AMERICA'S PHYSICIAN GROUPS

February 23, 2026

Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/document/CMS-2026-0034-0001

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-2026-0034)

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to 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. APG welcomes your agency's openness to stakeholder input and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposals, (III) a summary of APG's recommendations, (IV) our fuller comments and recommendations, and then (IV) our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Medicare beneficiaries have consistently accessible, high-quality, equitable, person-centered health care. This commitment pertains to all Medicare beneficiaries, regardless of whether they receive their benefits through the traditional, fee-for-service program or through a Medicare Advantage or Medicare Prescription Drug Benefit Program plan.

I. About America's Physician Groups

APG is a national association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and capitated and delegated relationships with Medicare Advantage (MA) health plans. APG members collectively employ or contract with approximately 270,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including an estimated 1 in 4 Americans and 1 in 3 MA enrollees.

APG's motto, "Taking Responsibility for America's Health," underscores these physician groups'

preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, multidisciplinary, team-based care; make investments in innovations in care delivery, including case management and care coordination; advance health equity; and manage our populations of patients in more constructive and accountable ways than if our members were merely compensated for the units of service that they provide.

II. CMS's Advance Notice

CMS's MA Advance Notice sets forth the agency's proposed policies for 2027 and provides an estimate of how these policies will interact with market trends to affect MA plans' expected change in revenue. This projection differs from payment updates that other Medicare providers receive each year, in that it reflects an average change in revenue across MA plans with a range of experience around that average and is the product of multiple factors that contribute to MA plans' revenue.

CMS projects that the average revenue across MA plans will be 0.09 percent greater in 2027 than in 2026. The agency arrives at this projection, in part, by estimating that on average plans' expected revenue will decrease by 4.85 percent due to proposed changes to how CMS calculates and pays for risk adjustment. The agency's projection also reflects an effective benchmark growth rate, which, per statute, reflects per capita spending for Medicare fee-for-service (FFS) beneficiaries of 4.97 percent.

The policy proposals included in the Advance Notice that are most germane to APG members include the following:

- **Effective growth rate:** CMS estimates the growth in MA benchmarks, largely by assessing the growth in Original Medicare per capita costs
- **HCC risk adjustment model:** CMS proposes to update the HCC risk adjustment model by incorporating more recent data and to exclude diagnoses from audio-only encounters and unlinked chart reviews.

III. Summary of APG's Recommendations [will update to reflect final versions in body]

A. Recommendation related to estimate of effective growth rate

- **APG recommends that CMS reflect expected higher spending growth in more recent utilization data when calculating the final effective growth rate for the MA Rate Announcement.**

B. Recommendations related to risk adjustment

- **APG recommends that CMS delay adoption of the proposed change to calibrate the HCC risk adjustment model using more recent underlying Original Medicare data (updated from 2018 diagnoses and 2019 expenditures to 2023 diagnoses and 2024 expenditures) until the agency provides detailed information about the effects of the v28 phase-in and the proposed calibration approach in a transparent manner in advance of the 2028 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the**

new model version before it is implemented.

- **APG recommends that CMS phase in over one to two years the implementation of the proposed policy to exclude diagnoses from unlinked chart review records from risk score calculation. In such a phase-in, for example, MA plans could be permitted a decreasing share of unlinked chart review records for one to two years before the requirement that 100 percent of such records be linked to specific evidence of care provided in health plan encounter data takes effect.**

- **APG recommends that CMS modify the proposal to exclude diagnoses from audio-only telehealth visits from risk score calculation by requiring in-person visits or audio-video telehealth visits for recording initial diagnoses for the purposes of risk adjustment, but to allow reconfirmation of those diagnoses subsequently through an audio-only telehealth visit.**

IV. APG's Detailed Comments and Recommendations

APG appreciates CMS's ongoing efforts to update MA payment rates and other technical aspects of the program to keep these up-to-date and accurate. The agency clearly strives to be a responsible steward of the Medicare Trust Funds while improving the MA program for the growing number of beneficiaries who choose this enrollment option.

Below, APG offers comments on proposed policies in these two areas: (A) the effective growth rate; and (B) the HCC risk adjustment model.

A. Effective Growth Rate

CMS projects that the effective growth rate in 2027 that reflects the current estimate of the growth in benchmarks used to determine payment for MA plans will be 4.97 percent. This growth rate is largely driven by the growth in Original Medicare per capita costs, as estimated by the Office of the Actuary.

APG notes that a core problem to CMS's statutorily mandated method for setting MA benchmarks and estimating the effective growth rate is that spending patterns in fee-for-service Medicare differ greatly from those in MA, because the two programs are fundamentally different. For example, nearly 17 percent of Original Medicare enrollees were only enrolled in Part A in 2023, 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.[1,2] The Medicare Payment Advisory Commission (MedPAC) has recommended that CMS include only those Medicare beneficiaries enrolled in both Part A and Part B in benchmark calculations.[3] In contrast to CMS's benchmark calculation approach, 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-

[1] https://www.kff.org/medicare/how-medicare-pays-medicare-advantage-plans-issues-and-policy-options/#:~:text=In%20each%20U.S.%20county%2C%20the,Part%20A%20and%20Part%20B.
[2] https://data.cms.gov/tools/medicare-enrollment-dashboard
[3] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf

administered drugs).

The CMS actuaries' projection for the effective growth rate in 2027 appears unrealistically low in several respects. For starters, the effective growth rate for 2026 was finalized at 9.04 percent based on evidence at the time of rising utilization of health care services in Original Medicare. 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 corresponding spending growth rate in MA as once again likely to be close to 9 percent in 2027. 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 based on the incorporation of more recent spending data, CMS increases the effective growth rate estimate from the time that the Advance Notice is issued until the time the final CMS Rate Announcement is issued. APG recognizes that CMS is constrained by statute to calculate MA benchmarks and the effective growth rate based on trends in per capita costs for beneficiaries in Original Medicare whose care is paid based on fee-for-service rates. APG requests that CMS reflect what is broadly anticipated to be higher spending growth in more recent utilization data when calculating the final effective growth rate for the MA Rate Announcement.

In summary:

- **APG recommends that CMS reflect expected higher spending growth in more recent utilization data when calculating the final effective growth rate for the MA Rate Announcement.**

B. HCC Risk Adjustment

CMS notes the agency's commitment to the sustainability of the MA program. As the agency considers opportunities for improving risk adjustment both in the 2027 Advance Notice and in the future, CMS is working towards a MA risk adjustment system guided by three principles: (1) simplicity to reduce day-to-day administrative burden for both plans and providers; (2) competition on creating value for patients where risk adjustment facilitates such competition equally for all varieties of plans irrespective of size or resources; and (3) payments that accurately reflect beneficiary health risk and facilitate the efficient use of healthcare resources, enhanced program integrity, and greater accountability.

CMS proposes to update the Part C risk adjustment model by continuing to use version 28 (V28) of the clinical classification system first implemented in the 2024 risk adjustment model while calibrating the model using more recent underlying Original Medicare data (updated from 2018 diagnoses and 2019 expenditures to 2023 diagnoses and 2024 expenditures) to reflect more current costs associated with various diseases, conditions, and demographic characteristics. The proposed model also includes refinements to exclude diagnoses generated from audio-only encounters. In addition, CMS proposes to exclude diagnosis information from unlinked Chart Review Records (CRRs) – that is, diagnosis information not associated with a specific beneficiary encounter – from risk score calculation. MA organizations may continue to submit diagnoses using unlinked CRRs, however, those diagnoses will no longer be used for calculating risk scores.

As APG noted when CMS last proposed significant changes to the HCC risk adjustment model with the introduction of the v28 risk adjustment model, physicians engaged in the provision of care to MA beneficiaries are concerned about significant changes that ensue when CMS issues new versions of the HCC risk adjustment model. The potential or probable impact on patients and the physician groups that serve them cannot be well

understood or assessed during the 30-day comment period that follows publication of the MA Advance Notice. Because the v28 risk adjustment model first began to be phased in in 2024 – and is only fully in effect during the current 2026 calendar year – utilization data are only now becoming available for study that could reveal more extremely useful information about the real-world impact of these changes.

In addition, the impact of the phase-in of the new v28 risk adjustment model has differed across MA plans, providers, and patients in ways that are not yet well understood. Some physician groups report significant reductions in funding from risk adjustment changes that impact their ability to fund essential health services. Risk-adjusted payments ensure that plans and physicians have the resources needed to provide care to manage individuals' chronic conditions and prevent undesirable outcomes, including repeat hospitalizations that further undermine their health. Risk-adjusted payments fund such aspects of care as regular diabetic foot checks, provision of nutritious food to fit strict dietary standards, mental health evaluations and support, and other services that would be unaffordable without this financial support.

APG's analysis is that the final year of phase-in of v28, coupled with the proposed change to calibrate the model using more recent data, will prove especially harmful to APG member organizations caring for large numbers of patients with multiple chronic conditions, particularly those dually eligible for Medicare and Medicaid. The proposed changes in risk adjustment 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 Original Medicare beneficiaries in their care.[4]

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

- A downgrading of risk adjustment coefficients 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 diagnoses relate mainly to primary care provided to individuals with these conditions. At the same time, risk adjustment coefficients have been increased for rarer conditions, such as multiple myeloma and other cancers.

- A similar upgrading of risk adjustment coefficients 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 coefficients 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 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 Original 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

[4] https://www.apg.org/wp-content/uploads/2025/10/APG-Data-Project-Studies.pdf

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 APG 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.

APG expects that these proposed changes to the HCC risk adjustment model coefficients could prove to be sufficiently harmful to APG member groups – and by extension, to their patients – that APG asks CMS to put them on hold rather than incorporating them into the final rate notice due in April. The health care ecosystem related to MA 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.

APG strongly encourages CMS to provide detailed information about the proposed approach in a transparent manner, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented. Furthermore, APG asks that CMS begin sharing this information as soon as it is available rather than waiting for next year's Advance Notice so that stakeholders have time to review the planned changes and provide informed feedback in advance of implementation of another sweeping change in risk adjustment.

In summary:

- **APG recommends that CMS delay adoption of the proposed change to calibrate the HCC risk adjustment model using more recent underlying Original Medicare data (updated from 2018 diagnoses and 2019 expenditures to 2023 diagnoses and 2024 expenditures) until the agency provides detailed information about the effects of the v28 phase-in and the proposed calibration approach in a transparent manner in advance of the 2028 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented.**

As noted above, CMS also proposes refinements to the HCC risk adjustment model to exclude diagnoses from audio-only encounters and from unlinked Chart Review Records (CRRs) – diagnosis information not associated with a specific beneficiary encounter – from risk score calculation. MA organizations may continue to submit diagnoses using unlinked CRRs, however, those diagnoses will no longer be used for calculating risk scores.

APG believes that a requirement of linkage between diagnoses incorporate from CRRs 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 these 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 (EHRs) – for example, by sub-capitated specialists who may be operating on different EHRs than their capitated provider partners or other health systems, such as the Veterans Health Administration

– 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.

In summary:

- **APG recommends that CMS phase in over one to two years the implementation of the proposed policy to exclude diagnoses from unlinked chart review records from risk score calculation. In such a phase-in, for example, MA plans could be permitted a decreasing share of unlinked chart review records for one to two years before the requirement that 100 percent of such records be linked to specific evidence of care provided in health plan encounter data takes effect.**

APG notes that the proposal to exclude from risk adjustment factors any diagnoses from audio-only telehealth visits could be acceptable if certain guardrails are added. 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. APG proposes that a reasonable compromise would be to require in-person visits or audio-video telehealth visits for recording initial diagnoses for the purposes of risk adjustment, but to allow reconfirmation of those diagnoses subsequently through an audio-only telehealth visit.

In summary:

- **APG recommends that CMS modify the proposal to exclude diagnoses from audio-only telehealth visits from risk score calculation by requiring in-person visits or audio-video telehealth visits for recording initial diagnoses for the purposes of risk adjustment, but to allow reconfirmation of those diagnoses subsequently through an audio-only telehealth visit.**

V. Conclusion

APG appreciates and welcomes CMS's proposed policies in this Advance Notice and supports the agency's ongoing efforts to ensure that payment rates and other technical aspects of the MA and Part D programs are up-to-date and accurate. APG encourages CMS to consider the modifications to the proposed policies described in this letter to further refine them and help to avoid unintended consequences that could harm MA and impede the delivery of optimal care to patients.

Sincerely,

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