January 26, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-801

Re: Proposed Rule: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program - RIN 0938-AV63

To Whom It May Concern:

On behalf of the Medicare Committee (Committee) of the American Academy of Actuaries,[1] we appreciate the opportunity to provide comments on the proposed rule, "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program."

The Committee is specifically commenting on the Request for Information (RFI) on Future Directions in Medicare Advantage (MA), Risk Adjustment and Quality Bonus Payments (QBP), emphasizing design tradeoffs, implementation risks, and the type of analysis actuaries need to ensure any MA policy changes improve program performance without creating avoidable instability for beneficiaries.

Key points to keep in mind

1. **Predictability and stability are key.** Risk adjustment and QBP mechanics feed directly into benefit design and bids. When rules create large year-to-year swings, beneficiaries see frequent changes in premiums, cost sharing, and supplemental benefits.
2. **Distributional impacts should be explicit.** Broad adjustments can affect populations in ways that are not aligned with the policy rationale. CMS can reduce unforced errors by publishing distributional results before adopting major changes.
3. **Modernization should be testable and auditable.** If CMS pursues new model inputs or methods, strong transparency and monitoring guardrails are needed so stakeholders can validate results and identify unintended consequences.

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

I. Risk adjustment (RFI Section VIII.B)

CMS requests input on strengthening risk adjustment, including options to limit diagnoses based on setting or follow-up care, options for timeframes used in risk adjustment, and whether to test alternatives to the current HCC-based approach (including inferred models and potential use of AI or machine learning).

A. Change management and timing

Risk adjustment changes directly affect benefit design, pricing, and a wide range of other health plan financial planning activities. For that reason, the Committee recommends that CMS treats change management as part of the policy design. Major changes need clear documentation, a stable release calendar, and enough lead time for plans and actuaries to model impacts and communicate them.

B. Coding intensity and normalization: focus on distributional impacts

The risk score formula is the sum of demographic factors and disease factors. CMS then applies methodological adjustments, including normalization and the MA coding pattern adjustment, to produce the payment risk score. CMS has described the fee-for-service (FFS) normalization factor as an adjustment meant to account for growth in average FFS risk scores over time.

Mechanically, some MA risk scores, such as certain new enrollee risk scores, rely heavily on demographic factors. That often results in broad adjustments having counterintuitive effects across populations. The Committee recommends that CMS highlights these effects explicitly in a distributional impact analysis and consider whether alternative approaches would better match the policy intent.

The Committee also recommends that CMS evaluates and publishes the distributional impacts of how these adjustments operate, particularly given that differential coding concerns are concentrated in diagnosis capture and documentation, not in demographics. Distributional reporting should include results by enrollee type, plan type and size, and geography.

C. Documentation quality and diagnosis validity

The Committee agrees that documentation and coding quality vary widely and that payment policy should avoid rewarding administrative effort that does not reflect true morbidity. CMS's RFI asks whether diagnoses should be supported by follow-up encounters or treatments, and whether some diagnoses should be excluded when not linked to specific services.

CMS could consider a targeted approach that concentrates on diagnoses and contexts (e.g., acute conditions in a physician's office) that drive outsized volatility or have higher susceptibility to weak documentation. That approach should be paired with monitoring for access and equity effects. A blunt exclusion regime risks unintended consequences if it discourages appropriate screening, care management, or identification of unmet needs.

D. Timeframe or lookback windows

CMS asks how to handle persistent conditions that may not be captured in a given year, and how to avoid carrying forward inactive conditions. Longer windows can reduce volatility and can help smaller plans and rural settings where encounter capture is less complete. That said, longer windows also risk propagating inaccurate diagnoses into future payments. If CMS explores longer windows, the design could be time-sensitive (for example, recency weighting or decay) and should include explicit evaluation of error persistence and administrative burden.

E. Alternative inputs, inferred models, and AI or machine learning

CMS asks whether it should test alternatives to the current HCC-based risk adjustment model, including inferred models and use of other data sources, and asks about potential use of AI or machine learning.

The Committee is open to testing, with two issues addressed directly:

- **Utilization incentives:** If utilization becomes an input, the model should be designed to minimize incentives for avoidable volume. Plans may have utilization management tools, but model incentives still matter.
- **Transparency and auditability:** The Committee recommends that CMS requires documentation sufficient for independent review and ongoing monitoring, including assessment of potential bias. This documentation should include appropriate use and review of AI to ensure fair and accurate modeling, assessment of potential bias, etc.

II. Quality Bonus Payments (RFI Section VIII.C)

CMS notes that the timing of the MA bid process affects QBP implementation. The statute requires bids by the first Monday in June, and CMS states that the QBP ratings used at the time of bid reflect a measure period from two calendar years prior, producing up to a three-year lag between measurement and payment. CMS also asks whether it should test an Innovation Center model that would delink QBPs from MA bids.

A. Reducing lag and the practical implications of delinking

Shortening the lag can improve the usefulness of quality incentives, but it has operational consequences. Delinking QBPs from bids could change the timing and predictability of rebate dollars and benefit design decisions. The Committee recommends that CMS treats this as an implementation issue, not only a policy concept.

If CMS considers delinking through Innovation Center testing, the test should include clear measures of success, such as:

- stability of benefit offerings over time,
- beneficiary disruption (premium and benefit changes),
- administrative complexity for plans and CMS, and

- whether timelier incentives produce measurable quality improvement.

B. Threshold effects and rebate volatility

CMS's Star Ratings are rounded to half-star increments using traditional rounding rules. Threshold structures can amplify year-to-year changes in rebates when contracts move around rating cut points. The result can be volatile benefit dollars and repeated benefit redesign.

Some stakeholders have historically recommended designing incentive programs that distribute rewards without "cliff" effects. The Committee suggests that CMS explores smoothing options and publishes volatility analyses under alternatives. Examples include limited multi-year averaging, transition corridors, or more continuous incentive gradients where feasible.

C. Benchmark add-ons and double-bonus counties

The Committee recognizes that key elements of QBP and benchmarks are statutory (e.g., plans in bonus status can receive benchmark increases of 5 percent, and in some counties 10 percent). Even so, CMS can evaluate and report on how current mechanics affect markets. The Committee recommends that CMS analyzes whether these add-ons align with policy goals, how they interact with competition and consolidation incentives, and whether they add complexity without corresponding beneficiary value.

D. Predictability as an explicit design objective

QBP and risk adjustment changes create second-order effects on bids and benefits. The Committee recommends that CMS treats stability and predictability as explicit objectives and uses phased implementation when adopting structural changes.

The Committee appreciates the opportunity to provide these comments on the proposed rule to amend the regulations for the MA program, Medicare Prescription Drug Benefit program, and the Medicare cost plan program. The Committee welcomes the opportunity to speak with you further to provide greater detail and answer any questions you might have regarding these comments. Please contact Katie Dzurec, director, state public policy outreach (dzurec@actuary.org).

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson, Medicare Committee
American Academy of Actuaries