AMERICA'S PHYSICIAN GROUPS

February 10, 2025

Stephanie Carlton
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/commenton/CMS-2024-0360-0001

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (CMS-2024-0360-0001)

Dear Acting Administrator Carlton:

America's Physician Groups (APG) appreciates the opportunity to respond to the Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. APG welcomes your agency's openness to stakeholder input and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposals, (III) a summary of APG's recommendations, (IV) our fuller comments and recommendations, and then (IV) our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Medicare beneficiaries have consistently accessible, high-quality, equitable, person-centered health care. This commitment pertains to all Medicare beneficiaries, regardless of whether they receive their benefits through the traditional, fee-for-service program or through a Medicare Advantage or Medicare Prescription Drug Benefit Program plan.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups committed to the transition to value and engaged in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

APG's motto, "Taking Responsibility for America's Health," underscores these physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS's Advance Notice

CMS's Advance Notice sets forth the agency's proposed policies for 2026 and provides an estimate of how these policies will interact with market trends to affect MA plans' expected change in revenue. This projection differs from payment updates that other Medicare providers receive each year, in that it reflects an average change in revenue across MA plans with a range of experience around that average and is the product of multiple factors that contribute to MA plans' revenue.

CMS projects that the average revenue across MA plans will be 4.33 percent greater in 2026 than in 2025. The agency arrives at this projection, in part, by estimating that plans will submit diagnostic information that results in risk scores and resulting payments that are 2.10 percent greater on average in 2025 than this year. Without the impact of this risk trend, the average change in revenue would be 2.23 percent. The agency's projection also reflects an effective benchmark growth rate, which, per statute, reflects per capita spending for fee-for-service (FFS) beneficiaries of 5.93 percent.

The policy proposals included in the Advance Notice that are most germane to APG members include the following:

- **MA v28 HCC risk model:** As currently scheduled, CMS in 2026 will complete the phase-in of the updated version 28 (v28) of the Hierarchical Conditions Category (HCC) risk model as finalized in the agency's 2024 Rate Announcement. CMS therefore proposes that risk scores for 2026 reflect only v28.
- **Medical education costs:** CMS also plans to continue to phase out indirect and direct graduate medical education costs from inclusion in MA benchmarks. CMS therefore proposes 100 percent removal of these costs in 2026.
- **Risk adjustment normalization:** For each payment year, CMS calculates a normalization factor for each model to project the average FFS risk score from the denominator year to the payment year. CMS applies this normalization factor to all risk scores from that model to account for underlying trends in FFS coding and population from the denominator year to the payment year and keep the average FFS risk score at the same average (1.0). In 2026, CMS will include information from years impacted by COVID-19 and will use a multiple linear regression model.
- **HCC risk adjustment model:** CMS shares the agency's intention to update the HCC risk adjustment model by calibrating it using MA encounter data beginning in 2027.
- **Star Ratings:** CMS indicates that the agency continues to move toward adopting Universal Foundation measures to align quality measures across all Medicare programs and proposes technical changes to several quality measures.

III. Summary of APG's Recommendations

A. Recommendations related to v28 risk adjustment model phase in

- **APG recommends that CMS in 2026 pause the v28 HCC risk adjustment model phase-in at 2025 levels to allow time to evaluate the impact to date of the new version before proceeding to full implementation.**

B. Recommendations related to phase out of medical education costs

- **APG recommends that CMS slow the phase out schedule for medical education costs, for example by removing 75 percent**

C. Recommendations related to risk adjustment normalization

- **APG recommends that CMS provide greater clarity in the final Rate Announcement about its reasoning underlying the decision to rely on three separate normalization factors: one for MA, one for MA-PD plans, and one for PDPs, and share evaluations of the effect on Medicare beneficiaries' access to and cost sharing for these plans.**

D. Recommendations related to future HCC risk adjustment model update

- **APG recommends that CMS provide detailed information about the proposed HCC encounter data-based calibration approach in a transparent manner in advance of the 2027 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders**

E. Recommendations related to Part D risk adjustment and anti-obesity medication coverage

- **APG recommends that CMS share methods for appropriately addressing AOM costs – including incorporating AOMs into the RxHCC risk adjustment model – transparently and in a timely manner to ensure that stakeholders have time to provide informed feedback before coverage begins.**

- **APG recommends that CMS evaluate the impact of anti-obesity medication coverage on Part D costs and make refinements – or suggest refinements for Congress to include in legislation – to Part D policies as needed.**

F. Recommendations related to Star Ratings

- **APG recommends that CMS adhere to its commitment to a Universal Foundation set of parsimonious but meaningful outcomes measures; cease the introduction of new process**

measures; and focus instead on the development of a limited number of quality measures that assess health outcomes that are meaningful to patients in terms of morbidity and mortality.

IV. APG's Detailed Comments and Recommendations

APG appreciates CMS's ongoing efforts to update MA payment rates and other technical aspects of the program to keep these up-to-date and accurate. The agency clearly strives to be a responsible steward of the Medicare Trust Funds while improving the MA program for the growing number of beneficiaries who choose this enrollment option.

Below, APG offers comments in these six areas: (A) the phase-in of the V28 HCC risk adjustment model; (B) the phase-out of medical education costs; (C) risk adjustment normalization; (D) the future update of the HCC risk adjustment model with the use of encounter data; (E) Part D risk adjustment and anti-obesity medication (AOM) coverage; and (F) Star Ratings.

A. v28 Risk Adjustment Model Phase In

CMS proposes to fully implement the new v28 HCC risk adjustment model in 2026, following the phase-in schedule originally finalized in the 2024 Rate Notice. The v28 model significantly expanded the number of condition categories, constrained the coefficients for certain HCCs to be equal, changed the coefficients for multiple HCCs, removed more than 2,000 diagnoses from the model, and remapped diagnoses to most of the condition categories.

As APG noted when CMS introduced the v28 risk adjustment model, physicians engaged in the provision of care to MA beneficiaries are concerned about the significant changes the new version makes to the HCC risk adjustment model. The resulting impact on patients and the physician groups that serve them is not well understood. Because the v28 risk adjustment model first began to be phased in in 2024, there will soon be utilization data available for study that could reveal more extremely useful information about the real-world impact of these changes.

The impact of the phase-in of the new v28 risk adjustment model has differed across MA plans, providers, and patients in ways that are not yet well understood. Some physician groups report significant reductions in funding from risk adjustment changes that impact their ability to fund essential health services. Risk-adjusted payments ensure that plans and physicians have the resources needed to provide care to manage individuals' chronic conditions and prevent undesirable outcomes, including repeat hospitalizations that further undermine their health. Risk-adjusted payments fund such aspects of care as regular diabetic foot checks, nutritious food to fit strict dietary standards, mental health evaluations and support, and other services that would be unaffordable without this financial support.

APG urges CMS in 2026 to pause the v28 HCC risk adjustment model phase-in schedule at 2025 weights to allow time to evaluate the impact of the new version before proceeding to full implementation. This pause will allow CMS and stakeholders to assess the effects of the v28 risk adjustment model on the care provided to Medicare patients enrolled in MA plans.

In summary:

- **APG recommends that CMS in 2026 pause the v28 HCC risk adjustment model phase-in at**

2025 levels to allow time to evaluate the impact to date of the new version before proceeding to full implementation.

B. Phase Out of Medical Education Costs

CMS proposes to resume the schedule that was originally finalized in the 2025 Rate Announcement for phasing out the inclusion of medical education costs in the United States Per Capita Costs (USPCCs) that are used for setting MA benchmarks. For 2025, CMS reduced the phase-out schedule, only applying 52 percent of the removal, compared to 33 percent in 2024. CMS proposes to remove 100 percent medical education costs for 2026. The removal of medical education costs reduces USPCCs and MA benchmarks.

APG is concerned about the substantial one-year increase from 52 percent to 100 percent of medical education costs being phased out of USPCCs. APG urges CMS to slow the phase out schedule for medical education costs, for example by removing 75 percent and 100 percent of medical education costs from USPCCs in 2026 and 2027, respectively.

In summary:

- **APG recommends that CMS slow the phase out schedule for medical education costs, for example by removing 75 percent and 100 percent of medical education costs from USPCCs in 2026 and 2027, respectively.**

C. Risk Adjustment Normalization

CMS notes that normalization is integral to the HCC risk adjustment model. Since the average risk score varies from year to year, CMS applies normalization as an adjustment to the trend between the denominator year and the payment year to keep average risk scores at 1.0. Before 2025, CMS calculated risk adjustment using a linear slope based on 5 years of average risk scores. Due to the COVID-19 pandemic, the 2021 risk scores were abnormally low, leading CMS to exclude them for the 2023 and 2024 normalization calculations.

For Part C in 2025, CMS began including the years affected by COVID (2019—2023) as part of the calibration and used a multiple linear regression model. For 2026, CMS proposes to continue to use a multiple linear regression model and to use data collected from 2020 to 2024.

For Part D in 2025, CMS replaced the single normalization factor with two different factors: one for MA prescription drug plans (MA-PDs) and one for stand-alone prescription drug plans (PDPs). For 2026, CMS proposes to continue applying different normalization factors for MA-PDs and PDPs and to introduce a multiple linear regression model like the one used for Part C.

As APG requested when CMS first added multiple linear regressions to risk adjustment normalization, APG urges CMS provide greater clarity in the final Rate Announcement about its reasoning underlying the decision to rely on three separate normalization methodologies: one for MA, one for MA-PD plans, and one for PDPs. Furthermore, CMS should evaluate the effect of the separate normalization factors on Medicare beneficiaries' access to and cost sharing for various types of MA and Part D plans. The agency should transparently share the results of these evaluations with stakeholders.

In summary:

- **APG recommends that CMS provide greater clarity in the final Rate Announcement about its reasoning underlying the decision to rely on three separate normalization factors: one for MA, one for MA-PD plans, and one for PDPs, and share evaluations of the effect on Medicare beneficiaries' access to and cost sharing for these plans.**

D. Future HCC Risk Adjustment Model Update

CMS notes that the agency has been working on calibrating the HCC risk adjustment model using MA encounter data (diagnosis, cost, and use data submitted to CMS by MA plans) and may be able to start phasing in an MA encounter data-based model as early as CY 2027. Use of an MA encounter data-based risk adjustment model is consistent with governing statute. Given that MA encounter data are likely to be a better predictor of relative costs in MA than FFS claims data from Traditional Medicare and would remove the need to make the adjustment for coding pattern differences, CMS believes that moving to a risk adjustment model based on encounter data will be an important improvement in achieving MA payment accuracy.

CMS notes that in response to prior Advance Notices, some commenters have cited wide variation in coding differences among MA plans and recommended that CMS develop a non-uniform adjustment approach to account for different coding behavior in MA and FFS to improve payment accuracy and address differential coding among MA plans. CMS has evaluated a variety of non-uniform approaches but has determined that more targeted approaches to adjust for coding pattern differences raise unique technical and methodological challenges.

The current HCC risk adjustment model is calibrated using fee for service diagnoses, utilization, and costs. It also makes a coding intensity adjustment (due to the differences between fee for service and MA populations) and requires MA plans to submit diagnoses. The coding intensity adjustment will be applied to risk scores until the implementation of risk adjustment that uses MA diagnostic cost and use data.

APG welcomes CMS's proposal to incorporate MA encounter data into calibrating the HCC risk adjustment model and agrees that this approach could be superior to the current one and could address many of the shortcomings of the current methodology. An MA encounter data-based model could rely on MA encounter data as a sole source for diagnoses and utilization and may not require a coding intensity adjustment. In addition, adoption of such a model could address the reality of inappropriate comparisons of diagnosis coding in MA versus TM. However, as detailed below, APG has concerns that a potential thirty-day comment period between the introduction of a possible encounter data-based model in an Advance Notice would preclude thoughtful consideration by multiple stakeholders of the many implications of such a major change.

APG has repeatedly expressed its concern about inappropriate coding comparisons between TM and MA. As we observed in our comment letter on the 2024 Advance Notice, it is illogical to compare diagnoses between the two programs given that the motivation to record diagnoses is completely different in from one to the other. That difference does not mean that the diagnoses that are recorded in MA are wrong and that the ones recorded in FFS are correct. In fact, given the lack of incentive to capture diagnoses in the FFS program, it is more likely that the opposite is true – that MA diagnoses provide a far more accurate reflection of the underlying health status of Medicare beneficiaries.

As noted, moving to a new calibration mechanism based on encounter data would address the concern about inappropriate coding comparisons between the two programs. However, the brief description that CMS has offered about the new calibration approach raises several questions. For example, (1) will MA benchmarks that reflect fee-for-service spending and interact with risk adjustment also be updated to incorporate encounter data; (2) will CMS extrapolate utilization for encounter data that are known to be less than complete, and (3) which data on costs will CMS use given that MA plans have multiple options for how these data are reported.

APG strongly encourages CMS to provide detailed information about the proposed approach in a transparent manner, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented. Furthermore, APG asks that CMS begin sharing this information as soon as it is available rather than waiting for next year's Advance Notice so that stakeholders have time to review the planned changes and provide informed feedback in advance of implementation of another sweeping change in risk adjustment.

In summary:

- **APG recommends that CMS provide detailed information about the proposed HCC encounter data-based calibration approach in a transparent manner in advance of the 2027 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented.**

E. Part D Risk Adjustment and Anti-obesity Medication Coverage

Separately in the 2026 MA and Part D proposed rule, CMS proposes to require Medicare Part D and Medicaid to cover anti-obesity medications (AOMs) intended to treat obesity. The new interpretation is based on the prevailing medical consensus that defines obesity as a disease. CMS would permit Part D sponsors to define obesity for the purposes of their prior authorization (PA) criteria if the Part D sponsor's PA criteria are not more restrictive than the FDA labeling for a given AOM. CMS notes that this approach is consistent with that regarding other disease states for which the agency does not specify diagnostic criteria, but for which it reviews Part D plan-submitted PA criteria for clinical appropriateness.

Concurrently, the Department of Health and Human Services has proposed that the AOMs Ozempic, Rybelsus, and Wegovy be included in the next round of Medicare Part D price negotiations. If this policy proceeds as planned, the negotiated prices would become effective in 2027.[1]

Despite the coverage expansion for AOMs proposed for 2026, the Advance Notice lacks any reference to AOMs. The proposed revisions to the RxHCC risk adjustment models used to calculate direct subsidy payments to MA-PD and PDP plans does not include AOMs.

[1] https://www.cms.gov/newsroom/press-releases/hhs-announces-15-additional-drugs-selected-medicare-drug-price-negotiations-continued-effort-lower

As APG noted in its comment letter in response to the 2026 MA and Part D proposed rule, APG members recognize the importance of effectively managing chronic conditions, to attain better health outcomes overall and improved quality of life. Given this recognition, APG welcomes CMS's proposal to cover AOMs, which have proven to be an important treatment for many patients.

However, as APG wrote in its comment letter on that proposed rule, APG acknowledges that coverage of AOMs would impose new costs on the Medicare Part D and Medicaid programs and enrollees, regardless of whether prices for the drugs are negotiated. APG further cautions CMS that if the agency finalizes the proposed policy to cover AOMs, the methods for appropriately addressing AOM costs must reflect stakeholder input and be implemented before coverage begins. These methods – including incorporating AOMs into the RxHCC model – should be shared transparently and in a timely manner to ensure that stakeholders have time to provide informed feedback. If AOM coverage is finalized, CMS should evaluate the impact of the expanded coverage on Part D costs and make refinements – or suggest refinements for Congress to include in legislation – to Part D policies as needed.

In summary:

- **APG recommends that CMS share methods for appropriately addressing AOM costs – including incorporating AOMs into the RxHCC risk adjustment model – transparently and in a timely manner to ensure that stakeholders have time to provide informed feedback before coverage begins.**
- **APG recommends that CMS evaluate the impact of anti-obesity medication coverage on Part D costs and make refinements – or suggest refinements for Congress to include in legislation – to Part D policies as needed.**

F. Star Ratings

The 2026 Advance Notice indicates that CMS continues to move toward adopting Universal Foundation measures to align quality measures across all programs, including MA, traditional FFS Medicare, ACOs, and others.

For 2026, CMS also proposes changes to several quality measures, including (1) modifying the age ranges and exclusion criteria for statin therapy; (2) changing four indicators for transitions of care after discharge from patient settings; (3) a possible new measure in functional status and medication review for care for older results; (4) reducing fall risk and improving bladder control review relevance for monitor physical activity; and (5) moving to electronic clinical data systems (ECDS) for collection of data on diabetes care.

CMS also proposes modifications to existing display measures, including (1) updating the social need screenings; (2) updating the Drug Therapy of chronic obstructive pulmonary disease (COPD) measures to align with clinical guideline updates; and (3) replacing the financial reasons for disenrollment measure and transitioning from a single general cost-related leave reason (found a plan that costs less) to three more specific cost-related reasons to leave plans (found a plan with lower prescription drug copayments; found a plan with lower copayments for doctor's visits; and found a plan with lower monthly premiums.)

APG supports CMS's overall strategy of establishing a core set of quality measures in the Universal Foundation to align quality measures across Medicare programs. However, APG cautions CMS that, in addition to seeking alignment, it should continue efforts to focus on a core set of measures that that reflect meaningful outcomes for patients and reduce undue administrative burdens on clinicians.

APG members continue to have concerns about the proliferation of clinical quality measurement that rely on process measures rather than outcome measures, and notes that CMS appears to be retreating from the previous goal of streamlining quality measurement. As it stands, the adoption of new measures, even those that offer an improvement relative to current options, increases reporting demands that are already significant. If CMS opts to continue to refine the Universal Foundation measure set, the agency must ensure there is not significant growth in the number of measures that MA plans, providers, and ACOs must report.

- **APG recommends that CMS adhere to its commitment to a Universal Foundation set of parsimonious but meaningful outcomes measures; cease the introduction of new process measures; and focus instead on the development of a limited number of quality measures that assess health outcomes that are meaningful to patients in terms of morbidity and mortality.**

V. Conclusion

APG appreciates and welcomes CMS's proposed policies in this Advance Notice and supports the agency's ongoing efforts to ensure that payment rates and other technical aspects of the MA and Part D programs are up-to-date and accurate. APG encourages CMS to consider the modifications to the proposed policies described in this letter to further refine them and help to avoid unintended consequences that could harm MA and impede the delivery of optimal care to patients.

Sincerely,

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