MEDPAC | Medicare Payment Advisory Commission

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

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February 25, 2026

Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2026-0034

Dear Dr. Oz:

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) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," published on January 26, 2026. We appreciate your staff's work on the notice, particularly considering the competing demands on the agency.

Our comments focus on the following provisions:

- CMS hierarchical condition category risk-adjustment model and sources of diagnoses for risk-score calculation
- MA coding pattern difference adjustment
- Prescription drug hierarchical condition category risk-adjustment model

CMS hierarchical condition category (CMS-HCC) risk-adjustment model and sources of diagnoses for risk-score calculation

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 their different enrollee populations—those with high expected medical spending as well as those likely to incur lower spending. The CMS hierarchical condition category (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 effects on expected spending are grouped into HCCs. Some closely related HCCs are grouped into hierarchies based on condition severity.

Each demographic and HCC variable in the risk-adjustment model has a coefficient that represents the expected medical expenditures associated with that variable. These coefficients are estimated using fee-for-service (FFS) Medicare claims data such that FFS Medicare spending in a year is distributed among the model variables. 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.

To aid risk adjustment, MA organizations submit encounter records for all items and services provided to their enrollees; CMS then identifies the encounters that are eligible to serve as a source of diagnoses for risk adjustment.[1] To do this, CMS applies a "filtering logic" to the encounter data to identify eligible encounters based on dates of service, type of bill codes, and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes.[2] The same filtering logic is applied to FFS claims data to identify risk-adjustment-eligible diagnoses used to calibrate the model and to calculate risk scores for FFS enrollees. Only encounters from inpatient hospital, outpatient hospital, and physician and other health professional services are considered for risk adjustment.[3] To filter outpatient and professional encounters, CMS uses a list of risk-adjustment-eligible CPT/HCPCS codes.[4] If at least one service line on an encounter record includes an acceptable CPT/HCPCS code, then diagnoses from all services lines for that encounter are eligible for risk adjustment. In addition, CMS requires only services provided face-to-face be used for risk adjustment. To enforce this requirement, CMS filters out, or excludes, audio-only telehealth services. (Some audio-only telehealth services are documented with their own CPT/HCPCS code (e.g., 98008–98015 for 2025), and those codes are not included in the list of risk-adjustment-eligible CPT/HCPCS codes.)

Between 2024 and 2026, CMS phased in a new version of the risk-adjustment model (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, representing an updated list of HCCs. The V28 risk model introduced in 2024 was calibrated using 2018 diagnostic data and 2019 spending data.

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[1] One exception is for unlinked chart reviews, where plans do not submit sufficient data for CMS to determine eligibility for risk adjustment, and therefore CMS currently relies on plans to submit only diagnoses on unlinked chart reviews that are eligible for risk adjustment.
[2] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FinalEncounterDataDiagnosisFilteringLogic.pdf.
[3] Inpatient encounters are filtered using type-of-bill codes. Outpatient encounters use both type of bill and the CPT/HCPCS code list. Professional encounters are filtered using the CPT/HCPCS code list.
[4] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors-items/cpt-hcpcs.

For 2027, CMS proposes to implement a "2027 model" that uses the same set of demographic and HCC variables and the same diagnosis code-to-HCC mapping as the V28 model did when it was first implemented in 2024, but makes three important changes:

- The 2027 model is calibrated using 2023 diagnostic data (instead of 2018 data) and 2024 spending data (instead of 2019 data).
- Two new modifier codes are used to exclude audio-only services more completely from the diagnostic data used to calibrate the model and to calculate risk scores.
- Unlinked chart reviews in MA encounter data are removed as a source for diagnoses in risk adjustment. Chart-review records include information from a review of a patient's medical record (or chart) and are typically used to add diagnostic information for risk adjustment.[5] Chart-review records can be linked to a specific encounter or unlinked to any encounter. The use of unlinked chart reviews in risk adjustment has raised concerns from the Office of Inspector General (OIG) and CMS because unlinked chart reviews lack sufficient information to ensure that risk-adjustment criteria are met. Instead, CMS has relied on MA organizations to submit unlinked chart reviews including only diagnoses that meet risk-adjustment-eligibility criteria. MA organizations attest that information they provide for risk adjustment is accurate, complete, and truthful.

Payments to MA plans rely on two main factors that incorporate data and policy effects from different time periods. First, the overall level of payment is tied to the United States Per Capita Cost (USPCC), which is the basis for setting benchmarks in MA. For the 2027 payment year, the USPCC uses claims data from 2025 and earlier to project what national average FFS spending will be in 2027. For the projection, CMS makes adjustments for FFS payment policy changes that will be in effect in 2027. Second, the overall level of payment is adjusted using risk scores. By necessity, the risk-adjustment model is calibrated using data from earlier years than those that are used to construct the USPCC. As noted above, for payment year 2027, CMS is proposing to recalibrate the risk model to use 2023 diagnoses and 2024 spending data, updated from 2018 diagnoses and 2019 spending data that were the basis for the risk model used for 2026 payments. CMS does not typically make adjustments to the data used to calibrate the risk model to account for FFS payment policy changes that affect the projected USPCC.

Comment

The Commission supports CMS's proposal to implement the 2027 model for payments to MA plans in 2027 and offers one consideration for the agency.

[5] Office of Inspector General, Department of Health and Human Services. 2021. *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments*. OEI-03-17-00474. Washington, DC: OIG. https://oig.hhs.gov/reports/all/2021/some-medicare-advantage-companies-leveraged-chart-reviews-and-health-risk-assessments-to-disproportionately-drive-payments/.

We support the use of updated data to calibrate the model. Periodic recalibration of the risk model helps to ensure that risk scores reflect the most recent coding guidelines and practices and their relationship to spending patterns. Updating the model to use more recent years of FFS data generally improves the accuracy of risk adjustment and payments to MA plans. This update is particularly important because, without it, the risk model would continue to rely on data from 2018 and 2019, which reflect dated diagnostic and spending trends prior to the pandemic and do not align with current claim documentation guidelines.

As noted above, payments to MA plans rely on two main factors, the USPCC and risk scores, which reflect different years of data and payment policies. Only the USPCC is adjusted to reflect the payment policies in place during the payment year—in this case, 2027. That misalignment between the years of data and payment policies reflected in the USPCC and risk model occurs every year and regularly introduces some inaccuracies. CMS does not typically make adjustments to correct for inaccuracies arising from the misalignment, which generally have the potential to increase plan payments in some years and decrease payments in other years. In cases where large anomalies in FFS spending patterns are reflected in one data source and not the other, there is a potential for those inaccuracies to cause meaningful distortions in plan payment.

Anomalous FFS spending on skin conditions treated by skin substitutes appears to be such a case where meaningful distortions in payments to MA plans may be introduced due to the misalignment of data and payment policies applied to the USPCC and risk model under the proposed policies. The distortion in this case may be material for two reasons. First, FFS spending on skin substitutes has changed substantially in recent years. FFS spending on skin substitutes increased rapidly, from about $1 billion in 2021 to $4.2 billion in 2023 and to over $10 billion in 2024.[6,7] As a result of payment policies introduced in 2026, CMS expects spending on skin substitutes to fall far below 2024 levels in 2026 and 2027.[8,9] Second, those changes in spending have been reflected in the data used for the USPCC and the risk model in a staggered manner in different payment years. Those two factors may distort the payment system's ability to accurately predict costs within the FFS population upon which MA payments are based. The effect of the misalignment on plan payments could be magnified if the prevalence of conditions treated by skin substitutes differs substantially in the MA and FFS populations.

The misalignment of data and payment policies between the USPCC and risk model likely resulted in higher payments to MA plans in 2025 and 2026 when the USPCC reflected

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[6] Medicare Payment Advisory Commission. 2025. *A data book: Health care spending and the Medicare program.* Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_Sec10_SEC-1.pdf.
[7] Medicare Payment Advisory Commission. 2025. MedPAC comment letter on CMS's proposed rule entitled: *Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Coverage and Payment Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.* September 11. https://www.medpac.gov/wp-content/uploads/2025/09/09112025_MedPAC_2026_PFS_COMMENT_v3_SEC.pdf.
[8] CMS final rule: *Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program*: https://www.govinfo.gov/content/pkg/FR-2025-11-05/pdf/2025-19787.pdf.
[9] CMS Office of the Actuary. *Trends supporting 2027 growth rates*: https://www.cms.gov/files/document/trends-supporting-2027-growth-rates.pdf.

higher FFS skin substitute spending and the risk model did not. For 2026, we estimate that the USPCC was roughly 2 percent higher than it otherwise would have been due to FFS spending on skin substitutes.[10] The higher USPCC increased the dollar impact of the coefficients on all HCC and demographic factors in the risk model when applied to plan payments in 2026, with no offsetting adjustments to the coefficients in that year.

The misalignment of data and payment policies would likely result in lower payments to MA plans in 2027 under proposed policies. The 2027 USPCC reflects much lower expected FFS spending on skin substitutes, while the proposed 2027 risk model reflects historically higher FFS skin substitute spending in 2024. Under the proposed model, the coefficients on many demographic and HCC factors for non-skin conditions decreased to reflect 2024 spending patterns. Those lower coefficients would not be offset by a higher USPCC because the 2027 USPCC reflects expected lower spending on skin substitutes in the payment year. For 2027, CMS estimates that the combined effect of implementing the 2027 risk model and of normalization would reduce payments to MA plans by 3.32 percent over last year. Some of that effect is likely due to higher FFS risk-score growth that we observed between 2023 and 2024 (similar to a "normalization effect") and other factors. However, an unknown portion of the effect plausibly reflects the misalignment of data and policies applied to the USPCC and risk model, before accounting for the effects of plans responding to updated coding incentives.

To reduce the impact of the misalignment between the FFS spending data used in the risk model and the USPCC for 2027, CMS should consider recalibrating the 2027 risk model after adjusting the 2024 FFS spending data to reflect the most recent FFS prices for skin substitutes. We strongly support CMS using the most recently available data to calibrate the risk model. Continuing to use a risk model that is calibrated on data from 2018 and 2019 is undesirable, because those data reflect dated diagnostic and spending patterns prior to the pandemic and do not align with current claim documentation guidelines. Adjusting the 2024 spending data to reflect the most recent prices for skin substitutes would address concerns about distortions from data misalignment. Further, we encourage CMS to recalibrate the CMS-HCC model again in the near future, as soon as the FFS spending on skin substitutes reflects prices consistent with data used to project the USPCC (e.g., barring additional changes to skin substitute prices, recalibrate with 2025 diagnoses and 2026 spending data).

We also support CMS's efforts to ensure that audio-only services are excluded from risk adjustment. Excluding audio-only services is important for ensuring the accuracy and reliability of diagnoses submitted for risk adjustment. To this end, CMS has always required that diagnoses included in the CMS-HCC model are made from a face-to-face encounter. Although some audio-only services can be identified by a CPT/HCPCS code, the new audio-only modifier codes introduced in 2022 can be applied to several

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[10] The total per member per month amount of FFS spending projected for physician administered drugs in 2026 dropped by about 2 percent between the 2026 MA rate announcement and the 2027 MA advance notice, which we interpret as primarily due to repricing skin substitutes. See the CMS Office of the Actuary, *Trends supporting 2027 growth rates*: https://www.cms.gov/files/document/trends-supporting-2027-growth-rates.pdf. The timing of data does not allow us to assess the effect on the USPCC for 2025, but it seems reasonable that the effect would be roughly consistent with the relative increase in FFS spending on skin substitutes, or a little less than a 1 percent increase.

CPT/HCPCS codes that are eligible for risk adjustment.[11] Some of the procedures represented by these codes can be provided through multiple places of service, such as in-person visits or via audio-only telemedicine. Given that CMS's proposed risk-adjustment model is calibrated on data after the introduction of the audio-only modifier codes, CMS's proposal to incorporate the new audio-only modifier codes into its "filtering logic" is a necessary step to prevent audio-only services from being inappropriately used as a source of diagnoses for risk adjustment.

We also support CMS's proposal to exclude unlinked chart reviews as a source of diagnoses for risk adjustment. Excluding unlinked chart reviews is an important step for payment integrity. As the OIG and CMS have noted, unlinked chart reviews may not contain sufficient information for CMS to ensure that risk-adjustment-eligibility criteria are being met. Both agencies have found instances where a beneficiary has an unlinked chart review but does not have a record of an encounter during which the medical chart would have been updated to establish new diagnoses. Although improved oversight is a sufficient reason to exclude unlinked chart reviews, we also discuss below how such chart reviews contribute to differences in diagnostic coding between FFS and MA.

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 variables in the model.

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

[11] We compared the list of CPT codes that may be used for reporting audio-only services when appended with Modifier T (found in CPT Appendix A Modifier 93) with the list of risk adjustment eligible CPT/HCPCS codes for 2025 (the most recent year available) and found that 20 risk-adjustment-eligible CPT/HCPCS codes could be appended with Modifier 93 to indicate an audio-only service.

adjustment of about 5.9 percent in 2018, where it will remain until the Secretary implements a risk-adjustment model that uses MA diagnostic data, MA utilization data, and MA plans' cost data.[12] For 2027, CMS proposes to apply an adjustment of 5.9 percent.

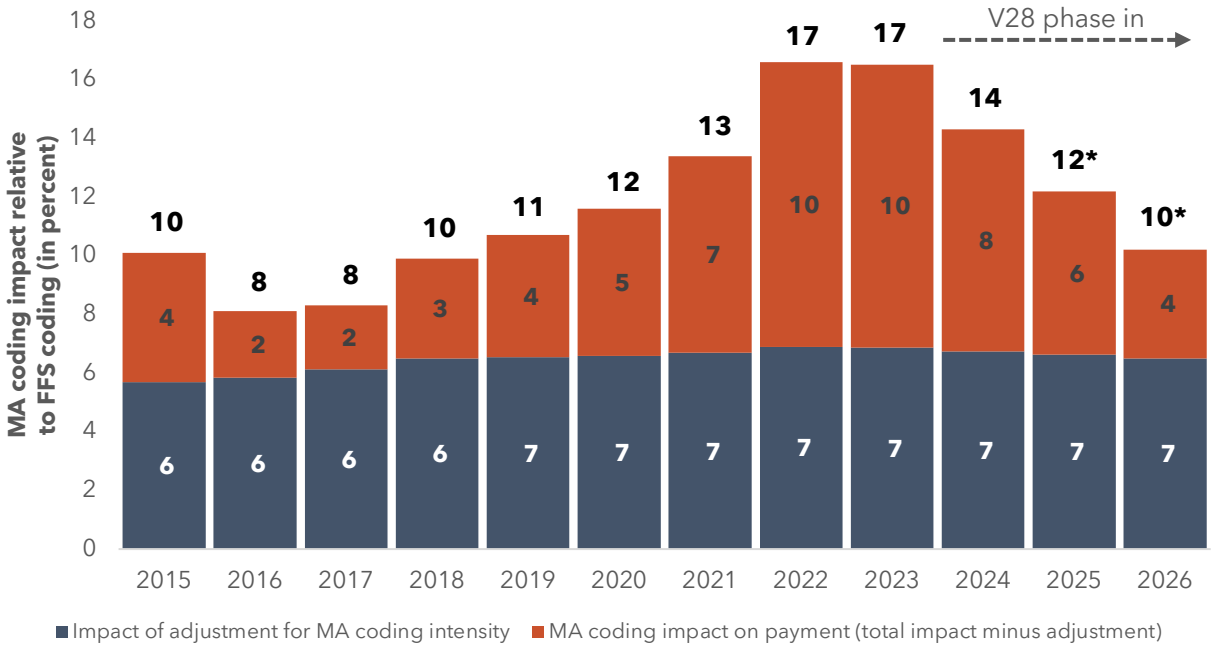
Comment

We support CMS's efforts to reduce overall coding intensity by using a multi-pronged approach that targets the highest-coding MA plans and reduces the competitive advantage that some plans have due to higher coding intensity. Furthermore, the effects of coding intensity have grown so large that an incremental approach to reducing coding intensity is necessary to balance that goal with the goal of maintaining a stable market environment for MA organizations. We applaud CMS for phasing in the V28 risk model over three years and then continuing to pursue policies in the 2027 Advance Notice aimed at reducing overall coding differences between MA and FFS.

For many years, the Commission estimated that MA coding intensity has been rising farther above FFS levels and the 5.9 percent coding adjustment, allowing for tens of billions of dollars in increased payments to MA plans annually. However, we estimate that the V28 risk model has substantially reduced MA coding intensity. For 2024, we estimate an 8.8 percentage point difference in MA coding intensity for the two risk models used to pay MA plans in that year, with coding intensity being lower under the V28 model and higher under the prior V24 model (data not shown in Figure 1). Figure 1 shows the impact of differences in coding intensity on MA risk scores over time 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). Each estimate reflects the risk model(s) used to pay MA plans in that year, which for 2024 was one-third V28 and two-thirds V24 and for 2025 was two-thirds V28 and one-third V24. With the full implementation of the V28 risk model in 2026, we project that MA coding intensity will increase payments to plans by 4 percent after applying the coding adjustment.

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

Figure 1 | Estimated impact of coding intensity on MA risk scores was larger than coding adjustment, 2015–2026



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 impact of the coding adjustment is calculated as the MA coding-intensity estimate relative to FFS, multiplied by the coding adjustment. For 2026, we calculate 1.10 × 5.9 percent = 0.065 or about 7 percent. Components may not sum to totals due to rounding. Coding intensity estimates reflect the risk model(s) used to pay MA plans in each year. The V28 risk model was phased in one-third in 2024, two-thirds in 2025, and completely in 2026.
* For 2025 and 2026, we project coding intensity based on the annual trend from 2023 through 2024 for the V24 risk model, an increase of 0.7 percentage points per year, and account for an estimated –2.9 percentage point annual effect due to the phase-in of the V28 risk model.

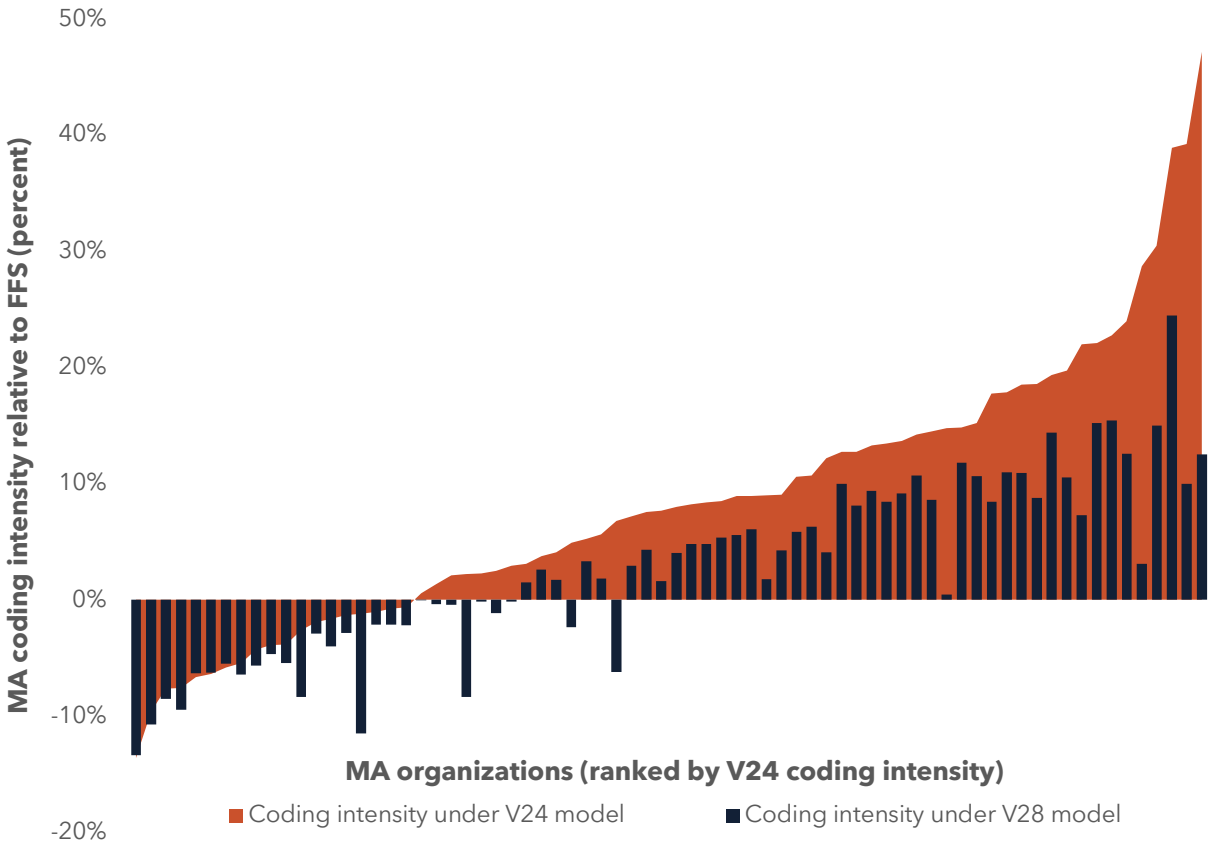
Source: MedPAC analysis of CMS enrollment and risk-score files.

At the same time, the Commission has estimated that coding intensity varies substantially across MA organizations and has voiced concern that the 5.9 percent reduction applied to all MA risk scores does not address these differences. MA organizations with higher coding intensity have a significant competitive advantage, as higher coding intensity results in higher rebates that allow plans to attract more enrollees by offering more extra benefits. Our analysis of newly available risk-score data from 2024 indicates that the V28 model helps to level the playing field by reducing coding-intensity variation across MA organizations.

For 2024, we estimated the difference between coding intensity under the two models across MA organizations. Figure 2 shows that, in 2024, the V28 risk model reduced coding intensity more for organizations with higher V24 coding intensity. The effects are smaller for organizations with lower levels of coding intensity, particularly those with coding

levels below that of FFS. These results suggest that the effects of V28 on coding intensity were relatively targeted to the organizations with the highest levels of coding intensity.

Figure 2 | Coding intensity under the V28 risk model was lower than under the V24 risk model, with larger differences among MA organizations with the highest V24 coding intensity, 2024



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, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees. MA organizations with 25,000 or more enrollees cover about 97 percent of eligible MA enrollment. This analysis compares coding intensity for V24 and V28 risk scores and does not reflect the blending of the two risk models used for paying MA plans in 2024.

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

In the Advance Notice, CMS stated, "We believe that the policies in this Advance Notice, if finalized, will address coding differentials between Medicare Advantage and Original Medicare for CY 2027." We applaud CMS's efforts to reduce overall coding intensity using approaches that target the highest-coding MA plans and reduce the competitive advantage

that some plans have due to higher coding intensity. We note that CMS has taken an incremental approach to reducing overall coding intensity by phasing in the V28 risk model over three years and by proposing to exclude unlinked chart reviews from risk adjustment after full implementation of V28. That exclusion, along with the implementation of a risk-adjustment model calibrated on more recent data, would improve the oversight of the risk-adjustment system and help ensure accurate and fair payments to MA plans.

CMS estimates that removing unlinked chart reviews as a source of diagnoses would reduce MA payments by 1.5 percent. That impact is roughly in line with our most recent estimates of the effect of chart reviews on MA risk scores multiplied by the share of chart reviews that are unlinked. (We have not separately estimated the effects of linked and unlinked chart reviews on MA risk scores.) We estimate unlinked chart reviews make up about 42 percent of all chart reviews in 2023 encounter data.[13]

However, we expect that MA organizations will be able to link most of their unlinked chart reviews in response to this policy. We conducted an analysis to match unlinked chart reviews in 2023 inpatient, outpatient, and physician encounter data files to encounters in the same encounter data file (inpatient, outpatient, or physician). We found that 80 percent of unlinked chart reviews had an encounter record with the same beneficiary identifier and dates of service; 86 percent had an encounter record with the same beneficiary identifier and overlapping dates of service in the same encounter data file. Therefore, we expect that the actual effect of excluding unlinked chart reviews for 2027 payments would be much lower than previously estimated due to the ability of plans to convert unlinked chart reviews to linked chart reviews.

While CMS has made important progress to reduce the effects of coding intensity, we estimate that in 2026, higher MA coding intensity will increase payments to MA plans by about $22 billion and thus remains an important issue. Further, we find that the gap between MA and FFS coding intensity increases annually, and differences in coding intensity across MA organizations continue to allow higher-coding plans to have a competitive advantage. Curbing the effects of MA coding intensity and continuing to reduce coding differences across MA organizations will require additional action.

The Commission has supported addressing the underlying causes of differences in MA and FFS coding practices as a first step to addressing the full effect of MA coding intensity. Our 2016 recommendation would eliminate the use of health risk assessments for risk adjustment.[14] Consistent with the Commission's approach, CMS should consider eliminating linked chart reviews, which are not used in FFS and contribute to differences in MA and FFS coding intensity, from use in risk adjustment. Finally, we note that CMS has successfully reduced differences in coding intensity by removing conditions from the risk model where differences in MA and FFS coding practices suggest that discretionary or inappropriate coding is occurring in conflict with risk-adjustment

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[13] This analysis is based on all chart reviews in the inpatient, outpatient, or physician encounter data files.
[14] See Chapter 12 of MedPAC's March 2016 report (Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC).

development Principle 10.[15,16] We encourage CMS to continue efforts to reduce the effects of discretionary or inappropriate coding.

Prescription drug hierarchical condition category (RxHCC) risk-adjustment model

In Part D, Medicare subsidizes most of the cost of basic drug benefits, with enrollees paying the remainder (about 13 percent, on average, in 2026) through monthly premiums.[17] Medicare's subsidy takes the form of two distinct payments: (1) prospective capitated monthly payments (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 (OOP) 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 account for differences in the expected costliness of each plan's enrollees, direct-subsidy payments are risk adjusted using the prescription drug hierarchical condition category (RxHCC) risk-adjustment 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, sex, and disability status) and certain diagnoses from the prior year to calculate a risk score for each beneficiary. Diagnoses included in the RxHCC model are grouped into condition categories, which are ranked into hierarchies for similar conditions (e.g., diabetes with and without complications). The method for calculating risk scores is similar to the CMS-HCC model. Notably, the sources of diagnostic information used in the CMS-HCC and the RxHCC models are the same, and there is substantial overlap in the diagnoses used in the two models.[18]

Each demographic and RxHCC component in the risk-adjustment model has a coefficient that represents the expected gross plan costs (the portion of gross drug spending for which plans bear insurance risk) associated with that component, which is estimated using Part D's prescription drug event data. These dollar-value coefficients are divided by the average predicted gross plan costs for the Part D basic benefit (across all Part D enrollees) and summed, establishing a 1.0 risk score for an enrollee with average expected costs. (Risk scores are then normalized to account for observed trends in risk-score growth between the calibration year and the payment year, given that the payment year is several

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[15] We estimated that the V22 risk model first introduced in 2014 reduced coding differences between 2 and 2.5 percentage points (see MedPAC's March 2021 report, Chapter 12: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf). CMS stated that they removed certain HCCs from the model introduced in 2014 specifically over concerns about differences in coding (see CMS's 2014 Advance Notice: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2014.pdf).
[16] The V28 risk model specifically eliminated or constrained coefficients of HCCs where coding practices did not align with risk-adjustment development Principle 10 (see CMS's 2024 Advance Notice: https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf). As noted above, for 2024, we estimate a -8.8 percentage point difference on coding intensity under the V28 risk model relative to the V24 risk model (not reflecting the blend of risk models used for payment in 2024).
[17] https://www.medpac.gov/wp-content/uploads/2025/08/Tab-K-Part-D-bids-Jan-2026.pdf.
[18] https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

years after the data year used to calibrate the risk model. CMS uses a regression method to calculate a normalization factor based on historical risk score growth; the RxHCC risk score is divided by this normalization factor, which CMS calculates annually.) Higher risk scores result in higher direct-subsidy payments because beneficiaries with higher risk scores are expected to have higher expenditures; similarly, lower risk scores result in lower direct-subsidy payments.

Because prescription drug events (PDEs) used to develop the RxHCC model are always from years prior to the payment year, for each PDE used for calibrating model expenditures, gross drug costs are reallocated among the plan, the beneficiary, the government, and manufacturers according to the benefit design in the payment year.[19] For example, for the 2026 RxHCC model (the "2026 model"), gross drug costs from 2023 PDEs were reallocated to reflect only costs for which the plan is financially liable under the standard benefit structure in 2026.

The Inflation Reduction Act of 2022 (IRA) 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 differential cost and coding trends between Medicare Advantage Prescription Drug plans (MA-PDs) and stand-alone prescription drug plans (PDPs)[20]—since 2025, CMS has used separate normalization factors for MA-PDs and PDPs to "more accurately reflect Part D costs" in these two markets. These differences 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."[21]

For 2027, CMS proposes to update the RxHCC model to reflect changes to the Part D benefit related to the IRA (the "2027 model").[22] In addition to the IRA-related changes, the agency proposes to make updates and methodological changes to the RxHCC model:

- To reflect more recent years of data[23] by using diagnoses from 2023 FFS claims and MA encounter data records and gross drug costs from 2024 PDE data;

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[19] For modeling, however, "benefit design" does not refer to benefit parameters (e.g., deductible and out-of-pocket threshold dollar values) for the payment year, but instead refers to the cost-sharing proportions for each entity (beneficiary, government, manufacturer, plan) in each phase of the standard Part D benefit (https://www.cms.gov/files/document/2025-advance-notice.pdf).
[20] https://www.cms.gov/files/document/2025-advance-notice.pdf.
[21] https://www.cms.gov/files/document/2025-advance-notice.pdf, https://www.cms.gov/files/document/2025-announcement.pdf, https://www.cms.gov/files/document/2026-announcement.pdf.
[22] For example, the agency proposes to make adjustments to the 2024 PDEs to reflect the lower annual OOP threshold under the IRA's redesign and 2027 amounts for manufacturer discounts, consistent with the statutory phase-in schedule for specified small manufacturers. The agency noted that it would continue to adjust the model to reflect the agreed-upon maximum fair prices (MFPs) for drugs selected under the Medicare Drug Price Negotiation Program with an initial price applicability year (IPAY) of 2026; the agency noted that it was unable to adjust gross drug costs to reflect MFPs for IPAY 2027 drugs because those prices were not available in time for calibration of the 2027 model and anticipates incorporating IPAY 2027 MFPs in future model calibrations.
[23] The 2026 model uses diagnoses from 2022 FFS claims and MA encounter data records and gross drug costs from 2023 PDE data.

- To exclude diagnoses from audio-only services, consistent with the agency's policy related to the CMS-HCC model used to risk adjust payments to MA plans;

- To exclude diagnoses from unlinked chart review records, consistent with the agency's proposed changes to the CMS-HCC model used to risk adjust payments to MA plans for 2027; and

- To separately calibrate the RxHCC model for beneficiaries enrolled in MA-PDs and PDPs within the continuing enrollee model segments and continue the use of separate normalization factors, which would both adjust for differences in risk score trends between the two markets and rescale risk scores to a 1.0 average in each market.

Because average risk scores calculated using the proposed 2027 model for MA-PDs and PDPs continue to exhibit different trends, the agency noted that it will continue to use separate normalization factors for MA-PDs and PDPs, consistent with its approach since the 2025 benefit year. Proposed normalization factors calculated based on the 2027 model (1.109 for MA-PDs and 1.005 for PDPs) are smaller in magnitude compared with those used in 2026 (1.194 for MA-PDs and 0.887 for PDPs).

Comment

It is important for the risk-adjustment model to accurately predict costs for MA-PDs and PDPs to ensure appropriate payments to both plan types, particularly given the findings that "plan costs tended to be overpredicted" for MA-PDs and "underpredicted" for PDPs[24]. The Commission has expressed concerns about the long-term stability of the PDP market and the role that risk adjustment plays in shaping plan payments, premiums, and competitive dynamics.[25]

Use of more recent data and excluding audio-only and unlinked chart reviews

The Commission supports CMS's proposal to base the 2027 model on more recent years of FFS claims, MA encounter, and Part D PDE data, which is an important update that is expected to improve the accuracy of risk adjustment and payments to Part D plans. Incorporating more recent years of data would help adjust for accelerated spending trends that have been more pronounced in certain segments of the Part D population, particularly among beneficiaries without the low-income subsidy (LIS). Recalibration of the risk model with the most recent available data helps to ensure that risk scores reflect the actual coding practices and spending patterns that are most closely aligned with the payment year.

The Commission supports removing diagnoses from audio-only claims. As with the CMS-HCC model, it is important to ensure that audio-only diagnoses are excluded from the RxHCC model. As noted above, audio-only services have never been an allowable source of

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[24] https://www.cms.gov/files/document/2025-advance-notice.pdf, https://www.cms.gov/files/document/2026-advance-notice.pdf.
[25] https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch4_MedPAC_Report_To_Congress_SEC.pdf, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

diagnoses for risk adjustment. Accordingly, the RxHCC model should align with the existing coding guidelines to promote both accuracy and fairness across MA–PDs and between the MA–PD and PDP markets.

The Commission also supports excluding diagnoses from unlinked chart reviews, which is an important step to promote payment integrity and is directionally consistent with our March 2016 recommendation to first address the underlying causes of coding differences and then to apply a coding adjustment that fully accounts for any remaining differences in coding between FFS and MA plans not accounted for by the risk-adjustment model.[26] As noted above, unlinked chart reviews may not contain sufficient information for CMS to ensure that risk-adjustment-eligibility criteria are being met. To the extent that the use of unlinked chart reviews varies across MA–PDs, their inclusion could contribute to inaccuracies in risk-adjusted payments across MA–PDs. In addition, because such chart reviews are not used on FFS claims, their use contributes to differences in diagnostic coding between FFS and MA.

In general, as we reported in our June 2025 report, there is a high degree of overlap in diagnoses used for risk adjustment in Part C and Part D.[27] This is because the sources of diagnostic information used in the CMS–HCC model and the RxHCC model are the same. For each of the years between 2019 and 2023, we found that about 82 percent of the diagnoses used in the RxHCC model were also used in the CMS–HCC model. Given this overlap, the inclusion of diagnoses from audio-only services and unlinked chart reviews could affect Part D risk scores for MA–PDs in a manner similar to their effects in Part C, potentially contributing to higher coding intensity observed among MA–PDs. In our analysis, the Commission also documented systematic differences in coding intensity between MA–PDs and PDPs.

Separate calibration and continued use of separate normalization factors for MA–PDs and PDPs

The Commission supports separately calibrating the RxHCC model for MA–PDs and PDPs, which is expected to improve the model's ability to predict spending by accounting for potentially different relationships between coded diagnoses and spending between PDP and MA–PD enrollees. In our June 2025 report, we documented diverging trends in risk scores and gross drug costs for MA–PDs and PDPs over the 2012–2023 period.[28] That analysis also found that, during the 2019–2023 period, risk-standardized costs—defined as gross costs divided by risk scores—were, on average, lower for MA–PDs than for PDPs. These findings suggest potential inaccuracies in earlier risk-adjustment models that did not separately calibrate or separately normalize for the two plan types. The analysis identified differences in coding intensity between MA–PDs and PDPs as one source of inaccuracy. For example, we estimate that in 2023, MA–PD risk scores under the RxHCC model were 7.6 percentage points higher than PDP risk scores due to differences in coding intensity, in

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[26] 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.
[27] https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch4_MedPAC_Report_To_Congress_SEC.pdf.
[28] https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

aggregate. However, those differences did not fully explain the observed differences in risk-standardized costs, indicating that other factors likely also played a role.

The Commission previously expressed support for CMS's use of separate normalization factors under a model that was calibrated on the entire Part D population as a way to address concerns raised by diverging risk-score trends in the two markets.[29] However, we also encouraged CMS to explore additional approaches to improving risk adjustment, because separate normalization is a relatively blunt tool that does not account for differences in diagnoses or spending patterns that may arise due to variations in coding intensity or utilization between MA–PD and PDP enrollees. We appreciate that CMS is proposing such an approach that takes those differences into account by separately calibrating the model. Separately calibrating the risk model is a more precise way to improve the predictive accuracy of the risk model, compared to the use of separate normalization alone.

CMS's proposal to continue using separate normalization factors under a separately calibrated model has two implications. First, using separate normalization factors would adjust for differences in risk-score trends between the two markets. The Commission has consistently found that MA coding intensity increases over time relative to FFS coding intensity under the CMS–HCC risk model used to adjust Part C payments. Consistent with those findings, we estimated that the difference between MA–PD and PDP coding intensity under the RxHCC model increased between 2019 and 2023, from 4.7 to 7.6 percentage points. Using separate normalization factors would help address the growing gap between MA–PD and PDP coding intensity over time. Second, using separate normalization factors rescales MA–PD and PDP risk scores to a 1.0 average in each market. That rescaling assumes that the overall level of absolute spending risk is the same in the two populations, which may not always be the case.

In general, the use of separate normalization factors presents a tradeoff: While it mitigates the effects of differential trends in coding intensity in the two markets, it may also introduce a different source of inaccuracy. Applying separate normalization factors to MA–PD and PDP enrollees (such that the average risk score for each plan type equals 1.0) implicitly assumes that the average MA–PD enrollee has the same level of absolute spending risk as the average PDP enrollee. However, that may not be the case if there are differences in the populations of beneficiaries enrolled in the two plan types. For example, drug spending may differ because of differences in health status or demographic characteristics between the two enrollee populations. One way to address this concern would be to incorporate a demographic adjustment to the separate normalization factors, which would allow average risk scores between the two populations to differ if they had different demographic profiles (such as LIS eligibility and age). Our analysis of data from 2019 to 2023 indicates that inaccuracies from demographic differences would be modest under recent enrollment patterns. However, those inaccuracies could become larger over time if enrollment patterns change.

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[29] https://www.medpac.gov/wp-content/uploads/2025/02/02102025_MA_PD-AN-CY-2026_MedPAC_COMMENT_v2_SEC.pdf.

Ensuring accurate normalization between the two markets is important because changes in Part D risk scores primarily have distributional rather than budgetary effects. Plans with higher risk scores, conditional on their enrollees' underlying risk, receive higher payments from Medicare, which can translate into lower premiums for beneficiaries and a competitive advantage in the market. However, those higher payments come at the expense of other plans that receive lower risk scores, conditional on their enrollees' underlying risk.

The Commission therefore encourages CMS to continue to explore ways to reduce inaccuracies in risk adjustment, with the goal of improving the fairness of payments to all Part D plans. This work is important because, even with the adoption of separate models, other concerns related to risk adjustment would remain. In particular, higher payments to MA–PDs with higher coding intensity than other MA–PDs would continue to be an issue because the models would be calibrated using all PDEs within each market. In interviews conducted with Part D actuaries, we also heard concerns about the persistence of risk selection within the PDP market.[30] That is, to the extent that coding practices and underlying risk profiles vary across plans within the same plan type, discrepancies between risk-adjusted payments and payments that accurately reflect enrollees' underlying risk would continue under separate models.

We also encourage CMS to explore whether it would be feasible to base the model on net costs (after accounting for postsale rebates and discounts), which could lead to a more accurate model. In doing so, CMS may need to assess whether use of net cost may disadvantage plans with disproportionately less access to rebates.

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

[30] https://www.medpac.gov/wp-content/uploads/2025/08/Tab-K-Part-D-bids-Jan-2026.pdf.