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February 3, 2025

Mr. Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
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

Dear Acting Administrator Wu:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," (January 10, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 159 U.S. medical schools accredited by the Liaison Committee on Medical Education; 14 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 201,000 full-time faculty members, 97,000 medical students, 158,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers International broadened participation in the AAMC by 70 international academic health centers throughout five regional offices across the globe.

The AAMC appreciates CMS' Advance Notice of the methodologies and payment policies the agency plans to implement in CY 2026 for MA and Part D plans. The rise in enrollment in MA plans continues to mark a dramatic shift in the makeup of the healthcare payer landscape, impacting providers as well as beneficiaries. In 2024, 54 percent of Medicare-eligible beneficiaries were enrolled in an MA plan, up from 19 percent in 2007.[1] This shift highlights the importance of having robust and transparent MA data in order for policymakers and stakeholders

[1] KKF, Medicare Advantage in 2024: Enrollment Update and Key Trends. (August 2024)

to effectively evaluate MA plans and their impact on the healthcare landscape. Because of this, we have an interest in better understanding the calculations and methodologies used to establish MA payments to improve health care delivery and health services research. AAMC member teaching health systems and hospitals remain committed to supporting efforts to ensure patients maintain access to care as coverage and reimbursement rates can impact where beneficiaries receive care. As Medicare beneficiaries continue to move from Traditional Medicare FFS plans to MA plans, we hope to continue working in partnership with policymakers to ensure access to high quality and specialized care.

Confirm Accuracy and Completeness of Encounter Data Prior to Using the Data in a Risk Adjustment Model for Medicare Advantage Payment Calculations and Methodologies

In the Advance Notice, the agency gives acknowledgement to its work on calibrating a risk adjustment model using MA encounter data, which includes data associated with diagnosis, cost, and utilization submitted by MA plans. CMS notes it could begin to phase in a risk adjustment model based on encounter data as soon as 2027. Currently, CMS utilizes FFS claims data from Traditional Medicare and adjusts for coding pattern differences as a predictor of relative costs in MA. As CMS has noted, MA encounter data is more granular and is expected to be a better predictor of relative costs and, if complete and accurate, would be an important step towards improving MA payment accuracy and consistency.[2] However, as it currently stands, compared to data availability and transparency in Medicare FFS, MA falls behind. Medicare FFS data submitted to CMS has 100 percent claim completeness and includes payment information. In contrast, MA data submitted to CMS includes possible upcoding issues and since 2017 has contained only 49 to 89 percent claim completeness depending on the setting. [3]

Further, the Medicare Payment Advisory Commission (MedPAC) has identified roadblocks to assessing the completeness of MA encounter data – in September 2022 it found that 21 percent of MA inpatient stays had no matching encounter record.[4, 5] In 2019, MedPAC recommended that Congress take action to ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with fee-for-service Medicare.[6] This recommendation is reiterated in the Commission's March 2024 Report to Congress, suggesting that the Commission has yet to observe improvement in the

[2] CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, https://www.cms.gov/files/document/2026-advance-notice.pdf
[3] MedPAC analysis of MA encounter data and MedPAR, risk-adjustments, MDS, and OASIS data, https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf
[4] L Serna and A Johnson, Medicare Advantage encounter data, slide 8, Medicare Payment Advisory Commission (September 2022).
[5] S Hammon, A Johnson, and L Serna, Assessing consistency between plan-submitted data sources for Medicare Advantage enrollees, slide 8, Medicare Payment Advisory Commission (April 2024), finding that updated assessments of MA encounter data are consistent with findings in September 2022.
[6] MedPAC June 2019 Report to Congress, Chapter 7: Ensuring the accuracy and completeness of Medicare Advantage encounter data (June 2019).

underlying quality of the data to facilitate comparisons with FFS Medicare.[7] This highlights the incompatibility of using MA encounter data to replace the current risk adjustment model. Without complete and validated encounter data, these calculations may be inaccurate, and without access to the data used to complete these calculations there is a lack of transparency for providers, researchers, and other relevant stakeholders – most importantly patients. Therefore, it is imperative that CMS evaluate encounter data for completeness and accuracy, prior to implementing a risk adjustment model calibrated with MA encounter data. Without ensuring this, an updated model could skew risk scores and further exacerbate variation in coding differences between MA and FFS, which has the potential to impact payments to providers. **With these discrepancies in mind, we strongly urge CMS to explore options to enforce the reporting of complete, timely, and accurate encounter data in MA plans across health care settings prior to utilizing encounter data in calculations for rate setting or benchmarking.** This could be achieved by setting new data completeness requirements for plan payment and/or adopting sufficient penalties for plans that submit incomplete data.

Consider Expanding Encounter Data Collected from MA Plans

Further, in addition to ensuring completeness and accuracy of encounter data, we urge CMS to consider expanding what is included in the encounter data collected and made public. Specifically, we urge CMS to include standardized costs in MA encounter data provided by the agency, and if needed, explore additional pathways to collect such data one does not currently exist. Creating transparency for researchers and stakeholders around the types of provider payments utilized by MA plans at the beneficiary level would also be beneficial. Specifically, being able to identify if the plan provides payments to providers through a fee-for-service payment structure, capitated payments, bundled payments, or some other combination or methodology. Lastly, providing data around MA plans' payment timelines would also be beneficial for providers. Medicare FFS payment timelines have historically been quick and if paid after 30 days include interest, whereas MA payment timelines often can be drawn out due to prior authorization and claims denials, creating uncertainty for providers. Providing this additional level of detail in data collected would create greater certainty for providers.

Address the Impact of Remedy for 340B- Acquired Drug Payment Policies in Medicare Advantage

Lastly, CMS addresses the Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule and how these policies have been reflected in the MA payment methodologies. CMS notes that the FFS United States Per Capita Costs (USPCC) have been re-estimated for 2018 - 2022 to reflect the lump sum payments made to covered entities for 340B-acquired drugs provided from January 1, 2018, through September 27, 2022, to remedy these hospitals for reductions in Part B drug payments that were subsequently found unlawful. CMS also updated the USPCC projected estimates for 2026 and beyond to reflect a 0.5 percent

[7] MedPAC March 2024 Report to Congress, Chapter 12: The Medicare Advantage program: Status report, page 398 (March 2024)

reduction for all Outpatient Prospective Payment System (OPPS) non-drug items and services each year until the entire 340B-acquired drug offset has been reached.[8] This offset was instituted to reflect CMS' belief that the remedy for the 340B drug payment reductions must be done in a budget neutral manner. The remedy requires CMS to implement a reduction in all OPPS payments for non-drug items and services by reducing the OPPS conversion factor by 0.5 percent beginning in CY 2026 for approximately 16 years until the total offset is reached.

This is significant as the growth rates for MA payments are based on these FFS USPCC estimates. Meanwhile the total USPCC, which incorporates FFS and MA, is used to calculate the benchmark cap for each county. The benchmark caps are then used by the MA plans and CMS to determine the payments CMS makes to MA plans for providing coverage to beneficiaries. CMS utilizes benchmarks as bidding targets for MA plans, essentially setting a limit for how much CMS will pay plans. Due to these uses of the benchmark cap, it is imperative that CMS utilize precise and accurate calculations to prevent beneficiaries from paying higher premiums or losing access to additional benefits.

The final 340B remedy rule fails to remedy the impact these polices had on MA payments.[9] During the timeframe that OPPS payments were reduced, many MA plans also reduced reimbursement for 340B-acquired drugs. It is unreasonable for CMS to then reflect the upcoming reduction in payment for non-drug OPPS services in FFS in its MA payment methodologies and calculations. **We ask CMS to work with policymakers and take all possible measures within its authority to ensure hospitals are made whole and not penalized twice with reductions in payments from MA plans.** This includes ensuring payment calculations and methodologies are updated in a way that does not double penalize providers for the unlawful changes in payment for 340B drug items and services and non-drug items and services. Even though these changes were implemented in policies related to OPPS FFS payments, many MA plans followed CMS' lead and implemented these policies into their payment plans. MA plans' refusal to pay the difference between the unlawful reduction in 340B policy amounts and what hospitals are owed would unfairly allow MA plans to pocket these dollars which goes against the goal of lessening the impact of CMS' past mistakes on the Part B Trust Fund.

CONCLUSION

Thank you for the opportunity to comment on this Advance Notice. We are encouraged by CMS' efforts to improve the accuracy of calculations and models related to Medicare Advantage payments. However, we ask the agency to ensure that data is complete, timely, and accurate prior to implementing these changes into models and calculations. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you

[8] CMS, Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, https://www.cms.gov/files/document/2026-advance-notice.pdf
[9] 88 FR 77150

have questions regarding our comments, please feel free to contact Katie Gaynor at kgaynor@aamc.org.

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer