MEDICARE RIGHTS CENTER
Getting Medicare right

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January 26, 2026

VIA ELECTRONIC SUBMISSION

The Hon. Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Baltimore, MD 21244

Re: RIN 0938-AV63: 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]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Contract Year 2027 C & D** notice of proposed rulemaking (NPRM). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

General Comments

Our comments are informed by our decades of experience helping people understand, access, and navigate the complexities of Medicare and Medicaid. These programs were meant to bolster the health, wellbeing, and economic security of beneficiaries, but far too often they fall short.

In this NPRM, there are some provisions that could improve transparency in ways that benefit Medicare enrollees and providers. Unfortunately, many other provisions are a step backward, eroding beneficiary protections while giving Medicare Advantage (MA) plans, agents, and brokers more freedom. This is despite evidence that there should be more oversight and accountability of these actors, not less.[1] For example, CMS proposes to return to a failed era of plan marketing by removing safeguards around the time and manner of beneficiary outreach. We strongly oppose such changes. Allowing plans, brokers, and agents greater leeway does not aid beneficiaries.

[1] Julie Appleby, "Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' for Primo Customers" (May 19, 2025), https://kffhealthnews.org/news/article/justice-department-accuses-medicare-advantage-insurers-kickbacks-top-customers/.

In areas, CMS points to beneficiaries needing additional information and education about their plan options. This is a compelling reason to bolster State Health Insurance Assistance Programs (SHIPs) through greater funding and additional exposure. These programs provide unbiased advice that is not driven by sales incentives or commissions. Where beneficiaries need more information, that information must be objective, clear, accurate, and actionable.

We urge the Centers for Medicare & Medicaid Services (CMS) to withdraw or revise provisions that prioritize insurance companies over older adults and people with disabilities and that remove sources of accurate, unbiased assistance.

We are also disappointed to see that this NPRM does not address the problem of insufficient or overly narrow provider networks. We urge CMS to take more action on networks to ensure that enrollees have adequate access to care, especially for behavioral health concerns and complex specialties.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes)

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

With a goal of streamlining access to the Special Enrollment Period (SEP) for Significant Change in Provider Network, CMS proposes to change the eligibility criteria for the SEP and to rename it as "the SEP for Provider Terminations." Plans would be able to use enrollee attestations to determine eligibility as an "affected enrollee," *i.e.*, "an enrollee who is assigned to, currently receiving care from, or has received care within the past 3 months from a provider or facility being terminated."[2] Enrollees would not be required to use 1-800-Medicare to access the SEP. We support these proposals, as provider terminations can disrupt care access and continuity.

We also support CMS's statement that this SEP right will be accompanied by a guaranteed issue (GI) right to purchase Medigap plans should the affected individual choose to return to traditional Medicare.

We urge CMS to ensure that the SEP for exceptional circumstances would still be available to individuals who face provider availability loss. There are many circumstances where a person would face high barriers to care due to network changes, but who would not get a Provider Termination notice or a notice that CMS has determined that the person's plan has had a "Significant Change in Provider Network." For example, a person may be on a waiting list to see a specialist for many months, without establishing a patient relationship that would trigger the Provider Termination notice. The SEP for exceptional circumstances remains useful in these types of scenarios.

C. Use and Release of Risk Adjustment Data

2. Overview of Proposed Regulatory Changes

[2] 90 Fed. Reg. 54894, 54941.

CMS is proposing to increase access to risk adjustment data while reducing regulatory burden and the resources expended by public and private organizations when requesting risk adjustment data. We support this change, as greater access to these data may improve research and oversight.

D. Strengthened Documentation Standards for Part D Plan Sponsors
3. Proposed Provisions

CMS proposes to require standardized, detailed documentation requirements for coverage determinations and POS claim adjudications, used for purposes of determining coverage under the Part D benefit. We support these proposals.

We also urge CMS to strengthen transparency and oversight over Part D formularies. Plan enrollees experience the repercussions of restrictive formularies and utilization management, but stakeholders have limited insight into how CMS evaluates formulary submissions and utilization management criteria, how CMS applies actuarial checks, what deficiencies CMS identifies, and how CMS verifies ongoing compliance throughout the year. Having this information would help policymakers, researchers, and advocates spot gaps and opportunities for better coverage and access to care.

Further, as Part D benefit redesign matures and plan incentives shift, CMS must provide meaningful transparency and proactive oversight to prevent inappropriate use of prior authorization, step therapy, and mid-year access barriers.

We urge CMS to: 1. Publish a plain-language annual summary of CMS's Part D formulary review and oversight process, including the criteria used to evaluate formularies and utilization management, and how CMS applies actuarial equivalence checks; 2. Create a structured process for beneficiary and stakeholder input on formulary design and utilization management trends (including prior authorization, step therapy, quantity limits) and describe how CMS incorporates this input into oversight; 3. Require standardized reporting and public transparency for key access indicators, such as prior authorization approval and denial rates, time-to-decision, appeals outcomes, and utilization management changes over the plan year; and 4. Use audit authorities to identify and address patterns of inappropriate denials or excessive hurdles and provide clearer standards for corrective action plans when sponsors are out of compliance.

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

CMS proposes to codify its current policy that for elections that are made based on certain special election periods, the beneficiary at issue must either have CMS approval for the use of that SEP through the use of a CMS-operated election mechanism (for example, 1–800–MEDICARE or the Online Enrollment Center (OEC)) or other means, such as enrollee receipt of a notice. While we understand the need for CMS approval of an SEP, a beneficiary should not be required to provide receipt of notice—CMS can confirm eligibility for an SEP for a given individual without the requirement that they provide documentation.

Further, CMS refers in this section to the involvement of an agent or broker assisting an enrollee. SHIPs should also be included in this context, and all other areas where beneficiaries need assistance with exercising their SEP rights.

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

Historically, callers to TPMOs were often confused by the information they received and about how many, or how few, carriers and plans the TPMOs represented.[3] To combat this, CMS began to require TPMOs to read a short disclaimer within the first minute of a call to inform callers about the breadth and depth of their offerings, including when they do not represent every plan in their area, as well as the number of organizations and the number of plans they represent. In addition, CMS currently requires TPMOs to include a reference to State Health Insurance Assistance Programs (SHIPs) in their disclaimers.

Now, CMS proposes to allow this disclaimer to occur later in a call, after the TPMO has gathered data and contact information from the beneficiary. CMS claims that this is due to TPMO concerns that the disclaimer can take longer than a minute, and that callers might be confused if the disclaimer comes too soon. We strongly disagree and oppose this proposal.

First, if necessary, CMS can clarify that the disclaimer must be started within the first minute and completed within two minutes, eliminating concerns that the disclaimer is too long to fit within a one-minute limit. Second, by delaying the disclaimer, the TPMOs would be able to harvest personal information from callers who would not share their information if they knew the limits of the plans on offer. TPMOs should not be permitted to gather personal information from callers without revealing the scope of what they are selling. This is especially important given the risk of abuse, steering, and discriminatory behaviors from plans, TPMOs, agents, and brokers.[4]

CMS also proposes to remove the requirement for TPMOs to point callers to SHIPs. We also strongly object to this proposal.

As we noted in our general comments above, SHIPs provide objective, free, one-on-one assistance to Medicare beneficiaries, their families, and caregivers. With locations in every state, over 2,000 offices in communities nationwide, and 12,500 trained staff and volunteers,[5] the SHIP network is a trusted resource with proven success: In 2022 alone, SHIP counselors provided education and support to over

[3] 90 Fed. Reg. 54894, 54950.
[4] Julie Appleby, "Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' for Primo Customers" (May 19, 2025), https://kffhealthnews.org/news/article/justice-department-accuses-medicare-advantage-insurers-kickbacks-top-customers/.
[5] Administration for Community Living, "State Health Insurance Assistance Program (SHIP)" (last accessed January 26, 2026), https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship.

four million older adults and people with disabilities, empowering them to make informed decisions about their coverage and care.[6]

And demand for SHIP services is only rising. Over the past decade, the number of people with Medicare has climbed by more than 25%, and the average SHIP counseling session has lengthened by nearly 20%. The drivers of these trends—a surging Medicare population approaching 70 million people,[7] more than half of whom are now enrolled in MA,[8] as well as increasingly complex Medicare enrollment and coverage decisions—show no signs of abating.

In 2025, beneficiaries had access to 42 MA plans, on average; this is more than double the number in 2018.[9] A cluttered plan landscape hinders effective evaluations, and aggressive TPMO marketing adds to beneficiary confusion and overwhelm. Beneficiary complaints about these abuses have risen in recent years, drawing attention to problematic TPMO incentive structures that lead to steering, sub-optimal enrollments, and barriers to care.[10]

SHIP counselors have no such conflicts. Unlike agents and brokers, they are not compensated by insurers for enrolling beneficiaries in certain plans. Their independence allows them to offer fully beneficiary-centered assistance.[11]

SHIPs are further distinguishable by the level of service they offer, complementing but not duplicating other key resources like CMS's 1-800-MEDICARE call center. A typical SHIP counseling session lasts 33 minutes and covers high-intensity issues. This is over three times as long as the average call to 1-800-MEDICARE (9.5 minutes), which generally focuses on more routine matters. These distinctions are widely recognized, including by CMS, which "often coordinates with local SHIP offices to refer beneficiaries whose cases are too complex to be addressed during calls to 1-800-MEDICARE alone."[12]

Ignoring these attributes now, by removing reference to SHIPs from the TPMO standard language, would create unnecessary hardships for beneficiaries. Instead, we encourage CMS to retain and

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[6] Administration for Community Living, "Justification of Estimates for Appropriations Committees" (March 2023) https://acl.gov/sites/default/files/about-acl/2024-03/FY2025ACL-CJ-508.docx.

[7] Centers for Medicare & Medicaid Services, "Medicare Monthly Enrollment" (last accessed January 26, 2026), https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.

[8] Jeannie Fuglesten Biniek, *et al.*, "Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans" (May 1, 2023), https://www.kff.org/medicare/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/.

[9] Meredith Freed, *et al.*, "Medicare Advantage 2025 Spotlight: A First Look at Plan Offerings" (November 15, 2024), https://www.kff.org/medicare/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/.

[10] Andrea Callow & Cristina Boccuti, "The State Health Insurance Assistance Program (SHIP): Trusted Medicare Assistance and Education" (December 2025), https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/state-health-insurance-assistance-program-ship-trusted-medicare-assistance-education.doi.10.26419-2fppi.00390.001.pdf.

[11] *Id.*

[12] Alex Cottrill, *et al.*, "The Role of SHIPs in Helping People with Medicare Navigate Their Coverage" (September 24, 2025), https://www.kff.org/medicare/the-role-of-ships-in-helping-people-with-medicare-navigate-their-coverage/.

strengthen the current language. Doing so would best ensure older adults and people with disabilities can access their local SHIP's unbiased, personalized Medicare counseling.

CMS should also reduce reliance on plans and TPMOs by maximizing the utility of the Medicare Plan Finder by improving the accuracy and relevance of the plan information provided, including provider networks and location.

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

1. Marketing Events Following Educational Events in Same Location

We oppose CMS's proposal to remove the restriction on marketing events following educational events within 12 hours. People with Medicare face an onslaught of marketing—some of it predatory, overwhelming, or misleading by design—from plans, agents, and brokers.[13] An educational event should be a pressure-free opportunity for Medicare enrollees to explore the market, not a thinly veiled sales pitch. CMS appears to be relying on family caregivers or friends to guard beneficiaries from undue pressure instead of preventing the undue pressure in the first place.[14]

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

We also object to CMS's proposal to eliminate the current 48-hour waiting period between the SOA form completion and the marketing appointment. Currently, there are two exceptions to this delay: The waiting period is not in effect for unscheduled walk-ins or during the last four days of a valid election period for the beneficiary. This is sufficient flexibility that does not strand beneficiaries without access to plans and does not expose them to unfettered hard sells.

Historically, CMS found that "the burden caused by the 48-hour SOA rule was outweighed by the potential benefit of providing beneficiaries, especially vulnerable beneficiaries, time to speak with caregivers and others who they may rely upon for help or advice or just provide the beneficiary additional time to consider their options." Now CMS downplays the importance of allowing beneficiaries time to consult with caregivers, claiming it is unnecessary because "There is often a built-in layer of added protection from any potential undue pressure, as evidenced by the tendency for vulnerable beneficiaries to have other people help them with plan options and making decisions (for example,

[13] Government Accountability Office, "CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue" Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives (December 2009), https://www.gao.gov/assets/gao-10-36.pdf; *see also* Dept. of Health & Human Services Office of Inspector General, "Beneficiaries Remain Vulnerable to Sales' Agents' Marketing of Medicare Advantage Plans" (March 2010), https://oig.hhs.gov/oei/reports/oei-05-09-00070.pdf; Dept. of Justice, "The United States Files False Claims Act Complaint Against Three National Health Insurance Companies and Three Brokers Alleging Unlawful Kickbacks and Discrimination Against Disabled Americans" (May 1, 2025), https://oig.hhs.gov/oei/reports/oei-05-09-00070.pdf.

[14] 90 Fed. Reg. 54894, 54952.

caregivers or authorized representatives)…."[15] This appears to be saying that beneficiaries do not need time to consult with others because they can consult with others—a baffling conclusion.

Rather than the current proposal, we encourage CMS to provide more guidance to private plans on educational activities. For example, CMS should provide plans with a standardized template for educational activities and require plans to cover plan-specific information in clear and accessible language. This should include topics such as out-of-pocket costs, supplemental benefits, and provider networks. Additionally, we encourage CMS to educate consumers on how to file complaints related to abusive private plan marketing practices with Medicare and provide more streamlined access to the SEP for enrollees impacted by private plan marketing violations.

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))

CMS proposes to remove the prohibition on the use of unsupported superlatives in marketing and communications materials. We oppose this proposal. Plans need clear guidelines regarding marketing, and this prohibition is extremely clear. Without it, Medicare enrollees, their families, and their caregivers would be tasked with verifying the accuracy of plan marketing materials and information, adding to the significant evaluation burdens they already face during Medicare Open Enrollment.

CMS states that this proposal "will not affect the existing beneficiary protections, which will still be in effect, but will reduce the administrative burden for all parties"[16] but prohibiting the use of superlatives does not constitute an administrative burden for "all parties," if any. Indeed it reduces burden on potential enrollees by limiting plan claims to those which are clearly supported. Allowing superlatives in advertising does not help beneficiaries compare the differences between plans and make informed decisions about their Medicare coverage options.

We urge CMS to do more, not less, to improve plan options and beneficiary decision-making. This includes uplifting and promoting the SHIP network's unbiased benefits counseling, as well as advocating for additional Congressional funding to ensure more Medicare enrollees have access to these services.

We also urge CMS to streamline the plan landscape.[17] Specifically, we urge CMS to reinstate the "meaningful difference" requirement and restrict approval to Medicare Advantage plans with benefit

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[15] *Id.*

[16] 90 Fed. Reg. 54894, 54957.

[17] Jeanne M. Lambrew & Christen Linke Young, "Lessons from the ACA: Simplifying Choices to Optimize Health Coverage" (Dec. 2, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage; *see also* Jason Abaluck & Jonathan Gruber, "Less Is More: Structuring Choice for Health Insurance Plans" (last accessed January 26, 2026), https://onepercentsteps.com/policy-briefs/less-is-more-structuring-choice-for-health-insurance-plans; Wändi Bruine de Bruin & Jonathan Blum, "Stop overloading older adults with Medicare plan choices: They don't help people make better selections—they just increase anxiety," STAT10 (Oct. 15, 2025), https://www.statnews.com/2025/10/15/medicare-open-enrollment-choice-help/; Medicare Rights Center,

packages that are "substantially different" from other plans offered by the same parent company in the same service area.[18] We also support standardizing and limiting plans to facilitate comparisons.

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))

CMS proposes to shorten the record retention requirement for sales and marketing calls from 10 years to 6 years. We oppose this proposal, especially in light of the risk of abuse, steering, and discriminatory behaviors from plans, TPMOs, agents, and brokers that may not immediately come to light.[19]

CMS goes even further by stating "based on the mixed findings from the review of call recordings, CMS is also considering, as an alternative, whether maintaining a recording, either audio or otherwise, of the marketing and sales portion of calls is necessary at all."[20] This is deeply perplexing. CMS correctly points out that this would mean that the agency and other oversight organizations would not have the ability to directly review agent and broker behavior.

Eliminating proper accountability for unburden agents, brokers and Medicare plans would be an abdication of CMS's regulatory and oversight role of the Medicare marketplace. Discarding the ability to "directly review agent and broker behavior" gives a free pass to those who engage in misconduct. CMS should strengthen oversight of the industry and provide for stronger consumer protections, not pursue the opposite course. For these reasons, we oppose this alternate option.

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

CMS proposes eliminating the requirement for MA and Part D sponsors to include a Notice of Availability (NOA) of language assistance services. CMS argues that the NOA could "potentially" be an issue in the future if the administration takes other arbitrary actions to harm access to language services.[21] We strenuously object to this harmful proposal. It will deny people with Medicare urgently needed information based on an unrealized future that is utterly within the control of the administration.

The NOA informs plan enrollees of their rights and how to access interpreters and auxiliary aids and services. Including the NOA requirement within the Medicare regulations addressing all materials and content that Medicare Advantage and Part D plans are required to provide is not duplicative. Rather, it provides clear directions to plans in one place and within the context of Medicare.

"Medicare Advantage Proliferation: Too Much of a Complicated Thing" (July 23, 2025), https://www.medicarerights.org/policy-documents/medicare-sustainability-ma-proliferation.

[18] 83 Fed. Reg. 16440, 16489.

[19] Julie Appleby, "Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' for Primo Customers" (May 19, 2025), https://kffhealthnews.org/news/article/justice-department-accuses-medicare-advantage-insurers-kickbacks-top-customers/.

[20] 90 Fed. Reg. 54894, 54959.

[21] 90 Fed. Reg. 54894, 54961.

Medicare enrollees often need to call their plans and seek help with issues ranging from provider access to coverage denials to billing. It is essential for enrollees with limited English proficiency (LEP) and with disabilities to know that they can get help navigating complex situations in their primary languages and that any necessary interpretation and auxiliary aids and services will be provided timely and are available free of charge. If an enrollee is unaware of the interpretation and other resources available to them, they may face impassible barriers to care.

While OCR regulations remain in place, these requirements are not tailored to Medicare plans, and do not have the same scope of coverage. For example, OCR requirements do not require plans to provide the notice in languages beyond the top 15 if they are the primary language of at least five percent of the individuals in the plan's service area. There are sizable communities with LEP who are not captured by the top 15 language threshold.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)
B. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)
1. Removing Measures

While removing topped out measures may make sense in keeping Star Ratings as a viable differentiator between plans, we fear that removing the measures without any continuing requirement that plans maintain strong compliance creates a boom or bust cycle where plans excel at meeting high standards—but only temporarily.

We urge CMS to do more to retain the gains from topped out measures to ensure that such measures are not simply abandoned once they no longer sustain profits.

h. Members Choosing to Leave the Plan (Part C and Part D)

CMS proposes to remove the Members Choosing to Leave the Plan (Part C and Part D) measure based on plan wishes that the measure be at the parent organization level versus the contract level and the desire for exclusions based on termination of provider networks. We oppose this proposal.

Disenrollment is a critical indicator of patient experience and quality; high disenrollment may reflect MA plans not meeting their enrollees' health and health care needs.[22] 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 disenroll compared to healthier enrollees.[23] This raises serious concerns about MA plan's ability to serve enrollees with complex care needs and warrants

[22] David J Meyers, *et al.*, "Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020" (August 25, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808747.
[23] 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.

further study and attention.[24] Rather than eliminating this measure, we urge CMS to build upon it by requiring additional information about the underlying reasons for disenrollment, so that CMS, lawmakers, and the public can definitively assess what is driving such high rates of plan disenrollment over time. MA plans must be held accountable for high rates of disenrollment, particularly if they are driven by MA plan abuses, mismanagement or the delivery of low-quality care or coverage.[25]

D. Health Equity Index Reward (§§ 422.166(f)(3) and 423.186(f)(3))

CMS proposes to remove the Health Equity Index (HEI) reward and replace it with the historical reward factor. We oppose this proposal.

Research consistently shows that the Star Ratings system using the historical reward factor does not improve quality of care for Medicare beneficiaries. Rather, it seems to embed disparate quality standards into the MA and Part D system, resulting in more resourced and healthier populations continuing to have access to higher quality plans. There is ample evidence that these plans are consistently denying patients needed care, both directly and indirectly.[26] By contrast, the HEI reward provides an appropriate incentive for plan sponsors to level the playing field and invest in quality improvements for dually eligible, low-income, and disabled beneficiaries.

VI. Improvements for Special Needs Plans
B. Passive Enrollment by CMS (§ 422.60)

Currently, in order to receive passive enrollments from a non-renewing D-SNP, the receiving plan must have a substantially similar provider and facility network to that of the relinquishing plan. CMS proposes to remove this requirement, arguing that plans rarely have such congruency of networks. Instead, CMS proposes that the receiving plan would have to provide 120 days of continuity of care. We strongly disagree with this proposal and suggest that the inability of plans to maintain substantially similar networks is a signal that passive enrollment should not be used. A slightly extended period for continuity of care does not make up for a future inability to see chosen providers.

We also note that in a well-functioning system, it should be at least somewhat common for two plans to have substantially similar networks. CMS's assertion that it is not practicable suggests that D-SNPs operate with networks that are far too narrow and fail to meet the needs of enrollees. Given the known failure of plans to weed out inactive or ghost providers, meeting a substantially similar threshold—at least on paper—should be routine.

By increasing the number of circumstances under which passive enrollment occurs, this proposal could lead to a paternalistic override of an individual's plan enrollment decision. There are alternative policy

[24] David J Meyers, *et al.*, "Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020" (August 25, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808747.
[25] *Id.*
[26] Legal Action Center, "Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020" (October 2024), https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf.

levers available to encourage individuals to choose another D-SNP following the termination or non-renewal of their current D-SNP, including making information better available about plan choices; encouraging better D-SNP provider networks; and making integrated care offerings more attractive. If CMS moves forward with finalizing the proposed rule, we ask CMS to clarify in regulation that the exemption in 42 C.F.R. § 422.60(3)(ii) applies to individuals who have affirmatively selected a standalone prescription drug plan.

We also ask that the continuity of care option should be at least 12 months, and plans should be required to provide information about the transition refill process for eligible enrollees whose prescriptions medications are not covered by the new plan. We ask that CMS require plans to make reasonable efforts to contract with providers that they have entered into continuity of care arrangements with, to improve network availability.

We are also concerned about a similar process, default enrollment. In default enrollment, the notice explaining the opt-out process comes from the new plans, which can easily be dismissed as junk mail. There are little public data about default enrollment: How many people are default enrolled each year and how many people are using the opt out process? Further, do default enrollment opt-out notices follow language and disability preferences of the enrollee? We need more and better data to understand whether default enrollment works for people and truly reflects their preferences.

C. Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid Fee-for-Service (§§ 422.107 and 422.514)

In states where D-SNPs share a parent organization with Medicaid plans in the same service area, starting in 2027, current policy would limit new D-SNP enrollment for full-benefit dual eligible individuals to individuals who are already enrolled in or who are enrolling in the affiliated Medicaid plan. Starting in 2030, plans would have to disenroll such individuals. In order to avoid enrollment disruptions, CMS proposes to allow D-SNPs that serve full-benefit dually eligible individuals in a HIDE SNP or coordination-only D-SNP 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.

We support the goal of fully aligned enrollment, but we recognize the advisability of flexibility to ensure that some dually eligible individuals do not experience significant enrollment disruptions or the inability to access integrated coverage options. But we encourage CMS to view this as an incremental step with the expectation that it will continue to use available policy levers to encourage progress toward aligned enrollment and integration, consistent with prior policies that have served as catalysts for state action. CMS should consider how to sustain that momentum even where limited exceptions are permitted.

In addition, we strongly support public reporting requirements related to care coordination for Medicaid FFS enrollees in coordination-only plans and CMS's proposal to require D-SNPs enrolling Medicaid FFS beneficiaries to report on care coordination activities, including outreach, assistance accessing Medicaid-covered services, grievance resolution, and service receipt. We also urge CMS to require D-SNPs to report on network congruency. Together, these requirements are critical for understanding

whether dually eligible enrollees can access both Medicare and Medicaid benefits. We urge CMS to make these reports and data publicly available and easily accessible to enable states, advocates, and other key stakeholders to assess whether these exceptions are improving access to Medicaid services, supporting integrated care goals, and reducing burden on enrollees.

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

CMS seeks input on the growth of C-SNP and I-SNP enrollment among dually eligible individuals and whether increasing enrollment in these plans is undermining federal and state strategies to promote integrated care through D-SNPs.

We appreciate CMS's focus on monitoring enrollment patterns across SNP types. As states increasingly invest in integrated models to improve care for dually eligible individuals, these efforts should not be offset by growth in non-integrated options that may function as workarounds to integration strategies.

We strongly support applying D-SNP look-alike thresholds to C-SNPs enrolling large proportions of dually eligible individuals, with targeted exceptions. We support applying the 60 percent D-SNP look-alike threshold to C-SNPs that enroll high proportions of dually eligible individuals to discourage MA Organizations from opening C-SNPs as substitutes for integrated D-SNP models. However, consistent with the position of the Medicare Payment Advisory Commission(MedPAC) that specialized C-SNP benefit design and care models may be appropriate for the dually eligible population for specific conditions such as HIV/AIDS, end-stage renal disease (ESRD), and serious mental illness (SMI), we support exceptions for C-SNPs serving individuals with these specific conditions.

We support CMS providing states an option to develop and oversee SMACs with C-SNPs if they determine that doing so would better support specific dually eligible populations.

As CMS considers the role of C-SNPs serving individuals with serious mental illness, it should also examine whether standard MA, D-SNPs, and C-SNPs adequately comply with coverage requirements for mental health and substance use disorder services.

CMS should continue to evaluate performance, beneficiary experience, and outcomes across all SNPs to better define and improve their respective value for dually eligible individuals.

VII. Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192
C. Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42))

Current policy requires MA plans to notify enrollees mid-year that they are eligible for supplemental benefits that they have not yet accessed. This is an important safeguard: Data on utilization of

supplemental benefits are limited but point to under-utilization.[27] Details about how to access and use supplemental benefits can be hard to find.[28]

Yet, CMS has halted enforcement of this policy and now proposes to eliminate it. Doing so would permanently leave many beneficiaries without important, actionable information that could improve their health. We strongly object to this proposal. CMS's assertion that "market competition naturally incentivizes MA organizations to ensure enrollees are aware of and utilize the supplemental benefits that differentiate their plans"[29] is not economically sound given that plans profit more by luring in enrollees through aggressive marketing of benefits that they never have to provide. And if plans really do want beneficiaries to use their benefits, what better way to ensure that than to remind them?

CMS also states that sending "additional information to enrollees, promoting benefits they will not necessarily be eligible for, could lead to enrollee confusion."[30] We appreciate this acknowledgement that details about supplemental benefit offerings and eligibility are often hidden and perplexing. Rather than worsening this opacity by withholding clarifying information, CMS should require plans to explain how their supplemental benefits work and ensure enrollees and potential enrollees fully understand how to evaluate plan options, assess their eligibility, and access their benefits. To that end, we also support standardizing supplemental benefits to ease comparison, administration, and uptake, and urge more robust data collection and plan accountability.

D. Revisions to Ensuring Equitable Access to Medicare Advantage Services

We oppose CMS's proposal to delete the following examples of Medicare enrollee populations that should be given equitable access to benefits: members of the LGBTQ population; people with disabilities; people living in rural areas; people from diverse religious backgrounds; and people affected by poverty. Individuals on this list face significant barriers to care. For example:

- Rural dually eligible individuals have higher mortality, and this mortality is not decreasing compared to non-rural dually eligible individuals.[31] Rural Medicare enrollees are more likely to

[27] Christopher L. Cai, *et al.*, "Use and Costs of Supplemental Benefits in Medicare Advantage, 2017-2021," JAMA Network Open (2025); Lisa E. Simon, *et al.*, "Medicare Advantage Dental Benefits in 2025: Steady Improvement or More of the Same?," Health Affairs (2025), https://www.healthaffairs.org/content/forefront/medicare-advantage-dental-benefits-2025-steady-improvement-more-same; Gretchen Jacobson, *et al.*, "What do Medicare Beneficiaries Value About their Coverage?" (2024), https://www.commonwealthfund.org/publications/surveys/2024/feb/what-do-medicare-beneficiaries-value-about-their-coverage.

[28] Julie Carter & Rachel Gershon, "Clearer Choices: Why Medicare Advantage Enrollees Need Better Information on Supplemental Benefits," Health Affairs (2025), https://www.healthaffairs.org/content/forefront/clearer-choices-why-medicare-advantage-enrollees-need-better-information-supplemental.

[29] 90 Fed. Reg. 54894, 54987.

[30] *Id.*

[31] Emefah Loccoh, *et al.*, "Rural-Urban Disparities in All-Cause Mortality Among Low-Income Medicare Beneficiaries," 2004-17, Health Affairs (February 2021), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00420.

express dissatisfaction with their care.[32] Rural hospitals are facing low reimbursement rates and delays in payment from MA plans.[33]

- MA enrollees with disabilities had worse health care experiences and outcomes, compared to enrollees without disabilities, especially for low-income enrollees with disabilities.[34] Medicare enrollees with severe functional disabilities had significantly greater out-of-pocket spending.[35] Medicare enrollees with activity limitations are more likely to report trouble getting needed health care.[36]

- About one percent of surveyed MA enrollees reported unfair treatment in health care settings due to culture or religion.[37]

- LGBTQ individuals face higher financial burdens with accessing health care.[38] Transgender Medicare enrollees were more likely to delay needed care due to discrimination and other factors, leading to higher rates of emergency health care needs.[39] Transgender adults report mistreatment in health care and long-term care settings, which leads to delays in needed care.[40]

- People with low incomes face greater barriers to care.[41]

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[32] Carrie Henning-Smith, *et al.*, "Differences by Rurality in Satisfaction with Care Among Medicare Beneficiaries," The Journal of Rural Health (May 2020), https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12423.
[33] Sarah Jane Tribble, "Tiny, Rural Hospitals Feel the Pinch as Medicare Advantage Plans Grow" (October 23, 2023), https://kffhealthnews.org/news/article/medicare-advantage-rural-hospitals-financial-pinch/.
[34] Centers for Medicare & Medicaid Services, "Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for Low-Income Subsidy and Disability" (May 2023), https://www.cms.gov/files/document/2023-disparities-health-care-medicare-advantage-associated-dual-eligibility-or-eligibility-low.pdf.
[35] Sungchul Park & Jim P. Stimpson, "Health Care Expenses and Financial Hardship Among Medicare Beneficiaries with Functional Disability" (June 17, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820090.
[36] Heather F. McClintock, *et al.*, "Disability Stages and Trouble Getting Needed Health Care Among Medicare Beneficiaries," Am J Phys Med Rehabil (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5391295/.
[37] Megan Matthews, *et al.*, "Medicare Advantage Enrollees' Reports of Unfair Treatment During Health Care Encounters" Health Affairs Scholar (May 2024), https://academic.oup.com/healthaffairsscholar/article/2/5/qxae063/7684870.
[38] Lindsey Dawson & Lunna Lopes, "Health Care Access and Financial Barrers Among LGBT People Amidst Looming Health Care Costs" (July 17, 2025), https://www.kff.org/health-costs/health-care-access-and-financial-barriers-among-lgbt-people-amidst-looming-health-care-cuts/.
[39] Gray Babbs, *et al.*, "Emergency Department Use Disparities Among Transgender and Cisgender Medicare Beneficiaries, 2011-2020," JAMA Internal Medicine (February 12, 2024), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2814649.
[40] Alex Montero, *et al.*, "LGBT Adults' Experience with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health," (April 2024), https://www.kff.org/racial-equity-and-health-policy/lgbt-adults-experiences-with-discrimination-and-health-care-disparities-findings-from-the-kff-survey-of-racism-discrimination-and-health/.
[41] Medicare Payment Advisory Commission, "Disparities in Outcomes for Medicare Beneficiaries with Different Social Risks" (July 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch5_MedPAC_Report_To_Congress_SEC.pdf.

Amending this rule will take away clarity for plans. The current list is specific, inclusive, and serves as a helpful guide.

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

We oppose CMS's proposal to remove the requirement that at least one member of the Utilization Management (UM) Committee have expertise in health equity, that the UM Committee conduct an annual analysis of health equity and prior authorization, and that the resulting analysis be publicly posted on plan's websites. The UM Committee is responsible for reviewing the utilization management policies of MA plans and ensuring that they are consistent with traditional Medicare coverage requirements. It is important to maintain and strengthen these requirements. In order to ensure that MA plans are meeting coverage requirements, this analysis needs to be done and there must be transparency for policymakers, researchers, and the public.

Instead of weakening current standards, we strongly urge CMS to increase publicly reported metrics around appeals, including the number of appeals and breakdowns of overturned denials by items and services and at each level of appeal.

In our experience, utilization management practices often yield harmful coverage denials that force beneficiaries to choose among a host of terrible options: seeking other care that was not the first choice of the provider or the beneficiary; paying out-of-pocket; going without care; or getting embroiled in a daunting appeals system. We hear from many enrollees who do not know where or how to begin, and from others who simply do not have time to wait for treatment or to wade through what might be a thicket of denials.

Even successful appeals come at a cost. While the most significant risks are care delays and negative health outcomes, they are also burdensome for beneficiaries and providers alike, creating strain, expense, and extra work. Many beneficiaries abandon the process altogether, along with the care they need. And when plans systematically and inappropriately deny claims, it may have a chilling effect on providers' willingness to prescribe or provide a treatment or cause providers to spend additional time and resources "over proving" claims to avoid denials.

Appeals are a necessary safety valve and important quality marker but currently function as a very poor substitute for sound plan decisions and robust independent oversight. Both the denials that unnecessarily force people into a broken appeals system, and that system itself, must be addressed.

For these reasons, we object to this and all proposals that lessen transparency, oversight, and accountability. Plans that inappropriately deny care must not be permitted to benefit from it.

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

CMS proposes to rescind the Quality Improvement Program health disparities requirement. We oppose this proposal. Deleting the equity requirement would undermine Medicare's success. The program

continues to see disparities in care across patient populations.[42] It is possible for insurers to use discriminatory practices to improve overall quality scores. For instance, a plan can use selective formularies to avoid enrollment by individuals with certain chronic conditions like HIV.[43] Requiring an equity element in the Quality Improvement Program builds expertise among health plans to be able to identify areas that they may not have noticed before. For instance, emerging evidence suggests that improvements in care seen in D-SNPs is not evenly distributed across racial groups.[44] Because managed care has the most data, their analysis can give insight into health equity outcomes.

VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

B. Risk Adjustment

MA risk adjustment requires fine calibration. Paying too much drives up program and beneficiary costs and negates the efficiency argument that is ostensibly the reason for MA or other private plans to exist[45] while paying too little results in plans leaving the market or engaging in discriminatory behavior.[46]

Since Medicare pays MA plans via risk-adjusted capitation, plans benefit when enrollees look as sick as possible.[47] This incentivizes plans to increase the appearance of ill health and high costs through sham diagnoses.[48]

To combat gaming, CMS should: 1. Apply a higher coding adjustment factor above and beyond what is minimally required in statute to fully account for MA plans' intensive coding, using a tiered approach that targets MA plans who engage in upcoding to the greatest extent in order to remove their unfair

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[42] Nancy Ochieng, *et al.*, "Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature" (December 3. 2023), https://www.kff.org/medicare/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-a-review-of-the-literature/.
[43] *See, e.g.*, Kathleen A. McManus, *et al.*, "Regional Disparities in Qualified Health Plans' Prior Authorization Requirements for HIV Pre-exposure Prophylaxis in the United States" (June 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766669.
[44] Morgan Perry, *et al.*, "D-SNP Enrollee Healthcare Access and Satisfaction: Does Insurance Level of Integration Make Difference?" (December 31, 2025), https://academic.oup.com/innovateage/article/9/Supplement_2/igaf122.3336/8408844; Eric Roberts & Jennifer Mellor, "Differences In Care Between Special Needs Plans and Other Medicare Coverage for Dual Eligibles," Health Affairs, 41(9), 1238–1247 (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00463.
[45] Medicare Rights Center, "The Overpayment Cycle: Payments to Medicare Advantage" (July 17, 2023), https://www.medicarerights.org/policy-documents/the-overpayment-cycle-payments-to-medicare-advantage.
[46] Medicare Rights Center, "Medicare Advantage History: Legislative Milestones" (July 17, 2023), https://www.medicarerights.org/policy-documents/medicare-advantage-history-legislative-milestones.
[47] Richard Gilfillan & Donald M. Berwick, "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game" (September 29, 2021), https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.
[48] Dept. of Health and Human Services Office of Inspector General, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments" (September 20, 2021), https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp

competitive advantage compared with other less-resourced MA plans; 2. Exclude information exclusively collected via in-home health risk assessments (HRAs) or chart reviews as a source of diagnoses for MA risk-adjustment scores and payments; 3. Use two years of Original Medicare and MA diagnostic data for calculating MA risk-adjusted payments and explore alternative sources of data for MA risk adjustment that industry cannot as easily game; and 4. Disallow codes that are disproportionately used by MA compared to fee-for-service providers.

C. Quality Bonus Payments in Medicare Advantage

The Quality Bonus Program is intended to reward plans based on quality and help beneficiaries meaningfully assess plan differences. Plans that have Star Ratings of four or five have a bonus of 5%. Those highly rated plans in qualifying counties—urban counties with low Original Medicare spending and high MA enrollment—get a double bonus of 10%.[49]

In recent years, as many as 90% of MA enrollees were in plans with 4 or 5 stars.[50] Yet, it is unclear whether the underlying Star Ratings system accurately measures plan quality.[51] Because the QBP is not budget neutral, it works as a giveaway to plans without holding them accountable for poor performance.[52]

Strengthening the QBP is a critical tool to ensure MA enrollees get the care they need. We urge CMS to: 1. Shift toward Star Ratings measures that assess outcomes and self-reported patient experiences, as well as measures that hold plans accountable for well-documented abuses such as in the areas of network adequacy, utilization management, and long-term care coverage and access; 2. Ensure that Star Ratings and bonus payments are afforded to MA plans along a normal distribution as is done in other CMS rating systems such as Nursing Home Compare; 3. Assess plan performance and calculate a Star Rating score at the plan or market level rather than the contract level; and 4. Seek legislative authority to incorporate financial penalties for subpar plan performance and ultimately make the QBP budget neutral.

Conclusion

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[49] Adam Markovitz, *et al.*, "Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements" (September 2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00349.

[50] Bob Herman, "The Lake Wobegon effect in Medicare Advantage," Axios (October 11, 2021), https://www.axios.com/2021/10/11/medicare-advantage-star-ratings-2022.

[51] Medicare Payment Advisory Commission, "Chapter 11: The Medicare Advantage program: Status report" (March 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf ("The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of the quality of care across MA plans.").

[52] Adele Shartzer, *et al.*, "Quality Bonus Payments in Medicare Advantage: How Access to Highly Rated Plans Varies across Enrollees and Counties" (July 2024), https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pdf.

Thank you again for the opportunity to provide comments. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

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