UNITEDHEALTH GROUP

February 25, 2026

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Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Chris Klomp
Director of Medicare,
Centers for Medicare & Medicaid Services
Chief Counselor,
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted Electronically: www.regulations.gov

Re: Calendar Year (CY) 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Oz and Director Klomp,

UnitedHealth Group (UHG) is pleased to respond to the Centers for Medicare and Medicaid Services (CMS) request for comments regarding the C*alendar Year (CY) 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.* We remain committed to strong stewardship of the Medicare program by protecting beneficiaries' access to high-quality, affordable care and supporting informed consumer choice.

UHG is focused on advancing solutions that improve health outcomes, strengthen quality and ensure that Medicare delivers lasting value for the people it serves. We share CMS's core objectives: payment accuracy, transparency, accountability, and a system that rewards high quality, coordinated care while protecting taxpayer resources. We look forward to continued opportunities to work with CMS and the Trump Administration to strengthen and modernize MA for the more than half of all Medicare beneficiaries enrolled in the program.

MA delivers significantly lower out-of-pocket costs for beneficiaries and provides more comprehensive and coordinated care that achieve better health outcomes, all while serving a lower-income and more clinically complex population than Medicare Fee-For-Service (FFS). MA beneficiaries report a 95% satisfaction rate with the program and save 54% in medical expenses compared to Medicare FFS.[1,2] Additionally, the MA program generates 9% savings to the Federal government compared to Medicare FFS through the more effective management of health care costs.[3] Overall, MA has an established track record of delivering better health outcomes, with a more than 40% lower rate of avoidable hospitalizations and 33% fewer

[1] ATI Advisory. "Medicare Advantage Medicare Advantage Beneficiaries Spend Less on Health Care Premiums and Out-of-Pocket Costs than Fee-For-Service Beneficiaries." March 2023. https://atiadvisory.com/resources/https-atiadvisory-com-resources-wp-content-uploads-2023-03-ma-cost-protections-data-brief-2023-pdf/
[2] Milliman. "Comparison of annual beneficiary health care costs across Medicare coverage options, 2025." January 2026. Comparison of annual beneficiary health care costs across Medicare coverage options, 2025
[3] Milliman. "Value of Medicare Advantage to the Federal Government." January 2026. Value of Medicare Advantage to the federal government, 2025

preventable emergency room visits than Medicare FFS beneficiaries.[4,5]

This year's MA Advance Notice comes at a critical moment. Seniors and providers across the country are navigating rising medical costs and increased utilization. CMS's proposed funding rate falls far short of what is needed to maintain stable, sustainable coverage and access for beneficiaries. The rate shortfall is primarily driven by growth rate assumptions that do not fully reflect real-world care patterns or cost drivers. The result is a proposal that would inadequately fund the program at a time when seniors, more than ever, need predictability and protection from further disruptions to their access to care, health benefits, and out-of-pocket costs.

Over the past three years, the MA program has already absorbed more than $130 billion in cumulative payment reductions from prior policy changes. The effects of these cuts have been profound and are directly impacting beneficiaries:

- More than 5 million seniors have been affected by plan closures between 2024 and 2026 – an 18-fold increase compared to the prior three-year period.
- Plan choice is narrowing with 335 fewer non-SNP plans being available in 2026.
- Rural seniors now face nearly twice the likelihood of a plan closure, underscoring widening disparities in regions that are already struggling with provider shortages.
- The average beneficiary has experienced a $900 increase in out-of-pocket maximums in just two years – an erosion of affordability that hits the most vulnerable the hardest.

When the MA program is underfunded, it directly translates into fewer resources for care coordination, increased out-of-pocket costs for seniors, reduced core and supplemental benefits, fewer plan choices, and less competition in the marketplace.

Growth Rate Assumptions Need to Reflect Real Utilization and Cost Trends

CMS's proposed +4.97% growth rate for 2027 significantly understates the expected health care cost trajectory for both FFS Medicare and the MA program. A more accurate estimate – based on full-year 2025 data, observed utilization patterns, and historical cost trends – is closer to 9% to 10%. Several factors drive this significant gap:

- Utilization is not decelerating as CMS assumes; demand for hospital, physician, and post-acute care is growing as seniors continue to access care and face more complex, higher-acuity health needs.
- Unit costs are not decelerating as CMS assumes; unit costs for hospital and physician services remain elevated, influenced by workforce shortages, inflation, and adoption of certain technologies.
- CMS's assumed medical trend projections rely on incomplete 2025 data, missing the later quarters that historically reflect higher-cost seasonal patterns.
- Likely congressional adjustments to the physician fee schedule, which have occurred in five of the last six cycles, are not considered in the 2027 medical trend or unit cost projections.

[4] Center for Innovation in Medicare Advantage, Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional FFS Medicare, December 2020. BMA-High-Need-Report.pdf

[5] Avalere. "Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare." July 2018. https://bettermedicarealliance.org/publication/medicare-advantage-achieves-better-outcomes-than-traditional-medicare/

If left uncorrected, these assumptions and the resulting overall proposed funding rate would reduce benefits by an estimated $50 per member per month – representing over $600 in lost value for seniors annually.

Appropriate, Predictable Implementation of Risk Adjustment Changes

We share CMS's goal of ensuring the risk adjustment model is accurate, data-driven, and clinically grounded. However, recalibrating v28 using only 2023 diagnoses / 2024 expenditures introduces significant volatility and risks misaligning payment with actual beneficiary needs.

Post-COVID FFS Medicare coding shifts and the anomalous 2024 surge in wound-care spending – largely driven by rapid growth in skin substitute utilization – distort condition weights and inadvertently provide greater future funding for wound care at the expense of funding for populations suffering from chronic disease. As a result, conditions such as chronic obstructive pulmonary disease (COPD), heart failure, chronic kidney disease (CKD), depression, rheumatoid arthritis, substance use disorders, and morbid obesity would be severely underfunded, and reduced recognition of disease interactions would further disadvantage the most medically complex seniors who depend on coordinated, multidisciplinary care. These pressures would also strain value-based care providers, who rely on stable, predictable funding to sustain care coordination and complex care models, behavioral health integration, and supplemental services that prevent avoidable hospitalizations and reduce the overall cost of health care.

To protect beneficiaries and maintain stable value-based care, CMS should adopt adjustments that smooth volatility in the v28 recalibration – specifically by phasing in or blending the update over a three-year period to minimize the unintended consequences of single year anomalies (e.g., skin substitute costs that spiked in 2024) or delaying implementation all together until recalibration can accurately normalize for predictive medical costs.

In the long-term, and consistent with UHG's response to the MA modernization Request for Information (RFI) included in the 2027 MA and Part D Proposed Technical Rule, we would like to partner with CMS on the development of a robust MA encounter-based model. Transitioning to such a model has the potential to more accurately address the cost and care patterns in the MA program and avoid unintended consequences like seen in this proposed v28 recalibration.

Support for Chart Review Modernization

UHG fully supports CMS's proposal to require that diagnoses derived from chart reviews be linked to underlying encounter data. Our organization has long backed CMS's work to modernize chart reviews in MA, and in our recent response to the 2027 MA and Part D RFI, we similarly urged reforms that strengthen data integrity and ensure diagnoses are consistently supported by clinical encounters.This policy reflects thoughtful modernization. The impact of CMS's proposed change to the chart review process aligns with CMS's own estimates of unaddressed coding pattern differences in MA as detailed in a recent Health Affairs study. We believe this is an appropriate and reasonable step that strengthens data integrity and promotes

payment accuracy.[6]

As CMS finalizes the policy, we recommend targeted operational refinements – including clear linkage criteria that reflect real-world billing patterns, a new member exception to ensure continuity for beneficiaries switching plans, and reasonable flexibility around encounter timing. These adjustments would strengthen program integrity safeguards and ensure risk adjustment continues to accurately support medically complex beneficiaries.

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UHG appreciates the opportunity to provide these comments and remains committed to working collaboratively with CMS. We look forward to continued partnership with CMS to implement updates that preserve program stability, reflect meaningful stakeholder input, and enhance the value and sustainability of MA for the more than 35 million seniors who depend on it.

Sincerely,

Bobby Hunter

CEO, UnitedHealthcare Government Programs

[6] Health Affairs Scholar. (2026) An Updated Analysis of Coding Pattern Differences in Medicare Advantage. https://academic.oup.com/healthaffairsscholar/article/4/1/qxag010/8430651

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CY2027 Advance Notice Technical Comments

Attachment I. Preliminary Estimates of the National Per Capita MA Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2027

Section B. 2027 Growth Percentage Estimates

CMS's proposed 2027 Medicare Advantage (MA) effective growth rate of 4.97% significantly understates underlying cost trajectories observed in published FFS rates and does not reflect the well documented, sustained rise in utilization that MA plans and providers are experiencing today and that is expected to continue into the future. By setting the growth rate four percentage points below the finalized 2026 MA growth rate of 9.04%, the proposal introduces a structural underfunding of MA that does not keep up with current utilization and health care cost increases. This significant gap would have material consequences for beneficiary affordability, benefit stability, and plan sustainability at a time when medical cost pressures continue to accelerate.

This gap would put a significant strain on providers—especially those in value-based care—by forcing hospitals and physician groups to absorb higher costs without adequate reimbursement, leading to staff cuts, fewer access points, and diminished resources for patients. When providers can't sustain the care coordination, analytics, and risk-management infrastructure they have invested in, they are more likely to pull back from downside-risk arrangements, slowing the nation's progress toward value-based care; ultimately, inaccurate trend assumptions amplify financial pressure across plans and providers alike, resulting in fewer benefits, reduced capacity, and a poorer experience and fewer choices for MA beneficiaries.

Recent experience makes clear that Medicare utilization and health care costs are rising in ways that directly contradict the deceleration assumed in the Advance Notice. Across 2023–2025, the delivery system has undergone a structural reset marked by sustained patient demand, higher acuity needs, and expanded provider capacity, with no indication that there will be a return to pre-2023 patterns. Cost pressures continue to intensify: inpatient, outpatient, and SNF unit cost trends have run higher than historical averages, driven by persistent wage inflation, pharmaceutical and supply costs, rising clinical complexity, and increasing case mix intensity.

These pressures are further amplified by chronic care backlogs, AI-enabled provider productivity gains, expanded clinical detection, and provider and hospital consolidation—all of which are driving more encounters, delivered at higher acuity, and at higher underlying prices. Emerging activities such as advanced revenue-cycle tools, ER upcoding, inflated lab billing, and expanded use of remote monitoring add even more upward pressure that is not fully reflected in CMS's assumptions.

Across the health industry, major health systems and physician organizations are projecting continued volume expansion and strong patient demand into 2026, underscoring the risk of underestimating utilization and costs. Independent industry analyses reinforce these findings.

- A PwC actuarial trend study noted that, "The US healthcare system is heading into another year of powerful inflationary forces exerting pressure with few deflationary forces in sight," with health systems facing escalating operating costs and adopting aggressive revenue-cycle strategies to maximize reimbursement and utilization.[7]
- Additional global trend reports from Lockton, Aon, and Mercer show accelerating medical trends that are expected to persist, highlighting that health cost drivers are decoupled from general inflation.[8] [9] [10]

Taken together, the evidence shows that pressures on the Medicare system are structural, not transitory, and that growth rate assumptions must be adjusted to reflect the realities facing beneficiaries, providers, and plans.

A more accurate growth rate—closer to 9–10%—is warranted, actuarially sound, and better aligned with prevailing utilization and cost realities. CMS's proposed rate is 4-5% too low, driven by assumptions that diverge sharply from recent experience and rely on incomplete or atypical data patterns that are unlikely to persist. CMS's growth rate methodology materially understates future program costs through methodological flaws, including:

- Relying on unsupported utilization assumptions.
- Using incomplete 2025 data, undermining reliability.
- Assuming declining hospital unit costs contrary to experience.
- Ignoring likely future physician fee schedule updates.

Recommendation: To accurately reflect expected cost and utilization pressures, CMS should raise the Effective Growth Rate by approximately 5%, supported by the following components: 1% from the 2025 base, 1.2% from inpatient utilization, 0.8% from physician utilization, 0.9% from 2027 physician and facility fee schedule impacts, and 1.1% from other emerging cost drivers observed in the accelerating 2025 medical trends.

<u>The Growth Rate relies on unsupported utilization assumptions</u>

CMS's forward-looking utilization trends for both physician and inpatient services are substantially below observed levels**.** Physician utilization has grown steadily—from 3.87% in 2023 to 5.57% in 2025—yet CMS projects an abrupt decline to 1.99% in 2026 and 2.93% in 2027. Similarly, inpatient utilization has risen from 2.86% in 2023 to 3.23% in 2025, yet CMS assumes it drops to 1.43% in 2026 and 0.64% in 2027. There is no policy, clinical, demographic, or payment related rationale that would support such steep and immediate deceleration. If recent average trends were simply carried forward, the growth rate would increase meaningfully, by an estimated 0.8% (physician) and 1.2% (inpatient) in 2027. CMS's assumption of sharp

[7] PricewaterhouseCoopers LLP. (2025, July 16). *Medical cost trend: Behind the numbers 2026*. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html
[8] Lockton (2025, November). 2026 Global Healthcare Cost Trend Report.
[9] Aon (2025). 2026 Global Medical Trend Rates Report.
[10] Mercer Marsh Benefits (2025). Health Trends 2026.

utilization declines is both unprecedented and inconsistent with the ongoing post-pandemic rebound in health care services demand.

Inpatient Utilization Trends	**Physician Utilization/Other Trends**
*CMS forward looking trends are **far below** recent years*	*CMS forward looking trends are **far below** recent years*
2023: 2.86% 2024: 3.56% 2025: 3.23% **2026: 1.43%** **2027: 0.64%**	2023: 3.87% 2024: 4.31% 2025: 5.57% **2026: 1.99%** **2027: 2.93%**
If inpatient trends remained consistent with current experience this would increase the growth rate by 1.2% in 2027.	**If outpatient trends remained consistent with current experience this would increase the growth rate by 0.8% in 2027.**

The evidence shows that rising utilization is not a temporary fluctuation but a durable, accelerating feature of today's Medicare environment. Higher-acuity needs continue to drive demand, fueled in part by post-pandemic chronic-care backlogs that are pushing more patients into complex care pathways. The health care system's capacity and productivity have expanded significantly: AI-enabled workflows, advanced clinical detection tools, and widespread scribe adoption have increased provider throughput, while revenue-cycle–enabled productivity technologies are boosting reimbursement yield by up to 3% per encounter, elevating both the frequency and intensity of services delivered. .[11,12, 13]

Consolidation across hospital systems and private-equity-backed physician groups are further scaling these productivity-enhancing models, enabling more encounters to be delivered at higher levels of acuity. Forward-looking indicators confirm that these pressures will persist:

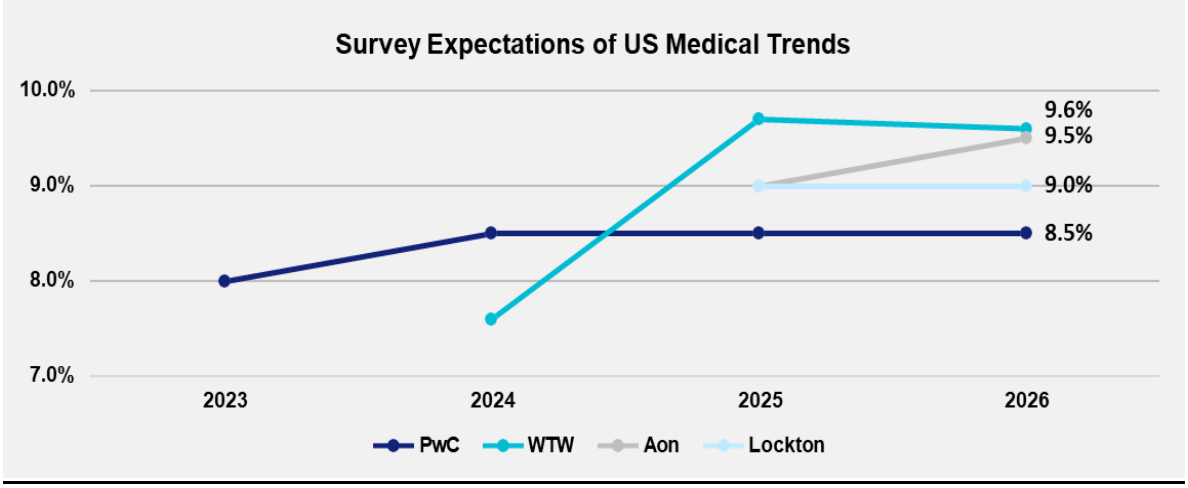
- According to a recent National Health Expenditures Report, elevated trends can be attributed to a rebound in service use and rising clinical intensity, noting that post-pandemic utilization and intensity surged, with hospital prices growing 2.7% in 2023 and 3.4% in 2024, the fastest since 2007. [14]
- PwC reports that medical cost trends are hovering at 15-year highs, driven by inflationary pressures from hospitals and health systems, and finds that over half of insurers expect trends to continue rising and remain elevated for at least three more years.[15]
- Willis Towers Watson similarly highlights that utilization has risen for two consecutive years, accelerated by demand recovery and expanded provider capacity—including the

[11] Based on UHC analysis, Trilliant Health Research.
[12] Trilliant (2025) "Changes in Coding Intensity Across Outpatient Settings" https://www.trillianthealth.com/market-research/studies/changes-in-coding-intensity-suggest-upcoding
[13] Vizient 2023 "Artificial Intelligence Current State and Future Strategy Survey Result" https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/97356e67411c48c48f4110f6d41671a8?v=010eda3e
[14] 2024 National Health Expenditures (2025) https://www.cms.gov/files/document/highlights.pdf
[15] PricewaterhouseCoopers LLP. (2025, July 16). *Medical cost trend: Behind the numbers 2026.* https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

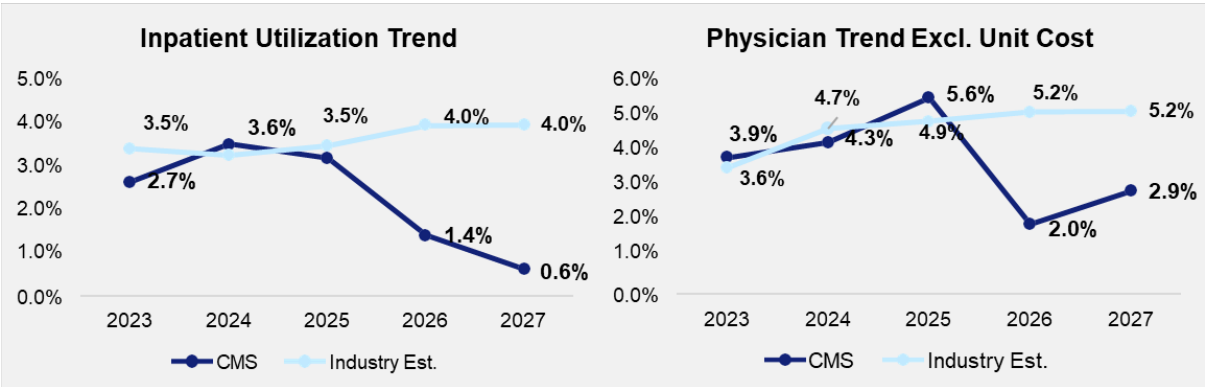
growing use of AI in clinical settings, which boosts throughput and enables more care to be delivered.[16]

- Mercer underscores that physician trends are being pushed upward by accelerating specialist utilization, as patients increasingly bypass PCPs, specialists expand their roles, and technology improves clinical detection and documentation—together increasing downstream care and overall trend levels.[17]

Public Sources Universally Predict that Trends will Remain Elevated



The medical trends detailed in the chart above far exceed CMS's estimates outlined in the 2027 MA Advance Notice. In the charts below, historical estimated industry trends are in line with CMS observed trends (2023-2025); however, significant variation exists in the forward-looking trends. Industry estimates reflect stable utilization levels other than the recognition of favorable 2025 calendar year impacts given the 2024 leap year that depressed 2025 trends.



Impact on Medical Trend *2026 = 0.5%; 2027 = 0.7%* Impact on Growth Rate	Impact on Medical Trend *2026 = 0.5%; 2027 = 0.3%* Impact on Growth Rate
1.2%	0.8%

[16] WTW (2025) 2026 Global Medical Trend Insurer Perspective – Survey Report
https://www.wtwco.com/en-us/insights/2025/10/2026-global-medical-trends-survey
[17] Mercer Marsh Benefits (2025). Health Trends 2026.

Trends are based on incomplete 2025 data, undermining reliability

This is a significant gap: Q3 and Q4 account for more than half of annual Medicare claims and are typically the highest utilization periods. Trends observed in the early months of 2025 therefore cannot be assumed to represent full year experience, and CMS's projections likely understate the intensity and volume of services that will ultimately be reflected in complete FFS claims.

Current experience shows that the ACO REACH FFS National Reference Population is trending closer to 9%. This suggests that the partial-year data CMS relied upon significantly understates the real trajectory of 2025 FFS cost growth.

Over the past several years, late year data has frequently been the driver of upward revisions to growth rates. It is essential to recognize that CMS has historically adjusted MA growth rates upward once full-year data — including Q3 and Q4 claims — becomes available. These late year updates have often been material, with significant swings occurring once CMS replaces partial-year experience with mature full-year claims data.

Because the 2027 MA Advance Notice is again based on partial year information, it likely understates true utilization and cost pressures—exacerbating the disconnect between CMS's projections and real-world health care costs. MA plans' 2027 bids are generally based on actual 2025 base period expenditures, completed through at least 2 months, and trended forward 2 years. To the extent that OACT underestimates 2025 expenditures in its 2027 FFS cost projections due to leveraging incomplete data, the disconnect causes MA benefit funding to be reduced even before 2026 / 2027 cost trends are reflected.

Trends assume declining hospital unit costs contrary to experience

CMS's proposal assumes declining hospital unit costs despite a consistent pattern of unit cost growth outpacing expectations in prior rate announcements. Hospitals continue to experience rising labor costs, persistent inflationary pressure on supplies and pharmaceuticals, and capacity constraints that drive acuity and case mix. The proposal does not reflect these structural cost drivers and instead relies on an assumption of cost moderation that has not been observed in FFS or MA claims.

Medicare unit costs are materially understated in the 2027 Advance Notice because CMS does not account for well-established, recurring increases in both physician and hospital payments. CMS also overlooks continued hospital cost pressures. The FY 2026 IPPS final rule included a 2.5% base rate increase and an additional 1.7% increase tied to uncompensated care, yet CMS assumes these pressures simply disappear in 2027—even though ongoing Medicaid and Exchange churn means higher uncompensated care costs will continue. By leaving out these known, ongoing cost increases, the Advance Notice significantly understates unit cost trends for 2027.

Provider benchmarking results reinforce this trend. Kaufman Hall data shows that net revenue per provider has climbed from $369,000 in late 2021 to more than $400,000 in late 2025, a clear indicator that each unit of care is more expensive than it was just a few years ago. At the same

time, many large health systems have experienced significant operating margin growth, supported by increased reimbursement per service and more sophisticated revenue cycle strategies.

Rates ignore likely future physician fee schedule updates

CMS's assumptions appear to ignore likely future updates to the physician fee schedule. Over the past decade, Congress has consistently intervened—often at the end of the calendar year or mid-year—to increase Medicare physician payments above what was originally scheduled, creating a well-established pattern of mid-year upward adjustments that meaningfully affect Medicare spending. This has consistently resulted in an increase of at least 2.5%.

We believe CMS has authority to incorporate this adjustment because its statutory responsibility is to reflect projected future costs across the entire Medicare health care system when setting MA rates. As CMS has acknowledged, accurate rate development requires accounting for expected changes in provider payment levels, such as the with adjustments to the Sustainable Growth Rate. In this case, Congress has already enacted modifications to the Physician Fee Schedule that materially affect physician reimbursement levels going forward. Because these Congressional adjustments directly influence the underlying cost of providing care, they should be incorporated into CMS's projections of physician costs for MA plan payments.

Even a modest update of this magnitude would translate into approximately a 0.5% increase in overall program costs. Omitting this from the growth rate projections understates expected spending and—given the regularity of congressional intervention—creates a foreseeable and avoidable gap.

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Taken together, these methodological issues produce a proposed growth rate that does not align with actual systemwide utilization, spending patterns, or policy expectations. This level of under-projection compounds across years, locking in benchmarks that are materially below the cost of delivering care in both 2026 and 2027. Ensuring adequate funding for MA is essential not only for maintaining plan stability and affordability for beneficiaries, but also for supporting provider networks and care delivery innovations that improve outcomes, quality, spending patterns, and policy changes. An accurate growth rate is the foundation of a stable Medicare program; when the underlying rate is correct, it provides the predictable funding needed to invest in innovation, modernize care delivery, drive meaningful affordability, and evolve the program to meet beneficiaries' changing needs.

For these reasons, we urge CMS to revise the proposed growth rate to more accurately reflect sustained utilization levels, complete and full year data, realistic unit cost trends, and expected physician payment updates. A growth rate in the 9–10% range is far more consistent with current experience and would provide a more sound and actuarially credible foundation for the program.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2027

Section G. CMS-HCC Risk Adjustment Model

We support CMS's continued efforts to refine the Medicare Advantage (MA) risk adjustment model and ensure accurate, equitable payment. CMS has a meaningful opportunity to ensure that risk adjustment remains an accurate, clinically grounded tool for reflecting beneficiary health needs over time. However, the proposed recalibration of the CMS-HCC model using 2023 diagnoses and 2024 expenditure data raises material concerns about volatility, misalignment with actual program costs, and destabilizing impacts to beneficiaries with complex and chronic conditions, as well as to the providers caring for those patients.

While we support CMS's goal of maintaining a modern, accurate risk adjustment system, the current proposal introduces significant volatility with the potential to disrupt beneficiary access and benefits, as well as undermine care for those with the greatest medical needs. We encourage CMS to further examine the drivers of the unexpected recalibration impacts and adopt a phased or delayed approach that promotes stability, accuracy, and continuity of care.

Volatility Resulting from a Single-Year Calibration

CMS's decision to recalibrate the v28 model using only one year of data (2023 diagnoses and 2024 expenditures) results in an unexpected overall reduction of **–3.32%** in industry risk adjustment payment—more than double the impact associated with a typical normalization (generally –1.5%). Given that the Medicare benefit design is stable and no HCC structural changes were made, it would be reasonable to expect a recalibration from 2018/2019 to 2023/2024 to produce results comparable to a standard normalization adjustment. The magnitude of the shift suggests underlying volatility in the data that requires further investigation before full implementation.

Post-COVID FFS Coding Dynamics Introduce Instability

The new calibration period reflects post-COVID FFS practices that differ significantly from pre-COVID patterns. These shifts—including deferred care, evolving documentation practices, and the lagging effects of COVID-related morbidity—may not represent stable long-term trends. CMS should closely examine how these post-pandemic influences affect the model and potentially distort risk scores, particularly for beneficiaries with multiple interacting conditions.

Misalignment Between Model Calibration and Actual 2027 Expenditures

Several conditions, most notably skin-related HCCs, have substantially increased weights due to unusually high 2024 wound care expenditures that were driven by elevated skin substitute costs. CMS has since mitigated these costs, meaning these expenditures are no longer representative of expected 2027 experience. Accordingly, using these inflated data points

creates an overfunding of certain skin conditions at the expense of other conditions and risks disconnecting payment from expected beneficiary need and actual health care cost. This highlights the danger of calibrating the entire model based on a single anomalous year.

Disproportionate Cuts for Vulnerable, High Needs Populations

The proposed model reduces payment for beneficiaries with chronic and co-occurring conditions such as COPD (HCC 280), CKD Stage 3 (HCC 329), Morbid Obesity (HCC 048), CHF (HCC 226), Major Depression (HCC 155), Rheumatoid Arthritis (HCC 093), and substance use disorders (HCC 137, HCC 139). These are populations that often face significant barriers to care and rely heavily on care coordination and supplemental benefits offered by MA plans. Such reductions may constrain plans' ability to sustain investments in care management and supplemental services for these beneficiaries, with similar impacts felt by value-based care providers.

Specifically, the proposed reductions to HCC coefficients would significantly and disproportionately cut funding for some of the most prevalent, high-cost, and clinically consequential chronic conditions in MA. Lowering coefficients for these high burden diseases risks destabilizing the clinical programs that keep patients well, including those focused on prevention, early detection, medication management, and longitudinal disease control. MA plans rely on adequate funding for these conditions to invest in these services; underweighting common and costly conditions will reduce outreach, narrow care management capacity, worsen outcomes, and ultimately result in more cost for the health care system. For beneficiaries, this could result in greater disease progression, higher hospitalization rates, and the potential loss of supplemental benefits that help maintain independence and quality of life. For the Medicare program, insufficient funding now is likely to shift costs downstream, increasing expenditures as unmanaged conditions lead to greater acuity and more expensive care.

CMS changes for COPD illustrate the consequences clearly. It remains one of the leading causes of emergency visits and hospital admissions among older adults. Effective COPD management—pulmonary rehabilitation, medication optimization, smoking cessation support, and symptom surveillance—requires sustained, predictable investment. Reducing the COPD coefficient misaligns payment with the level of clinical effort needed to prevent exacerbations. Programs that successfully reduce hospitalizations cannot be maintained if payment declines, and downstream Medicare costs will rise as avoidable acute events increase.

Heart failure presents similar concerns. It is a high acuity, high-cost condition requiring intensive, coordinated management, including frequent follow-up, medication titration, fluid status evaluation, and integration across cardiology, primary care, and home-based supports. Even modest reductions in the heart failure coefficient can meaningfully underfund care for a population with the highest hospitalization and readmission rates in Medicare. Reducing coefficients for heart failure risks destabilizing evidence-based programs that slow disease progression, maintain function, and reduce total cost of care.

Behavioral health is also adversely affected. Proposed reductions in coefficients for Major Depressive Disorder (MDD), combined with prior removal of mild MDD and MDD in remission, weaken support for a chronic condition strongly associated with higher medical complexity and

worse outcomes. MDD in older adults drives increased comorbidities, disability, hospitalization, and mortality. Reductions in risk directly limit the resources necessary for screening, collaborative care models, psychotherapy access, and relapse prevention—precisely the supports required to maintain stability in a relapsing condition.

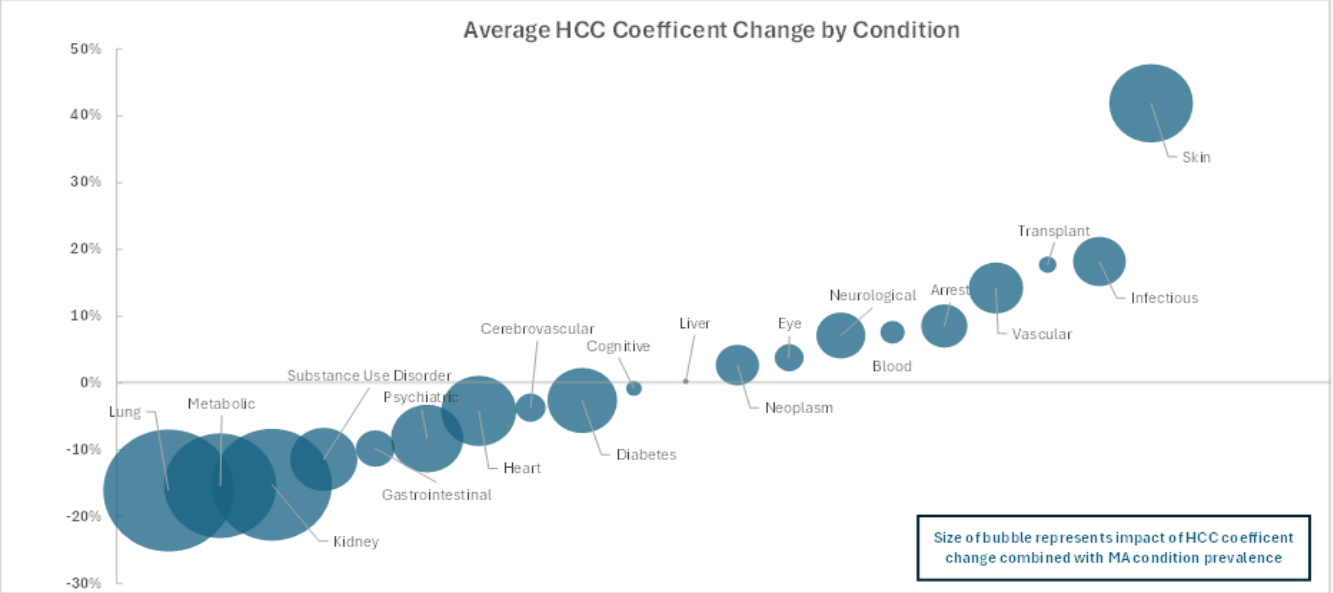
Example HCCs with Large Negative Impacts	
HCC048	Morbid Obesity
HCC093	Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders
HCC137	Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications
HCC139	Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications
HCC155	Major Depression, Moderate or Severe, without Psychosis
HCC226	Heart Failure, Except End Stage and Acute
HCC280	Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
HCC329	Chronic Kidney Disease, Moderate (Stage 3, Except 3B)

Additionally, CMS's proposed changes also reduce the payment for disease interactions and members with five or more conditions. This disconnects payment from clinical reality and undermines care for the most medically complex beneficiaries. These interaction terms are the model's only mechanism for recognizing that multimorbidity is not additive—conditions like heart failure, COPD, diabetes, chronic kidney disease, and depression do not occur in isolation. They compound risk, intensify symptoms, and dramatically increase avoidable utilization. When payment for disease interactions and members with several HCCs are reduced, the model stops accounting for these compounded needs, and payment no longer reflects the true clinical profile of high-risk patients.

This misalignment creates a clear disincentive for plans to invest in intensive care management, behavioral health integration, and specialty care coordination on which complex patients rely. Without adequate payment for medically complex beneficiaries, programs that prevent exacerbation, avoid hospitalizations, and improve quality become financially unsustainable—precisely for the members who need them most.

In short, reducing coefficient for disease interactions and members with five or more conditions means systematically underpaying for the undisputedly sickest beneficiaries, making it harder for plans to deliver the higher touch, multidisciplinary care that keeps these individuals stable. It ultimately undermines the care models that MA was intended to advance and runs counter to CMS's stated objectives of driving innovation, proactive care management, and beneficiary support to achieve sustained wellness.

Changes to Disease Group from Current Model to CMS's Proposed Model for 2027



Recommendations to Stabilize the Model and Avoid Disruption

Given these concerns, we urge CMS to adopt one of the following pathways:

- **Phase in or blend the current v28 model with the updated v28 recalibration over multiple years.** This would allow CMS to smooth unexpected year-over-year variation, neutralize single year anomalies such as those observed in 2024, and ensure changes are grounded in stable, representative data. This also allows more time to evaluate whether one-year calibration is appropriate for any model.
- **Delay implementation** of the updated model until calibration anomalies are fully evaluated, including the impact of post-COVID coding patterns and whether one-year calibration is appropriate.
- A longer-term solution should be rooted in stable, complete MA encounter data which would better support program integrity and ensure equitable reimbursement.

Section L. Sources of Diagnoses for Risk Score Calculation

UHG supports CMS's proposal to require that diagnoses derived from chart review records (CRRs) be linked to encounter data. CMS's focus on strengthening data integrity and advancing consistent, clinically grounded risk adjustment is essential to the long-term sustainability of the MA program. By aligning chart review diagnoses with documented clinical encounters, CMS is taking an important step to reinforce public trust and ensure the program continues to pay accurately for the needs of beneficiaries.

Strengthening this policy framework is vital for the future of MA. We fully support CMS's commitment to improving payment precision and believe the agency's direction is consistent with the evolution of risk adjustment toward more clinically validated, encounter-based data sources.

As CMS finalizes this important policy, we recommend several targeted technical and operational refinements to ensure that the linking requirement functions smoothly and does not inadvertently exclude clinically validated diagnoses that reflect real patient care. Our suggestions are not intended to alter CMS's policy direction, but rather to enhance its operational clarity so that risk adjustment continues to pay accurately and equitably for beneficiaries' actual health needs.

First, we recommend that CMS establish clear, operational linkage criteria that account for real-world provider billing patterns. For example, plans frequently encounter situations where a claim is billed by a provider group, but the underlying medical record identifies a specific clinician within that group. These represent the same clinical encounter and should be considered linked. Clear standards that allow linking based on member identity, date of service, and provider type would promote consistency across MA organizations while maintaining CMS's goals for data accuracy.

Second, to preserve accurate payment for beneficiaries who are new to a plan—particularly those enrolled in Special Needs Plans (SNPs), which see higher rates of turnover—we encourage CMS to adopt a technical new-member exception. As per the June 2017 HPMS memo "RAPS Submission of Data Collection Year Diagnosis Codes", plans are able to submit diagnosis codes for years when a beneficiary was enrolled in a different plan. However, when an encounter occurred when the member was enrolled in a prior MA plan, the current plan cannot submit an encounter data record (EDR), nor does the current plan have access to the original EDR submitted by the prior plan. Therefore, when performing a chart review and identifying a documented diagnosis that is valid and clinically grounded, linking the CRR to the EDR is not possible. Allowing plans to include unlinked CRRs for dates of service when a beneficiary was enrolled with a different MA organization, or permitting submission of EDRs for prior-plan encounters evidenced in the medical record, would ensure continuity in risk adjustment and avoid underpayment for medically complex enrollees. This refinement would support CMS's objectives without altering the underlying policy rationale.

Finally, CMS should allow linkage when chart review dates fall within a reasonable window of the associated encounter date. This flexibility would reflect normal variation in provider

documentation workflows while maintaining the requirement that diagnoses be tied to a clinical event. These natural variations originate from provider billing and documentation practices and are not the result of any specific action or control from the plans.

Each of these recommendations is intended to support CMS's effort to modernize risk adjustment by tightening the connection between diagnoses and care delivery, while also ensuring operational clarity and continued accuracy in capturing patient complexity. By refining the technical parameters of the linking requirement, CMS can achieve its program integrity goals while preserving the clinical completeness necessary for the model to function effectively in future years.

In closing, our organization has *long supported* CMS's efforts to modernize and strengthen the use of chart reviews within the MA program. In response to CMS's recent Request for Information (RFI) included in the 2027 MA and Part D Technical Proposed Rule, UHG advocated for reforms that promote data integrity, standardization, and alignment between diagnoses and clinical encounters. We emphasized our support of linking chart reviews for risk adjustment purposes and the importance of developing clear operational standards for chart review processes, including how chart-derived diagnoses interact with encounter submissions and how plans should reconcile documentation inconsistencies. Detailed below is the response we provided in the prior submission:

Allow diagnoses added through chart reviews to count toward risk adjustment only if they are linked to a provider claim

Chart reviews play an essential role in MA by ensuring that a beneficiary's medical record accurately reflects their true clinical profile — especially for seniors with multiple chronic conditions, complex health needs or previously undocumented diagnoses. They help close documentation gaps, support care coordination, and allow risk adjustment to more accurately account for the fact that MA disproportionately serves sicker, lower income and more socially vulnerable beneficiaries than Medicare FFS.

When used appropriately, chart reviews strengthen the integrity of beneficiaries' complete health status and ensure plans can coordinate care around the full picture of a patient's health needs. Eliminating chart reviews outright would risk under documenting serious conditions, misaligning payment for medically complex adults, and ultimately harming the very beneficiaries risk adjustment is designed to protect.

Chart review is an integral part of administering an MA plan. When filing claims forms, providers often do not identify all the medical conditions they have diagnosed for their patients because providers are generally reimbursed for procedures, not diagnoses, and thus are not incentivized to report in claims forms all the diagnoses a patient may have and that are present in the patient's medical record. This can result in an incomplete understanding of the person's full health status. MA plans therefore review medical charts to capture code diagnoses that providers made during an encounter and that are documented in the medical record but may not have been included on the claims forms.

By obtaining the full picture of a patient's health conditions, we can coordinate care and enroll the beneficiaries in appropriate care management programs. One example occurs when a member has diabetes, but diabetes is not submitted on the claim. If the diabetes diagnosis is appropriately documented on the medical record, this provides a more complete picture of the member's health conditions and allows us to enroll the member into our Diabetes Navigator program. Another example occurs when the member has hypertension submitted on the claim, but the chart review documents additional conditions such as COPD and CHF. In this instance, identifying the two additional conditions would qualify the member for our Complex Care Management program.

MA plans do not create diagnoses during chart review; they simply report to CMS conditions already diagnosed and documented in medical records by providers. Chart reviews are an industry-standard part of operating an MA plan. CMS requires MA plans to submit all diagnoses and accepts chart reviews as an appropriate method of ensuring that the encounters reflect all the diagnoses made by the provider. And in fact, because the government imposes a downward adjustment to MA plans' payments based on the assumption that plans are conducting chart reviews (called the Coding Intensity Adjustment), a plan that does not conduct chart reviews would almost certainly be reimbursed at a level below the actuarial equivalence of Medicare FFS.

UHG works to confirm that the diagnoses added during chart review are accurate and requires its coders to pass an assessment before coding charts. Coders must also participate in a biweekly testing and calibration program in which results are monitored, and additional training is provided as needed. All codes that are added during chart review and impact MA payments are also confirmed through a Quality Assurance process that uses senior certified coding professionals. Conditions that are reviewed during that Quality Assurance process and determined not to be appropriately documented in the chart are removed from submission.

CMS currently encourages plans to link chart review diagnoses to a previously submitted provider claim, and in most cases, plans can successfully match a diagnosis to the underlying encounter. However, there are important situations where linkage is not feasible. The most common occurs when a member is newly enrolled in the plan and prior year claims — which correspond to the chart being reviewed — are not available to the new plan. In other cases, linkage becomes difficult when the claim and chart reflect different provider identifiers, even though they clearly relate to the same clinical encounter. For these reasons, CMS has historically not required plans to link diagnoses to specific claims for those diagnoses to be included in risk adjustment.

To address these challenges and improve accuracy, CMS could help reduce the variation and support more consistent linkage by establishing clearer billing standards — such as requiring that the rendering provider's National Provider Identifier (NPI) always be included on the claim, even when the billing provider differs. Standardizing this information would improve transparency, enhance documentation integrity, and ensure that diagnoses documented in the medical record can be more reliably associated with the corresponding claims encounter. CMS should consider additional refinements to this policy — such as offering clearer expectations for how plans should link clinical documentation to claims and how to address situations where linkage is not possible — to promote accuracy and uphold program integrity.

CMS could provide clear guidance on how to link medical records to claims. UHG suggests that linking occur when there is a match in data regarding the member, date of service, and place of service type (e.g., inpatient, outpatient, physician).

In any event, UHG recommends that CMS treat unlinked chart review diagnoses from chart review for dates of service before the beneficiary was a member of the health plan differently from other unlinked charts. A plan can't link a chart review to the appropriate claim if the plan does not have the claim because the member was enrolled in a different plan on the date of the medical encounter. Plans could include an indication in the linking field that the member was not enrolled on the date of service.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2027

Section F. RxHCC Risk Adjustment Model

Proposed Updates to the RxHCC Models
In the CY 2026 RxHCC model, CMS adjusted gross cost to reflect the agreed-upon MFPs for the selected drugs for which an MFP is in effect for IPAY 2026. In the proposed CY 2027 RxHCC model, CMS again adjusted gross costs to reflect the agreed-upon MFPs for the selected drugs for which an MFP is in effect for IPAY 2026. CMS stated that they did not adjust for IPAY 2027 since the information was not available in time to calibrate the model. Using the IPAY list that is in effect for bid year would more accurately reflect the relative plan liability resulting in more accurate risk score projections. We encourage CMS to make every effort to use the IPAY 2028 when calibrating the 2028 RxHCC model.

Attachment IV. Updates for Part C and Part D Star Ratings

Section E. Categorical Adjustment Index for the 2027 Star Ratings

UHG recommends that CMS enhance the Categorical Adjustment Index (CAI) methodology to more accurately account for the unique characteristics of plans serving highly complex populations, including those with high concentrations of dual eligible (DE), low-income subsidy (LIS), and disabled members, such as by ensuring that contracts with high (90%+) LIS/DE membership receive the highest CAI value. UHG also recommends removing risk adjustment from the medication adherence measures and continuing to rely on the CAI to address population differences.

Section G. Changes to Existing Star Ratings Measures for the 2027 Measurement Year and Beyond

Plan All-Cause Readmissions
UHG supports the proposed updates to the Plan All-Cause Readmissions measure. Incorporating denied claims into the calculation will improve the accuracy and completeness of the measure by capturing a more comprehensive picture of member care patterns.

UHG also supports CMS's proposal to re-estimate the associated risk-adjustment models. We recommend that the re-estimation process explicitly incorporate the effects of adding denied claims to ensure the risk model remains properly calibrated and continues to reflect true underlying differences in patient risk.

Transitions of Care
UHG does not support the proposed modifications to the Transitions of Care measure. As this measure is reevaluated, UHG recommends that CMS and NCQA maintain the current timeframes for the patient engagement after discharge and medication reconciliation indicators. Shortening these windows would increase provider burden at a time when the healthcare system is facing a primary care clinician shortage.[18, 19] It is clinically appropriate for providers to prioritize following up with patients according to their risk; for lower-risk patients, a follow-up conducted after 14 days may still meet clinical needs and support safe, effective care.[20]

If CMS and NCQA do update this measure, we recommend a comprehensive reevaluation of the entire measure, with particular attention to the significant administrative and documentation burden associated with the Receipt of Discharge Information and Notification of Inpatient Admission indicators. Streamlining these indicators would promote more meaningful care coordination while reducing burden on providers and plans.

Statin Use in Persons with Diabetes (SUPD)
UHG supports the addition of the new exclusion which makes the measure more accurate for patients who are appropriately receiving non-statin cardiovascular protective therapies. We recommend that CMS and PQA align and streamline the specifications by applying the same logic currently used for PCSK9 inhibitors and bempedoic acid across all SUPD exclusions – removing a beneficiary from the denominator after determining whether the numerator criteria are met. This approach is appropriate because it accounts for where guideline-based therapies may not be appropriate while not removing valid compliance.

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[18] Bazemore, A. W., Petterson, S. M., & McCulloch, K. K. (2025). U.S. primary care workforce growth: A decade of limited progress, and projected needs through 2040. *Journal of General Internal Medicine, 40*(2), 339–346. https://doi.org/10.1007/s11606-024-09121-x
[19]Health Resources and Services Administration. (2025). *State of the primary care workforce, 2025.* U.S. Department of Health and Human Services, Bureau of Health Workforce. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf
[20] Coppa, K., Kim, E. J., Oppenheim, M. I., Bock, K. R., Conigliaro, J., & Hirsch, J. S. (2021). Examination of post-discharge follow-up appointment status and 30-day readmission. *Journal of General Internal Medicine, 36*(5), 1214–1221. https://doi.org/10.1007/s11606-020-06569-5

Section H. Efforts to Simplify and Refocus the Measure Set to Improve the Impact of the Star Ratings Program

UHG recommends that CMS further simplify and strengthen the Star Ratings measure set by shifting emphasis from subjective, survey-based measures toward more objective, clinically meaningful screening and follow-up measures. Objective measures better reflect actionable clinical activities, reduce variability associated with differences in survey response rates, and more accurately capture whether members receive timely and appropriate care.

For example, UHG recommends replacing the survey-based Improving or Maintaining Mental Health measure with the Depression Screening and Follow-Up measure. While the Depression Screening and Follow-Up measure focuses specifically on depression, it provides a more reliable assessment of whether plans and providers are identifying mental health conditions and ensuring appropriate follow-up. Additionally, robust screening processes help reduce misdiagnoses of other mental health conditions. Other screening and follow-up measures (such as Functional Status Assessment Follow-Up under development by NCQA) can also ensure diagnoses are not missed and follow-ups are clinically appropriate.

Another way CMS can reduce low-value care is by updating existing measures to better target areas where care is needed most. For example, the Osteoporosis Management in Women who had a Fracture measure could be focused on patients who had a hip or vertebral fracture who were treated for osteoporosis.

Diabetes Care – Eye Exam
An existing measure that plays a key role in preventing missed diagnoses is the Diabetes Care – Eye Exam measure, which CMS has proposed to remove. UHG recommends that this measure be maintained in the Star Ratings measure set. While we appreciate CMS's intent to streamline measures and eliminate duplication, this measure is not duplicative to other diabetes-related measures because it is the only measure that addresses diabetic ophthalmic care. Besides meeting CMS's stated goal of ensuring that diagnoses of diabetic retinopathy are not missed, maintaining this measure also aligns with CMS's priority of focusing the measure set on clinical care.

Diabetes affects approximately 3 in 10 of UHG's MA plan members, with some plans (e.g., Special Needs Plans) having closer to 6 in 10 diabetic plan members. In 2021, an estimated 9.6 million people in the United States were living with diabetic retinopathy (DR), of which 1.84 million had vision-threatening DR.[21] The prevalence is highest among people ages 65-79 at 28.4%.[22] Per the American Academy of Ophthalmology, only 60% of diabetic individuals have the recommended annual retinal screening for retinopathy. [23] This is most likely due to the lack of symptoms until the retinopathy has progressed or resulted in macular edema. A 10-year

[21] E.A. Lundeen et al. (2023). Prevalence of Diabetic Retinopathy in the U.S. in 2021. JAMA Ophthalmology, 141 747.
[22] E.A. Lundeen et al. (2023).
[23] American Academy of Ophthalmology (2025). Diabetic Retinopathy Preferred Practice Pattern 2024.

observation study at Joslin Diabetes Center found that 89% of patients with mild diabetic retinopathy reported that they were unaware of any eye disease. [24]

Early detection through annual eye exams is essential to prevent irreversible vision loss and including Diabetes Care – Eye Exam in the measure set ensures prioritization and promotion of annual retinal screenings; since the 2012 Star Ratings, screening rates have improved by 16%. Other diabetes metrics (adherence to medications, management of A1c) do not address this important concern. In addition, advances in the pharmacological treatment plans for diabetes have led to new retinopathy findings. Rapid, tight glucose control can lead to accelerated or early onset diabetic retinopathy, as seen with semaglutides and other newer agents — indicating that the importance of annual retinal screenings will only increase with the increase in semaglutide use. [25]

Medication Therapy Management Program Completion Rate for Comprehensive Medication Review

In alignment with CMS's goal of not incentivizing low-value care, UHG recommends that the updated and expanded MTM CMR measure not be added to the Star Ratings. The updates to this measure finalized in 2024 have broadened the eligible population in ways that do not align with where comprehensive medication reviews are most effective.

Some conditions included in the updated measure may not directly benefit from a medication review and would be better addressed through coordinated care or disease management programs involving interdisciplinary teams. By letting this measure return in its updated form, CMS risks diluting its impact and placing undue burden on plans and pharmacists, rather than focusing on meaningful improvements in member care.

For these reasons, UHG urges CMS to consider more targeted approaches that truly reflect the value of comprehensive medication management.

Section J. Retirement of Display Measures

UHG supports CMS's proposal to retire the designated display measures. Streamlining the measure set by removing measures that are no longer aligned with program priorities will help reduce reporting burden and ensure that Star Ratings remain focused on measures with the greatest clinical and operational impact.

Section K. Potential New Measure Concepts and Methodological Enhancements for Future Years

UHG supports CMS's efforts to simplify the Star Ratings program, and we recommend that CMS focus these efforts on areas where complexity has increased without delivering measurable value. Specifically, as outlined below, UHG recommends removing adjustments to measures

[24] American Academy of Ophthalmology (2025).
[25] American Academy of Ophthalmology (2025).

that add complexity without improving the validity or reliability of performance measurement. We also recommend maintaining the current measure threshold methodology, as the proposed replacement would not simplify the Star Ratings. Shifting to a percentile-based methodology would in fact increase the number of cutpoint methodologies needed and, as a result, would not streamline the Star Ratings structure.

Medication Adherence Risk Adjustment

Over time, CMS has added layers of risk adjustment to the Star Ratings measures to account for differences in beneficiary populations and help ensure the program measures quality rather than population characteristics. While this goal is important, the cumulative effect of these changes has significantly increased complexity, reduced transparency, and added administrative burden for both CMS and health plans.

UHG recommends CMS restore the adjustments to the three Part D medication adherence measures (Medication Adherence for Cholesterol, Diabetes, and Hypertension) for inpatient (IP) and skilled nursing facility (SNF) stays and reverse the updates that implement risk adjustment based on Sociodemographic Status (SDS). Reversing these updates will increase the measures' accuracy while also reducing their complexity and burden for CMS and health plans. Risk adjusting for SDS obscures the objective measurement of health outcomes and effectively creates different adherence standards for different populations. Instead, there should be one consistent set of medication adherence standards by which plans are measured. Risk adjustment based on SDS also adds further complexity and administrative burden to an already complex Star Ratings program with multiple separate risk adjustment models without delivering proportional improvements in quality measurement. The risk adjustment calculations are so complex that CMS can only produce them in the final monthly patient safety report of the measurement year, rather than in each monthly report, due to the time commitment involved. This limits transparency and makes it harder for plans to monitor and improve performance throughout the year. UHG recommends CMS continue to use the CAI to adjust for these measures.

UHG also recommends reinstating the IP and SNF adjustments. CMS noted in the CY2024 Final Rule that applying both SDS risk adjustment and IP/SNF stay adjustment "added complexity to the measure and created concerns about the accuracy of the SDS risk adjustment."[26] Without the SDS risk adjustment, these concerns no longer apply, and the IP/SNF adjustments should be reinstated. CMS introduced the IP stays adjustment in 2011 and expanded that adjustment to SNF stays in 2013 to ensure adherence calculations accurately reflected periods when medication fills do not occur under Part D. Because skilled stays are covered under Part A, without these adjustments, members would be incorrectly classified as nonadherent simply because Part D claims are not generated during these stays. Removal of the IP/SNF adjustments disproportionately impacts some of the most vulnerable members (those receiving inpatient care) by reversing policy in a way that ignores how their care is delivered, with no clear health or clinical value for the members.

[26] Centers for Medicare & Medicaid Services. (2023). *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*. *Federal Register, 88*, 22120.

Until these updates are reversed, we request that CMS increase transparency around the underlying risk adjustment methodology. Greater visibility into both member-level risk adjusted scores and contract-level calculations would enhance our ability to identify performance drivers and monitor results effectively. For example, incorporating each member's predicted probability into the Acumen Patient Safety Reports' denominator file would improve clarity and support more accurate performance oversight. Additionally, providing the number of members in each SDS category, along with comparable counts at the industry level, would offer important context for interpreting risk adjusted results. Furthermore, we request that CMS provide a more timely and regularly updated reference table for the current industry population. Producing this table only once a year, after the measurement year has concluded, limits the ability to compare predicted adherence probabilities with actual performance. We encourage CMS to update the reference table on a quarterly basis during the measurement year to support more effective monitoring and decision-making.

CAHPS Star Assignment

UHG also recommends that CMS remove the CAHPS reliability and significance testing star adjustments. The CAHPS final star adjustment is an additional step after the traditional measure Star Rating calculation step (using final rounded rates and cutpoints) where the measure star may theoretically be adjusted up or down one star based on the contract's measure score significance, reliability and standard error. In practice, however, this methodology produces highly asymmetric outcomes. While designed to allow for both upward and downward movement, approximately 98% of all adjustments result in a downward star change. This imbalance reflects an unintentional methodological bias: the adjustment assumes a normal distribution, while the underlying CAHPS data is actually slightly skewed.

Furthermore, CMS has consistently said that CAHPS measures demonstrate high statistical reliability, calling into question the added value of a star-level correction designed to address variability. The current adjustment is an over-correction, introducing unnecessary volatility into results and risking misclassification rather than preventing it.

Measure Thresholds

UHG does not support using percentile distribution cut offs to assign measure stars, because a properly implemented percentile system would add complexity to the Star Ratings program. Although the current clustering methodology relies on an algorithm, it has meaningful advantages: it aligns similar plan performance with similar Star Ratings and helps ensure that differences in measure stars reflect real, not arbitrary, differences in performance.

By contrast, under a percentile model, a large number of contracts could fall within 0.5% of each other and arbitrarily receive different Star Ratings due to irrelevant differences in performance. The current clustering methodology mitigates this issue by grouping results based on actual distribution characteristics rather than rigid percentile cutoffs. The clustering approach is also distribution-agnostic, functioning appropriately across a variety of measure distributions. A percentile=based threshold system, however, would require CMS to incorporate additional layers of methodology to address the fact that percentiles are only suited to normal distributions. This would necessitate objective statistical tests to classify each measure's distribution, different sets of percentiles for normal, high-skew, and low-skew distributions, and potentially fluctuating methodologies from year to year as performance distributions change.

Should CMS move forward with implementing percentile thresholds, UHG recommends that each measure's distribution be annually tested for skewness and a different set of percentiles be applied depending on if the distribution skewed high, was normal, or skewed low. This approach would help preserve some alignment between measure distributions and star assignments, ensuring that differentiated performance is reflected in differentiated measure stars.