AMGA
Advancing High Performance Health

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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies [CMS-4212-P]

Dear Dr. Oz:

On behalf of AMGA and our members, I appreciate the opportunity to provide comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. AMGA represents multispecialty medical groups and integrated delivery systems, with more than 177,000 physicians who collectively care for one in three Americans. Many of our members participate in the MA program as contracted providers and MA plan sponsors, making this annual rate and policy announcement critical to their ability to provide high-quality, high-value care.

AMGA appreciates CMS' continued commitment to payment accuracy and program integrity within MA. However, we have significant concerns regarding several proposals in the CY 2027 Advance Notice that, taken together, threaten program sustainability and could undermine AMGA members' ability to continue delivering high-quality, coordinated care to MA beneficiaries.

AMGA is pleased to offer the following comments and recommendations on the CY 2027 Advance Notice:

- **Payment Update:** The proposed 0.09% payment update is insufficient to account for rising healthcare costs and risks destabilizing the MA market.
- **Risk Adjustment Methodology:** CMS should prioritize predictability and stability in risk adjustment methodology, including phased implementation of major changes.
- **Audio-Only Encounters:** Diagnoses from audio-only encounters should remain eligible for risk adjustment, subject to appropriate safeguards.
- **Chart Review Records (CRRs):** CMS should adopt a more nuanced policy regarding CRRs that addresses program integrity concerns without undermining legitimate clinical documentation and care delivery.

Payment Update: Inadequate Rate Increase Threatens Program Sustainability

AMGA is deeply concerned that the proposed 0.09% increase in MA plan payments from 2026 to 2027 is wholly inadequate to address the rising costs of delivering care. This essentially flat payment update, particularly when compared to last year's 5.06% increase, fails to account for several critical factors:

Growing Beneficiary Demand

MA enrollment continues to grow, with more than half of eligible Medicare beneficiaries now enrolled in MA plans. This growth reflects beneficiaries' strong preference for the coordinated care, supplemental benefits, and enhanced care management services that MA offers. However, maintaining and expanding these valued services requires adequate and predictable financial resources.

Rising Healthcare Costs

Medical groups and integrated delivery systems face substantial increases in operational costs driven primarily by significant inflationary pressures across all aspects of care delivery. Workforce expenses continue to rise as organizations compete to attract and retain qualified physicians, nurses, medical assistants, care coordinators, and administrative personnel in an increasingly tight labor market. Inflationary pressures have dramatically affected the costs of medical supplies, pharmaceuticals, and facility operations, with many essential items experiencing double-digit price increases.

At the same time, organizations must make ongoing investments in health information technology and care coordination infrastructure to meet evolving regulatory requirements, support quality reporting, and enable the data exchange necessary to succeed in high-value care arrangements. These cost pressures are persistent and compounding, yet the proposed 0.09% rate increase provides virtually no resources to address them, creating an unsustainable gap between the cost of delivering comprehensive care and the revenue available to support it.

Risk of Market Instability

Insufficient payment updates introduce meaningful risks for program stability. More than 1.8 million MA members were enrolled in 2024 plans that were not offered in 2025.[1] When payments fail to keep pace with care delivery costs, plans are forced to narrow provider networks, with MA plans often having limited and transient networks of providers, which can restrict the choice of physicians and hospitals. Plans are also limiting supplemental benefits that address social needs, as many major plans have cut these benefits and some high-priced medications from their formularies. In addition, some MA plans are reducing their dental and vision coverage and raising co-pays to see specialists.

[1] Product Exits Cause Shakeup in Medicare Advantage Offerings. Gregory Berger, Lindsay Knable, Brooks Conway, Shannan Brown, and Brinda Doshi. Oliver Wyman, oliverwyman.com/our-expertise/perspectives/health/2024/oct/plan-exits-cause-shakeup-in-medicare-advantage-offerings.html.

Additionally, in some areas, particularly rural and underserved areas, insurers are exiting the market entirely, leaving beneficiaries with fewer options. These market exits and benefit reductions inevitably lead to increased beneficiary cost-sharing, creating barriers to accessing necessary care for vulnerable populations who depend on MA's comprehensive benefits and lower out-of-pocket costs.

Contribution to Concierge Medicine Growth

Inadequate reimbursement in the broader Medicare program, including MA, is accelerating the trend toward concierge medicine models, particularly in primary care. When traditional payment models fail to cover the true cost of comprehensive, relationship-based primary care, physicians increasingly turn to direct-pay arrangements. This trend threatens access for Medicare beneficiaries who cannot afford concierge fees and undermines efforts to build vhigh-value care systems that serve all patients equitably.

AMGA strongly urges CMS to reconsider the proposed rate update and ensure that payment growth adequately supports the infrastructure, workforce, and services necessary to deliver high-quality care to the growing MA population.

Risk Adjustment Methodology: The Need for Predictability and Stability

AMGA supports a risk adjustment model that accurately accounts for the clinical complexity of MA beneficiaries and ensures appropriate resources for their care. However, frequent and substantial methodological changes create uncertainty that disrupts long-term planning and investment.

Importance of Predictability

Medical groups and health systems make multi-year investments in care delivery infrastructure, including:

- Hiring and training care management staff
- Implementing disease management programs
- Developing quality improvement initiatives
- Building community partnerships to address social needs
- Investing in value-based payment arrangements with physicians and other providers

These investments require financial stability and the ability to project future revenue with reasonable accuracy. When risk adjustment methodologies change substantially from year to year, it becomes extremely difficult for plans and providers to appropriately plan for future expenses and make the long-term commitments necessary to improve quality and outcomes.

As we noted in our CY 2026 Advance Notice comments, the shift from a three-year rolling average to a two-year average for risk score trend significantly lowered the risk score trend from 3.86% in CY 2025 to 2.10% in CY 2026. Continued volatility in risk adjustment methodology compounds these concerns and makes it increasingly challenging for providers to maintain the comprehensive care management programs that MA beneficiaries value.

Request for Stability
AMGA urges CMS to prioritize stability in risk adjustment methodology, allowing adequate time for the healthcare delivery system to adapt to changes before implementing additional modifications. When changes are necessary, they should be:

- Phased in gradually to allow for planning and adjustment
- Accompanied by comprehensive modeling to assess impacts on different types of plans and provider organizations
- Subject to extensive stakeholder engagement before finalization

Audio-Only Encounters: Exclusion from Risk Adjustment

AMGA opposes the proposal to exclude diagnoses from audio-only telehealth encounters from risk adjustment calculations. This exclusion fails to recognize important realities about the patient population utilizing audio-only services and the clinical validity of diagnoses made through these encounters. Audio-only telehealth services are disproportionately utilized by:

- Older beneficiaries who may lack access to video-capable technology or broadband internet
- Patients with visual or hearing impairments that make video visits challenging
- Beneficiaries in rural areas with limited broadband infrastructure
- Individuals with lower socioeconomic status who cannot afford smartphones or computers with video capability
- Patients with mobility limitations or transportation barriers

These patient populations tend to be older, sicker, and more socially vulnerable, precisely the beneficiaries that risk adjustment is designed to consider. Excluding audio-only encounters from risk adjustment will systematically underrepresent the risk profiles of plans and providers serving these vulnerable populations.

Clinical Validity
Many chronic conditions can be appropriately diagnosed, monitored, and managed through audio-only encounters, particularly for established patients with documented conditions. Physicians regularly assess:

- Symptom progression in patients with known chronic diseases
- Response to treatment modifications
- Need for medication adjustments
- Complications of existing conditions
- Acute exacerbations requiring intervention

The inability to see a patient via video does not render these clinical assessments invalid or the documented diagnoses inappropriate for risk adjustment purposes.

Alternative Approach
Rather than categorically excluding audio-only encounters, AMGA recommends that CMS work with stakeholders to develop appropriate safeguards against potential misuse while preserving

recognition of legitimate clinical care delivered through this modality. This could include:

- Requiring documentation standards for audio-only encounters
- Limiting risk adjustment for audio-only diagnoses to established patients with prior documentation of the condition
- Implementing claims edit protocols to identify potentially inappropriate patterns

This approach would protect program integrity while recognizing legitimate clinical care.

Chart Review Records: A More Nuanced Approach Is Needed

AMGA appreciates CMS' efforts to address program integrity concerns raised by stakeholders, including the Office of Inspector General and the Medicare Payment Advisory Commission, regarding the use of unlinked CRRs in risk adjustment. We agree that diagnoses used for risk adjustment should be tied to actual patient care, and we support efforts to ensure payment accuracy and reduce inappropriate coding practices. However, AMGA believes the proposed blanket prohibition on unlinked CRRs is overly broad and risks excluding clinically valid diagnoses.

Clinical Reality of Chronic Disease Management

Many patients with chronic conditions require ongoing management but may not have face-to-face encounters for each condition in every payment year. This is especially true when conditions are managed through established medication regimens, assessed during comprehensive visits that do not generate separate claims for each diagnosis, and supported by objective laboratory or diagnostic findings, or when patients face access barriers that limit visit frequency.

Example: Chronic Systolic Heart Failure (I50.20) in a patient who is clinically stable and being managed remotely.

Consider a patient with well-documented chronic systolic heart failure who is stable on an optimized medication regimen. The patient is monitored through a remote care management monitoring program—tracking daily weights, blood pressure, and symptoms. No acute exacerbation occurs during the data collection year, so no face-to-face visit is generated and no claim-based HCC code is submitted. But the diagnosis is clearly and thoroughly documented in the chart, the patient carries substantial clinical risk and resource utilization potential, and the absence of a visit reflects successful, proactive management—not a care gap.

Implications for Risk-Based Payment Models

AMGA members rely on risk-adjustment payments to support comprehensive, coordinated care for complex populations. These resources fund care coordinators, social workers, outreach programs, disease registries, and population health infrastructure.

These services and investments are particularly critical for high-risk patients whose conditions may be documented through chart review rather than claim-linked encounters.

Removing recognition of these diagnoses weakens the financial foundation of care models designed to proactively manage chronic illness and reduce avoidable utilization.

Risk Adjustment Supports Care Delivery in an Inadequate Reimbursement System
Risk adjustment plays a critical role in supplementing traditional fee-for-service reimbursement, which often does not fully cover the cost of primary care services, care coordination, behavioral health integration, or management of complex, multi-morbid patients.

Overly restrictive limitations on risk adjustment, including categorical exclusion of unlinked CRRs, threaten the viability of high-value care models that depend on adequate risk-adjusted payments.

Recommended Alternative Approach
AMGA recommends that CMS develop a more nuanced policy that:

1. **Allows unlinked CRRs with objective clinical evidence:** Permit chart-documented diagnoses supported by laboratory values, imaging results, or other objective clinical data that confirm the diagnosis, even when not linked to a specific claim.
2. **Implements diagnosis-specific standards:** Establish clear criteria for which types of diagnoses may be documented through unlinked CRRs, focusing on chronic conditions with objective diagnostic criteria.
3. **Requires enhanced documentation:** Mandate specific documentation standards for chart-documented diagnoses, including:
    - Reference to objective clinical findings
    - Explanation of why the condition is relevant to the patient's current care needs
    - Documentation of ongoing management, even if not claim-generating
4. **Phases implementation:** If moving toward more restrictive policies, phase them in gradually while monitoring impacts on different providers and plan types, particularly those serving high-risk populations.
5. **Provides education and guidance:** Work with stakeholders to develop clear guidance on appropriate use of chart documentation for risk adjustment purposes.

This approach would address legitimate program integrity concerns while preserving accurate representation of patient acuity.

As stated in our Feb. 10, 2025, comments on the CY 2026 Advance Notice, AMGA supports a risk adjustment model that fairly accounts for complex health needs while ensuring adequate resources for care delivery. We remain concerned about methodological changes that disproportionately affect providers serving high-risk populations and urge CMS to ensure that the methodology reflects ongoing realities of population health trends and coding practices.

Similarly, our Jan. 27, 2025, comments emphasized the importance of reducing administrative burdens on providers. The proposals in the CY 2027 Advance Notice must be evaluated not only for their impact on payment accuracy but also for their effects on providers' ability to deliver high-quality care to vulnerable populations.

Conclusion

Medicare Advantage continues to be a vital program for millions of beneficiaries, and AMGA remains committed to working with CMS to strengthen its long-term sustainability. However, the

proposals in the CY 2027 Advance Notice raise significant concerns about the financial viability of the program and the ability of plans and providers to continue delivering the comprehensive, coordinated care that MA beneficiaries value.

AMGA urges CMS to:

- Reconsider the inadequate 0.09% payment update to better reflect care delivery costs
- Prioritize stability and predictability in risk adjustment methodology
- Maintain audio-only encounters as valid sources of diagnosis information
- Develop a more nuanced approach to chart-documented diagnoses

We appreciate the opportunity to provide feedback and look forward to continued engagement with CMS on these critical issues. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or ddrevna@amga.org.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA