Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted via www.regulations.gov

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program and Medicare Cost Plan Program

Dear Administrator Oz:

The Alliance of Community Health Plans (ACHP) appreciates the Trump Administration's commitment to strengthening and expanding the Medicare Advantage (MA) and Part D programs. We support Administration efforts to revamp this program which serves 33 million beneficiaries at a cost of hundreds of billions in annual federal spending.

CMS has a historic opportunity to challenge entrenched interests, foster genuine competition and drive transformational change to better serve the next generation of seniors. Given the program's scale, growth trajectory and influence on care delivery nationwide, policy decisions made today will shape beneficiary outcomes, market competition and program sustainability for decades.

ACHP is uniquely positioned to join your efforts to make transformational reforms to this vital public-private partnership. Medicare Advantage is an essential element to the health of America's seniors and it is for that reason that ACHP three years ago unveiled a comprehensive set of changes to take it to the next level.

While ACHP offers comments on a wide range of provisions within this proposed rule, we are particularly supportive of the Administration's efforts to take MA from good to great by raising the bar on quality and initiating a long-overdue modernization of MA risk adjustment. Strengthening quality incentives and aligning payment more closely with true clinical need are essential to protecting beneficiaries, promoting fair competition and ensuring the long-term sustainability and credibility of MA. ACHP commends CMS advancing reforms that prioritize outcomes over process and focusing on steps to discourage gaming to refocus the program on delivering high-value, person-centered care.

1. **Eliminate the Health Equity Index (HEI) and Continue the Reward Factor:** ACHP strongly supports eliminating the Health Equity Index, which has disproportionately disadvantaged plans serving smaller, rural and community-based populations while

introducing volatility that does not reliably reflect improvements in care or equity. The HEI's design risks penalizing high-performing plans based on factors beyond their control, undermining confidence in the Star Ratings program and distorting incentives away from genuine quality improvement that serve all patients. ACHP also strongly supports reinstating and continuing the reward factor, which appropriately recognizes and rewards sustained, high-level performance over time. Together, these changes are imperative to restoring fairness, stability and credibility to the Stars program, ensuring that plans are rewarded for delivering consistently high-quality care rather than navigating unpredictable and imperfect measurement constructs. We commend the Administration for these provisions.

2. **Overhauling MA Stars for Better Quality Measurement:** ACHP supports CMS's continued efforts to strengthen the MA Star Ratings program by simplifying measure sets, reducing reliance on topped-out and administratively burdensome process measures and refocusing Stars on outcomes and meaningful beneficiary experience. ACHP generally supports CMS's proposal to remove several low-value measures and to add a Depression Screening and Follow-Up measure, subject to targeted refinements to specifications, data capture and implementation timing. At the same time, ACHP recommends delaying exclusion of certain measures that continue to provide important insight into care coordination, preventive care and beneficiary experience until appropriate, objective replacement measures are established. ACHP has identified additional measures that should be eliminated and looks forward to continued collaboration with the Administration to modernize Stars in a way that improves value, reduces burden and preserves accountability.

3. **Risk Adjustment:** ACHP strongly supports modernizing the MA and Part D risk adjustment framework to better align payments with clinical need, reduce administrative burden and curb incentives that reward coding intensity rather than care delivery. Building on ACHP's *MA for Tomorrow* framework, we urge CMS to pursue reforms that level the playing field for local**,** nonprofit plans while strengthening program integrity. ACHP recommends streamlining and simplifying the risk adjustment model by focusing on objective demographic factors and a limited set of high-impact chronic conditions. This approach would reduce the need for annual recapture of lifelong diagnoses and exclude unsupported diagnoses from in-home health risk assessments and unlinked chart reviews. ACHP also supports recalibrating the model using MA encounter data, adopting a stratified coding intensity adjustment to better address variation in coding practices and targeting RADV audits to plans with the highest risk of unsupported coding. ACHP is interested in continued dialogue with CMS on inferred risk adjustment concepts, including potential testing through CMMI, provided appropriate safeguards, protections for underserved populations and thoughtful transition strategies are in place. Collectively, these recommendations include both near-term improvements and longer-term structural reforms that would improve

accuracy, fairness and sustainability in the MA program while supporting competition that benefits beneficiaries and taxpayers.

Part D Redesign Provisions:

Treatment of Supplemental Benefits in True Out-of-Pocket (TrOOP) Accumulation

ACHP recommends CMS exclude plan-funded supplemental benefits from incurred costs to support predictable financing and preserve employer-sponsored retiree coverage options. TrOOP has traditionally tracked the amount a beneficiary pays toward the Part D out-of-pocket limit. Counting plan-funded supplemental benefits toward TrOOP would advance beneficiaries through the benefit phases even when the beneficiary did not incur those costs, shifting liability earlier to plans and manufacturers. This approach may increase bid pressure and could weaken incentives for employers and plans to continue offering supplemental retiree coverage.

Mid-Year Notifications and Beneficiary Communications

ACHP is strongly supportive of removing the mid-year supplemental benefits notice requirement which forced plans to run mid-year analyses to identify members who may benefit from unused supplemental benefits, apply subjective criteria for who is "likely to benefit," and then generate and mail another targeted notice with access instructions on a tight timeline. That requirement simply added burden and duplicative outreach without clear incremental value to enrollees.

Third-Party Payment Arrangements and Part D Benefit Progression

ACHP is concerned that references to "certain other third-party payment arrangements" as incurred costs for Medicare Part D benefit progression could be read to include manufacturer-sponsored copayment assistance, coupons or patient assistance programs. Ambiguity on this point risks inconsistent implementation across plans and pharmacies and could undermine longstanding Medicare Part D safeguards intended to limit manufacturer influence on cost sharing and utilization. ACHP urges CMS to clearly state in the final rule and related guidance that manufacturer copayment assistance and patient assistance programs do not count toward TrOOP accumulation or Part D benefit phase progression.

General MA Provisions:

Stars & Quality

ACHP has long supported efforts to raise the bar on Star Ratings and refocus the program on measures that meaningfully reflect clinical quality and beneficiary experience. It's important to simplify the program and reduce reliance on low-value, topped-out and administratively burdensome process measures.

ACHP generally supports the proposal to remove several topped-out administrative and process measures and add the Depression Screening and Follow-Up measure, subject to targeted refinements to the measure specifications. ACHP supports removing the Call Center, Medical Price Function (MPF) Price Accuracy and Customer Service/Rating of Health Care Quality measures. If CMS proceeds with removing the Call Center measure, ACHP also recommends removing the Care Coordination measure, which largely reflects provider network performance rather than plan-level accountability. ACHP does not believe a replacement measure is clinically necessary prior to removal of Statin Use in Persons with Cardiovascular Disease and opposes retaining language suggesting otherwise.

ACHP recommends delaying removal of the SNP Care Management measure, as it is highly correlated with positive health outcomes and plays a critical role in ensuring beneficiaries have a coordinated plan for preventive screenings and ongoing care beyond the Stars-measured scope.

ACHP also recommends delaying removal of the Complaints and Members Choosing to Leave the Plan measures. These measures capture meaningful signals related to quality and beneficiary experience and should be replaced with more objective, empirical measures before being eliminated. ACHP also opposes removing the Diabetes Care – Eye Exam measure, which remains a meaningful indicator of preventive clinical care.

ACHP recommends removing Statin Use in Persons with Diabetes (SUPD), as its intent is already captured within the Medication Adherence measure, along with removal of Statin Therapy for Patients with Cardiovascular Disease. SUPD focuses on prescription dispensing rather than adherence and is more susceptible to gaming, while adherence measures more accurately reflect whether medications are taken as prescribed and meaningfully impact member health. ACHP also recommends removing Getting Needed Care rather than Customer Service, as Getting Needed Care substantially overlaps with Getting Appointments and Care Quickly, which remains in the program. Eliminating this redundancy would streamline measurement while preserving focus on timely access to care.

ACHP supports CMS's proposed timeline for measure removal and is conducting additional analysis to identify measures that could be removed earlier in MY2026 rather than waiting until MY2027. Many measures CMS proposes removing have become increasingly difficult to achieve at the thresholds required for high Star Ratings, particularly given rising costs, tighter utilization management and recent CMS policy changes. For example, ACHP recommends prioritizing removal of Complaints About the Health Plan/Drug Plan in MY2026, as CMS's recent

provider communications are likely to increase complaint volume in the Complaint Tracking Module (CTM) independent of plan performance.

ACHP agrees with adding greater focus on depression to the Star Ratings program but recommends separating Depression Screening and Depression Follow-Up into distinct measures. Screening and follow-up represent different clinical processes with unique operational challenges and quality implications. Combining them risks obscuring true performance. ACHP also has concerns regarding current reporting capabilities, including data capture, interoperability and documentation standards, which should be addressed prior to implementation. In addition, because the Depression Screening and Follow-Up measure overlaps conceptually with Improving and Maintaining Mental Health HOS questions, ACHP recommends CMS move forward with only one of these approaches to reduce administrative burden and redundancy.

ACHP reiterates support for investing in modernizing survey methodologies to ensure they effectively reach appropriate populations and produce statistically reliable results. As administrative measures are removed, the remaining Star Ratings measures become increasingly dependent on survey-based instruments. ACHP is concerned that these surveys are being weighted too heavily given low response rates, unclear question framing for beneficiaries and questions about whether results accurately reflect plan performance. In many cases, respondent counts are not statistically significant to justify outsized impact on overall Star Ratings. CMS should invest in modernizing survey methodologies, including reassessing weighting, improving survey clarity and ensuring results are credible, representative and statistically reliable before they drive a disproportionate share of plan ratings.

CMS should also consider topic overlap when evaluating survey measures and redesign surveys to improve balance and accuracy. While ACHP agrees that survey-based measures currently play an outsized role in Star Ratings, removal of the proposed process measures would not materially change the overall proportion of survey-based measures, as most categories would increase at similar rates.

Finally, ACHP encourages CMS to consider additional measures in future rulemaking, including influenza vaccination, Care Coordination and Medication Therapy Management, where evidence supports meaningful impact on beneficiary outcomes.

<u>Enrollment & Beneficiary Protections</u>

ACHP supports the proposal to expand the special enrollment period (SEP) for provider terminations, provided the policy is narrowly tailored and clearly defined. Ensuring beneficiaries have meaningful enrollment options when access to care is disrupted is appropriate. However, overly broad application of this SEP could increase mid-year enrollment volatility and

exacerbate adverse selection. ACHP recommends CMS clearly define triggering events and guardrails to ensure the SEP is used as intended.

ACHP supports codifying CMS-controlled election mechanisms for select SEPs. Standardizing how SEPs are administered improves program integrity, reduces confusion for beneficiaries and promotes consistent application across plans. This proposal aligns with ACHP's longstanding support for clearer, more predictable enrollment rules.

ACHP supports increased transparency related to MA risk adjustment data but urges CMS to proceed cautiously. Expanded release of risk adjustment data should include appropriate context, safeguards and limitations to avoid misinterpretation or misuse. ACHP continues to emphasize that risk adjustment data, when divorced from clinical and operational context, can lead to misleading conclusions and undermine trust in the program.

ACHP supports the proposal to standardize documentation requirements for Part D coverage determinations. Greater standardization can improve consistency, reduce administrative burden and enhance beneficiary understanding of coverage decisions, provided CMS avoids adding duplicative or overly prescriptive documentation requirements.

Marketing, Communications and Outreach

ACHP supports the proposal to revise the timing of the third-party marketing organization disclaimer. The current disclaimer requirements are confusing for beneficiaries and unnecessarily disruptive to the enrollment process. Allowing greater flexibility in how and when disclaimers are delivered maintains transparency while improving the beneficiary experience.

ACHP strongly supports the proposal to remove several outreach timing and procedural requirements, including the 12-hour rule and the 48-hour Scope of Appointment (SOA) waiting period. These requirements delay beneficiary access to information, create unnecessary administrative barriers and do not meaningfully enhance consumer protections. Removing them aligns with modernizing MA and Part D marketing rules and reduce low-value compliance activities.

ACHP supports rescinding the mid-year unused supplemental benefits notice and reverting the "Ensuring Equitable Access" regulatory text to the prior "cultural considerations" framework. ACHP also supports removing health equity analysis requirements for utilization management committees and quality improvement programs, which impose process-oriented obligations without clear evidence of improved outcomes.

Deregulatory Actions

ACHP supports excluding account-based plans from creditable coverage disclosure requirements. These arrangements do not function as comprehensive prescription drug coverage. Requiring creditable coverage determinations creates confusion for beneficiaries and imposes administrative burden without corresponding consumer benefit. This proposal appropriately aligns disclosure requirements with the nature of the coverage offered.

ACHP supports removing the supplemental benefit pathway at § 422.102(e). This pathway has not been utilized by plans and is unnecessary given existing mechanisms to offer supplemental benefits through the bid process, including primarily health-related supplemental benefits and SSBCI. Eliminating this provision reduces regulatory complexity without constraining benefit design.

ACHP supports removing the special rule for non-compliant D-SNPs that sunsets at the end of CY 2025. Retaining an expired enforcement authority in regulation is unnecessary and potentially confusing. Removing this provision improves regulatory clarity while preserving CMS existing oversight tools. ACHP also supports CMS's proposal to waive Part D call center hour requirements in LI NET regions. This flexibility appropriately reflects the unique structure of the LI NET program and avoids duplicative requirements.

Duals Provisions:

<u>Improving Alignment Between Medicare and Medicaid</u>

ACHP supports streamlining passive enrollment. Passive enrollment is designed to preserve aligned coverage for full-benefit dual-eligible individuals when an integrated Dual-Eligible Special Needs Plan (D-SNP) exits the market. However, the current requirement that receiving plans, or those that accept passively enrolled members, maintain a "substantially similar" provider and facility network has proven unworkable, deterring use of the authority and leaving many beneficiaries without integrated coverage. Removing the substantially similar network requirement will allow plans to use passive enrollment as intended and safeguard integrated coverage for dual-eligibles.

ACHP also supports minimizing care disruptions by requiring a continuity of care period for dual-eligibles transitioning between D-SNPs. Receiving D-SNPs and their care coordination teams need sufficient time to acclimate dual-eligibles to their new plan environment and ensure effective care management. The time required for a successful transition varies. Mandating a 120-day transition period, during which time enrollees can receive care from out-of-network providers and receive services without utilization management review, can create financial risk. ACHP recommends CMS require a 90 to 120-day continuity of care range. This will create flexibility to meet patient needs while balancing exposure for non-contracted and unmanaged care. ACHP also requests that CMS clarify the definition of "care coordinator staff."

ACHP supports providing flexibility for D-SNP enrollment in Medicaid fee-for-service states.

Allowing Highly Integrated Dual-Eligible Special Needs Plans and Coordination Only Special Needs Plans to continue enrolling Medicaid fee-for-service dual-eligibles will help accommodate diversity in state managed care requirements while preserving opportunities for integrated care for all dual-eligibles. ACHP is highly aligned with these goals.

The proposed approach addresses challenges in New York. However, the proposed rule does not address the barriers to integration among Medicaid fee-for-service dual-eligibles in Pennsylvania. In Pennsylvania, the majority of full-benefit dual-eligibles ages 21 and up are mandated into the state's Medicaid Long-Term Services and Supports managed care plan, Community HealthChoices. The remaining dual-eligibles are not eligible for this program and must enroll in fee-for-service Medicaid. CMS specifies flexibility in enrollment of Medicaid fee-for-service dual-eligibles only for D-SNPs with a majority of Medicaid fee-for-service, which is not feasible in Pennsylvania given the relatively small size of the non-managed care dual-eligible population.

To ensure that dual-eligibles enrolled in Medicaid fee-for-service can access integrated coverage, CMS should permit Pennsylvania to include full-benefit dual-eligibles enrolled in Medicaid fee-for-service in the state Medicaid agency contract and allow these beneficiaries to voluntarily enroll in aligned HIDE-SNPs. This option allows dual-eligibles enrolled in fee-for-service Medicaid who are not eligible for Medicaid managed care in their state to remain enrolled in their integrated D-SNP, rather than requiring them to change plans. Alternatively, CMS could waive the majority fee-for-service requirements for Pennsylvania and allow parent companies to offer a D-SNP for Medicaid fee-for-service beneficiaries who are not eligible for Medicaid managed care. This option would create a pathway for Medicaid fee-for-service dual-eligibles to access integrated care. However, a separate D-SNP may not meet the minimum enrollment necessary for actuarial soundness, given the small population of Medicaid fee-for-service duals in Pennsylvania.

<u>D-SNP Operations</u>

ACHP recommends extending the model of care (MOC) submission period. As plans prepare to implement new and complex integration requirements, D-SNPs will need flexibility to revise their MOCs to reflect state-specific policies and operational changes. The two proposed three-month submission windows may not align with the timing of federal rule finalization, state Medicaid agency policy updates or the release of CMS sub-regulatory guidance. To allow plans to respond promptly to federal and state actions, CMS should accept off-cycle MOC revisions year-round.

If CMS chooses to finalize the proposed off-cycle windows, ACHP requests clarification regarding when states can request MOC updates to align with new revision windows.

Request for Information on Dually Eligible Individual Enrollment in C-SNPs and I-SNPs:

The Alliance of Community Health Plans (ACHP) and its member health plans are committed to delivering high-quality care for dual-eligible individuals. Representing provider-aligned, community-based health plans, ACHP brings extensive experience serving individuals with complex medical and social needs through models that emphasize accountability, coordination and continuity of care. Rapid growth in dual-eligible enrollment in non-integrated Medicare Advantage Special Needs Plans has sparked concerns that Chronic Condition Special Needs Plans (C-SNPs) and

Institutional Special Needs Plans (I-SNPs) may divert beneficiaries away from care that best suits their needs. To protect this vulnerable population, ACHP strongly supports CMS ensuring issuers do not use non-integrated models to divert dual-eligibles from aligned care.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering high-quality coverage and care. As local, non-profit insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C., remaining in their markets even when other carriers exit. The sustainability of regional health plans is critical to maintaining delivery models that emphasize care coordination, local provider partnerships and continuity of care, particularly for dual-eligibles with complex health needs.

ACHP opposes applying D-SNP look-alike contracting limitations to I-SNPs and recommends CMS continue to monitor I-SNP enrollment trends. While I-SNPs enroll large numbers of dual-eligibles, they serve a clearly defined institutional population and provide intensive care management that meets dual-eligibles' needs. Additionally, dual-eligible enrollment in I-SNPs has remained relatively stable over time.

C-SNPs raise greater concern due to fewer care management requirements and higher levels of dual-eligible enrollment. **ACHP recommends that CMS closely monitor dual-eligible enrollment in C-SNPs, particularly among plans already exhibiting rapid growth** to assess whether enrollment patterns reflect appropriate care delivery or diversion from integrated options.

To ensure that dual-eligibles enroll in coverage models best suited to their care needs, ACHP supports applying a 60 percent look-alike threshold among full-benefit dual-eligible enrollment in C-SNPs, with state waiver flexibility. CMS should exclude dual-eligibles with chronic conditions well-served by C-SNPs such as HIV/AIDS, end-stage renal disease and disabling mental health conditions from the enrollment threshold calculation. If adopted, CMS should evaluate the effects of this policy to ensure that the threshold is directing dual-eligible enrollees toward more integrated options without limiting access to appropriate C-SNP enrollment.

ACHP also recommends reducing incentives that shift dual-eligible enrollment away from integrated care by eliminating year-round enrollment in C-SNPs and aligning enrollment rules between C-SNPs and D-SNPs. Year-round C-SNP enrollment coupled with more limited D-SNP enrollment periods create a disparity that may promote inappropriate enrollment. Standardizing enrollment rules across SNP types would promote more stable plan selection and help ensure that dual-eligibles enroll in models that best support their care needs.

To ensure that C-SNPs better meet the needs of their remaining dual-eligible enrollees, **ACHP recommends strengthening care coordination requirements for C-SNPs and better aligning Model of Care requirements across SNP types.** However, ACHP cautions against requiring C-SNPs

to establish State Medicaid Agency Contracts, which will create undue administrative burden on states and plans.

ACHP and its member companies appreciate the opportunity to comment on this request for information. We look forward to continuing to engage with CMS on policies that promote high-quality care for dual-eligible enrollees. Please contact Emma Liebman, Associate Director of Public Policy, at eliebman@achp.org with any questions.

Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments and Wellbeing and Nutrition):

The Alliance of Community Health Plans (ACHP) and its member health plans strongly support efforts to modernize and strengthen the Medicare Advantage (MA) program. Payment policy, risk adjustment and quality measurement must evolve to address incentives that distort competition, create loopholes and undermine value for beneficiaries and taxpayers. ACHP and its member plans are committed to advancing policy solutions that promote a level playing field across the MA market, ensuring that competition is based on value, quality and care delivery rather than scale or coding intensity. For seniors to have a full panoply of choices, it is imperative the Administration mitigate structural advantages that favor large national insurers and smooth market distortions that undermine fair competition and waste tax dollars.

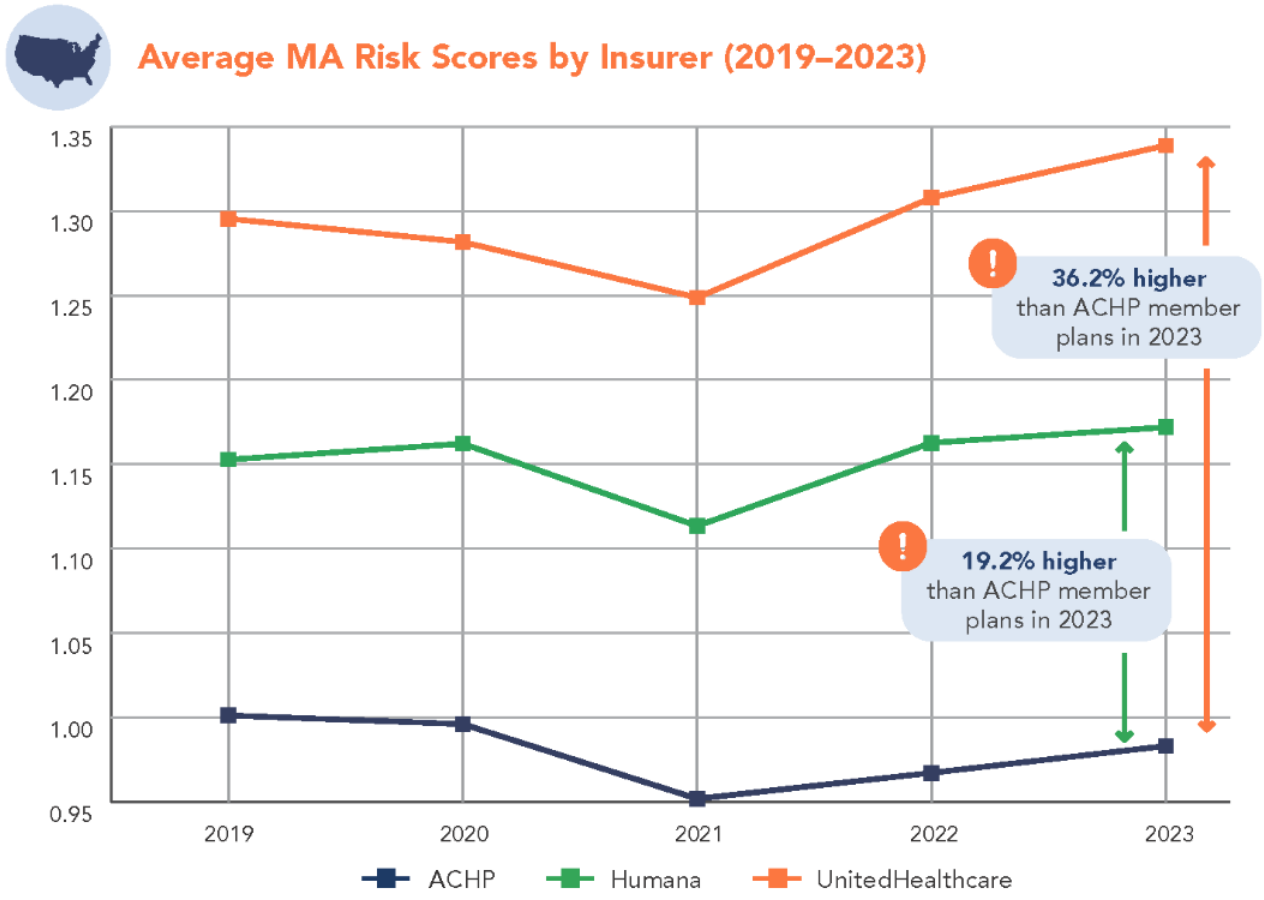
ACHP is the only national organization advancing a unique payer-provider aligned model of health care that consistently tops the quality charts. As local, non-profit insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C., remaining in their markets even when other carriers exit. The sustainability of regional health plans is of paramount importance to an innovative and competitive insurance industry, ensuring consumers have robust choices for their health coverage.

In 2023, ACHP released *MA for Tomorrow*, a framework to advance a simpler, higher-quality MA program that raises the quality bar, modernizes risk adjustment focused on care rather than coding and promotes innovation and competition. *MA for Tomorrow* aligns with the Administration's efforts to eliminate waste and abuse within the MA program and strengthen the program for today's beneficiaries and tomorrow's seniors.

Medicare Advantage is at an inflection point and CMS has a historic opportunity to fight entrenched interests, revive competition and drive transformational change. Rather than defend the status quo, we at ACHP recognize MA is overdue for a healthy dose of disruption. No other payer association has advanced a comprehensive vision for strengthening MA. The bold recommendations that follow include near-term improvements and longer-term structural reforms that will better align risk adjustment with clinical reality, enhance accountability and put the emphasis squarely on the health of 35 million seniors and counting.

MA Risk Adjustment Focused on Care, Not Codes

As CMS has observed, the current MA risk adjustment system disproportionately advantages large, well-resourced national plans at the expense of smaller, regional and nonprofit plans. The current V.28 risk-adjustment model, while an improvement from the prior version and supported by ACHP, provides thousands of opportunities for gaming, leaving the government to chase after billions of dollars in inappropriate payment. In 2023 alone, the largest MA plan collected $6 billion more in risk adjustment payments than would have occurred if those beneficiaries were enrolled in an ACHP member company (See Fig. 1 below).



ACHP Analysis, 2025

The system no longer fulfills its core purpose. While risk adjustment is intended to ensure adequate resources for beneficiaries with greater clinical need, it has increasingly rewarded aggressive coding practices rather than higher-quality care. ACHP analysis of CMS data indicates that higher risk scores among large national insurers are driven primarily by differential coding practices, not meaningful differences in beneficiary health status. Numerous news organizations and Senate

investigations have reinforced that the model has become overly complex, administratively burdensome and susceptible to manipulation. Sadly today, the result is billions of dollars in excess spending without commensurate improvements in care.

This Administration has a unique opportunity to make historic reforms to the MA risk adjustment model to better reflect patient need while limiting financial gaming. ACHP offers the following recommendations.

Streamline and Simplify the MA Risk Adjustment Model

The current risk adjustment framework has grown into a sprawling warren of diagnosis on top of diagnosis. Paying for thousands of diagnoses—many of which are inconsistently documented or easily inflated—has not translated into better care for beneficiaries. Instead, it has increased administrative burden, distorted incentives and driven up costs. A streamlined model would better align payments with true patient need, reduce unnecessary administrative activity and allow clinicians and plans to focus resources on care delivery rather than documentation.

To protect beneficiaries with complex needs and mitigate adverse selection, CMS should incorporate a targeted reinsurance component into the risk adjustment framework. Reinsurance would enhance market stability by covering rare, extremely high-cost cases, enabling plans to compete based on quality and efficiency rather than risk selection. This approach would reduce the need for an expansive list of diagnoses in the core model while preserving access for the sickest beneficiaries.

A streamlined model should rely on objective demographic factors—such as age, sex, institutional status and end-stage renal disease status that are verifiable and not susceptible to manipulation—combined with a less expansive, clearly defined set of high-impact conditions that can be empirically identified. In consultation with stakeholders, CMS should identify a limited set of condition categories that meaningfully drive health care spending, such as, but not limited to, autoimmune disease, cancer, chronic kidney disease, COPD and congestive heart failure. We look forward to providing a more detailed list of recommended condition categories and codes.

Any condition included in the model should be substantiated using evidence in addition to encounter-based documentation, such as laboratory results, prescription drug data or chronic care management care delivery. The model should also prioritize conditions that drive sustained variable costs, rather than attempting to capture every diagnosis a beneficiary may have. CMS can further reduce administrative burden by excepting lifelong chronic conditions from annual reconfirmation and exploring mechanisms for mid-year submission of significant newly identified conditions discovered during the plan year.

Leverage Technology to Collect MA Risk Adjustment

ACHP is excited to collaborate with CMS to explore opportunities to leverage technology to streamline MA risk adjustment. There is great potential in inference-based risk-adjustment

approaches that complement broader risk adjustment reforms, reduce differential in coding practices and allow physicians to focus on care delivery instead of paperwork. It is imperative that any technology focused approach includes safeguards against incentivizing unnecessary utilization, protections for plans serving historically underserved or under-treated populations and a thoughtful transition to provide stability for beneficiaries.

Calibrate the MA Risk Adjustment Model on MA Encounter Data

The current MA risk adjustment model is calibrated using fee-for-service (FFS) claims data, which reflects an outdated volume-based delivery system and does not account for differences in coding practices under value-based care. With the majority of Medicare beneficiaries now enrolled in MA, calibrating the model using FFS data distorts payment accuracy and creates inappropriate comparisons.

Consistent with the FY 2026 Labor-HHS Joint Explanatory Statement and the accompanying House Report 119-271, CMS should incorporate MA encounter data when calibrating MA risk adjustment models. CMS has collected MA encounter data for more than a decade and relies on it for multiple program integrity and payment functions. Recalibrating the model using MA encounter data would improve accuracy and reduce distortions associated with aggressive coding. We recommend CMS begin recalibrating based on MA encounter data starting in CY 2028.

Tier The Coding Intensity Adjustment

Since 2010, CMS has applied a uniform coding intensity adjustment across all MA plans. However, MedPAC and other researchers have consistently documented wide and growing variation in coding intensity across MA organizations. MedPAC's March 2025 report found a growing number of MA plans are disproportionately penalized by the uniform adjustment, while coding outliers—often among the largest organizations—continue to receive substantial excess risk adjustment payments.

Although recent changes implemented to the CMS-HCC model through V28 beginning in 2024 may reduce the overall level of coding intensity, substantial differences in coding trends across plans persist. This high variability in risk score growth across payers creates distortions in the MA market by impacting the generosity of plan benefit design and the enrollment trends that follow. It has been well documented that the majority of MA program-wide coding intensity is generally concentrated in a small number of large, national carriers. In contrast, regional non-profit plans are concentrated in the lower range of the distribution in coding intensity.

A tiered coding intensity adjustment that scales with coding aggressiveness, with larger adjustments targeted to plans that materially exceed industry norms, would deter excessive coding, improve equity across plans and level the competitive playing field.

Target Risk Adjustment Data Validation (RADV) Audits

RADV audits are a critical program integrity tool to recover improper payments and discourage inappropriate coding. Audits are most effective when done in conjunction with risk adjustment process changes that protect MA dollars before going out the door. It is always better to pay appropriately the first time than pay and chase after the fact. Audits are resource-intensive for both CMS and plans and must be strategically targeted. Multiple studies by CMS, the HHS Office of Inspector General, MedPAC and independent researchers demonstrate substantial variation in coding practices and the fact that reported diagnoses lack medical record support.

CMS should establish transparent criteria to target RADV audits toward plans with the highest risk of unsupported coding. A focused approach would improve audit effectiveness, reduce unnecessary administrative burden on compliant plans and better protect the Medicare Trust Fund.

Exclude Diagnoses from In-Home Health Risk Assessments Except for Annual Wellness Visits and "Unlinked" Chart Reviews

Home health care delivery and risk assessments are important care delivery tools, particularly for low-income and rural beneficiaries. However, these assessments have been vulnerable to unsupported coding because they are often not tied to clinical intervention, treatment or ongoing care. CMS should exclude diagnoses generated through in-home health risk assessments from risk adjustment, except when documented as part of an Annual Wellness Visit or supported through independently verifiable clinical data.

Similarly, diagnoses derived from "unlinked" chart reviews that are not connected to a face-to-face clinical encounter or documented care delivery should be excluded from risk adjustment. These practices have contributed to unsupported coding without corresponding clinical intervention and undermine the integrity of the model.

Raising the Quality Bar

ACHP strongly supports CMS' commitment to revitalizing the MA Stars program. Raising the quality bar will align quality measurement with meaningful patient outcomes, reduce administrative burden on providers and support value-based care delivery.

ACHP recommends CMS:

- **Eliminate topped-out or highly variable measures (e.g., HOS):** Measures that have reached performance ceilings or demonstrate significant year-over-year variation outside plan control fail to drive meaningful improvement and may distort quality bonus calculations. Removing or replacing these measures ensures that incentives reward genuine quality improvements.

- **Set predetermined cut points to improve predictability:** Transparent and pre-established thresholds for Star Ratings measures allow health plans to understand

performance expectations, plan interventions strategically and provide stable incentives to improve care rather than chasing year-to-year fluctuations.

- **Adopt measures for prevention and management of chronic disease aligned with the risk adjustment model:** Aligning quality metrics with the conditions included in risk adjustment ensures consistency between payment and patient need. Measures should capture preventive care, chronic disease management and care coordination that demonstrably improve outcomes and reduce downstream costs.

- **Reward adoption of value-based care delivery:** Incentives should recognize plans that implement care models emphasizing coordination, patient-centered care and population health strategies. Incorporating metrics or bonus factors for adoption of value-based approaches encourages systemic transformation toward higher-quality, lower-cost care.

- **Consider reforms to the FFS benchmark and alternative approaches if CMMI tests new payment methods:** As CMS explores novel quality payment methodologies in MA, any benchmarking approach should reflect MA's current landscape and dominant role in Medicare. Adjusting FFS benchmarks to better align with MA performance and exploring alternative structures will enhance the relevance, fairness and effectiveness of quality bonus incentives.

ACHP and its member companies are excited to continue collaborating, seizing this unique moment for truly unprecedented change to ensure a MA program that delivers higher quality and better outcomes, levels the competitive playing field and focuses on patients over paperwork. It is imperative that CMS engage with stakeholders throughout the process through technical expert panels, white papers or roundtables. This collaborative process will improve the final policy and allow for efficient implementation. Please contact Michael Bagel, Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions and to continue the partnership.

Well-being and Nutrition

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to provide feedback on tools, measures and policies to enhance well-being and nutrition for Medicare Advantage (MA) beneficiaries. As local, non-profit health plans, ACHP members are uniquely positioned to implement prevention-focused strategies that improve health outcomes, reduce unnecessary utilization and support seniors in living independently with a high quality of life. For example, Baylor Scott and White Health Plan's innovative "Be Well with Diabetes" program provides personalized one-on-one health coaching and nutrition support to empower patients to manage their diabetes in ways that work best for them. Additionally, Group Health Cooperative of South-Central Wisconsin's Diabetes Improvement Team collaborates with a local food pantry, leverages technology and focuses on wraparound care and education. Further reflecting this commitment, our member organizations signed a decade-long effort to reduce diabetes, hypertension and other chronic conditions through a range of prevention strategies and community partnerships.

Comprehensive Well-Being Assessment

ACHP supports the development and adoption of validated tools and measures to comprehensively assess well-being among MA beneficiaries. Beyond traditional clinical metrics, well-being assessment should include physical, cognitive and social domains, as well as measures of engagement in preventive services and community activities. Evidence-based, standardized surveys and population-level analytics can enable MA plans to identify gaps and target interventions effectively, while ensuring comparability across plans and populations.

Nutrition and Lifestyle Management as Foundational Health Strategies

Nutrition and lifestyle management are foundational to health, particularly for older adults managing or at risk for chronic conditions. ACHP encourages CMS to:

- Integrate nutrition and lifestyle screening into routine primary care visits, including screening for social determinants of health.
- Expand access to medically tailored meals, nutrition counseling and evidence-based community programs.
- Incentivize MA plans to invest in nutrition and lifestyle-focused benefits that demonstrably improve outcomes.
- Align quality metrics and payment structures with nutrition- and lifestyle-related outcomes to drive sustained plan investment.

Strengthening Prevention Through Expansion of Medicare Diabetes Prevention Program and Alignment With GLP-1 Coverage

Prevention should remain central to MA policy and program design. In 2022, we launched a Chronic Disease Pledge, uniting our member organizations in a decade-long commitment to reduce the incidence of diabetes, hypertension and other chronic conditions. ACHP strongly supports leveraging existing, proven prevention infrastructure to support emerging therapies and benefit designs. CMS should expand and modernize the Medicare Diabetes Prevention Program (MDPP) to serve as a foundational lifestyle management program for beneficiaries who will become newly eligible for GLP-1 therapies under TrumpRx beginning in 2026.

The MDPP has demonstrated success in supporting lifestyle change, weight loss and reductions in overall cost of care. However, current eligibility criteria, largely limited to beneficiaries with a diagnosis of prediabetes, constrain the program's ability to support broader prevention and chronic disease management goals.

ACHP recommends CMS:

- **Deem MDPP a comprehensive lifestyle management program**, rather than a narrowly defined diabetes prevention intervention.
- **Expand MDPP enrollment and qualification criteria** to align with the GLP-1 patient access criteria established under TrumpRx and the BALANCE Model.
- **Allow MDPP suppliers to enroll and bill CMS** for beneficiaries who meet either the current MDPP criteria or the expanded GLP-1 access criteria.

MDPP eligibility should also be expanded to include individuals who meet the following GLP-1 access criteria:

- **BMI ≥ 27** with prediabetes or established cardiovascular disease, including a history of stroke, heart attack or peripheral artery disease.
- **BMI ≥ 30** with stage 3A chronic kidney disease or higher, uncontrolled hypertension (blood pressure >140/90 despite use of two antihypertensive medications for at least six months) or heart failure with preserved ejection fraction (HFpEF).
- **BMI ≥ 35** with no additional clinical requirements.

CMS should move expeditiously to expand MDPP qualification criteria in advance of, or concurrent with, the summer 2026 launch of TrumpRx GLP-1 coverage. Doing so would ensure that beneficiaries who newly qualify for GLP-1 therapies are simultaneously enrolled in an established, evidence-based lifestyle management program that supports sustainable behavior change and maximizes therapeutic effectiveness.

Moreover, early expansion of the MDPP would provide CMS with a clear, standardized mechanism to track beneficiary enrollment in structured lifestyle programs, evaluate GLP-1 utilization in conjunction with lifestyle interventions, and measure clinical outcomes, adherence and cost-of-care impacts associated with integrated pharmacologic and lifestyle management approaches.

Proven Prevention and Community-Based Models

Proven prevention and community-based models already demonstrate that coordinated, upstream investment can improve outcomes while strengthening care delivery for older adults, yet current Medicare policy does not fully leverage these approaches. Programs such as the Diabetes Prevention Program and MDPP show that structured lifestyle interventions can delay or prevent disease progression, but broader impact will require expanded eligibility and payment and quality frameworks that reward measurable outcomes rather than episodic participation. Similarly, evidence-based physical activity programs like SilverSneakers illustrate how integrating movement, mobility and social engagement into care coordination can improve functional status and overall well-being, particularly when Medicare Advantage plans are incentivized to treat these services as core elements of care rather than supplemental benefits. Community-integrated, whole-person models, such as Geisinger Health Plan's 65 Forward, further underscore the value of embedding

prevention, social connection and chronic disease management within trusted local settings. CMS has an opportunity to build on these proven models by piloting and scaling approaches that explicitly recognize the clinical and cost-saving benefits of community engagement, prevention and coordinated care for seniors.

Leveraging AI-Enabled Tools to Support Nutrition and Lifestyle Change

AI-enabled tools offer significant opportunities to enhance patient understanding, engagement and shared decision-making, particularly for older adults managing multiple chronic conditions. These tools can reinforce lifestyle interventions by providing personalized, interactive education on nutrition, physical activity, medication management and self-care. ACHP encourages CMS to consider AI-enabled health literacy and engagement tools through testing or integration in CMMI models, particularly those focused on primary care transformation, care coordination and aging populations. We also suggest that CMS promotes incentivization through payment and quality frameworks that reward patent understanding, engagement and experience in addition to clinical outcomes.

ACHP urges CMS to view well-being, nutrition and prevention policy as a strategic opportunity to partner with Medicare Advantage plans to keep beneficiaries healthier, more independent and engaged in their communities. ACHP member plans are deeply rooted in the regions they serve and have demonstrated the ability to innovate at the community level. By aligning policy, payment and quality frameworks with these proven approaches, CMS can accelerate innovation that improves outcomes, reduces avoidable utilization and strengthens the sustainability of the MA program. ACHP stands ready to collaborate with CMS on piloting, refining and scaling community-based solutions that support long-term health and well-being for Medicare beneficiaries. ACHP appreciates CMS's leadership and consideration of these recommendations. Please contact Michael Bagel, Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions and next steps.

Conclusion

ACHP appreciates CMS's leadership and willingness to engage with stakeholders as it advances this comprehensive CY 2027 MA and Part D proposed rule. Taken together, the proposals addressed in this letter and accompanying RFI responses represent a meaningful opportunity to strengthen MA and Part D by improving quality measurement, modernizing risk adjustment, reducing unnecessary regulatory burden and reinforcing beneficiary protections.

ACHP strongly supports the Administration's clear commitment to outcomes-driven policy, program integrity and consumer value. We believe these reforms will help ensure that MA and Part D continue to deliver high-quality, affordable coverage for millions of beneficiaries. ACHP stands ready to partner with CMS as these policies are finalized and implemented, including through continued

dialogue, technical assistance and participation in pilots or demonstrations where appropriate. Please contact Michael Bagel, Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions.

Ceci Connolly



President and CEO
ACHP