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Humana

March 1, 2024

Dr. Meena Seshamani, M.D., Ph.D., Deputy Administrator and Director, Center for Medicare
Ms. Jennifer Lazio, F.S.A., M.A.A.A., Director, Parts C & D Actuarial Group,
Office of the Actuary, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted electronically via regulations.gov

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Seshamani and Ms. Lazio:

This letter is in response to the "Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" issued by the Centers for Medicare & Medicaid Services (CMS) on January 31, 2024.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves approximately 5.9 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.9 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As one of the nation's top contractors for MA, we are distinguished by our long-standing, comprehensive commitment to Medicare beneficiaries across the United States. These beneficiaries – a large proportion of whom depend upon the MA program as their safety net – receive integrated, coordinated, quality, and affordable care through our plans. Our perspective is further shaped by the comprehensive medical coverage we provide for Medicaid beneficiaries in seven states.

While we have provided more detailed comments below, we wanted to briefly share several of our key recommendations.

Summary of Humana's Key Issues and Recommendations

- **Normalization Factor:** While Humana appreciates CMS's commitment to the three-year phase-in of the CY 2024 risk adjustment model (v28) and the Agency's efforts to revise the normalization methodology to address the unique challenges related to COVID-19, we have serious concerns about the proposed normalization methodology. We strongly urge CMS to consider alternative modeling approaches to project 2025 Fee-for-Service (FFS) risk scores for

both 2020 (v24) and 2024 (v28) models in the development of normalization factors. We believe that the proposed methodology for determining 2025 normalization factors fails to achieve CMS's stated policy objectives of giving a reasonable 2025 FFS risk score projection and achieving payment accuracy for MA organizations. In our comments, we propose three effective modeling strategies for CMS to consider when selecting a 2025 normalization methodology – all of which would effectively mitigate the impact of the anomalously low 2021 FFS risk score. We also offer two potential alternative methods, as examples, that illustrate how adopting key enhancements will improve the model and ensure more accurate payments.

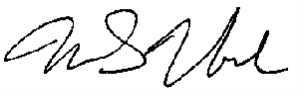
- **Growth Rate:** Humana acknowledges CMS's continued effort to improve the level of detail regarding the methodology and components of the projected USPCCs and growth rates. However, we are concerned that CMS's proposed growth rate does not accurately reflect utilization increases for covered services. Humana asks that CMS provide additional details on the information and analyses used to draw their conclusions.

- **Part D:** Humana commends CMS's proposal to use more current data for calculating the RxHCC model. To further promote stability in the Part D program, we encourage CMS to exercise its demonstration authority to test whether temporarily narrowing the statutorily established risk corridors would allow the Part D program to better maintain robust formulary coverage, ensure stable premiums, and reduce the number of Low-Income Subsidy (LIS) reassignments.

We hope that you consider our comments as constructive feedback aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to beneficiaries, focused on improving their total health care experience.

If you have any questions, please do not hesitate to reach out to me at mhoak@humana.com and 571-466-6673.

Sincerely,



Michael Hoak
Vice President, Public Policy

2025 Medicare Advantage and Part D Advance Notice Fact Sheet

Frequently Asked Questions (FAQs) on the 2025 Medicare Advantage and Part D Advance Notice
In the FAQs, CMS provides a combined estimated payment impact due to Risk Model Revision and FFS Normalization of -2.45%.

> **Humana Comment:** Humana appreciates CMS's transparency in breaking out the -2.45% Risk Model Revision and FFS Normalization impact into their distinct components. However, we were not able to replicate the -4.44% model phase-in impact and are concerned that this impact may be understated. Understating the model phase-in impact may have implications for other impacts shown in the Fact Sheet (e.g., expected average change in revenue). So that stakeholders may fully understand these significant changes, **Humana urges CMS to provide additional transparency in the derivation of the +1.99% normalization factor and -4.44% risk adjustment model phase-in impacts.**
>
> In particular, Humana requests:
>
> - The specific calculation, including values, used to derive the +1.99% normalization impact.
> - The specific calculation, including values, used to derive the -4.44% risk model phase-in impact.
> - Which payment year(s) of raw risk scores is (are) used to compute the -4.44% impact.
> - CMS's method for trending the raw risk scores to 2025 to assess the impact of 2025 proposed model blending.
> - If CMS is not trending raw risk scores to 2025, Humana requests that CMS provide the rationale for this approach.
>
> In the CY 2025 Advance Notice Fact Sheet, CMS provided a combined estimated payment impact due to Risk Model Revision and FFS Normalization of -2.45%.[1] In FAQ #11, CMS provided impacts due to raw risk adjustment model phase-in (-4.44%) and FFS normalization (+1.99%). In Attachment V, Section A3 of the CY 2025 Advance Notice, CMS states "The CY 2025 impact on MA risk scores of the proposed blended Part C CMS-HCC models, relative to the blend in CY 2024, is projected to be -2.45%."[2]
>
> In terms of normalization, which will be addressed in section K of this document, we note that the proposed normalization factors for 2025 will result in a reduction to risk scores of -0.61% in the v24 model and -2.87% in the v28 model.[3] The derivation of the +1.99% noted in the fact sheet is misleading on the surface, as it appears to include the impact of shifting from 33% v28 in 2024 to 67% v28 in 2025. Despite this fact, we generally understand the methodology CMS appears to be using and can closely replicate the computation used to compute the +1.99% impact.[4] Conversely, our attempts to reproduce the -4.44% impact due to raw risk adjustment

[1] https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet
[2] https://www.cms.gov/files/document/2025-advance-notice.pdf
[3] v24 2025 normalization impact = -0.61% = (1.146/1.153) – 1. v28 2025 normalization impact = -2.87% = (1.015/1.045) - 1
[4] Humana attempted to replicate the +1.99% impact using 2024 applied normalization factors and 2025 proposed normalization factors and arrived at +2.04%. Specifically, we computed blended 2024 and 2025 normalization

model phase-in have been unsuccessful and we are unclear on the method used by CMS to calculate this impact.

Humana attempted to reproduce the -4.44% impact using publicly available data. Milliman's February 2023 "High-level impacts of the proposed CMS-HCC risk score model on Medicare Advantage payments for 2024," presents, in Figure 1, raw MA risk scores for payment year 2020 at 1.275 for v24 and 1.108 for v28.[5]

FIGURE 1: RISK SCORE MODEL IMPACT BY PLAN TYPE – BASED ON 2019 DIAGNOSES

Plan Type	Member Months	Raw Current Risk Scores	Raw Proposed Risk Scores	2023 Norm Risk Scores	Proposed 2024 Norm Risk Scores	Model Impact
Medicare Fee-for-Service	362,166,961	1.108	1.026	0.983	1.011	2.8%
Medicare Advantage						
General Enrollment	189,292,118	1.192	1.040	1.058	1.025	-3.1%
EGWP	54,550,644	1.183	1.049	1.050	1.033	-1.6%
D-SNP	32,667,568	1.771	1.502	1.572	1.480	-5.8%
C-SNP	4,064,389	1.989	1.593	1.765	1.570	-11.1%
I-SNP	891,632	2.899	2.563	2.572	2.525	-1.8%
MA Total	281,466,351	1.275	1.108	1.131	1.092	-3.5%
Grand Total	643,633,312	1.181	1.062	1.048	1.047	-0.1%

Blending these raw risk scores by the CY 2024 applied ratio (67% for v24, 33% for v28) and the CY 2025 proposed ratio (33% for v24, 67% for v28) results in risk scores of 1.220 and 1.163, respectively. The percentage change of these two blended raw risk scores is -4.65%, which is reasonably close to CMS's published estimate of -4.44%.

While CMS is likely using a more current payment year than 2020 to arrive at the -4.44% impact, it is unlikely CMS is using trended 2025 raw risk score data to assess the impact because (1) the impact was close to -4.44% using payment year 2020 MA risk scores and (2) CMS estimates diverging MA risk score trend for v24 vs. v28 model risk scores from 2023 through 2025.[6] If this hypothesis that CMS is not using 2025 trended risk scores is true, then CMS's estimated -4.44% impact is understated simply based off CMS's own published information on MA risk score trend.

Based on CMS published documents, we know there is diverging MA risk score trend between the v24 and v28 models. CMS notes in Attachment II, Section G of the CY 2025 Advance Notice that annual average MA risk score trend from 2018 to 2020 was 5.0% for the v24 model and 3.3% for the v28 model. CMS is assuming these trends as part of their 2025 payment impact (blended impact of 3.86%) and assumed these trends as part of their final 2024 payment impact (blended impact of 4.44%), as noted in the 2024 Rate Announcement Fact Sheet.[7] As we will

factors equal to 1.103 and 1.081 (rounded to three decimal places) and then computed the payment impact as: (1/1.081)/(1/1.103) – 1 = +2.04%. While not exactly equal to 1.99%, it is reasonably close.

[5] https://www.milliman.com/-/media/milliman/pdfs/2023-articles/2-28-23_2024-proposed-cms-hcc-model-impact.ashx

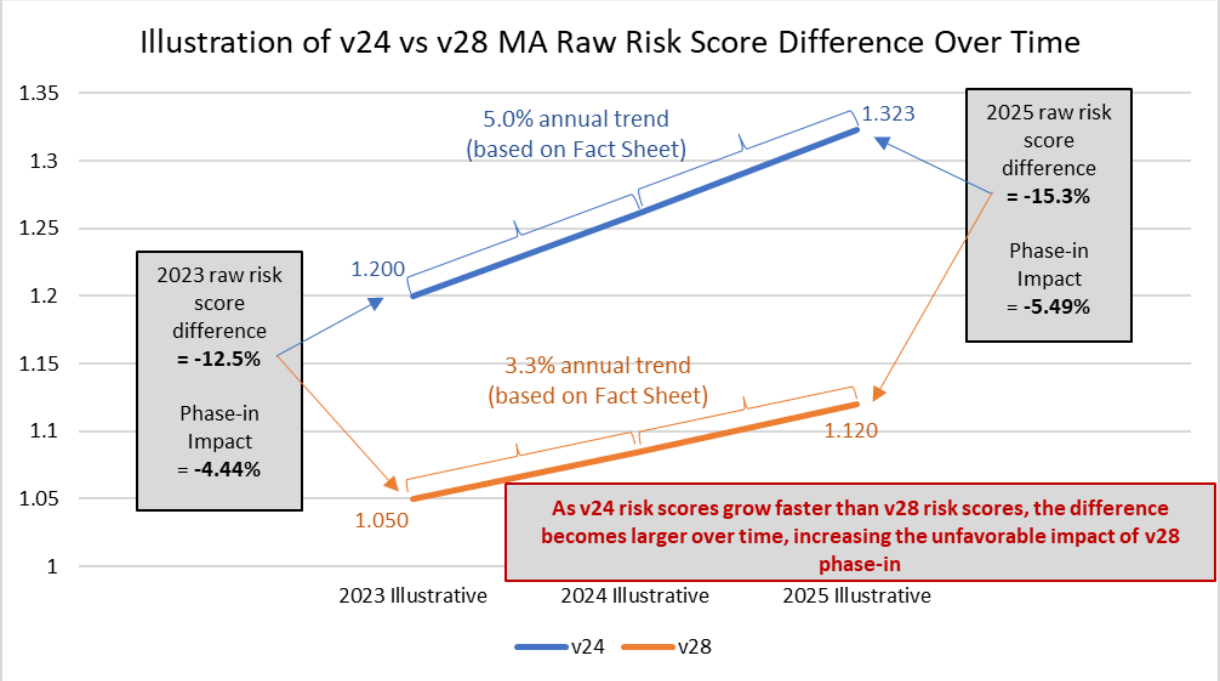
[6] We believe this because CMS provided payment year 2021 risk scores to MA plans to assess the impact of the v28 model as part of the 2024 Rate Notice cycle.

[7] https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement

illustrate below, the widening gap between v24 and v28 risk scores over time results in a larger negative impact of model phase-in.

To demonstrate the concern mentioned above, we set up the following illustrations by assuming that the -4.44% phase-in impact is based on payment year 2023 raw risk scores and is computed by taking CY 2025 blending ratio of 2023 raw risk scores divided by CY 2024 blending ratio of 2023 raw risk scores minus one.[8] This implies that the total percentage difference between v24 and v28 raw risk scores in 2023 is -12.5%. Using the CMS published annual trends of 5.0% for v24 and 3.3% for v28 to trend each respective model's risk score forward to 2025, the percentage difference between v24 and v28 risk scores grows to -15.3%, resulting in a phase-in impact of -5.49%.[9] Note that had we assumed the -4.44% impact was based on an earlier time period's risk scores for this illustration, the phase-in impact would be even greater than -5.49% because of the divergent risk score trend between models.

Fig. 1.1 Illustration[7] of v24 vs v28 MA Raw Risk Score Difference Over Time



In figure 1.2, we are providing an illustrative example of our concern in the format of the CMS advance notice fact sheet.

[8] We arbitrarily set payment year 2023 v24 model risk score to 1.200 and solved for v28 model risk score using the following formula: v28 risk score = [(v24 risk score*(1-.0444)*.67)-(v24 risk score*.33)] / [0.67-(1-.0444)*.33] = 0.8748*v24 risk score. The arbitrary selection of v24 risk score has no impact on our analysis.

[9] -5.49% phase-in impact = [(1.323*0.33 + 1.120*0.67)/(1.323*0.67 + 1.120*0.33)] - 1

Fig 1.2 Illustration of Restated Fact Sheet, if v28 Impact missing 2 years of MA risk score trend

Impact	2025 CMS Advance Notice Fact Sheet	Restated, If missing 2 Years of Trend
Effective Growth Rate	2.44%	2.44%
Rebasing/Re-pricing	TBD	TBD
Change in Star Ratings	-0.15%	-0.15%
MA Coding Pattern Adjustment	0%	0%
Risk Model Revision and FFS Normalization	-2.45%	-3.50%
Risk Model Revision (v28 @67%)	***-4.44%***	***-5.49%***
Normalization	*1.99%*	*1.99%*
MA risk score trend	3.86%	3.86%
Expected Average Change in Revenue	**3.70%**	**2.65%**
Change to Fact Sheet		-1.05%

If our hypothesis of CMS not using trended 2025 MA risk scores to assess the impact of risk adjustment model phase-in is true, then there is a disconnect with how the normalization impact to payment is being calculated. We believe that CMS is computing the +1.99% normalization impact by comparing blended 2024 applied normalization (1.103) to blended 2025 proposed normalization (1.081). This is appropriate and uses "trended" 2024 and 2025 FFS risk scores to compute the impact. The impact due to risk model phase-in also must use trended 2025 MA risk scores to properly compute the impact, otherwise there is a disconnect in how overall MA revenue growth for 2025 is being assessed, ultimately leading to an overstatement in the MA revenue growth projection.

Humana affirms the importance of CMS providing stakeholders with accurate estimates of MA revenue growth and component drivers of that growth. To that end, and stated previously, **Humana requests transparency on the methodology, assumptions, and data sources for CMS's calculations underpinning the Risk Model Revision and FFS Normalization estimates** to enable stakeholders to replicate CMS's calculations and offer meaningful comment. Based on the available information, Humana is concerned that CMS is understating the -4.44% impact to raw risk adjustment model phase-in by not using trended 2025 MA risk scores, which in turn is overstating the projected MA revenue growth for 2025 payment.

Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2025

<u>Section C. USPCC Estimates</u>

CMS estimates that the FFS Non- End-Stage Renal Disease (ESRD) USPCC growth percentage will be 2.57%, the total national per capita MA growth percentage will be 1.98%, and the Dialysis only USPCC growth rate is 3.12%.

Humana Comment: Humana thanks CMS for its continued effort to improve the level of detail regarding the methodology and components of the projected USPCCs and growth rates. With respect to the FFS USPCC growth percentage of 2.57%, we note that the -1.17% restatement of prior years is mostly driven by a 3.7% decrease in the 2022 to 2023 Part A FFS USPCC trend and a 1.8% decrease in the 2023 to 2024 Part B FFS USPCC trend.

On the February 22, 2024 Actuarial User Group Call, CMS explained that the 2024 Part B FFS USPCC trend is down 1.86% primarily due to a new assumption that outpatient utilization will not return to pre-pandemic levels.[10] This assumption seems to conflict with recent commentary from publicly-held hospital companies, who reported strong fourth quarter 2023 results due to continued volume strength and that inpatient and outpatient volumes are expected to grow between two and four percent in 2024. Also, we noticed that the increase in the 2023 to 2024 Part B FFS USPCC is projected to be under 4%[11] while the 2024 Medicare Part B premium[12] is increasing nearly 6%. **Humana asks that CMS provide additional details on the information and analyses used to update the assumptions supporting the revised 2024 Part B trend projection.**

We also observe that CMS projects 2024 and 2025 FFS USPCC trends to be the lowest trend experienced since 2017, excluding 2020. However, as shown below, a review of non-hospice expenditures incurred through November 2023 in the January 2024 ACO REACH National Reference Population file indicate that fourth quarter trends are coming back up and the lower trends seen in the third quarter are not continuing.

January 2024 National Reference Population Data Report

Quarterly PMPM trends for Aged Population (excludes ESRD)

Expenditures incurred through November 2023, paid through January 2024

CY 2023	Q1	Q2	Q3	Oct-Nov
Part A	3.8%	4.7%	-0.5%	0.6%
Part B	11.0%	9.4%	8.3%	10.6%
Part A + Part B	7.6%	7.4%	4.5%	6.3%

These results are consistent with recent announcements from publicly-held hospital companies and MA payers that fourth quarter 2023 volumes are higher than anticipated and it is expected that the elevated utilization will persist through 2024. Given the historically low projected USPCC trend, Humana is concerned CMS may be extrapolating off the third quarter 2023 trends to set their projections and the assumptions supporting 2024 and 2025 may not be actuarially sound in light of this other data supporting higher trends. Therefore, **we request that CMS provide details on the development of their assumptions for the FFS USPCC projections as well as a breakout of 2024 and 2025 FFS unit cost, utilization, and normalized trend assumptions by service category.**

Additionally, Humana notes that on the January 31, 2024, stakeholder call following the Advance Notice publication, CMS commented that the data supporting the USPCCs was through September 2023. Humana requests that CMS please explain if and how emerging experience is factored into the development of the projection factors that support the USPCCs. **We strongly encourage CMS to account for emerging experience, including fourth quarter 2023,** when

[10] https://www.cms.gov/files/document/cy-2025-actuarial-bid-questions.pdf (2/22/2024, Topic #11)

[11] Derived from Table I-5 (Comparison of Current & Previous Estimates of FFS USPCC – Non-ESRD) of 2025 Advance Notice

[12] CMS Fact Sheet: 2024 Medicare Parts A & B Premiums and Deductibles

setting their projection factors for the CY 2025 USPCCs given 2023 ACO REACH experience through November indicates fourth quarter 2023 trends are coming back up.

For 2024, it is unclear whether the 2024 Rate Announcement used actual experience incurred through third or fourth quarter 2022. In the "Narrative supporting 2024 growth rate," CMS Office of the Actuary (OACT) states that the "projections supporting RA 2024 are based on incurred experience through September 30, 2022 and cash activity through December 31, 2022."[13] However, on page 42 of the 2024 Rate Announcement, OACT's response to a question about the factors contributing to the revised projections stated "The CY 2022 non-ESRD FFS USPCC is lower in the CY 2024 Advance Notice and CY 2024 Rate Announcement due to reflection of actual incurred experience through 3rd quarter 2022 in the CY 2024 Advance Notice and through 4th quarter 2022 in the CY 2024 Rate Announcement..."[14] **Humana asks for CMS to confirm whether the FFS and Total USPCCs in the 2024 Rate Announcement were based on actual experience incurred through 3rd quarter or 4th quarter 2022. We further request that CMS clearly state whether the CY 2025 Rate Announcement uses actual experience incurred through 3rd quarter or 4th quarter 2023.**

Humana encourages CMS to continue taking steps to improve the level of transparency related to the data, methodologies, and assumptions supporting the development of the USPCCs and county benchmarks. For example, **when publishing the Advance Notice, CMS should disclose the incurred and paid through dates of the data supporting the USPCCs and any expected updates to the data supporting the Final Notice.**

Lastly, with Part B drug spending continuing to rapidly increase, **Humana requests that CMS explain their Part B drug projection methodology in more detail.** On the April 20, 2023 Bid Actuarial User Group call, CMS commented that projection factors for Part B drugs are based on historical trends.[15] We ask that CMS provide more details about their methodology, including at what level of detail projections are calculated (e.g., by drug class), which historical trends are used to project costs, and whether more weight is put on recent utilization and cost trend. We further request that CMS explain how new to market drugs are accounted for in the projections and what criteria they use to determine whether a new to market drug or class of drugs will have an impact on Part B FFS spending.

Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2025

Section B. Calculation of Fee for Service Cost

B2. AGA Methodology

For Puerto Rico, CMS will continue to include five years (2018-2022) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim.

[13] Key Components of United States Per Capita Cost (USPCC) Trends: 2020-2024 (cms.gov)

[14] Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (cms.gov)

[15] Advance Questions from actuarial-bids@cms.hhs.gov for OACT User Group Calls

Humana comment: Humana supports the continuation of adjusting the FFS calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Parts A and B.

B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico

CMS is considering whether the adjustment for the FFS experience of beneficiaries enrolled in Puerto Rico reflecting the nationwide propensity of beneficiaries with zero claims should be applied for 2025.

Humana comment: Humana appreciates CMS's ongoing efforts to improve the ratebook development methodology, and we recommend that CMS apply a similar adjustment for 2025.

CMS proposes to continue using the methodology of including five years of FFS experience for MA benchmarks in Puerto Rico, believing this methodology mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons and providing stability in the rates. CMS is also seeking comments on any alternative adjustment approaches that may be appropriate.

Humana comment: Humana appreciates CMS's consideration of public input and suggestions regarding methodological changes that may be appropriate. Humana supports using five years of FFS experience for each county as a way to mitigate annual fluctuations and anomalies in the data.

Section C. Adjustments to the AGAs

Section C3. IME Phase Out

CMS proposes to revise the data and methodology used to develop the DGME and IME carveouts for hospitals participating in the Maryland Total Cost of Care (TCOC) model.

Humana comment: Humana thanks CMS for its efforts to improve the level of detail regarding the methodology and components of the FFS cost calculation. It is unclear whether the technical update to Medical Education Payments in the Non-ESRD USPCC baseline reflects a similar change in data and methodology. If not, we request that CMS provide additional details as to why this methodology is preferred over the methodology that was implemented last year using the hospital cost reports to determine the USPCC technical adjustment. We also ask that CMS detail whether the agency has performed a reconciliation of the two adjustments to demonstrate the two methods are consistent, and if so, report the outcomes.

Section D. MA ESRD Rates

CMS is proposing to continue to apply in large part the same methodology as in previous years in calculating the MA ESRD state rates for CY2025.

Humana comments: We request that CMS provide additional detail and insight into the historical restatements of the ESRD-Dialysis USPCC. On the February 22, 2024, Actuarial User Group Call, CMS stated part of the restatement was due to removal of an assumption that dialysis utilization will return to pre-2020 levels. Humana requests that CMS please explain the change in utilization assumptions between pre and post COVID levels given the clinical need for consistency in dialysis treatment.

Section F. MA Employer Group Waiver Plans (EGWPs)

F1. Bid-to-Benchmark Ratio

CMS intends to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2025. CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2023 Rate Announcement. In 2025, CMS proposes to use bid-to-benchmark ratios based on 2024 bids and weighted by February 2024 enrollment. CMS also published preliminary bid-to benchmark ratios for EGWPs in this Advanced Notice.

> **Humana comment:** Humana supports the agency's proposal to continue using the CY 2024 MA EGWP payment methodology in CY 2025.
>
> Additionally, we support and appreciate OACT's inclusion of preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice. We recognize that changes may result to the final ratios through updating from January to February enrollment, but we believe that using January enrollment data to determine preliminary ratios has provided plans with valuable information. EGWP negotiations with employer groups often occur well before the publication of the April rate announcement. We believe that having this information in February will greatly help in creating the most accurate benefit and premium quotes for our members.

F2. MA Rebates and Part B Premium Buy-Down

For 2025, CMS will continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

> **Humana comment:** We strongly support CMS's proposal to allow MA EGWPs to reduce beneficiary costs by buying down Part B premiums, as this will lead to more consistency between individual and group MA plans.

CMS reiterates that MA EGWPs will be subject to the same maximum Part B buydown amount as non-EGWP plan and that the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. As such, the MA organization must establish two separate EGWP plan IDs, each with the specific buy-down amount, if the MA organization intends to reduce Part B premiums by different amounts for different employer groups.

> **Humana comment:** Group quoting occurs throughout the year, with the arrangements typically finalized after the initial submission of plan benefit packages (PBPs) in June. A component of these arrangements has been the Part B buy-down amount. Given the uncertainty around which Part B buy-down amount may ultimately be agreed upon between the group client and the plan, multiple PBPs are filed with only differing Part B buy-down amounts. To reduce the number of PBPs, Humana recommends that CMS establish a process using segment ID to facilitate additional flexibility with Part B buy-downs. Each segment ID would correspond to the amount of Part B buy-down, established as a whole dollar, up to the same maximum Part B buy-down amount as non-EGWP plans. However, a PBP for each unique segment ID would not be filed (only the segment "XYZ" would be filed). This would allow EGWP carriers to offer a range of Part B buy-down amounts, without having to file additional PBPs.

Humana understands that there may be system limitations or other operational considerations in pursuing this option, and we stand ready to partner with CMS to determine and implement the necessary changes to facilitate the implementation of this proposal for the upcoming plan year.

Section K. Normalization Factors

For CY 2025, CMS is proposing a significant change to the calculation of all FFS normalization factors for CMS-HCC models, using a multiple linear regression methodology. The proposed methodology incorporates historical FFS risk scores from the most current five years of average FFS risk scores (2019-2023) and includes a flag that identifies whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic in 2020. FFS risk scores prior to 2021 are considered "pre-COVID-19" and those from 2021 onward are "post-COVID-19." CMS proposes to also continue the phase-in of the 2024 CMS-HCC risk adjustment model, calculating CY 2025 risk scores as a blend of the 2020 CMS-HCC (33%) and 2024 CMS-HCC (67%) models' risk scores and proposes to continue to use the 2023 ESRD risk adjustment models to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

Humana Comment: Humana appreciates CMS's commitment to the three-year phase-in of the CY 2024 risk adjustment model (v28) announced in the CY 2024 Rate Notice. Humana also supports CMS's efforts to revise the normalization methodology to address the unique challenges related to COVID-19. However, **Humana has serious concerns about the proposed normalization methodology and strongly urges CMS to consider alternative modeling approaches to project 2025 FFS risk score for both the 2020 (v24) and 2024 (v28) models in the development of normalization factors.** Humana believes that the proposed methodology for determining 2025 normalization factors fails to achieve CMS's stated policy objectives of giving a reasonable 2025 FFS risk score projection and achieving payment accuracy for MA Organizations.

Humana agrees with CMS on the need for improvements in the methodology for developing normalization factors, recognizing that COVID has presented unique challenges to examining morbidity trends. We applaud CMS's willingness to explore novel methods, such as multiple linear regression, to effectively utilize the most current available data. We are also appreciative of CMS's eagerness to receive feedback from the public on their approach. Humana agrees with CMS that the main objectives of the normalization factor methodology should be 1) to ensure that the 2025 FFS risk score projections are reasonable and 2) to achieve payment accuracy. Nonetheless, we have significant concerns that the proposed methodology will not achieve these objectives. We encourage CMS to adopt more rigorous methods in evaluating the appropriateness of their model when selecting among various modeling alternatives.

Our comments that follow are intended to:

- Demonstrate that, if implemented as proposed, the proposed 2025 CMS normalization methodology results in an overprediction of 2025 FFS risk scores due to the anomalously low 2021 FFS risk score.
- Offer a data-driven framework CMS should consider when evaluating the reasonability of normalization methodology alternatives.

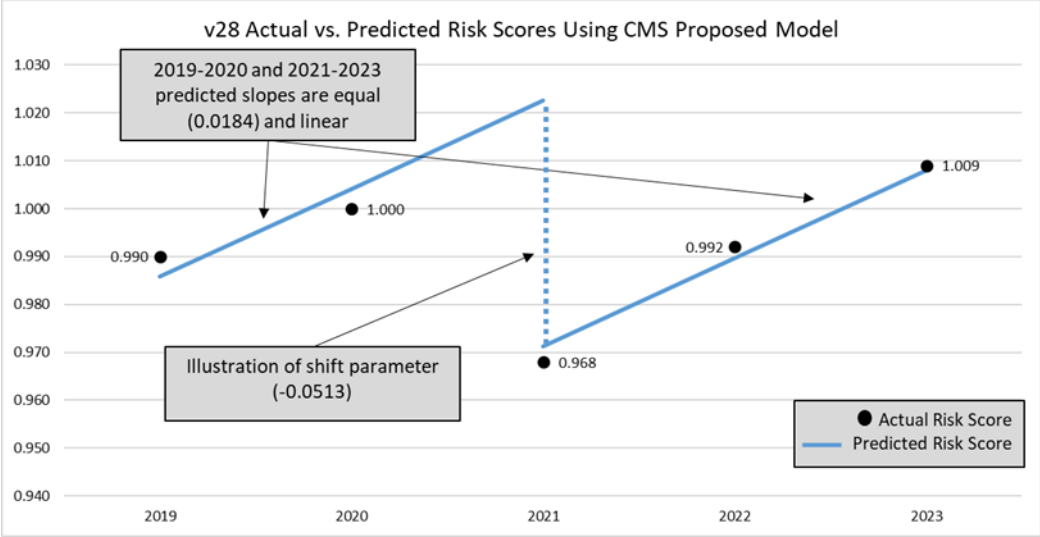
- Propose three effective modeling strategies CMS should consider when selecting a 2025 normalization methodology that effectively mitigate the impact of the anomalously low 2021 FFS risk score.
- Offer two potential alternative methods, as examples, that illustrate how adopting key enhancements will improve accuracy and ensure more accurate payments.

Overview of the Proposed Model

The model proposed by CMS within the Advance Notice utilizes a multiple linear regression approach with three parameters: the intercept (β0), slope (β1) and shift (β2). In this modeling approach, the β0 and β1 parameters operate in the conventional way that simple linear regression works. The "shift" parameter (β2), as outlined within the Notice, effectively allows a one-time break in the regression line, beginning in 2021 payment year.

Humana observes some important features of this proposed modeling approach. First, this methodology forces a linear relationship between the input data and the target prediction for both pre-COVID and post-COVID time periods. Second, the linear relationship for both pre-COVID and post-COVID time periods is fixed at the same slope, ensuring that the model predicts the exact same rate of risk score growth in both pre- and post-COVID periods.

Fig. 1.1[16]

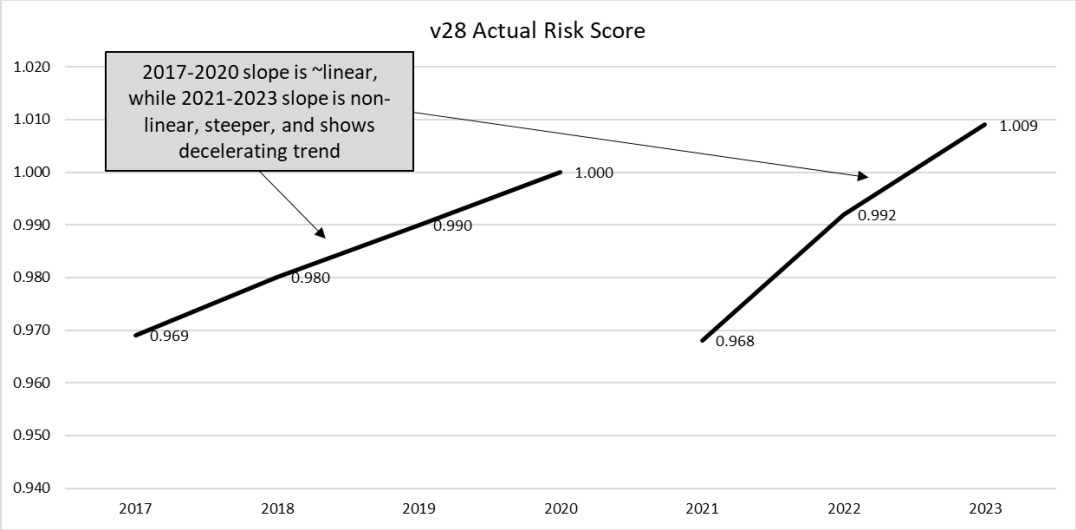


Visual inspection shows that the proposed model's structure does not align well to the input data

In evaluating the appropriateness of the proposed model, Humana began by assessing the reasonability of the model's two key features. First, we examine the pre-COVID and post-COVID data to see if both time periods exhibit the pattern the proposed model assumes, i.e., that a linear pattern in both time periods would have approximately equal slope. On this point we visually inspect the data and find that the post-COVID period, *if modeled linearly*, shows a noticeably higher rate of increase than the pre-COVID timeframe.

[16] Fig. 1.1 uses the v28 model, but all features described, and all provided commentary apply equally to the v24 and ESRD models.

Fig. 1.2



Next, we examine the second feature of the proposed model – that the post-COVID risk score trends exhibit a linear relationship over time. On this account, we visually inspect the data and observe that the pre-COVID years reflect a linear pattern, but the post-COVID period may be exhibiting more of a curved pattern than linear, where the curve shows a decelerating trend. That observation is consistent with an understanding of the impact that COVID had on FFS risk scores.

Based on this initial visual inspection, Humana observes that the historical risk score pattern may not align well to the proposed model's structure. Further examination outlined below gives a more in-depth review of the historical FFS risk score data and commentary on the appropriateness of the proposed model for its intended application.

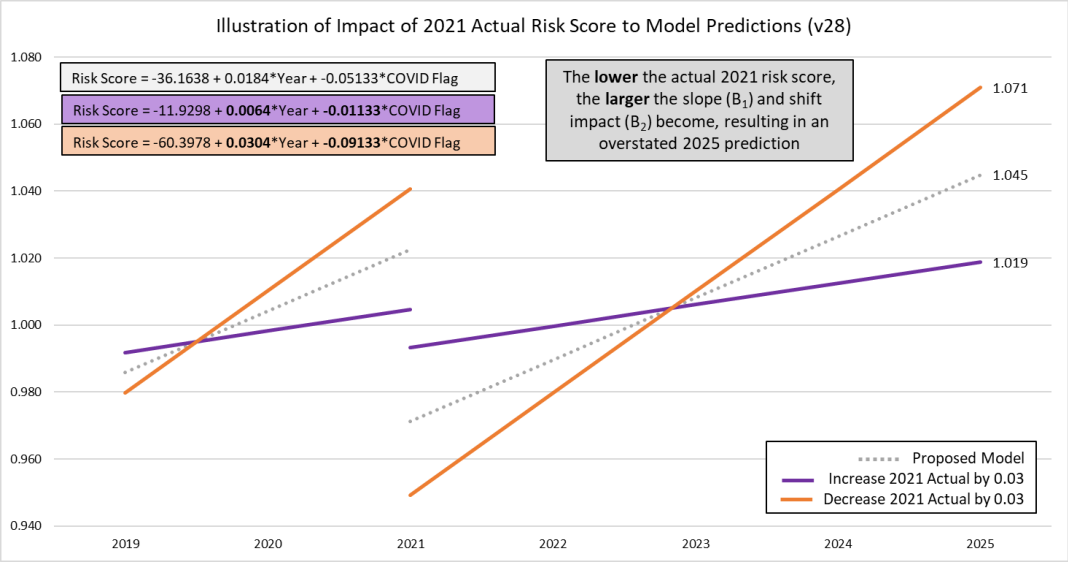
<u>The 2021 data point is anomalous and undermines the validity of the proposed model</u>
Humana believes that the 2021 payment year FFS risk score of 0.968 represents an outlier observation to the general historical FFS risk score trend and CMS itself recognizes this, describing the 2021 FFS risk scores as "anomalous."[17] Unlike other post-COVID years, 2021 risk scores were directly affected by nationwide lockdowns during 2020 that suppressed medical utilization and contributed to significant under-documentation of conditions within the FFS population.[18]

As we explain below, Humana believes that the proposed model's shortcomings stem from treating the anomalously low 2021 FFS risk score as though it were representative of the historical FFS morbidity trend.

[17] Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (pg. 63)
[18] See: COVID-19 Experiences Among the Medicare Population (cms.gov) and Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020 | MMWR (cdc.gov)

Humana observes that the unusually low 2021 FFS risk score distorts the coefficients within the proposed model, resulting in overestimating the predicted FFS risk score growth. The structure of the proposed model assumes that 1) the post-COVID and pre-COVID time periods will observe the same risk score growth rates and 2) that the post-COVID risk score patterns will follow a linear relationship. Because of these features of the proposed model, the anomalously low 2021 risk score and year-over-year bounce back in 2022 will necessarily produce two effects; first, the model overestimates the amount of the shift (β_2) that occurred in the FFS morbidity due to COVID and, second, the model overestimates the general rate of risk score growth (β_1). Fig. 1.3 provides an illustration intended to show that the proposed model's growth estimate (β_1) and shift estimate (β_2) are sensitive to the anomalous 2021 data point. We show here that, had the 2021 data point been 0.03 lower than it was, this would have resulted in both a larger growth estimate and larger (negative) shift estimate, whereas if the 2021 data point been 0.03 higher than this, it would have resulted in a lower growth and shift estimates. Fig. 1.3 shows how the proposed model's structure, when calibrated with the anomalously low 2021 data point, results in inflated growth rate and shift estimates.

Fig 1.3



Impact of the anomalous 2021 data point causes the model to lose predictive accuracy outside of the years used in model calibration

The phenomenon described in the previous paragraph is not purely theoretical; the proposed model's coefficients are, in fact, affected by the anomalous 2021 risk score, causing the shift (β_2) parameter to overestimate the downward impact in morbidity due to COVID and the slope (β_1) parameter to overestimate the general growth in FFS risk scores, both pre-COVID and post-COVID. We observe this most clearly by noting that the model produces a FFS growth coefficient (β_1) of 0.0184, per year, for the v28 model and 0.0254 for v24. This proposed model's estimated growth rate is noticeably larger than the historically observed FFS risk score growth rate.

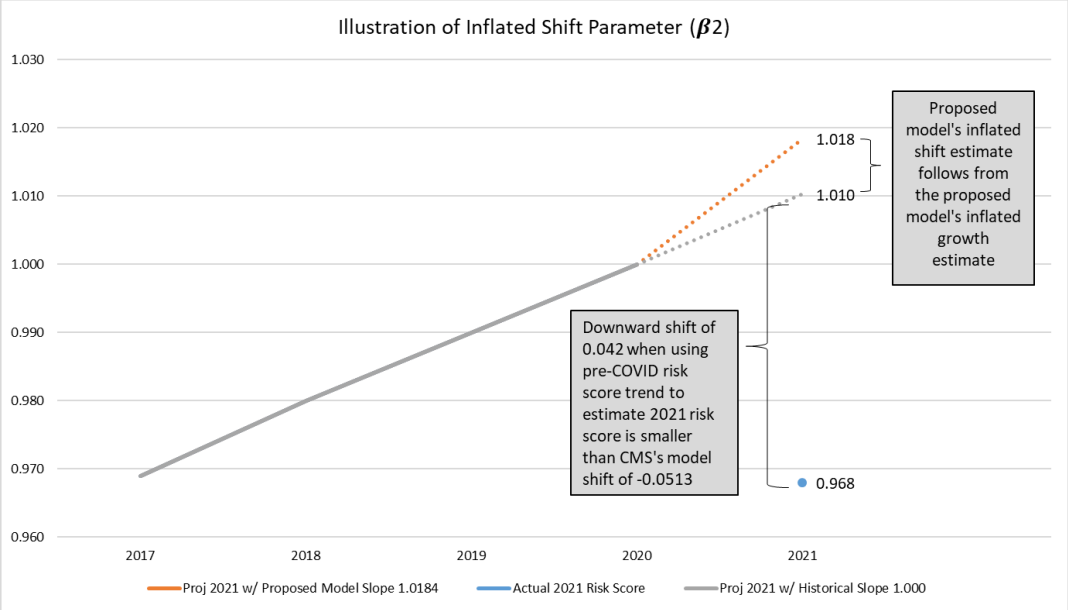
Table 1.1

	V28		V24	
Year	Actual	Growth	Actual	Growth
2014			0.998	
2015			1.000	0.002
2016			1.020	0.020
2017	0.969		1.031	0.011
2018	0.980	0.011	1.049	0.018
2019	0.990	0.010	1.064	0.015
2020	1.000	0.010	1.079	0.015
2021	0.968	-0.032	1.048	-0.031
2022	0.992	0.024	1.079	0.031
2023	1.009	0.017	1.104	0.025

Looking at the v28 growth rate by year, we see that the historical pre-COVID growth rate was consistently close to 0.010. In fact, the only observation where we see growth rates more than the proposed model's 0.0184 is in 2022, which is, uncoincidentally, the first year of post-COVID risk score growth. The 2022 growth of 0.024 clearly stands as an outlier relative to historical rates, both pre- and post-COVID. The high 2022 growth straightforwardly results from the anomalously low 2021 data point.

Additionally, we can see from Table 1.1 that, without COVID, we might have expected the v28 risk score for 2021 to have been 1.010, based on pre-COVID growth rates of around 0.010 and a 2020 risk score of 1.000. Based on this expectation of a 1.01 risk score for 2021, we estimate that the actual shift due to COVID is -0.042 (equal to the difference between our 1.01 expectation and the 0.968 risk score observed). This shift of -0.042 is significantly smaller than the CMS model's estimation of the shift (β_2) of -0.0513. The inflated shift estimate from the proposed model results gives us an additional reference point for examining the model calibration's reasonability and we see that the model coefficients are likely to be distorted. The proposed model's inflated shift estimate (β_2) follows from the proposed model's inflated growth estimate (β_1). Implicitly, the model is saying that, in the absence of COVID, 2021 FFS risk scores would have been expected to be 1.0184. Examining the pre-COVID trends visually, we can see how the inflated shift parameter follows from the inflated growth estimate.

Fig. 1.4



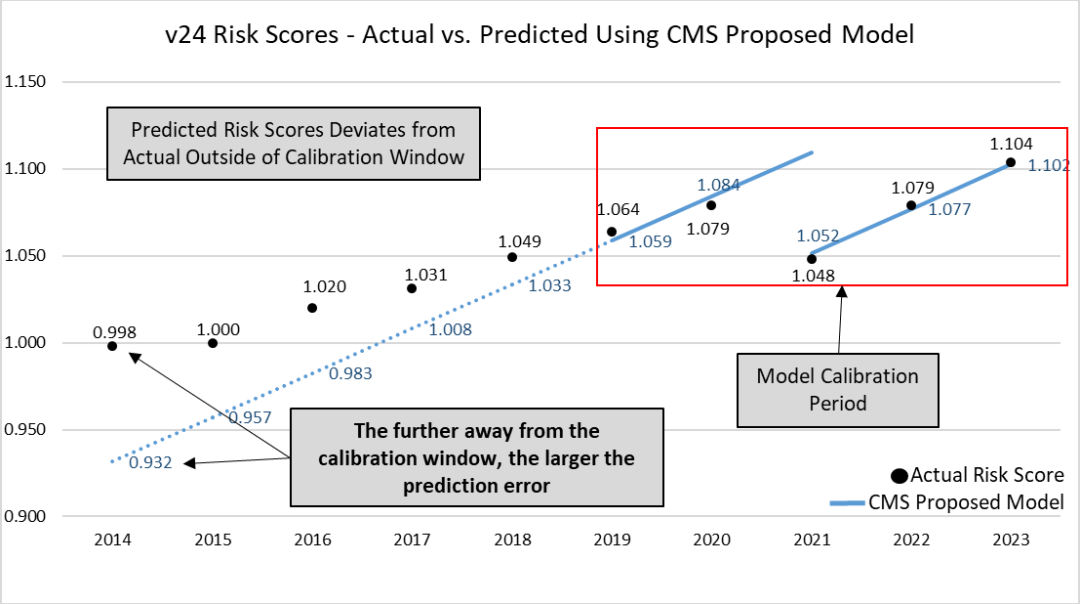
The same occurrence is observed for v24 where we might have expected a non-COVID risk score for 2021 to have been 1.094, a shift of 0.046, significantly less than the CMS proposed 0.0580.

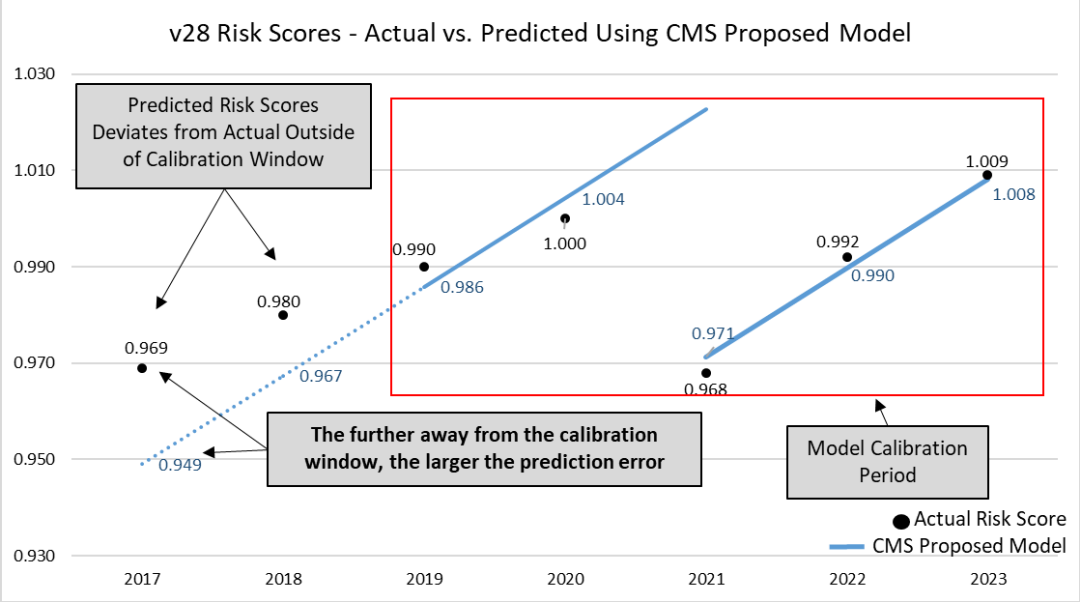
The overestimated growth rate (β1) gives rise to significant concerns about the proposed model's predictive accuracy when used to make predictions outside of the 2019-2023 timeframe used to calibrate the model. Compared to a model with an appropriate growth rate, the proposed model's excessive growth rate will tend to produce lower risk score predictions in years prior to 2019 and higher risk score predictions in years after 2023.

<u>Back Testing</u>

Lacking 2024 (or later) data, we cannot directly verify that the model over-predicts future years' risk scores. Indeed, predicting future years' risk scores is the objective of the model precisely because that data is unavailable. However, the excessive growth estimate will also have the effect of systematically *underpredicting* risk scores for years prior to 2019. In this case, *we do have the relevant data* to verify that the growth rate is too high. We can observe this clearly by visually comparing the model's predictions against actual experience for payment years 2017-2018, for the v28 model, and 2014-2018, on the v24 model.

Fig. 1.5





The above charts clearly show that, for both v24 and v28, the proposed model systematically under-predicts risk scores in the years prior to 2019. Furthermore, the amount of prediction error increases as we examine predictions further back in time. **This gives strong empirical evidence that the proposed model's growth (β_1) estimate is unreasonably high.**

The implications of the model's growth rate being too high is that the model will tend to overpredict FFS risk scores in years beyond 2023. Since the model is developed with the intended purpose of predicting FFS risk scores in 2025, **Humana has serious concerns about the appropriateness of the proposed methodology for determining the 2025 normalization factors.**

The proposed model is "overfit", leading to low predictive accuracy beyond the data used for calibration

Statistical best practices require examining whether the amount of available data is sufficient for the choice of model being employed. When the amount of data is insufficient, models run the risk of "overfit," a condition where a statistical model begins to describe the random error in the data rather than the relationships between variables. In regression analysis, overfitting can produce misleading R-squared values, regression coefficients, and p-values.

We note that, based on visual inspection, CMS observed a relatively good fit within the 2019-2023 data points used for v28 normalization model calibration. However, it is to be expected that models that are overfit tend to look accurate on measures of goodness-of-fit *within the data set used to calibrate the model* but tend to perform poorly at predicting for new data points.

We commend CMS for taking steps to review the proposed model for predictive accuracy. **However, we believe that, because of model overfit, the visual inspection of model performance over the 2019-2023 timeframe is giving a false representation of the model's predictive accuracy.**

The proposed multiple linear methodology requires the calibration of three parameters: intercept (β_0), slope (β_1) and COVID-shift (β_2). However, the data set used to calibrate the models includes only five data points. The large number of estimated parameters within the proposed model, relative to the small number of data points, gives rise to concerns about potential overfit. Since overfit models tend to produce high measures of goodness-of-fit, such as R-squared, a common way of testing for model overfit is to assess the model's performance on data points not used in the model calibration. As we have shown, the model performs poorly for years outside of the 2019-2023 range used to calibrate it. This observation reinforces Humana's concern of potential overfit within the model, leading to poor predictive performance.

CMS should take additional steps to assess the reasonability of their predictive model

Humana recommends CMS test the accuracy of the proposed model predictions for years prior to 2019. In keeping with the intended purpose of the model – to predict FFS risk scores for payment year 2025 – it is incumbent on CMS to ensure that the model can accurately predict outside of the 2019-2023 timeframe used for calibration. Since no data is available for 2024 forward, the only way to gain confidence about the model's predictive power outside of the data-calibration range is to test for predictive accuracy in the years prior to 2019. Humana notes that CMS has historical risk scores readily available for model v28 going back as far as 2017 and for model v24 as far back as 2014.

CMS should test predictive accuracy *for each model's entire historical available data* by doing all of the following:

1) Visually inspecting the model predictions compared to actual historical risk scores
2) Observing the model's slope and shift parameters for reasonableness
3) Calculating model R-squared

In isolation, each of these tests represent valid, but limited, approaches to checking the reasonability of model performance. Applying all three approaches *in concert* ensures a more comprehensive and well-rounded model testing approach that is likely to avoid common modelling pitfalls, such as overfit. Humana recognizes that CMS is inherently limited in their ability to employ many common statistical approaches for testing their model, such as partitioning the available data into modelling and testing subsets, due to the nature of the FFS data available and purpose of the model. However, those limitations make it even more important that CMS employ all the model testing techniques available.

Humana recognizes that other features of a projection model may be relevant to CMS when deciding among alternatives, such as avoiding unnecessary complexity, ease of explanation, and ability to carry the modeling approach forward consistently into future years' normalization projections. Humana acknowledges the importance of these (and other) features and recommends that CMS consider these factors in conjunction with, *but not instead of*, the model assessment steps recommended above.

Finally, Humana notes that, when performing model evaluation, it is not strictly necessary for the final selected model to achieve any standard on each of the assessment steps. Rather, these steps serve as a basis of comparison among model alternatives, providing an objective framework for evaluating incremental improvements among the modeling approaches. In the sections that follow, Humana proposes additional model alternatives and the results of the evaluation steps outlined above.

Effective Strategies to Improve the Model Accuracy/Reasonableness

As previously stated, Humana believes that the proposed model, if scrutinized within the appropriate testing framework, suffers from systematic inaccuracies, particularly when used to predict outside of the years used in model calibration.

Humana proposes that CMS consider three modeling strategies that, if adopted, can be demonstrated to mitigate the impact of the anomalous 2021 data point, and significantly improve model reasonability and predictive accuracy. These strategies may be fruitfully used either in isolation or in combination.

Strategy #1: Remove the 2021 payment year risk score from the modeling data

This approach aligns with what CMS has done in recent years to account for the anomalous FFS risk score in 2021. As discussed in our above comments, removing the outlier data point will help to achieve an estimated slope that is more aligned with historical trends and improve predictive accuracy prior to 2019.

Strategy #2: Include years prior to 2019 in the modeling data

This approach would expand the existing data to include years prior to 2019, such as 2018 or 2017 and 2018, as part of the data used to calibrate the modeling coefficients. Expanding the data collection to earlier years improves the model by reducing the risk of overfit. The additional data gives the model more relevant information on historical FFS risk score trends that can be expected to improve forecasting accuracy.

Strategy #3: Adopt a non-linear "Decay" model to account for the unique post-COVID FFS risk score pattern

This approach is tailored to accommodate post-COVID risk score trend patterns, where the decrease in FFS risk score observed in 2021 was the result of an initial shift that, over the subsequent years, appears to gradually be returning to a normal historical growth rate. The Decay model recognizes that the initial post-COVID growth from 2021 to 2022 is likely to be higher than growth from 2022 to 2023 and so forth into years beyond 2024. This modeling approach assumes that, as the initial shock of COVID to FFS risk scores wear off, the risk score growth rates will eventually return to historical levels, while still incorporating a post-COVID "shift" (as is contemplated in the current proposed model). The Decay approach allows the model to retain the anomalous 2021 data point, while using a non-linear assumption to mitigate the bias that a linear model would have (i.e., overestimating the risk score growth (β_1)).

Each of these modeling strategies can help to achieve CMS's stated objectives: providing a reasonable prediction of FFS risk scores in 2025 and achieving payment accuracy for MA organizations. As our below alternative model suggestions demonstrate, these strategies can be employed in combination to achieve improved predictive accuracy relative to the proposed model.

Alternative Models for Consideration

Humana evaluated two alternative approaches to applying the above modeling strategies for mitigating the impact of the anomalous 2021 data point. In addition to providing guidance on applying the recommended modeling strategies, this section evaluates the effectiveness of those strategies using the model evaluation strategies recommended previously. This section therefore serves to 1) provide CMS with viable alternative models and 2) demonstrate the practical steps CMS should take when evaluating any alternative proposal.

Alternative Model #1: "Seven-Year-Minus-One"

The "Seven-Year-Minus-One" model follows the same multiple linear regression modeling approach as the proposed model, but with two changes: 1) expanding the calibration data to include 2017 and 2018 and 2) removing the 2021 data point from the calibration data set. This model incorporates the above strategies #1 and #2 concurrently to mitigate the impact of the anomalous 2021 data point and improve predictive accuracy. Prior to formally evaluating the model performance, we note that the "Seven-Year-Minus-One" model's additional data points help to reduce the risk of model overfit, while also removing the anomalous 2021 data point to reduce the risk of inflating the model's growth (β_1) estimate. We apply this modeling approach for both v28 and v24 normalization projections.

Tables 1.2 and 1.3 show the data points used to calibrate the "Seven-Year-Minus-One" model and the relevant model parameters, respectively:

Table 1.2

Data Points used in Calibration			
Year	**COVID Flag**	**v24**	**v28**
2017	0	1.031	0.969
2018	0	1.049	0.980
2019	0	1.064	0.990
2020	0	1.079	1.000
2022	1	1.079	0.992
2023	1	1.104	1.009

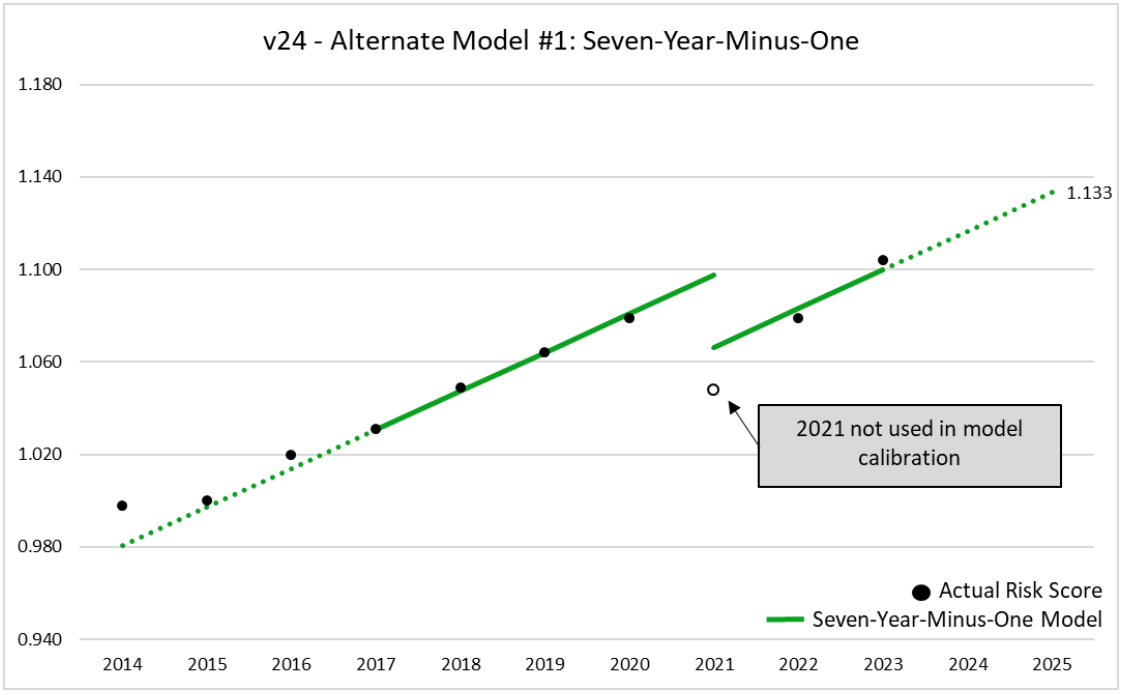
Table 1.3

Model Parameters

	v24	**v28**
B_0	-32.7083	-21.0353
B_1	0.0167	0.0109
B_2	-0.0312	-0.0279

Following the previously recommended steps to assess the model, we begin by visually inspecting the model predictions compared to actual historical risk scores over the timeframes of 2017-2023 for v28 and 2014-2023 for v24.

Fig 1.6



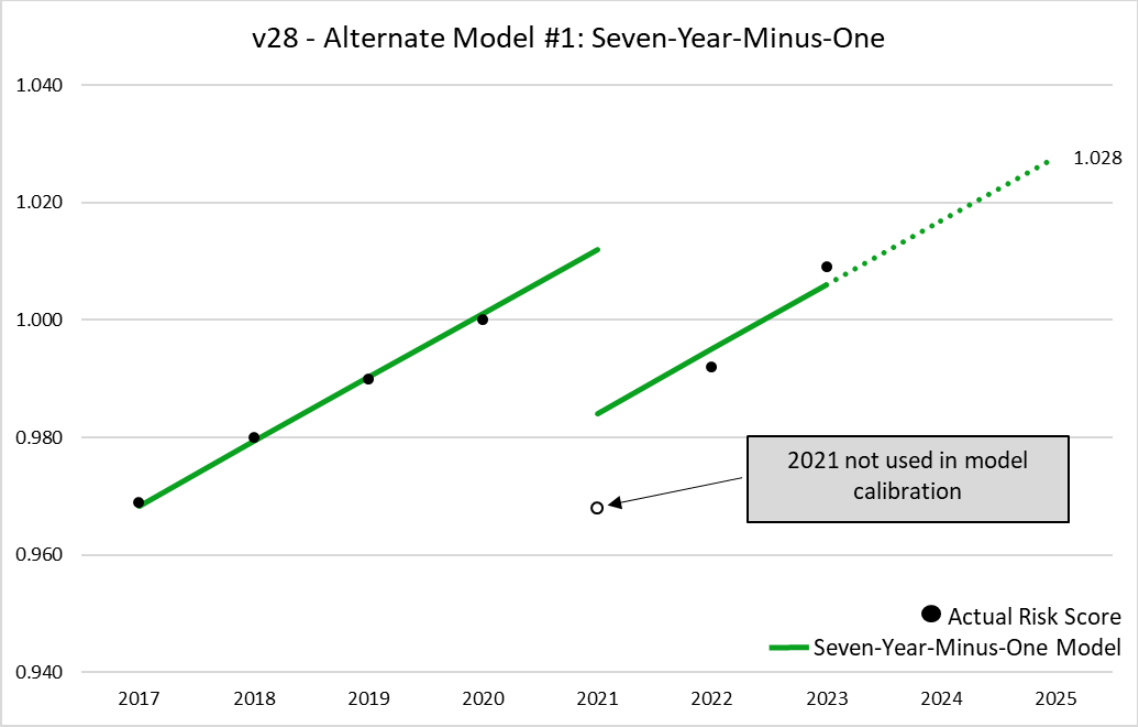


Table 1.4

	v24			v28		
Year	Actual	Predicted	Prediction Error	Actual	Predicted	Prediction Error
2014	**0.998**	**0.980**	-0.018			
2015	**1.000**	**0.997**	-0.003			
2016	**1.020**	**1.014**	-0.006			
2017	**1.031**	**1.031**	0.000	**0.969**	**0.968**	-0.001
2018	**1.049**	**1.047**	-0.002	**0.980**	**0.979**	-0.001
2019	**1.064**	**1.064**	0.000	**0.990**	**0.990**	0.000
2020	**1.079**	**1.081**	0.002	**1.000**	**1.001**	0.001
2021	**1.048**	**1.066**	0.018	**0.968**	**0.984**	0.016
2022	**1.079**	**1.083**	0.004	**0.992**	**0.995**	0.003
2023	**1.104**	**1.100**	-0.004	**1.009**	**1.006**	-0.003
2024		**1.117**			**1.017**	
2025		**1.133**			**1.028**	

We note that, for both v28 and v24, the “Seven-Year-Minus-One" alternative model achieves a broadly good fit on the data points used for calibration. The model shows a significant overprediction for 2021, which is expected and is not concerning from a model assessment perspective given the 2021 outlier data point is removed from the calibration. The v24 model shows that predicted risk scores prior to 2017 tend to be lower than actuals and that the degree of error tends to increase the further back in time we look. This indicates that the model likely retains some bias, inflating the growth estimate (β_1). A visual inspection indicates that the bias causes 2015 risk scores to be underpredicted by 0.003. Note that we examined the bias as of 2015 because this represents two years prior to the data used for model calibration, which

serves as the most reasonable estimate for an *overprediction* bias we might expect in 2025 (two years *after* the data used for calibration).

Next, we observe the reasonability of the growth estimates (β_1) and shift (β_2). For v28 and v24, the models' growth estimates are 0.0109 and 0.0167, respectively, which are roughly in line with historical pre-COVID growth rates. For v28 and v24, the models' shift parameters are -0.0279 and -0.0312 which, because this model excludes the 2021 data point, only reflects the more moderate shift for the 2022 and 2023 observations.

Finally, we calculate the R-squared statistic for both models. For v28 and v24, R-squared values are 0.9657 and 0.9795, respectively, indicating an overall acceptable level of model fit.

Alternative Model #2: "Seven-Year Decay"

For a second alternative model, Humana examined the "Seven-Year Decay" model, which follows the same multiple linear regression modeling approach as the proposed model, but with two changes: expanding the data to include 2017 and 2018 data points and applying a non-linear "decay" function to post-COVID data points. This model incorporates a combination of the above-mentioned strategies #1 and #3 to mitigate the impact of the 2021 anomalous data point and improve the predictive accuracy.

The decay variable here is set to an initial COVID-related shift equal to two and gradually scales back to one using a rate of geometric decay of 50 percent per year. In setting the shift assumption to two and scaling back to one, we assume that the initial COVID-related shift (in 2021) is double the long-run COVID-related shift. Further, the 50 percent per year geometric decay assumes a reasonable return to the long-run rate of risk score growth. For prediction years 2024, the Decay Fx variable continues the geometric decline, using data points of 1.125 and 1.0675 respectively.

We note that these input assumptions are made by Humana based on visual inspection of the data, not determined empirically. In theory, it is possible for the Decay model to calibrate both the initial shift and decay parameters. However, in practice, determining the shift and decay parameters empirically would result in a model with five calibrated parameters (intercept, growth, COVID-shift, amount of initial shift that remains, and rate of decay). Humana notes that, even expanding to include data points to 2017-2018 only leaves seven data points within the model and thus a five-parameter model runs significant risk of model overfit due to insufficient data. Humana recommends that, should CMS adopt a decay model, CMS explore a sensitivity analysis with respect to these input assumptions.

Tables 1.5 and 1.6 show the data points used to calibrate the "Seven-Year Decay" model and the relevant model parameters, respectively:

Table 1.5

Data Points used in Calibration			
Year	**Decay Fx**	**v24**	**v28**
2017	0	1.031	0.969
2018	0	1.049	0.980
2019	0	1.064	0.990
2020	0	1.079	1.000
2021	2	1.048	0.968
2022	1.5	1.079	0.992
2023	1.25	1.104	1.009

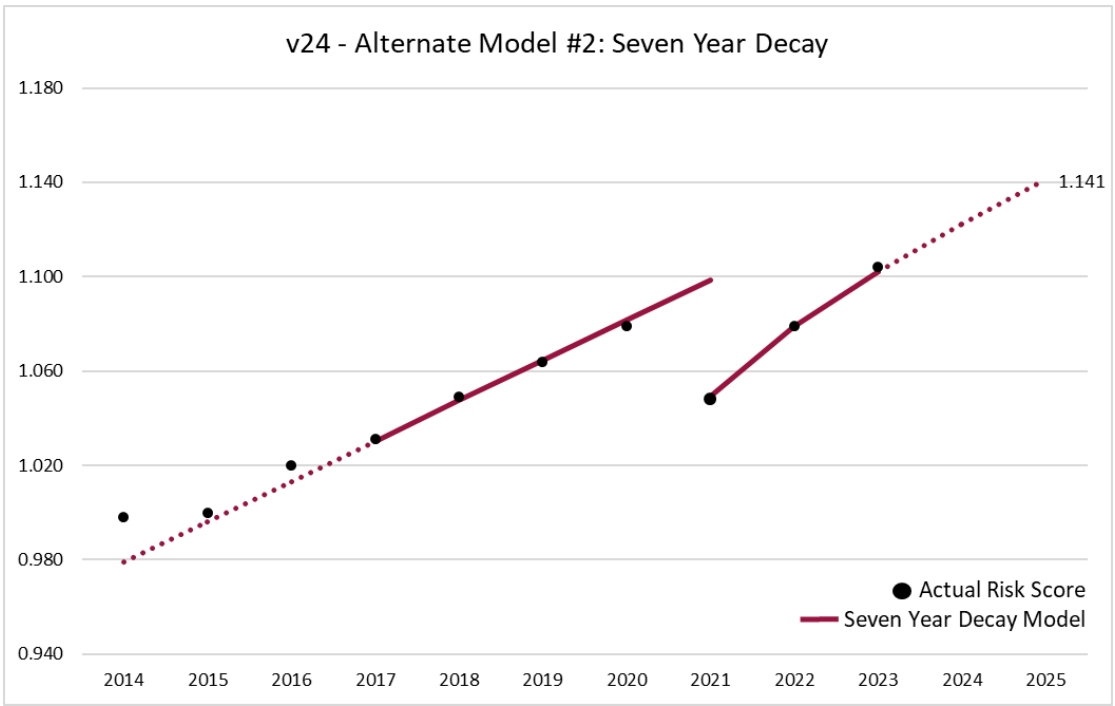
Table 1.6

Model Parameters

	v24	**v28**
B_0	-33.4643	-21.5642
B_1	0.0171	0.0112
B_2	-0.0247	-0.0218

Again, following the previously recommended steps to assess the model, we begin by visually inspecting model performance over the historical timeframe: 2017-2023 for v28 and 2014-2023 for v24.

Fig. 1.7



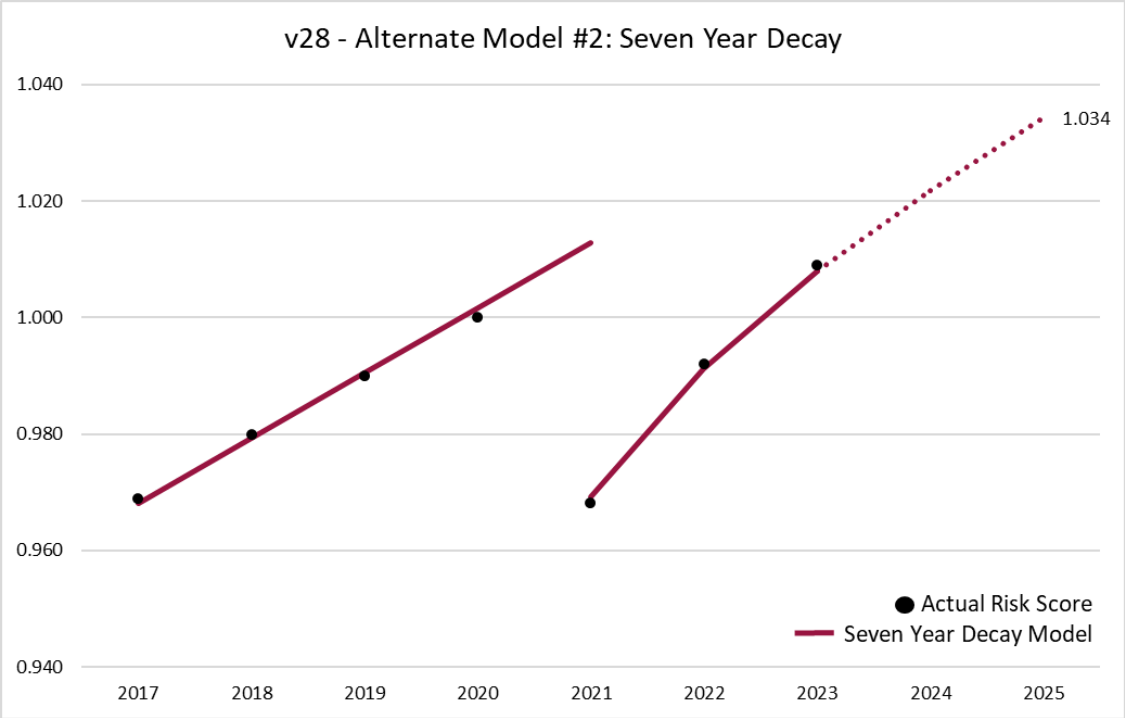


Table 1.7

	v24			v28		
Year	Actual	Predicted	Prediction Error	Actual	Predicted	Prediction Error
2014	**0.998**	**0.979**	-0.019			
2015	**1.000**	**0.996**	-0.004			
2016	**1.020**	**1.013**	-0.007			
2017	**1.031**	**1.030**	-0.001	**0.969**	**0.968**	-0.001
2018	**1.049**	**1.047**	-0.002	**0.980**	**0.979**	-0.001
2019	**1.064**	**1.064**	0.000	**0.990**	**0.990**	0.000
2020	**1.079**	**1.082**	0.003	**1.000**	**1.002**	0.002
2021	**1.048**	**1.049**	0.001	**0.968**	**0.969**	0.001
2022	**1.079**	**1.079**	0.000	**0.992**	**0.991**	-0.001
2023	**1.104**	**1.102**	-0.002	**1.009**	**1.008**	-0.001
2024		**1.122**			**1.022**	
2025		**1.141**			**1.034**	

We note that, for both v28 and v24, the "Seven-Year Decay" alternative model achieves an excellent fit on the data points used for calibration. The v24 model shows that predictions prior to 2017 tend to be slightly lower than actuals and the degree of error tends to increase the further back in time we look. This indicates that the model likely retains some bias, inflating the growth estimate (β_1). A visual inspection indicates that the bias causes 2015 risk scores to be underpredicted by 0.004. Note that we examined the bias as of 2015 because this represents two years prior to the data used for model calibration, which serves as the most reasonable

estimate for an *overprediction* bias we might expect in 2025 (two years *after* the data used for calibration).

Next, we observe the reasonability of the growth (β_1) estimates and shift (β_2). For v28 and v24, the model's growth estimates are 0.0112 and 0.0171, respectively, which are roughly in line with historical pre-COVID growth rates. For v28 and v24, the model's shift parameters are –0.0218 and –0.0247, which are reasonable. Note that, because the Decay Fx input uses a value of two for 2021, the shift parameters must be doubled to estimate the degree of COVID impact that the model predicts. Therefore, the model's shift parameters for v28 and v24 (–0.0218 and –0.0247 respectively) give estimated COVID shifts of –0.0436 for v28 and –0.0494 for v24, which are both in line with our expectations. With the decay model, unlike the other simpler models, the growth value (β_1) represents the long-term growth that is predicted to remain after the Decay Fx input reaches one in the future. The Decay Fx provides the means for which, in the near term, we see the specific yearly growth values predicted to still be recovering from the 2021 Covid impact.

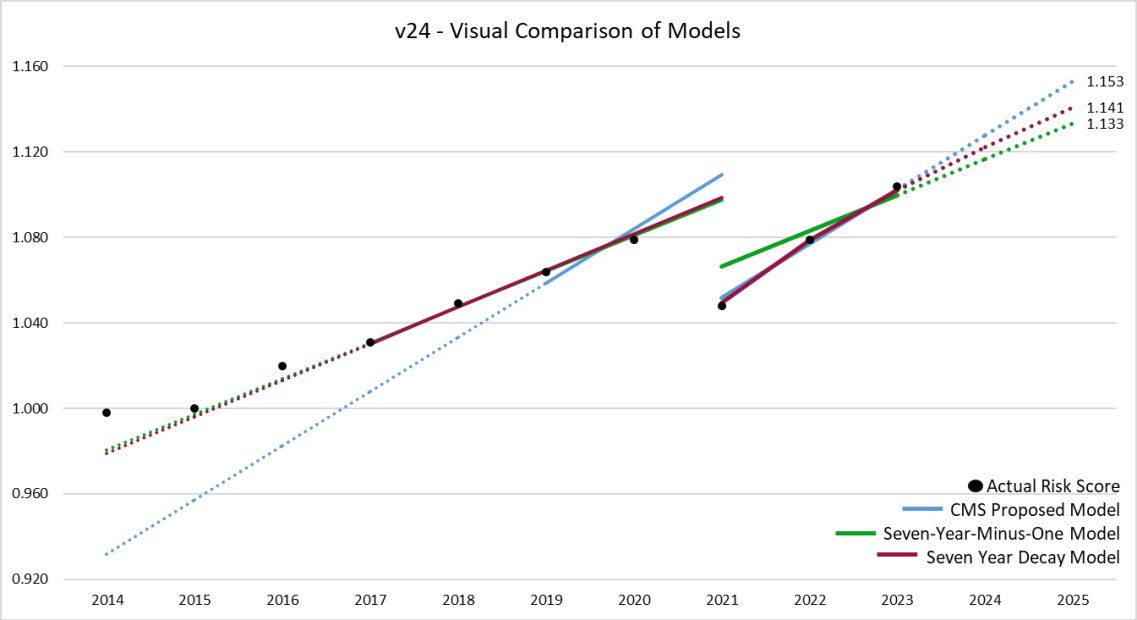
Finally, we calculate the R-squared statistic for both models. For v28 and v24, R-squared values are 0.9922 and 0.9935 respectively, indicating an overall acceptable level of model fit.

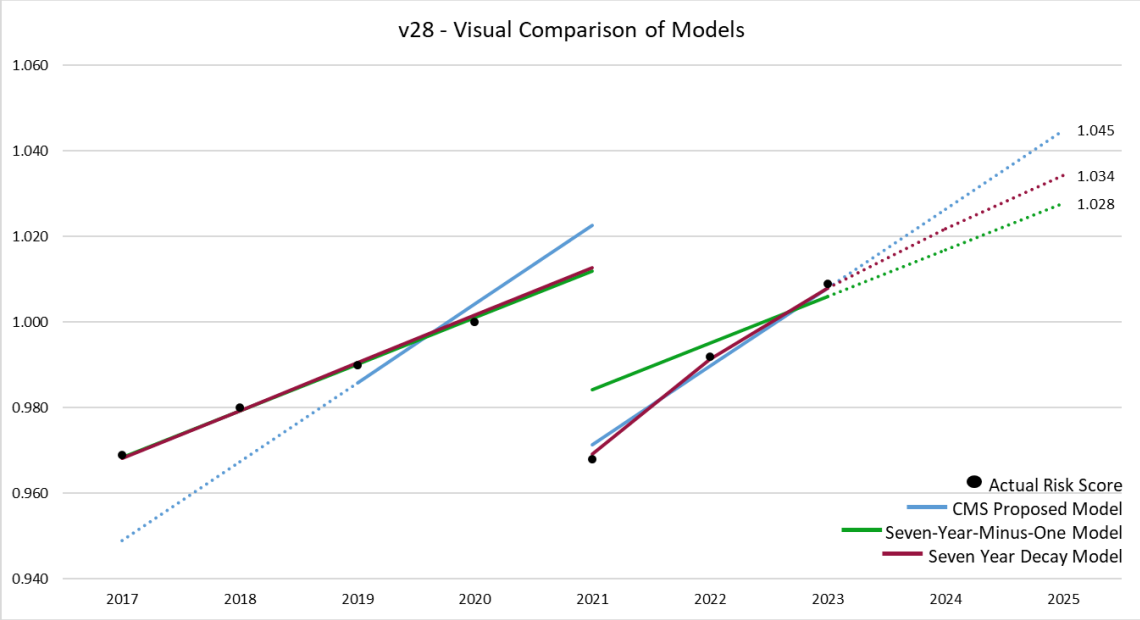
While our comments here are focused on the proposed normalization factors for the Part C CMS-HCC Model, we note that we also reviewed and arrived at similar conclusions for the Proposed Normalization Factors for the ESRD Dialysis and Functioning Graft Models.

<u>Alternative Models Perform Better than the Proposed model and Give More Reasonable Predictions</u>

First, looking at the historical predictive accuracy, while both the "Seven-Year-Minus-One" and "Seven-Year Decay" models show some level of under-prediction within the years prior to model calibration (before 2017), both models perform significantly better than the proposed model in predicting historical risk scores for 2017-18, and the v24 versions of the alternative models succeed at predicting beyond the calibration time frame as far back as 2014-2016 much more accurately than the proposed model.

Fig. 1.8





Comparing the model growth rates, we observe that both alternative models achieve reasonable estimates of risk score growth that are in line with pre-COVID experience.

Table 1.8

	Growth Rate (Observed or B_1)	
Model	**v24**	**v28**
Actual Pre-COVID Trend*	0.0153**	0.0106
CMS Proposed	0.0254	0.0184
Seven-Year-Minus-One	0.0167	0.0109
Seven Year Decay	0.0171	0.0112

**Average annual trend in observed data*

***Excludes 2014-2015 trend*

The R-squared values for each of the models indicate a satisfactory level of predictive accuracy.[19] We note that the R-squared values from the alternative models are less likely to be misleading, due to the additional data points being used.

Table 1.9

	Adj R^2	
Model	**v24**	**v28**
CMS Proposed	0.9146	0.8879
Seven-Year-Minus-One	0.9795	0.9657
Seven Year Decay	0.9935	0.9922

Humana observes that the "Seven-Year Decay" model performs well on the post-COVID data, including the 2021 data point, by recognizing the non-linearity of post-COVID risk score patterns. The Decay modelling approach also makes use of the most current available data. However, the "Seven-Year-Minus-One" model is the least complex and, unlike the Decay model, is not sensitive to arbitrariness in input assumptions. After considering all the quantitative and non-quantitative features, **Humana believes that both Alternative Models presented here achieve superior predictive accuracy compared to the proposed model.**

Summary

As shown within these comments, the proposed methodology overestimates the 2025 normalization factor for MA (v24 and v28). The overestimates stem from inclusion of the anomalously low 2021 data point when calibrating the model. The low 2021 FFS risk score, resulting from suppressed 2020 utilization, distorts the calibration of the multiple linear regression model, tending to artificially overstate the predicted risk score growth rate (β_1) and overstate the downward shift due to COVID (β_2). It has been verified here that the overstated growth rate contributes to the model materially under-predicting risk scores in years prior to 2019, giving compelling evidence that the model is biased towards overestimating risk scores in years beyond 2023.

Humana recommends that CMS take appropriate steps to mitigate the bias within the proposed model, stemming from the anomalously low 2021 data point. **To that end, Humana**

[19] R^2 for each model is measured based on the data points used for model calibration and adjusted to control for the prediction improvement due to any additional model parameters.

proffers three effective strategies: 1) remove the 2021 data point from model calibration; 2) expand the data collection to include years prior to 2019; and 3) employ a decay model to recognize non-linearity in post-COVID FFS risk score trends. Our comments provide two viable alternative modeling approaches that apply the bias-mitigation strategies, along with outlining model validation steps to ensure that the alternative approaches satisfy statistical measures of fit and achieve reasonable predictions.

Humana reaffirms its support for CMS in exploring alternative modeling approaches and appreciates the challenges inherent in forecasting risk score trends considering COVID's impact to recent years' experience. We agree with CMS on the fundamental importance of achieving reasonable risk score predictions and intend these comments to be constructive to that purpose.

Attachment III. Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2025

C. Part D Premium Stabilization

CMS indicates that calculation of the base beneficiary premium (BBP) for CY 2025 will be the lesser of the BBP as it would have been calculated absent enactment of the Inflation Reduction Act (IRA) or 106 percent of the CY 2024 BBP, per IRA requirements. Consistent with CY 2024, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan's basic Part D beneficiary premium.

Humana Comment: The Part D redesign and other related IRA provisions will make 2025 the most challenging year for plans since the inception of the program in 2006. We are supportive of the premium stabilization program and its potential to protect beneficiaries from excess premium growth. However, this tool will only address the average premium increase – creating the potential for significant beneficiary impacts in any plans that incur larger than average premium increases from CY 2024 to CY 2025. We continue to have concerns related to potential premium increases resulting from the benefit redesign and caution that at least some beneficiaries could be adversely affected. Throughout our comments, we encourage CMS to seek additional mechanisms to assist Part D plan sponsors in successfully implementing the programs and policies mandated under the IRA while preserving the affordability associated with Part D plans.

Section D. Part D Calendar Year EGWP Prospective Reinsurance Amount

CMS makes prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year, which for CY 2025 would be CY 2022.

However, given that the reinsurance percentages and methodology are changing significantly in CY 2025, the methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors also needs to be updated. CMS plans to announce the CY 2025 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Bid Amount (NAMBA), Part D BPP, and related Part D bid information in the summer of 2024.

Humana comment: Humana supports the continued use of prospective reinsurance payments for EGWPs. We also support the updated methodology for CY 2025. CMS is calculating the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors using the weighted average of PMPM prospective reinsurance amounts submitted by Part D sponsors for enhanced alternative (EA) plans as part of the Part D bid submissions for the payment year in question. This update will allow for the prospective payments to be more in line with the expected payment.

E. Part D Risk Sharing

CMS notes that it is prohibited by statute from narrowing the existing risk corridors but could conceivably widen the risk corridors under existing authority. CMS does not intend to do so, and thus the risk corridors for CY 2025 will remain unchanged from those in place during CY 2024.

Humana Comment: Humana strongly recommends CMS consider using demonstration authority to offer an optional payment model in which risk corridors are narrowed for a finite period beginning in 2025. Section 402 of the Social Security Amendments provides the Secretary of Health and Human Services authority to waive compliance with certain requirements of the Medicare program in order to develop and engage in demonstration models aimed at "increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services."[20] In addition, the Secretary also holds authority to develop demonstration programs under the Center for Medicare and Medicaid Innovation (CMMI) established by the Patient Protection and Affordable Care Act of 2010.[21] CMS has previously exercised these authorities to implement demonstration programs such as the Part D Senior Savings Model, which can be seen as the precursor to IRA-mandated caps on beneficiary cost sharing for insulin products. We believe CMS should exercise its demonstration authorities to assist Part D plan sponsors in mitigating the financial uncertainties associated with Part D redesign. **Specifically, we ask that CMS test whether temporarily narrowing the statutorily established risk corridors would allow the Part D program to maintain robust formulary coverage, stable premiums, and reduce the churn from LIS reassignments.**

Indeed, there is precedent for a demonstration program seeking to narrow the risk corridors. In 2019, CMS suggested it would offer such a demonstration if a proposed rule[22] modifying the safe harbor protection under the Anti-Kickback Statute applicable to the rebates paid by drug manufacturers to Part D plans sponsors were finalized.[23] While the proposed rule was finalized in 2020, it has not been implemented and was subsequently repealed under the IRA. Accordingly, CMS has not previously implemented a voluntary narrowed risk corridor program, though we believe the myriad Part D benefit changes occurring in CY 2025 offer an ideal opportunity for such a demonstration.

G. RxHCC Risk Adjustment Model

[20] 42 U.S.C. § 1395b-1(a)(1)(A).
[21] 42 U.S.C. § 1315a.
[22] 84 Fed. Reg. 2340 (Feb. 6, 2019)
[23] "Guidance Regarding Part D Bids," CMS (April 5, 2019), Guidance Regarding Part D Bids.

G1. Background on RxHCC Risk Adjustment Model

CMS provides a detailed summary of the components and calculations underlying the existing RxHCC risk adjustment model.

> **Humana Comment: Humana supports CMS's efforts to update the RxHCC Risk Adjustment model for CY 2025 and we applaud the Agency for taking action to improve the predictive nature of the model.** Humana has historically raised concerns about and continues to strongly advocate for CMS to make additional modifications to the underlying structure of the RxHCC Risk Adjustment Model to further enhance its predictive power and more appropriately reimburse plan sponsors for the relative costs associated with Part D beneficiaries and their prescription drug costs. The Medicare Payment Advisory Commission (MedPAC) has also evaluated the effectiveness of the RxHCC model, with a limited lens on two classes of drugs with different utilization profiles, where they note "Part D's risk adjustment may no longer provide adequate adjustment to mitigate against plan sponsors' incentives to engage in risk selection."[24] This continues to illustrate that the current model is unable to effectively assess the relative cost of prescription drug coverage. The inadequacies of the model could lead to changes in formulary coverage, benefit changes, plan consolidations, or other actions that may adversely impact beneficiaries and do not suit the needs of the Medicare population.

G2. Recalibrated RxHCC Model to Reflect CY 2025 Part D Benefit Structure

CMS summarizes changes made to the RxHCC model to reflect the new benefit design phases and cost-sharing proportions established by the IRA. CMS intends to use these refined parameters to map drug costs incurred in prior years to the redesigned Part D benefit.

> **Humana Comment:** Humana appreciates that CMS has provided additional transparency on the proposed changes to the RxHCC model. We have previously requested that CMS take care to ensure the model is appropriately updated in advance of CY 2025 bid submission deadlines and appreciate the additional details on model components and calculations.

G3. Updates to Data Years Used to Calibrate the Model

CMS proposes to calibrate the RxHCC model for CY 2025 on 2021 diagnoses and 2022 expenditure data from PDE records, the most recent complete data available. While utilization during calendar years 2021 and 2022 was impacted by the COVID-19 pandemic, CMS asserts that the impact to Part D spending was limited the benefit of using more recent data outweighs concerns about the potential impact of the pandemic on the model coefficients.

> **Humana Comment: We commend CMS for recognizing the value of calibrating the RxHCC model using the most up-to-date data available and support the proposal to use 2021 diagnosis and 2022 expenditure data.** We have repeatedly advocated for such a change to the model calibration process in recent years and continue to believe that such an approach will improve the predictive power of the model by more accurately estimating current risks and liabilities faced by Part D plan sponsors.
>
> CMS correctly notes that the traditional lag time for updating the underlying claims data in the existing RxHCC model is four to six years. For CY 2024, CMS used 2018 FFS claims and MA-PD

[24] MedPAC, March 2021 Report to the Congress: Medicare Payment Policies – Chapter 13: The Medicare prescription drug program (Part D): Status Report, mar21_medpac_report_ch13_sec.pdf.

encounter data submissions and expenditure data from 2019 PDE records. Over the past six years, there have been significant changes in the prescription drug market. For example, there have been expanded indications on immunology drugs like Rinvoq and Skyrizi that have significantly changed the cost profile of various disease states. Additionally, during this time period, we have also seen advancements in other commonly used treatments like triple therapy inhalers for COPD.

Furthermore, given expanded indications of GLP-1 and SGLT2 therapies into Cardiovascular and Renal conditions, patients utilizing these therapies now represent a different level of disease burden than seen in 2021 diagnoses and 2022 PDE data. We expect significant increases in utilization of these therapies in 2025.

G5. Changes in Age Category Model Constraints

CMS notes that the updated RxHCC models tend to have lower coefficients for age categories. A higher number of age category coefficients were negative under the new benefit design, which in prior years would involve constraining these coefficients to zero to prevent a negative risk score. However, because more age categories would have coefficients of zero under the new model, this posed a risk of having more beneficiaries with risk scores of zero if they did not have any of the RxHCCs included in the model. Accordingly, CMS proposes to constrain negative coefficients for age categories to be equal to other age categories that have positive coefficients, such that the resulting coefficient represents an enrollment-weighted average of the negative and positive coefficients. This is intended to prevent a beneficiary from receiving a risk score of zero under the revised model.

Humana Comment: Humana supports the proposed policy adjusting the age category coefficients under the revised risk score model. The proposed process is consistent with past practices used by CMS to smooth the age-related coefficients to ensure that the risk model assigns a valid risk score to each beneficiary. For future model iterations, due to the IRA's effect of producing negative or low coefficient values for age categories, Humana suggests CMS consider widening the existing age ranges under the model and reducing the total number of age categories. Such an approach could produce similarly smoothed coefficient values with less manual manipulation by CMS.

G7. Predictive Ratios for CY 2025 RxHCC Models

CMS summarizes its proposed approach to developing predictive ratios under the RxHCC model using the proposed model calibration, which relies on 2021 diagnoses and 2022 expenditure data from PDE records.

Humana Comment: Humana appreciates CMS's disclosure of the predictive performance of the proposed RxHCC model; however, we stress that the predicted liability values within the model should be further refined to address high-cost RxHCCs. Specifically, we encourage CMS to weigh the following considerations when developing model coefficient values:

- The average plan liability produced by the RxHCC model is inconsistent with plan bids for which risk scores are applied and thus suppresses coefficient values for individuals with high-cost RxHCCs. Direct and Indirect Remuneration (DIR) is excluded from the RxHCC liability, and since DIR is not uniform across conditions, overpredictions of liability occur depending on the amount of DIR associated with each condition. If the denominator liability of $2,708.40 were to be reduced by 20%, for example, to reflect DIR by condition,

coefficient values for high-cost conditions within the model that have little to no association with DIR would increase by as much as 25%. Correspondingly, conditions largely associated with DIR would have coefficient values decrease. This would ensure more appropriate payment relative to plan liability and disincentivize plans from targeting or avoiding individuals with certain conditions.

- The model does not account for drug use variation within each condition. The model's predicted liability for a high-cost condition is an average among individuals utilizing the high-cost drugs indicated for that condition, and individuals who do not use drugs indicated for that condition. Each Part D plan will not have the same proportion of non-utilizing individuals for that condition, which will cause overpayments and underpayments for each plan, dependent upon that proportion. A recent Milliman White Paper highlights this issue and suggests that CMS could include drug claims for condition imputation so that the coefficient values reflect treatment costs.[25] Humana further suggests that drug utilization also be used to impute conditions for plan payment, ensuring appropriate payment for high-cost members.

H. Normalization Factors for the RxHCC Models

The RxHCC risk adjustment models are calibrated with diagnostic and cost information for beneficiaries enrolled in standalone prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans. In establishing prospective risk estimates, CMS applies a normalization factor to risk scores in the payment year to account for trends in the average risk score between a base year and the payment year. CMS has historically used one normalization factor across both PDPs and MA-PD plans but proposes to apply separate normalization factors for MA-PD plans vs PDPs in CY 2025.

> **Humana Comment**: Humana supports CMS's proposal to establish separate normalization factors for MA-PD plans and PDPs, which should improve the sustainability of the stand-alone Part D program. However, we are concerned that this change, when compounded with others, could create unintended disruption across MA-PD plans. Humana is apprehensive about the adverse consequences to MAPD plans if CMS does not propose an increase to the proposed Contract Year 2025 total beneficiary cost (TBC) threshold. The normalization changes for MA-PD and PDP will adversely impact MA-PD premiums while lowering PDP premiums. These combined effects with the restrictions set by TBC could result in plan exits or threats to health plan solvency. CMS should consider the appropriateness of an increase in the TBC threshold given the variability and magnitude of MA-PD premium impacts likely to be seen under the change to Part D plan liability under IRA combined with the FFS normalization changes.

Attachment IV. Updates for Part C and D Star Ratings

Changes to Existing Star Ratings Measures for the 2025 Measurement Year and Beyond

CMS solicits comments on new measures and various measure updates.

> **Humana Comment:** Humana appreciates the opportunity to comment on potential changes to the Part C and D Star Ratings Program. However, given the quantity of potential changes discussed in the CY 2025 Advance Rate Notice, **Humana urges CMS to move slowly with**

[25] Milliman, Inc. "Potential IRA interactions with Medicare Part D Risk Adjustment: Calibration Data Timing Consideration". Available at Potential IRA interactions with Medicare Part D Risk Adjustment: Calibration Data Timing Considerations (milliman.com).

adoption of any new or adjusted measures to allow providers, plans, and the rest of the industry adequate time to implement the changes and to avoid potential confusion or abrasion with beneficiaries.

Future Universal Foundation Star Ratings Measures

As announced in the 2024 Rate Announcement, CMS added Depression Screening and Follow-up for Adolescents and Adults (Part C) and Adult Immunization Status (Part C) measures to the display page for the 2024 measurement year. In addition to these two measures, CMS also submitted the Initiation and Engagement of Substance Use Disorder Treatment (Part C) through the 2023 Measures Under Consideration (MUC) process for review by the Measure Application Partnership. CMS states that it is continuing to work to include all of the Universal Foundation measures as part of the Part C and D Star Ratings pending future rulemaking.

> **Humana Comment**: Humana supports the effort to create measure alignment across programs. However, as shared in Humana's CY 2025 Part C and D policy and technical proposed rule comments, **Humana continues to urge CMS to allow plans at least three years with these measures on display to ensure plans and providers have the necessary digital reporting and interoperability tools in place for the exchange of data.**

Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions (Part C)

CMS is considering updates to the Maximus Medicare Health Plan Reconsideration Process Manual Medicare Managed Care Reconsideration Projection, including eliminating additional days the IRE allows for any mail delays and using the electronic system receipt date and time as the date the appeal was received by the IRE, regardless of if it was received outside of normal business hours.

> **Humana Comment:** By eliminating the buffer time, plans would have to staff outside of business hours to ensure that they meet the requirements at 42 CFR § 422.590, particularly subsection (e)(5) requiring plans "submit a written explanation and the case file to the independent entity contracted by CMS… [no] later than within 24 hours of its affirmation" of an adverse expedited organization determination. As stated in the proposed rule, "CMS is considering updating the IRE Manual and process to allow case files submitted via the portal to be considered received on the date and time of portal submission, even if it is outside of normal business hours. This means that cases received up to 11:59 p.m. (Eastern Time) each day via the portal would be considered received on that day. (However, the processing timeframe for the IRE-level review would not commence until the following business day.)"[26] This would increase administrative burden and cost on plans without adding any value to beneficiaries. Given that the IRE would not begin to process the case until the start of the following business day, **Humana proposes that a case should be deemed timely if, when a case is due outside of IRE business hours, it is submitted prior to the start of business hours the following business day.**[27]

Cross cutting: Gender-Affirming Quality Measurement in HEDIS (Part C)

NCQA is expanding work to evaluate approaches to update measure specifications where eligible populations area currently defined with gendered language.

[26] Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (pg. 123)

[27] https://www.medicareappeal.com/sites/default/files/Documents/New-Manual-November-2022_FINAL002.pdf

Humana Comment: Humana supports being more inclusive of gender diverse individuals and getting beneficiaries what they need. Humana will continue to work with CMS and NCQA on how best to assess this population, as we recognize the sensitivity of the data and current dependence on providers to provide this data.

Care Coordination (Part C)

Driven by 2022 field testing, CMS is proposing the replacement of two questions within the Care Coordination composite measure and a slight modification of one of the other four current questions in the current version of the composite measure.

Humana Comment: Humana supports the three CMS goals in replacing existing care coordination items that are no longer performing well psychometrically, to refresh the concept in a way that incorporates high performing, recently developed items, and to not appreciably increase the number of items on the survey. However, **Humana continues to urge CMS to work with health plans and industry partners to review the overall effectiveness of the CAHPS methodology and move towards a more holistic improvement in measuring member experience.**

Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)

CMS began reporting the IOP-LD measure to Part D sponsors through the Patient Safety reports in Measurement Year 2020 and has publicly reported the measure on the Part D display page since 2023. CMS intends to propose to add the IOP-LD measure to the Part C and D Star Ratings in future rulemaking.

Humana Comment: Humana opposes the addition of IOP-LD and any other quality measure with a lower-is-better rate, as the industry response is primarily focused on point-of-sale edits which are likely to generate beneficiary and provider abrasion. In addition, given alternative means to access medications outside of the Part D benefit such as discount cards and cash payments, Humana does not believe the measure will lead to the improved outcomes CMS is intending (e.g., hospitalizations, overdoses).

Members Choosing to Leave the Plan (Part C & D)

CMS plans to adjust the years of service area data used to identify beneficiaries leaving a contract due to a move out of the contract service area to better reflect contract service area at the time of the disenrollment.

Humana Response: Based upon our understanding of the proposed change related to a member moving out of a service area, Humana agrees with CMS's observation that this change is not substantive and has no concerns with the proposal. However, to ensure Humana is not misinterpreting the guidance, **Humana requests CMS provide an example of how the proposed change would be applied to ensure alignment.**

With respect to the exclusion related to Applicable Integrated Plan (AIP) movement, Humana has no concerns with the proposed recommendation.

Display Measures

Follow-Up After Hospitalization for Mental Illness (Part C)

NCQA is reevaluating this measure for continued relevance and validity, as well as its alignment with the larger suite of HEDIS behavioral health care coordination measures.

> **Humana Response:** Humana supports relaxing the denominator to include primary and secondary diagnoses in the initial encounter and agrees the follow-up should address mental health concerns anywhere in the claim rather than strictly the primary claim. While this expansion will add value for beneficiaries given that it will drive inclusion of a greater number of medical admissions for beneficiaries who also have psychiatric concerns, Humana has concerns that this will make achieving high rates of follow-up more difficult for health plans and providers.
>
> As NCQA continues with their evaluation, Humana believes it will be important to account for the increase in the scope of provider type to complete the follow-up and the importance of the documentation and sharing of initial discussions and follow-up as they draft additional technical specifications.

Social Need Screening and Intervention (Part C)

NCQA is exploring the addition of a utilities insecurity screening rate and intervention rate to the Social Need Screening and Intervention measure for measurement year 2026.

> **Humana Response:** Humana has been a longtime advocate for addressing loneliness and social isolation among MA enrollees and participated in the field testing of this proposed measure.[28]
>
> Consistent with feedback previously provided to NCQA and CMS, Humana does not believe the addition of a new domain is in the best interest of beneficiaries while the industry is still refining the current process and adoption of current data collection tools, including the FHIR Implementation Guides standards, remains slow. Humana continues to work with providers on connections and the sharing of data, but considerable manual work persists.
>
> Additionally, Humana supports The American College of Physicians' clinical policy recommendations on Social Determinants of Health and Health Equity, which include several prerequisites to widespread measurement and accountability for addressing social needs.[29] Humana encourages CMS and NCQA to consider this feedback before further development.

Retirement of Display Measures

CMS proposes to retire the Antidepressant Medication Management (Part C) measure.

> **Humana Comment:** Humana supports the retirement of the Antidepressant Medication Management (Part C) measure with no further comments.

[28] Loneliness Issue Brief. (2021). https://populationhealth.com/wp-content/uploads/2021/10/SDOH-Issue-Brief_Loneliness_October2021-EXTERNAL.pdf

[29] 04.-SNS-E.pdf (ncqa.org)

Potential New Measure Concept and Methodological Enhancements for Future Years Health Outcomes Survey (Part C)

CMS is seeking OMB approval to conduct a field test to evaluate the measurement properties of potential new survey items, the effects of revised survey content, and the addition of a web-based survey mode to the existing mixed mode protocol.

> **Humana Response:** Humana supports the continued advancement of the Health Outcomes Survey to ensure that it adequately assesses the health status of Medicare beneficiaries. Humana believes that a phased approach would be prudent to ensure that there are no unintended consequences. For example, adding the new web-mode to the survey may change the evidence and relevance related to questions that are proposed to be removed.
>
> Additionally, Humana does not believe that a survey question about specific interventions would accurately track or measure performance for addressing health-related social needs (HRSNs), and that the proposed intervention options being measured are too narrow and do not effectively assess plan performance.

Blood Pressure Control for Patients with Hypertension (Part C)

CMS states that it would consider replacing the existing Controlling Blood Pressure Measure if a new HEDIS measure is introduced.

> **Humana Response:** While Humana supports the intent, these changes would be significant and, without clear standards and verified ability of adoption of standards, Humana has concerns about whether the industry would be able to deliver value to beneficiaries with the new measure. Humana continues to urge CMS to allow plans and providers time to implement ECDS tools and processes before moving any other measures.

Breast Cancer Screening Follow-Up (Part C)

CMS welcomes feedback on a concept the NCQA is exploring which would expand the current Breast Cancer Screening measure to include follow-up of abnormal mammogram results.

> **Humana Response:** Humana supports efforts to encourage follow-up with the beneficiary after an abnormal result. However, given the clinical and sensitive nature of this particular scenario, Humana urges CMS and NCQA to consider an approach outside of a health plan rated measure. Humana has concerns that involving the health plan may cause undue stress to the beneficiary and risks conflicting with clinical judgment, decision making, and care planning of the clinicians involved with the beneficiary.

Social Connection Screening and Intervention (Part C)

CMS welcomes feedback on proposal of a Star Ratings measure NCQA is developing to assess the percentage of members aged 65 and older who were screened at least once during the measurement year for social isolation, loneliness, or inadequate social support and received a corresponding intervention for members who screened positive.

> **Humana Response:** Humana acknowledges the detrimental effect loneliness can have on the health-related quality of life of our members. While all HRSNs have root causes in social and structural drivers, many experts in the area of social isolation and loneliness point to the need

for societal "interventions" and public awareness to combat these health harming factors, rather than clinical intervention.[30]

Humana is concerned that the structure of this measure may have the unintended consequence of screening and referring for loneliness/social isolation rather than treating a mental or behavioral health condition or leveraging cognitive behavioral therapy or motivational interviewing to improve chronic conditional management.

If NCQA and CMS move forward with this measure, Humana requests additional clarification on LOINC codes and Z codes that would be utilized, given that current coding would not provide the level of detail needed for health plans and providers to take appropriate action.

Chronic Pain Assessment and Follow-Up (Part C)

NCQA is developing a new measure that would assess chronic pain and follow-up in Medicare members aged 65 and older.

Humana Comment: Humana understands that a pain assessment alone does not necessarily improve quality of care for beneficiaries and a focus on follow-up may have a positive effect. However, consistent with Humana's comments in the CY 2024 Advance Notice, Humana seeks clarification of the follow-up services CMS considers in scope for this measure. For example, whether follow-up services are specific to medication dispenses or if there are proposed timeframes for follow-ups to occur.

The main challenge that the Chronic Pain Assessment Follow-Up presents is the subjectivity of pain and how different the experience can be for every individual.[31] Any future measure should consider that patient interest in engaging with follow-up treatment may vary, such that the follow-up regimen cannot be too prescriptive. Given the follow-up plan will differ per individual, we are concerned the outcomes tied to a wider population may not fairly reflect the informed care planning between patients and their ongoing care providers.

Finally, Humana has concerns as to the scope of the expanded population and the administrative burden it will create for plans and providers alike. Furthermore, targeted populations can help bring visibility to what is most relevant to the needs of a specific area and help plans assess the most meaningful tactic to improve quality of care. It is also important to note that if a larger population requires evaluation, an alternative to Health Risk Assessments will need to be developed and will add administrative burden.

Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (Part C)

NCQA is exploring the development of two new measures related to tobacco use screening and lung cancer screening.

Humana Response: Humana recognizes the negative impact smoking can have on a beneficiary's health; however, given the multiple tobacco cessation measures that exist within

[30] Foundation for Social Connection, https://www.social-connection.org/

[31] Melzack, R., & Katz, J. (2012). Pain. *Wiley Interdisciplinary Reviews: Cognitive Science*, *4*(1), 1–15. https://doi.org/10.1002/wcs.1201

the Medicaid space, Humana suggests CMS and NCQA consider adoption and/or consolidation of an existing measure rather than the addition of a new one.

Functional Status Assessment Follow-Up (Part C)

NCQA is exploring the development of a new measure to assess follow-up after a Functional Status Assessment.

Humana Response: Humana supports the idea that a follow-up after a functional status assessment would add value to the beneficiary experience. However, Humana reiterates concerns related to the proposed expanded population for the Functional Status Assessment measure, which would ultimately impact any follow-up measure as well.

Medicare Plan Finder Drug Pricing Measure (Part D)

CMS is considering a new measure to evaluate the accuracy of sponsors' pricing data displayed on the Medicare Plan Finder (MPF) tool driven by the concern that some plans may be submitting artificially high or low prices to display on the MPF during the Annual Election Period (AEP).

Humana Response: Humana appreciates CMS's concern related to the beneficiary experience and how intentional manipulation of MPF submissions could be a tactic deployed to influence beneficiary plan choice. While Humana does not engage in these deliberate practices, we welcome the opportunity to help craft a measure that addresses this potential issue.

Humana believes measuring the stability of submissions will be the most effective approach to identify artificially high or low prices submitted during AEP. As minor price variations can occur at the NDC level, stability of submissions will be the most direct method to detect intentional manipulation of AEP submissions. In addition, Humana recommends calculating price changes as a percent variance. This would account for small ($0.02) variances that could be deemed as immaterial for both payers and beneficiaries. Humana would welcome the opportunity to collaborate with CMS on a specific percent variance to hold plans accountable to. We also recommend that CMS account for the volatility in list prices that can occur each year. CMS should consider the wholesale acquisition cost (WAC), average wholesale price (AWP), and national average drug acquisition cost (NADAC) variances that can occur post AEP submissions and plans should only be held accountable to variances outside the bounds of that volatility.

In addition, Humana would like to clarify that this measure is not intended to replace the current Part D MPF Price Accuracy Star measure. It is Humana's understanding that the intent is to create a new measure that would have a materially different objective.

Lastly, Humana would like to comment on the current Part D MPF Price Accuracy Star measure. In this Notice, CMS acknowledges the industry-wide volatility of list prices (e.g., WAC and AWP). In the current measure specification, plans are held accountable to small ($0.02) variations between MPF prices based on one representative NDC and PDEs of which there could be many NDCs with varying list prices. Health plans also do not have direct oversight of pharmacy NDC selection, which creates a challenging performance dynamic. This is exacerbated by market dynamics related to industry list prices (e.g., WAC and AWP) and PBM maximum allowable costs (MAC). For plans contracted to reimburse pharmacies using AWP, MAC prices are generally submitted for generic medications. Due to the more volatile nature of WAC, plans contracted to reimburse using WAC have a mixture of WAC and MAC submissions. This environment puts

plans using WAC for reimbursement at a unique disadvantage for this measure. For example, WAC submissions can be consistent and accurate based on the representative NDC, but the volatility of the list price can create common and consistent scenarios where PDEs are slightly inflated. Conversely, plans that price using AWP consistently submit MAC prices and nearly all PDEs reflect that pricing structure. Humana encourages CMS to consider the intersection of these dynamics and recommends CMS return the Part D MPF Price Accuracy Star measure to display. By doing so, this would allow the industry to focus on the truly inappropriate and inaccurate pricing tactics brought forth in this Notice and expedite measure creation.