

# USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY

March 6, 2023

Dr. Meena Seshamani  
Director, Center for Medicare  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services

## **Re: Advance Notice for Part C and Part D Payment Policies [CMS-2023-0010]**

Dear Dr. Seshamani:

Thank you for the opportunity to comment on the 2024 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies issued by the Centers for Medicare and Medicaid Services (CMS). This letter comments briefly on CMS' proposed changes to the CMS-HCC risk adjustment model, specifically its proposals to update the data used for model calibration and to rebuild the model's hierarchical condition categories (HCCs).<sup>1</sup>

Many of CMS' proposed changes are likely to bring CMS closer to meeting its legal obligation to ensure that payments to MA plans are aligned with the claims risk of MA enrollees. Indeed, CMS' proposal to begin using 2018 and 2019 data for calibration (instead of 2014 and 2015 data) will help ensure that the model better reflects current utilization patterns, which is likely to improve the accuracy of its estimates of the relative risk of different types of enrollees. Similarly, CMS' proposal to rebuild the HCCs based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes will ensure that HCCs reflect the most up-to-date approach to diagnosis classification. This may improve the model's accuracy in cases where ICD-10-CM diagnosis codes offer more clinical specificity than was previously available.

CMS' review of how the prevalence of specific diagnosis codes is affected by MA plans' coding efforts—and its resulting proposals to shift some diagnoses to non-payment HCCs, remove some HCCs from the model, and constrain certain HCC coefficients—also have the potential to improve payment accuracy by reducing MA plans' ability to garner higher payments through aggressive coding.<sup>2</sup> Moreover, where feasible, changes like these have advantages over other ways of addressing higher coding intensity in MA, such as coding intensity adjustments. Notably, CMS' proposed changes would likely have a larger effect on plans that adopt more aggressive coding practices, thereby reducing plans' incentives to invest in those practices in the first place and potentially shifting market share toward the plans that are best at creating value for enrollees, not those best at coding diagnoses.

However, CMS should keep in mind that approaches like these can involve tradeoffs, as they have the effect of reducing how much information the model can draw on to predict enrollee costs. Any resulting reduction in the accuracy of enrollee-level predictions can create new incentives for MA plans to attract certain enrollees and

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<sup>1</sup> Please note that the views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself.

<sup>2</sup> For evidence on the extent of plans' current coding efforts, see, for example, Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 128, no. 3 (March 2020): 984–1026, <https://doi.org/10.1086/704756>; Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2022, [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

avoid others. That, in turn, can cause insurers to reduce the quality of the plans they offer in an effort to promote this type of risk selection. If insurers are successful, this could also partially or fully offset the improvements in payment accuracy achieved by making the model less susceptible to plans' coding efforts.

For that reason, CMS should evaluate how changes in this vein affect the model's predictive power, including by assessing changes in measures of model fit, like the model  $R^2$ . In the future, CMS should also consider reporting measures of model fit when it updates the CMS-HCC model, as CMS does when it updates the risk adjustment methods used in the individual and small group markets.<sup>3</sup> To be clear, model fit is not the only factor CMS should consider when evaluating risk adjustment methods. Model fit captures a model's effectiveness in predicting spending at the *enrollee* level *within* traditional Medicare, whereas the goal of risk adjustment is to offset differences in risk mix at the *plan* level *between* each MA plan and traditional Medicare. These two objectives will not always coincide, whether due to the coding considerations at issue here or because there are aspects of health status that are not directly observed for risk adjustment purposes.<sup>4</sup> Nevertheless, measures of model fit can still provide useful information about how much the excluded diagnoses (or constrained coefficients) contribute to the model's ability to predict enrollee cost and, thus, how much of a tradeoff potentially exists.

In weighing the tradeoffs involved in these types of model changes, CMS should also remain cognizant of the fact that MA plans are likely to adjust their coding behavior in response to the incentives that exist under any new model. For that reason, the actual improvement in payment accuracy brought about by these types of model changes may be smaller than the improvements that CMS has estimated by analyzing how payments to plans would differ between the old and new models under historical diagnosis coding patterns.

Thank you again for the opportunity to comment on the advance notice. If I can provide any additional information, please do not hesitate to contact me.

Sincerely,

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<sup>3</sup> See, for example, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024," Federal Register, December 21, 2022, <https://www.federalregister.gov/documents/2022/12/21/2022-27206/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024>.

<sup>4</sup> Jacob Glazer and Thomas G. McGuire, "Optimal Risk Adjustment in Markets with Adverse Selection: An Application to Managed Care," *The American Economic Review* 90, no. 4 (2000): 1055–71; Jacob Glazer and Thomas G. McGuire, "Setting Health Plan Premiums to Ensure Efficient Quality in Health Care: Minimum Variance Optimal Risk Adjustment," *Journal of Public Economics*, ISPE Special Issue, 84, no. 2 (May 1, 2002): 153–73, [https://doi.org/10.1016/S0047-2727\(01\)00123-2](https://doi.org/10.1016/S0047-2727(01)00123-2).