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Getting Medicare right

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VIA ELECTRONIC SUBMISSION

March 6, 2023

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

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

General Comments

We strongly support the proposals in the Advance Notice (AN) that would improve Medicare Advantage (MA) payment accuracy. Modest but important, these changes would begin to correct the decades-long problem of MA overpayments while ensuring that people with Medicare continue to benefit from ample plan choice and market stability.

The risk adjustment updates in particular would make MA payment methodology more accurate and rates more rational. We encourage CMS to finalize this proposal and to revise others, including by more forcefully combatting coding variances and abuses. Taken together, CMS notes the changes in the AN would raise plan payments by 1% next year.[1] This clear increase comes on top of the 8.5% raise plans received in 2023.[2]

[1] Centers for Medicare & Medicaid Services, "2024 Medicare Advantage and Part D Advance Notice Fact Sheet," (February 1, 2023), https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-advance-notice-fact-sheet.
[2] *Id.*

Reining in MA overpayments is long overdue. Independent research consistently confirms that excess payments to private MA plans are negatively impacting Medicare's finances and long-term sustainability, along with beneficiary premiums and taxpayer costs. The AN is largely responsive to these findings, and to the concerns many current and future Medicare beneficiaries have about paying for care,[3] rising Medicare costs,[4] and the program's future.[5]

The amounts inappropriately paid to plans are significant and well documented. For example, the Government Accountability Office found that in 2013, MA plans received an extra $14 billion,[6] and the Medicare Payment Advisory Committee (MedPAC) has cataloged $140 billion in MA overpayments over the past 12 years.[7] Between 2007 and 2023, MA coding intensity generated $124 billion additional dollars[8] and could cost $600 billion over the next decade.[9] Of that amount, $85 billion would be paid by beneficiaries through higher Part B premiums.[10] In 2018, CMS identified $650 million in overpayments to 90 plans from 2011 through 2013; some analysts calculated at least twice that much.[11] CMS estimates that in 2021 alone, plans were improperly overpaid by $23 billion.[12]

MedPAC notes MA plan overpayments are due to several factors:

> The Commission has found that payments to MA plans are inflated as a result of plans maximizing the diagnoses they report for their enrollees in order to gain higher payments, while the underlying risk adjustment model relies on diagnoses collected from claims from fee-for-service (FFS) providers, who lack the same incentives to code diagnoses. MA plans also receive quality bonuses that increase Medicare spending for the majority of MA enrollees, yet the MA quality rating system does not provide meaningful information about plans' quality of care. MA spending is also driven up by plan benchmarks that are set so high that the Medicare program ends up subsidizing the substantial extra benefits that MA plans offer to their enrollees—benefits that are not available to FFS enrollees.[13]

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[3] *See, e.g.,* Juliette Cubanski, *et al*., "How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?," Kaiser Family Foundation (November 9, 2019), https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/ and Alex Montero, *et al.,* "Americans' Challenges with Health Care Costs," Kaiser Family Foundation (July 14, 2022), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

[4] Shannon Shumacher, *et al.*, "KFF Health Tracking Poll December 2022: The Public's Health Care Priorities for the New Congress," Kaiser Family Foundation (December 20, 2022), https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-december-2022/.

[5] West-Health and Gallup, "2022 Healthcare in America Report," (October 6, 2022), https://s8637.pcdn.co/wp-content/uploads/2022/10/2022-Healthcare-in-America.pdf.

[6] U.S. Government Accountability Office, "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments," (April 2016), https://www.gao.gov/assets/gao-16-76.pdf.

[7] Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, And the Medicare 'Money Machine,' Part 1: The Risk-Score Game," Health Affairs (September 29, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210927.6239/.

[8] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," (January 12, 2023), https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf.

[9] Richard Kronick, *et al*., "Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity," SSRN (November 17, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446.

[10] *Id*.

[11] Fred Schulte, "Government Lets Health Plans That Ripped Off Medicare Keep the Money," Kaiser Health News (January 30, 2023), https://khn.org/news/article/cms-audits-medicare-advantage-plans-can-keep-hundreds-of-millions-in-federal-overpayments-maybe-more/.

[12] Leslie Gordon, "Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight," U.S. Government Accountability Office (June 28, 2022), https://www.gao.gov/assets/gao-22-106026.pdf.

[13] Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

The AN addresses some of these policies, including the MA risk adjustment model and coding intensity. Others—such as soaring rebate payments that help finance benefits not available in Original Medicare and egregious upcoding that allows plans to benefit from paper-only diagnoses without providing care—are beyond its scope, but no less urgent.

Swift, comprehensive action is critical because MA costs will only escalate as plan and enrollment numbers do. Relaxed regulations, such as the elimination of meaningful difference and uniformity requirements,[14] and burgeoning profits[15] have led to an unduly cluttered MA marketplace. For 2023, beneficiaries had access to an average of 43 MA plans, over twice as many as in 2018.[16] MA enrollment has similarly surged, more than doubling in the last decade.[17] The Congressional Budget Office projects the share of beneficiaries enrolled in MA, now 48%, will hit 61% by 2031.[18]

Payments to MA plans are also climbing. As a portion of total Medicare dollars, they increased from 26% in 2010 to 45% in 2020, and may reach 54% by 2030.[19] Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with Original Medicare.[20] MedPAC estimates Medicare pays MA plans 6% more than Original Medicare for similar enrollees, translating to an extra $27 billion in 2023.[21] Unless these imbalances are corrected, their impacts will deepen. Higher payments per MA enrollee are expected to cost Medicare $183 billion in the coming years.[22]

This system was not envisioned and is not sustainable. A driving premise behind MA was its potential to save Medicare dollars. But it never has. Instead, MA costs more, both per enrollee and in the aggregate, than Original Medicare.[23] Without intervention, this will remain true, and the harmful cycles it perpetuates will continue: MA enrollment growth will further increase Medicare spending, raising Part B premiums and taxpayer costs while worsening Medicare solvency challenges.[24] Policymakers must reverse these trends and prevent these outcomes. We appreciate the AN provisions that attempt to do so.

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[14] 86 FR 16440, 16491.
[15] *See, e.g.*, Paige Minemyer, "2022 Forecast: Medicare Advantage is the Industry's Hottest Market. Don't Expect that to Change Next Year," Fierce Healthcare (December 22, 2021), https://www.fiercehealthcare.com/payer/medicare-advantage-industry-s-hottest-market-2022-don-t-expect-to-change and Jared Ortaliza, *et al*., "Health Insurer Financial Performance in 2021," Kaiser Family Foundation (February 28, 2023), https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/ and Megan Houston, "Where the Bread is Really Buttered: Insurers' Q4 Earnings Reports Show Heavy Reliance on Government Business," Georgetown University Center on Health Insurance Reforms (March 7, 2022), https://chirblog.org/bread-really-buttered-insurers-q4-earnings-reports-show-heavy-reliance-government-business/.
[16] Meredith Freed, *et al*., "Medicare Advantage 2023 Spotlight: First Look," Kaiser Family Foundation (November 10, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.
[17] *Id.*
[18] Congressional Budget Office, "Baseline Projections," (May 2022), https://www.cbo.gov/system/files?file=2022-05/51302-2022-05-medicare.pdf.
[19] Jeannie Fuglesten Biniek, *et al*., "The Growth in Share of Medicare Advantage Spending," Kaiser Family Foundation (April 7, 2022), https://www.kff.org/medicare/slide/the-growth-in-share-of-medicare-advantage-spending/.
[20] Jeannie Fuglesten Biniek, *et al.*, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges," Kaiser Family Foundation (August 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.
[21] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," (January 12, 2023), https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf.
[22] Jeannie Fuglesten Biniek, *et al.*, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges," Kaiser Family Foundation (August 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.
[23] Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=401.
[24] *Id.*

Troublingly, CMS's proposed steps towards payment accuracy are causing some plans to consider, or at least to threaten, to scale back benefits, raise premiums, or both.[25] In context, however, this response and risk appear exaggerated. Following through would require plans to act against their own self-interest, as beneficiaries would be more likely to reject pared back or more costly coverage, endangering enrollment and profit gains. Cutbacks are additionally unlikely because they would undermine the industry's most powerful marketing tool: supplemental benefits. MA plans are required to cover the same services as Original Medicare and may offer benefits beyond that, ranging from gym memberships to limited vision and dental care.[26] Virtually all plans do so, and market them to maximize enrollment—with great success. In 2022, supplemental benefits were the most common reason enrollees cited for choosing an MA plan over Original Medicare,[27] despite an alarming lack of data on their utilization, quality, and value.[28]

Payment rate modeling reinforces that any cost-shifting to enrollees is entirely the plan's choice. They could instead operate within the increased payment rate parameters or achieve savings without disturbing access or benefits, such as by reducing profits or administrative expenses.[29] MA profit margins, which are consistently higher than other insurers, underscore plan capacity to lower costs internally. In 2021, per enrollee gross margins for MA plans were more than 200% higher than plans offered in the individual/non-group market, the fully insured group/employer market, and the Medicaid managed care market.[30]

Past plan behaviors, including in response to the Affordable Care Act's (ACA) comparatively severe MA payment changes, cast further doubt on current posturing. Despite fears and assertions that plans would reduce benefits or leave the market, the post ACA period has been one of robust and sustained MA expansion.[31]

Industry claims that they cannot provide a competitive product without being overpaid is either a startling admission of their own inefficiencies, a ploy to pad profits, or both. We urge CMS not to be swayed, and to move forward with beneficiary-centered reforms as outlined below.

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[25] Better Medicare Alliance, "Biden Administration Proposal Could Reduce Medicare Advantage Benefits By $540 Per Beneficiary in 2024, Independent Analysis Finds," (February 15, 2023), https://bettermedicarealliance.org/news/biden-administration-proposal-could-reduce-medicare-advantage-benefits-by-540-per-beneficiary-in-2024-independent-analysis-finds/.

[26] Jeannie Fuglesten Biniek, *et al*., "Extra Benefits Offered by Medicare Advantage Firms Vary," Kaiser Family Foundation (November 16, 2022), https://www.kff.org/medicare/issue-brief/extra-benefits-offered-by-medicare-advantage-firms-varies/.

[27] Faith Leonard, *et al*., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why," The Commonwealth Fund (October 17, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.

[28] Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

[29] *See, e.g*., Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System: Report to the Congress," (June 2021), https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/ and Jeannie Fuglesten Biniek, *et al.*, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges," Kaiser Family Foundation (August 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.

[30] Jared Ortaliza, *et al*., "Health Insurer Financial Performance in 2021," Kaiser Family Foundation (February 28, 2023), https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/.

[31] *See, e.g*., Jeannie Fuglesten Biniek, *et al.*, "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges," Kaiser Family Foundation (August 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/ and Richard G. Frank, *et al.*, "Profits, Medical Loss Rations, and the Ownership Structure of Medicare Advantage Plans," USC-Brookings Schaeffer Center on Health. Policy (July 13, 2022), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/07/13/profits-medical-loss-ratios-and-the-ownership-structure-of-medicare-advantage-plans/.

Attachment II. Changes in the Part C Payment Methodology

Section A. MA Benchmark, Quality Bonus Payments and Rebate: The changes outlined in this section would more than offset the risk adjustment modifications discussed below: together they would constitute a 1% increase in MA payment. We support the proposals and reiterate the need for a comprehensive approach to MA financing reform.

Section G. CMS-HCC Risk Adjustment Model for CY 2024: CMS proposes to revise the MA risk adjustment model in several important ways, including by updating the hierarchical condition categories (HCCs) based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes, and by constraining or removing several HCCs to reduce the impact of MA coding variation on risk scores.

We strongly support these changes. The use of the standard ICD-10-CM diagnosis codes to replace the out-of-date ICD-9 codes would allow for a greater level of detail and more precision in the identification of specific conditions. In addition, disregarding or limiting HCCs associated with discretionary diagnostic categories would help prevent coding variations and abuses from distorting risk scores. Diagnoses should only be permitted to raise risk scores if they are closely related to costs. These and other proposed model modernizations would more closely align MA with current practices and yield more accurate payments.

Section J. Medicare Advantage Coding Pattern Difference Adjustment: We are disappointed that CMS is again proposing to apply the 5.9% statutory minimum coding pattern adjustment, rather than a higher and more effective rate.

The minimum adjustment, unchanged since 2018, is not keeping pace with MA coding intensity or the resulting excess plan payments.[32] As it falls ever shorter—and is applied to an ever-growing number of MA enrollees—overpayments will only rise.[33] MedPAC estimates that in 2020, risk scores for MA enrollees were already 9.5% higher than what they would have been for a similar beneficiary in Original Medicare, funneling an extra $12 billion to plans and clearly exposing the inadequacy of a 5.9% adjustment.[26] By 2021, the scores and payments had jumped to 11% and $17 billion, respectively.[34] Medicare is projected to overpay plans by $44 billion in 2022 and 2023.[35] Applying the minimum adjustment in 2024 would generate another $25 billion, bringing total coding intensity-related overpayments since 2007 to $150 billion, with 45% of that coming in the last three years.[36]

We strongly encourage CMS to revisit this proposal and to finalize an approach that more sufficiently accounts for coding differences between Original Medicare and MA.

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[32] *See, e.g.*, Section 1853 (a)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395w–23(a)(1)(C)(ii)] and Fred Schute, "Medicare Advantage's Cost to Taxpayers has Soared in Recent Years, Research Finds," NPR (November 11, 2021), https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding.

[33] Medicare Payment Advisory Commission, "January 2022 MedPAC Meeting Transcript," (January 13, 2022), https://www.medpac.gov/wp-content/uploads/2021/10/Jan22_MedPAC_Meeting_Transcript_SEC.pdf.

[34] Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," (January 12, 2023), https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf.

[35] *Id.*

[36] Medicare Payment Advisory Commission, "MedPAC Comment on CMS's Advance Notice of Methodological Changes for CY 2024 for Medicare Advantage Capitation Rates and Part C and D Payment Policies," (March 1, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf.

Conclusion

We applaud CMS's efforts to modernize MA payment methodology and support further action to control soaring and unnecessary MA costs.

MA payment must strike a balance between encouraging insurer participation and delivering value for beneficiaries, taxpayers, and Medicare. Currently, the needle has swung too far towards plans, as carriers inundate the market and are rewarded with extreme profits, at the expense of Medicare solvency and individual Americans' financial security.

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy JCarter@medicarerights.org or 202-637-0962.

Sincerely,

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