American Health Information Management Association
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January 23, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Oz:

On behalf of the American Health Information Management Association (AHIMA), I am writing in response to the Centers for Medicare and Medicaid Services (CMS) Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program proposed rule published in the November 28, 2025 *Federal Register* (CMS-4212-P).

AHIMA is a global nonprofit association of health information (HI) professionals, with over 61,000 members and more than 88,500 credentials in the field. The AHIMA mission of empowering people to impact health® drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

The following are our comments and recommendations on two requests for information included in the proposed rule.

VIII. Request for Information on Future Directions in Medicare Advantage

B. Risk Adjustment

CMS seeks feedback on options for risk adjustment, including near-term changes to the existing risk adjustment methodology and entirely new approaches for risk adjustment, including recent advances in technology and additional data elements, approaches that do not solely rely on diagnoses data, and approaches that advance competition.

AHIMA appreciates CMS evaluating the Medicare Advantage (MA) risk adjustment methodology and processes for areas of improvement. As stated in the rule, risk adjustment is a key part of the payment methodology in MA to account for a beneficiary's expected healthcare costs based on their demographic and health characteristics. The goal of risk adjustment is sound: fairly adjust payments to MA plans and in turn healthcare providers based on patient health, ensuring continued coverage and access to care for beneficiaries who are likely to incur higher than average costs. However, the broader goals of improving access to care and health outcomes and reducing costs are compromised given the current structure and implementation of risk adjustment methodology.

As stated in the rule, risk adjustment impacts competition across MA plans, could lead to plans coding more intensely compared to traditional Medicare, and could lead plans to invest more in coding activities rather than care management or treatment. Even with the coding adjustment factor imposed each year, coding in MA continues to be higher compared to traditional Medicare for similar patient populations. In recent studies, MA risk scores have shown to be consistently higher than scores for similar beneficiaries in fee-for-service (FFS) Medicare.[1] The different coding requirements and methodologies across Medicare make it difficult to compare and evaluate coding across Medicare and MA programs, let alone coding intensity in MA, and determine whether plans and providers are coding appropriately. There have also been reports of invalid or incorrect diagnosis coding leading to increased risk-adjusted payments.[2,3,4] As a result, the current environment of compliance has become unwieldy, extremely burdensome on both plans and healthcare providers, and does not adequately contribute to solving the needs of the healthcare system of today and the future. Additionally, these issues prevent the program from achieving the original intent of MA, which was to bring down the costs of healthcare that were seen in traditional Medicare.

The Critical Roles and Experiences of HI Professionals

The roles and workstreams of HI professionals are directly involved in every facet of risk adjustment, both in healthcare provider organizations, and MA plans. HI professionals serve in roles including, but not limited to, medical coders, Hierarchical Condition Categories (HCC) or risk adjustment coders, auditors, analysts, release of information (ROI) specialists, and compliance officers. Importantly, these HI professionals exist in both MA plan organizations and healthcare provider organizations, and while workstreams may differ, many of the burdens and concerns resulting from risk adjustment are similar and aligned with the concerns stated in the rule.

A major burden identified by HI professionals is the challenging processes involved with appropriately capturing diagnostic data that accurately reflects the patient. To comply with risk adjustment, MA plans need provider organizations to focus on ensuring the correct diagnoses codes are documented in the patient's medical record to ensure the assigned HCCs appropriately predict beneficiaries' total care costs. As a result, HI professionals have identified that ample staff, time, and resources are needed to ensure that diagnostic data is appropriately captured. This also includes the issue of recoding, where healthcare organizations must code longstanding patient diagnoses each year to achieve an appropriate HCC risk adjustment score, increasing the burden on providers. Additionally, in efforts to streamline the process, MA plans may give organizations initiatives or directives indicating areas of focus for coding that will determine accurate risk adjustment. However, this detracts resources and time from other necessary documentation in the patient's record that contributes to a more holistic view of the patient, their medical state, and treatment needs, which is beneficial to determining appropriate and tailored medical care for each patient. In other words, coding is not just for risk adjustment.

For example, one patient's chronic obstructive pulmonary disease (COPD) is different than another patient's COPD in the way that each patient would utilize healthcare resources. One patient may have managed their COPD with little intervention, while another may have a more severe case that requires more frequent monitoring,

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[1]Available at: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_ExecutiveSummary_MedPAC_Report_To_Congress_SEC.pdf.
[2]Available at: https://www.grassley.senate.gov/news/news-releases/grassley-report-details-unitedhealths-record-of-appearing-to-game-the-medicare-advantage-system-turning-risk-adjustment-into-its-own-business.
[3]Available at: https://www.beckershospitalreview.com/legal-regulatory-issues/kaiser-permanente-to-pay-556m-to-settle-medicare-advantage-whistleblower-lawsuit/?origin=CFOE&utm_source=CFOE&utm_medium=email&utm_content=newsletter&oly_enc_id=1337J8699690E3V.
[4]Available at: https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf.

intervention, and treatment. These differences cause both patients to use different levels of healthcare resources and incur different levels of cost. In the current risk adjustment methodology, the two patients would reflect the same level of risk, illustrating that risk adjustment may not be the most accurate method or strategy to predict and address healthcare costs.

Another burden is the prevalence of manual processes across healthcare and how these impact risk adjustment workflows. AHIMA supports CMS' efforts to reduce burdensome manual processes where possible to focus more on quality patient care. The specific documentation needed for risk adjustment is just one of these manual processes, in addition to fulfilling requests for medical records. Medical record requests and ROI requests have long been a resource-intensive workstream, and with this becoming a more substantial part of the risk adjustment process, it forces organizations to prioritize different ROI requests. Given that MA plans and providers must code diagnoses comprehensively and timely, it takes away from other workstreams or requests that might inhibit patient or provider access to information. This includes time needed to be spent on gathering information for audits, particularly Risk Adjustment Data Validation (RADV) audits, that can detract from other important processes and workflows. One member noted their health system, consisting of eight hospitals, had over 18,000 requests in 2025 for records to fulfill Medicare risk adjustment audits. This figure includes volume through their ROI vendor and does not include record requests through the Epic Payer Platform.

Finally, as discussed in the rule, AHIMA agrees with CMS that the timing of risk adjustment coding requirements compared to payment is too substantial of a lag. Our members have noted the time lag between diagnosis to risk adjustment payment can be anywhere from 18 months to two years, meaning risk adjustment payments are made based on historical data utilizing a patient population that has likely changed at some level during that time. This makes it challenging and unattainable to fulfill RADV audits, make financial predictions on healthcare utilization, or demonstrate any kind of improvement or return on investment from risk adjustment initiatives. Additionally, related to the structure of risk adjustment methodology, any changes to the HCC categories and codes, including the recent update to HCC Version 28, require significant time and resources to educate clinicians and staff in plan and provider organizations and to restructure documentation accordingly.

Policy Recommendations

AHIMA supports CMS' efforts to evaluate the risk adjustment methodology in MA in search of opportunities for improvement. Regardless of changes to the MA risk adjustment methodology, **AHIMA recommends CMS engage stakeholders to create educational resources and guidance around risk adjustment methodology for both MA plans and healthcare providers, including resources to promote compliance with coding guidelines.** As one of the Cooperating Parties that approves the *ICD-10-CM Official Guidelines for Coding and Reporting* and official coding guidance published in *Coding Clinic for ICD-10-CM/PCS*, CMS should promote adherence to these official guidelines and coding guidance by MA plans and providers. The official coding guidelines were developed to assist both healthcare providers and coding professionals in identifying diagnoses that are to be reported. Adherence to these guidelines would help to ensure accurate and compliant coding and documentation practices and is required under the Health Insurance Portability and Accountability Act (HIPAA). A mutual understanding of requirements such as the coding guidelines, as well as each other's workflows, burdens, and areas of opportunity will help strengthen relationships between plans and providers.

In the RFI, CMS inquired about incorporating additional data beyond diagnosis data into risk adjustment methodology. **AHIMA recommends CMS consider incorporating treatment and monitoring data in addition to diagnosis data to improve the methodology and accuracy of evaluating a patient's risk score.** As part of the Make Health Tech Great Again initiative, HHS has discussed the benefits of access to data as well as using data to

improve health outcomes. This principle should be applied to improve risk adjustment. We believe diagnosis data is important to maintain in risk adjustment methodology and believe adding treatment data to diagnosis data provides a clearer picture of a patient's healthcare utilization and spending, especially given the uniqueness of how a diagnosis presents in each patient and variances in treatment needs.

Alternative payment models (APMs) can move the industry closer to high-quality, coordinated care through innovative payment and service delivery approaches, rewarding participants for effectively delivering value-based care.[5] CMS should consider ways to incentivize the alignment of healthcare operations in ways that can satisfy goals and requirements of risk adjustment, either through a new APM for risk adjustment or including risk adjustment considerations or workflows in APMs developed for other initiatives. The nature of APMs being focused on approaches to recognize and acknowledge providers treating patients and providing value-based care, for both high risk and low risk patients, is an area apt to harmonize with risk adjustment.

Many of the burdens identified by HI professionals relate to documentation, coding, ROI, and audits. In addition to education for payer and provider organizations on the documentation needs and goals associated with risk adjustment, **AHIMA encourages CMS to find other ways to streamline and harmonize requirements and processes across HHS and CMS programs, where possible.** For example, the HHS Office of the Inspector General (OIG) conducts its own risk adjustment audits, different from those that CMS conducts, which causes confusion and burden on staff who must respond separately. These conflicting audits could be aligned, either by when they are conducted, or by the data and documentation needed to comply with an audit. We appreciate and applaud CMS hearing stakeholders and adjusting the RADV audits by bringing the audit timeframes closer to present day. We encourage CMS to continue to find opportunities to streamline the various requirements where risk adjustment documentation is needed in other areas. Streamlining these requirements also includes addressing the issue of recoding, and we encourage CMS to consider proposing solutions to ensure those types of longstanding diagnoses are captured once. Additionally, **AHIMA encourages CMS to collaborate with the Assistant Secretary for Technology Policy / Office of the National Coordinator for Health IT (ASTP/ONC) to incentivize health IT developers to offer reasonable and attainable capabilities in electronic health records (EHRs) that would facilitate easier and less burdensome documentation for HCCs through the Health IT Certification Program.** This would improve efficiency and data exchange between both plans and providers.

Artificial intelligence (AI) holds great promise for healthcare operations, when used appropriately, and with human oversight and review. No AI solution should independently make a risk adjustment decision, but the supervised use of such technology could be helpful in reducing the burdens clinical documentation and responding to audits impose on healthcare organizations. As we are all on a different journey in interacting with AI, **AHIMA encourages CMS to consider the varying experience levels, resource and staff availability, and access to such technologies of different entities when incorporating AI into facets of MA risk management.** This includes CMS itself using AI, requiring plans or providers to use it, or implementing policies with requirements that are only attainable using AI. Whether used by CMS, plans, or providers, we must work together to ensure AI tools are appropriate for the task they are working to improve. If CMS, plans, or providers are using AI in risk adjustment, transparency on the use of the tool, data used in the tool, and how the tool works is fundamental to trust. Finally, AI should not be seen as the one solution to improving risk management. If the data being used in an AI tool is not appropriate, accurate, or complete, no AI tool will improve operations and will instead cause error and more burden.

[5]Available at: https://www.cms.gov/priorities/innovation/about/alternative-payment-models.

It is critical that any change or intervention CMS pursues is tested using real-world data in secure environments, includes the perspectives of end-users working for both MA plans and healthcare providers, and provides ample time before implementation to allow the industry to prepare. Transparency of all these components creates a system that makes it easy for plans and providers to work together. When processes such as risk management are manageable for all parties involved, it facilitates stronger working relationships, which trickles down to better patient care and improved health outcomes.

D. Well-Being and Nutrition

CMS seeks feedback on tools and policies that improve overall health, happiness, and satisfaction to improve well-being, as well as tools and policies that achieve optimal nutrition and improve preventive care in MA.

AHIMA encourages CMS to consider the value that screening and reporting, value-based payment arrangements, care coordination, and supplemental benefits that incorporate social determinants of health (SDOH) and other upstream drivers of health can contribute to understanding and managing patients' well-being and nutrition. The rule states that well-being is a comprehensive approach to disease prevention and health promotion that emphasizes person-centered care by promoting the well-being of patients and family members. Social risk factors contribute significantly to patients' well-being and nutritional status, and no comprehensive approach to promote health and prevent disease can be effective without considering social risk factors. Growing evidence demonstrates that specific social risk factors are directly associated with patient health outcomes as well as healthcare utilization, costs, and performance in quality- and value-based payment programs.[6] Health-related social needs negatively impact a person's health or healthcare and are significant risk factors associated with worse health outcomes as well as increased healthcare utilization. Consistent collection of high-quality data on SDOH and understanding how many patients experience challenges in these areas will enable clinicians to work together with patients, leveraging community support services and resources to manage chronic disease, improve health outcomes, prevent disease, and promote health.

For example, poor nutrition may be related to food insecurity, which is defined as limited or uncertain access to adequate quality and quantity of food at the household level.[7] It is associated with diminished mental and physical health and increased risk for chronic conditions. Food insecurity is also associated with high-cost healthcare utilization, including emergency department visits and hospitalizations. Therefore, AHIMA believes that measuring a patient's nutritional status should include screening for food insecurity. Accordingly, the patient can be connected to appropriate resources to ensure adequate access to food so that nutritional status, and thus health, can be improved.

Screening for these social risk factors would allow healthcare providers to identify and help address health-related social needs as part of treatment plans and contribute to long-term improvements in patient outcomes and prevention and mitigation of chronic diseases. This has the potential to reduce healthcare provider burnout by systematically acknowledging patients' social needs that contribute to adverse health outcomes and linking providers with community-based organizations to enhance patient-centered treatment. The availability of quality SDOH information could help clinicians and organizations, as well as state and federal agencies, better understand the prevalence and trends of various social risk factors within communities and enable the analysis of

[6]Available at: https://aspe.hhs.gov/topics/health-health-care/social-drivers-health/social-risk-factors-medicares-valuebasedpurchasing-programs.
[7]Available at: Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Managed Care. 2018 Sep;24(9):399-404.

the impact of these factors on the severity of illness, resource utilization, healthcare costs, and health outcomes. Widely adopted, consistent documentation and reporting mechanisms would aid in formulating more comprehensive and actionable policies to improve health outcomes, promote the highest quality care for all patients, and reduce healthcare costs overall.

AHIMA continues its commitment to improving health outcomes through its Data for Better Health® initiative.[8] Data for Better Health provides tools, resources, and education to advance the collection, sharing, and use of SDOH data to improve health outcomes. The goals of the initiative include:

- Engaging healthcare professionals working with SDOH data to understand the business case for the collection of SDOH data and share strategies for success;
- Educating and engaging with consumers to build trust and a greater understanding of SDOH and the benefits of sharing SDOH data with healthcare professionals;
- Advancing policy and advocacy among policymakers by developing and promoting a SDOH advocacy agenda; and
- Supporting innovation within the healthcare ecosystem to accelerate the adoption of best practices and new models related to SDOH.

AHIMA encourages CMS to consider the importance of tools and measures that screen for and address SDOH to inform improved and more holistic assessments of patient well-being and nutrition. AHIMA is committed to working with CMS on appropriate policies, programs, and payment mechanisms to encourage the collection, access, sharing, and use of all data that impacts individuals' well-being, nutrition, and overall health.

Thank you for the opportunity to comment on the proposed rule. If AHIMA may provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Tara O'Donnell, manager, regulatory affairs, at Tara.ODonnell@ahima.org.

Sincerely,

Lauren Riplinger, JD
Chief Public Policy & Impact Officer

[8]Available at: www.dataforbetterhealth.com.