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Department of Health and Human Services
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Re: Contract Year 2027 Medicare Advantage and Part D Proposed Rule *(CMS-4212-P)*

The Health Care Transformation Task Force (HCTTF) appreciates the opportunity to share recommendations on the Contract Year 2027 Medicare Advantage and Part D Proposed Rule *(CMS-4212-P)*. HCTTF believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of increasing access to high-quality, value-based care (VBC) while eliminating waste, fraud, and abuse.

HCTTF is a non-profit collaborative that supports accelerating the pace of delivery system transformation to better pay for the value of care received. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health through high-quality care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our comments address (1) Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (section V of the proposed rule), (2) Improvements for Special Needs Plans (section VI), and (3) Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition) (section VIII). Our recommendations are offered in the spirit of collaboration, with the goal of strengthening CMS' ability to deliver high-quality, accessible, affordable care to Medicare beneficiaries.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

I. MA Star Ratings Measure Removals & Additional Proposals

Background & Proposal

CMS proposes to remove 12 Medicare Advantage (MA) Star Ratings measures (Figure) to refine the measure set to focus on outcomes. CMS's rationale is to remove topped out measures and measures focused on process rather than outcome. In addition, CMS proposes to add a

depression screening and follow up measure to the Star Ratings program, to address the critical role of behavioral health care.

Figure: Proposed Medicare Advantage Star Ratings Measure Removals

Star Measure	Part C/D	Proposed Removal Year	Comments
Plan Makes Timely Decisions About Appeals	C	2029	Administrative / low variation
Reviewing Appeals Decisions	C	2029	Administrative / low variation
SNP Care Management	C	2029	Operational / care coordination
Call Center – Foreign Language Interpreter & TTY Availability	C	2028	Administrative / customer service measure
Call Center – Foreign Language Interpreter & TTY Availability	D	2028	Administrative / customer service measure
Complaints About the Health/Drug Plan	C & D	2029	Patient experience / complaints
Medicare Plan Finder Price Accuracy	D	2029	Operational / administrative measure
Diabetes Care – Eye Exam	C	2029	Clinical process measure
Statin Therapy for Patients with Cardiovascular Disease	C	2028	Clinical process measure
Members Choosing to Leave the Plan	C & D	2029	Experience / disenrollment measure
Customer Service	C	2029	Experience / satisfaction measure
Rating of Health Care Quality	C	2029	Experience / satisfaction measure

HCTTF Recommendations

HCTTF is broadly supportive of CMS's proposal to streamline the MA Star Ratings measure set by retiring measures that are administratively burdensome, topped out, or insufficiently tied to meaningful clinical outcomes. HCTTF appreciates CMS's goal of reorienting the Star Ratings program toward a more focused, outcomes-driven framework. We support CMS's goal to better reflect beneficiary health and care quality rather than plan administrative processes, while ensuring that there continues to be opportunities to survey enrollees on their experiences receiving care through their MA plan of choice.

HCTTF appreciates the opportunity to highlight several key considerations:

- **HCTTF supports CMS's proposal to add a depression screening and follow-up measure to the Star Ratings program.** Behavioral health remains a critical area of need for Medicare beneficiaries, and the inclusion of a depression screening measure aligns with efforts to promote early identification and appropriate follow-up care. **While supportive**

of this measure, we encourage CMS to carefully consider technical specifications and implementation details to ensure feasibility, accuracy, and alignment with existing clinical workflows. CMS should collaborate with vendors to ensure that certified EHRs are capturing all CMS required measures accurately in Quality Reporting Document Architecture (QRDA).

- **HCTTF cautions against removal of two measures: (1) *Plan Makes Timely Decisions about Appeals* and (2) *Reviewing Appeals Decisions*.** HCTTF recommends that CMS reconsider the removal of those two measures in order to continue ensuring patient access to timely, high-quality care.

While HCTTF supports CMS's emphasis on outcomes-oriented measures, we have concerns about the pace and scale of the proposed measure removals. In particular, the proposal to eliminate 12 measures over a two-year period represents a rapid transition that would eliminate almost 30% of the current 42 measure set. This compressed timeframe risks undermining the predictability and stability that plans rely on to support benefit design, quality improvement investments, and long-term planning. Abrupt changes of this magnitude may also introduce unintended volatility into Star Ratings performance and beneficiary experience. HCTTF also cautions against efforts to accelerate turnover. **HCTTF recommends CMS adhere to the existing expectation that measures remain on the display page for at least two years prior to inclusion in Star Ratings**. HCTTF looks forward to continued collaboration with CMS to refine the Star Ratings program in to meaningfully reflect beneficiary outcomes, support sustained quality improvement, and maintain confidence in the program's stability.

II. Removal of the Health Equity Index & Retention of the Reward Factor

Background & Proposal

CMS proposes to remove the Health Equity Index (HEI) in favor of returning to reward factor. CMS believes this change will ensure provider stability, predictability, and transparency within the Star Ratings program while still appropriately recognizing high performance.

HCTTF Recommendations

HCTTF supports the goals for predictability and transparency, while appropriately rewarding high performance. We also believe that CMS should continue to help clinicians identify and address non-medical factors that are relevant to patients' health, extending beyond the clinic to address lifestyle factors – which are frequently most essential for the highest risk, highest cost patients. The more clinicians understand about their patients' lives, the better they can provide holistic care to patients. **CMS should explore opportunities to create incentives to identify and address upstream drivers of health, such as nutrition, fitness, and transportation and create a standardized means of collecting data related to nutrition, fitness, transportation, and other related drivers of health**.

III. Special Needs Plans Proposals & Request for Information

Background & Proposal

CMS proposes changes to several policies related to MA Special Needs Plans (SNPs):

- Creating two submission windows for SNP Model of Care changes: January 1 to March 31 and October 1 to December 31.
- Revising of current passive enrollment rules
- Removing provider network similarity requirements to require integrated Dual-Eligible Special Needs Plans (D-SNPs) to ensure continuity of care for at least 120 days for incoming enrollees.

CMS additionally shared a request for information (RFI) on improvements to policies and procedures for care and coverage for Special Needs Plans under Medicare.

HCTTF Recommendations

HCTTF supports CMS's interest in strengthening oversight and improving care integration within the SNP program, while emphasizing the importance of preserving the distinct statutory purposes and roles of each SNP type. HCTTF agrees that C-SNPs were designed to serve Medicare beneficiaries with specific chronic conditions, while D-SNPs are the appropriate and intended vehicle for serving dual-eligible beneficiaries, particularly in light of substantial federal, state, and plan investments in integrated D-SNP models.

HCTTF shares CMS's concerns about the rapid growth of dual eligibles enrolled in C-SNPs, noting that public data indicate nearly 27% of new dual-eligible enrollment in C-SNPs between CY 2024 and CY 2025 originated from integrated products, including D-SNPs. HCTTF cautions that this trend – driven in part by targeted marketing practices – risks undermining the integrated care infrastructure established through bipartisan legislation and years of coordinated federal and state policy efforts. CMS's framing of this issue over the CY 2021–CY 2025 growth period was viewed as appropriate and timely.

HCTTF supports CMS's exploration of D-SNP look-alike safeguards for C-SNPs and I-SNPs, including the use of a dual-eligible concentration threshold. **HCTTF proposes a threshold on the order of 40% dual enrollment could serve as a reasonable guardrail to prevent plans from functioning as de facto D-SNPs, while still allowing flexibility for legitimate C-SNP and I-SNP designs.** HCTTF emphasizes that such an approach would help prevent further erosion of integrated D-SNP enrollment without unnecessarily disrupting existing SNP offerings. HCTTF also supports applying a D-SNP look-alike threshold to C-SNPs, with an appropriate waiver process that allows states to request exceptions where warranted. Strengthening care coordination requirements for dual-eligible beneficiaries enrolled in C-SNPs is a positive step to ensuring that beneficiaries receive appropriately integrated and patient-centered care.

HCTTF cautions against policy changes that could blur program distinctions or destabilize existing arrangements. In particular, HCTTF has concerns that imposing State Medicaid Agency Contract (SMAC) requirements on C-SNPs or Institutional Special Needs Plans (I-SNPs) could unintentionally undermine the current SNP framework and the targeted role of D-SNPs. **HCCTF encourages CMS to focus on creating accurate targeted guardrails and oversight mechanisms that reinforce alignment between beneficiary populations and plan types, while recognizing market variation and the availability of integrated D-SNP options.**

Finally, HCTTF welcomes CMS's focus on improving care quality and integration for dual eligibles, including individuals with **serious mental illness and complex behavioral health needs**. HCTTF encourages CMS to use the RFI as an opportunity to strengthen coordination across SNP types and reinforce beneficiary-centered, high-quality care models – while ensuring that future policy changes build upon, rather than disrupt, the existing SNP structure and investments. HCTTF recommends that CMS eliminate year-round enrollment in C-SNPs in order to better align enrollment policies across C-SNPs and D-SNPs and reinforce the distinct statutory roles of each plan type.

Request for Information on Future Directions in Medicare Advantage

IV. Risk Adjustment

Background & Proposal

CMS seeks input on improving MA risk adjustment by ensuring accurate and fair payments, exploring alternatives to the current HCC model, and reducing administrative burden while preventing gaming. The agency is considering incorporating new data sources and advanced technologies like AI to enhance predictive accuracy, as well as strategies to account for persistent conditions. Additionally, CMS seeks input to balance tradeoffs by mitigating unintended consequences and designing risk adjustment to incentivize high-value care and deliver maximum benefit for beneficiaries and taxpayers.

HCTTF Recommendations

HCTTF applauds CMS's decision to solicit input on the future direction of MA risk adjustment and support efforts to ensure that the program continues to deliver **accurate, fair, consistent, and reliable payment adjustments**. Risk adjustment is foundational to the success of MA and VBC models, as it enables plans and providers to appropriately identify, support, and be rewarded for caring for beneficiaries with the greatest clinical needs. Any refinements to the risk adjustment framework should therefore strengthen – rather than undermine – the program's ability to sustain investments in care for high-risk, high-cost populations.

As CMS considers future reforms, HCTTF recommends consideration of several priority areas:

- **MA risk adjustment should reward meaningful clinical care and prevention for all patients, particularly those with high-risk chronic conditions.** As CMS explores opportunities to refine current risk adjustment methodologies, HCTTF urges the prioritization of **predictability, beneficiary stability, and operational feasibility** to ensure

that any significant changes to risk adjustment are **thoroughly tested in real-world environments**. We recommend that CMS to be particularly cautious about inferred risk methodologies if they rely predominantly on utilization, because this would specifically undervalue preventive care with the highest-risk patients – because avoiding high-cost utilization for high-risk patients would be explicitly undervalued in a utilization-based risk adjustment model. As CMS explores new risk adjustment approaches, this should be accompanied by transparent modeling of impacts, and implemented through a **multi-year, phased transition** with adequate lead time to avoid disruption to beneficiaries, providers, and care delivery systems.

- **MA risk adjustment should reflect diagnoses that are meaningfully connected to clinical evaluation, care planning, or ongoing treatment, regardless of care setting, and supported by transparent, verifiable clinical data.** Home-based assessments and documentation reviews play an important role in identifying unmet needs, particularly for medically complex, rural, and underserved beneficiaries. For example, patients that live in nursing homes or assisted living facilities may appropriately receive the majority of their care in their home. HCTTF recommends that diagnoses used for payment be clearly linked to accountable clinical care or ongoing care management. Ensuring that risk-adjusted diagnoses are efficiently tied to care delivery or independently auditable clinical evidence without overburdening care providers will strengthen model integrity, promote equity across care models, and preserve trust in the MA program. Importantly, MA plans cannot force members to receive follow up care, so there must be an allowance for outreach attempts to meet the criteria of ongoing care management.
- **New data sources and methodologies should be transparent, standardized and consistently available before they are broadly applied to MA risk adjustment.** While there is broad appreciation of CMS's interest in leveraging additional data beyond claims, HCTTF notes that many of the data sources under consideration – such as electronic medical records, wearables, or broader data aggregation approaches – are not yet sufficiently standardized, consistently available, or transparent across both payers and providers to support a national payment model. While we support CMS's long-term interest and investment in potential new data sources, we believe CMS should ensure that new data sources are incorporated judiciously and carefully. As CMS explores alternative data sources, we believe the agency could include Prescription Drug Event (PDE) data as a potential source. For downstream risk-bearing provider organizations that contract with MA plans, it is essential that they have ability to independently understand, replicate, and monitor risk scores over time. HCTTF urges CMS to prioritize **standardized, auditable data sources** that preserve transparency and to avoid approaches that rely on opaque data pipelines that could introduce unintended consequences.

- **As CMS works to test and validates new, standardized data sources and methodologies, we encourage CMS to prioritize three key principles**: (1) greatly reduce the model's sensitivity to coding intensity, (2) incorporate more non-clinical data into the model, and (3) generate a more ideal distribution of health care resources to better support rural and other underserved communities.

- **Ensure methodological consistency across MA and Medicare fee-for-service (FFS)**. Any policies governing diagnosis validity, encounter types, severity thresholds, or condition

persistence applied to MA should be reflected in the FFS calibration datasets and methodologies used to establish the model. HCTTF cautions against the adoption of MA-only standards that are not similarly applied to the FFS baseline, as such asymmetry risks distorting payment accuracy and undermining confidence in the model.

- CMS should explore mechanisms to **reduce administrative burden related to annually re-documenting permanent or lifelong conditions**. A substantial portion of clinical time is currently devoted to repeatedly re-documenting chronic or irreversible conditions – such as amputations or congestive heart failure – that do not meaningfully change year to year. HCTTF encourages CMS to explore refinements that better account for the persistent nature of such conditions, including longer revalidation intervals or re-attestation only when clinical severity changes, thereby allowing clinicians to focus more fully on prevention, disease management, and emerging risk.

As a multi-stakeholder collaborative of payers, providers, purchasers, and patient advocacy organizations, HCTTF looks forward to working with CMS to thoughtfully implement these recommendations and strengthen the MA program for beneficiaries and providers alike.

V. Quality Bonus Payment

Background & Proposal

CMS is seeking input on whether an alternative policy is needed for the CMS Quality Bonus Payment system, what that might look like, and potential advantages and disadvantages. CMS is also soliciting input on the timing of when quality bonus payments should be finalized and disbursed how to better incentivize cost containment in MA while improving care quality.

HCTTF Recommendations

HCTTF appreciates CMS's interest in reassessing the structure, timing, and design of the MA Quality Bonus Payment (QBP) program. We generally support efforts to ensure that quality incentives meaningfully improve care while promoting stability and predictability for plans and providers. HCTTF recommends that any changes to QBP policy should be carefully calibrated to avoid unnecessary disruption and should reinforce, rather than weaken, the program's role in supporting high-quality, cost-effective care.

HCTTF encourages CMS to use this RFI as an opportunity to clarify and improve the broader long-term direction of the Star Ratings program:

- **CMS should continue to eliminate topped-out process measures and measures subject to substantial year-over-year variation outside of plan control**. HCTTF recommends this through the establishment of predetermined cut points to improve predictability, and transition toward more objective and empirical measures of quality, greater emphasis placed on prevention and chronic disease management, with condition-specific measures aligned with those conditions in the risk adjustment model most predictive of spending.
- **All reforms to quality-based payment approaches in MA should be accompanied by a reassessment of the underlying FFS benchmark methodology.** In particular, CMS should explore approaches that more appropriately reflect MA as the dominant form of

Medicare coverage, including consideration of benchmarks based on Parts A and B spending.

- Reduce time lag **and improve alignment for incentive payments**. HCTTF notes that the lag between when quality performance is achieved and when bonus payments are ultimately disbursed—often extending multiple years—can dilute the incentive effect, particularly for downstream provider organizations.

HCTTF looks forward to working with CMS to ensure that QBP reforms strengthen incentives for high-quality, cost-effective care, while maintaining predictability for payers and providers.

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The Task Force appreciates the opportunity to provide feedback on the CY 2027 MA and Part D Proposed Rule. Please contact Theresa Dreyer, the CEO of HCTTF (theresa.dreyer@hcttf.org) and David Goldstein, HCTTF Director of Policy and Strategic Initiatives (david.goldstein@hcttf.org) with questions related to these comments.

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