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The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to this proposed rule: **Medicare Program: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. 42 CFR Parts 422 and 423.** Our comments focus on selected sections of the proposed rule, as indicated by headers and sub headers in the paragraphs that follow.

Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies

A. Special Enrollment Period for Provider Terminations

The RUPRI Health Panel concurs with the CMS proposal to change the eligibility criteria to reflect that determination of change by CMS or an MA organization is not necessary for an enrollee to be eligible for the SEP. We suggest CMS explicitly include changes in pharmacy networks to be a rationale for eligibility for an SEP. Given the scarcity of pharmacy sites in rural areas, a change in provider network affecting only a few pharmacies can have a major impact on access to pharmacy services for rural enrollees.

C. Use and Release of Risk Adjustment Data

The RUPRI Health Panel applauds efforts to improve transparency of data by removing restrictions on the use and release of risk adjustment data (see page 54944). In particular, we agree with making MA data available through policies similar to those that affect release of claims data from Original Medicare. While the focus of this proposed rule is on risk adjustment data, we encourage similar approaches to being sure encounter data are released, with protections of enrollee identity. Continuous assessment of the effectiveness of the Medicare program and of the health benefits for enrollees requires access to data by the research community. Such access can be achieved without jeopardizing either enrollee identity or proprietary information about MA plans.

D. Adding, Updating, and Removing Measures (Sections 422.164 and 423.184)
Removing Measures

The RUPRI Health Panel concurs with retiring measures for which there is little variation, and which indicate high performance by all plans. However, we urge CMS to consider two critical needs, one general and one that is particularly important to plans serving rural enrollees: 1)

Maintain a reporting requirement after the measure is removed, to be certain that performance continues to be high. Should there be a drop-off or future variation, consider reinstating the measure. 2) Examine the data to see if the performance of plans serving rural enrollees score well on the measures suggested for removal, or if there are reasons to believe those measures help entice plans to rural areas because they can perform well on them, affecting star ratings and therefore attractiveness of the rural counties to MA plans. Considering the measures proposed for removal, the Panel has no specific reasons to question them, but we suggest being sensitive to effects on rural plans, providers and beneficiaries. The data and narrative presented in the proposed rule are at the aggregate level and may disguise effects in particular services areas (counties) such as not yet being at high performance levels. If that is true for rural areas, plans in those areas will not have an opportunity to improve scores because of reaching high levels. And there would not be the same incentives to improve quality scores through improving services to rural beneficiaries.

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

As shown below, growth in plans and enrollment across C-SNPs and I-SNPs reflected in national data presented by CMS is also true if we examine rural-specific data (Data retrieval and presentation completed by the RUPRI Center for Rural Health Policy Analysis).

Table 1. Metropolitan and Nonmetropolitan C-SNP Enrollment Proportion, 2016-2025

	Metropolitan			Nonmetropolitan		
		(% of MA)	(annual growth)		(% of MA)	(annual growth)
2016	243,402	(1.6%)		58,901	(2.7%)	
2017	241,995	(1.5%)	(-0.6%)	62,675	(2.6%)	(6.4%)
2018	259,754	(1.5%)	(7.3%)	66,064	(2.5%)	(5.4%)
2019	266,683	(1.4%)	(2.7%)	65,757	(2.3%)	(-0.5%)
2020	283,233	(1.4%)	(6.2%)	69,556	(2.1%)	(5.8%)
2021	299,722	(1.3%)	(5.8%)	67,925	(1.8%)	(-2.3%)
2022	307,616	(1.3%)	(2.6%)	59,767	(1.4%)	(-12.0%)
2023	376,845	(1.4%)	(22.5%)	60,967	(1.3%)	(2.0%)
2024	548,329	(2.0%)	(45.5%)	91,129	(1.8%)	(49.5%)
2025	941,755	(3.2%)	(71.7%)	165,814	(3.1%)	(82.0%)

Data source: MA monthly enrollment by contract/ plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Table 2. SNP Plan Counts*, Overall and by Metropolitan/Nonmetropolitan and Type, 2016-2025**

Year	Total SNP Count	Metropolitan County Plan Counts				Nonmetro. County Avg. Plans			
		All SNPs	C-SNP	D-SNP	I-SNP	All SNPs	C-SNP	D-SNP	I-SNP
2016	548	546	136	331	79	374	74	260	40
2017	562	561	120	358	83	377	61	274	42
2018	610	608	130	381	97	417	60	300	57
2019	695	693	125	443	125	459	61	330	68
2020	828	826	160	516	150	537	66	391	80
2021	945	943	200	571	172	618	71	449	98
2022	1,126	1,125	263	678	184	755	99	546	110
2023	1,256	1,253	298	765	190	859	125	625	109
2024	1,313	1,311	308	828	175	968	145	705	118
2025	1,417	1,417	373	881	163	1,087	215	750	122

* Distinct plans (any) available across all counties in category.
** C-SNP: Chronic or Disabling Conditions; D-SNP: Dual Eligible Special Needs Plans; I-SNP: Institutional.
Data source: MA monthly enrollment by contract/plan/state/county data, Special Needs Plan data, and Medicare enrollment data

While we were unable to breakdown enrollment by dual eligibility, if there is any expectation of the data showing a rural difference, we would expect it to be that there are proportionally more dual eligible beneficiaries in rural communities, given that, per a report from KFF, 23% of rural beneficiaries are also enrolled in Medicaid, as compared to 18% of urban beneficiaries. Therefore, we concur with the CMS observation that potential differences in opportunities for care coordination across Medicare and Medicaid between D-SNPs and C-SNPs warrants analysis and perhaps policy action. We are not prepared to comment about differences in coordinated care across types of special needs plans in rural places, so we support additional analysis as a high priority need given the shifting pattern of plans offered and beneficiary enrollment. CMS expressed a challenge to policy options that rest on enrolling in D-SNPs rather than C-SNPs because “many C-SNPs do not have a D-SNP in the same services areas as the C-SNP.” We examined data on MA plan offerings to test that assumption, with counties classified as metropolitan, micropolitan, and noncore. As shown in Table 3, we found that the scenario of a C-SNP being offered in counties without a D-SNP also being offered was true in only 16 counties overall, although that phenomenon was disproportionately rural.

Table 3. MA Plan Offerings in the 50 United States and D.C., 2026

	Overall	Metropolitan	Micropolitan	Noncore
Total Counties*	3,143	1,186	657	1,300
Counties with no MA plans	74	6	11	57
Counties with no SNPs	163	6	36	121
Counties with no C-SNPs	805	147	161	497
Counties with no D-SNPs	194	12	47	135
Counties with no C-SNPs or D-SNPs	178	8	41	129
Counties with C-SNPs, but no D-SNPs	16	4	6	6

* In some cases, these are actually “county equivalents”: places that are comparable to counties for administrative purposes but referred to by a different name. For example, Louisiana has parishes, Alaska has organized boroughs and census areas. Pre-2022 counties were used for Connecticut.
Data source: Special Needs Plan data

Requests for Information on Future Directions in Medicare Advantage (Ris Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

D. Well-Being and Nutrition

The Panel supports increasing incentives for MA plans to develop and implement programs to improve well-being and nutrition. A critical element of well-being is self-assessed quality of life, which affects both mental and physical health. We suggest using Cantril’s Ladder to measure life satisfaction.

Respectfully submitted,

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