

March 1, 2024

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-2024-0006]

Dear Dr. Seshamani:

Thank you for the opportunity to comment on the 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies published by the Centers for Medicare and Medicaid Services (CMS).¹ This letter comments briefly on two proposals related to MA and Part D risk adjustment, making two main points:

- **CMS' proposed new method for calculating MA risk score normalization factors would generate more accurate factors and, in turn, more accurate MA payments.** The method CMS has previously used to project average fee-for-service (FFS) risk scores—and, in turn, set MA risk score normalization factors—would likely perform poorly in the face of the unusual risk score dynamics that have followed the COVID-19 pandemic. Relying on this past method would likely cause CMS to pay MA plans more than it intends, whereas CMS' proposed method would likely be relatively accurate. CMS' proposed method does implicitly (and, in our view, implausibly) assume that the pandemic's effects on risk scores are permanent, but alternative methods that allow the pandemic's effects to fade over time produce very similar estimates for 2025.
- **Separately normalizing risk scores for standalone Part D prescription drug plans (PDPs) and MA prescription drug plans (MA-PDs) would place PDPs and MA-PDs on a more level playing field.** Average observed risk scores are higher in MA-PDs than in PDPs. However, evidence suggests that MA-PD risk scores overstate the actual risk of MA-PD enrollees due to higher coding intensity in MA and favorable selection into MA. In reality, MA-PD enrollees are likely no higher risk—and may actually be lower risk—than PDP enrollees. CMS' proposal to separately normalize MA-PD and PDP risk scores so that each market segment has an average risk score of 1.0 would therefore help level the playing field between the two plan types. Indeed, placing MA-PDs and PDPs on a truly level playing field may actually require going farther than CMS proposes.

The remainder of our letter expands on these two main points.

¹ The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than ourselves.

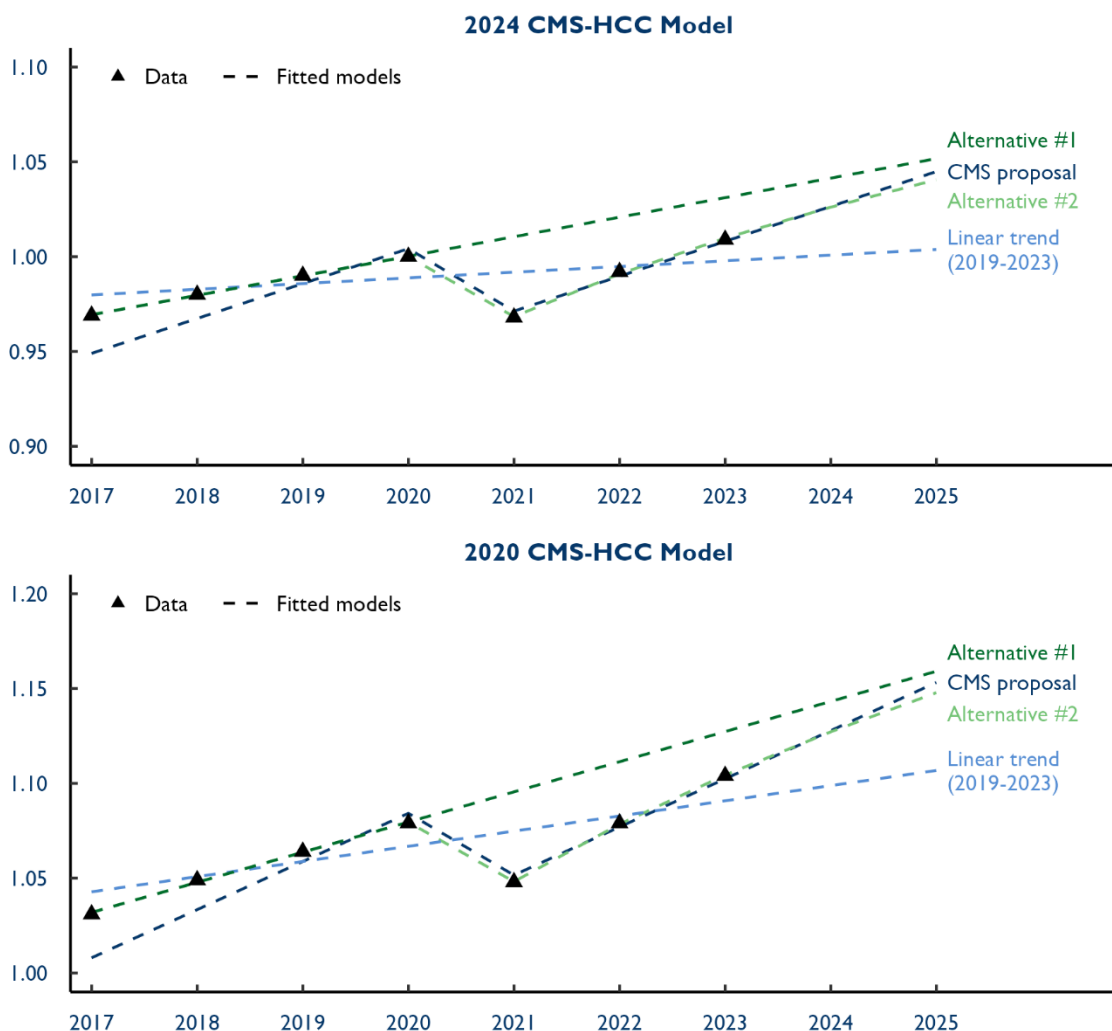
MA Risk Score Normalization Factors

We begin with CMS’ proposed method for projecting average FFS risk scores and, in turn, setting the normalization factors used to ensure that average normalized FFS risk scores are approximately 1.0, as the MA payment system assumes. The accuracy of CMS’ projections has major implications for MA plan payments. If CMS’ projection of the average FFS risk score is too low, then the normalized risk scores used to pay MA plans will be higher than intended, and payments will be too high as well. If CMS’ projection is too high, then the reverse will occur.

We agree with CMS that the method it has used to project average risk scores in most past years—estimating a linear trend using the most recent five years of risk score data and then using the estimated slope coefficient to project forward from the denominator year to the payment year—is inappropriate in the current environment. As depicted in Figure 1, a simple linear model does a poor job capturing the two main factors that have driven risk score trends in recent years: (1) the underlying trend toward higher risk scores; or (2) the sharp reduction in risk scores that occurred

Figure 1. Comparing Methods for Projecting Average FFS Risk Scores

Average FFS risk score



in 2021, which likely reflected the reduced number of patient diagnoses documented during 2020 due to lower health care utilization during the COVID-19 pandemic. As such, this type of model offers a poor basis for projecting future risk scores. In practice, it appears that using such a model would lead CMS to severely underestimate 2025 risk scores.²

We also agree that discarding data for some post-COVID years (either 2021 alone, as CMS did for the 2023 and 2024 payment years, or both 2021 and 2022, as CMS considers and rejects in this year's Notice) but continuing to use a linear projection methodology is not an adequate solution. Notably, we suspect that lingering effects of the pandemic continued to depress risk scores in 2022 and 2023—and may continue to do so to some degree in future years. As such, sensibly incorporating data for 2022 and 2023 and then projecting into the future requires a method that can separate the effect of the COVID-19 pandemic from the underlying trend in risk scores; CMS' existing linear trend methodology is simply not capable of doing that.

We therefore agree with CMS that a more fundamental methodological change is needed. In the Notice, CMS proposes to use the most recent five years of data (2019-2023) to estimate a regression model with two explanatory variables: (1) the usual linear time trend; and (2) an indicator variable for years 2021 and later that is intended to capture the effect of the COVID-19 pandemic on risk scores. CMS would then use the estimated model to predict the 2025 average risk score. We view this proposed method as an improvement on CMS' past methods.

However, CMS' proposed regression model does have the unappealing feature that it treats the effect of the COVID-19 pandemic on risk scores as *permanent* and *unchanging*. By contrast, we suspect that diagnosis coding patterns will move back toward their pre-COVID trend as utilization patterns continue to normalize (although this may take some time since utilization has taken time to normalize and since diagnoses missed when utilization was depressed may not be captured immediately after utilization returns to its normal level). Consistent with this view, risk scores have risen unusually rapidly as the pandemic has receded. For the 2024 CMS-HCC model, average FFS risk scores rose 2.4 percentage points in 2022 and 1.7 percentage points in 2023, whereas the corresponding increases averaged only around 1.0 percentage point during the pre-COVID years. Average risk scores for CMS' other risk score models have exhibited similar rebounds.

For that reason, we investigated two alternative approaches that account for the possibility that the pandemic's effects on risk scores will fade over time. In our first alternative method ("Alternative #1"), we assume that the pandemic's effects on risk scores will have fully dissipated by 2025. We then estimate a regression model with a simple linear time trend using four years of pre-pandemic data (2017-2020) and use the estimated model to predict the average risk score for 2025. In effect, this method extrapolates the pre-pandemic risk score trend forward to 2025.

² For comparability with the other projection methods we consider here, the "linear trend" depicted in Figure 1 represents the predicted values from a regression of average risk scores on a simple linear time trend. As noted above, when CMS has used the linear trend method in the past, it has used the slope coefficient from this regression to project forward from the denominator year to the payment year rather than relying on the predicted values. That method leads to modestly different projections for 2025, but either method would lead to projections that are likely too low.

In our second method (“Alternative #2”), we estimate a regression model of the following form by non-linear least squares using data for the period 2017-2023:

$$y_t = \beta_0 + \beta_1 t + \beta_2(t \geq 2021)\delta^{t-2021}.$$

This model is, in essence, an augmented version of CMS’ proposed regression model that allows for the possibility that the pandemic effect β_2 may decay over time at a constant rate δ . We then use the estimated model to predict the average risk score for 2025. We note that both of our alternative methods implicitly or explicitly depend on being able to reliably estimate the pre-pandemic risk score trend, so we estimate the relevant regression models using data back to 2017.

The projections generated by these alternative approaches are reported alongside those from CMS’ proposed approach in Figure 1 (for the 2020 and 2024 CMS-HCC models, which apply to most MA beneficiaries) and in Table 1 (for all of CMS’ MA risk score models). In general, Alternative #1 generates predictions that are slightly higher than CMS’ proposed approach, while Alternative #2 generates predictions that are slightly lower. We conclude that our alternative approaches would generate similar estimates for 2025, notwithstanding their conceptual advantages.

Table 1: Projected Average FFS Risk Scores Under Various Methodologies

Risk score model	CMS proposal	Alternative #1	Alternative #2
2024 CMS-HCC Model	1.045	1.052	1.041
2020 CMS-HCC Model	1.153	1.159	1.148
2017 CMS-HCC Model	1.157	1.170	1.154
2023 ESRD Dialysis Model	1.044	1.046	1.042
2019 ESRD Dialysis Model	1.103	1.107	1.103
2023 ESRD Functioning Graft Model	1.074	1.075	1.066
2019 ESRD Functioning Graft Model	1.159	1.170	1.156

Separately Normalizing PDP and MA-PD RxHCC Risk Scores

We next discuss CMS’ proposal to begin setting different normalization factors for PDP and MA-PD risk scores under the Part D risk adjustment system, with the goal of ensuring that both market segments have a (normalized) average risk score of 1.0. The Notice reports that, under CMS’ proposed risk score model (and without the new normalization policy), average risk scores would have been around 18% higher in MA-PDs relative to PDPs in 2022.³ Thus, this change will make the Part D risk adjustment system more generous to PDPs and less generous to MA-PDs.

We believe that this change would place MA-PDs and PDPs on a more level playing field, as evidence strongly suggests that current risk scores overstate the claims risk borne by MA-PDs relative to PDPs and, thus, that risk adjustment is too generous to MA-PDs relative to PDPs. There are two main reasons that risk scores overstate claims risk for MA-PDs relative to PDPs:

- *Diagnosis coding differences:* MA-PD risk scores are calculated from diagnoses in MA encounter data, while PDP risk scores are calculated from diagnoses in FFS claims. There is abundant evidence that diagnosis coding intensity is higher in MA than FFS due to MA

³ This estimate pertains to the model for non-Program of All-Inclusive Care for the Elderly (PACE) organizations.

plans' incentives to report more diagnoses.⁴ The staff of the Medicare Payment Advisory Commission (MedPAC) recently estimated that higher coding intensity will increase average CMS-HCC risk scores by 20% in MA relative to FFS in 2024.⁵ These coding differences likely similarly inflate RxHCC risk scores for MA-PDs relative to PDPs.

- *Favorable selection:* MA plans also attract relatively healthy enrollees among enrollees with a given risk score (even after adjusting for coding intensity differences).⁶ Recent MedPAC staff estimates imply that, on average, the risk scores of MA enrollees relative to FFS enrollees will overstate MA enrollees' actual relative claims risk by 9% in 2024 (after adjusting for coding intensity differences).⁷ While MedPAC's analysis applies to Part A and B costs, this favorable selection likely similarly causes RxHCC risk scores to overstate the claims risk borne by MA-PDs (which, by definition, serve MA enrollees) relative to the claims risk borne by PDPs (which, by definition, serve FFS enrollees).

The evidence on Part D spending that CMS presents in the Notice is also consistent with the view that the current system is overly generous to MA-PDs relative to PDPs. CMS reports that actual per enrollee spending was 11% higher in PDPs than in MA-PDs in 2021 and 2022 even as risk scores (and, in turn, predicted spending) were markedly higher in MA-PDs. While spending differences may reflect factors other than just enrollee risk, this evidence—together the evidence on the magnitude of coding intensity differences and favorable selection described above—suggests that PDP enrollees may actually have *higher* claims risk, on average, than their MA-PD counterparts. If this is correct, then merely equalizing risk scores between the two market segments, as CMS proposes, may actually fall short of placing MA-PDs and PDPs on a fully level playing field. Nevertheless, CMS' proposed approach would be a major step in the right direction.

Thank you for the opportunity to comment on this proposed rule. We hope that this information is helpful to you. If we can provide any additional information, we would be happy to do so.

⁴ For a recent review of this evidence, see Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.

⁵ Stuart Hammond, Andy Johnson, and Luis Serna, "The Medicare Advantage Program: Status Report" (Medicare Payment Advisory Commission, January 2024), <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>.

⁶ For a review of relevant evidence, see Medicare Payment Advisory Commission (MedPAC), "Medicare and the Health Care Delivery System," June 2023, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

⁷ Hammond, Johnson, and Serna, "The Medicare Advantage Program: Status Report."

Sincerely,

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