February 25, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2026-0034-0001
Submitted electronically to: https://www.regulations.gov

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

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the CY 2027 Advance Notice for MA. 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. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP), the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, specialty care models, and other alternative payment models (APMs). Beyond Medicare, our members participate in accountable care arrangements across payers, including with Medicare Advantage organizations (MAOs).

Through risk-bearing arrangements with MAOs, our members are accountable for costs and outcomes of MA beneficiaries. The proposed rates, risk adjustment changes, and Star Ratings updates carry substantial downstream impacts for these providers who bear financial risk in MA. Our comments reflect our members' shared goal of driving accountable care forward in MA by enabling providers to innovate care. NAACOS supports the need for quality measure alignment and thoughtful recalibrations to the risk score calculations, with appropriate guardrails and sufficient transition periods, to ensure new approaches preserve meaningful incentives for providers in VBC arrangements. We look forward to continuing collaborations with the Centers for Medicare and Medicaid Services (CMS) to sustain and expand opportunities for providers to engage in accountable care in MA.

Risk Adjustment Recalibration

CMS proposes to use more recent encounter data and recalibrate the CMS-HCC risk adjustment model for CY 2027 using 2023 diagnoses and 2024 expenditures data. This approach raises significant concerns due to substantial coefficient shifts driven disproportionately by spending patterns associated with skin substitutes and wound-related services, which are believed to be associated with fraud, waste, and abuse (FWA) rather than legitimate clinical need. The magnitude of this anomalous spending was well-documented in a recent Office of the Inspector General report that highlighted "skyrocketing" skin-substitute payments. **We urge CMS to delay all risk model changes for CY 2027, including use of the recalibrated V28 coefficients, by at least one year to prevent unintended impacts.** A phased-in approach, consistent with prior HCC updates would minimize disruption and allow time to address impacts associated with wound care.

Specifically, we ask that CMS **normalize the skin substitute and wound-related services spending by employing a consistent approach across both the benchmark growth calculation and the risk adjustment model.** As currently proposed, CMS removed skin-substitute spending from the USPCC data used in benchmark growth-rate calculations to reflect the 2026 payment policy change that will place caps on the unit cost of skin substitutes; however, the risk-adjustment recalibration still incorporates spending levels prior to the policy change, inflating calculations for HCCs where these products are prevalent.

This inconsistency disadvantages providers caring for clinically complex patients and risks embedding anomalous billing patterns in future payments, rather than aligning risk scores with true patient complexity. The proposed recalibration could potentially produce disproportionately large increases in coefficients for skin diseases and wound-care-related conditions, while devaluing chronic conditions. Early analyses indicate some increases for conditions such as cancer and sepsis, but significant decreases in condition categories including chronic obstructive pulmonary disease (COPD), heart failure, morbid obesity, type 2 diabetes, and stage 3 chronic kidney disease – conditions that drive the bulk of avoidable spending and require sustained management to prevent disease progression. These shifts place unintended financial pressure on providers caring for high-risk patients and risk creating inequities driven by coefficient fluctuations rather than clinical need or true cost of care.

CMS should refine the risk adjustment model coefficients to ensure the model accurately captures clinical complexity. In doing so, CMS should conduct and publish an analysis that models future spending by repricing historical claims using the new payment rates, producing a more thoughtful evaluation of skin-substitute spending, and developing a more consistent and accurate methodology. By reassessing these changes and aligning coefficients with actual clinical complexity rather than historical anomalous spending patterns, CMS can promote more accurate, equitable, and stable risk-adjustment policy. A more consistent and data-driven approach will help ensure that future policies reflect the true characteristics of the MA population, support sustainable VBC arrangements, and maintain reliable access for beneficiaries with the greatest medical needs.

Removing Unlinked Chart Review Diagnoses from Risk Score Calculations

CMS proposes excluding diagnoses from unlinked chart review records (CRRs) in risk score calculations starting in 2027. **NAACOS supports this change but urges CMS to delay implementing this proposed change for at least one year.** Abruptly removing unlinked chart-review diagnoses may create gaps in diagnostic information and lead to inaccuracies in risk score calculations, particularly impacting

providers who care for beneficiaries with multiple, complex conditions. A one-year delay will allow organizations to prepare and ensure diagnoses documented through CRRs are captured through other methods.

Overall Risk Adjustment Changes

CMS should recalibrate the risk adjustment model and normalize data to properly account for complex beneficiaries so that these proposed methods do not directly undermine VBC entities' ability to enter, remain in, and sustainably operate MA risk-bearing contracts.

To that end, as NAACOS commented on improving risk adjustment in our CY 2027 Medicare Advantage (MA) Program Proposed Rule comment letter, CMS should consider:

- Reflecting the acuity of populations and real patient complexities in risk adjustment models.
- Incorporating electronic health record (EHR) and other clinical data sources within risk adjustment. Comprehensive data sets can be derived from clinical records, electronic health records (EHRs), labs, and pharmacy data.
- Providing transparency around how data sets are leveraged as significant inputs in risk adjustment calculations, as providers must be able to view, analyze, and validate how inputs impact risk scores.
- Avoiding policies that promote data collection solely for risk score calculations and carefully evaluating any new or updated requirements that increase burden without improving accuracy.
- Leveraging existing data sets to create an interoperable data ecosystem that streamlines data collection, sharing, and reporting to avoid duplication and reduce administrative burden.
- Rewarding meaningful clinical care and prevention for all patients, particularly those with high-risk chronic conditions.
- Adding transition time to make changes and consistent processes to reduce administrative burden.
- Clearly linking diagnoses used for payment to accountable clinical care, regardless of care setting.
- Limiting use of health risk assessments (HRAs) unless they are tied to actual home-based clinical encounters. To maintain alignment with the intent of the proposed policy changes, CMS should refine the HRA definition to exclude home-based primary care services, ensuring that diagnoses arising from legitimate in-home clinical encounters continue to be recognized in risk scoring and payment accuracy.
- Engaging plans, providers, and other risk-bearing entities in the development of a more accurate model that reflects the growing complexity of MA populations.

Quality Measures

CMS proposes adopting the updated Colorectal Cancer Screening measure beginning with the 2027 Star Ratings. **NAACOS supports this change; however, CMS should first align the colorectal cancer screening measure across programs to reduce provider burden.** Specifically, the proposed Star Ratings measure and the measure used in MSSP have near identical intent, age parameters, and screening intervals, yet they differ significantly in data sources. MSSP relies predominantly on clinical data, including EHR-based data extracts that depend on structured clinical documentation. In contrast, MA Star Ratings largely rely on the HEDIS framework, which emphasizes administrative and supplemental

data sources, such as claims and certain patient-reported information. As a result, cross-program comparisons are not possible, and providers have the burden of documenting numerator compliance differently.

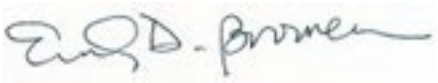
More broadly, consistent measure specifications across MA, MSSP, and other CMS models would lower administrative complexity, reduce infrastructure costs associated with maintaining multiple versions of substantively similar measures, and allow providers to focus resources on delivering high-quality, evidence-based care rather than reconciling conflicting technical requirements.

CMS should also continue its work with the Core Quality Measures Collaborative (CQMC) to advance alignment across payers and programs. Consistent measures and specifications promote clear accountability between health plans and VBC providers, reduce duplicative services, and reinforce shared responsibility for improving health outcomes and patient experience.

Conclusion

Thank you for the opportunity to provide feedback on the CY 2027 MA Advance Notice. 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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