January 26, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4212-P
Submitted electronically to: https://www.regulations.gov

RE: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage and Part D Programs Proposed Rule

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Contract Year (CY) 2027 Medicare Advantage (MA) Program Proposed Rule. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care (VBC) entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation to improve quality of care for patients and reduce health care costs. NAACOS represents more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, such as the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, and specialty care models, along with other alternative payment models (APMs). Beyond Medicare, our members participate in accountable care arrangements across payers, including Medicaid and MA programs.

We share the commitment to identifying overpayments, advancing health outcomes, and improving efficiency. Our comments reflect key recommendations from our members and our shared goal of driving accountable care in MA by enabling providers to innovate care.

Through risk-bearing arrangements, our member providers are accountable for costs and outcomes of MA beneficiaries. The proposed rule and subsequent requests for information (RFIs) carry substantial downstream implications for these providers who bear financial risk in MA. NAACOS supports the need for thoughtful updates to the risk adjustment model and Star Ratings program with appropriate guardrails and sufficient transition periods to ensure new approaches preserve meaningful incentives for providers in VBC arrangements, lessen provider burden, and avoid any payment cuts. We look forward to continuing collaborations with CMS to sustain and expand opportunities for providers to engage in accountable care in MA.

Star Ratings Measure Changes

CMS proposed to remove 12 MA Star Rating measures to reduce administratively burdensome measures in favor of measures that focus on clinical performance and meaningful patient experiences.

CMS should consider these principles when considering measures for inclusion in the Star Ratings:

- Measures that are targeted with aligned specifications across payers reduce administrative burden for VBC providers
- Including fewer measures also helps providers focus on clinical activities and performance that directly drive improvement in patient outcomes and quality of life
- Conversely, any amount of variation between and within metrics also causes compounding operational lift and reporting complexities – all of which can reduce the resources available for quality improvement initiatives.

Out of the 12 measures proposed for removal, **NAACOS opposes removal of "Plan Makes Timely Decisions about Appeals" and "Reviewing Appeals Decisions" measures without implementing robust prior authorization (PA) processes.** We recommend CMS continue to use these two measures that directly impact and address timely access to care, as these two measures are critical to maintaining foundational plan processes and operations. Removing these measures would make it difficult to find patterns regarding claims denials, as they inform effectiveness of prior authorization as a utilization management (UM) tool. Furthermore, removal of these measures could impact provider payments and negatively impact patients' access to appropriate and needed care.

NAACOS continues to support CMS in finding more streamlined and transparent approaches to PA, such as collecting detailed data from plan-level appeals that provide more information on UM and PA practices. Transparency in this process and creating standards for reporting will contribute to better care coordination and understanding of network access.

Furthermore, **NAACOS asks CMS to collect data, make information public, and create guardrails requiring MA plans to report all services (at the procedure level)** that require PA along with the indicated rates of denial, including:

- Total number of denials, successful overturns of denials to approvals, and any payment information,
- Total number of denials that stayed denied and received no payments for rendered services, and
- Timing of decision processes from denials and approvals, appeals and overturns, and decisions leading to payment.

As for evaluating topped out process measures, there are some novel ways and long-term options that CMS could consider such as creating a composite of these measures on access and operations, establishing predetermined cut points, or determining minimum performance thresholds that must be achieved to improve predictability. Ultimately, **NAACOS encourages CMS to understand the full impact of these changes when making decisions about removing or adding measures.**

Addition of Depression Screening and Follow-Up Measures to Star Ratings

CMS proposed adding Depression Screening and Follow-Up Measures to the Star Ratings program to address behavioral health gaps and assess outcomes.

Overall, NAACOS strongly supports creating greater measure alignment across plans and more consistency in measures tied to incentives across VBC arrangements. Stars and measurement changes provide opportunities for VBC providers and their payer partners to collaborate on targets, contracts, and incentives to reach their shared goals of increasing access to behavioral health providers. Variation in measure sets across payers, contracts, and models creates significant challenges for VBC providers and drives up administrative burden and infrastructure costs. Providers, payers, and programs must align on a unified set of expectations to support shared goals for patient care.

Before finalizing the inclusion of the Depression Screening and Follow-Up measure to Star Ratings, CMS must ensure that it is aligned to the greatest extent possible with QID 134, Preventive Care & Screening: Screening for Depression and Follow-Up Plan, which is currently used in the Merit-based Incentive Payment System (MIPS) and Medicare Shared Savings Program (MSSP).

Specifically, **CMS should identify the strongest attributes of each measure and establish a unified, standardized version that applies across programs to reduce provider burden.** There are several important points to consider for an aligned measure:

- Include features from the proposed Depression Screening and Follow-Up measure, such as a 30-day follow-up window, two reporting rates, and screening and follow-up requirements that are not tied to specific encounters.
- Allow the use of any digital data source, including both claims and clinical data. Relying solely on claims data leads to inaccurately low scores for many providers and requires additional administrative work to correct. Leveraging both claims-based and clinical data ensures a more accurate and complete picture of performance.
- Create the measure so that it recognizes validated screening tools directly, avoiding the need for additional clinical interpretation which can introduce inconsistency.
- Avoid duplicative requirements, such as re-screening patients already diagnosed with depression, which creates unnecessary work and frustration for both providers and patients who already have an established care plan.

NAACOS believes a single aligned measure that incorporates the best elements of both would allow providers to leverage effective care management on targeted populations instead of stretching already limited resources across broad populations. Broadly, CMS can continue working with the Core Quality Measures Collaborative (CQMC) to help ensure measures are aligned across the continuum. More consistent measures and specifications also support clear accountability between plans and VBC providers, avoiding duplicative services and reinforcing shared responsibilities for achieving health outcomes and improving patient experiences.

Special Enrollment Period for Provider Terminations

CMS proposed enhancements to the current process where enrollees are provided with the option to change plans when one or more of their providers leave a plan's network.

This policy represents an important step in alleviating burdensome patient enrollment processes, advancing beneficiary choice-making, and protecting patient choice. Processes that improve patient informed decision-making and expedited administrative processes can lessen the time patients can re-enroll and thus, preserve care continuity.

Clear, timely, consistent communication of this special enrollment policy will be key, especially in this current volatile environment where provider acquisitions and regional plan departures are escalating. **CMS should ensure beneficiaries are promptly notified of network terminations and are educated about the enrollment selection process, including both ACO and MA options.** The provider-patient relationship is foundational to effective care delivery, particularly for beneficiaries with chronic or complex conditions. Shifting these longstanding relationships can often cause confusion, disrupt care, reduce care coordination, and ultimately, impact health outcomes, medication adherence, and patient satisfaction.

Preserving these relationships is key to increased patient engagement, but the necessary data and patient information need to be tracked and coordinated for a seamless transition period. **CMS should ensure that more clarity and real-time data on provider network updates and availability are clearly communicated.** For providers who have committed to managing risk through advanced primary care and population health management, more transparent data can help support providers managing patients, such as implementing effective patient engagement and maintaining care continuity processes. To make these files more accessible and usable to providers, we ask that **CMS require plans to report accurate and timely MA network data, particularly on network adequacy and in- and out-of-network providers, in standardized file formats that are easily accessible, updated, and digestible for providers**.

Requests for Information (RFIs) on Future Directions in Medicare Advantage

Risk Adjustment

CMS seeks input on opportunities for improving risk adjustment, such as exploring risk model methodologies, patient complexity, accurate and fair payments, and reductions in administrative burden. CMS also solicits comments on incorporating various risk score models, alternative data sources, and advanced technologies such as AI/machine learning features.

As more VBC entities and providers hold responsibility for total cost of care and quality outcomes in MA risk arrangements, ensuring accurate payments for more complex beneficiaries is key. Building confidence in risk score accuracy encourages predictability and transparency.

NAACOS supports modernizing the risk adjustment model to improve accuracy and reduce overpayments in MA. We support refinements in the model that aim to:

- **Ensure stable payments to VBC providers** and encourage MA plans to sustain and expand VBC arrangements
- **Include a glidepath, phased in over several years with extensive testing to avoid destabilizing VBC arrangements**. The transition process should account for implementation time, such as evaluating operational feasibility, provider education, downstream effects on provider payments, and impacts to clinical delivery and beneficiary access and experiences.
- **Share model updates or new approaches transparently and include the necessary data** to map model impacts across multi-year scenarios.

Including Essential Diagnoses in Risk Adjustment Models

NAACOS supports risk adjustment models that accurately reflect acuity of populations and real patient complexities. MA risk adjustment should reward meaningful clinical care and prevention for all patients, particularly those with high-risk chronic conditions. It should avoid penalizing coding intensity unless they reflect actual changes in patient complexity.

Risk adjustment diagnoses should remain closely tied to conditions that are predictive of costs. Diagnoses should only be excluded where their impact on risk score is minimal, as risk scores reflect the actual financial risk borne by providers. Chronic, complex conditions that disproportionately affect elderly beneficiaries and drive utilization should remain included.

Diagnoses used for payment should be clearly linked to accountable clinical care regardless of care setting. The definition of a "Health Risk Assessment" is so broad that it includes home-based primary care services. When these in-home evaluations and visits are categorized as health risk assessments, the resulting diagnoses are not counted appropriately, leading to inaccurate coding and misaligned payment for homebound beneficiaries. To account for this, **CMS should exclude home-based evaluation and management services from the definition of health risk assessment.** This change would ensure that diagnoses arising from true in-home primary care encounters are properly recognized and continue to support accurate risk adjustment and payment.

Removing Annual Recording Requirements

NAACOS supports a multi-year carryover approach that reflects clinical reality and reduces administrative burden for certain irreversible conditions. Many diagnoses – such as amputations, paralysis, Type 1 diabetes – do not resolve and rarely change year-over-year, yet the current approach forces clinicians to re-document them annually. Removing annual recording requirements for stable, permanent conditions will help alleviate clinical time to focus on patients with highly complex conditions or at emerging risk of poor outcomes. CMS could also explore refinements, such as longer revalidation intervals or documentation only when clinical severity changes.

Assessing Diagnoses from Denied Paid Encounters

NAACOS supports risk adjustment models NOT tied to health plan approved or denied payments for a service. Diagnoses should reflect patient complexity or morbidity, not specific processes or practices from MA plans. Payment processes and decisions are too varied and internally derived to be tied to broader risk adjustment approaches. Furthermore, tying risk scores to payment status would inject inconsistencies and possibly create perverse incentives and gaming opportunities without improving coding accuracy.

Testing New Risk Adjustment Methods that Replace Current Hierarchical Condition Category (HCC)-Based Model

Replacing the existing HCC model with inferred or utilization-based approaches risks penalizing providers who effectively manage care and prevent disease progression. The concern is that these models could unintentionally reward utilization instead of accurately recognizing the risk of morbidity. **We caution CMS about adopting inferred risk methodologies that rely predominantly on utilization**. These models would undervalue preventive care in the highest-risk patients to avoid high-cost utilization for high-risk patients.

We urge CMS to consider making smaller changes that could refine risk adjustment models incrementally. For healthier, more stable populations, extending the risk adjustment lookback window from 12 to 24 months is a meaningful improvement. A two-year window smooths normal year-to-year variation and provides a more complete picture of chronic conditions. Repeated analysis by MedPAC has indicated that using two years of information allows Fee-For-Service (FFS) data to be a better reflection of beneficiary utilization and cost patterns. However, for sicker, more complex patients and those that are "aging-in" to Medicare, a two-year extension alone is not sufficient to cover the "tail" problems of prospective models.

Risk adjustment models often underestimate high-cost and overestimate low-cost utilizers. This happens when the acuity of a condition is not fully captured in assessment or documentation. As a result, when high-risk patients are underestimated, plans are underpaid and care management resources are misaligned. When low-risk patients are overestimated, the model inflates expected spending. Any refinements to the risk adjustment framework should therefore strengthen – not weaken – the system's ability to sustain investments in caring for high-risk, high-cost populations.

NAACOS supports implementing a concurrent risk adjustment model that can be applied across the general population but is especially critical for accurately capturing high-risk, complex, and age-in beneficiaries. Blending in concurrent risk scoring helps solve prospective HCC models' underpredicting cost of complex patients and ensures that care management resources are aligned with actual patient needs. The ACO REACH model has proven that concurrent risk adjustment better reflects the complexity of high-risk, complex populations. Additionally, patients that "age-in" to Medicare are provided a proxy that is arbitrarily low and often not a good indicator of the patient's actual acuity nor does it predict their true utilization patterns. In growing risk populations such as in MA, this could lead to rebasing issues over time while waiting for the patient to establish historical data.

With any transition away from the current risk adjustment methods, CMS should always provide phased implementation timelines. Recent efforts such as CMS-HCC V28 to focus on truly chronic and high-cost conditions represent a constructive step toward reducing burden while preserving predictive accuracy. These changes under V28 included a phased-in approach that is crucial for providers to model the updates, budget for operational lift, and make the necessary changes before providers are held fully accountable for accuracy of the process.

Minimizing Administrative Burden for Providers

NAACOS supports greater transparency, transition time to make changes, and consistent processes that are essential to reducing administrative burden and limiting opportunities for manipulation. The most helpful burden reduction is creating and maintaining stability and consistency. Slowing the pace of

change in risk adjustment models would give providers time to adapt and allow for thoughtfully planned approaches to model refinement. A meaningful way to reduce burden is to maintain consistency in how risk adjustment is operationalized.

The focus on risk score calculations should be derived from work that providers are already doing and accurately reflect the clinical complexities of real-time patients. Policies that require new documentation practices, workflow changes, or training place burden on providers to make significant financial and resource investments. **We urge CMS to avoid policies that promote data collection solely for risk score calculations and carefully evaluate any new or updated requirements that increase burden without improving accuracy.**

Ensuring Level Playing Fields

NAACOS supports advancing competition, removing anti-competitive barriers, and ensuring a level playing field for regional, smaller, and less well-resourced plans. Many rural and underserved regions are increasingly dependent on smaller, locally based MA plans for coverage options. These plans have the agility and community partnerships needed to develop collaborative provider partnerships and sustain innovative VBC arrangements. As providers take on the growing risk of rural and underserved populations, they should not be subject to risk adjustment models that penalize serving complex patients, preventing disease progression, or managing care efficiently. Without equitable payment policies and fair contracting conditions, regional MA plans also cannot offer the same level of incentives, stability, or willingness to invest in provider care delivery and transformation that national plans can. As we note above, concurrent risk adjustment approaches can support more accurate risk coding for certain populations.

NAACOS supports changes to risk adjustment that promote fairness, ensure accuracy, and prevent overpayment or gaming. Currently, risk adjustment approaches in ACO models have arbitrarily constrained risk score growth, resulting in benchmarks that are not reflective of the costs for the patient population. Historically, FFS is known to have lower coding intensity because the population is not as complex or reflective of growing risk populations as in MA. CMS must consider differences in coding patterns between MA and traditional Medicare when determining MA payment adjustments.

To create a more level playing field, CMS should move toward a single, modernized risk adjustment model that captures the strengths of the models and applies them similarly across both MA and ACO programs. MA's model is generally more robust and better calibrated for today's risk profiles. Aligning ACO methodologies more closely to those used in MA would improve comparability and reduce burden for providers managing to different programs.

Ultimately, both programs should rely on a shared, updated risk-adjustment approach that accurately reflects patient complexity, discourages inappropriate coding behavior, and supports high-quality care delivery across all Medicare beneficiaries.

Leveraging Artificial Intelligence (AI) and Machine Learning

Advanced technology offers the tools and platforms to optimize innovations in care delivery, operational efficiency, and financial performance – but only if coupled with proper governance, provider engagement, and reporting requirements that meet MA plan and CMS standards. **NAACOS urges CMS to establish a clinical oversight process and place guardrails on AI to ensure accurate and transparent**

processes across the board. The most advanced AI and machine learning technologies are still dependent on accessibility of data sources and defined contractual parameters, services, and population cohorts. There need to be intentional, precise boundaries in the design and working parameters of AI's capabilities across the full spectrum of health plan and provider operations. Any input derived from AI products needs to be validated by a clinician for accuracy, context, and nuanced decision-making. Furthermore, algorithms leveraging AI for any predictive modeling or risk scoring should be made known.

We also urge CMS to re-evaluate complex methods that increase administrative burden and decrease transparency, while not substantially improving accuracy or predictability. Any AI-based algorithms should be thoroughly vetted before implementation and providers must be allowed transition periods to test on their own systems.

Calibrating Risk Adjustment Models Based on Encounter Data
The role of technology has become increasingly pivotal because risk score accuracy is foundational to VBC bearing risk. This MA encounter data is one of the most Important data sets for insights into MA programs, but it is limited compared to FFS data, which prohibits meaningful comparisons. **We urge CMS to provide more data transparency and release MA encounter data in the same timeline and format as FFS data** so that providers gain greater context for comparing utilization rates across plans and allow greater insights into network adequacy. Encounter data may reduce the need for a coding intensity adjustment, but its benefits relative to current methods remain uncertain. Additionally, while encounter data could help reduce disparities, the data is incomplete and will need to be normalized over time.

Support for Comprehensive Data Sets
With advanced technology, **CMS should review existing data sets to create an interoperable data ecosystem that streamlines data collection, sharing, and reporting to avoid duplication and reduce administrative burden.** Ideal, comprehensive data sets can be derived from clinical records, electronic health records (EHRs), labs, and pharmacy data. Furthermore, leveraging Fast Healthcare Interoperability Resources (FHIR) to create more streamlined approaches to data collection will align to provider operations and capabilities. By leveraging clinical data available in EHRs, providers can identify high-risk patients, a necessary capability in chronic disease management. CMS should be transparent about how data sets are leveraged as significant inputs and provide ample transition time, as providers must be able to view, analyze, and validate how inputs impact risk scores.

Exploring New Data Sources
Claims-based data remains the most reliable and standardized input for risk adjustment. They have been foundational to plan practices and operations and have the highest level of adoption and credibility. We appreciate and support CMS' long-term interest in exploring new data sources to refine risk adjustment models. **We urge CMS to address foundational interoperability issues when testing alternative or new data sources.** CMS should:

- Ensure any alternative data inputs tie back to patient-provider relationships and cost risk
- Ensure any new data sources and methodologies are transparent, standardized, and consistently made available before broadly applied to MA risk adjustment

- Update risk adjustment methods to account for real-time fluctuations so that systems are more adept at capturing events and changes in patients' health status
- Coordinate regularly with health IT vendors and health information exchanges (HIEs) and hold them accountable to support regulatory requirements without generating insurmountable implementation costs
- Work to incorporate social factors, demographic, and geographic data to improve predictability and incorporate local, community environments to patient access
- Ensure models emphasize well-care and prevention, providing reassurance that providers are appropriately rewarded for contributing to reductions in total cost of care

Quality Bonus Payment (QBP) Structure

CMS is seeking input on potential refinement to the QBP structure for MA plans, including what alternative policies could look like and timing on when quality bonus payments should be finalized and disbursed to better incentivize cost containment while improving care quality.

Condensing Timelines on Adding New Measures to Star Ratings
NAACOS recommends CMS continue allowing measures to remain on the display page for at least two years prior to inclusion in Star Ratings. CMS should also provide advance notice of any changes or additional measures under consideration, including clear metric specifications and reporting details. We believe the two-year transition is the best approach across all quality programs. In year one, it is crucial for providers to plan for and put operations in place. An additional year allows them to test and report on data requirements before being held accountable, reporting publicly, and having measures tied to performance incentives. This transition time is imperative for providers and care management teams to integrate workflow changes and ensure proper training. Any changes should also avoid introducing volatility or fragmentation between plan-level measures and provider-level care accountability.

NAACOS encourages CMS to use this RFI as an opportunity to consider developing a measure that assesses plans on adoption of VBC contracts. Incorporated into Star Ratings over time, this measure would help promote greater availability of VBC arrangements in MA.

Reducing Lag Between Measurement and Payment Years for Existing Measures
Conceptually, NAACOS supports closing the lag between measurement and payment years for existing measures and encourages CMS to put guardrails in place to account for any downstream impact on providers, including payment and reporting requirements. Because this lag often extends multiple years and happens across all Medicare programs, the scope and consequences of this change would be extensive. CMS should understand the realities of system capabilities and how far-reaching this initiative would be to evaluate any unintended consequences.

An interim step could be to make data collection and sharing more robust such that providers receive actionable data feeds early enough in the performance year to influence outreach, update workflows, and engage patients when outcomes could count in the same performance year. Exploring earlier disbursement of bonus payments, or disbursement through a staged approach could help improve cash flow for providers and reinforce desired behaviors more promptly. **CMS can address cost containment and quality improvement by ensuring incentives are paid timely and predictably, encouraging long-term provider participation, and closely aligning providers' responsibility for outcomes**. A more

measured approach to test data, capabilities, and timeliness can lessen payment time and strengthen incentives without introducing large-scale disruptions or destabilize existing programmatic processes.

Delinking QBPs from MA bids

NAACOS supports CMS exploring and testing approaches to delink Star Ratings QBP from MA bids process.

Conceptually, separating QBPs from the bid process could create a clearer line of sight between plan performance and quality rewards, addressing the disconnect between measurement and payment years. A delinked structure could also give CMS the flexibility to evaluate how quality is measured and funded, and how payments are disbursed.

However, it is unclear whether plans would remain sufficiently motivated to improve quality and provide beneficiaries with timelier and actionable quality information if the current QBP processes are delinked from bid and rebate structures that provide economic incentives. Removing QBPs from the bid process could also create major shifts in plan revenue, which could create significant downstream shifts in provider payments. QBPs are woven into how plans structure benefits, rebates, and base provider contracts. Maintaining a stable QBP framework is essential for VBC contract growth and sustainability, as many VBC arrangements are addendums on top of these base contracts. Delinking bid processes could add layers of complexity and would increase administrative burden for both plans and VBC providers.

Prior to any policy changes, we ask that CMS collect data to understand the structure of provider incentives in MA risk arrangements so that any proposed changes would account for any implications for downstream provider payments. Any change must avoid unnecessary payment delays or provider payment cuts. Ultimately, providers in full risk and VBC arrangements rely on these incentives, so it is imperative that CMS and MA plans preserve meaningful incentives and not further deter growth of accountable care in MA.

Any incremental changes should be announced, tested thoroughly, provided with ample transition time, and carefully constructed to avoid unnecessary disruption to existing processes. A measured approach should add meaningful value, predictability, transparency, and reinforcement of high-quality, cost-effective care. Otherwise, a change of this magnitude could be detrimental and skew too far into accounting for cost and not prioritizing quality – potentially compounding additional implementation costs for both plans and VBC providers.

<u>Supplemental Benefits Usage and Utilization Data Reporting</u>

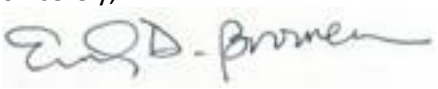
Many VBC providers in MA are delegated the responsibility of supplemental benefits without clear information about services included or excluded from VBC arrangements. For example, certain supplemental benefit expenses (e.g., transportation, gym memberships, etc.) may be better categorized in the administrative portion of the MLR calculation as they are non-clinical expenditures. For providers in risk-bearing arrangements, when these expenditures are considered medical expenses, the provider is held accountable for spending without any insight or influence to manage these services or costs for their patients.

CMS should work to increase transparency and ensure MA plans share information with providers on supplemental benefits available to patients in real time, at the point of care, and in a standardized manner. This will allow providers to incorporate these services into their care plans, to better serve their patients, and to prevent any duplicative interventions in managing costs. Furthermore, increased coordination of benefit usage and costs better supports providers in communicating accurate and updated information to their patients about their care options and allows enrollees to make more informed decisions.

Conclusion

Thank you for the opportunity to provide feedback on CY27 MA Proposed Rule. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement in driving sustainability and innovation in accountable care within MA. If you have any questions, please contact Aisha Pittman, senior vice president of government affairs at aisha_pittman@NAACOS.com.

Sincerely,



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