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February 25, 2026

Chris Klomp, Deputy Administrator and Director, Center for Medicare
Jennifer Wuggazer Lazio, Director, Parts C & D Actuarial Group, Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via regulations.gov

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

Dear Deputy Administrator Klomp and Director Wuggazer Lazio:

This letter is in response to the "Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" issued by the Centers for Medicare & Medicaid Services (CMS) on January 26, 2026.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 7 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 3.8 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states.

As a leader and strong proponent of providing better health outcomes at lower costs to members, Humana urges CMS to ensure funding for Medicare Advantage fully reflects projected increases in costs for providing care to Medicare beneficiaries. Plans need stable funding to continue current care improvement efforts and to develop new and innovative approaches for beneficiaries. These programs require multi-year planning and investments that can be seriously disrupted in an unstable funding and policy environment. A Wakely analysis of the Advance Notice concluded that the proposed changes to benchmarks and risk scores could "lead to significant reductions in rebate dollars available to plans, resulting in a direct impact on member benefits and out of pocket costs."

While we have provided more detailed comments below, we wanted to briefly share several of our key recommendations.

Summary of Humana's Key Issues and Recommendations

- **Growth Rate:** Humana appreciates CMS's decision to publish the components of the growth rates for CY 2021-2027 with this Advance Notice and we encourage CMS to continue this practice with future rate notices; however, based on our review of the details provided, Humana has several questions and concerns regarding the reasonableness of the data and assumptions used to develop the FFS USPCCs.
- **Risk Model Recalibration:** Humana has significant concerns with the proposed substantive changes to the risk adjustment model and CMS's analysis regarding the impact of the proposed changes to risk scores and payments. Given the impact of the new model on funding for MA benefits, CMS should follow past precedent and continue to phase in major risk model revisions over 3-4 years to mitigate the impact on beneficiaries (particularly considering the payment cuts to the industry over last 3 years due to V28). We also urge CMS to delay recalibrating the CMS-HCC model to allow CMS and plans time to fully assess V28 impacts which will inform thoughtful input on future reform.
- **Chart Review Records:** Humana supports CMS's proposal to remove diagnoses from unlinked chart review records from the risk score calculation; however, we strongly recommend that CMS make an exception and allow MAOs to submit unlinked chart review records for new plan members, and improve data sharing between the Agency and payers to facilitate linking of chart reviews for new enrollees to help improve the accuracy of diagnoses submitted for risk adjustment.

We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to beneficiaries, focused on improving their total health care experience.

If you have any questions, please do not hesitate to reach out to me at mhoak@humana.com and 571-466-6673.

Sincerely,

Michael Hoak
Vice President, Public Policy

2027 Medicare Advantage and Part D Advance Notice

Underlying Coding Trend in MA (from Footnote #5 within the Fact Sheet)
For CY 2027, CMS expects the MA risk scores to increase, on average, by 2.45% due to the underlying coding trend.

- **Humana Comment:** Page 64 of the CY 2026 Rate Announcement[1] states "CMS anticipates returning to a three-year approach for CY 2027, when three years of post-pandemic MA risk scores will be available for trend estimation." Humana requests that CMS confirm whether the Fact Sheet's 2.45% risk score trend is a three-year trend. CMS should provide supporting information for how the expected growth of MA risk scores is calculated, including methodology, data sources and historical years evaluated.

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 A. Data and Assumptions Supporting USPCCs
In this section of the CY 2027 Advance Notice, CMS provides details and descriptions regarding the development of the USPCCs.

Humana Comment: Humana appreciates the additional detail included in the Trends Supporting 2027 AN Growth Rates file, as it meaningfully enhances transparency around certain assumptions supporting the USPCCs. To further support stakeholder understanding support actuaries in objectively assessing the reasonableness of these assumptions, Humana strongly encourages CMS to continue enhancing transparency – particularly for assumptions with material impact – around regarding the data, methodologies, and assumptions underlying supporting the development of the USPCCs and county benchmarks in order to comply with section 3.2 of Actuarial Standard of Practice No. 41: Actuarial Communications (ASOP 41) .

Despite these improvements, the information remains insufficient for actuaries Specifically, to assess the reasonableness of key assumptions – most notably the inpatient utilization trends. The 2027 supporting file shows projected inpatient utilization trends of 1.43% for 2026 and 0.64% for 2027, which are materially lower than trends observed over the past three years. In addition, a comparison of the Trends Supporting 2026 Ratebook Growth Rates file to the updated 2027 file shows that CMS restated the 2026 inpatient utilization trend assumption downward nearly 40 basis points, resulting in a 2026 trend more than 1.5% below the 2025 trend. Without explanation, actuaries are unable to assess the reasonableness of these material changes or understand the basis for anticipating such a substantial deceleration in year-over-year inpatient utilization trends.

Given the need for additional explanation of these material assumptions, it is important to note that in prior years actuaries could submit questions and receive additional information on the February Actuarial User Group Call to help assess the reasonableness of assumptions. However, during the February 19, 2026 Actuarial User Group Call, CMS acknowledged receiving numerous questions related to the USPCCs and growth rates and advised stakeholders to submit

[1] Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

comments via the Advance Notice comment process instead. Humana strongly recommends that CMS either (1) resume responding to all actuarial questions on the February Actuarial User Group Call going forward or (2) significantly expand the supporting documentation to include explanations for material changes in assumptions in order to comply with ASOP 41.

In addition, when publishing Advance and Final Notices, CMS should disclose the incurred and paid through dates of the data supporting the USPCCs and any expected updates to the data supporting the Final Notice. Without this information, another actuary is unable to make an objective appraisal of the reasonableness of this actuarial report.

For example, Humana notes that while the supporting trend file does state "Actual YTD spending through June 2025 for inpatient and SNF exceeded amounts projected in 2026 RA," it does not clearly state the incurred through date for Part A or the incurred and paid through dates for Part B. At minimum, Humana recommends that CMS include the incurred and paid through dates in the Trends Supporting the Growth Rate supplemental document, consistent with CMS practice prior to the CY 2025 Final Notice.

Section C. USPCC Estimates

CMS estimates that the FFS Non-ESRD USPCC growth percentage will be 5.10%, the total national per capita MA growth percentage will be 4.04%, and the Dialysis only USPCC growth rate is 6.17%.

Humana Comment: Humana thanks CMS for publishing the components of the growth rates for CY 2021-2027 with this Advance Notice and encourages CMS to continue this practice with future rate notices.

Based on review of the details provided, Humana has several questions and concerns regarding the reasonableness of the data and assumptions used to develop the FFS USPCCs.

2026 and 2027 Inpatient Trend

As noted above, upon reviewing the Trends Supporting 2027 AN Growth Rates file, Humana observed that the projected inpatient utilization trends of 1.43% for 2026 and 0.64% for 2027 are materially lower than trends observed in recent years. The 2026 assumption also appears lower than expected relative to recent commentary from the largest publicly reported hospital company, which reported strong fourth quarter 2025 results, including admissions increasing at rates comparable to equivalent admissions, and communicated expectations for equivalent admission growth between two and three percent in 2026.

Humana estimates that if inpatient utilization trends for 2026 and 2027 were aligned with the three-year historical average, the effective growth rate would increase by approximately 1.3%. In light of this information, Humana requests that CMS review the reasonableness of their assumptions considering recent historical trends and industry data. To better assess the reasonableness of these assumptions, Humana further requests that CMS explain the factors driving the lower utilization assumptions – including an explanation of why CMS is anticipating such a substantial deceleration in year-over-year inpatient utilization trends – and provide additional details regarding on the sources and analyses used to support supporting the projected inpatient utilization and case-mix assumptions reflected in both the Advance and Final

2027 Uncompensated Care Payments and Trend Component Methodology

Humana is concerned CMS is not adequately accounting for higher 2027 projected uncompensated care payments resulting from the passage of H.R. 1, the "One Big Beautiful Bill Act." The Congressional Budget Office (CBO) projects that the budget reconciliation package will increase the number of uninsured by nearly 4 million in 2027[2]. For comparison, CBO previously projected the number of people without insurance will rise by 2.2 million in 2026 if the expanded premium tax credit structure provided in the American Rescue Plan Act of 2021 (ARPA, Public Law 117-2) was not extended[3], and CMS projected a $2 billion increase in uncompensated care payments in the FY 2026 IPPS final rule largely driven by a higher uninsured rate.[4] Given the projected significant increase in the uninsured population for 2027, uncompensated care payments are expected to rise even more in FY2027, thereby increasing FFS spending. In light of the scale of the expected increase in the uninsured population and resulting increase uncompensated care payments, Humana urges CMS to reassess its assumptions and account for this expected increase in 2027 FFS USPCC.

Humana also requests clarification regarding what is included in the unit cost component for each service category for which a trend breakout is provided. Specifically, Humana requests that CMS clarify:

- Which component of inpatient trend includes changes in uncompensated care payments and outlier payments?
- Which component of outpatient trend includes the 340B Remedy OPPS adjustment (0.5% reduction for all non-drug items and services to all OPPS providers, except those that enrolled in Medicare after January 1, 2018)?
- What unit cost related changes are included in the 'Other' component of the physician trend?

More broadly, Humana requests clarification on how CMS determines whether specific payment adjustments are reflected in unit cost trends versus other components of trend.

Finally, Humana requests the following additional information:

- **Physician "Other" Trend:** The 'Other' component of the physician trend was +1.45% in 2025 and -1.43% in 2026. Please provide the factors driving the higher trend in 2025 and the decline in 2026, and provide an explanation of the major assumptions and costs underlying this component.
- **Inpatient "Other" Trend Restatements:** Between the 2026 Rate Announcement and the 2027 Advance Notice, the 2023 and 2024 "Other" components of the inpatient trend were each restated downward by at least 1%. Please explain what factors drove the material reductions.

Skin Substitute Provision in 2026 Physician Fee Schedule

On the February 19, 2026 Actuarial User Group Call, CMS stated that the 2026 total skin substitute spending included in the non-ESRD FFS USPCC was $9.6 billion for the 2026 Rate

[2] https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx

[3] https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf

[4] https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0

Announcement and $0.5 billion for the 2027 Advance Notice. Given the magnitude of this change, Humana requests additional information regarding the assumptions and underlying data used in the 2027 Rate Announcement:

- What is the impact of the skin substitute policy change on the Part B FFS USPCC for 2026 and 2027?
- Can CMS please provide separate PMPMs and trends for skin substitutes vs. all other physician administered drug costs for 2023-2027? If not, please provide additional details on the assumptions used to quantify this impact.
- What utilization assumption did CMS use for skin substitute spending in 2026?
- More generally, does CMS's trend projections incorporate assumptions about provider behavioral responses, such as shifting utilization to alternative services when payment for a particular service is reduced, when regulatory or legislative changes occur, and if so, which component of the trend are these effects reflected?

2027 Physician Fee Schedule

Over the last several years, Congress has regularly passed legislation after CMS has published the Rate Announcement to increase physician payments for the upcoming year. Because CMS bases the projected growth rate on the law as it exists on the date of the Rate Announcement, the MA ratebook does not appropriately capture the higher physician unit costs that ultimately occur. As a result, MA plans are systematically underpaid due to the timing of the legislation and how the FFS effective growth rate is calculated.

For example, in the 2026 Rate Announcement, CMS assumed a 0.5% increase in physician unit cost for 2026. Yet, on July 4, 2025, Congress enacted H.R. 1, the "One Big Beautiful Bill Act," which provided a 2.5% one-year increase to the 2026 Medicare physician fee schedule conversion factor. In the 2027 Advance Notice, CMS retroactively incorporated this Congressional action by assuming a 3.0% increase in 2026 physician unit cost but then offset nearly all the 2026 increase with a negative 2.0% reduction for 2027. This approach effectively neutralized the higher 2026 physician costs, leaving MA plans underpaid and never receiving payment for the higher 2026 physician cost that occurred.

If CMS instead had included a more reasonable physician unit cost assumption in the 2026 Announcement – consistent with Congress's longstanding pattern of mitigating scheduled fee cuts – the 2026 MA ratebook would have more accurately captured the higher 2026 physician costs. Any difference between the assumed increase and actual increase enacted by Congress could then have been reconciled through the 2027 effective growth, ensuring MA plans were paid appropriately for the physician costs incurred in 2026.

Humana's analysis shows that if the 2026 physician unit cost trend was based on the five-year historical average of Congressional physician fee schedule mitigation actions, the 2026 effective growth rate would have been 0.4% higher. This demonstrates that CMS's assumptions have a material impact on the FFS USPCC, and in turn, MA payments.

Given Congress's history of mitigating scheduled physician fee schedule cuts and the material impact on the FFS USPCC, CMS should use its discretionary authority to acknowledge Congress's future action to address the physician fee schedule reduction. This change would ensure MA plans are paid accurately and reflect the actual costs observed in Medicare FFS.

Experience Period Timing and Consistency

During the January 26, 2026, stakeholder call, CMS stated that FFS experience supporting the FFS USPCCs was based on experience incurred and paid through June 2025 for Part A and September 2025 for Part B. Humana is concerned about CMS's departure from its longstanding practice of using Part A and Part B experience incurred and paid through September of the prior year when developing USPCCs for the Advance Notice, as well as the lack of explanation for this change. Prior to last year (with the exception of CY 2022), CMS has consistently used experience through September of the prior year for the Advance Notice for both Part A and Part B. In response to comments in the 2026 Rate Announcement, CMS stated "We continue to consider it best practice to base the growth rates on the most recent data and assumptions available at the time those values are announced. Therefore, for each release of the growth rates, CMS updates historical enrollment and claims, as well as projection factors, based on the most recent data."[5] Humana requests clarification regarding what has changed in the last two years such that Part A experience paid through September of the prior calendar year is not the most recent data available at the time of the Advance Notice publication.

Lastly, Humana strongly urges CMS to use consistent experience periods for the Advance and Final Notices every year and to clearly communicate the experience periods used. MA plans are held to this standard when developing bids. For example, the 2026 MA Bid Instructions clearly state that MA plans must use 2024 base period experience with at least one month of runout for 2026 bids.[6] Given that bids are compared to benchmarks to ultimately determine MA plan payments, it is imperative that the MA ratebook reflect the most current experience available and be held to a similar standard as MA bids.

Section D. Proposed changes to tables in Attachment II of CY 2027 Rate Announcement

CMS is proposing comprehensive changes to the table structure and content within Attachment II of the CY 2027 Rate Announcement.

Humana Comment: Humana supports the removal of FY Part A total reimbursement incurred and total Part B trend from Table II-5 as well as Tables II-7a and II-8a. However, Humana requests that CMS continue to publish separate aged and disabled enrollment in Table II-6, Medicare Enrollment Projections. Since CMS projects disabled and non-disabled enrollment separately and Medicare FFS enrollment projections are calculated as the difference between total Medicare enrollment and MA enrollment, this information is helpful in assessing reasonableness and supports transparency.

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

Section B. Calculation of Fee-for-Service Cost

CMS proposes to make two new adjustments to the FFS experience used in the development of FFS per capita costs for the 2027 ratebook. First, CMS will include Rural Emergency Hospital (REH) additional facility payments for 2023 and 2024. Second, CMS will exclude 2023 and 2024 Significant, Anomalous,

[5] https://www.cms.gov/files/document/2026-announcement.pdf

[6] Pages 10-11 of INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOLS FOR CONTRACT YEAR 2026

and Highly Suspect (SAHS) Billing Activity from FFS experience used in the tabulation of FFS per capita costs for the 2027 ratebook.

Humana Comment: Humana appreciates CMS's efforts to improve the accuracy of MA benchmarks. As CMS considers changes to the tabulation of FFS experience, Humana encourages CMS to calculate the FFS USPCC and standardized county FFS rates using FFS costs for beneficiaries enrolled in both Part A and Part B, consistent with MA eligibility requirements. Beneficiaries enrolled in Part A-only and Part B-only are not eligible to enroll in MA, and including these enrollees in the FFS population used to set MA benchmarks creates a fundamental misalignment between the population underlying MA benchmarks and the population MA plans are required to serve.

A 2025 Wakely report found that about 16% of the Original Medicare population is Part A-only and beneficiaries with both Part A and Part B have spending that is 6.1% higher than beneficiaries with Part A or Part B.[7] This indicates CMS's FFS cost calculations reflect a population whose spending patterns are significantly different from those of the MA eligible population.

CMS has already acknowledged this issue with Puerto Rico. In the 2012 Rate Announcement[8], CMS determined that Puerto Rico's FFS rate should be based on enrollees in both Part A and Part B, because including beneficiaries enrolled in Part A-only and Part B-only distorted FFS spending and undermined benchmark accuracy. As part of their justification, CMS explained that Puerto Rico had a higher proportion of beneficiaries enrolled in MA and that beneficiaries remaining in fee-for-service were much less likely to enroll in Part B. Although Puerto Rico was initially treated as a unique case, the market dynamics that supported CMS's decision in 2012 are no longer unique to Puerto Rico: national MA penetration exceeds 50% and the share of Part A-only beneficiaries in FFS continues to grow.

While CMS maintains their methodology is consistent with the law, Humana does not believe the spirit of the law intended for MA benchmarks to be based on a population that is not eligible for MA enrollment. Humana encourages CMS to update its calculation to promote consistency between requirements for eligibility for MA and the determination of payment rates.

Regarding the proposed changes, Humana supports the addition of REH additional payments and removal of SAHS billing activity to the FFS costs used in the development of the FFS USPCC and average geographic adjustment (AGA). With respect to the removal of SAHS billing activity, Humana requests additional clarification on the following:

- Please confirm whether SAHS adjustments are reflected in the 2023 and 2024 FFS USPCCs published with the 2027 Advance Notice.
- In the 2026 Rate Announcement,[9] CMS stated the "…CY 2026 Rate Announcement includes a revised adjustment of -$3.5 billion to account for the suspended payment of claims, largely based on more complete financial reporting on CMS program integrity

[8] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/announcement2012.pdf
[9] https://www.cms.gov/files/document/2026-announcement.pdf

activities." Please confirm whether the 2023 SAHS adjustments were reflected in the 2023 FFS USPCC published with the 2026 Rate Announcement.

- Please clarify whether any 2024 SAHS adjustments were reflected in the 2024 FFS USPCC published with the 2026 Rate Announcement, and if so, the impact of those adjustments.
- CMS referenced the Medicare Shared Savings Program (MSSP) financial calculation Final Rule in its discussion of excluding SAHS billing activity. Please clarify whether CMS intends to exclude SAHS billing activity that is codified in the MSSP final rule from the FFS costs used in rate development in future years.

Section B.3. AGA Methodology

CMS will reprice the historical 2020-2024 claims. As noted on page 35 of the CY 2022 Rate Announcement, and consistent with prior years, CMS does not reprice Part B drugs, and they have not developed the data and systems to support such repricing. Therefore, CMS does not reprice Part B drugs as part of their adjustments to the Average Geographic Adjustment (AGA) irrespective of the 340B remedy rule provision for lump sum remedy payments for services rendered from January 1, 2018, through September 27, 2022, for each 340B covered entity.

Humana Comment: Humana requests clarification on whether skin substitute claims will be repriced for purposes of the AGAs. While CMS indicates that Part B drugs are not repriced as part of the adjustments to the AGAs, the Trends Supporting 2027 AN Growth Rates file indicates skin substitute claims are included in the physician administered drug category, creating ambiguity regarding whether they will be repriced or not.

Given the material impact of skin substitute reimbursement changes on the 2026 FFS USPCC, Humana is concerned that not repricing these claims could distort geographic cost relationships. Accordingly, Humana strongly urges CMS to reprice skin substitute claims using FY 2026 Physician Fee Schedule payment rates to ensure the accuracy of the AGAs.

Section B.7. Proposed consolidation of files published with the CY 2027 Medicare Advantage Ratebooks

CMS proposes to consolidate and streamline several of the adjustment files to improve ease of use for stakeholders, including merging the separate Durable Medical Equipment (DME) files, discontinuing publication of FFSyyPR.xlsx and FFSyyCC.xlsx, consolidating service-level repricing files into one file and consolidating innovation model adjustment files into one file.

Humana Comment: Humana supports the consolidation of the service-level repricing files and the innovation model adjustment files into separate, comprehensive files with clear identification fields. We also support combining the calculation of DME Competitive Bidding Area (CBA) and DME non-CBA repricing into a single file and request a field be included to clearly distinguish the impact of the two different pricing approaches.

In addition, while Humana supports the discontinuation of the FFSyyCC.xlsx file, Humana requests that CMS continue to publish the FFSyyPR.xlsx file. Although the Puerto Rico AGA development is limited to beneficiaries enrolled in Part A and Part B, the FFS USPCC includes Puerto Rico beneficiaries enrolled in Part A and/or Part B. Continued publication of this file allows stakeholders to clearly understand the Puerto Rico experience underlying the USPCCs and supports transparency in the ratebook development.

Section F. MA Employer Group Waiver Plans (EGWP)

Section F.1. Bid-to-Benchmark Ratio

In connection with the continuation of this waiver, for 2027, CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2026 Rate Announcement. For 2027, CMS will use bid-to-benchmark (B2B) ratios based on 2026 bids and weighted by February 2026 enrollment, which is generally consistent with how CMS has developed these EGWP payments since 2019. For 2027, the B2B ratios will be weighted by February 2026 enrollment.

> **Humana Comment:** Humana supports the Agency's proposal to continue using the CY 2026 MA EGWP payment methodology in CY 2027. We support and appreciate OACT's inclusion of preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice. We recognize that there may be changes to the final ratios when updating from January to February enrollment, but we believe that using January enrollment data to determine preliminary ratios has provided valuable information. EGWP negotiations with employer groups often occur well before the publication of the April rate announcement. We believe that by having this information included in the Advanced Notice, it will greatly help us create the most accurate benefit and premium quotes for our members.

Section F.2. MA Rebates and Part B Premium Buy-Down

For 2027, CMS will continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

> **Humana Comment:** We strongly support CMS's proposal to continue to allow MA EGWPs to reduce beneficiary costs by buying down Part B premiums, as this will lead to more consistency between individual and group MA plans.

Section G. CMS-HCC Risk Adjustment Model

The proposed 2027 CMS-HCC model incorporates the following technical updates:

- More recent data years used for model calibration whereby the underlying FFS data years are updated from 2018 diagnoses predicting 2019 expenditures to 2023 diagnoses predicting 2024 expenditures,
- More recent denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, changing from payment year 2020 to payment year 2024, and
- Exclusion of diagnoses from audio-only services to align with MA diagnosis submission policy.

> **Humana Comment:** Humana strongly urges CMS to withdraw the proposed risk model revisions for CY2027 and work with stakeholders to address concerns. CMS should then implement a revised proposal for CY2028 that is phased in to mitigate beneficiary impact while still achieving the Agency's policy goals. As described below, Humana has significant concerns with the proposed substantive changes to the risk adjustment model and CMS's analysis regarding the impact of the proposed changes to risk scores and payments. These concerns are magnified

considering the short Advance Notice review and comment period and CMS's proposal to apply the changes fully to Contract Year 2027 rather than use a multi-year-blended model approach.

Delay Further Model Changes Until Thorough Assessment of V28 is Conducted

Under V28, CMS made significant changes to the HCC Model diagnoses creating disruption and reduced financial incentives for participation in MA. MedPAC's most recent estimate[10] of MA payments attributed a significant reduction in coding intensity variation between MA and FFS (from 10% in 2023 to 4% in 2026) to changes made under V28. Given this latest estimate, which now suggests minimal coding differences between MA and FFS, **Humana encourages CMS to delay any risk adjustment model changes to allow CMS and plans time to fully assess V28 impacts which will inform thoughtful input on future reform.**

Concerns Regarding Significant Fluctuations in Model Coefficients Between the 2024 and Proposed 2027 Risk Adjustment Model Versions

Despite minimal structural changes to the CMS-HCC model, there are significant fluctuations in the model coefficients from the 2024 version of the V28 model and the proposed 2027 version. Humana observes that, when comparing the proposed 2027 version of the V28 model to the legacy 2024 model version, the proposed 2027 V28 model has a range of 53% to 81% of HCCs having a +/- 10% change across the six Community segments and in HCCs with at least 5% prevalence, nearly 70% of coefficients experienced a decrease in value. For example:

- Within the community, non-dual, aged segment, model coefficients appear to decline more than 40% for HCC35 (-77.7%), HCC138 (-46.6%), HCCs 283 (-57.4%), as well as significant decreases within multiple interactions, such as heart failure and chronic lung (-50.0%), heart failure and kidney (-53.4%).
- Humana observes a decrease in payment for all HCC count variables within the community, non-dual, aged segment, where HCC counts 5 and 6 declined by 68.0% and 32.4%, respectively.
- At the same time, there appears to be unexpectedly large increases in model coefficients for HCC191 (115.7%), HCC195 (105.8%), HCC196 (122.9%). Importantly, model coefficients increase significantly for six out of seven HCCs for skin-related diagnoses – HCCs 379 through 385 – with three of these conditions' coefficients increasing more than 40%; HCC379 (77.4%), HCC380 (43.5%) and HCC385 (57.3%).

Such large fluctuations in model coefficients undermine stability in MA plan payments, possibly leading to adverse incentives for MA plans to enroll beneficiaries with certain conditions or leading to benefit and premium instability for beneficiaries. The proposed risk adjustment changes will be particularly impactful for the most vulnerable seniors in our country, specifically older adults, those with chronic conditions, and enrollees with multiple comorbid conditions due to the disproportionate changes in the coefficients and the multiple disease multiplier.

The proposed changes will have a particularly negative and de-stabilizing impact on primary care practices that are critical for preventative care. The amount of funding that was already removed from chronic disease management for many conditions in V28 is exacerbated further with these changes, raising the risk that there will not be sufficient funding for valued-based

[10] Stuart Hammond, Andy Johnson, Luis Serna, and Grace Oh, The Medicare Advantage Program: Status Report, January 16, 2026, Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf

primary care practices to provide necessary care to the most vulnerable and chronically ill members to improve the health and well-being of beneficiaries. Humana recommends that CMS undertake a comprehensive assessment of the sources of fluctuation in the model coefficients and consider evaluating the coefficients over an extended time horizon to ensure the values are appropriate.

Humana recommends that when CMS relooks at chronic disease categories of codes, the Agency consider a longer timeframe for actuarial analysis (3+ years) to improve value-based incentives for providers and to reflect the true preventive opportunity and the true cost of secondary prevention and management. It is notable that the model changes this year increase funding significantly for acute and, in many cases unpreventable conditions, but decreases funding for chronic conditions for which risk bearing providers are a critical partner to CMS in reducing costs through primary and secondary prevention of chronic disease.

Concerns Regarding Inconsistent Treatment of Skin Substitutes for Benchmarks and Proposed Risk Adjustment Model

In particular, Humana believes that the unprecedented growth in Medicare spending on skin substitutes may be a significant contributor to the large model coefficient increases for skin-related HCCs, which may indirectly contribute to the relative decreases observed for other conditions. CMS has significantly decreased reimbursement for most skin substitutes beginning in 2026 and the 2027 USPCC growth rates reflect a substantial projected reduction in FFS spending.[11,12]

Humana believes that consistent adjustments for skin substitutes were not made for the proposed risk adjustment model. Given both the magnitude of the coefficient increases for skin-related conditions and the significant reduction in skin substitute reimbursement beginning in 2026, **Humana recommends that CMS delay recalibrating the CMS-HCC model by one year to mitigate the impact of unprecedented cost trend in skin substitute claims as a source of model instability and allow stakeholders time to further study and comment on a revised model.**

CMS Should Follow Past Precedent and Phase-in Major Risk Model Revisions Over Multiple Years to Mitigate Beneficiary Impact

After V28 is fully implemented and CMS achieves consistency in the treatment of skin substitutes for benchmarks and risk adjustment, CMS should follow past precedent and phase-in major risk model revisions over three years to mitigate the impact on beneficiaries. When CMS has previously made major updates to the risk model, the Agency has elected to phase in those changes over time, allowing plans to better understand and prepare for the impact of the changes and to reduce the year-over-year impact on beneficiaries. Specifically:

- In 2014, CMS expanded the number of HCCs from 70 to 79 and used a blended formula (75% of the 2014 CMS-79 HCC model, 25% of the 2013 CMS-70 HCC model) to phase-in the new model.
- In 2015, CMS reduced the weighting of the 2014 CMS-79 HCC model to slow the transition to the 2014 model.

[11] CMS Modernizes Payment Accuracy and Significantly Cuts Spending Waste | CMS
[12] Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) | CMS

- Similarly, when CMS introduced the 2019 CMS-83 HCC model to expand from 79 to 83 HCCs, it used a blended approach with the then-existing model.
- Recognizing the complexity of implementing major model changes, the 2020 CMS-86 HCC model was phased in over a three-year period.
- Finally, the 2024 CMS-HCC Model (also known as V28) was phased in over the three-year period from 2024-2026.

See Appendix for a list of risk model changes since 2010.

Impact on Total Beneficiary Cost (TBC)

Humana is concerned that CMS's proposed 2027 CMS-HCC model updates and the exclusion of risk model considerations from the TBC evaluation pose a risk to health plan solvency and could result in plan exits and unnecessary disruption for beneficiaries.

CMS's longstanding approach to the TBC evaluation has included the calculation of plan-specific adjustments. These adjustments capture the impact of some anticipated changes in plan funding and MA rebates, such as those caused by county benchmark changes, projected bid growth, and movement in Star Ratings. Risk adjustment model changes have historically not been accounted for in the calculation of these adjustments. This exclusion causes the TBC evaluation to be underinformed and incomplete. The aforementioned items in-scope for TBC adjustment and the out-of-scope risk model revisions both ultimately impact plan funding and MAOs must consider their total impact during bid development. This may necessitate premium increases or benefit reductions to mitigate solvency pressures; however, MAOs may be unable to adequately execute these steps due to the incongruity present in the TBC adjustments. These constraints could result in plan exits and cause unintended member disruption.

Humana notes that in the April 16, 2025 memorandum titled "Final Contract Year (CY) 2026 Standards for Part C Benefits, Bid Review and Evaluation," CMS expressed concerns with reflecting risk model impacts in the TBC evaluation: "*Risk scores are not known for the upcoming contract year, and therefore the plan payment adjustment does not make any assumptions for changes in payment related to the risk score.*" While Humana appreciates this concern, the TBC adjustment-setting process already includes an assumption for unknown quantities in the upcoming contract year, namely, the growth in plan-level A/B bid amounts. All bids are assumed to grow at the national per capita MA growth percentage, though actual A/B bid changes regularly vary materially from this amount. Humana believes it would be appropriate and consistent to incorporate risk model impacts using a comparable global assumption in the TBC adjustment calculation.

Humana would appreciate greater flexibility for MAOs to ensure that their plans offer appropriate benefit value to their members while also reflecting the realities of the funding environment. **If the Agency chooses to move forward with the proposed risk adjustment model updates in part or in full, Humana suggests that CMS consider (1) reflecting the risk model impacts globally in the TBC adjustment-setting process, or (2) increasing the 2027 TBC threshold to permit MAOs appropriate flexibility in making bid decisions.**

In January 2026, Paragon Health Institute hosted an event titled "Directing Medicare: Past, Present, and Future with CMS Medicare Director Chris Klomp"[13] during which Deputy Administrator Klomp stated that Congress put risk adjustment in place to "prevent the adverse selection against beneficiaries who might be sicker." He also discussed the importance of stability and integrity of the Medicare program. On page 51 of the CY 2027 Advance Notice[14], CMS states that the technical updates to the model, specifically using more recent data and denominator years and excluding certain diagnoses, improve the accuracy of the model. Given Humana's aforementioned concerns regarding significant fluctuations in model coefficients, along with the inconsistent treatment of skin substitutes in the growth rate assumptions and risk adjustment model calibration, Humana questions the accuracy of the proposed risk adjustment model at the HCC level and urges CMS to consider potential unintended consequences to the stability and integrity of the model and to beneficiaries and the Medicare program. **Humana strongly recommends that CMS delay implementation of the CY 2027 Risk Adjustment Model to CY 2028 to fix the inconsistent treatment of skin substitutes and then phase-in the model over three years, assuming the skin substitute inconsistency is resolved.**

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2027, CMS will continue to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90%.

Humana Comment: Humana strongly supports CMS's proposal to apply the statutory minimum MA coding pattern difference adjustment factor of 5.9%.

CMS's "An Updated Analysis of Coding Pattern Differences in Medicare"[15] in the January issue of Health Affairs Scholar provides "new estimates of coding differentials that differ from other prominent estimates and incorporate recent policy changes." The paper estimates "1.5%-2.0% of "uncorrected" coding in MA relative to OM [Original Medicare] in 2022 after accounting for statutorily mandated payment adjustments and recent changes to the MA risk adjustment model." MedPAC's most recent estimate[16] of MA payments is closer to the CMS analysis, attributing a significant reduction in coding intensity variation between MA and FFS (from 10% in 2023 to 4% in 2026) to changes made under V28. Humana has undertaken an internal study of the Demographic Estimate for Coding Intensity (DECI) method, which was the method employed by MedPAC and which informs CMS's January publication. Humana's study found that the existing DECI method fails to account for meaningful geographic differences, as well as differences in rates of Part D enrollment. Humana's research suggests that accounting for these additional demographic differences would reduce the DECI estimate, removing the justification for additional risk model changes to reduce MA risk scores due to coding. Consequently, **Humana encourages CMS to delay implementing any risk adjustment model changes to allow CMS and plans time to fully assess V28 impacts which will inform thoughtful input on future reform.**

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[13] Directing Medicare: Past, Present, and Future with CMS Medicare Director Chris Klomp

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

[15] Updated analysis of coding pattern differences in Medicare Advantage | Health Affairs Scholar | Oxford Academic

[16] Stuart Hammond, Andy Johnson, Luis Serna, and Grace Oh, The Medicare Advantage Program: Status Report, January 16, 2026, Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf

Additionally, Humana requests that CMS provide plans with information on whether the agency's annual analysis of MA coding patterns employs the methodology outlined within the 2010 Rate Notice, the method recently published within the aforementioned January 2026 issue of Health Affairs Scholar, or if CMS will employ some other methodology. Humana appreciates that CMS shared the January 2026 analysis and believes it is imperative for the Agency to continue engaging with stakeholders on important issues where there is not industry consensus such as with coding pattern differences. Humana encourages CMS to share its insights and any analyses it has conducted on additional important issues lacking industry consensus, such as favorable selection, and provide opportunities for stakeholders to engage with the Agency on these topics.

Section L. Sources of Diagnoses for Risk Score Calculation

For CY 2027, for organizations other than PACE, CMS will continue the policy first adopted in the CY 2022 Rate Announcement to calculate risk scores for payment using only risk adjustment-eligible diagnoses from encounter data and FFS claims. In addition, CMS proposes that diagnoses from audio-only services and diagnoses from unlinked chart review records be excluded from the calculation of risk scores for Part C beneficiaries, including those in ESRD status. Consistent with the model calibration, beginning in CY 2027, CMS is proposing to exclude diagnoses obtained from audio-only encounters using modifier "93" or "FQ" (where applicable) from risk score calculation when no other line on the encounter data record, chart review record, or FFS claim is risk adjustment eligible.

Humana Comment: Humana generally agrees that chart review records should be linked to the encounter data record (EDR). However, there are instances where linking a chart review to the EDR proves challenging. As a result, Humana recommends that CMS move forward with the proposal to exclude unlinked chart review records from the risk score calculation with an explicit exception for new enrollee chart reviews. In addition, Humana recommends that CMS implement the requirement of linked chart reviews beginning with CY 2028, rather than CY 2027. This would allow health plans and providers to be informed of the policy change ahead of submitting risk adjustment data to CMS. Otherwise, this policy change would be changing the requirements after risk adjustment data has already been submitted to CMS for CY 2027.

Humana strongly recommends that CMS make an exception to allow unlinked chart review records (CRR) to be included in risk score calculations for new plan members. Currently, when an enrollee switches plans, the new MAO does not have access to risk adjustment data filed by the previous plan and therefore lacks access to the EDR to be able to link a chart review record for these new enrollees. As stated in CMS's memo on August 28, 2018, with the subject "Additional Guidance for Chart Review Record Submissions," "MAOs can submit diagnoses on CRRs for prior periods when a beneficiary was enrolled in the plan of another MAO. In this case, the previously enrolling MAO would submit the EDR." Because the previously enrolling MAO would have submitted the EDR, the new MAO does not have access to the EDR, or the ICN number to be able to submit a linked chart review. Still, it is reasonable and beneficial to the enrollee to submit new enrollee chart review records to support accurate risk adjustment data adequate funding for care, and the MAO's ability to identify appropriate services and programs related to the enrollee's diagnosed health conditions. CMS should provide an exception to allow for these chart review records to be unlinked and still included in the risk score calculation due to the data limitations or should provide the necessary information or technical enhancement to

allow MAOs to appropriately link these chart review records to the original encounter data record.

Additionally, Humana encourages CMS to make sensible improvements to promote data quality and transparency and reduce administrative burden to providers and plans. CMS should improve interoperability and data sharing between the Agency and payers to facilitate review, including:

- Permitting the new plan to successfully submit linked chart review records for new enrollees where the enrollee was enrolled in the plan of another MAO who submitted the encounter data record.
- Sharing encounter level data for plan switchers with new plans so that they can verify diagnosis and payment accuracy and delete a diagnosis submitted by the predecessor plan that is not supported by the member's medical record.
- Providing plans more detailed documentation, especially for new plan enrollees that includes which diagnoses were used to generate the HCCs and the corresponding dates of service to further drive accuracy of risk adjustment data and payment.

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

Section B. Part D Premium Stabilization

CMS reiterates that the Base Beneficiary Premium (BBP) for CY 2024 through CY 2029 is equal to the lesser of the prior year's BBP increased by 6%, or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted. Therefore, the BBP for CY 2027 will not be greater than CY 2026 BBP, which was $38.99 (as released in the July 28, 2025 HPMS memorandum) increased by 6%, or $41.33.

Humana Comment: Humana is supportive of the IRA's premium stabilization program and its potential to protect beneficiaries from excess premium growth. However, this tool will only address the average premium increase – creating the potential for significant beneficiary impacts in plans that incur larger than average premium increases from CY 2026 to CY 2027. We continue to have concerns related to potential premium increases resulting from the Part D benefit redesign and caution that at least some beneficiaries could be adversely affected. In our comments below, we encourage CMS to seek additional mechanisms to assist Part D plan sponsors in successfully implementing the programs and policies mandated under the IRA while preserving the affordability associated with Part D plans.

Section C. Part D Calendar Year EGWP Prospective Reinsurance Amount

CMS proposes that the program instructions for Part D Calendar Year EGWP prospective reinsurance contained in the Final CY 2025 Part D Redesign Program Instructions will also apply to CY 2027. As in CY 2025 and CY 2026, CMS plans to announce the prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Monthly Bid Amount (NAMBA), Part D BBP, and related Part D bid information.

Humana Comment: Humana supports the continued use of prospective reinsurance payments for EGWPs. We also support the continued use of the CY 2025 methodology for CY 2027. CMS is calculating the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors

using the weighted average of PMPM prospective reinsurance amounts submitted by Part D sponsors for EA plans as part of the Part D bid submissions for the payment year in question. This update will allow for the prospective payments to be more in line with the expected payment.

Section D. Part D Risk Sharing

CMS intends to keep risk percentages and payment adjustments for Part D risk sharing unchanged from CY 2026. CMS will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Humana Comment: Humana recommends CMS consider using demonstration authority to narrow risk corridors for a finite period beginning in CY 2027. A narrower risk corridor for plan losses was a parameter of the voluntary PDP Premium Stabilization Demonstration for CY 2025 to address concerns about costs under the Part D redesign but was not included as part of the CY 2026 demonstration year. Meanwhile, Part D plan sponsors are experiencing higher-than-anticipated annual costs, reflective of the IRA's benefit redesign itself, unexpected induced utilization among beneficiaries reaching the out-of-pocket cap – which is often much less than the maximum – as well as continued growth in the prescription drug pipeline.[17] This presents challenges for development of CY 2027 bids and could further complicate plans' ability to elect to participate in the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive Health) Model to increase access to select glucagon-like peptide-1 (GLP-1) medications and healthy lifestyle interventions.

Humana believes CMS should exercise its demonstration authorities to once again impose narrower risk corridors for CY 2027, but this time in a two-sided approach (encompassing both plan losses and gains) and for all Part D plan sponsors (MAPD and PDP). Furthermore, Humana strongly encourages CMS to announce any changes to risk corridors for CY 2027 as part of the Final Rate Announcement to allow for more accurate plan pricing. This CMS action would mitigate the continued financial uncertainties associated with Part D redesign and resulting potential premium increases, minimizing potential disruptions to beneficiaries.

Section F. RxHCC Risk Adjustment Model

Section F2. Updates to the RxHCC Models Proposed for CY 2026

CMS intends to make the following changes to the RxHCC model:

- Adjusting the annual OOP thresholds for pre-IRA data years to estimate what the threshold would have been in the prior year if the IRA were in place at the time, as described in the CY 2026 Advance Notice;
- Increasing manufacturer discounts for specified manufacturers and specified small manufacturers to reflect CY 2027 amounts according to the phase-in schedules under the IRA;
- Updating the model's list of adult vaccines and covered insulin products with revised cost-sharing under the IRA to reflect the most recent applicable national drug codes (NDCs);

[17] Milliman MedIntel Part D trend insights: Utilization trends for non-low income Part D members show no signs of slowing in the first half of 2025

- Continuing to adjust gross drug costs to account for the MFPs of the selected drugs for which an MFP is in effect for initial price applicability year (IPAY) 2026 as part of the Medicare Drug Price Negotiation Program;
- Updating the underlying data used in the model calibration to more recent years, specifically using diagnoses from 2023 FFS claims and MA encounter data records and gross drug costs from 2024 PDEs;
- Updating the denominator year from 2023 to 2024;
- Updating the model to exclude diagnoses from audio-only services and those submitted on unlinked chart review records (CRRs); and,
- Updating the model to use separate continuing enrollee model segments for beneficiaries in MA-PD plans and PDPs.

Humana Comment: Humana has long advocated for modifications to the RxHCC risk adjustment model to enhance its predictive power to reflect the relative cost of Part D coverage more appropriately for Medicare beneficiaries. Under the IRA's Part D redesign, the accuracy of the RxHCC model is even more fundamental to promote the sustainability of the Part D program as more of Medicare's subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments. There is growing consensus that significant changes to the RxHCC model are needed. Results of interviews with 11 actuaries with Part D expertise published by MedPAC in January 2026 indicate wide agreement that improving risk adjustment is crucial for long-term PDP market stability.[18]

We appreciate that CMS is taking steps to update the RxHCC model with the CY 2027 Advance Notice. However, we are disappointed CMS will not be reflecting the Maximum Fair Prices (MFP) for selected drugs in effect for initial price applicability year (IPAY) 2027 as part of the Medicare Drug Price Negotiation Program (MDPNP) in the model. Continuing to use historical drug costs instead of the MFPs for drugs subject to Medicare negotiation keeps predicted RxHCC liability misaligned with expected plan liability in bids. Since CMS has provided and made public the MFPs for the selected drugs in advance of their implementation, we believe it is practical and more accurate for CMS to restate past drug costs when determining plan liability under the IRA as part of RxHCC model development. If the timing of the publication of MFPs for 2028 and future years does not align with the lead time OACT would need to include those prices in the model, we encourage CMS to include an MFP estimation for the relevant selected drugs (for example, by using applicable ceiling prices under the MDPNP).

Additionally, we believe that CMS should consider additional changes to the RxHCC model to improve the model's predictive accuracy for MA-PD plans and PDPs. Below, we offer alternative mechanisms that could be used to enhance Part D risk adjustment in ways beneficial to both enrollees and the broader Medicare program for CY 2028 and future years. Specifically, we encourage CMS to weigh the following considerations when developing model coefficient values:

- The model does not account for drug use variation within each condition. The model's predicted liability for a high-cost condition is an average among individuals utilizing the high-cost drugs indicated for that condition, and individuals who do not use drugs indicated for that condition. Each Part D plan will not have the same proportion of non-utilizing individuals for that condition, which will cause overpayments and

[18] Tab-K-Part-D-bids-Jan-2026.pdf

underpayments for each plan, dependent upon that proportion. A 2023 Milliman White Paper highlighted this issue and suggested that CMS could include drug claims for condition imputation so that the coefficient values reflect treatment costs.[19]

- Accounting for Direct and Indirect Remuneration (DIR) in the risk adjustment model would decrease risk scores for conditions with higher levels of manufacturer rebates due to lower net plan liability and increase them for conditions with lower levels of rebates, better aligning predicted RxHCC liability with expected plan liability in bids. Over time, the reflection of MFPs partially achieves this; however, it is more prudent to reflect DIR in the model now to ensure more appropriate payment relative to plan liability and disincentivize plans from targeting or avoiding individuals with certain conditions.

Stakeholders have raised concerns that inadequacies in the current RxHCC model could lead to changes in formulary coverage, benefit changes, plan consolidations, or other actions that may adversely impact beneficiaries and do not suit the needs of the Medicare population. Accordingly, we encourage CMS to consider our suggestions and fully engage stakeholders as part of any future efforts to update and modify the RxHCC model.

Section F3. Predictive Ratios for the Proposed 2027 RxHCC Model (2023/2024 calibration)

CMS presents predictive ratios for the 2023/2024 model calibration by the decile of predicted risk for each model segment. These predictive ratios reflect the ratio of plan spending predicted by the model for CY 2024 to the actual Part D plan expenditures for that year. CMS contends that the proposed 2023/2024 RxHCC model that reflects segmented calculations for MA-PD plans and PDPs generates accurate predictions for a majority of population deciles.

Humana Comment: Humana recognizes the improvement in overall predictive ratios for each of MA-PD and PDP when separate segments are used; however, we request additional granularity when it comes to the evaluation of the predictive performance of the proposed RxHCC model. In the CY 2026 Advance Notice, predictive ratio tables included income status and a separate table for the New Enrollee model segment. Additionally, these tables included predictive ratios for the Top 5%, Top 1%, and Top 0.1% of predicted liability, which allowed plan sponsors to better evaluate the model performance for members with the highest costs.

Attachment IV. Updates for Part C and D Star Ratings

Section C. Measure Updates for 2027 Star Ratings

CMS provides a complete list of the measures that will be used to calculate the 2027 Star Ratings with details about the measure type, weight, and measurement year.

Humana Comment: Humana supports CMS's proposal to the following changes to existing Star Ratings Measures without additional commentary:

- Concurrent Use of Opioids and Benzodiazepines (COB) (Part C)
- Statin Use in Persons with Diabetes (SUPD)
- Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D)
- Colorectal Cancer Screening (COL)

[19] edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/11-7-23_IRA-Medicare-Part-D-Risk-Adjustment.pdf

- Care for Older Adults – Functional Status Assessment (COA-FSA)
- Diabetes Care – Blood Sugar Controlled (HBA)
- Care for Older Adults – Pain Assessment (COA-PA)
- Medication Reconciliation Post-Discharge

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

Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C)

Humana Comment: Recent manual updates have resulted in the Independent Review Entity (IRE), MAXIMUS, using an updated methodology for determining timeliness in the 2024, 2025, and 2026 measurement years. This methodology used by the IRE is not aligned with the established methodology used for the Star Ratings measure, "Plan Makes Timely Decisions about Appeals." Because of this discrepancy, the data produced by MAXIMUS as part of the manual update may appear inconsistent when compared to the metrics and processes historically associated with this Star Ratings measure. This has created questions for plans regarding how to interpret the information they are receiving and whether it will influence their future Star Ratings performance calculations.

Given that CMS has not issued any changes to the measure specifications for the 2025 measurement year and the associated 2027 Star Ratings, we urge CMS to provide confirmation that it will continue to follow the existing Stars specifications. Plans need assurance that the calculations based on the current IRE manual specifications from MAXIMUS should not be viewed as representative of the data that will be used for 2027 Stars Rating calculations. Clarifying this distinction will help prevent misinterpretation and ensure that plans continue relying on the established, published methodology for performance monitoring and preparation.

Medication Therapy Management (MTM) Comprehensive Medication Review (CMR) Completion Rate Measure

Humana Comment: As outlined in the Advance Notice, CMS has expressed its intention to "simplify and refocus the measure set on clinical care, outcomes, and patient experience." Consistent with this direction—and considering CMS's recent commentary and previous actions to remove process-oriented measures—Humana believes that reintroducing the Medication Therapy Management (MTM) / Comprehensive Medication Review (CMR) measure into Star Ratings would be out of alignment with CMS's stated priorities. Given this inconsistency, we encourage CMS to maintain the MTM CMR measure on Display while evaluating a path toward either the development of a new, clinically meaningful measure or the potential retirement of the existing one.

MTM is a CMS-mandated program that specifies member eligibility and requires an annual CMR. CMS moved the CMR measure to Display for MY2025–2026 in recognition of both the expanded MTM population and the operational burden associated with administering the measure at scale. CMS now proposes to return the measure in MY2027. Humana believes that reinstatement would contradict the agency's ongoing efforts to remove measures driven primarily by administrative completion rather than clinical value. The MTM CMR metric remains fundamentally process-based—focused on completion of a structured interaction rather than on

its clinical consequences—making it inconsistent with CMS's commitment to emphasizing meaningful outcomes and patient experience within the Star Ratings program.

Rather than reintroducing a process-oriented MTM metric, Humana encourages CMS to collaborate with the Pharmacy Quality Alliance (PQA) to understand the systematic changes required to support the development of an outcomes-based MTM measure. PQA's recent work to advance MTM quality explicitly calls for measures that move beyond tracking service completion to reflect outcomes and to incorporate the patient voice throughout measure development. These priorities are directly aligned with CMS's direction toward patient-reported and outcomes-driven performance measures.

In parallel, Humana remains actively engaged in broader industry efforts to evolve MTM measurement. A multi-stakeholder MTM Quality Index Industry Coalition is developing an outcomes-oriented framework that integrates several existing Star Ratings measures influenced by MTM interventions into a unified indicator of program effectiveness. This work aims to incentivize meaningful advancements in MTM strategies that improve medication adherence and chronic condition management for MTM-eligible members. Although still in development, the framework represents important progress toward approaches that better align with CMS's emphasis on clinically meaningful outcomes and reduced reliance on administrative processes.

Accordingly, Humana recommends that CMS refrain from reinstating the current administrative MTM CMR measure in Star Ratings. Instead, we urge CMS to maintain the measure on Display while thoughtfully evaluating an appropriate path forward—whether through the development of a new, clinically meaningful measure or through consideration of the existing measure's potential retirement. Humana stands ready to collaborate to modernize MTM measurement in a manner that reflects clinical relevance, member impact, and operational feasibility—consistent with CMS's vision for a streamlined, outcomes-focused Star Ratings program.

Plan All-Cause Readmissions (PCR) (Part C)

NCQA may update the measure to add denied claims and update risk-adjustment for this measure starting 2028 measurement year. Because adding denied claims is a major change, the updated measure would first appear on the display page for 2 years and will go through rulemaking before being added to Star Ratings.

Humana Comment: Humana respectfully offers cautious support for CMS's proposed changes; however, we underscore the critical importance of establishing a clear and standardized approach for consolidating denied claims within the measure methodology. Without explicit consolidation rules, the risk to plans increases substantially, particularly in cases where denied inpatient admissions reflect potentially preventable events or instances in which provider performance may not have met expected standards. In such scenarios, counting repeated admissions for the same member as separate denied-claim events would inaccurately inflate both the numerator and denominator, resulting in distortions that do not reflect true plan behavior. For example, if a member is admitted five times for the same issue and all five claims are denied, it is essential that CMS clarify whether this constitutes one consolidated event or five separate denominator entries.

Humana strongly urges CMS to ensure that multiple denied claims and inpatient admission events associated with a single member and a single clinical episode are combined to prevent

the artificial inflation of measure results and the unintended penalization of plans. From a data perspective, Humana does not foresee operational challenges, as we already receive and process denial-related claim data.

Humana encourages CMS to adopt a clearly defined, episode-based consolidation methodology to promote fairness, accuracy, and consistency across the industry.

Transitions of Care (Part C)

NCQA is reevaluating this four-part care coordination measure and plans to create a new ECDS version, with updates informed by expert input, testing and data standards. NCQA plans to conduct measure testing in 2026 and implement any updates for measurement year 2028.

Humana Comment: Humana appreciates CMS's continued focus on improving care transitions and understands the intent behind the proposed changes to the Transition of Care (TRC) measure. However, we anticipate the revised requirements may negatively impact performance in the short term as plans, providers, and operational teams adjust to the compressed timelines. The shortened engagement window will require increased resourcing and operational intensity, placing added workload on providers who are already managing significant administrative and clinical demands. Accelerating the cadence of 14-day outreach and completion timeline could create unintended negative consequences to successful transitions of care, particularly for populations with complex needs. For instance, providers often have limited availability for appointments. The 30-day timeframe window allows providers to appropriately engage members for transitions of care activity depending on their clinical needs and risk. Narrowing the window to 14-days may result in providers prioritizing highest needs members for transitions of care activities and removes the incentive to complete follow up after 14 days for lower acuity members.

We also note that the proposed adjustments may unintentionally function as a mechanism that inappropriately degrades measure performance, as plans and providers will have limited time to adequately complete required activities. For these reasons, Humana urges CMS to consider the operational realities associated with accelerated TRC requirements and to ensure any final measure specifications support both clinical intent and feasible execution.

Section I. Display Measures

Humana Comment: Humana supports CMS's changes being considered for the following display measures without additional commentary:

- Follow-up After Hospitalization for Mental Illness (Part C)
- Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (Part C)
- Hospitalization for Potentially Preventable Complications (Part C)
- Antipsychotic Use in Persons with Dementia (APD) (Part D)
- Use of Opioids at High Dosage in Persons without Cancer (OHD) (Part D)
- Initiation and Engagement of Substance Use Disorder Treatment (Part C)

Section J. Retirement of Display Measures

Humana Comment: Humana supports CMS's retirement of the following display measures without further commentary:

- Antipsychotic Use in Persons with Dementia for Long-Term Nursing Home Residents (APD-LTNH) (Part D)

Section K. Potential Methodological Enhancements for Future Years

Humana Comment: Humana supports CMS's changes being considered for the following display measures without additional commentary:

- Categorical Adjustment Index (CAI) in contract consolidation

Simplify the Methodology for Determining Measure Thresholds

CMS proposes to make the calculations easier to understand and implement, such as changes to simplify the methodology for determining measure thresholds. For example, one such approach could involve using percentile distribution cut offs to assign measure stars instead of the current clustering methodology for non-CAHPS measures.

Humana Comment: Humana appreciates CMS's ongoing efforts to streamline and enhance the logic of the MA and Part D Star Ratings methodology. A simplified, transparent, and methodologically consistent approach is critical to support members' ability to compare plan performance and to ensuring program stability for MAOs and Part D sponsors. As CMS considers potential refinements to the measure level Star assignment process, we encourage the Agency to pursue options that maintain methodological clarity without introducing unintended volatility.

Humana cautions against the use of percentile-based distributions, especially when implemented in broad 20-percentile groupings. This structure can systematically compress performance, reduce differentiation among plans, and potentially artificially depress average Star Ratings without any change in quality. We believe alternative, evidence-based approaches could better support CMS's goal of simplicity, predictability, and meaningful performance measurement.

Appendix I

Historical Changes in the CMS Risk Score Model			
Payment Year	**Model(s)**	**EDS/RAPS**	**R^2**
2026	2024 CMS-115HCC 6-Community Split	**2024 CMS-115HCC Model:** EDS & FFS data	**2024 CMS-115HCC** Non-dual aged: 0.1355 Non-dual disabled: 0.1472 Partial benefit dual aged: 0.1159 Partial benefit dual disabled: 0.1589 Full benefit dual aged: 0.1246 Full benefit dual disabled: 0.1889
2025	67% 2024 CMS-115HCC 6-Community Split 33% 2020 CMS-86HCC 6-Community Split	**2024 CMS-115HCC Model:** EDS & FFS data **2020 CMS-86HCC Model:** EDS & FFS data	**2024 CMS-115HCC** Non-dual aged: 0.1355 Non-dual disabled: 0.1472 Partial benefit dual aged: 0.1159 Partial benefit dual disabled: 0.1589 Full benefit dual aged: 0.1246 Full benefit dual disabled: 0.1889 **2020 CMS-86HCC** Non-dual aged: 0.1257 Non-dual disabled: 0.1148 Partial benefit dual aged: 0.1122 Partial benefit dual disabled: 0.0987 Full benefit dual aged: 0.1214 Full benefit dual disabled: 0.1317
2024	33% 2024 CMS-115HCC 6-Community Split 67% 2020 CMS-86HCC 6-Community Split	**2024 CMS-115HCC Model:** EDS & FFS data **2020 CMS-86HCC Model:** EDS & FFS data	**2024 CMS-115HCC** Non-dual aged: 0.1355 Non-dual disabled: 0.1472 Partial benefit dual aged: 0.1159 Partial benefit dual disabled: 0.1589 Full benefit dual aged: 0.1246 Full benefit dual disabled: 0.1889 **2020 CMS-86HCC** Non-dual aged: 0.1257 Non-dual disabled: 0.1148 Partial benefit dual aged: 0.1122 Partial benefit dual disabled: 0.0987 Full benefit dual aged: 0.1214 Full benefit dual disabled: 0.1317
2022	2020 CMS-86HCC 6-Community Split (previously known as the APCC model)	**2020 CMS-86HCC Model:** EDS & FFS data	**2020 CMS-86HCC** Non-dual aged: 0.1257 Non-dual disabled: 0.1148 Partial benefit dual aged: 0.1122 Partial benefit dual disabled: 0.0987 Full benefit dual aged: 0.1214 Full benefit dual disabled: 0.1317
2021	25% 2017 CMS-79HCC 6-Community Split 75% 2020 CMS-86HCC 6-Community Split (previously known as the APCC model)	**2017 CMS-79HCC Model:** RAPS & FFS data **2020 CMS-86HCC Model:** EDS, RAPS Inpatient only, & FFS data	**2017 CMS-79HCC** Non-dual aged: 0.1189 Non-dual disabled: 0.1200 Partial benefit dual aged: 0.1117 Partial benefit dual disabled: 0.1234 Full benefit dual aged: 0.1207 Full benefit dual disabled: 0.1140 **2020 CMS-86HCC** Non-dual aged: 0.1257 Non-dual disabled: 0.1148 Partial benefit dual aged: 0.1122 Partial benefit dual disabled: 0.0987 Full benefit dual aged: 0.1214 Full benefit dual disabled: 0.1317
2020	50% 2017 CMS-79HCC 6-Community Split	**2017 CMS-79HCC Model:** RAPS & FFS data	**2017 CMS-79HCC** Non-dual aged: 0.1189 Non-dual disabled: 0.1200 Partial benefit dual aged: 0.1117

Historical Changes in the CMS Risk Score Model			
Payment Year	**Model(s)**	**EDS/RAPS**	**R^2**
	50% 2020 APCC CMS-86HCC 6-Community Split	**2020 APCC CMS-86HCC Model:** EDS, RAPS Inpatient only, & FFS data	Partial benefit dual disabled: 0.1234 Full benefit dual aged: 0.1207 Full benefit dual disabled: 0.1140 **2020 APCC CMS-86HCC** Non-dual aged: 0.1257 Non-dual disabled: 0.1148 Partial benefit dual aged: 0.1122 Partial benefit dual disabled: 0.0987 Full benefit dual aged: 0.1214 Full benefit dual disabled: 0.1317
2019	75% 2017 CMS-79HCC 6-Community Split 25% 2019 CMS-83HCC 6-Community Split	**2017 CMS-79HCC Model:** RAPS & FFS data **2019 CMS-83HCC Model:** EDS, RAPS Inpatient only, & FFS data	**2017 CMS-79HCC** Non-dual aged: 0.1189 Non-dual disabled: 0.1200 Partial benefit dual aged: 0.1117 Partial benefit dual disabled: 0.1234 Full benefit dual aged: 0.1207 Full benefit dual disabled: 0.1140 **2019 CMS-83HCC** Non-dual aged: 0.1245 Non-dual disabled: 0.1142 Partial benefit dual aged: 0.1107 Partial benefit dual disabled: 0.0981 Full benefit dual aged: 0.1198 Full benefit dual disabled: 0.1310
2018	2017 CMS-79HCC 6-Community Split	85% RAPS & FFS 15% EDS & FFS	Non-dual aged: 0.1189 Non-dual disabled: 0.1200 Partial benefit dual aged: 0.1117 Partial benefit dual disabled: 0.1234 Full benefit dual aged: 0.1207 Full benefit dual disabled: 0.1140
2017	2017 CMS-79HCC 6-Community Split	75% RAPS & FFS 25% EDS & FFS	Non-dual aged: 0.1189 Non-dual disabled: 0.1200 Partial benefit dual aged: 0.1117 Partial benefit dual disabled: 0.1234 Full benefit dual aged: 0.1207 Full benefit dual disabled: 0.1140
2016	2014 CMS-79HCC	90% RAPS & FFS 10% EDS & FFS	0.1189
2015	33% 2014 CMS-79HCC 67% 2013 CMS-70HCC	N/A	2014 CMS-79HCC: 0.1189 2013 CMS-70 HCC: 0.1184
2014	75% 2014 CMS-79HCC 25% 2013 CMS-70HCC	N/A	2014 CMS-79HCC: 0.1189 2013 CMS-70 HCC: 0.1184
2013	2013 CMS-70HCC	N/A	0.1184
2012	2009 CMS-70HCC	N/A	0.1091
2011	2009 CMS-70HCC	N/A	0.1091
2010	2009 CMS-70HCC	N/A	0.1091