GEORGETOWN UNIVERSITY McCourt School of Public Policy CENTER ON HEALTH INSURANCE REFORMS

Medicare Policy Initiative

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Center on Health Insurance Reforms
500 First St NW
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Administrator Mehmet Oz
Centers for Medicare and Medicaid Services

Secretary Robert F. Kennedy Jr.
Department of Health and Human Services

Re: Medicare Program; Request for Information on Future Directions in Medicare Advantage – Risk Adjustment and Quality Bonus Payments

Dear Administrator Oz and Secretary Kennedy:

Thank you for the opportunity to offer comments on how the Centers for Medicare and Medicaid Services (CMS) could improve the Medicare Advantage (MA) risk adjustment and Quality Bonus Payment (QBP) program.[1,2] MA accounts for over half of Medicare enrollment, and accounts for an ever-increasing amount of Medicare spending. As CMS has noted, there are clear shortcomings in the current methodologies used to calculate MA payment that can lead to gaming of the system. Shortcomings in the current approaches for setting MA payments have led to competitive pressures to focus too heavily on capturing diagnosis codes and pursuing high star ratings to obtain quality bonuses codes rather providing the best care for the lowest cost. That approach favors large MA Organizations (MAOs) that have more resources to invest in a robust infrastructure to capture diagnosis codes – unlike smaller MAOs and plans, which cannot shift their attention away from their primary functions without compromising the quality of care and coverage they offer. It is essential to reform MA in such a way that considers the perspectives of smaller MAOs and plans to promote a robust competitive MA market beyond just the largest players. As CMS has noted, addressing the factors that may place smaller plans at a disadvantage is crucial to creating a robust, competitive market that could foster greater innovation in benefit design and care models. We applaud CMS for its interest in pursuing approaches that advance competition and promote a level playing field between all types of MA plans and MAOs.

The Medicare Policy Initiative (MPI) at Georgetown University is responding to this RFI with detailed information from two sources. First, MPI held a closed-door roundtable with "smaller" MAOs to facilitate a conversation around improving their ability to compete with larger MA plans. Second, MPI has established an MA Enrollee Advisory Group comprised of Medicare

[1] The views expressed in this letter are our own and do not necessarily reflect the views of Georgetown University or anyone affiliated with Georgetown University other than ourselves.
[2] The recommendations in this letter are drawn primarily from the Medicare Policy Initiative's prior work. See Molly T. Turco and Rachel Schmidt, "Reforms to Medicare Advantage: Perspectives of Local and Regional Plans," September 24, 2025, *https://georgetown.box.com/s/3z3rffkqfkbtbedkbjryh8ui8cwofdux*

beneficiaries who gather to give input on how policy decisions have impacted their experiences with MA.

Small MA Plan Roundtable: From March through July 2025, the Medicare Policy Initiative (MPI) conducted interviews with **small and midsize MAOs**, defined as those MAOs with under 500,000 enrollees as of 2025. In June 2025, MPI hosted a closed-door roundtable, which consisted of representatives from a dozen small and midsize MAOs that operate local and regional plans. **Key questions of this roundtable focused on these MAOs' perceptions of the current state of the MA market and potential policy options to improve the program for beneficiaries**. We believe that this roundtable provides many key insights crucial to informing how future policies may affect competition and viability of small and midsize MAOs (referred to as "smaller MAOs" hereafter). Of the over 34 million Medicare Advantage enrollees in 2025, 77 percent of them were enrolled in one of 8 large carriers. In contrast, less than a quarter are enrolled in one of 150 local and regional MA plans. These smaller plans typically have different business models, methods of operation, limited geographic reach, and financial resources than the larger, national plans that currently dominate the market.

MA Enrollee Advisory Group: In November 2025 MPI held the first meeting of its new MA enrollee advisory group. Approximately 20 MA enrollees from across the country gathered to share input about their experiences with open enrollment and their use of tools such as the Medicare Plan Finder, star ratings, and interactions with various third-party marketers. MPI will publicly report out on the recommendations from this Advisory Group at a later date.

In this letter, we inform CMS's requests for information to improve MA by elevating the perspectives, concerns, and policy considerations shared from MAOs in the roundtable as well as MA enrollees themselves. We hope this letter provides you with information as to how those perspectives may be considered in future changes to risk adjustment and the QBP program.

Policy Options for Risk Adjustment:

- **Address the Methods of Collecting Diagnosis Codes**: Among roundtable participants, there was a consensus that the current approach to risk adjustment is "unsustainable" and that smaller MAOs face pressures to aggressively code diagnoses, sometimes over managing enrollee health. Lower-resourced MAOs struggle to match the expensive upcoding practices at the scale many large national MAOs have achieved. Roundtable participants were interested in policies that would maintain plans' ability to capture codes in the home but require confirmation of those diagnoses through a subsequent doctor and/or in-office visit.
- **Strategically Target Oversight and Audits**: Audits are an effective way to hold MAOs accountable. They can also be time-consuming, expensive endeavors for some MAOs. For smaller and less well-resourced MAOs, frequent, even annual Risk Adjustment Data Validation (RADV) audits can be a level of cost and administrative burden that weakens

their ability to compete in markets and may take away from focus on enrollee care. CMS may consider targeting RADV audits to MAOs with demonstrated problematic behaviors, such as those with higher rates of coding intensity relative to other plans in a local or regional market, or that excessively capture diagnoses from in-home HRAs.

- **Adjust Risk Scores According to Coding Intensity**: The current coding intensity adjustment reduces all MA risk scores by a minimum of 5.9 percent to account for the different coding patterns between Traditional Medicare (TM) and MA. Some MAOs, particularly smaller MAOs that code less aggressively, have suggested that the current blanket adjustment factor, which that reduces all MA risk scores by the same amount, penalizes them unfairly. CMS may consider exploring an approach that would tier coding intensity adjustments, such as providing a lower or zero coding pattern adjustment to MAOs that code less intensely, while implementing a higher coding pattern adjustment to MAOs that code more aggressively. This could be implemented with modifications to the coding pattern adjustment to account for legitimate risk differences between plans.
- **Explore Leveraging Technology to Predict Risk**: Roundtable participants generally supported policies to shift payment incentives away from revenue-generating activities that have high administrative burden and low clinical value, like aggressively capturing diagnosis codes, and toward activities related to care management and customer service. There was openness to the exploration of the use of artificial intelligence and/or encounter data (or other medical record data) to assign risk scores to individuals. However, an "inferred risk" model would need to be designed in a way that would not incentivize inappropriate care or reinforce historical patterns of undertreatment.
- **Calibrate the Risk Adjustment Model**: Participants expressed openness to exploring various ways of updating the current Hierarchical Condition Category (HCC) MA Risk Adjustment model but stated there was a need for more analyses to better understand their impacts and how incentives could shift. Some of the ideas participants were open to included simplifying the model to reduce the number of HCC payment categories, using two years of data when building the model to capture more TM diagnosis codes, and using "zero-sum" risk adjustment as is used in the individual market. There was openness to recalibrating the model to MA encounter data rather than TM spending, but one interviewee was concerned that the approach could perpetuate higher coding intensity that is already "baked into" current risk scores.

Policy Options for Quality Measurement and Quality Bonus Payments:

- **Measure Quality at a Local Level**: The existing MA QBP program methodology can be challenging for smaller MAOs. Roundtable participants recommended that CMS consider calibrating Star Rating cutpoints by region to reflect geographical differences in

populations and social risk factors. Participants heavily recommended that CMS evaluate relative quality performance within local and regional markets.

- **Maintain and Improve Quality Bonus Payments**: Roundtable participants did not support reducing quality bonus payments or making the program budget neutral. However, they voiced concern about "cliff effects" in MA's quality bonuses, whereby minor differences in scores can result in large differences in payment if an MAO just misses the threshold for obtaining an overall rating of 4 or more stars. Some participants suggested exploring a more graduated bonus structure that would smooth payment differences between star rating levels. We understand that while the CMS may not have the statutory authority to pursue this change, the CMS Innovation Center (CMMI) may possess the authority to waive certain statutory requirements in order to test innovation models. As such, CMS may consider utilizing a CMMI model to test a more graduated bonus structure that would smooth payment differences between star rating levels.
- **Beneficiaries Need a More Useful Quality Evaluation Tool**: Today, Stars Ratings are arguably used more for payment purposes than for helping Medicare beneficiaries weigh their plan options. Many specific measures within the Star Ratings may not be relevant to individuals as they compare plans, which led one roundtable participant to suggest that CMS display a subset of quality measures most relevant to beneficiary experience. Steps to move away from a contract-level approach would also help beneficiaries compare MA plans options at a more localized level, spurring local-level competition and innovation. Such a change could be of high value to beneficiaries, as even the most engaged beneficiaries from our MA Enrollee Advisory Group, who thoroughly researched their plan options, did not naturally find value in CMS's current set of defined, formal performance measures when comparing plans.

Overarching Themes from MPI's Roundtable:

- **Consensus That Reforms to the MA Program are Urgently Needed**: Participants consistently noted that all plans face competitive pressures to focus on aggressive diagnosis coding, star ratings, and supplemental benefits more than managing enrollee health and improving outcomes. Those forces, in turn, put upward pressure on MA program spending, in contrast with the program's aim. Participants generally supported shifting incentives away from revenue-focused practices with limited clinical value—such as aggressive diagnosis coding—and toward care coordination and customer service.
- **Phase-In Major Reforms to Prevent Unintended Consequences**: Roundtable participants urged policymakers to be mindful that smaller MAOs may have less bandwidth and resources to implement large-scale changes compared to larger MAOs. Many believe that the MA program currently favors large MAOs and encourages consolidation. Providing robust opportunities for MAOs to comment and phase-in large changes may help prevent smaller, local MAO withdrawals from MA and further market

consolidation. They warned of potential unintended consequences affecting smaller MAOs' ability to maintain local and regional competition and plan choice for beneficiaries if changes are not carried out in a targeted way and with enough time for implementation.

Participants further cautioned that there are already other potentially tumultuous pressures already ahead in the broader health care environment: higher rates of utilization in the MA market; a major Part D redesign, negotiated Medicare drug prices and Medicaid funding cuts. These market changes may further reduce the bandwidth of smaller MAOs, requiring additional resources for them to be able to adapt to MA reforms. Participants suggested that **CMS establish a timeline for shorter- and longer-term changes outside of the MA program's regular Rate Announcement and rulemaking process so that smaller MAOs can weigh in more frequently, as well as plan and prepare accordingly.**

Thank you for the opportunity to provide information, context, and considerations on these critical issues. We hope that this information is helpful to you. If we can provide any additional information, we would be happy to do so.

Sincerely,

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Appendix A: Detailed Information to Improve Risk Adjustment

Address the Methods of Collecting Diagnosis Codes

According to many roundtable participants, CMS should ensure accurate payments and reduce gaming of the current risk adjustment methodology while considering the perspectives of smaller MAOs. There was consensus among roundtable participants that MA plans face competitive pressures to focus on aggressive diagnosis coding, rather than focusing on enrollee care. One participant stated, "We are in a situation where the number one success factor for Medicare Advantage plans, at least from a financial perspective, is doing really 'creative' risk adjustment." All the executives we spoke with noted the competitive pressure to identify more diagnosis codes. Another noted, "We are in an arms race that we will never be prepared to compete on in the current [risk adjustment] model."

There was agreement that some larger MAOs use in-home HRAs for the purpose of gathering diagnosis codes and may not be providing appropriate follow-up care, while **smaller MA plans often cannot or do not misuse in-home HRAs in this manner**. Most roundtable participants argued that large, publicly traded MAOs were among the more aggressive coders. However, independent estimates suggest aggressive coding is not limited to large MAOs, and not all large plans code aggressively.[3]

There was agreement among roundtable participants that CMS should consider putting limits on the use of in-home HRAs and chart reviews. However, they warned that unless CMS introduces reforms in a targeted way, smaller plans may be adversely affected, further consolidating the market. Specifically, roundtable participants stated that in-home HRAs can be useful tools for evaluating an enrollee's social and health care needs, and as such, potential limits should refrain from curbing their appropriate uses.

Many participants were interested in policies that would maintain MA plans' ability to capture provide in-home diagnoses codes, but require confirmation of those diagnoses through a hand off to a doctor and an in-office visit. One participant also supported an approach in which CMS would target in-home HRAs in its audit program. Participants felt these actions would ensure that MAOs limit their use of in-home visits to ways that improve and coordinate care rather than solely increasing risk scores. It would also ensure equity for smaller, less-resourced plans that rely on in-home HRAs as a primary way of reaching enrollees.

Many participants voiced support for requiring that chart review codes be linked to an encounter data record, rather than being prohibited altogether, for the purposes of risk adjustment. **Participants noted that smaller MAOs with less sophisticated coding apparatuses must rely on chart reviews to ensure accurate payment**. This would prevent chart review misuses without penalizing less-resourced MAOs.

[3] See Kronick op cit., Brown University op cit., and MedPAC op cit.

Many participants stated that encounter data is the most common method for verifying receipt of care. Since MAOs are already required to submit encounter data for all diagnoses rendered, **linking codes captured from in-home HRAs and chart reviews to an encounter could also serve as a greater incentive for more complete encounter data reporting, as payment would be tied to encounter data verification as a result**.

However, one interviewee expressed concern that **if CMS began using MA encounter data as the basis for costs in its risk model, the higher coding intensity already used by some MAOs would be included in risk scores and perpetuated into the future**. CMS must be sure to consider the ways that existing practices and coding patterns may structurally influence cost expectations and calculations in any new risk adjustment methodologies.

Strategically Target Oversight and Audits

CMS may consider specific targeted audit approaches or future coding adjustment approaches to maximize incentives to offer high-quality coverage rather than investment in administrative and coding practices that may not improve enrollee health.

Audits are a key aspect of the MA risk adjustment system. In May 2025, CMS announced that it would be expanding RADV audits to all plans, every year, for payment years 2018-2024 and beyond. As a result of the 2023 MA RADV final rule (CMS-4185-F2), CMS planned to use an extrapolation method to recoup overpayments to MAOs discovered through RADV audits. Ongoing litigation has halted the provisions of the final rule, but it seems CMS will continue to expand RADV audits.

Roundtable participants described that audits can and should be used as a tool to prevent fraud, waste, and abuse, but also expressed hesitation at the unprecedented expansion of these audits. They raised feasibility concerns and operational challenges because some smaller MAOs have less-developed health IT systems and may not be able to handle the overall capacity for large audits relative to larger MAOs. Such expanded audits may bear a larger toll on less well-resourced smaller market competitors and may result in smaller MAOs further investing already-limited resources into administrative audit departments, at the expense of enrollee care.

Therefore, roundtable participants argued that *targeting* audits may be a more effective means to mitigate fraud, waste, and abuse. **Participants suggested that CMS focus audits specifically on those MAOs or plans with the highest average coding rates relative to county-level TM coding rates (or a local average).** Such a threshold could be developed at the county or regional level rather than on a national scale to account for differences in population.

Finally, roundtable participants said that CMS should consider targeting RADV audits to MAOs for certain *types* of coding behavior, such as those that tend to capture diagnoses from in-home HRAs at above-average rates. CMS could consider a comparison to a county or regional average for relative coding intensity, or relative rate of diagnosis-capture from in-home

HRAs as opposed to a national average. This would allow for competition within local and regional markets while addressing waste, fraud, and abuse concerns.

Adjust Risk Scores According to Coding Intensity

Participants expressed support for CMS exploring **tiered downward adjustments—larger than the 5.9 percent statutory minimum—to the risk scores of plans with the highest average coding rates.** MA plans with lower coding rates would have a lower or no coding pattern adjustment, while those with higher coding rates would receive a higher adjustment, with refinements to account for legitimate differences in population risk among plans. This would avoid sweeping adjustments that could disproportionately affect local and regional MA plans, while still targeting those with the highest risk and highest likelihood of overpayment.

One interviewee was concerned about the burden of estimating a specific adjustment for each MAO each year. Several roundtable participants supported "grading" MAOs on their coding behavior and varying payment reductions across ranges of coding intensity. However, the discussants wanted to better understand the ramifications of a specified approach, and to be able to weigh in on the approach as it is developed with ample time to test for potential challenges or pitfalls specific to smaller MAOs in the future.

Lastly, CMS and a variety of researchers have estimated MAOs' coding intensity differently, and so the design details for a tiered coding pattern adjustment would matter a great deal; for example, how risk increases over time are estimated, what the cut off points are for different levels of the adjustment, what level to set the adjustment (parent organization vs. contract), etc.

Explore Leveraging Technology to Predict Risk

Participants generally supported policies to shift payment incentives away from revenue-generating activities that have high administrative burden and low clinical value, like aggressively capturing diagnosis codes, and toward activities related to care management and customer service.

Potential solutions discussed included inferring risk with using AI and encounter data, or other potential paths to leverage more medical record data through increasing interoperability and AI. Some participants hoped that, through some of these policy options, policymakers could completely alter how MA risk adjustment is designed and address many concerns. One interviewee suggested scrapping the current payment model for a more traditional approach of actuarial underwriting as is used for the employer-sponsored insurance market.

Some roundtable participants stated that they would not be opposed to the exploration of AI and/or encounter data (or other medical record data) to assign risk scores to individuals, after comparing their use of services to beneficiaries with similar characteristics and conditions. One interviewee noted that because CMS now requires MAOs to submit data for all

MA encounters (whether they include diagnoses eligible for risk adjustment or not), they believe the agency has a broad set of information it could use to assign risk scores more directly and fairly. However, such an approach would need to be designed in a way that **would not incentivize inappropriate care or reinforce historical patterns of undertreatment**.

At the same time, many roundtable participants were confused about what policymakers might specifically have in mind for applying "inferred risk" in MA risk adjustment. When discussing this general idea, they warned of feasibility concerns and operational challenges that some smaller MAOs have because their health IT systems are not as well integrated with providers.

Of particular concern to smaller MAOs is that many reforms often sound promising until they are modeled and in practice – at which point MAOs are able to realize whether a change disproportionately harms certain regions. If an MAO only operates in such an affected region, the MAO, unlike large national MAOs who may operate in many regions, will lack the ability to "even out" the costs of such a change.

For example, participants noted that large MAOs have a comparative market advantage in that they can spread the cost of major investments in IT systems to automate diagnosis code collection across their enrollees. This creates hesitation and amplifies the sentiment among the roundtable participants that thorough research and analyses are needed to better understand any potential changes' impacts and shifts in incentives, especially at the local and regional levels. Despite these risks, some participants recommended that policymakers "swing for the fences" because they felt the MA risk adjustment system was so broken that it incentivized bad behavior, encouraged MAOs to focus on the wrong things, wasted taxpayer dollars, and was not working in the best interest of MA enrollees. **Participants made clear that they would need to see more details, analyses, and have a robust comment period before supporting specific changes.**

Appendix B: Information to Improve the Quality Bonus Payment Program

Measure Quality at a More Local Level

Currently, MA star ratings are measured at the contract level, and even though some contracts can span large regions or across multiple states. **Multiple participants agreed that the Quality Bonus Payment system needs to more effectively reflect quality at the local level,** especially as participants noted that large MAOs can use leverage the size of their contract areas to dilute the scores of lower performing areas, thus obscuring their true performance in a certain region.

For example, one participant voiced support for a policy that would set local Star Ratings measure "cut points" – threshold levels at which CMS distinguishes between a higher or lower star rating on each individual quality measure. **These threshold levels would differ by region to better address geographic differences in populations and social risk factors and make the system better reflect quality at the local level.**

Roundtable participants also voiced some support for breaking up large, consolidated contracts, although one executive raised concern about the year-to-year stability of quality measures for plans with small sample sizes. The main consensus was that policymakers should explore the above options to better understand their potential impacts and feasibility, especially for smaller plans.

Beneficiaries Need a More Useful Quality Evaluation Tool

MAO roundtable participants discussed whether Star Ratings should be primarily for payment purposes, geared towards helping beneficiaries consider MA plan offerings, or a combination of both. One interviewee voiced a strong opinion that **CMS should display a subset of quality measures that are most relevant to beneficiaries' experience with MA plans to help beneficiaries select among plan options.** Some roundtable participants noted that steps to modify Star Ratings to a more local-level could also partially empower consumers more effectively shop for MA plan offerings, even if CMS foregoes development of an entirely separate set of consumer-specific measures.

However, other participants felt that Star Ratings should be used as exclusively a tool for payment rather than for consumer choice. From their perspective, **trying to design the Star ratings system for both purposes of payment and beneficiary education may make it a less effective tool for promoting local level competition**, and CMS should pursue other avenues to help consumers choose among plans, such as a beneficiary-specific set of measures that is not tied to payment, but informative for consumers to support greater competition on enrollee preferences.

The statistics and measures that CMS finds valuable for oversight and payment incentives may not always align with beneficiaries' tastes and preferences for comparing and contrasting MA

plans. For example, when asked about how they chose which MA plan to enroll in, participants in MPI's Medicare Advantage Expert Enrollee Advisory Group[4] notably omitted any mentions of Star Ratings or Display page statistics as key factors in their comparison process. They primarily made their decisions according to whether their preferred providers, drugs, and benefits were covered at an acceptable level. **Even the most engaged beneficiaries who thoroughly researched their plan options did not naturally find value in CMS's defined, formal performance measures when comparing plans.**

In a public webinar panel MPI hosted on January 14th, 2026, one MA enrollee (who was also a participant in the Advisory Group) expanded on this sentiment. He explained that he found no use for the Stars Ratings as they currently exist during this Annual Enrollment Period (AEP), because it was unclear to him what statistics went into their calculation. His only use for them was when the score was very low, such as a 2–2.5-star rating, which he felt clearly indicated a significant difference in quality. After learning more about the Star Ratings following the AEP, he also noted the challenges in evaluating whether an individual Star Rating score was applicable to him and his preferences. For example, he felt as though he could not evaluate plan performance according to his needs, because CMS does not currently report the "reasons why" for ratings like *Complaints About the Plan* and *Members Choosing to Leave the Plan*, which he mentioned would have been the most relevant measure for his choice.

Overall, it was made clear by roundtable participants and Advisory Group members that, as they exist today, the Stars Ratings do not seem to meaningfully assist beneficiaries in choosing the best MA plan for them. Fundamentally, taking no action to address this key issue may diminish the efficacy of consumer choice as a way to steer the market. CMS may consider alternative avenues to leverage quality measures in a way that empowers informed beneficiary-consumers while promoting competition in the market and incentivize continued innovation according to consumer needs.

[4] This Advisory Group consists of MA enrollees from various regions of the country and aims to uplift their voices, experiences, and recommendations to improve the MA program. As people who actually use the program and who are affected by it daily, we believe this Advisory Group is a key resource to find ways to improve the program.