



March 3, 2023

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the “Advance Notice of Methodological Changes for Calendar Year 2024 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies” that was published February 1, 2023.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work in the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide range of issues including commercial sector prices, provider payment incentives, Medicare sustainability, prescription drug prices, and complex care.

First, we want to thank the agency for its important work to help improve the Medicare Advantage program, and for the opportunity to provide input. Before we comment, we want to be clear that we support Medicare Advantage as an option for beneficiaries and believe that Medicare Advantage plans have the ability to efficiently deliver care and coordinate and organize systems to improve care. We also believe there are opportunities to improve the efficiency of care delivered to beneficiaries in fee-for-service Medicare. That said, Medicare continues to overpay Medicare Advantage plans. While we support Medicare Advantage plans as a choice in Medicare, we do not support overpaying plans and believe major reforms to Medicare Advantage are urgently needed to ensure the program delivers value to beneficiaries and taxpayers.

The evidence consistently shows that Medicare Advantage plans are paid more than traditional Medicare for similar enrollees. The Medicare Payment Advisory Commission (MedPAC) estimates that payments to Medicare Advantage plans are six percent higher than traditional Medicare, resulting in an estimated \$27 billion in overpayments in 2023 alone.¹ A major driver of the overpayments is the prevalence of upcoding, where Medicare Advantage plans intensively code beneficiary diagnoses to make them appear less healthy and increase plan payments.

The proposed revisions to the risk adjustment system are a reasonable initial step to address plans’ discretionary coding of beneficiary diagnoses. However, the evidence on the extent of upcoding and its effect on plan payments strongly suggests CMS must do more to meaningfully

¹ The Medicare Payment Advisory Commission (MedPAC). [The Medicare Advantage program: status report](#). January 12, 2023.



address excessive coding. The goal of risk adjustment is to predict variation in expected costs across plans based on patients' specific health needs while maintaining appropriate incentives for plans to care for high-risk beneficiaries. We urge CMS to increase the coding intensity factor used to account for the coding differences between Medicare Advantage and traditional Medicare and to further reform the risk adjustment system to reduce the opportunities for gaming while maintaining appropriate incentives for plans to compete by delivering value rather than by engaging in risk selection.

The evidence shows that despite the overheated rhetoric of organized interest groups, the payment changes made in 2010 did not lead to the demise of the managed care industry. Instead, Medicare Advantage plans are now bidding more efficiently and enrollment has doubled since 2010. The rebate dollars plans use to fund extra benefits to enrollees are at a historic high.² Reforms are essential to improve the value and sustainability of Medicare Advantage and past experience and evidence suggests reasonable reforms to address overpayments are unlikely to have a major impact on beneficiaries or the robustness of the Medicare Advantage market. In fact, reforms to reduce overpayments to Medicare Advantage plans would reduce the premiums that Medicare beneficiaries pay for their coverage.

There are a number of topics in the notice related to our work; our comments focus on CMS' proposals to limit the coding intensity factor to the minimum set in statute and revisions to the risk adjustment model. We provide more details on our feedback below.

Coding Pattern Difference Adjustment

CMS proposes to limit the coding intensity factor in the risk adjustment model to the minimum set in statute, 5.9 percent. We strongly disagree and urge CMS to increase the coding intensity factor. There is clear evidence that the current coding intensity adjustment is too small.

MedPAC estimates that Medicare Advantage plans' risk scores were 10.8 percent higher than risk scores for similar beneficiaries in fee-for-service in 2021.³ Even after accounting for CMS' current coding adjustment, this cost the taxpayer \$17 billion in excess payments to Medicare Advantage plans in 2021 and is projected to cost taxpayers \$23 billion in 2023.⁴ MedPAC estimates that an increase of 4.9 percent is needed to fully account for coding differences between Medicare Advantage and fee-for-service.⁵ Other estimates suggest a higher increase is needed, including

² MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.

³ MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.

⁴ MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.

⁵ MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.



estimates that risk scores were 20 percent higher than in fee-for-service in 2019 and that Medicare Advantage plans were overpaid by more than \$106 billion between 2010 and 2019.^{6,7} Notably, the problem is getting worse. CMS' coding intensity adjustment has remained constant, yet the impact of upcoding is growing, resulting in higher and higher overpayments each year.⁸

We understand that there is variation in coding across Medicare Advantage plans, so we encourage CMS to contemplate increasing the coding intensity adjustment to target the worst offenders.⁹ For example, plans with the most intensive upcoding could receive the largest coding adjustments while plans with less evidence would receive smaller adjustments, with adjustments averaging to 4.9 percent. **We urge CMS to use its authority to apply a higher coding adjustment factor than what is minimally required of it in statute to fully account for intensive coding.**

Risk Adjustment Model Revisions

Under the current risk adjustment model, there is ample opportunity for Medicare Advantage plans to engage in aggressive coding to inflate their payments. CMS has proposed several technical changes to the risk adjustment model, including revisions that target Hierarchical Condition Categories (HCCs) that are more susceptible to aggressive coding. Specifically, the proposed model reclassification seeks to remove certain HCCs and apply constraints to HCCs for diabetes and congestive heart failure. The revisions are intended to reduce the model's sensitivity to coding variation and proliferation.

We support CMS' proposed changes to reduce incentives for Medicare Advantage plans to engage in aggressive coding by reducing the impact these HCCs have on payment. Revising the risk adjustment model to make it less prone to gaming by Medicare Advantage plans is an important first step toward improving program integrity and reducing overpayment to plans. Similar to the recently finalized rule regarding Medicare Advantage Risk Adjustment Data Validation (RADV), we are supportive of the overall direction and intent of these changes, and we urge CMS to contemplate additional changes that more directly address the significant level of overpayments to Medicare Advantage plans, including by increasing the coding intensity adjustment, as mentioned above, and through the following changes:

⁶ Kronick, Richard and Chua, F. Michael. [Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity](#). November 11, 2021.

⁷ Schulte, Fred. "[Researcher: Medicare Advantage Plans Costing Billions More Than They Should.](#)" Kaiser Health News. November 11, 2021.

⁸ MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.

⁹ MedPAC. [The Medicare Advantage program: status report](#). January 12, 2023.



- **Exclude information collected via in-home health risk assessments (HRAs) and chart reviews as a source of diagnoses for Medicare Advantage risk adjustment**, consistent with recommendations made by MedPAC and the OIG.^{10,11} MedPAC found that nearly two-thirds of Medicare Advantage coding intensity could be due to chart reviews and HRAs and that these two tactics are a primary factor driving coding differences among plans.¹² OIG found that diagnoses reported only on HRAs resulted in over \$2.6 billion in overpayments to plans in a single year.¹³
- **Use two years of diagnostic data in risk adjustment** to help mitigate differences in coding intensity between fee-for-service and Medicare Advantage.¹⁴
- **Contemplate larger scale reforms to CMS' approach to risk adjustment.** In consideration of emerging evidence, a long-term vision for CMS' risk adjustment should contemplate major changes to the methodological approach including:
 - **Modified approaches to traditional risk adjustment, such as combining a truncated or more parsimonious model with reinsurance**, which may reduce the potential for plan gaming.¹⁵ MedPAC, for example, analyzed a modified risk adjustment model that incorporates the principles of reinsurance and repayment to address payment inaccuracies for outliers.¹⁶
 - **Alternative sources of data for risk adjustment**, with a focus on sources that cannot be directly influenced by plans to minimize the opportunity for plan gaming.
 - **Approaches that leverage risk adjustment as a tool to improve equity**, including by reallocating the distribution of health care resources to better serve underserved beneficiaries and reduce selection bias, which is a strategy that aligns with CMS' health equity goals.

Conclusion

Reducing overpayments and improving program integrity in Medicare Advantage are critical to improve the affordability and sustainability of the Medicare program. In addition to ensuring the

¹⁰ Testimony of Erin Bliss, HHS OIG. "[Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans.](#)" June 28, 2022.

¹¹ MedPAC. [The Medicare Advantage program: Status report.](#) March 2016.

¹² MedPAC. [The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans.](#) March 2022.

¹³ HHS OIG. [Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns.](#) September 2020.

¹⁴ MedPAC. [The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans.](#) March 2022.

¹⁵ Sherri Rose. [A Machine Learning Framework for Plan Payment Risk Adjustment.](#) *HSR*, 51(6). December 2016.

¹⁶ MedPAC. [Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS's risk-adjustment model.](#) June 2022.



program delivers value to beneficiaries and taxpayers, reforms would improve the solvency of the Medicare Hospital Insurance Trust Fund, as nearly 45 percent of Medicare Advantage funding comes from the trust fund. With the trust fund facing insolvency in 2028, the Medicare program cannot afford this magnitude of continued and worsening overpayments to Medicare Advantage plans.¹⁷ More accurately adjusting for coding intensity could reduce Medicare spending by as much as \$198 to \$355 billion over the next decade (2021-2030), with slightly less than half of savings accruing to the Hospital Insurance Trust Fund, thereby extending solvency.¹⁸

In contrast to CMS projections, interest groups have stated that if the proposed changes included in the Advance Notice are finalized, Medicare Advantage plans will see a payment cut.¹⁹ The 2024 Advance Notice is expected to result in a one percent payment increase; the 2023 Advance Notice generated an eight percent increase. We applaud CMS for moving in the right direction to reduce overpayments to Medicare Advantage. The evidence shows that this can be done with little impact on beneficiaries and is critical for ensuring the fiscal sustainability and integrity of the Medicare program.

Again, we appreciate the opportunity to comment on the proposed rule. Please contact Erica Socker at esocker@arnoldventures.org or Mark Miller at mmiller@arnoldventures.org with any questions.

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¹⁷ The Centers for Medicare and Medicaid Services. [2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#). June 2, 2022.

¹⁸ Committee for a Responsible Federal Budget. [Reducing Medicare Advantage Overpayments](#). February 23, 2021.

¹⁹ Better Medicare Alliance. [BMA Statement on CMS Proposal to Cut Medicare Advantage](#). February 2, 2023.