DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 405, 406, 407, 410, 414, 415, 417, 422, 423, 424, 425, 427, 428, and 512

[CMS–1848–F]

RIN 0938–AV82

Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; codification of establishment of new policies for: the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act of 2022; limiting Medicare coverage of certain individuals; the Ambulatory Specialty Model; updates to drugs and biological products paid under Part B; Medicare Shared Savings Program requirements; updates to the Quality Payment Program; updates to policies for Rural Health Clinics and Federally Qualified Health Centers; update to the Ambulance Fee Schedule regulations; codification of the Inflation Reduction Act and Consolidated Appropriations Act, 2026 provisions; updates to Clinical Laboratory Fee Schedule regulations; updates to the Medicare Promoting Interoperability Program.

DATES: These regulations are effective on January 1, 2027.

FOR FURTHER INFORMATION CONTACT:

MedicarePhysicianFeeSchedule@cms.hhs.gov, for any issues not identified below. Please indicate the specific issue in the subject line of the email. For all questions related to reporting a service on a claim, please contact your Medicare Administrative Contractor.

Michael Soracoe, Morgan Kitzmiller, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to practice expense, work RVUs, conversion factor, and PFS specialty-specific impacts.

Hannah Ahn, Allison Bramlett, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to potentially misvalued services under the PFS.

Mikayla Murphy, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to direct supervision using two-way audio/video communication technology, telehealth, and other services involving communications technology.

MedicarePhysicianFeeSchedule@cms.hhs.gov, for issues related to E/M overlap between stand-alone visits and global periods, and E/M visit complexity add-on code (B1 and B2).

Terry Simananda, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to smoking and tobacco use cessation, screening, brief intervention, and referral to treatment, psychiatric collaborative care model, and shared medical appointments.

Sarah Leipnik, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to global surgery payment accuracy.

Pamela West, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to comprehensive outpatient rehabilitation facility (CORF) services and KX modifier thresholds.

Zehra Hussain, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to payment of skin substitutes.

Laura Kennedy, (410) 786–3377, Rebecca Ray, (667) 414–0879, and Jae Ryu, (667) 414–0765 for issues related to Drugs and Biological Products Paid Under Medicare Part B.

Lisa Parker, (410) 786–4949, or *FQHC–PPS@cms.hhs.gov*, Michele Franklin, (410) 786–9226, or *RHC@cms.hhs.gov*, and Patrick Sartini, (410) 786–9252 for issues related to FQHC and RHC payments.

Patrick Sartini, (410) 786–9252, or *CLFS_Inquiries@cms.hhs.gov* for issues related to the Clinical Laboratory Fee Schedule.

Sabrina Ahmed, (410) 786–7499, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to the Medicare Shared Savings Program (Shared Savings Program) quality performance standard and other quality reporting requirements.

Kimberly Spalding Bush, (410) 786–3232, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to the Shared Savings Program certified electronic health record technology (CEHRT) use requirements.

Janae James, (410) 786–0801, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to Shared Savings Program beneficiary assignment and financial methodology.

Lucy Bertocci, (443) 681–0762, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to reducing or eliminating Part B cost sharing, prepaid shared savings, beneficiary notifications, advance investment payments or identifying ACOs experienced with performance-based risk.

Elisabeth Daniel, (667) 290–8793, for issues related to the Medicare Prescription Drug Inflation Rebate Program.

Benjamin Picillo or Genevieve Kehoe, *AmbulatorySpecialtyModel@cms.hhs.gov*, or 1–844–711–2664 (Option 4) for issues related to the Ambulatory Specialty Model.

Amy Gruber, (410) 786–1542, for issues related to Ambulance Fee Schedule.

Kati Moore, (410) 786–5471, for inquiries related to the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP).

Trevey Davis, (410) 786–6600, for inquiries related to the Advanced Alternative Payment Models (APMs) track of QPP.

Jessica Warren, (410) 786–7519, and Lisa Marie Gomez, (410) 786–1175, for inquiries related to the Medicare Promoting Interoperability Program.

Steve Manning, (410) 786–1691, for inquiries related to limiting Medicare coverage of certain individuals.

SUPPLEMENTARY INFORMATION:

Addenda Available Only Through the Internet on the CMS Website: The PFS Addenda along with other supporting documents and tables referenced in this final rule are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*. Click on the link on the left side of the screen titled, ''PFS Federal Regulations Notices'' for a chronological list of PFS **Federal Register** and other related documents. For the CY 2027 PFS final rule, refer to item CMS—1848–F. Readers with questions related to accessing any of the Addenda or other supporting documents referenced in this proposed rule and posted on the CMS website identified above should contact *MedicarePhysicianFeeSchedule@cms.hhs.gov*.

CPT (Current Procedural Terminology) Copyright Notice: Throughout this final rule, we use CPT codes and descriptions to refer to a variety of services. We note that CPT

The March 2026 Correcting Amendment was intended to correct typographical and technical errors in the CY 2026 PFS final rule. However, the March 2026 Correcting Amendment contained an erroneous amendatory instruction for § 512.750(c)(1)(i). The instruction was intended to revise only the introductory text of § 512.750(c)(1)(i) but instead inadvertently removed paragraphs (A) through (E) of § 512.750(c)(1)(i) from the CFR. This removal was not intended.

Accordingly, we are restoring § 512.750(c)(1)(i)(A) through (E) through this final rule.

(1) Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect, in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, this notice-and-comment procedure may be waived if the Secretary finds, for good cause, that notice and comment is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of that finding and the reasons therefor in the notice.

We find good cause to waive notice and comment under 5 U.S.C. 553(b)(B) and section 1871(b)(2)(C) of the Act to restore paragraphs (A) through (E) of § 512.750(c)(1)(i). Notice and comment is unnecessary because the regulatory text we are restoring was previously proposed, subject to public comment (90 FR 32609), and finalized in the CY 2026 PFS final rule (90 FR 49688). The March 2026 Correcting Amendment did not intend to remove or substantively modify § 512.750(c)(1)(i)(A) through (E), and such revision was not discussed nor described in the preamble of that document.

We also find good cause to waive the 30-day delay in effective date under 5 U.S.C. 553(d)(3) and section 1871(e)(1)(B)(ii) of the Act because application of a delay would be impracticable Delaying restoration of the regulatory text at § 512.750(c)(1)(i)(A) through (E) would unnecessarily prolong a discrepancy between the CFR and our policy previously finalized through notice-and-comment rulemaking under the CY 2026 PFS and could result in confusion among the public and affected parties.

Accordingly, this final rule restores paragraphs (A) through (E) of § 512.750(c)(1)(i) as finalized in the CY 2026 PFS final rule.

b. Technical Correction to Small Practice Definition

We are also making a correction to the definition of ''small practice'' at § 512.705 such that a small practice means ''a TIN consisting of 15 or fewer clinicians at the time CMS identifies ASM participants for an ASM performance year as described at § 512.710(g)''. The definition at § 512.705 finalized in the CY 2026 PFS states that a small practice is ''a practice consisting of 15 or fewer clinicians . . .''.

In the CY 2027 PFS proposed rule preamble, we described a small practice as ''a TIN with 15 or fewer clinicians'' (91 FR 43971). This statement reflects our policy intent and how we will operationalize ASM's policies that may involve a small practice. We did not propose to amend § 512.705 in the CY 2027 PFS proposed rule to expressly provide that the operative unit for defining a ''small practice'' is the TIN. However, using the TIN as the operative unit of a ''practice'' for purposes of identification is supported by the ASM regulatory scheme and by broader Medicare policies and is consistent with our policy intent.

We find good cause to waive notice-and-comment rulemaking for finalizing the change to the definition of ''small practice'' such that it is defined at the TIN-level as notice-and-comment is unnecessary. As explained earlier in this section of this final rule, this amendment makes clear that we will use the TIN as the unit for identifying a small practice and brings our regulatory text into alignment with our preamble statements (91 FR 43971, 91 FR 43972) and policy intent. This amendment does not adopt a different mechanism for counting clinicians, change the 15-clinician threshold, or modify the time at which practice size is determined. Nor does this amended definition change which practices qualify for small-practice treatment or alter the applicable scoring or reporting policies. An additional opportunity for public comment is unnecessary because the amendment simply aligns the regulatory definition with the policy intent as described in preamble statements rather than establishing or changing substantive criteria for small-practice treatment.

Accordingly, we are finalizing a correction to ''small practice'' at § 512.705 to better reflect our intent and policy such that the definition reflects that a small practice means a TIN consisting of 15 or fewer clinicians.

E. Limiting Medicare Coverage of Certain Individuals

1. Background

On July 4, 2025, Public Law 119–21, which we refer to as the ''Working Families Tax Cut'' (WFTC) legislation, was enacted. Section 71201 of the WFTC legislation amended title XVIII of the Social Security Act (the Act) to add a new section 1899C, which provides that, subject to subsection 1899C(b) of the Act, an individual may be entitled to, or enrolled for, Medicare benefits only if the individual is in one of the following four groups: (1) a citizen or national of the United States; (2) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (lawful permanent resident or LPR); (3) an alien who has been granted the status of Cuban and Haitian entrant (CHE); [207] or (4) an individual who lawfully resides in the United States [208] in accordance with a Compact of Free Association (COFA migrant).

Prior to enactment of the WFTC legislation, benefits payable under the Medicare program for noncitizens generally depended on whether the individual was ''lawfully present.'' Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Pub. L. 104–193, August 22, 1996), codified at 8 U.S.C. 1611, generally provides that, subject to certain exceptions, only ''qualified aliens'' are eligible for Federal public benefits. However, section 401(b)(3) of PRWORA provides that Medicare benefits under title XVIII of the Act are not limited solely to ''qualified aliens,'' but instead may be available to individuals who are lawfully present in the United States. Section 401(b)(2) of PRWORA similarly provides that noncitizens who are lawfully present in the United States may be eligible for benefits payable under title II, such as Social Security retirement or disability insurance benefits. Historically, before paying Medicare or title II benefits, the Social Security Administration (SSA) used a common process to verify an individual's lawful presence status by determining whether the applicant was a U.S. citizen or was otherwise lawfully present in the United States and whether the individual resided in the United States. The SSA maintains a large set of policy and operational guidance, called Program Operations

[207] As defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422).

[208] See section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

Manual System (POMS), that CMS and the SSA update as needed. The SSA's procedures for verifying lawful presence before payment of title II and Medicare benefits are delineated in POMS. Prior to the statutory changes to Medicare eligibility made by the WFTC legislation, a noncitizen could qualify for payment of Medicare benefits if they met all other eligibility criteria and the individual was in an immigration status or category considered lawfully present under 8 CFR 1.3(a), which encompasses a broad range of immigration classifications. These ''lawfully present'' categories included, but were not limited to, the following:

- An alien who is an LPR.[209]
- An alien who is granted asylum.[210]
- An alien admitted to the United States as a refugee.[211]
- An alien who is paroled into the United States for a period of at least 1 year.[212]
- An alien who is a Cuban and Haitian entrant.[213]
- An individual who lawfully resides in the United States under a Compact of Free Association (COFA).[214]

The WFTC legislation did not modify the requirements for payment of title II benefits under sections 202(y) and 223 of the Act. As such, noncitizens who are lawfully present in the United States, as defined by 8 CFR 1.3(a), may remain eligible for payment of title II benefits. As a result, eligibility for payment of title II benefits is no longer coextensive with eligibility for payment of Medicare benefits under title XVIII of the Act for certain noncitizens. Because continued reliance on the lawful presence verification framework used to determine noncitizen eligibility for payment of title II benefits would conflict with section 1899C of the Act when applied to Medicare, we proposed to establish Medicare-specific definitions and related enrollment and termination criteria concerning citizenship, nationality, and immigration status.

2. Limiting Coverage Under Medicare Part A and Part B to Certain Individuals

a. Amending the Eligibility Criteria for Part A and Part B

Sections 226 and 226A of the Act establish the conditions under which individuals are entitled to Medicare Part A benefits based on attainment of age 65, disability, or end-stage renal disease (ESRD). Individuals entitled to Medicare Part A under these provisions are not required to pay premiums for such coverage (known herein as premium-free Medicare Part A) and may elect to enroll in Medicare Part B. In general, individuals entitled to title II retirement benefits prior to attaining age 65 or entitled to title II disability benefits, upon attainment of age 65 or after satisfying any applicable waiting period, respectively, are automatically enrolled in premium-free Medicare Part A and will be enrolled automatically in Medicare Part B unless they decline Medicare Part B enrollment.[215] There are no statutory requirements for citizenship, nationality, immigration status, or residency in sections 226 and 226A of the Act. Eligibility determinations, including citizenship and lawful presence verification, for premium-free Medicare Part A have historically been made through the title II lawful presence verification framework administered by the SSA.

Section 1818 of the Act establishes the conditions under which certain individuals who are not entitled to premium-free Medicare Part A may enroll in the hospital insurance program by paying a monthly premium (herein referred to as premium Medicare Part A). Under section 1818 of the Act, an individual who has attained age 65, enrolled in Medicare Part B, and is not otherwise entitled to premium-free Medicare Part A may enroll if the individual is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided continuously in the United States for the 5 years immediately preceding the month in which the individual applies for enrollment.

Section 1836 of the Act establishes eligibility requirements for Medicare Part B (also known as supplementary medical insurance). Under section 1836 of the Act, an individual may enroll in Medicare Part B if the individual is entitled to Medicare Part A or, alternatively, has attained age 65, is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided continuously in the United States for the 5 years immediately preceding the month in which the individual applies for enrollment. The WFTC legislation did not eliminate the 5-year continuous residency requirement for LPRs in sections 1818(a)(3) and 1836(a)(2) of the Act and, as a result, we did not propose to alter this requirement. In other words, LPRs who meet the 5-year continuous residency requirement and other applicable Medicare requirements would maintain their Medicare benefit.

Similar to premium-free Medicare Part A, enrollment in Medicare Part B under section 1836(a)(1) of the Act has historically been administered in coordination with the SSA's lawful presence verification framework for confirming citizenship, nationality, lawful presence, and residency status for payment of title II benefits. However, section 1899C of the Act establishes specific statutory categories of individuals who may be entitled to, or enrolled in, Medicare under title XVIII of the Act. As a result, title II's lawful presence requirements no longer fully align with the Medicare Part B eligibility framework established by section 1899C of the Act.

To align Medicare eligibility regulations with section 1899C of the Act, we proposed to add a new definition of ''eligible noncitizen'' at 42 CFR 400.200 that includes the categories of noncitizens eligible for Medicare under sections 1899C(a)(2) through (4) of the Act. Specifically, the proposed definition would state that an ''eligible noncitizen'' is an individual who is (1) an alien lawfully admitted for permanent residence under the INA; (2) an alien who has been granted the status of CHE, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422); or (3) an individual who lawfully resides in the United States in accordance with a COFA referred to in 8 U.S.C. 1612(b)(2)(G).

The proposed definition of ''eligible noncitizen'' was not intended to apply to noncitizen U.S. nationals who are expressly eligible for Medicare under section 1899C(a)(1) of the Act. The proposed definition of ''eligible noncitizen'' applicable to Medicare eligibility would be distinguishable from the immigration status or category criteria in 8 CFR 1.3 applicable to noncitizen eligibility for title II benefits, which continues to be based on the ''lawfully present'' framework in section 401(b)(2) of PRWORA.

Further, we proposed to amend regulations at 42 CFR part 406 (Medicare Part A) and 42 CFR part 407 (Medicare Part B) to incorporate the proposed definition of ''eligible noncitizen.'' We proposed to add that, effective July 4, 2025, an individual must be a citizen or national of the United States or an eligible noncitizen

[209] Under the Immigration and Nationality Act (INA) [8 U.S.C. 1101 *et seq.*].

[210] Under section 208 of INA [8 U.S.C. 1158].

[211] Under section 207 of INA [8 U.S.C. 1157].

[212] Under section 212(d)(5) of INA [8 U.S.C. 1182(d)(5)].

[213] As defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422).

[214] Public Law 99–239; Public Law 99–658; see also 8 U.S.C. 1612(b)(2)(G).

[215] Section 1837 of the Act and the enrollment process outlined in 42 CFR 407.17.

as a basis for entitlement. These changes were proposed to be added or included in the following sections:

• Premium-Free Medicare Part A:

++ New paragraph (a)(2) was proposed to be added to § 406.5 (Basis of eligibility and entitlement). This proposed new paragraph would add the requirement that, in addition to satisfying the applicable age, disability, or ESRD-based entitlement criteria, an individual must also be a citizen or national of the United States or an eligible noncitizen. This revision would align the eligibility and entitlement criteria for premium-free Medicare Part A with section 1899C(a) of the Act.

++ New paragraph (a)(2) was proposed to be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security benefits). This proposed new paragraph would clarify that individuals age 65 or over who otherwise qualify for premium-free Part A through Social Security or Railroad Retirement pathways must also satisfy the citizenship, nationality, or immigration status or category requirements established by section 1899C(a) of the Act. This would ensure that automatic or application-based entitlement under this section is limited to U.S. citizens, U.S. nationals, and eligible noncitizens.

++ Paragraph (b)(2) was proposed to be revised in § 406.11 (Individual age 65 or over who is not eligible as a Social Security or Railroad Retirement benefits beneficiary, or on the basis of government employment). This proposed revision would align the eligibility language in § 406.11 with section 1899C(a) of the Act and clarify that individuals qualifying under this pathway must also satisfy the citizenship, nationality, or immigration status or category standards in section 1899C(a) of the Act. This change would ensure that entitlement is not available under this section unless the individual is a U.S citizen, U.S. national, or eligible noncitizen.

++ New paragraph (a)(2) was proposed to be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits). This proposed new paragraph would provide that individuals under age 65 who otherwise qualify for premium-free Part A on the basis of disability must also meet the citizenship, nationality, or immigration status or category requirements of section 1899C(a) of the Act. This would align the regulation implementing premium-free Part A entitlement based on disability with the requirements in section 1899C(a) of the Act.

++ New paragraph (c)(4) was proposed to be added to § 406.13 (Individual who has ESRD). This proposed new paragraph would clarify that individuals who otherwise qualify for premium-free Part A on the basis of ESRD must also be a citizen or national of the United States or an eligible noncitizen. This revision would align the regulation implementing premium-free Part A entitlement based on ESRD with the eligibility limitations in section 1899C(a) of the Act.

• Premium Medicare Part A:

++ In § 406.20 (Basic Requirements), paragraphs (b)(2)(i) and (b)(2)(ii) were proposed to be revised and new paragraphs (b)(2)(iii), (b)(2)(iv), and (c)(5) were proposed to be added. These proposed revisions would update the eligibility requirements for enrollment in premium Part A to incorporate the proposed definition of eligible noncitizen. These changes would align premium Part A eligibility with section 1899C(a) of the Act by clarifying that only U.S. citizens, U.S. nationals, and eligible noncitizens may enroll under this pathway.

• Medicare Part B:

++ New paragraphs (a)(2)(ii)(A) through (D) were proposed to be added in § 407.10 (Eligibility to Enroll). These proposed revisions would update the Part B enrollment regulation to incorporate the proposed definition of eligible noncitizen. These proposed changes would align the Part B eligibility regulation with section 1899C(a) of the Act and clarify that only U.S. citizens, U.S. nationals, and eligible noncitizens may enroll under this pathway.

We noted in the proposed rule that the WFTC legislation also has implications for the Medicare Part B Immunosuppressive Drug benefit (Part B–ID) under section 1836(b) of the Act. Part B–ID is a limited Part B benefit that provides coverage only for immunosuppressive drugs for certain individuals whose entitlement to Medicare based solely on end-stage renal disease (ESRD) ended 36 months after a successful kidney transplant and who do not have other disqualifying health coverage. Although eligibility for Part B–ID is governed by the specific criteria set forth in § 407.55, individuals seeking to enroll in, or remain enrolled in, Part B–ID must also satisfy the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act. Accordingly, we proposed to revise § 407.55 (Eligibility to Enroll) to add new paragraphs (a)(1) and (2) to clarify that eligibility for Part B–ID is also subject to the limitations established by section 1899C(a) of the Act.

We received a number of comments that were outside the scope of the policies discussed in the proposed rule (for example, general immigration policies, general opposition or support of the WFTC, effects on safety-net providers, eligibility requirements for other HHS programs, the broader health care system, and employers). We will not be addressing those comments in this rulemaking.

We also received a number of comments on the changes to the eligibility criteria as well as general comments on CMS and the SSA's implementation of these statutory changes. The following is a summary of the general comments we received and our responses.

Comment: Multiple commenters expressed general opposition to, or concern regarding, implementation of section 71201 of the WFTC legislation and the mandated changes to the eligibility criteria for all parts of the Medicare program. Some commenters, while noting CMS's obligation to implement the statute, urged CMS to use its available administrative authority to minimize harm with the implementation of these provisions and take into consideration the disproportionate impact on certain populations that have greater communication barriers, resources, and physical and mental health care needs and the potential harm to broader community health, such as preventable hospitalizations and communicable disease outbreaks.

Response: We acknowledge the commenters' feedback. The WFTC legislation established section 1899C of the Act, which requires that, in order to be enrolled or entitled to Medicare, an individual must be a U.S. citizen or national, a lawful permanent resident, an alien who is a CHE, or a COFA migrant, and these new eligibility requirements apply to all parts of Medicare. As noted by the commenters, CMS is obligated to implement the new Medicare eligibility requirements as established by section 1899C of the Act.

To help beneficiaries impacted by the statutory changes prepare for implementation of these changes, CMS, along with the SSA, plans to conduct an outreach effort for impacted individuals, caregivers, and relevant interested parties including healthcare providers, taking into account the needs of the impacted population, such as using existing resources to address language barriers. In addition, we are finalizing policies in this final rule to notify those

who will be terminated from coverage due to not meeting requirements in section 1899C of the Act and to provide information regarding how individuals can regain Medicare should they become eligible again. Finally, we appreciate commenters' concerns regarding potential broader community health effects, including preventable hospitalizations and communicable disease outbreaks. However, these potential downstream effects are beyond the scope of this rulemaking.

Comment: Multiple commenters noted that implementation of these new Medicare requirements are being implemented at the same time similar changes are occurring with Medicaid and eligibility for premium tax credits (PTCs) as enacted in sections 71109 and 71301 of the WFTC legislation, respectively. Commenters also expressed concern that the cumulative effect of these coverage changes could increase administrative burdens on healthcare providers and disproportionally impact dual-eligible populations. A commenter also suggested that CMS coordinate implementation and information provided regarding the Medicaid and Medicare eligibility changes to limit disruption on dual-eligible enrollees.

Response: We acknowledge the commenters' concerns. Implementation of changes to Medicaid and changes to eligibility for PTCs in the WFTC legislation and the potential impact due to loss of coverage from those two programs are outside of scope of this final rule. We note that the related statutory provisions have different applicability dates: section 71109 applies beginning October 1, 2026; section 71302 applies for taxable years beginning after December 31, 2025; and section 71301 applies for plan years beginning on or after January 1, 2027. These differing statutory timelines limit the extent to which implementation of the Medicare, Medicaid, and Marketplace changes can be aligned. We acknowledge that the cumulative changes could impact health care providers and dual-eligible enrollees disproportionately. CMS plans to conduct outreach to impacted individuals, caregivers, providers, plans, and other interested parties on the changes to Medicare eligibility. We plan to include states and those serving dual-eligible enrollees who are losing eligibility for both Medicare and Medicaid in our outreach efforts.

Comment: A commenter requested that CMS and HHS urge Congress to grandfather individuals who were already Medicare beneficiaries when the law was enacted and who had Medicare taxes withheld for many years. The commenter also requested clarification on the treatment of individuals pursuing lawful permanent residence status and if Medicare coverage could continue without interruption while status is pending. Another commenter requested clarification on whether individuals who were granted asylum and are currently enrolled in Medicare would be impacted.

Response: We appreciate the commenters' concerns. The new eligibility criteria in section 1899C of the Act does not provide the authority to grandfather individuals enrolled into Medicare prior to enactment. The commenter's request that CMS and HHS advocate for such a legislative change is outside the scope of this rulemaking, which implements section 1899C as enacted. Further, the new eligibility criteria require that an individual be either a U.S. citizen or national or an eligible non-citizen in order to be enrolled or entitled to Medicare, and once this rule goes into effect, coverage must be terminated in accordance with this final rule if an individual does not meet that requirement. Further, noncitizens who do not meet the new eligibility requirements set forth in section 1899C of the Act will no longer be eligible to be entitled to or enrolled in Medicare, including individuals granted asylum, unless the individual also has an immigration status or category that meets the requirements of section 1899C(a). Further, the fact that an individual has applied for an immigration status or category that, if approved, would meet the requirements of section 1899C(a) does not, in itself, confer eligibility. In other words, a pending application for a particular immigration status or category is not sufficient. An individual's application for an immigration status or category that meets the requirements of section 1899C(a) must have been granted.

Comment: A commenter expressed concern that the title and abstract of the proposed rule did not specifically identify the provisions addressing Medicare eligibility based on citizenship, nationality, or immigration status or category and that beneficiaries, immigrant rights organizations, and other interested parties primarily focused on Medicare eligibility could therefore have difficulty identifying or locating these provisions.

Response: We acknowledge the commenter's concern. Including this provision, ''Limiting Medicare Coverage of Certain Individuals,'' in the Physician Fee Schedule proposed rule provided CMS with the opportunity to reach a broad audience of interested parties and ensure timely implementation of the new statutory requirements, especially in regard to the grace period population outlined in Section 1899C(b)(2)(A) and (B). In addition to being included in the broader proposed rule, this provision was highlighted in fact sheets and outreach materials on the proposed rule. Based on the comprehensive feedback we received from a variety of stakeholders on the proposed rule, we are confident that interested parties were able to locate these provisions and provide thoughtful feedback.

Comment: Multiple commenters requested that CMS and the SSA conduct robust outreach and interested parties' engagement before implementing section 1899C of the Act. Commenters' recommendations include training, educational materials, frequently asked questions (FAQs), phone scripts, provider education, and other resources to organizations that will assist affected individuals, including State Health Insurance Assistance Programs (SHIPs), Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging, legal services organizations, immigrant-serving organizations, disability and aging organizations, community health centers, religious organizations, Medicare providers, Medicare Advantage (MA) organizations, Part D sponsors, Medicaid managed care organizations, and Programs of All-Inclusive Care for the Elderly (PACE) organizations.

Response: We plan to conduct a robust outreach and education effort that is accessible, multimodal, and broad in reach. CMS and the SSA have been working to develop a comprehensive communications plan to support implementation of section 1899C of the Act and to provide timely and understandable information to affected individuals and the organizations that assist them. We also plan to use existing communication and education channels, including the Medicare Learning Network (MLN), to provide information and educational resources to Medicare providers and other interested parties. We have also notified the SHIPs of the changes in eligibility and are planning additional communications to the provider community. CMS will continue to coordinate with the SSA and other partners, as appropriate, to refine materials and outreach activities.

Comment: Several commenters noted the impact on providers needing to verify Medicare eligibility and to provide guidance to their patients who lose Medicare due to not meeting the requirements in section 1899C of the

Act. Commenters requested guidance for providers and other interested parties that includes information on the implementation timing, guidance on eligibility file updates, and on processes related to the new enrollment periods.

Response: We acknowledge the commenters' request for guidance. As mentioned above, CMS and the SSA plan to conduct a robust outreach and education effort that includes using MLN to share relevant information with providers regarding the implementation of the new eligibility criteria, including information on timing and enrollment periods. CMS will take the feedback provided by the commenters into account when developing future communications. Regarding eligibility verification, there are no changes proposed to the HIPAA Eligibility Transaction System (HETS) associated with the implementation of section 1899C of the Act and providers should continue to use this system to verify Medicare eligibility using existing procedures.

Comment: A commenter requested that CMS work with the SSA to establish new POMS processes and procedures for implementing section 1899C of the Act and protecting individuals affected by the new Medicare eligibility restrictions. The commenter also requested that the new POMS provisions be made available to the public for comment before implementation.

Response: CMS recognizes that implementation of section 1899C of the Act will require coordination with the SSA and clear operational instructions for the review, notice, termination, correction, and enrollment processes. CMS will coordinate with the SSA, as appropriate, regarding updates to operational guidance, including POMS instructions, needed to support implementation of section 1899C of the Act. As POMS represent internal agency guidance and technician instructions, POMS are not made available to the public prior to publication.

CMS will continue to coordinate with the SSA, as appropriate, to support accurate implementation of section 1899C of the Act and to provide information needed by affected individuals, the SSA staff, and other partners.

Comment: Multiple commenters recommended that CMS engage in ongoing data analysis and monitoring of the implementation of section 1899C of the Act. Commenters recommend tracking the number of notices sent, eligibility determinations corrected prior to termination and actual terminations due to ineligibility based on the criteria in section 1899C(a) of the Act. A commenter also recommended that CMS track related appeals, challenges, complaints, requests for language access, use of the newly established SEP, and track the dates between attaining qualifying eligibility status for Medicare and reinstating coverage, which should be considered a core implementation outcome. This commenter recommended that where legally permissible and statistically reliable, these outcomes should be examined by State, language, disability status, race and ethnicity, and other relevant characteristics.

Commenters also recommended monitoring impacts to individuals after Medicare coverage is terminated including tracking gaps in coverage, uncompensated care due to loss of Medicare, ability to acquire alternative health coverage, emergency health care use, and interruptions in care.

Multiple commenters suggested that CMS make the number of individuals who lose or regain Medicare eligibility due to the implementation of section 1899C of the Act publicly available. In addition, several commenters also recommended that CMS report on a variety of measures publicly, including terminations, corrections, reenrollment, coverage gaps, language assistance, complaints, and the impact of uncompensated care particularly on safety-net providers, and unnecessary use of acute care due to loss of Medicare. A commenter recommended using CY 2026 as a baseline for these measurements and reporting annually on these measures compared against the baseline year.

Response: We thank the commenters for their suggestions on monitoring and oversight of the implementation of section 1899C of the Act and the recommendation to report data and analysis publicly. CMS and the SSA track a number of internal measures to monitor enrollment and eligibility in Medicare and will utilize existing resources to monitor the number of individuals who receive notice of termination, if terminations become effective, and those who regain eligibility. CMS and the SSA also monitor enrollment periods used and will continue to monitor the use of all SEPs, including the newly established SEP. CMS does track the amount of uncompensated care reported to us by hospitals for purposes of Medicare Uncompensated Care Payments and we will monitor this data to help assess the impact of section 1899C to the extent that the changes are significant enough to fall outside the expected variability range. We will take the commenters' suggestions on additional measures to monitor implementation into consideration in our oversight and monitoring of the implementation of section 1899C of the Act. We do not track and analyze the healthcare experience of individuals who are no longer enrolled in Medicare.

Finally, we do not publicize granular data on Medicare terminations or enrollments. Currently, we publish enrollment reports that provide summarized information on total Medicare enrollees, Original Medicare enrollees, Medicare Advantage and other health plan enrollees, newly enrolled beneficiaries, deaths, Medicare-Medicaid enrollees, and Medicare Part D enrollees by yearly trend, demographic characteristics, and geography. We will take the recommendations for making additional data and analysis publicly available into consideration.

Comment: A commenter recommended that CMS establish a formal mechanism through which SHIPs, community health centers, civil-rights organizations, aging organizations, disability groups, legal-service providers, and other community-based organizations could report implementation issues for section 1899C of the Act.

Response: We appreciate the commenter's recommendation. We have regular communication with interested parties, including SHIPs, States, providers, and community-based organizations and appreciate feedback provided during those communications on our programs, especially newly implemented policies. We will take this recommendation into consideration on whether additional communication channels are warranted to monitor the implementation of section 1899C of the Act.

Comment: Several commenters opposed the proposed definition of ''eligible noncitizen'' and requested that CMS retain the prior, broader definition to allow a larger group of lawfully present noncitizens to remain eligible for Medicare. A commenter suggested that CMS provide clear and consistent definitions across Medicare programs.

Response: We thank commenters for their comments regarding the proposed definition of ''eligible noncitizen.'' As noted above, Section 1899C(a) of the Act establishes the categories of individuals who may be entitled to, or enrolled for, Medicare based on citizenship, nationality, or immigration status or category. Because these eligibility categories are established by statute, CMS does not have authority to retain the prior, broader lawful-presence

standard for Medicare eligibility. The defined term of ''eligible noncitizen'' provides a clear and consistent way to refer to the three categories of noncitizens who remain eligible under section 1899C(a), rather than repeating each category throughout the Medicare regulations. Using the term ''eligible noncitizen'' across the applicable Medicare regulations promotes consistency and readability while maintaining the eligibility requirements established by statute.

After consideration, we are finalizing the definition of ''eligible noncitizen'' at § 400.200, and the incorporation of that definition into the eligibility requirements in 42 CFR 406 (§§ 406.5, 406.10 through 406.13, 406.20) and 42 CFR 407 (§§ 407.10 and 407.55), as proposed.

b. Termination of Entitlement for Individuals Who Were Entitled to, or Enrolled for, Medicare as of July 4, 2025, in Accordance With Section 71201 of the WFTC Legislation (''Grace Period'' Population)

Due to the statutory changes to Medicare eligibility made by section 71201 of the WFTC legislation, individuals who are not U.S. citizens or U.S. nationals and who have an immigration status or category other than LPR, CHE, or COFA migrant, and who were entitled to, or enrolled for, Medicare as of July 4, 2025, will no longer be eligible for Medicare on the date that is 18 months after July 4, 2025. As shorthand, we are referring to this 18-month time period as the ''grace period'' and the applicable individuals identified and notified during the grace period as the ''grace period population.'' Section 1899C(b)(2)(A) of the Act directs the SSA to complete a review of all individuals entitled to, or enrolled for, Medicare as of July 4, 2025, and identify those beneficiaries entitled to, or enrolled for, Medicare as of July 4, 2025, who do not meet the requirements of section 1899C(a) of the Act. Section 1899C(b)(2)(A) of the Act provides the SSA with 1 year to complete this task for the grace period population. Section 1899C(b)(2)(B) of the Act directs the SSA to provide notice to such beneficiaries as soon as practicable after identifying such beneficiaries that their entitlement to, or enrollment in, Medicare will be terminated as of the date that is 18 months after July 4, 2025.

As stated in the proposed rule, the notice will inform them that the SSA records indicate that they do not meet one of the eligibility criteria in section 1899C(a) of the Act, and their Medicare entitlement and enrollment will be terminated if they cannot provide evidence proving eligibility. The proposed rule also stated that individuals would be instructed to contact the SSA if they believe the information is incorrect and to provide updated evidence of eligibility before their entitlement and enrollment is terminated. In addition, the proposed rule also stated that, if applicable, the notice would state that a formal initial determination of ineligibility will be sent prior to their termination date if the individual takes no action to update their records or if the individual confirms that they do not meet the eligibility criteria in section 1899C(a) of the Act. As proposed, the SSA would provide a termination notice towards the end of December 2026 to all identified individuals determined to be ineligible based on data available to the SSA. The termination notice would explain that the identified individuals do not satisfy the requirements in section 1899C(a) of the Act and therefore are not entitled to, and may not be enrolled for, Medicare. As explained in the proposed rule, the notice would state that termination of enrollment will be effective February 1, 2027. The notice would inform individuals of their appeal rights under existing appeals regulations for initial determinations delineated in 42 CFR, part 405, subpart I, specifically 42 CFR 405.900(b)(1), which establishes that appeals of initial determinations for entitlement to benefits under Part A or Part B of Medicare are administered in accordance with the SSA's regulations governing reconsiderations of these initial determinations at 20 CFR, part 404, subpart J.

We noted in the proposed rule that entitlement to premium-free Part A and enrollment in premium Part A and Part B are referenced in the Act as ''monthly insurance benefits'' or ''benefits for a month'' (see section 226(c)(1) and (2) of the Act) and entitlement to or enrollment in Medicare always begins on the first day of the month and always ends on the last day of the month (see section 1838(a) and (b) of the Act). Consequently, the termination in proposed §§ 406.14(d)(2), 406.28(g)(3)(ii), and 407.27(e)(3)(ii) would be at the end of the calendar month.

Accordingly, we proposed to amend the following regulations to implement termination procedures for individuals who were entitled to, or enrolled for, Medicare as of July 4, 2025, but do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act:

- Premium-Free Medicare Part A:

++ New § 406.14 (End of Entitlement Due to Change in Citizenship, Nationality, or Immigration Status or Category) was proposed to be added, in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were entitled to premium-free Part A as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, new paragraph (b) would provide that individuals entitled or enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 406.5(a)(2) will be identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 406.5(a)(2) requirements will have their entitlement or enrollment terminated in accordance with paragraph (d).

++ New paragraph (b)(3) was proposed to be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security benefits) to add a cross reference to the termination provision in the new § 406.14.

++ New paragraph (d)(2)(v) was proposed to be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits) to add a cross reference to the termination provision in the new § 406.14.

++ New paragraph (f)(3) was proposed to be added to § 406.13 (Individual who has end-stage renal disease) to add cross reference to the termination provision in the new § 406.14(b).

- Premium Medicare Part A:

++ New paragraph (g)(1) was proposed to be added to § 406.28 (End of Entitlement Due to Change in Citizenship, Nationality, or Immigration Status or Category) in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were entitled to, or enrolled for, premium Part A as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, the new paragraph (g)(1) would provide that individuals entitled to or enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 406.20(b)(2) will be identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 406.20(b)(2) requirements will have their entitlement or enrollment terminated in accordance with paragraph (3).

- Medicare Part B:

++ New paragraph (e)(1) was proposed to be added to § 407.27 (Termination of entitlement: Individual), in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were enrolled in Part B as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, the new paragraph (e)(1) would provide that individuals enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 407.10(a)(2) will be identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 407.10(a)(2) requirements will have their enrollment terminated in accordance with paragraph (3).

We address all comments related to the proposed termination processes in the next section.

c. Termination Process for Certain Noncitizens Entitled to, or Enrolled for, Medicare Who Were Not Identified and Notified by the SSA Per Section 1899C(b)(2) of the Act (Outside of the ''Grace Period'' Population)

We turn now to the proposed termination processes that would be used for all other individuals whose eligibility for Medicare, including both initial eligibility and continued eligibility, is impacted by the statutory changes to Medicare eligibility made by section 71201 of the WFTC legislation and whose entitlement and enrollment was not terminated by the SSA under the processes implementing section 1899C(b) of the Act. The proposed termination processes for this population provides the framework to terminate enrollment in Medicare if they are not eligible to be entitled or enrolled per section 1899C of the Act while ensuring all impacted individuals are notified of termination and retain their appeal rights. Under this proposal, all terminations made under section 1899C of the Act would be prospective.

We proposed that entitlement and enrollment for those not identified during the grace period and found not to meet the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act would end according to the termination processes in the following proposals: § 406.14(c) and (d) for those with premium-free Part A, § 406.28(g)(2) and (3) for those with premium Part A, and § 407.27(e)(2) and (3) for those with Part B benefits. The proposed termination processes in §§ 406.14(d), 406.28(g)(3) and 407.27(e)(3) included providing notice to such individuals that their entitlement and enrollment for Medicare will be terminated if they do not meet section 1899C(a) of the Act, and for terminating entitlement or enrollment where the SSA determines that the individual either does not or no longer meets the requirements of section 1899C(a) of the Act.

As stated, this proposed termination process would apply to anyone enrolled in Medicare whom the SSA determines does not meet eligibility requirements under section 1899C(a) of the Act and was not part of the grace period population per section 1899C(b)(2)(B) of the Act. The proposed rule acknowledged that there would be a period of time between enactment of the WFTC legislation on July 4, 2025, and the SSA starting to screen individuals for new Medicare enrollment under the criteria in section 1899C(a) of the Act, which we noted in the proposed rule is expected to begin in 2026. Individuals enrolled after enactment of the WFTC legislation but before screening procedures are implemented do not fall into the grace period population because they were not enrolled as of the date of enactment. Thus, the proposed rule noted that individuals enrolled during the previously discussed time period who do not meet the eligibility requirements in section 1899C(a) of the Act would be terminated according to proposed §§ 406.14(d), 406.28(g)(3) or 407.27(e)(3), as appropriate.

Additionally, the proposed termination process would apply to anyone enrolled in Medicare whom the SSA determines does not meet the eligibility requirements in section 1899C(a) of the Act and was not notified as part of the grace period population per section 1899C(b)(2)(B) of the Act. This would include individuals whose status changed prior to the finalization of this rule, such as an individual who was enrolled in Medicare in October 2024 and met the eligibility requirements under section 1899C(a) of the Act based on their conditional LPR status when the SSA identified and notified the grace period population. Therefore, they were not included in the grace period population per section 1899C(b)(2)(B) of the Act. However, if the SSA's records indicate that their conditional LPR status is scheduled to expire in December 2026, and the status is not extended and is terminated accordingly, this proposed termination process would apply upon termination of their conditional LPR status and would provide the framework for this individual's Medicare enrollment to be terminated as they would no longer satisfy the requirements of section 1899C(a) of the Act. We emphasized that the same process would also apply to individuals enrolled after this proposed rule is implemented, if finalized as proposed. As an example, consider the case of an individual enrolled in Medicare with conditional LPR status whose enrollment began in April 2028. In February 2030, the SSA records indicate that the individual's conditional LPR status expires in April 2030, and the status is not extended. Upon termination of the individual's status following expiration of their conditional LPR status in April 2030, the individual would no longer satisfy the requirements of section 1899C(a) of the Act, and the SSA would send notice to the individual that they no longer meet the requirements of section 1899C(a) of the Act. As a result, under the proposed process for termination of enrollment, the individual's Medicare enrollment would be terminated at the end of the month following the month in which the notice is dated.

There are several circumstances in which individuals are identified as no longer meeting the requirements of section 1899C(a) of the Act outside the grace period. We proposed the same termination process for individuals in these circumstances in proposed §§ 406.14(d), 406.28(g)(3) or 407.27(e)(3), as appropriate.

For these individuals outside the grace period, we proposed that a termination notice from the SSA would be sent to each individual identified as ineligible. We proposed the notice would explain that, per data available to the SSA, the individual does not satisfy the requirements of section 1899C(a) of the Act. Under the proposed termination process, an individual would not lose Medicare entitlement or enrollment during the month in which the SSA determines that the individual does not or no longer meets the requirements of section 1899C(a) of the Act. Rather, Medicare entitlement or enrollment would terminate at the end of the month following the month in which the notice is dated. For example, if the date of the termination notice is in March 2027, termination would be effective at the end of April 2027. This proposed termination timeline would be explained in the notice. We emphasized that the SSA will not terminate anyone's entitlement or enrollment prior to notification. Further, no termination of Medicare would occur for any individual entitled to, or enrolled for, Medicare for failure to meet the requirements of section 1899C(a) of the Act prior to the effective date of this rule, if finalized as proposed. We proposed an effective date of January 1, 2027.

We proposed that individuals whose Medicare entitlement and enrollment are terminated because they do not meet the requirements of section 1899C(a) of the Act would be provided appeal rights under our existing appeals regulations for initial determinations. Appeals of initial determinations for entitlement to benefits under Medicare Part A or Part B are administered in accordance with 20 CFR, part 404, subpart J (*see* 42 CFR 405.900(b)(1)). We proposed to include the information about appeal rights in the proposed termination notices.

We also proposed that termination notices would be sent to affected individuals on an ongoing basis, as applicable, when the SSA receives information that an individual enrolled in Medicare does not meet the requirements of section 1899C(a) of the Act.

In the proposed rule, we explained that these proposals are necessary to ensure implementation of section 1899C of the Act is consistent with the efficient administration of the Medicare program under section 1102(a) of the Act. Therefore, to implement the proposed termination framework, we proposed adding and revising the following sections:

- Premium-Free Medicare Part A:

++ New § 406.14 (End of entitlement due to change in citizenship, nationality, or immigration status or category) would be added. The proposed new § 406.14(c) would provide the termination framework for individuals entitled to premium-free Part A who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA to not meet the requirements of § 406.5(a)(2). Proposed § 406.14(d) describes the proposed termination notice and appeal rights in accordance with existing regulations governing Medicare entitlement determinations, states the effective date of premium-free Part A entitlement termination, and states that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, premium-free Part A benefits.

++ New paragraph (b)(3) would be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security benefits). This proposed new paragraph would add a cross-reference to § 406.14 so that individuals entitled to, or enrolled for, premium-free Part A through the age-65 pathway would be subject to the termination procedures in that section if they do not or no longer meet the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

++ New proposed paragraph (d)(2)(v) would be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits). This proposed new paragraph would add cross-references to § 406.14(b) and (c) so that disability-based premium-free Part A entitlement would be subject to the proposed termination procedures for an individual who does not or no longer meets the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

++ New proposed paragraph (f)(3) would be added to § 406.13 (Individual who has ESRD). This proposed new paragraph would add a cross-reference to § 406.14 to specify that individuals entitled to, or enrolled for, premium-free Part A on the basis of ESRD would be subject to the proposed procedures for termination when an individual does not or no longer meets the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

- Premium Medicare Part A:

++ New proposed paragraph (g)(2) was proposed to be added to § 406.28 (End of entitlement) for individuals who were entitled to, or enrolled for, premium Part A, who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA as not meeting the requirements of § 406.20(b)(2). Under proposed paragraph (g)(2), entitlement would end as provided under paragraph (g)(3) of this section.

++ New proposed paragraph (g)(3) was proposed to be added to § 406.28 (End of entitlement). It describes the proposed termination notice, which would specify the individual's appeal rights in accordance with existing regulations governing Medicare entitlement determinations, state the effective date of premium Part A enrollment termination, and state that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, premium Part A benefits.

++ Paragraphs (a) and (b) of § 406.50 was proposed to be revised to change the word ''alien'' to ''eligible noncitizen.''

- Medicare Part B:

++ New proposed paragraph (e)(2) was proposed to be added to § 407.27 (Termination of entitlement: Individual enrollment). This new paragraph would specify that individuals who are enrolled in Part B, who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA as not meeting the requirements of § 407.10(a)(2), would have their enrollment terminated under the new proposed paragraph (e)(3) of the section.

++ New proposed paragraph (e)(3) would be added to § 407.27 (Termination of entitlement: Individual enrollment). This new paragraph would describe the termination notice, which would specify the individual's appeal rights in accordance with existing regulations governing Medicare entitlement determinations, state the effective date of Part B enrollment termination, and state that the individual should contact the SSA if their citizenship, nationality, immigration status or category changes such that they may be enrolled for, Part B benefits.

We received public comments on the proposed termination process. The following is a summary of the comments we received and our responses.

Comment: Multiple commenters recommended that the preliminary notice be sent to the grace period population as early as possible and well in advance of their termination date. Commenters requested multiple notices, with several commenters specifying at least three notices and several recommending that preliminary notices be sent at least 90 days before termination. A commenter suggested color coded notices and another recommended patient navigators and providing notices through a variety of methods, such as phone calls, text messages, e-mails, and letters.

Response: We acknowledge the comments regarding the timing and frequency of notices to the grace period population. We stated in the proposed rule that, in accordance with section 1899C(b)(2)(B) of the Act, the SSA would send, as soon as practicable, notice to individuals identified as not meeting or potentially not meeting one of the eligibility criteria in section 1899C(a). Accordingly, the SSA plans to send to these individuals a preliminary notice in November 2026. As such, preliminary notices will be sent almost 90 days before a termination would take effect. The preliminary notice will instruct the individual to contact the SSA and provide updated evidence of eligibility and inform them that they could potentially lose entitlement to Part A and/or enrollment in Part B. Individuals who do not establish continued eligibility will subsequently

receive a formal termination notice in December 2026 before their Medicare entitlement and/or enrollment terminates.

Additionally, CMS plans to send a notice in December 2026 to those affected following the SSA's preliminary notice. CMS's notice will emphasize the importance of reviewing SSA's preliminary notice and encourage individuals to call 1–800–MEDICARE or reach out to the SSA for any needed assistance. CMS will include in the notice taglines in 14 different languages for those with limited English proficiency. CMS also plans to send emails to beneficiaries who have a *Medicare.gov* account and are receiving a disenrollment notice from the SSA. CMS's and the SSA's call centers are prepared for calls from beneficiaries. CMS has also notified the SHIPs of the changes in eligibility and is planning communications to the provider community.

At this point, color-coded notices are not feasible. We will take into consideration other mechanisms of communication, such as outbound telephone calls and text messages, as those avenues become available. We believe the SSA preliminary notice, the CMS notice, and the SSA termination notice, as well as emails to those with a *Medicare.gov* account, provide several opportunities for affected and potentially affected individuals to be informed in advance of proposed termination dates.

Comment: Multiple commenters recommended that notices explain the basis for the determination of ineligibility (including the specific immigration status of the individual), the effective date of termination, the information or records relied upon, the documentation the individual may submit to establish continued eligibility or correct the determination, applicable appeal or review rights, the availability of good-cause extensions of appeal deadlines, and where the individual may obtain free assistance. Another commenter suggested that CMS make notices to impacted individuals available for comment and review before distribution.

Response: CMS appreciates the commenters' recommendations regarding the content of notices. The preliminary notice will explain that based on the information that the SSA has, the individual does not or potentially does not meet the requirements of section 1899C(a) of the Act and will instruct the individual to contact the SSA and provide updated evidence if they believe the determination is incorrect. The notices will also explain how to obtain a copy of and correct their immigration record with the United States Citizenship and Immigration Services (USCIS). The preliminary notice will provide contact information for the SSA, including the website, customer service number, and a telephone number for contacting their local office.

If the individual fails to provide updated or sufficient evidence of eligibility and the SSA subsequently determines that the individual does not meet the requirements of section 1899C(a) of the Act, the termination notice will explain the determination, state the effective date of termination, and provide information regarding the individual's appeal rights. The termination notice will also inform the individual that an appeal filed after the deadline may be accepted if the individual shows good cause for the late filing. For assistance, the notice provides the SSA customer service number, website, and telephone number for contacting their local SSA office.

CMS and SSA have an existing process for developing notices and communications to Medicare enrollees and will follow the current process for issuance of these new notices consistent with applicable statutory and regulatory requirements and we will not be issuing these notices for public comment prior to release.

Creating individualized notices delineating the sources relied upon, the immigration status of each individual, and the specific documentation needed to maintain eligibility is not operationally feasible at this time. The notices are similar in content to what was previously used for individuals who were not lawfully present. However, the SSA will ensure that guidance for evidentiary requirements for Medicare entitlement and enrollment is clear for both employees and the public. Finally, CMS and the SSA will take these suggestions regarding including individualized information in the preliminary notice into consideration for future updates.

Comment: Multiple commenters requested that notices clearly explain that a determination under section 1899C of the Act concerns Medicare entitlement or enrollment and does not, by itself, terminate an individual's Social Security title II benefits.

Response: We thank commenters for the recommendation. The SSA will be issuing notices based on whether the individual is receiving Medicare only or both title II and Medicare benefits. That is, if the individual is only receiving Medicare coverage, the notice will only refer to Medicare benefits, whereas individuals that are entitled to title II benefits, but not entitled to Medicare, will receive a notice stating that they will continue to receive title II benefits and their Medicare entitlement and enrollment will be terminated.

Comment: A commenter requested that CMS require that notices sent out by the SSA and any other entity contain an explanation of the Cuban and Haitian Entrant (CHE) classification, how to prove the classification, and community resources to assist individuals in determining whether they qualify as a CHE.

Response: We thank the commenter for this recommendation. The preliminary and termination notices from the SSA will state the citizenship and immigration categories that qualify for Medicare entitlement and enrollment under section 1899C of the Act. In addition, the notices will direct individuals to the USCIS to get a copy of their immigration record to determine their status and how to correct the records, if necessary. The USCIS also provides information on the types of documentation that may be presented to demonstrate CHE status.[216] Finally, as noted above, CMS and the SSA plan outreach to community resources, such as organizations that assist affected individuals, including SHIPs and other community-based and immigrant-serving organizations, to help connect individuals with additional information and assistance regarding the new Medicare eligibility requirements.

Comment: Multiple commenters requested that notices comply with the language-access requirements of section 1557 of the Affordable Care Act and other Medicare language access requirements; be written in plain language and at an accessible reading level; be translated into commonly spoken languages; and be accessible to individuals with disabilities and limited English proficiency.

Response: We thank commenters for these recommendations. The SSA will develop and issue these notices consistent with current applicable Federal plain-language, language-access, and accessibility requirements.

The SSA has existing procedures for providing notices in accessible formats to certain individuals who are blind or visually impaired through its Special Notice Option program. Under these procedures, available notice options include Braille, large print, audio CD, a Microsoft Word file on CD, certified mail, or first-class mail accompanied by a follow-up telephone call, as

[216] *https://www.uscis.gov/save/resources/information-for-save-users-cuban-haitian-entrants.*

applicable. The SSA's POMS GN 00211.001, Section 504 of the Rehabilitation Act of 1973: Standard and Non-Standard Accommodations, also provides procedures for requests for other notice accommodations. These existing accessibility processes will continue to apply, as appropriate, to individuals receiving the SSA's communications.

The SSA also provides language assistance to individuals who prefer to conduct business in a language other than English. The SSA provides free interpreter services by telephone and in Social Security offices, where interpreters are available in more than 200 languages. The SSA translates most Social Security notices into Spanish; notices not available in Spanish include a Spanish-language cover letter offering translation assistance through a local Social Security office. The SSA also makes public information materials available in multiple languages through its Multilanguage Gateway.

Finally, CMS plans to send a courtesy notice to the grace period population and to those individuals outside the grace period following the SSA's notice. CMS's notice will include taglines in 14 different languages for those with limited English proficiency and contains a statement informing individuals that they can request accommodations.

Comment: A couple of commenters recommended that Medicare termination notices include information to help affected individuals maintain access to health care after their Medicare entitlement or enrollment ends. Commenters requested that CMS and the SSA provide information regarding continuity-of-care considerations and resources that may assist individuals in identifying other health coverage options for which they may be eligible. Some commenters also recommended that CMS and the SSA facilitate handoffs to alternate coverage options or providers to help individuals transition from Medicare coverage.

Response: We appreciate the commenters' concerns regarding continuity of care and access to other health coverage following termination of Medicare. As availability of other coverage options will be dependent on an individual's circumstances, it will not be feasible to include information on other health care options in individual notices or facilitate handoffs to alternative coverage options. CMS and the SSA plan to implement a robust outreach and education effort with the implementation of section 1899C of the Act and will include relevant information on other health coverage options available, whenever possible.

Comment: Multiple commenters requested that CMS and the SSA provide individuals outside the grace period population with earlier and more robust notice before terminating Medicare entitlement or enrollment under section 1899C of the Act. Commenters recommended that individuals outside the grace period population receive a preliminary notice at least 90 days before termination. Commenters also recommended that preliminary notices be provided on an ongoing basis for individuals identified after the initial implementation period.

Response: We thank commenters for their recommendations regarding advance notice for individuals outside the grace period population. The SSA plans to send a preliminary notice in November 2026 to all individuals it has identified as not meeting or potentially not meeting the requirements of section 1899C(a) of the Act, regardless of whether the individual is within the grace period population. As such, preliminary notices will be sent almost 90 days before a termination would take effect. The preliminary notice will inform individuals that the SSA's records indicate that they may not meet the requirements of section 1899C(a) of the Act, instruct them to contact the SSA and provide updated evidence of eligibility, and inform them that they could potentially lose entitlement to Part A and/or enrollment in Part B. Similar to the grace period population, individuals who receive the preliminary notice who do not establish continued eligibility will subsequently receive a formal termination notice in December 2026 before their Medicare entitlement and/or enrollment terminates. As discussed previously, termination for those individuals outside of or not notified as part of the grace period population will be effective at the end of the month following the month in which the termination notice is dated. Therefore, for these individuals, this final rule provides that, based on a December 2026 termination notice date, the earliest that Medicare entitlement/enrollment termination will occur is at the end of January 2027. In practical terms for Medicare beneficiaries, this means that they will not have Medicare coverage beginning February 1, 2027.

To note, the SSA and CMS currently plan to send preliminary notices only to Medicare enrolled individuals that the SSA is able to identify before November 2026 as not meeting or potentially not meeting the requirements of section 1899C(a) of the Act. The preliminary notice is an additional implementation measure intended to provide affected individuals with an opportunity to update their records during the initial transition to the new Medicare eligibility requirements established by section 1899C of the Act. Because this rule implements new statutory eligibility requirements and establishes a new termination framework, we believed that additional advance communication was appropriate during this transitional period. However, once the new requirements have been fully implemented, notices will be sent consistent with the process described in this final rule.

Comment: Multiple commenters requested that CMS explicitly hold harmless individuals who became entitled to, or enrolled in, Medicare after July 4, 2025, before the SSA implemented screening procedures for the new eligibility requirements under section 1899C of the Act, and who are subsequently determined not to meet the new eligibility requirements. A commenter requested that terminations not apply retroactively to physician payments and that guidance be provided regarding services rendered prior to an individual's termination date.

Response: We thank commenters for these recommendations. Individuals who were enrolled in Medicare after July 4, 2025, but before the SSA implemented screening for the requirements of section 1899C(a) of the Act, and who are subsequently determined not to meet those requirements, will have their Medicare entitlement or enrollment terminated prospectively under the termination process described previously. Their Medicare entitlement or enrollment will not be retroactively terminated for the months in which they were enrolled.

Accordingly, CMS will take no action to recover any Medicare payments for services rendered before the individual's prospective termination due to not meeting the requirements of section 1899C(a) of the Act. Claims for services rendered prior to a termination of entitlement and enrollment will be processed according to existing procedures. Because the termination framework does not retroactively terminate the individual's Medicare entitlement or enrollment for those months, a separate hold-harmless policy is not necessary.

Comment: Multiple commenters were concerned with the high likelihood of erroneous terminations and requested that CMS and the SSA delay implementation to establish stronger pre-termination review procedures and safeguards for all individuals whose

Medicare entitlement or enrollment may be terminated under section 1899C of the Act. A commenter also recommended that CMS extend the 18-month grace period, which would in effect delay implementation of terminations for individuals in the grace period population.

Response: We appreciate the commenters' recommendations. The SSA used and is using the most current information and verification tools available to it to make accurate determinations under section 1899C of the Act, including information or documentation provided by individuals. Individuals identified as potentially not meeting the requirements of section 1899C(a) of the Act, including those individuals in the 18-month grace period population, will receive a preliminary notice and have an opportunity to provide updated evidence to the SSA before a formal determination of ineligibility is made. We believe that sufficient safeguards have been established to identify ineligible individuals and to provide them with opportunities to furnish updated evidence of eligibility and appeal determinations that individuals believe are erroneous. Further, section 1899C(b)(1) of the Act specifies that individuals entitled to, or enrolled for Medicare benefits as of July 4, 2025, who no longer meet the requirements under section 1899C(a) of the Act, will have their Medicare entitlement and enrollment terminated beginning on the date that is 18 months after July 4, 2025. No provision in section 1899C of the Act permits extension of the grace period.

Comment: Multiple commenters stated that, regardless of when or how an individual is identified as potentially ineligible, the individual should have a meaningful opportunity to correct inaccurate, incomplete, outdated, or inconsistent citizenship, nationality, or immigration status or category information before coverage ends or to promptly restore coverage.

Response: We thank commenters for these recommendations. As noted previously, individuals identified as not meeting or potentially not meeting the requirements of section 1899C(a) of the Act prior to November 2026 will be sent preliminary notices from the SSA instructing them to contact the SSA and provide updated evidence if they believe they meet the requirements of section 1899C(a) before a formal notice of termination of entitlement and enrollment is sent. Further, any individual identified as not meeting the requirements of section 1899C(a) of the Act will receive a termination notice stating that their enrollment will be terminated at the end of the month following the month in which the notice is dated and will have the opportunity for successive levels of appeals, including a reconsideration, a hearing before an administrative law judge, a hearing before the Appeals Council, and filing a complaint with a Federal district court, subject to any applicable requirements for each level of appeal.

Comment: Multiple commenters also requested that CMS clarify what happens when an individual submits documentation before the scheduled termination date but agency review remains pending. Commenters urged CMS and the SSA to delay Medicare terminations when an individual has timely submitted documentation or other information to establish continued eligibility under section 1899C of the Act but agency review remains pending, and not to terminate coverage solely on the basis of an automated data match or incomplete administrative record..

Response: We appreciate the commenters' request for clarification and recommendation that Medicare termination be delayed while an eligibility review or correction request is pending. Except as provided in section 1899C(b)(1) of the Act, an individual may not remain entitled to, or enrolled for, Medicare unless the individual meets the requirements of section 1899C(a) of the Act. CMS therefore does not have authority to establish a continued-coverage exception based solely on the pending status of an eligibility review or correction request. In some cases, an individual may submit documentation before termination, but the SSA may not complete its review until after the termination has taken effect. If the SSA subsequently determines that the individual met the applicable Medicare eligibility requirements at the time of termination, existing procedures allow the prior determination to be corrected and Medicare entitlement or enrollment to be reinstated retroactively, as appropriate. For premium Part A or Part B, the individual may be responsible for applicable premiums for any retroactive period. Once entitlement or enrollment is restored retroactively, Medicare claims for covered services furnished during the restored period may be processed, consistent with applicable Medicare claims rules.

Individuals have the right to file an appeal, or a request for reconsideration, within 60 days of receiving notice of the SSA's determination. The 60-day timeframe for filing a request for reconsideration may be extended for good cause. Finally, in making a determination under section 1899C(a), the SSA will consider available information from its records and any updated information or documentation provided by the individual. As available to SSA and appropriate, SSA will also consider information available from records from other agencies.

Comment: Multiple commenters requested that termination notices clearly explain applicable reconsideration, appeal, and judicial review rights, including how to challenge an erroneous determination. Further, multiple commenters requested that Medicare coverage continue during a timely appeal process.

Response: We appreciate these comments and note that termination notices sent by the SSA to individuals that do not meet the requirements of section 1899C(a) of the Act will provide information regarding the individual's appeal rights and how to request the first level of appeal, which is a request for reconsideration. Appeals of Medicare Part A and Part B entitlement determinations are administered under 20 CFR part 404, subpart J. This process provides for reconsideration, a hearing before an administrative law judge, Appeals Council review, and judicial review, as applicable. However, section 1899C of the Act does not provide CMS with authority to extend Medicare coverage during an appeal.

Comment: Multiple commenters also requested that notices explain how individuals may request good-cause extensions of appeal deadlines when they need additional time to gather documentation, are receiving medical treatment, or otherwise cannot file within the standard timeframe.

Response: We appreciate the commenters' request. As noted previously, appeals of initial determinations, or a request for reconsideration, regarding Medicare Part A or Part B entitlement and enrollment are governed by existing SSA appeals procedures. Under those procedures, a request for reconsideration generally must be filed within 60 days after the individual receives notice of the initial determination. An individual who misses the filing deadline can request an extension based on good cause, including where the individual did not timely receive the notice. Termination notices will state that individuals can file beyond the 60-day reconsideration deadline if they have a good reason.

Comment: Several commenters requested expedited appeal or pre-termination review procedures for individuals who are terminated or denied enrollment in order to challenge

for enrollment in Medicare following a change in their citizenship, nationality, or immigration status or category. Individuals will need to provide information requested in the CMS–10797 to enroll or re-enroll in Medicare using the newly established SEP. We do not have historical data on which to base a precise estimate of SEP utilization, as this is a newly proposed enrollment pathway with no prior utilization experience. OACT estimates that approximately 32,000 individuals will lose Medicare coverage beginning in 2027. Therefore in the proposed rule, for purposes of this burden estimate, we assumed that approximately 10 percent of individuals projected to lose Medicare coverage, approximately 3,200 (32,000 × 0.10) individuals annually, may utilize the SEP to re-enroll in Medicare following a change in their citizenship, nationality, or immigration status or category. We estimated 3,200 total respondents annually at 0.25 hours per response, for an addition of 800 hours (3,200 responses × 0.25 hr/response) and $19,240 (800 hr × $24.05/hr), or $6.01 per respondent ($19,240/3,200 respondents), beginning in CY 2027. We assumed that the 0.25 hours per response applies to this SEP, as the burden associated with establishing or reestablishing immigration status or category and updating documentation, as necessary or applicable, is outside the Medicare enrollment process and, therefore, this burden estimate only accounted for time to enroll in Medicare.

The updated total burden for OMB control number 0938–1426, inclusive of both the currently approved burden and the additional SEP burden, was 37,812 respondents (34,612 + 3,200), 9,453 hours (8,653 hr + 800 hr), and $227,345 ($208,105 + $19,240).

The procedural steps that MA and Part D plans must take to receive and process disenrollment transactions are currently approved by OMB under control numbers 0938–0753 (CMS–R–267) and 0938–0964 (CMS–10141). We are not attributing any additional burden to this provision since the change is small relative to the number of disenrollment transactions processed by MA and Part D plans annually.

We sought public comments on all aspects of the proposed changes to entitlement and eligibility rules for Parts A and B, the underlying burden assumptions, and the changes to limit coverage under Medicare cost plans, MA plans, and Part D plans. We received the following comments on the underlying burden assumptions.

Comment: Some commenters noted that CMS's estimate of 32,000 individuals that will lose Medicare coverage in 2027 is lower than CBO's estimate of individuals potentially losing Medicare coverage. Commenters noted that if this estimate is incorrect, it may risk skewing the 2027 cost estimate related to the burden on individuals who need to complete the CMS–10797 form to enroll using the new SEP, as the burden estimate assumed approximately 10 percent of the 32,000 estimated to lose coverage would use the SEP to re-enroll in coverage after regaining status.

Response: We acknowledge the commenters' concerns. There is very little information available on the number of beneficiaries who will be affected by this provision of the law. CMS actuaries and CBO both prepare estimates to inform policymakers of the potential impact of enacted legislation and other regulatory policy proposals. Because of varied assumptions using this limited information, the estimates are likely to be different, and one may turn out to be more accurate than the other. However, based on the SSA's most recent estimate of approximately 300,000 preliminary notices that will be sent to individuals in November 2026 to request updated evidence of eligibility, we are revising our estimate of individuals using the newly established SEP to 10 percent of 300,000 or 30,000. Since the SEP is available to any individual who loses coverage or does not enroll due to the new eligibility requirements in section 1899C, we believe that a percentage of the individuals who receive the notices and will potentially lose coverage is a reasonable approximation of who will use the SEP to re-enroll.

Therefore, for purposes of the revised burden estimate for OMB control number 0938–1426, we assume that approximately 10 percent of individuals who receive the November preliminary notice, approximately 30,000 (300,000 × 0.10) individuals annually, may utilize the SEP to re-enroll in Medicare following a change in their citizenship, nationality, or immigration status or category. As noted in the proposed rule, there is no historical precedent on which to base the estimate and CMS will take into account actual utilization data in future years to estimate the burden of this new SEP. We estimate 30,000 total respondents annually at 0.25 hours per response, for an addition of 7,500 hours (30,000 responses × 0.25 hr/response) and $180,375 (7,500 hr × $24.05/hr), or $6.01 per respondent ($180,375/30,000 respondents), beginning in CY 2027. We assume that the 0.25 hours per response applies to this proposed SEP, as the burden associated with reestablishing immigration status and updating documentation is outside the Medicare enrollment process and therefore this burden estimate only accounts for time to enroll in Medicare.

The updated total burden for OMB control number 0938–1426, inclusive of both the currently approved burden and the additional SEP burden, is 64,612 respondents (34,612 + 30,000), 16,153 hours (8,653 hr + 7,500 hr), and $388,480 ($208,105 + $180,375).

4. ICRs Regarding Rebate Reduction Requests Under Sections 11101 and 11102 (§§ 427.402, 428.302, and 428.303)

This ICR collects information from manufacturers of Part B rebatable biosimilar biological products and generic Part D rebatable drugs and biosimilars that are requesting rebate reductions to inform CMS' determinations regarding such rebate reduction requests pursuant to the policies adopted in the CY 2025 PFS final rule (89 FR 97710). The information collection requirements for the Rebate Reduction Requests under sections 11101 and 11102 of the IRA ICR currently approved under OMB Control Number 0938–1474 are scheduled to expire on July 31, 2027. Upon publication of the CY 2027 PFS final rule, we will request renewal of this collection from OMB prior to its expiration. The renewal will continue the currently approved requirements with technical updates to the forms, such as the email address to submit rebate reduction requests and references to relevant sections of the CY 2025 PFS final rule. These technical updates do not materially affect burden from respondents or CMS. No policy changes related to this collection are proposed in this rule. Consequently, we are not setting out any proposed burden estimates under this section of this final rule.

5. ICRs Regarding Medicare Prescription Drug Inflation Rebate (§ 428.203(c))

The following changes will be submitted to OMB for approval under control number 0938–1485 (CMS–10930).

In section III.F.3.c.2.c. of this final rule, we are requiring all providers and suppliers that are covered entities as defined under § 10.3 (hereinafter collectively ''340B providers'' unless otherwise noted) to submit data elements from their Part D 340B claims to the 340B repository for all covered Part D drugs billed to Medicare Part D by such covered entity or its contractor(s) beginning in 2027 for Part

change payments or impose additional costs.

5. Impacts Related to the Ambulatory Specialty Model (ASM)

In section III.D. of this final rule, we discuss the Ambulatory Specialty Model (ASM) tested by the CMS Center for Medicare and Medicaid Innovation (hereinafter ''Innovation Center'') under the authority of section 1115A of the Act. Section 1115A of the Act authorizes the Innovation Center to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. ASM will test whether adjusting payment for eligible specialists who furnish services related to ASM's targeted chronic conditions (that is, heart failure and low back pain) based on performance across targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management. By testing ASM, we aim to reduce avoidable hospitalizations and unnecessary procedures, improve patient experience and outcomes, and lower Original Medicare expenditures by incentivizing preventive care, more effective management of chronic conditions, and enhanced coordination and collaboration among specialists and primary care providers. We finalized ASM's provisions in the CY 2026 PFS final rule (90 FR 49562 through 49720), including the framework for identifying ASM participants, performance evaluation, scoring, and payment adjustments.

Based on feedback we received from interested parties after the publication of the CY 2026 PFS final rule and our own internal review, we proposed and are finalizing several technical refinements and adjustments to ASM, including but not limited to revising select definitions, revising and adding ASM participant exceptions from specific ASM requirements, adjusting data submission requirements, incorporating a rural scoring adjustment to final scores, adjusting provisions related to collaborative care arrangements under ASM, and making minor adjustments to specific ASM performance category policies in this final rule. We believe our final policies will improve the clarity, practicality, and alignment of ASM implementation. Further, our final policies do not modify the fundamental framework of ASM for identifying ASM participants over the course of the ASM test period, overall performance evaluation, scoring, or payment adjustments and continue to support CMS priorities related to reducing low—value care, promoting preventive care, enhancing management of chronic conditions, and improving coordination and collaboration among specialists and primary care providers.

Accordingly, we believe our finalized policies in this final rule would not increase federal costs or alter the estimated Medicare program savings described in the CY 2026 PFS final rule (90 FR 49969 through 49975). In the CY 2026 PFS final rule, we estimated an impact of $177 million in net savings to the Medicare program due to ASM from January 1, 2029 through December 31, 2033 (90 FR 49972). This estimate reflects relevant finalized provisions including the ASM test period, geographic scope, participant eligibility, ASM risk levels, the amount of ASM incentive pools distributed to ASM participants in the form of payment adjustments, and the estimated amount of Medicare Part B covered professional service payments subject to ASM payment adjustments. We refer readers to the ASM section of the regulatory impact analysis of CY 2026 PFS final rule for additional information on our methodology and sensitivity analysis (90 FR 49969 through 90 FR 49975). Because we did not propose changes to key assumptions used to previously calculate the Medicare program savings estimate, we do not expect the final policies in this final rule to materially affect the Medicare program savings estimates in the CY 2026 PFS final rule. For example, we do not anticipate that the provisions related to ASM participant exceptions from specific ASM requirements would substantially affect the number of ASM participants meeting ASM requirements over the ASM test period because we believe any exceptions would be balanced by other participation provisions that allow for clinicians who newly meet the ASM participant eligibility criteria to be added as ASM participants over the course of the ASM test period. Therefore, ASM's previously estimated financial impact to the Medicare program remains unchanged from the CY 2026 PFS final rule.

6. Impacts Related to the Limiting Medicare Coverage of Certain Individuals

Section 71201 of the Working Families Tax Cut (WFTC) legislation, which added section 1899C to the Social Security Act (the Act), restricts Medicare eligibility to individuals who meet one of the following criteria: (1) U.S. citizens or nationals; (2) lawful permanent residents; (3) Cuban and Haitian entrants; or (4) individuals who lawfully reside in the United States in accordance with a Compact of Free Association. Individuals who do not meet these criteria and who were enrolled in Medicare on or before July 4, 2025, will have their coverage terminated effective February 1, 2027, which is the date that is 18 months after enactment of the WFTC legislation (July 4, 2025). As established in section 1899C(a) of the Act, individuals enrolled after July 4, 2025, who do not meet the eligibility requirements, are subject to denial or termination under the framework established at proposed §§ 406.14, 406.28 and 407.27.

Based on estimates from OACT, approximately 32,000 individuals are projected to lose Medicare coverage beginning in 2027, representing approximately 0.05 percent of the total Medicare-aged enrollment. OACT's estimate was derived from a 2025 Pew Research study on race and ethnicity in the United States and by using a Congressional report authored by the Department of Homeland Security (DHS). Recently, the SSA has estimated that approximately 300,000 notices will be sent out in November 2026 to individuals who may lose coverage. These individuals will get the opportunity to provide the necessary documentation to continue eligibility so the actual number who lose coverage remains unknown. Because of this, and significant time constraints, OACT is not revising their estimate.

In addition, citing research on lower health care utilization by immigrants, OACT assumes that affected individuals have average Medicare spending equal to approximately two-thirds of the average Medicare beneficiary, reflecting the generally healthier and younger age profile of this population, as well as lower utilization due to increased barriers in accessing health care including language barriers, limited familiarity with the U.S. health system, and concerns related to immigration status that may discourage enrollment and utilization even among those who are eligible. The population captured in this estimate is certain immigrants with temporary protections who no longer meet the revised eligibility requirements of section 1899C(a) of the Act.

TABLE D-B5: ESTIMATED IMPACT ON MEDICARE SPENDING – LIMITING MEDICARE COVERAGE OF CERTAIN INDIVIDUALS ($ MILLIONS)

Year	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2027-2036 Total
FY Cash	-$220	-$390	-$420	-$450	-$490	-$520	-$560	-$600	-$640	-$680	-$4,970

Source: Office of the Actuary (OACT), May 1, 2026. Negative values indicate reductions in Medicare program outlays.

The financial impact of this provision is classified as a transfer—specifically, a reduction in Medicare program outlays that would otherwise have been paid to plans and providers on behalf of affected individuals. Based on OACT's estimates, the 10-year reduction in Medicare spending attributable to this provision is approximately $4.97 billion, ranging from approximately $220 million in 2027 to approximately $680 million in 2036 (see Table D–B5).

Disenrollments from Medicare Advantage, Part D, and Medicare cost plans resulting from loss of entitlement to Part A and/or enrollment in Part B (as applicable) will be processed automatically by CMS when SSA provides updated eligibility and entitlement records. Plans do not process these disenrollments and are not required to provide additional notification, as SSA provides a loss of entitlement notice directly to affected individuals. All information impacts related to the procedural steps plans must take to receive and process enrollment and disenrollment transactions have already been accounted for under OMB control numbers 0938–0753 (CMS–R–267) and 0938–0964 (CMS–10141). The burden associated with the revision of Medicare initial enrollment forms to support eligibility determinations under this provision is described in the Collection of Information Requirements section of this rule.

Dahl and Forbes (2023) estimate that 46 percent of individuals are willing to pay $638 per person, in 2011 dollars—or approximately $873 when updated for inflation—to avoid switching medical providers (specifically, primary-care physicians).[423] For purposes of this regulatory impact analysis, it is assumed that $873 is a reasonable estimate of an average that includes the 46-percent of WTP amounts above it and the 54-percent below. Multiplying this $873 annual amount by 32,000 disenrollments yields a cost estimate of $28 million. This quantitative estimate is characterized by various forms of uncertainty, including:

- *Tendency toward underestimation.* Switching insurance plans, or newly lacking insurance coverage altogether, involves a more sweeping set of changes than just reestablishing a new primary-care physician, so WTP to avoid the latter probably understates WTP to avoid the former.
- *Tendency toward overestimation.* The relatively low level of churn associated with employer-sponsored insurance (ESI) may offer a greater opportunity to establish doctor-patient relationships than what is available to individuals affected by this provision (due to many of them having non-permanent immigration status), so extrapolating an ESI-derived estimate may overstate the WTP for continuity that would be relevant for this regulatory impact analysis.

We received multiple comments on the regulatory impact analysis of the provisions related to limiting Medicare coverage of certain individuals. The following is a summary of the comments we received and our response.

Comment: Several commenters noted that CMS's estimates of individuals that will lose Medicare coverage due to the implementation 1899C was lower than the Congressional Budget Office's (CBO) estimate that 100,000 people will lose coverage. Commenters shared concerns that CMS may be underestimating the number of impacted individuals and that accurate projections are necessary for legislators, policy makers, and external stakeholders to assess policy impacts and make future budget decisions. CMS should consider other reliable data sources, including CBO, for more accurate projections.

Response: We acknowledge the commenters' concerns. There is very little information available on the number of beneficiaries who will be affected by this provision of the law. CMS actuaries and CBO both prepare estimates in order to inform policymakers of the potential impact of enacted legislation and other regulatory policy proposals. Because of varied assumptions using this limited information, the estimates are likely to be different, and one may turn out to be more accurate than the other. However, the implementation of this provision is independent of the estimate and is not the only data used to estimate the operational needs to implement the new provision. CMS is working closely with SSA to monitor the number of potentially impacted individuals and resources needs and will continue to do so throughout the implementation of 1899C.

7. Impacts Related to the Medicare Prescription Drug Inflation Rebate Program

In section III.F. of this final rule, as part of our continued implementation of the Inflation Reduction Act of 2022 (IRA), which established the Medicare Prescription Drug Inflation Rebate Program under sections 11101 and 11102 of the Act, we finalized several modifications. For the Medicare Part B Drug Inflation Rebate Program, this rulemaking modifies the excluded product category for Part B rebatable drugs so that the exclusion applies only to certain skin substitute products and clarifies what Consumer Price Index for all Urban Consumers (CPI–U) data CMS will use in the event CPI–U data are unavailable. Additionally, we are clarifying the definition of ''first marketed date'' as used in the context of the Part B Drug Inflation Rebate Program. For the Medicare Part D Drug Inflation Rebate Program, this rulemaking clarifies what CPI–U data CMS will use in the event CPI–U data are unavailable, modifies the methodology finalized in the CY 2026 PFS final rule to account for 340B-eligible units for AIDS Drug Assistance Programs (ADAPs), and requires all providers and suppliers that are covered entities as defined under § 10.3 (hereinafter collectively ''340B providers'' unless otherwise noted) to submit data elements from their Part D 340B claims to the 340B repository beginning in 2027. As described in III.F.3.c.2.c. of this final rule, we are finalizing a delayed deadline for the first mandatory reporting deadline by 1 quarter. That is, 340B providers would not need to submit claims with dates of service between January 1, 2027 and March 31, 2027 to the 340B repository until September 30, 2027, though they

[423] Dahl, G.B. & Forbes, S.J. (2023). Doctor switching costs. *Journal of Public Economics, 221,* 104858, *https://doi.org/10.1016/j.jpubeco.2023.104858.*