Center on Health Policy at BROOKINGS

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

**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 Administrator Oz:

Thank you for the opportunity to comment on the 2027 Part C and D Advance Notice published by the Centers for Medicare and Medicaid Services (CMS).[1] This letter makes three main points:

- **Higher MA coding intensity continues to inflate payments to MA plans.** Preliminary estimates from the Medicare Payment Advisory Commission (MedPAC) suggest that higher MA coding intensity will inflate payments to plans by 4% in 2026, after the coding pattern adjustment. This differential has tended to grow over time absent policy changes, so it would likely be higher than 4% in 2027 under current policies. Thus, achieving the statutory goal of actuarial equivalence requires action to address coding intensity.

- **Excluding unlinked chart review records (CRRs) from risk adjustment calculations might reduce MA coding intensity, but insurer efforts to recapture the lost diagnoses may limit the proposal's effectiveness or even make it harmful on balance.** In practice, insurers may often be able to link currently unlinked CRRs to encounter records or induce providers to directly report the relevant diagnoses on encounter records. Thus, this proposal may reduce MA coding intensity by much less than CMS expects, even as insurers' recapture efforts generate new compliance costs. Whether these costs are worth bearing depends on how large they are, how much recapture occurs, and how targeted the remaining reduction in coding intensity is to the insurers with the highest coding intensity. It also depends on whether a higher coding pattern adjustment is a viable alternative, as a higher adjustment could reduce coding intensity without the same compliance costs.

- **CMS' proposed coding pattern adjustment is likely too small to fully offset higher MA coding intensity.** CMS' projections imply that, under the policies in the Advance Notice (which include maintaining the statutory minimum coding pattern adjustment), the coding differential between MA and traditional Medicare will fall by 2.4 percentage points

[1] The views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Richard Frank for comments on a draft of this letter, Samuel Peterson for research assistance, and Rasa Siniakovas for editorial assistance.

in 2027. Because this decline is smaller than MedPAC's estimate of the coding intensity differential in 2026, it follows that achieving actuarial equivalence in 2027 would likely require implementing a higher coding pattern adjustment. Moreover, if insurers succeed in recapturing most of the diagnoses currently reported via unlinked CRRs, then the required increase in the adjustment would be larger than these estimates imply.

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

**Current State of MA's Coding Advantage**

There is abundant evidence that MA plans report more health conditions for their enrollees than would be reported for the same enrollees if they were enrolled in traditional Medicare. Preliminary estimates from MedPAC indicate that higher MA coding intensity will inflate payments to MA plans by 4% in 2026.[2] MedPAC's estimates suggest that MA's coding advantage has tended to grow over time absent policy changes, so it would likely be larger in 2027 under current policies.

Thus, if CMS wants to ensure that payments to MA plans satisfy the statutorily required actuarial equivalence standard, measures to address higher MA coding intensity are necessary. In prior writing, I have offered views on how policymakers might achieve this objective.[3] In the remainder of this letter, I offer comments on two relevant proposals of the Advance Notice.

**Assessing CMS' Proposal to Exclude Unlinked Chart Review Records**

The Advance Notice proposes to begin excluding unlinked CRRs from risk score calculations. CMS predicts that excluding unlinked CRRs will reduce payments to MA plans by 1.53% in 2027. This estimate appears to assume that if diagnoses reported on unlinked CRRs were excluded from risk score calculations, insurers would have little scope to capture those diagnoses in other ways.[4] For a couple of reasons, this may be an unrealistic assumption, especially in the long run.

First, insurers may often be able to convert unlinked CRRs to linked CRRs. For a diagnosis to be captured by a chart review, a patient must typically have had *some* interaction with a provider that led to the condition being recorded on the patient's chart. Consistent with this, the data that CMS presents in the Advance Notice indicate that fewer than 0.1% of MA enrollees have an unlinked

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[2] 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.

[3] "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities," with Matthew Fiedler, July 22, 2025, https://www.brookings.edu/articles/matthew-fiedlers-testimony-on-medicare-advantage/; Matthew Fiedler, "Comments on the 2027 Medicare Advantage and Part D Proposed Rule," January 26, 2026, https://www.brookings.edu/articles/comments-on-the-2027-medicare-advantage-and-part-d-proposed-rule/.

[4] In particular, published estimates indicate that diagnoses contributed by unlinked CRRs increased average risk scores in MA by an estimated 1.8% as of 2021. See, in particular, Appendix Exhibit 1 from Paul D. Jacobs, "In-Home Health Risk Assessments And Chart Reviews Contribute To Coding Intensity In Medicare Advantage," *Health Affairs* 43, no. 7 (2024): 942–49, https://doi.org/10.1377/hlthaff.2023.01530. Thus, unless the contribution of unlinked CRRs has increased markedly in subsequent years, CMS' estimate seems to reflect an assumption that insurers would be able to recapture only a small fraction of the diagnoses reported via unlinked CRRs.

CRR but no actual encounter records during the year.[5] Thus, it is plausible that there is typically an encounter record that these CRRs could be linked to if the insurer had a payment incentive to do so. In this regard, it is notable that the share of CRRs that is linked to an encounter record varies widely across insurers, with some insurers linking nearly all of their CRRs to encounter records.[6] While it is possible that some insurers simply decline to submit CRRs that are challenging to link to encounters, a more likely explanation is that linking a CRR is typically feasible and some insurer's systems are set up to link CRRs in most cases, while others are not.

Second, even where insurers cannot link the affected CRRs to an encounter record, insurers may be able to capture the diagnoses in other ways. For example, they may be able to encourage providers to document the diagnoses during a future encounter (e.g., a health risk assessment), thereby ensuring that the diagnosis continues to appear on a risk-adjustment-eligible record.

If insurers are able to recapture some or all of the diagnoses currently reported on unlinked CRRs, that has a couple of important implications for policymakers. First, it suggests that this policy change may reduce payments to MA plans by less, perhaps much less, than CMS expects.

Second, if insurers' efforts to recapture these diagnoses were successful enough, it would raise questions about the wisdom of this policy change. The main rationale for excluding diagnoses from unlinked CRRs is to reduce MA coding intensity, thereby bringing federal payments to MA plans more in line with what the law intends. Because this change would plausibly have the largest effects on the plans with the highest coding intensity,[7] it could also help to level the playing field across MA plans. But those potential benefits would come at a cost. Insurers' efforts to recapture diagnoses would likely generate new compliance costs, some of which would likely be passed along to some combination of the federal government and MA enrollees via increases in insurers' bids.[8] Whether this change is worth pursuing thus depends on how successful insurers are in recapturing diagnoses and how large these compliance costs actually are. It also depends on

[5] As of 2022, this amounted to around 13,000 beneficiaries. For comparison, there were an estimated 8.2 million unlinked CRRs that contributed risk-adjustment-eligible diagnoses as of 2016, and this number may now be larger. See Office of the Inspector General, United States Department of Health and Human Services, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns* (2019), https://oig.hhs.gov/documents/evaluation/2792/OEI-03-17-00470-Complete%20Report.pdf. Thus, the overwhelming majority of unlinked CRRs must be attributable to beneficiaries who had some interaction with a provider during the year (although these data do not show that it was the provider whose records support the CRR).

[6] Office of the Inspector General, United States Department of Health and Human Services, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns*.

[7] Use of chart reviews is a substantial part of why coding intensity is higher in MA and is known to vary widely across plans. See 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; Jacobs, "In-Home Health Risk Assessments And Chart Reviews Contribute To Coding Intensity In Medicare Advantage."

[8] It would likely be appropriate to place some weight even on the portion of the additional compliance costs that fell on insurers themselves, particularly to the extent that it ultimately reduced federal tax revenues.

whether a higher coding pattern adjustment is a viable alternative, as a higher coding pattern adjustment could reduce MA's coding advantage without generating the same compliance costs.

**Assessing the Proposed MA Coding Pattern Adjustment for 2027**

CMS proposes to maintain the statutory minimum 5.9% coding pattern adjustment for 2027. This adjustment would likely be too small to fully offset higher coding intensity in MA.

As noted above, preliminary MedPAC estimates imply that higher MA coding intensity, net of the current coding pattern adjustment, will inflate payments to MA plans by 4% in 2026. Even if one takes CMS' projections of underlying risk score trends and the effects of the risk adjustment policies in the Advance Notice at face value, MA's coding advantage will fall by only around 2.4 percentage points in 2027, which implies that an increase in the coding pattern adjustment of around 1.6 percentage points would be needed to offset that advantage.[9] Moreover, as discussed above, CMS is likely overestimating the effect of its proposal on unlinked CRRs. If insurers are, in practice, able to recapture all of the diagnoses currently reported via unlinked CRRs, then an increase in the coding pattern adjustment of around 3 percentage points would be needed.

I note that one common objection to addressing higher MA coding intensity using a coding pattern adjustment is that coding pattern adjustments affect all plans equally, despite the fact that coding intensity varies widely across MA plans.[10] It would, quite clearly, be preferable to apply a coding pattern adjustment tailored to each plan's circumstances and behavior. But doing so is difficult, and declining to set an adjustment that matches average coding behavior merely ensures that payments to plans will be less accurate, on average, than they would otherwise be.[11]

Thank you for the opportunity to comment on the Advance Notice. 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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[9] The 2.4 percentage point reduction in MA risk scores reflects the net effect of the model calibration and normalization proposal (-3.32%), the unlinked CRR proposal (-1.53%), and the risk score trend projection (+2.45%).

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

[11] Portions of this paragraph are adapted from my comments on CMS' 2027 MA and Part D proposed rule. See Fiedler, "Comments on the 2027 Medicare Advantage and Part D Proposed Rule."