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Summary of CMS's Contract Year 2027 Proposed Rule for Medicare Programs

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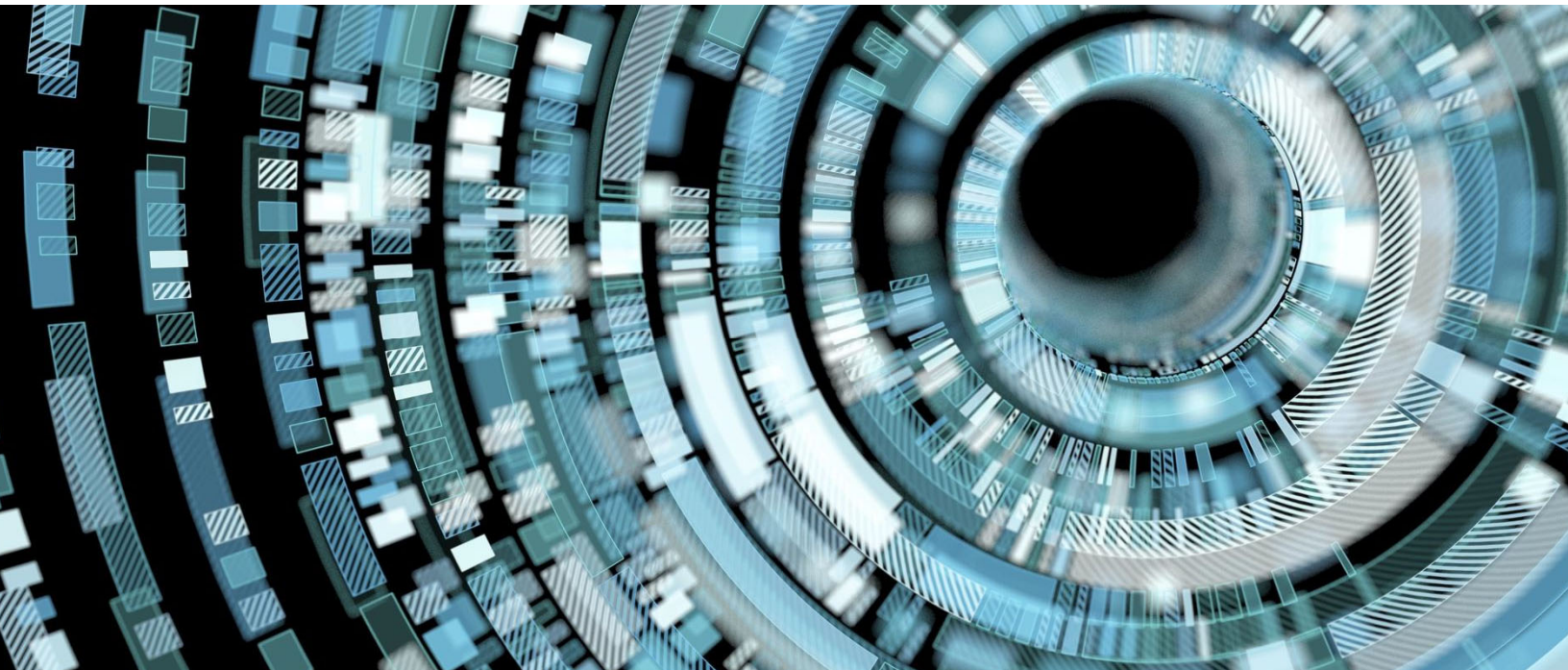

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EXECUTIVE SUMMARY

On November 26, 2025, the Centers for Medicare & Medicaid Services (CMS) released the "Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program". The deadline to submit comments is January 26, 2026.

The proposed rule includes numerous suggested regulations for contract year (CY)2027 and beyond affecting Part D, the quality rating system, marketing and special enrollment period requirements, creditable coverage, elimination of health equity-related rules, and consideration of applying Dual-Eligible Special Needs Plan (D-SNP) rules to Chronic Condition Special Needs Plans (C-SNPs).

This summary is focused primarily on the financial and actuarial aspects of the Proposed Rule and is not intended to provide a comprehensive description of all portions of the Rule.

Following is a brief summary of the more consequential proposals in the Rule.

- Codification of rules from the Inflation Reduction Act (IRA) and clarifications of related definitions for the drug discount program and creditable coverage
- Proposals related to reopening of Manufacturer Discount Program (MDP) and IRA Subsidy Amount calculations under certain conditions
- Numerous operational changes, including minor operational changes to special enrollment period rules, the use and release of risk adjustment data, various changes to marketing rules, and modifications to Prescription Drug Event audits and reporting
- Proposal to remove 12 Stars measures related to operational and administrative measures, as well as a proposal to remove the Health Equity Index (HEI) reward from the Star Ratings methodology and continue the historical current reward factor
- Special Needs Plan proposals including model of care submission timing, passive enrollment rules, and a solicitation for feedback on CMS potentially imposing dual look-alike and care coordination requirements on C-SNPs
- Exclusion of account-based plans (e.g., Health Reimbursement Accounts) from creditable coverage requirements
- Rescission of the requirement to report Supplemental Health benefits usage at mid-year

In addition, CMS issued a wide-ranging request for information (RFI), with the overall goal being to "level the playing field for smaller [Medicare Advantage] plans" to promote better benefits,

plan designs, and improved health outcomes for beneficiaries. More specifically, CMS is seeking ideas to modify the following key components of the Medicare Advantage (MA) program:

- Risk Adjustment:
  - Approaches that do not rely on collection of diagnosis data and reduce the ability of plans to manipulate the risk adjustment system
  - Number of years over which to collect diagnosis data
  - Potential use of alternative risk adjustment models, such as inferred risk or models that leverage artificial intelligence (AI)
- Quality Bonus Payment:
  - Ways CMS could shorten timelines for new measures and address the lag between measurement and payment for existing measures
- Policy changes regarding disease prevention and health promotion

The remainder of this report provides brief summaries of the sections in the Proposed Rule.

ATTACHMENT II. IMPLEMENTATION OF CERTAIN PROVISIONS OF THE INFLATION REDUCTION ACT OF 2022 AND THE SUBSTANCE USE DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT OF 2018

Section A. Medicare Part D Redesign

CMS proposes to codify the Inflation Reduction Act (IRA) Part D program changes, most prominently the Part D benefit redesign, for which CMS was granted temporary authority to implement via program instructions through 2026. The proposal includes a technical correction to the definition of a specialty drug, but the correction does not appear to have a material impact on the calculation of the 30-day cost threshold that determines which drugs are eligible to be designated as specialty drugs.

CMS also proposes making minor changes to several of the calculations for the annual percentage increase (API) in drug expenditures used to update the key Part D parameters each year, but it is not expected to have a significant impact on the calculations. The proposal also calls for technical changes to the definition of Gross Covered Prescription Drug Costs, but these changes are (again)expected to be of minimal impact.

Section B. Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program (CGDP), established in January 2011, required pharmaceutical manufacturers to enter the program for their applicable drugs to be covered under Part D. The program allowed manufacturer discounts to be made to Part D enrollees who were ineligible for the low-income subsidy (LIS) at the point of sale while they were in the coverage gap phase of the Part D benefit.

The IRA of 2022 eliminated the gap phase of the Part D benefit starting January 1, 2025, along with the CGDP and all agreements.

The termination of the coverage gap was part of the IRA redesign and established the Manufacturer Discount Program (MDP). Through the MDP, manufacturers will pay discounts for their applicable drugs prescribed to Part D enrollees during the initial and catastrophic phases of coverage.

For applicable drugs dispensed before January 1, 2025, the CGDP responsibilities and agreements will still be enforced, even if the payments are made after the termination date.

To distinguish and clarify similar definitions and terms between the CGDP and the MDP, revisions in the text will be made. Examples include:

- Subpart W will replace the shorthand term “Discount Program” with “Coverage Gap Discount Program”

- The definition of "Applicable Discount" for the CGDP in Subpart W will be revised to specify:
  - 50 % of negotiated price for plan years before 2019
  - 70% of negotiated price for plan years 2019 through 2024
- CMS proposes to codify the Manufacturer Discount Program (MDP) Final Guidance for CY2027 and beyond.
- In this section, CMS updates definitions for many terms related to the MDP and its predecessor, the CGDP.
- All of these proposed definitions are as expected and should require no material change in how Part D costs are modeled for pricing.

Section C. Medicare Part D Manufacturer Discount Program

CMS proposes to codify the Manufacturer Discount Program (MDP) Final Guidance for CY2027 and beyond.

In this section, CMS updates definitions for many terms related to the MDP and its predecessor, the CGDP. All of these proposed definitions are as expected and should not materially change how Part D costs are modeled for pricing.

Much of this section codifies the criteria for manufacturers to qualify for phase-in discounts that are less than the 10%/20% discounts non-eligible manufacturers must pay. The detail in the determination of phase-in eligible manufacturers is exhaustive but does not seem to meaningfully change how phase-in eligible manufacturers are determined.

Much of the remainder of Section C describes the invoicing and cash flow processes and timelines. We recommend that plan sponsors review these guidelines to understand how the reconciliation process operates under the MDP.

Section D. Definition of Creditable Coverage

Beneficiaries will be subject to late enrollment penalties (LEPs), increases in monthly beneficiary premiums, if they are without *creditable coverage* for a continuous period of Part D eligibility of 63 days or longer prior to Part D enrollment.

- Creditable Coverage is defined as "only if the actuarial value of which to the individual equals or exceeds the actuarial value of standard prescription drug coverage (CMS's Part D Defined Standard)."

The definition of "Creditable Coverage" has been changing over time since the start of the Part D program in 2006, but because of changes made in the IRA, another definition change has become necessary with the sunset of the CGDP and the establishment of the MDP.

- Any discount provided under the MDP would not be considered when determining actuarial value of the qualified retiree coverage.
- Enrollees in qualified retiree prescription drug plans would be excluded as an applicable beneficiary for the MDP.

Because of the IRA changes, CMS had previously proposed for 2025 that the simplified determination methodology of creditable coverage would no longer be valid, but the agency ultimately kept the methodology and used the contract year as extra time to observe and assess how the simplified methodology would continue moving forward.

The proposed revised simplified methodology for 2026:

- Provides reasonable coverage for brand name and generic prescription drugs, as well as biological products, which have now been added to the definition.
- Provides reasonable access to retail pharmacies.
- Designed to pay on average at least 72% of participants' prescription drug expenses. (Pre-IRA was 60%, but IRA changes enhanced the defined standard benefit significantly.)
    - Not included in the new proposed definition because of its removal are the following:
        - Removed annual and lifetime maximum requirements
        - Removed deductible requirements

During the 2026 transition policy year, non-RDS group plans could either use full actuarial equivalence testing or the simplified methodology to determine creditable coverage at either 60% or 72%, but CMS intends to eliminate the 60% starting in 2027.

Starting in 2027, CMS proposes to raise the required share of prescription drug costs covered by non-RDS group health plans under the simplified methodology from 72% to 73%.

The process CMS used to arrive at the 73% required figure is as follows:

- Use recent prescription drug event (PDE) data
- Re-adjudicate each line as if it were covered under the future defined standard benefit, estimating benefit parameters and deflating historical claim year's dollars
- Aggregate results and determine the average percentage of gross drug cost covered and round to the nearest whole number

Section E. Outlier Prescriber Criteria

Under the SUPPORT Act, the Secretary of the US Department of Health and Human Services (HHS) is required to identify and notify Part D prescribers of opioids who are considered "outliers." In the notifications the prescribers receive, they are also given information on how they compare with their peers in the same geographic area (i.e., opioid prescribers in the same

National Plan & Provider Enumeration System [NPPES] taxonomy and state), along with resources on proper prescribing methods.

An "outlier" is currently defined as being in the top 25th percentile in utilization for both of the following criteria when compared with their peers:

- Co-Prescribing opioids and benzodiazepines
- Average daily morphine milligram equivalent (MME)

A couple of exclusions apply to the above methodology for determining "outlier" status, including:

- Beneficiaries who have cancer or sickle cell disease, are enrolled in hospice, or reside in a long-term care (LTC) facility
- Providers under investigation by CMS or the HHS Office of Inspector General (HHS-OIG)

Although there have been no criteria or thresholds to determine the definition of "persistent," the SUPPORT Act also established the following requirements for "outlier" prescribers who are also identified as "persistent" outliers:

- Persistent outliers can enroll in a Medicare program, but only after appropriate remedies have been provided, such as technical assistance on best practices related to prescribing opioids.
- The Secretary must notify Part D plan sponsors of such persistent outliers annually.

CMS is proposing revisions to the definitions of "outlier" and "persistent" as follows:

- An "outlier" prescriber would be defined as a statistical outlier when compared with their peers.
- To be defined as "persistent," a prescriber must have been identified as an outlier three consecutive times by the same methodology.
    - CMS is seeking public comments about the threshold for identifying prescribers as "persistent outliers."

Section F. Reopening and Payment Appeals

The IRA made a few amendments to Part D, including the MDP, the Selected Drug Subsidy Program, and the Inflation Reduction Act Subsidy Amount (IRASA).

- The IRASA is the temporary retrospective subsidy for the cost-sharing and deductible for adult vaccines and insulins recommended by the Advisory Committee on Immunization Practices (ACIP) that was limited to contract year 2023.

Payments for MDP and the selected drug subsidy would be made in monthly prospective payments for estimated costs submitted with bids, with final payments based on plan's actual costs through cost-based reconciliations.

Payments for IRASA would be reimbursed by Medicare during the 2023 Part D payment reconciliation.

CMS has a few proposals regarding these amendments:

1. Definition of IRASA
   a. IRASA is the difference between the following:
      - Beneficiary cost-sharing for a covered insulin product or ACIP-recommended adult vaccine under the plan's approved bid submission for contract year 2023
      - Applicable statutory maximum cost-sharing for the covered insulin product or ACIP-recommended adult vaccine for contract year 2023
   b. The statutory maximum cost-sharing is as follows:
      - $0 and no deductible for ACIP-recommended adult vaccines
      - $35 monthly maximum for covered insulin products in contract years 2023–2025
      - Lesser of $35, 25% of Maximum Fair Price, or 25% of Negotiated Price for covered insulin products in contract years 2026 and on
   c. For 2026 and onward, the insulin and vaccine cost-sharing impacts will be built into the plan structure via benefit design instead of IRASA.
2. Reopenings
   a. CMS has proposed adding the MDP reconciliation, selected drug subsidy reconciliation, and IRASA reconciliation to the list of payment determinations that may be reopened and revised upon audits under CMS's discretion.
   b. The selected drug subsidy reconciliation payment determination and IRASA reconciliation payment determination would be included in scheduled global as well as targeted reopenings.
   c. CMS anticipates that the MDP reconciliation payment determinations would rarely be opened, like the CGDP reconciliation payment determinations, because invoicing and payments continue for 17 quarters (4.25 years).
3. Payment Appeals
   a. CMS has proposed adding the reconciled IRASA payment for contract year 2023, the reconciled MDP payment, and the reconciled selected drug subsidy payment to the list of payment determinations that would be subject to appeal.
   b. The appeal process applies only to errors CMS has made in the payment methodology, not by incorrect payment information submitted by Part D plan sponsors.
      - Data/information that has been submitted to CMS is final and would be unappealable.
      - CMS also proposes that Risk Corridor Payment information submitted to CMS would be final and unappealable, correcting a previous omission.
4. Payment Appeals Timing
   a. CMS has proposed two amendments to the timing of payment appeals:

- "15 days within" has now been clarified as "15 *calendar* days within"
- Instead basing the deadline on the date of the final payment received, it would now be based on the release of the reconciliation report.

ATTACHMENT III. ENHANCEMENTS TO THE MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAMS

Section A. Revised List of Non-Allowable Special Supplemental Benefits for the Chronically Ill (SSBCI) (§422.102)

In the April 2025 Final Rule, CMS codified new regulation language that cannabis products are prohibited under SSBCI because marijuana and other cannabinoids are illegal substances under federal law.

The 2018 Farm Bill added a definition of hemp to federal law, defining the plant as cannabis sativa L. and its derivatives containing no more than 0.3% of delta-9 THC and removed hemp from the federal definition of marijuana under the Controlled Substances Act.

The Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, updates that definition effective November 12, 2026. Under the new definition, hemp excludes synthetically produced drugs and human use products with more than 0.4 mg of certain naturally occurring cannabinoids per container.

Products meeting the current definition remain legal until November 11, 2026. After that, only those meeting the new definition will be federally legal. CMS proposes clarifying that only cannabis products legal under state and federal law, including the Federal Food, Drug, and Cosmetic Act (FFDCA), may qualify as SSBCI.

Epidiolex is the only Food and Drug Administration (FDA)-approved drug that meets the 2018 hemp definition. Because it is a Part D drug, Medicare Advantage (MA) plans cannot offer it as a Part C supplemental benefit. The FDA has also recognized three hemp seed ingredients—hulled hemp seed, hemp seed protein powder, and hemp seed oil—as generally recognized for safe for use in food, so MA plans may offer these as SSBCI if otherwise appropriate and compliant with federal and state laws. CMS reminds MA organizations about the importance of ensuring that the items and services provided to enrollees, including any foods containing these hemp-derived ingredients, meet the requirements for being offered as an SSBCI. Cannabis products with more than 0.3% delta-9 THC remain Schedule I and illegal. After November 12, 2026, any product outside of the amended hemp definition will also become Schedule I and prohibited by CMS.

CMS seeks comments on all aspects of this proposal and may consider revisions to the final policy based on the comments received.

ATTACHMENT IV. STRENGTHENING CURRENT MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM POLICIES (OPERATIONAL CHANGES)

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

The proposed changes to the special election period (SEP) will simplify the process for enrollees affected by provider terminations.

Currently, when CMS determines a change in a plan's provider network to be significant, affected beneficiaries are eligible for a SEP and may use it to request enrollment in another MA plan. Affected beneficiaries are individuals who are assigned to, are currently receiving care from, or have received care within the past three months from a provider who is being terminated from the plan's provider network.

According to CMS data, the use of the current SEP by eligible beneficiaries is low. In 2024, approximately 3.6% of eligible MA enrollees who were notified that they were eligible for a SEP changed plans.

Under the proposed rule, affected beneficiaries will no longer need a CMS determination of significant network change to qualify for the SEP. The SEP will allow enrollees to change plans or disenroll from their current MA plan when their provider is terminated.

Notifications regarding the SEP will be included in provider termination notices to streamline communication. The SEP will last for two additional calendar months after notification.

Section B. Coordination of Election Mechanisms for MA and Part D (§§ 422.62, 422.66, 423.32, 423.36, and 423.38)

The proposed regulations are intended to streamline the election process for MA and Part D plans by requiring CMS approval for certain SEPs.

Specific SEPs, such as those for contract violations or sanctions or for individuals who were inadequately informed of a loss of creditable prescription drug coverage, will require prior CMS approval before enrollment requests can be processed. This change is intended to ensure appropriate oversight and prevent organizations from incorrectly determining eligibility for SEPs.

The proposal codifies existing practices and should impose no additional burdens on plan sponsors or beneficiaries.

Section C. Use and Release of Risk Adjustment Data

CMS is required to risk adjust payments made to MA organizations. To conduct risk adjustment, MA organizations submit data to CMS. Due to growth in MA enrollment and the more detailed risk adjustment data CMS started collecting in 2012 (i.e., encounter data), the number and variety of requests CMS receives for risk adjustment data has increased.

With the increased variety of requests for risk adjustment data and CMS's better understanding of the requests received, CMS recognizes the need to ease restrictions on the use and release of this data. Overall, the proposed changes are intended to support better administration of MA and other federal healthcare programs. The changes would ease restrictions while maintaining the protections in place for beneficiary identifying information and for plan-submitted dollar amounts reported for an encounter.

Current policy allows the following specific uses of risk adjustment data:

- Calculating the risk adjustment factors used to adjust payments
- Updating risk adjustment models
- Calculating Medicare Disproportionate Share Hospital (DSH) percentages
- Conducting quality review and improvement activities
- Medicare coverage purposes
- Conducting evaluations and other analyses to support the Medicare program and to support public health initiatives and other healthcare-related research
- Carrying out activities that support the administration of the Medicare program
- Completing responsibilities conducted to support program activity
- Fulfilling purposes authorized by other applicable laws

CMS proposes to improve access to risk adjustment data while reducing regulatory burden and resources required by removing the specific uses listed above. This change would enable CMS to align more closely with standards applicable to fee-for-service (FFS) claims and other MA and Part D data and allow the data to be used for more purposes. Through the data requests the agency has received, CMS has identified additional reasonable uses that were not originally anticipated. CMS receives requests to use risk adjustment data from a range of entities, including academic institutions, government bodies, and oversight entities), for purposes such as research, health care operations, and oversight of public benefits programs.

CMS's release of data would remain contingent on federal law and CMS data-sharing procedures. CMS has an established process to evaluate requests for data and ensure compliance with applicable federal laws, regulations, and CMS data policies. A data-sharing agreement is established between CMS and the requester(s) prior to releasing data. Safeguards to protect beneficiary identifying information and confidentiality are included in the terms and conditions. These data-sharing agreements also contain enforcement mechanisms, including penalties such as fines or imprisonment.

Existing restrictions on the release of the minimum necessary data and on the release of dollar amounts at the encounter level will remain in place. CMS may only release aggregated dollar amounts for an associated encounter.

Current law also imposes a restriction that risk adjustment data will remain unavailable for release before reconciliation for the applicable payment year has been completed unless CMS determines that it is necessary for a specific exception. CMS proposes to remove the list of exceptions and allow flexibility when CMS receives requests for data that are unreconciled. CMS would review requests for the release of risk adjustment data before reconciliation to assess whether pre-reconciled data are necessary and appropriate for the requester's purpose.

Section D. Strengthened Documentation Standards for Part D Plan Sponsors

The current requirements for Part D plan sponsors address documentation maintenance and availability but do not outline the documentation needed to be maintained to support the appropriateness of a Part D coverage determination or point of sale (POS) claim adjudication that is used to determine coverage under the Part D benefit. The standardization of sufficient documentation to support a drug's coverage under the Part D benefit will allow CMS to conduct more effective audits and ensure CMS can verify that a drug was accurately paid under Part D.

CMS seeks to require standardized, detailed documentation for coverage determinations and POS claim adjudications used to determine coverage under the Part D benefit. The proposed documentation requirements include all documentation or information from all written, electronic, and verbal communications between the pharmacist, prescriber, enrollee, or other relevant stakeholders, in addition to what is included on the pharmacy claim, which is used when a Part D plan sponsor makes a coverage determination or otherwise permits a POS claim adjudication that determines coverage of a drug under the Part D benefit. This information includes:

- The date and time the request for a coverage determination or POS claim adjudication was received and the identity of the individual who submitted the request
- The name and title of the individual Part D plan sponsor contacted to verify the request
- The information obtained, including the questions asked and the responses received, and the final decision rendered
- The diagnosis code for the coverage determination or POS claim adjudication used to support a medically accepted indication
- Any additional information that the Part D plan sponsor used to determine the outcome of the coverage determination or POS claim adjudication request

If a coverage determination is extended, the original determination must be maintained as documentation. The documentation covered by these standards must be made available to CMS during Part D program integrity PDE record review audits.

Section E. Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements (§§ 422.2267 and 423.2267)

Current regulations require Third-Party Marketing Organizations (TPMO) to verbally convey a standardized disclaimer during sales calls with beneficiaries. This disclaimer was intended to address the concern that beneficiaries were not receiving comprehensive information about all their plan choices, thereby limiting their ability to make an informed decision about the plan best able to meet their healthcare needs. The April 2023 Final Rule required that the disclaimer be stated within the first minute of a sales call and added State Health Insurance Assistance Programs (SHIPs) as a source of information for beneficiaries.

CMS proposes the following changes to the required disclaimer:

- Require that TPMOs state the disclaimer "prior to the discussion of any benefits" during the call, instead of requiring the disclaimer within the first minute of the call
- Remove SHIPs as a source of information from the disclaimer

According to CMS, removing the requirement to state the disclaimer within the first minute of the call will allow for a more natural flow of conversation. It will also allow the TPMO to gather information to determine whether the call should proceed with the benefit discussion before the disclaimer is stated.

CMS recognizes that SHIPs can be a source of unbiased information for beneficiaries but also may add to the confusion, as volunteers may lack the expertise or training to help beneficiaries navigate complex programs. CMS is maintaining guidance so that beneficiaries can contact Medicare.gov or call 1-800-MEDICARE for plan advice.

CMS is soliciting comments on this proposal.

Section F. Removing Rules on Time and Manner of Beneficiary Outreach (§§ 422.2264, 423.2264, 422.2274, and 423.2274)

CMS proposes changes to three rules regarding beneficiary outreach. These proposals and clarifications are intended to reduce the burden on beneficiaries, plans, and agents/brokers. The proposals align with Executive Order 14192, "Unleashing Prosperity Through Deregulation," and the Administration's policy goals to promote prudent fiscal management and alleviate unnecessary regulatory burdens. CMS proposes the following changes:

1. Marketing Events Following Educational Events in Same Location
    a. CMS is proposing to eliminate a 12-hour delay requirement, which prohibits marketing events from occurring within 12 hours of an educational event in the same location.
    b. Included in the April 2023 Final Rule, this rule is intended to protect beneficiaries from feeling pressured to stay for a marketing event after having attended an educational event.

c. CMS has received feedback that the requirement adds to the burden on beneficiaries, plans, and agents/brokers by requiring that the events take place at separate locations or on separate days.
d. CMS proposes that plans, agents, brokers would be required to notify beneficiaries when the event switches focus from educational to marketing and provide beneficiaries sufficient opportunity to leave the event.

2. Timing of Personal Marketing Appointment after Scope of Appointment (SOA) Form Completion

a. CMS proposes to eliminate the mandatory 48-hour waiting period between SOA completion and a personal marketing appointment. Under this proposal, plans and agents/brokers would no longer be required to wait 48 hours between obtaining an SOA and speaking with a beneficiary about plan products.
b. Initially introduced in the September 2011 Final Rule, agents/brokers must wait 48 hours after a SOA before a sales appointment with a beneficiary. The rule was removed in the January 2021 Final Rule, then reinstated in the April 2023 Final Rule.
c. If the rule is finalized, a sales appointment would still require an advanced agreement but without a specified time limit. Beneficiaries could complete an SOA just before discussing plan products or could fill out an SOA for a future personal marketing appointment.
d. CMS also proposes to more clearly define that personal marketing appointments are for purposes of discussing marketing topics.
    - The proposed language states, "Personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple) for purposes of discussing marketing topics."
    - Plans and agents/brokers hosting a personal marketing appointment may do any of the following:
        - Provide marketing materials
        - Distribute and accept plan applications
        - Conduct marketing presentations
        - Review the individual needs of the beneficiary, including healthcare needs and history, commonly used medications, and financial concerns
e. CMS proposes removal of "scheduled" before "personal marketing appointment." This change would mean that an SOA would be required for all appointments that meet the definition of personal marketing appointments, regardless of who initiated the appointment.
f. CMS proposes that a SOA must be in writing for in-person personal marketing appointments. Similarly, CMS clarifies that there are many ways that an agent/broker can complete an SOA record, such as an audio recording or an electronic record would

suffice for a personal marketing appointment that occurs electronically or telephonically.

3. Scope of Appointment (SOA) Forms at Educational Events
   a. CMS proposes to eliminate the regulations that prohibit plans and agents/brokers from making available and receiving SOA forms from beneficiaries at educational events. If finalized, this would revert the regulation to the January 2021 Final Rule language.
   b. This rule was introduced to reduce pressure or obligation beneficiaries may feel to complete the SOA or provide contact information at educational events.
   c. CMS recognizes that the current regulation introduces additional burden on the beneficiary and agent/broker to complete the SOA form and reduces the likelihood that the SOA form will be completed following the event.

These proposals are expected to have no economic impact on the Medicare Trust Fund, nor are they expected to have any negative impacts based on capital investments associated with the requirements that CMS proposes to remove. CMS is soliciting comments on this proposal.

Section G. Relaxing the Restrictions on Language in Advertising (§§ 422.2262(a)(1)(i), 422.2262(a)(1)(ii), 423.2262(a)(1)(i), and 423.2262(a)(1)(ii))

Under the current rule, CMS prohibits MA organizations and Part D sponsors from making unsubstantiated statements (except in logos or taglines) or using superlatives, unless the source of data is referenced in the material. CMS now believes the current superlative restriction is unnecessary as MA organizations and Part D sponsors are already broadly prohibited from providing marketing and communications materials that are misleading, confusing, or materially inaccurate. Although this restriction is being lifted, CMS may still request data that supports the contents of advertising materials, either as part of the formal review process or based on complaints. Hence, entities must continue to maintain internally validated, audit-ready quantitative evidence for any superlatives used. If finalized, CMS would continue to encourage MA organizations and Part D sponsors to make supporting data publicly available.

Section H. Third-Party Marketing Organization (TPMO) Oversight: Revising the Record Retention Requirements for Marketing and Sales Call Recordings (§§ 422.2274(g)(2) and 423.2274(g)(2))

MA organizations and Part D sponsors are expected to retain sales and marketing call recordings for 10 years. CMS proposes to update this to 6 years, while maintaining the requirement that enrollment records be retained for 10 years. MA organizations or Part D sponsors must ensure that related parties also record calls with beneficiaries. If finalized, the retention requirement would be effective immediately and calls that occurred more than 6 years ago could be eliminated from the record. An alternative to the proposed 6-year retention

requirement is to reduce the marketing and sales portion to a 3-year retention requirement. CMS acknowledges that this approach may make it more challenging to identify longer-term trends, including potential trends associated with TPMOs. Another alternative under consideration is written retention (i.e., a transcript) of the marketing and sales portion of calls in lieu of audio recordings or a hybrid approach that requires audio recordings for 3 years, followed by written documentation for the remainder of the retention period. CMS is also considering, as an alternative, whether maintaining a recording, audio or otherwise, of the marketing and sales portion of calls is necessary.

Section I. Rescinding the Requirement for the Notice of Availability (§§ 422.2267(e)(31) and 423.2267(e)(33))

At present, CMS's Notice of Availability of language assistance services and auxiliary aids and services (NoA) requirements closely align with HHS Office for Civil Rights (OCR) mandates. CMS proposes to eliminate the NoA requirement and to defer to OCR's definition. This would mitigate the potential for future misalignment and the need for additional modifications to CMS requirements as policy evolves.

Section J. Appeals Process for Part D Program Integrity Prescription Drug Event Record Review Audits

CMS conducts Part D PDE record review audits. If CMS identifies PDE records to be improper, plan sponsors must submit supporting documentation to rebut this finding.

At this time, Part D plan sponsors have only one opportunity to submit documentation demonstrating that a PDE record was appropriate for coverage. CMS proposes to establish a three-level appeals process for the Part D program.

CMS defines what may or may not be subject to appeal and the processes for each of the three levels of appeal, including: (1) request for reconsideration, (2) hearing official review, and (3) review by the Administrator. The proposed modifications would establish review timeframes for the different review entities at each level of appeal.

CMS proposes to amend the language describing what is or is not considered appealable. CMS proposes to require that plan sponsors provide documentation. Accordingly, failure to provide this information would result in an improper determination that is unappealable. CMS proposes to add a time limit on when the independent reviewer's decision needs to be reached and communicated (within 60 calendar days after the time limit for filing a rebuttal has expired).

In the existing regulatory text, CMS outlines the process for a hearing official review. CMS proposes revising this language to replace references to the "Part D RAC" with "CMS," to amend the phrase "nor CMS may submit" to "nor CMS is permitted to submit," and to replace "60 days" with "60 calendar days after the timeframe for filing a rebuttal has expired."

The present regulatory language describes the process for the Administrator's review. CMS proposes several revisions to this provision, including replacing the phrase "nor CMS may submit" with "nor CMS is permitted to submit," replacing "45 days" with "30 calendar days," and adding a 45-calendar-day timeframe for the Administrator to furnish a final decision.

Section K. Prescription Drug Event Submission Timeliness Requirements (§ 423.325)

Under the General PDE Submission Timeliness Requirements, Part D sponsors must submit initial PDE records within 30 calendar days of receiving a claim and submit adjustment or deletion records within 90 calendar days of identifying or being notified of an issue. Rejected PDE records likewise must be resolved within 90 calendar days of the rejection. At present, this includes submitting a revised PDE record within 90 calendar days of receiving a rejected status from CMS. CMS proposes establishing new requirements related to the resolution of rejected PDE records.

CMS proposes that Part D sponsors must submit a PDE record within 90 calendar days from receipt of the rejection and within every 90 calendar days thereafter until a revised PDE record is accepted, unless the claim associated with the rejected PDE record is reversed or deleted or the PDE record is otherwise found to have been submitted in error. This provision would be inapplicable if the claim associated with the rejected PDE record is reversed or deleted, or if the PDE record was submitted in error.

ATTACHMENT V. MEDICARE ADVANTAGE/PART C AND PART D PRESCRIPTION DRUG PLAN QUALITY RATING SYSTEM (STAR RATINGS)

CMS continues to identify enhancements to the Star Ratings program. In this rule, CMS has proposed several changes estimated to save the (MA program $13.2 billion from 2027 through 2036. These savings represent 0.15% of Medicare payments to private health plans. Additionally, CMS solicits comments on further ways to simplify and modify the Star Ratings program.

Proposed changes:

1. Adding, Updating, and Removing Measures
    a. CMS has proposed removing the following 12 measures:
        - Seven measures focused on operational and administrative performance – better suited as measures to monitor plan performance and compliance rather than as quality measures, many are sensitive to small changes in performance because they have smaller denominators, and CMS has seen improvement on these measures such that performance rates are consistently fairly high.

- Three measures focused on process of care (Diabetes Care – Eye Exam, Statin Therapy for Patients with Cardiovascular Disease, and Members Choosing to Leave the Plan).
- Two measures focused on patient experience of care (Customer Service and Rating of Health Care Quality).
- These measures will be removed under the following schedule:

TABLE 1: MEASURES PROPOSED TO BE REMOVED FROM THE STAR RATINGS

Part C or D	Measure Name	Star Ratings Year Proposed for Removal
C	Plan Makes Timely Decisions about Appeals	2029 Star Ratings
C	Reviewing Appeals Decisions	2029 Star Ratings
C	Special Needs Plan (SNP) Care Management	2029 Star Ratings
C	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
D	Call Center – Foreign Language Interpreter and TTY Availability	2028 Star Ratings
C and D	Complaints about the Health/Drug Plan	2029 Star Ratings
D	Medicare Plan Finder Price Accuracy	2029 Star Ratings
C	Diabetes Care – Eye Exam	2029 Star Ratings
C	Statin Therapy for Patients with Cardiovascular Disease	2028 Star Ratings
C and D	Members Choosing to Leave the Plan	2029 Star Ratings
C	Customer Service	2029 Star Ratings
C	Rating of Health Care Quality	2029 Star Ratings

  - Performance in these measures is exceedingly high; therefore, this change will have a negative impact on Overall Star Ratings.

b. CMS has proposed adding the following measure:
   - Depression Screening and Follow-Up (Part C) – proposed for addition in Star Rating Year (SY) 2029. This measures the percentage of eligible MA plan members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days.

2. Health Equity Index / Excellent Health Outcomes for All Reward

a. The HEI reward, also known as the Excellent Health Outcomes for All Reward (EHO4all), was a planned addition for SY 2027. The reward was intended to further incentivize a focus on improving care for enrollees that are dually eligible, receive a low-income subsidy, or are disabled.
b. CMS has proposed removing the reward from Star Ratings methodology and instead continue the historical current reward factor.
c. Typically, CMS has proposed and finalized changes to the Star Ratings in advance of the measurement year (2025 for SY 2027). However, this change will be implemented immediately, impacting the 2025 measurement year.

3. Additional Information Available in the Plan Preview of Star Ratings

a. This proposal codifies the current practice of providing sample data for one of each type of measure during the second plan preview to allow MA and Part D organizations to validate CMS's cut point calculations.

4. Impact of Proposed Changes
    a. The CMS simulation of proposed changes includes removing the HEI reward, keeping the historical reward factor, and removing the 12 measures. Using data from the SY 2025, results are as follows:
        - 62% of contracts have no change in the Overall Star Rating
        - 13% of contracts increase by 0.5 Stars in the Overall Rating
        - 25% of contracts decreased by 0.5 Stars in the Overall Rating

ATTACHMENT VI - IMPROVEMENTS FOR SPECIAL NEEDS PLANS (SNPS)

Section A. Model of Care (MOC) Off-Cycle Submission Window (42 CFR 422.101)

Beginning CY2027, D-SNPs and Institutional Special Needs Plans (I-SNPs) may submit MOC updates/corrections in two windows annually:

- January 1–March 31
- October 1–December 31

This timeline replaces the current six-month continuous window with split periods to align with CMS/National Committee for Quality Assurance (NCQA) review cycles.

Section B. Passive Enrollment by CMS (§ 422.60)

When an integrated D-SNP terminates, CMS has noted difficulties with passively enrolling members into integrated D-SNPs with a similar network. To improve operational the feasibility of passive enrollment when integrated D-SNPs terminate, CMS proposes to remove the requirement for the provider networks to be substantially similar between the two plans.

Additional proposed new requirements include:

- Receiving D-SNPs must provide continuity of care for 120 days for incoming enrollees.
- Receiving D-SNPs must demonstrate care coordinator staffing capacity to manage passive enrollment.

Section C. Continuity in Enrollment for Full-Benefit Dually Eligible Individuals (§§ 422.107 and 422.514)

CMS is proposing to amend §§ 422.107(d)(1) and 422.514(h) to allow D-SNPs that serve full-benefit dually eligible individuals in highly integrated D-SNPs (HIDE SNPs) or coordination-only D-SNPs to continue enrollment of full-benefit dually eligible individuals in a D-SNP in the same service area where those individuals are enrolled in Medicaid FFS. The proposal also includes updating State Medicaid Agency Contract (SMAC) language accordingly.

CMS also proposes an exception to MA organizations operating in US territories that have yet to adopt MSP from the requirements to only offer one D-SNP under their parent organization.

Section D. Contract Modifications Following SMAC Termination (§ 422.510)

CMS is proposing to codify its authority to treat SMAC loss as a valid basis for immediate contract termination of a D-SNP contract.

Section E. Limitation on D-SNP-Only Contracts Submitting Materials Under the Multi-Contract Entity Process (§§ 422.2261 and 423.2261)

MA organizations and Part D sponsors must submit all marketing materials, election forms, and certain communication materials to CMS through the Health Plan Marketing System (HPMS) Marketing Module, which serves as the official system for review and storage. Plans may submit materials via a TPMO (if used by multiple plans) after obtaining each plan's prior review. Plans must also use standardized identifiers such as contract or Medicare Code Editor (MCE) numbers (H- or Y-numbers) on materials for oversight and beneficiary tracking.

States may require MA organizations with exclusively aligned D-SNPs to operate D-SNP-only contracts and to use integrated Medicare/Medicaid materials, including the Summary of Benefits, Formulary, and Combined Provider/Pharmacy Directory. When a State requires these contracts, CMS grants the State Medicaid agency access to HPMS for oversight, including review of marketing materials submitted under the D-SNP-only contract numbers.

Separately, Medicaid rules (§ 438.10 and § 438.104) require states to ensure that Medicaid managed care entities provide mandated enrollee information and obtain state approval before distributing marketing materials, and that these materials are accurate.

D-SNP-only contracts must meet both CMS and State material requirements. Previously, plans had to submit materials separately to each, but states with D-SNP-only contracts now have HPMS access, allowing plans to submit materials once for joint review, reducing burden and speeding approvals. States, however, only may view materials submitted under the specific D-SNP-only contract IDs, not under broader MCE numbers that span multiple states. Because MCE submissions would block state access, CMS and States prohibit D-SNP-only contracts from submitting materials using an MCE number and require submission under the contract ID instead.

CMS clarifies that D-SNP-only contracts may not submit materials under an MCE number, and TPMOs also may not submit materials for these contracts using an MCE number. All materials must be submitted under the contract's specific ID. Because states and HPMS already enforce this approach, current practices will remain in place. Furthermore, because TPMOs cannot submit under contract IDs and MCE submissions are prohibited, MA organizations, not TPMOs, must submit all materials intended for TPMO use for D-SNP-only contracts.

CMS proposes requiring that MA organizations with exclusively aligned D-SNP-only contracts submit all materials in HPMS under the specific contract ID, rather than an MCE number. Neither plans nor TPMOs would be allowed to use the MCE number for these submissions. CMS invites comments on this proposal.

Section F. Request for Information: C-SNP and I-SNP Growth and Dually Eligible Individuals

This request for information (RFI) is exempt from the Paperwork Reduction Act (PRA) because it solicits public comments without requiring personal information beyond self-identification.

Medicare Special Needs Plans (SNPs) are targeted MA plans for specific populations and include:

- C-SNPs: Enroll individuals with severe or disabling chronic conditions (as defined in §422.2, updated April 2024)
- D-SNPs: Enroll individuals eligible for Medicaid under a state plan (Title XIX)
- I-SNPs: Enrolled institutionalized or institutional-equivalent individuals, including three new subtypes as of April 2024: FI-SNP, HI-SNP, and IE-SNP

C-SNPs have grown significantly in recent years. From CY 2021 to CY 2025, the number of C-SNPs increased to 385 from 207 (85% growth), and total enrollment rose to 1,103,194 from 387,920 (184% growth).

The number of C-SNPs with high concentrations of dually eligible enrollees (≥60%) grew to 66 in CY2025 from 16 in CY2021 (313% increase), with dual-eligible enrollment rising to 104,237 from 59,164. From CY 2021–2025, at least one high-dually eligible C-SNP was available in 26 states. In CY2025, 14 states offered these types of C-SNPs, with the most in California (31), followed by Arizona (7), Illinois (6), and New Mexico (5). Most enrollees (85.4%) in these plans were full-benefit, dually eligible individuals.

In CY2025, states with C-SNPS where dually eligible individuals comprise at least 60% of enrollment include California, Connecticut, Idaho, Illinois, New Hampshire, New Mexico, Oregon, and Vermont.

I-SNP offerings have remained relatively stable, with 139 I-SNPs in CY2021 and 144 in CY2025, peaking at 171 in CY 2023. Enrollment grew 39% to 121,188 from 87,037, with dually eligible individuals comprising approximately 90% of enrollees. In CY 2025, New York had the most I-SNPs (12), followed by Florida (10), Ohio and Texas (8), North Carolina (7), California, Indiana, Missouri, Oregon (6), and Arizona and Pennsylvania (5). Across CY2021–2025, I-SNP enrollees were mostly in Facility-Based Institutional Special Needs Plans (FI-SNPs) (73%).

Dually eligible individuals face fragmented care across Medicare and Medicaid. CMS has promoted integrated care through D-SNPs aligned with Medicaid managed care to improve coordination, reduce cost-shifting, and create a seamless experience. To prevent proliferation

of "D-SNP look-alikes", CMS limits contracting for such plans, ensuring compliance with D-SNP requirements like SMACs, care coordination, health reimbursement arrangements (HRAs), and evidence-based MOCs.

In CY2025, 14 states required Medicaid managed care organizations (MCOs) that enroll dually eligible individuals to offer affiliated D-SNPs to full-benefit enrollees only. By CY2026, more states, including those transitioning from the Financial Alignment Initiative, will adopt similar requirements. These SMAC-driven strategies are designed to increase integration, and states like California, Illinois, and Arizona have seen growth in C-SNPs with higher concentrations of dually eligible enrollees.

C-SNPs may be serving as a workaround to Federal and State integration efforts. A substantial share of full-benefit dually eligible individuals newly enrolling in C-SNPs previously participated in integrated plans. In CY2024, over 40,000 people enrolled in C-SNPs, with 13% coming from high-integration plans. This number increased to upward of 68,000 new C-SNP enrollees in CY2025, with 14% coming from high-integration plans. This trend reflects a 71% increase in one year of individuals leaving integrated plans (D-SNPs, PACE, MMPs) to enroll in C-SNPs, with most transitions from the highest level of integration. Integration level in D-SNPs remains a key factor.

Like D-SNPs, C-SNPs and I-SNPs must have approved models of care (MOCs), HRAs, and individualized care plans. They offer benefits tailored to C-SNPs or I-SNPs. In CY2024, 84% of C-SNPs offered SSBCI, commonly including food and general living support, which appeals to dually eligible individuals who have higher rates of chronic conditions, institutionalization, and poor health than non-dual-eligible Medicare beneficiaries. C-SNPs and I-SNPs, however, are not subject to state contracting requirements or key integrated care elements (coordination, cost-shifting mitigation, seamless experience). Preliminary evidence suggests integrated plans may reduce hospitalizations and improve patient outcomes.

C-SNPs and I-SNPs are exempt from D-SNP lookalike contracting limits, but CMS monitors enrollment to detect plans that primarily serve dually eligible populations without meeting D-SNP requirements, as recommended by the Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission (MACPAC). Transitions from D-SNP lookalikes into C-SNPs have grown sharply, likely because C-SNPs are exempt from the D-SNP lookalike prohibition. This reflects a rapidly increasing use of C-SNPs as a destination for lookalike plan enrollment.

CMS is seeking public feedback on the following six policy options to strengthen integrated care for dually eligible individuals, given the rapid growth of C-SNP and I-SNP enrollment:

1. SMAC Requirements
    a. CMS is seeking input on whether to establish a SMAC requirement similar to the existing requirement for D-SNPs.

b. CMS is considering a requirement that C-SNPs and I-SNPs with at least 60% dually eligible enrollment have Medicaid agency contracts, similar to D-SNPs.

2. Expanded Care Coordination Requirements
   a. CMS is seeking input on methods to increase care coordination for dually eligible individuals enrolled in C-SNPs and I-SNPs.
   b. C-SNPs and I-SNPs currently have fewer required care coordination elements than D-SNPs. CMS is considering:
      - Adding new care coordination obligations
      - Adding new MOC requirements
      - Potentially aligning HRA, ICP, and care transition requirements with those used for D-SNPs
3. Applying D-SNP Lookalike Contracting Limits to C-SNPs
   a. CMS is seeking input on ways to prevent C-SNPs from functioning like D-SNP lookalikes without meeting integration standards. Options include:
      - Applying the D-SNP lookalike rules directly to C-SNPs, removing their exemption.
        i. Excluding partial-benefit duals from the 60% threshold given that their care coordination needs differ.
      - Applying the limit only in states with integrated D-SNPs, allowing C-SNPs to continue in states without integrated products.
   b. CMS also notes challenges. Many C-SNPs operate in areas where no D-SNP exists, meaning that applying these limits could force enrollees into non-SNP MA plans or Original Medicare.
4. Additional Policy Suggestions
   a. CMS invites other ideas that could strengthen integrated care and ensure protections for dual-eligible individuals in C-SNPs and I-SNPs.
5. Quality and Benefits Monitoring
   a. CMS is analyzing quality and supplemental benefits across D-SNPs, C-SNPs, and I-SNPs and welcomes input/evidence to shape future regulation.
6. Mental Health and Substance Use Disorder (SUD) Care
   a. CMS seeks input on improving access to treatment for individuals with serious mental illness (SMI) or SUD through SNPs.
      i. Only two mental-health-focused C-SNPs currently exist (serving ~2,600 people).
   b. CMS requests feedback on barriers, incentives, performance metrics, and whether C-SNPs or D-SNPs are better suited to serve individuals with SMI.

ATTACHMENT VII. REDUCING REGULATORY BURDEN AND COST IN ACCORDANCE WITH EXECUTIVE ORDER 14192

Section A. Exclusion of Account-based Medical Plans from Entities Required to Make Disclosures of Creditable Coverage (§ 423.56)

Under the Social Security Act, entities that "offer prescription drug coverage" must provide the HHS Secretary and Part D eligible individuals with disclosures regarding whether their coverage is "credible" or has changed in such a way as to be less than credible.

- Credible coverage "equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D-11(c) of the Act)".
- The Secretary can also identify "other coverage" that may be deemed credible and thus subject to the relevant requirements and procedures.

Certain Group Health Plans (GHPs) qualify as "entities that offer prescription drug coverage" and thus need to submit credible coverage disclosures. Beneficiaries and plans in this category include:

- Those enrolled in the Federal Employees Health Benefits Program
- Qualified retiree prescription drug plans

While legally classified as GHPs, account-based plans do not "offer prescription drug coverage," so they are not subject to the credibility disclosure requirements. Examples include HRAs, flexible savings accounts (FSAs), health savings accounts (HSAs), etc.

CMS lists the following justifications for the exclusion:

- Account-based plans tend to be limited to financial benefits, whereas prescription drug plans can convey numerous benefits.
- The extra reporting requirements create an undue administrative burden on the account-providing entities.
- Individuals are sometimes confused regarding whether their account-based plan and prescription drug plan have conflicting credibility status.

Section B. Deregulate § 422.102(e) Pathway for Certain D-SNPs to Offer Supplemental Benefits (§ 422.102)

Under § 422.102(e), CMS has made multiple expansions to the definition of primary benefits to allow for incorporation into D-SNP plans.

- CY2013 CY: Allowed for certain non-skilled service providers, subject to performance standards, that better integrate care to qualify as primary health benefits.

- CY2019 CY: Expanded the definition of "primary health related" standard to include items that aid in physical well-being, decrease financial impact, or alleviate medical burden.

The Bipartisan Budget Act of 2018 established SSBCI, allowing for plans to cover "non-primarily health related" services if they maintain or improve the health of a chronically ill individual.

Through § 422.102(e), D-SNP plans have offered assistive home safety devices and meal benefits.

- Meals can be labeled as "primary health benefits" if necessary for limited periods such as hospitalizations.
- Meals can be labeled as supplemental beyond a limited period if provided to a chronically ill enrollee.

In CY 2013-2026, the number of D-SNP PBPs offering benefits via § 422.102(e) ranged from 0–2 per year. CMS, therefore, proposes that § 422.102(e) be removed and reserved for future rulemaking. CMS anticipates no adverse consequences to the removal. CMS anticipates that D-SNPs that were providing benefits via § 422.102(e) could instead use the SSBCI pathway.

Section C. Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42))

In the 2024 final rule, CMS codified that MA organizations must provide a mid-year notice to enrollees. This notice would inform them of any unused supplemental benefits and how to access them. The combination of feedback and utilization data that CMS collected showed that utilization frequency was higher than anticipated.

The following reasons were listed to justify rescinding the Mid-Year Notice:

- Undue financial and administrative burden, especially on smaller MA plans, including:
  - The development and maintenance of a system to track enrollee benefit usage
  - The requirement to send potentially millions of enrollees the statutory notification in paper format
  - The diversion of resources in the mid-year period that could be better used for required patient care coordination or quality improvement activities
- Redundant provision of information, particularly with the annually required Evidence of Coverage (EOC) document
- Recent survey data suggest that enrollees are "generally aware" of their benefits and are using them.

    - "CMS acknowledges that at this time, information on MA enrollee use of supplemental benefits is limited."
- The expectation that market incentives will drive MA organizations to keep their enrollees aware of their benefits.
- Transmitting information to enrollees regarding benefits that they may be ineligible to receive can create confusion.
- Alternative methods of communication such as coordination activities and outreach programs have proven successful to increase benefit utilization.

Section D. Revisions to Ensuring Equitable Access to Medicare Advantage (MA) Services

In the April 2024 final rule, CMS changed the paragraph on "Cultural Considerations" to "Ensuring Equitable Access to Medicare Advantage (MA) Services".

In January 2025, the Trump Administration issued executive orders (E.O.s) 14148 and 14192, and CMS concluded the combination of the two E.O.s entails reverting the change in § 422.112(a)(8) from the 2023 Final Rule. CMS states that change will streamline the MA process by keeping the relevant enrollee protections without the minutiae regarding several subpopulations.

Consequently, the paragraph now has its previous heading and text:

"*Cultural considerations*. Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds."

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

The April 2023 final rule, "The Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," required that MA plans establish a Utilization Management (UM) Committee to annually review all UM policies and procedures. CMS received a substantial number of concerns over rationale, feasibility, and administrative burden associated with implementation of the regulatory requirements.

In April 2024, CMS finalized the requirements related to the UM Committee and determined these requirements would provide useful baseline of data, but signaled intent to change future requirements based on comments received.

In the proposed CY2026 rule, released December 2024, CMS required metrics to be reported on each item/metric rather than aggregated. Commenters expressed concern over the complexity of the disaggregated data, as well as the increased administrative burden on MA

organizations. CMS did not finalize the proposal to expand the annual health equity analysis of UM policies and procedures. CMS did implement the additional UM Committee requirements from the April 2024 rule, which increased regulatory burden for MA organizations by requiring the addition of a member of the UM Committee with expertise in health equity, additional data collection, and the public posting of an annual health equity analysis.

CMS has since revised its stance on the health equity analysis requirement introduced in the April 2024 final rule. It now considers the analysis ineffective for gathering baseline prior authorization. The final rule is eliminating certain health equity analysis and UM Committee requirements from the April 2024 rule, citing limited impact, high administrative burden, and a preference for alternative data collection methods.

On June 16, 2025, CMS released an HPMS memorandum, which placed a temporary pause on UM policy enforcements to reevaluate the requirements and consider potential changes. CMS proposes to remove the requirement that the UM committee includes one member with expertise in health equity and the requirement to conduct an annual health equity analysis along with the requirement to post the analysis to plan's website.

CMS welcomes comments on this proposal, and requests feedback on ways to reduce the administrative burdens associated with other UM Committee requirements, including:

- Whether CMS should revise UM Committee composition requirements
- Whether CMS should revise the UM Committee responsibilities

CMS seeks policy solutions that eliminate redundant reporting and unnecessary requirements, streamline MA governance, and reduce inefficiencies and financial burdens while maintaining high-quality care for Medicare beneficiaries.

Section F. Rescinding the Quality Improvement Program Health Disparities Requirement (§ 422.152(a)(5))

All MA organizations are required to have an ongoing Quality Improvement (QI) Program for the purpose of improving the quality of care provided to enrollees. In the April 2023 final rule, CMS added a requirement that directs MA organizations to incorporate one or more activities that reduce disparities in health and healthcare as part of their QI program to comply with health equity mandates, stemming from E.O. 13985.

In January 2025, E.O. 14148 revoked E.O. 13985, and E.O. 14192 was issued to address the burden of complex regulations on Americans and economic growth, innovation, and global competitiveness. As a result, CMS proposes to eliminate the regulatory requirement for QI programs. The provisions established by QI programs under CMS were unaligned with E.O. 14148 because it mandates race equity and ethnicity-conscious health equity activities, which E.O. 14148 explicitly revoked as part of its directive to eliminate federal programs and policies

that prioritize considerations based on race, ethnicity, and other demographic characteristics. CMS revised proposal aligns with the directives of E.O. 14192, to deregulate and reduce the administrative burden on MA organizations while preserving quality.

CMS has addressed public comments asserting that some MA organizations were already addressing disparities in care for underserved populations through a variety of quality initiatives. MA organizations will continue to retain the flexibility to implement quality initiatives that address the needs of all enrollees, including the option to continue their current QI program or otherwise make their own determinations regarding whether and how to target health disparities. This proposed deregulation reflects CMS's continued commitment to high-quality health care, while reducing any unnecessary administrative burden.

Section G. Deregulate Special Rule for Non-Compliant D-SNPs (§ 422.752)

The Bipartisan Budget Act of 2018 amended section 1859 to establish new minimum standards for all D-SNPs related to integration with Medicaid services and to authorize the Secretary to impose an enrollment sanction on MA organizations offering a D-SNP that has failed to meet at least one of the new integration standards in plan years 2021 through 2025. CMS used this sanction to suspend enrollment for D-SNPs when contracting with the State Medicaid agency is unexpectedly delayed. However, since the statutory authority for the enrollment sanction expires at the end of plan year 2025, CMS proposes to remove this rule.

Section H. Waiver of Part D Customer Call Center Hours for All Regions Served by LI NET (§ 423.2536)

The new subsection Limited Income Newly Eligible Transition (LI NET) Program in the 2021 Consolidated Appropriations Act directs the Secretary to conduct a program to provide transitional coverage for covered Part D drugs for LI individuals by January 1, 2024. For CY 2024, CMS published the Policy and Technical Changes to the MA Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly final rule in April 2023 establishing the LI NET program as a permanent part of Medicare Part D.

The Act requires that the program be administered through a contract with a single program administrator and exempts the LI NET program from certain beneficiary protection requirements for qualified prescription drug coverage. CMS proposes to codify a waiver for the LI NET program with respect to customer call center hours of operation for all regions served by LI NET, and part D sponsors are required to have mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request. Mechanisms include a toll-free customer call center in all regions served by the Part D plan, and pharmacists or pharmacies must be open when any network pharmacy in the region is open.

This proposal aligns with the E.O., "Unleashing Prosperity Through Deregulation," and CMS estimates that waiving the requirement for customer call center hours in all regions served by LI NET will save the program approximately $800,000 to $1,000,000 each year.

CMS proposes to add the customer call center hours of operation for all regions served by the Part D plan, and maintains that the proposed changes would have limited to no effect on the LI NET sponsor, individuals' access to prescription drug benefits, the Medicare Trust Fund, and administrative paperwork.

ATTACHMENT VIII. REQUEST FOR INFORMATION ON FUTURE DIRECTIONS IN MEDICARE ADVANTAGE (RISK ADJUSTMENT, QUALITY BONUS PAYMENTS, AND WELL-BEING AND NUTRITION)

Section A. Introduction

The MA program has grown significantly, and as a result, CMS is exploring ways to strengthen the program, including enhancing the risk adjustment system and the quality bonus payment (QBP) program, consistent with findings from multiple studies by the Medicare Payment Advisory Commission (MedPAC). Specifically, CMS wants to enhance competition and level the playing field for smaller MA plans, which will result in better benefits, plan designs, and improved health outcomes for beneficiaries.

The two channels determined by CMS for MA changes are rulemaking and assessing innovative payment and service delivery models on either a regional or national scale. The goals and requirements of the second channel are to nationally expand a tested model through rulemaking if certified by the CMS Chief Actuary to reduce or maintain spending, improve or maintain quality of care, and ensure coverage and benefits are not denied. A CMS Innovation Center Model can be a channel for testing policy ideas that would benefit from testing. Examples of previous models include the Diabetes Prevention Program and the Value-Based Insurance Design (VBID), which sunset December 31, 2025.

Section B. Risk Adjustment

Risk adjustment is a core component of the MA payment system, using individual risk scores based on demographics and health status to predict costs and set plan payments. Because it directly affects payment policy, it influences MA plan strategies, including enrollment targeting, marketing, benefits, drug coverage, provider contracting, and care delivery. The model's reliance on diagnoses can incentivize more intensive coding, and higher payments tied to risk scores may lead plans to prioritize coding activities over care management or treatment.

Plans need a coding adjustment factor to account for coding pattern differences in MA versus Original Medicare. The adjustment for 2019 and subsequent years has been 5.9% or higher.

CMS is requesting feedback for risk adjustment. CMS has contemplated including MA encounter data, rather than relying solely on FFS data, in the calibration of risk adjustment models. CMS requests ideas for additional data sources and approaches that are independent of the collection of diagnosis data. CMS is interested in innovations that advance competition and foster a level playing field between MA organizations.

CMS is soliciting comments regarding the following topics:

- Advancing competition, removing anti-competitive barriers, and ensuring a level playing field
- Reducing manipulability of the risk adjustment system
- Ensuring accurate payments for sicker beneficiaries, while rewarding effective treatment and favorable patient outcomes
- Mitigating unintended consequences and effectively navigating tradeoffs
- Incentivizing provision of tangible and high-value benefits and services and maximizing the value that beneficiaries, as well as taxpayers, get from payments to MA plans

CMS requests direct comments on the following questions:[1]

- **Essential Diagnoses**: Which diagnoses should be included in the MA risk adjustment model? Should CMS limit diagnoses based on severity, setting, follow-up care, or exclude those from plan-initiated encounters without follow-up?
- **Time limits for Data**: Over what periods should diagnostic data be used? How should CMS manage persistent conditions not captured annually or past conditions that remain coded but are inactive?
- **Payment Status**: Should CMS consider the payment status of encounters when using diagnostic data (e.g., denied, or improper payments)?
- **Alternative Models**: Should CMS assess new models beyond hierarchical condition categories (HCCs), such as inferred models using service utilization or other inputs? How can models minimize gaming, administrative burden, and support fair competition?
- **Technology Use**: How might AI and machine learning improve risk adjustment? What are benefits from shifting from existing linear regression to one that utilizes AI? What are benefits, risks, best practices, and protections to ensure fairness and reduce fraud?
- **Additional Data Sources**: Should CMS use new or existing data sources (e.g., prescription drug data, surveys, EMRs, lab data)? How should CMS address accessibility and usability for all beneficiaries?

[1] Questions are summarized here. For the complete questions, go to: https://www.federalregister.gov/public-inspection/current.

- **Policy Approaches**: What policies ensure that risk adjustment incentivize high-quality coverage rather than excessive coding practices?

Section C. Quality Bonus Payments in MA

CMS has released an RFI to seek stakeholder input to guide future policy development and refine the QBP structure for MA plans and its impact on rebates. This RFI builds on prior feedback and issues raised on reforms to prevent gaming of risk and quality scores. The solicitation also addresses concerns previously documented by MedPAC, academic researchers, and public comments on the annual Advance Notice of Methodological Changes for MA Capitation Rates and Part C and Part D Payment Policies.

CMS is requesting feedback on potential options and to shorten timelines for implementation of new measures and address the lag between measurement and payment for existing measures. CMS is required to announce potential measures through the Advance Notice and Final Rate announcement and display measures on the CMS website.

MA plans submit their bids no later than the first Monday in June prior to the start of the contract year, and an MA plan's quality bonus amount affects its bid submission. CMS uses the latest QBP ratings available at the time. The ratings are lagged from two calendar years prior, resulting in up to a three-year lag between measurement and payment. This approach creates a disconnect between quality and financial reward, as quality may not be reflected at the time of the financial reward.

CMS is soliciting responses to the following questions:

- What could an alternative policy look like if one is needed at all?
- What are the potential advantages and disadvantages of the suggested alternative?
- When should bonus payments be finalized and disbursed? More broadly, how might CMS better incentivize cost containment within the MA program, while improving care quality?

Section D. Well-Being and Nutrition

MA programs are incentivized to support interventions that promote health over the long term and therefore avoid the high costs associated with chronic conditions. CMS is seeking input on policy changes regarding disease prevention and health promotion, as it integrates mental and physical health while emphasizing preventative care to proactively address potential health issues.

CMS is seeking comments on tools and policies that improve overall health, happiness, and satisfaction in life, including aspects of emotional well-being, social connection, and personal fulfillment.

CMS is also seeking feedback on policy changes focused on optimal nutrition and improving preventive care in MA, including strategies to promote healthy eating, physical activity, and sleep. Comments should focus on how incentives can be improved so MA organizations have adequate motivation to support beneficiaries in improving nutritional habits. CMS intends to use this feedback to inform future policy development efforts but will not be responding to comments on this RFI.

ATTACHMENT IX. TECHNICAL CHANGES TO TERMINOLOGY IN RISK ADJUSTMENT AND IN PAYMENTS TO SPONSORS OF RETIREE PRESCRIPTION DRUG PLANS

CMS is proposing to update their regulations related to MA and PD programs to align with E.O. 14168 to replace the word “gender” with “sex.” This will add no operational burden on organizations.

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