NATIONAL HEALTH COUNCIL

February 25, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies [CMS-2026-0034]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice).

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, and sustainable health care. Our membership includes nearly 200 national health-related organizations, including leading patient organizations representing individuals with chronic disease, disability, and rare conditions, as well as provider associations, caregivers, researchers, and health-related businesses.

Overarching Observations

The CY 2027 Advance Notice advances CMS' ongoing recalibration of MA and Part D payment methodologies, including further updates to risk adjustment, normalization, and Part D modeling related to implementation of the Inflation Reduction Act (IRA). While CMS projects a modest average net payment impact of approximately 0.09 percent year over year, the effects of these changes are not uniform and may differ across plans and beneficiary populations, particularly when layered atop prior year adjustments.[1]

[1] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," in *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2025), 337-339.

In carrying out its statutory responsibilities to align payments with beneficiary risk and address coding differentials between MA and Original Medicare, CMS must also consider the implications of payment methodology changes for access stability among patients with chronic conditions and complex care needs.[2] Even changes that are directionally sound from a program integrity perspective may affect access if not accompanied by appropriate safeguards, transition planning, and monitoring.

Given CMS' statutory responsibilities and the importance of access stability for high-need beneficiaries, our comments focus on three cross-cutting priorities:

1. Supporting access stability for high-need beneficiaries during a period of cumulative payment recalibration, with particular attention to beneficiaries with chronic conditions, disabilities, and complex care needs who may be more sensitive to changes in plan payment, benefit design, and care management practices.[3]
2. Ensuring transparency and accountability in risk model changes and normalization factors, including clear explanation of methodological updates, their expected effects, and the assumptions underlying payment adjustments.
3. Monitoring and mitigating potential downstream effects on benefits, provider networks, formularies, and utilization management, particularly where payment changes may create incentives that affect beneficiary access to needed services and treatments.

In the sections that follow, the NHC offers more detailed observations and recommendations related to these priorities, with a focus on monitoring, implementation safeguards, and ongoing engagement to ensure that payment methodology changes are operationalized in a manner that preserves access and stability for the patients we represent.

Medicare Advantage Risk Adjustment Updates (Part C)

Recalibration of the CMS-HCC Model Using 2023/2024 Data

CMS proposes to recalibrate the CMS-HCC risk adjustment model using more recent diagnosis and expenditure data. Updating the calibration base can improve accuracy and better reflect contemporary utilization and cost patterns, particularly as care delivery, coding practices, and treatment modalities continue to evolve. The NHC recognizes the importance of periodically updating model inputs to ensure that payment methodologies remain grounded in current experience.

At the same time, recalibration occurs within a broader context of ongoing methodological change. For CY 2027, recalibration coincides with the continued phase-in of prior HCC model revisions, the application of normalization adjustments, coding

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[2] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report" (presentation, MedPAC Public Meeting, Washington, DC, January 16, 2026).

[3] MedPAC, *March 2025 Report*, 346-350.

pattern differentials between Medicare Advantage and Original Medicare, and behavioral responses by plans and providers to earlier payment changes. While each of these elements may be analytically sound when considered independently, their combined effects may be more difficult to anticipate in real time, particularly at the plan and beneficiary level.[4]

Taken together, these overlapping adjustments warrant close attention to their cumulative impact, especially for plans with a higher concentration of beneficiaries with chronic, multi-morbid conditions.[5] Beneficiaries who rely on specialty care, durable medical equipment, or high-cost therapies may be more sensitive to shifts in payment adequacy, even where aggregate impacts appear modest.[6] In such contexts, access implications may emerge gradually through changes in benefit design, care management approaches, or network composition, rather than through discrete policy actions.[7]

Understanding how these interacting changes affect payment adequacy and plan behavior is therefore critical to ensuring continued access for high-need populations. Greater visibility into the distributional effects of recalibration would support more informed stakeholder engagement and facilitate timely identification of any unintended consequences as implementation proceeds.

To support transparency and informed implementation, the NHC recommends that CMS make available disaggregated analyses alongside the final Rate Announcement that illustrate how risk score and payment changes affect distinct beneficiary populations. Such analyses could include, for example, individuals with multiple chronic conditions, dual-eligible beneficiaries, beneficiaries with disabilities under age 65, and enrollees in Special Needs Plans or plans with higher clinical risk profiles.[8]

Exclusion of Diagnoses from Audio-Only Services and Unlinked Chart Reviews

The NHC supports CMS' efforts to strengthen data integrity and to ensure that diagnoses used for payment are grounded in meaningful clinical encounters. Clear and

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[4] Centers for Medicare & Medicaid Services, "Special Needs Plan (SNP) Data," Medicare Advantage/Part D Contract and Enrollment Data, last modified September 10, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data.

[5] Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (Baltimore: CMS, January 26, 2026), 58-62.

[6] MedPAC, *March 2025 Report*, 339, 371-372; see also CMS, *CY 2025 Rate Announcement*, 72-77.

[7] Jeannie Fuglesten Biniek et al., "Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization," KFF, August 8, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/.

[8] MedPAC, "The Medicare Advantage Program" (presentation).

consistent standards for diagnosis reporting are important to maintaining confidence in risk adjustment and to supporting program integrity across MA. At the same time, changes to how diagnoses from specific care settings or documentation pathways are treated warrant careful consideration of their potential effects on access and risk recognition.

Audio-only services continue to serve as an important access modality for some Medicare beneficiaries, particularly individuals with mobility limitations, cognitive impairment, sensory disabilities, or limited access to broadband or digital technologies.[9] For these populations, audio-only encounters may function as a supplement to in-person care or as a bridge to more comprehensive evaluation. Excluding diagnoses associated with these encounters may therefore have implications for how clinical complexity is reflected in risk scores, even where the underlying care needs are legitimate and ongoing.

Similarly, chart review processes have historically played a role in reconciling incomplete or fragmented encounter data, particularly for beneficiaries receiving care across multiple providers or settings.[10] While CMS has appropriately sought to address inappropriate coding practices, changes to the treatment of unlinked chart reviews may also affect the recognition of clinical risk in circumstances where encounter data are delayed, incomplete, or dispersed across care systems.

Given these considerations, the NHC encourages CMS to closely monitor the effects of these exclusions on beneficiaries with disabilities or other access barriers and recommends assessing whether the changes lead to systematic under-recognition of legitimate clinical risk for certain populations.[11] The NHC further urges CMS to remain prepared to revisit these policies if implementation experience or empirical evidence indicates persistent underpayment or access challenges for high-need beneficiaries.

Normalization Factors and Coding Pattern Adjustments

CMS continues to apply normalization factors to maintain budget neutrality and to address systemic coding differences between MA and fee-for-service Medicare.[12] The NHC recognizes normalization as a long-standing and necessary component of MA

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[9] Centers for Medicare & Medicaid Services, “2027 Medicare Advantage and Part D Advance Notice,” Fact Sheet, January 26, 2026, https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice.

[10] U.S. Department of Health and Human Services, Office of Inspector General, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions*, OEI-03-23-00380 (Washington, DC: OIG, October 21, 2024).

[11] Leslie V. Gordon, *Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight*, GAO-22-106026 (Washington, DC: Government Accountability Office, June 28, 2022).

[12] CMS, “2027 Advance Notice Fact Sheet.”

payment methodology, intended to ensure consistency and comparability across payment years as model inputs and coding patterns evolve.

At the same time, normalization remains one of the least transparent elements of MA payment policy from the perspective of patients and many stakeholders.[13] While the actuarial rationale for normalization is well established, the translation from technical model adjustments to practical implications for plans and beneficiaries is often difficult to discern outside of specialized analyses. This challenge is heightened when normalization adjustments occur alongside other methodological changes, such as recalibration and risk score trend updates.

The CY 2027 Advance Notice reflects downward pressure associated with normalization and risk score trend adjustments. Although CMS has described the technical basis for these changes, the extent to which normalization may interact with other payment adjustments to influence plan decision-making is not always apparent at the time of the Advance Notice. In such circumstances, potential effects on benefit design, provider networks, supplemental benefits, or utilization management may emerge gradually rather than as a direct or immediate response to any single policy change.[14]

Greater clarity regarding the expected effects of normalization adjustments would help stakeholders better understand how these policies operate in practice and would support more informed engagement during implementation. In this context, the NHC recommends that CMS assess whether normalization adjustments, in combination with other methodological changes, may influence plan decisions related to provider networks, utilization management approaches, or the availability of supplemental benefits that are particularly important for high-need beneficiaries.[15]

The NHC further encourages CMS to establish structured mechanisms through which patient organizations can flag emerging access concerns potentially associated with normalization-driven payment changes. Such mechanisms would strengthen oversight and accountability by allowing CMS to identify trends early and to distinguish between transient implementation effects and more persistent access challenges.

Part D Risk Adjustment and IRA-Related Updates

Updates to the RxHCC Model

The NHC supports CMS' efforts to update the RxHCC model to reflect the redesigned Part D benefit under the IRA, including changes to manufacturer discounting and

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[13] MedPAC, *March 2025 Report*, 353-359, 392.

[14] U.S. Government Accountability Office, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, GAO-15-710 (Washington, DC: GAO, August 31, 2015).

[15] Avni Gupta, Gretchen Jacobson, and Faith Leonard, "How Much Do Medicare Advantage Enrollees Value and Use Their Supplemental Benefits? Findings from the 2025 Commonwealth Fund Medicare Beneficiary Survey," Commonwealth Fund, February 2025.

catastrophic liability.[16] Aligning Part D risk adjustment with the redesigned benefit structure is an important step toward ensuring that plan payments appropriately reflect beneficiary drug spending and liability under the new framework. Accurate and timely risk adjustment is essential to avoiding unintended incentives that could discourage plans from enrolling or effectively serving beneficiaries with high drug costs.

At the same time, the redesigned Part D benefit is being implemented in a period of rapid change in the pharmaceutical pipeline, particularly with respect to specialty therapies and treatments for complex or rare conditions. As CMS continues to refine the RxHCC model, it is important to ensure that payment adequacy keeps pace with real-world utilization patterns, including the uptake of new therapies whose cost and clinical impact may not be fully reflected in historical data at the time of model calibration.[17]

In this context, ongoing monitoring will be critical to identifying potential access issues that may emerge during implementation. Such monitoring could include, for example, tracking formulary placement and coverage conditions for high-value therapies, observing trends in the use of utilization management tools such as prior authorization or step therapy, and assessing beneficiary out-of-pocket exposure despite the statutory cap.[18] These indicators can help distinguish between transitional implementation effects and more persistent access barriers, informing any future refinements to the model or related policies.

As CMS continues to refine the model, it is important to ensure that payment adequacy keeps pace with real-world utilization of specialty and high-cost therapies, particularly as new treatments enter the market.[19] Ongoing monitoring of formulary placement for high-value therapies, the use of utilization management tools such as prior authorization and step therapy, and beneficiary out-of-pocket exposure despite the statutory cap will be critical to identifying unintended access barriers.

Interaction with the IRA Out-of-Pocket Cap and Manufacturer Discount Program

The NHC continues to support the Inflation Reduction Act's $2,000 annual out-of-pocket cap and the Manufacturer Discount Program as important steps toward improving prescription drug affordability for Medicare beneficiaries.[20] Together, these provisions represent a substantial restructuring of financial liability across beneficiaries, plans, manufacturers, and the Medicare program, with the potential to improve predictability and reduce catastrophic exposure for patients with high drug costs.

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[16] CMS, *2025 Rate Announcement*, 1, 6, 106-107.

[17] MedPAC, *March 2025 Report*, 360-361.

[18] U.S. Government Accountability Office, *Inflation Reduction Act of 2022: Initial Implementation of Medicare Drug Pricing Provisions*, GAO-25-106996 (Washington, DC: GAO, April 28, 2025), 12-15; see also MedPAC, *March 2025 Report*, 407-412.

[19] Murray Aitken et al., *The Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2028* (Parsippany, NJ: IQVIA Institute for Human Data Science, April 2024).

[20] Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818 (2022).

At the same time, these statutory changes are being implemented alongside broader adjustments to Part D payment policy and risk adjustment. As plan liability and manufacturer contributions evolve under the redesigned benefit, it will be important to understand how payment adequacy and risk adjustment interact with these shifts in practice. In some cases, changes that reduce beneficiary cost exposure at the point of sale may be accompanied by greater reliance on care management and utilization tools as part of broader cost containment strategies, particularly for high-cost or specialty therapies.[21]

In this context, the NHC recommends that CMS evaluate whether CY 2027 payment changes are associated with observable changes in plan behavior that could affect beneficiary access. Such evaluation could include examining trends in utilization management, delays in therapy initiation, formulary design and coverage conditions, and administrative requirements for patients and providers. Monitoring these dynamics will be essential to ensuring that the affordability gains achieved through the IRA are realized in practice and are not offset by new non-price barriers to access.[22]

Star Ratings and Quality Measurement

The NHC appreciates CMS' continued efforts to refine the Star Ratings program and to solicit stakeholder input on future measurement concepts. The Star Ratings program plays a significant role in shaping plan incentives, beneficiary information, and quality improvement priorities across MA and Part D.[23] As such, changes to the measure set can have meaningful downstream implications for how plans allocate resources and design care management strategies.

As CMS considers simplifying and refocusing the measure set, it is important that quality signals remain meaningful for patients with chronic conditions and complex care needs. Measures related to chronic disease management, medication adherence, and continuity of care provide important insight into plan performance for beneficiaries who rely on ongoing treatment and coordinated services.[24] Refinements that reduce measurement burden while preserving these signals can help ensure that quality improvement efforts remain aligned with patient needs.

In this context, the NHC encourages CMS to ensure that future refinements preserve measures relevant to chronic disease management and medication adherence, avoid creating incentives that could discourage enrollment or retention of high-risk beneficiaries, and are accompanied by sufficient transition time and stakeholder

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[21] MedPAC, *March 2025 Report*, chap. 13.

[22] GAO, *Initial Implementation of Medicare Drug Pricing*.

[23] Centers for Medicare & Medicaid Services, Medicare 2025 Part C & D Star Ratings Technical Notes (Baltimore, MD: CMS, October 3, 2024).

[24] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," in *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2024), 371-375.

engagement to support effective implementation.[25] Clear communication regarding the rationale for measure changes and their expected effects will further support stability and predictability for plans and beneficiaries alike.

Monitoring, Transparency, and Stakeholder Engagement

Given the scope, interaction, and cumulative nature of the methodological changes proposed for CY 2027, robust monitoring and transparency will be essential to effective implementation.[26] As payment methodologies evolve across Part C and Part D, timely visibility into access, utilization, and beneficiary experience can help CMS distinguish between expected transitional effects and more persistent patterns that may warrant closer attention.

In this context, the NHC urges CMS to commit to publicly reporting on key indicators following implementation, including measures of access, utilization, and beneficiary experience, and to use these data to identify unintended consequences at an early stage. Transparent monitoring can support course correction where appropriate, while also providing plans, beneficiaries, and other stakeholders with greater confidence in how methodological changes are operating in practice.

Ongoing engagement with patient organizations will further strengthen this process. Patient organizations can provide real-world insight into how changes are experienced at the beneficiary level, particularly for individuals with chronic conditions, disabilities, or complex care needs whose experiences may not be immediately apparent in aggregate data.[27] Structured, regular engagement can help surface emerging issues, contextualize quantitative findings, and inform future refinements in a timely and collaborative manner.

Sustained dialogue with patient stakeholders will therefore be critical to ensuring that payment methodology changes are operationalized in a manner that supports access, stability, and continuity of care for the populations Medicare Advantage and Part D are intended to serve.

Conclusion

The NHC recognizes the complexity of CMS' task in balancing payment accuracy, program integrity, and beneficiary protection. The CY 2027 Advance Notice reflects a significant recalibration of MA and Part D payment policy. Whether these changes ultimately succeed will depend not only on actuarial soundness, but on CMS' willingness to monitor, adjust, and respond as appropriate when patient access is at risk.

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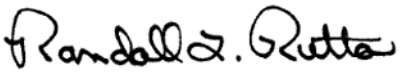
[25] MedPAC, *March 2024 Report to the Congress*, 360-361.

[26] GAO, *Continued Monitoring and Implementing GAO Recommendations*, 5-8.

[27] Centers for Medicare & Medicaid Services, *CMS Framework for Health Equity 2022–2032* (Baltimore, MD: CMS, April 2022), 69.

We appreciate CMS' consideration of these comments and look forward to continued engagement to ensure that Medicare Advantage and Part D remain stable, accessible, and responsive for the patients we represent. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs at kbeer@nhcouncil.org or Shion Chang, Senior Director, Policy & Regulatory Affairs at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



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