MEDPAC | Medicare Payment Advisory Commission

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January 22, 2026

Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-4212-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program," *Federal Register* 90, no. 227, pp. 54894–55030 (November 28, 2025). We appreciate your staff's work on the notice, particularly given the many competing demands on the agency's staff.

This proposed rule includes many provisions that would revise regulations for the Medicare Advantage (MA) program (Part C) and the Prescription Drug Benefit program (Part D). Our comments focus on the following provisions:

- Marketing oversight and agent/broker regulation, including the special enrollment period for provider terminations, relaxing the restrictions on language in advertising, and the request for information;
- Updating third-party marketing organizations (TPMO) disclaimer requirements;
- TPMO oversight: Revising the record-retention requirements for marketing and sales call recordings;
- Request for information on reporting processes and data collection for network adequacy;
- MA/Part C and Part D prescription drug plan quality-rating system (star ratings);
- Passive enrollment by CMS; and
- Request for information: Chronic condition special needs plan (C–SNP) and institutional special needs plan (I–SNP) growth and dually eligible beneficiaries.

Marketing oversight and agent/broker regulation

CMS proposes numerous changes to streamline enrollment and marketing, including removing rules on the time and manner of beneficiary outreach and coordination of election mechanisms for MA and Part D. CMS intends to (1) ensure beneficiaries receive accurate information about plan choices; (2) conduct oversight on potential bad actors who fail to adhere to requirements; and (3) reduce the burden on beneficiaries, TPMOs (individuals and organizations, such as independent agents and brokers, that are paid to perform lead generation, marketing, sales, and enrollment-related functions), and MA and Part D plans.

Among other proposals, CMS proposes to streamline the special enrollment period (SEP) available to enrollees affected by a change to their provider network. The proposal would (1) replace the current SEP for significant change in provider network with a new, broader SEP for provider terminations, thereby removing the need for CMS to make a determination on the significance of the change before enrollees are eligible for the SEP, and (2) require that MA organizations provide information about SEP eligibility as part of their notification to enrollees of an upcoming change in their provider's network status. CMS has also requested comments on ways to modernize their approach to marketing oversight and agent/broker regulations in the Medicare program while ensuring beneficiaries continue to receive accurate information.

Comment

The Commission supports CMS's efforts to streamline the SEP available to enrollees affected by a change to their provider network.

In our annual focus groups with beneficiaries, we hear from participants that they often select their plans based on whether their providers are in network. Midyear network changes can be disruptive to beneficiary care. We encourage CMS in the final rule or in guidance to clarify the types of provider network terminations that would count for this SEP, such as whether a single practitioner in a group practice who is retiring would be a sufficient network change for an enrollee to use this SEP, and whether Medigap guaranteed issue rights would be available in all circumstances.

The Commission recognizes that, along with the importance of facilitating continuity of care for beneficiaries in MA during midyear network changes, the broadening eligibility for this SEP has the potential to alter market dynamics, such as increasing the leverage that providers have in negotiating MA contracts or offering enrollees considered to be "less profitable" by a plan an additional opportunity to switch to another plan or return to fee-for-service (FFS) Medicare (particularly if the process expands Medigap guaranteed issue rights). If the SEP is finalized, sharing information on the rate of use of this SEP by enrollees, the coverage options that SEP users choose, and any known impacts on market dynamics between MA organizations and providers would be helpful for all stakeholders.

The Commission has been discussing issues related to the complexity of choices for Medicare beneficiaries and the information and assistance available to beneficiaries

when making choices.[3] In our annual focus groups, beneficiaries often report confusion about enrolling in Medicare and their different coverage options.[4] Adding to the confusion regarding Medicare choices, many participants described the amount of information they receive about Medicare plans as overwhelming. Participants report receiving stacks of pamphlets, "constant" phone calls, and frequent mailings from insurance companies, especially during annual enrollment. In one focus group, a beneficiary who eventually enrolled in a MA plan said, "Well, before turning 65, I was getting the mail. A little overwhelming at first.... So, I just signed up with that without, you know, thinking too much about it." Other participants report receiving many phone calls related to enrolling in Medicare plans with one noting, "Why is it—it's like every day, somebody calling you about your insurance? I already did this for this year already" and another estimating, "I get five, six [calls] a day." Several Medicare beneficiaries have described seeking a health insurance agent or broker because they need guidance through the complexity of decision-making.

The complexity of the choices, various time frames during which choices can be made, potential for lifelong penalties, and the differing sources of information make it difficult for individuals to understand the requirements and relevant time frames so they can make the Medicare enrollment choice that is best for them. Medicare should prioritize the needs of the beneficiaries who navigate this complex process and reduce beneficiary confusion whenever possible. As CMS considers ways to modernize marketing oversight and streamline the burden for plans and TPMOs, it should ensure that beneficiaries making Medicare enrollment decisions have access to accurate information that is transparent about the source and validity of the information.

Updating TPMO disclaimer requirements

CMS proposes some updates to the TPMO disclaimer requirements, including removing from the standardized disclaimer language that beneficiaries can contact their local State Health Insurance Program (SHIP) to get information on all of their options. Currently, MA organizations and Part D sponsors must ensure that the TPMOs with whom they do business (directly or indirectly) verbally convey a standardized disclaimer during sales calls with beneficiaries. The current standardized disclaimer language for a TPMO not offering all plans in a beneficiary's area reads, "We do not offer every plan available in your area. Currently, we represent [insert number of organizations] organizations which offer [insert number of plans] products in your

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[3] Medicare Payment Advisory Commission. 2025. March 2025 public meeting transcript. https://www.medpac.gov/wp-content/uploads/2024/08/March-2025-public-meeting-transcript.pdf.

[4] NORC at the University of Chicago. 2025. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2025 focus groups in St. Louis, Missouri, and 2021–2025 rural focus groups*. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Bethesda, MD: NORC.
NORC at the University of Chicago. 2024. B*eneficiary and clinician perspectives on Medicare and other issues: Findings from 2024 focus groups in select states.* Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Chicago, IL: NORC.

area. Please contact medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

CMS states that, while SHIPs can be a source of unbiased information about plan choices, informing beneficiaries on every sales call about the SHIP may not lead to beneficiaries receiving complete advice due to the increasingly complex nature of the MA and Part D programs. CMS also states that beneficiaries enrolled in the MA and Part D programs may be more effectively served by information and entities over which CMS has direct oversight.

CMS also recognizes that each SHIP works differently and provides different training to its counselors, which can vary further at the local level. The agency reports that these differences can result in Medicare beneficiaries receiving information that varies depending on the SHIP and SHIP counselor they use. CMS contends that, for the TPMO disclaimer, 1–800–MEDICARE is a better option to assist beneficiaries with health care choices because that line has representatives available 24/7 to assist beneficiaries, provides standardized training to its customer service representatives, and is centrally monitored and controlled by CMS, leading to a one-stop shop for all beneficiaries regardless of the state in which they live.

Comment

The Commission does not support CMS's proposal to remove references to the availability of SHIPs from the TPMO disclaimer requirement. TPMOs may have financial incentives to steer beneficiaries to certain plans and may not offer all plans available to a beneficiary. Further, CMS has stated that sales and enrollment call records between TPMO staff and beneficiaries demonstrate "… that beneficiaries are confused by TPMOs, including confusion regarding who they are speaking to, what plans the TPMOs represent, and that the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations."[5] Beneficiaries should continue to be made aware of other important information sources, including SHIPs, before discussing plan options with a TPMO.

The federal help line, 1-800-MEDICARE, provides general information, but SHIPs are the only federally funded source of independent, individual-level counseling available to Medicare beneficiaries, their families, and caregivers. The Administration for Community Living (ACL) has invested in the SHIP Technical Assistance (TA) Center to provide training, technical assistance, and resources, including an online counselor certification tool and Medigap Plan Finder for SHIP counselors, to the nation's 54 SHIPs.[6] SHIPs cover counseling topics in greater depth and offer more personalized assistance in comparison to 1-800-MEDICARE. For this reason, SHIPs often take referrals from 1-800-MEDICARE and other

[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. *Medicare program: Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs proposed rule.* https://www.govinfo.gov/content/pkg/FR-2022-01-12/pdf/2022-00117.pdf.

[6] Northwest Iowa Area on Aging. 2025. About the Technical Assistance Center. https://www.shiphelp.org/what-we-do/about-the-center/

federal aging and disability resources to address more complex beneficiary concerns, including the intersection of Medicare benefits with retiree or Medicaid coverage. The average length of time a SHIP counselor spent assisting beneficiaries increased from 28 minutes in 2014 to 33 minutes in 2020.[7] This is more than three times the 9.5-minute call average to the 1-800-MEDICARE call center reflecting the greater complexity of issues handled by SHIPs in comparison to 1-800-MEDICARE.

A 2022 Commonwealth Fund survey found that about one in 20 Medicare beneficiaries use a SHIP counselor to guide their coverage decisions.[8] But resources for SHIPs have been limited for years, and SHIP funding is currently less than $1 per Medicare beneficiary. In 2008, the Commission recommended that the Secretary increase SHIP funding for outreach to low-income Medicare beneficiaries.[9] The ACL reported that over a one-year period (April 2021 to March 2022) over 12,500 SHIP team members (roughly half were volunteers) in over 2,200 local organizations provided one-on-one counseling to almost 1.8 million individuals.[10] The Commission encourages CMS to continue to include SHIPs in the disclaimer and recommends increased funding for this valuable source of independent information for beneficiaries.

TPMO oversight: Revising the record-retention requirements for marketing and sales call recordings

To reduce the burden on MA organizations, Part D sponsors, TPMOs, and first-tier, downstream, and related entities, CMS proposes to change the 10-year retention period for audio recordings of marketing and sales calls to 6 years. CMS is considering alternatives, such as reducing the audio recording retention period to 3 years with a written transcript, requiring retention of a transcript only, or not requiring retention of the audio recordings or a transcript. Audio call files are large, taking a substantial amount of data storage, and CMS has received comments from industry groups noting the costs associated with recording and retaining the recordings. CMS states that it is helpful to review the recordings when beneficiaries complain about being misled into choosing a plan but notes that it is highly unlikely to review calls past the 6-year mark.

Comment

The Commission recognizes the financial burden that the audio recording retention policy places on the relevant entities and appreciates CMS's consideration of the balance between maintaining appropriate oversight while reducing the burden whenever

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[7] Administration for Community Living (ACL) Justification of Estimates for Appropriation Committees, FY 2025.

[8] Leonard, F., G. Jacobson, L. A. Haynes, et al. 2022. *Traditional Medicare or Medicare Advantage: How older Americans choose and why.* New York: Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.

[9] Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[10] Administration for Community Living (ACL) Justification of Estimates for Appropriation Committees, FY 2025.

possible. These audio files are important to help resolve beneficiary complaints and maintain program integrity by overseeing the work of the entities involved in Medicare enrollment. It seems necessary to retain the audio files for a time sufficient to accurately resolve beneficiary issues, which may be less than 10 years, and to identify trends in beneficiary communications that may require oversight actions, considering there may be a lag in obtaining sufficient enrollment information to determine trends. We encourage CMS to share analysis of how frequently the audio recordings are used, and the length of time those recordings had been stored before usage. Such analysis could inform a new record-retention policy.

Request for information on reporting processes and data collection for network adequacy

CMS has requested comments on current reporting processes and data collection related to network adequacy to identify areas where requirements can be simplified, consolidated, or eliminated while maintaining program integrity and beneficiary protections. CMS provides some examples of potential changes, such as simplifying the data required to be submitted for network reviews, the timing or frequency of those reviews, or creating a separate pattern-of-care exception for areas where the pattern of care is unique and the organization believes their contracted network is consistent with or better than the pattern of care in FFS Medicare.

Comment

The Commission commends CMS for its attention to opportunities to reduce administrative burden and simplify processes with respect to assessing and ensuring network adequacy in MA. At the same time, the Commission maintains that protecting beneficiary access to care is paramount and that assessing MA provider networks is important to ensure that plans provide adequate access to the full range of statutorily defined Medicare benefits. We encourage CMS to carefully weigh the potential impacts of any changes to network-adequacy standards and review processes on beneficiaries.

MA/Part C and Part D prescription drug plan quality-rating system (star ratings)

CMS develops and publicly posts 5-star ratings for MA and Part D plans. The Part C and Part D star-ratings system is used to determine quality-bonus payment (QBP) ratings for MA plans. Plans rated 4 stars or higher ("in bonus status") are rewarded by receiving an increase in their MA benchmarks of 5 percent or, in some counties, 10 percent.

For star-rating year 2029, CMS proposes to remove seven measures focused on operational and administrative performance, three additional measures focused on processes of care, and two additional measures focused on patient experience of care. CMS aims to strike a balance between streamlining the measure set and continuing to include enough measures to assess performance across the range of health care quality and to avoid plans "teaching to the test" or focusing performance improvement efforts on a limited number of measured areas. Although these measures would not be included in the star ratings and therefore not

tied to bonus payments, CMS states that it would continue to monitor plan performance and issue compliance actions as needed and would continue to monitor access issues through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures.

CMS also proposes not moving forward with the implementation of the Health Equity Index (HEI) reward, which was to be implemented beginning with the 2027 star ratings, and to instead continue to include the historical reward factor in the star-ratings methodology. CMS explains that rather than incentivizing improvement among certain populations like those included in the HEI, the agency would instead incentivize improvement efforts on clinical care, outcomes, and patient experience.

For the star-ratings updates, CMS estimates the net impact to be between $5.02 billion in 2028 and $0.95 billion in 2036, resulting in a 10-year net impact estimate of $13.1 billion, which equates to 0.15 percent of the Medicare payments to private health plans for the years 2027 through 2036.

Comment

The Commission supports CMS's proposal to remove operational and administrative measures and "topped-out" process measures from the QBP scoring, consistent with the Commission's 2020 recommendation to replace the QBP, and the Commission's principle that quality-measurement programs should focus on measures tied to clinical outcomes, patient experience, and value. It is important for CMS to continue to collect, monitor, and take action if needed on insurance function and administrative measures, such as appeals and complaints, but we agree that these measures should not be tied to quality payments.

The Commission maintains that Medicare payments should not be made without considering the quality of care delivered to beneficiaries and has formalized a set of principles for designing Medicare quality-incentive programs.[11] The Commission has determined that the Medicare's QBP for assessing quality performance in the MA program is not consistent with these principles, is administratively burdensome, adds significantly to program costs, and does not meaningfully improve quality. In our June 2019 report to the Congress, we outlined flaws of the QBP program, which:

- scores too many measures, including "insurance function" or administrative measures;
- uses measures reported at the MA contract level, even for contracts encompassing disparate geographic areas, making plan ratings not necessarily a useful indicator of quality provided in a beneficiary's local area;
- has allowed companies to consolidate contracts to obtain unwarranted bonuses;

[11] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

- does not appear to adequately account for differences in enrollee social risk factors;

- has moving performance targets that do not permit plans to know ahead of time how their quality results translate to a QBP score; and

- is not budget neutral because it is financed with additional program dollars—unlike quality-incentive programs in Medicare's traditional fee-for-service program that are either budget neutral (balancing penalties and rewards) or penalty only.[12]

Because of these flaws, in June 2020, the Commission recommended that the Congress replace the current MA quality-bonus program with a new MA value-incentive program that scores a small set of population-based measures, evaluates quality at the local-market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.[13]

The Commission's 2020 recommendation would replace the rewards-only QBP with a budget-neutral MA value-incentive program, a change that would require Congressional action. In the meantime, we encourage CMS to make improvements to the QBP that are under the Secretary's authority and consistent with the Commission's 2020 recommendation and that would not further increase program spending. The MA quality-bonus program already increased MA payments by about $15 billion in 2025, and that amount has more than doubled from 2019 when the QBP cost $6 billion. CMS should consider changes such as evaluating quality at the local market level, instead of at the contract level, which can cover disparate geographic areas with varying quality levels. In January 2024, over half of MA enrollees were in contracts that spanned two or more states.[14] A third of MA enrollees were in multistate MA contracts that spanned noncontiguous states. The largest MA contract, with 2.6 million enrollees, had over 1,000 MA enrollees in each of 46 states and over 20,000 enrollees in each of 30 states. Another multistate contract had about 200,000 enrollees in Florida; 100,000 enrollees in Indiana; 70,000 enrollees in Arizona; and 40,000 enrollees in Oregon. The star ratings for such contracts reflect performance averaged across different service areas and thus are unlikely to accurately reflect plan quality in any one of those areas nor provide beneficiaries in these areas with reliable information on quality of care when choosing an MA plan.

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[12] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[13] Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[14] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Passive enrollment by CMS

Dual-eligible special-needs plans (D-SNPs) are specialized MA plans that serve beneficiaries who receive both Medicare and Medicaid benefits. Some states have developed integrated care programs where insurers offer both a D-SNP and a Medicaid managed care plan for dually eligible beneficiaries, thus enabling the insurers to provide both Medicare and Medicaid benefits. Most states contract with a limited number of Medicaid plans and periodically re-procure those plans using a competitive process. If an incumbent insurer is not selected as part of a re-procurement, the company may have to close both its Medicaid plan and its D-SNP, potentially disrupting coverage for beneficiaries who had been receiving integrated care through those two plans.

Current regulations aim to avoid this disruption by allowing CMS to take dually eligible beneficiaries who are enrolled in an integrated D-SNP—where the plan or its parent insurer also provides some level of Medicaid coverage—and passively enroll them in other integrated D-SNPs to "promote integrated care and quality of care." D-SNPs must satisfy several requirements before they can receive beneficiaries who are passively enrolled, including a requirement that their provider network is "substantially similar" to the network of the beneficiary's previous D-SNP.

However, CMS has not been able to use this process because the D-SNPs that would otherwise receive passively enrolled beneficiaries have not been able to meet the "substantially similar" requirement. Under the proposal, CMS would eliminate this requirement and instead require the receiving D-SNPs to provide incoming enrollees with continuity of care for at least 120 days (meaning that beneficiaries who are receiving treatment could continue using providers who are not in the new D-SNP's provider network and would not have to obtain prior authorization).

Comment

We support this proposal. The Commission has long been supportive of integrated D-SNPs; for example, in our June 2019 report we examined several policies that would promote greater integration.[15] We agree that the use of passive enrollment in these specific circumstances would reduce the likelihood that dually eligible beneficiaries see their care become more fragmented and believe that the continuity-of-care requirement will reduce disruption for the affected beneficiaries. The passive-enrollment process also includes a number of other beneficiary protections, such as notifying beneficiaries at least 60 days before they are passively enrolled, letting them opt out of passive enrollment, and giving beneficiaries who have been passively enrolled a special election period if they want to leave their new plan.

[15] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Request for information: C-SNP and I-SNP growth and dually eligible beneficiaries

In addition to D-SNPs, the MA program has two other types of special-needs plans: chronic-condition special-needs plans (C-SNPs), which are limited to beneficiaries who have certain chronic conditions, and institutional special-needs plans (I-SNPs), which are limited to beneficiaries who need the level of care provided in a nursing home. Like D-SNPs, C-SNPs and I-SNPs must meet some additional requirements that do not apply to conventional MA plans, such as having a model of care that is tailored to the distinctive care needs of the plan's target population and has been approved by the National Committee on Quality Assurance, but they differ from D-SNPs because they are not required to have a state Medicaid contract.

In the proposed rule, CMS notes that the total number of dually eligible beneficiaries enrolled in C-SNPs (and, to a lesser degree, in I-SNPs) has grown rapidly and that, for some of those plans, the share of enrollees who are dually eligible is greater than 60 percent, the threshold that CMS has established to determine whether a conventional plan is a D-SNP "look-alike" plan. CMS requests information on several potential policy changes that would, in various ways, address the growth in the number of dually eligible beneficiaries enrolled in C-SNPs and I-SNPs.

Comment

Our comment addresses two potential policy changes that are discussed in the request for information (RFI):

(1) Requiring certain C-SNPs and I-SNPs to have state Medicaid contracts, along the lines of the existing requirement for D-SNPs, and

(2) Requiring C-SNPs to comply with the restrictions on D-SNP look-alike plans that now apply only to conventional plans.

Requiring certain C-SNPs and I-SNPs to have state Medicaid contracts

CMS suggests that C-SNPs and I-SNPs in which the share of enrollees who are dually eligible is greater than 60 percent (that is, above the look-alike threshold) would need to have a state Medicaid contract to operate. CMS says such a requirement would allow states to determine what, if any, role those plans would play in its overall approach for integrating care for dually eligible beneficiaries.

We contend that I-SNPs should not be required to have state Medicaid contracts. Our comments focus on the impact of such a requirement on long-stay nursing home (NH) residents, who account for about 85 percent of I-SNP enrollment, and are informed by the Commission's recent work on Medicare beneficiaries in NHs and I-SNPs that was part of our June 2024 report to the Congress.

The vast majority of I-SNP enrollees living in NHs (97 percent in 2023) are dually eligible beneficiaries. Some observers have criticized I-SNPs—particularly facility-based I-SNPs—because they provide Medicare-covered services only and argued that they have incentives to keep enrollees in NHs instead of trying to return them to a community setting. However, it is unclear how many residents can plausibly return to the community after being in a NH for 90 days (a requirement for enrolling in an I-SNP). One researcher that we interviewed as part of our 2024 work said that efforts to return NH residents to the community are more likely to succeed if they target residents shortly after they have been admitted and become progressively harder when residents have been in a NH for longer periods of time. If the number of long-stay residents who could be returned to the community is relatively small, requiring I-SNPs to be more closely integrated with Medicaid may have little effect.

Given the difficulties of returning long-stay NH residents to the community, efforts to improve care within the NH setting may be a better focus for policymakers. One priority should be reducing hospitalizations and emergency department (ED) visits. These services are disorienting for beneficiaries, and research indicates that some service use is potentially avoidable.

The I-SNP model is based on the premise that the plan can improve the quality of care for long-stay residents by delivering more care within the NH and reducing the use of inpatient care and ED visits. Our analysis of Healthcare Effectiveness Data and Information Set (HEDIS) risk-adjusted utilization measures suggests that this model may be at least somewhat effective: In 2023, the NHs that participated in I-SNPs had fewer hospital discharges, all-cause readmissions, and ED visits (on a risk-adjusted basis) than NHs that did not participate. Academic studies of I-SNPs have also found that they reduce the use of inpatient care, with no clear positive or negative effect on other quality measures.[16]

Given this evidence of the model's success, we are concerned that requiring I-SNPs to have a state Medicaid contract could reduce the availability of I-SNPs (e.g., if a state chose not to contract with any I-SNPs or limited the number of insurers that could offer them), without providing a better alternative. For example, even highly integrated D-SNPs will likely be less successful than I-SNPs because they face structural barriers that limit their ability to replicate the I-SNP model. One particular barrier is that nearly all NHs that participate in I-SNPs contract with a single insurer; this one-to-one relationship makes it easier for the I-SNP to generate enough enrollment to operate in a cost-effective manner and is preferable for NHs because their clinical staff need to become familiar with only one insurer's care model.

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[16] Chen, A. C., and D. C. Grabowski. 2024. A model to increase care delivery in nursing homes: The role of institutional special needs plans. *Health Services Research* (October 9). Epub ahead of print.
McGarry, B. E., and D. C. Grabowski. 2019. Managed care for long-stay nursing home residents: An evaluation of institutional special needs plans. *American Journal of Managed Care* 25, no. 9 (September): 438–443.

Requiring C-SNPs to comply with the restrictions on D-SNP look-alike plans

In the RFI, CMS asks for comments on three potential approaches for applying the restrictions on look-like plans to C-SNPs:

(1) Apply the existing restrictions without modification,

(2) Exclude partial-benefit dually eligible beneficiaries when determining whether a C-SNP exceeds the look-alike threshold of 60 percent, and

(3) Exempt C-SNPs that operate in states that do not have any type of integrated D-SNP.

The Commission raised concerns about the use of conventional plans as look-alike plans in its June 2018 and June 2019 reports to the Congress, and has consistently expressed support (in 2020, 2023, and 2024 comment letters) for CMS's efforts to limit the practice.

With respect to C-SNPs, our own analysis, which we discussed at our January 2026 meeting, is largely consistent with the analysis that CMS presented in the RFI and indicates that part of the rapid recent growth in the C-SNP market is due to MA insurers using these products as a new type of look-alike plan. We found that:

- The number of C-SNPs where the share of enrollees who are dually eligible exceeds the look-alike threshold began to grow rapidly in 2022 and 2023, when the look-alike restrictions on conventional MA plans went into effect.

- Many C-SNPs with a high concentration of dually eligible enrollees are being offered in states such as Arizona, California, Idaho, Illinois, and New Mexico that limit participation in their D-SNP markets to insurers that offer Medicaid managed care plans for dually eligible beneficiaries.

- In 2024, among C-SNPs that targeted beneficiaries with cardiovascular disease, chronic heart failure, or diabetes, the plans that had a high concentration of dually eligible enrollees had distinctive features that would limit their appeal to non-dually eligible beneficiaries, such as a high Part C out-of-pocket limit, the maximum Part D deductible, and a nonzero Part D premium (that was nonetheless less than or equal to the amount covered by Part D's low-income subsidy).

Based on these findings, we believe that some C-SNPs are being used to circumvent the additional requirements that apply to D-SNPs and undermine federal and state efforts to develop integrated care programs for dually eligible beneficiaries. Given the importance of those efforts, we believe that applying the restrictions on look-alike plans to C-SNPs would be appropriate.

If CMS applies the look-alike restrictions to C-SNPs, the current restrictions could largely be used without modification. For example, the methodology used to calculate whether a C-SNP exceeds the look-alike threshold should continue to include both full-benefit and partial-benefit dually eligible beneficiaries given the primary role that states play in

determining how those populations will be served in their D–SNP markets. In addition, the current exemption that allows look-alike plans to operate in states without any D–SNPs seems appropriate. Using a broader exemption for C–SNPs that are look-alike plans, such as allowing them to operate in states without any *integrated* D–SNPs, could impede future efforts in those states to develop their own integrated care programs.

However, if CMS decides to apply the look-alike restrictions to C–SNPs, it may want to consider including an exception for C–SNPs that target beneficiaries with three chronic conditions— chronic and disabling mental health conditions, chronic kidney disease, and HIV/AIDS. A disproportionately high share of the beneficiaries with these conditions are dually eligible, and some C–SNPs that target these populations may exceed the look-alike threshold. However, these conditions affect a relatively small share of the Medicare population and are unlikely to be used as part of a look-alike plan.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair