Center for American Progress
1333 H Street NW, Suite 100E
Washington, DC 20005
202.682.1611
americanprogress.org

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via regulations.gov

RE: CMS-4212-P — Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz:

The Center for American Progress (CAP) appreciates the opportunity to comment on the Contract Year 2027 Medicare Advantage and Part D Proposed Rule. CAP is an independent, nonpartisan policy institute that advances evidence-based solutions to improve Americans' health and economic security. Our health policy team studies Medicare and Medicare Advantage extensively and understands how regulatory decisions affect beneficiary access, costs of care, and long-term program sustainability.

With over half of Medicare beneficiaries now enrolled in Medicare Advantage (MA),[1] the proposed changes in the CY 2027 Rule have significant implications for millions of Americans and for the Medicare program as a whole. Our comments address five areas: (1) risk adjustment modernization, (2) rescission of health equity requirements, (3) deregulation of marketing and communications practices, (4) Star Ratings and quality measurement reforms, and (5) prior authorization oversight.

I. Risk adjustment modernization

The current risk adjustment model rewards plans for documenting diagnoses rather than for delivering appropriate care or improving health outcomes. The result is predictable: plans channel their investments into chart reviews, health risk assessments, and AI-assisted coding—activities that inflate risk scores but are not associated with improved health outcomes.[2] MedPAC estimates that these practices raised MA risk scores by approximately 12 percent in 2025, generating $28 billion in excess payments. The statutory

[1] KFF, "Medicare Advantage in 2025: Enrollment Update and Key Trends," August 11, 2025, available at https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/.
[2] Jinhyung Jung, Caroline S. Carlin, and Roger Feldman, "Coding Intensity through Health Risk Assessments and Chart Reviews in Medicare Advantage: Does It Explain Resource Use?," *Medical Care Research and Review* 81 (1) (2024): 47–58, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC11974351/.

minimum coding intensity adjustment of 5.9 percent captures only a fraction of this gap—after the adjustment, MA risk scores still exceed fee-for-service equivalents by roughly six percent.[3]

Beneficiaries and taxpayers bear the cost. Overpayments accelerate depletion of the Hospital Insurance Trust Fund,[4] increase Part B premiums for all Medicare beneficiaries,[5] and divert resources that could otherwise be used to expand supplemental benefits or reduce cost sharing across the program.[6] CMS has taken important steps to curb upcoding—including phasing in the V28 model revisions and strengthening RADV audits—but significant opportunities remain both to correct overpayments within the current framework and to develop alternative approaches to risk adjustment altogether.

Correcting overpayments within the current risk adjustment model

1. **Raise the minimum coding intensity adjustment above the current 5.9 percent** to account for the full magnitude of documented coding differences between MA and traditional Medicare, and recalibrate annually.

2. **Develop plan-specific coding intensity adjustments that reflect each organization's observed coding practices.** Among the ten largest MA organizations, coding intensity varies by 26 percentage points.[7] The current uniform adjustment penalizes plans whose coding mirrors fee-for-service patterns while allowing aggressive coders to retain excess payments. Plan-specific adjustments would redistribute revenue toward plans that code appropriately and eliminate the competitive advantage that aggressive coding currently confers.

3. **Exclude diagnoses identified through health risk assessments (HRA) and retrospective chart reviews from risk score calculations**. MedPAC has found that nearly two-thirds of MA coding intensity is attributable to diagnoses identified through HRAs and chart reviews, and 37 percent of those diagnoses do not appear on any other encounter data.[8] This pattern raises questions about whether beneficiaries receive follow-up care for documented conditions—or whether the diagnoses are accurate at all. For these reasons, CMS should not only exclude HRA- and chart review-derived diagnoses from risk adjustment, but also require that any diagnosis counted toward a risk score be linked to evidence of active treatment or clinical management.

4. **Extend the diagnosis lookback period to two years.** Using two years of diagnostic data—as MedPAC has proposed—produces more stable and accurate risk scores by capturing persistent

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[3] Stuart Hammond and others, "The Medicare Advantage Program: Status Report" (Washington: Medicare Payment Advisory Commission, 2026), available at https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf.
[4] Committee for a Responsible Federal Budget, "Analysis of the 2024 Medicare Trustees' Report" (Washington: May 2024), available at https://www.crfb.org/papers/analysis-2024-medicare-trustees-report.
[5] Paul N. Van de Water, "Growth in Medicare Advantage Raises Concerns," Center on Budget and Policy Priorities, January 10, 2025, available at https://www.cbpp.org/research/health/growth-in-medicare-advantage-raises-concerns.
[6] Cori Uccello, Gretchen Jacobson, and Melinda J.B. Buntin, "The Opportunity Costs of Medicare Advantage Plan Rebates," *New England Journal of Medicine* 391 (16) (2024): 1468–1470, available at https://www.nejm.org/doi/10.1056/NEJMp2405572.
[7] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (Washington: 2025), available at https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/.
[8] Medicare Payment Advisory Commission, "Improving MedPAC's Estimate of Medicare Advantage Coding Intensity" (Presentation, Washington, September 7, 2023), slide 5, available at https://www.medpac.gov/wp-content/uploads/2023/03/Tab-E-MA-coding-intensity-Sept-2023.pdf.

clinical conditions rather than one-time or transient diagnoses.[9] It also reduces incentives for aggressive annual coding and better aligns payments with true beneficiary health needs, preserving appropriate compensation for chronically ill enrollees while limiting distortions driven by documentation intensity.

Exploring alternative approaches to risk adjustment

CMS has requested input on new approaches to risk adjustment. The following recommendations identify data sources and payment structures that more accurately predict costs and are less susceptible to manipulation than diagnosis-based methods alone.

1. **Explore supplemental data sources that plans cannot easily influence,** such as pharmacy claims, laboratory values, and functional status assessments. Diagnosis codes can be inflated through documentation activity, but medication fills and lab results reflect actual clinical status. Part D pharmacy data already exists within CMS systems and could validate or supplement diagnosis-based risk scores. Research has demonstrated that prescription drug patterns predict Medicare costs independently of diagnosis codes[10]—and unlike diagnoses, these data cannot be manipulated through chart reviews or health risk assessments. CMS should pilot the use of pharmacy-based risk adjustment as a complement to the current model.

2. **For beneficiaries who switch from fee-for-service to MA, incorporate actual FFS expenditure history into risk-adjusted payments.** Diagnosis-based risk scores systematically overpredict costs for recent switchers—their observed spending in FFS is lower than their diagnoses would suggest.[11] Using expenditure history directly would improve payment accuracy for this population. CMS could implement this as a blended approach: incorporating expenditure data for recent switchers while retaining diagnosis-based adjustment for long-term enrollees.

II. Removal of Excellent Health Outcomes for All reward and related provisions

The Center for American Progress strongly opposes CMS's proposal to abandon implementation of the Excellent Health Outcomes for All (EHO4all) reward and to rescind the health disparities requirement within the quality improvement program. Together, these policies are the central mechanisms for holding Medicare Advantage plans accountable for outcomes among underserved populations. The EHO4all reward conditions bonus eligibility on performance for high-need enrollees, while the quality improvement requirement obligates plans to build the analytic infrastructure and operational capacity necessary to identify, target, and reduce persistent gaps in care. Eliminating both incentives strips the program of its primary tools for ensuring that strong aggregate performance translates into improved outcomes for all beneficiaries.

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[9] Medicare Payment Advisory Commission, *Mandated Report: Impact of Changes in the 21st Century Cures Act to Risk Adjustment for Medicare Advantage Enrollees*, in *Report to the Congress: Medicare and the Health Care Delivery System* (June 2020), available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch4_reporttocongress_sec.pdf

[10] Paul D. Jacobs and Richard Kronick, "Getting What We Pay For: How Do Risk-Based Payments to Medicare Advantage Plans Compare with Alternative Measures of Beneficiary Health Risk?" *Health Services Research* 53, no. 6 (2018): 4997–5015, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC6232441/.

[11] Paul B. Ginsburg, Steven M. Lieberman, and Eugene Lin, "Lowering Medicare Advantage Overpayments from Favorable Selection by Reforming Risk Adjustment," Health Affairs Forefront, July 13, 2023, available at https://www.healthaffairs.org/content/forefront/lowering-medicare-advantage-overpayments-favorable-selection-reforming-risk-adjustment.

CMS's stated rationale—that the agency prefers to incentivize improvement across all measures rather than focusing on specific populations—misunderstands the purpose of equity-focused measurement. Aggregate quality improvement does not automatically reduce disparities; it can mask widening gaps. CMS's own stratified reporting documents persistent disparities in care quality for dual-eligible beneficiaries, people with disabilities, and racial and ethnic minorities.[12]

Independent research further underscores this concern. Studies show that contracts with higher overall star ratings often exhibit larger racial, ethnic, and socioeconomic disparities in quality, and that simulated star ratings for Black and Hispanic enrollees are substantially lower than those for White enrollees within the same contract.[13] Without targeted equity measures, high aggregate performance can coexist with poor outcomes for the beneficiaries who need the most support.

As enrollment among people of color and dual-eligible individuals continues to grow,[14] CMS should strengthen—not retreat from—its approach to disparity-focused accountability. CAP recommends that CMS:

1. **Proceed with implementation of the EHO4all reward.**

2. **Maintain and strengthen the health disparities quality improvement program.** The current requirement that plans incorporate "one or more activities" to reduce disparities provides flexibility but lacks specificity.[15] CMS should require plans to analyze stratified quality data at the contract level, implement targeted interventions with measurable goals, and report annually on outcomes.

III. Marketing and communications deregulation

The proposed rule would relax several marketing restrictions, including allowing marketing events immediately after educational events, permitting collection of Scope of Appointment forms at educational sessions, and loosening oversight of Third-Party Marketing Organizations (TPMOs). CAP opposes these changes.

Federal oversight bodies—including the HHS Office of Inspector General[16] and the Majority Staff of the U.S. Senate Committee on Finance[17]—have repeatedly identified aggressive and misleading MA

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[12] Centers for Medicare & Medicaid Services, Office of Minority Health, "Stratified Reporting," available at https://www.cms.gov/priorities/health-equity/minority-health/research-data/stratified-reporting.
[13] David J. Meyers et al., "Association of Medicare Advantage Star Ratings With Racial, Ethnic, and Socioeconomic Disparities in Quality of Care," *JAMA Health Forum* 2, no. 6 (June 2021): e210793, available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781100.
[14] Jingyan Gao et al., "Medicare Switching: Patterns Of Enrollment Growth In Medicare Advantage, 2006–22," *Health Affairs* 42, no. 9 (September 2023), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00224.
[15] Centers for Medicare & Medicaid Services, "2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)," April 5, 2023, available at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
[16] U.S. Department of Health and Human Services, Office of Inspector General, "Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers" (Washington, DC: 2024), available at https://oig.hhs.gov/documents/special-fraud-alerts/10092/Special%20Fraud%20Alert:%20Suspect%20Payments%20in%20Marketing%20Arrangements%20Related%20to%20Medicare%20Advantage%20and%20P.pdf.
[17] U.S. Senate Committee on Finance, Majority Staff, "Deceptive Marketing Practices Flourish in Medicare Advantage" (Washington, DC: 2022), available at https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

marketing as a significant program integrity concern. These practices contribute to beneficiary confusion and inappropriate enrollment, particularly among those vulnerable to high-pressure sales tactics. Relaxing existing safeguards would exacerbate these problems.

CAP supports reducing unnecessary administrative burden, but not at the expense of beneficiary protection. We recommend:

1. **Retaining the 12-hour separation between educational and marketing events,** allowing beneficiaries to learn about Medicare options without being subjected to immediate sales pressure or unknowingly providing contact information that triggers aggressive follow-up.

2. **Strengthening enforcement of existing marketing requirements.** Despite well-documented marketing violations, CMS has rarely used its enforcement authority to impose meaningful sanctions on plans.[18] To improve accountability, the agency should publish plan-level compliance and enforcement data and establish penalty structures that meaningfully outweigh the economic incentives for non-compliance.

3. **Banning differential compensation for TPMOs based on plan selection.** Federal oversight bodies[16] and CMS[19] have repeatedly identified differential TPMO compensation as a driver of biased marketing and inappropriate enrollment. While CMS has strengthened disclosure rules, it should go further by mandating plan-neutral compensation—eliminating steering incentives at their source rather than relying on transparency alone.

IV. Star Ratings and quality measurement

The Star Ratings system distributes billions in bonus payments and heavily influences beneficiary plan selection. Yet evidence shows little association between high ratings and improved health outcomes[20]—largely because plans can earn top scores through administrative and process measures that bear little relationship to clinical performance or beneficiary experience. CAP strongly supports CMS's proposal to remove 12 such measures from the program. As CMS notes, these metrics show uniformly high performance with little variation across contracts, limiting their ability to distinguish genuine quality differences.

To ensure Star Ratings and bonus payments reflect genuine plan quality, CAP recommends:

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[18] Susan Jaffe, "Complaints About Gaps in Medicare Advantage Networks Are Common. Federal Enforcement Is Rare," KFF Health News, November 20, 2025, available at https://kffhealthnews.org/news/article/medicare-advantage-insurance-network-adequacy-standards-cms-federal-enforcement/.

[19] Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," 89 Fed. Reg. 30,448 (April 23, 2024), available at https://www.federalregister.gov/documents/2023/11/15/2023-24118/medicare-program-contract-year-2025-policy-and-technical-changes-to-the-medicare-advantage-program.

[20] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (Washington, DC: MedPAC, 2019), available at https://www.medpac.gov/document/june-2019-report-to-the-congress-medicare-and-the-health-care-delivery-system/; Sarah Klein and Martha Hostetter, "Taking Stock of Medicare Advantage: Quality Reporting and Quality Bonuses," Commonwealth Fund, March 3, 2022, available at https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-quality-reporting-and-quality-bonuses.

1. **Requiring minimum performance on outcome measures for bonus eligibility**, ensuring that administrative or process scores alone cannot qualify a plan for a 5 to 10 percent benchmark bonus.

2. **Replacing topped-out process measures with outcome measures that differentiate plan performance.** Measures on which nearly all contracts score above 90 percent cannot distinguish quality and should be retired in favor of metrics where meaningful variation exists and improvement directly benefits enrollees.

3. **Calculating and publicly report quality measures at the local market level** rather than the contract level, so beneficiaries can assess plan performance in their area.

4. **Adding prior authorization metrics to Star Ratings.** Prior authorization (PA) directly determines whether beneficiaries receive timely, medically necessary care, yet Medicare Advantage plans currently face no quality accountability for delays, inappropriate denials, or abandonment of care driven by PA requirements.

   Evidence suggests many denials fail to meet Medicare's own coverage standards. HHS OIG has found that MA plans denied a substantial share of prior authorization requests that satisfied Medicare coverage rules, and that plans overturn roughly 80 percent of denials when beneficiaries appeal.[21] Because only a small fraction of beneficiaries appeal, plans retain savings from barriers most enrollees never challenge—a dynamic that grows more troubling as plans increasingly deploy automated and AI-driven utilization management tools.[22]

   The downstream harms are well documented. The American Medical Association's 2024 Prior Authorization Physician Survey found that 93 percent of physicians report care delays attributable to PA requirements, and 29 percent report that PA has led to a serious adverse event.[23]

   The infrastructure to hold plans accountable for these harms already exists. Beginning in January 2026, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)[24] requires Medicare Advantage plans to publicly report standardized prior authorization data—including denial rates, decision timeframes, and reasons for denials—and to make these data accessible via APIs. CMS has also finalized requirements for public reporting of aggregated prior authorization metrics, creating consistent, comparable data suitable for performance measurement.

   CMS should use this data to incorporate prior authorization measures into Star Ratings. At a minimum, these measures should include initial denial rates and reversal rates on appeal; time from prior authorization request to final determination, inclusive of appeals; rates of care

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[21] HHS Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp.
[22] American Medical Association, "How AI is Leading to More Prior Authorization Denials," March 2025, https://www.ama-assn.org/practice-management/prior-authorization/how-ai-leading-more-prior-authorization-denials.
[23] American Medical Association, "2024 Prior Authorization Physician Survey" (Chicago, IL: American Medical Association, 2024), available at https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[24] Centers for Medicare & Medicaid Services, "CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)," January 17, 2024, https://www.cms.gov/regulations-and-guidance/guidance/interoperability/index.

abandonment following delays or denials; and stratification by race, ethnicity, and dual-eligible status to identify disparate impacts.

V. Additional concerns related to prior authorization oversight

1. Strengthen AI and algorithmic decision-making guardrails

CAP notes that CMS declined to finalize proposals related to AI and algorithmic decision-making in the CY 2026 rule, stating the agency would consider future rulemaking.[25] We urge CMS to prioritize this issue. Reporting indicates MA plans increasingly use AI tools to make coverage determinations and utilization management decisions, raising concerns about whether these tools comply with existing requirements that decisions be based on individual clinical circumstances.[26]

At minimum, CMS should require that: (1) any AI or algorithmic tool used in coverage determinations must produce outcomes consistent with determinations made through individualized clinical review; (2) beneficiaries and providers are informed when AI tools are used in coverage decisions; and (3) plans maintain human oversight of AI-generated recommendations with authority to override algorithmic outputs.

2. Monitor CMS-0057-F implementation

The CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) established important requirements including electronic PA, 72-hour decision timeframes, and transparency requirements.[27] However, early evidence suggests these requirements have not reduced physician administrative burden—physicians report submitting more PA requests and spending more time on documentation.[28] CMS should actively monitor implementation, document non-compliance, and be prepared to pursue enforcement action or additional rulemaking if the rule's goals are not achieved.

Conclusion

The fundamental challenge facing Medicare Advantage regulation is one of incentive alignment. The current payment system rewards plans for documenting diagnoses rather than managing care; the quality measurement system rewards administrative performance rather than health outcomes; and the absence of

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[25] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly," 90 FR 15792 (April 15, 2025), available at https://www.federalregister.gov/documents/2025/04/15/2025-06008/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare.

[26] Michelle M. Mello and others, "The AI Arms Race In Health Insurance Utilization Review: Promises Of Efficiency And Risks Of Supercharged Flaws," Health Affairs 45 (1) (2026): 6-13, available at https://www.healthaffairs.org/toc/hlthaff/45/1.

[27] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program," 89 FR 8758 (February 8, 2024), available at https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[28] Stephen G Salzbrenner and others, "Perceptions of prior authorization by use of electronic prior authorization software: A survey of providers in the United States," Journal of Managed Care and Specialty Pharmacy 28 (10) (2022): 1066-1196, available at https://www.jmcp.org/doi/epdf/10.18553/jmcp.2022.28.10.1121.

prior authorization accountability allows plans to profit from barriers that harm beneficiaries. Meanwhile, the proposed rule would weaken the limited equity and marketing safeguards that currently exist.

CAP's recommendations address each of these misalignments. On risk adjustment, we urge CMS to raise the coding intensity adjustment, develop plan-specific adjustments, exclude HRA- and chart review-derived diagnoses, and pilot supplemental data sources that cannot be manipulated through documentation activity. On quality measurement, we support the removal of topped-out process measures and recommend adding prior authorization metrics that hold plans accountable for delays and denials. On health equity, we urge CMS to retain and strengthen the Excellent Health Outcomes for All reward rather than abandon the program's only mechanism for ensuring high-need populations benefit from quality improvement.

These reforms would redirect tens of billions of dollars from coding infrastructure to care delivery, create accountability for utilization management practices that currently operate without consequence, and ensure that program growth benefits all beneficiaries rather than masking persistent disparities.

Thank you for the opportunity to comment. For any questions regarding this letter, please contact Neda Ashtari at nashtari@americanprogress.org.

Respectfully,

Neda Ashtari, MD MPP
Associate Director of Health Policy
Center for American Progress
nashtari@americanprogress.org