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January 26, 2026

Robert F. Kennedy Jr.
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via regulations.gov

RE: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P)

Dear Secretary Kennedy:

This letter is in response to the "Medicare Program; Contract Year 2027 Policy and Technical Changes" proposed rule as issued by the Centers for Medicare & Medicaid Services (CMS) on November 28, 2025.

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 5.8 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.4 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.

While we have provided more detailed comments below, we wanted to briefly share several of our key recommendations.

Summary of Humana's Key Issues and Recommendations

- **Risk Adjustment:** Humana generally supports CMS's broad goal to modernize the MA program and improve existing risk adjustment methodologies that align with Star reforms. We appreciate this opportunity to provide input on how best to improve program integrity and payment accuracy. However, because each option for modernizing the risk adjustment system comes with benefits and tradeoffs, we encourage CMS to identify the specific items they are seeking to solve for as part of risk adjustment reform. In our comments, we provide greater detail as to what an ideal risk adjustment reform process should include.

- **Stars:** Humana shares CMS's goal of creating a simplified quality rating system that strengthens MA, promotes high quality care, and provides enrollees with the information they need to choose the best plan. We support the proposed measure removals to focus more on outcomes, as well as the elimination of the Health Equity Index and the continued inclusion of the reward factor. As CMS considers future updates to the Star Ratings program, we urge CMS to work closely with stakeholders to ensure any changes promote transparency and stability for plans and enrollees.
- **Marketing:** Humana takes seriously the importance of beneficiaries finding, selecting, and enrolling in the health coverage that is right for their unique health and life needs. We appreciate CMS's request for comment on its approach to marketing oversight and agent and broker regulation, including efforts to reduce unnecessary regulatory burden and drive program improvements. In our comments, we offer recommendations to streamline requirements while also improving oversight and accountability.

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,

Michael Hoak
Vice President, Public Policy

I. Executive Summary

I.D. Supplemental Requests for Information

CMS is requesting comments on several specific areas beyond the various comment opportunities already presented throughout the proposed rule, including ways to modernize their approach to marketing oversight and agent/broker regulation in the Medicare program. More specifically, CMS is requesting feedback on the following:

Modifying the current definition of third-party marketing organization (TPMO) to delineate the roles of and requirements applicable to the different kinds of TPMOs.

> **Humana Comment:** The current definition of TPMO is broad sweeping and there are no definitions for the different kinds of TPMOs. In addition, CMS regulations apply certain requirements to specific types of TPMOs that are not defined. For example, CMS compensation requirements only apply to "independent agents and brokers," but "independent agents and brokers" is not a defined term. This lack of clearly delineated roles and requirements creates ambiguity and uncertainty. Humana believes that a clear definition of TPMO and distinct definitions of each kind of TPMO are critical to CMS establishing a regulatory framework that is applied consistently across the industry, which would result in reduced costs to the Medicare program while protecting beneficiaries. Humana requests that CMS develop definitions for each various type of TPMO including, but not limited to, sales agencies, agents and brokers, independent agents, captive agents, and lead companies. Once those definitions have been developed, Humana recommends that CMS revise the agent, broker, and other third-party requirements at 42 CFR 422.2274 to clarify the requirements that apply to each type of TPMO.

Modifying the 5 percent translation requirement.

> **Humana Comment:** Humana does not recommend any changes to the 5 percent translation requirements at this time. Limiting the translation requirement to the primary languages spoken by at least 5 percent of individuals in a plan benefit package service area correctly balances the interest in providing materials in a format beneficiaries can best understand with the administrative burden and cost of translating required materials experienced by MAOs.

Removing the requirement for CMS approval of plan use of the Medicare Card image.

> **Humana Comment:** Humana appreciates CMS's goal of modernizing and simplifying aspects of the marketing oversight and review process. However, objective and clear CMS oversight and guardrails provide stability and consistency across MA organizations and TPMOs while protecting beneficiaries. We are concerned that eliminating this requirement could leave beneficiaries vulnerable to fraudulent or deceptive marketing behavior by bad actors. The approval process for the use of the Medicare card image provides a checkpoint that helps protect beneficiaries from confusing and/or misleading advertising. Removing this safeguard runs the risk of harm to beneficiaries which compromises the integrity of the program.
>
> Should CMS decide to move forward with this change, we recommend that CMS implement objective guardrails for appropriate use of the Medicare Card image to mitigate risks to beneficiaries, such as allowing the card image only when:

- The material makes it abundantly clear that the advertiser is not affiliated with the federal government or Medicare.
- The material explains how the card relates to the product being marketed.
- The material discloses the name of the individual or entity that will be reached if a potential enrollee makes outreach using the contact information displayed on the material.

Eliminating the Outbound Enrollment Verification.

Humana Comment: Humana believes that outbound enrollment verification is useful in helping ensure members are enrolled in a plan that best fits their health needs; however, while Humana supports eliminating the outbound enrollment verification requirement for agent supported/agent assisted enrollments, we recommend that CMS encourage MA organizations to complete enrollment verification and allow agent/brokers to be part of that enrollment verification outreach. Humana believes that sales agents are often better suited to have the enrollment verification discussion with members and can assist the member with identifying alternative options if the enrollee determines that the selected plan is not appropriate for their needs.

Modifying testimonial requirements.

Humana Comment: Humana supports the testimonial requirements and believes that they create objective guardrails that help reduce the risk of beneficiaries being misled by marketing that utilizes testimonials. Humana recommends that CMS clarify whether a testimonial can be entirely fictious or whether it must reflect the actual opinions or beliefs of someone other than the MA organization. Humana also recommends that the testimonial requirements be drafted to address TPMOs that market for multiple MA organizations. Lastly, given the growing use of artificial intelligence tools in communications to beneficiaries, we recommend that CMS consider incorporating AI-related standards into the MA marketing requirements around testimonials, especially where AI-generated images and videos may lead beneficiaries to believe that an actual human is expressing his or her experiences with a plan or TPMO.

Eliminating mailing statement requirements.

Humana Comment: Humana supports CMS's proposal to eliminate the mailing statement requirements for certain communications with beneficiaries. This change would reduce administrative burden without compromising protections for beneficiaries.

CMS is also requesting feedback on potential regulatory changes aimed at oversight and enforcement of TPMOs.

Humana Comment: Humana takes seriously the importance of beneficiaries finding, selecting, and enrolling in the health coverage that is right for their unique health and life needs. We believe CMS regulations governing TPMOs go a long way to protect the beneficiary from misleading marketing practices; however, we believe additional regulatory changes are needed to better oversee TPMO activities and enforce CMS regulations. Below, we offer potential solutions that CMS can take to: 1) ensure the consistent application of CMS regulations to agents and brokers, 2) reduce unnecessary filing burdens on MA organizations and CMS, 3)

reduce ambiguity among state regulators regarding MA organization compensation flexibilities, 4) improve the process for reviewing marketing materials developed by TPMOs as well as MA organizations, 5) create more accountability and incentivize better TPMO behavior through greater data sharing, and 6) modernize the Health Plan Management System (HPMS) framework.

- **Compensation to Agents downline of TPMOs**: CMS compensation regulations at 42 CFR 422.2274(d) govern how MA organizations pay independent agents and brokers. TPMOs often have hierarchies of downline TPMOs, including individual agents and brokers under the first line TPMO which is directly contracted and receiving compensation from the MA organization. It is currently unclear whether downstream payments from the TPMO to its contracted or employed agents, brokers or other TPMOs are subject to the requirements at 422.2274(d). Humana requests that CMS issue regulations clarifying that the compensation requirements also apply to payments made downstream of the payment by the MA organization to the first tier TPMO.

- **Elimination of compensation filing requirements:** Humana recommends eliminating the regulations at 42 CFR 422.2274(c)(5) and 42 CFR 422.2274(c)(6), as explained below.

  The requirement under 42 C.F.R. § 422.2274(c)(5) requires, on an annual basis by the last Friday in July, MA organizations to report to CMS whether the MA organization intends to use employed, captive, or independent agents or brokers in the upcoming plan year and the specific rates or range of rates the plan will pay independent agents and brokers. Following the reporting deadline, MA organizations may not change their decisions related to agent or broker type, or their compensation rates and ranges, until the next plan year. Many MA organizations file a range from $0 to the maximum annual fair market value compensation rate permitted by CMS in each service area. This flexibility is important to allow MA organizations the ability to adjust to CMS plan benefit changes as well as industry and market dynamics that occur after the July filing and prior to the start of the Annual Enrollment Period. If the majority of MA organizations file the full compensation range, then Humana suspects that the filing has little utility to CMS and is therefore, an unnecessary and burdensome step for both MA organizations and CMS and should be eliminated.

  In addition, 42 C.F.R. § 422.2274(c)(6) states that MA organizations must: "On an annual basis by October 1, have in place full compensation structures for the following plan year. The structure must include details on compensation dissemination, including specifying payment amounts for initial enrollment year and renewal year compensation." This regulation is subject to varying interpretations. Some MA organizations believe they are permitted to modify their compensation payments throughout the plan year within the range of $0 to the maximum fair market value; while others believe that this regulation requires them to set a specific compensation amount for each plan benefit package prior to October 1 and not alter it after that date. This creates an unlevel playing field in the industry. MA organizations that modify their compensation payments during the plan year are better able to manage costs and adjust to changing market dynamics than MA organizations who contractually fix their specific payment amounts with agents and brokers as of October 1. Humana requests that CMS clarify its interpretation of 422.2274(c)(6) or eliminate the regulation because it creates

confusion and uncertainty among MA organizations who are interpreting the regulation differently.

- **Clarifying compensation payment flexibilities:** To address concerns from State Departments of Insurance, Humana also requests that CMS issue regulations clarifying that MA organizations are permitted to pay $0 commissions for one or more plan benefit packages in various service areas and are permitted to change those commissions within the range of $0 to the maximum CMS defined Fair Market Value throughout the plan year. These new regulations should also clarify that MA organizations are under no obligation to utilize sales agents to sell any particular plan or type of plan and can reassess whether to utilize agents at any time throughout the plan year.

- **Establish AI-assisted review:** To improve the consistency of CMS review of marketing materials, CMS could establish an automated review system (similar to the compliance rules engine tool currently being piloted by Humana, Red Marker). The tool identifies risks in content based on customized compliance rules that can be developed by CMS with the help of MAOs and TPMOs. CMS, MAOs, and TPMOs could leverage the tool for reviewing marketing materials and the tool would consistently flag compliance risks and provide identical feedback to all stakeholders. Red Marker claims that its marketing review process is up to 30 times faster than traditional, manual review.[1] Additionally, a case study by Messagepoint highlighted that automating the preparation of CMS-compliant Medicare marketing materials led to a 70 percent reduction in time and effort.[2] CMS could establish a file and use process for any materials that are run through a compliance rules engine that they approve/certify.

- **Share data across plans regarding agent issues:** CMS currently requires MA organizations to share with CMS a monthly report of agent disciplinary actions and regulatory violations. Humana believes that some agent bad actors move between MA organizations intentionally because MA organizations are not aware of the behavior of the agent at the other MA organization. Humana recommends that CMS share the agent disciplinary data it obtains from MA organizations' monthly across all MA organizations to help MA organizations recognize bad actors and avoid them. This would create accountability for agents, incentivizing better behavior and eliminate known bad actors' continual access to Medicare beneficiaries by contracting with another MAO.

- **HPMS modernization:** To keep pace with technological advancements or evolving regulatory requirements at both federal and state levels, CMS could take steps to modernize the Health Plan Management System (HPMS) framework.

  For integrated dual eligible special needs plans, states play an active role in reviewing marketing materials distributed to their constituents and the lack of consistent filing and submission standards has created unnecessary administrative burden for plans and TPMOs seeking to comply with the varying requirements and processes (for example, some states utilize HPMS while others do not). CMS should work with states to create a

[1] https://redmarker.ai/en-us/solutions/document-scanning

[2] https://www.messagepoint.com/wp-content/uploads/2020/11/CS-Anon-Med-20-11-6.pdf

consistent and streamlined process for submission of marketing and communication materials for all Dual Eligible Special Needs Plans.

To address these and other concerns, we suggest that some fields and options be adjusted within HPMS for Medicare filings to make it more efficient. For example:

- As a way to reduce strain on the system, allow one TPMO to opt into another TPMO's existing HPMS filing when both (or many) TPMOs use the same material to attract leads.
- As new digital media formats continue to evolve (e.g. social media videos), CMS should account for these materials to ensure clarity and consistency. For example, some MA organizations or TPMOs file social media videos as "social media" while others file them as "videos."
- Enabling plans and TPMOs to modify existing filings for minor changes to improve efficiency (e.g. the ability to make a modification to an existing HPMS filing as opposed to submitting a new filing in full or to correct the HPMS intake form if an error is made).

CMS is also seeking comment on current reporting processes and data collections to identify specific areas where requirements can be simplified, consolidated, or eliminated while maintaining program integrity and beneficiary protections in several areas.

Humana Comment: Humana appreciates CMS's efforts to reduce plan reporting burden and simplify reporting processes. Below we provide specific recommendations for areas in which reporting burden can be reduced while maintaining program integrity.

<u>Supplemental Benefit Reporting</u>
Humana recommends CMS modify the reporting requirements for supplemental benefits. We recommend that CMS adjust the due date for this data to later in the calendar to align with the submission timeline for the Bid Pricing Tool. We also recommend that CMS exempt EGWPs from these reporting requirements as EGWP supplemental benefits are not filed with CMS. Supplemental benefit reporting requires that utilization data be mapped to filed benefits. Given that EGWP supplemental benefits are not filed with CMS, it creates additional administrative complexity for plans to report on the 'unit' of utilization for these benefits.

Additionally, plans receive supplemental benefit utilization data from vendors in various formats and often not at the level of granularity required by CMS for these reporting requirements. Due to this, and the fact that supplemental benefits are not standardized and differ across MAOs, comparisons between these benefits are challenging. We recommend CMS narrow the scope of these requirements to a small subset of common supplemental benefit categories such as dental, vision, hearing, and transportation benefits.

Further, MAOs report on supplemental benefits through the MA encounter data system and via MLR reporting requirements at §§422.2460, in addition to the above-mentioned Part C reporting requirements. We recommend that CMS examine the volume of reporting on supplemental benefits that is required of plans and eliminate duplicative requirements.

<u>MA Prior Authorization Reporting - §§ 422.122(c) and Part C Reporting Requirements</u>

Current reporting requirements related to prior authorization are duplicative and can be simplified without affecting the integrity of the Medicare program. For example, the data reporting requirements at §§ 422.122(c) require plans to report the percentage of coverage request approvals and denials made by the plan. The Part C reporting requirements already necessitate MAOs to report the total number of approvals and denials. CMS should evaluate and align reporting requirements related to prior authorization to remove duplicative requirements and to remove unnecessary administrative burdens and associated costs.

II. Implementation of Certain Provisions of the Inflation Reduction Act (IRA) of 2022 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018

II.A. Medicare Part D Redesign

CMS proposes to codify changes to the Part D benefit made by the IRA related to the deductible, initial coverage limit, the coverage gap, and the annual out-of-pocket threshold. CMS also proposes to codify formulas that drive annual benchmarks under the Part D program which have previously been released as part of the annual rate notice process (specialty tier threshold, annual percentage increases, reinsurance methodology, etc.).

Humana Comment: Humana supports the CMS proposal to codify changes to the Part D benefit design made by the IRA. The Medicare Part D Program has now facilitated access to prescription drug coverage for Medicare beneficiaries for over two decades. The IRA made the most significant changes to the Part D program since its inception, including restructuring the Part D benefit design to increase plan liability for beneficiaries' drug costs and adding a maximum out-of-pocket cap for beneficiaries, among other changes.

Challenges to the Part D program under the prior benefit design are well documented[3], and Humana agrees that the program was in need of updates as the prescription drug market has evolved, including the development and launch of high-cost, specialty medicines that were far less prevalent when the program was initiated. However, now that we are entering the second year of the redesigned benefit, we have concerns about the unintended consequences of the IRA's changes.

Specifically, under the Part D redesign, plans have experienced higher-than-anticipated annual costs, despite initial projections that the impact of the redesigned benefit would be a limited, one-time event. Increased costs appear to be reflective of the benefit redesign itself and the associated changes in plan liability, but also unexpected, induced utilization among beneficiaries reaching the out-of-pocket cap as well as continued growth in the prescription drug pipeline. According to the Congressional Budget Office, CY 2026 bids anticipate a 35 percent increase in annual per-enrollee costs in 2026; previously, CBO expected that costs would increase by roughly 5 percent in 2026 and later years.[4] If current utilization trends continue, stakeholders observe that there may be additional pressure on bids looking ahead to CY 2027.[5]

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[3] See Redesigning Medicare Part D to Realign Incentives - AAF and jun19_ch2_medpac_reporttocongress_sec.pdf.

[4] A Call for New Research in the Area of Spending on Medicare Part D | Congressional Budget Office

[5] Milliman MedIntel Part D trend insights: Utilization trends for non-low income Part D members show no signs of slowing in the first half of 2025

While the IRA's Part D benefit redesign brought changes to plan, manufacturer, and government responsibility in financing the benefit, the $2000 maximum out-of-pocket limit substantially increased the generosity of the benefit overall – according to CMS' calculation, the actuarial value of standard coverage increased from 60 percent prior to the IRA's implementation to 72 percent in 2026.[6] PDPs and MAPDs made changes to beneficiary cost-sharing below the MOOP to account for the increased generosity of the benefit in totality, including increased deductibles and cost-sharing. These changes have been particularly stark among MAPDs, where average deductibles increased from $62 in 2024 to $224 in 2025, while the share of enrollment in plans with coinsurance for preferred brand drugs increased from 2.6% to 27.5% in the same year.[7]

Previously, we have expressed concerns related to premium increases resulting from the Part D benefit redesign and cautioned that at least some beneficiaries could be adversely affected. We appreciate CMS's development of the voluntary PDP Premium Stabilization Demonstration for CY 2025 and CY 2026, which somewhat insulated Medicare beneficiaries from potentially burdensome year-over-year premium increases. However, with the anticipated discontinuation of the stabilization demonstration at the same time that utilization trends are increasing, it is clear that additional policy changes are needed, especially in standalone PDP market, where plans manage prescription drug costs alone. We are encouraged by President Trump's Executive Order entitled "Lowering Drug Prices by Once Again Putting Americans First," which acknowledged the need for policy intervention to stabilize and reduce Medicare Part D premiums.[8]

As part of potential efforts to stabilize the Medicare Part D market, we encourage CMS to seek additional mechanisms to assist Part D plan sponsors in preserving the affordability historically associated with Part D plans. Specifically, under the Part D redesign, the accuracy of the RxHCC model is fundamental to promote the sustainability of the Part D program, as more of Medicare's subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments. The accuracy of the RxHCC model is therefore fundamental to promote the sustainability of the Part D program. Humana has long advocated for modifications to the RxHCC risk adjustment model to enhance its predictive power to reflect the relative cost of Part D coverage more appropriately for Medicare beneficiaries. Results of interviews with 11 actuaries with Part D expertise published by MedPAC in January 2026 indicate wide agreement that improving risk adjustment is crucial for long-term PDP market stability.[9] To address inaccuracies with the RxHCC model, we encourage CMS to reflect Direct and Indirect Remuneration (DIR) in the model to ensure more appropriate payment relative to plan liability and disincentivize plans from targeting or avoiding individuals with certain conditions. Additionally, since the current RxHCC model uses medical diagnoses to predict Part D plan liabilities, it does not account for variation in drug costs for members with the condition, including those with no drug utilization. To account for variations in enrollment across Part D plans, we suggest that drug utilization be used to impute conditions for plan payment, ensuring appropriate payment especially for high-cost members. For more detail on our policy suggestions for improvements to the RxHCC model in our comment letter in response to the

[6] See page 54936 of the proposed rule.
[7] Shifting Cost-Sharing Burden to Beneficiaries in Medicare Part D - June 19, 2025 - USC Schaeffer
[8] Lowering Drug Prices by Once Again Putting Americans First – The White House
[9] Tab-K-Part-D-bids-Jan-2026.pdf

Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

Additionally, we encourage CMS to provide additional flexibility to Part D plans to manage costs by streamlining regulations and reducing administrative burdens. Humana provided suggestions specific to the Part D program as part of the April 2025 Request for Information entitled "Unleashing Prosperity Through Deregulation of the Medicare Program."

Humana stands ready to discuss these recommendations in further detail and support policymakers as they seek to ensure the Part D program continues to be a stable and reliable source of drug coverage for Medicare beneficiaries today and in future years to come.

In addition to these initial comments, Humana offers specific section-by-section responses to CMS's proposals codifying the Part D redesign below.

II.A.3.b. Limit on Specialty-Tier Cost Threshold Adjustment

CMS proposes to amend the specialty tier cost threshold to allow for reductions in the threshold under certain circumstances. At present, CMS has clear authority to make periodic increases in the threshold but not reductions. CMS believes that the effects of the IRA and direct negotiations may warrant a reduction in the cost threshold at some point in the future.

Humana Comment: Humana supports the CMS proposal to allow for future reductions in the specialty-tier cost threshold, should market conditions dictate such adjustments. The proposed change provides CMS with full authority to set an appropriate threshold, which could improve the practical application of the threshold by plan sponsors. Humana appreciates efforts by CMS to provide plan sponsors with adaptable standards that facilitate development of responsible drug formularies.

II.A.4. Changes in True Out-Of-Pocket (TrOOP) Costs

CMS proposes to codify the TrOOP policies established in the Final CY 2025 Part D Redesign Program Instructions for CY 2025 and applied via the Final CY 2026 Part D Redesign Program Instructions for CY 2026 with respect to the definition of incurred costs for 2025 and subsequent years, without modification. This proposal would continue the current policy of counting enhanced alternative benefits towards an enrollee's TrOOP.

Humana Comment: Humana recognizes the importance of affordability for Medicare Part D enrollees and the value created by the maximum out-of-pocket cap (MOOP) established by the IRA, which ensures that there are reasonable limits on what a beneficiary pays for covered Part D drugs each year. In the proposed rule, CMS proposes to codify its established interpretation of incurred costs that must be counted towards an enrollee's TrOOP, developed previously as part of the program instruction guidance. However, we encourage CMS to consider the broader implications of the incurred costs standard it seeks to codify here and propose modifications moving forward if the current policy creates unintended consequences in the Part D program's operations.

Specifically, in the Final CY 2025 Part D Redesign Program Instructions, CMS established that supplemental Part D coverage provided by enhanced alternative (EA) Part D plans and other health insurance will be counted as incurred costs and included in the calculation of TrOOP.

However, by including the "value" of EA benefits in the TrOOP calculation, many enrollees in EA plans will enter the catastrophic phase despite spending considerably less than the annual MOOP on covered drugs. In fact, Milliman found that some non-low-income Medicare Part D beneficiaries who reached the catastrophic phase by June 2025 spent only $1,220 out-of-pocket, driven by the CMS interpretation of EA benefits in the TrOOP calculation (referred to as the "greater of" logic).[10] Given the potential for induced utilization once a beneficiary enters the catastrophic phase of the benefit, the proposed CMS policy could create distortions in plans' incentives to set copays or coinsurance less than the basic benefit.

As we highlighted above, Humana has concerns around the stability of the Part D program after the implementation of the IRA, including increasing beneficiary utilization and accelerating drug costs. We encourage CMS to monitor the impact of the incurred cost definition and interactions with broader program trends and to propose changes accordingly.

II.E. Outlier Prescriber Criteria

II.E.2. Proposed Provisions

CMS proposes to establish a threshold to identify persistent outlier prescribers of opioids as those outlier prescribers who receive three consecutive outlier prescriber notifications from CMS based on the methodology established in the SUPPORT Act of 2018. If there is an update to the methodology, only prescribers that have been identified three times by the same methodology would be considered "persistent." CMS seeks comments on this threshold.

Humana Comment: Humana supports CMS's continued efforts to identify and counsel outlier prescribers of opioids. Humana seeks to ensure that opioid prescribing practices closely align with clinical guidelines whenever possible. To that end, our teams already conduct outreach to practitioners whose opioid prescribing practices exceed certain thresholds to offer education on best practices for opioid therapies and nonopioid alternatives. We appreciate any flexibility that CMS can grant plan sponsors in overseeing the appropriate use of opioid therapies.

The proposed definition of "persistent outlier prescriber of opioids" is consistent with the goals of the SUPPORT Act. Humana supports CMS efforts to limit overuse of opioids and focus those efforts on prescribers who consistently outpace their peers with regard to opioid prescribing represents a logical next step. If this definition is adopted, we encourage CMS to partner with plan sponsors to find ways of strengthening drug utilization controls concerning outlier prescribers, such as at the point-of-sale, that require outliers to provide sufficient clinical information to substantiate opioid prescribing compared to peers who demonstrate responsible prescribing. We suggest CMS continue to appropriately refine the Part D drug management program, such as when CMS expanded the definition of "at-risk beneficiary" to include a history of opioid-related overdose, which we believe will facilitate proper prescribing regimens. Further, we welcome the opportunity to engage with CMS in advancing these types of reasonable safeguards to protect Part D beneficiaries while also limiting fraud and abuse within the Part D program.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

[10] MOOP there it is: In 2025, Part D beneficiaries are spending $1,200 on average to satisfy the $2,000 out-of-pocket maximum.

III.A. Revise List of Non-Allowable Special Supplemental Benefits for the Chronically Ill (SSBCI)
CMS proposes to state more precisely that cannabis products that are illegal under applicable state or federal law are not allowable as SSBCI. Currently, only one product that meets the definitions of hemp under the 2018 Farm Bill has been approved as a drug in the US: the prescription drug Epiodolex which is covered under Part D and therefore is not permitted to be offered as a Part C supplemental benefit. However, the FDA has completed evaluation of 'generally recognized as safe notices' for three hemp seed-derived food ingredients: hulled hemp seed, hemp seed protein powder, and hemp seed oil. As such, CMS proposes to allow MAOs to offer these three hemp seed-derived food ingredients as SSBCI to qualifying enrollees to the extent otherwise appropriate as SSBCI and under federal and applicable state law.

Humana Comment: Humana supports this proposal.

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

IV.A. Special Enrollment Period for Provider Terminations
CMS proposes to expand eligibility for special election periods (SEPs) when a beneficiary's provider leaves the network. CMS is proposing a change in the eligibility criteria for the current SEP for Significant Change in Provider Network to reflect that neither an MA organization determination nor a CMS determination of significant provider network change is necessary for an enrollee who is affected by the provider network change to be eligible for the SEP. CMS also proposes that information regarding eligibility for the SEP be included in the provider termination notice (currently, notice of SEP eligibility is sent separately from the provider termination notice).

Humana Comment: Humana appreciates CMS's efforts to streamline access to SEPs for enrollees impacted by provider terminations; however, we are concerned that verbal attestations absent any additional verification controls in the process may inadvertently lead to abuse and misuse by agents and brokers, as has been seen with other SEPs. Should CMS move to finalize this proposal, we strongly recommend that controls be implemented to adequately demonstrate that the beneficiary qualifies for the SEP to ensure the attestation is being applied consistently.

We are further concerned that this proposed change to the provider termination SEP will lead to unintended consequences that may further exacerbate provider network changes. Providers could use the broad language of this proposed SEP to leverage increased rates from plans, raising costs and leading to reduced benefits for enrollees. Additionally, the proposed SEP change could lead to aggressive marketing to beneficiaries from agents and brokers who would stand to obtain mid-year commissions for enrollee plan changes. We are particularly concerned about this potential given our above stated concerns that verbal attestations can be more readily misused.

In the proposed rule, CMS acknowledges a distinction between routine, smaller scale changes in provider networks from more substantial changes; however, CMS does not make any such distinction in its proposal to change eligibility criteria for the significant change SEP to reflect that a determination of a significant provider network change is no longer necessary. CMS proceeds to discuss adding the SEP information to the member notification, again, without

addressing an exception for routine, smaller scale changes. Should CMS finalize this proposal, additional clarification would be needed regarding the member notification for those individual, smaller scale changes since the SEP would not be applicable in those scenarios.

In the Medicare Managed Care Manual, Chapter 4, section 110.1.2.5, CMS indicates that SEPs will not be granted when MA plans make changes to their network that are effective on January 1 of the following contract year, as long as affected enrollees are notified of the changes prior to the Annual Enrollment Period. Should CMS finalize this proposal, we strongly recommend this exception still apply.

IV.B. Coordination of Election Mechanisms for MA and Part D

CMS is proposing to codify current policy that for elections that are made based on certain special election periods (SEPs), the beneficiary must either have CMS approval for the use of that SEP through the use of a CMS-operated election mechanism (for example, 1-800- MEDICARE or the Online Enrollment Center (OEC)) or other means, such as enrollee receipt of a notice.

Humana Comment: Humana supports this proposal.

IV.C. Use and Release of Risk Adjustment Data

CMS proposes to ease restrictions on the use of risk adjustment data at § 422.310(f)(1) and to repeal the limitations surrounding the release of risk adjustment data at § 422.310(f)(2) and f(3), other than protections currently in place for plan-submitted payment amounts. CMS believes this will allow for the use and release of risk adjustment data that is more aligned with the use and release of FFS claims and other MA data.

Humana Comment: Humana supports this proposal, as well as CMS's goals of creating consistent standards between MA and FFS, improving transparency, reducing regulatory burden, and promoting research and innovation that may improve program integrity, increase efficiency, or reduce waste. Humana appreciates CMS's commitment to maintain current protections for beneficiary identifying information and plan-submitted dollar amounts reported for an associated encounter.

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

IV.D.3. Proposed Provisions

CMS proposes standardized, detailed documentation requirements for coverage determinations and POS claim adjudications, used for purposes of determining coverage under the Part D benefit. Specifically, CMS wishes to review original format documentation or information from all written, electronic, and verbal communications between the pharmacist, prescriber, enrollee, or other relevant stakeholders, in addition to what is included on the pharmacy claim, that is relied upon by the Part D plan sponsor to make a coverage determination or otherwise permit a point-of-sale claim adjudication that determines a drug's coverage under the Part D benefit. CMS also proposes to require submission of additional information, such as dates, times, and diagnosis codes, related to coverage determinations and POS pharmacy claim adjudications.

Humana Comment: Humana appreciates CMS's recognition of the distinction between point-of-sale (POS) claim adjudications and coverage determinations. The adjudication of POS claims for

purposes of determining coverage under the Part D benefit facilitates accurate payment while minimizing impact to members. Humana has participated in several Part D program integrity Prescription Drug Event (PDE) record review audits and, during these audits, has consistently provided CMS with sufficient documentation for both prior authorizations and POS claim adjudication edits.

Humana supports CMS's efforts to standardize documentation requirements. However, we respectfully seek clarification regarding the proposed requirement at §423.505(d)(2)(xiii)(B), which calls for the inclusion of the name and title (as applicable) of the individual contacted by the Part D plan sponsor to verify the request (for example, pharmacist, prescriber, enrollee, or enrollee representative). In many circumstances, direct verification may not occur, as requests may be processed electronically or via phone without necessitating additional outreach. Typically, as provided for in the "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance," Humana and other Part D sponsors initiate outreach only when additional clinical information is required to complete a request.

We encourage CMS to clarify the expectation for documenting the name and title of individuals contacted in scenarios where additional information is not required. Alternatively, we suggest that CMS consider updating the language to specify that this proposed requirement applies only in instances where outreach is necessary to obtain additional clinical information.

We appreciate CMS's attention to this matter and its ongoing commitment to program integrity and operational clarity.

IV.E. Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements

CMS is proposing changes only to the TPMO disclaimer provision and is not proposing to alter the existing requirements. CMS states that this proposal would not change existing requirements provided within §§ 422.2267(e)(41)(i), (iii), (iv), and (v); and 423.2267(e)(41)(i), (iii), (iv), and (v) which state that any TPMO that sells plans on behalf of more than one MA organization or Part D sponsor, must electronically convey the TPMO disclaimer when communicating with a beneficiary through email, online chat, or other electronic means of communication, prominently display the disclaimer on TPMO websites, and include the disclaimer in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO. CMS is proposing to remove references to the SHIPs in the disclaimer, while maintaining guidance for beneficiaries to contact Medicare.gov or 1-800-MEDICARE for plan advice. Additionally, CMS is proposing to require TPMOs to provide the TPMO disclaimer during sales calls before engaging in discussions about benefits rather than requiring TPMOs to verbally convey the disclaimer during the first minute of a sales call.

Humana Comment: Humana supports CMS's proposal to replace the existing requirement for TPMOs to read the disclaimer within the first minute of a sales call with a requirement to read the disclaimer prior to the discussion of any benefits. This change would improve the call experience for the beneficiary by allowing the conversation to flow more easily into the discussion about benefits. It would also allow the TPMO to foster a better connection with the beneficiary. Humana would also like to call CMS's attention to the portion of the TPMO disclaimer that states: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area." It is difficult on national websites or national marketing materials for TPMOs to insert accurate information into the brackets prior to the TPMO knowing in which area a beneficiary lives. We request that CMS maintain this portion

of the disclaimer for sales calls but eliminate it from the TPMO disclaimer when it is (i) electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication; (ii) prominently displayed on TPMO websites; or (iii) included in marketing materials, including print materials and television advertisements, developed, used or distributed by TPMOs. In the alternative, we request that CMS issue clarifying guidance advising how TPMOs should calculate the bracketed information in the disclaimer when used on national websites or marketing materials prior to knowing a beneficiary's service area. Additionally, we request that CMS provide clarity around removing references to SHIPs from marketing materials.

IV.F. Removing Rules on Time and Manner of Beneficiary Outreach

CMS is proposing several changes to requirements regarding the time and manner of plans' outreach to beneficiaries, including eliminating the 12-hour separation between educational and marketing events, removing the 48-hour waiting period between obtaining a scope of appointment (SOA) and a personal marketing appointment, and allowing SOA collection at educational events. CMS is also proposing to more clearly define what qualifies as a personal marketing appointment (the proposed language reads as follows: "personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple) for purposes of discussing marketing topics."), and clarifying that a small group, for purposes of an SOA, is a limited number of people, generally related or living in the same household.

Humana Comment: Humana supports CMS's proposal to eliminate the 12-hour separation between educational and marketing events to increase efficiency so long as the appropriate oversight measures are implemented to ensure the beneficiary is not subject to a pressured sales environment. We would also recommend that the requirement that plans and agents/brokers give the beneficiary a sufficient opportunity to leave the educational event prior to the start of the marketing event be defined as a minimum 15 minute break in between to establish a clear distinction between events and ensure beneficiaries are aware of the shift from educational to marketing to eliminate confusion.

Humana supports CMS's proposal to eliminate the requirement that agents/brokers wait 48 hours between obtaining the SOA and having the personal marketing appointment. Humana also recommends strengthening the SOA requirements to include the following:

- Require the SOA to include a question that must be asked by the sales agent regarding the beneficiary's preference for when the marketing appointment occurs, and
- Require the SOA to include a question that must be asked by the sales agent regarding whether the beneficiary needs someone else to be present with them during the marketing appointment.

Humana supports CMS's proposal to allow plans and agents/brokers holding or participating in educational events with beneficiaries to make available and receive SOA forms at those same educational events. This change would make it easier for members to find the information they need quickly and efficiently.

Humana supports CMS's proposals to more clearly define what qualifies as a personal marketing appointment and agrees with CMS's clarification that a small group, for purposes of an SOA, is a limited number of people, generally related or living in the same household.

IV.G. Relaxing the Restrictions on Language in Superlatives

CMS proposes to remove the prohibition of using superlatives in marketing and communications materials without providing supporting documentation.

> **Humana Comment:** Humana shares CMS's goals of eliminating unnecessary administrative burden on plans and TPMOs, while at the same time ensuring the beneficiary is protected from misleading marketing practices. Humana does not support the elimination of the prohibition of using superlatives in marketing and communication materials without supporting documentation. We believe that the supporting documentation is an important safeguard to ensure that the entity developing the material has a reasonable basis for making the superlative claim. Should CMS decide to move forward with this change, however, we believe TPMOs would benefit from additional guidance about what CMS considers to be misleading in the use of a superlative to avoid adding further subjectivity to the marketing review process.

IV.H. TPMO Oversight: Revising the Record Retention Requirements for Marketing and Sales Call Recordings

CMS is proposing to reduce the amount of time that MA Organizations and Part D sponsors are required to retain recordings of marketing and sales calls to 6 years, while maintaining the requirement that enrollment records be retained for 10 years. CMS states it is also considering several other alternatives to the above proposal and states that it may instead finalize an alternative policy.

> **Humana Comment:** Humana believes that retaining marketing and sales call recordings is a necessary compliance tool that protects the beneficiary and the agent while strengthening program integrity. However, we believe that the duration of maintaining the marketing and sales call recording should align with the lookback period from the current plan year for which MA organizations must respond to complaints to Medicare regarding marketing practices. In Humana's experience, complaints can arise as long as four years after the plan year. Humana believes that the appropriate duration of the complaint lookback period as well as the recording retention requirement for the marketing and sales portion of calls should be 3 years from the current plan year. If CMS does not put a 3 year limit on the receipt and investigation of complaints to CMS, then Humana believes that the retention period for marketing and sales call recordings should be 6 years. This would ensure that MA organizations are able to adequately investigate issues and produce documentation to CMS related to complaints if requested.
>
> A shorter retention window and complaint lookback window of 3 years would reduce the need for excess resources, storage, and unnecessary administrative burden. Additionally, a shorter timeframe minimizes potential cybersecurity risks involving sensitive beneficiary information stored for longer periods of time.

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

CMS is proposing to eliminate the current Notice of Availability of language assistance services and auxiliary aids and services (NoA) material (formerly known as the Multi-language insert) requirement and instead, defer to the Office for Civil Rights' (OCR) oversight and management of any requirements related to language assistance and auxiliary aids and services notifications.

> **Humana Comment:** Humana opposes the proposal to rescind the CMS NOA rules and instead defer to OCR's NOA requirements. Instead, Humana recommends that CMS revert to the

previously used Multi-Language Insert (MLI) requirements that required plans to include the top 15 non-English languages nationally, instead of the top 15 languages in the state/states. Many plans cross state lines and the requirements to change the languages for each state significantly increases the page count for plan materials and require enrollees to look through numerous irrelevant pages to find their pertinent state materials. These additional pages also increase printing and mailing costs for limited enrollee benefit. CMS could significantly reduce plan burden by reverting to the previous requirement of including the top 15 languages nationally.

Further, Humana recommends that CMS work with OCR to revise the 1557 Rule to limit the number of required communications that NOA must be included in. The printing is costly and leads to poor member experience when they receive multiple documents in every mailing. CMS should require the inclusion of the NOA in the Annual Notice of Coverage (ANOC), Evidence of Coverage (EOC), Explanation of Benefits (EOB), and Summary of Benefits documents.

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

IV.J.2. Appeals Process

CMS proposes to establish a three-level appeals process for Part D program integrity PDE record review audits. Under this proposed appeals process, Part D plan sponsors would receive an audit close out letter including: (1) an explanation of the drug, item, or service under audit; (2) a high-level overview of improper and proper PDE record counts; (3) an attached PDE level record file denoting improper and proper PDE records; (4) requirements for the submission of deletion records or adjustment records for the PDEs determined to be improper; and (5) instructions on how the Part D plan sponsor may appeal the findings. There would be no minimum threshold for an appeal at any level.

Humana Comment: Humana supports CMS's efforts to further formalize the Part D program integrity PDE record review audits and supports this specific proposal to establish a three-level appeals process. Humana would also recommend CMS consider establishing a standard timeframe by which PDE record review audits must be completed, so that plans receive findings or recommendations and delete improper PDE records accordingly. In some instances, Humana has received close out letters for Part D program integrity PDE record reviews several years after the audit was initiated.

IV.K. Prescription Drug Event Submission Timeliness Requirements

CMS proposes to modify the General PDE Submission Timeliness Requirements by amending language related to the submission of PDE records to resolve a rejected PDE record. Under the current rule, Part D sponsors must submit a revised PDE record to resolve a PDE record that CMS rejected through the PDE editing process within 90 calendar days of the receipt of rejected record status from CMS. CMS here proposes to require that Part D sponsors submit a PDE record within 90 calendar days from receipt of the rejection and within every 90 calendar days thereafter until a revised PDE record is accepted unless the claim associated with the rejected PDE record is reversed or deleted, or the PDE record is otherwise found to have been submitted in error.

Humana Comment: Humana supports CMS in its efforts to improve the process by which rejected PDE records are revised and reconsidered. However, the changes proposed here by CMS are administratively burdensome, and would not necessarily provide CMS with additional information on the underlying status of the rejected PDE records. As CMS recognizes in the preamble to the proposed rule, submission of a revised PDE record is not always appropriate. In

some cases, Humana or another plan sponsor may be waiting for a response from CMS on a pending eligibility case. Our interpretation of the proposed change is that the plan sponsor would still need to resubmit the PDE record within the 90-calendar day window proposed here even in situations when a CMS decision is pending, or additional information has been requested.

In addition, we are concerned about the potential impact of this proposal on both our contracted pharmacy audit partners and pharmacies. It seems likely that the proposed resubmission requirements would necessitate changes to current research processes related to rejected PDE records. It is also very possible that Humana and other plan sponsors would need to increase the speed and frequency of interactions with pharmacy providers in order to meet the revised resubmission standards, recognizing that pharmacies already have limited resources to dedicate to this work.

Humana participates in various Acumen PDE audits where CMS flags claims and requests additional information and suggests that CMS consider utilizing a similar approach if there are questions related to the status of rejected PDE records. Minimally, we ask that CMS clarify its expectations related to rejected PDE records which are actively under research or rework with the goal of limiting the administrative burden on plan sponsors, vendors, and pharmacies.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings)

V.B. Adding, Updating, and Removing Measures

CMS proposes language at §§ 422.164(e)(3) and 423.184(e)(3) to clarify existing policy that the removal of measures for any reason not stated in paragraph (e)(1) will be proposed and finalized through rulemaking. CMS is proposing language at §§ 422.164(e)(2) and 423.164(e)(2) to clarify that removals for the reasons stated in paragraph (e)(q) will either be announced through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the SSA (which governs the Annual Rate Notice) or proposed and finalized in rulemaking. CMS states that this language change would reflect that where one of the bases for measure removal applies, the agency will pursue removal using the process that allows for the most expedient notice to MAOs and Part D sponsors at that time.

Humana Comment: Humana supports the clarification related to measure removals. The comment and response opportunity for measure retirements is an imperative part of the overall measure removal process, and we support CMS's efforts to continue to use this process in most cases for measure removal.

As detailed in our comments below, we support CMS's efforts to streamline the Star Ratings measure set and to focus the remaining measure set on outcomes and patient experience. We do have concerns about the potential instability the retirement of twelve measures in only two years could cause in the program and the potential negative impact that could result on enrollee costs and benefits. As such, we recommend that CMS consider amending the proposed timeline to spread the removal of these measures out over more program years.

V.B.1.a. Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C)

CMS proposes removing the Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C) measures effective as of the 2029 Star Ratings / 2027 Measurement Year. CMS would

continue to monitor plan performance and issue compliance actions based on appeals data as needed and would continue to monitor access issues through the CAHPS survey measures.

> **Humana Comments**: Humana supports the retirement of these measures as currently structured and implemented. However, Humana would caution CMS from relying solely on the CAHPS survey measures as an indicator of member experience, given the challenges with low response rates and other concerns that we have previously raised about CAHPS (see further comments in our response below to the QBP RFI).

IV.B.1.b. Special Needs Plan (SNP) Care Management (Part C)

CMS proposes to remove Special Needs Plan (SNP) Care Management effective as of the 2029 Star Ratings / 2027 Measurement Year since the current measure does not provide any information about whether enrollees received care as indicated by their assessments. The measure would move to the display page.

> **Humana Comment**: Humana supports the retirement of this measure.

IV.B.1.c. Call Center – Foreign Language Interpreter and TTY Availability (Part C and Part D)

CMS proposes removing the Call Center – Foreign Language Interpreter and TTY Availability (Part C and Part D) measures effective as of the 2028 Star Ratings / 2026 Measurement Year. CMS would continue to monitor plan performance and compliance, and the Star Ratings would continue to capture similar issues related to customer service through the CAHPS survey measures.

> **Humana Comment**: Humana supports the retirement of these measures but would caution CMS from relying solely on the CAHPS survey measures as an indicator of member experience.

IV.B.1.d. Complaints about the Health/Drug Plan (Part C and Part D)

CMS is proposing the removal of the Complaints about the Health/Drug Plan (Part C and Part D) measure effective as of the 2029 Star Ratings / 2027 Measurement Year. CMS would continue to monitor plan performance and issue compliance actions as needed, and the Star Ratings would continue to capture similar issues related to access to care and patient experience through the CAHPS survey measures.

> **Humana Comment**: Humana supports the retirement of these measures but would caution CMS from relying solely on the CAHPS survey measures as an indicator of member experience.

IV.B.1.e. Medicare Plan Finder (MPF) Price Accuracy (Part D)

CMS proposes removal of the MPF Price Accuracy (Part D) measure effective as of the 2029 Star Ratings / 2027 Measurement Year given high average scores across plans.

> **Humana Comment**: Humana supports the retirement of this measure.

IV.B.1.f. Diabetes Care – Eye Exam (Part C)

CMS proposes removing the Diabetes Care – Eye Exam (Part C) measure effective as of the 2029 Star Ratings / 2027 Measurement Year as part of effort to streamline the Star Ratings measure set and given there are other measures that focus on diabetes care. The measure will remain on the display page.

Humana Comment: Humana supports the move of this measure to the display page but would urge CMS and NCQA to continue to monitor retinopathy screening rates with potential re-assessment of the measure's inclusion in the Stars program in the future if subsequent declines are noted.

IV.B.1.g. Statin Therapy for Patients with Cardiovascular Disease (Part C)

CMS proposes removing the Statin Therapy for Patients with Cardiovascular Disease (Part C) effective as of the 2028 Star Ratings / 2026 Measurement Year measure as part of the effort to streamline the Star Ratings measure set and increase the focus on patient experience and outcome measures.

Humana Comment: Humana supports the retirement of this measure.

IV.B.1.h. Members Choosing to Leave the Plan (Part C and Part D)

CMS is proposing the removal of the Members Choosing to Leave the Plan (Part C and Part D) measure effective as of the 2029 Star Ratings / 2027 Measurement Year as part of our effort to streamline the Star Ratings measure set and increase the focus on patient experience and outcome measures.

Humana Comment: Humana supports the retirement of this measure.

IV.B.1.i. Customer Service and Rating of Health Care Quality (Part C)

CMS proposes removing the Customer Service and Rating of Health Care Quality (Part C) measures effective as of the 2029 Star Ratings / 2027 Measurement Year as part of effort to streamline the Star Ratings measure set and given there is less variation in performance across contracts on these measures

Humana Comment: Humana supports the retirement of these measures.

IV.B.2.a. Depression Screening and Follow-Up (Part C)

CMS proposes to add the Depression Screening and Follow-Up (Part C) to the 2029 Star Ratings (measurement year 2027). CMS will begin reporting this measure on the display page for the 2026 Star Ratings. This is a process measure with a weight of 1.

Humana Comment: Humana recognizes the value of supporting mental health for our members and is generally aligned with the inclusion of the Depression Screening and Follow-Up measure in the Star Program in the future.

We do have continued concerns about the inclusion of measures that rely solely on the use of the electronic clinical data systems (ECDS) reporting method, given the obstacles many MA plans have encountered with ECDS reporting, such as challenges with the availability and interoperability of electronic data. In particular, we have experienced disparities in the adoption of the ECDS reporting method among our own rural and urban providers that result in lower performance by rural providers that is attributable to reporting, not actual performance. Smaller providers may also struggle to share electronic data with plans, which would impact efforts by both plans and providers to successfully calculate measure performance. We urge CMS to consider maintaining this measure on the display page for the 2029 Star Ratings until these data reporting concerns can be more fulsomely addressed.

IV.C. Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures

CMS solicits feedback on ways to streamline and modify the Star Ratings methodology to further incentivize quality improvement and suggestions for new outcomes measures to promote prevention and wellness for Part C and Part D enrollees. CMS also solicits feedback on additional measures for removal.

Humana Comment: Humana shares CMS's goal of creating a simplified quality rating system that strengthens MA, promotes high quality care, and provides enrollees with the information they need to choose the best plan. We are generally supportive of the agency's efforts to reduce measurement burden and move to a more outcomes focused measure set, particularly when these changes are paired with further reforms to the Star Ratings calculation methodology as detailed further in our comments below on the Quality Bonus Payment RFI.

Medication Therapy Management (MTM) Comprehensive Medication Review (CMR) Completion Rate Measure

As stated in this proposed rule, CMS intends to "simplify and refocus the measure set on clinical care, outcomes, and patient experience." In alignment with this approach and as detailed above, CMS proposes to remove several measures focused on operational or administrative performance. Aligned with this approach, **Humana urges CMS to permanently retire the MTM / CMR measure from the Star Program**, not returning it to the Star Ratings program from the display page. Humana believes the return of MTM CMR to the Stars program does not align with CMS's priorities of focusing the measure set on clinical care, outcomes, and patient experience. The MTM CMR Star measure is administrative in nature, focuses on the member's completion of a process, and does not measure the clinical value of the program. Humana recommends CMS allow key industry stakeholders, like the Pharmacy Quality Alliance (PQA), to devise a new measure evaluating the clinical outcomes associated with MTM before bringing a measure related to the MTM program back into the Star Ratings.

Past Performance

CMS added Star Ratings to the calculation methodology for past performance, adding points to a plan's past performance score if the plan received any combination of Part C or Part D summary ratings of 2.5 or less in both of the two most recent Star Rating periods. CMS should eliminate the inclusion of Star Ratings from the past performance methodology at §§ 422.502(b)(1)(D) and 423.503(b)(1)(D). Humana believes that the inclusion of Star Ratings in the past performance methodology is duplicative of other CMS regulations that protect Medicare beneficiaries from enrolling in low performing plans (i.e., §§ 422.510(a)(4)(xi) and 423.509(a)(4)(x)) establishing CMS's authority to terminate a sponsor contract if the Part C or D summary rating score falls below 3 stars for three consecutive years and the posting of Star Ratings, with a low-performing indicator, on Medicare Plan Finder).

Additionally, if CMS finalizes the removal of several measures as proposed, more than 20% of measures will be removed from the program, creating a level of instability that will take time for plans to adjust to. This is likely to create further impacts to plan past performance given that Part C and Part D summary ratings are used in its calculation, and the proposed retirements significantly alter the measure mix at the summary level. Given that, as noted, CMS has other authority to protect Medicare beneficiaries from enrolling in low performing plans, Humana urges CMS to remove the inclusion of Star Ratings from the past performance methodology.

Part D Star Ratings

Humana has significant concerns about the instability for PDPs that may result from the proposed removal of Part D measures, and we urge CMS to evaluate the Part D Star Ratings program to determine if additional modifications are necessary to ensure stability in the program and fair outcomes for plans. While we are supportive of the proposed measure removals related to the goal of focusing on outcomes, given the much smaller number of Part D measures, small changes to performance by a PDP are likely to have an outsized impact on a plan's Star Ratings and the resulting ratings could be an unreliable metric for members to use when choosing a plan. This volatility is likely to produce a misleading picture of a plan's actual performance that would not reasonably represent the likely experience an enrollee may have on the plan or the clinical outcomes produced by the plan.

If the proposed measure retirements are finalized, the Patient Safety measures would make up 57% of the PDP Star Rating (or 75% without the Improvement measure) once the Medication Adherence measures return to 3x weighted. Plans largely utilize member outreach programs to influence members to increase medication adherence. While adherence is important, the increased volatility of the reduced Part D Stars measure set will likely lead to substantially more member outreach as plans seek to improve performance, which may result in a poorer enrollee experience.

IV.D. Health Equity Index Reward

CMS proposes to remove the HEI reward from the Star Ratings methodology. CMS proposes not to implement the HEI reward with the 2027 Star Ratings and instead continue the historical reward factor. CMS states that rather than implement the change to the methodology to add the HEI reward and remove the reward factor, the agency proposes to keep the current methodology consistent as it explores ways to simplify the methodology in the future.

Humana Comment: Humana supports the proposal not to implement the HEI reward beginning with the 2027 Star Ratings and to continue utilizing the historical reward factor. Humana has been supportive of efforts to focus on and improve the quality of care provided to our most vulnerable members, but we have shared our concerns with the unnecessarily rushed HEI implementation process and with the lack of timely performance data shared with plans. To date, CMS has not adequately shared the data required for plans to fully understand the methodology and performance outcomes, both for their plans and the industry, on HEI, even as the agency had publicly said it would. In advance of the first measurement year, only one year of data was shared and it was shared with plans only days before the measurement period began, leaving plans with virtually no time to understand their performance.

While Humana supports not moving forward with the HEI in the Star Ratings, we recommend that CMS provide data to plans on their performance, and that of the industry, on this subpopulation of members with social risk factors (SRFs) as CMS has stated it would, even without implementation of the HEI. MA plans do not receive granular data on subpopulations of enrollees and having more data about plan performance with vulnerable populations will serve to help plans improve the quality of care for our members who need it most. As CMS states in the preamble to the proposed rule, "any improvements in performance among these populations will still contribute to higher performance" and having the data on plan performance on enrollee populations with SRFs is vital to improved quality.

CMS proposes to codify the current practice of providing sample data for one of each type of measure during the second plan preview.

> **Humana Comment:** Humana recommends that CMS expand the current practice and provide sample data for all measures, rather than for just one of each type of measure. Humana has found errors in the data during plan previews and believes plans should be given more sample data in order to enable us to validate CMS's methodologies and calculations.

VI. Improvements for Special Needs Plans

VI.A. Model of Care (MOC) Off-Cycle Submission Window

As a follow-on to the September 2025 HPMS email titled "Contract Year 2027 Model of Care Submission Timeline Updates," in which CMS moved the initial and renewal MOC submission deadline to the Friday before the first Monday of June, starting with the contract year (CY) 2027 MOC submission period, CMS acknowledges the new MOC submission deadline and subsequent NCQA evaluation overlaps with the current off-cycle MOC submission window. To accommodate the CY 2027 MOC submission deadline change and ensuing operational considerations both for NCQA and CMS's HPMS, CMS states that a new timeline for the off-cycle submission process is needed. As such, CMS is proposing that for CY 2027 and subsequent years, D-SNPs and I-SNPs seeking to revise their NCQA-approved MOC during the MOC approval period must submit updates and corrections between January 1 and March 31 and October 1 and December 31 of each calendar year.

> **Humana Comment:** Humana acknowledges and supports CMS's efforts to align the MOC off-cycle submission process with the new annual deadline in order to improve operational efficiency in review and approval procedures. However, the proposed shortened submission windows of January 1–March 31 and October 1–December 31 may introduce challenges for plans responding to NCQA feedback and the proposed submission windows may not be sufficiently flexible to accommodate implementation timeframes for state-directed changes. Specifically, the time required for review and approval may prevent plans from adequately addressing and curing deficiencies if initial submissions are deemed unacceptable, potentially leading to non-compliance within the designated timeframe.
>
> Humana recommends that CMS extend the proposed submission window to begin on September 1 and continue through December 31. Should CMS proceed with the shorter off-cycle submission windows, Humana urges CMS to provide additional clarification regarding the cure process. For example, with a three-month window as proposed, the duration necessary for NCQA review and approval may result in the window closing before a health plan can address any identified deficiencies. If this occurs during the first submission window, plans would be required to wait until October to resubmit, which could impede operational efficiencies and delay processes, impacting member experience and outcomes. To mitigate this, Humana recommends that plans have the ability to cure deficiencies after the three-month window closes to ensure operational continuity and compliance.
>
> Additionally, state-directed changes often require implementation by January 1. The proposed submission periods may not provide sufficient flexibility to accommodate these regulatory requirements, potentially delaying timely updates in response to state mandates. Therefore, Humana respectfully requests that CMS consider offering greater flexibility or expanding the submission periods for off-cycle MOC updates. This adjustment would enable plans to better

fulfill both federal and state operational and compliance requirements while continuing to meet the review standards of CMS and NCQA. For example, extending the second submission window to begin on September 1 and end on December 31 would afford additional time for plans to implement changes resulting from State Medicaid Agency Contracts (SMACs) and other regulatory modifications, as well as to address any necessary cures.

Furthermore, Humana recommends reconsidering what constitutes as a significant change that necessitates off-cycle submission. For example, permitting routine redline changes to quality metrics used to measure performance would reduce administrative burdens for both plans and NCQA. Another consideration is to remove the requirement for a MOC to be implemented prior to allowing off-cycle changes, given the current pace and volume of changes driven by operational strategy, state requirements, and the regulatory environment, which may require updates prior to the MOC go-live date.

VI.B. Passive Enrollment by CMS

CMS proposes to remove the requirement that the passive enrollment receiving integrated D-SNPs have substantially similar networks to the relinquishing integrated D-SNPs and, instead, require receiving integrated D-SNPs to provide continuity of care for all incoming enrollees for a minimum of 120 days. CMS also proposes that the D-SNP receiving passive enrollment must have the care coordinator staffing capacity to receive dually eligible enrollees through passive enrollment. This proposed change would also remove the current language that requires the passive enrollment receiving plan to have substantially similar Medicare- and Medicaid-covered benefits as the relinquishing integrated D-SNP.

Humana Comment: Humana supports the proposal to remove the requirement that the receiving integrated D-SNP have a substantially similar network to the relinquishing D-SNP. This change would allow for the passive enrollment option to be more readily used and facilitate continued enrollment in an integrated plan for eligible beneficiaries.

Regarding the proposed staffing requirements, receiving plans will need adequate notice of the impending enrollment in order to meet any staffing update requirements. Humana recommends that CMS provide at least 90-days' notice to the receiving plan prior to the enrollment of the transferring beneficiaries in order to provide the receiving plan sufficient time to increase care coordinator staff levels. In cases where it is not possible for CMS to provide at least 90-days' notice to the receiving plan, we recommend that CMS provide the receiving plan with flexibility in meeting the care coordinator staffing requirements as it takes time to hire and train staff and may be challenging to do under a tight timeframe.

VI.C. Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid Fee-for-Service

CMS proposes to allow D-SNPs that serve full-benefit dually eligible individuals in a HIDE SNP or coordination-only D-SNP to continue enrollment of full-benefit dually eligible individuals in a D-SNP in the same service area where those individuals are enrolled in Medicaid FFS. This proposed change would avoid the need for MAOs in states without mandatory Medicaid managed care to cease enrolling full-benefit dually eligible individuals who are in Medicaid FFS starting in 2027 and to disenroll those members in 2030 as currently required.

Humana Comment: Humana supports this proposal. Allowing HIDE SNPs and coordination-only D-SNPs to continue to enroll members who are enrolled in FFS Medicaid will permit plan

sponsors to avoid disenrolling full-benefit dually eligible beneficiaries, preventing disruptions in their care and ensuring that these enrollees receive the benefits provided by more integrated plan offerings for their Medicare benefits. This proposal would also allow full benefit dual eligible individuals more choices for their Medicare coverage.

CMS proposes to limit the proposed exception for allowing MAOs to offer one or more additional D-SNPs for full-benefit dually eligible individuals to HIDE SNPs with a majority of enrollees in Medicaid FFS.

Humana Comment: Humana supports this proposal as it would allow HIDE SNPs to continue enrolling full benefit dually eligible individuals and avoid the disruption of having to remove these enrollees from a plan beginning in 2030. This proposal will permit these fully dual eligible enrollees to continue receiving the benefits of enrolling in a D-SNP to complement their Medicaid FFS coverage. Humana also encourages CMS to more clearly define what it considers to be a "majority" of enrollees in Medicaid FFS. This would provide plans with more certainty about whether the proposed exception would allow them to offer additional D-SNPs.

Humana also recommends that CMS allow an exception that permits MAOs to offer one or more D-SNPs for full-benefit dually eligible individuals in states where the SMAC agreement provides capitated payments to D-SNPs for coverage of Medicaid benefits. For example, in Florida, D-SNPs provide coverage of Medicaid wrap around benefits to full-benefit dually eligible enrollees through the SMAC. Humana also contracts with the state as a Medicaid MCO. Without an exception, under current rules, Humana and other parent entities that hold Medicaid MCO contracts and operate D-SNPs will be limited to one D-SNP per overlapping service area while parent entities that do not contract as Medicaid MCOs will be permitted to offer multiple D-SNPs. This could provide a disincentive for parent entities to contract with Florida as a Medicaid MCO. Given that D-SNPs structured like those in Florida already provide aligned Medicare and Medicaid enrollment (as CMS notes in the CY 2025 Final Rule[11]), we urge CMS to allow an exception for MAO parent entities to offer one or more D-SNPs when Medicaid coverage is provided via capitated payment for coverage of Medicaid benefits in the SMAC.

CMS proposes to update the SMAC requirements to permit coordination-only D-SNPs that enroll full-benefit dually eligible individuals who are enrolled in Medicaid FFS.

Humana Comment: Humana does not support this proposal and urges CMS not to finalize it. While Humana supports efforts to improve the quality of care provided to dually eligible enrollees and to enhance coordination between the Medicare and Medicaid programs, we continue to have significant concerns about the collective impact of CMS's recent major changes to the D-SNP program and about the impact this proposal to reduce the scope of coordination-only D-SNPs will have on the availability of plan choices for dual enrollees. We urge CMS to avoid continuing to pursue "one-size-fits-all" approaches to integration and instead work with state and plan partners to develop more thoughtful, targeted solutions.

Providing high quality, comprehensive care to dually eligible beneficiaries is vitally important to the Medicare and Medicaid programs and to Humana. D-SNPs serve as an important tool to

[11] 2024-07105.pdf. Footnote 220. "Any switch between D-SNPs in Florida is not excluded because all D-SNPs in Florida are directly capitated by the State for Medicaid services and therefore already provide aligned Medicare and Medicaid coverage."

reduce gaps in care by increasing the coordination between the Medicare and Medicaid programs and improving care delivery and member experience. D-SNPs establish a multidisciplinary care team that includes community resources, build comprehensive provider networks, and provide person-centered care coordination for beneficiaries.

This abrupt change would be highly disruptive and could result in costly impacts to health outcomes. Hundreds of thousands of low-income elderly or disabled dual-eligible enrollees would be abruptly terminated from the health plan they selected. Trusted relationships with care managers, PCPs, and other providers will be disrupted and care plans will be impacted for members managing chronic diseases and for those in end-of-life care. Many enrollees could lose access to vital benefits that are covered by their chosen D-SNP, but not necessarily their Medicaid MCO's aligned D-SNP.

Policies such as those finalized in the CY 2025 Policy and Technical Changes to the Medicare Advantage Program rule (CMS-4205-F) that result in limiting the number of D-SNPs available in a service area are likely to result in forcing the highest-quality and most experienced D-SNPs out of state markets in many areas. In several states across the country, there are plans that serve the dual eligible population through D-SNPs that have not historically served the Medicaid managed care population. These D-SNPs bring strong expertise and experience serving older individuals and those with chronic illness and complications. Medicaid MCOs offer expertise in serving pregnant and postpartum individuals, children, and other Medicaid populations; however, many of them do not have longstanding experience serving dual eligibles and offer a D-SNP only when it is required by the state. Further, most state Medicaid managed care procurement, contracting, and oversight processes do not evaluate the quality of available D-SNPs in the state.

Currently, 200,000 of Humana's D-SNP members are in plans receiving a Star rating of 4+. However, in multiple states that use selective contracting for their Medicaid managed care contracts, Humana is prohibited from offering a D-SNP without a Medicaid managed care contract, even when our MA plans have significantly higher quality ratings than those offered by the contracted Medicaid managed care organizations. For example, in one state that uses selective contracting, all of the D-SNPs aligned to the contracted Medicaid MCO parent entity are rated under 4 Stars, with some aligned D-SNPs rated at 3 and 2.5 Stars. Further, in another state using selective contracting, 90% of dual enrollees in D-SNPs are in 3 Star plans. In yet another state employing selective contracting, 90% of dually eligible individuals are enrolled in plans with Star ratings below 4. Proposals such as those in this section that would limit D-SNP enrollment to an affiliated Medicaid MCO could result in dually eligible beneficiaries losing their ability to enroll in a high-quality D-SNP.

As stated above, we are concerned about limiting the existing D-SNP options in many states to plans with less experience in serving Medicare and dually eligible beneficiaries and with lower quality ratings. It is not in the best interest of these vulnerable beneficiaries to limit their plan options based on state Medicaid procurement cycles and decisions, which vary in timing and can involve lengthy legal challenges, resulting in changes that may force a beneficiary from their preferred D-SNP and further complicate attempts to align across Medicare and Medicaid plans. This proposal further reduces the already limited choices a dual enrollee will have in 2027 by removing their ability to enroll in a coordination-only D-SNP offering. In states in which the contracted Medicaid parent entity has a low performing D-SNP, eligible enrollees will only have

the option of enrolling in the low-performing plan or in Medicare FFS, an option with no integration at all.

Humana supports CMS's goal to increase coordination between the Medicare and Medicaid programs, but we believe that the availability of different models to serve dual eligibles also provides flexibility for states and plans to design programs that best meet the needs of the beneficiaries within each market. For example, in Florida, where Humana serves dually eligible beneficiaries, operate unique HIDE-SNP models through which D-SNPs cover Medicaid wraparound benefits (e.g., behavioral health and non-emergency medical transportation) without requiring plan participation in the mainstream Medicaid managed care program. As such, when a Humana D-SNP member in Florida needs Medicaid behavioral health services, Humana is responsible for covering the member's care, even though we do not participate in the Medicaid managed care program. This provides the enrollee with integrated care but allows them to keep their preferred D-SNP. In addition, Nevada is exploring a new contracting approach for D-SNPs in which the state will competitively select plans based upon their experience and quality, ensuring only high-quality D-SNPs may participate in the state. DSNPs will continue to be coordination-only D-SNPs but will include enhanced elements in the State Medicaid Agency Contract (SMAC) to further advance coordination and the provision of whole-person care.

Models such as coordination-only D-SNPs also help prevent mass disruption for dual eligibles when states and territories re-procure their Medicaid managed care contracts, by allowing these vulnerable members to stay in their choice of D-SNP regardless of the state's procurement decision. Limiting the availability of coordination-only D-SNPs in certain markets will lead to decreased availability of these plan offerings, which have been proven successful at providing high-quality care for dual eligibles.

Humana does not support this proposal to limit enrollment in coordination-only D-SNPs, and we have significant concerns about the impact this will have on dually eligible beneficiaries. CMS should continue to work with stakeholders to explore alternative options for enhancing coordination between Medicare and Medicaid that will not cause as drastic a disruption for dual enrollees. For example, CMS should consider freezing coordination-only D-SNP enrollment in states with Medicaid managed care to new enrollment, instead of requiring coordination-only D-SNPs to terminate beneficiaries who are enrolled in the Medicaid MCO offered by a different parent entity. Some states already pursue this option, preventing non-aligned D-SNPs from enrolling new full benefit dually eligible individuals but allowing these beneficiaries to remain in the D-SNP option that they chose until they make an affirmative decision to switch. We also recommend that should CMS move forward, this proposal should be phased in over time in order to give states, D-SNPs, and enrollees more time to prepare for this significant change. This would be consistent with CMS's previous major updates to the D-SNP integration requirements. CMS should consider aligning this change to enrollment in coordination-only D-SNPs with the requirement that unaligned beneficiaries be disenrolled from D-SNPs where the parent entity holds a Medicaid MCO contract and delay implementation until 2030.

VI.D. Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination

CMS is proposing to establish that CMS may terminate a contract if the MA organization is no longer eligible to offer a D-SNP because the MA organization does not hold a contract with the State Medicaid agency

Humana Comment: Humana supports this proposal.

VI.E. Limitation on D-SNP-Only Contracts Submitting Materials under the Multi-Contract Entity Process

CMS is proposing to require that MA organizations with D-SNP-only contracts submit all materials for the contract in HPMS under the MA organization's contract number. CMS also proposes that MA organizations and TPMOs may not submit materials for the contract under the organization's MCE number.

Humana Comment: Humana generally supports this proposal. We understand that states requiring D-SNP-only contracts want to review submitted materials and that plans filing through the MCE process in HPMS limits the state Medicaid agency's ability to access the materials. Requiring plans to use the contract number when filing in HPMS will alleviate this issue for states.

Humana does have concerns with the potential burden this could cause should states significantly increase the scope of materials they will require for review and given that there are likely to be differences across states in what the reviewable materials are for each. Humana recommends that CMS work with states to align their review requirements with CMS's definition of marketing and communications and adopt similar file and use requirements for reviewed member communications.

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

CMS solicits comments on potential policy changes to support integrated care and improved health outcomes given the significant growth of dually eligible individuals enrolling in C-SNPs and I-SNPs.

Humana Comment: Humana understands CMS's concerns about the growth of dually eligible individuals enrolling in C-SNPs and I-SNPs; however, we encourage CMS to consider potential unintended consequences of placing additional enrollment limits on these plans.

C-SNPs

In order to enroll in a C-SNP, a beneficiary must have a diagnosis of a specific disabling or severe chronic condition. By definition, these are some of the most vulnerable Medicare beneficiaries and given the higher likelihood of dually eligible beneficiaries having multiple chronic conditions, it is not surprising that there is overlap in the populations eligible for D-SNPs and C-SNPs.[12] C-SNPs offer supplemental benefits that are targeted for treating the designated chronic condition as well as specialized provider networks specific to treating that chronic condition. While Humana supports efforts to improve integration for dually eligible enrollees, we do not believe this should come at the expense of beneficiary choice and access to targeted supplemental benefits and specialized provider networks. Potential policy options such as applying the D-SNP lookalike threshold to C-SNPs would limit options for beneficiaries who are likely to benefit from the increased care management and chronic condition focus of a C-SNP solely because the enrollee is also dually eligible. As such, Humana encourages CMS not to pursue the D-SNP lookalike threshold as an option related to C-SNPs.

[12] 2025 Beneficiaries Dually Eligible for Medicare and Medicaid

Humana also does not recommend that CMS establish a SMAC requirement for C-SNPs similar to the existing requirements for D-SNPs. The D-SNP SMAC development and approval process is administratively complex and requires significant resource allocation by state Medicaid agencies. At a time when state administrative capacity is already constrained, expanding SMAC requirements would strain limited state resources even further. Additionally, Humana has concerns about how a SMAC could be administered by a state when there would be C-SNP enrollees in the plan who are not dually eligible and as such, the state would not have authority over many aspects of their care.

I-SNPs

I-SNPs serve Medicare beneficiaries who require institutional-level care and who often have complex behavioral health and chronic medical conditions. These plans focus exclusively on long-term care (LTC) residents who have care needs that are distinct from those of other dually eligible, Medicare, and Medicaid populations and as such, extending D-SNP requirements to I-SNPs would not only limit beneficiary choice, but could lead to unintentionally negative consequences for I-SNP enrollees. For example, adding a SMAC requirement for I-SNPs would greatly increase administrative costs and complexity, potentially leading to reduced supplemental benefits that these members rely on. Additionally, most I-SNPs are currently provider-owned and added administrative requirements would likely disproportionately burden smaller I-SNPs and risks reducing competition, increasing market consolidation, and stifling innovation in the I-SNP market. Humana encourages CMS to consider the potential negative impacts of additional requirements on I-SNPs and whether that market disruption and limitation on beneficiary choice is worth pursuing given the relatively flat changes in dual eligible enrollment in these plans.

VII. Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192

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

CMS proposes to remove and reserve § 422.102(e) for future rulemaking. 422.102(e) specifies that, subject to CMS approval, and as specified annually by CMS, certain D-SNPs that meet integration and performance standards may offer additional Medicare supplemental benefits beyond those other MA plans are currently allowed to offer, where CMS finds that the offering of such benefits could better integrate care for the dually eligible population. CMS notes that very few plans have requested to provide these additional benefits and instead have offered similar benefits through primarily health-related supplemental benefits or SSBCI.

Humana Comment: Humana supports this proposal.

VII.C. Rescind Mid-Year Supplemental Benefits Notice

CMS proposes to rescind the Mid-Year Notice of Supplemental Benefits requirement.

Humana Comment: Humana strongly supports this proposal and urges CMS to finalize it.

VII.E. Request for Comment on Utilization Management Committee (UMC) Administrative Burden Reduction

CMS solicits comments on ways to reduce administrative burdens associated with UMC requirements for consideration in future rulemaking.

Humana Comment: To reduce administrative burden associated with current UMC requirements, Humana recommends modifying the practicing physician requirement in 42 C.F.R. § 422.137f(c)(1) from requiring "a majority of members who are practicing physicians" to a requirement that the UMC "include at least 2 members who are practicing physicians." This change would preserve appropriate engagement of practicing physicians in the UMC, while also reducing barriers to a plan's ability to expand membership to non-practicing physicians with helpful expertise or specialties. Currently, when a plan identifies a non-practicing physician whose membership could benefit the UMC, the plan must balance the benefits of including that non-practicing physician against a potential disruption to the majority balance.

VIII. Request for Information on Future Directions in Medicare Advantage

VIII.B. Risk Adjustment

CMS is soliciting comments on opportunities for improving risk adjustment, inviting comments from a broad range of stakeholders and interested parties, including MA organizations, beneficiary advocates, healthcare providers, and industry experts. CMS is particularly interested in comments on how to achieve the following goals with risk adjustment, relative to the current state:

- Advancing competition, removing anti-competitive barriers, and ensuring a level playing field for regional, smaller, and less well-resourced plans.
- Reducing manipulability of the risk adjustment system as well as the day-to-day administrative burden for both plans and providers.
- Ensuring accurate payments for sicker beneficiaries, while rewarding effective treatment and favorable patient outcomes.
- Mitigating unintended consequences and effectively navigating tradeoffs. (For example, how to approach a situation where a potential input to the risk adjustment model improves the predictive accuracy of the model but would also directly disincentivize valuable treatments for patients.)
- Incentivizing provision of tangible and high-value benefits and services and maximizing the value that beneficiaries, as well as taxpayers, get from payments to MA plans.

Humana Comment: Unlike fee-for-service (FFS) Medicare, where reimbursement is retroactively based on the services provided, MA payment is prospective and not tied directly to the services members receive. That is, the plan receives a fixed payment for a member based on their health profile. Some members will require more services than expected and some less, and it is up to the plan to manage these costs in aggregate. Unlike FFS, this prospective payment design creates a strong incentive for MA plans to coordinate patient care, improve the quality of care provided, and reduce overall costs.

Ideally, a well-designed risk adjustment model provides the appropriate funding for patients with complex, chronic conditions so that plans are adequately funded to care for beneficiaries with complex conditions. By that measure, while the MA risk adjustment system has worked well to date, Humana supports CMS's broader goal to improve upon existing risk adjustment methodologies. However, it is critical that any changes to the program account for the impact on predictability for plans, providers and beneficiaries year to year in order to ensure a stable MA benefit environment *and* continued support for moving toward more preventive-oriented care while ensuring the health care system capacity for increased patient volumes.

With specific regard to the most essential diagnoses, Humana recommends that CMS prioritize including the following in its MA risk adjustment model:

- Diagnoses that are expected to incur significant or ongoing medical expenditures (examples include cancers, transplants, diabetes, and chronic heart diseases).
- Diagnoses for which expanded screening will improve beneficiary outcomes (examples include mental health and kidney disease).
- Diagnoses whose capture will encourage health plan outreach and support, including care and disease management programs (examples include morbid obesity and chronic obstructive pulmonary disease).

In certain instances, CMS should limit the use of diagnoses in risk adjustment based on a minimum threshold of disease severity or to patient encounters within specific settings. In fact, this already exists in the model with certain levels of severity for mood disorders, cognitive impairment, kidney disease and others. Humana recommends that CMS should continue to evaluate conditions which cover a spectrum of severity and adapt the model accordingly.

Near-Term Policy Approach

Humana believes there is an opportunity to re-consider the current Risk Adjustment model and payment program; however, that will take several years to evaluate options, consider ramifications and implement changes. In the short term, Humana believes the conversation should focus on how plan programs ensure complete and accurate diagnostic data. Changes to programs such as in-home health risk assessments and medical record reviews can help drive improvement in accuracy and better connect members with follow-up care that is identified as needed from these programs. Below, we outline our near-term suggestions for changes followed by longer-term policy options aimed at enhancing model integrity and strengthening the overall MA program.

<u>Delay Further Model Changes Until Thorough Assessment of V28 is Conducted</u>

Under V28, CMS made significant changes to the HCC Model diagnoses creating disruption and reduced financial incentives for participation in MA. Given the significant instability in the MA program over the past several years (including reductions in offerings and market exits), we urge CMS to provide a period of stability and predictability before introducing additional major changes. When future changes are pursued, they should be approached carefully and deliberately. To that end, **Humana encourages CMS to delay any risk adjustment model changes until no earlier than CY 2029**. **This would provide CMS and plans time to fully assess V28 impacts to inform thoughtful input on future reform.**

<u>Promote Data Quality and Transparency and Reduce Administrative Burden</u>

In the meantime, CMS could make sensible improvements to the existing CMS-HCC model to **promote data quality and transparency and reduce administrative burden to providers and plans**. For example, CMS should:

- Improve interoperability and data sharing between the agency and payers. Proposed changes could include:

- Sharing encounter level data for plan switchers with new plans so that they can verify payment accuracy and delete a diagnosis submitted by the predecessor plan that is not supported by the member's medical record.
- More detailed documentation regarding which diagnoses were used to generate the HCCs and the corresponding dates of service for plan switchers (this would further improve accuracy of data and payment).
- Providing plans with a file on new plan members that includes the diagnoses that generate the HCCs and the corresponding dates of service.
- Permitting the new plan to successfully submit data corrections to delete diagnosis codes for payment submitted by the preceding plan in error if needed.

Guardrails for Chart Reviews and In-Home Health Risk Assessments

Humana also supports guardrails for chart reviews and in-home health risk assessments (HRAs) to promote consistency, remove anti-competitive barriers, and improve follow-up care for members. Our specific recommendations are summarized below.

Humana generally agrees that chart review records should be linked to the original encounter data record. However, there are instances where linking a chart review to an original encounter proves challenging for the MAO (e.g., plan switchers as described earlier). As a result, if implemented as a requirement, Humana recommends that stakeholder feedback be sourced to account for all challenges and consider implementation of certain exceptions.

As discussed above, Humana recommends **improved data sharing between the agency and payers**. Humana supports **requiring chart reviews be linked to specific medical encounters assuming solutions can be developed to address situations where linking is challenging.** If data sharing cannot be improved and CMS requires all chart review encounters to be linked, CMS could consider evidence on another encounter for any new diagnoses identified in an unlinked chart review record which would also improve care of beneficiaries through encouraging follow-up care.

For HRAs, Humana supports risk adjustment reform that would: 1) improve the accuracy of diagnoses captured during HRAs and 2) improve care coordination for beneficiaries with chronic conditions by leveraging HRAs as an assessment and referral tool. Humana supports reform that accomplishes these goals without excluding, for payment purposes, legitimate diagnoses by qualified clinicians that paint a more complete picture of a beneficiary's health status.

Humana – along with other industry stakeholders – strongly supports **CMS strengthening and codifying the in-home health risk assessment best practices** that were recommended, but not mandated, by CMS in the CY 2016 Rate Notice and Call Letter.

As stated earlier, Humana generally supports CMS's broad goal to modernize the MA program and improve upon existing risk adjustment methodologies. Risk adjustment model changes being considered have potentially significant impacts on benefit stability for Medicare beneficiaries and plan operations. Humana urges CMS to avoid making more than one big model change at the same time or during a shortened time period. In other words, **Humana strongly encourages CMS to pick a single model to evaluate for implementation (e.g., using two years**

of diagnostic data, encounter data based, inferred risk, or any other large model change being considered by CMS), rather than introducing multiple model changes at the same time.

Proposed Longer Term Solutions

Recommended Foundational Actions Prior to New Model Implementation

Looking ahead, regardless of the selected model, Humana urges CMS to take the following steps prior to implementing a new risk adjustment model.

- Engage external stakeholders by being transparent in methodology, sharing data, model testing standards, and giving adequate time for meaningful feedback. Specifically, stakeholders need more time than allowed for in the 30-day comment period in the Advance Notice.
- Implement a new model cautiously, slowly and with consideration of all stakeholders, to preserve benefit and premium stability. **Humana suggests a minimum of a 3-year phase in period for any new model implementation, and potentially longer depending on the complexity of the change.**
- Develop a set of guiding principles to inform future Risk Adjustment policy reform (i.e. any reform should improve the predictive nature of the risk adjustment model).
- Consider risk model changes that work well within the context of a broader MA payment system, accounting for benchmarks, benefits, and margin/bid requirements.
- Ensure that the selected model satisfies the statutory requirements of actuarial equivalence.
- Ensure appropriate recognition of beneficiaries' individual health needs to facilitate resource allocation and care coordination.

Recommendations for New Model Rollout and Governance

For the selected model, Humana recommends a **phased, transparent rollout** with clearly defined objectives, metrics, and safeguards.

- **Public technical documentation:** CMS should publish model specifications, data elements, variable definitions, treatment of missingness, calibration procedures, and versioning history. For models using AI/ML, CMS should articulate model class (e.g., gradient boosting, regularized GLM), feature selection strategies, fairness constraints, and monitoring protocols.
- **Explainability:** Provide stakeholders with model level and feature level explainability resources (e.g., feature importance summaries) suitable for oversight and operational use.
- **Update cadence and governance:** Implement a predictable update schedule (e.g. annual) with a change management process and impact analyses prior to adoption. CMS should identify the regulatory process (e.g. Advance Notice, Proposed Rule). that will be used to announce proposed model changes and solicit public feedback.
- **Geographic pilots:** Conduct pilots targeting selected geographies that collectively represent urban, suburban, and rural contexts; diversity in provider and payor market

structure (e.g. HMO, PPO, etc.); and variation in beneficiary demographics and social risk factors.

- **Clear inclusion/exclusion criteria:** Define which contracts and populations are included and maintain a contemporaneous comparison group using the current HCC model to support rigorous evaluation.
- **Pre-publish the evaluation framework:** The framework should include metrics for assessing predictive performance and payment accuracy, model assessments which assess stability and volatility, an evaluation for potential administrative burden, changes in utilization patterns, and impact analyses by race / ethnicity, disability, rurality, dual eligibility, and language (fairness constraints should also be documents in model design).
- **Baseline Performance Standards:** Minimum performance thresholds for each domain should be met to consider expansion, with corrective action triggers if thresholds are not met or if equity risks are observed.

Additionally, Humana urges CMS to account for the following before implementing any new model:

- **Data harmonization:** Prioritize nationally scalable, standardized inputs (e.g., NCPDP for pharmacy, LOINC for select lab values, CPT/HCPCS for procedures, care setting flags) and avoid inputs that are not uniformly available or that create structural disadvantages.
- **Model parsimony:** Favor simpler, auditable models when performance gains from added complexity are marginal. Parsimony improves interpretability, reduces burden, and enhances stability.
- **Version control and backward compatibility:** Maintain version identifiers, change logs, and backward compatibility references to support plan operations, bid development, and audit continuity.

Humana Comments on Specific Risk Adjustment Models

Using Two Years of Diagnostic Data to Calibrate the CMS-HCC Model

Humana is aware that some stakeholders have suggested, and CMS has investigated, the use of an expanded data collection window for identifying beneficiary conditions within the HCC model. However, the decision to expand the data collection window may have material impacts on the HCC model's predictive validity or appropriateness for use for making capitated payment to MA plans. In CMS's "December 2024 Report to Congress: Risk Adjustment in Medicare"[13], CMS outlines considerations for developing a two-year model, including data limitations, delay in diagnosis-based risk scores, structural complexity and sample size issues, clinical and statistical implications. Humana's internal analysis has also indicated that expanding the data collection window would result in no significant gains (and potential losses) in the model's predictive accuracy, as measured by either Pearson correlation or inspection of predictive ratios, compared to the current model. Humana observes that expanding the data collection window makes beneficiary clinical markers less relevant, due to the longer amount of time elapsed between diagnosis and the targeted cost prediction and reduces the relevance of the diagnosis

[13] Report to Congress: Risk Adjustment in Medicare Advantage, December 2024 – pp. 67-69

data collected in the more recent time period. These findings raise concerns about expanding the data collection window – specifically, its appropriateness for achieving sustainable and equitable plan payments, and achieving benefit and premium stability within Medicare plans. **Therefore, Humana urges CMS to consider whether the broader policy aims that CMS is intending to achieve are best accomplished by expanding the data collection window.**

Encounter-Based Model

Given the growing proportion of Medicare enrollees covered under MA, Humana supports CMS's plan to investigate a potential model calibrated using MA encounter data rather than FFS data. Humana co-sponsored research and analysis discussed in "Medicare Risk Adjustment Overhaul Raises Critical Questions | Health Affairs" in November 2025[14]. In addition to the questions raised in that article, Humana has identified several considerations around developing and implementing a model based on MA encounter data, including:

- **Encounter Cost Amounts:** Does CMS intend to use plan-submitted cost amounts as the target variable within the regression model? If so, can CMS comment on, and publish, any methodology for addressing limitations within the plan-submitted cost (e.g., treatment of zero/null/inaccurate cost amounts submitted by capitated HMO provider groups)?

  Alternatively, if CMS intends to develop an imputed cost amount to apply to MA encounters, Humana recommends that CMS publish all methods for developing such imputed costs, along with any testing for accuracy.

  Previous research by MedPAC[15] has indicated MA encounter data may suffer from potential incompleteness or other inaccuracies. Humana cautions that such data inaccuracies could affect the reliability and accuracy of an encounter-based risk-adjustment model. For that reason, Humana recommends that CMS take appropriate steps to evaluate and mitigate the impact of any such data inaccuracies on the model's integrity. For example, CMS should leverage methods published by MedPAC and others to evaluate completeness of encounter utilization for all MA contracts and then remove those contracts with identifiably low utilization rates from the dataset used to calibrate the encounter-based risk model coefficients.

- **Model Structure / Design:** Does CMS intend to keep basic features of the HCC model structure consistent between the encounter-based model and the current FFS-based model? For example, will the model use similar population segmentation for income and disability?

  Humana recognizes that adoption of the encounter-based model would require evaluation of the condition categories to be included in the model. To enable stakeholders to meaningfully comment on this evaluation of the model conditions, Humana requests that CMS make public the full mapping of HCC-to-diagnosis- codes (where the only mappings available currently include just HCCs which are payable within the model).

[14] Medicare Risk Adjustment Overhaul Raises Critical Questions | Health Affairs

- **Denomination / Normalization:** Does CMS intend to continue to use the average predicted cost for the FFS population as the denominator for converting dollar-based model coefficients into relative-weight-based coefficients? Humana notes that calculating the denominator from the FFS population ensures that the average nationwide FFS risk score equals 1.000, which corresponds to the FFS USPCC. Humana cautions that, to maintain actuarial equivalence within MA payments, shifting the denominator to being calculated on the MA population would require making other changes to the way benchmarks are established, and plan bids are developed. To minimize such disruptions, Humana advises that model denomination continue to be based on the FFS population, as is done currently.

- **Coding Intensity Factor:** CMS has previously indicated that, in accordance with 42 U.S.C. 1395w-23(a)(1)(C)(ii)(IV), the adjustment to plan risk scores to adjust for differences in coding patterns between MA and FFS would no longer be applied, after adopting a model based on MA encounter data.[15] Humana concurs with CMS's interpretation of statute

- **Model Testing and Sensitivity Analysis:** Humana recognizes that one of the primary goals of moving to a model based on MA encounters is to improve the accuracy of payments to MA plans. To that end, can CMS comment on any/all steps that will be taken to ensure that the encounter-based model in fact does achieve superior payment accuracy, compared to the current FFS-based payment model?

  Humana cautions that if CMS were to develop the encounter-based model using imputed cost (as opposed to plan-submitted cost), imputed costs would be inadequate to serve as "actual" cost amounts when evaluating model accuracy (e.g. when calculating correlation statistics or predictive ratios). Humana recommends that CMS should evaluate the model's predictive accuracy using plan-submitted cost amounts (restricted to wherever plan-submitted cost amounts are deemed to be reliable).

  Humana recommends that CMS publicly report all evaluations of the model's accuracy and determinations of appropriateness for use in establishing actuarially sound payments to MA plans, including any methods employed.

Given the significance of such a model change, Humana would have serious concerns about a potential plan to start phasing in an MA-based model as early as CY 2027, as indicated in the CY2026 Advance Notice. CMS must give stakeholders opportunity to review and comment on the proposed model prior to implementation. A reasonable proposal must address the methodological challenges cited in CMS's "December 2024 Report to Congress: Risk Adjustment in Medicare"[16] and concerns about the completeness and accuracy of MA encounter data

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[15] Report to Congress: Risk Adjustment in Medicare Advantage, December 2024 (p. 65) – *"Section 1853(a)(1)(C)(ii)(IV) of the Act requires the coding adjustment to apply to risk scores until the Secretary implements risk adjustment using MA data. . . This means that once CMS uses an MA risk adjustment model calibrated using MA encounter data (MA diagnoses and costs), as per statute, CMS will no longer apply an MA coding pattern adjustment to risk scores."*

[16] Report to Congress: Risk Adjustment in Medicare Advantage, December 2024

described in MedPAC's June 2024 Report to Congress. Regardless of CMS's ultimate proposed approach to these issues, stakeholders require sufficient time to provide input on CMS's proposal. Humana is dubious that CMS could present a proposal through appropriate notice-and-comment rulemaking and address concerns from all stakeholders to implement a new model that maintains actuarial equivalence by CY 2027. Given that, **Humana strongly recommends that CMS delay implementation of an MA encounter data-based model to no earlier than CY 2029**, and potentially later if more time is needed to evaluate the impact of the model.

Inferred Risk Model

Properly designed, an inferred model could reduce gaming, improve payment accuracy through timely incorporation of relevant data elements, and enhance prediction of expected costs for diverse populations, thereby improving accuracy for sicker beneficiaries and reducing under or overpayments.

However, while Humana endorses the general aims, we urge CMS to proceed cautiously and to address the following risks before implementing an inferred model at scale.

Administrative Burden for MA Providers and Plans

CMS should assess the impact of the inferred model to providers, plans, and other stakeholders to ensure that any aspects of the inferred model which add to administrative burden are necessary for meeting other policy aims. Below, we highlight several areas for CMS to consider.

- **Data Availability and Standardization:** Incorporating expanded and granular data sources will require robust standards, consistent definitions, and reliable data exchange infrastructure. Without uniformity, plans and providers (particularly smaller and less-resourced entities) could face inconsistent requirements and costly system changes.
- **Complexity of Model Operations:** Advanced models may require ongoing data engineering, governance, quality control, and monitoring to ensure completeness, accuracy, and timeliness. This complexity can drive operational costs, necessitate specialized expertise, and increase compliance workload.
- **Provider Workflow Impact:** If model inputs depend on more granular clinical information, providers may need to adjust documentation and data sharing practices, adding EHR workflow steps or reporting obligations that do not directly improve clinical care which will take time to implement across all providers.

Should CMS proceed with an inferred risk model, Humana recommends defining a minimal, standardized set of data inputs, provide technical implementation guides, and require vendors and intermediaries to adhere to common data quality benchmarks. CMS should also identify any steps taken to address data missingness, incompleteness or inconsistency in reporting, and ensure there is adequate time to test the complex nature and advanced technology needed to implement an inferred risk model. CMS should also transparently share results of evaluating the impact of an inferred risk model with the industry and provide ability to source feedback and concerns to ensure multiple perspectives are evaluated to minimize any risks of implementation.

Unintended Consequences for Enrollment and Treatment Patterns

CMS should assess the inferred model for possible unintended consequences and incorporate broad feedback from industry stakeholders on the effect an inferred model will have on workflows, data transfer and treatment patterns.

In some cases, well-intentioned data submission efforts have unintended negative consequences. One recent noteworthy example – under the Stars program, the Colorectal Cancer Screening measure moved to fully electronic administrative reporting for the 2025 Star Ratings, eliminating the hybrid reporting option. The thresholds for all four-Star Ratings levels decreased to the guardrail maximum of 5%. If not for the guardrails, three of the four Star level thresholds would have decreased further.

Other unintended consequences could include:

- **Enrollment/disenrollment incentives:** If MA payments become sensitive to inferred utilization or to specific indicators of severity, plans may face incentives to avoid individuals with highly variable or resource intensive patterns. Or, conversely, plans might disproportionately target individuals whose utilization patterns yield more favorable predicted payments.
- **Treatment distortions:** Providers and plans could adjust care delivery to influence model inputs (e.g., ordering or avoiding certain services, testing, or care settings), which may not always align with evidence based, high value care. Over or underutilization risks must be anticipated and mitigated.
- **Equity impacts:** Inferred indicators could inadvertently embed structural biases if certain data elements (e.g., service utilization, access to labs, or encounter frequency) reflect non-clinical barriers. This could under-predict need for beneficiaries in underserved communities and lead to inequitable payments.

Departure from Diagnosis-Code-Centric Clinical Model

The inferred risk model concept represents a potential shift away from the diagnosis-code-centric, chart-supported paradigm that has anchored the CMS-HCC risk adjustment model since its inception. Diagnosis data, as documented using the International Classification of Disease (ICD) by a treating clinician and supported by a medical record, remains a transparent, clinically grounded signal of disease presence. Moving to a model that relies more heavily on nondiagnostic proxies (e.g., patterns of care, pharmacy fills, procedures, or lab values) raises foundational questions about validity, auditability, and alignment with clinical practice.

Should CMS proceed with an inferred risk model, **Humana recommends a formal, public re-evaluation of CMS's longstanding ten risk adjustment principles**[17] to ensure they remain fit for purpose. Additionally, **we recommend that CMS advise on any structural changes in Risk Adjustment Data Validation (RADV) audits** that would accompany implementation of an inferred model.

Use of Machine Learning and AI Technologies

[17] Report to Congress: Medicare Advantage Risk Adjustment - December 2021, section 2.3

As CMS and industry stakeholders explore modernization of risk adjustment methodologies, the potential application of machine learning (ML) and artificial intelligence (AI) warrants careful consideration. These technologies offer advanced analytical capabilities that can improve predictive accuracy and operational efficiency, but they also introduce new challenges related to transparency, governance, and administrative complexity. Below, we have summarized key benefits and risks associated with moving toward ML and AI-based approaches.

Machine Learning (ML) and Artificial Intelligence (AI) have the potential to improve risk adjustment. ML models can improve predictive accuracy by capturing non-linear relationships and complex interactions that traditional regression methods may overlook, while also enabling richer data utilization through a broader set of features and signals to reduce unexplained trends. These technologies provide adaptability and resilience, offering tools to handle outliers and structural breaks—such as pandemic-era shocks—and allowing models to be retrained more frequently to reflect emerging trends in population health and care patterns. Advanced algorithms can enhance program integrity by detecting anomalous patterns, and they can support more granular segmentation to enable beneficiary-specific identification of clinical risk.

There are also well-identified risks associated with implementing a risk model based on ML or AI technologies. Compared to current approaches, ML and AI models generally offer lower explainability and transparency, which may complicate oversight and stakeholder trust. They also raise fairness concerns, as models can inadvertently embed or amplify biases present in training data if not carefully monitored or controlled. Without appropriate guardrails and stability checks, ML and AI models may introduce greater year-over-year volatility in risk scores and payments, creating uncertainty for plans and beneficiaries. Implementing ML and AI solutions can also increase administrative burden and cost, requiring robust data quality standards, governance frameworks, ongoing monitoring, and specialized technical resources.

We support CMS's exploration of an inferred risk adjustment model as a promising avenue to **reduce gaming** and **improve payment accuracy**. However, this approach entails meaningful operational and policy shifts that warrant **careful, transparent, and equity conscious testing**. To ensure appropriate resource allocation and the best health outcomes for beneficiaries, we encourage CMS to:

1. Examine the implications of inferred model's use of nondiagnostic inputs and/or adopting machine learning or AI technologies. If necessary**, revise the Ten Principles of Risk Adjustment** for relevance, and **advise on any structural changes to RADV audits.**
2. **Implement a phased CMMI pilot** in defined geographies with rigorous, pre-specified evaluation standards across accuracy, administrative burden, stability, equity, incentives, and program integrity.
3. **Maintain robust transparency, auditability, and stakeholder engagement** throughout development, testing, and any contemplated expansion.

With these safeguards and a commitment to public accountability, CMS can modernize risk adjustment while sustaining trust, protecting beneficiaries, and fostering fair competition across MA plans.

VIII.C. Quality Bonus Payments in Medicare Advantage

CMS solicits input from stakeholders to inform future policy development and potential refinement to the QBP structure for MA plans.

Humana Comment: Humana shares CMS's goal of creating a simplified quality rating system that strengthens MA, promotes high quality care, and provides enrollees with the information they need to choose the best plan. The Star Ratings system is tremendously important to the operation of the MA program by incentivizing plans to provide high-quality care and services, rewarding high-performing plans through increased rebate dollars to either lower costs for enrollees or to provide additional benefits and providing consumers with information about plan quality to inform decision making. Given the importance of the program to MA overall, it is imperative that any future policy changes be carefully considered and implemented to ensure a smooth transition and minimize disruption of beneficiary costs and benefits while improving the accuracy, predictability, and effectiveness of quality measurement. We offer below several reform proposals that could be implemented using CMS's current authority to increase the predictability and stability of the Stars program.

<u>Overview</u>

The current Star Ratings program relies on a complicated methodology and assessment practices that do not always capture the most critical aspects of an MA plan's performance. In addition, the lack of transparency in how ratings are determined has resulted in uncertainty for MA organizations, making it difficult to strategically allocate resources for meaningful plan improvements. To determine the Star Ratings thresholds, CMS converts raw numerical scores into the 1-to-5 measure-level Star Ratings. The cut points are intended to set the quality benchmarks for each measure while incentivizing continuous improvement. However, the opacity in the data used to determine thresholds and the potential for abrupt swings year-over-year can hinder plans' ability to improve performance and detracts from overall quality.

Due to the current method of determining cut points, there is little room for error on many measures, with some requiring perfection in order to receive a 5-star rating. Furthermore, sudden changes in the threshold calculation can significantly lower Star Ratings, despite consistent performance by plans on these quality measures. For example, a single phone call not scored as successful by CMS can have an outsized impact on a plan's overall Star Rating for the current TTY-Foreign Language Interpreter measure, despite it representing no significant change in overall plan quality.

More recently, CMS has implemented the Tukey outlier deletion methodology to remove statistical outliers in a dataset before setting cut points which has destabilized thresholds. The intent behind this approach is to prevent extreme values from unduly influencing Star Ratings and to reduce year-over-year volatility. However, in practice, this method has failed to achieve the intended predictability and has actually caused significant swings in the year-to-year cut points.

In addition, a large portion of the current Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey which is used to measure patient experience with their MA plan consists of questions that, while important to patient experience, are less relevant in the majority of MA markets where health plan provider networks overlap substantially with one another. In these cases, CAHPS results are not differentiated across health plans since many individual providers participate in multiple health plan networks and their patients receive a

consistent experience from the provider regardless of health plan. Therefore the Star Ratings based on questions about plan providers do not effectively provide a comparison across MA plans.

Recommendations for Refinement

Humana advocates for a Star Ratings program that accurately reflects and rewards quality. Star Ratings should provide a reliable measure of plan performance, ensuring fairness and predictability in industry benchmarking. In alignment with CMS's stated goals, we recommend continuing to refine the measure set to focus on quality measures that are most impactful to enrollee health outcomes and experience, reduce provider burden, and ensure that plans are rewarded for quality outcomes and access.

Measure Set

Simplifying the measure set should include consolidating and removing measures. As mentioned in our above comments, Humana supports the proposed removal of several administrative focused measures to simplify and focus the measure set. In addition, CMS should consolidate measures that aim to evaluate plan performance for similar clinical experiences and in doing so, prioritize outcomes measures (e.g., Med Adherence for Diabetes Medications and Diabetes - Blood Sugar Controlled). Changes to the measure set such as this to remove narrowly focused process measures would allow for plans to focus on conditions that can be treated and managed with a more holistic model of care.

CMS should also work with measure stewards to develop innovative measures that incentivize plans to provide access to quality care and promote better clinical outcomes and that also include metrics that are within the plan's reasonable ability to influence. Measure stewards should consider developing composite measures that are designed to give plans credit for their efforts to improve performance and influence care without devaluing outcomes or inappropriately constraining a beneficiary's ability to choose what health care they receive. For example, Humana agrees with CMS on moving from process measures to more meaningful measures of follow up care (e.g., the Colorectal Cancer Screening and Follow-up measure under consideration by NCQA). However, we caution that the measure specifications must be designed so that plans are rewarded for efforts to engage providers and beneficiaries in accessing the follow up and incentivized to improve performance while not being penalized for enrollees choosing not to receive the care. With the development of more innovative composite measures, CMS should consider retiring associated process measures (e.g., Colorectal Cancer Screening in the example above).

Participants in the MA and Part D programs would benefit from a simplified measure set in several important ways. A more focused measure set would lower the burden on providers, with a focus on fewer measures allowing more opportunities for patient care as opposed to operational considerations to meet measure requirements. Additionally, with a smaller set of measures to focus on and more stability in cut points (see below recommendations), providers will have clearer goals and standards across plans they work with. A simpler measure set will make it easier for MA and Part D plans to focus and potentially improve performance through more targeted investment and more efficient allocation of resources. Beneficiaries would benefit from a simpler to understand ratings system that prioritizes the care they receive and their experience with their health plan.

Glide Path to Measure Set Changes

Fundamental changes to the measure set will impact performance and ratings as plans adjust to a program with fewer measures. The benefit of a smaller measure set focused on clinical and outcomes measures is that it will allow significant focus of resources devoted to solving the complexities of member health, outcomes, and care delivery. These measures have historically been more challenging to influence that operational and process measures, but MA plans have had to divert resources to those less meaningful measures – in part because they are easier to influence. However, data access delays present challenges for plans in understanding their performance and that of the broader industry, a challenge that will be magnified with a more compact measure set. To navigate the transition to a smaller, more focused measure set, CMS should establish a transition glide path to smooth the process and ensure there are no disruptions to member care access, quality, or benefit availability, similar to that proposed in this rule for most of the potentially removed measures.

Establish Cut Points Using Multiple Years of Data

A major challenge for plans is that the current cut point methodology can result in significant changes to the thresholds year-over-year, making it difficult for plans to truly understand how good quality is defined. Plans also receive little insight into industry performance throughout the measurement period, making it difficult for plans to understand how thresholds may shift and can lead to lower Star Ratings even if a plan improved performance.

Humana recommends that CMS update the Star Ratings calculation methodology to determine cut points based on a rolling three-year average of actual plan performance. In order to ensure that cut points reflect changing performance over time and value the most current performance scores, CMS could use a weighted data approach, weighing the most recent year of performance higher than the previous two years.

This would enhance predictability and stability, enabling Humana and other MAOs to achieve greater overall quality through more efficient allocation of resources. A methodology using multiple years of performance data would allow for cut points to continue to increase over time – mitigating concerns about incentivizing continuous improvement – while providing additional predictability for plans. Additionally, providing this enhanced predictability and stability will benefit providers as it will assist in providing clearer goals and standards across MA plans. This would be particularly valuable for advancing and sustaining value-based care initiatives and reducing burden on providers.

Eliminate Tukey Outlier Deletion Method

CMS added the Tukey Outlier Deletion methodology to the calculation of the Star Ratings for measurement year 2024. An analysis conducted by Wakely Consulting Group on behalf of Humana found that the addition of the Tukey outlier method to the program decreases Star ratings, does not increase cut point stability in any meaningful way, and will negatively impact beneficiaries' access to benefits associated with high quality plans. The Tukey outlier deletion methodology is statistically inappropriate for Star measure threshold calculation because Star measure distributions are often highly skewed and/or heavy-tailed. It is well documented in the statistical literature that Tukey is inappropriate in these cases and consequently, the number of outliers is overestimated. This has a substantial unfavorable effect on Stars thresholds and removes many low-performing contracts even though they are legitimate and representative scores for those measures, causing instability and unpredictability in thresholds.

Humana recommends that given the negative impact to Stars scores the Tukey methodology has had and that analysis has found "the inclusion of an outlier removal methodology may not be necessary to accomplish cut point stability," CMS should eliminate the use of the Tukey method in determining plan Star Ratings and instead use alternative methods to ensure performance is accurately measured and cut points are stable.

Continue Use of Mean Resampling and Guardrails
CMS began implementing the use of mean resampling in the 2022 Star Ratings. Mean resampling is intended to minimize the impact that outliers have on measure level cut points by segmenting contract performance data into ten even samples and then calculating ten unique cut points by removing one sample from each cut point run. These ten unique cut points are then averaged to create one aggregate set of cut points. Wakely's analysis of the introduction of mean resampling determined that cut point stability improved with the application of mean resampling alone, but that by itself, mean resampling is unlikely to "stabilize cut points when a few contracts have significantly different values than others."

Additionally, CMS began implementing guardrails for the first time in the 2023 Star Ratings. These cut point guardrails limit changes to the cut points year-over-year to either less than five percentage points (for measures on a 0 to 100 scale) or a 5 percent range where the minimum and maximum values are from the prior year.

Wakely's analysis found that "the greatest change in stability comes from the application of guardrails to year over year cut points" and that this suggests "that with CMS already implementing mean resampling and guardrails, the inclusion of an outlier removal methodology may not be necessary to accomplish cut point stability."

Humana recommends that CMS continue to utilize mean resampling and guardrails in its calculation of Stars scores, without the inclusion of an outlier removal methodology.

Revamp Patient Experience Survey
The current Star Ratings system uses the CAHPS survey to measure patient experience with their MA plan. CAHPS focuses on aspects of quality that patients are best qualified to assess, such as rating the ease of access to healthcare services. CMS selects a random sample of health plan members to receive the survey.

While CAHPS has served an important role in measuring patient experience, its deficiencies are increasingly evident. For example:

- CAHPS surveys are administered to a relatively small standard sample of 800 beneficiaries for each contract, with response rates around 34% and declining. This raises concerns about whether the results accurately reflect the overall patient experience, as non-response bias and survey fatigue may skew the findings.
- The CAHPS survey is currently excessively long with 68 questions, likely contributing to the above-mentioned low completion rates.
- CAHPS requires beneficiaries to recall specific interactions with their plan over the previous six months, which can lead to inaccuracies or gaps in how patients assess their care, particularly in the general MA beneficiary demographic.

- Plans do not have sufficiently granular data from CAHPS to enable them to interpret and act on the results. For example, plans are not permitted to receive beneficiary-level details and any non-standard cuts of the data responses have a long approval timeline, with relatively few requests approved, making it difficult to identify meaningful patterns and insights in official survey data that can be translated into specific actions needed to improve patient experience.
- Certain CAHPS survey questions assess beneficiary experiences with providers who contract with multiple plans, making it difficult for performance to be truly differentiated. For example, with the question "In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?", a doctor who sees patients from multiple health plans does not explain things differently to a Humana enrollee than to a patient enrolled in a competitor health plan.

A patient survey should remain a key component of the program, but it must be consumer-friendly and support informed decision-making. The next iteration of the Stars program presents an opportunity for a streamlined, easy-to-complete survey focusing on what patients value most. To improve accuracy and participation, the survey should be administered to a larger sample of beneficiaries through multiple survey methods at multiple points throughout the year, with fewer questions and a shorter recall period. CMS should issue a Request for Comment (RFC) to gather industry input on refinements, ensuring the survey effectively captures beneficiary experiences and aligns with quality measurement priorities.

While CMS seeks stakeholder feedback and makes changes to the patient experience survey and methodology, the agency should consider additional structural reforms to the Stars program to improve program performance, stability, and transparency.

Enhanced Transparency
Enhancing the transparency of Star Ratings data and calculations is vital to a better functioning program. CMS should increase in-year insight into industry data so Humana and other MAOs can understand their performance at multiple points throughout the year.

For measures that have data submitted to a regulatory entity during the measurement period, plans should be provided access to de-identified interim industry data during the measurement period. Considerations for measures that do not have regular submissions throughout the measurement period include process changes that would allow plans mid-year transparency, such as partial year HEDIS submission or rolling patient experience surveys.

<u>Future Policy Development</u>
Given the importance of the Star Ratings and QBP to the overall MA program, it is imperative that any major changes be carefully considered and implemented across a multi-year timeframe. The QBP program is unique as it relates to CMS quality ratings programs in that beneficiaries are directly impacted by the amount of payment their plan receives as a result of its performance. Unlike quality payments in other CMS programs, plans must use their QBP revenue and any enhanced rebate percentage amounts to lower cost sharing and increase supplemental benefit offerings for enrollees. Changes in the amount plans receive based on changes in the QBP calculations and methodology, not directly tied to actual plan performance, can lead to substantial benefit and cost changes for enrollees year over year and result in

inconsistent enrollee experiences. As such, any significant reforms to the QBP structure must take this into account.

In considering a potential model that decouples the QBP from the bid process, CMS should have a fulsome understanding of the impact this could have on the supplemental benefit offerings and cost sharing reductions that many MA members rely on before implementation. CMS should work with stakeholders to carefully consider these potential impacts.

Access to data about plan and industry performance is critical to ensure high quality performance and maintaining stability in the Star Ratings program. In order to make changes to the current measurement and payment timelines, CMS will need to adjust some of its processes to facilitate plan access to performance data. Plans need sufficient time to collaborate with providers and implement strategies necessary to achieve high performance on new measures.

In order to speed up the timeline of adding measures to the Star Ratings, data reporting timelines – both plan data reporting and CMS providing plans with data on their performance – will need to be addressed and improved. Current structures such as plan preview periods are essential to ensuring that plans and CMS have time to evaluate performance, to identify any potential concerns with the data such as reliability or validity issues, and to consider adjustments that may need to be made. Efforts to shorten timelines will take careful consideration and if CMS wants to pursue major changes to the existing timeline, we urge the agency to work with plan stakeholders to explore these challenges and potentially mitigate any negative impacts that could result.

Improving the stability of the Star Ratings program should be a top consideration as CMS considers major program changes or new model testing. Improved and increased access to quality and performance data is critical to enhancing stability, enabling Humana and other MAOs to achieve greater overall quality and a more efficient allocation of resources. Humana appreciates CMS's interest in improving the Star Ratings program and looks forward to collaborating with the agency on reforms that will make the program work better for enrollees, plans, and CMS.

VIII.D. Well-Being and Nutrition

CMS is seeking feedback on tools and policies that improve overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment. CMS is also seeking feedback on tools and policies that achieve optimal nutrition and improve preventive care in MA.

Humana Comment: As a leader and strong proponent of providing better health outcomes at lower costs to members, Humana is deeply encouraged by CMS's focus on these areas. We offer the following recommendations for continued support.

- **Stable and adequate funding:** MA funding that adequately accounts for projected increases in costs and minimizes disruptive policy changes is critical to ensuring plans have the resources to continue current efforts and develop new and innovative approaches that support well-being and nutrition goals. These programs require multi-year planning and investments that can be seriously disrupted in an unstable funding and policy environment.

- **Continued flexibility to support innovation:** We urge CMS to preserve and build upon the unique structure and flexibility of the MA program to allow plans to be innovative and nimble in tailoring interventions to improve health of beneficiary and reduce costs.