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Administrator Dr. Mehmet Oz
The Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

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

Administrator Oz:

On behalf of Better Medicare Alliance, we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2027 Medicare Advantage Advance Notice. As the leading advocacy organization dedicated to strengthening and protecting the Medicare Advantage program, Better Medicare Alliance represents a broad and diverse coalition of stakeholders united by a shared commitment to improving health outcomes, expanding access, and promoting affordability for seniors and people with disabilities.

Our coalition includes organizations and individuals with deep experience across the health care system and first-hand understanding of how Medicare Advantage delivers value to beneficiaries. Through this broad representation, we provide a unique, beneficiary-centered perspective on policy development and implementation.

Medicare Advantage currently serves more than half of all Medicare beneficiaries and plays a critical role in advancing CMS' strategic objectives related to quality, affordability, care coordination, and value-based care. The program delivers better health outcomes at a lower cost to beneficiaries than Fee-for-Service Medicare, with high levels of beneficiary satisfaction, improved access to coordinated care, and meaningful supplemental benefits that address gaps in traditional Medicare coverage. For millions of seniors—especially those living with chronic conditions, limited incomes, or social risk factors—Medicare Advantage plays a vital role in supporting their health, independence,

and financial stability.[1]

BMA is supportive of thoughtful program modernization and appreciates CMS' efforts to strengthen Medicare Advantage and enhance program integrity. Our organization has a long history of supporting updates to chart review policies that improve accuracy while ensuring beneficiaries continue to receive high quality- care. We urge CMS to move forward with the proposal to remove unlinked chart reviews, but to do so with appropriate guardrails to protect beneficiaries and ensure operational feasibility.

While supportive of modernization, we have concerns that the 2027 Medicare Advantage and Part D Advance Notice proposal does not adequately fund the program and will have significant impacts on beneficiaries. Primarily, CMS' proposal does not appropriately keep pace with rising costs and utilization. This lack of adequate funding could leave beneficiaries exposed to reduced benefits, higher costs, and plan closures that disrupt their care. Indeed, we are already seeing these impacts. For 2026, roughly 3 million seniors were forced to find new coverage due to Medicare Advantage plan closures or market exits — the direct result of recent policy and funding pressures on the program. At the same time, beneficiaries have faced an average $900 increase in out-of-pocket maximums over the past two years, while important health benefits such as transportation to medical appointments and nutrition support have been scaled back. Our comments focus on ensuring that the CY 2027 policy and payment environment reflects current cost realities, the complexity and acuity of the Medicare Advantage population, and supports continued access to affordability and supplemental benefits.

KFF research demonstrates that modest increases in cost sharing are associated with delayed or forgone care, particularly among beneficiaries in fair or poor health and those managing multiple chronic conditions. For individuals with limited income or high disease burden, these changes can have meaningful clinical consequences.[2]

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[1] Better Medicare Alliance, State of Medicare Advantage 2025, October 2025. Available here.
[2] Kaiser Family Foundation, Income and Assets of Medicare Beneficiaries in 2024, August 2025. Available here.

Unfortunately, CMS' 2027 AN growth rate projections underestimate trends in utilization and spending. BRG modeling commissioned by BMA demonstrates that even small deviations in the Effective Growth Rate have material payment consequences. For example, BRG estimates that if the Effective Growth Rate understates actual medical trend by a mere 1 percentage point, payments would decline by approximately $12 per member per month (PMPM), or $144 annually, creating financial pressure comparable to a payment cut. A 5 percentage point deviation would translate into approximately $63 PMPM, or $756 annually.[3]

Attached to this cover letter is Better Medicare Alliance's detailed policy analysis and recommendations regarding the CY 2027 Advance Notice. BMA is concerned that the proposed CY 2027 Effective Growth Rate and risk model updates, would materially undermine payment adequacy and introduce destabilizing volatility into the Medicare Advantage program.

CMS leaders have publicly stressed the need for stability and predictability for Medicare Advantage after years of policy disruption and inadequate payments - and we agree. However, we believe the Advance Notice has policy proposals that if not adjusted would be a step in the wrong direction for the 35 million beneficiaries who depend on Medicare Advantage. CMS should:

- **Growth Rate:** Reevaluate and revise the CY 2027 Effective Growth Rate to reflect current medical cost trends and utilization more accurately to preserve program stability and protect beneficiaries. BMA is concerned by CMS' proposal to reduce the growth rate from 9.04% to 4.97%. Such a substantial downward adjustment requires a clear and transparent rationale, including the underlying assumptions about utilization patterns and health care cost trends, which has not been provided.

[3] Berkely Research Group, 2027 Medicare Advantage Advance Notice Analysis, February 2026. Independent commissioned report prepared for Better Medicare Alliance.

- **Risk Adjustment Model:** Delay full implementation of the revised risk model to allow for reevaluation of anomalous spending patterns, particularly those associated with 2024 skin substitute utilization. If CMS proceeds with implementation after reviewing the risk model, BMA recommends a phase-in of the model revision to address any one-year anomalies.

We respectfully urge CMS to carefully evaluate the cumulative impact of the proposed changes and to adopt policies that sustain Medicare Advantage's ability to deliver high-quality, affordable, and accessible coverage for seniors.

We appreciate CMS' continued engagement with stakeholders. We welcome the opportunity for ongoing dialogue to protect and strengthen Medicare Advantage for the long-term success of the program for seniors and people living with disabilities.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

cc: Chris Klomp, Chief Counselor, HHS, Director of Medicare and Deputy Administrator, CMS
John Brooks, Senior Counselor, HHS, Chief Policy and Regulatory Officer and Deputy Administrator, CMS
Alec Aramanda, Principal Deputy Director, CMS
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Stephanie Carlton, Chief of Staff, and Deputy Administrator, CMS
Theo Merkel, Special Assistant to the President for Domestic Policy, White House

ATTACHMENT
Better Medicare Alliance (BMA) Comments and Recommendations on Proposed Policy Changes

I.

- **Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2027**

2027 Growth Percentage Estimates

CMS is proposing a 4.97% Effective Growth Rate. The Effective Growth Rate reflects the current estimate of the growth of the payment benchmarks used in the Medicare Advantage program and is largely determined by projected growth in Fee-for-Service (FFS) Medicare per capita costs.

BMA Comments

National Health Expenditure Accounts (NHEA) data published by the Centers for Medicare & Medicaid Services demonstrate sustained health care cost growth that exceeds long-term pre-pandemic norms and may not be fully reflected in the proposed CY 2027 Effective Growth Rate. Total national health spending grew approximately 7.2 percent in 2024, reaching an estimated $5.3 trillion. Growth was driven in significant part by continued increases in hospital care (approximately $1.6 trillion) and physician and clinical services (approximately $1.1 trillion), which together account for more than half of total health expenditures.[4]

In addition, retail prescription drug spending continued to rise and now represents nearly nine percent of total health spending, reflecting expanded adoption of specialty and high-cost therapies. Medicare spending trends similarly reflect continued per-enrollee growth.

[4] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Accounts (NHEA) Summary and Infographic Materials. Available here.

These objective CMS expenditure data indicate that persistent medical inflation, elevated utilization, provider labor cost pressures, and growth in high-cost therapies continue to drive expenditures above historical averages. Accordingly, we are concerned that the proposed CY 2027 Effective Growth Rate may severely underestimate the underlying cost trends facing Medicare Advantage organizations.

If CMS underestimates the growth rate, Medicare Advantage plans would experience an effective payment cut. For example, for every 1-percentage-point the 2027 EGR is set too low, total plan payments would decrease by roughly $12 PMPM (about $144 annually), and a 5-percentage-point understatement would reduce payments by approximately $63 PMPM (about $756 annually).[5]

Under the proposed Effective Growth Rate, benchmark growth falls materially short of projected cost growth. Absent an upward adjustment, plans are likely to face a structural gap between revenue and expected medical expenditures.

Because Medicare Advantage operates within a competitively bid framework, this gap will translate directly into benefit reductions, increased cost sharing, and constrained plan offerings.

Specifically, insufficient benchmark growth is likely to result in:

- Reductions in supplemental benefit offerings, including dental, vision, hearing, transportation, and over-the-counter allowances that support the upstream prevention and management of chronic conditions
- Increases in beneficiary cost sharing and higher maximum out-of-pocket limits.
- Narrower provider networks and reduced access to specialty care.
- Contraction in plan availability, particularly in rural and underserved markets.
- Declines in the availability of zero-premium plan options.

[5] Berkely Research Group, 2027 Medicare Advantage Advance Notice Analysis, February 2026. Independent commissioned report prepared for Better Medicare Alliance.

These outcomes would materially affect beneficiary access, affordability, and continuity of care, undermining the stability and predictability that are foundational to Medicare Advantage's success. As KFF research demonstrates, beneficiaries are highly sensitive to increases in cost sharing and reductions in benefit generosity. Higher out-of-pocket costs are associated with delayed or forgone care, particularly among beneficiaries in fair or poor health and those managing chronic conditions.[6]

This structural feature underscores the importance of calibrating the Effective Growth Rate to reflect realistic cost trends, particularly in periods of heightened medical inflation and utilization growth.

It is also important to note that mix intensity, utilization, and chronic disease prevalence within the Medicare Advantage population has increased materially over the past five years.[7] These shifts include:

- Increased prevalence of chronic conditions such as diabetes, congestive heart failure, chronic kidney disease, and chronic obstructive pulmonary disease.
- Growth in dual-eligible enrollment, with associated increases in care complexity and social support needs.
- Greater utilization of behavioral health services, home-based care, and post-acute services.
- Rising prescription drug utilization, particularly specialty pharmaceuticals.

The current modeling framework does not appear to fully incorporate these changes. Failure to account for updated population characteristics risks systematic underestimation of plan costs, resulting in benchmark inadequacy and payment misalignment.

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[6] Kaiser Family Foundation, Income and Assets of Medicare Beneficiaries in 2024, August 2025. Available here.
[7] Kaiser Family Foundation, Medicare Advantage in 2024: Enrollment Update and Key Trends, August 2024. Available here.

KFF research further confirms that Medicare Advantage increasingly serves beneficiaries with multiple chronic conditions, disabilities, and dual eligibility status.[8] These vulnerable populations exhibit higher utilization rates, increased care coordination needs, and greater reliance on supplemental benefits.

BMA Recommendations

To preserve payment adequacy, program stability, and beneficiary protections, Better Medicare Alliance respectfully recommends that CMS:

1. Reevaluate and revise the CY 2027 Effective Growth Rate to reflect current medical cost trends and utilization growth more accurately.
2. Update beneficiary mix and utilization modeling assumptions to reflect contemporary demographic and clinical characteristics.
3. Add Third and Fourth Quarter data
4. Not implement the risk model changes proposed in this Advance Notice for 2027 and instead initiate notice comment and rulemaking for risk model changes in future years. If CMS decides to finalize the proposed risk model changes for 2027, we recommend they be phased in over multiple years to mitigate payment volatility to plans and value-based care providers and avoid beneficiary disruption.
5. Ensure assumptions forward looking assumptions appropriately reflect increasing costs and utilization.
6. Promote methodological transparency and policy predictability to enable long-term investments in quality improvement, care coordination, and value-based care delivery.

II.
Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2027

[8] Kaiser Family Foundation, Medicare Advantage in 2024: Enrollment Update and Key Trends, August 2024. Available here.

- **CMS-HCC Risk Adjustment Model for CY 2027 – Risk Adjustment Model Development Using Medicare Advantage Encounter Data**

CMS proposes to update the CMS-HCC risk adjustment model for CY 2027 while continuing to use Version 28 of the clinical classification system. The updated model incorporates 2023 diagnosis data projected to 2024 expenditures and updates the denominator year to 2024.

BMA Comments

BMA notes that there are concerns with the current changes, specifically several HCCs with higher coefficients in the revised model appear to be influenced by 2024 skin substitute spending patterns and subsequently create concern regarding actuarial equivalency and beneficiary impact.

As CMS evaluates the proposed CY 2027 CMS-HCC recalibration, we urge CMS' consideration of how unusually elevated 2024 skin substitute spending may affect the relative valuation of beneficiaries with ongoing chronic health needs.

The CMS-HCC model is designed to predict expected Medicare spending by assigning relative weights to health conditions and demographic characteristics. By design, the model must match total observed Fee-for-Service spending in the data year used for calibration. This means that when spending in one category increases, the model necessarily adjusts other coefficients downward to maintain balance.[9]

Between 2019 and 2024, CMS data show that skin substitute spending increased dramatically, rising from approximately $256 million to approximately $10 billion.[10] Because the proposed 2027 recalibration relies on 2024 data, this rapid growth has a direct influence on how relative weights are calculated. As a result, the benchmark component assumes that Fee-for-Service spending has been corrected for skin

[9] Kornfield, T, Observations on the CY 2027 Advance Notice and Implications for HCC Recalibration, February 2026. Available here.
[10] HHS Office of Inspector General, Review of Skin Substitute Spending in Medicare, 2024. Available here.

substitute overutilization, while the risk adjustment component continues to reflect historical, elevated spending levels.

Because the CMS-HCC model is normalized, this issue does not only affect skin-related factors. Elevated spending in one category influences the relative weights assigned across other HCCs as well.

This creates a potential internal inconsistency within the payment framework, as one component reflects the updated policy environment while the other reflects pre-reform spending patterns. When a single category grows at that magnitude, the model must offset the increase by reducing relative weights elsewhere. As a result, conditions unrelated to skin substitutes may receive comparatively lower coefficients than they otherwise would, even if the underlying clinical needs of those beneficiaries have not changed.

Independent analysis conducted by BRG further estimates that the proposed CY 2027 CMS-HCC risk model changes—excluding the elimination of unlinked chart reviews—would reduce total payments to Medicare Advantage plans by approximately $27 PMPM, or $324 annually, relative to current methodology.[11] When combined with benchmark pressures, these changes represent a material reduction in plan funding that may affect benefit design, plan participation, and beneficiary affordability.

As such, we urge CMS to review this alignment to ensure consistency across payment components and support actuarial soundness in the CY 2027 model

For beneficiaries living with chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, diabetes with complications, depression, or vascular disease, risk scores are critical to ensuring that plans receive appropriate resources to support care coordination, medication management, and preventive interventions. These beneficiaries often require sustained primary care

[11] Berkely Research Group, 2027 Medicare Advantage Advance Notice Analysis, February 2026. Independent commissioned report prepared for Better Medicare Alliance.

engagement, behavioral health integration, and specialty coordination to avoid hospitalizations and complications.

If the relative valuation of these chronic conditions is compressed due to temporary spending anomalies in an unrelated category, plans may face financial pressure that affects the stability of benefits and care management programs designed for medically complex individuals.

We strongly encourage CMS to consider whether the use of 2024 data appropriately reflects long-term beneficiary needs and whether additional analysis may be warranted to ensure that the model continues to accurately support beneficiaries with chronic disease, multiple comorbidities, and social risk factors.

Preserving stable and accurate valuation of chronic conditions is essential to sustaining prevention-oriented, value-based care models that help keep high-need beneficiaries healthy and in their communities.

Dual-eligible beneficiaries and individuals with multiple chronic conditions have high prevalence of chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, diabetes with complications, major depressive disorder, substance use disorders, and vascular disease.[12] These conditions require sustained primary care engagement, medication management, behavioral health integration, and coordinated specialty care.

Ensuring that recalibration accurately reflects durable clinical complexity is critical to sustaining value-based, prevention-oriented care models serving medically complex populations.

BMA Recommendation

[12] Kaiser Family Foundation, Medicare Advantage in 2024: Enrollment Update and Key Trends, August 2024. Available here.

BMA recommends delaying full implementation of the revised risk model to allow for reevaluation of anomalous spending patterns, particularly those associated with 2024 skin substitute utilization. Immediate incorporation of these data into risk adjustment coefficients may introduce artificial volatility rather than reflect long-term cost trends.

If CMS finalizes the risk model changes for 2027, these must be phased-in to mitigate the impact on plans, providers, and patients. Phasing in risk adjustment changes over multiple years would distribute financial risk more evenly and allow plans to adjust benefit design, pricing, and care management strategies in a measured approach, avoiding major disruptions that will impact beneficiaries. This approach would enhance predictability and reduce the likelihood of abrupt market exits or benefit reductions, providing stability for the program and the millions of beneficiaries it serves.

- **Sources of Diagnoses for Risk Score Calculation**

CMS is proposing that diagnoses from unlinked chart review records are excluded from the calculation of risk scores for Part C beneficiaries.

BMA Comments

BMA supports CMS' proposal to remove unlinked chart reviews from risk adjustment calculations, provided appropriate guardrails are established.

Health plans use chart reviews as a systematic process to examine a beneficiary's medical records and ensure that documentation accurately reflects the beneficiary's clinical conditions and treatments. Chart reviews serve multiple functions that support program integrity, quality improvement, and beneficiary care.

Specifically, chart reviews support:

- Quality improvement initiatives.
- Care management and coordination activities.

- Provider engagement and education.
- Fraud, waste, and abuse (FWA) detection and prevention; and
- Compliance with CMS regulatory requirements.

As a condition of contracting with CMS, Medicare Advantage organizations are required to implement quality improvement programs and report on quality performance. Chart reviews enable plans to meet these obligations and support beneficiaries in accessing medically necessary services and achieving improved health outcomes.

For example, plans use chart reviews to:

- Ensure accurate and complete reporting for CMS oversight and Medicare Advantage Star Ratings.
- Validate achievement of quality metrics (e.g., blood pressure control and HbA1c testing).
- Assess the effectiveness of quality improvement interventions; and
- Verify provider adherence to clinical practice guidelines.

Chart reviews are also integral to care management. They help plans identify high-risk beneficiaries with unmet clinical needs that may not be apparent through claims or encounter data alone. Through chart review, plans may identify care gaps and facilitate targeted interventions, such as post-discharge outreach, referral to care or disease management programs, or enhanced coordination for beneficiaries with uncontrolled chronic conditions. These activities promote improved health outcomes and more efficient use of Medicare resources.

In addition, Medicare Advantage organizations have obligations to ensure payment integrity and prevent, detect, and correct potential FWA. Plans must maintain compliance programs consistent with federal laws and regulations and participate in CMS payment integrity initiatives. As part of these responsibilities, plans use chart reviews to verify that diagnoses, treatments, and documentation are consistent with

provider claims. During this process, plans may confirm, add, or remove diagnoses to ensure the medical record accurately reflects the beneficiary's condition.

BMA Recommendations

BMA supports CMS' proposal to remove unlinked chart reviews from risk adjustment calculations, provided appropriate guardrails are established.

1. **Accommodation for New to Plan Enrollees, including Mid-Year Enrollees**

   CMS should permit the continued use of unlinked chart reviews for beneficiaries who newly enroll in a Medicare Advantage plan during the coverage year. Plans frequently lack historical encounter data for these individuals, and chart reviews may be the only mechanism available to ensure accurate and complete diagnosis capture during the transition period. Absent this flexibility, risk scores for new enrollees may not reflect their clinical complexity, potentially disrupting care coordination, and payment accuracy.

2. **Operational Transition for Rendering and Billing Providers**

   CMS should address operational challenges related to the distinction between rendering and billing providers. This distinction can create barriers to linking chart review findings to encounter submissions. Providers will require sufficient time to modify billing practices, contractual arrangements, and information systems to ensure appropriate alignment. Immediate implementation without a transition period may result in incomplete or inaccurate diagnosis reporting and unintended program disruption.

3. **Interoperable Data Infrastructure**

   If CMS restricts the use of unlinked chart reviews, the agency should ensure that interoperable data solutions are available to support accurate and timely diagnosis capture. Without such infrastructure, plans may experience material data gaps that undermine risk score accuracy and payment alignment. Specifically, CMS should consider how the application programming interfaces (APIs) required under the

Interoperability and Prior Authorization Final Rule may be used to support this data capture and transfer. Since implementation of the API structure is not required until January 1, 2027, CMS permit exceptions for new to plan members until sufficient testing is performed to ensure the infrastructure supports the necessary transfer of data.

BMA appreciates CMS' continued focus on data integrity and program oversight and looks forward to working collaboratively to ensure that policy changes strengthen the Medicare Advantage program while preserving beneficiary access to high-quality, coordinated care.

Conclusion

Medicare Advantage is a cornerstone of the Medicare program and a primary source of affordable, coordinated coverage for millions of seniors and people with disabilities. Payment adequacy and methodological stability are essential to sustaining beneficiary access to plan choice and crucial benefits that provide affordable healthcare and help keep beneficiaries healthy.

We urge CMS to carefully evaluate the cumulative effects of the CY 2027 policy proposals and to adopt targeted modifications that preserve program stability while advancing the agency's goals related to quality, equity, and value.