February 20, 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 Advance Rate Notice

[File code CMS-2026-0034]

Dear CMS Administrator:

Arnold Ventures welcomes the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the "Advance Notice of Methodological Changes for Calendar Year 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" that was published on January 26, 2026.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. 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.

First, we want to thank the agency for its important work to help improve the MA program, and for the opportunity to provide input. 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. We also believe there are opportunities to improve the efficiency and quality of care for beneficiaries in traditional fee-for-service Medicare (TM). However, there are substantial overpayments in MA and action is urgent to ensure MA delivers on its promise of robust competition leading to value for beneficiaries and taxpayers, and the sustainability of the Medicare trust fund.

Over the last three years, CMS – across two Administrations – has taken significant action to reduce overpayments in MA. In this advance notice, the agency proposes to continue this initiative through further changes to the risk adjustment system. **Arnold Ventures strongly supports CMS's efforts and urges CMS to finalize these changes – especially the proposal to remove chart-review-based diagnoses not tied to medical encounters from risk adjustment.**

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 abuses while still allowing MA to be an attractive option for beneficiaries and enhancing competition between national carriers and smaller regional plans.[1,2,3] 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 insurance benefits most closely related to medical care.[4]

Despite the recent risk adjustment changes, and even if the important changes proposed in the advance notice are finalized, it is still clear from numerous studies, investigations, and audits that MA plans are substantially overpaid relative to TM. The Medicare Payment Advisory Commission (MedPAC), The Congressional Budget Office, CMS, and the HHS OIG, have all pointed to what drives overpayments and their costs to taxpayers and Medicare beneficiaries.[5] MedPAC, which produces the most up-to-date overpayment estimates, has suggested that in 2026, MA plans will be paid at least 14 percent higher than if beneficiaries were in TM – costing the government $76

billion.[6] Projecting those overpayments out over the next decade leads to an estimated cost to the federal budget of over $1.2 trillion, with beneficiaries paying over $240 billion in higher Medicare premiums.[7]

The payment policies leading to overpayment will require further reform to address the continued reward to private insurance plans from gaming MA's system of risk adjustment, favorable selection into MA, an expensive and ineffective quality bonus system, and other waste, abuse, and deceptive practices.[8,9,10,11,12] Our comments below primarily focus on overpayments due to diagnostic coding and risk adjustment.

Overpayments to MA Plans Due to Upcoding

Medicare Advantage was created to deliver efficiencies and cost-savings to the Medicare program. However, MA has never produced savings relative to traditional Medicare, and in fact, actually costs the program – and taxpayers – substantially more per enrollee than traditional Medicare. MedPAC estimates that Medicare premiums – paid by beneficiaries in both TM and MA – were about $13 billion higher in 2025 because of excess payments to MA plans.[13]

Excess payments to MA plans are due to many factors, but there is strong empirical evidence pointing to the important role played by the upcoding of diagnoses to game the risk adjustment system.[14,15,16] The system's basic design incentivizes MA insurers to engage in aggressive – and in some cases fraudulent – diagnosis coding to make their enrollees appear less healthy, which generates higher Medicare payments.[17] As a result, insurers, particularly those who account for most MA enrollment, have turned risk adjustment into a profit generation strategy.[18]

This is a serious program-integrity concern and distorts competition. Plans are rewarded for building the most effective coding infrastructure – sophisticated data and analytics capabilities and teams dedicated to capturing diagnoses rather than delivering high-quality and cost-effective care.[19] This dynamic can disadvantage smaller and regional plans that are less able to finance extensive coding capabilities, undermining what should be the MA program's goal: fostering fair insurer competition based on care delivery, benefit design, and enrollee experience.

MedPAC has estimated that in both 2022 and 2023, intense coding drove risk scores 17 percentage points higher than risk scores for similar beneficiaries in TM, at a cost of over $30 billion in each year.[20] CMS has found the same coding-related risk score differential for 2022 when using the same method for their calculation.[21]

Due to this trend, and despite intense opposition from the insurance industry, CMS updated the CMS-HCC model to version 28 (v28) and phased in those revisions from CY 2024 to CY 2026. **Arnold Ventures commends CMS for this bold and successful program integrity initiative that has limited the gameability of certain diagnoses most associated with upcoding on risk scores.** Both MedPAC and CMS have calculated that fully phased-in, v28 likely reduces coding intensity by around 8 percent annually.[22] Furthermore, MedPAC data suggests that v28 appears to have improved competition in the MA program by targeting its impact at the plans that engage in more egregious discretionary coding, which helps level the playing field a bit so that plans compete on price and benefit design, instead of competing on who can code the most intensely.[23] Evidence also suggests that plans responded to v28 by absorbing over three-quarters of the revenue impact; leaving benefits, cost sharing, and premiums largely unchanged for enrollees.[24]

CMS Proposal on Delinked Chart Reviews

Even after full implementation of v28, MedPAC suggests that in 2026, excess coding will lead to plan overpayments of 4 percent, costing Medicare $22 billion.[25] MedPAC has found that about half of MA coding intensity is due to chart reviews and Health Risk Assessments (HRAs) and that these two tactics are a primary factor driving coding variation among different plans.[26]

Chart reviews involve retrospective analysis of any medical record to validate a diagnosis submitted by plans to the risk adjustment system for payment. The idea is that such analysis could both add or subtract diagnosis to improve accuracy. In practice, chart reviews, as the *Wall Street Journal* has reported, can often lead to diagnoses being coded for a beneficiary without it being linked to medical encounters or treatment, and in some cases, without the beneficiary or physician even knowing.[27] The HHS OIG has found that almost half of MA insurers were paid for such unlinked reviews in a single year without any claim from the beneficiary in that year.[28] Research analyzing billions of encounter records shows that in 97 percent of the cases, chart reviews increased rather than decreased

diagnoses.[29] Other research has shown that for the largest MA insurers, with the highest levels of coding intensity, chart reviews are a greater source of these unlinked codes than HRAs.[30,31]

Arnold Ventures believes CMS has taken an important step forward with its proposal in the advance notice to remove from risk adjustment any diagnoses from chart reviews not tied to medical services. CMS projects that it will reduce overpayments due to upcoding by around 1.5 percent, over $7 billion in 2027. The proposal will also be procompetitive by reducing the gains from systemic gaming used most often by the bigger insurers in the MA market.[32]

More Improvements Needed to Address Overpayments

Our suggestions below largely focus on risk adjustment and coding given their direct relationship to the advance notice. However, it's worth noting the other areas of MA reform that need to be considered by both CMS and lawmakers. The MA quality bonus system costs around $13 billion annually despite evidence that it does not improve quality, that ratings are consistently gamed by MA plans, and that the program doesn't provide useful information to help beneficiaries when they chose a plan.[33] Additionally, favorable selection into MA of beneficiaries with lower-than-expected spending given their risk scores is a problem that MedPAC estimates will lead to around $57 billion in plan overpayments in 2026 alone. Other researchers estimate favorable selection impacts around the same level or higher.[34]

It is clear much more needs to be done to rein in overpayments, hold plans more accountable, and work to increase competition in MA – while moving to a playing field for that competition focused on plan design and beneficiary health and experience, and not a coding and risk selection arms race. Thus, CMS should continue to make incremental changes, similar to the proposal on chart reviews, while also planning for larger scale changes to the risk adjustment model. CMS can use its authority to:

- **Exclude information collected via in-home health risk assessments (HRAs) as a source of diagnoses for risk adjustment**, consistent with recommendations made by MedPAC and OIG.[35, 36] As mentioned above, MedPAC has found that about half of MA coding intensity is due to chart reviews and HRAs and that these two tactics are a primary factor driving coding variation among plans.[37] OIG has also found that diagnoses reported only on HRAs resulted in billions of dollars in overpayments to plans in a single year.[38] Excluding HRAs from risk adjustment is a natural next step after finalizing the exclusion of unlinked chart reviews.
- **Use two years of diagnostic data in risk adjustment** from both MA and TM, which 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.[39]
- **Continue to identify the most often gamed HCC categories**, as CMS did in v28, to target diagnoses exhibiting outsized coding growth and wide plan-to-plan variation, and exclude them from, or materially reduce their weight in, the risk adjustment model.

While v28 has been a success in reducing excess coding in aggregate, there is still excess coding and a wide variation in upcoding behavior across plans and MA organizations, even though v28 somewhat reduced this variation. Some plans still code at levels of 10 to 20 percent above TM, costing billions.[40] **Thus, we urge CMS to use its authority to apply a higher coding adjustment factor than what is minimally required of it in statute via an approach that addresses variation in coding and targets those who code most intensely.** For example, plans could be tiered based on their coding intensity where plans in the highest tier would receive the largest coding adjustment while plans in the less intensive upcoding tier would receive a smaller adjustment.

To address the other sources of MA overpayments from the risk adjustment system, CMS should contemplate larger scale reforms. A long-term vision should contemplate major methodological changes including:

- **Modified approaches to traditional risk adjustment, such as combining a truncated or more parsimonious model with reinsurance,** which may reduce the potential for plan gaming.[41] MedPAC, for example, analyzed a modified risk adjustment model that includes reinsurance and repayment to address payment inaccuracies for outliers.[42] 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.

- **Using alternative sources of data for risk adjustment,** with a focus on sources that cannot be directly influenced by plans to minimize the opportunity for plan gaming. For example, 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.[43,44] Additionally, CMS could explore the inclusion of data on pharmaceutical usage. However, 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.[45,46]

Conclusion

Reducing overpayments and improving program integrity in MA are critical to the affordability and sustainability of the Medicare program. With the trust fund facing insolvency by 2032, the Medicare program cannot afford this magnitude of continued overpayments to MA.[47]

The evidence shows that despite the overheated rhetoric of organized interest groups, further reforms will not lead to the demise of MA plans. The program changes that have been made by CMS and Congress over time to address overpayments, including the shift to v28, certainly have not done so. A recent analysis by the Actuarial Research Corporation shows that average beneficiaries have access to nearly 40 options – a vast majority of them with "zero-premiums" beyond the standard Medicare Part B premium.[48] Compared to 2019, beneficiaries have seen the number of plan options increase by 67%, while the number of zero-premium plans has increased 175%. One-third of plans offer lower premiums than the standard Part B premium, with insurers using rebate dollars to buy-down the premium. Nationwide, 99.5% of Medicare beneficiaries have a choice of multiple MA plans. Furthermore, benefit offerings remain robust and near all-time highs with near universal vision, dental, and hearing benefits.

Additionally, since payment reductions in 2010 – that were criticized at the time as potentially catastrophic – MA enrollment has more than doubled, beneficiaries have greater choice in plans, rebates to plans that fund extra benefits and lower premiums and cost sharing reached historic highs, and plans are bidding more efficiently for contracts with the federal government.

We applaud CMS for continuing to move in the right direction to reduce overpayments to MA plans by targeting unlinked chart reviews. However, the job is not finished and evidence shows that larger reforms to CMS' risk adjustment system are needed to ensure the fiscal sustainability and integrity of the Medicare program and to ensure MA delivers value to beneficiaries and taxpayers.

We appreciate the opportunity to comment on the Advance Notice. Please contact Mark Miller at mmiller@arnoldventures.org with any questions.

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