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CMS Proposes CY 2028 Changes to Medicare Advantage and Part D

On November 20, 2026, the Centers for Medicare & Medicaid Services (CMS) released its Medicare Program; Contract Year 2028 Policy and Technical Changes to the Medicare Proposed Rule, which contains proposed policies for Medicare Advantage (MA) and Medicare Part D plans in contract year (CY) 2028. See the press release here and the fact sheet here. In this rule, CMS proposes to:

- Update special enrollment periods (SEPs), including the Disaster/Emergency SEP; provider terminations; and start, end, and effective dates for certain SEPs.
- Update network adequacy requirements;
- Revise the agent and broker compensation structure to include 1) base compensation and 2) supplemental compensation, among other changes impacting agents, brokers, and third-party marketing organizations (TPMOs);
- Require care coordination for dually eligible individuals in Special Needs Plans (SNPs);
- Establish a "healthy food" standard for supplemental benefits;
- Implement requirements to facilitate maximum fair price (MFP) effectuation in MA for Part B drugs selected for negotiation under the Medicare Drug Price Negotiation Program (MDPNP);
- Require in-network providers to submit prior authorization (PA) requests through the plan's FHIR-based PA Application Programming Interface (API) for non-drug items and services;
- Update MA Star Ratings, including removing and adding measures and making methodological adjustments; and
- Implement a mandatory model for MA plans that tests changes to risk adjustment and Quality Bonus Payment (QBPs), beginning in 2029.

The agency also releases Requests for Information (RFIs) regarding continuation of coverage under MA, in which enrollees of commercial and Marketplace health plans would enter an MA plan offered by the same MA organization during their initial coverage election period if they

do not choose other coverage; additional network adequacy changes; and strategies MAOs use to serve individuals with serious mental illness and dementia.

This proposed rule is scheduled to be published in the *Federal Register* on November 25, 2026. Comments are due January 19, 2027.

SEP AND OTHER COVERAGE CHANGES

Pages 54-71 and 103-121[1]

CMS proposes updates to MA Special Enrollment Periods (SEPs), including:

- **Disaster/Emergency SEP:** Following reports of misuse of the Disaster SEP, CMS is proposing that, in order to use the Disaster/Emergency SEP, CMS approval through 1-800-MEDICARE would be required. This would allow for the agency to oversee the election mechanism and the SEP generally to ensure appropriate use. CMS may consider expanding this to other mechanisms in the future, including the Online Enrollment Center.
- **Provider Terminations**: CMS proposes to codify criteria used to identify whether a provider termination constitutes a "significant" change in a plan provider network. CMS also proposes to revise the criteria for affected enrollees who then qualify for a SEP using a 12-month lookback period to capture those with an active relationship with a terminating provider. CMS further revises Medicare Advantage organizations' (MAOs) notification requirements to send a notice to the enrollee within 5 business days and to include SEP eligibility information. Finally, CMS proposes a new continuity of care requirement, under which plans must continue to cover services furnished by terminated providers to affected enrollees at in-network rates for at least 90 days.
- **SEP Dates:** CMS proposes several technical changes to the start, end, and effective dates for specific SEPs. These changes largely codify language that is already included in subregulatory guidance.[2]

These proposals shift the short-term burden of provider network disruptions to MA organizations, while strengthening CMS oversight of SEPs.

[1] All page number reference the unpublished proposed rule.
[2] These proposals are summarized in Table 111.B-1 on page 70 and 71 of the unpublished rule.

NETWORK ADEQUACY AND APPLICATION REQUIREMENTS

Pages 305-322

CMS proposes several changes to MA network adequacy requirements intended to reduce administrative burden on plans, increase competition among plans, and provide greater flexibility in establishing provider networks.

Key proposals include:

- **Network Adequacy Reviews:** Eliminate network adequacy reviews during the application process for new or expanded service areas. Instead, MA organizations would attest to compliance by the beginning of the contract year, with CMS conducting reviews during the first year of operation. CMS would also eliminate the new applicant credit and use of letters of intent during application reviews.
- **Behavioral Health Network Adequacy:** Consolidate Clinical Psychology and Clinical Social Work into the Outpatient Behavioral Health (OBH) category, eliminating separate network adequacy standards. CMS would also expand the list of qualifying providers to include supervised peer support specialists and community health workers, and revise the OBH time and distance standards.
- **Telehealth Network Adequacy Credit:** Increase the existing 10-percentage-point telehealth credit to up to 30 percentage points, potentially varying by geographic area or specialty. Existing in-person access and minimum provider requirements would remain in place.

Through an RFI, CMS also seeks input on additional network adequacy changes, including revised time and distance standards and allowing nurse practitioners, physician assistants, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to satisfy certain primary care or behavioral health network requirements.

While proposals will ease burden for plans, network adequacy changes may narrow access for beneficiaries.

AGENT AND BROKER COMPENSATION AND OVERSIGHT CHANGES AND TPMO DISCLAIMER REQUIREMENT REMOVAL

Pages 335-396

CMS proposes to revise the agent and broker compensation structure for MA and Part D to better reflect current market practices, align with statutory requirements, and respond to a court decision that vacated parts of the April 2024 compensation regulations. Specifically, CMS is proposing to:

- Modify the definitions of "compensation" and "fair market value" and add a definition for "base compensation outlier."
- Enhance reporting of agent and broker compliance issues.
- Remove duplicative requirements for agent and broker training and as related to scope of appointment documentation.
- Provide for a new market-based approach for compensation that includes distinctions between base and supplemental compensation.
- Expand safeguards designed to guarantee the use of compensation creates incentives for agents and brokers to enroll individuals in the MA plan that best meets their health needs.
- Implement a methodology to identify compensation outliers through reporting of base compensation amounts and details on supplemental compensation.
- Streamline and reorganize agent, broker, and third-party marketing organization (TPMO) regulations through modifications to testing requirements and enhanced flexibility for acceptance of third-party training programs, among others.
- Eliminate certain fee and compensation caps.

SNP CHANGES

Pages 255-285

CMS proposes changes for SNPs, including:

- **Care Coordination for Dually Eligible Individuals:** Add requirements for chronic condition SNPs (C-SNPs), institutional SNPs (I-SNPs), and hybrid institutional SNPs (HI-SNPs) to coordinate care delivery for beneficiaries dually eligible for Medicare and Medicaid, when more than 60 percent of the plan's population is dually eligible.
- **Interdisciplinary Care Teams (ICTs):** Require all SNP ICTs to include behavioral health providers actively treating or coordinating care for the enrollee, as applicable.

"HEALTHY FOOD" STANDARD FOR MA SUPPLEMENTAL BENEFITS

Pages 17-32

In order to determine whether MA plans offer food benefits that are primarily health related or appropriate as supplemental benefits, CMS is proposing to define "healthy food" and to require food-related supplemental benefits offered by MA plans to be limited to "healthy food," as MA plans currently have broad discretion in making this determination.

In January 2026, the Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) released the 2025-2030 Dietary Guidelines for Americans (DGA). CMS proposes to link the "healthy food" standard to the 2025-2030 DGA to allow for this standard to evolve over time as future DGA cycles are completed. Building upon the current DGA, CMS proposes to define "healthy food" as whole, nutrient-dense foods. CMS also proposes to codify a non-exhaustive list of examples of foods that align with this definition and provide insight into food and beverage items that would not meet this standard. To preserve the ability for a treating provider to make individualized recommendations for their patients, CMS proposes that any food or beverage recommended by a beneficiary's provider to address the beneficiary's medical condition qualifies as "healthy food" for purposes of MA supplemental benefits as long as the item is not otherwise prohibited. CMS seeks comment on various aspects of this proposal.

This proposal may narrow the food-related benefits MA plans offer by reducing their discretion in determining "healthy food" and may make these benefits more uniform across plans that offer them.

MFP EFFECTUATION IN MA

Pages 159-185

Beginning with 2028, Part B drugs are eligible for inclusion in the MDPNP. In 2026 and 2027, only Part D drugs are included. CMS proposes policies to address operational differences for Part B drugs administered to beneficiaries with MA, including:

- **Provider Enrollment in the Medicare Transaction Facilitator (MTF) Data Module (DM):** Require contracts between MAOs and providers to include a provision requiring providers administering Part B selected drugs to maintain enrollment in the MTF DM, which allows for the exchange of data and information needed to effectuate MFP.
- **Shortened Encounter Data Submission Deadline for MAOs:** Require MAOs to submit encounter data records for selected Part B drugs within 30 days of the claim-from date. This timeframe is significantly shorter than the 13-month deadline for submitting encounter data for risk adjustment purposes and is intended to reduce cash flow concerns for Part B providers. CMS suggests that if finalized, Part B providers would be expected to receive MFP refunds in 46-51 days. CMS also proposes requiring the MAO to certify the completeness and accuracy of the submitted data.
- **National Drug Code (NDC) Submission Claims:** Require MA organizations to collect 11-digit NDCs on MA encounter data records for selected Part B drugs. As an alternative, CMS solicits feedback on whether requiring the use of claims modifiers would be preferable compared to NDC submission. An NDC or claims modifier is needed to appropriately identify claims for selected drugs.

- **Cost-Sharing Limits for Out-of-Network Part B Selected Drugs:** Base MA out-of-network cost-sharing limits for selected Part B drugs on a price that is equal to or less than the MFP. CMS's goal is to ensure that MA patients who use out-of-network drugs benefit from the MFP, and to prevent plans from discouraging patients who receive selected Part B drugs from enrolling in MA.

Additional details on the MFP effectuation process for Part B drugs in MA, and on the options considered by CMS to address the topics above, are available in the Medicare Drug Price Negotiation Draft Guidance: Manufacturer Effectuation of the MFP for IPAY 2028.[3] Final guidance is expected this fall.

Providers and MAOs will need to prepare for new requirements for selected drugs. While the requirement for MAOs to submit encounter data for selected drugs may alleviate some cash flow concerns, the NDC-11 collection requirement poses new operational burden.

PRIOR AUTHORIZATION INTEROPERABILITY

Pages 147-158

CMS is concerned that non-standard prior authorization processes can increase administrative burden for providers, delay patient care, and contribute to inefficiencies. While MAOs are already required to implement a Prior Authorization API, beginning January 1, 2027, CMS proposes to contractually require in-network providers to use the FHIR-based Prior Authorization API and to test providers' ability to use the API annually.

The proposal in this rule applies only to PA for non-drug items and services in the MA program. However, CMS proposes to expand this rule's requirements to align with the agency's previously proposed *2026 CMS Interoperability Standards and Prior Authorization for Drugs* rule,[4] which addresses PA API standards for medical benefit transactions, if that rule is finalized prior to this rule.

Recognizing that rural hospitals, small groups, and individual providers may face challenges in implementing the proposed requirements, CMS is seeking feedback from these groups to identify how best to support them, including on key challenges to adoption and whether a hardship exemption is needed.

STAR RATINGS UPDATES

Pages 219-240

CMS proposes updates to MA Part C and Part D Plan Star Ratings, including:

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[3] See https://www.cms.gov/initiatives/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/regulations-guidance-policy-documents

[4] See https://www.federalregister.gov/documents/2026/04/14/2026-07205/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-standards

- **Removal of 19 Star Ratings Measures:** CMS proposes to remove 19 measures across Part C and D star ratings. All measure removals would be effective for the 2030 Star Ratings/2028 measurement year.[5]
- **Addition of Controlling Blood Pressure Measure:** This new Part C Star Ratings measure would be added for the 2030 Star Ratings/2028 measurement year.
- **Removal of the Reward Factor from the Star Ratings Methodology:** The proposed removal would place downward pressure on Star Ratings and would create additional incentives for contracts to improve performance.
- **Modification of the Hold Harmless Methodology:** CMS proposes to apply the improvement measure hold harmless provision to only contracts with 4.5 and 5 stars for their highest rating beginning with the 2030 Star Ratings.
- **Modification of the Cut Point Methodology:** CMS proposes to calculate the Star Ratings measure cut points for MA contracts using adjusted measure scores for model contracts to avoid biasing the cut points for non-model contracts and to avoid impacting non-model contracts' Star Ratings.

CMS proposes to remove several measures while only adding one, continuing CMS's efforts to make the measure set smaller. If proposals are finalized, the 2030 Star Ratings measure set will continue 15 measures.

MANDATORY MA MODEL TO REFORM RISK ADJUSTMENT, QUALITY INCENTIVES, AND SUPPLEMENTAL BENEFITS

Pages 416-572

CMS, through the CMS Innovation Center (CMMI), proposes to establish the Aligning Data and Value to Nurture Competition and Efficiency in Medicare Advantage (ADVaNCE MA) Model, a mandatory, 10-year model intended to improve quality, strengthen local competition among MA organizations, and reduce Medicare expenditures. The model would operate from January 1, 2029, through December 31, 2038, with a pre-implementation period beginning June 8, 2027.

Mandatory Participation and Geographic Scope

CMS proposes to randomly select 12 states for mandatory participation, with states identified in the final rule. Eligible plans would include HMOs, local PPOs, Chronic Condition Special Needs Plans (C-SNPs), Private Fee-for-Service plans, and D-SNPs, although states could elect to exclude D-SNPs. I-SNPs, regional PPOs, Medical Savings Account plans, and employer

[5] For a full list of proposed removals, see Table IV.B-2 on page 225 of the unpublished rule.

group waiver plans would be excluded. Participating organizations would also be required to establish state-specific contracts and separate D-SNP and general enrollment populations.

Risk Adjustment Methodology

CMS proposes to test a new *CMMI Inferred Risk Adjustment Model* that would supplement the existing Hierarchical Condition Category (HCC) framework with additional data sources, potentially including Original Medicare claims, MA encounter data, enrollment information, and advanced analytical technologies. Beginning in 2028, CMS would conduct a shadow test comparing risk scores generated under the new methodology with existing CMS-HCC risk scores. This test would not affect MA payments but would be used to inform future risk adjustment policy.

Diamond Ratings Quality System and Quality-Based Payment Adjustments

CMS proposes to replace threshold-based Quality Bonus Payments (QBPs) with incremental benchmark and rebate adjustments based on relative Diamond Ratings performance. For states and cohorts with at least three qualifying parent organizations, benchmark adjustments would generally range from 0 to 5 percentage points and rebates from 50% to 70%. CMS would also eliminate additional quality bonuses in qualifying "double bonus" counties, potentially affecting plan revenue and supplemental benefits

Targeted Supplemental Benefits

CMS proposes to allow participating MA organizations to offer certain supplemental benefits specifically to beneficiaries eligible for the Part D Low-Income Subsidy (LIS), without requiring beneficiaries to meet the existing eligibility criteria for Special Supplemental Benefits for the Chronically Ill (SSBCI). Eligible benefits would include healthy food and produce, transportation for non-medical needs, and caregiver supports, intended to improve outcomes and reduce avoidable healthcare utilization.

RFI: Payment Carve-out for ESRD

CMS is considering, but not currently proposing, a carve-out under which outpatient maintenance dialysis for MA enrollees with end-stage renal disease (ESRD) would be covered by Original Medicare and reimbursed under the ESRD Prospective Payment System. MA organizations would remain responsible for other covered services. Any such policy would require future rulemaking.

This is the long-awaited replacement of the Value-Based Insurance Design (VBID) Model. It is a longer, 10-year model that will not start until a new Administration and includes new benefits, such as additional benefits for patients eligible for the Low-Income Subsidy (LIS), a healthy food initiative, in addition to testing risk adjustment changes.

REQUESTS FOR INFORMATION

- **Seamless Continuation of Coverage for Newly-Eligible Beneficiaries (pages 72-81):** CMS seeks comments on an optional process that would move enrollees of commercial and Marketplace health plans into an MA plan offered by the same MA organization

during their initial coverage election period, if they do not choose other coverage. CMS would require MAOs to obtain CMS approval before implementing seamless continuation of coverage, to have at least a 3-star rating, and to notify enrollees in advance. In addition to comments regarding the process itself, CMS is seeking comment on any anticipated administrative or implementation issues and opportunities for plans intending to use this seamless enrollment option.

- **Strategies MAOs Use to Serve Individuals with Serious Mental Illness and Dementia (pages 211-218):**
    - **Serious Mental Illness:** CMS seeks feedback on how MAOs serve individuals with serious mental illness, with a particular interest in care models, benefit design, community partnerships, and ways to engage individuals with serious mental illness. The agency states that comments that mainly focus on risk adjustment, utilization management, cost-sharing, and other matters outside of the scope of MA plan operations and care delivery are not a focus of this RFI.
    - **Dementia:** CMS seeks feedback to inform its understanding of opportunities and challenges MA plans experience when serving patients with dementia and associated conditions.

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