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

Submitted electronically via https://www.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 (CMS-2026-0034)

Dear Director Klomp:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to provide comments on the Contract Year (CY) 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the CY 2027 Advance Notice). CareFirst is one of the nation's largest not-for-profit healthcare organizations, serving 3.5 million members across Maryland, Washington, DC, and Northern Virginia. Throughout our more than 85-year history, we have dedicated our efforts to providing our members with access to affordable, high-quality healthcare where and when they need it. Today, CareFirst provides MA coverage to over 50,000 members across Individual and Group plans.

For many years, Maryland's Medicare Advantage market has faced instability due to the payment distortion between the Maryland Total Cost of Care (TCOC) Model and Medicare Advantage benchmark rates. Maryland's challenging Medicare Advantage landscape has led to significant disruptions in coverage and fewer choices for beneficiaries. In 2025 alone, more than 50,000 of the approximately 285,000 Marylanders enrolled in Medicare Advantage were notified that their plan would no longer be available in 2026 because of plans exiting the market. We are concerned that the proposed 0.09% increase is too low to accurately reflect the cost of care and would further erode the Maryland Medicare Advantage market if finalized.

Proposed Removal of Diagnoses from Unlinked Chart Review Records

The CY 2027 Advance Notice proposes to exclude diagnosis information from unlinked chart review records from risk score calculation starting in 2027. CareFirst supports policies that promote coding and payment accuracy; however, we are concerned by the impact this proposal will have on smaller, regional Medicare Advantage plans such as our own that are experiencing substantial new membership. Due to recent market exits and service area reductions in Maryland, CareFirst has seen significant new enrollment for 2026 from individuals switching their Medicare Advantage plan. These new members frequently have clinical information that is not adequately represented in accepted encounters late in the base year. Under these circumstances, unlinked chart review records are the only means for plans to ensure the member's risk score accurately reflects their health status upon enrollment. Eliminating this mechanism prevents plans from capturing a complete health picture, leading to under-funding for sicker new members who require immediate, complex care. In addition, requiring every historical diagnosis to be

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linked to a specific encounter may lead to certain conditions being missed in cases where the condition is present but not recorded as the reason for the visit. Providers also frequently omit secondary conditions on standard billing claims if they were not the primary focus of a specific visit. We urge CMS to consider delaying the implementation of the policy and creating a narrow exception for established beneficiaries who switch their Medicare Advantage plan. Such a policy would promote both program integrity and payment accuracy.

Proposed Updates to the RxHCC Models

For the first time, the CY 2027 Advance Notice proposes to use separate continuing enrollee model segments for MAPD plans and PDPs. We believe this policy does not sufficiently account for rising MAPD utilization and costs. We recommend that CMS delay implementation of the policy until the model can be calibrated using 2025 data, given the model in its current form does not reflect post Inflation Reduction Act utilization data.

Percentile Distribution Cut-offs for Stars Measures

We appreciate CMS's interest in simplifying the Star Ratings program. The CY 2027 Advance Notice seeks feedback on using percentile distribution cut-offs to assign measure stars instead of the current clustering methodology for non-CAHPS measures. We believe such an approach has the potential to improve Star Ratings measurement. However, any change to Star Ratings methodology should be implemented only after a multi-year process that allows for comprehensive analysis and public feedback on the proposed change. This process will help reduce volatility and increase transparency in the program.

Carve-outs for Maryland Total Cost of Care Model

As a Maryland-based Medicare Advantage plan, CareFirst faces unique challenges in large part due to interactions between the Medicare Advantage benchmark methodology and the Maryland TCOC Model, a Center for Medicare and Medicaid Innovation demonstration that holds our state fully at risk for the total cost of care of Medicare beneficiaries. A key element of the TCOC Model is that rates for hospital services are set by an independent state agency, the Health Services Cost Review Commission (HSCRC), rather than by CMS. Under the new Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, HSCRC will maintain its Medicare rate-setting authority for 2027. Therefore, CareFirst is particularly sensitive to any policy changes that could unintentionally result in inaccurate payments or impede our ability to provide affordable coverage including supplemental benefits. It is critical to ensure payment policies adequately reflect the expected costs of providing covered services and that appropriate adjustments are thoughtfully developed, particularly when they have a significant impact on the Maryland Medicare Advantage market.

Consistent with the CY 2026 Rate Announcement, CMS is proposing to continue using an alternative data and methodology to develop the direct graduate medical education (DGME), indirect medical education (IME), and kidney acquisition cost (KAC) carve-out for hospitals participating in the Maryland TCOC Model.

For CY 2025, CMS calculated a significant rate reduction for all Maryland counties from the IME/DGME carve-out. Although CMS did not provide updated impacts of the DGME/IME carve-out for Maryland hospitals in CY 2027, CareFirst expects similar impacts next year. In the CY 2026 Advance Notice, CMS estimated aggregate county-level impacts of the KAC carve-out. The most dramatic reductions were in Baltimore City and Baltimore County, which have a higher-than-average number of low-income beneficiaries. On average, counties across Maryland were estimated to experience a reduction of nearly $94,000. By comparison, the next highest reduction in any county in the country was $38,000 for Sussex, Delaware. Overall, CMS estimated more than 350 counties across the country would be impacted by the KAC carve-out for Maryland facilities.

The combined impacts of continuing the DGME/IME and KAC carve-out methodologies disproportionately impact Maryland counties and add further disruption to an already suboptimal Medicare Advantage

market. As such, we strongly recommend CMS reconsider its DGME/IME and KAC carve-out methodologies in CY 2027.

Thank you for your consideration of our comments. We appreciate your continued partnership and welcome the opportunity to discuss our comments in more detail or answer any questions.

Sincerely,



David Schwartz