January 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: 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]

Dear Administrator Oz:

Thank you for the opportunity to comment on the policy changes that the Centers for Medicare and Medicaid Services (CMS) is proposing for Medicare Advantage (MA) and Medicare Part D for the 2027 contract year.[1] In this letter, I first comment on CMS' proposal to broaden its authority to release MA encounter data, making three main points:

- Broadening CMS' authority to release encounter data has the potential to facilitate research that would improve understanding of MA, at least if this authority is used effectively.

- Because CMS would continue to bar the release of dollar amounts reported on encounter records, it would remain difficult or impossible to use encounter data to answer a range of important questions about MA, including how plans pay providers, what plans spend on different types of care, and how much cost-sharing enrollees bear.

- CMS' stated rationale for barring release of these data is that it wishes to keep the prices that MA plans negotiate with providers secret. But it is doubtful that disclosure would harm market outcomes, and, in any event, this approach runs directly contrary to the Trump administration's stated policy of expanding price transparency.

I then examine several potential changes to risk adjustment policy that CMS raises in its request for information on strategies to improve risk adjustment, making the following points:

- Adopting an "inferred risk" model, under which enrollee health risk would be measured based solely on their health care utilization, could create incentives that would seriously distort care delivery. However, incorporating carefully selected utilization data *alongside* the diagnosis data currently used has clear potential to improve the risk adjustment system.

- Excluding diagnoses obtained from certain sources, such as health risk assessments and chart reviews, from risk adjustment calculations might reduce MA coding intensity and put plans on a more level playing field. However, plans would likely seek to capture these diagnoses in other ways, which could at least partly offset the reduction in coding intensity and create new inefficiencies, including wasted provider time and low-value utilization.

- Contrary to what CMS has suggested in the past, calibrating the CMS-HCC model using encounter data may not help address coding intensity and selection problems, but it might create legal obstacles to applying an appropriate coding intensity adjustment.

- While structural improvements to the risk adjustment model are important to explore, improving the processes that CMS uses to set coding intensity adjustments and creating a similar adjustment aimed at addressing favorable selection could also play an important role in improving the accuracy of the risk adjustment system.

The remainder of this letter examines these points in greater detail.

Proposal on the release of encounter data[2]
CMS proposes to revise its regulations at 42 CFR 422.310 to broaden its authority to release MA encounter data to outside entities. MA encounter data are the only source of comprehensive, granular information on MA enrollees' receipt of health care services, which makes them the best available tool for answering many questions about care delivery in MA, including about the efficiency and quality of that care. As such, broadening access to these data has the potential to give the public and policymakers a better picture of the MA program's performance.

However, while CMS' proposal would remove some restrictions on release of these data, CMS proposes to retain the provision of its existing regulations that states that any releases are "subject to the aggregation of dollar amounts reported for the associated encounter to protect commercially sensitive data." As a practical matter, this limitation would prevent CMS from releasing encounter-level data on what plans pay providers or what enrollees pay in cost-sharing. Thus, it would remain difficult or impossible to use encounter data to study spending patterns in MA, MA enrollees' cost-sharing burdens, or the methods that MA plans use to pay providers. All of these are of first-order importance for understanding the MA program's performance, so this is a major limitation.

In justifying its approach, CMS refers back to concerns it expressed when it finalized its existing regulations in 2014 that "release of payment data at the level of the encounter record might reveal proprietary negotiated payment rates between MA plans and providers."[3] But it is unclear why

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[2] Parts of this section of this comment letter are adapted from prior comments that I submitted to CMS jointly with Loren Adler. See Loren Adler and Matthew Fiedler, "Response to a Request for Information on Improving Data on Medicare Advantage," June 3, 2024, https://www.brookings.edu/articles/response-to-a-request-for-information-on-improving-data-on-medicare-advantage/.

[3] Centers for Medicare and Medicaid Services (CMS), "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Hospitals and Certain Teaching Hospitals; Provider Administrative Appeals and

increasing transparency around negotiated payment rates would be harmful. While it is sometimes argued that disclosing what health plans pay providers could raise negotiated prices, the balance of the evidence suggests that transparency reduces prices, on net, albeit only slightly.[4] MA plans may also argue that disclosing prices would compromise their competitive position vis-à-vis other MA plans (e.g., by making it easier for competitors to enter the market); however, weakening the market power of incumbent plans would likely benefit beneficiaries and reduce federal costs, meaning that this would be a potential *benefit* of disclosure. (Additionally, many prices that MA plans negotiate with hospitals are already publicly available under the hospital price transparency rules, so disclosing data on the prices of these services could not possibly do harm.)

It is worth noting that CMS' desire to keep the prices that MA plans pay providers secret runs directly contrary to stated Trump administration policy. Executive Order 14221 states that it is the policy of the federal government "to promote universal access to clear and accurate healthcare prices" and directs federal agencies, including the Department of Health and Human Services, to act in accordance with this goal. Consistent with this, CMS is currently in the midst of a separate rulemaking effort aimed at revising the Transparency in Coverage rules, with the explicit goal of improving access to information on the prices negotiated between commercial health plans and health care providers. Similarly, CMS has also recently finalized steps to expand the data that hospitals must disclose under the hospital price transparency rules (which, as noted above, already require disclosure of some information on MA prices).[5] It is unclear why CMS is opting to take a fundamentally different approach to price transparency in the context of MA.

In closing, I note that the policy changes in this proposed rule do not, in themselves, expand access to MA encounter data. That will require future policy decisions by CMS. In prior comments to CMS, Loren Adler and I highlighted several concrete ways that CMS could expand data releases to improve understanding of the MA program; notably, CMS could release: the claims adjustment reason codes that appear on encounter data records (which may be helpful in studying how MA plans manage utilization); the encounter records that are now being collected on the use of supplemental benefits; and the final risk scores used in payment calculations.[6,7]

Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program," August 22, 2014, https://www.federalregister.gov/documents/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the.

[4] Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (2022), https://www.cbo.gov/publication/58222.

[5] Centers for Medicare and Medicaid Services (CMS), "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots," November 25, 2025, https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

[6] Adler and Fiedler, "Response to a Request for Information on Improving Data on Medicare Advantage."

[7] Some or all of these steps may have been permissible even under CMS' existing regulations, but insofar as CMS believed that it faced legal barriers to disclosure, the revised regulations should remove them.

Request for information on improving MA risk adjustment

CMS also requests information on how to improve the MA risk adjustment system. As CMS notes, the MA risk adjustment system is performing poorly. Because of higher diagnosis coding intensity in MA and because MA enrollees are favorably selected in ways that the risk adjustment system does not offset, the system fails to ensure that payments to MA plans appropriately reflect differences between the MA enrollee population and the traditional Medicare population, whose spending serves as the basis for setting MA payment rates. Indeed, preliminary estimates from the staff of the Medicare Payment Advisory Commission (MedPAC) indicate that these failures of the risk adjustment system will inflate payments to MA plans by around 15% in 2026.[8]

The limitations of the current system also skew competition among MA plans. Coding intensity appears to vary markedly across plans, giving the best coders an advantage over their competitors.[9] The fact that the risk adjustment system does not capture all relevant aspects of health status (as evidenced by the fact that MA enrollees are favorably selected even after risk adjustment) also discourages plan designs that appeal to types of enrollees whose costs tend to be underpredicted. For example, this may be one reason that MA provider networks tend to be narrow, at least in relation to the networks typically offered by employer-provided plans.[10]

The remainder of this letter comments on several changes to the risk adjustment system that CMS specifically raises in its request for information as well as some reforms CMS does not mention.

Using utilization data to measure enrollee health risk

I begin with the question of whether CMS should use information on enrollee utilization to measure health risk. I consider, in turn, both "inferred risk" approaches under which enrollee risk would be measured using utilization data alone and less radical approaches under which utilization data would be used to augment the current diagnosis-based risk adjustment model.[11]

A pure "inferred risk" approach has the potential to create serious unintended consequences. While there has been little research fleshing out how such a system would work, developing a model that would come close to matching the predictive power of the existing diagnosis-based model would likely require using a rich set of utilization measures as predictor variables. That, in turn, would create strong incentives for plans to encourage delivery of the services that the model uses to infer health risk, thereby generating wasteful utilization and distorting patient care. While the current diagnosis-based system obviously also spurs substantial gaming efforts by MA plans, these efforts mostly do not directly distort patient care and plausibly waste fewer real resources (e.g., labor). For these reasons, I suspect that the disadvantages of an inferred risk approach would outweigh its

[8] Stuart Hammond et al., "The Medicare Advantage Program: Status Report," Medicare Payment Advisory Commission, January 16, 2026, https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf.

[9] Hammond et al., "The Medicare Advantage Program: Status Report."

[10] John A. Graves et al., "Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets," *JAMA Network Open* 3, no. 12 (2020): e2029419, https://doi.org/10.1001/jamanetworkopen.2020.29419.

[11] Abe Sutton and Gabriel Drapos, "Inferred Risk: Reforming Medicare Risk Scores To Create A Fairer System," *Health Affairs Forefront*, ahead of print, April 24, 2024, https://doi.org/10.1377/forefront.20240423.744938.

potential advantages, although research aimed at fleshing out how an inferred risk approach might work and what incentives it would create for MA plans could be useful.

By contrast, using utilization data to augment the current diagnosis-based model may be more promising. One approach would be to use receipt of certain carefully selected services to either impute diagnoses or to serve directly as predictor variables. Under this approach, CMS would select services for which clinical or other considerations suggest that there is little risk of inappropriate delivery. While many services likely do not meet this standard, some likely do. Indeed, the risk adjustment system that CMS operates in the individual and small group market has used receipt of certain prescription medications as predictor variables. Incorporating these variables has improved the model's predictive performance, albeit only to a modest degree.[12]

Another approach would be to add a reinsurance component to the risk adjustment model. While there are a variety of ways of doing so, one approach would be to construct risk scores that have two pieces: (1) a spending-based "reinsurance" component; and (2) a diagnosis-based component. The spending-based component would be calculated as a percentage of the portion of an enrollee's spending that exceeded a specific threshold.[13] The diagnosis component, on the other hand, would closely resemble the current risk score, except that the outcome variable in the regression used to estimate the model coefficients would net out the amounts used in calculating the spending-based component. CMS has incorporated a reinsurance mechanism similar to this one into the risk adjustment system that it operates in the individual and small group markets.[14]

Like any approach that incorporates information on enrollee utilization, this approach would create incentives to increase utilization among high-spending enrollees since some of the added cost would now fall on the reinsurance system. However, some research suggests that the improvement in the system's ability to account for differences in enrollee costs across plans (and between MA

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[12] Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program," Federal Register, December 22, 2016, https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018; Centers for Medicare and Medicaid Services, "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper," March 24, 2016, https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ra-march-31-white-paper-032416.pdf.

[13] For a closely related approach, see Thomas G. McGuire et al., "Reinsurance, Repayments, and Risk Adjustment in Individual Health Insurance: Germany, the Netherlands, and the US Marketplaces," *American Journal of Health Economics* 6, no. 1 (2020): 139–68, https://doi.org/10.1086/706796.

[14] Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program."

plans and traditional Medicare) may be large in relation to these potential downsides.[15] Reducing the importance of the diagnosis-based component would also help reduce coding incentives.

Adding a reinsurance mechanism might also distort the prices that MA plans pay for care by encouraging plans to renegotiate those prices in ways that tend to shift costs onto the reinsurance mechanism. For example, in resolving payment disputes with providers, a plan could agree to pay a higher price for care delivered to a high-cost enrollee (recognizing that much of the additional cost would be borne by the reinsurance mechanism) in exchange for the provider accepting a lower price for other care. Similarly, plans and providers could negotiate high prices for *services* that are particularly likely to be used by enrollees in the spending range where reinsurance applies in exchange for lower prices on other services. These types of schemes could be particularly easy to execute in cases where the plan and provider are vertically integrated. This type of gaming behavior could be addressed relatively easily by calculating plan spending for reinsurance purposes as if all services were paid for at traditional Medicare rates.

Excluding diagnoses from specific sources
CMS also asks whether it should begin excluding diagnoses from certain sources from risk adjustment calculations. The proposed rule explicitly mentions in-home health risk adjustments, but others (e.g., the Medicare Payment Advisory Commission) have identified diagnoses captured in other health risk assessments or chart reviews as also potentially worth excluding.[16]

Diagnoses identified in chart reviews and health risk assessments account for around half of the difference in coding intensity between MA and traditional Medicare as of 2023,[17] which suggests that excluding these diagnoses could go a long way to addressing the MA coding intensity problem. It could also help level the playing field around MA plans since plans vary widely in how successful they have been in using these tools to identify additional diagnoses.[18]

There is, however, an important caveat. Plans would likely respond to this type of policy change by seeking other ways to identify the diagnoses currently being identified via health risk assessments and chart reviews. In the case of chart reviews, this could include giving providers financial or other incentives to ensure that as many diagnoses as possible are directly reflected in claims records, thereby obviating the need for chart reviews. In the case of health risk assessments, this could include encouraging enrollees to make other types of visits to health care providers that

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[15] Michael Geruso and Thomas G. McGuire, "Tradeoffs in the Design of Health Plan Payment Systems: Fit, Power and Balance," *Journal of Health Economics* 47 (May 2016): 1–19, https://doi.org/10.1016/j.jhealeco.2016.01.007; McGuire et al., "Reinsurance, Repayments, and Risk Adjustment in Individual Health Insurance."

[16] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy* (2025), https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/.

[17] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy*.

[18] David J. Meyers and Amal N. Trivedi, "Medicare Advantage Chart Reviews Are Associated With Billions in Additional Payments for Some Plans," *Medical Care* 59, no. 2 (2021): 96, https://doi.org/10.1097/MLR.0000000000001412; Hannah O. James et al., "Medicare Advantage Health Risk Assessments Contribute Up To $12 Billion Per Year To Risk-Adjusted Payments," *Health Affairs* 43, no. 5 (2024): 614–22, https://doi.org/10.1377/hlthaff.2023.00787.

would facilitate capture of the same diagnoses. How successful these efforts would be is unknown, but it is conceivable that they would offset much of the reduction in risk scores attributable to excluding these diagnoses. Furthermore, these new efforts would carry real resource costs for plans, providers, and enrollees, which could partly, fully, or more than fully offset the resource savings associated with no longer conducting chart reviews or health risk assessments.

There is also evidence that the diagnoses captured via chart reviews and health risk assessments contain some useful information about enrollee health risk.[19] To the extent that this is the case, excluding these diagnoses could reduce the risk adjustment system's ability to offset true differences in health risk across plans and, thus, exacerbate selection incentives.

Calibrating the risk adjustment model using encounter data
CMS also suggests that it is continuing to consider calibrating the CMS-HCC model using MA encounter data rather than traditional Medicare claims data. As I noted in my comments on the 2026 Advance Notice, it is doubtful that this change would achieve what CMS hopes it would.[20]

In particular, contrary to CMS' statements in the 2026 Advance Notice, a coding intensity adjustment would remain necessary after this change because MA plans would continue to have higher coding intensity and having more diagnoses would continue to predict higher costs. Indeed, my letter shows that depending on the exact characteristics of the enrollees who receive diagnoses when enrolled in MA but not in traditional Medicare, the size of the coding intensity problem could either rise or fall. My letter also notes that because of how the statutory authority that governs coding intensity adjustments is structured, calibrating the model using encounter data could make it harder for CMS to apply an appropriate adjustment. It is also unclear whether calibrating the model using encounter data would make it more or less effective at addressing selection concerns.

In sum, while it is possible that calibrating the model using encounter data would improve the risk adjustment system's overall performance, this is far from guaranteed, and it is unlikely to do so unless CMS develops a viable strategy for continuing to apply coding intensity adjustments.

Improving coding intensity adjustments and creating a favorable selection adjustment
CMS' request for information focuses on potential structural improvements to the risk adjustment model. As discussed above, several of the approaches that CMS inquires about are worth exploring. However, most involve tradeoffs, and, even if implemented, would likely fall short of fully addressing the coding intensity and favorable selection problems that exist in MA.

With respect to coding intensity, this means that an appropriate coding intensity adjustment will remain an important part of CMS' toolkit for ensuring accurate payments to MA plans. A key

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[19] Jeah Jung et al., "Coding Intensity Through Health Risk Assessments and Chart Reviews in Medicare Advantage: Does It Explain Resource Use?," *Medical Care Research and Review* 80, no. 6 (2023): 641–47, https://doi.org/10.1177/10775587231191169.

[20] Matthew Fiedler, "Comments on the 2026 Medicare Part C and D Advance Notice," The Brookings Institution, February 12, 2025, https://www.brookings.edu/articles/comments-on-the-2026-medicare-part-c-and-d-advance-notice/.

challenge is that the coding intensity adjustment applied by CMS appears to have been persistently too small in recent years.[21] Improving the process that CMS uses to set that adjustment is thus important. One potential step in that direction would be for CMS to publicly specify the analytic method it uses to estimate the appropriate coding intensity adjustment in each year. That greater transparency could help CMS "bind itself to the mast" by making it more costly for CMS to adopt a coding intensity adjustment that lacks an appropriate analytic justification.

A similar adjustment could also help to address favorable selection. Similar to the approach laid out for coding intensity, CMS could publicly specify the methodology it uses to estimate the degree of favorable selection into MA and then make a corresponding adjustment to risk scores annually. (If CMS currently lacks a suitable methodology, it could adopt the one used by MedPAC.)

A common objection to the current coding intensity adjustment is that it affects all plans equally, despite the fact that coding behavior varies across plans;[22] a similar objection would likely apply to a favorable selection adjustment like the one described above. It would, of course, be preferable to apply adjustments tailored to each plan's situation. But doing so is difficult, and making no adjustment at all does nothing to level the playing field across MA plans; it merely ensures that payments to plans will be less accurate, on average, than they would otherwise be.

Thank you for the opportunity to comment on this proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

Sincerely,

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[21] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy*.

[22] With respect to coding intensity, see Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy*.