AMERICA'S PHYSICIAN GROUPS

Memorandum To: APG Members

From: Susan Dentzer and APG Policy and Advocacy Team

Re: Medicare Advantage Advance Notice and APG Advocacy

Date: February 18, 2026

Dear APG Member:

We want to bring you up to date on APG's advocacy relative to the CMS Medicare Advantage (MA) Advance Notice for 2027 (see here).

Below, we list highlights of our response in three categories: I. Identification of core issues with the proposed regulation; II. APG's likely key requests, or "asks," in its comment letter to CMS, due Feb. 25; and III. An accounting of where, how, and with whom APG has lodged these requests so far.

I. Identification of core issues: APG has collected considerable input from members on the Medicare Advantage 2027 Advance Notice through one-on-one conversations as well as a focus group held on Feb. 12. From that process, APG has identified the real threat that – if policies put forward through the Advance Notice are implemented as proposed – they will decimate the delivery of value-based care through Medicare Advantage with concomitant deleterious effects on beneficiaries' health and outcomes.

There are two key features of the Advance Notice that will produce this result, as follows:

- A **projected Effective Growth Rate** (EGR) in Medicare Parts A and B spending in the Traditional Medicare program in 2027 of 4.97 percent. The EGR is the starting point from which the Centers for Medicare & Medicaid Services calculates per-beneficiary payment rates for Medicare Advantage plans.

  A core problem is that spending patterns in fee-for-service Medicare differ greatly from those in MA, because the two programs are fundamentally different. For example, at least several million Traditional Medicare enrollees are only enrolled in Part A, not Part B, and therefore spending totals do not reflect that they made any visits at all to physicians or other Part B clinicians, nor that they received any costly physician-administered drugs paid for under Part B. By contrast, an individual can only join an MA

plan if s/he is enrolled in both Parts A and B, so all MA spending reflects activity in both categories (inpatient hospitalization and outpatient physician care, inclusive of administration of very expensive physician-administered drugs).

The rate that the CMS actuaries have projected for the EGR in 2027 appears unrealistically low in several respects. For starters, the EGR projected for 2026 was 9.04 percent, based on the recent evidence at the time of rising utilization of health care services in both traditional Medicare and MA. It appears unlikely that this tide of rapidly growing utilization has receded to such a degree that the effective growth rate should have fallen since then by four percentage points, even with changes that CMS has cited, such as new payment methodology for skin substitutes that the agency believes will curb the explosive recent growth of spending in that category. Actuaries affiliated with APG members peg the spending growth rate in MA in 2027 as once again likely to be close to 9 percent. It is impracticable to believe that MA spending growth can be held to less than a 5 percent growth rate without serious negative effects on the care provided, and on beneficiaries' health.

Fortunately, it is typically the case that CMS increases the EGR number from the time that the Advance Notice is issued until the time the final CMS rate notice is issued. CMS also has time to gather more data from recent quarters to evaluate how spending growth has or has not increased. APG is now likely to advocate to CMS that the EGR be raised to reflect the decidedly faster spending growth expected in the MA program.

- A second major issue in the Advance Notice is **a suite of changes in risk adjustment** that will prove especially harmful to APG member organizations caring for large numbers of patients with multiple chronic conditions, and particularly those dually eligible for Medicare and Medicaid. Coming on top of the third year of phase-in of the Version 28 risk adjustment program, the proposed changes would effectively slash the resources available for comprehensive primary care for these populations. They would make it difficult, if not impossible, to sustain infrastructure for case management, care coordination, and support of integrated care teams that include behavioral health providers and pharmacists, among other key interventions. As recently published literature demonstrates, APG members in two-sided risk relationships with MA plans have employed these approaches to achieve superior health outcomes for both the MA and Traditional beneficiaries in their care.

  The proposed changes in risk adjustment are complex and lie in multiple key domains, as follows:

  - A downgrading of risk adjustment factors for at least four of the most prevalent chronic conditions, including heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and morbid obesity. The affected risk factors relate mainly to primary care provided to individuals with these conditions. At the same time, risk adjustment factors have been increased for rarer conditions,

such as multiple myeloma and other cancers.

- A similar upgrading of risk adjustment factors for individuals with the highly prevalent chronic conditions cited above **when these conditions worsen and patients are more likely to be treated in hospitals.** This change appears to reflect rising hospital expenditures in traditional Medicare.

- A downgrading of risk adjustment factors related to patients' demographic status, such as age, sex, disability status, and dually-eligible and institutionalization status, which effectively has twice the negative impact on the dually-eligible population versus non-duals; of factors related to disease interactions among patients with multiple conditions and the clinical complexity required to treat them; and of factors related to the sheer number of diagnoses that a given patient has. Risk adjustment factors for patients with five to nine conditions in particular take an even greater hit.

- A concomitant upgrading of risk adjustment factors for diagnoses related to skin conditions, an anomaly apparently driven by the fact that spending in traditional Medicare has soared due to the use of costly skin substitutes – much of the use of which has been wasteful, fraudulent, or abusive.

  Taken together, these risk adjustment changes amount to a strange and unwelcome set of penalties for organizations seeking to manage patients' multiple chronic conditions when they are present, but not as far advanced as they might become, without the intense case management, care coordination, and other interventions needed to keep them relatively healthier and out of hospital emergency departments and inpatient units. By contrast, the rewards inherent in the proposed risk adjustment changes would increase as patients become sicker and end up in hospitals. A standalone hospital or health system in MA might benefit from this calculus, but since multiple AGP groups are at risk for these hospital expenditures as well, they will be hit from both sides: less money coming in the door to manage patients' primary care needs, and more money going out the door when patients inevitably become sicker and end up in hospitals.

II. APG's Core "Asks:"

These and other aspects of the Advance Notice could prove to be sufficiently harmful to APG member groups – and by extension, to their patients – that APG will ask CMS to put many of them on hold rather than incorporating them into the final rate notice due in April. The health care ecosystem related to Medicare Advantage is only now stabilizing as the phase-in of the version 28 risk adjustment model is now in its third and final year. Until further analysis can be done and more input received from stakeholders about the impact of additional risk adjustment changes, it is best to **do no further harm** to this delicate ecosystem. It would be far

better to take time to evolve, study, and test new risk adjustment models that drive toward the goal of enhancing value-based care, not undermining it.

There are additional aspects of the Advance Notice that also pose some problems for APG members, but that could be rectified with modifications, as described below.

- One is a proposed new requirement that all diagnoses captured in chart reviews for the purposes of risk adjustment be linked to evidence in health plan encounter data that care was provided for these diagnoses. The proposed change appears to stem from concerns that chart reviews conducted by health plans result in coded diagnoses for the purposes of risk adjustment without evidence that care is actually provided to match these diagnoses. APG believes that a requirement of linkage between coded diagnoses and care in encounter data makes sense in the abstract, but there are multiple logistical and other issues inherent in assuring that all providers and MA plans can fulfill its terms. With a one-year to two-year phase in, organizations would have time to make certain that legitimate diagnoses and records of care evident in electronic health records – for example, by sub-capitated specialists that may be operating on different EHRs than their capitated provider partners – find their way into these health plan reports shared with CMS. Similarly, medical groups and health plans will need time to catch up when a person with preexisting medical conditions becomes newly enrolled with an MA plan, a chart review is undertaken, care is provided and the health plan's encounter data on that patient is complete. APG is likely to make these points in its comment letter to CMS.

- Another aspect of the Advance Notice that is at first glance problematic, but that could be acceptable with certain guardrails attached to it, relates to a proposed plan to discount for risk adjustment purposes any diagnoses that are made on the basis of an audio-only telehealth visit. Although it is well understood that, for many conditions, either a video telehealth visit or an actual in-person visit is necessary, many MA enrollees in areas with low internet connectivity or who lack the requisite technology for a video visit still rely heavily on their phones for consultations with clinicians. A reasonable compromise would be to require in-person visits for recording initial diagnoses for the purposes of risk adjustment, but to allow reconfirmation of those diagnoses subsequently through an audio telehealth visit. APG is also likely to make these points in its comment letter to CMS.

III. How APG Has Undertaken Its Advocacy

In the past week, APG pursued two major routes to consult with policymakers about its concerns with the Advance Notice.

First, multiple members of APG's Board of Directors held virtual meetings with key congressional staff from both parties on committees with jurisdiction over Medicare Advantage, as well as with staff of lawmakers who have been especially active on MA-related

issues. All congressional staff with whom our board members met were very interested in our analysis. It is typically the case that these staff members then advise the lawmakers with whom they work of our views, and both lawmakers and staff are likely to hold discussions with CMS staff as a result. CMS has full authority to conduct rulemaking and Congress cannot override it, but congressional influence can be helpful in nudging CMS to take certain steps and reach somewhat different conclusions than those in its initial proposals.

Second, and even more important, several APG Board members and key APG staff held a virtual meeting with roughly ten CMS staff who work directly with the Center for Medicare that will oversee and produce the final rate notice by April 6, 2026. They also listened closely to our concerns and welcomed our recommendations. Subsequent discussions with other organizations underscored that many health plans and provider groups within the MA ecosystem have nearly identical concerns and are advocating strongly that they be addressed.

We once again invite members who want to raise additional issues to get in contact with us directly, and to send us any analyses they have done on the likely impact on their operations of the Advance Notice changes or to schedule a time to speak with our policy and advocacy team. Please email me directly at sdentzer@apg.org and cc your email to jcallahan@apg.org.

Thank you for your support as we seek to make APG members' voices heard at this critically important time.

Kind regards,

Susan Dentzer and Team

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