January 26, 2025

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-2025-1393-0002

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P)

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the proposed rule from the Centers for Medicare & Medicaid Services (CMS) on Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. APG welcomes your agency's openness to stakeholder input and 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 these comments and recommendations 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 (MA) plan.

I. About America's Physician Groups

APG is a national association representing approximately 340 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 health plans in MA. APG members collectively employ or contract with approximately 260,000 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.

Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by plans on a fee-for-service basis. Delegation of risk from all payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in

care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS's Proposed Rule

CMS's proposed rule aims to improve quality and access to care for people enrolled in MA and Part D programs by proposing updates to MA and Part D Star Ratings quality measurements and streamlining certain enrollment processes. In addition, CMS is seeking public feedback on the future direction of MA that would inform actions on maximizing the value of the MA program for beneficiaries and taxpayers, driving innovation in care models as well as benefit designs, and producing improved health outcomes for beneficiaries.

III. Summary of APG's Recommendations

A. Recommendations Related to MA Star Ratings

- **APG recommends that CMS finalize the policies to remove 12 measures focused on administrative processes and areas where beneficiaries cannot distinguish performance between plans due to high performance and little variation, while adding a new Part C Depression Screening and Follow-Up measure.**

IV. APG's Detailed Comments and Recommendations

CMS advances multiple proposals to improve the functioning of the MA and Part D programs in the proposed rule. APG provides feedback on key proposals regarding MA Star Ratings, as well as responses to multiple requests for information (RFI) that are particularly pertinent to our members.

A. MA Star Ratings

The MA Star Ratings system helps Medicare beneficiaries compare health and drug plan quality and determines Quality Bonus Payments and rebates for MA contracts, currently rating MA-PD contracts on up to 43 measures, MA-only contracts on up to 33 measures, and Part D plans on up to 12 measures across five categories: outcomes, intermediate outcomes, process, patient experience, and access.

CMS proposes two sets of major changes to the Part C and Part D Star Ratings system. First, CMS proposes not to implement the Excellent Health Outcomes for All reward (previously called the Health Equity Index reward) – which was designed to reward high measure-level scores for the subset of enrollees with specified social risk factors – from the 2027 Star Ratings, and CMS would return to the historical reward factor that encouraged consistently high performance across all quality measures. Second, CMS is proposing to streamline and refocus the measure set by removing for the 2027 and 2028 measurement year 12 measures focused on administrative processes and areas where beneficiaries cannot distinguish performance between plans due to high performance and little variation, while adding a new Part C Depression Screening and Follow-Up measure to address behavioral health gaps starting with the 2027 measurement year and 2029 Star Ratings.

CMS designed the proposed changes to refocus the program on clinical care, outcomes, and patient experience where there is meaningful variation in performance across contracts. The agency also seeks to reduce administrative burden on plans by removing operational and process measures that have achieved high performance with little variability, thus allowing plans to concentrate resources on areas that directly affect patient care and health outcomes.

APG welcomes CMS's MA Star Ratings proposals to remove 12 measures focused on administrative processes, and in areas in which beneficiaries cannot distinguish performance among plans due to the high-performance rates of plans and little variation among them. APG also welcomes CMS's proposal to add a new Part C Depression Screening and Follow-Up measure. APG continues to support CMS's overall strategy of establishing a core set of quality measures in the Universal Foundation to align quality measures across Medicare programs. APG members have concerns about the proliferation of clinical quality measurement that rely on process measures rather than outcome measures and applaud CMS efforts to rededicate to streamlining quality measurement.

- **APG recommends that CMS finalize the policies to remove 12 measures focused on administrative processes and areas where beneficiaries cannot distinguish performance between plans due to high performance and little variation, while adding a new Part C Depression Screening and Follow-Up measure.**

B. Requests for Information (RFIs)

CMS seeks stakeholder feedback through three comprehensive RFIs designed to strengthen the MA program and better serve dually eligible beneficiaries. The first RFI solicits input on measures to enhance competition among MA plans and making other improvements in the MA program, through changes in risk adjustment and the Quality Bonus Program. CMS recognizes that the current risk adjustment system may disadvantage smaller, newer, and less well-resourced plans and may encourage plans to prioritize investment in coding activities that could lead to MA plans coding more intensively than is the case in Original Medicare. CMS is exploring modernization opportunities including a next-generation risk adjustment model that could employ artificial intelligence and alternative data sources, as well as ways to streamline the quality measurement timeline and reduce the current two-year lag between measurement and payment.

The second RFI addresses the significant growth in chronic condition special needs plans (C-SNPs) enrollment, with particular concern about dually eligible individuals enrolling in these plans rather than dual eligible special needs plans (D-SNPs) that offer integrated Medicare-Medicaid benefits. CMS is exploring potential solutions including adopting a State Medicaid Agency Contract requirement for C-SNPs and/or institutional special needs plans (I-SNPs) with high concentrations of dually eligible individuals, like existing D-SNP requirements.

The third RFI is seeking public input on well-being and nutrition policy changes for future years. Specifically, the RFI is seeking comments on tools and policies that improve overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connection, purpose,

and fulfillment, in addition to tools that would achieve optimal nutrition and improve preventive care in Medicare Advantage, including possible incentives for MAOs to support beneficiaries seeking to improve their nutrition.

These RFIs reflect CMS's commitment to maximizing program value for beneficiaries and taxpayers while promoting integrated care for vulnerable populations. The RFIs seek comprehensive input from MA organizations, beneficiary advocates, healthcare providers, and industry experts to inform future policy decisions that could be implemented through regulatory changes or CMS Innovation Center models. The feedback will help guide the modernization of MA to ensure enhanced competition, improved health outcomes, and better coordination of care for the nation's most vulnerable Medicare beneficiaries.

1. Responses to CMS Request for Information on Future Directions in Medicare Advantage Risk Adjustment

CMS solicited feedback on options for risk adjustment, including "near-term changes to the existing risk adjustment methodology and entirely new approaches for risk adjustment, such as those that account for recent advances in technology. The agency sought ideas for additional data sources and data elements for risk adjustment, and for how those data sources should best be incorporated, particularly to minimize opportunities for gaming by MA organizations, incentivize positive health outcomes, and minimize administrative burden for plans and providers.

In particular, CMS sought ideas for risk adjustment approaches that do not rely on collection of diagnoses data and, instead, incorporate alternative factors to infer a patient's health risk as well as the severity of that risk. It cited a series of additional goals it sought in a revised risk adjustment program, including one that would ensure a level playing field for regional and smaller plans and reducing the manipulability of the RA system while rewarding effective treatment and favorable patient outcomes. It also sought specific comments on potential methods for improving the RA program, including moving to a risk adjustment model calibrated based on encounter data; using technologies such as AI and machine learning; and/or drawing on additional data sources beyond HCC coding.

Because the list of issues raised is extensive, APG has chosen to confine its comments mainly to a set of principles it hopes that CMS will follow in evaluating all these alternatives to the existing RA program. Multiple APG groups are in delegated, and often capitated, relationships with MA plans and participate actively in the RA activities themselves; thus, APG groups have a clear vested interest in reasonable reforms that will meaningfully improve the RA system, which we believe would best be achieved by following a list of core principles to devise these improvements, as enumerated below.

a. Previous APG Statements on MA Risk Adjustment

In the first quarter of 2025, APG issued a major report: *Medicare Done Right -- Prescriptions for Success: Reshaping an Essential Program for the 21st Century.*[1] In this report, APG recommended the following:

[1] Report is available at https://www.apg.org/wp-content/uploads/2025/04/Medicare-Done-Right-Final-4.1.25.pdf

i. Because risk adjustment is essential in risk-based models – not just within MA, but also within other alternative payment models with RA components – policymakers should develop and test new approaches that will better tie assessments of Medicare Advantage enrollees' health conditions with funding that reflects realistic costs of their care. Therefore, requisite steps in the near term should be taken as follows:
ii. Evaluation of the full effects of implementation of the current V28 risk adjustment model.
iii. Maintenance of robust federal audits of coding practices and data and continued enforcement actions in instances of fraud and abuse
iv. Preservation of the use of tools such as Health Risk Assessments and chart reviews under new guardrails.
v. Investment of federal time and resources in better understanding the actual resource use necessary to care appropriately for Medicare beneficiaries with various health conditions.

APG is aware that CMS is committed to item #1 above, and that it is making headway on item #iii above– the maintenance of robust federal audits in the context of the current RA system. However, to date, APG sees little overt sign that items #ii, iv, and v above have yet received adequate attention. APG would argue that, unless and until these activities are undertaken, future efforts to revise RA are not likely to result in positive change.

b. APG's Current Assessment of MA Risk Adjustment

Although the three-year phase in of the V28 model blunted the impact somewhat, it is generally understood that the move to the current risk adjustment model has resulted in substantial change in a relatively short time, as evident in the recently published analysis by key CMS officials suggesting a drastic compression of the coding differential between MA and traditional Medicare.[2] The pace and breadth of the change has produced considerable disruption to MA, causing contraction in the MA market; driving some medical groups out of business or pushing them out of full-risk MA arrangements with their plan partners; and resulting in historically low margins for MA plans. As a result, the appetite for taking on more MA risk has cooled considerably. MA plans have not had the inclination or bandwidth to consider more two-sided risk arrangements with physician partners; and physician groups without experience in full-risk MA arrangements see no reason – and indeed, every reason not to – engage in such models.

This situation is neither desirable nor sustainable. APG and many other participants in the market would argue that CMS adopted the V28 model with a poor understanding of the likely effects. What's more, APG is not aware that CMS has published any thorough analysis of these trends to learn from history and shed light on the dangers of making such changes without careful advance testing and broad input from sophisticated stakeholders. APG recognizes that this current RFI in fact reflects CMS's commitment to seeking input and open feedback, but the first major component – a robust analysis of what has occurred through V28 – is still missing.

These facts underscore the first core principle that APG would put forward in the context of this RFI: Do No Harm. Whatever CMS elects to do next in risk adjustment, no major reforms should be adopted without considerable advance testing of their practicality, feasibility, and workability, and clear evidence that they produce meaningful changes that clearly tie demonstrated realities of patients' conditions with actual costs of caring for such individuals and commensurate adjustments in payment rates to reflect these costs. Without such testing and modeling, there is no prospect that CMS will

[2] Albanese J, Aramanda A, Brooks J, Klomp C. An Updated Analysis of Coding Pattern Differences in Medicare Advantage, *Health Affairs Scholar*, 2026, qxag010, https://doi.org/10.1093/haschl/qxag010

achieve its stated goal in this RFI of "ensuring accurate payments for sicker beneficiaries, while rewarding effective treatment and favorable patient outcomes."

A related, second principle is that CMS must follow through on recommendation #2(d) in APG's Medicare Done Right report: that there must be "considerable investment of federal time and resources in understanding the actual resource use necessary to care appropriately for Medicare beneficiaries with various health conditions." To state the problem baldly, right now, what is known is what is being spent on these beneficiaries in the context of coding and claims amid rapidly rising utilization, and in what is still primarily a fee-for-service environment in terms of how most MA plans pay providers. That is a long way from understanding "the actual resource use necessary to care appropriately" for Medicare beneficiaries.

APG would point to its series of recently published articles about the superior results obtained for MA and traditional Medicare beneficiaries by APG physician groups with substantial experience in two-sided risk MA models. This research would constitute an appropriate starting point for understanding more appropriate levels of resource use for beneficiary populations, but CMS could, and should, build on this research by incentivizing further development of such models and studying the effects, among other components of necessary research.

As part of this research, CMS should devote attention to one drawback of the current RA system. Even though it is a prospective model designed to calculate RA-related payments going forward, it estimates the costs of caring for patients based on their past experience by linking enhanced payment to diagnoses already recorded, and after considerable monies have already been expended to provide care for ailing beneficiaries. Optimally, plans and providers should be incentivized from the moment individuals become enrolled in MA to expend substantial resources on both primary and secondary prevention and forestall exacerbations of illnesses such as diabetes and heart failure. CMS should develop a better understanding of the actual resources costs that should be made on such care from the moment beneficiaries become enrolled in MA and determine how best to channel these resources via RA to plans and there partnered medical groups in a timely way.

As the chief medical officer of one of our large members said in contemplating a response to the CMS RFI, "In the current state, you get paid later" for work that is already undertaken to improve patients' health status, and there is no mechanism to "true up" later for these actual costs. Prevention and secondary prevention are not cost-free; substantial effort and infrastructure costs are expended to preserve and maintain beneficiaries' health from the start of their enrollment and affiliation with a given provider group. As another chief medical officer put it, "Medicare Advantage should reward groups that can proactively prevents patients from getting sicker. That is the work that I want to do."

A corollary of this second principle is that, in the context of understanding the actual resource costs expended in caring for MA beneficiaries, CMS should pay special attention to the extremely high and growing costs of particular populations of patients – most notably those with various cancers and neurological conditions, given rapid changes in treatments and technologies. These costs will only grow with the aging population in MA, and APG members assert that the current RA structure does not adequately fund treatment of these groups of beneficiaries today, let alone in the future.

A related third principle that APG would put forward is that, in conceptualizing a new approach to risk adjustment, CMS should dispense with the terminology of "risk," even while recognizing that plans and many provider groups are indeed at insurance risk for costs. With respect to beneficiaries,

however, the appropriate terminology may be closer to "health status factor" – what is the state of a given beneficiary's health at the moment she/he/they become enrolled in MA, and what appropriate steps must be undertaken at that point forward to maintain and improve the beneficiary's health? With better knowledge of the actual resource costs inherent in caring for a beneficiary with a given set of initial health conditions, an initial "health status factor" rating could be assigned that would link an appropriate payment adjustment to that status. Subsequent ratings of the beneficiary's health status factor would then reflect, presumably, lower expenditures due to preservation and/or improvement of the beneficiary's health, or other expenditures as onset of other conditions – such as cancers or neurological conditions – occurred.

c. Applying These Principles to Future RA Changes

APG members as a whole possess no special expertise in the intricacies of the use of encounter data for calibrating a new RA model, nor in the use of a potential "inferred risk" model, nor in the use of AI and other technologies in these contexts. APG's next comments about these alternative methodologies will simply underscore why it would be important to apply the principles enumerated above as CMS weighs the evolution of RA.

APG is aware that CMS previously signaled the intention to calibrate the RA model with encounter data, and that the agency may be about to signal its further intentions in that vein in a forthcoming Advance Notice for changes in the model beginning in 2027. However, APG would caution against moving wholesale to such a new calibration methodology without substantial further research and evaluation of the likely program effects.

It is well known that there are multiple challenges with the encounter data collected by MA plans that do not offer great assurance that calibration based on such counter data would be an improvement from the existing calibration methodology. For example, as has been noted, "the generation of encounter data is as variable as MA plans' payment arrangements are with practitioners. Some payment arrangements rely on billing claims, while others, such as sub-capitated agreements, do not." [3] Encounter data sets also vary widely in the degree of completeness, as the Medicare Payment Advisory Commission has pointed out, with the degree of completeness [variable] across MA plans, contracts, and capitated arrangements," such that "certain types of payments and utilizations," including nursing home stays, "may not be captured in the encounter records at all." As a result, "MA data are likely incomplete in comparison with TM claims data, underestimating MA utilization among MA beneficiaries."[4] At the same time, use of encounter data would not eliminate concerns about upcoding in RA, since plans retain the incentive to "capture and report a maximum number of diagnosis codes for each beneficiary." [5]

APG is not aware of any published research stemming from a test run on a broad sample of MA plan encounter data that would illuminate the results that calibration of RA against such data would yield. Although it might be that a move to this new calibration model ultimately is feasible and appropriation, for now it would seem premature, if not foolish, to potentially replicate the mistakes of V28 by moving wholesale to such a revised calibration approach without sufficient research and

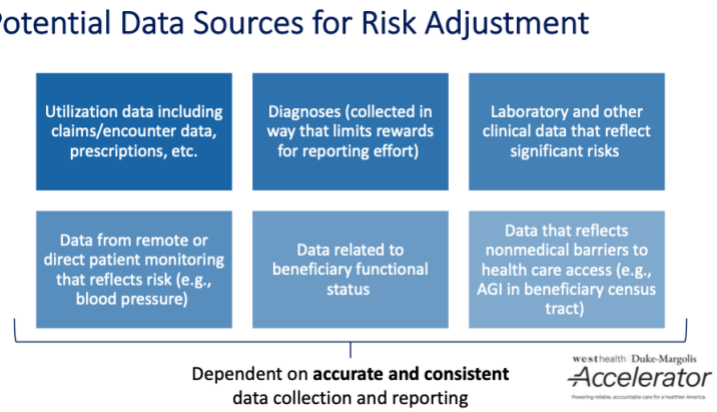
[3] Meyers, D., & Werner, R. (2025). Studying Medicare Advantage With Existing Data—Pitfalls, Challenges, and Opportunities. JAMA Network Open, 8(7), e2522833. https://doi.org/10.1001/jamanetworkopen.2025.22833
[4] Ibid.
[5] Ibid.

informed stakeholder input. Doing so would violate APG's first principle stated above: Do No Harm. APG would repeat its request that any changes and proposed moves to any new calibration model should be thoroughly studied in advance; the results of such studies released; and all stakeholders be afforded an opportunity to comment on any new model before it is adopted.

To build on APG's third principle – moving to an RA system that was better suited to assignment of a "health status factor" – APG offers these brief comments on use of other data sources and an "inferred risk" model, coupled with a better understanding of actual resource use costs for caring for patients with different conditions and their degree.

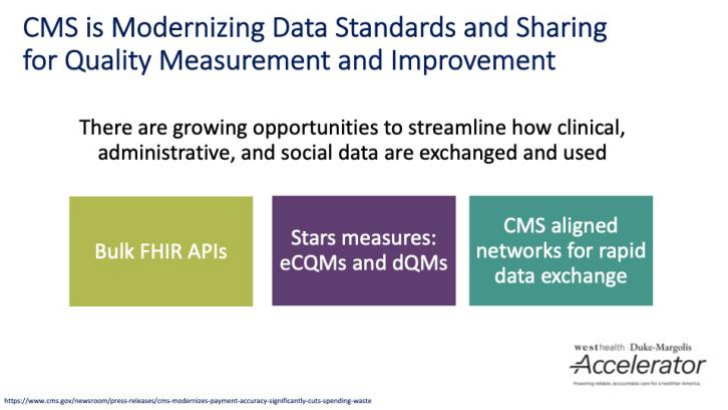
CMS must adopt a system that incorporates existing, but unused, data sources, as well as entirely new sources of data, to understand beneficiaries' actual health status. As has been noted, "the requisite data are available, and data science capabilities are sufficiently advanced, to infer diagnoses and associated risk scores for aggregate populations." [6] APG would posit, as have others, that such data sources extend vastly beyond claims and other retrospective sources of data, and these disparate data sources could well inform an inferred risk model.

For example, an analysis by the Duke-Margolis Institute for Health Policy and the WestHealth Institute depicts multiple data sources that could be incorporated into an inferred risk model, as the illustration below shows:



In addition, there are an increasing number of ways to collect such data, as CMS is already moving to do:

[6] Sutton A, Drapos G, Inferred Risk: Reforming Medicare Risk Scores To Create A Fairer System. Health Affairs Forefront, April 24, 2024, doi 10.1377/FOREFRONT.20240423.744938



If data were to be gathered automatically – for example, through APIs linked to electronic health records – there would be no need to have these data gathered exclusively by MA plans, as the data could be shared directly once gathered with plans and CMS alike. For each MA enrollee, an accountable clinician could be required to review and sign off on the fact that appropriate and accurate data had been gathered.

Once the data were collected, an AI-enabled system could then generate a "health status factor" score or series of scores, along with a predictive score of what could occur if these underlying "health status factors" were not addressed through primary or secondary prevention. These estimates would then be matched against new CMS-gathered estimates of the costs of caring for patients and thus generate a "health status factor adjusted" payment that would be transferred to an MA plan or plan-provider dyad immediately. Plans and providers would then have clear incentives to adopt the preventive strategies needed to preserve and improve beneficiaries' health status. One year later, the process would be repeated, providing additional data that would allow generation of a new "health status factor," as well as insights as to whether the care strategies employed succeeded in improving or preserving enrollees' health.

As Sutton and Drapos note in their article, a proposed system along these lines would most likely require less ongoing, day-to-day administrative investment than the current HCC coding system does now. It would also be less "gameable" by providers, and arguably easier to audit, as CMS would have equivalent access at all times to the data used to generate the health status factor scores.

The technical requirements for developing such a system would undoubtedly take several years to accomplish, and as per APG's first principle mentioned above, a new system would have to be tested extensively and refined as needed prior to mandatory widespread deployment. But assuming that it could be made to work satisfactorily, it would be so vastly superior to what exists now that it makes sense for CMS to announce a move in this direction immediately, along with a transparent multiyear timeline for testing, refinement, and full implementation.

2. APG Response to RFI Questions on Quality Bonus Payments in Medicare Advantage

CMS asked for information from stakeholders to inform future policy development and potential refinement to the Quality Bonus Payment (QBP) structure for MA plans. Among issues that it identified

were the timeline it takes to test, validate, and add a new measure to Parts C and D Star Ratings, and whether CMS should test an Innovation Center model that would delink QBPs from MA bids, "with the aim of further incentivizing health plans to improve quality and providing beneficiaries with more timely and actionable quality information."

APG member organizations are not MA plans, but almost all of them are either providers within MA plan networks or have delegated and frequently capitated payment arrangements with MA plans. Therefore, APG will comment from this perspective, and will restrict its comments to aspects of the QBP program that it believes have material impact on the operations of its member organizations.

As APG has repeatedly emphasized, and as CMS surely knows, Medicare Advantage is an ecosystem, of which MA plans are simply one part. The plans by and large do not provide health care themselves but rather contract with provider networks to deliver care to MA enrollees. Any aspects of CMS's plan-related payment policy thus flow through to providers in one way or another, from risk adjustment to the QBP program. Just as APG delineated some of the impact on recent changes in risk adjustment in the previous section of this comment letter, APG will now delineate some of the issues with the current QBP program that materially – and sometimes, deleteriously – affect providers in MA networks, such as APG members.

APG will not comment on the timing of QBP payments, but rather the structure and purpose of the Star Ratings, the links to QBP payments, and needed changes in these facets of the QBP program. APG will also confine its comments to the Part C Star Ratings, rather than to the Part D ratings.

APG has previously commented to CMS that quality should be assessed through a parsimonious list of "measures that matters," such as CMS has expressed through the Universal Foundation set of measures. APG continues to point to this recommendation and to urge CMS to undertake reforms of the Star Ratings measures. Not only are there too many measures in the program, but the Star Ratings are also overly focused on plan's business-related activities. As APG commented above, it is highly appropriate that CMS has proposed to winnow this list for 2027, removing 12 measures focused primarily on administrative processes and areas with limited variation across plans. Material financial impact from changes in Star Ratings flows through to provider groups in the context of payment pressure from plans, so it is highly appropriate that, as a first step, these extraneous administrative measures be eliminated.

To the degree that Star Ratings pertain to actual quality of care – an activity that lies more within providers' domain – it is appropriate that there be, in effect, joint risk between plans and providers in achieving robust quality metrics. Even so, with respect to the quality metrics inherent in the Stars program, there are too many measures insufficiently focused on outcomes that truly matter to patients.

Consider these realities of the current nine domains of the 40 separate MA Star Rating components: The single domains that focus on activities in which medical providers in plan networks can play a meaningful role, are those focused on appropriate screenings and management of chronic illness. As useful as these may be, even they focus too much on process – such as obtaining appropriate screenings, tests, and vaccines, or how well plans help members manage long-term illnesses – rather than outcomes that truly matter to patients. The other domains, assessing members' experience with their health plans based on CAHPS surveys; member disenrollment from plans and complaints; and health plan customer service, all pertain to plans' business operations and have little or nothing to do with the quality-of-care enrollees receive from their health care providers, let alone with enrollees' health outcomes.

APG is highly sympathetic with the views expressed in a recent *Health Affairs Forefront* analysis that described an alternative framework for MA Star Ratings.[7] The analysis proposed, first, narrowing the current list of Star Ratings measures to a "smaller set of clinically relevant population health and clinical outcome measures, as well as patient-reported experience measures," and employing these measures in Star Ratings at the plan level, rather than at the contract level. APG agrees that these are important objectives and notes that applying these measures at the plan level will reinforce the close connections and accountability that providers and plans must have to deliver on superior outcomes for MA enrollees.

The same analysis also pointed to another criticism of Star Ratings with which APG is highly sympathetic: that not all the Star Ratings measures "belong in a payment-linked system." The measures that reflect plan operations, such as prior authorization and marketing practices, can not only be gamed by Medicare Advantage organizations, but they also lie outside health care providers' control. But here again, to the degree that the QBP program does or does not create revenues for MAOs, the effects will flow through to provider organizations despite their lack of responsibility for, and influence over, these aspects of MA plan operations. Thus, it is time to move these health plan-business-related measures outside the Star Ratings and QBP program and create a separate "MA Transparency Scorecard" or similar arrangement that CMS can use to monitor plans' performance and share with MA enrollees, as the *Health Affairs Forefront* analysis proposes.

APG would offer two more comments about Star Ratings and QBP payments for CMS's consideration in the context of future policy changes.

First, as a general rule, APG groups have the perception that, when MAOs receive sizable or increased QBP payments, they do not share these equally with contracted medical groups, even if it is clear that these partners helped MAOs to achieve these quality metrics. Although CMS may have an expectation that health plans should, and do, "share the wealth," the fact is that they do not.

Second, APG wishes to underscore its objection to the proposal in the 2027 technical rule to eliminate the Excellent Health Outcomes for All reward (EHO4all or Health Equity Index reward), which was designed to reward improved measure-level scores for enrollees based on social risk factors. These social risk factors are real and have genuine impact on enrollees' health status and outcomes, and have great relevance in MA, given the overall demographics of MA enrollment and clear evidence from measures such as the Centers for Disease Control and Prevention's social vulnerability index that many MA enrollees live in these communities. It would be possible to recategorize this index and reward as a "Make America Healthy Again" reward and tie it more directly to stated MAHA objectives for health improvement, independent of factors such as race or ethnic minority status.

[7] Fowler E et al, Aligning The Stars: Modernizing Quality Incentives And Increasing Transparency In Medicare Advantage. Health Affairs Forefront, Jan. 22, 2026, at 10.1377/FOREFRONT.20260120.716125

3. APG Response to RFI Questions on Well-being and Nutrition in MA

Reflecting their commitment to value-based care, APG members have been at the forefront of using wellness and nutrition programs to achieve high-quality outcomes in population health management. Often these programs employ organizations' disease management teams, which include different types of clinicians in addition to physicians, nurse practitioners, and physician assistants, such as registered dieticians, pharmacists, and social workers. APG supports CMS's focus on the importance of nutrition and wellness for MA enrollees.

Original Medicare only covers Medical Nutrition Therapy (MNT) for beneficiaries with diabetes or renal disease, leaving significant gaps in access to nutrition care. The flexibility offered by MA's use of supplemental benefits, capitation, and risk-based payments, allows for the incorporation of nutrition counseling and other wellness services for a wide variety of conditions, such as pre-diabetes, diabetes, gestational diabetes, cardiovascular disease, cancer, eating disorders, hypertension, obesity, congestive heart failure, and others.

APG notes that nutrition screening using standardized tools and thoughtfully designed interventions are essential for nutrition and well-being services achieve desired outcomes. Suggested standardized tools to consider include: 1) the Mini-Nutritional Assessment Short Form and 2) Seniors in the Community Risk Evaluation for Eating and Nutrition. Best practices for incorporating in holistic nutrition care for seniors include the following:

- Individualized Nutrition Care: Delivered by registered dietitians, tailored to medical conditions and cultural preferences.
- Community-Based Programs: Access to congregate and home-delivered meals, social services, recreational activities, and health programs.
- Referral Networks: Robust options enhance long-term outcomes and support research opportunities.

V. Conclusion

APG appreciates and welcomes CMS's proposed policies in this proposed rule and supports the agency's ongoing efforts to ensure that the MA and Part D programs continue to evolve to better serve the needs of Medicare beneficiaries. APG looks forward to continuing to partner with CMS as the agency works on developing rulemaking and program details to support new efforts described in the RFIs.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups
sdentzer@apg.org