

May 5, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-10185 Medicare Part C and D Reporting Requirements

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') revised Medicare Part C and D Reporting Requirements.

As CMS has recognized, these reporting data play a critical role in the agency's ability to conduct effective oversight, monitoring and compliance activities across the Medicare Advantage (MA) program. Robust, sufficiently granular reporting enables CMS to identify outliers, detect emerging patterns and evaluate whether MA Organizations (MAOs) are adhering to program requirements, particularly where beneficiary protections and access to medically necessary care are at stake. The importance of strong MAO reporting has become even more pronounced in light of recent program changes, including CMS' decision in the contract year (CY) 2027 MA final rule to simplify and refocus the Star Ratings measure set by removing certain measures, including removing the appeals and complaints measures. Thus, the AHA strongly supports CMS' continued collection of meaningful MAO reporting data, which are essential to effective oversight and enforcement of MA standards.

Moreover, the financial incentives tied to the Star Ratings play an important role in shaping plan behavior. Removing these measures reduces the direct incentive for MAOs to invest upfront resources in identifying and addressing problems related to coverage decisions, appeals and member complaints before they escalate. As a result, CMS must rely on its direct oversight and enforcement tools, including robust, granular



reporting data, to identify emerging patterns of problematic MAO behavior that may affect access to medically necessary care or undermine beneficiary protections.

The AHA recommends that CMS consider refinements to its MA reporting requirements to strengthen oversight, monitoring and health plan accountability across key areas of plan performance. In particular, CMS should consider modest enhancements to reporting on organization determinations and reconsiderations and grievances (such as additional stratification or standardized categories) that would make the data more actionable for identifying patterns and potential systemic concerns. CMS also should consider whether expanded transparency, including appropriate public reporting, would further support CMS' oversight efforts and help beneficiaries, providers and policymakers better understand MAO practices and performance.

Organization Determinations and Reconsiderations

CMS' reporting on organization determinations and reconsiderations is particularly critical to understanding how MAOs make, implement and revisit coverage decisions. CMS currently collects contract-level data on organization determinations and reconsiderations, including total volumes, requestor type, disposition and reopenings. This section is one of the most important tools available to CMS for understanding how MAOs make coverage decisions and how those decisions change when challenged. Because these data capture both the initial coverage decision and whether that decision is later sustained, modified or reversed through reconsideration and reopening, they give CMS one of its clearest views into whether MAOs are creating inappropriate barriers to medically necessary care.

The AHA encourages CMS to refine this section so the data are more actionable for oversight and enforcement. In particular, we recommend considering modest additional stratification for the agency to better distinguish among key types of decisions and appeals pathways. For example, we recommend that CMS consider whether reporting can better differentiate expedited and standard cases, and better identify the types of services or requests most frequently associated with adverse outcomes and reconsiderations. These refinements would improve CMS' ability to identify patterns that may signal inappropriate barriers to medically necessary care, noncompliance with MA coverage rules or systemic problems in how MAOs process coverage requests.

Grievances

While organization determination and reconsideration data illuminate how coverage decisions are made and appealed, grievance reporting provides a complementary perspective on how beneficiaries experience plan operations more broadly. CMS continues to collect contract-level grievance data, including the total number of grievances, timely notifications, expedited grievances and dismissals. Grievance data can provide an important signal of beneficiary experience and plan performance, particularly when patterns emerge across contracts or over time.

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The AHA recommends that CMS consider strengthening this section by requiring a limited number of standardized grievance categories so grievances can be grouped into meaningful issue types, such as access delays, coverage and authorization problems, provider network issues, customer service concerns or payment-related problems. CMS also should consider whether grievance data can be structured to better support trend analysis and identification of recurring problems within or across contracts. Even modest refinement in this area would materially improve the utility of the data for monitoring and enforcement.

Transparency and Accountability

Beyond CMS' internal use of these reporting data for monitoring, compliance and enforcement, we urge the agency to consider how greater transparency can reinforce accountability across all reporting domains discussed above. CMS' reporting requirements note that certain reported data are published annually in a limited data set. Greater transparency can complement CMS' own oversight efforts and help beneficiaries, providers and policymakers better understand MAO performance.

We thank you for the opportunity to comment. We look forward to continued engagement with CMS on strengthening MA oversight and accountability. Please contact me if you have any questions, or feel free to have a member of your team contact Noah Isserman, AHA's director of health insurance and coverage policy, at nisserman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

PUBLIC SUBMISSION

As of: 3/12/26, 9:00 AM
Received: March 11, 2026
Status: Draft
Category: Individual
Tracking No. mmm-crcl-ld9a
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0001
Comment on CMS-2026-0958-0001

Submitter Information

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General Comment

CMS needs to create the following APIs for Medicare Advantage to be used for Part C and part D reporting

- CMS MA Enrollment and Attribution APIs
- CMS MA Claims and Encounter APIs
- CMS MA Quality Performance APIs
- CMS MA Financial and Payment APIs
- CMS MA Risk Adjustment APIs
- CMS MA Utilization Management APIs
- CMS MA Network Management APIs
- CMS MA Benefit and Plan Design APIs
- CMS MA Appeal and Grievance APIs
- CMS MA Social Determinants APIs
- CMS MA Care Coordination APIs
- CMS MA Patient-Reported Outcomes APIs
- CMS MA Pharmacy APIs
- CMS MA Compliance and Program Integrity APIs
- CMS MA Marketing and Communications APIs
- CMS MA Member Services APIs
- CMS MA Coverage Determination APIs
- CMS Part D Prescription Drug Event (PDE) APIs
- CMS Medication Therapy Management APIs

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.

CMS investments in standards-based exchange infrastructure should enable automated care coordination transfer when a beneficiary changes primary care providers or network.

Manual portal submission of care gaps and risk adjustment documentation by clinical staff 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).

First tier, downstream and related entities (FDR) (i.e. all delegate entities) shall be required to use all of the latest Da Vinci FHIR IGs, including:

- 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

First tier, downstream and related entities (FDR) (i.e. all delegate entities) shall be required to use all of the latest CARIN Alliance FHIR IGs, including:

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

First tier, downstream and related entities (FDR) (i.e. all delegate entities) shall be required to use all of the latest Gravity Project FHIR IGs, including the SDOH Clinical Care FHIR IG.

CMS needs to disallow manual based reporting using PDFs, CSVs, spreadsheets, image files (such as JPEGs and TIFFs) when an API alternative (including FHIR alternative) exists and will reduce both clinical and administrative burden.

For example, 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.

CMS has required APIs for the MA plans, but interoperability gaps persist in delegated entities and secondary coverage workflows (such as the remaining state Medicaid not using live FHIR APIs and latest FHIR IGs).

Incentivizing API adoption through MLR recognized interoperability improvement activities could close this gap.

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.

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: 3/12/26, 9:01 AM
Received: March 11, 2026
Status: Draft
Category: Individual
Tracking No. mmm-ehgv-q889
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0002
Comment on CMS-2026-0958-0001

Submitter Information

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General Comment

CMS needs FHIR terminology services to allow automated reporting for Part C and Part D sponsors. Terminology services will allow the usage of code validation and standardized value sets (such as SNOMED CT, LOINC, rxnorm) to ameliorate the accuracy and interoperability of reported data. CMS needs to promote standards based APIs (such as FHIR APIs) for enrollment, claims, risk adjustment, quality, pharmacy, and other relevant domains for Part C and D reporting.

The National Library of Medicine (NLM) is the terminology authority with terminology stewardship (such as the SNOMED CT, rxnorm, and LOINC).

CMS needs to coordinate with ASTP/ONC, NLM and the recognized coordinating entity for such measure governance for real time reporting across plans and delegated entities.

PUBLIC SUBMISSION

As of: 3/24/26, 11:03 AM
Received: March 14, 2026
Status: Draft
Category: Individual
Tracking No. mmq-mtge-qz9m
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0003
Comment on CMS-2026-0958-0001

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General Comment

CMS needs to modernize Part C and Part D reporting with standards-based APIs (such as FHIR APIs) where the MA organizations, Part D sponsors, delegated entities can extract health data from EHR systems, value added resellers, population health vendors, and other vendors.

CMS needs to modernize Part C and Part D reporting for the dual eligibles population with Medicaid interoperability infrastructure across all 50 states and US territories.

Medicare advantage beneficiaries and beneficiaries with Part D deserve interoperable data with the beneficiaries' consent that is not siloed inside EHRs and value-added resellers so that Part C and Part D reporting can interoperate at scale via a health tech ecosystem.

PUBLIC SUBMISSION

As of: 3/24/26, 11:05 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-la9c-dk83
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0005
Comment on CMS-2026-0958-0001

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General Comment

CMS and ASTP/ONC need to accelerate the adoption of the latest versions of USCDI and USCDI+ to align with Part C and Part D reporting requirements, and encourage the utilization of the latest versions to ensure that data remains interoperable. 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, 11:06 AM
Received: March 21, 2026
Status: Draft
Category: Individual
Tracking No. mn0-m3oh-g6lo
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0006
Comment on CMS-2026-0958-0001

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General Comment

CMS and ASTP/ONC need to accelerate the adoption of the latest versions of USCDI and USCDI+ to align with Part C reporting (including D-SNPs), Part D reporting, and managed Medicaid care reporting requirements and contract requirements, and encourage the utilization of the latest versions to ensure that data remains interoperable. This would increase nationwide interoperability across states, territories, payers, PDPs, PBMs, and delegated entities to use the latest versions of USCDI and USCDI+ at scale.

PUBLIC SUBMISSION

As of: 3/24/26, 11:08 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-m3s1-921r
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0008
Comment on CMS-2026-0958-0001

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General Comment

CMS needs to require that delegated urgent care providers utilize ASTP/ONC certified FHIR API connectivity to MA plans to elevate the accuracy of Part C and D reporting.

Urgent care chains utilize a mix of vendors: proprietary, franchise and health system EHRs.

Standardized interoperability will reduce administrative burden for plans and providers.

PUBLIC SUBMISSION

As of: 3/24/26, 11:10 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-zwoe-dqvj
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0011
Comment on CMS-2026-0958-0001

Submitter Information

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General Comment

CMS needs to establish the condition that all first tier, downstream, and related entities (i.e. 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.

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-add³** 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 enrollment⁴ 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

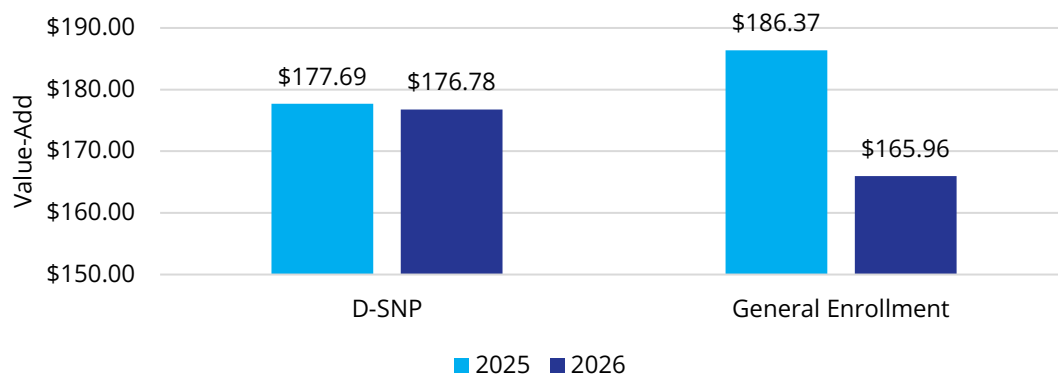
Why It Matters

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

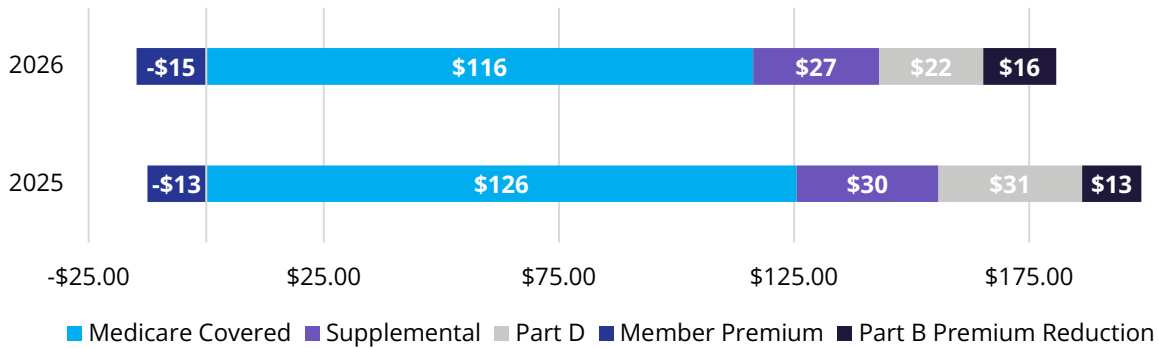
Using the WMACAT value-add metric, we summarized the average plan value-add for 2025 and 2026 for all MA-PD D-SNPs and General Enrollment plans in **Figure 1**. On average, both D-SNP and General Enrollment plan types experienced a reduction in plan value-add by 0.5% and 11.0%, respectively.

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

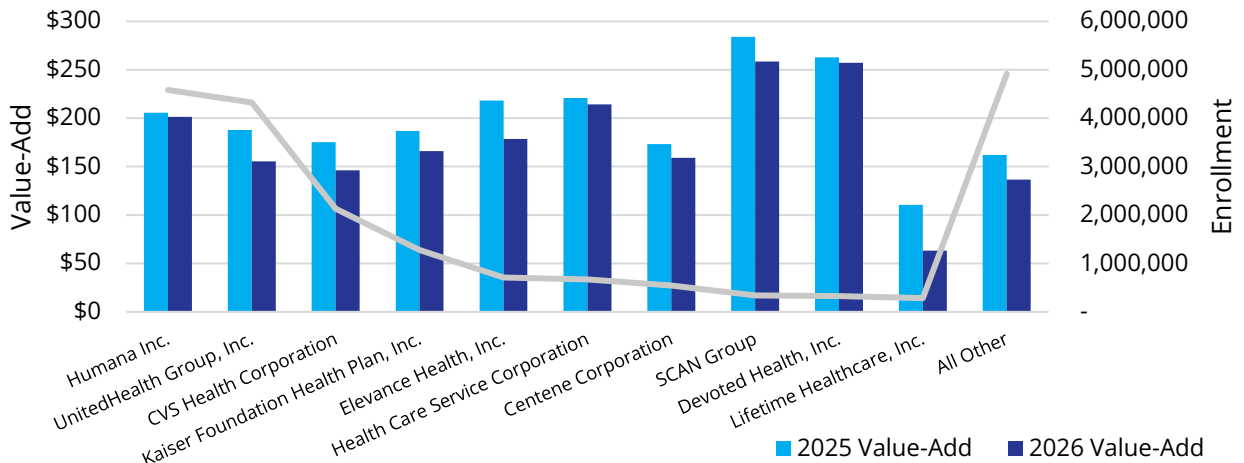
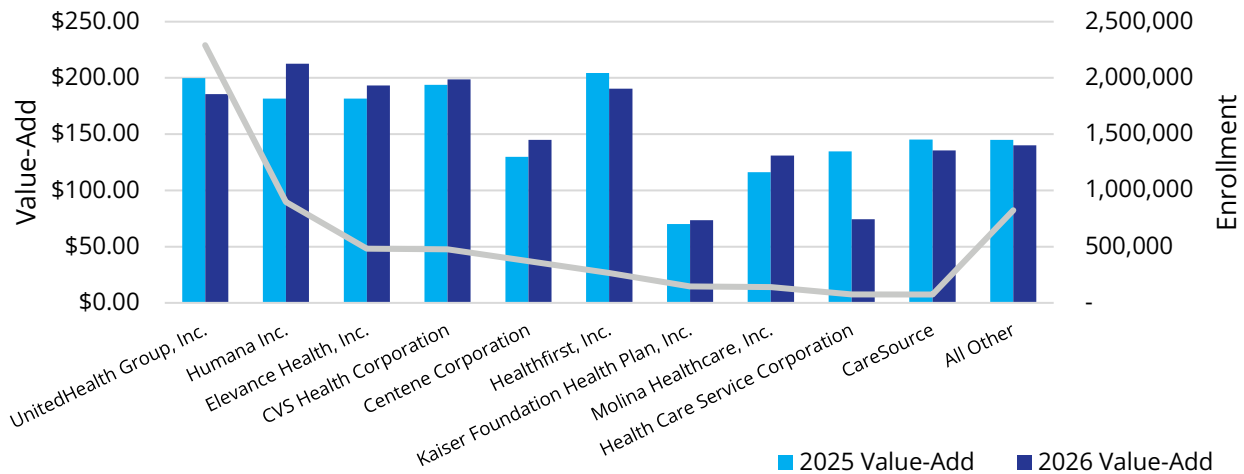


Figure 4. Value-Add Changes, Top 10 Parent Organizations, D-SNP



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

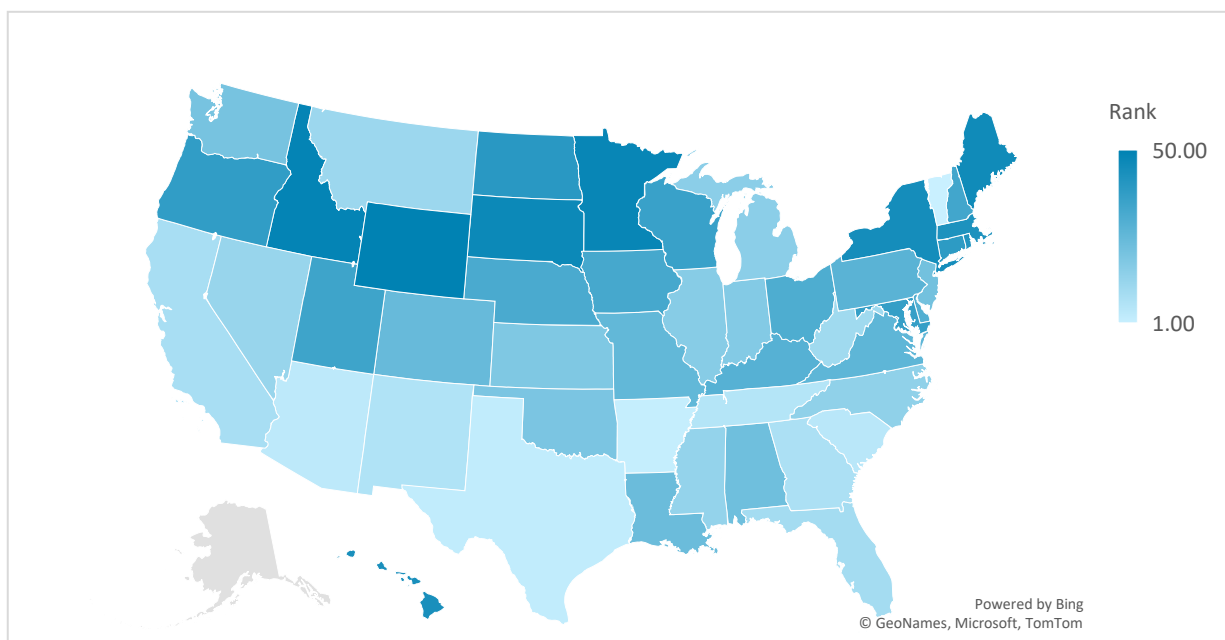
Figure 5 (next page) presents the enrollment-weighted value-add by state for the general enrollment population. To develop this view, we first calculated each state’s value-add change from 2025 to 2026. We then ranked states from those experiencing the least reduction (or greatest enhancement) to those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

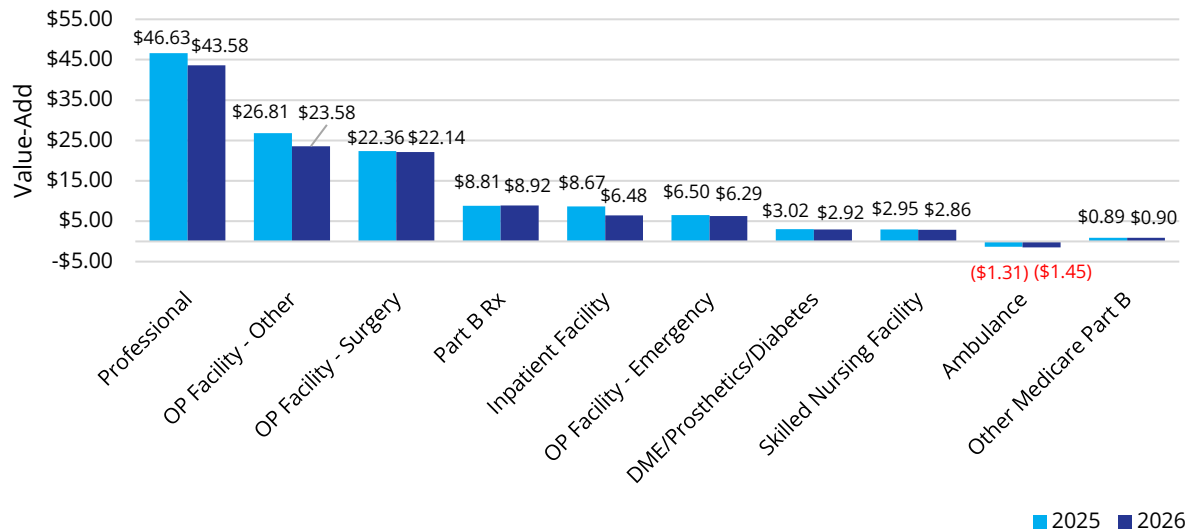


Wyoming, Idaho, and Minnesota reduced benefits in general enrollment plans to the greatest extent from 2025 to 2026. Conversely, Arkansas, Texas, and Arizona reduced benefits the least from 2025 to 2026. Vermont is the only state to indicate an increase in benefit enhancement, on average, between 2025 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



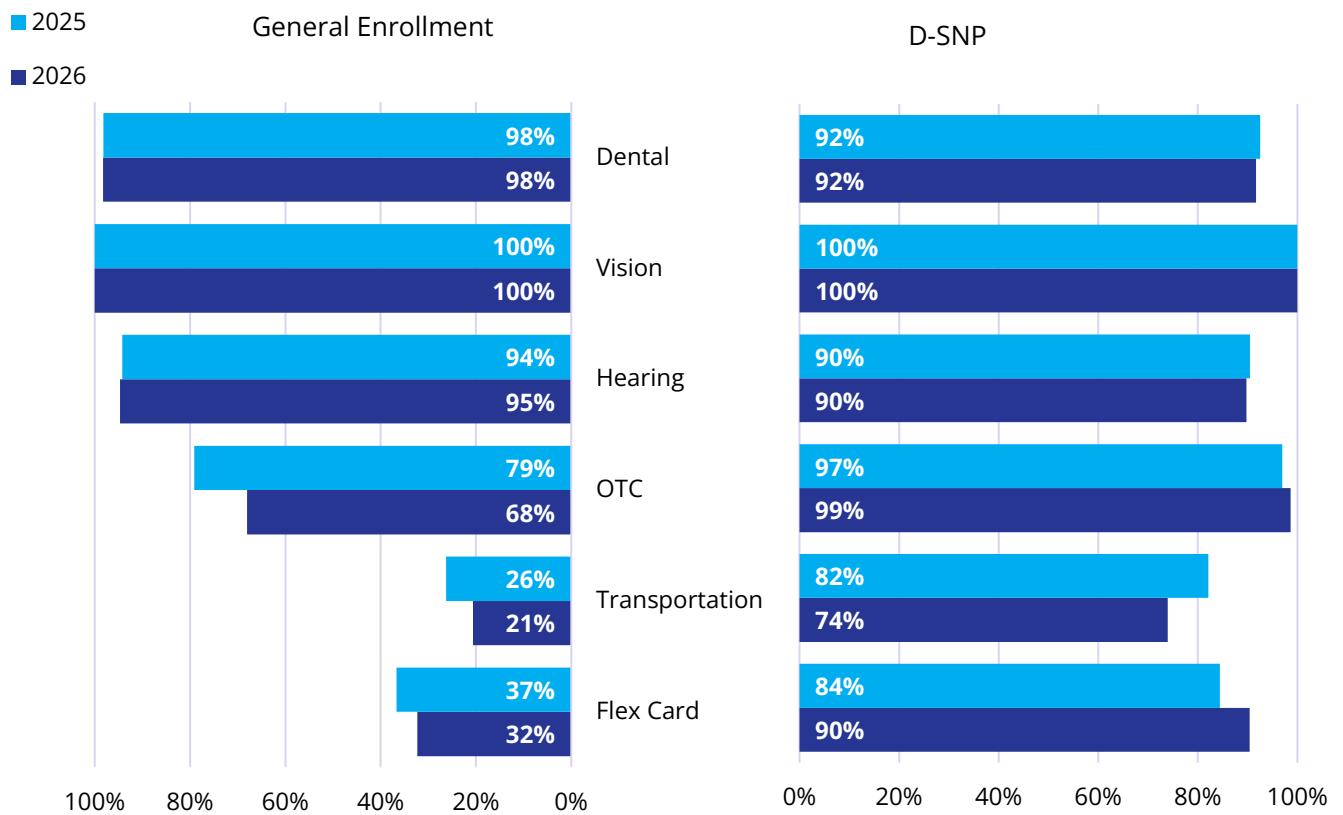
Across all service categories, the Part C Medicare-covered value-add decreased from \$125.28 in 2025 to \$116.14 in 2026, indicating a 7% reduction in benefit richness. This decrease is primarily driven by Professional and Outpatient (OP) Facility – Other services. Note that the value-add metrics reflect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

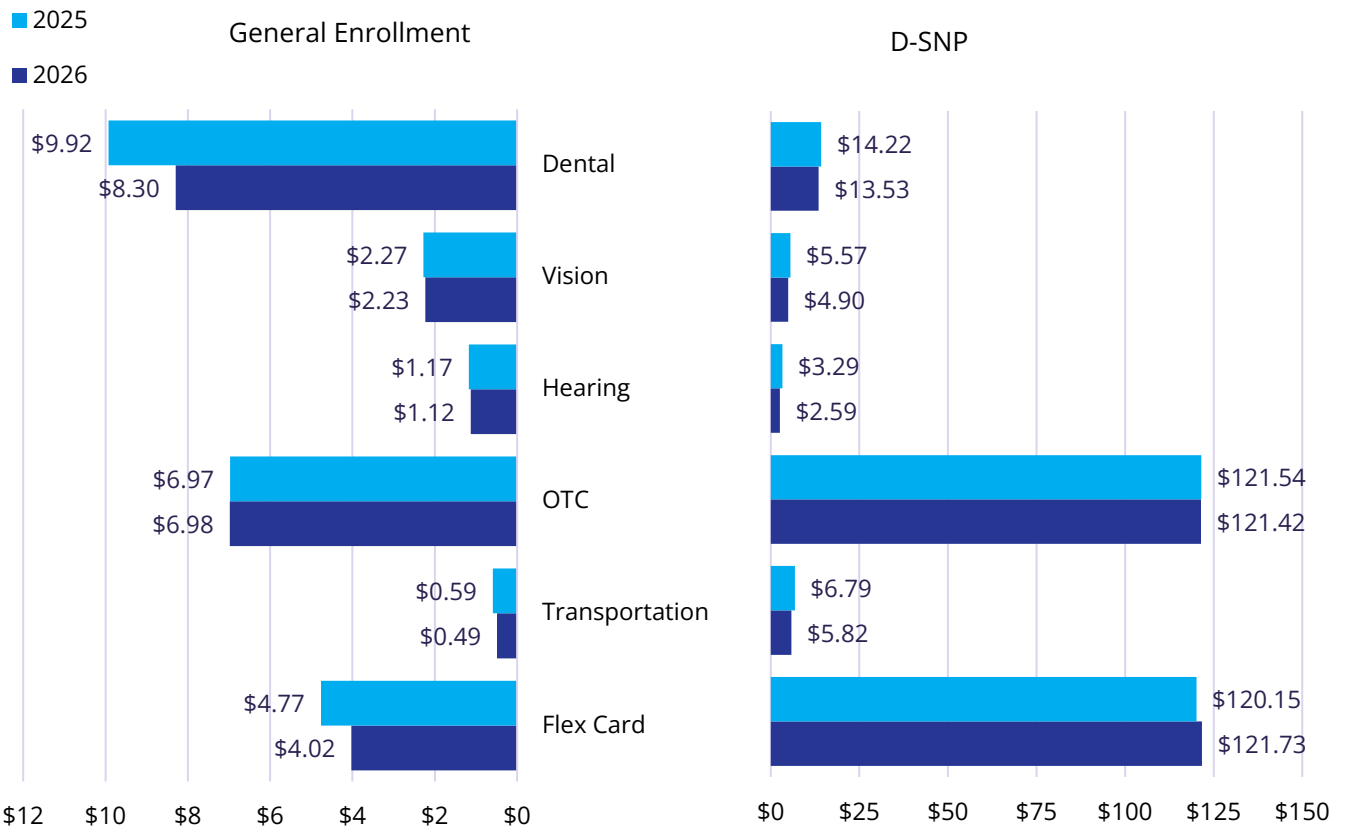
Plans have grown more creative in how they offer supplemental benefits over the years. **Figure 7** shows the percentage of enrollment in plans with several common supplemental benefits in 2025 and 2026, separated by general enrollment plans and D-SNPs. **Figure 8** (next page) depicts the change in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

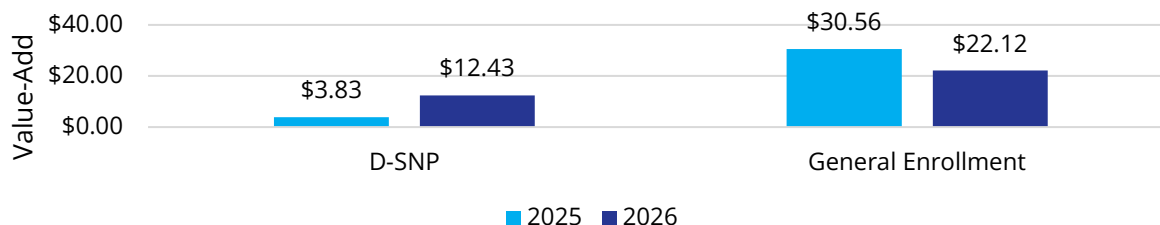


Notably, general enrollment plans maintained their OTC benefits and reduced Dental and Flex Card benefits. D-SNPs on average maintained supplemental benefit levels from 2025 to 2026. For the purposes of **Figure 8**, Flex Cards that allow funds to be used on OTC benefits are shown in both the OTC and 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: 3/24/26, 11:11 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn4-2wbs-thfs
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0012
Comment on CMS-2026-0958-0001

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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:
 $18,339,325 / 28,591,241 = \text{approx. } 64\%$
 $6,034,053 / 18,339,325 = \text{approx. } 33\%$
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

PUBLIC SUBMISSION

As of: 3/24/26, 11:12 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-mdze-gwo0
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0009
Comment on CMS-2026-0958-0001

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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, 11:13 AM
Received: March 23, 2026
Status: Draft
Category: Individual
Tracking No. mn3-upyg-38ty
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0010
Comment on CMS-2026-0958-0001

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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: 3/25/26, 9:39 AM
Received: March 24, 2026
Status: Draft
Category: Individual
Tracking No. mn4-xw9z-3pqn
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0013
Comment on CMS-2026-0958-0001

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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 helpful for Part C and Part reporting.

PUBLIC SUBMISSION

As of: 3/26/26, 11:26 AM
Received: March 25, 2026
Status: Draft
Category: Individual
Tracking No. mn6-xok0-ke6o
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0014
Comment on CMS-2026-0958-0001

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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, pharmacy techs, 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 for further effectiveness of Part C and Part D reporting.

PUBLIC SUBMISSION

As of: 3/27/26, 10:39 AM
Received: March 26, 2026
Status: Draft
Category: Individual
Tracking No. mn7-zojq-z8th
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0015
Comment on CMS-2026-0958-0001

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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, care delivery organization, and affiliated providers to elevate the consistency of organizational relationships and program participation for Part C and Part D reporting

PUBLIC SUBMISSION

As of: 3/27/26, 10:41 AM
Received: March 26, 2026
Status: Draft
Category: Individual
Tracking No. mn8-az7p-xlhi
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0016
Comment on CMS-2026-0958-0001

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General Comment

First tier, downstream, and related entities (i.e. delegated 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, 3:11 PM
Received: March 28, 2026
Status: Draft
Category: Individual
Tracking No. mna-phx2-4n1o
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0017
Comment on CMS-2026-0958-0001

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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 Part C and Part D reporting. Terminology services is needed to normalize and map information and data across systems using standards-based APIs.

PUBLIC SUBMISSION

As of: 4/1/26, 8:31 AM
Received: March 31, 2026
Status: Draft
Category: Individual
Tracking No. mnf-h6lv-kk0v
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0018
Comment on CMS-2026-0958-0001

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General Comment

State Medicaid interoperability remains fragmented for financial management workflows. The states, US territories, delegated entities (first tier, downstream and related entities aka FDRs) will need to use the following FHIR resources for financial management:

- Claim
- ClaimResponse
- Contract
- CoverageEligibilityRequest
- CoverageEligibilityResponse
- EnrollmentRequest
- EnrollmentResponse
- ExplanationOfBenefit
- Invoice
- PaymentNotice
- PaymentReconciliation

Dual eligible beneficiaries who enroll in Medicare Advantage Dual SNPs will need a seamless digital experience with respect to interoperability using FHIR APIs.

PUBLIC SUBMISSION

As of: 4/16/26, 10:43 AM
Received: April 09, 2026
Status: Draft
Category: Individual
Tracking No. mns-38km-jn2k
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0020
Comment on CMS-2026-0958-0001

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General Comment

The contracted implementation vendors for MA and Part D, such as value-added resellers (VARs) and downstream implementation vendors, need to support FHIR APIs and FHIR terminology services for interoperable Part C and D reporting.

PUBLIC SUBMISSION

As of: 4/16/26, 10:44 AM
Received: April 10, 2026
Status: Draft
Category: Individual
Tracking No. mnt-b0pz-0v11
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0021
Comment on CMS-2026-0958-0001

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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 Part C and D reporting.

PUBLIC SUBMISSION

As of: 4/16/26, 10:44 AM
Received: April 10, 2026
Status: Draft
Category: Individual
Tracking No. mnt-e3ga-7wmm
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0022
Comment on CMS-2026-0958-0001

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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 Part C and D reporting.

PUBLIC SUBMISSION

As of: 4/16/26, 10:45 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-a659-1frf
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0023
Comment on CMS-2026-0958-0001

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General Comment

Part C and D reporting need to ameliorate visibility into the delegated entities' functions of delegated:

- Care coordination
- Quality reporting
- Risk adjustment reporting
- Pharmacy management
- Utilization Management

CMS needs to elevate delegated entities' functional transparency of such delegated operations.

PUBLIC SUBMISSION

As of: 4/16/26, 10:45 AM
Received: April 12, 2026
Status: Draft
Category: Individual
Tracking No. mnw-fbhg-bgmr
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0024
Comment on CMS-2026-0958-0001

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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, 10:46 AM
Received: April 13, 2026
Status: Draft
Category: Individual
Tracking No. mnx-90gu-covp
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0025
Comment on CMS-2026-0958-0001

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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, and ongoing workgroup committee participation, should count as quality improvement activities in Part C and D reporting. Clinicians are beneficial for the creation of standards development for existing and new use cases in standards development.

PUBLIC SUBMISSION

As of: 4/22/26, 8:21 AM
Received: April 21, 2026
Status: Draft
Category: Individual
Tracking No. mo9-2izp-g7if
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0026
Comment on CMS-2026-0958-0001

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General Comment

The CMS health tech ecosystem is moving to FHIR APIs and standards-based exchange. Manual and file-based exchange shall not be sufficient to meet requirements for Part C and D reporting programs.

PUBLIC SUBMISSION

As of: 4/24/26, 2:29 PM
Received: April 24, 2026
Status: Draft
Category: Individual
Tracking No. moc-fetd-k11q
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0027
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS needs to significantly accelerate the move from electronic PDFs, electronic faxes, CSVs and spreadsheets to FHIR APIs and FHIR terminology services for Part C and D reporting.

PUBLIC SUBMISSION

As of: 4/24/26, 2:30 PM
Received: April 24, 2026
Status: Draft
Category: Individual
Tracking No. moc-fka6-89tx
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0028
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS and the ONC need to allow FHIR as a HIPAA adopted standard for financial and administrative data so that electronic PDFs, electronic faxes, CSVs, and spreadsheets can be phased out as part of the United States' competitiveness with EHDS. This will be helpful for Part C and Part reporting.

PUBLIC SUBMISSION

As of: 4/24/26, 2:32 PM
Received: April 24, 2026
Status: Draft
Category: Individual
Tracking No. moc-fr9f-axkr
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0029
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS needs to create disincentives for entities that continue to exchange electronic PDFs, electronic faxes, CSVs, and spreadsheets for Part C and D reporting.

PUBLIC SUBMISSION

As of: 4/28/26, 3:01 PM
Received: April 26, 2026
Status: Draft
Category: Individual
Tracking No. mog-d6lm-o3tt
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0030
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS and the states can create disincentives for continued reliance on flat file reporting (e.g. CSVs, spreadsheets). CMS and the states should create incentives towards FHIR API based exchange, FHIR terminology services and data normalization.

PUBLIC SUBMISSION

As of: 4/28/26, 3:02 PM
Received: April 26, 2026
Status: Draft
Category: Individual
Tracking No. mog-mdp6-42xc
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0031
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS, the ONC, the NLM, states, US territories, delegated and downstream entities, will all need to significantly accelerate the upgrades of interoperability infrastructure for nationwide interoperability at scale, as the US has an opportunity to be a global benchmark.

PUBLIC SUBMISSION

As of: 4/30/26, 7:33 AM
Received: April 29, 2026
Status: Draft
Category: Individual
Tracking No. mok-vo05-as79
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0032
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

Updated comment:

CMS and the ONC need to allow FHIR as a HIPAA adopted standard for financial and administrative data so that electronic PDFs, electronic faxes, CSVs, and spreadsheets can be phased out as part of the United States' competitiveness with EHDS, as this will be helpful for Part C and Part D reporting.

PUBLIC SUBMISSION

As of: 5/7/26, 11:30 AM
Received: May 02, 2026
Status: Draft
Category: Individual
Tracking No. moo-x15d-677x
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0033
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

Interoperability needs to be built into the incentive structures of modern healthcare, including Part C and Part D reporting.

The quintuple aim will not fully be achieved without a sixth aim, which is a computable, interoperable, and accountable national knowledge infrastructure.

PUBLIC SUBMISSION

As of: 5/7/26, 11:31 AM
Received: May 02, 2026
Status: Draft
Category: Individual
Tracking No. moo-xtf0-ozol
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0034
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

The value-based care and economic performance in Medicare Part C and Part D reporting will be based on a computable, interoperable and accountable national knowledge infrastructure that reaches across all delegated, downstream, and related entities.

PUBLIC SUBMISSION

As of: 5/7/26, 11:33 AM
Received: May 02, 2026
Status: Draft
Category: Individual
Tracking No. moo-ywca-jzx8
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0035
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

Interoperability and accountable care need to converge for Medicare Part C and D reporting.
Interoperability and value based care need to converge for Medicare Part C and D reporting.

PUBLIC SUBMISSION

As of: 5/7/26, 11:36 AM
Received: May 05, 2026
Status: Draft
Category: Individual
Tracking No. mot-bagr-46xz
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0037
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS, the NCQA need to significantly accelerate the FHIR IGs for the 4 transition of care quality measures:
Notification of patient admission
Receipt of discharge information
Patient engagement after inpatient discharge
Medication reconciliation post discharge

These 3 quality measures are an increasing burden to clinical and administrative staff:
Notification of patient admission
Receipt of discharge information
Patient engagement after inpatient discharge

The FHIR-ization of these quality measures will reduce clinical and administrative burden for Part C and D reporting and the pressure exerted on them by delegated entities.

The Notification of patient admission measure from delegated entities are still encouraging the communication from hospital staff, ED staff, inpatient practitioner via phone call, email fax.
Although the measure does allow for ADT alerts or shared EMR, the FHIRization of the process will be useful.

The receipt of discharge information measure is pulling documentation of pending tests or documentation of no tests pending, instructions for patient care post discharge, diagnoses at discharge, current med list, procedures or treatment provided, practitioner responsible for patient's care during inpatient stay.

Patient engagement after inpatient discharge measure
Conversation occurred regardless of practitioner type, interactions between patient's caregiver and practitioner, virtual care visits, outpatient visit including office visits and home visits

PUBLIC SUBMISSION

As of: 5/7/26, 11:37 AM
Received: May 06, 2026
Status: Draft
Category: Individual
Tracking No. mou-w4c9-36gq
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0038
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS needs to significantly accelerate the FHIRization of Part C and Part D reporting requirements. The Part C and D reporting requirements need to be available as FHIR IGs so that the reporting requirements are computable, and available in real time reporting to communicate with states, delegated entities, downstream entities, and territories. Part C reporting needs a standardized model incentive contract logic.

Part C and D reporting could become a real time operating system that is reported as computable, executable standards using FHIR APIs for membership, care delivery, provider payment, appeals, supplemental benefits.

The Drug Utilization Review controls need to become real time computable artifacts across payers, states, territories, delegated entities, and downstream entities.

CMS and the states need a Part D compliance layer in real time.

PUBLIC SUBMISSION

As of: 5/7/26, 11:37 AM
Received: May 06, 2026
Status: Draft
Category: Individual
Tracking No. mou-wdsd-iky0
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0039
Comment on CMS-2026-0958-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

Part C and D reporting requirements need to FHIRize into computable operations as an real time event driven managed care operating system model.

Humana Inc.
101 E. Main St.
Louisville, KY 40202
www.humana.com

Humana

May 11, 2026

William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts,
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Agency Information Collection Activities: Revision of a currently approved collection; Title of Information Collection: Medicare Part C and D Reporting Requirements (CMS-10185; OMB Control Number: 0938-0992; Document ID: CMS-2026-0958-0001)

Dear Mr. Parham:

This letter is in response to the Centers for Medicare and Medicaid Services (CMS) agency information collection notice "Medicare Part C and D Reporting Requirements (CMS-10185)" as issued on March 10, 2026.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 7.1 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 3.8 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states.

Feedback and Recommendations

Audit Timing: In certain instances, plans are required to respond to CMS audit requests for information during the initial bid submission period, when data and related assumptions are still being finalized. While it is feasible for plans to compile this information, submitting the data at this point in time increases the potential for duplicative analysis. Delaying audits until *after* plans submit initial bids would streamline and increase efficiency in the reporting process without affecting the integrity of the Medicare program or CMS's oversight efforts.

Outlier Inquiry Timing: In order to develop and compile the data needed to accurately respond to CMS's outlier inquiries, we request that CMS delay distributing outlier inquiries to plans until a later point in the reporting cycle (ideally, no earlier than May). This timeline would provide plans with adequate time to respond using the most accurate information and reduce unnecessary administrative burden by responding at a point in the process when all comparative data has been finalized.

Outlier Review Process for Part D Formularies: CMS currently reviews formularies submitted as part of Part D bids and conducts an outlier review to assess formulary adequacy. While we support CMS's role in this process, the agency's approach can lack transparency and, in some cases, result in limited-notice formulary updates that increase plan and program costs. CMS could improve the effectiveness and efficiency of the outlier review process by making the following changes:

1. Increase transparency of the formulary outlier review process, including providing clear rationale, specificity, and citations when a formulary is flagged or rejected. This would allow plans to more readily and accurately address CMS's concerns; and
2. Provide more flexible opportunities during the annual submission process for Part D plans to update utilization management criteria after initial submission. This would enable plans to respond more effectively to CMS feedback and concerns.

If implemented, these changes would result in more clarity on the CMS review process, support better-designed formularies, and help reduce unnecessary costs for the Medicare program and beneficiaries.

Enhanced Validation Error Descriptions: To better assist plans in identifying and correcting errors more efficiently, we urge CMS to provide more descriptive language in validation error messages. For example, when data is not reported for a category that is identified as a covered category in the approved PBP, CMS could respond to the plan using a message such as: "Data not reported for a service category that is indicated as covered in the approved PBP filing." More descriptive messaging would increase operational efficiency for plans while also bolstering program integrity.

Advance Notice of Changes to Reporting Processes: While we understand and support CMS's efforts to maintain a more efficient system through regular changes to reporting processes, system features, or validation rules / criteria, we urge CMS to inform plans of such changes in advance. This advance notice would better support timely reporting and accurate data submissions by giving plans enough time to make necessary updates to internal processes, communicate with vendors, update data, and conduct testing.

Maintain Reporting at the Contract-Plan-Segment Level: To promote consistency and accuracy in data reporting, we recommend that CMS maintain its existing requirements for reporting at the Contract-Plan-Segment (CPS) level rather than transitioning to Plan Benefit Package (PBP)-level reporting. Changes to the current reporting structure would introduce unnecessary operational burden and complexity on plans without any added improvements to the quality of data.

We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to beneficiaries, focused on improving their total health care experience.

If you have any questions, please do not hesitate to reach out to me at mhoak@humana.com and 571-466-6673.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Hoak". The signature is fluid and cursive, with the first name being more prominent.

Michael Hoak
Vice President, Public Policy

PUBLIC SUBMISSION

As of: 5/11/26, 12:19 PM
Received: May 08, 2026
Status: Draft
Category: Health Plan or Association
Tracking No.: mox-81ja-pe4y
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0040
Comment on CMS-2026-0958-0001

Submitter Information

Email: Xiomara.A.Lafaurie@kp.org
Organization: Kaiser Foundation Health Plan

General Comment

In the proposed CY 2027 Part C and D Reporting Requirements, in Section XIV Medicare Prescription Payment Plan (Part D), under new “Subsection 4: Other Information,” CMS is adding Data Element “P” for plans to indicate whether there is data to report for respective Plan IDs (PBPs). Instead of adding a field like this, we would strongly suggest that CMS consider revising the Medicare Prescription Payment Plan reporting level parameters altogether, so that it does not require plans to report the data at the PBP level. In this first year of the reporting, we found that reporting at the PBP level was inefficient as there are often PBPs that had no data to report or very low volumes by PBP. We strongly feel this change would be less burdensome on plans while not reducing the value of the data that CMS is receiving in the spirit of reducing inefficiencies across the industry. CMS will still be able to assess volumes of M3P by contract to learn more about the effectiveness of this program.

PUBLIC SUBMISSION

As of: 5/11/26, 12:21 PM
Received: May 08, 2026
Status: Draft
Category: Health Plan or Association
Tracking No. mox-869c-mmhl
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0041
Comment on CMS-2026-0958-0001

Submitter Information

Email: Xiomara.A.Lafaurie@kp.org
Organization: Kaiser Foundation Health Plan

General Comment

In the Supporting Statement document under the Burden Estimates section, specifically in the table under item 15 “Changes to Burden” CMS is estimating significant reductions in the change in burden hours per reporting section from CY 2026 to CY 2027. CMS advises that these changes are due to adopting a unified approach in how it calculates the burden estimates. While we appreciate CMS recalculating the hours, we want to point out that we do not believe there will be a significant reduction in the level of burden or in the hours it takes to conduct the reporting based on the changes CMS is proposing to the reporting requirements for CY 2027 when compared with CY 2026. Consolidating the separate Part C and D reporting requirements documents into one simplifies the guidance that plans must follow for the reporting, but it does not decrease the time it takes to pull the data, validate it and report it in CMS’ systems. For example, in some areas, like Part C Enrollment and Disenrollment reporting, it will require more effort and time as MA-only contracts will have to report additional data elements for CY 2027 that have been added to these sections. We wanted to acknowledge that health plans will not experience a significant decrease in burden based on the changes being proposed in case this has been lost in the revised burden estimates approach.

PUBLIC SUBMISSION

As of: 5/11/26, 12:23 PM
Received: May 08, 2026
Status: Draft
Category: Health Plan or Association
Tracking No. mox-8jxm-f5wr
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0042
Comment on CMS-2026-0958-0001

Submitter Information

Email: Xiomara.A.Lafaurie@kp.org
Organization: Kaiser Foundation Health Plan

General Comment

Thank you for the opportunity to provide comments on the CY2027 Medicare Part C and D Reporting Requirements. The Annual Part C Supplemental Benefits Reporting team reviewed Revision History section 11. Supplemental Benefit Utilization and Costs reporting section and we have the following comment. In subsection a. Consistent with other reporting sections, contract ID and PBP ID are no longer data elements. Kaiser Permanente is not concerned with contract ID no longer being a data element as we assume CMS will still require the Contracts to be uploaded separately to HPMS. We would like the PBP ID to be retained as a data element as the various PBPs within a contract may have different benefit offerings.

PUBLIC SUBMISSION

As of: 5/11/26, 12:24 PM
Received: May 08, 2026
Status: Draft
Category: Health Plan or Association
Tracking No. mox-8qtz-dyy4
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0043
Comment on CMS-2026-0958-0001

Submitter Information

Email: Xiomara.A.Lafaurie@kp.org
Organization: Kaiser Foundation Health Plan

General Comment

Thank you for the opportunity to provide comments on the CY2027 Medicare Part C and D Reporting Requirements. The Annual Part C Supplemental Benefits Reporting team reviewed Revision History section 11. Supplemental Benefit Utilization and Costs reporting section and we have the following comment. In subsection f. Element L is no longer a free text field, and there is now a specific list of options to pick from. Kaiser Permanente would prefer Element L - The type of payment arrangement(s) the plan used to implement the benefit- remain free form rather than shift to a list of options to pick from, because we believe the choices shared would increase the complexity of reporting and would open a level interpretation.

PUBLIC SUBMISSION

As of: 4/7/26, 11:56 AM
Received: April 05, 2026
Status: Draft
Category: Health Care Industry - PI015
Tracking No. mnl-r9kb-xbzf
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0019
Comment on CMS-2026-0958-0001

Submitter Information

Name: Nakul Karkare
Address:
STONY BROOK, NY, 11790
Email: office@cortho.org
Phone: 6319812663

General Comment

The 88,504 annual hours reported here reflect a burden rooted in a deeper structural problem: procedure coding is physician-subjective. When two MAO providers performing the same service can legitimately submit different codes, the data CMS collects for oversight, Star Ratings, and compliance becomes irreducibly noisy. Monitoring and accountability efforts are working against the ambiguity baked into the source data itself.

I have developed a deterministic procedure code standard that removes physician discretion from code selection entirely. Every code is generated automatically from information already present on the claim. Same service, same documentation, same output — across every provider, every plan, every region. Every element of every code traces directly to its source. Nothing is opaque.

Applied to Part C and D reporting, this would sharpen CMS's ability to detect anomalies, compare across MAOs, and evaluate performance with precision that subjective coding cannot support. It would also reduce the reconciliation burden that currently inflates those 88,504 hours.

The standard is complete, tested, and available at no cost.

Nakul Karkare MD
<https://www.newyorkhipknee.com/>
<https://www.cortho.org>



May 11th, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Re: Medicare Part C and D Reporting Requirements (CMS-10185)

Dear Administrator Oz:

On behalf of the New Hampshire Hospital Association (NHHA), we appreciate the opportunity to comment on the proposed revisions to the Medicare Part C and Part D Reporting Requirements.

Hospitals rely on accurate and timely data to ensure that Medicare beneficiaries receive appropriate, accessible and high-quality care, particularly as these programs continue to grow in enrollment and complexity. As CMS notes, the data collected through these reporting requirements are used for oversight, monitoring, compliance and performance evaluation, including informing Star Ratings and other quality measures. As CMS continues to update the Star Ratings program, it is important that the underlying data provides a clear and complete picture of how plans operate in practice.

More Granular and Actionable Data

We support continuing these reporting requirements but urge CMS to require more specific data. The current approach relies heavily on aggregated information, which makes it difficult to identify patterns of inappropriate denials, delays in care or barriers to medically necessary services. We recommend that CMS require more detailed reporting in certain key areas, including:

- Prior authorization requests, approvals, denials and overturns, broken down by service type, diagnosis and care setting;
- How long plans take to respond to authorization requests and appeals, and whether they meet required timeframes;
- And appeals and grievance outcomes, including how often decisions are reversed.

Today, CMS primarily receives summary metrics, such as the percentage of decisions made within required timeframes. While this shows whether plans meet minimum standards, it does not show how these processes affect patient care. More detailed, case-level data would allow

CMS to see where delays and denials are occurring, identify outliers and better understand the impact on patients and providers.

Alignment with Star Ratings and Performance Measurement

As Star Ratings increasingly influence plan payments and patients' enrollment decisions, it's imperative that the data used to calculate these measures accurately reflect plan performance and beneficiary experience. Without more detailed data, there is a risk that Star Ratings may miss important issues related to access to care. For example, plans may appear to perform well overall while still creating delays or barriers for certain services or patient types.

As CMS continues to place greater emphasis on outcomes and patient experience, reporting requirements should also capture the factors that drive those outcomes. More detailed data on delays, denials and utilization management would help ensure that Star Ratings reflect real-world performance.

Oversight and Transparency

Hospitals frequently experience challenges related to prior authorization, delayed payments and administrative burden associated with MAO and Part D plans. These challenges are often difficult to quantify under current reporting frameworks. More granular data collection would improve CMS's ability to:

- Conduct targeted audits and enforcement actions;
- Identify patterns of concern across plans;
- And promote transparency plan operations while providing clearer information to providers and beneficiaries.

We also encourage CMS to make appropriate information publicly available in a user-friendly format to support transparency and informed decision-making.

Conclusion

We recognize CMS's obligation under the Paperwork Reduction Act to consider reporting burden. However, we believe that the value of more detailed data collection, particularly in a program of this size and significance, outweighs any additional burden on plans.

In summary, we support CMS's proposed revisions and strongly urge the agency to enhance the granularity, transparency and utility of data collected from MAOs and Part D sponsors. Doing so is essential to ensuring effective oversight, particularly as CMS refines Star Ratings and other performance measures that have many implications for patients, providers and the Medicare program.

We appreciate CMS's consideration of these comments and welcome the chance to work alongside the agency to strengthen these programs and improve care for Medicare beneficiaries.

Please contact Christian Ramsey, NHHA's Director of Financial Policy & Reimbursement, at 603-415-4253 or cramsey@nhha.org if you have questions.

Sincerely,

Steve Ahnen

Steve Ahnen

President

New Hampshire Hospital Association

May 11, 2026

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier: CMS-10185/OMB Control Number: 0938-0992
Room C4-26-05
7500 Security Boulevard, Baltimore, Maryland 21244-1850
Submitted electronically: www.regulations.gov

Re: Medicare Part C and D Reporting Requirements (CMS-10185 (OMB 0938-0992))

To Whom It May Concern:

Health Care Service Corporation (HCSC) appreciates the opportunity to provide comments on the revisions to the Medicare Part C and D Reporting Requirements (CMS-10185) published in the Federal Register (91 FR 11553) on March 10, 2026.

HCSC is the largest non-investor-owned health insurer in the United States. HCSC's Medicare business offers a full suite of products for every need, budget, and lifestyle. We serve nearly 4 million Medicare beneficiaries nationwide. This includes offering Medicare Advantage plans in 31 states, Medicare Supplement plans in 48 states and the District of Columbia, and standalone Prescription Drug Plans in 48 states, the District of Columbia, and the U.S. territory of Puerto Rico. At HCSC, we are deeply committed to providing our Medicare Advantage and Part D members with a high-quality care experience.

In the attached, HCSC offers one request for clarification regarding the reporting of supplemental benefit utilization and cost information.

Thank you for considering our comments. We appreciate CMS' continued engagement with the stakeholders on these topics.

Sincerely,



Eva DuGoff
Executive Director - Health Policy

MEDICARE PART C AND D REPORTING REQUIREMENTS

CMS-10185

SUPPLEMENTAL BENEFIT UTILIZATION AND COSTS (PART C)

- Historically, CMS has asked plans on the Supplemental Benefit Utilization and Cost report to report at the Plan Benefit Package (PBP) level. Based on the information provided, it seems plans would only provide data at the PBP Category level. Please confirm if this is correct.

Section (Page #)	CY 2025 Part C or Part D Reporting Requirements	CY 2027 Part C and D Reporting Requirements	Comment/Request for Clarification.
CMS-10185_CY2027 Part C and D Reporting Requirements (Pages 29-30)	Elements A and B: Contract ID and PBP ID	Removed as Data Elements	<ul style="list-style-type: none"> Historically, plans would submit one report per H contract and within each report indicate the PBP and its respective benefits. See Example 1 below. Can CMS confirm that plans should remove PBP from each contract report and only provide data at the PBP Category level? See Example 2 below.

EXAMPLE 1

CONTRACT	PBP	PBP CATEGORY	...	ELIGIBLE MEMBERS
H4513	001	1A1	...	100
H4513	002	1A1	...	200
H4513	003	1A1	...	300

EXAMPLE 2

CONTRACT	PBP CATEGORY	...	ELIGIBLE MEMBERS
H4513	1A1	...	600



MEMORANDUM

To: Hon. Robert F. Kennedy, Jr., Secretary of Health and Human Services
Hon. Mehmet Oz, MD, Administrator, Centers for Medicare and Medicaid Services

From: Andrew Langer, President, Main Street Foundation

Date: May 11, 2026

Re: Comments on the Department of Health and Human Services Information Collection Request, “Medicare Part C and D Reporting Requirements (CMS-10185),” Docket #CMS-2026-0958, Fed. Reg. 2026-04605, Published March 10, 2026

Below are comments of the Main Street Foundation’s Center for Regulatory Analysis and Engagement (CRAE) in response to the Department of Health and Human Services Centers for Medicare and Medicaid Services Information Collection Request, “Medicare Part C and D Reporting Requirements (CMS-10185),” Docket #CMS-2026-0958, Fed. Reg. 2026-04605, published March 10, 2026.

CRAE is a project of the Main Street Foundation, a recently-formed non-profit, non-partisan 501(c)(3) research and education foundation. Our mission is to bring a disciplined, common-sense perspective to the regulatory process, one grounded in real-world experience, sound science, and rigorous economic analysis. We work to ensure that the costs, risks, and benefits of regulatory proposals are evaluated transparently and accurately, and that the voices, interests, and freedoms of Americans, particularly small businesses and working families, are meaningfully represented in regulatory debates. Above all, we focus on outcomes: regulations should address real problems, function effectively in practice, and improve conditions on the ground—not exacerbate the challenges they are intended to solve.

INTRODUCTION

The Center for Regulatory Analysis and Engagement (“CRAE”) appreciates the opportunity to submit these comments regarding the Centers for Medicare & Medicaid Services’ proposed revision and extension of the Medicare Part C and Part D Reporting Requirements information collection. CRAE’s mission is to promote transparent, evidence-based, and economically

realistic regulatory policy that properly balances legitimate oversight objectives with the operational realities facing regulated entities, consumers, and the broader healthcare system. These comments focus primarily on the administrative, economic, and competitive implications of the reporting framework associated with Medicare Advantage and Part D program administration.

CRAE recognizes that reporting requirements play an important role in supporting oversight, program integrity, accountability, and transparency within Medicare Advantage and Medicare Part D programs. CMS possesses a legitimate interest in ensuring that participating organizations comply with applicable statutory and regulatory obligations, maintain beneficiary access to covered services, and operate in a manner consistent with program requirements. Effective healthcare governance depends in part upon the availability of reliable operational information that allows regulators, stakeholders, and policymakers to evaluate program performance and identify areas requiring corrective action or additional administrative attention.

At the same time, reporting obligations impose substantial operational and economic burdens that frequently extend well beyond formal paperwork estimates alone. Regulated entities must devote significant resources to data collection, information management, compliance review, interoperability maintenance, internal auditing, and administrative coordination in order to satisfy increasingly complex federal reporting expectations. These burdens must also be evaluated cumulatively rather than in isolation, particularly within highly regulated healthcare markets already subject to overlapping federal and state compliance obligations, quality-reporting systems, utilization oversight requirements, and extensive administrative documentation mandates.

Escalating reporting complexity may also produce broader structural effects within Medicare Advantage and Part D markets. Large national organizations are often better positioned to absorb rising compliance costs through economies of scale, extensive legal and compliance departments, and sophisticated technological infrastructure. Smaller organizations, regional plans, provider-sponsored entities, and prospective market entrants frequently face comparatively greater operational strain when navigating expanding reporting obligations. Over time, disproportionate administrative burdens may contribute to market consolidation, reduced competition, fewer consumer choices, and diminished incentives for innovation and operational experimentation within healthcare delivery and plan administration.

CRAE therefore encourages CMS to ensure that reporting systems remain carefully calibrated to demonstrable oversight needs and measurable program objectives. Information collection requirements should remain proportionate, administrable, transparent, and operationally realistic rather than evolving into unnecessarily expansive administrative frameworks disconnected from practical regulatory utility. Reporting systems function most effectively when they are narrowly tailored to meaningful oversight goals, minimize duplicative or low-value reporting obligations, and preserve sufficient flexibility for regulated entities to allocate resources toward patient care, service improvement, technological modernization, and long-term program participation.

These comments accordingly recommend that CMS continue refining the reporting framework with greater emphasis on burden calibration, transparency, harmonization, reduction of duplicative reporting obligations, technological modernization, and long-term administrability. CRAE further encourages CMS to evaluate the cumulative economic and operational consequences of reporting expansion, improve interoperability and reporting efficiency, and maintain oversight structures that remain compatible with competitive healthcare markets and

sustainable long-term program administration. Durable oversight depends not merely upon the volume of information collected, but upon whether reporting systems remain practical, economically disciplined, operationally useful, and capable of supporting effective healthcare governance over time.

EXECUTIVE SUMMARY

The Center for Regulatory Analysis and Engagement (“CRAE”) supports CMS’ legitimate oversight responsibilities within the Medicare Advantage and Medicare Part D programs, including the collection of information necessary to promote accountability, transparency, and program integrity. At the same time, reporting obligations must remain proportionate, operationally realistic, economically disciplined, and administratively sustainable. Reporting systems function most effectively when they are carefully aligned with clearly defined oversight objectives, minimize unnecessary administrative friction, and preserve the ability of regulated entities to devote resources toward patient care, innovation, competition, and long-term program participation rather than excessive compliance activity alone.

Our comments make the following points:

- **CMS likely understates the true economic and operational burden associated with the Medicare Part C and Part D reporting framework by focusing primarily on direct paperwork hours while undercounting broader compliance infrastructure, technological integration, audit preparation, legal review, and administrative coordination costs.**
- **Reporting obligations should be evaluated cumulatively rather than in isolation because Medicare Advantage and Part D sponsors already operate within a highly layered regulatory environment involving overlapping federal and state compliance systems, quality-reporting obligations, utilization oversight programs, and documentation requirements.**
- **Excessive reporting complexity may disproportionately burden smaller organizations, regional plans, provider-sponsored entities, and prospective market entrants that lack the economies of scale and compliance infrastructure available to larger national organizations.**
- **Over time, escalating administrative complexity may contribute to market consolidation, reduced competition, diminished consumer choice, and weakened incentives for innovation within healthcare plan administration and service delivery.**
- **Reporting systems should remain tied to clearly defined statutory, operational, and oversight objectives rather than evolving into open-ended data collection frameworks disconnected from measurable regulatory utility or practical administrative value.**
- **CMS should continue identifying and eliminating duplicative, redundant, low-value, or obsolete reporting obligations that no longer materially contribute to meaningful oversight or program administration.**
- **Technological modernization, standardized reporting formats, interoperability improvements, and automated submission systems should be utilized to reduce unnecessary administrative friction and improve long-term reporting efficiency.**
- **CMS should provide greater transparency regarding how collected information is utilized in oversight, enforcement, quality evaluation, and program administration**

in order to improve accountability and ensure that reporting obligations remain appropriately targeted.

- **CMS should periodically reevaluate whether existing reporting categories continue to generate meaningful oversight value and whether evolving market conditions justify modification, consolidation, or elimination of particular reporting requirements.**
- **Oversight systems should prioritize measurable outcomes, operational effectiveness, and meaningful program integrity objectives rather than relying excessively upon procedural reporting volume or expanding administrative formalism.**

CRAE encourages CMS to continue refining the Medicare Part C and Part D reporting framework in a manner that preserves accountability while improving proportionality, transparency, technological practicality, and long-term administrability. Durable Medicare oversight depends not merely upon increasing the quantity of information collected, but upon maintaining reporting systems that remain disciplined, economically realistic, operationally useful, and compatible with competitive healthcare markets. Effective reporting frameworks should strengthen program integrity and beneficiary protection without imposing unnecessary cumulative burdens that may undermine innovation, competition, affordability, or long-term healthcare system sustainability.

I. CMS SHOULD ENSURE THAT REPORTING REQUIREMENTS REMAIN PROPORTIONAL, NECESSARY, AND OPERATIONALLY DISCIPLINED

The Paperwork Reduction Act reflects an important principle of administrative governance: federal information collection requirements should remain necessary, proportionate, and practically useful in relation to clearly defined agency objectives. Reporting obligations inevitably impose economic, operational, and managerial costs upon regulated entities, and those costs should therefore be justified by demonstrable oversight value. Effective reporting systems should provide CMS with meaningful information necessary to support program integrity and administration without creating unnecessary administrative expansion or imposing burdens that exceed the practical utility of the information being collected.

Reporting frameworks function most effectively when they are closely tied to identifiable regulatory, operational, and program-integrity objectives. Agencies possess a legitimate interest in collecting information necessary to evaluate compliance, monitor beneficiary access, assess plan performance, and identify potential risks within Medicare Advantage and Part D programs. However, reporting systems should not evolve into generalized data accumulation exercises disconnected from measurable oversight needs. Information collection obligations should remain carefully targeted toward categories of information that materially contribute to meaningful program administration, accountability, and operational evaluation.

Administrative reporting systems also possess a natural tendency to expand incrementally over time. New reporting categories, documentation requirements, validation procedures, and submission obligations may gradually accumulate as agencies respond to evolving policy priorities, technological developments, enforcement concerns, or isolated compliance failures. While some degree of adaptation may be appropriate, cumulative expansion can eventually produce reporting frameworks that are substantially broader and more administratively burdensome than originally contemplated. Without disciplined limitations and periodic

reassessment, reporting systems risk becoming increasingly complex administrative structures that generate diminishing oversight value relative to their operational costs.

Importantly, reporting obligations do not operate in isolation. Medicare Advantage organizations and Part D sponsors already function within a highly layered regulatory environment involving quality reporting systems, utilization-management oversight, network adequacy requirements, audit programs, risk-adjustment documentation, state-level compliance obligations, and numerous additional federal administrative mandates. Each individual reporting requirement may appear manageable when evaluated independently, yet the cumulative effect of overlapping obligations can create substantial operational strain. PRA analysis should therefore account for the aggregate burden imposed across the broader healthcare regulatory ecosystem rather than evaluating individual reporting requirements in isolation from surrounding compliance structures.

Escalating reporting complexity may also divert organizational resources away from productive healthcare functions. Regulated entities must devote personnel, technological infrastructure, managerial attention, and financial resources toward maintaining compliance with evolving reporting systems. Those resources are necessarily unavailable for alternative purposes such as beneficiary services, network expansion, care coordination, technological innovation, customer support, or operational improvements. Excessive administrative layering may therefore generate indirect costs that extend beyond formal paperwork estimates alone. Overly expansive reporting frameworks risk shifting organizational focus toward procedural compliance activity rather than measurable improvements in healthcare delivery and beneficiary outcomes.

CMS should therefore periodically reassess whether existing reporting categories continue to provide meaningful oversight value relative to their associated administrative costs. Reporting requirements that no longer materially contribute to effective program administration, beneficiary protection, or operational accountability should be revised, consolidated, streamlined, or eliminated where appropriate. Similarly, CMS should evaluate whether evolving technological capabilities, interoperability improvements, or changes in market conditions permit more efficient methods of collecting necessary information. Continuous review and recalibration are essential to ensuring that reporting systems remain targeted, efficient, and administratively sustainable over time.

Ultimately, effective oversight depends not upon continually increasing the quantity of information collected, but upon maintaining reporting systems that remain disciplined, targeted, operationally useful, and economically realistic. Durable administrative frameworks should prioritize high-value oversight objectives while minimizing unnecessary complexity, duplication, and administrative friction. CMS can best promote long-term program integrity and effective healthcare governance by ensuring that reporting obligations remain carefully calibrated to practical regulatory needs rather than allowing reporting systems to expand beyond their useful operational purpose over time.

II. CMS LIKELY UNDERSTATES THE TRUE ECONOMIC AND OPERATIONAL COSTS OF COMPLIANCE

CMS' formal paperwork estimates likely understate the full economic and operational impact associated with the Medicare Part C and Part D reporting framework. While the Paperwork Reduction Act necessarily requires agencies to quantify reporting burdens, narrow estimates

focused primarily upon direct reporting hours often fail to capture the broader compliance ecosystem that regulated entities must maintain in order to satisfy complex and evolving administrative requirements. As a result, official burden calculations may significantly underrepresent the practical costs imposed upon Medicare Advantage organizations and Part D sponsors attempting to maintain continuous reporting compliance across multiple operational and regulatory systems.

Compliance costs extend well beyond the direct preparation and submission of reports. Reporting obligations frequently require organizations to maintain extensive internal administrative infrastructure dedicated to data collection, validation, coordination, monitoring, recordkeeping, and quality assurance activities. Organizations must often establish recurring compliance workflows involving multiple operational departments, external vendors, managerial review structures, and ongoing internal auditing processes. Even relatively routine reporting obligations may therefore require substantial institutional investment in personnel, organizational systems, and operational coordination that is not fully reflected in narrow paperwork-hour calculations or traditional form-completion estimates.

Information technology and interoperability burdens represent particularly significant components of the overall compliance framework. Medicare Advantage organizations and Part D sponsors frequently must integrate reporting systems across multiple technological platforms, maintain compatibility with evolving CMS submission requirements, adapt internal software infrastructure, and ensure the accuracy and consistency of transmitted information. These obligations may require substantial expenditures related to software development, cybersecurity protections, data standardization, interoperability maintenance, vendor contracts, system upgrades, and ongoing technical support. Technological adaptation costs can be especially significant where reporting standards evolve frequently or require continual modifications to existing administrative systems.

Compliance with federal reporting requirements also depends upon extensive professional review and oversight functions. Organizations frequently rely upon compliance personnel, attorneys, auditors, consultants, actuaries, pharmacists, quality-review specialists, and senior administrative staff to evaluate reporting obligations, interpret evolving guidance, verify submission accuracy, and address potential deficiencies identified during audits or oversight reviews. These activities frequently involve highly compensated personnel possessing specialized expertise in healthcare regulation and administrative compliance. Consequently, the true economic burden associated with reporting systems extends substantially beyond simple clerical or administrative labor calculations commonly reflected in formal paperwork estimates.

Reporting obligations may additionally create significant indirect operational costs by redirecting organizational resources and managerial attention away from productive healthcare functions. Time and resources devoted toward maintaining compliance infrastructure are necessarily unavailable for alternative purposes such as improving beneficiary services, expanding provider networks, investing in technological innovation, enhancing care coordination, or developing new healthcare delivery models. Administrative complexity may therefore impose broader opportunity costs that affect organizational efficiency, service quality, and long-term operational flexibility. These indirect effects are difficult to quantify precisely but nonetheless represent meaningful economic consequences associated with increasingly expansive reporting systems.

The relative burden associated with reporting compliance may also fall disproportionately upon smaller plans, regional organizations, and provider-sponsored entities. Large national

organizations are often better positioned to absorb compliance costs through economies of scale, centralized legal departments, sophisticated technological infrastructure, and dedicated administrative personnel. Smaller entities frequently lack comparable institutional resources and may therefore experience substantially higher per-enrollee or per-reporting-unit compliance costs. Excessive administrative complexity may consequently discourage smaller organizations from entering or remaining within Medicare Advantage and Part D markets, thereby reducing competition and limiting beneficiary choice over time.

For these reasons, realistic burden evaluation requires consideration of the broader compliance ecosystem rather than narrow paperwork metrics alone. Effective PRA analysis should account not only for direct reporting hours, but also for the operational infrastructure, technological adaptation, professional review functions, managerial coordination, and opportunity costs necessary to sustain ongoing compliance within highly regulated healthcare markets. A more comprehensive understanding of compliance costs would better enable CMS to calibrate reporting requirements appropriately and develop oversight frameworks that remain economically realistic, operationally sustainable, and compatible with long-term healthcare market stability.

III. REPORTING FRAMEWORKS SHOULD SUPPORT COMPETITION, INNOVATION, AND LONG-TERM MARKET STABILITY

Administrative complexity can materially influence the structure and competitive dynamics of healthcare markets. Reporting systems are not merely technical compliance mechanisms; they also shape the operational environment within which Medicare Advantage organizations and Part D sponsors compete, allocate resources, and make long-term investment decisions. As reporting obligations become more extensive and administratively demanding, compliance infrastructure itself increasingly functions as a barrier to market participation. CMS should therefore consider the broader competitive implications associated with cumulative reporting expansion when evaluating the long-term sustainability and practical effects of existing administrative requirements.

Large national organizations are generally better positioned to absorb escalating reporting and compliance obligations than smaller competitors. Major incumbents often possess extensive legal departments, sophisticated technological infrastructure, centralized compliance operations, and substantial financial resources that permit them to distribute administrative costs across broad enrollee populations and multiple business lines. As a result, additional reporting obligations may impose comparatively modest incremental burdens upon large organizations while creating substantially greater operational strain for smaller entities with more limited institutional capacity. Over time, this imbalance may unintentionally reinforce existing market concentration trends within Medicare Advantage and Part D markets.

Smaller plans, regional organizations, provider-sponsored entities, and prospective market entrants frequently operate with narrower administrative margins and reduced compliance infrastructure. Disproportionate reporting burdens may therefore discourage participation by organizations that otherwise could contribute to market diversity, localized innovation, and expanded beneficiary choice. Administrative complexity may also reduce the ability of smaller entities to devote resources toward care coordination, service improvements, or competitive product development. In some circumstances, cumulative compliance obligations may ultimately

encourage consolidation, acquisition, or market withdrawal as organizations conclude that maintaining regulatory compliance has become operationally or financially unsustainable.

Reduced competition within Medicare Advantage and Part D markets may produce meaningful downstream consequences for beneficiaries and the broader healthcare system. Competitive markets often promote innovation, encourage operational efficiency, improve customer service, and place downward pressure on costs. Conversely, excessive market concentration may reduce incentives for product differentiation, diminish consumer choice, and limit the availability of regionally tailored healthcare offerings. Administrative systems that unintentionally favor large incumbents over smaller or emerging competitors may therefore undermine broader policy objectives related to affordability, accessibility, innovation, and long-term healthcare market resilience.

CMS should accordingly continue developing reporting systems that remain scalable and administrable for organizations of varying size, structure, and operational capacity. Reporting frameworks should seek to preserve meaningful oversight while minimizing unnecessary complexity, duplicative submissions, and disproportionate burdens that fall most heavily upon smaller entities. Technological modernization, standardized reporting formats, interoperability improvements, and carefully targeted reporting categories may help improve administrative efficiency without sacrificing accountability. Scalable reporting systems are particularly important within dynamic healthcare markets that benefit from competition, operational flexibility, and continued participation by a diverse range of organizations.

Finally, durable oversight frameworks should preserve both accountability and competitive market participation. Effective healthcare regulation requires balancing legitimate oversight objectives against the practical economic and operational realities facing regulated entities operating within highly complex healthcare markets. Reporting systems that become unnecessarily burdensome, administratively rigid, or operationally excessive risk undermining competition and discouraging innovation without producing corresponding improvements in oversight effectiveness. CMS can best promote long-term program stability by maintaining reporting structures that remain transparent, proportionate, technologically practical, and compatible with sustainable market participation across organizations of varying scale and structure.

IV. CMS SHOULD CONTINUE MODERNIZING THE REPORTING FRAMEWORK TO IMPROVE EFFICIENCY, CLARITY, AND ADMINISTRABILITY

CMS can further strengthen both oversight quality and administrative efficiency through targeted refinements to the Medicare Part C and Part D reporting framework. Effective reporting systems should provide regulators with meaningful operational information while minimizing unnecessary administrative complexity and compliance friction for regulated entities. Continuous modernization is particularly important within rapidly evolving healthcare markets that rely heavily upon technological integration, data interoperability, and dynamic administrative coordination. Thoughtful refinement of reporting systems can improve accountability and transparency while simultaneously reducing operational burdens and improving long-term administrability across the Medicare Advantage and Part D landscape.

CMS should continue pursuing opportunities to harmonize overlapping reporting obligations across multiple programs, systems, and administrative frameworks. Medicare Advantage

organizations and Part D sponsors frequently must navigate duplicative or partially overlapping reporting expectations associated with quality reporting, utilization oversight, audit preparation, network adequacy monitoring, and other federal compliance systems. Greater coordination among reporting requirements could substantially reduce unnecessary administrative duplication while preserving CMS' ability to obtain meaningful oversight information. Consolidated reporting structures, standardized definitions, and harmonized submission timelines may improve efficiency for both CMS and regulated entities without compromising program integrity or regulatory accountability.

CMS should also provide greater transparency regarding how collected information is utilized within oversight, enforcement, quality evaluation, and program administration activities. Regulated entities are better positioned to prioritize reporting accuracy and allocate compliance resources efficiently when they possess a clearer understanding of how specific reporting categories inform agency decision-making. Increased transparency may additionally help identify reporting categories that provide limited practical oversight value or duplicate information already available through alternative administrative channels. More transparent communication regarding data use could therefore strengthen confidence that reporting obligations remain appropriately targeted, operationally necessary, and meaningfully connected to legitimate oversight objectives.

Technological modernization should remain a central component of CMS' long-term reporting strategy. Expanded use of standardized reporting formats, interoperability tools, automated submission systems, machine-readable data structures, and modernized digital interfaces may substantially reduce administrative friction while improving reporting accuracy and operational efficiency. Healthcare organizations increasingly rely upon integrated technological systems to manage complex compliance obligations, and reporting frameworks should evolve in a manner compatible with contemporary administrative infrastructure. Technological modernization may also improve data consistency, reduce manual processing burdens, facilitate more efficient oversight analysis, and minimize operational disruptions associated with evolving reporting requirements.

CMS should additionally consider implementing greater correction and remediation flexibility for minor reporting inaccuracies, technical errors, or inadvertent submission deficiencies. Highly complex reporting systems inevitably create circumstances in which organizations encounter isolated technical issues, formatting inconsistencies, or inadvertent administrative mistakes despite good-faith compliance efforts. Safe-harbor provisions, correction windows, or remediation opportunities may encourage cooperative compliance while reducing unnecessary enforcement friction associated with immaterial technical deficiencies. Flexible correction mechanisms can improve overall reporting quality by allowing organizations to resolve minor issues efficiently without diverting disproportionate resources toward procedural disputes or repetitive administrative remediation processes.

Oversight systems should likewise prioritize meaningful operational outcomes and measurable program-integrity objectives rather than procedural reporting volume alone. Expanding the quantity of collected information does not necessarily improve oversight effectiveness if reporting categories fail to generate actionable insights or materially contribute to beneficiary protection and program administration. CMS should therefore continue evaluating whether existing reporting obligations produce meaningful regulatory value relative to their associated administrative costs. Outcome-oriented oversight frameworks focused upon operational performance, beneficiary access, service quality, and measurable compliance objectives are more

likely to promote efficient and durable healthcare governance than systems emphasizing administrative volume for its own sake.

In sum, administrable and technologically realistic reporting systems strengthen long-term regulatory durability and improve the sustainability of healthcare oversight frameworks. Reporting systems that remain transparent, interoperable, operationally practical, and appropriately calibrated are more likely to maintain industry participation, support accurate compliance, and preserve confidence in the legitimacy of the broader regulatory framework. CMS can best promote effective long-term oversight by continuing to modernize reporting systems in ways that improve efficiency and clarity while minimizing unnecessary administrative burden, technological fragmentation, and operational complexity across Medicare Advantage and Part D programs.

CONCLUSION

The Center for Regulatory Analysis and Engagement (“CRAE”) appreciates the opportunity to submit these comments regarding CMS’ proposed revision and extension of the Medicare Part C and Part D Reporting Requirements information collection. CMS’ willingness to solicit public input regarding the operational and administrative implications of federal reporting systems represents an important component of transparent and accountable regulatory governance. Ongoing evaluation of reporting frameworks is particularly important within complex healthcare markets where administrative obligations can materially influence organizational operations, technological infrastructure, market participation, and the long-term sustainability of healthcare delivery systems.

CRAE supports appropriate oversight, transparency, and program integrity within Medicare Advantage and Medicare Part D administration. CMS possesses a legitimate interest in obtaining information necessary to evaluate compliance, monitor beneficiary access, assess operational performance, and identify potential risks within federally supported healthcare programs. Carefully designed reporting systems can contribute meaningfully to accountability and effective program administration when they remain clearly connected to identifiable oversight objectives. Durable healthcare governance depends in part upon maintaining reporting structures that generate useful operational information while preserving reasonable administrative and economic balance for regulated entities.

At the same time, reporting systems materially shape how regulated healthcare markets function in practice. Reporting obligations influence organizational resource allocation, technological investment decisions, staffing priorities, compliance infrastructure development, and long-term participation incentives across Medicare Advantage and Part D markets. Administrative systems therefore produce effects extending well beyond simple information collection alone. As reporting obligations become more extensive and operationally complex, compliance infrastructure itself increasingly affects market structure, organizational behavior, and the ability of healthcare entities to devote resources toward innovation, beneficiary services, and operational improvement initiatives.

CRAE remains concerned that excessive administrative layering and cumulative reporting burdens may ultimately undermine competition, efficiency, innovation, and long-term healthcare affordability. Reporting obligations should be evaluated not only individually, but also cumulatively alongside the broader network of federal and state compliance systems already

governing Medicare Advantage and Part D sponsors. Escalating administrative complexity may disproportionately burden smaller organizations, regional plans, and prospective market entrants that lack the institutional scale and compliance infrastructure available to larger incumbents. Over time, these pressures may contribute to consolidation trends that reduce consumer choice and weaken competitive market dynamics.

CRAE therefore encourages CMS to continue prioritizing proportionality, transparency, interoperability, operational realism, and administrative discipline as it modernizes the reporting framework in future years. Greater harmonization of overlapping reporting systems, improved technological integration, clearer communication regarding data use, and periodic reassessment of existing reporting categories may substantially improve long-term efficiency and administrability. Reporting systems function most effectively when they remain targeted toward meaningful oversight objectives while minimizing unnecessary duplication, excessive procedural complexity, and operational burdens that generate limited practical regulatory value.

Ultimately, durable healthcare oversight depends not merely upon expanding reporting volume, but upon maintaining administrative frameworks that are practical, economically realistic, technologically administrable, competitively neutral, and operationally sustainable over time. Effective reporting systems should strengthen accountability and program integrity while preserving competitive healthcare markets, encouraging innovation, and supporting long-term beneficiary access to high-quality healthcare services. CMS can best promote sustainable and effective healthcare governance by ensuring that reporting obligations remain disciplined, targeted, and proportionate to legitimate oversight objectives rather than allowing administrative complexity to expand beyond its useful operational purpose.

Sincerely,

A handwritten signature in black ink that reads "Andrew M. Langer". The signature is written in a cursive, flowing style.

Andrew M. Langer
President
Main Street Foundation

May 11, 2026

VIA ELECTRONIC FILING – <http://www.regulations.gov>

Mr. William N. Parham, III
Director, Division of Information Collections and Regulatory Impacts
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-10185
7500 Security Boulevard
Baltimore, MD 21244

Re: Contract Year 2027 Medicare Part C and D Reporting Requirements

Dear Mr. Parham:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on the Contract Year 2027 Medicare Part C and D Reporting Requirements.

PhRMA represents the country’s leading innovative biopharmaceutical research companies, which are focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat, and cure disease. PhRMA member companies have invested more than \$850 billion in the search for new treatments and cures over the last decade, supporting nearly five million jobs in the United States.^{1,2} Since its inception, the Medicare Prescription Drug Benefit Program (Part D) has played a crucial, successful role in ensuring patients have affordable access to the medicines they need, improving health outcomes, and reducing downstream medical costs. PhRMA and our member companies are committed to the continued success of this program.

PhRMA offers recommendations for Medicare Part C and D reporting requirements in 2027 and future years to align with the Administration’s recent efforts to improve transparency and ensure beneficiary access to medicine. Our comments address data collection related to Part C Organization Determinations & Redeterminations as well as Part D Coverage Determinations, to ensure CMS collects and makes publicly available the data necessary to hold plans accountable for patient access. We also offer recommendations related to CMS’ oversight and evaluation of the Part D Medicare Prescription Payment Plan.

* * *

¹ PhRMA. (July 2025). 2025 PhRMA Annual Membership Survey. Available [here](#).

² TEconomy. (May 2024). The Economic Impact of the U.S. Biopharmaceutical Industry: 2022 National and State Estimates. Available [here](#).

I. Medicare Part C and D Plan Reporting on Organization Determinations and Reconsiderations of Part D Medicines

Expanding Reporting Requirements to Include Denials of Part D Medicines at the Point of Sale

The Inflation Reduction Act (IRA) made changes that incentivize Part D sponsors to increase utilization management (UM) on Part D medicines. However, the ultimate impact of Part D sponsors' implementation of UM and the appeals processes are opaque and currently not available to either CMS or the public for review. Moreover, recent analysis suggests that plans' UM practices often present beneficiaries with excessive barriers to timely access to Part D medicines. In fact, a study of brand medicines in five therapeutic areas found that for four of those areas, over 70 percent of patients were initially denied coverage when trying to fill a new prescription and some faced delays in receiving their medicine of five weeks or longer.³ Additionally, nearly half (47 percent) of all initial attempts to fill a new brand medicine through Medicare Part D were initially denied coverage in 2025, up from 37 percent in 2021.⁴

Although plan sponsors report certain coverage determinations and reconsiderations for denied items and services, these reporting requirements only begin after a beneficiary experiences a negative point of sale coverage adjudication, and a beneficiary or their provider takes action to initiate the coverage determination process. As a result, the current requirements do not reflect the experiences of beneficiaries who have been denied clinically appropriate services or products but have not initiated the often arduous and lengthy coverage determination, exception and appeals process. CMS has expressly excluded Part D medicines from the proposed requirements for Medicare Advantage plans and other payers to publicly disclose prior authorization metrics in its recently released 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P), noting “the Part D program already has reporting requirements for aggregated coverage determinations, redeterminations, and reopenings for covered Part D drugs.”⁵ However, the data collected under the existing reporting requirements, which are the focus of these comments, are considerably less detailed than what CMS proposes in the recent rulemaking for other markets.

Existing reporting requirements do not capture denials at the point of sale for which beneficiaries (or their providers) do *not* follow up by requesting coverage determinations, exceptions or appeals,⁵ and are not released publicly in a transparent and accessible manner. Consequently, CMS and other stakeholders lack the ability to fully assess the impact that plan sponsors' formulary, UM and appeals requirements have on beneficiaries. CMS already has broad authority to collect these data under 42 CFR 422.516 and 423.514, which require reporting on the “procedures related to and utilization of [MA organizations' and Part D sponsors'] services and items”; the “availability, accessibility, and acceptability of [such] services”; and “[o]ther matters that CMS may require.” ***As such, we urge CMS to expand the Medicare Part C and D Reporting Requirements to include additional metrics that would provide CMS with insight into how beneficiaries experience denied coverage of their medicines at the point of sale, as well as the results when beneficiaries attempt both formal coverage determinations and appeals.***

³ IQVIA. (June 2025). The Impact of Formulary Controls on Medicare Patients in Five Chronic Therapeutic Areas. Available [here](#).

⁴ IQVIA. (March 2026). Increasing Payer Control for Medicare Patients Initiating Branded Medicines. Available [here](#).

⁵ “An enrollee, an enrollee's prescriber, or an enrollee's representative may request a standard or expedited coverage determination by filing a request with the plan sponsor” See: <https://www.cms.gov/medicare/appeals-grievances/prescription-drug/coverage-determinations>

Specifically, when a beneficiary experiences a negative point of sale coverage adjudication (pharmacy rejection) or a negative coverage determination, CMS should collect and report the following data annually, and separately for generic and brand medicines:⁶

- Total number and percentage of claims for which the initial point of sale coverage adjudication resulted in a rejection, broken down by therapeutic class, and reported separately for denials due to prior authorization, step therapy, formulary exclusions, quantity limits, or “other” reasons.
- Total number and percentage of claims for which the initial point of sale coverage adjudication resulted in a rejection, broken down by therapeutic class, for which the beneficiary ultimately receives the prescribed medicine or a different medicine within the same class. These data should be stratified by the date the prescribed medicine or alternative is approved: within same day of initial rejection, within 2-14 days, 15-28 days, or more than 28 days after initial rejection.
- Mean and median number of days between the initial rejection at the pharmacy and the date coverage is approved (either for the medicine initially prescribed or a therapeutic alternative, reported separately), broken down by therapeutic class.
- Percentage and number of beneficiaries subject to any rejection or denial, including an exception denial, who progress to each subsequent level of reconsideration or appeal.
- The number and percentage of denials for which a subset of clearly defined denial rationale categories apply (e.g., incomplete or missing information, administrative or technical error, prior authorization requirement not met, formulary exclusion, medical necessity determination or other clinical rationale).

Across these metrics, CMS should also consider stratifying data for oversight purposes by beneficiaries that are new to a health plan compared to returning members. This would allow CMS to validate whether plan sponsors are appropriately applying “look-back” periods as required in 42 CFR 423.120(b)(3) and the Part D Manual at 30.4 for beneficiaries stable on a medicine.⁷

The collection of these metrics would further strengthen CMS’ efforts to oversee plan sponsors’ UM practices by taking into consideration the experience of beneficiaries for whom a claim was denied but elect not to undergo the coverage determinations, exceptions and appeals processes. This more complete picture of beneficiaries’ experience would provide critical transparency into the true impact of coverage denials on Medicare beneficiaries.

PhRMA acknowledges that CMS previously collected but chose to discontinue the requirement for similar reporting metrics for prescription medicines, as CMS concluded that the findings were not sufficient to warrant the burden placed on plans to report these metrics.⁸ Since that time, however, Part D plan sponsors’ use of formulary exclusions and utilization management restrictions has continued to increase,⁹ and a growing body of recent evidence demonstrates that beneficiaries frequently encounter pharmacy rejections when attempting to begin treatment with brand medicines, often resulting in treatment delays.¹⁰ In discontinuing these prior reporting

⁶ See <https://www.federalregister.gov/d/2026-06600/p-821> for an explanation of how CMS distinguishes between point of sale claim adjudications and Part D coverage determinations.

⁷ See 30.4- Transition. <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf>

⁸ <https://oig.hhs.gov/documents/evaluation/3141/OEI-09-16-00411-Complete%20Report.pdf>

⁹ Joyce G., Blaylock B., Chen J, et al. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions On Prescription Drugs, 2011–20. Health Affairs. Available [here](#).

¹⁰ See Wang Y., Levy J.F., Mattingly T.J., et al. (April 2026). Prior Authorization and Associated Delays and Denials of Branded Medication Dispensation. JAMA Health Forum. Available [here](#); IQVIA. (March 2026). Increasing Payer Control for Medicare Patients Initiating Branded Medicines. Available [here](#); IQVIA. (June 2025). The Impact of Formulary Controls on Medicare Patients in Five Chronic Therapeutic Areas. Available [here](#).

requirements, we are concerned that CMS failed to consider plan sponsors' growing use of coverage restrictions and the likely variation in denial and appeal rates for certain categories of prescriptions, such as initial fills versus refills and brand medicines versus generics, and believe that stratifying analytics by these categories could yield significantly different results than CMS' prior findings.¹¹ The HHS Office of Inspector General (OIG) has also characterized CMS' decision to discontinue routinely collecting pharmacy rejection data as "concerning," noting that "the large number of pharmacy rejections issued each year underscores the need for ongoing oversight to protect beneficiary access to needed drugs."¹² OIG recommended that CMS conduct additional oversight to reduce inappropriate pharmacy rejections, an objective that could be advanced through more robust Part D reporting requirements.

Plan Level Reporting of Utilization Management, Determination, and Reconsideration Metrics

In addition to increasing the number of metrics on which plans should be required to report, PhRMA recommends that CMS require Medicare Part C and Part D sponsors to report UM determination and reconsideration metrics at the plan level, rather than the contract level, to ensure meaningful transparency and oversight. Contract-level reporting masks substantial variation across individual plans and benefit designs, limiting CMS' ability to detect outlier practices and failing to account for beneficiaries' real-world experiences with prior authorization, step therapy and the appeals process. Plan-level reporting would provide a more accurate picture of how specific plans apply UM, allow for accurate comparisons between plans and better support CMS' oversight and protection of beneficiary access.

Given significant variation among plan benefit designs, plan-level reporting is essential to inform beneficiaries of potential access barriers and delays in care, allowing them to enroll in a plan that best suits their specific clinical needs. Additionally, this granular level of reporting is essential to CMS' ability to hold Part C and D plan sponsors accountable in ensuring they offer plans that adequately address the health and well-being of their beneficiaries.

Public Reporting to Promote Transparency

Finally, CMS should make the data plan sponsors provide to CMS publicly available to promote transparency and accountability across the Medicare Part C and Part D programs. Public reporting would allow beneficiaries, caregivers, researchers and policymakers to better understand how plan sponsors use prior authorization, step therapy and other UM tools, and to identify those that impose excessive or inappropriate barriers to care. Making these data accessible would support informed plan selection, strengthen CMS oversight and create meaningful incentives for plans to improve access and reduce unnecessary delays in receiving clinically appropriate medicines.

II. Medicare Part C and D Plan Reporting on Medicare Prescription Payment Plan Enrollment

PhRMA remains strongly committed to the successful implementation of the Medicare Prescription Payment Plan (MPPP) and believes that it presents a significant opportunity to improve medicine affordability for some of the sickest and most vulnerable beneficiaries, particularly those managing multiple chronic and high-cost conditions. Despite the MPPP's strong potential, early adoption has been significantly lower than expected. While CMS

¹¹ In other words, CMS concluded that "only 1 percent of contracts" exceed the failure rate threshold – but the agency's analysis did not independently consider different categories of prescriptions, such as new therapy starts or brand medicines.

¹² <https://oig.hhs.gov/documents/evaluation/3141/OEI-09-16-00411-Complete%20Report.pdf>

projected enrollment of up to 6 percent of Part D beneficiaries (approximately 2.4 million individuals), recent data shows that only 0.4 percent have enrolled.¹³ Further, polling in the first year of implementation found that 74 percent of seniors had heard little to nothing on MPPP and nearly half knew nothing at all.¹⁴ The combination of low uptake and limited public awareness makes it even more important for CMS to continue monitoring enrollment trends through Medicare Part C and D Reporting Requirements as well as real-time claims monitoring for enrollment trends and monitoring of 1-800-Medicare and other venues for complaints.

Successful implementation of the MPPP will require comprehensive efforts to educate Medicare beneficiaries on the program and how to elect to participate, as well as operational changes to simplify enrollment. We support CMS' collection of certain likely to benefit information and election request processing data, which will allow CMS to monitor the continued implementation of this program. Specifically, PhRMA recommends that CMS use these data to regularly evaluate the appropriateness of the likely to benefit threshold.

We also encourage CMS to publicly report these data, as well as detailed data on total enrollment with breakdowns by beneficiary subgroups and demographics (e.g. beneficiaries with specific chronic conditions or living in rural areas). CMS should also consider developing additional mechanisms to hold health plans accountable for ensuring beneficiaries are aware of this program and able to elect participation without undue burden. Finally, we refer CMS to our prior comment letters for detailed recommendations to improve this important program, including a real-time point of sale election option.^{15,16}

* * *

PhRMA appreciates the opportunity to comment on the Contract Year 2027 Medicare Part C and D Reporting Requirements and welcomes the opportunity to discuss our recommendations further with CMS staff. Please do not hesitate to contact Sarah Rayel (srayel@phrma.org) or Judy Haron (jharon@phrma.org) if we can provide additional information or answer any questions related to our comments.

Sincerely,

/s/

Sarah Snyder Rayel
Deputy Vice President, Policy & Research

/s/

Judy Haron
Deputy Vice President, Law

¹³ Milliman. (April 2025). MedIntel Insights: Early look at Medicare Prescription Payment Plan enrollment. Available [here](#).

¹⁴ Partnership to Fight Chronic Disease. (April 2025). New Poll: Majority of Seniors with Medicare Prescription Drug Coverage Remain Unaware of New Payment Options. Available [here](#).

¹⁵ See, e.g., PhRMA comments to CMS re: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule, January 23, 2026.

¹⁶ See, e.g., PhRMA comments to CMS re: Contract Year 2026 Medicare Part D Reporting Requirements, July 14, 2-25.

PUBLIC SUBMISSION

As of: 5/13/26, 10:29 AM
Received: May 11, 2026
Status: Draft
Tracking No. mp1-t7j2-0nvd
Comments Due: May 11, 2026
Submission Type: API

Docket: CMS-2026-0958
Medicare Part C and D Reporting Requirements (CMS-10185)

Comment On: CMS-2026-0958-0001
Medicare Part C and D Reporting Requirements (CMS-10185)

Document: CMS-2026-0958-DRAFT-0050
Comment on CMS-2026-0958-0001

Submitter Information

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General Comment

The data elements required by reporting section Organization Determinations & Reconsiderations represents significant overlap with the new Service Level Data Collection for Initial Determinations and Appeals (CMS-10905, OMB:0938-1489). Although still in pilot, "CMS anticipates expanding the data collection to all plans in 2027." Plans should only be required to report one set of data elements; not both.



May 11, 2026

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Document Identifier/Form Number: CMS-10185
OMB Control Number: 0938-0992
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted Electronically: www.regulations.gov

Re: Medicare Part C and D Reporting Requirements

Dear Sir/Madam:

UnitedHealthcare (UHC) is pleased to respond to the CMS's request for comments regarding the Contract Year (CY) 2027 *Medicare Part C and D Reporting Requirements* published in the Federal Register on March 10, 2026 (91 FR 11553).

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience, and delivering access to high-quality care. UnitedHealthcare is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes, and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

Proposed Introduction of “No Data to Report” Data Element

CMS proposes adding a new data element to allow sponsors to indicate that there is “no data to report” for a particular Plan ID for certain reporting sections that require reporting at the plan-level. This proposed change would apply to the Employer Group Plan Sponsors, Special Needs Plans (SNPs) Care Management, D-SNP Enrollee Advisory Committee, D-SNP Transmission of Admission Notifications, and Medicare Prescription Payment Plan reporting sections.

UHC recommends that CMS consistently exclude Plan Benefit Packages (PBPs) with no reportable data from reporting requirements across reporting sections. Requiring this new data element and thus requiring reporting for plans that have no data will introduce additional burden for MA Organizations (MAOs) in report creation and CMS in report review. MAOs would need to allocate additional administrative resources to enlist data suppliers, IT, compliance, and

reporting staff to coordinate, produce, and certify records that do not reflect actual plan activity. In addition, this change will introduce unnecessary operational complexity such as additional conditional programming, record-level exceptions, and custom business rules to support placeholder submissions. The additional reporting of “no data report” will not add value, as there is no enrollment, benefits or reportable activity. Excluding these PBPs will better align reported data with actual plan activity during the reporting period.

Supplemental Benefit Utilization and Costs Reporting Section

Contract ID and PBP ID Data Elements

Under the proposed Supplemental Benefit Utilization and Costs reporting section, CMS notes that the Contract and Plan ID are no longer included as data elements consistent with other reporting sections. UHC recommends that CMS not proceed with this proposed change. UHC strongly believes that the Contract and PBP fields are critical for MAOs, particularly for aggregation, edit checks, and maintaining consistency with other PBP-based reporting requirements.

If CMS proceeds with this proposed change, UHC seeks clarification regarding how reported data will be tied back to PBP-specific information in the file record layout. This clarification is important to understand how CMS intends to validate submissions and ensure that reported data remain accurately aligned at the PBP level in the absence of these key identifiers.

EGWP Reporting

In the Supplemental Benefit Utilization and Costs reporting section, UHC recommends that CMS allow Employer Group Waiver Plan (EGWP) PBPs with no groups sold and no enrollment during the reporting period to be excluded from reporting. EGWP PBPs are submitted as Standard Bids and filed with Original Medicare cost sharing and cost share limits only, as defined by CMS. These PBPs may ultimately be used to support employer groups with supplemental benefits, but not all EGWP PBPs filed have groups or members associated with the PBP during the plan year. As a result, EGWP PBPs with no sold groups have no enrollment, no applicable benefits, and no meaningful plan activity on which to report. Requiring reporting for these PBPs creates administrative burden and operational complexity with the production and filing of non-substantive or placeholder records that do not reflect actual plan operations, and these files would not provide CMS with meaningful oversight value. Allowing the exclusion of EGWP PBPs with no enrollment or reportable activity would better focus MAO and CMS resources on PBPs with active groups or enrolled members, reducing administrative burden

Release of Technical Specifications Document

CMS historically releases the *Medicare Part C and D Reporting Requirements: Technical Specifications Document* for review and comment along with the Medicare Part C and D Reporting Requirements. These specifications are essential to the effective implementation of the Medicare Part C and D Reporting Requirements. While the Reporting Requirements outline the necessary data elements, the Technical Specifications provide crucial operational guidance, including data definitions, validation logic, and insight into CMS’s review and analysis processes. Though the Technical Specifications do not alter the approved data collection itself, they have a direct impact on how requirements are interpreted and operationalized.

UHC recommends that CMS release the proposed 2027 Technical Specifications associated with the proposed combined Part C & D Reporting Requirements for advance review and comment before CMS finalizes the 2027 Medicare Part C and D Reporting Requirements. This related comment opportunity is critical to ensure a shared understanding, to identify potential reporting challenges, and to clarify any ambiguities before moving forward with implementation.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jennifer Martin', with a horizontal line extending to the right.

Jennifer Martin
Director, Regulatory Affairs
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763-283-4469