BETTER MEDICARE ALLIANCE

1425 K Street NW, Suite 700
Washington, DC 20005
202.735.0037

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

February 10, 2025

Acting Administrator Stephanie Carlton
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) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Acting Administrator Carlton:

On behalf of the Better Medicare Alliance and the more than 34 million beneficiaries enrolled in Medicare Advantage, we are pleased to submit the following comments on the Advance Notice of Methodological Changes for CY 2026 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies ("Advance Notice"). Better Medicare Alliance (BMA) is a diverse coalition of over 200 Ally organizations and more than one million beneficiaries who value Medicare Advantage. Together, our Alliance of community organizations, providers, health plans, aging service organizations, and beneficiary advocates share a deep commitment to ensuring Medicare Advantage remains a high-quality, affordable option for current and future Medicare beneficiaries.

Medicare Advantage is now the primary form of Medicare coverage in the U.S. Fifty-five percent of Medicare beneficiaries choose Medicare Advantage for high-quality, comprehensive care that costs them less on average than Fee-for-Service Medicare. The program also serves Americans nationwide, across geographies, and attracts a diverse population of beneficiaries, with Latino, Black, and Asian and Pacific Islander Americans enrolling at higher rates than Fee-for-Service.[1] Beneficiaries rely on Medicare Advantage for affordable health coverage, with the average beneficiary spending over $2,500 less in premiums and out-of-pocket costs compared to Fee-for-Service Medicare beneficiaries.[2] Seniors and individuals with disabilities choose and trust the affordable, quality, and innovative health care available in Medicare Advantage that delivers better outcomes, with an estimated 35.7 million beneficiaries choosing Medicare Advantage this year.[3]

Recent instability in Medicare Advantage has led to plan closures, higher costs, and reduced benefits for 2025. The last two years of reduced payments in a time of escalating costs bear this out. More than 2 million beneficiaries enrolled in Medicare Advantage were forced to find new plans for 2025 due to plan closures, with 6.54% fewer Medicare Advantage plans available this year, the first decline in more than a decade.[4] The average out-of-pocket maximum is up 8% in 2025, from $5,000 to $5,400. Benefits such as transportation, healthy meal delivery, and in-home support services saw significant reductions for 2025.[5] These critical benefits close

[1] Better Medicare Alliance, Medicare Advantage Enrollment Map. Available here; Better Medicare Alliance, State of Medicare Advantage 2024. Available here.
[2] Better Medicare Alliance, Medicare Beneficiary Spending 2024. Available here.
[3] Kaiser Family Foundation. Medicare Advantage 2025 Spotlight: First Look. November 2024. Available here ; Centers for Medicare & Medicaid Services. "Medicare Advantage and Medicare Prescription Drug Programs to Remain Stable in 2025," September 27, 2024. Available here.
[4] Better Medicare Alliance, Analysis of the 2025 Medicare Advantage Plan Landscape, October 2024. Available here.
[5] *Id.*

coverage gaps and help keep beneficiaries healthier. A stable Medicare Advantage program enables widespread access to care and supplemental benefits, significant cost savings on premiums and out-of-pocket costs for beneficiaries, and high-quality care with better outcomes, including fewer avoidable hospitalizations and greater use of preventative care services.[6]

Better Medicare Alliance believes the 2026 Advance Notice provides an opportunity to create much needed stability in Medicare Advantage and support seniors and individuals with disabilities. To that end, there are three actions CMS should take to ensure a strong final notice, summarized below and detailed in full in the attached. CMS should:

- **Growth Rate**: Ensure the Medicare Advantage growth rate is reflective of increases in cost and utilization, consistent with recent experience and providing greater transparency than in past years with the most recent data.

- **Removal of IME**: Spread the remaining phase-in of removing Medicare Advantage IME payments over two years – 2026 and 2027.

- **Normalization Factors**: Reconsider the multilinear regression methodology to calculate the Fee-for-Service normalization factor adopted for CY 2025 until further evaluation and engagement with relevant partners is conducted to understand the impact this methodology will have. Similarly, monitor the impact of calculating two different normalization factors for the RxHCC models and consider waiting until more complete data is available.

Better Medicare Alliance is committed to preserving and strengthening Medicare Advantage as a critical choice for Medicare beneficiaries. We appreciate the opportunity to submit comments and look forward to working with this Administration to ensure stability and affordability for the millions of beneficiaries who choose and rely on Medicare Advantage.

Sincerely,

Mary Beth Donahue
President & CEO
Better Medicare Alliance

cc: Kim Brandt, Chief Operating Officer and Deputy Administrator, CMS
John Brooks, Chief Policy and Regulatory Officer and Deputy Administrator, CMS
Heather Flick, Chief of Staff, HHS
Theo Merkel, Special Assistant to the President for Domestic Policy

[6] Better Medicare Alliance, Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional Fee-for-Service Medicare, December 2020. Available here.

ATTACHMENT

Better Medicare Alliance's Comments on Proposed Policy Changes

Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2026

- **2026 Growth Percentage Estimates**

Better Medicare Alliance urges CMS to include the most recently available data in calculating the Effective Growth Rate to account for current utilization and medical cost trends.

CMS is proposing a 5.93% Effective Growth Rate. The Effective Growth Rate reflects the current estimate of the growth of the payment benchmarks used in the Medicare Advantage program. This rate is mostly determined by the growth in Fee-for-Service Medicare per capita costs.

BMA Comments

In recent years Better Medicare Alliance has expressed its concerns with the proposed growth rates, arguing they do not reflect current medical trends in cost and utilization. As CMS explains in the Advance Notice, it uses historical Fee-for-Service claims from the National Claims History (NCH) file to calculate historical benefit expenditures, while relying on completion factors developed from recent program experience to gross up historical Fee-for-Service claims to account for more recent years. Better Medicare Alliance understands, for example, that the Part A Fee-for-Service data used in the Advance Notice is only through 2023 and could lead to a growth rate that does not reflect the current and accelerating beneficiary utilization trends and medical costs.

We raise here that using recent program experience to establish completion factors may be less likely to accurately predict future costs in a rapidly changing cost environment. Using the latest data is important, as other cost trend studies have estimated costs to be accelerating. Milliman recently published a white paper highlighting CMS data that estimated medical costs in Fee-for-Service Medicare to be increasing from 2023 to 2024 by 8%.[7] PwC released its "Medical Cost Trend: Behind the numbers 2025" presentation where they noted that medical cost trends for the commercial market will grow 8% in 2025 after growing an estimated 7% in 2024 and 6% in 2023.[8] Additionally, Milliman's commercial medical cost index showed a 7% increase in costs in 2024.[9] While the PwC and latter Milliman analyses are for commercial plans, all three analyses show cost pressures above the Advance Notice's Effective Growth Rate and are significantly above what CMS proposed for the Medicare Advantage growth rate.

As proposed, the CY 2026 Advance Notice risks failing to properly account for rise in medical costs. If implemented as proposed, the payment model would fail to keep pace with expected costs and will fail to cover Medicare beneficiaries' cost of care.

---

[7] Milliman, "PY 2025 ACO REACH RTA Tailwind." Available here.
[8] PwC, "Medical Cost Trend: Behind the Numbers 2025." Available here.
[9] Milliman, "2024 Milliman Medical Index." Available here.

Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2026

- **IME Phase Out**

Better Medicare Alliance recommends that CMS spread the implementation of the technical change of removing indirect graduate medical education (IME) costs from the growth rate over two years, CY 2026 and CY 2027.

CMS proposes implementing the remaining 48% of a one-time technical correction that accounts for removal of IME costs in CY 2026. CMS previously included these costs in the calculation of the growth rate and has been removing them over a period of three years. In the CY 2024 Rate Announcement, CMS proposed implementing the IME technical correction over three years, with a one-third portion each year. In the CY 2025 Rate Announcement, CMS proposed phasing out the IME technical correction more slowly in CY 2025 and leaving nearly half of the entire phase out (48%) for CY 2026.

BMA Comments
Better Medicare Alliance recommends that CMS spread the implementation of the technical change of removing IME costs from the growth rate over two years, CY 2026 and CY 2027. The Advance Notice estimates fully implementing the IME phase out in CY 2026 lowers the Fee-for-Service growth rate by 1.42%. We appreciate the reasons for this technical change but encourage CMS to consider ways to reduce volatility in a challenging cost environment. We believe spreading removal of the remaining IME costs over two years would provide greater predictability for health plans operating in the current environment and more reasonably align with the initial proposed phase out schedule put forth in CY 2024. The added predictability in Medicare Advantage payments would help stabilize the program and minimize disruption to beneficiaries after the previous two years of payment rates that came in below the growth rates Medicare Advantage plans experienced.

- **Normalization Factors**

Better Medicare Alliance asks CMS to reconsider the multilinear regression methodology to calculate the Fee-for-Service normalization factor adopted for CY 2025 until further evaluation and engagement with relevant partners is conducted to understand the impact the methodology will have. We reiterate our request for additional information and clarification on the methodology.

CMS has implemented a new multilinear regression methodology to calculate the Fee-for-Service normalization factor. The proposed methodology departs from the linear slope methodology CMS largely followed from 2007 to 2024, in part to account for the effects of COVID-19 on average risk scores and trends.

BMA Comments
Better Medicare Alliance appreciates the focus on understanding and accounting for the effect COVID-19 has across federal health care programs, including Medicare Advantage. The multilinear regression methodology to calculate the Fee-for-Service normalization factor seeks to account for the effects of COVID-19. However, we are concerned the methodology change overly weights the COVID-19 data years and may not reflect future risk score trends. Further, the impact of the new methodology has put additional pressure on the stability of Medicare Advantage.

Like the introduction of the V28 risk adjustment model, the introduction of multilinear regression model for calculating normalization factors could have benefited from greater stakeholder engagement throughout the policy development process. Better Medicare Alliance encourages CMS to provide greater transparency on the process used to evaluate these methodologies and determining their predictive accuracy and reasonableness, including whether additional data years would improve the predictive accuracy and to engage with stakeholders on alternative methodologies under consideration to better align the intent and policy proposals.

- **Normalization Factors for the RxHCC Models**

Better Medicare Alliance requests CMS carefully monitor the impact of calculating two different normalization factors for the RxHCC Models of Medicare Advantage Prescription Drug (MA-PD) plans and standalone Prescription Drug Plans (PDPs) and consider waiting to implement until additional data is available to better understand the impact.

CMS proposes to apply separate normalization factors for MA-PD plans and PDPs for the second year in a row.

BMA Comments
Better Medicare Alliance requests CMS carefully monitor the impact of calculating two different normalization factors for the RxHCC Models of MA-PD plans and PDPs. As nearly all Medicare Advantage beneficiaries (98%) are enrolled in an MA-PD plan compared to a Medicare Advantage only plan, BMA is concerned calculating separate normalization factors for the MA-PD and PDP RxHCC Models may have a greater impact on MA-PD plans than PDPs.[10] Further, waiting for more complete data to better understand the impact could be helpful and more insightful to CMS and stakeholders. Nevertheless, we encourage CMS to engage stakeholders should it begin to see a widening of the relative impact of the two normalization factors.

- **Medicare Advantage ESRD Rates**

Better Medicare Alliance appreciates the ongoing efforts to ensure Medicare Advantage ESRD payment rates are adequate and accurate. Since over 50% of Medicare beneficiaries with ESRD are now enrolled in Medicare Advantage, we urge CMS to continue its evaluation of alternate payment methodologies to ensure there are no unnecessary distributional impacts that could limit access.

CMS proposes to continue setting Medicare Advantage ESRD rates at the state-level using updated Fee-for-Service costs, including reimbursement and enrollment data from 2019-2023. CMS also notes that it reviewed experience data for ESRD enrollees for 2021 and 2022 using the CY 2023 and CY 2024 Bid Pricing Tools (BPT) and found "revenues for ESRD enrollees exceed the corresponding net medical costs for most plans."

BMA Comments
Better Medicare Alliance supports access to Medicare Advantage for beneficiaries with end-stage renal disease (ESRD), in order to provide supplemental benefits and enhanced care

[10] Analysis of CMS Monthly Enrollment Files. June 2024.

coordination offered by Medicare Advantage. Beneficiaries with ESRD clearly want and use this access, as shown by MedPAC's recent evaluation that found the share of beneficiaries with ESRD in Medicare Advantage plans increased from 27% in 2020 to 52% in 2023.[11] We continue to urge CMS to evaluate whether state-level payment rates are adequate within more local areas, to ensure that beneficiaries in certain regions do not see higher out-of-pocket costs, reduced benefits, or limited service areas due to payment pressures.

While Better Medicare Alliance appreciates CMS' analyses of the BPT data, we note that the findings that revenues exceed costs for "most plans" suggest some plans had costs above revenues. Without access to the same data, we are concerned that there may be geographic concentrations of plans with unfavorable economics, which could indicate an alternate payment approach would be more appropriate. A study from 2019 found significant geographic payment to cost variation within local areas[12], and Better Medicare Alliance continues to request that CMS evaluate whether statewide payment rates are the best solution for this high-need population.

- **Medicare Advantage EGWPs**

Better Medicare Alliance supports CMS' proposal to continue the current payment methodology and the continuation of the policy permitting EGWPs to buy down Part B premiums. We also appreciate and support CMS publishing preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice.

CMS is proposing to continue the current payment methodology used in 2025 for CY 2026, as well as waiving BPT bidding requirements. The policy permitting EGWPs to buy down Part B premiums will also continue. CMS again published preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice following inclusion in 2022.

BMA Comments

Employer Group Waiver Plans (EGWP) represent a successful public-private partnership that addresses the health care needs of an important segment of today's retirees and accounts for approximately 17% of the Medicare Advantage population.[13] EGWPs successfully enable employers nationwide to maintain consistent benefits and manage costs for over 5.7 million retirees' health coverage.[14] Employers, state and local governments, and unions increasingly rely on Medicare Advantage to provide lower cost health benefits to retirees that often live on fixed incomes.

Accordingly, Better Medicare Alliance supports CMS' proposal to continue the current methodology and the BPT waiver for EGWPs for CY 2026, and we support the continuation of the policy permitting EGWPs to buy down Part B premiums. Furthermore, we appreciate CMS' intent to continue adjusting the individual plan bid-to-benchmark ratios to account for enrollment differences based on the timing of the Rate Announcement release and publishing preliminary bid-to-benchmark ratios ahead of the Final Rate Announcement. Providing the additional month supports EGWPs by informing their expectations for the upcoming year.

---

[11] Medicare Payment Advisory Commission (MedPAC). "Assessing payment adequacy and updating payments: Outpatient dialysis services". December 13, 2024. Available here.

[12] Better Medicare Alliance. "Analysis of End-Stage Renal Disease Payment Adequacy in Medicare Advantage". December 13, 2019. Available here.

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

[14] *Id.*

- **CMS-HCC Risk Adjustment Model for CY 2026 – Risk Adjustment Model Development Using Medicare Advantage Encounter Data**

Better Medicare Alliance strongly encourages CMS to engage with us and the broader Medicare Advantage community before proposing a transition to an encounter-based risk adjustment model.

CMS noted (but did not propose) that it has been working on calibrating the risk adjustment model using Medicare Advantage encounter data, including diagnosis, cost and use data submitted to CMS by Medicare Advantage plans, and CMS may be able to start phasing in an Medicare Advantage encounter data-based model as early as CY 2027.

BMA Comments
Better Medicare Alliance strongly encourages CMS to engage with us and the broader Medicare Advantage community before proposing a transition to an encounter-based risk adjustment model. CMS should make clear what an encounter-based risk adjustment model is and how it would operate *prior to* proposing it in rulemaking. Better Medicare Alliance stands ready to share input on how such a model would affect beneficiaries, providers, health plans, and the program's stability throughout (and especially early on in) any process to transition to such an encounter-based risk adjustment model.

We emphasize these comments not only apply to transitioning to an encounter-based risk adjustment model, but also to changes to the risk adjustment model in general. Engaging stakeholders by publicly collaborating with the broader Medicare Advantage community, including providers, health plans, and Medicare and aging-focused groups, throughout the development of any type of revision to the risk adjustment model raises the likelihood health plans can implement updates without disruption to the benefits Medicare beneficiaries rely on year to year. We look forward to partnering with CMS as we work towards Medicare Advantage's long-term stability.

Updates for Part C and D Star Ratings

- **Universal Foundation**

Better Medicare Alliance appreciates CMS implementing a Universal Foundation of quality measures and offers comments specific to that consideration.

CMS is implementing a Universal Foundation of quality measures, which is a core set of quality measures aligned across CMS programs, to focus attention on measures that are meaningful across beneficiary populations and reduce provider burden by streamlining measures to focus on clinical care, outcomes, and patient experience.

BMA Comments
Better Medicare Alliance appreciates the commitment to ensuring high-quality care is delivered in Medicare Advantage and across all CMS programs, and we are supportive of CMS' intent to align standards across certain measure domains. The domains that CMS focuses on, including wellness and prevention, chronic conditions, behavioral health, care coordination, person-centered care, and screening for social factors that drive health outcomes are all domains Better Medicare Alliance recognizes as critical components of the Medicare Advantage model and

where beneficiary impact is greatest. We further support the reasoning for establishing a core set of measures, including reducing burden for stakeholders, especially providers who typically navigate a variety of payers in a single day, promoting uniformity, and increasing the focus on outcomes-based measures.

Better Medicare Alliance asks that CMS be mindful when considering measures for inclusion in the Universal Foundation. We request that in their approach, CMS thinks holistically about how the measures work together and whether there are opportunities to streamline existing measures. CMS should also provide impact analyses before switching out measures and allow adequate time for a notice and comment period. The Universal Foundation in Stars has great potential to examine quality across all CMS programs, but we want to make certain that the measures all contribute to assessing quality rather than becoming overly burdensome. As CMS considers additional core measures and program specific add-ons, we request it be done with stakeholder input, and we look forward to engaging with the Administration on the identification and inclusion of the Universal Foundation in Medicare Advantage.

- **Display Measures – Social Need Screening and Intervention**

Better Medicare Alliance supports efforts to assess health plan use of standardized screening tools and data collection to screen beneficiaries for social risk factors. As CMS reviews and formulates a potential measure, it should consider the many collection tools already deployed and the dynamics and resources available for referrals within the local communities where beneficiaries reside.

NCQA added the Social Need Screening and Intervention measure to the display page for the 2025 ratings. The current measure only captures LOINC codes mainly in use in electronic records, but NCQA is considering G and Z codes for inclusion, in CY 2026 at the earliest.

BMA Comments
Better Medicare Alliance commends CMS for its efforts in understanding how beneficiaries are screened for social risk factors. While many health plans do currently screen beneficiaries for social risk factors, further incentivizing health plans to conduct or implement screening will help ensure beneficiaries have access to the care and services they need. As this measure is further conceptualized, we urge CMS, as we did last year, to consider the variety of methods and tools health plans, providers, and community partners have developed in recent years to collect beneficiary data related to social risk factors. There is a robust data ecosystem that now exists among stakeholders, so it is pertinent that current tools and methods are accounted for as a collection tool for purposes of this measure. The level of sophistication employed in collecting this data varies as well, ranging from traditional pen and paper to integrated software platforms that providers, community partners, and health plans can access. For example:

- Wellsky, formerly Healthify, developed a platform that identifies social needs, finds local services, enables bi-directional referrals, and coordinates care with an accountable network community- based organization (CBO) to address social needs. This platform can be integrated into health plan and provider clinical systems, further easing the burden of logging into multiple systems and allows stakeholders across the continuum

of care to follow beneficiaries.[15]

- Community-based organizations like Meals on Wheels America and their local member programs partner with health plans for their core meal delivery and wellness check-in services. Health plans also recognize the value of Meals on Wheels programs having regular contact with and access to beneficiaries and worked with Meals on Wheels to develop and refine their data capabilities in order to collect additional information about beneficiary needs. That information can then be shared back to health plans to inform them about what their members' needs are and the type of services that may be offered to address those needs.[16]
- SCAN Health Plan, a non-profit plan serving over 273,000 Medicare beneficiaries in California, Arizona, Nevada, New Mexico, and Texas, is a leader in addressing social risk factors in its beneficiaries. The health plan has roots in social service and currently incorporates questions related to social drivers of health (SDOH) into its health risk assessments (HRA). The SDOH information collected in the HRA is then used to assign beneficiaries to the appropriate care management tier based on their risk, and various interventions are deployed depending on risk tier and targeted based on needs identified.[17]

For a comprehensive picture of the many data collection tools and methods developed by stakeholders, we recommend CMS engage with and conduct outreach to further inform the development of a measure for Stars and ensure stakeholders have the appropriate and necessary infrastructure and technology needed to adequately screen and connect beneficiaries to the appropriate intervention.

Moreover, we support actions that incentivize and promote screening and interventions on behalf of the beneficiary to address social needs. However, our Allies and stakeholders have previously expressed concern that even when a need is identified through screening, more harm results because the community lacks the resources necessary to properly address the unmet need.[32] As such, we are concerned that if the measure necessitates beneficiaries receiving services through referral and intervention, health plans may be unfairly penalized for lack of resources in the community. We request CMS continue engaging with stakeholders as it considers developing a measure based on NCQA's work for screening and intervening for social needs.

- **Retirement of Display Measures – Health Equity Index**

Better Medicare Alliance urges CMS to contemplate whether the Health Equity Index (HEI) reward will meaningfully address disparities as intended and looks forward to engaging the Administration further.

In the CY 2026 Policy and Technical Changes Proposed Rule (CMS-4208-P), CMS proposed three updates to how the HEI reward is calculated 1) for contract consolidations for the second year following consolidation, 2) for plans that have or will move a D-SNP in an existing contract to a D-SNP only contract to satisfy state Medicaid requirements, and 3) for permissible I-SNPs. In the CY 2026 Advance Notice, CMS seeks feedback on adding Social Risk Factors (SRF) such as

---

[15] Center for Innovation in Medicare Advantage, Case Study Report: Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries, January 2022. Available here.
[16] *Id.*
[17] *Id.*

geography (and how to define "geography") to the HEI reward.

BMA Comments
As we noted in our comments to the CY 2026 Policy and Technical Changes Proposed Rule, Better Medicare Alliance appreciates the clarifications in the proposed rule as stakeholders prepare for the application of the HEI. It is critical that populations with the specified social risk factors are contemplated and actively addressed by health plans to reduce disparities and improve health outcomes of these populations. Nevertheless, we urge CMS to contemplate whether the HEI reward will meaningfully reduce disparities as intended. Better Medicare Alliance looks forward to engaging the Administration to discuss the unique opportunities within Medicare Advantage to address the underlying drivers of health within the population.