/fact-sheets/2026/01/fact-sheet-president-donald-j-trump-calls-on-congress-to-enact-the-great-healthcare-plan/.

especially if they are a MH or SUD provider with whom trust and a therapeutic relationship has been built. We encourage CMS to finalize this proposal, and to promulgate guidance and notices in plain language so consumers can meaningfully take advantage of this right.

F. Updating Third-Party Marketing Organizations Disclaimer Requirements (§§ 422.2267 and 423.2267)

LAC opposes CMS's proposal to update the third-party marketing organization (TPMO) disclaimer requirements. We believe it is imperative that TPMOs continue to read the disclaimer in the first minute of the conversation and be required to identify State Health Insurance Assistance Programs (SHIPs) as a source of information. SHIPs are unbiased resources that provide person-centered assistance, while we have more serious concerns that TPMOs may not. Accordingly, we encourage CMS to withdraw this proposal and instead provide more funding and resources for SHIPs, as this would more effectively achieve CMS's goal of ensuring beneficiaries receive correct and appropriately tailored information.

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Thank you for considering our views. We would be happy to speak with you further about these comments, and we look forward to working with you to continue to improve access to SUD and MH care for MA and Part D beneficiaries.

Sincerely,

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