ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

February 10, 2025

Stephanie Carlton, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

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

Dear Acting Administrator Carlton:

The Alliance of Community Health Plans (ACHP) is pleased to again partner with the Trump Administration to make rapid and significant improvements to the MA program which remains the choice of America's seniors. The 2026 MA and Part D Rate Notice provides an early opportunity for the Administration to finalize common sense changes that will provide certainty for health plans and disrupt the status quo to enhance competition and deliver better choices for seniors. In addition to the Rate Notice, ACHP is eager to partner with the Administration to implement *MA for Tomorrow*, a vision for the MA program which levels the competitive playing field, raises the bar on quality and access and delivers value for every federal Medicare dollar. Together we can take the MA program from good to great.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering both high-quality coverage and care. As regional, 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 health plans 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.

While ACHP offers comments on a wide array of the provisions within the Advance Notice, we raise the following comments for the Administration's priority consideration:

1. Fully implementing the 2024 CMS-HCC Risk Adjustment is critical for MA program integrity and should be finalized.

2. Patient acuity continues to not adequately be accounted for in MA rates. COVID-19 data years skew the normalization factor and artificially depress actual cost trends.

3. Continuing to use Part A-only beneficiary and Part B-only beneficiary data for calculating both the growth percentage and the Fee-for-Service Cost by County, despite CMS' own recognition that the methodology is wrong and should be immediately remedied.

We offer the following additional comments to support a robust Medicare Advantage and Part D program:

2026 Risk Adjustment Model

ACHP strongly supports the full transition to the 2024 CMS-HCC Risk Adjustment Model. Finalizing this transition is critical to ensuring responsible risk adjustment practices. Further, operating just one risk-adjustment model significantly reduces burden for payers, providers and CMS.

We support a risk adjustment model calibrated solely with encounter data and recommend CMS develop such a model with stakeholder input. The MA program is well over half of all Medicare beneficiaries. It is no longer practical to base the MA risk adjustment model on FFS data. ACHP has previously recommended that the model be calibrated with MA utilization data and MA cost data from non-capitated plans, with the possibility of the cost data being supplemented by fee-for-service cost data. With this methodology, the MA encounter data does not contain spending information for services paid under a capitated amount. Over time, as encounter data improves, the need for supplementing with fee-for-service cost data would decline. This recommendation is a key proposal in our *MA for Tomorrow* initiative to advance common sense policies to improve risk adjustment practices.

Risk Score Trend Methodology

ACHP recommends CMS implement a tiered coding intensity adjustment to address the discrepancy of risk growth between companies. This proposal is critical without an encounter data-based risk adjustment model, which would negate inappropriate coding practices driving increases in risk scores. 2024 saw countless exposés on the cadre of large, for-profit carriers that manipulate the risk adjustment system to make patients appear sicker and increase payments. An in-depth review of regional health plan risk scores clearly shows significantly lower scores and year-over-year risk score growth. The average growth rate for ACHP member companies was -0.5% from 2019 to 2023. Compare that to the CMS stated industry average above 2 percent. Clearly not all health plans risk adjust the same and should not be adjusted the same.

Effective Growth Rate

ACHP requests CMS reflect the increasing patient acuity and utilization in the CY 2026 Final Rate Notice. We remain concerned that increased patient acuity and anticipated utilization trends are not accurately captured in the growth rates. ACHP member companies continue to experience utilization upticks with more complex need patients. In addition to the ongoing pandemic fallout, ACHP anticipates drug related expenses to account for a significant increase in 2026 spending levels, particularly with the significant rise in GLP-1s. The combination of increased acuity (i.e., acute public health events and increased disease prevalence) and the ongoing utilization recovery in a post-pandemic environment continues to drive cost trends significantly.

Calculation of United States Per Capita Costs (USPCCs)

MA Growth Percentage Calculation

ACHP continues to request CMS exclude Part A-only and Part B-only beneficiaries from the Total United States Per Capita Costs (USPCCs) used to calculate the growth percentage. Including these beneficiaries in the MA capitation rate calculations is inappropriate. This is a widely recognized issue, including by CMS itself, in the calculation of MA payment rates as MA plans cannot enroll Part A only or Part B only members.

In the Medicare Data for Geographic Variation Public Use File: A Methodological Overview, CMS states that beneficiaries are excluded from the study population if they were enrolled at any point in the year in Part A-only or Part B-only because spending for those beneficiaries cannot be compared directly to spending for beneficiaries that are enrolled in both Part A and Part B. ACHP agrees. CMS should apply this logic to the MA payment rates and exclude Part A-only and Part B-only beneficiaries from the USPCCs. It is important to make this adjustment to have USPCCs reflective of MA beneficiaries, especially as the percentage of Part A-only enrollees continues to increase. Including Part A-only and Part B-only distorts the county's FFS costs, particularly in high MA penetration counties.

County Benchmark Calculations

ACHP requests CMS eliminate Part A-only and Part B-only beneficiaries FFS costs for establishing county benchmarks. As MedPAC recommended on numerous occasions, county benchmarks should only account for those individuals who are eligible for MA – those who have both Parts A and B coverage. The USPCCs continue to include both Part A-only and Part B-only beneficiaries. While an immediate change would be most appropriate, CMS could implement a phased-in approach for counties with MA penetration over a certain percentage and gradually lower the threshold with subsequent Rate Notices.

Quality Payments Benchmark Cap

ACHP continues to strongly recommend that CMS exclude quality payments from the benchmark cap calculation. We previously provided CMS with a legal analysis that shows CMS has flexibility under the statute to exclude the quality payments from the benchmark cap calculation. Correcting this interpretation aligns with Congressional intent and is essential for ensuring that seniors receive the highest possible quality of care. Correcting this issue also eliminates significant payment inequity that undermines health plans' ability to fund expanded benefits or reduced premiums for seniors.

CMS previously acknowledged that the quality bonus program does not adequately incentivize MA plans to continuously improve quality because the application of the benchmark cap policy reduces the quality payments to many high-quality plans. The loss of those quality incentive payments undermines value-based care, disincentivizes quality and diminishes benefits to seniors.

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Part D Normalization Factor

ACHP does not support separate normalization factors for MA-PD plans and PDP plans. ACHP remains concerned that separate normalization factors will impact the low-income (LIS) subsidy population and create steering into PDPs when integrated care and coordination in an MA-PD is more appropriate. ACHP recommends CMS withhold on finalizing this change while other policies that have a broader impact to the Part D program are in motion. Notably, the ongoing Part D redesign and new Part D risk model introduce several dynamics.

Part C and Part D Star Rating Measures

ACHP encourages CMS to streamline star rating measures by moving away from process measures and increasing patient experience and outcome measures. Retiring process measures reduces provider burden and aligns with the wise Trump administration goals to reduce unnecessary regulation. We were pleased that several of ACHP's recommended measures to retire from *MA for Tomorrow* were included in the list CMS is considering retiring. We strongly support immediately retiring these measures, specifically the:

- Medicare Plan Finder Price Accuracy Part D Measure
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR) Part D Measure
- Care for Older Adults – Medication Review Measure

We recommend the following additional measures be considered for retirement:

- Care for Older Adults – One Pain Assessment in a Year
- Diabetes Care – Kidney Disease Monitoring
- Patient-Reported Annual Flu Vaccine
- Monitoring Physical Activity Conversation with Physician
- Osteoporosis Management in Women Who Have Had a Fracture
- Patient-Reported Improving Bladder Control Conversation with Physician
- Patient-Reported Fall Risk Reduction Conversation with Physician

We look forward to working with the Administration to ensure seniors continue to receive the high-quality, affordable coverage and care they deserve. Please contact Michael Bagel, Associate Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss our recommendations further.

Regards,

Ceci Connolly

Ceci Connolly, President and CEO