

March 6, 2023

Submitted Electronically via [www.regulations.gov](http://www.regulations.gov)

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: Docket No. CMS-2023-0010-0002; Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**

Dear Administrator Brooks-LaSure:

The Center for Medicare Advocacy (the Center) is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality healthcare. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with long-term conditions. The Center's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues. Additionally, the Center provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit these comments to the Advance Notice (AN).

## Introduction/Overview

As discussed further below, there is consistent and growing evidence that Medicare Advantage (MA) plans are paid more on average than traditional Medicare spends on a given beneficiary, and such spending is growing per person, with significant implications for Medicare programmatic spending. These overpayments stem, in part, from MA plans "upcoding" – reporting their enrollees as being more sick or requiring more intense levels of care than their medical records support in order to receive higher risk-adjusted payment.

When CMS recently issued its long-awaited rules concerning risk adjustment data validation (RADV) audits, along with this Advance Notice (AN), the Center issued a statement<sup>1</sup> noting that while we are encouraged by many of the steps taken by this Administration to increase oversight of MA plans and strengthen consumer protections, when it comes to MA overpayments, it appears to be doing too little, too late. Further, while CMS appears to be taking steps to address overpayments by revising risk adjustment methodology in order to more accurately determine

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<sup>1</sup> "Center for Medicare Advocacy Statement on Recent Medicare Advantage Payment Policies and Proposals" (Feb. 3, 2023), available at: <https://medicareadvocacy.org/center-for-medicare-advocacy-statement-on-recent-medicare-advantage-payment-policies-and-proposals/>.

appropriate payment amounts, CMS is not proposing to use its discretion to employ a higher coding intensity adjustment.

Given the significant insurance industry pushback against these relatively minor payment adjustments, we urge CMS to hold fast against this pressure, and to reinforce its efforts to rein in and recoup Medicare Advantage overpayments. The Medicare program, the people it serves, and taxpayers cannot afford any other course of action. We therefore strongly support the proposals in the AN that would improve MA payment accuracy and urge CMS to build upon these modest but important reforms to more fully address the long-standing problem of MA overpayments.

### *Medicare Advantage Overpayments*

Independent observers of the Medicare program, including the Medicare Payment Advisory Commission (MedPAC), have continued to sound an alarm regarding the need for policymakers to act on Medicare Advantage overpayments and oversight, in part, because of the strain that MA overpayments put on Medicare's finances.

For example, citing MedPAC, an October 2022 *Bloomberg Law* article<sup>2</sup> notes that “[i]n their 37-year history, private Medicare managed care plans have never produced aggregate savings for the program.” The same article quotes Richard Kronick, a former HHS official and current professor of public health, as stating that “[i]n addition to depleting more quickly the trust fund that finances hospital care in traditional Medicare, MA overpayments also swell the federal deficit and drive up costs for beneficiaries, who pay for 25% of the cost for Medicare's ‘Part B’ coverage.”

A recent Kaiser Family Foundation (KFF) report<sup>3</sup> notes:

Payments to Medicare Advantage plans for Part A and Part B benefits nearly tripled as a share of total Medicare spending between 2011 and 2021, from \$124 billion to \$361 billion, due to steady enrollment growth in Medicare Advantage plans and higher per person spending in Medicare Advantage than in traditional Medicare.

The KFF report states: “Medicare pays more to private Medicare Advantage plans for enrollees than their costs would be in traditional Medicare, on average, and these higher payments have contributed to growth in spending on Medicare Advantage and overall Medicare spending.” The report outlines that, according to the Congressional Budget Office (CBO), these higher payments are due to: a “payment methodology [that] is based on benchmarks that are higher than traditional Medicare spending in half of all U.S. counties”; MA “enrollees have higher ‘risk scores’ than traditional Medicare beneficiaries in part because plans have a financial incentive to code for diagnoses, which increases the amount they are paid per enrollee”; and “higher payments based on their quality-based star ratings [...that] do not apply to traditional Medicare.”

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<sup>2</sup> *Bloomberg Law*, “Growth of Private Medicare Plans Clouded by Payment Questions” by Tony Pugh (Oct. 18, 2022), available at: <https://news.bloomberglaw.com/health-law-and-business/growth-of-private-medicare-plans-clouded-by-payment-questions>.

<sup>3</sup> *Kaiser Family Foundation*, “What to Know about Medicare Spending and Financing” (Jan. 2023) by Juliette Cubanski and Tricia Neuman, available at: <https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/>.

In short, as noted in comments to this AN submitted by a group of 38 health care experts,<sup>4</sup> including former MedPAC and CMS officials:

MedPAC has estimated that in 2023 there will be \$27 billion in excessive and unwarranted payments to MA Plans. Others have projected these overpayments will cost taxpayers \$600 billion over the next 8 years. Beneficiaries will ultimately directly shoulder approximately 14% of this, almost \$90 billion in increased Part B premiums.

Absent Congressional action, it is up to the Administration and CMS to act. The need to rein in the MA industry and stop wasteful payments could not be more clear. We applaud CMS for taking some initial steps to start doing so.

### *Insurance Industry Claims Ring Hollow*

The Medicare Advantage insurance industry – led by AHIP and their paid supporters at Coalition for Medicare Choices and Better Medicare Alliance – have sunk millions into an ad campaign to characterize CMS’ payment proposals as “unprecedented cuts” and have threatened that higher premiums and fewer benefits will necessarily result.

The Center has tried to highlight both the industry’s misleading arguments about these payment proposals being “cuts” and the fact that plan sponsors have considerable discretion over setting the benefits, premiums and cost-sharing structures of the plans they offer.<sup>5</sup>

A recent publication by the Kaiser Family Foundation<sup>6</sup> notes that “[t]he proposed payment changes for 2024, taken together, are unlikely to have a meaningful impact on the trajectory of Medicare Advantage spending, which CBO estimates will exceed \$7 trillion (cumulative) through the decade that ends in 2032.” The paper further explains:

Some in the industry say the payment changes will lead to premium increases or cuts in benefits for Medicare beneficiaries, though there is no clear evidence to suggest that. Plans use payments from the federal government in excess of the cost of providing Medicare benefits to provide extra benefits or lower premiums to beneficiaries. In theory, lower payments from the federal government could reduce the surplus available for extra benefits. However, plans also compete aggressively for enrollees with zero premiums and those extra benefits.

During the debate over the Affordable Care Act, when Congress made significant reductions in Medicare Advantage payments, there were similar warnings that plans would respond by pulling out of the market and dropping extra benefits, when in fact, the opposite happened. The Medicare Advantage market has proven to be robust and

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<sup>4</sup> Comment letter (Feb. 27, 2023) is available here: <https://justcareusa.org/experts-comment-on-cms-proposed-payment-changes-to-medicare-advantage-plans/>.

<sup>5</sup> See, e.g., *CMA Alert* “[Medicare Advantage Industry Continues to Mislead Public to Protect Their Overpayments](#)” (March 2, 2023); *CMA Alert* “[Insurance Industry Response to Proposed Medicare Advantage Payment for 2024](#)” (Feb. 16, 2023).

<sup>6</sup> *Kaiser Family Foundation* titled “[Is the Biden Administration Proposing Cuts to Medicare Advantage?](#)” by Jeannie Fuglesten Biniek (Feb. 17, 2023), available at: <https://www.kff.org/policy-watch/is-the-biden-administration-proposing-cuts-to-medicare-advantage/>.

relatively profitable. Plans may very well continue to offer extra benefits, and zero-premium offerings, to attract and retain enrollees, and grow market share. Medicare Advantage plans have responded to payment changes in the past by reducing their profits or lowering administrative costs. And plans have more money than ever to pay for extra benefits. Since 2018, the portion of Medicare Advantage payments that is used to fund extra benefits, called rebates, has doubled from \$1,140 per enrollee in 2018 to \$2,352 per enrollee in 2023.

In short, the Kaiser report concludes that “current efforts to improve the accuracy of payments made by the federal government, and improve program integrity, are unlikely to have a major impact on the program, the insurance industry or beneficiaries, given relatively generous payments to plans and the robustness of the Medicare Advantage market.”

Similarly, MedPAC notes in their comments to this AN<sup>7</sup>:

the Commission believes that modest reductions in payments to MA plans would not have a substantial effect on premiums, cost sharing reductions, or supplemental benefits because payment generosity is already very high and, based on the Commission’s analysis, plans would reduce profit, administrative costs, or net medical costs to preserve the benefits that are most important for attracting enrollees.

We urge CMS not to be swayed by specious self-interested insurance industry arguments, and, at the very least, retain the MA payment changes outlined in the Advance Notice.

## **Risk Adjustment**

CMS proposes to revise the current risk adjustment model to improve payment accuracy. We support transitioning the model to the ICD-10 diagnostic classification system that has been in place since 2015 and been in use in other settings, such as the Affordable Care Act marketplace and Medicare Part D. As noted by MedPAC in their comments to this Advance Notice<sup>8</sup> with respect to CMS’ proposal to use ICD-10 diagnosis codes, “[r]evising the model with more recent data years and a new diagnosis-to-HCC mapping will reflect more recent utilization, cost, and diagnostic patterns.”

We also share MedPAC’s support for CMS’ proposal to use the new (v28) risk adjustment model for 2024 payment to MA plans. As MedPAC notes, “[b]asing the model on more recent years of data and using ICD–10 diagnosis codes to estimate model coefficients are important updates that will improve the accuracy of risk adjustment and payments to MA plans.” As further explained by MedPAC:

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<sup>7</sup>Medicare Payment Advisory Commission (MedPAC) comments to Advance Notice (March 1, 2023), available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023\\_MA\\_C\\_AND\\_D\\_CY-2024\\_MedPAC\\_COMMENT\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf).

<sup>8</sup> Medicare Payment Advisory Commission (MedPAC) comments to Advance Notice (March 1, 2023), available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023\\_MA\\_C\\_AND\\_D\\_CY-2024\\_MedPAC\\_COMMENT\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf).

The Commission shares CMS’s concern that discretionary or inappropriate coding in MA can undermine payment accuracy independent from model fitness. For the HCCs proposed for elimination or constraint, it seems plausible that excess payment due to discretionary or inappropriate MA coding more than offsets any benefits to model fit from including the HCCs in the model. While these changes are a step in the right direction, we encourage CMS to continue efforts to identify other HCCs with discretionary or inappropriate MA coding and eliminate or constrain those HCCs, giving appropriate consideration to the potential for adverse effects on the fit of the risk adjustment model.

As noted in the above-referenced comments to this AN submitted by a group of 38 health care experts,<sup>9</sup> these proposed changes are not projected to significantly impact MA plans’ finances:

CMS now proposes to decrease the coding revenue opportunities by eliminating some HCC’s that have been abused and standardizing the prices associated with categories of codes to avoid upcoding for some conditions. The net result is projected to be a 1% increase in payments in 2024. In practice, the changes will be concentrated among MA plans and providers that are using the eliminated codes or adding more codes per patient. The proposed changes will leave the MA Plans, in aggregate, in a strong financial position while penalizing those who game the risk adjustment system. Efficient, ethical, and cost-effective providers will continue to be adequately reimbursed to deliver high quality care.

### **MA Coding Pattern Adjustment**

As the Center noted in our above-referenced statement concerning CMS’ final RADV audit rule and the Advance Notice,<sup>10</sup> while we applaud CMS for taking steps to address overpayments by revising risk adjustment methodology in order to more accurately determine appropriate payment amounts, we are disappointed that the agency is not proposing to use its discretion to employ higher coding intensity adjustment, which is meant to adjust for the fact that some plans may be coding too intensely. CMS has the authority to adjust plans’ payment more than the 5.9% statutory minimum, but so far the agency has not used this discretion despite, as MedPAC estimated that in 2020, the risk scores for MA enrollees were about 9.5% higher than what they would have been for a similar beneficiary in traditional Medicare. Using a higher adjustment is a measure supported by many stakeholders ranging from MedPAC to the Center for American Progress to the Committee for a Responsible Federal Budget.<sup>11</sup>

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<sup>9</sup> Comment letter (Feb. 27, 2023) is available here: <https://justcareusa.org/experts-comment-on-cms-proposed-payment-changes-to-medicare-advantage-plans/>.

<sup>10</sup> “Center for Medicare Advocacy Statement on Recent Medicare Advantage Payment Policies and Proposals” (Feb. 3, 2023), available at: <https://medicareadvocacy.org/center-for-medicare-advocacy-statement-on-recent-medicare-advantage-payment-policies-and-proposals/>.

<sup>11</sup> As discussed in this *CMA Alert*, “Special Report | Recent Articles and Reports Shed Light on Medicare Advantage Issues” (Oct. 31, 2022), available here: <https://medicareadvocacy.org/special-report-recent-articles-and-reports-shed-light-on-medicare-advantage-issues/>.

As MedPAC states in its comments to this Advance Notice<sup>12</sup>:

coding intensity now generates tens of billions of dollars in excess payments to MA organizations annually. The cost of those payments is borne by the taxpayers, Medicare beneficiaries, and state Medicaid agencies who fund the Medicare program.

The evidence documented by the Commission and others over many years indicates that stronger action is needed. Although we applaud CMS's efforts to reduce MA and FFS coding differences by eliminating or constraining certain HCCs in the risk adjustment model proposed for 2024, those efforts are inadequate to address growing MA coding intensity and the resulting excess payments to MA plans. We urge the Secretary and CMS to increase the coding intensity adjustment to more fully reflect the magnitude of this excess spending.

MedPAC further outlines the cumulative impact of growth in MA enrollment, in part, fueled by unaddressed coding intensity increases:

Exacerbating the effects of coding intensity-driven overpayments is the fact that the number of beneficiaries enrolled in MA is greater than ever and MA enrollment continues to grow rapidly. The combination of large MA enrollment and increasing coding intensity has resulted in excess Medicare spending of about \$23 billion due to MA plan coding intensity in 2023 alone (Figure 5). By the end of 2023, Medicare will have cumulatively paid MA plans nearly \$124 billion just due to coding intensity. About one-third, \$44 billion, of that total will be paid to plans in 2022 and 2023.

MedPAC states that “[i]f CMS applies the minimum statutory adjustment for coding intensity of 5.9 percent in 2024 as proposed, we estimate that uncorrected coding intensity will generate more than \$25 billion in 2024, which would bring the total coding-intensity-related payments from 2007 through 2024 to about \$149 billion.”

MedPAC further describes how the significant financial imbalance between MA payment and traditional Medicare is driving MA enrollment: “[a]lthough the resources devoted to coding intensity offer no societal benefit, coding intensity likely increases MA enrollment as added extra benefits influence more Medicare beneficiaries to choose to enroll in an MA plan rather than FFS Medicare.”

MedPAC concludes:

For nearly a decade, the Commission has documented overpayments to MA plans due to coding intensity and has recommended policies to address the problem. Overpayments due to coding intensity are now tens of billions of dollars annually and are increasing by billions each year. The Commission's recommendation and other proposals to address these overpayments are fully within the Secretary's authority; yet, the Secretary has not taken significant action in response, except through modest adjustments to HCC coefficients as in the new v28 risk adjustment model that, while directionally correct, are insufficient to address the magnitude of excess Medicare spending related to MA coding

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<sup>12</sup> Medicare Payment Advisory Commission (MedPAC) comments to Advance Notice (March 1, 2023), available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023\\_MA\\_C\\_AND\\_D\\_CY-2024\\_MedPAC\\_COMMENT\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf).

intensity. Given the dire financial status of the Medicare program, it is imperative that CMS act now to fully account for the impact of coding intensity.

We join MedPAC in urging the Secretary to do everything within his authority to address this “magnitude of excess Medicare spending relating to MA coding intensity.” While Congress bears ultimate responsibility for setting Medicare payment and coverage policy, HHS can and should do more.

### **Conclusion**

We applaud CMS’ efforts to modernize MA payment methodology and support further action to control soaring and unnecessary MA costs. Given the growing imbalance between spending on MA and in traditional Medicare, and the corresponding wasteful payment to MA plans that exert further pressure on the Medicare program’s finances, however, we urge the agency to do more, including using its discretion to increase the coding intensity adjustment.

We appreciate the opportunity to submit these comments. For additional information, please contact David Lipschutz, Associate Director at [DLipschutz@medicareadvocacy.org](mailto:DLipschutz@medicareadvocacy.org) or (202)293-5760.

Sincerely

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