CENTER FOR REGULATORY FREEDOM
PROJECT OF CPAC FOUNDATION

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M E M O R A N D U M

To: **Hon. Robert F. Kennedy, Jr., Secretary, US Department of Health and Human Services**
Dr. Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services
From: **Andrew Langer, Director, Center for Regulatory Freedom**
Date: **April 13, 2026**
Re: **Comments to US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) in response to an Information Collection Request, "Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)," Docket #CMS-2026-0529, Fed. Reg. 2026-02603, Published February 10, 2026**

Below are comments of the American Conservative Union Foundation's (d/b/a. Conservative Political Action Coalition Foundation) (hereinafter "CPAC Foundation") Center for Regulatory Freedom (hereinafter "CRF"), in response to an Information Collection Request, "Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)," Docket #CMS-2026-0529, Fed. Reg. 2026-02603, published February 10, 2026.

CRF is a project of the CPAC Foundation, a non-profit, non-partisan 501(c)(3) research and education foundation. Our mission is to inject a common-sense perspective into the regulatory process, to ensure that the risks and costs of regulations are fully based on sound scientific and economic evidence, and to ensure that the voices, interests, and freedoms of Americans, and especially of small businesses, are fully represented in the regulatory process and debates. Finally, we work to ensure that regulatory proposals address real problems, that the proposals serve to ameliorate those problems, and, perhaps most importantly, that those proposals do not, in fact, make public policy problems worse.

The CPAC Foundation Center for Regulatory Freedom appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed extension of the information collection associated with Medical Loss Ratio (MLR) reporting for Medicare Advantage (MA) organizations and Prescription Drug Plan (PDP) sponsors. The Paperwork Reduction Act (PRA) process plays a critical role in ensuring transparency and accountability in federal information collection activities, particularly where such requirements impose meaningful administrative obligations across large segments of the healthcare system. Notices such as this serve as an

important mechanism for evaluating what might otherwise become embedded and insufficiently scrutinized regulatory requirements.

We support CMS's broader objective of ensuring accountability in the administration of Medicare Advantage and Part D programs. At the same time, the effectiveness of any information collection must be evaluated not only in terms of its statutory basis, but also in terms of its analytical utility, interpretability, and proportionality relative to the burden imposed. As discussed below, the current MLR reporting framework raises important questions regarding whether it continues to meet these standards under the PRA.

CMS proposes to extend an existing information collection used to assess compliance with the statutory requirement that MA and Part D contracts maintain a minimum medical loss ratio of 85 percent. The agency estimates that this collection affects approximately 660 respondents and imposes a total annual burden of more than 40,000 hours. This scale warrants careful review to ensure that the data collected meaningfully advances CMS's regulatory objectives.

The current MLR framework relies on a high-level aggregate measure of spending that does not distinguish between efficient and inefficient expenditures, nor between high-value and low-value care. While such aggregation may be sufficient for determining whether a contract meets a statutory threshold, it limits the usefulness of the data as a broader analytical or policy tool. As a result, the collection may generate substantial volumes of information without providing commensurate insight into the underlying drivers of healthcare cost or value.

Moreover, CMS appears to use MLR data primarily for threshold compliance and enforcement purposes—namely, determining whether a contract meets the 85 percent requirement and whether remittances or other sanctions are warranted. This is, by design, a binary application. Where the primary use of the data is limited in this way, it is appropriate to ask whether the level of reporting granularity and associated administrative effort are fully justified under PRA standards.

The estimated burden associated with this collection—over 40,000 hours annually across affected entities—is not insignificant. From a PRA perspective, this raises a fundamental question of burden-to-utility calibration: whether the regulatory value derived from the information collected is proportionate to the resources required to generate it. Where information is used primarily to support compliance determinations, agencies should take particular care to ensure that reporting requirements are narrowly tailored and avoid unnecessary complexity or redundancy.

Additional concerns arise from classification and reporting challenges inherent in the MLR framework. In particular, distinctions between clinical spending and administrative costs—especially in the context of pharmacy benefit structures—can introduce variability across reporting entities. Differences in how rebates, fees, and other financial flows are categorized may reduce comparability and undermine the consistency of the data.

These challenges may be further compounded by ongoing policy developments affecting pharmacy benefit managers (PBMs) and drug pricing structures. As compensation models and

rebate arrangements evolve, the boundary between medical and administrative spending may shift in ways that introduce additional measurement instability over time. **This underscores the importance of clear, standardized definitions and reporting conventions to ensure that the data collected remains meaningful and comparable.**

It is also worth noting that the MLR metric functions as a spending allocation constraint rather than a direct measure of efficiency. While this observation does not bear directly on the necessity of the information collection, it highlights the importance of ensuring that the data collected is interpreted within its appropriate analytical context and not assumed to provide insight beyond its design.

To improve the utility and effectiveness of the collection, CMS should consider refining and standardizing key reporting definitions, particularly with respect to pharmacy-related financial flows and the classification of administrative versus clinical expenditures. Greater consistency in these areas would enhance comparability across plans and improve the interpretability of the data for regulatory purposes.

CMS should also evaluate opportunities to reduce reporting burden through the elimination of non-essential data elements and increased reliance on automated data collection mechanisms or existing CMS data streams. Periodic retrospective review of the collection's utility would further help ensure that it remains aligned with PRA principles over time and does not accumulate unnecessary complexity.

We appreciate CMS's continued commitment to transparency and accountability in its administration of Medicare Advantage and Part D programs. The MLR reporting framework plays an important role in supporting statutory compliance, but its effectiveness will ultimately depend on whether the information collected is sufficiently precise, consistent, and analytically useful to justify the administrative burden it imposes. We encourage CMS to take this opportunity to ensure that the collection remains disciplined, proportionate, and well-calibrated to its intended purpose.

Sincerely,

Andrew M. Langer
Director
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PUBLIC SUBMISSION

As of: 3/3/26, 7:49 AM
Received: February 28, 2026
Status: Draft
Category: Individual
Tracking No. mm6-qwyb-n9bi
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0001
Comment on CMS-2026-0529-0001

Submitter Information

Name: David Rocha
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General Comment

The medical loss ratio needs to be broken down further for:
MLR % paid to first tier, downstream, and related entities (FDRs) aka delegated entities
MLR % payment reimbursed to clinicians

PUBLIC SUBMISSION

As of: 3/3/26, 7:50 AM
Received: February 28, 2026
Status: Draft
Category: Individual
Tracking No. mm6-sou5-17oc
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0002
Comment on CMS-2026-0529-0001

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General Comment

the MLR % actually given to clinicians could be broken down by category:
• Physicians (MDs, DOs)
• Mid-levels (NPs, PAs
• Pharmacists
• Nurses / care coordinators

PUBLIC SUBMISSION

As of: 3/4/26, 10:39 AM
Received: March 03, 2026
Status: Draft
Category: Individual
Tracking No. mmb-18m6-48ii
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0003
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Explicit treatment of interoperability investments

CMS needs to align MLR numerator eligibility with:
• FHIR adoption
• FHIR terminology services
• Measurable care improvement which improves outcomes
• Delegated entity transparency

Machine readable MLR data submission
Need to submit via FHIR APIs versus static reporting

MLR numerator Interoperability spend could include:

• Clinical Data exchange for care coordination that reduces readmissions, care fragmentation, and duplicate testing
• Total cost of care reporting via FHIR APIs
• Multi payer quality measurement
• Price transparency APIs integrated into clinical workflows
• FHIR based electronic case reporting
• Image sharing across MA networks
• SDOH FHIR exchange (e.g. Gravity Project FHIR IGs)
• Data quality validation tools (e.g. PIQI framework)
• Risk adjustment FHIR exchange

CMS API endpoint for
• Contract level MLR
• Plan level MLR
• Innovation investment percentages
• Remittance amounts

PUBLIC SUBMISSION

As of: 3/4/26, 10:39 AM
Received: March 03, 2026
Status: Draft
Category: Individual
Tracking No. mmb-1uep-q6cn
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0004
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

The MLR numerator needs to be tied to downstream adoption:
FHIR IG adoption (Risk Adjustment FHIR IG, Bulk FHIR, FHIR subscriptions)
Phase out the portal only workflows

Require API based data exchange in delegation agreements
MA contracts need to require standards based exchange for delegated:
• Care coordination
• Quality reporting
• Risk adjustment
• Utilization management
• Credentialing
• Electronic prior authorization

Risk bearing care delivery organizations which participate in MA must support standards based API exchange for delegated functions.

Contract level reporting needs to be done for:
% of delegated entities transacting FHIR
% of prior auth submitted via standards based APIs
% of quality reporting via standards based APIs
% of risk adjustment reporting via standards based APIs

FHIR terminology service reporting for the MLR numerator in interoperability for:
% of clinical transactions validated via FHIR terminology service
% of digital quality measures using live ValueSet $expand calls
% of risk adjustment codes mapped via Structured ConceptMap APIs
% of delegated entities connected to a central terminology service

% of code sets updated within __ days of annual release
Using the latest ICD-10 release, CPT release, HCPCS, rxnorm, SNOMED CT release
% of prior auth rules referencing ValueSets instead of proprietary code lists
% of care gap logic with Versioned ValueSets

PUBLIC SUBMISSION

As of: 3/4/26, 10:41 AM
Received: March 03, 2026
Status: Draft
Category: Individual
Tracking No. mmb-2888-a7yi
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0005
Comment on CMS-2026-0529-0001

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General Comment

MLR reporting needs to transition to structured, machine readable submission to ameliorate audit efficiency and reduce industry burden (especially the delegated entities). This will support the digitization of digital quality, digital risk adjustment and interoperability investments.

PUBLIC SUBMISSION

As of: 3/5/26, 7:50 AM
Received: March 04, 2026
Status: Draft
Tracking No. mmc-p8ob-96sy
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0006
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Standards based interoperability investments, such as implementation of nationally recognized implementation guides, need to be eligible quality improvement activities operationally which will reduce administrative burden.

PUBLIC SUBMISSION

As of: 3/5/26, 8:04 AM
Received: March 04, 2026
Status: Posted
Posted: March 05, 2026
Category: Individual
Tracking No. mmc-r7kj-tauk
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-0008
Comment on CMS-2026-0529-0001

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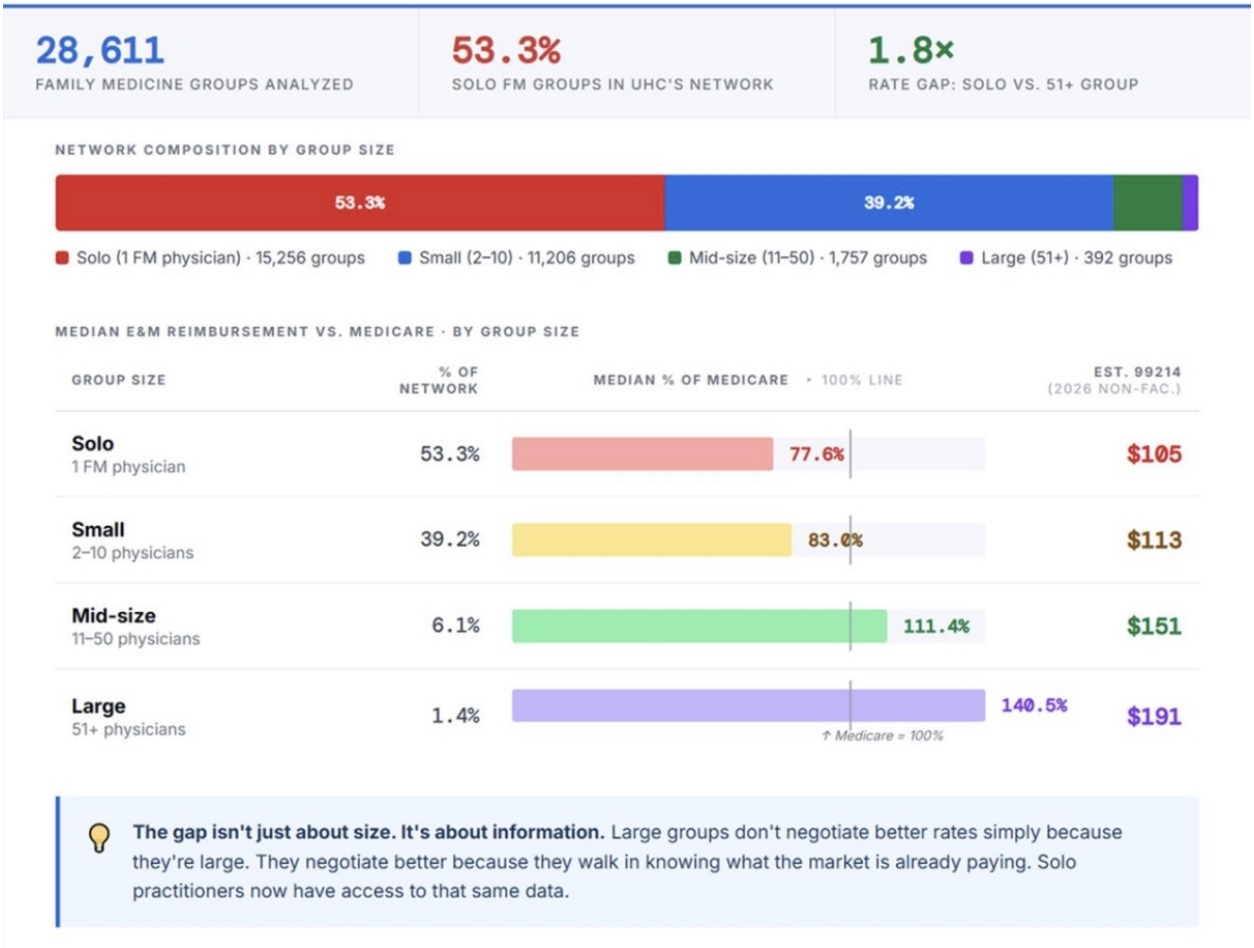
General Comment

CMS needs to evaluate if the distribution of medical spending by provider group size (solo, small, medium, large) correlates with improved outcomes, quality, access, interoperability and total cost of care.



The above screenshot came from Pricemedic

PUBLIC SUBMISSION

As of: 3/10/26, 1:58 PM
Received: March 06, 2026
Status: Draft
Category: Individual
Tracking No. mmf-t3tu-8mve
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0010
Comment on CMS-2026-0529-0001

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General Comment

Health plans and delegated entities rely too much on intermediaries, network operators, population health platforms, downstream entities, related entities, EHR value added resellers (EHR VARs) to do manual data exchange.

The MLR needs to clarify that the expenditures associated with manual data exchange infrastructure such as:
• PDF exchange
• electronic PDF exchange
• electronic fax exchange
• CSV exchange
• spreadsheet exchange
• non-standardized portals

should not qualify as quality improvement activities.

MLR investments should not be allocated to maintain spreadsheet systems.
MLR investments needs to shift towards interoperability infrastructure.

PUBLIC SUBMISSION

As of: 3/10/26, 2:00 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmh-v7ws-534v
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0011
Comment on CMS-2026-0529-0001

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General Comment

CMS investments in standards-based exchange infrastructure need to enable automated care coordination transfer when a beneficiary changes primary care providers or network entities to qualify as medical loss ratio quality improvement activities (MLR QIAs).

For example,
A dual eligible Medicare advantage HMO beneficiary moves from a PCP affiliated with a delegated entity in Montana to a PCP affiliated with a delegated entity Hawaii.

Currently Montana does not have live FHIR APIs for its state Medicaid and Hawaii does not live FHIR APIs for its state Medicaid (per Flexpa).
This would affect the secondary Medicaid API data exchange for the above use case when moving from Montana to Hawaii. The information needs to follow the consumer when moving across state lines.

PUBLIC SUBMISSION

As of: 3/10/26, 2:01 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-1jhy-objs
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0012
Comment on CMS-2026-0529-0001

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General Comment

Manual portal submission of care gaps and risk adjustment documentation by clinical staff, especially at delegated entities, has created an immense burden that could be eliminated with standards-based API exchange and using nationally recognized implementation guides
(FHIR IGs including Da Vinci FHIR IGs, Gravity Project FHIR IGs, FAST FHIR IGs, Vulcan FHIR IGs, Helios FHIR IGs, Vulcan FHIR IGs, CodeX FHIR IGs).

CMS needs to disallow particular QIA workflows as qualified QIA spending under the MLR when an API alternative (including FHIR alternative) exists and will reduce both clinical and administrative burden.

PUBLIC SUBMISSION

As of: 3/10/26, 2:02 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-1qtp-vh6v
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0013
Comment on CMS-2026-0529-0001

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General Comment

Front desk staff and administrative staff at delegated entities have spent too much time on the manual processing of electronic PDFs, electronic faxes, and electronic image files, since they have not been trained on standards based exchange alternatives.

Administrative workflows involving manual processing of PDFs, electronic PDFs, faxes, electronic faxes, JPEGs, TIFF files, PNG files, scanned records should not qualify as Quality Improvement Activities when standards-based exchange mechanisms exist.

PUBLIC SUBMISSION

As of: 3/10/26, 2:04 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-27q6-5a8a
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0014
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Administrative workflows also involving the manual processing of CSVs and spreadsheets (including member attribution lists, care gap lists, risk adjustment reporting, quality measurement reporting) should not qualify as Quality Improvement Activities when standards-based exchange mechanisms exist. Historically, this has been happening at delegated entities because they have not collectively upgraded to standards based APIs.

PUBLIC SUBMISSION

As of: 3/10/26, 2:04 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-2i3r-7vfw
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0015
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Clinical staff at delegated entities are still using portals, electronic faxes, and electronic PDFs for prior authorization approvals, referral approvals, results (such as lab results, imaging results and procedure results), even within EHR workflows.
Such administrative and clinical workflows should not qualify as Quality Improvement Activities when standards-based exchange mechanisms exist (when applicable FHIR IGs exist).

PUBLIC SUBMISSION

As of: 3/10/26, 2:05 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-56z0-2jn2
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0016
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

The MLR interoperability investments, including FHIR API adoption and adoption of nationally recognized implementation guides (including FHIR IGs) could be a new category called “Interoperability Improvement Activities” which would qualify towards MLR QIA reporting.

PUBLIC SUBMISSION

As of: 3/10/26, 2:06 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-5w65-jkz6
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0017
Comment on CMS-2026-0529-0001

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General Comment

CMS has required APIs for the MA plans, but interoperability gaps persist in delegated entities and secondary coverage workflows (such as the remaining state Medicaids not using live FHIR APIs and latest FHIR IGs). Incentivizing API adoption through MLR recognized interoperability improvement activities could close this gap.

PUBLIC SUBMISSION

As of: 3/10/26, 2:07 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-aqxf-27s1
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0018
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

The top 25 high-cost beneficiaries for delegated entities are core to utilization management and risk adjustment. It is important that the delegated entities and TPAs which manage the high cost, high risk beneficiaries are required to use FHIR APIs for real time data exchange between payers, providers, and delegated entities. This will be useful when such top 25 high-cost beneficiaries' data need to follow them across organizations, delegated entities, states, and across contracted care networks to reduce waste and improve outcomes.

The transfer of data from one delegated entity to another delegated entity should not need to reassemble the data (including utilization management data) from scratch.

PUBLIC SUBMISSION

As of: 3/10/26, 2:08 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-ces1-0h6n
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0019
Comment on CMS-2026-0529-0001

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General Comment

Delegated prescription drug plans (PDPs) shall be required to adopt the latest FHIR IGs, such as the complete suite of Da Vinci FHIR IGs and CARIN Alliance FHIR IGs, as indicated below.
Da Vinci FHIR IGs:
• PDex: Payer Data Exchange
• CDex: Clinical Data Exchange
• ATR: Member Attribution List
• Notifications
• CRD: Coverage Requirements Discovery
• DTR: Documentation Templates and Rules
• PAS: Prior Authorization Support
• PCT: Patient Cost Transparency
• VBPR: Value-Based Performance Reporting
• DEQM/GIC: Data Exchange for Quality Measures/Gaps In Care
• RA: Risk Adjustment
• HRex: Health Record Exchange
• Common CQL Artifacts for FHIR
• Postable Remittance
• Formulary
• Plan Net/Directory

CARIN Alliance FHIR IGs
• CARIN IG for Blue Button
• CARIN IG for Digital Insurance Card
• CARIN Patient-facing Real Time Pharmacy Benefit Check

In addition, the delegated PDPs need to adopt the following FHIR IGs:
• US PDMP FHIR IG
• Pharmacist Care Plan FHIR IG

• CodeX Medication REMS FHIR IG
• US Medications FHIR IG
• Specialty Medication Enrollment FHIR IG
• US Standardized Medication Profile FHIR IG

The Pharmacist Care Plan FHIR IG
https://hl7.org/fhir/us/phcp/

CodeX Medication REMS FHIR IG
https://build.fhir.org/ig/HL7/fhir-medication-rems-ig/

US Meds FHIR Implementation Guide
https://hl7.org/fhir/us/meds/

Specialty Medication Enrollment FHIR IG
https://hl7.org/fhir/us/specialty-rx/

PUBLIC SUBMISSION

As of: 3/10/26, 2:09 PM
Received: March 08, 2026
Status: Draft
Category: Individual
Tracking No. mmi-cm0m-ikiy
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0020
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Delegated prescription drug plans (PDPs) need to adopt FHIR APIs where the adoption of the latest pharmacy related FHIR IGs needs to count towards MLR Quality Improvement Activities (MLR QIAs).

PUBLIC SUBMISSION

As of: 3/10/26, 2:10 PM
Received: March 09, 2026
Status: Draft
Category: Individual
Tracking No. mmj-zumj-v7a8
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0021
Comment on CMS-2026-0529-0001

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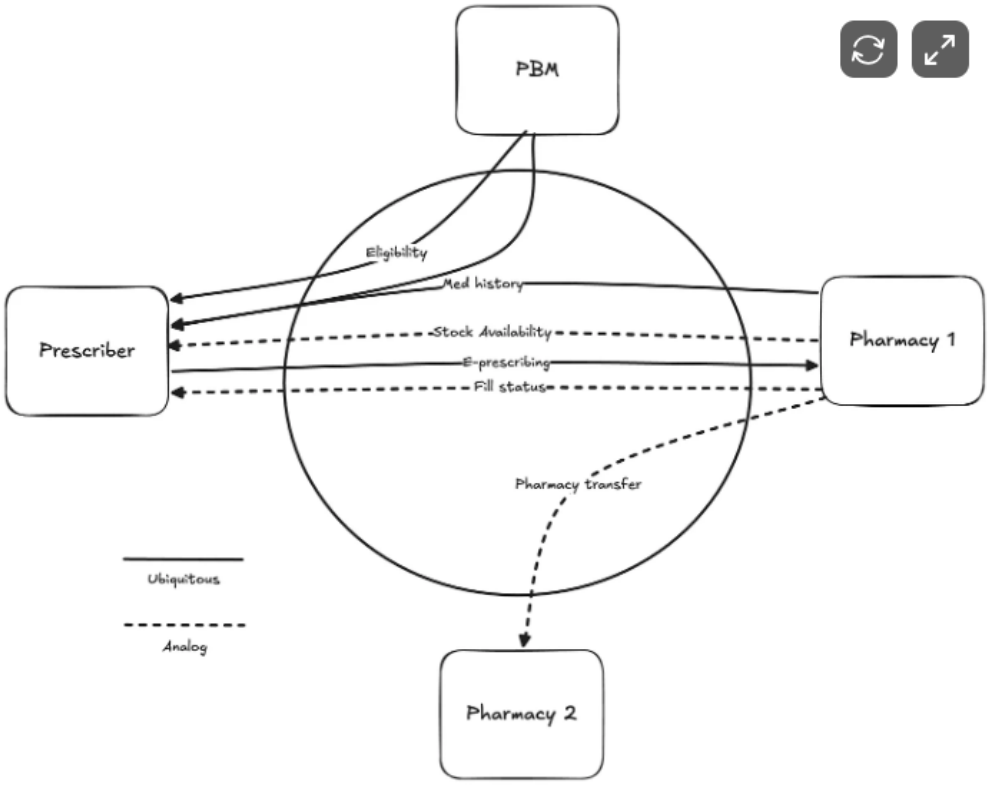
General Comment

For the value added resellers (VARs) which are vendors of payers or delegated entities (including delegated PDPs), then the following VAR activities could count towards Interoperability Improvement Activities for the MLR, at least in the short term or medium term of nationwide interoperability infrastructure:
• Implement FHIR APIs
• FHIR terminology services (such as SNOMED CT, LOINC, rxnorm)
• Standards based exchange (such as FHIR API exchange) for:
o Diagnostic image exchange
o Imaging data exchange
o Laboratory data exchange
o Financial data exchange (such as from X12 to FHIR) which aligns to faster care coordination, reduced treatment delays, and increased care coordination
o Care coordination data exchange
o Transitions of care data exchange
o Utilization management data exchange
o Quality reporting data exchange
o Risk adjustment data exchange
o FHIR subscriptions
o Bulk FHIR

FHIR based interoperability for pharmacy can enhance fee transparency for PBM disclosure and has the potential to improve quality outcomes via the MLR quality improvement activities for PDPs.

Pharmacy workflows for real time stock availability, fill status updates to prescribers, and pharmacy-to-pharmacy are still not ubiquitous as seen on a blog post below from Brendan Keeler.

https://healthapiguy.substack.com/p/interoperability-half-finished



Brendan Keeler wrote it best that “we did not see the mission to completion” and “the prescription moves at the speed of light in one direction and moves at the speed of fax in another.”

PUBLIC SUBMISSION

As of: 3/10/26, 2:17 PM
Received: March 09, 2026
Status: Draft
Category: Individual
Tracking No. mmk-1xwg-0cn0
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0022
Comment on CMS-2026-0529-0001

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General Comment

FHIR based interoperability for pharmacy can enhance fee transparency for PBM disclosure and has the potential to improve quality outcomes via the MLR quality improvement activities for PDPs.

Pharmacy workflows for real time stock availability, fill status updates to prescribers, and pharmacy-to-pharmacy are still not ubiquitous.

Attachments

MLR PDP and PBM comment DR

PUBLIC SUBMISSION

As of: 3/12/26, 9:04 AM
Received: March 10, 2026
Status: Draft
Category: Individual
Tracking No. mml-3v50-3jw3
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0023
Comment on CMS-2026-0529-0001

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General Comment

The interoperable exchange of therapy status (such as gene therapy status) and outcomes data should support QIPs for patient safety, medication adherence, and long-term monitoring using standards-based data exchange (such as FHIR APIs). Such interoperable exchange of gene therapies need to be done for the PDPs and delegated entities. Such activities can align with the MLR for quality improvement activities for patients (especially rare disease patients) receiving gene therapies with respect to care coordination, improvement in health outcomes, and medication adherence.

Types of gene therapies include but are not limited to:
AAV gene therapies
CRISPR gene therapies
Non-AAV gene therapies
Cell based gene therapies
Gene silencing therapies
RNA based gene therapies

PUBLIC SUBMISSION

As of: 3/12/26, 9:04 AM
Received: March 11, 2026
Status: Draft
Category: Individual
Tracking No. mml-izuz-q66k
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0024
Comment on CMS-2026-0529-0001

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General Comment

The below CMS MA APIs could be integrated for MA and the delegated entities as part of MLR Interoperability Improvement Activities
• Benefit and Plan Design APIs
• Patient Experience APIs: exchanging CAHPS survey using APIs with digital identity integrated
• Appeal and Grievance APIs
• Appeal status tracking APIs
• Clinical evidence exchange APIs
• Automated case notifications APIs
• Social Needs APIs
• Transportation and Logistics APIs
• Provider Administration Burden Metrics APIs
• Patient Navigation APIs
• Network management APIs (especially at the delegated entity and FDR level)
o Specialist referral availability
o Appointment availability
o Faster PCP access
o Faster specialist access
• Patient reported outcomes
o feedback and outcome data
o symptom reporting
o functional status
o post procedure recovery data
o caregiver observations and patient status (mobility, feeding, ulcer monitoring, rehab progress)

PUBLIC SUBMISSION

As of: 3/12/26, 9:06 AM
Received: March 11, 2026
Status: Draft
Category: Individual
Tracking No. mml-kcd6-077o
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0025
Comment on CMS-2026-0529-0001

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General Comment

Workforce education on interoperability and health data standards will support the effectiveness of quality improvement programs by empowering clinical and administrative staff to utilize interoperable systems for care coordination, quality reporting, and monitoring of medication safety.

Plans need to consider the incorporation of interoperability performance measures into gainsharing or surplus payment arrangements with delegated entities to elevate adoption of standards based exchange that promotes care coordination, quality reporting, and monitoring of medication safety.

PUBLIC SUBMISSION

As of: 3/24/26, 11:23 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mmz-tmpi-9qs6
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0026
Comment on CMS-2026-0529-0001

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General Comment

CMS advancing FHIR APIs with the parallel reliance on X12 transactions and CDA attachments standards shows duplicative requirements for interoperability.

Plans and delegated entities are supporting redundant and overlapping interoperability frameworks (X12, CDA, and FHIR) for the same clinical and administrative data.

Medicare Advantage, Part D plans, and the delegated entities are charged with the maintenance of parallel infrastructures to support the overlapping standards.
Such fragmentation increases the administrative costs that are not appropriately reflected in the MLR calculations.
CMS is increasing administrative burden with fragmented standards.
CMS needs to consider how interoperability that is regulatory driven affects the intent of MLR reporting and better align standards adoption.

CMS and ASTP/ONC need to accelerate the transition from CDA to FHIR to align with MLR reporting using FHIR APIs.
CMS and ASTP/ONC need to accelerate the transition from X12 to FHIR for claims data sharing using FHIR at scale.
CMS needs to evaluate a better pathway towards FHIR based standards to reduce redundancy and align with interoperability policy with the MLR program goals.

PUBLIC SUBMISSION

As of: 3/24/26, 11:24 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mmz-tykn-j8cv
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0027
Comment on CMS-2026-0529-0001

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General Comment

CMS's rule on CMS 0053 F shows the continued reliance on legacy CDA and legacy X12 standards for claims attachments, in which Medicare Advantage and delegated entities will need to maintain overlapping frameworks. This duplication by CMS will increase administrative costs with MLR reporting as it does not use standards based APIs at scale.
To mitigate the impacts, CMS needs to align with a nationwide migration to FHIR APIs by 2035 or the latest by 2037 to compete with the European Health Data Space (EHDS). Such nationwide migration to FHIR by 2035 would streamline administrative processes and reduce duplication in MLR calculations.

PUBLIC SUBMISSION

As of: 3/24/26, 11:26 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-l4hb-qvf8
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0028
Comment on CMS-2026-0529-0001

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General Comment

ASTP/ONC released the draft for USCDI v7 late January 2026.

ASTP/ONC stewards USCDI+ which currently has domains for:
• Behavioral Health
• Cancer
• Maternal Health
• Public Health
• Quality
• Other Use Cases: Respiratory Illness

CMS needs to accelerate the adoption of the latest versions of USCDI and USCDI+ to count towards the MLR quality improvement activities or MLR interoperability improvement activities. This would increase nationwide interoperability across payers, PDPs, PBMs, and delegated entities to use the latest versions of USCDI and USCDI+ at scale.

PUBLIC SUBMISSION

As of: 3/24/26, 11:28 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-nypx-o8ir
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0029
Comment on CMS-2026-0529-0001

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General Comment

CMS should allow the delegated entities' and PDP's transition from X12 to FHIR to count towards MLR's quality improvement activities or interoperability improvement activities.
CMS should allow the delegated entities' and PDP's transition from CDA to FHIR to count towards MLR's quality improvement activities or interoperability improvement activities.

PUBLIC SUBMISSION

As of: 3/24/26, 11:28 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-o02u-1ywt
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0030
Comment on CMS-2026-0529-0001

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General Comment

CMS should allow the delegated entities' and PDP's transition from HL7 V2 to FHIR to count towards MLR's quality improvement activities or interoperability improvement activities.

PUBLIC SUBMISSION

As of: 3/24/26, 11:30 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-o3po-p5fw
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0031
Comment on CMS-2026-0529-0001

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General Comment

The transition away from legacy standards (V2, CDA, X12) to FHIR shall qualify as MLR quality improvement activities as it enables structured data exchange, reduces administrative burden, reduces clinician burden, and ameliorates quality reporting, risk adjustment reporting, and care coordination across Medicare Advantage, Part D, and delegated entities, states and territories.

PUBLIC SUBMISSION

As of: 3/24/26, 11:30 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-q4h1-a1pa
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0032
Comment on CMS-2026-0529-0001

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General Comment

Once ASTP/ONC certifies AI agents for interoperability, CMS and ASTP/ONC should consider the recognition of AI agent to AI agent (agent to agent) interoperability, where AI agents can exchange healthcare data to close care gaps, risk adjustment reporting, and streamline such reporting to count towards MLR quality improvement activities across Medicare Advantage, Part D, and delegated entities.

In addition, conversation interoperability (COIN) should count towards MLR quality improvement activities or interoperability improvement activities.

PUBLIC SUBMISSION

As of: 3/24/26, 11:31 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-xe05-bpj9
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0033
Comment on CMS-2026-0529-0001

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General Comment

Organizational interoperability will be closer to reality when it is aligned to incentives (gainshare payment, surplus payment, shared savings distribution), quality and accountability.

PUBLIC SUBMISSION

As of: 3/24/26, 11:31 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-m0ia-3dur
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0034
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

CMS needs to accelerate high volume urgent care providers to use FHIR API connectivity for MLR reporting purposes.
Urgent care chains utilize a mix of vendors: proprietary, franchise and health system EHRs.
Without standardized interoperability, MA plans and delegated entities (FDRs) face inconsistent flows, which will undermine the strength of MLR reporting.

PUBLIC SUBMISSION

As of: 3/24/26, 11:31 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-mcvz-pb3i
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0035
Comment on CMS-2026-0529-0001

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General Comment

For the urgent care providers and delegated urgent care providers already capable of FHIR APIs, the lack of staff education at scale highlights a need to provide training on the FHIR based interoperability which currently exists or will exist for MLR reporting, and Part C and reporting.

PUBLIC SUBMISSION

As of: 3/24/26, 11:32 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-uqms-41pd
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0036
Comment on CMS-2026-0529-0001

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General Comment

The expansion of TEFCA participation to include urgent care providers will strengthen the information and accuracy for MLR calculations and Part C and Part D reporting for Medicare Advantage plans, and PDPs.

PUBLIC SUBMISSION

As of: 3/24/26, 11:33 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-zz51-iijq
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0037
Comment on CMS-2026-0529-0001

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General Comment

CMS needs to establish the condition that all first tier, downstream and related entities (delegated entities) involved in the control of negotiated rates or capitation arrangements on behalf of a reporting entity in MLR calculations and Part C and Part reporting shall be based on the notion of standardized, interoperable, and timely access to standards-based APIs to negotiated rate, capitation and cost data.

PUBLIC SUBMISSION

As of: 3/24/26, 11:33 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn4-2t50-l111
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0038
Comment on CMS-2026-0529-0001

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General Comment

Wakely Consulting issued a white paper entitled “The Value Shift: How Medicare Advantage Benefits Are Evolving for 2026.”
The data from Wakely’s paper details some 2025 Medicare Advantage data:

https://www.wakely.com/wp-content/uploads/2026/02/The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026.pdf

64% of the MA lives have HMO coverage.
33% (about 1/3) of the HMO population have Dual SNP.

Calculation of 2025 data:
18,339,325 / 28,591,241 = approx. 64%
6,034,053 / 18,339,325 = approx. 33%
Data from pp. 3-4 of the report.

18.3 million beneficiaries are in an MA HMO plan.
Of the 64% MA HMO covered beneficiaries, CMS would be able to calculate the percentage breakdown of how many lives are in a delegated plan vs a non-delegated plan.
10.25 million beneficiaries are in an MA PPO plan.
Of the 36% MA PPO covered beneficiaries, CMS would be able to calculate the percentage breakdown of how many lives are in a delegated plan vs a non-delegated plan.

If CMS does not have this data, CMS should calculate percentage breakdowns of covered MA lives in a delegated plan vs non delegated, and the further breakdown of dual SNPs in a delegated plan.

Previous interoperability efforts have focused on non-delegated MA PPO beneficiaries.
Interoperability efforts will need to include delegated MA HMO beneficiaries and delegated MA PPO beneficiaries.

Attachments

The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026

Wakely
An HMA Company

Wakely.com

WHITE PAPER

The Value Shift: How Medicare Advantage Benefits Are Evolving for 2026

2026 Enrollment Updates

Dani Marino, ASA, MAAA

Amanda Nelessen, FSA, MAAA

FEBRUARY 2026

Leveraging Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Strategic Market Analysis and Ranking Tool (SMART), this analysis builds on part 1, "How Medicare Benefits Are Evolving for 2026: Insights on Premium Trends, Supplemental Benefits, and Plan Benefits," and highlights how enrollment in Medicare Advantage plans is being affected.

INTRODUCTION

The Medicare Advantage (MA) market continues to undergo rapid transformation, shaped by intensifying competition, evolving regulatory requirements, shifting financial dynamics, and member expectations for increasingly rich and differentiated benefits. As these forces continue to reframe the market heading into 2026, timely insight into benefit design trends remains critical for stakeholders seeking to maintain competitiveness and deliver sustainable value.

Building on our prior analysis of the MA benefit landscape, this paper updates and extends Wakely's earlier work to reflect the January and February 2026 contract/plan/state/county (CPSC) enrollment data,[1] which was released earlier this month. As the first paper in Wakely's 2026 MA market paper series, this analysis offers an updated, high-level assessment of the 2026 MA benefit landscape, highlighting key trends and notable changes relative to prior years.

This updated analysis examines benefit enhancements, reductions, and shifts in overall plan value using Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Wakely's Strategic Market Analysis and Ranking Tool (SMART). By leveraging these tools, we assess plan competitiveness beyond traditional measures and provide refreshed insights into how plans are positioning themselves in an increasingly dynamic MA environment.

Key findings include:[2]

- **The average member premium** for general enrollment plans was $12.09 per member per month (PMPM) in 2025, compared with $14.27 PMPM in 2026 based on 2026 enrollment, yielding an 18% increase in average member premium. While the average member premium increased between 2025 and 2026, the number of plans with a premium stayed relatively consistent at around 32% of plans. The percentage of members in a premium plan increased slightly from 23% in 2025 to 24% in 2026.
- **The average Part B premium reduction** increased from $15.43 PMPM in 2025 to $19.14 PMPM in 2026 for general enrollment plans based on 2026 enrollment, an increase of roughly 24%. Like the member premium, the number of plans offering a Part B premium reduction stayed relatively consistent at 32% in 2025 and 2026; however, the percentage of members in a plan offering a Part B premium reduction decreased slightly from 32% to 31% from 2025 to 2026.

[1] Centers for Medicare & Medicaid Services. Monthly Enrollment by CPSC. January and February 2026. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-contract/plan/state/county.
[2] Excludes Prescription Drug Plans and Employer Group Waiver Plans.

- **The average maximum out-of-pocket (MOOP)** amount increased to $5,434 in 2026 from $5,129 in 2025 for general enrollment plans based on 2026 enrollment – a 6% increase between the two years.
- **The average plan value-add**[3] for general enrollment plans decreased roughly 11.0% between 2025 and 2026. Similarly, dual eligible special needs plans (D-SNPs) also saw a decrease in average plan value-add, but to a much smaller degree than general enrollment plans—only about 0.5%.

ENROLLMENT CHANGES FROM 2025 TO 2026

Table 1 summarizes MA enrollment trends from 2025 to 2026, highlighting changes by plan type, enrollment category, coverage type, premium structure, and Part B premium reduction status. It presents both absolute enrollment changes and percentage growth or decline, providing a comprehensive view of where enrollment is expanding, stabilizing, or contracting across major segments of the MA market. Overall totals are included to contextualize segment-level shifts within the broader enrollment landscape. Note that Prescription Drug Plans (PDPs) and Employer Group Waiver Plans (EGWPs) are excluded.

Table 1. Enrollment Trends, 2025–2026

Plan/Enrollment/ Coverage Type	2025 Enrollment	2026 Enrollment	Difference	% Difference
Plan Type				
HMO	18,339,325	18,852,844	513,519	2.8%
PPO	10,251,916	9,838,318	(413,598)	-4.0%
Enrollment Type				
General Enrollment	21,039,614	20,923,865	(115,749)	-0.6%
C-SNP	1,392,290	1,601,515	209,225	15.0%
D-SNP	6,034,053	6,041,326	7,273	0.1%
I-SNP	125,284	124,456	(828)	-0.7%

[3] Wakely metric calculated using the methodology described in the "WMACAT Value-Add Metric: How It Assesses Plan Value" section of this paper.

Plan/Enrollment/ Coverage Type	2025 Enrollment	2026 Enrollment	Difference	% Difference
Coverage Type				
MA-PD	27,826,335	27,872,929	46,594	0.2%
MA-Only	764,906	818,233	53,327	7.0%
Premium Type (GEs Only)				
$0 Premium	16,210,140	15,907,615	(302,525)	-1.9%
Non-$0 Premium	4,829,474	5,016,250	186,776	3.9%
Part B Premium Reduction Type (GEs Only)				
$0 Part B Buydown	6,748,447	6,440,012	(308,435)	-4.6%
Non-$0 Part B Buydown	14,291,167	14,483,853	192,686	1.3%
Total Enrollment	**28,591,241**	**28,691,162**	**99,921**	**0.3%**

The growth by plan, coverage, and enrollment types from 2025 to 2026 offers insights into how the market is trending, such as:

- **Overall enrollment growth remains modest.** Total enrollment increased by approximately 100,000 members year over year, representing growth of just 0.3%, indicating a relatively mature and competitive market.
- **HMO growth contrasts with PPO decline.** HMO enrollment grew by 2.8%, adding more than 500,000 members, while PPO enrollment declined by 4.0%. Historically, PPO plans have seen growth, with a 12% increase in enrollment from 2023 to 2024, and a 2.3% increase from 2024 to 2025.
- **Special needs plans continue to drive growth.** Enrollment in Chronic Condition Special Needs Plans (C-SNPs) increased by 15.0%, the fastest-growing segment highlighted in the table, while D-SNP enrollment was essentially flat and enrollment in Institutional Special Needs Plans (I-SNPs) declined slightly.
- **General enrollment edged downward.** General MA enrollment declined by 0.6%, reinforcing that overall growth is being driven by specific niches rather than broad-based expansion.
- **MA-only enrollment is growing faster than MA-PD.** MA-only plans grew by 7.0%, significantly outpacing MA-PD growth of 0.2%, which may reflect affordability pressures or increased availability of stand-alone Part D options.
- **Premium sensitivity is evident.** Enrollment in premium plans grew by 3.9%, while $0 premium plans declined by 1.9%, suggesting some willingness among members to pay premiums, potentially in exchange for richer benefits or improved networks.
- **Part B premium reduction offerings are losing share.** Plans with a Part B premium reduction experienced a 4.6% enrollment decline, whereas plans without a Part B premium reduction grew by 1.3%.

The top 10 parent organizations based on 2026 enrollment[4] are explored in **Table 2** (next page). Humana experienced the biggest gains by far, adding over 1 million members (+20%) between December 2025 and February 2026. Devoted Health, Inc., and SCAN Group show the fastest growth, although at a smaller scale. UnitedHealth Group, while still the largest parent company, is experiencing the largest absolute decline in enrollment (-726K, -8.7%).

[4] Excludes PDP, EGWP, private fee-for-service, National Program of All-Inclusive Care for the Elderly (PACE), Medicare Medical Savings Accounts, and 1876 Cost Plans.

Table 2. Enrollment Trends by Top Parent Organizations, 2025–2026

Parent Organization	2025 Enrollment	2026 Enrollment	Difference	% Difference
UnitedHealth Group, Inc.	8,342,871	7,617,249	-725,622	-8.7%
Humana Inc.	5,150,093	6,188,896	1,038,803	20.2%
CVS Health Corporation	2,864,295	2,723,193	-141,102	-4.9%
Kaiser Foundation Health Plan, Inc.	1,402,365	1,429,688	27,323	1.9%
Elevance Health, Inc.	1,660,517	1,351,542	-308,975	-18.6%
Centene Corporation	961,091	932,009	-29,082	-3.0%
Health Care Service Corporation	858,694	761,162	-97,532	-11.4%
Devoted Health, Inc.	206,447	455,579	249,132	120.7%
SCAN Group	309,397	422,887	113,490	36.7%
Healthfirst, Inc.	362,180	367,332	5,152	1.4%
Other	6,473,291	6,441,625	-31,666	-0.5%
Total	**28,591,241**	**28,691,162**	**99,921**	**0.3%**

WMACAT VALUE-ADD METRIC: HOW IT ASSESSES PLAN VALUE

The WMACAT value-add metric is a proprietary metric that Wakely developed to provide a comprehensive assessment of MA plan value. It can be used as a comparative metric to evaluate relative changes in plan design year over year and is not intended to represent pricing.

This metric incorporates **five** core components:

1. **Part C Medicare-Covered Reduction in Cost Sharing**

Wakely leverages its MA Part C pricing model to assess plan benefit design using a consistent claims-based benchmark. Each plan's design is compared with the amount a member would pay under Medicare fee-for-service (FFS). The differential between FFS cost sharing and each plan's benefit design represents the quantified value-add. This approach ensures comparability across plans by applying a uniform evaluation standard. Note that D-SNPs are excluded from the cost sharing evaluation.

2. **Part C Supplemental Benefits**

Each benefit is evaluated using different assumptions based on Wakely data and models. Although WMACAT does not model plan-specific utilization, it applies a consistent methodology to estimate relative value, enabling standardized comparisons across diverse benefit offerings.

3. **Part D Prescription Drug Coverage**

Prescription drug coverage is assessed using the 2026 Centers for Medicare & Medicaid Services (CMS) out-of-pocket cost (OOPC) model, which calculates member cost sharing under a defined standard benefit design versus the plan's benefit design.

4. **Member Premium**

We incorporate premium amounts as reductions to the plan value-add.

5. **Part B Premium Reduction**

We incorporate Part B premium reduction as an enhancement to the plan value-add.

The total plan value-add is a combination of these five components. For D-SNPs,[5] we exclude Part C Medicare-covered reduction in cost sharing, member premium, and Part B premium reduction due to integration with Medicaid coverage. Note that the total value-add calculation excludes MA-only plans.

[5] There may be state-specific adjustments to plan design for D-SNPs (e.g., addition of supplemental benefits in the bid from one year to the next). These are not explicitly adjusted for in the D-SNP value-add and may be affecting the results.

General enrollment value-add = Part C Medicare-covered reduction in cost sharing + Part C supplemental + Part D – member premium + Part B premium reduction

D-SNP value-add = Part C supplemental + Part D

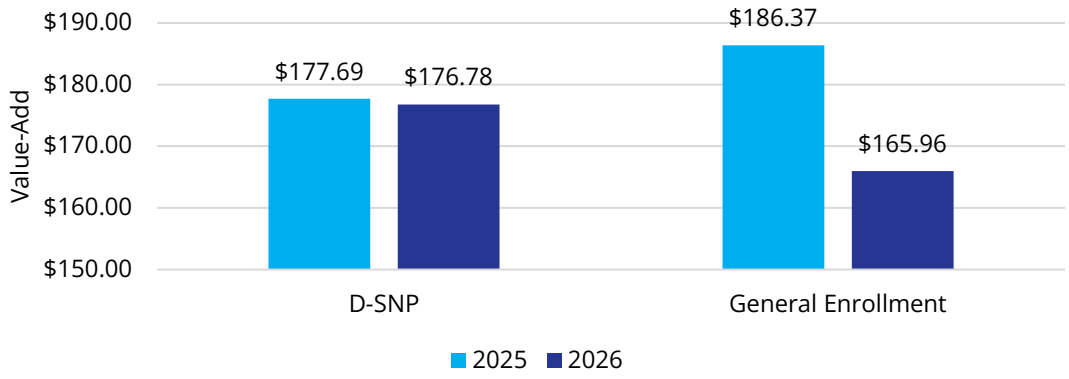
Why It Matters

By harmonizing these components under a unified framework, the WMACAT value-add metric provides stakeholders with a robust, apples-to-apples comparison of plan value, accounting for both affordability and benefit richness. This methodology supports strategic decision-making, competitive benchmarking, and market positioning in an increasingly complex MA environment.

SUMMARY OF BENEFIT VALUE CHANGE FROM 2025 TO 2026

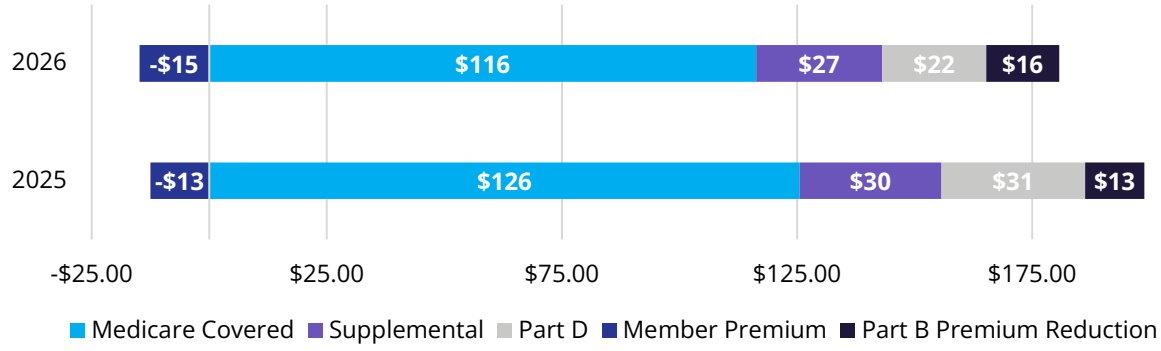
Using the WMACAT value-add metric, we summarized the average plan value-add for 2025 and 2026 for all MA-PD D-SNPs and General Enrollment plans in **Figure 1**. On average, both D-SNP and General Enrollment plan types experienced a reduction in plan value-add by 0.5% and 11.0%, respectively.

Figure 1. Change in Plan Value-Add from 2025 to 2026



For general enrollment plans, average value-add between 2025 and 2026 is decreasing across all core components except for the Part B premium reduction, as shown in **Figure 2**. The decrease in Part C Medicare-covered reduction in sharing and Part D are the main drivers.

Figure 2. Plan Value-Add by Component for General Enrollment Plans for 2025 to 2026



PLAN VALUE-ADD CHANGE BY PARENT ORGANIZATION

Wakely also analyzed the plan value-add change for the top 10 largest enrollment parent organizations, separated between general enrollment and D-SNP. These organizations enroll roughly 76% of the general enrollment population and approximately 86% of the D-SNP population. **Figure 3** (below) and **Figure 4** (next page) summarize the plan value-add metric and 2026 enrollment for general enrollment plans and D-SNPs, respectively, for 2025 and 2026.

Figure 3. Value-Add Changes, Top 10 Parent Organizations, General Enrollment

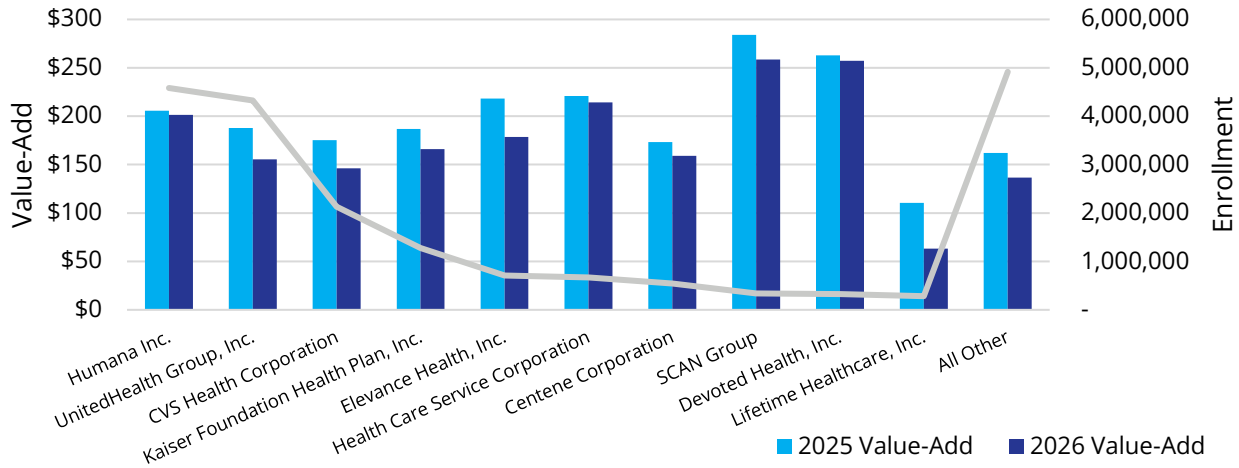
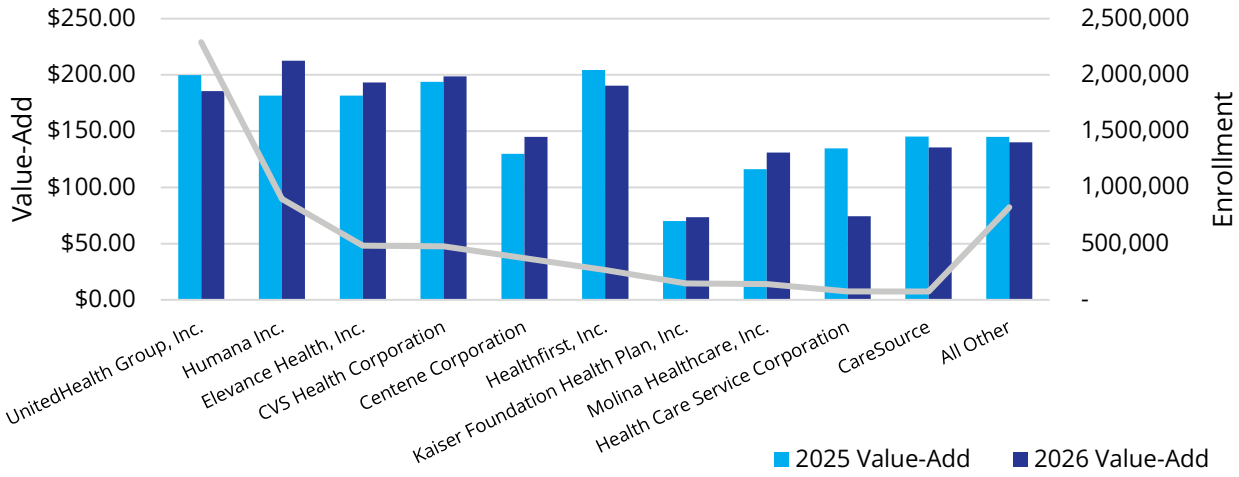


Figure 4. Value-Add Changes, Top 10 Parent Organizations, D-SNP



As **Figure 3** demonstrates, general enrollment plans, on average, show a decrease in plan value-add between 2025 and 2026. Humana surpassed United Healthcare as having the largest enrollment for this population and maintained a relatively stable value-add between 2025 to 2026, compared to United Healthcare's decrease of 17%.

For D-SNPs, **Figure 4** indicates that the value-add for 2025 and 2026 is in flux, depending on the parent organization's size. In fact, the 2026 enrollment indicates six of the top 10 parent organizations (Humana, Elevance, CVS, Centene, Kaiser, and Molina) are offering a richer benefit package in 2026, whereas those outside of the top 10 show roughly a 3% reduction in plan value-add. There is a clear distinction between the general enrollment and D-SNP population product design strategies, as some large organizations may have invested more in D-SNP products.

VALUE-ADD METRIC HEATMAP

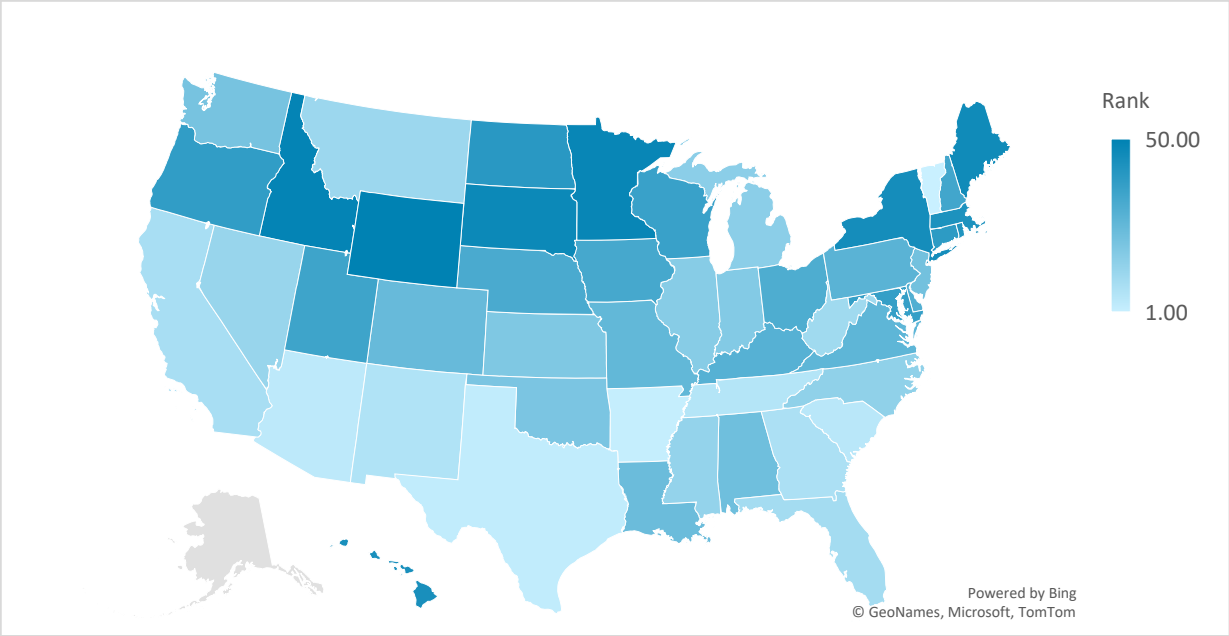
Figure 5 (next page) presents the enrollment-weighted value-add by state for the general enrollment population. To develop this view, we first calculated each state's value-add change from 2025 to 2026. We then ranked states from those experiencing the least reduction (or greatest enhancement) to those experiencing the largest reduction in value-add.

The resulting ranking drives the color coding shown in **Figure 5**:

- Lighter blues represent states with smaller declines in value-add between 2025 and 2026.
- Darker blues represents states with larger average percentage reductions in value-add over the same period.

This visualization allows for a clear comparison of how value-add shifts vary across states as indicated by the percent change in value-add from 2025 to 2026.

Figure 5. Ranking of Value-Add Percent Change by State, General Enrollment

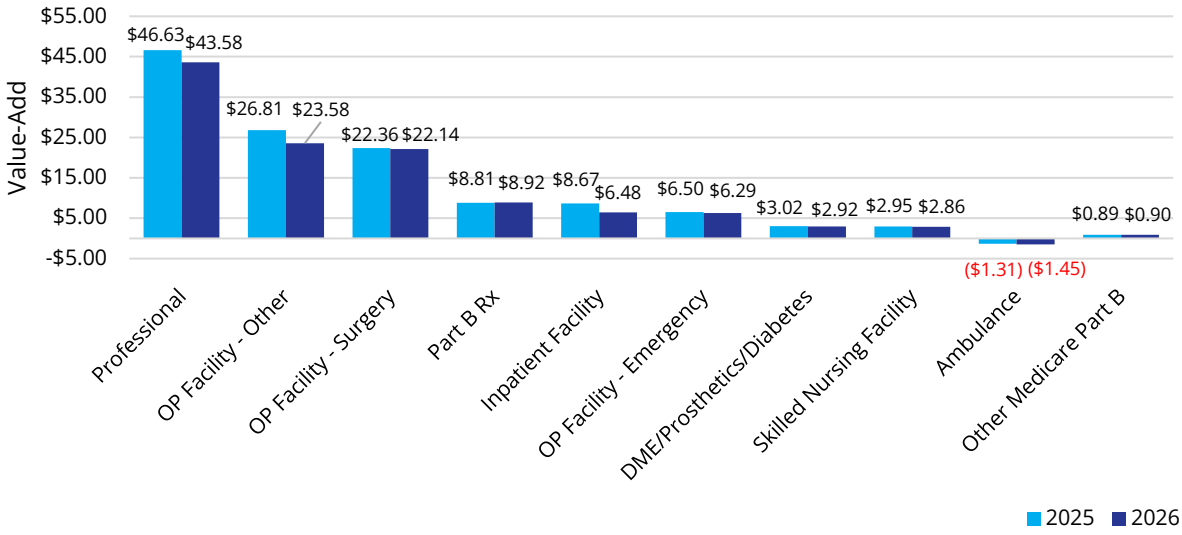


Wyoming, Idaho, and Minnesota reduced benefits in general enrollment plans to the greatest extent from 2025 to 2026. Conversely, Arkansas, Texas, and Arizona reduced benefits the least from 2025 to 2026. Vermont is the only state to indicate an increase in benefit enhancement, on average, between 2025 and 2026. The appendix contains more details on the state specific value-add changes from 2025 to 2026.

REDUCTION IN MEDICARE-COVERED COST SHARING

Figure 6 shows the average Part C Medicare-covered plan value-add for 2025 and 2026 by major type of service category for general enrollment plans.[6]

Figure 6. Reduction in Cost Sharing Value-Add by Type of Service, General Enrollment



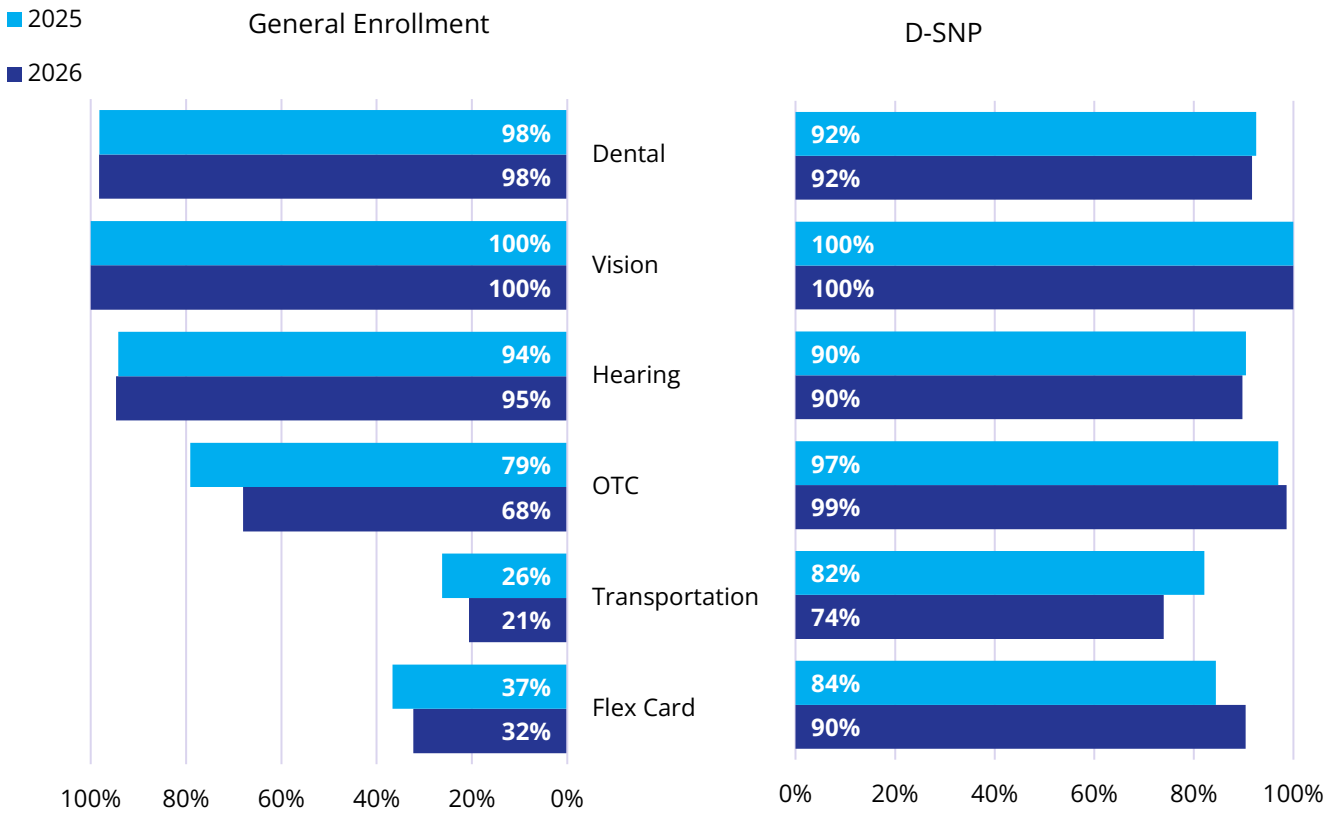
Across all service categories, the Part C Medicare-covered value-add decreased from $125.28 in 2025 to $116.14 in 2026, indicating a 7% reduction in benefit richness. This decrease is primarily driven by Professional and Outpatient (OP) Facility – Other services. Note that the value-add metrics reflect the impact of the MOOP and plan deductible, as well as the benefit cost sharing parameters.

[6] Includes MA-only plans, so numbers differ slightly from **Figure 2**.

SUPPLEMENTAL BENEFITS

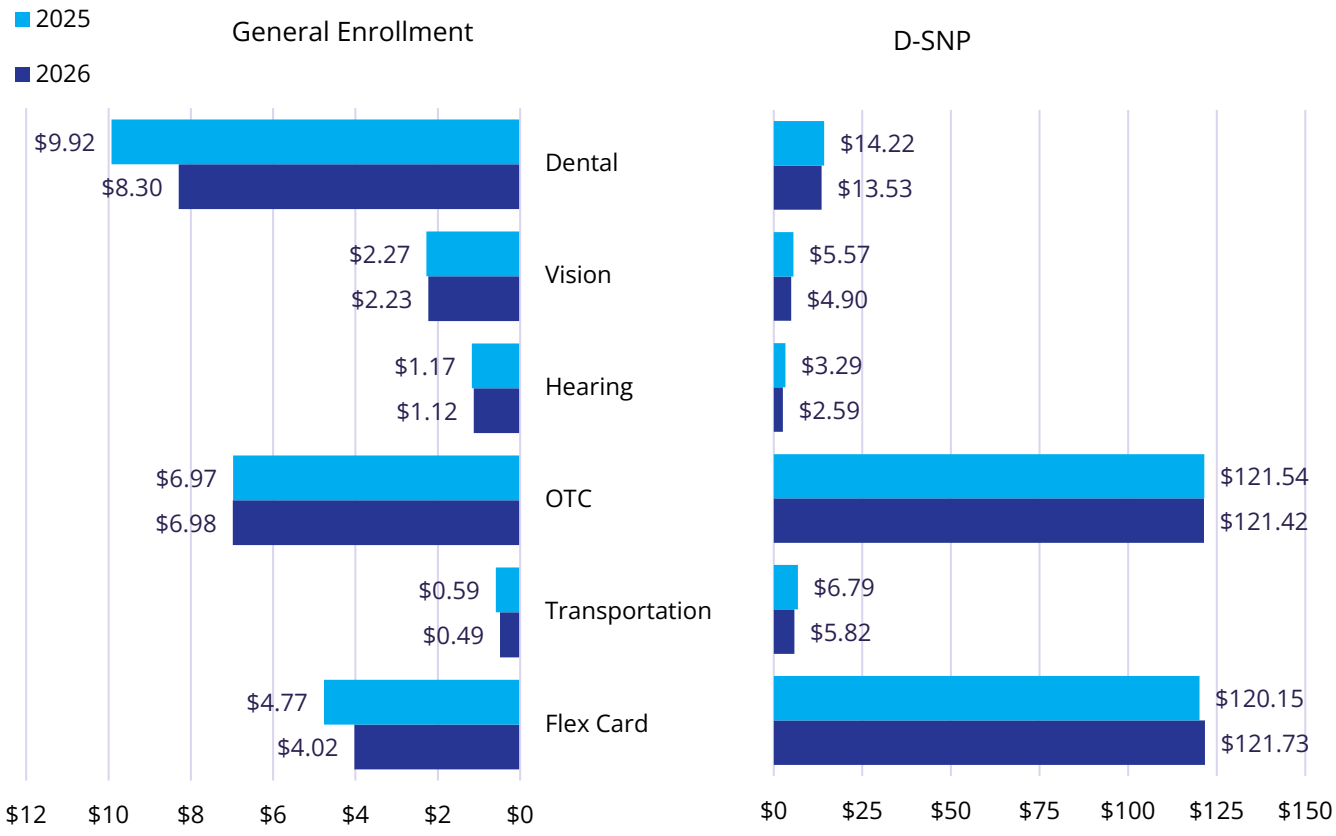
Plans have grown more creative in how they offer supplemental benefits over the years. **Figure 7** shows the percentage of enrollment in plans with several common supplemental benefits in 2025 and 2026, separated by general enrollment plans and D-SNPs. **Figure 8** (next page) depicts the change in supplemental value-add between 2025 and 2026.

Figure 7. Percent of Enrollment in Common Supplemental Benefits



Between 2025 and 2026, the percentage of members with access to common supplemental benefits has, on average, stayed consistent or slightly decreased among the general enrollment population. The percentage of members who are enrolled in plans that offer over the counter (OTC) drug coverage, transportation, and Flex Card benefits has decreased by 11%, 6%, and 4%, respectively. Conversely, the D-SNP population saw in increase in member access to a supplemental benefit categories except transportation (an 8% decrease). Notably, almost all D-SNP beneficiaries have OTC as a supplemental benefit.

Figure 8. Supplemental Value-Add by Plan Type

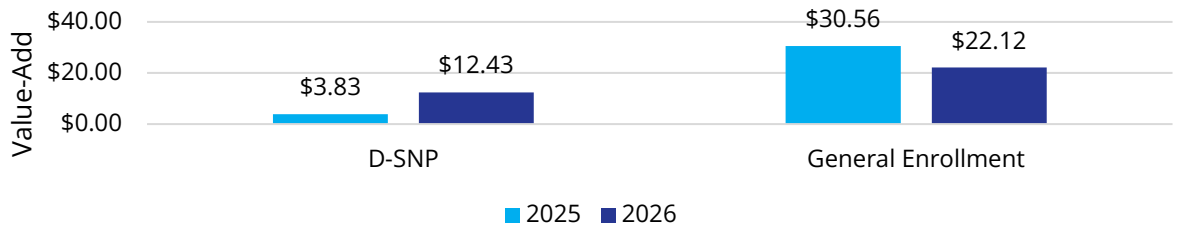


Notably, general enrollment plans maintained their OTC benefits and reduced Dental and Flex Card benefits. D-SNPs on average maintained supplemental benefit levels from 2025 to 2026. For the purposes of **Figure 8**, Flex Cards that allow funds to be used on OTC benefits are shown in both the OTC and Flex Card data points.

PART D

Part D continues to evolve rapidly as plans navigate the dual impact of the Inflation Reduction Act (IRA) reforms and the sunset of the Value-Based Insurance Design (VBID) model. The IRA's restructuring of the Part D benefit has reshaped plan economics, and **Figure 9** highlights how these policy shifts are reflected in overall Part D value-add across plan types.

Figure 9. Part D Value-Add by Plan Type.



The increase in Part D value-add for D-SNPs is potentially tied to the subset of plans that participated in the VBID model. Through VBID, plans were able to lower cost sharing for low-income members, driving additional value that is now rolling off with the program's end. Alternatively, this increase could be driven by enhancements to the benefit structure in response to the increase in the direct subsidy payment from CMS to plans. A follow-up paper will take a deeper look at specific plan design adjustments in response to the VBID sunset.

In contrast, general enrollment plans reduced Part D benefits by roughly 28% on average, reflecting the broader pressure of IRA-driven benefit redesign and more rigid revenue environments.

CONCLUSION

The 2026 MA landscape is undergoing meaningful recalibration. Tightening revenue, evolving federal policies, and varying strategic priorities across general enrollment and D-SNP plans are driving broad reductions in benefit richness. Early enrollment results suggest that these design changes are influencing member behavior, reinforcing that affordability and value tradeoffs are now central to plan strategy.

Key 2026 Market Dynamics

- **Overall contraction in benefit richness** driven by revenue pressure and policy changes.
- **Divergent strategies across segments:**
    - General enrollment plans: Notable declines across nearly all WMACAT value-add components
    - D-SNP plans: Comparatively stable value-add, with several large parent organizations *enhancing* benefits for 2026
- **Part D enhancements in D-SNPs** could be linked to both the sunset of the VBID model and increased direct subsidy.

Looking ahead, organizations will need to navigate sustained revenue constraints, the ongoing rollout of IRA reforms, the planned 2027 regulatory change, and the operational and financial effects of VBID's sunset. Achieving the right balance between affordability, benefit relevance, and financial sustainability will be central to competitive positioning in the 2027 and 2028 bid cycles.

Wakely will continue to monitor these emerging trends and provide deeper analysis, including a forthcoming paper focused specifically on plan responses to the VBID sunset and other structural pressures that are influencing Part D and supplemental benefit strategies.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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APPENDIX

Change in Plan Value-Add by State for 2025 to 2026, General Enrollment Plans

State	% Change	$ Change	Rank[7]
VT	21.3%	$27.03	1.00
AR	-4.0%	-$7.36	2.00
TX	-6.0%	-$11.91	3.00
AZ	-6.0%	-$12.26	4.00
SC	-6.3%	-$11.57	5.00
TN	-6.4%	-$11.88	6.00
NM	-6.6%	-$11.49	7.00
GA	-6.8%	-$11.87	8.00
CA	-6.9%	-$15.63	9.00
FL	-7.3%	-$18.88	10.00
WV	-7.4%	-$13.10	11.00
MT	-7.7%	-$10.24	12.00
NV	-8.1%	-$18.84	13.00
MS	-8.1%	-$13.07	14.00
NC	-8.1%	-$14.99	15.00
MI	-8.1%	-$13.07	16.00
IL	-8.2%	-$15.62	17.00

[7] Rank is based on % change, not $ change.

State	% Change	$ Change	Rank[7]
IN	-8.3%	-$15.44	18.00
KS	-9.2%	-$17.11	19.00
OK	-9.5%	-$17.44	20.00
WA	-9.6%	-$14.45	21.00
NJ	-9.7%	-$14.97	22.00
AL	-10.0%	-$17.46	23.00
LA	-10.1%	-$19.83	24.00
CO	-10.4%	-$19.22	25.00
MO	-11.1%	-$21.97	26.00
VA	-11.4%	-$21.13	27.00
PA	-12.1%	-$19.98	28.00
KY	-12.2%	-$23.91	29.00
DE	-13.4%	-$23.33	30.00
OH	-14.4%	-$27.45	31.00
NE	-14.4%	-$23.78	32.00
IA	-14.5%	-$25.22	33.00
NH	-16.0%	-$23.18	34.00
UT	-16.7%	-$29.42	35.00
WI	-18.8%	-$30.97	36.00
MD	-19.0%	-$23.75	37.00

State	% Change	$ Change	Rank[7]
OR	-20.5%	-$29.87	38.00
CT	-23.7%	-$35.20	39.00
ND	-24.9%	-$31.00	40.00
DC	-25.5%	-$38.60	41.00
RI	-26.1%	-$45.09	42.00
MA	-26.4%	-$39.47	43.00
HI	-28.6%	-$36.49	44.00
NY	-29.7%	-$37.26	45.00
ME	-30.7%	-$52.53	46.00
SD	-38.4%	-$52.04	47.00
MN	-39.9%	-$45.37	48.00
ID	-41.9%	-$73.51	49.00
WY	-58.8%	-$90.39	50.00

PUBLIC SUBMISSION

As of: 3/25/26, 9:46 AM
Received: March 24, 2026
Status: Draft
Category: Individual
Tracking No. mn4-xvfm-vyuw
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0039
Comment on CMS-2026-0529-0001

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General Comment

CMS and ASTP/ONC need to allow FHIR as a HIPAA adopted standard for administrative and financial data exchange so that CDA and X12 can be phased out as part of the United States' competitiveness with EHDS. This will be important for MLR reporting, as well as Part C and Part D reporting.

PUBLIC SUBMISSION

As of: 3/25/26, 9:44 AM
Received: March 24, 2026
Status: Draft
Category: Individual
Tracking No. mn4-y1k0-2xxl
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0040
Comment on CMS-2026-0529-0001

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General Comment

Updated comment:

HHS and OIG need to allow FHIR as a HIPAA adopted standard for administrative and financial data exchange so that CDA and X12 can be phased out as part of the United States' competitiveness with EHDS.

PUBLIC SUBMISSION

As of: 3/26/26, 11:26 AM
Received: March 25, 2026
Status: Draft
Category: Individual
Tracking No. mn6-xmtm-gcug
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0041
Comment on CMS-2026-0529-0001

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General Comment

FHIR and interoperability training has been siloed at the corporate enterprise level (corporate vendors, corporate informatics professionals, corporate IT) but not disseminated to the frontlines (all staff especially at regional health systems, local health systems, value-added resellers) and even the front desk (including intake personnel, referral coordinators, verification specialists, etc.)
The IT staff at the regional health systems, local health system level, and value-added resellers need training on interoperability, health data standards (such as FHIR).
The staff responsible for registration, scheduling, verification of coverage, referrals, and care coordination at all levels of the organization must understand the capabilities of interoperability and data exchange and where this fits within their workflow.

Such training will be helpful to align to MLR reporting and MLR interoperability improvement activities.

PUBLIC SUBMISSION

As of: 3/27/26, 10:39 AM
Received: March 26, 2026
Status: Draft
Category: Individual
Tracking No. mn8-03ao-q1ww
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0042
Comment on CMS-2026-0529-0001

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General Comment

CMS should consider the verifiable legal entity infrastructure such as GLEIF/vLEI, which would help with the verification and proofing of delegated entities, downstream entities, related entities, care delivery organization, and affiliated providers to elevate the consistency of organizational relationships and program participation for MLR reporting.

The adoption of GLEIF/vLEI would be very useful for:
• Entity ambiguity
• Vertical integration
• Payment flows
• Delegated operations

PUBLIC SUBMISSION

As of: 3/27/26, 10:40 AM
Received: March 26, 2026
Status: Draft
Category: Individual
Tracking No. mn8-axjh-3k0f
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0043
Comment on CMS-2026-0529-0001

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General Comment

The delegated and downstream entities exchanging electronic PDFs, electronic faxes, spreadsheets, CSVs, image files are not interoperable, especially when the corporate parent organizations are claiming standards-based interoperability.

The hidden subcontracting layer of first tier, downstream, and related entities (FDRs) shall not be allowed to remain analog while the parent organizations claim digital interoperable compliance.

PUBLIC SUBMISSION

As of: 3/31/26, 3:10 PM
Received: March 28, 2026
Status: Draft
Category: Individual
Tracking No. mna-ph85-jr1v
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0044
Comment on CMS-2026-0529-0001

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General Comment

There is a dichotomy of software vendors creating the latest AI agents when the same vendors are using CSV exchange and CSV exports for terminology services.
Organizations are doing terminology exchange and terminology exports using CSVs and spreadsheets instead of standards-based APIs (such as FHIR APIs), which affects semantic interoperability of terminology services for MLR reporting of MA and PDP plans.
Terminology services is needed to normalize and map information and data across systems using standards-based APIs.

PUBLIC SUBMISSION

As of: 3/31/26, 3:10 PM
Received: March 30, 2026
Status: Draft
Category: Individual
Tracking No. mnd-pwer-v6yc
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0045
Comment on CMS-2026-0529-0001

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General Comment

MLR quality improvement activities need to include electronic exchange (such as FHIR APIs) of TPAs, delegated entities, MA plans, PDPs to allied health providers, post-acute care providers, and community based organizational partners, as well as the FDRs within post-acute care, allied health and CBOs.

Care coordination will not be optimal if post acute, allied health, and CBOs are left out of the picture.

PUBLIC SUBMISSION

As of: 4/1/26, 8:31 AM
Received: March 31, 2026
Status: Draft
Category: Individual
Tracking No. mnf-1wc3-mmjl
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0046
Comment on CMS-2026-0529-0001

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General Comment

Federal interoperability policy will continue to fragment when one agency promotes FHIR APIs and the other still clings to CDA and X12.
Healthcare should not claim AI readiness when attachment and document workflows are still dependent on PDFs, X12, and CDA.

PUBLIC SUBMISSION

As of: 4/16/26, 9:30 AM
Received: April 08, 2026
Status: Draft
Category: Individual
Tracking No. mnq-89uh-g4wn
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0048
Comment on CMS-2026-0529-0001

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General Comment

IIS barriers exist with:
• Authorized query users
• Can the patient be discovered
• Does the state or territory allow out of state provider access
• Can a delegated/downstream entity touch immunizations data
• Can immunizations data be used for managed care operations and quality reporting

First tier, downstream, and related entities (FDRs aka delegated entities) need to prove that immunizations occurred, especially if done across state lines.

Interstate immunization query and improved vaccine normalization would be useful for care continuity for MA and MA part D beneficiaries (even those with MA PDP plans) who move across state lines. This is also applicable for pharmacy, and care management.
Immunization interoperability across all US states and territories needs to be treated as a quality infrastructure issue to be applicable for MLR reporting.

The US will need to consider NUVA as an immunizations standard in place of solely CVX for improved semantic interoperability of immunization and vaccine data (including the MA population).

PUBLIC SUBMISSION

As of: 4/16/26, 9:32 AM
Received: April 08, 2026
Status: Draft
Category: Individual
Tracking No. mnq-hdpb-0xmv
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0049
Comment on CMS-2026-0529-0001

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General Comment

CMS, with the help of the ONC and NLM, needs to accelerate chronic disease HCCs towards:
• Genomics HCCs (Monarch Initiative's HPO)
• Mendelian HCCs (John Hopkins' OMIM)
• Rare Disease HCCs (Inserm's Orphanet/Orphacodes)

To move MLR reporting and risk adjustment reporting into the future.

PUBLIC SUBMISSION

As of: 4/16/26, 9:33 AM
Received: April 08, 2026
Status: Draft
Category: Individual
Tracking No. mnq-hxdy-3dr7
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0050
Comment on CMS-2026-0529-0001

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General Comment

FHIR terminology services for
• Genomics HCCs (Monarch Initiative's HPO)
• Mendelian HCCs (John Hopkins' OMIM)
• Rare Disease HCCs (Inserm's Orphanet/Orphacodes)

In addition to SNOMED CT, LOINC, rxnorm, will ameliorate the accuracy and granularity of MLR reporting, risk adjustment reporting and better care coordination. In addition, the AI will be more informed of the patients' genomics profile for greater precision medicine.

PUBLIC SUBMISSION

As of: 4/16/26, 9:34 AM
Received: April 10, 2026
Status: Draft
Category: Individual
Tracking No. mnt-aiow-823m
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0051
Comment on CMS-2026-0529-0001

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General Comment

CAQH and Stanford Medicine released an issue brief entitled “Payer and Provider Contracting: Why a Critical Process Is Stuck in the Past.”
The issue brief stressed the following points of “developing computable contracts could offer a pathway to improved efficiency for health payers and providers across the health care system and “to align contracting with downstream systems and reducing the time spent reconciling contract terms with operational process” (p. 7).

The US needs to scale computable contracts (referred to as "structured data contracts") for MLR reporting to not only include payers, providers, Medicare Advantage organizations, but also the delegated entities: first tier, downstream, and related entities.

Reference:

https://www.caqh.org/hubfs/Industry%20Research/CAQH_Stanford_Contracting%20Issue%20Brief_March%202026.pdf

Attachments

CAQH_Stanford_Contracting Issue Brief_March 2026

ISSUE BRIEF

Payer and Provider Contracting: Why a Critical Process is Stuck in the Past

An Industry Insights Brief from CAQH and Stanford Medicine

Brooke Shearon, MPP; Brooke Istvan, MBA; Kristine Burnaska, PhD; Erin Weber, MS; Kevin A. Schulman, MD

Contracting between payers and providers quietly shapes how care is financed, how networks are built, and how organizations work together to move healthcare forward.[1] By defining the services providers deliver and how payers reimburse them, contracting ensures patients can access the care they need.[2] Yet new findings from the 2025 CAQH Index[3] show that this critical process is still stuck in the past, relying on various manual methods. Drawing on the industry's most comprehensive view of administrative transactions and contracting practices, CAQH collaborated with Stanford Medicine to understand why contracting has lagged behind other technological advancements and what payers, providers, consultants, and policymakers can do to drive modernization.

The 2025 CAQH Index[4] reveals a contracting environment that remains manual, fragmented, and out of step with the industry's shift toward more connected, data-driven systems.[5] As other administrative workflows modernize[6], contracting continues to rely on manual tools and individualized practices that create inconsistency across the industry that drives up costs for all.

These inconsistencies reflect differences in organizational capacity, resources, and priorities, which shape how teams approach contracting and influence an organization's willingness to change its processes. On the provider side, larger practices often approach contracting with more tools and support, while smaller practices face constraints that limit their ability to change. Payers and providers also prioritize different outcomes, making it harder to move toward shared processes or standardized formats.

This Insights Brief examines why current variation exists in contracting and possible opportunities for improvement. By addressing fragmented payment

arrangements, standardizing contracts, and simplifying payment processes, the industry can begin reducing the billing and insurance-related burden consuming a substantial share of United States healthcare spending without wholesale reform of coverage.[7,8,9,10]

Contracting Is Still Document Driven, Not Data Driven

Contracting across payers and providers continues to rely on manual, document-based workflows that have changed little over time.

Exhibit 1: Tools Currently Used in Payer/Provider Contracting Strategies, Medical and Dental, 2025 CAQH Index

Response Option	Medical Payers (n=9)	Dental Payers (n=3)	Medical Providers (n=324)	Dental Providers (n=219)
Contract Management Software (e.g., Conga, Icertis, DocuSign CLM)	44.4%	N/A	15.4%	25.1%
Manual Spreadsheets (e.g., Excel, Google Sheets)	66.7%	100%	28.1%	26.9%
E-signature Platforms (e.g., DocuSign, Adobe Sign)	44.4%	33.3%	46.6%	40.2%
Provider Network Management Systems	78.7%	100%	18.8%	20.1%
CRM or Sales Tools (e.g., Salesforce, HubSpot)	33.3%	66.7%	2.8%	5.0%
Contract Analytics or AI Review Tools (e.g., Kira, ThoughtTrace)	22.2%	N/A	3.4%	5.9%
Payer/Provider Portals or Contract Submission Platforms	44.4%	66.7%	32.7%	32.0%
Homegrown or Custom-Built Contracting Solutions	55.6%	66.7%	4.3%	5.5%
Policy and Regulatory Compliance Tools	22.2%	66.7%	8.3%	11.0%
External vendors	56.5%	100%	14.5%	11.4%
Lawyers	66.7%	100%	7.1%	7.3%
Other (please specify)	N/A	N/A	2.2%	0.5%
We did not use any formal tools	N/A	N/A	13.0%	18.3%
Unsure	11.1%	N/A	17.0%	11.9%

This question was multi-select, and users were instructed to select all that apply. Percentages may add up to more than 100%, as respondents could select more than one response.

N/A = 0 respondents selected this option.

Two-thirds of medical payers and all dental payers report using spreadsheets and lawyers as primary tools for their contracting processes. Providers similarly report use of manual tools, with more than one quarter of medical and dental organizations using spreadsheets for core contracting tasks and more than 30 percent utilizing payer/provider portals.

Reliance on unstructured documents or external relationships makes it challenging to maintain consistent records, understand contract changes over time, or align contract terms with downstream administrative processes. Tools like spreadsheets do not capture reimbursement methodologies or structured regulatory language in ways that support automation, an important factor in reducing operational burden and lowering administrative costs.[11,12]

Digital tools, such as contract execution through e-signature platforms, are being used to perform specific tasks, with over 40 percent of medical payers, medical providers, and dental providers reporting use. However, these systems do not transform the underlying content into structured data. Contracts largely remain as PDFs or static files that cannot be easily analyzed or integrated with claims or provider data systems, leaving contracting disconnected from other administrative workflows.[13,14] Additionally, managing numerous health payer contracts, each with its own platform, format, and timeline, can create a nearly constant stream of administrative work for practices.[15,16]

While more advanced solutions, such as provider network management, contract management software, and contract submission platforms, are available to everyone, they tend to be used by larger organizations with more resources. As shown in Exhibit 2, 42 percent of hospitals and 31 percent of large generalists (practices with 5 or more providers) rely on contract management software compared to 14 percent of small generalists.

Different Stakeholders, Different Pressures: Why Variation Persists

Despite the overarching use of manual tools across the industry, approaches to contracting differ across organizations, shaped by variation in size, staffing, and administrative capacity.

Providers

Larger provider practices tend to approach contracting with more infrastructure behind them. On average, they are about 10 percentage points more likely to involve legal review, adopt digital tools such as e-signature platforms, and maintain contract management software than smaller practices across specialties. Larger practices also show higher willingness to adopt new contracting formats (on average, about 14 percentage points more than smaller practices), suggesting that scale and available resources may influence how organizations evaluate potential changes.

Smaller practices operate under different conditions. With fewer administrative resources, they often rely more heavily on external vendor support and portals to manage contracting tasks than larger practices (on average, about 3 percentage points more). These constraints also affect how they view modernization. Findings show that smaller practices report lower willingness to change their contracting format, particularly if a new approach would introduce additional burden for their teams.

Exhibit 2: Tools Currently Used in Payer/Provider Contracting Strategies by Medical Provider Specialty and Size, 2025 CAQH Index

Response Option	Generalists (n=100)		Specialists (n=99)		Behavioralists (n=113)		Hospitals (n=12)
Number of Physicians in Practice	<5 (n=71)	5+ (n=29)	<5 (n=74)	5+ (n=25)	<5 (n=97)	5+ (n=16)	
Contract Management Software (e.g., Conga, Icertis, DocuSign CLM)	14.1%	31%	13.5%	20%	9.3%	12.5%	41.7%
Manual Spreadsheets (e.g., Excel, Google Sheets)	22.5%	31%	28.4%	44%	18.6%	68.8%	41.7%
E-signature Platforms (e.g., DocuSign, Adobe Sign)	49.3%	58.6%	44.6%	48%	38.1%	62.5%	58.3%
Provider Network Management Systems	18.3%	17.2%	21.2%	24%	16.5%	31.3%	N/A
CRM or Sales Tools (e.g., Salesforce, HubSpot)	1.4%	3.4%	4.1%	8%	N/A	6.3%	8.3%
Contract Analytics or AI Review Tools (e.g., Kira, ThoughtTrace)	1.4%	10.3%	2.7%	8%	N/A	12.5%	8.3%
Payer/Provider Portals or Contract Submission Platforms	35.2%	31%	37.8%	32%	28.9%	43.8%	8.3%
Homegrown or Custom-Built Contracting Solutions	N/A	10.3%	5.4%	8%	1%	18.8%	8.3%
Policy and Regulatory Compliance Tools	5.6%	13.8%	9.5%	12%	3.1%	25%	16.7%
External vendors	16.9%	13.8%	14.9%	12%	15.5%	12.5%	N/A
Lawyers	7%	13.8%	1.4%	16%	5.2%	12.5%	16.7%
Other (please specify)	1.4%	N/A	4.1%	4%	2.1%	N/A	N/A
We did not use any formal tools	14.1%	N/A	14.9%	N/A	19.6%	N/A	16.7%
Unsure	22.5%	27.6%	16.2%	16%	12.4%	6.3 %	16.7%

This question was multi-select, and users were instructed to select all that apply. Percentages may add up to more than 100%, as respondents could select more than one response.

N/A = 0 respondents selected this option.

These patterns align with national research indicating that administrative burden falls disproportionately on smaller practices, who often face higher relative administrative costs and have fewer resources to dedicate to modernization efforts.[17,18,19] These dynamics make it harder to adopt new systems or participate in standardization efforts. They also contribute to the economic pressures pushing physicians into employed arrangements.[20]

Exhibit 3: Willingness to Change Payer/Provider Contracting Format, by Medical Provider Specialty and Size, 2025 CAQH Index

Response Option	Generalists (n=100)		Specialists (n=99)		Behavioralists (n=113)		Hospitals (n=12)
Number of Physicians in Practice	<5 (n=71)	5+ (n=29)	<5 (n=74)	5+ (n=25)	<5 (n=97)	5+ (n=16)	
5 – High, our contract structure is burdensome	26.8% (19)	37.9% (11)	27% (20)	40% (10)	14.4% (14)	31.3% (5)	33.3% (4)
4							
3	38.0% (27)	31.0% (9)	47.3% (35)	40% (10)	49.4% (48)	62.5% (10)	33.3% (4)
2							
1 – Low, we will not change even with positive return-on-investment (ROI)	35.2% (25)	31.0% (9)	25.7% (19)	20% (5)	36.1% (35)	6.3% (1)	33.3% (4)

In addition to size, contracting priorities vary by specialty. As shown in Exhibit 4, while hospital-based respondents and generalists cited value-based care or alternative payment models as key influences on their contracting strategies, other specialties placed greater emphasis on quality improvement and outcomes-based care. Additionally, generalists and specialties ranked cost containment and financial performance higher than behavioralists and hospitalists. However, behavioralists and hospitalists were more likely to express interest in changing their organizational or contracting structure, which may indicate that some specialties focus on improving financial performance within existing contracts while others are more inclined to pursue broader structural changes.

What this means for providers: Smaller practices need modernization options that reduce net workload, not add new steps. Larger organizations can use contract management tools to model terms and downstream impacts, but they still depend on payers to simplify reimbursement structures and align contract language with systems.

Exhibit 4: Factors Influencing Payer/Provider Contracting Strategies by Medical Provider Specialty and Size, 2025 CAQH Index

Response Option	Average Rank of Generalists (n=100)		Average Rank of Specialists (n=99)		Average Rank of Behavioralists (n=113)		Average Rank of Hospitals (n=12)
Number of Physicians in Practice	<5 (n=71)	5+ (n=29)	<5 (n=74)	5+ (n=25)	<5 (n=97)	5+ (n=16)	
Cost containment and financial performance	1.92	1.83	1.72	1.75	1.88	2	2.17
Network adequacy and access requirements	2.05	2.33	1.95	2	2.36	2	2.25
Quality improvement and outcomes-based care	1.92	1.38	2	1.4	1.71	1.86	2.13
Regulatory and compliance requirements	2.05	2.38	2	2	1.96	2	1
Value-based care or alternative payment model alignment	1.84	2	1.94	2.5	2.11	2	1
Market competitiveness and differentiation	2.09	2.75	2.38	1.67	1.82	2.13	1.75
Provider/payer relationship management and collaboration	2.19	1.58	1.74	2.25	2.05	1.33	2.2
Member/patient satisfaction and experience	2	1.9	2.27	2.38	1.91	2.6	2.5
Data-driven insights and performance analytics	2.2	2	2	2	2.33	1.67	2
Other (please specify)	1.8	N/A	N/A	2.33	1.83	N/A	N/A
I am unsure of my organization's payer/provider contracting strategy.	1.27	1	1.50	1	1.25	1	1

Due to the small sample size, payer data cannot be reported for this table.

Users were instructed to rank their top 3 factors, with "1" being their organization's top priority.

N/A = 0 respondents selected this option

Payers

Payers approach contracting through a different operational lens, influenced by the scale and complexity of their systems. Most medical and dental payers involve their legal teams throughout the contracting process. More than half of medical payers emphasize maintaining alignment between contracting and operational functions such as claims, payments, and provider data. This reflects the scale and complexity of payer operations but may not align directly with smaller provider needs.[21]

Payers recognize a clear connection between contracting complexity and administrative performance. More than half of medical payers (56 percent) and one third of dental payers said they would change their contracting format to improve operational efficiency. This highlights a clear opportunity to simplify workflows and reduce administrative burden. Payers are also motivated to pursue contracting changes if those investments lead to better negotiated terms or reimbursement rates (one third of medical and dental payers).

By contrast, medical and dental providers were primarily concerned with reducing the burden on their contract negotiation (46 percent and 53 percent, respectively) and showed substantially less interest in negotiated terms (3 percent of medical providers and 2 percent of dental providers). Overall, these findings suggest that payers view contracting as a strategic lever to improve both administrative efficiency and financial performance, rather than solely as a transactional process.

Exhibit 5: Biggest Incentive to Change Contracting Format, Medical and Dental, 2025 CAQH Index

Response Option	Medical Payers* (n=9)	Dental Payers (n=3)	Medical Providers (n=324)	Dental Providers (n=219)
Less burden on our contract negotiations team	11.1% (1)	N/A	46.3% (150)	53.4% (117)
Better negotiated terms or reimbursement rates	33.3% (3)	33.3% (1)	2.5% (8)	1.8% (4)
Opportunity for improved efficiency of back-end processes (e.g., claims, payments, provider data)	55.6% (5)	33.3% (1)	6.2% (20)	3.2% (7)
Improved compliance with regulatory or accreditation requirements	11.1% (1)	N/A	4.3% (14)	2.3% (5)
Faster contract turnaround time	11.1% (1)	33.3% (1)	3.1% (10)	2.3% (5)
Enhanced visibility and tracking across contract lifecycle	11.1% (1)	N/A	8.0% (26)	6.8% (15)
Greater alignment with value-based care models or alternative payment	N/A	N/A	10.8% (35)	11.9% (26)
Other (please specify)	N/A	N/A	1.5% (5)	1.8% (4)
Unsure	22.2% (2)	N/A	17.3% (56)	15.5% (34)

* Due to plans mistakenly erroneously responding to more than one response option, the total percentage exceeds 100.

N/A = 0 respondents selected this option

What this means for payers: Plans recognize the link between contract complexity and administrative performance. The next step is to design contracts as structured, computable data that can flow through claims, provider data, and payment integrity systems, not just as PDFs that legal teams file away.

Where Contracting Must Go Next, and How to Start

The findings point to a clear opportunity: contracting can become more consistent, predictable, and easier to navigate. Through stakeholder collaboration and element standardization, the industry can align and address underlying sources of variation and ultimately reduce administrative burden. Industry workgroups can help define technical guidance to facilitate the use of structured data and workflows. Greater consistency in areas like reimbursement methods, renewal terms, and data-sharing expectations would create a more uniform foundation to work from.[22] Developing computable contracts could offer a pathway to improved efficiency for health payers and providers across the healthcare system.[23]

To ensure that improvements are effective, it will be essential to support smaller practices. These organizations often face a disproportionate administrative load on already burdened staff, and tools that simplify documents or offer ready-made templates could help modernize the contracting process, making it more feasible. Larger organizations may also benefit from clearer structures, making it easier to align contracting with downstream systems and reducing the time spent reconciling contract terms with operational processes.[24]

For consultants and government agencies, these findings point to a need for end-to-end contracting transformation, not only better rate negotiations. While negotiated outcomes are driven by market dynamics, investments in contracting capabilities can support greater standardization, improved data quality, and more efficient contracting processes. For regulators in particular, standardizing core contracting elements such as reimbursement methodologies, renewal terms, and data sharing expectations can help advance policy goals related to network adequacy, payment integrity, and provider directory accuracy.

Driving meaningful change requires stakeholders to prioritize modernization efforts, invest in tools and processes that reduce administrative complexity, and collaborate to create a more consistent, data-driven contracting environment. Stronger alignment between payers and providers can reduce administrative steps, increase predictability, and clarify expectations across organizations, regardless of size or stakeholder. By understanding the costs tied to manual processes, organizations can prioritize changes with meaningful impact and become better positioned to support the industry's shift toward more connected and data-driven systems.[25,26]

Endnotes

1 Payor Contracting for Health Care 101 | AMA.
2 Medical Practice Payer Contracting Glossary | MGMA.
3 The CAQH Index Report | CAQH.
4 Ibid.
5 Application Programming Interfaces (APIs) and Relevant Standards and Implementation Guides (IGs) | CMS.
6 The CAQH Index Report | CAQH.
7 Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence | PMC.
8 High U.S. Health Care Spending: Where Is It All Going? | The Commonwealth Fund.
9 Reducing administrative costs in US health care: Assessing single payer and its alternatives | PMC.
10 Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System | JAMA.
11 Understanding Healthcare Contract Compliance: What You Need to Know | Sirion.
12 The Hidden Costs of Spreadsheets in Physician Contract Management | NTRACTS.
13 Payer Contract Management: A Complete Guide for Healthcare Practices | SolumHealth.
14 Understanding the Revenue Cycle in Healthcare: Payer Contracts | Aroris.
15 The Hidden Causes of Inaccurate Provider Directories | CAQH.
16 2024 AMA Prior Authorization Physician Survey | AMA.
17 Administrative Burden in Primary Care: Causes and Potential Solutions | The Commonwealth Fund.
18 Reducing regulatory burden – a major opportunity for new administration | AMA.
19 Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs | ONC Health IT.
20 PAI-Avalere Report on Physician Employment Trends and Acquisitions of Medical Practices: 2019-2023 | Physicians Advocacy Institute.
21 Navigating the Challenges of Narrowing Provider Networks | VGM & Associates.
22 CAQH Operating Rules | CAQH.
23 Addressing Health Care's Administrative Cost Crisis | JAMA.
24 The Real ROI of Modernizing Contract Management in Healthcare | symplr.
25 The CAQH Index Report | CAQH.
26 Active steps to reduce administrative spending associated with financial transactions in US health care | PubMed.

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PUBLIC SUBMISSION

As of: 4/16/26, 9:35 AM
Received: April 10, 2026
Status: Draft
Category: Individual
Tracking No. mnt-aqum-pzuc
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0052
Comment on CMS-2026-0529-0001

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General Comment

First tier, downstream, and related entities need to expose computable contract data via FHIR APIs and FHIR representations of contract terms.
Interoperable, computable contracting needs to become a regulatory requirement for MLR reporting.

PUBLIC SUBMISSION

As of: 4/16/26, 9:35 AM
Received: April 10, 2026
Status: Draft
Category: Individual
Tracking No. mnt-e0rd-2l0v
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0053
Comment on CMS-2026-0529-0001

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General Comment

Payers, providers, delegated entities (first tier, downstream, and related entities), need to move to structured computable contracts at scale.
CMS needs to consider the transformation of manual based contracts to computable contracts using standards-based APIs as part of MLR interoperability improvement activities.

PUBLIC SUBMISSION

As of: 4/16/26, 9:36 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-7hak-0n7c
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0054
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

Updated comment below:

Administrative workflows involving manual processing of PDFs, electronic PDFs, faxes, electronic faxes, JPEGs, TIFF files, PNG files, scanned records, CSVs, and spreadsheets should not qualify as Quality Improvement Activities when standards-based exchange mechanisms exist.

Front desk staff and administrative staff at delegated entities have also spent too much time on the manual processing of CSVs and spreadsheets, since they have not been trained on standards based exchange alternatives.

PUBLIC SUBMISSION

As of: 4/16/26, 9:37 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-7szt-ayx1
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0055
Comment on CMS-2026-0529-0001

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General Comment

Administrative and clinical staff at delegated entities are still using CSVs and spreadsheets for utilization management, quality reporting, risk adjustment reporting, care coordination, and credentialing. Such administrative workflows using manual based exchange (including the exchange of CSVs and spreadsheets) should not quality as MLR Quality Improvement Activities when standards-based mechanisms exist (when applicable FHIR IGs exist).

PUBLIC SUBMISSION

As of: 4/16/26, 9:38 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-8k2z-t2is
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0056
Comment on CMS-2026-0529-0001

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General Comment

MLR reporting needs to evolve into continuous, real-time reporting.
If the MLR APIs are slow, that will be a problem in terms of speed, latency, and usability.
The future of MLR reporting can include FHIR APIs to track data provenance.
MLR reporting tied to outcomes, such as FHIR terminology services to reduce readmissions and prevent duplicate testing using FHIR APIs and the latest FHIR IGs, should be a future endeavor.
CMS can consider the creation of an MLR reporting interoperability maturity of API certification tiers (with maturity levels).
Basically the lower levels are not using interoperability at scale and the higher levels are using the latest FHIR IGs, FHIR terminology services, semantic infrastructure, genomics, etc.

PUBLIC SUBMISSION

As of: 4/16/26, 9:39 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-8ypo-e2sj
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0057
Comment on CMS-2026-0529-0001

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General Comment

MLR reporting needs further decomposition of MLR spending:
• Care Coordination
• Credentialing
• Pharmacy management
• Quality reporting
• Risk adjustment
• Utilization management
Delegated operations for MLR reporting definitely need a further decomposition of MLR spending, including delegated:
• Care Coordination
• Credentialing
• Pharmacy management
• Quality reporting
• Risk adjustment
• Utilization management

CMS needs better transparency on where the financial and operational spend is flowing.
CMS needs to understand what the delegated entities are doing and how the functions are flowing both financially and operationally.

PUBLIC SUBMISSION

As of: 4/16/26, 9:39 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-9uj9-2ro1
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0058
Comment on CMS-2026-0529-0001

Submitter Information

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General Comment

The MLR spend needs to decompose the medical spending by delegated operational layer.
The MLR breakdowns can show:
% of the MLR based on medical spending
% of the MLR based on delegated entities' medical spending
% of the MLR based on incentive (gainshare, surplus) spending
% of the MLR based on delegated entities' incentive (gainshare, surplus) spending

PUBLIC SUBMISSION

As of: 4/16/26, 9:40 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-fam9-3d50
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0059
Comment on CMS-2026-0529-0001

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General Comment

CMS needs to incorporate interoperability criteria into value based care (VBC) payment arrangements with delegated entities, including the gainshare payment, surplus payment, and shared savings distribution, to elevate wide scale adoption of standards-based exchange and increased data normalization.

PUBLIC SUBMISSION

As of: 4/16/26, 9:41 AM
Received: April 13, 2026
Status: Draft
Category: Individual
Tracking No. mnx-8uu5-u1i9
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0060
Comment on CMS-2026-0529-0001

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General Comment

Clinician and administrative engagement in standards development organizations such as the creation of new value sets, reference sets, standards profiles, implementation guides, technical specifications, ongoing workgroup committee participation, should count as quality improvement activities in MLR reporting. Clinicians are beneficial for the creation of standards development for existing and new use cases in standards development.

PUBLIC SUBMISSION

As of: 4/16/26, 9:43 AM
Received: April 13, 2026
Status: Draft
Category: Individual
Tracking No. mnx-ewqy-qc4o
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0062
Comment on CMS-2026-0529-0001

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General Comment

Interoperability standards needs to reflect real world implementation and work for complex Medicare Advantage populations involved in MLR reporting.
The clinician and administrative contributions to the creation of new value sets, reference sets, standards profiles implementation guides, technical guides, and ongoing, proactive workgroup committee participation to count towards quality improvement activities should align to the improvement of patient outcomes and care delivery.
The functions of utilization management, risk adjustment reporting, quality reporting, care coordination would all benefit from such standards development.
Such implementation needs to be measured and aligned to real world implementation in which the new value sets, reference sets, technical specifications, implementation guides could assist and ameliorate beneficiary overall wellness, health, and outcomes.

PUBLIC SUBMISSION

As of: 4/7/26, 11:59 AM
Received: April 05, 2026
Status: Draft
Category: Health Care Industry - PI015
Tracking No. mnl-x5zc-aqia
Comments Due: April 13, 2026
Submission Type: Web

Docket: CMS-2026-0529
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Comment On: CMS-2026-0529-0001
Medical Loss Ratio (MLR) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP) (CMS-10476)

Document: CMS-2026-0529-DRAFT-0047
Comment on CMS-2026-0529-0001

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General Comment

The MLR framework depends entirely on the accuracy and consistency of what gets reported as incurred claims. But when two clinicians delivering the same service can legitimately assign different procedure codes to that encounter, the denominator becomes permanently unreliable. Variance in code selection is not noise — it is a structural flaw that undermines the very foundation of MLR integrity across all 660 reporting contracts.

I have developed a deterministic procedure coding system that removes selection entirely from the clinician. Every code is derived automatically from data elements already present in the encounter record. No two providers making different choices for the same service. No ambiguity. No auditor discretion required. Each component of every generated code is traceable back to its source without exception.

Applied upstream of MLR reporting, this system would make incurred claims data measurably more comparable across contracts, more resistant to manipulation, and far easier to audit against the 85% threshold CMS enforces.

The system is complete and has been tested. I welcome discussion with CMS on applicability to this reporting framework.

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