October 8, 2026

Administrator Mehmet Oz, M.D.
The Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Advancing Medicare Advantage Reform: Recommendations for Developing an Inferred Risk Adjustment Model

Dear Administrator Oz:

Reforming Medicare Advantage (MA) is essential to its long-term sustainability, ensuring the program delivers high-quality care, protects beneficiary choice and uses taxpayer dollars responsibly. Central to that effort is a risk adjustment model that more accurately reflects beneficiaries' health care needs and supports fair competition among health plans. The Alliance of Community Health Plans (ACHP) has long advocated for these changes, particularly as locally- operated, nonprofit plans continue to lose ground to national behemoths that devote substantial resources to maximizing risk scores and revenue. This competitive imbalance underscores the urgency of reform, including CMS' exploration of an inferred risk approach. Alongside this work, ACHP requests CMS continue improving the current model, as outlined in our recent letter providing early feedback on the anticipated CY 2028 MA and Part D Technical Regulation.

As you know, ACHP is the only national organization promoting the unique payer-provider aligned model in health care. ACHP member companies collaborate with their clinical partners to deliver higher-quality coverage and care to tens of millions of Americans nationwide, including more than four million MA beneficiaries. Our commitment to MA drives our call for reforms that strengthen the program, sustain community-based coverage options and preserve meaningful choice for Medicare beneficiaries.

Despite recent improvements, the V28 risk adjustment model continues to reward coding intensity and allows national, for-profit insurers to gain a competitive advantage through aggressive coding practices. CMS must modernize risk adjustment to improve risk prediction, accurately reflect beneficiary needs, reduce administrative burden and support fair competition without creating new opportunities for gaming. Achieving these goals requires CMS to establish a strong technical advisory process, engage a broad range of stakeholders and experts, use data from established federal infrastructure and rigorously test any new model before implementation.

If CMS pursues an inferred risk approach, it must provide transparency throughout development and implementation, evaluate performance across plan types, populations and care delivery environments and establish ongoing standards to assess whether the model meets its objectives. ACHP stands ready to contribute to successful design and implementation and offers the following recommendations:

Overarching Inferred Risk Model Design and Implementation

Establish a Technical Advisory Panel: This panel would guide the design and implementation of an inferred risk model and include balanced representation from relevant stakeholders and experts, including health plans, clinicians and provider organizations, actuaries, researchers, think tanks and government agencies. The Technical Advisory Panel should advise CMS on key model design and implementation decisions, including data selection and weighting, model performance standards and appropriate guardrails. An ongoing forum for technical review and stakeholder input throughout model development, testing and implementation is imperative.

Define Inferred Risk: CMS must establish a clear and consistent definition of inferred risk. ACHP recommends defining inferred risk as "using clinical and non-clinical data, including but not limited to documented diagnoses, to estimate beneficiary risk, disease burden, care needs and expected health care costs." A clear definition will help CMS keep the model focused on its intended purpose, improving the accuracy of identifying underlying beneficiary risk and expected costs rather than simply replacing one set of flawed payment incentives with another.

Establish Core Principles: ACHP recommends any inferred risk model:

- *Improve Risk Prediction Accuracy:* Use additional and more timely data to better assess beneficiary risk and expected health care needs. Model changes should be evaluated based on whether they improve predictive performance and payment accuracy.
- *Level the Competitive Playing Field:* Reduce inappropriate incentives associated with coding intensity and promote competition based on care delivery and value rather than coding volume. The model should distinguish differences that reflect underlying beneficiary risk from differences that result from plan operations, care delivery or other legitimate factors.
- *Minimize Administrative Burden:* Decrease reliance on clinicians and health plan staff for coding-related activities and limit unnecessary audit exposure. Consistently available data should be used along with existing federal infrastructure wherever possible to avoid adding reporting, technology or operational requirements that do not materially improve risk prediction.
- *Better Reflect Whole-Person Risk:* Design the model to capture the broader clinical and social factors that drive beneficiary health needs and expected costs rather than relying primarily on the number of documented diagnoses.

Data Elements Utilized in Inferred Risk

Use Relevant and Readily Available Data: Transparency and predictability of the data used in any inferred risk model is essential. The initial model should be built using relevant data available through established federal infrastructure:

- Fee-for-service claims data
- Medicare Advantage Encounter Data System data that provide utilization and cost signals
- Part D prescription drug event data
- Enrollment and demographic data

CMS should identify and normalize outlier data points within each source to promote consistent model performance and continue to evaluate the role of chart reviews carefully. Removing chart reviews could reduce administrative burden and coding-related incentives, but chart reviews can also provide clinically-relevant information that claims and encounter data do not capture.

Evaluate Additional Data: ACHP expects that additional data will be valuable to improve the predictive accuracy of any inferred risk model. However, adding new data infrastructure for unevaluated datasets in a model is administratively and operationally challenging. Evaluating additional data sources through a transparent process will be important to determine if they materially improve risk prediction and advance the model's core principles. New data elements should only be added when they demonstrate improved predictive performance. Before incorporating new data sources, CMS should release its evaluation for public review and comment and establish a feasible, standardized pathway for data access and ingestion.

Future data sources could include:

- Social risk information, including housing instability, food insecurity, transportation barriers and area deprivation indicators
- Longitudinal clinical records, including medication history, imaging results and problem lists
- Laboratory data
- Post-acute care assessments

The Technical Advisory Panel should be consulted before incorporating sources into the model. CMS and the advisory panel can establish appropriate data privacy, security, validation and use guardrails, including data reporting formats, technical specifications and implementation timelines. The administrative burden and feasibility of collecting and reporting each new data element should also be weighed across plans and providers.

Model Architecture Considerations

Model Phase-In: Any new risk adjustment model should be phased-in over several years. This approach will give plans, providers and other stakeholders sufficient time to understand the changes and make necessary operational and administrative adjustments. A phased transition becomes particularly important if CMS moves from the current model architecture toward a fundamentally different approach to risk prediction. Plans need adequate time to evaluate changes in risk scores, understand their operational implications and assess model performance across different beneficiary populations and care delivery environments.

Reduce Coding Incentives: Any new model should reduce the reliance on diagnosis-code volume as the primary driver of risk adjustment. The architecture should deprioritize diagnosis-code volume and instead incorporate a broader set of condition specific clinical and non-clinical signals to more accurately reflect beneficiary risk and expect health care needs. The model should also protect against utilization inducements and better distinguish underlying beneficiary risk from differences in documentation practices.

Benchmarking and Model Performance Expectations

Conduct Shadow Testing: CMS should conduct shadow testing before implementing a new model. The shadow-testing period can identify unintended consequences and make appropriate adjustments before implementation. This testing allows industry to understand how CMS would evaluate material financial and distributional impacts across plans, populations and markets before implementation. During the shadow-testing period, plans should have sufficient access to model outputs and supporting information to:

- Assess changes in risk scores
- Identify the conditions and factors driving those changes
- Distinguish differences attributable to underlying clinical risk from differences attributable to utilization, documentation or data availability
- Evaluate operational and financial implications of the proposed model

Benchmark Model's Performance: CMS should evaluate and release for public review and comment model performance across the current CMS-HCC model, the current CMS-HCC framework enhanced with inferred risk and a new risk model architecture that may be wholly or partially inclusive of inferred risk. The performance report should further distinguish the impact of adding inferred risk data from the impact of adopting a fundamentally different model architecture. This analysis will allow stakeholders to understand which changes drive differences in predictive performance and payment outcomes.

Set Performance Standards: CMS should establish ongoing performance standards that measure predictive accuracy, stability, equity and other factors that demonstrate whether the model continues to meet its intended objectives. The Technical Advisory Panel should advise CMS on these standards and help CMS evaluate model performance over time. CMS and the advisory panel should also evaluate how certain conditions that do not meet established performance standards would be handled before moving into payment.

Validate Performance Across Several Variables: The model's performance should be assessed and validated across different plan types, geographic markets, network structures and care delivery models. This analysis can identify whether the model systematically advantages or disadvantages plans because of differences in utilization patterns, access to care, data availability or care delivery approaches rather than differences in underlying beneficiary risk. CMS should evaluate and publicly report the impact of an inferred risk approach on specialized populations, including Special Needs Plan (SNP) enrollees, as part of model development and testing. In addition, the model should evaluate whether regional adjustments are necessary to account for geographic variation in health care utilization, costs and other factors.

Oversight and Model Validation Considerations

Provide Plan Testing Capabilities: In addition to conducting a shadow-testing period, plans need sufficient access to model outputs and performance information to understand, replicate and test the model before and during implementation. Transparency will become particularly important as CMS incorporates new data sources and potentially more complex methods of inferring beneficiary risk. Plans should understand the factors driving model results and have the information necessary to determine whether those results appropriately reflect the underlying health needs of their members.

Monitor for Gaming: Risk adjustment gaming is one of the primary concerns with any changes to the risk adjustment program. The risks only increase with the possibility of a new model architecture. ACHP strongly recommends CMS monitor for unintended incentives and model manipulation. CMS should assess whether identifiable model inputs could create opportunities for plans or providers to target or manipulate behaviors in ways that undermine the model's objectives. Additionally, CMS should monitor emerging patterns (including outliers) associated with model inputs and make appropriate adjustments when those patterns create unintended incentives.

The new model should not simply shift incentives from diagnosis coding to utilization, procedures, prescriptions or other model inputs. The model should reward accurate reflection of beneficiary risk and appropriate care delivered rather than activity undertaken primarily to boost payment.

Prospective, Concurrent and Retrospective Adjustments in Inferred Risk

Assess Prospective and Concurrent Adjustment Practices: The current prospective adjustment approach is familiar and aligns with current health plan bid practices yet does fail to capture the care realities for certain patient populations, such as end-of-life care and individuals aging into Medicare. CMS should maintain a prospective approach to risk adjustment, while considering concurrent elements specifically for the Medicare Age-In population. CMS should also evaluate whether a retrospective adjustment could appropriately account for end-of-life care and the unique utilization and cost patterns associated with beneficiaries approaching the end of life.

Today's MA risk adjustment is deeply flawed, wasting billions in taxpayer dollars and distorting the market. ACHP commends CMS for its appreciation of this problem and its interest in a fairer, more accurate inferred risk approach. If executed well, we see significant potential for additional timely, relevant clinical and non-clinical information to improve the predictive accuracy of MA risk adjustment. These initial recommendations offer a foundation for further analysis, and we look forward to working with CMS on an inferred risk adjustment approach. At the same time, we are available to discuss our recommendations to continue improving the current model via the anticipated CY 2028 MA and Part D Technical Regulation. Please contact Michael Bagel, Vice President of Public Policy, at mbagel@achp.org or 202-897-6121.

Sincerely,

Ceci Connolly

Ceci Connolly
President and CEO
Alliance of Community Health Plans