MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Amol Navathe, M.D., Ph.D., Vice Chair
Paul B. Masi, M.P.P., Executive Director

February 10, 2025

Stephanie Carlton
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2024-0360

Dear Ms. Carlton:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," published on January 10, 2025. We appreciate your staff's work on the notice, particularly considering the competing demands on the agency.

Our comments focus on the following provisions:

- Technical update to medical education payments in the non–end-stage renal disease (ESRD) United States per capita costs (USPCC) baseline
- CMS hierarchical condition category (CMS-HCC) risk-adjustment model for calendar year 2026
- MA coding pattern difference adjustment
- Normalization factors for CMS-HCC risk-adjustment models
- Normalization factors for CMS's prescription drug hierarchical condition category risk-adjustment model

Technical update to medical education payments in the non-ESRD USPCC baseline

Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by the MA plan bid—which is intended to represent the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which

is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.[1]

MA benchmarks are based on fee-for-service (FFS) spending in each county and are established in the April prior to a given payment year so that MA plan sponsors have the information to prepare bids.[2] Therefore, the county-level FFS spending estimates used in MA benchmarks are projections of FFS spending in each county for the payment year. These county-level FFS spending estimates used for MA benchmarks are the product of two factors: the national FFS per capita cost (also called the USPCC) and a county-level geographic index called the average geographic adjustment.

The USPCC includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs, which are not covered by plans) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs. The USPCC is projected for the payment year based on the most recent program experience and accounts for various trends, including unit cost changes; utilization and intensity of services; changes in population mix; and changes in Medicare coverage due to legislation, regulation, or national coverage decisions. CMS pays hospitals directly for indirect medical education (IME) and direct graduate medical education (DGME) costs on behalf of MA enrollees, so IME and DGME payments made on behalf of FFS beneficiaries are removed from the FFS spending estimates used for MA benchmarks. In practice, IME and DGME payments made on behalf of the FFS beneficiaries are included in the USPCC and are then removed from the county-level geographic index to account for the geographic variation in those IME and DGME payments.

In the advance notice for 2024, CMS noted that, historically, the hospital cost data that support the modeling of the non-ESRD FFS USPCC did not separately identify payments made on behalf of FFS enrollees from payments made on behalf of MA enrollees, so the non-ESRD FFS USPCC has included IME and DGME payments to inpatient facilities on behalf of both FFS beneficiaries and MA enrollees. The inclusion of payments made on behalf of MA enrollees in the FFS USPCC means that MA benchmarks have included IME and DGME spending for MA enrollees, resulting in Medicare making duplicative payments for MA-related IME and DGME costs: one payment directly to inpatient facilities, and one payment to MA plans through higher benchmarks. However, CMS is now able to separate the payments made to inpatient facilities on behalf of MA enrollees from those made on behalf of FFS beneficiaries.

In 2024, CMS began a three-year phase-in of an approach to remove the MA-related IME and DGME spending from the historical and projected expenditures supporting the non-ESRD FFS USPCCs. For 2024, CMS phased in the removal of 33 percent of that spending,

---

[1] If a plan's bid is above the benchmark, the plan's MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. If a plan's bid is below the benchmark, its base payment rate is its bid plus a share of the difference between the plan's bid and the benchmark.
[2] There are separate payment rates for enrollees with ESRD and without ESRD, and so there are separate FFS spending estimates for each group. This comment only pertains to the non-ESRD FFS spending estimates.

and in 2025, CMS increased the phase-in to remove 52 percent of that spending. For 2026, CMS proposed to complete the removal of MA-related IME and DGME spending.

Comment

MedPAC reiterates our support for CMS's efforts to remove MA-related IME and DGME payments from the non-ESRD FFS USPCC estimates. Completing the removal of these duplicative payments will make payments to MA organizations more accurate in future years. We appreciate CMS's ongoing efforts to improve the accuracy of Medicare's payments to MA plans, and the transparency of those efforts.

CMS-HCC risk-adjustment model for calendar year 2026

Medicare payments to MA plans are adjusted to account for differences in enrollees' expected medical spending. The purpose of risk adjustment is to ensure that plans are adequately and fairly compensated for treating all categories of enrollees—those with high expected medical spending as well as those likely to incur lower spending. The CMS-HCC risk-adjustment model uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses to calculate a risk score for each enrollee. Diagnoses associated with similar medical conditions and with similar spending are grouped into HCCs. Some closely related HCCs are grouped into hierarchies based on condition severity.

Each demographic and HCC component in the risk-adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated using FFS Medicare claims data such that all FFS Medicare spending in a year is distributed among the model components. The sum of these dollar value coefficients is normalized into an index, called a risk score. Normalization, applied to all risk scores for FFS and MA enrollees, establishes a 1.0 risk score for a beneficiary with expected spending equal to average FFS Medicare spending. Higher risk scores generate higher payments because beneficiaries with higher risk scores are expected to have higher expenditures; similarly, lower risk scores generate lower payments.

For 2024, CMS began phasing in a new risk-adjustment model version (V28) that is based on more recent FFS data and uses a new International Classification of Diseases, 10th Revision (ICD-10) diagnosis code-to-HCC mapping and an updated list of HCCs. (The prior model version was V24.) Revising the model with more recent data and a new diagnosis-to-HCC mapping will reflect more recent FFS diagnostic, FFS utilization, and FFS spending patterns.

The V28 risk-adjustment model also excludes or constrains the coefficients of certain HCCs that CMS identified as being subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans or providers. To do this, CMS identified the conditions in the model where coding in MA is highest relative to FFS and reviewed those conditions with clinical experts to determine if the coding differential likely indicates coding variation due to differences in diagnostic discretion. As a result of

this process, CMS removed HCCs for protein-calorie malnutrition, angina pectoris, and atherosclerosis of arteries of the extremities with intermittent claudication. At the same time, CMS eliminated the levels of severity for two 3-HCC hierarchies, effectively combining each set of three HCCs into a single group with the same coefficient. CMS applied the hierarchy constraint to diabetes (with glycemic, unspecified, or no complications; with chronic complications; and with severe acute complications) and congestive heart failure (heart failure, except endstage and acute; acute heart failure (excludes acute on chronic); and acute on chronic heart failure).[3]

For 2024, CMS used a 33 percent / 67 percent risk score blend of the V28 / V24 models. For 2025, CMS used a 67 percent / 33 percent risk score blend of the V28 / V24 models. For 2026, CMS proposes to base risk scores for MA payments entirely on the V28 model.

CMS has also been calibrating a version of the risk-adjustment model using MA encounter data (diagnosis, cost, and use data) and may be able to start phasing in an MA encounter data–based model as early as 2027. CMS believes that MA encounter data is likely a better predictor of relative costs in MA than FFS claims data and using an MA encounter data-based model would be an improvement in MA payment accuracy. CMS also states that using an MA encounter data–based model would remove the need to make an adjustment for coding pattern differences under 1853(a)(1)(c)(ii).

Comment

MedPAC continues to support CMS's proposal to complete the phase in of the V28 risk-adjustment model for 2026 payment to MA plans. Basing the model on more recent years of FFS data and using ICD-10 diagnosis codes to estimate model coefficients are important updates that will improve the accuracy of risk adjustment and payments to MA plans.

We particularly support CMS's efforts to reduce the effects of coding differences between MA plans and FFS Medicare providers through the V28 risk model, and we share CMS's concern that discretionary or inappropriate coding in MA can undermine payment accuracy and distort competition between MA plans. In our comment on CMS's initial proposal to implement the V28 model (in the advance notice for 2024), we reported higher rates of discretionary coding for eliminated or constrained HCCs (relative to FFS coding) among MA contracts with higher overall coding intensity.[4] As we noted in that comment letter, when diagnostic discretion, intentional or unintentional, leads to large differences in the coding rates between MA and FFS and across MA plans, it diminishes the accuracy of risk-adjusted payments to MA plans and increases the payments that MA plans receive due to higher coding intensity. Eliminating HCCs and constraining the coefficients of HCCs that are found to have excessive discretionary coding variation is a reasonable strategy to improve payment accuracy and reduce overall MA coding intensity relative to FFS. We

[3] We interpret this proposal as an indication that CMS's analysis found that coding of the higher-severity HCCs in these hierarchies (rather than coding of any HCC in each hierarchy) was greater in MA relative to FFS. We also note that the three congestive heart failure HCCs are the lower three severity levels of a 6-HCC hierarchy that also includes heart failure with heart assist device/artificial heart, end-stage heart failure, and heart transplant status/complications.
[4] MedPAC's comment letter on the advance notice for 2024 can be found here: https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf

encourage CMS to continue efforts to identify other HCCs with discretionary or inappropriate MA coding and eliminate or constrain those HCCs, giving appropriate consideration to any effects on the accuracy of the risk-adjustment model overall and for beneficiaries with discretionary HCCs.

The Commission has long had concerns about the performance of the current approach to risk adjustment and its ability to produce accurate payments to MA plans. In 2016, the Commission made a set of recommendations to improve risk adjustment.[5] At this time, we have not analyzed the effects of moving to a risk-adjustment model based on MA encounter data. Such a move would mark a significant change from how risk adjustment is currently implemented in MA, requiring many important policy and technical decisions, such as how to calculate annual spending for MA enrollees using encounter data, the impact of any missing encounter records, and whether to maintain a coding-intensity adjustment. In addition to the decisions about how to calibrate an MA encounter data–based model, moving to a new model should include careful consideration of the interaction between the risk-adjustment system and other aspects of MA payment policy, including MA plan bids and benchmarks. Depending upon how those decisions are made, moving to a new model could improve, worsen, or not address problems with payment accuracy.

CMS noted that using an MA encounter data–based model would eliminate the statutory requirement to make an adjustment for coding pattern differences between MA and FFS Medicare. First, we caution that it would be important to analyze how any new risk-adjustment model would affect Medicare's payments to MA plans before deciding whether an adjustment for MA and FFS coding differences should be continued, modified, or eliminated. Second, aside from coding differences between MA and FFS, our analysis has found substantial and persistent variation in coding intensity across MA organizations (see Figure 2 below), such that higher-coding organizations have a competitive advantage because they received larger payments for enrolling the same beneficiaries as other organizations. Because of these higher payments, they can offer more supplemental benefits and attract new enrollees, simply because of their coding efforts.

Under an MA encounter data–based model, higher payments for MA organizations with higher coding intensity would continue to be an issue. Because the model would be calibrated with all MA encounter data, the resulting risk scores would implicitly assume—incorrectly—that coding practices are the same across the entire MA industry. Moving to an MA encounter data–based model would also require careful consideration of ways to reduce differences in coding intensity across the MA industry to improve the fairness in payments to all MA organizations.

---

[5] See Chapter 12 of our March 2016 report to the Congress: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf.

MA coding pattern difference adjustment

As noted above, Medicare payments to MA plans are adjusted to account for differences in enrollees' expected medical spending using the CMS-HCC risk-adjustment model. The model uses FFS Medicare claims data to estimate the model coefficients. Therefore, the model calculates an expected spending amount based on Medicare spending and diagnostic coding patterns for FFS beneficiaries. Most diagnoses for FFS beneficiaries are reported on physician and hospital outpatient claims. In FFS Medicare, such claims tend to be paid based on procedure codes, so there is little financial incentive for providers to document diagnoses that are not the primary reason for the visit. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, including the coefficients for age and sex categories.

Because FFS spending and diagnoses are used to calibrate the CMS-HCC risk model, payments to MA plans assume similar levels of diagnostic coding between FFS and MA. But MA plans have significant financial incentives to code more diagnoses (and have the tools to do so), because greater coding intensity can result in higher HCCs for their enrollees, which leads to higher payments from Medicare.

Since 2010, the Congress has required CMS to adjust MA enrollees' risk scores to reduce the impact of MA and FFS Medicare coding differences. An adjustment reducing MA risk scores by 3.41 percent was applied from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to a minimum adjustment of about 5.9 percent in 2018, where it will remain until the Secretary implements a risk-adjustment model that uses MA diagnostic, MA utilization, and MA plans' cost data.[6] To date, the Secretary has opted to reduce MA risk scores by the minimum amount required by law. For 2026, CMS proposes once again to apply the minimum required adjustment of 5.9 percent.

Comment

We understand the agency's inclination to proceed cautiously in making large changes to Medicare payments—whether provider payments under FFS, or payments to health plans under Medicare Advantage—in order to ensure that beneficiary access is not compromised. However, for nearly a decade, the Commission has documented increased payments to MA plans due to coding intensity and has recommended policies to address the problem. We estimate that, in 2025 alone, coding intensity will increase Medicare's payments to MA organizations by about $40 billion dollars. The cost of those increased payments is borne by taxpayers and by the Medicare beneficiaries and state Medicaid agencies who help finance the Medicare program through Part B premiums. We estimate that Part B premiums will be higher for all Medicare enrollees by about $6 billion in 2025

[6] Section 1853 (a)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395w-23(a)(1)(C)(ii)].

because of increased spending due to higher MA coding intensity.[7] Moreover, the Commission has estimated that coding intensity varies significantly across different MA plans, which can distort competition in the program.

The evidence documented by the Commission and others over many years indicates that stronger action is needed. Although we applaud CMS's efforts to reduce MA and FFS coding differences by eliminating or constraining certain HCCs in the V28 risk-adjustment model, those efforts are inadequate to address growing MA coding intensity and the resulting increased payments to MA plans. The Commission's recommendation (outlined below) and other proposals to more fully address coding intensity are within the Secretary's authority. Given the fiscal burden on the taxpayers and beneficiaries who finance the Medicare program, it is imperative that CMS act now to better account for the effects of coding intensity.

CMS's adjustment does not fully account for coding differences

Over the past several years, a growing body of research has demonstrated that the impact of MA and FFS coding differences are far larger than the minimum adjustment that the Secretary has routinely applied. At least eight independent studies, using a variety of methods and data sources, corroborate the Commission's estimates that the impact of plan coding intensity has always been larger than the adjustment that CMS applied in any given year.[8,9,10,11,12,13,14,15,16]

Figure 1 shows the estimated impact, for 2007 through 2023, of differences in coding intensity on MA risk scores relative to FFS and the impact of the coding-intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity). The percentages at the top of each bar show our estimate of the impact of coding intensity for each year. The lower, dark blue portion of each column shows the effect of the

---

[7] Many Medicare beneficiaries and state Medicaid agencies help fund the Medicare program through Part B premiums. Part B spending represents about 60 percent of all FFS Medicare spending (which is assumed to be the same share of spending on Part B services by MA plans). Twenty-five percent of Part B spending is financed through premiums paid by all Medicare Part B enrollees. The estimate does not account for the reduction in Part B premiums that is offered by some MA plans as a supplemental benefit.

[8] Kronick, R., F. M. Chua, R. Krauss, et al. 2025. Are fewer diagnoses better? Assessing a proposal to improve the MA payment system. *Health Affairs* 44, no. 1 (January): 66–74.

[9] Kronick, R., and F. M. Chua, Department of Health and Human Services. 2021. *Industry-wide and sponsor-specific estimates of Medicare Advantage coding intensity*. November 11. https://ssrn.com/abstract=3959446.

[10] Jacobs P. D., and R. Kronick. 2018. 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(6): 4997-5015.

[11] Hayford, T. B., and A. L. Burns. 2018. Medicare Advantage enrollment and beneficiary risk scores: Difference-in-differences analyses show increases for all enrollees on account of market-wide changes. *Inquiry* 55 (January–December): 46958018788640.

[12] Congressional Budget Office. 2017. *Effects of Medicare Advantage enrollment on beneficiary risk scores*. Working paper 2017-08. Washington, DC: CBO.

[13] Geruso, M., and T. Layton. 2020. Upcoding: Evidence from Medicare on squishy risk adjustment. *Journal of Political Economy* 12, no. 3 (March): 984–1026.

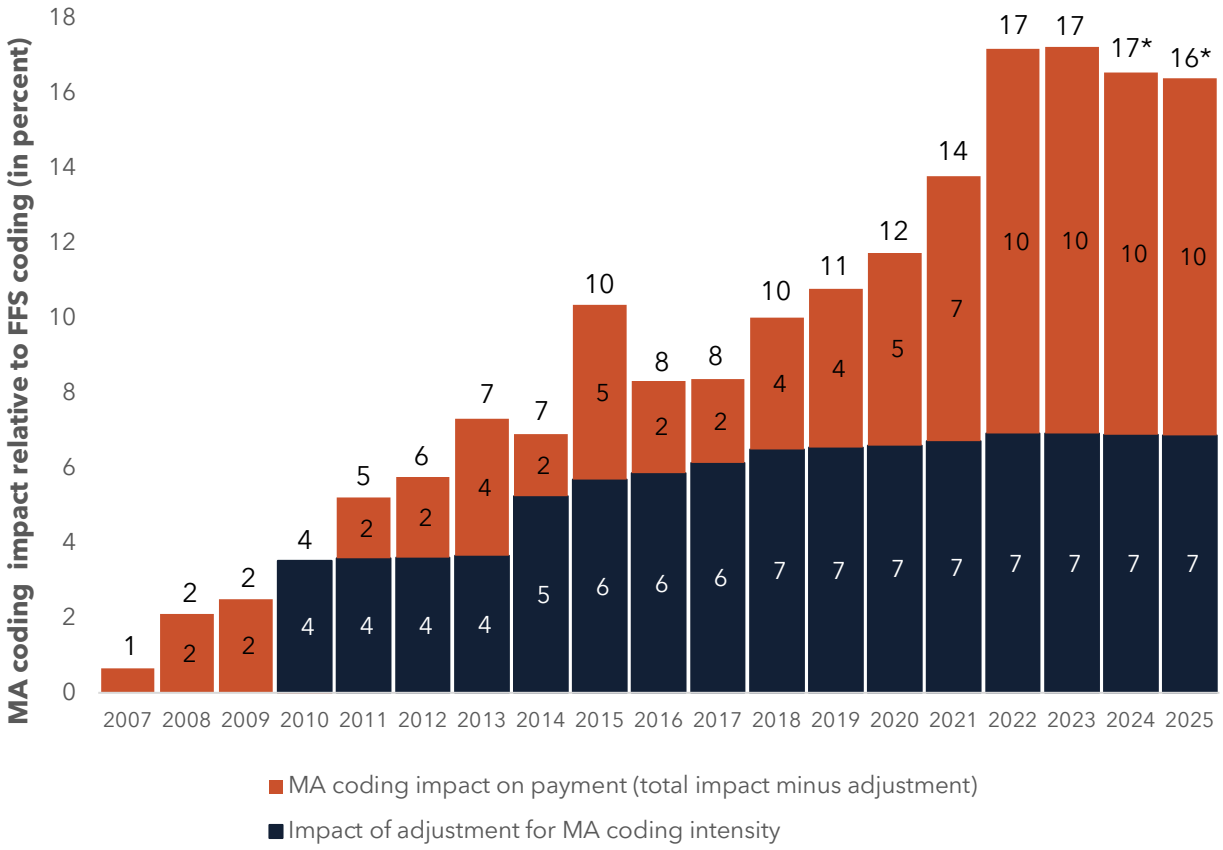
[14] Kronick, R., and W. P. Welch. 2014. Measuring coding intensity in the Medicare Advantage program. *Medicare & Medicaid Research Review* 4, no. 2.

[15] Government Accountability Office. 2013. *Medicare Advantage: Substantial excess payments underscore need for CMS to improve accuracy of risk score adjustments*. GAO-13-206. Washington, DC: GAO.

[16] Government Accountability Office. 2012. *Medicare Advantage: CMS should improve the accuracy of risk score adjustments for diagnostic coding practices*. GAO-12-51. Washington, DC: GAO.

coding adjustment that CMS applied in each year and the upper, orange portion shows the share of coding intensity in excess of CMS's adjustment that results in higher payments to MA plans. MA coding intensity has been above FFS levels since 2007 and has increased steadily, with a few exceptional years, to about 17 percent in 2023. CMS's coding intensity adjustment began in 2010 and has been lower than overall MA coding intensity since 2011.

Figure 1 | Estimated impact of coding intensity on MA risk scores was larger than coding adjustment, 2007–2025



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico are excluded. The annual adjustment for MA coding began in 2010. MA coding intensity has increased MA risk scores annually, but increases were offset by new versions of the risk-adjustment model in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017. The impact of the coding adjustment is calculated as the MA coding-intensity estimate relative to FFS, multiplied by the coding adjustment. For 2025, we calculate 1.16 × 5.9 percent = 0.069 or about 7 percent. Components may not sum to totals due to rounding.

* For 2024 and 2025, we project coding intensity based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the phase-in of the V28 risk-adjustment model, which is –2.3 percentage points in 2024 and –1.8 percentage points in 2025, as discussed in the Commission's public meeting on January 17, 2025: https://www.medpac.gov/wp-content/uploads/2024/08/Tab-M-MA-status-report-January-2025-SEC.pdf.

Source: MedPAC analysis of CMS enrollment and risk-score files.

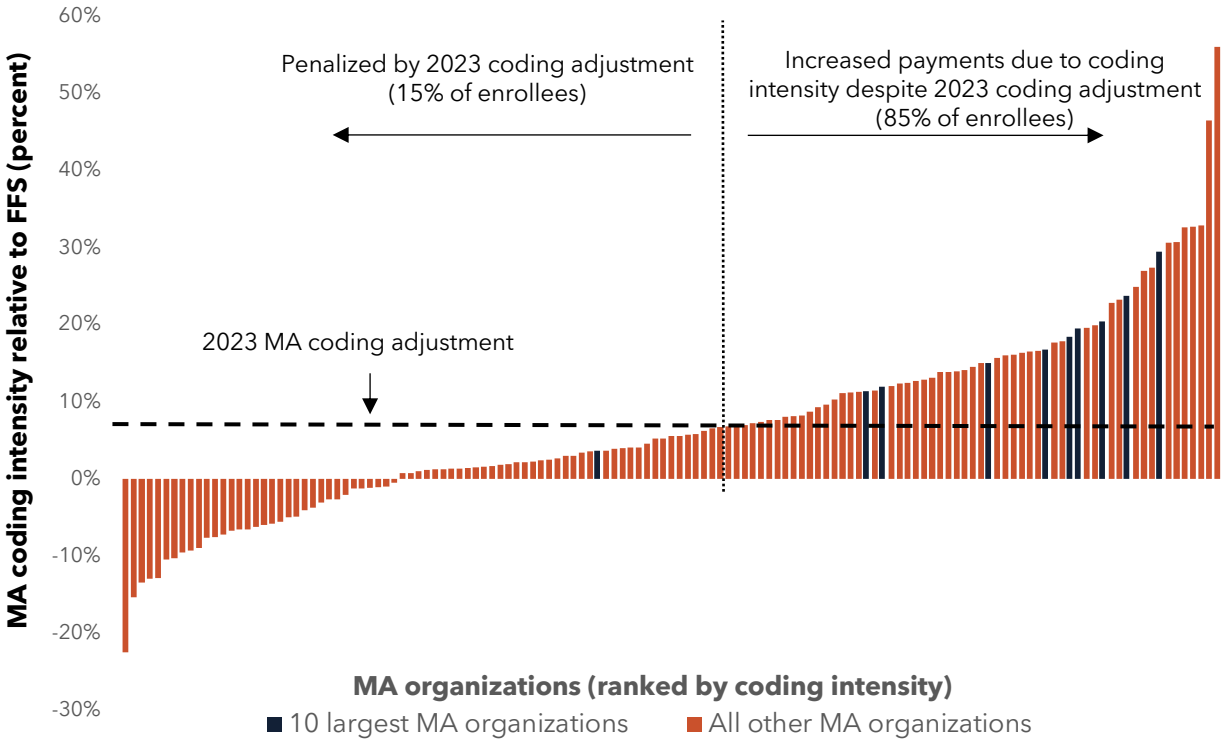
Because the data required to estimate coding intensity are not yet available for 2024 and 2025, we project coding intensity for those years based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. In analysis presented at the Commission's January 2025 public meeting, we estimate that phasing in the V28 risk-adjustment model effectively reduced the coding-intensity estimate for 2024 by –2.3 percentage points and by –1.8 percentage points in 2025 for a net change in coding intensity of -0.7 percentage points from 2023 to 2024 and of -0.2 percentage points from 2024 to 2025. There is uncertainty about the impact of moving to the V28 model for MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able. We expect to have risk score data for 2024, the first year of the V28 implementation, for our March 2026 report.

For 2025, we project that MA risk scores will be about 16 percent above risk scores for comparable FFS beneficiaries, far more than the impact of CMS's coding-intensity adjustment.

Applying an across-the-board coding-intensity adjustment generates payment imbalance across MA contracts and organizations

We estimated the effect of coding intensity separately for each MA organization and found substantial variation in coding for 2023. Figure 2 shows coding intensity relative to FFS coding by MA parent organization, excluding beneficiaries who reside in Puerto Rico or are enrolled in a chronic-condition special-needs plan and organizations with fewer than 2,500 enrollees in the analysis.

Figure 2 | Coding intensity relative to FFS varied widely across MA organizations, 2023



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

Source: MedPAC analysis of CMS enrollment and risk score files.

Consistent with prior years, we found that coding intensity varied significantly across MA organizations in 2023. We estimate that about half of MA organizations (covering 15 percent of MA enrollees) had coding intensity that was lower than CMS's 2023 coding adjustment; by contrast, the other half of organizations (covering 85 percent of MA enrollees) had coding intensity that increased their payments from Medicare even after the 2023 coding adjustment was applied. These differences demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all risk scores by the same amount, generates imbalance across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

We also found significant variation in coding intensity across the largest 10 MA organizations (covering 81 percent of MA enrollees), ranging from about 4 percent to about 29 percent above FFS levels. Nine of the 10 largest MA organizations had greater coding intensity than the 2023 coding adjustment and therefore received increased payments due

to their coding practices. These differences are large enough to give MA organizations with higher coding intensity a significant competitive advantage by increasing the size of plan rebates and helping them to attract more enrollees.

MedPAC's approach to addressing coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality. The Commission's approach to reduce the impact of MA coding intensity has been to address the underlying causes first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach.

The recommendation, which would replace the existing mandatory minimum coding-intensity adjustment (which has reduced MA risk scores by 5.9 percent since 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart review data from risk adjustment (consistent with the Commission's approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. Our analysis shows that health risk assessments and chart reviews alone account for roughly half of MA coding intensity.[17] The Commission carefully considered options for addressing coding intensity and supports this approach because it balances implementation feasibility, administrative burden, and effectiveness.

Adjusting for any remaining coding intensity differences could also improve equity across MA contracts. Under one approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding-intensity adjustment would be applied based on each tier's average estimated level of coding intensity.[18] CMS has used a similar approach

---

[17] See Chapter 12 of our March 2024 report: Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

[18] Medicare Payment Advisory Commission. 2016. Medicare Advantage: Calculating benchmarks and coding intensity. Presentation at the Commission's November public meeting. http://medpac.gov/docs/default-source/meeting-materials/ma-ab-coding-nov16-for-laptop.pdf?sfvrsn=0.

to select MA contracts for risk-adjustment data validation audits.[19] This policy would improve the overall equity of the coding-intensity adjustment relative to the single, across-the-board adjustment used today. Finally, we note that in 2016, when the Commission voted on this recommendation, estimates of MA coding intensity net of CMS's coding adjustment were much smaller than they are for 2025. Given that the impact of the Commission's recommendation, which would fully account for the effects of higher MA coding intensity, has grown substantially, policymakers could contemplate phasing in and monitoring the impact of the Commission's recommendation.

Normalization factors for CMS-HCC risk-adjustment models

The CMS–HCC risk-adjustment models are calibrated with diagnostic and spending information for beneficiaries enrolled in FFS Medicare. The risk-adjustment models are prospective in that they use health conditions in a base year (i.e., data collection year) to estimate spending in the following year (i.e., the payment year). Each demographic component (e.g., age, sex, Medicaid eligibility, and institutional status) and health condition in the risk-adjustment model has a coefficient that represents the expected medical expenditures associated with that component or condition. The dollar-valued coefficients are converted into a risk factor by dividing by the predicted average per capita expenditure for beneficiaries in FFS Medicare in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health conditions from the prior year. The average risk score is 1.0 among FFS beneficiaries in the denominator year.

The average FFS risk score changes each year due to an underlying trend that reflects changes in the health status and demographic characteristics of the population, and coding practices. Therefore, when a risk-adjustment model predicts expenditures in years subsequent to the denominator year, the average FFS risk score may no longer be 1.0, as it was in the denominator year. Accordingly, an adjustment must be applied to account for the FFS risk score trend between the denominator year and the payment year, and the adjustment (the normalization factor) must be is a specific to each risk model.

In the past, CMS has used a 5-year linear trend of FFS risk scores to estimate a normalization factor for the payment year. However, CMS found that fluctuations in FFS risk scores during the COVID-19 pandemic required changes to the normalization factor estimation method. CMS found that the average FFS risk score (V28 model) changed –3.2 percent between 2020 and 2021, +2.5 percent 2021 to 2022, +1.7 percent 2022 to 2023, and +1.8 percent 2023 to 2024.

Because of these fluctuations, for 2025, CMS developed a regression approach using 2019 to 2023 risk scores with a COVID-19 flag applied to 2021 and later years. The approach uses risk scores for all five years, but accounts for the level change in FFS risk scores that is

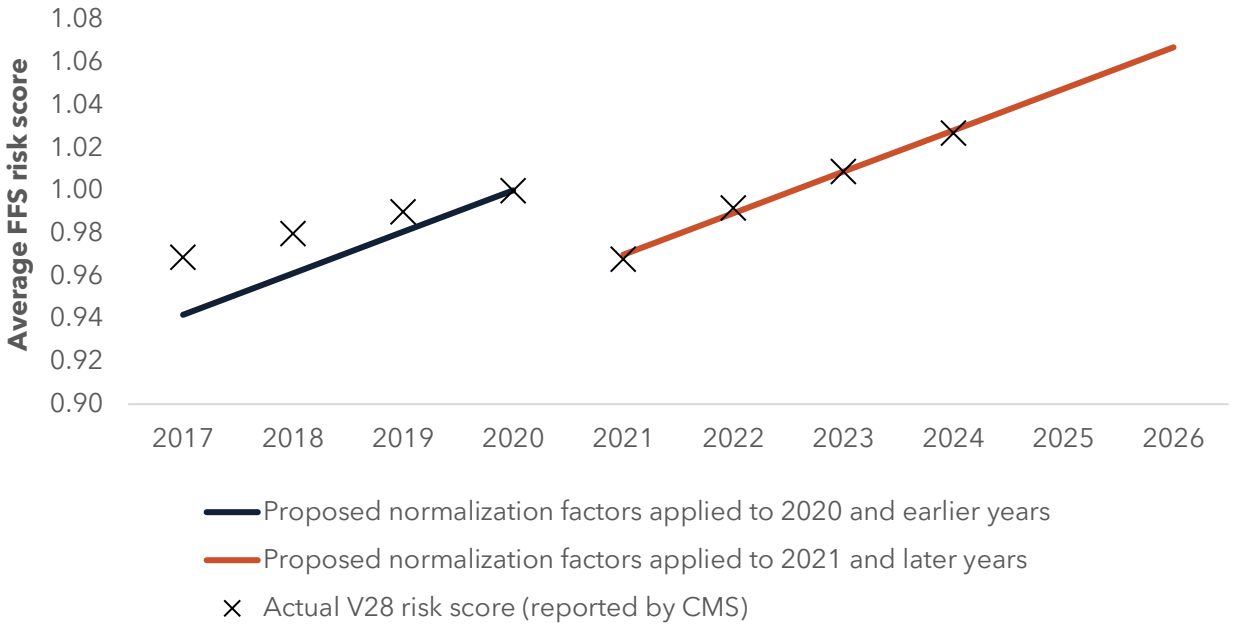
[19] For risk-adjustment data validation audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.

observed between 2020 and 2021. For 2026, CMS proposes to use the same regression approach with a COVID-19 flag applied to 2021 and later years but would use risk-score data for 2020 to 2024.

Comment

The Commission acknowledges the difficulty in predicting average FFS risk scores in light of the fluctuations that have occurred in recent years and supports CMS's proposed regression approach for estimating the normalization factor for 2026. We find that the proposed regression factors fit actual FFS risk scores reasonably well, including for post-COVID years (Figure 3).

Figure 3 | Proposed normalization factor approach for V28 model fits average FFS risk score data well in post-pandemic years



Note: FFS (fee-for-service). Figure shows V28 model normalization factors (Intercept –38.188, annual change in FFS risk score 0.0194, and COVID-19 flag –0.0495 as reported by CMS) applied to 2017 through 2026, and actual average FFS risk scores as reported by CMS for 2017 through 2024.

Source: MedPAC analysis of CMS normalization factor data for V28 model on page 66 of "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies."

Normalization factors for CMS's prescription drug hierarchical condition category risk-adjustment model

In Part D, Medicare aims to subsidize about 75 percent of the cost of basic drug benefits with enrollees paying the remainder (about 25 percent) through monthly premiums.

Medicare's subsidy takes the form of two distinct payments: 1) prospective capitated payments called the direct subsidy; and 2) cost-based reinsurance payments that cover a portion of an individual's drug costs above the benefit's annual out-of-pocket threshold. Direct subsidy payments are based on plan bids that reflect their estimates of the expected costs of providing Part D's basic benefit for an enrollee of average risk. To limit plan incentives to engage in risk selection, direct subsidy payments are risk adjusted using the prescription drug hierarchical condition category risk-adjustment (RxHCC) model.

Similar to the CMS-HCC risk-adjustment model used to adjust Part C payments to MA plans, the RxHCC model is prospective in that it uses demographic characteristics (e.g., age and sex) and health conditions in a base year to estimate incremental drug costs in the payment year. Each demographic and RxHCC component in the risk-adjustment model has a coefficient that represents the expected drug costs associated with that component, which are estimated using Part D's prescription drug event data. The sum of these dollar value coefficients is normalized into an index, called a risk score. Normalization accounts for underlying trends such as changes in demographic characteristics and diagnostic coding and establishes a 1.0 risk score for a beneficiary with average Part D spending. Higher risk scores generate higher payments because beneficiaries with higher risk scores are expected to have higher expenditures; similarly, lower risk scores generate lower payments.

The Inflation Reduction Act of 2022 (IRA) significantly increased plan liability, the costs for which plans will be at risk and subject to risk adjustment. Given the increased importance of risk adjustment in Part D payment—and the diverging trend in average MA-PD and prescription drug plan (PDP) risk scores—for CY 2025, CMS finalized the use of separate normalization factors for MA-PDs and PDPs to "more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they are able to manage, the lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs."[20,21]

For CY 2025, CMS did not believe it was prudent to apply the multiple linear regression methodology that was proposed (and finalized) for the CMS-HCC model due to data limitation, and as a result, continued to rely on the linear slope methodology.[22] For CY 2026, CMS has evaluated the appropriateness of continuing to use the historical linear slope methodology. However, the agency's analysis has found that the linear slope methodology, even when data years affected by the COVID-19 pandemic are excluded, does not produce reasonable projections of risk score growth for MA-PDs or PDPs.

---

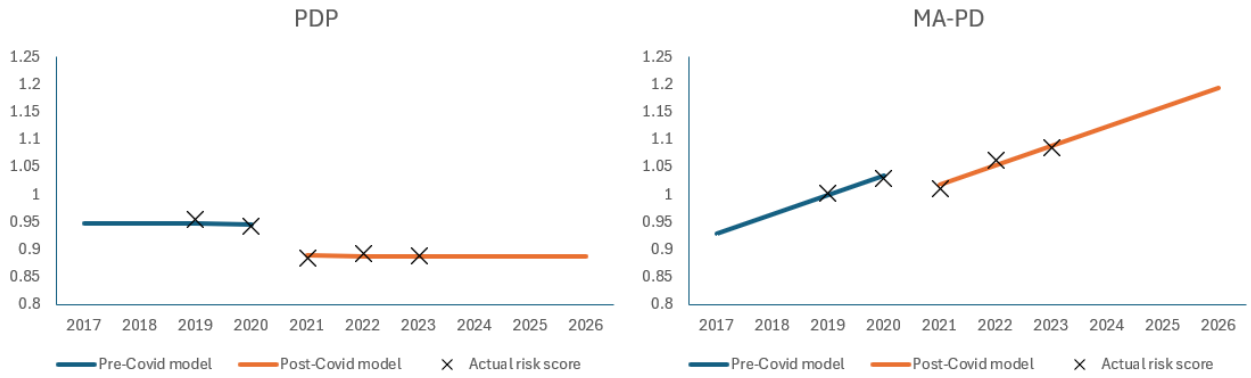
[20] The divergence in trend between MA-PD and PDP risk scores has meant that the RxHCC model tended to overpredict MA-PD plan costs and underpredict PDP costs, putting an "upward pressure on standardized bids for PDPs" and creating "an unlevel playing field that generally inhibits fair competition between MA-PD plans and PDPs" (https://www.cms.gov/files/document/2025-advance-notice.pdf).
[21] https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-rate-announcement.
[22] Because CMS-HCC model relies only on FFS data to calculate the normalization factor, for CY 2025, CMS was able to use risk-score data through 2023. In contrast, because the RxHCC risk-adjustment model uses both MA and FFS risk scores, the most recent final RxHCC risk score was for 2022, which meant that the "post-COVID" portion of the trend would have only reflected risk score change from 2021 to 2022, potentially distorting the normalization factors as the change would have included the rebound of risk scores after the pandemic when utilization began to increase.

For CY 2026, with the addition of the 2023 RxHCC risk score data, CMS proposes to use a multiple linear regression methodology, which is the same methodology the agency used to calculate the Part C normalization factors for the CMS-HCC model starting with CY 2025 payment. The multiple linear regression methodology includes a flag for risk scores in 2021 and subsequent years, indicating risk scores occurring after the start of the coronavirus pandemic. As with the Part C model, this methodology allows CMS to incorporate the most recent average RxHCC risk scores in calculating the normalization factors without excluding any years of risk scores.

Comment

The Commission appreciates the difficulty in predicting average risk scores for Part D as it simultaneously faces programmatic changes related to the IRA, while adjusting to the differential cost and coding trends between the MA-PD and PDP markets. Given the diverging trends in risk scores for MA-PDs and PDPs, and the likelihood for improved predictive accuracy of the multiple linear regression method, the Commission supports CMS's proposed regression approach to estimate separate normalization factors for MA-PD plans and PDPs. The regression factors proposed for the RxHCC models fit actual risk scores reasonably well for both MA-PD and PDP (Figure 4).

Figure 4 | Proposed normalization factor approach for the RxHCC model fits average risk score data well for both MA-PD and PDP



Note: RxHCC (prescription drug hierarchical condition category), PDP (stand-alone prescription drug plan), MA-PD (Medicare Advantage-prescription drug plan). Figures show RxHCC model normalization factors (Intercept -1.3514, annual change in risk score -0.0002, and COVID-19 flag -0.059 for PDP and Intercept -70.0704, annual change in risk score 0.0352, and COVID-19 flag -0.0513 for MA-PD as reported by CMS) applied to 2017 through 2026, and actual average risk scores as reported by CMS for 2019 through 2023.

Source: MedPAC analysis of CMS normalization factor data for the RxHCC model in "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies."

The figures also demonstrate the distinct risk-score trends for the two markets: the average risk score for MA-PDs has consistently risen in recent years, while the average risk score for PDPs has experienced a modest decline.

For years, the Commission has been concerned about the coding difference between FFS and MA that contributes to inaccurate Part C payment adjustment using the CMS-HCC risk adjustment model (see the section on MA coding pattern difference adjustment). Given the overlap of conditions in the CMS-HCC and RxHCC models, higher coding intensity by MA plans for medical conditions could increase coding intensity for conditions that are also used in the RxHCC model. Unlike the CMS-HCC risk-adjustment model, the RxHCC model is calibrated using costs and diagnostic data for beneficiaries enrolled in both FFS and MA. However, when there are large, systematic differences between the two sectors in coding intensity and patterns of medication use (for a given diagnosis), the RxHCC model's accuracy for predicting costs for either sector would be compromised. The growing divergence in risk scores for MA-PD plans and PDPs suggests the existence of a systematic difference in coding intensity and/or utilization patterns between the two sectors.

As CMS noted, a risk adjustment that, on average, systematically underpays PDPs while overpaying MA-PDs can have a direct impact on the sustainability of the PDP market. This is because when the model underpredicts costs for PDPs, these plans face greater pressure to charge higher premiums than MA-PD plans whose costs are overpredicted, making PDPs less competitive. Using a separate normalization factor for the two sectors of the Part D market could help level the playing field between PDPs and MA-PDs. However, we encourage CMS to continue to monitor the trends in Part D risk scores and to explore additional approaches to ensure that systematic differences between the two sectors do not result in a financial disadvantage to PDPs, which in turn could affect the stability of the PDP market.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

MC/aj/ss/toh