January 26, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: 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:

The California Public Employees' Retirement System (CalPERS) and Covered California appreciate the opportunity provided by the Centers for Medicare and Medicaid Services (CMS) to comment on the proposed rule titled "Contract Year (CY) 2027 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program."

CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. In 2024, we spent over $12.4 billion to purchase health benefits for approximately 1.5 million active and retired members and their families on behalf of the State of California (including the California State University system) and nearly 1,200 public agencies and schools. In 2024, CalPERS spent approximately $728 million to provide benefits for 330,811 MA and Medicare Supplement members.[1]

Covered California, the nation's largest state-based health insurance marketplace, has provided coverage to over 6.3 million Californians – about one in six residents – since its launch in 2014.[2] As the 2026 open enrollment period deadline approaches, Covered

[1] See CalPERS' Health Benefits Program, 2024 Annual Report, November 2025, available at https://www.calpers.ca.gov/documents/health-benefits-program-annual-report-2025/download?inline
[2] See Covered California Reaches Landmark Achievement with Nearly 2 Million Enrolled as Open Enrollment Concludes, available at https://www.coveredca.com/newsroom/news-releases/2025/02/20/covered-california-reaches-landmark-achievement-with-nearly-2-million-enrolled-as-open-enrollment-concludes/

California continues to provide health insurance to nearly two million Californians accessing health insurance through the Marketplace in 2025.[3]

Given these shared commitments, CalPERS and Covered California strongly recommend CMS carefully assess the implications of its star ratings changes, the health equity deregulatory proposals, and the amendment to the specialty tier threshold. We also urge CMS to explore alternative approaches that reward plans to effectively improve health outcomes of vulnerable populations.

We respectfully submit the following detailed comments regarding the proposed rule.

MA and Part D Quality Rating System (Star Ratings)

We support the alignment, streamlining, and transparency of the MA Star Ratings and CMS' intent to simplify and focus the measure set on clinical care, outcomes, and patient experience care measures in the proposed rule. CalPERS, Covered California, and the Department of Health Care Services have aligned our quality measure sets to improve health outcomes, reduce disparities, simplify reporting, and increase accountability across the large public purchasers in California. This alignment reflects a coordinated effort among the state's largest public purchasers to drive meaningful improvements in care delivery and population health while reducing administrative burden for health plans and providers.

However, this alignment of public purchasers in California was also coupled with direct and substantial financial incentives for health plans to meet the target benchmarks. In our collective programs, this was structured as downside risk only to health plans rather than the current bonus payment structure of the Star Ratings program. The first two years of this program have already led to meaningful improvements in health plan performance impacting the outcomes for millions of Californians. Several plans moved from below the 25th percentile to above the 66th percentile by restructuring their quality improvement teams, increasing provider and patient incentives, and investing in data exchange among other activities.

We welcome the opportunity to share more details with the CMS team as an example of a program that increased resource stewardship, reduced fraud and "gaming" of the quality program, and made the business case for quality measures.

We applaud CMS for its commitment to aligning and harmonizing quality measures across programs and care settings. These efforts enhance transparency, promote consistency, and empower patients, payers, and providers to make informed decisions. We recommend Star Ratings be included in CMS' broader alignment initiatives beyond the proposed rule, as fostering greater comparability and coordination can lead toward improving health outcomes and advancing quality of care across the nation.

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[3] See Covered California Encourages All Californians to Explore Health Insurance Options Before Dec. 31 Deadline to Get Coverage for All of 2026, available at https://www.coveredca.com/newsroom/news-releases/2025/12/22/covered-california-encourages-all-californians-to-explore-health-insurance-options-before-dec-31-deadline-to-get-coverage-for-all-of-2026/

CMS also proposes to add a measure, “Depression Screening and Follow-Up” (DSF), to the 2026 measure display page which quantifies the percentage of MA plan members who were screened for clinical depression using a standardized instrument, and if marked as positive, received follow-up care within 30 days. Although measures on the display page do not contribute to the Star Ratings, adding the DSF measure increases transparency and encourages plans to prioritize mental health care. Public reporting allows beneficiaries to compare plan performance and supports accountability, while also helps plans identify areas for quality improvement. This can result in earlier detection and better management of depression, improved member outcomes, and valuable data for future policy decisions.

CalPERS appreciates CMS’ shift in focus to measures that prioritize patient outcomes and experience, and the inclusion of the DSF measure. However, eliminating several process measures could mean a decline in oversight of administrative operations. Specifically, CalPERS cautions CMS against removing the call center measures, as they ensure equitable health care access for beneficiaries who rely on foreign language interpreters and teletypewriter services. Without ongoing evaluation of plan performance in these areas, vulnerable populations may face barriers to accessing the services they need.

Deregulatory Proposals focused on Health Equity
Health equity is a cornerstone of our health care strategies, aligning with broader evidence that equitable health systems lead to better health outcomes, improved patient satisfaction, and more efficient use of resources. Both CalPERS and Covered California are deeply committed to providing quality, equitable, accessible, and affordable care for our members, while also working to reduce health disparities across California. Our initiatives are intentionally designed to advance these strategic goals by maintaining a consistent infrastructure that drives improvements in health outcomes, narrows health disparities, and fosters a culture of health equity for all CalPERS members and all Covered California enrollees.

CMS’ proposed revisions to MA regulations raise significant concerns about the future of equitable access and care for vulnerable populations. Key changes outlined in the proposed rule include the removal of explicit requirements for culturally competent care, the rescission of annual health equity analyses in utilization management, and the elimination of mandates to address health disparities in quality improvement programs. Such revisions risk weakening the safeguards that promote transparency, accountability, and targeted support for those most at risk of experiencing inequities. These shifts could have far-reaching implications for the quality and fairness of MA services. Covered California’s Plan Performance Report, which stratifies data across quality and utilization metrics pulled from our all-plan claims database, reveals significant differences in rates of access to and quality of care when we consider region, gender, or other population characteristics.

Revisions to Ensuring Equitable Access to MA Services
CMS' proposal to remove the expanded list of specific populations requiring MA organizations to provide culturally competent care risks leading to inconsistent implementation. Reverting to more general language may also widen disparities in access to care for groups who are not explicitly named. While the obligation to provide culturally competent services remains, the absence of explicit examples may reduce attention to the unique needs of certain vulnerable populations.

Rescinding the Annual Health Equity Analysis of Utilization Management (UM) Policies and Procedures
The proposal to rescind the requirement for MA plans to include a health equity expert on their UM committees, as well as the mandates to conduct annual health equity analyses and public reporting of prior authorization policies, undermines safeguards that promote transparency and accountability. Without these safeguards in place, understanding how prior authorization impacts individuals with social risk factors and determining whether approval processes create or perpetuate disparities becomes more difficult. The proposed rule risks allowing inequities in care access to persist, and to go undetected and unaddressed.

Rescinding the Quality Improvement Program Health Disparities Requirement
The proposal rescinds the mandate that MA organizations incorporate activities specifically aimed at reducing health and health care disparities as part of their Quality Improvement Program. Although organizations can still choose to address disparities, the absence of a regulatory requirement may lead to decreased emphasis on equity-focused quality initiatives. This could slow progress in closing gaps in care for underserved populations and undermine efforts to ensure all enrollees receive quality, equitable care.

Despite ongoing efforts to reduce health disparities for all Californians, people of color in California face barriers accessing culturally competent quality health care and are most likely to experience poor health outcomes in the health care system. About 1 in 5 Latinos do not have a usual source of care, and 1 in 6 Latinos reports difficulty finding a specialist. Additionally, Blacks have the highest rates of new prostate, colorectal, and lung cancer cases and the highest death rates for breast, colorectal, lung, and prostate cancer. In Covered California-specific data, women are nearly twice as likely to access a preventive care visit as compared with men, despite having access to the same health plans, same networks, and same benefits. And adults living in rural areas of California are much less likely to utilize behavioral health services as compared with adults living in urban areas. Health equity work is critical to preserve our ability to uncover and address these differences in health between communities. Given these persistent inequities, we disagree with the removal or reduction of health equity requirements in the proposed rule and urge CMS to prioritize addressing disparities in the MA program, rather than taking steps that diminish the importance of health equity.

Health Equity Index (HEI) Reward
CMS is proposing to remove the yet to be implemented HEI reward, finalized under the Biden administration through the "CY 2024 Policy and Technical Changes to the MA and Medicare Prescription Drug Benefit Programs" final rule. This measure, set for 2027 implementation, was designed to reward plans for high performance among enrollees with social risk factors, including dual eligibles, low-income beneficiaries, and those with disabilities. If CMS finalizes this proposal and the HEI reward is not implemented, we urge CMS to consider alternative approaches in the future that hold MA plans accountable to, and reward those that succeed in, improving the unique needs of these vulnerable populations.

Limit on Specialty-Tier Cost Threshold Adjustment
Under this proposal, CMS would be allowed to decrease the specialty tier cost threshold to reflect changing health care dynamics, such as with the Medicare Drug Price Negotiation Program. CalPERS and Covered California are concerned that this change could result in more drugs being classified as specialty medications, which would result in members having to pay higher cost-sharing and higher out-of-pocket expenses for drugs now categorized as specialty, and exposure to more prior authorization requirements. We recommend CMS consider the broader implications of more drugs being designated as specialty and take the necessary steps to ensure access to such products remains stable. Additionally, pharmacy benefit managers could be further perversely incentivized to select higher-cost drugs for their formularies, without proper reforms in place. As such, we suggest an increased oversight of Part D formularies and implementation of utilization management tactics.

Request for Information (RFI) on Well-Being and Nutrition
While CalPERS supports CMS' efforts to address well-being and nutrition, we would like to highlight the unique challenges that come with evaluating the impact of non-medical supplemental benefits. To date, there has been a lack of evidence to support the widespread use of special supplemental benefits for the chronically ill (SSBCI). There is evidence that non-medical services, such as meal delivery and medical transportation for certain populations, can improve overall health. There is also early evidence that demonstrates decreased loneliness and improved medication management can result from implementing various interventions.

However, there is a lack of measurable return on investment and real-world evidence to inform decisions to adopt specific SSBCI. As stated in our May 29, 2024 letter to CMS regarding the RFI on MA data, CalPERS recommends CMS establish uniform reporting requirements that include quality metrics and beneficiary experience for all MA benefits. This would help to inform our analyses to better identify the most valuable and cost-effective supplemental benefits for our Medicare members. Collecting this information nationwide would provide national benchmarks for every MA benefit, including nutrition.

We thank you for your consideration and we welcome the opportunity to work with you on our shared goal of improving health care access and affordability. Please do not hesitate to contact Donald Moulds, CalPERS Chief Health Director, at (916) 795-0404,

Danny Brown, Chief of the CalPERS Legislative Affairs Division, at (916) 795-2565, Monica Soni, Covered California's Chief Medical Officer, at (916) 954-3225, or Kelly Green, Covered California's Director of External Affairs and Community Engagement, at (916) 228-8309, if we can be of any assistance.

Sincerely,

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