October 6, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Strengthening Medicare Advantage in 2028: Bolstering Competition and Protecting Beneficiary Choice

Dear Administrator Dr. Oz,

Medicare Advantage (MA) beneficiaries face fewer choices and disruptions in care as national, for-profit insurers exit markets, placing growing pressure on local, nonprofit health plans that remain committed to serving their communities. In 2026, 4.6 million beneficiaries had their MA plan disrupted and millions more will be disrupted in 2027. Without meaningful reform, external pressures threaten the ability of regional plans to sustain high-quality, coordinated care in 2028 and beyond. The Alliance of Community Health Plans (ACHP) urges policy changes to stabilize the market, preserve beneficiary choice and ensure that plans rooted in their communities can continue serving the people who depend on them.

As you know, ACHP represents the nation's best local, nonprofit health plans, providing high-quality coverage to tens of millions of Americans. ACHP is the only national organization advancing a unique partnership model of coverage and care that fosters a truly competitive market. Our members are dedicated to improving the MA program, ensuring that they best serve the patients and communities they serve and thrive in their markets.

The CY 2027 MA and Part D Policy and Technical Final Rule delivered important reforms that ACHP and our member companies strongly supported, including eliminating the Health Equity Index, also known as Excellent Health Outcomes for All, and removing Star Ratings process measures. The CY 2028 rule must build on that progress to address persistent barriers to a more competitive, sustainable MA program. Tailored reforms towards simplifying risk adjustment, modernizing network composition and further refining Star Ratings would enable community-based plans to direct more resources toward high-quality care and better outcomes for beneficiaries. We offer the following recommendations for the CY 2028 MA and Part D regulation.

Streamline and Simplify MA Risk Adjustment

The current risk adjustment system rewards the ability to maximize diagnosis coding, giving national, for-profit insurers a competitive advantage over community-based, nonprofit plans that prioritize coordinated care. Reform is essential to sustain a competitive market for Americans over age 65. ACHP calls on CMS to return to the original intent of risk adjustment: providing adequate resources to deliver needed care, NOT pump up revenue for outliers. It's time to curb gaming and align payment with care.

Align expenditures in calibration data years with payment year policy. The risk adjustment model's data lag between calibration and payment year creates a discrepancy between the spending patterns reflected in the risk adjustment model, the plan year payment rates and the methodology used to calculate county-level benchmarks. The timing mismatch can lead to the calculation of relative factors that are higher or lower than expected once the current payment policy is in place. Spending on skin substitute products illustrates this issue. Part B spending for skin substitutes rose roughly forty-fold from 2019 to 2024. CMS' payment change in the 2026 Physician Fee Schedule (PFS) is expected to reduce gross Original Medicare spending by $19.6 billion in 2026. Using unadjusted spending on skin substitutes in the data used to calibrate the risk adjustment model would result in a discrepancy between predicted cost and CMS' projection of reduced spending based on the PFS payment change. In its recalibration of the LEAD ACO Model risk adjustment model, CMS removed skin substitute-related procedure codes from the calibration data to avoid this distortion.

Exclude "high risk" diagnoses from the risk adjustment model. The HHS Office of the Inspector General (OIG) identified a series of diagnosis codes that, in combination with certain places of service or treatment patterns, have been found in targeted audits of MA plan risk adjustment data to be unsupported by patient medical records in 70 percent or more of cases (e.g., an acute stroke diagnosis in a physician office without a corresponding inpatient or outpatient hospital claim). OIG estimated that CMS made approximately $462 million in potential net overpayments to MA organizations that incorrectly submitted high-risk acute stroke diagnosis codes. Similar patterns have been identified for sepsis, acute myocardial infarction and pulmonary embolism.

Constrain acute coefficients to prevent unwarranted differences in predicted costs. CMS' practice of applying constraints to coefficients for chronic conditions to account for small samples, or in cases for variation or discretion in diagnosis coding, preserves predictability in projected spending and costs. Certain acute conditions (e.g., sepsis, acute heart disease, injury) warrant the same level of stability and predictability in the calculation of relative factors as chronic conditions. CMS should publish all unconstrained and constrained values, as well as the specific reason for each constraint.

As CMS continues to refine the V28 risk adjustment model, ACHP encourages CMS to assess how additional refinements can further enhance the stability, accuracy and predictability of the model.

Align expenditures in calibration data years with payment year policy. CMS should develop a standard approach to align the expenditures used for model calibration with policy applicable in the payment year. This includes repricing historical claims with a final payment policy effective by the payment year changes the unit-payment method or rate by a material amount (e.g., exceeds the "significant cost" threshold) and removing CMS-designated significant, anomalous and highly suspect billing or other clearly superseded spending.

Identify year-over-year changes in the relative factors for chronic conditions that exceed historical trends. Recent research estimates that claims-based documentation of comorbidities after the COVID-19 pandemic is lower than pre-pandemic in both Original Medicare and MA populations. ACHP is concerned this will bias risk adjustment model development. CMS should develop a framework to measure historical

prevalence of and rate of change in chronic conditions and their relative factors by HCC and population segment. CMS should also assess whether the change in relative factor in a given year, or years, is consistent with this prior range. For significant changes, CMS should flag the relative factor, articulate underlying assumptions and publish additional data or analyses to support these assumptions.

Modernizing Network Composition

Health plans face significant and growing challenges to network adequacy standards from antiquated requirements. The nation is facing widespread MA market contraction, driven by national insurers pulling back. ACHP member companies also face the realities of operating in communities across the country that are rural, frontier, low-income and provider shortage areas.

CMS should implement policies to level the competitive playing field and preserve additional MA plan options in areas where plans may not be able to offer comprehensive coverage and care because of outdated network adequacy standards. This is a critical moment for reform, particularly given the 10% decline in nationwide MA plan offerings. Now, more than ever, it is essential that regional plans have the regulatory flexibility to remain in their markets and expand where possible. ACHP recommends CMS:

Allow Travel Flexibilities to Address Unique Geographic Challenges. Many ACHP member companies provide coverage and care to beneficiaries in rural and frontier areas. In these areas, it can be more cost effective to pay for beneficiary travel and care from a contracted provider that is outside of the time and distance standards. Health plans do not get credit for this level of access since the contracted providers fall outside of the current standards. For example, it can be more efficient and result in better care to fly a beneficiary from Hawaii to the mainland than to provide care on remote islands.

Create Transparency Exception Qualifying Circumstances. The current exceptions process is opaque. ACHP member companies regularly contend with exception denials for reasons that are inconsistent with high-quality patient care and needs. For example, an ACHP member company requested an exception due to too few (or any) specialists in an extremely rural area. This request was denied on the grounds that they should have contracted with a provider over 300 miles away, even when they were able to contract with a provider only ~90 miles away. This is just one example of many depicting the challenges with the current exceptions process, especially in rural and frontier counties.

CMS should establish guardrails and safe harbors for unique circumstances due to provider contracting, geography or other scenarios. For example, a safe harbor could address scenarios in which an otherwise qualifying provider is unwilling or unavailable to contract with a MA plan. Current network adequacy guidance generally does not recognize an organization's inability to contract with a provider as sufficient grounds for an exception, which can create challenges when a plan has identified an appropriate provider but cannot compel that provider to participate in its network. CMS should establish criteria that a health plan must demonstrate to show good-faith contracting efforts, process and outcomes. This approach addresses the tension between network adequacy standards and unsuccessful negotiations that can constrain plans' contracting flexibility, particularly in markets with limited provider supply without necessitating unfavorable contracting arrangements.

Expand Recognition of Virtual Care Providers. Virtual care improves access to timely services, particularly in resource constrained and geographically challenging areas. CMS should increase the telehealth credit from 10 to 30 percent to help plans meet network adequacy requirements with high value clinicians and services. With the increased telehealth credit, plans would be able to overcome negotiating obstacles where dominant health systems leave plans with limited alternatives to satisfy adequacy requirements. We further recommend that virtual care availability satisfy appointment wait time requirements.

Create Alternative Pathways for Demonstrating Network Adequacy. Current network adequacy standards do not fully capture the range of way health plans provide timely and meaningful access to providers and facilities. CMS should introduce additional criteria to the network adequacy metrics, allowing health plans to either:

a. Continue using the current time and distance, provider ratio and appointment wait time requirements; or
b. Choose two of the current metrics along with two new metrics:
    i. At least ten percent of health plan's contracted primary care providers/locations have after-hours care.
    ii. Health plan offers consumers 24/7 clinical support services.
    iii. For a renewing health plan, the MA contract must have achieved 4+ star rating for Patient Access and Outcome metrics.

Continue Steady Refinements to the Star Ratings Program

Prioritize Clinical Outcomes Over Duplicative Process Measures. CMS should continue replacing topped-out, duplicative and administratively burdensome process measures with measures tied to prevention, chronic disease management, care transitions and clinical outcomes. New measures should be supported by evidence that plans can meaningfully influence performance and should not duplicate existing measures or hold plans accountable primarily for provider-level documentation practices.

Establish Predictable Star Ratings Cut Points. As CMS considers returning to prospective or predetermined cut points, the agency should evaluate and account for key lessons learned since the original removal in 2016. This should include considering how prospective cut points interact with the Part C and Part D improvement measures so the model continues to recognize both strong performance and meaningful improvement. We support giving plans performance expectations before the measurement period begins. Predictable thresholds would allow plans and providers to direct resources toward meaningful quality improvement rather than responding to retrospective changes in relative performance. At a minimum, CMS should strengthen guardrails that limit year-to-year movement in cut points while it evaluates a prospective methodology.

Apply a Hold Harmless Methodology to the 2027 Star Ratings. While the Clover Health litigation remains unresolved, CMS should calculate each MA contract's overall 2027 Star Rating using both the methodology communicated to plans before the 2025 measurement year and a methodology that excludes measures affected by the litigation, then assign the higher rating. This approach would maintain the precedent established for the 2026 Star Ratings and prevent retrospective methodological changes from

reducing ratings despite unchanged plan performance. CMS should also identify the affected measures, explain how it is implementing the court's decision and adopt any permanent methodological changes prospectively with sufficient notice and an appropriate transition period.

Evaluate the Current State of Survey-based Methodologies. CMS should modernize and improve survey-based methodologies deployed in the MA Star Ratings program. We encourage CMS to conduct and assess these methodologies, including the challenges associated with declining response rates, response bias and factors outside the care delivery system that may influence mentally reported measures. We support particular attention to medical complex populations, such as special need plan members, where health status, functional limitations and social factors can influence survey responses independent of care quality.

Create Industry Alignment on Quality Measurement. CMS is uniquely positioned to promote alignment across Medicare, Medicaid, commercial quality programs, providers and health systems. Greater standardization would reduce administrative burden, improve data quality and allow plans and providers to focus more resources on improving outcomes rather than navigating varying measurement approaches.

ACHP urges CMS to adopt these recommendations in the CY 2028 rulemaking to preserve beneficiary choice, strengthen competition and sustain access to high-quality, coordinated care. We stand ready to work with CMS to ensure Medicare Advantage remains a reliable, affordable option for the people who depend on it. Please contact Michael Bagel, Vice President of Public Policy, at mbagel@achp.org or 202-897-6121 to discuss further.

Regards,

Ceci Connolly

Ceci Connolly
President and CEO
ACHP