January 26, 2026

Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on the CY 2027 Medicare Advantage and Medicare Prescription Drug Benefit Program Proposed Rule

[File code CMS-4212-P]

Dear Administrator Oz:

Arnold Ventures welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" (CMS-4212-P) that was published in the Federal Register on November 28, 2025.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. As a philanthropy, we do not accept funding from industry or have a financial stake in policy outcomes. We work to develop evidence to drive reform across a range of issues including health care, education, and criminal justice. Our work within the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it serves.

We want to thank the agency for its important work to help improve the Medicare Advantage (MA) and Prescription Drug Benefit programs. Our feedback in this letter will focus on the MA program. Before we comment, we want to be clear that we support MA as an option for beneficiaries and believe that MA plans have the potential to efficiently deliver care and coordinate systems to improve care. However, numerous studies, investigations, and audits have consistently shown that MA plans are overpaid by billions of dollars annually, in part due to plans gaming the MA risk adjustment system and other waste, abuse, and deceptive practices (e.g., inappropriate prior authorization and aggressive marketing practices).[1,2,3,4] We also believe there are opportunities to improve the efficiency and quality of care for beneficiaries in traditional Medicare (TM).

We applaud CMS for continuing to advance integrated models for dual eligible individuals. There are numerous provisions in the proposed rule that we see as highly aligned with improving integration, either by giving states more control over their programs or by working to simplify the already highly complex reality of making these systems work together. We are broadly supportive of the proposed policies concerning integration through Dual Eligible

Special Needs Plans (D-SNPs) and believe that they will strengthen states' abilities to tailor their programs to their specific populations and integrated care environments.

We recognize the high volume of comment letters that you will receive and the competing priorities you are facing, and we appreciate the opportunity to provide input.

The chart below summarizes our comments and what follows is more detailed feedback.

Provision	Comment
Adding, Updating, and Removing Measures (§§ 422.164 and 423.184); Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures	We do not recommend finalizing the proposed changes to the Star Ratings measure set. Conceptually, we support simplifying the Star Ratings measure set and focusing on measures that meaningfully differentiate plan performance; however, the proposed changes would substantially increase Medicare spending without making needed reforms to the Star Ratings and Quality Bonus Program to improve its usefulness and effectiveness. If CMS streamlines the measure set in future rulemaking, we recommend combining with other QBP reforms to ensure that it does not add to cost.
Passive Enrollment by CMS (§ 422.60)	We are supportive of CMS' proposal to passively enroll beneficiaries in D-SNPs while requiring that receiving plans provide continuity of care for at least 120 days.
Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid Fee-for-Service (§§ 422.107 and 422.514)	We are supportive of CMS' proposal to allow certain D-SNPs to enroll beneficiaries who receive Medicaid benefits through fee for service programs.
Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination (§ 422.510)	We are supportive of CMS' proposal to modify plan contracts after the state terminates its contract with a D-SNP.
Request for Information: C-SNP and I-SNP Growth and Dually Eligible Individuals	We strongly encourage CMS to extend the look-alike policy to C-SNPs. Furthermore, we support states having the ability to require I-SNPs and C-SNPs to sign a contract as a condition of enrolling dually eligible beneficiaries.
Request for Information: Risk Adjustment	Overpayments driven by plan upcoding underscore the need for risk adjustment reform. CMS should prioritize less gameable model inputs and designs, including greater reliance on non-plan provided data sources and approaches like a truncated model paired with reinsurance. CMS should also fully correct for coding differences between Medicare Advantage and traditional Medicare to prevent wasteful Medicare spending and ensure a level playing field.
Request for Information: Quality Bonus Payments in Medicare Advantage	We support a broad redesign of the QBP so that it is budget-neutral, targets bonuses to truly high-performing plans, and is resistant to gaming. CMS should evaluate Star Ratings at the plan (not contract level), limit the share of plans earning 4–5 stars, and exclude employer and union group plans from QBP payment determinations.

V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)

B.–C. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184); Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures

Background: CMS proposes changes intended to simplify and refocus the Star Ratings program. Specifically, CMS proposes to remove 12 existing Star Ratings measures, including Customer Service and Rating of Health Care Quality, over a phased-in timeline and to add the Depression Screening and Follow-Up measure for MA beginning with the 2029 Star Ratings. CMS also solicits feedback on ways to further streamline and modify the Star Ratings methodology and measure set, including potential new measures and additional measures that could be removed in future years.

Star Ratings and the Quality Bonus Program (QBP) do not reliably distinguish true plan quality and are vulnerable to insurer gaming.[5,6] Star ratings are assigned at the contract level and materially affect insurer payments, as contracts with 4+ stars receive a benchmark that is 5 percent higher than the standard benchmark. However, Star Ratings do not consistently reflect true quality; plans can "teach to the test" by concentrating on metrics that are easier to improve, and large, consolidated insurers can inflate scores as they gain ownership and control over providers. In addition, "topped out" measures do not meaningfully differentiate performance across plans and undermine the value of Star Ratings for beneficiaries choosing coverage. These shortcomings are particularly concerning given the growth of QBP spending. The QBP is the only quality program in Medicare that is not budget-neutral, and bonus payments have increased dramatically over the last decade, from $3 billion in 2015 to nearly $13 billion in 2025.[7]

Policy Position: We do not recommend finalizing the proposed changes to the Star Ratings measure set. Conceptually, we support simplifying the Star Ratings measure set and focusing on measures that meaningfully differentiate plan performance. However, the proposed changes would substantially increase Medicare spending ($13.18 billion over ten years), adding to the billions of dollars spent each year on the QBP, which fails to assess true quality. If CMS streamlines the measure set in future rulemaking, this should be done in a way or combined with other QBP reforms (discussed in the QBP RFI) to ensure that it does not add to cost.

We discuss broader issues with Star Ratings and the QBP and our recommendations for reforms in greater detail in our response to CMS' Request for Information later in this comment letter.

VI. B.–D. Passive Enrollment by CMS (§ 422.60); Continuity in Enrollment for Full-Benefit Dually Eligible Individuals in a D-SNP and Medicaid Fee-for-Service (§§ 422.107 and 422.514); Contract Modifications for D-SNPs Following State Medicaid Agency Contract Termination (§ 422.510)

Background: Dual Eligible Special Needs Plans, or D-SNPs, are required to adhere to all MA rules as well as additional federal regulations specific to the product. Moreover, D-SNPs must hold a State Medicaid Agency Contract (SMAC) and adhere to state-specific requirements. This system ensures a baseline level of integration across D-SNPs while providing states with flexibility to tailor plans to the needs of their specific state market landscape, dually eligible populations, and Medicaid offerings.

CMS proposes making multiple changes to support integration or to otherwise improve the ability for states to oversee plans that serve people who are dually eligible:

- Passive enrollment flexibility: When a D-SNP's contract ends, CMS permits passive enrollment in another integrated D-SNP with a "substantially similar network" as the originating plan. Responding to practical limitations, CMS proposes replacing this requirement with requiring the receiving plan to provide continuity of care for at least 120 days so long as it's an integrated plan.
- Exclusively aligned enrollment flexibility: Between 2027 and 2030, certain D-SNPs will be required to move to Exclusively Aligned Enrollment (EAE), meaning that all of their full-benefit dual eligible members must be enrolled in a Medicaid plan under the same carrier. People in these states who are carved-out from Medicaid managed care and have fee-for-service Medicaid coverage will no longer be able to enroll in these integrated plans. CMS proposes to allow these people to enroll in integrated D-SNPs where they exist and requires such plans to assist enrollees with Medicaid service coordination.
- Mid-year contract terminations: States have full discretion over revoking the contract that D-SNPs must have to operate in their state and may do so mid-year. CMS proposes that a state terminating the SMAC (or the affiliated Medicaid MCO contract) be considered sufficient cause for CMS to terminate the associated MA contract and that it can happen mid-year.

Policy Position: We are supportive of these changes proposed by CMS. These regulations will empower states to have more control over their integrated care programs and support further integration and more enrollment in integrated models.

Justification: Without integration of Medicare and Medicaid services, dually eligible beneficiaries may face confusion over covered benefits, unaligned networks, inappropriate billing, and other barriers to receiving needed care.[8] Moreover, when beneficiaries are only enrolled in Medicare benefits under a carrier, such as in an unaligned D-SNP, there can be distorted incentives for plans to cost-shift to Medicaid-covered services.[9]

Almost all states allow D-SNPs to operate in their markets and they therefore present a scalable chassis to integrate Medicare and Medicaid. Medicaid programs vary significantly between states, however, while Medicare adheres to nationally uniform eligibility and benefit requirements governed by federal regulations. As such, the requirement that states sign contracts with these plans is a meaningful leverage point that allows states to tailor how dually eligible people are served in their specific environments. Yet, through contracting, states have no ability to waive federal MA rules even when they conflict with states' Medicaid environments and support integration.

States must make significant investments to stand up these integrated care products: reorganizing their Medicaid managed care landscape, conducting procurement, creating SMAC agreements, regulating plan requirements, adhering to new CMS rules, and monitoring plan performance. Given the high capacity required by states to launch and maintain integrated plans, it is important that new D-SNP policies support states' decision-making as long as these choices lead to a more integrated environment. The provisions proposed by CMS give states more autonomy over their programs by making it easier for them to modify their D-SNP contract landscape and by allowing states to make independent choices about their Medicaid managed care landscape without impeding integration. We applaud

CMS for setting core parameters for integration and letting states iterate further on top of those parameters, and we believe that the changes proposed by CMS will allow states to have more control over their landscapes and promote enrollment in integrated plans.

VI. F. Request for Information: C-SNP and I-SNP Growth and Dually Eligible Individuals

Background: Special Needs Plans (SNPs) are designed to serve the needs of defined populations and restrict enrollment accordingly. These plan types include D-SNPs for the dually eligible population, C-SNPs for beneficiaries with specific chronic diseases, and I-SNPs for those needing an institutional level of care.

The dually eligible population has higher rates of chronic illness than general Medicare beneficiaries.[10] Moreover, people that are dual eligible are eight times as likely to live in an institution.[11] As a result, C-SNPs and I-SNPs inherently have higher levels of dual enrollment than standard MA plans or TM. Although a higher prevalence of dual eligibility in these plans is expected, C-SNP enrollment by dual eligibles has doubled since 2021. Many new enrollees transitioned from integrated coverage, suggesting that carriers may be shifting beneficiaries to more profitable offerings since other SNP types are not beholden to the same integrated care coordination requirements as D-SNPs.

CMS restrictions on look-alike plans—MA plans whose enrollment comprises 60 percent+ dually eligible beneficiaries—were broadly created to support state and federal integration efforts, minimizing the opportunity for carriers to use these vehicles as alternatives to integration. In their June 2020 final rule, however, CMS excluded C-SNPs and I-SNPs from look-alike limitations.

After monitoring the trends mentioned above, CMS is requesting information around these growth trends and input on applying certain restrictions to SNP plans, including requiring State Medicaid Agency Contracts (SMACs), requiring integrated care coordination, and/or applying look-alike restrictions to these plan types.

Policy Position: We strongly encourage CMS to extend the look-alike policy to C-SNPs and to reconsider what happens when a plan is deemed a look-alike. Furthermore, we strongly support states having the ability to require I-SNPs and C-SNPs to sign a contract as a condition of enrolling dually eligible beneficiaries.

Justification: Integrated D-SNPs coordinate Medicare and Medicaid benefits, minimize cost-shifting between programs, and create a better beneficiary experience. Integration is critical for the 12.8+ million Americans who rely on both programs to afford access key services, especially those with lifelong disabilities. Yet, these programs were never built to work together. Without integration, beneficiaries are left to navigate a fragmented system where they may face inappropriate balance billing, misaligned provider networks, and opaque appeals processes. Integration provides value to states and the federal government by aligning financial incentives across Medicare and Medicaid payers while addressing key concerns for beneficiaries.

The value of C-SNPs, however, remains questionable. In 2013, MedPAC recommended closing C-SNPs with some limited exceptions for plans serving HIV/AIDs, End-Stage Renal Disease (ESRD), and Serious Mental Illness (SMI). Despite this recommendation, C-SNPs were permanently authorized. Today, 96 percent of all C-SNPs enrollees are in a plan focused on diabetes or cardiovascular disease,[12] conditions that are prevalent among people over 65 and/or dually eligible. People with these conditions often have multiple comorbidities or dual eligibility that

are more important to address in order to improve outcomes.[13,14] Except in cases where these illnesses are particularly advanced, people may not benefit from a tailored plan and there is no evidence demonstrating that C-SNPs improve quality of care.[15]

The limited clinical value of C-SNPs suggests that they may be serving another function: a means for MA plans to cherry pick people who are relatively healthy but have chronic disease diagnoses and/or to circumvent the state-level integration requirements that apply to D-SNPs. Plans may try to attract people with early-stage or well-controlled diseases or these people may be more likely to select MA plans. In either instance, plans receive increased capitation rates because of their conditions; given that they are also more likely to have multiple comorbidities or be dual-eligible, plans can also document those conditions. This process enables plans to select for community-dwelling, relatively healthy dual eligibles, who are associated with higher capitation rates but are unlikely to require proportionally higher expenditure. This provides little-to-no additional value for beneficiaries and drives up costs for the federal government.

As a result, we encourage Congress to consider closing these plans except in limited instances as recommended by MedPAC and strongly recommend that CMS apply the existing look-alike policy to C-SNPs, which represents a critical first step to addressing these distorted market incentives. We are not supportive of excluding partial benefit dual eligibles from the threshold calculation or restricting look-alike requirements to states with certain levels of integration, as this may make it more challenging for states to launch integrated care models in the future. Additionally, we encourage CMS to reconsider what happens when a plan is deemed a look-alike. Rather than passively enrolling people who are dual eligible in this situation into another plan with the same MA carrier, which is the current policy, we recommend that they should be passively enrolled into an integrated plan (i.e., applicable integrated plan (AIP)) if it exists.[16]

We also urge CMS to allow states to require C-SNPs and I-SNPs to sign a contract as a condition of serving people who are dually eligible in their state. While D-SNPs must contract with the state to operate using a State Medicaid Agency Contract (SMAC), other SNP types do not currently need a SMAC, creating an uneven playing field. This lack of C-SNP and I-SNP accountability strips states of influence over plans enrolling their Medicaid beneficiaries and impedes states' ability to strengthen integration.[17] Given that these plans disproportionately attract dual eligibles and greatly influence the state-specific integration environment, it is important that states have a lever to oversee SNPs broadly.

Finally, until Congress heeds MedPAC's suggestion of C-SNP closure, many duals may be enrolled in these plans not because beneficiaries have actively chosen them but due to aggressive marketing tactics and insufficient consumer education. Therefore, we suggest that CMS create further infrastructure to bolster public education about the plan options available to dual eligible beneficiaries. This could include a variety of mechanisms related to enrollment materials, such as providing support to states to run outreach specific to their environments. We also suggest that CMS consider requiring states to inform dual-eligibles enrolled in C-SNPs or I-SNPs about the integrated plan types available in their area to ensure that beneficiaries are aware of their options.

VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

B. Risk Adjustment

A large and growing body of evidence indicates that MA costs substantially more per enrollee than TM. MedPAC estimates that payments to MA plans will be at least 14 percent higher than fee-for-service Medicare in 2026, costing the federal government $76 billion this year alone.[18] Of this amount, about $22 billion reflects plan upcoding practices to drive higher risk-adjusted payments.[19] Projections from CBO and others suggest that total excess MA payments could exceed $1 trillion over the next decade, increasing Medicare premiums for beneficiaries in MA and TM, and exacerbating Medicare's fiscal challenges.[20,21] Reducing overpayments is crucial to ensure the MA program creates robust competition and value for beneficiaries and taxpayers.

Risk adjustment is central to payment accuracy in MA, but tying payment to diagnoses that plans can manipulate creates incentives to upcode. As a result, insurers, particularly those who account for most MA enrollment, have turned risk adjustment into a profit generation strategy.[22] Overpayments from upcoding are a serious program integrity concern and distort competition. Plans are rewarded for building the most effective coding infrastructure—sophisticated data and analytics capabilities and teams dedicated to capturing diagnoses[23]—rather than delivering high-quality and cost-effective care. This dynamic can disadvantage smaller and regional plans that are less able to finance extensive coding capabilities, undermining fair competition based on care delivery, benefit design, and enrollee experience.

We understand that risk adjustment is essential to paying MA plans appropriately for enrolling sicker patients. However, the persistent evidence of substantial overpayments, of which upcoding remains an important driver, underscores the need for reforms. Accordingly, CMS should prioritize data sources and model redesigns that plans cannot easily manipulate, minimizing opportunities for coding practices to influence payment. This includes greater reliance on alternative data sources that improve accuracy while limiting plan control over the inputs used for risk adjustment. Our recommendations below include near-term changes CMS could implement to the current risk adjustment model and long-term, fundamental reforms. Additionally, CMS should fully correct for coding differences between MA and TM to prevent overpayments and ensure a level playing field.

CMS should be encouraged by recent evidence from the MA market, which indicates that targeted reforms to improve the risk adjustment model and address overpayments can effectively curb coding abuses while still allowing MA to be an attractive option for beneficiaries and enhancing competition between national carriers and smaller regional plans.[24,25,26,27] MedPAC estimates that the updated 2024 CMS-HCC model (V28) reduced upcoding by about 8.8 percentage points and improved fairness and competition between MA plans by disproportionately targeting plans with the most aggressive coding practices.[28] Further, with MA rebates projected to hit a record high in 2026 and far exceed levels from five years ago, CMS has greater room to pursue reforms with minimal disruptions to the supplemental benefits most closely related to medical care.[29]

Our recommendations include:

1. Near-term changes to the risk adjustment model:
    - **Exclude diagnoses identified through health risk assessments (HRAs) and chart reviews from risk adjustment.** MedPAC and other experts have estimated that roughly half of MA upcoding is attributable to HRAs and chart reviews, and that these tactics are a major driver of coding variation across plans.[30,31,32,33] Others, including OIG and investigative journalists at the *Wall Street Journal*, have found that diagnoses added using these tactics, often without evidence of treatment or beneficiary awareness, produced billions of dollars in overpayments to plans in a

single year.[34,35] CMS has previously raised concerns about whether excluding in-home HRAs from risk adjustment could reduce access to legitimate home-based care; however, excluding a service from risk adjustment does not prohibit plans from continuing to cover or provide the service.[36,37]

- **Use two years of diagnostic data in the risk adjustment model.** Moving from a one-year lookback to two years of diagnoses for both MA and TM would reduce distortions driven by upcoding and improve the stability of measured risk, particularly for chronic conditions that may be intermittently captured year-to-year in TM.[38]
- **Pare back the diagnosis-based model and incorporate alternative data sources that are less gameable than plan-provided data**.
    i. **Further limit the diagnoses most associated with upcoding.** CMS' decision to complete the three-year phase-in of the updated 2024 CMS-HCC model (V28) was an important program integrity step that begins to limit the effect of the diagnoses most associated with upcoding on risk scores. CMS should continue to identify additional HCC categories exhibiting outsized coding growth and wide plan-to-plan variation and exclude them from, or materially reduce their weight in, the risk adjustment model.[39]
    ii. **Incorporate beneficiary survey data.** CMS could complement a pared back diagnosis-based model with health data reported by beneficiaries in surveys, including from the existing Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Medicare Health Outcomes surveys. Survey-based health data have been shown to improve risk adjustment performance and are less gameable than plan-provided diagnoses, mitigating incentives for plans to upcode.[40,41]
    iii. **Explore incorporating prescription drug utilization data.** If CMS were to include this data source, it should do so in a way that minimizes potential downsides, including creation of a potential incentive to overprescribe, while failing to capture conditions without existing drug treatments.[42,43] Beneficiary survey data may be a preferable alternative data source.
- **We do not recommend recalibrating the risk adjustment model to MA encounter data.** Doing so would not eliminate incentives for plans to code aggressively, nor would it resolve the need to adjust for coding differences between MA and TM given that MA benchmarks remain tied to TM spending.

2. Longer-term changes to replace the current risk adjustment model:
    - **Pair reinsurance with a parsimonious risk adjustment model.** While a more parsimonious risk adjustment model (e.g., based on demographics and a small number of diagnosis-based variables[44]) would mitigate upcoding incentives, it may also exacerbate risk selection if not paired with reinsurance. In a parsimonious risk adjustment model, plans would likely have stronger incentives to avoid the highest cost enrollees. CMS should consider pairing such a model with reinsurance to mitigate upcoding and risk selection.[45,46] MedPAC recently analyzed an approach, developed by McGuire, Schillo, and van Kleef, combining reinsurance with repayment to address mispricing for outliers, illustrating how these design elements can work together. [47,48] However, CMS should include guardrails to limit cost-shifting into the reinsurance range to preserve cost management incentives, as reinsurance itself may weaken incentives for plans to control very high spending.

- **Explore the feasibility of other approaches, including an Inferred Risk Adjustment Factor (RAF) model, which likely need further development and testing.** We support CMS exploring additional structural reforms to risk adjustment, including concepts like inferred RAF, which is intended to reduce reliance on diagnostic coding and potentially lessen administrative burden by drawing on more standardized data across MA and TM.[49] However, we have material concerns about data availability and accuracy at scale, statistical noise for smaller plans, and the risk of introducing new incentives for utilization and gaming as the model expands to incorporate additional features. These issues should be further explored before determining whether this is a viable approach for risk adjustment in MA.

3. Additional reforms to address overpayments due to coding and promote competition:
    - **CMS should increase the coding intensity adjustment above the statutory minimum 5.9 percent using a targeted approach that accounts for variation across plans.** Evidence indicates that the current minimum adjustment remains far below what is needed to correct for MA upcoding, even after CMS applies its adjustment.[50] CMS should use its existing authority to apply a higher adjustment than the minimum required. This would ideally be done by tiering plans based on their level of upcoding so that entities coding most aggressively face the largest adjustment and entities engaged in less upcoding face smaller adjustments.
    - **CMS should release its analysis used to justify maintaining the 5.9 percent adjustment**, including underlying data and key assumptions. CMS has referenced its internally required coding analysis to justify using the statutory minimum rate.[51] Releasing the analysis and its inputs would materially improve transparency and enable meaningful public evaluation of CMS' approach to coding pattern adjustments.

C. Quality Bonus Payments in Medicare Advantage

The MA Star Ratings program was designed to support informed plan choice for beneficiaries and serve as the basis for the QBP, which links plan payment to performance.[52] The QBP increases benchmarks and rebate percentages for plans based on their Star Rating with the goal of encouraging MA organizations (MAOs) to improve clinical quality, beneficiary experience, and administrative effectiveness.[53] Over time, however, the QBP has increased Medicare spending without a clear link to improvements in quality or meaningful differentiation for beneficiaries.[54] Unlike Medicare's budget-neutral fee-for-service quality incentive programs, the QBP is financed with additional program dollars. In 2025, bonus payments were nearly $13 billion, and a large majority of MA enrollees were in contracts which received a bonus.[55] Moreover, the average Star Rating now exceeds the bonus-qualifying threshold, meaning that average performance can qualify for bonuses, while contract-level ratings can obscure meaningful within-market variation and fail to provide beneficiaries with information that reflects local plan performance.[56,57] Because many Star Ratings measures are tied to provider behavior and administrative processes, the QBP also influences plan competition. Performing well on these measures often requires resources dedicated to administrative capacity and clinician coordination, which larger, vertically integrated MAOs are generally better positioned to deploy to boost their ratings. As a result, these organizations may be able to heighten ratings in ways that can disadvantage smaller, non-integrated plans; do not always reflect meaningful differences in quality; and strengthen financial incentives for plans and providers to consolidate.[58]

Given the QBP's substantial and growing cost and its failure to reliably measure quality, drive improvement in plan performance, or serve as a useful tool for beneficiaries, we recommend a broad redesign of the QBP guided by three principles:

- First, the QBP should be budget-neutral, financing quality incentives through redistribution rather than additional program dollars.
- Second, the QBP should not be a widely available payment increase for insurers. The program should be designed so that bonus payments are concentrated among truly high-performing plans rather than structured to routinely reward average performance with bonuses, weakening incentives for improvement and the usefulness of Star Ratings for beneficiary decision-making.
- Third, the QBP should be resistant to gaming and reflective of the plan-level performance that beneficiaries experience. Bonus payments should indicate meaningful quality and enrollee experience at the plan level and should not be driven by contract-level design features that can mask within-contract variation or enable strategic contract consolidation. The QBP should also promote competition among plans rather than reward administrative capacity and organizational scale to the advantage of large, vertically integrated MAOs.

While CMS can take important steps through rulemaking (discussed below), we acknowledge that some key structural reforms to the QBP require statutory changes. Congress should make the QBP budget-neutral, eliminate the statutory doubling of benchmark bonuses in "double-bonus" counties, and redesign the benchmark bonus to be tiered by performance (e.g., by reducing bonuses for 4- and 4.5-star plans).

We recommend CMS prioritize the following regulatory reforms:

1. **Evaluate quality at the plan level within a local market, rather than at the contract level.** CMS should modify the Star Ratings methodology to assign ratings at the plan level within the local market, rather than averaging across contracts that may include multiple plans across different markets. MA contracts can be expansive; for example, in 2021, 12 large contracts each included plans in over 21 states.[59] Larger insurers can structure their contracts and manage market entries and exits in ways that leverage highly rated plans while masking the poor performance of other plans in the same contract, advantaging large MAOs. Evaluating Star Ratings at the plan level would strengthen market competition by making Star Ratings a more peer-to-peer comparison within local markets, rather than a contract-level average benefitting large MAOs. This change would also improve the usefulness of Star Ratings for beneficiary decision-making by ensuring that the rating attached to a plan reflects the performance of the specific option a beneficiary can enroll in, rather than the average performance of other plans bundled into the same contract.
2. **Limit the overall share of plans that can earn 4- and 5-star ratings.** CMS should revise the methodology so that only a set percentage of plans attain 4 or 5 stars to ensure that high ratings reflect truly exceptional performance rather than average performance that has become increasingly common under the current system.[60,61] This could be implemented through predetermined parameters (e.g., a normal distribution or other thresholds) so that Star Ratings meaningfully differentiate top-performing plans and strengthen incentives for continuous improvement.
3. **Streamline the Star Ratings measure set to reward meaningful plan performance in care delivery and enrollee experience, rather than administrative sophistication.** We acknowledge that accurately measuring quality and designing pay-for-performance programs is difficult, often ineffective, and can

create unintended incentives.[62] The Star Ratings measure set should incorporate measures that meaningfully differentiate quality and enrollee experience and are difficult for insurers to optimize without meaningful improvements in care. We support retiring topped out or process measures that do not differentiate performance, but we recommend CMS incorporate stronger enrollee experience measures in a slimmed down measure set to avoid narrowing the program toward administrative and clinical process measures which may be easier for insurers—especially large, vertically integrated organizations—to game. If CMS concludes that the enrollee experience measures are topped out, we recommend replacing them with measures that better capture enrollee experience with plan operations and care management (e.g., timely access to care and service, plan responsiveness, and administrative frictions that affect enrollees and providers), to improve the usefulness of Star Ratings for beneficiaries when comparing plans.

4. **Limit Star Ratings to only include plans enrollees can choose (i.e., exclude employer and union group plans from Star Ratings).** MA plans offered only through a former employer or union are included in the QBP even though beneficiaries do not choose these plans based on Star Ratings. Group plans also tend to have high enrollment and enrollees with healthier risk profiles, which can contribute to higher average ratings and additional program spending on bonus payments.[63,64] If CMS continues to assess Star Ratings at the contract level, CMS should exclude employer and union group plans from Star Ratings and QBP bonus calculations so that group plan enrollment does not inflate bonus eligibility.

Conclusion

Arnold Ventures is prepared to assist with any additional information needed. Please contact Hunter Kellett at hkellett@arnoldventures.org or Erica Socker at esocker@arnoldventures.org. Thank you again for the opportunity to comment and your consideration of the above.

Mark E. Miller, Ph.D.
Executive Vice President of Health Care
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