Advancing High Performance Health

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January 26, 2025

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

RE: [CMS-4212-P] 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:

On behalf of AMGA, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Contract Year (CY) 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program proposed rule.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

AMGA appreciates CMS' continued focus on advancing accountable care within Medicare Advantage (MA) and strongly supports the agency's broader goal of expanding value-based relationships across the program. Our comments specifically respond to the Request for Information on Future Directions in MA, with a focus on risk adjustment, Quality Bonus Payments and Star Ratings, and well-being and nutrition.

Key Recommendations:

Risk Adjustment Modernization: Shift toward models that reflect patient acuity, functional impairment, and social risk factors while reducing documentation burden and emphasizing persistent, clinically meaningful conditions.

Provider-Payer Incentive Alignment: Require Medicare Advantage Organizations (MAOs) to pass through acuity-adjusted capitated payments directly to providers delivering care to complex patients, ensuring clinicians are adequately reimbursed for the care they deliver.

Medical Loss Ratio (MLR) Transparency and Reform: Refine MLR policies to promote clarity in spending categories and account for regional cost variations, as well as exclude Part D costs into a separate risk pool.

Payment Adequacy and Stability: Ensure risk-adjustment modifications do not widen the gap between reimbursement and actual care delivery costs, providing the payment certainty necessary for long-term investments in accountable care.

Star Ratings Enhancement: Incorporate outcome-based measures—including prior authorization timeliness, denial overturn rates, and prevention of functional decline—into Star Ratings and Quality Bonus Payments.

Data and Payment Timeliness: Reduce the current two- to three-year lag between performance measurement and quality bonus payment (QBP) determination to enable more responsive care management.

Nutrition and Well-Being Support: Allow MA plans to waive cost-sharing for evidence-based nutrition and wellness services, ensure adequate capitation rates, and recognize care coordination and timely transitions as foundational well-being interventions.

AMGA's full comments are detailed below.

Risk Adjustment Modernization

As CMS considers updates to the MA risk adjustment methodology, AMGA urges the agency to continue shifting toward models that better reflect patient acuity, functional impairment, and upstream drivers of health, while reducing unnecessary documentation burden. Risk adjustment should prioritize clinically meaningful, persistent conditions tied to ongoing treatment, supported by longitudinal utilization patterns and functional status indicators, rather than one-time diagnosis capture.

We commend CMS' recognition of inferred risk and the increased emphasis on persistent conditions and longitudinal care needs. Incorporating additional indicators of social risk and functional status would further align risk adjustment with real-world care delivery and enable providers to reinvest limited resources into care delivery, care management, and quality improvement, including through pilot initiatives.

It is critical that any reforms or changes to risk adjustment in MA result in an accurate portrait of the patient population. The most recent changes to MA risk adjustment, namely the transition to version 28 of the Hierarchical Condition Category (HCC) model, resulted in significant operational challenges for physician practices. The HCC model uses specific diagnosis codes to calculate risk scores, requiring detailed understanding of coding guidelines. However, Version 28's change to the CMS-HCC is resulting in unintended consequences. For example, under V28, a patient with uncomplicated Type 2 diabetes now receives the same risk score as a patient with diabetes

complicated by chronic kidney disease, diabetic retinopathy, or peripheral vascular disease—despite the latter requiring significantly more clinical resources, specialist coordination, and intensive management to prevent costly complications.

The reimbursement implications of this transition are particularly concerning. Because the HCC model directly influences MA plan payment rates, and the changes in version 28 have resulted in lower risk scores for many patients with complex, chronic conditions. The reduced risk scores and payments are in stark contrast to overwhelming data showing the prevalence of beneficiaries with multiple comorbidities is rising dramatically over the past decade. Consequently, plans are reimbursing physicians less for providing at minimum the same level, and often times, a higher level of care for these patients, solely due to modifications in the risk adjustment model rather than any change in patient acuity or care delivery.

The accuracy challenges posed by version 28 extend beyond reimbursement to affect critical care management functions. Risk scores serve as essential tools for identifying patients who would benefit most from additional services, including care management programs, disease-specific interventions, transportation assistance, and other population health initiatives. The removal of thousands of codes from the model has diminished the precision of risk stratification, making it substantially more difficult to target limited resources to the patients with the greatest need—a particularly acute problem given current staffing and resource constraints across the healthcare system.

It is vital that any modifications to the MA risk adjustment methodology result in fair and sufficient reimbursement to providers who deliver care to program beneficiaries. Adequate payment is fundamental to maintaining the infrastructure, staffing, and resources necessary to effectively serve patients with complex, chronic conditions. When risk adjustment changes result in reduced reimbursement despite unchanged patient acuity or care intensity, providers face difficult decisions about resource allocation that can directly impact care quality and access.

Physician practices must be able to sustain the care teams, clinical programs, technology systems, and care coordination services required to meet the needs of at-risk populations. Insufficient reimbursement not only threatens the financial viability of practices—particularly smaller, independent groups and those serving vulnerable populations—but also undermines the core promise of MA to deliver high-quality, coordinated care. Fair payment that accurately reflects patient complexity and the resources required to manage chronic disease is essential to ensuring providers can continue to invest in the high-value care models, population health initiatives, and care management programs that improve outcomes for Medicare beneficiaries. Any risk adjustment policy that fails to achieve this balance ultimately jeopardizes the sustainability of the MA program itself.

Provider-Payer Incentive Alignment

To achieve CMS' goal of having all beneficiaries in accountable care relationships by 2030, financial accountability must align with clinical responsibility. Today, MA risk adjustment allows additional payments associated with higher-acuity beneficiaries to remain largely at the plan level, creating a disconnect between payment and care delivery.

AMGA urges CMS to require MAOs to pass through acuity-adjusted capitated payments to providers, ensuring that those delivering care to the most complex patients receive

commensurate resources. This alignment is foundational to high-value care and would strengthen accountability, encourage provider participation in MA risk arrangements, and support sustained investment in care coordination, workforce, and infrastructure.

AMGA also reiterates its request for targeted reforms to MLR policy, including tighter controls on nonmedical expenses, total transparency in financial responsibility, and adjustments that account for regional variation. In addition, CMS should explore separating or excluding Part D costs into a distinct risk pool, recognizing the unique dynamics of prescription drug spending and the limited ability of providers to control these costs.

Medical Loss Ratio Alignment and Transparency

AMGA encourages CMS to continue refining MA MLR policies to promote transparency, predictability, and alignment with high-value care objectives. Clearer, well-defined parameters around what categories of spending may be included in MLR calculations would improve program integrity and reduce downstream uncertainty for both plans and providers. AMGA also urges CMS to ensure that MLR targets align with the expenses that plans intend to include in their bids and to consider regional cost differentials when establishing benchmarks, recognizing variation in labor, infrastructure, and care delivery costs across markets. In addition, CMS should explore greater alignment between plan reconciliation timelines and CMS reconciliation processes to improve consistency and financial predictability. Finally, AMGA reiterates its recommendation to exclude Part D costs or place them in a separate risk pool, reflecting the distinct market dynamics of prescription drug spending and the limited ability of providers to influence these costs.

Payment Adequacy and Stability

AMGA strongly cautions CMS to ensure that modifications to the risk adjustment methodology do not exacerbate the growing gap between reimbursement and the actual cost of delivering care. Providers are already facing significant pressures, including workforce shortages, inflation, and chronic underpayment, particularly under Medicare Part B.

Long-term success in accountable care requires payment certainty and structural reform, not incremental technical adjustments that introduce volatility and increase compliance burden. As outlined in AMGA's MACRA and Value-Based Care Task Force Recommendations, providers can only make the long-term investments necessary to transform care delivery when supported by a predictable, stable, Medicare reimbursement system. Ensuring accurate payment for social complexity and functional impairment is essential to sustaining access, supporting care management, and meeting the needs of high-risk populations.

Star Ratings Enhancement

MA Star Ratings play a critical role in measuring plan quality and informing beneficiary choice. AMGA urges CMS to strengthen Star Ratings by incorporating outcome-based measures that reflect timely transitions of care, accountability in prior authorization, and prevention of functional decline, particularly for beneficiaries moving between acute, post-acute, and community settings.

Delays in authorization and care transitions are not merely administrative inconveniences; they contribute directly to functional decline, increased caregiver burden, patient stress, and avoidable utilization. While existing Star Ratings measures acknowledge access and patient

experience, they do not adequately capture these outcomes. Incorporating metrics such as authorization timeliness and denial overturn rates into Star Ratings and tying them to QBPs would better align incentives for plans, providers, and beneficiaries, while reducing costly delays in care.

CMS should also reward preventive and function-preserving interventions—such as fall prevention and chronic condition management, that slow functional decline, rather than focusing exclusively on utilization reduction.

Data and Payment Timeliness

AMGA strongly supports CMS' focus on improving the timeliness of data and payment. The current two- to three-year lag between performance measurement and QBP determination weakens accountability and limits providers' ability to justify near-term investments in staffing, care coordination, and infrastructure.

Reducing this lag—and improving provider access to complete, timely claims data—would enable more responsive care management, reduce duplicative services, and lower total cost of care. As emphasized in AMGA's MACRA and Value-Based Care Task Force Recommendations, as near to real-time data access as possible is essential to effective population health management.

Nutrition and Well-Being Support

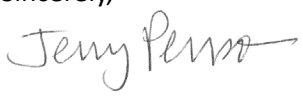
AMGA strongly supports CMS' efforts to promote nutrition and well-being as core components of preventive care. AMGA is fully committed to advocating for patient access to evidence-based services and interventions to improve nutrition and well-being through reduced cost sharing. As cost remains a significant barrier to improving Americans' nutrition and overall well-being, AMGA urges CMS to continue to support MA flexibility to waive beneficiary cost-sharing for services that demonstrably improve nutrition, functional status, and continuity of care. Such services may include telehealth and remote patient monitoring to support longitudinal functional assessment, nutrition management, and early intervention. Reducing or eliminating beneficiary cost-sharing for high-value services is a proven mechanism to improve uptake and outcomes.

AMGA members are well-positioned to deliver nutrition and well-being interventions; however, insufficient reimbursement limits access and scalability. CMS should ensure that capitation rates align with the agency's stated emphasis on nutrition and wellness, enabling providers to deliver these services in practice rather than in theory. Adequate payment would support improved beneficiary health while reducing long-term program costs.

Care coordination and timely transitions of care are foundational well-being interventions. Unstable or delayed transitions increase stress, accelerate functional decline, and place additional strain on caregivers and providers. CMS should explicitly recognize these dynamics within MA policy and quality measurement frameworks, including through Star Ratings, to better reflect their impact on beneficiary well-being and outcomes.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Senior Director of Regulatory Affairs Darryl M. Drevna at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,



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