February 25, 2026

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Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2026-0034-0001; Advance Notice of Methodological Changes for CY 2027 for MA Capitation Rates and Part C and Part D Payment Policies

Physicians for MA Beneficiaries, a coalition of risk-bearing value-based care provider organizations (RBOs), submits the following comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies*. Our coalition was formed so that CMS could hear the perspective of physicians on the front line of day-to-day care for MA beneficiaries.

Our coalition was formed to educate federal policy makers on the reality that reductions in federal payments to MA plans are generally passed through to beneficiaries and providers. Value-based care arrangements for delivering advanced primary care typically consist of RBO providers like our coalition members taking on sole responsibility for entire health services spend on a percentage of risk adjusted premium.

Therefore, our coalition members can attest to how the V28 risk adjustment model and other MA payment cuts over the last few years directly lead to reductions in advanced primary care services, closure of offices, fewer physicians or clinical staff to treat patients, longer wait times and less access for MA enrollees. These adverse effects undermine the promise of the MA program and its advantages over FFS in terms of outcomes, access and patient satisfaction. Our comments address how CMS may reverse that trend.

Additional reductions to MA will undermine the value-based care goals CMS has already achieved through MA. Stable, predictable federal funding is a prerequisite to the private

investments needed to make value-based care available to beneficiaries. The alternative to risk-assuming, entrepreneurial providers supported by private investment is standard FFS practices of 1 or 2 physicians that lack funding for NP/PA staff support and tech infrastructure to enable patient engagement and patient follow-up, as well as the additional services listed above to improve outcomes and prevent ED Visits and Hospital Admissions.

I. EFFECTIVE GROWTH RATES

CMS projects that MA non-ESRD benchmarks will increase by 0.09 on average, reflecting a projected FFS growth rate of 5.10% with corresponding adjustments for risk model revision and normalization and changes in star ratings. Analysis of the same inputs by Wakely projects the \policies in the Advance Notice will lead to a cut in MA benchmarks in 2027. Given that the 2026 grown rate was 9.04%, it is implausible that Medicare utilization trends fell so precipitously. Other stakeholders are sharing analysis that finds that, based on the information provided in the Advance Notice, the MA-only cost growth rate for 2027 is closer to 9.0%.

Both utilization and costs of health care services continue dramatic acceleration as identified in independent analysis and experienced by our members. Level MA rates in the face of increased costs drive reductions in services, benefits, and cost-sharing assistance. Our coalition members attest to the reality that reductions in MA payments penalize providers who have done the most to deliver the reality of value-based care to Medicare beneficiaries.

Additional reductions to MA will undermine the value-based care goals CMS has already achieved through MA. We suspect that increases in utilization are driven by more hospital admissions due to diminishing access to primary care services. The diminishment of primary care is the result of (1) federal MA rates that fall below the cost of care, and (2) MA plans free to redirect more funding away from primary care services and into debit cards and other cash benefits that act as marketing expenses.

RECOMMENDATION: We encourage CMS to increase the average annual effective growth rate for 2027 to be consistent with the estimates presented in the Medicare Trustees Report and CMS Office of the Actuary estimates.

II. PART C RISK ADJUSTMENT MODEL

a. Background – V28 Impact

For context, CMS finalized in 2026 the phase-in of the V28 Risk Adjustment Model, which removed more than 2,000 ICD-10 diagnosis codes from the CMS-HCC model. V-28 degraded our ability to deliver advanced primary care to Medicare beneficiaries. Finalizing the model in 2026 has led to MA-serving RBOs closures, terminating physicians and clinical staff, and reductions in services. Additional provider bankruptcies are also expected.

Risk adjustment is intended to reduce or eliminate "the incentives to enroll only the healthiest, and thus least expensive, beneficiaries while steering clear of the sickest and costliest—thereby rewarding Medicare Advantage insurers to the extent that they achieve genuine efficiencies over traditional Medicare in addressing the same health conditions."[1] The changes implemented in the V28 model work against this intent by disincentivizing MA plans from enrolling patients with certain conditions

b. 2027 Proposals

CMS proposes a new Part C risk adjustment model for 2027. The model will continue to use hierarchical condition categories (HCCs) from v28 and the data underlying the model will be updated to reflect diagnoses from 2023 to predict 2024 claims. In addition, CMS proposes to exclude all diagnoses submitted on unlinked chart review records from the risk score calculation. CMS also proposes to exclude diagnoses from audio-only services. There are several aspects of this proposal that will impose the largest negative impact ultimately on providers treating the sickest and poorest beneficiaries.

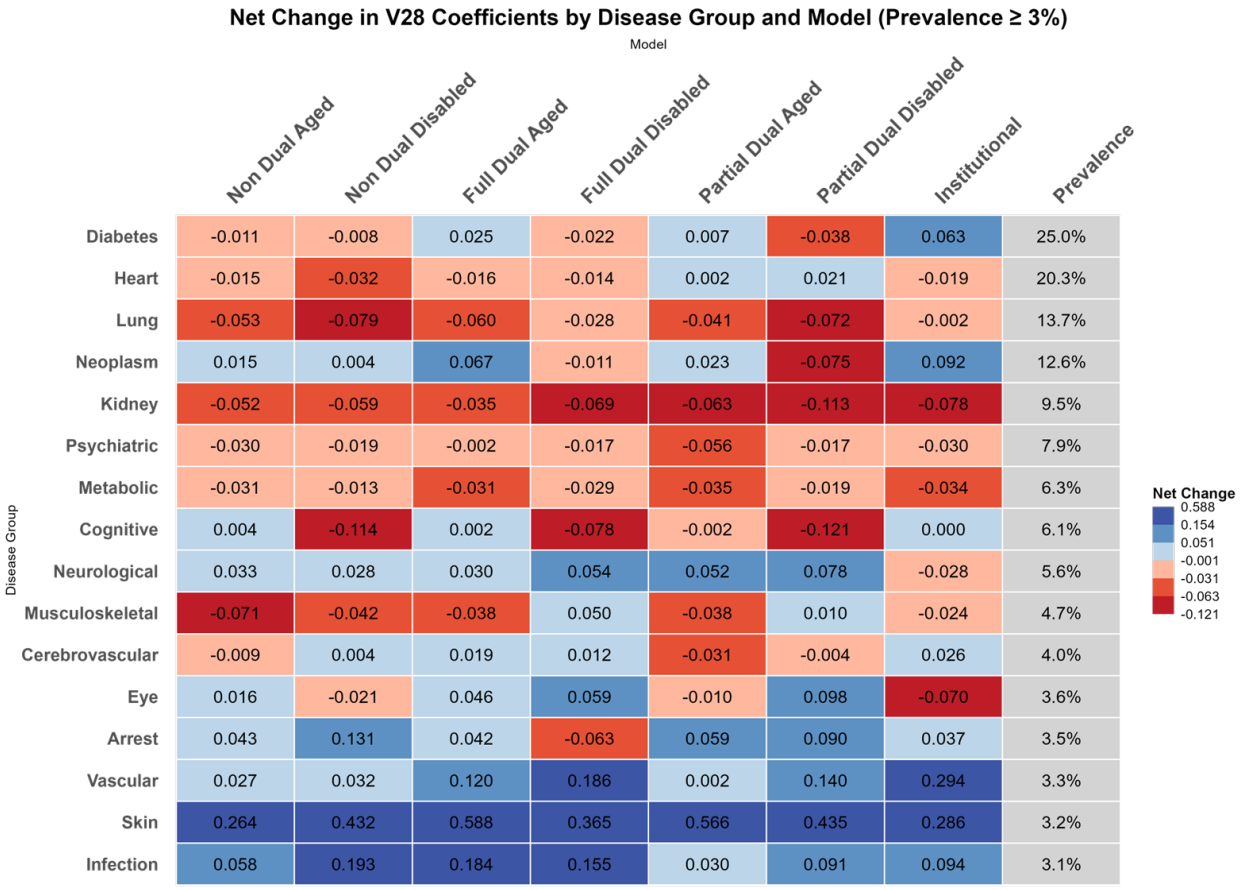
A downgrading of risk adjustment factors for the most prevalent chronic conditions: Heart failure; COPD; chronic kidney disease; and morbid obesity. These changes result in less funding for conditions treated in the primary care setting, thus undercutting the administration's promotion of strong primary care and community-based services.

CMS proposes a narrow upgrading of risk adjustment factors for individuals with the highly prevalent chronic conditions cited above *when these conditions worsen and patients are more likely to be treated in hospitals.* This change appears to reflect rising hospital expenditures in Medicare which we attribute to CMS policies that allow MA plans to underfund primary care in order to fund marketing expenses and classify them as supplemental benefits.

a. Disproportionate Impacts on Those Treating Duals and Patients with Multiple Chronic Conditions

CMS further downgrades the risk adjustment factors related to patients' demographic status, such as age, sex, disability status, and dually-eligible status, and downgrades factors for patients who have the largest number of separate diagnoses. Again, the result of this policy will be reduction in funding for coverage and services for the populations most in need of such services. RBOs like ours that care for a disproportionately high number of duals will experience the largest cuts relative to the rest of the nation.

[1] *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 873-74 (D.C. Cir. August 13, 2021, reissued Nov.1, 2021), cert. denied, 142 S. Ct. 2851 (U.S. June 21, 2022) (No. 21-1140).



b. <u>Skin Substitutes</u>

CMS projects a county benchmark growth rate of 4.97% for 2027, reflecting updated fee-for-service (FFS) spending assumptions, including revised payment polices for skin substitutes. Following a 400% increase in FFS spending on skin substitutes between 2019 and 2024, CMS finalized prospective payment policy changes in the 2026 Medicare Physician Fee Schedule that are projected to reduce spending on these services by nearly $20 billion in 2026.

In contrast, the proposed 2027 CMS-HCC risk model recalibration has not been updated to account for the new FFS skin substitute payment policy. CMS calibrated the model using 2023 diagnoses and 2024 Medicare FFS expenditure data that includes the peak, anomalous skin substitute spending in FFS that justified CMS' 2026 payment policy change. Consequently, the recalibration increases coefficients for several skin ulcer-related HCCs, embedding past skin substitute spending into the risk adjustment model despite new CMS policy to significantly reduce such spending beginning in 2026. Also, because of normalization and coefficient interactions within the risk adjustment model, the increased coefficients for skin ulcer HCCs cause coefficient reductions in unrelated HCCs.

A foundational element of the MA payment statute is the requirement that payments to plans be adjusted to account for the health status of enrolled beneficiaries via a risk adjustment process so that MA payments are actuarially equivalent to FFS payments. Risk adjustment

modifies payments to plans to account for estimated healthcare costs of enrollees. The failure to update the risk adjustment model to account for new FFS skin substitute spending projections risks overstating MA costs for these conditions in 2027 and beyond. This calls into question whether the 2027 model as proposed accurately reflects expected FFS spending patterns in the payment year.

c. Unlinked Chart Review

Next, is the proposal that all diagnoses captured in chart reviews for the purposes of risk adjustment be linked to evidence in health plan encounter data that care was provided for these diagnoses.

The proposed change appears to stem from concerns that chart reviews conducted by health plans result in coded diagnoses for the purposes of risk adjustment without evidence that care is actually provided to match these diagnoses. This policy is related to our concern over diagnosis codes not generated by providers but it must be implemented carefully so as not to unintentionally further reduce necessary resources to treat complex patients. A multi-year phase-in would allow time to verify that legitimate diagnoses and records of care evident in electronic health records – for example, by sub-capitated specialists that may be operating on different EHRs than their capitated provider partners – find their way into these health plan reports shared with CMS.

Similarly, medical groups and health plans will need time to catch up when a person with preexisting medical conditions becomes newly enrolled with an MA plan, a chart review is undertaken, care is provided and the health plan's encounter data on that patient is complete. This is even more of a concern when a newly enrolled member comes from a plan that exited the market. We are seeing that in such cases, when a plan knows it is exiting the market, risk adjustment operations cease, providers are not required or incentivized to comprehensively record diagnoses, and therefore patient records lack relevant diagnosis information.

Regardless, these concerns serve to reinforce the value of furthering the transition to Encounter Data for risk adjustment purposes. Encounter data includes detailed records of diagnosis, treatment, and utilization, providing a more precise predictor of health expenditures compared to legacy FFS sources. By using actual encounter records, CMS can better validate that diagnoses are supported by medical services, thereby reducing "upcoding". Finally, relying on MA-specific encounter data ensures payments are tied to how care is actually delivered within these plans, rather than being benchmarked against potentially unrepresentative FFS data.

d. Principles for Reform

Finally, we remind CMS of our proposals for risk adjustment reform as shared in our January 26, 2026 comment letter on the 2027 MA & Part D Policy and Technical Changes proposed rule:

- Ensure that the adjustment factors for any diagnosis for dual eligible enrollees shall not be less than the adjustment for the same diagnosis for enrollees who are not duals.
- Ensure the risk adjustment methodology includes positive adjustments and weights for the top costly conditions among beneficiaries.
- Focus on diagnosis codes generated by providers.

RECOMMENDATION: Do not implement proposed changes to the risk adjustment which would have outsized negative impact on RBOs treating higher proportions of dual eligibles and seniors with the costliest chronic conditions. As always, we recommend that CMS return codes for the following conditions back into the model with previous weights: Depression; Diabetes; Vascular; Angina.

III. PART C AND D STAR RATINGS

CMS seeks initial feedback on substantive measure specification updates and comments on new measure concepts. We share here perspectives first offered in our January 26, 2026 comment letter on the 2027 MA & Part D Policy and Technical Changes proposed rule.

We welcome and support CMS' interest in refocusing the MA program on clinical care, outcomes, and patient experience. However, under the current MA model, a disconnect often exists between the incentives of the star measures, QBP and the providers responsible for clinical care of patients. Positive clinical outcomes are the achievement physicians and providers, but QBPs related to star measures go to the MA plan without an obligation to pass them through to RBOs.

Too often, MA plans undermine the promise of value-based care and the MA program in how they treat QBP in relation to RBOs. Regardless of an RBO's role in achieving positive star ratings, plans pass through to providers 100% of premium reduction due to lower QBPs, but when QBP increases are achieved, plans use the increase to fund non-clinical items that are essentially marketing expenses, like cash debit cards.

Reform of star measures and QBPs requires a formal means to delineate between plans and risk-bearing providers who is responsible for stares ratings and who ultimately will control corresponding QBPs and how they are utilized to improve health outcomes. Regarding specific new measures, to the degree MA plans are incentivized by enrollment over outcomes, the proportion of the plan service fund dedicated to RBOs, and provider expenses will be cut to fund cash benefits and other supplemental benefits that act as marketing tools. As provider compensation drops below the cost of care, physician practices close, as has been witnessed in Florida, threatening robust access to MA physicians for beneficiaries.

CMS could counter this trend by adding new QBP measures for primary care provider availability. For example, a standard could measure, "Percentage of the beneficiaries residing in large metro and metro counties who have access to at least one provider/facility of each specialty type within the published time and distance standards." CMS could add standards to require at

least two or more primary care providers that are not owned by the payer. CMS could add standards for wait-time to schedule primary care appointment.

IV. Additional Recommendations for Regulatory Reform or Testing Through Innovation Center Demonstration Projects

A fundamental barrier to expanding value-based care through MA and seeing more providers bear risk is the current ability of MA plans to put RBOs at risk for items and services outside of the control of the providers that are unconnected to clinical care. So long as plans can overtime pass more losses to RBOs and dedicate more of the program fund away from clinical care and into marketing and administrative expenses, the clinical and cost benefits of value-based care will be frozen.

CMS should use its authority through the Centers for Innovation to run demonstration programs to test new ways of allocating MA risk between plans and provides. For instance, CMS could strength the role of RBOs in the MA program through the establishment of a standard Division of Financial Risk (DOFR) agreement. When providers are truly at risk, meaning the providers control the medical spend, then the providers get to make the medical necessity decisions, not plans.

Further, CMMI could test a new policy that, as a part of professional actuary certification of bids, attestation includes that bids do not assume that contracted RBOs will operate at a loss. This is intended to prevent the plan practice of plans advancing competitive products based on underpaying providers. Further CMS could require plans to share MMR data to RBOs that breaks down C & D spend from rebate. Otherwise, we don't know if we are being paid correctly. Finally, CMS could limit amount of rebate that can go to debit card benefits to instead incentivize funds to cost-sharing reduction and benefits related to health outcomes.

V. Background: The Role of RBOs in Caring for MA Beneficiaries

Our member RBOs are at the forefront of value-based care, implementing advanced practice staffing and innovative programs to improve beneficiary health status, reduce costly hospitalizations, leading to more efficient use of federal Medicare funds. MA evolves and adapts to manage specific health needs of beneficiaries. The providers who comprise our coalition already make this value-based care vision a reality for our Medicare patients today in a way that FFS does not:

- Frequent check-in visits for patients identified as high acuity
- Advanced care clinic with additional clinical services to specifically serve patients who would otherwise go to the ED
- Post discharge timely follow-up and transition of care coordination with hospitalist teams
- Kidney care program serving patients in their home

- 24-hour access to providers through same-day access at walk-in clinics and 24/7 nurse line
- Dedicated in house and partnered pharmacists to support medication adherence, medication reconciliation, and appropriate therapeutic treatments
- Onsite spirometry to assess pulmonary function
- On site specialty care and other care, such as labs, imaging, x-ray, vascular ultrasounds, fundoscopy for diabetic retinal exams, echoes for early detection of heart failure
- ER Follow-up coordinators
- Preferred provider network of specialists who have proven patient health outcomes and cost efficiency
- Physician-led patient education sessions weekly or monthly
- Onsite wellness centers for social, mental and physical well-being, which may include exercise equipment, hair salons, educational seminars, exercise classes
- Ambulatory Care management
- Transitional care management
- Employed hospitalist model
- Case conferences for complex patients
- Protocol orders and/or acute rescue kits for patients with history of exacerbations/acute events
- Transportation to provider visits
- Home visit nurse practitioners and home health services
- Virtual Care clinic

We have built the capacity to give our patients longer appointments of face-to-face time with their physicians, as well as giving our physicians fewer patients to focus on daily, providing time to develop treatment plans for all chronic conditions, rather than just treating one acute condition. "Medicare Advantage enrollees were more likely than beneficiaries in traditional Medicare to receive preventive care services, such as annual wellness visits and routine checkups, screenings, and flu or pneumococcal vaccines, based on several studies, with similar findings for people of color and beneficiaries under age 65."[2] This is because the efficiency of coordinating care through primary care visits reduces the demand for specialty care services.

MA has substantially lower utilization and expenditures than FFS, even after rigorously adjusting for member enrollment differences across the two programs, including baseline demographic, clinical, and social risk factors. MA enrollees have more than 50% fewer inpatient stays and 22% fewer emergency doctor (ED) visits.[3] These improvements in outcomes are driven

[2] Kaiser Family Foundation, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature* (Sept. 16, 2022); https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/#:~:text=Preventive%20services%3A%20Medicare%20Advantage%20enrollees,for%20people%20of%20c olor%20and.

[3] Harvard-Inovalon Medicare Study: *Utilization and Efficiency Under Medicare Advantage vs. Medicare Fee-for-Service*, pg. 8; https://www.inovalon.com/wp-content/uploads/2023/11/PAY-23-1601-Insights-Harvard-Campaign-Whitepaper_FINAL.pdf.

by purposeful investment in programs to allow 24-hour access through nurse triage, same day walk in access, home based care delivered by clinicians, nurses, paramedics, etc.

Care coordination from inpatient to outpatient is a crucial component of readmission control. Clinical pharmacists and wellness visits help assure medication adherence in the ambulatory setting. There are programmatic investments for disease management, case management and accentuated focus on patients who utilize a lot of services. All these investments seem to pay off with reduced need for hospitalization despite patients having multiple chronic illnesses.

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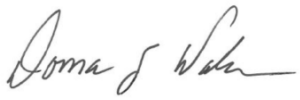
Thank you for your attention to these comments on the Advance Notice. We remain available to answer any technical questions that may arise out of these comments. Please feel free to reach us at Donna.Walker@inhealthmd.com or Phall@ebglaw.com.

Respectfully,



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