MEDICARE RIGHTS CENTER
Getting Medicare right

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March 1, 2024

VIA ELECTRONIC SUBMISSION

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

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 [CMS-2024-0006]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the proposed Calendar Year (CY) 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice). 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 over three million people with Medicare, family caregivers, and professionals.

General Comments

We strongly support the policies in the Advance Notice that would make MA payment methodology more accurate and rates more rational.

Overpayments to private plans are negatively impacting Medicare's finances and long-term sustainability, as well as driving up beneficiary premiums and taxpayer costs. The amounts inappropriately paid to plans are significant and well documented,[1] with the Medicare Payment Advisory Commission (MedPAC) projecting that MA plans will be paid 123% of fee-for-service Medicare costs in

[1] Medicare Rights Center, "The Overpayment Cycle: Payments to Medicare Advantage" (July 20, 2023), https://www.medicarerights.org/pdf/medicare-advantage-101-overpayment-cycle.pdf.

2024 through a combination of favorable selection and coding,[2] driving up Part B premiums by $13 billion.[3]

It is both unjust and unsustainable to expect beneficiaries and other taxpayers to shoulder the costs of MA overpayments. Many people with Medicare live on fixed or limited incomes that make it difficult to absorb such costs. Half of all beneficiaries, over 30 million people, live on $36,000 or less per year and one quarter have less than $17,000 in savings.[4] Health-related expenses comprise a large and disproportionate share of beneficiary budgets. In 2021, their average health care spending burden (15% of total spending) was twice as large as that of non-Medicare households (7%).[5] One in three spent 20% or more, compared to one in 14 non-Medicare households.[6] And financial challenges are common. In 2023, over 30% of beneficiaries said it was difficult to afford their health coverage and care.[7] More than 20% skipped or delayed services because of cost, and a similar share said health care expenses made it harder for them to pay for other essentials, like food and utilities.[8]

Unless these payment imbalances are corrected, their impacts will deepen—flaws in the MA methodology yield inflated payments, which are tied to and rise with MA enrollment.[9] Today, MA provides coverage for more than half (51%) of all eligible beneficiaries, a share that could reach 62% by 2033.[10] Allowing overpayments to grow in tandem would put individual economic security and program sustainability at ever-greater risk.

The Advance Notice addresses some of the key forces behind these problematic overpayments, including through the updated MA risk adjustment model. As finalized last year, this model should help to gradually advance payment accuracy and we appreciate its continued phase-in.[11] Elsewhere, however, the 2025 proposal falls short, including by failing to apply a stronger coding intensity adjustment. Other overpayment drivers—such as soaring rebates that help finance benefits not available in OM and some coding abuses that allow plans to financially benefit from paper-only diagnoses without providing care—are in some ways beyond its scope, but no less urgent. As discussed

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[2] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.
[3] Stuart Hammond, *et al.*, "January 2024 Public Meeting Transcript," (January 11, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/January-2024-meeting-transcript.pdf.
[4] Alex Cottrill, *et al.*, "Income and Assets of Medicare Beneficiaries in 2023" (February 5, 2024), https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/.
[5] Nancy Ochieng, *et al.*, "Medicare Households Spend More on Health Care Than Other Households" (July 19, 2023), https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/.
[6] *Id.*
[7] Gretchen Jacobson, *et al.*, "Can Medicare Beneficiaries Afford Their Health Care?" (October 26, 2023), https://www.commonwealthfund.org/publications/2023/oct/can-medicare-beneficiaries-afford-their-health-care-2023-survey.
[8] *Id.*
[9] Medicare Rights Center, "Payments to Medicare Advantage: The Methodology" (July 20, 2023), https://www.medicarerights.org/pdf/medicare-advantage-101-payments-methodology.pdf.
[10] Nancy Ochieng, *et al.,* "Medicare Advantage in 2023: Enrollment Update and Key Trends" (August 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.
[11] CMS, "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" (March 31, 2023), https://www.cms.gov/files/document/2024-announcement-pdf.pdf.

previously and in our comments below, we implore CMS to pursue the full range of policy reforms, working with Congress to make necessary legislative changes.

Of course, correcting harmful MA overpayments may cause some plans to choose, or at least to threaten, to scale back on benefits, raise premiums, or both. In context, however, this risk appears 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 OM and may offer benefits beyond that, ranging from gym memberships to some vision and dental care.[12] 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 OM,[13] despite an alarming lack of data on their utilization, quality, and value.[14]

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.[15] MA profit margins 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.[16]

Past plan behaviors, including in response to the Affordable Care Act's (ACA) MA payment changes, cast further doubt on such 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.[17] Similarly, despite plan claims that last year's payment changes would lead to dramatic cutbacks and irreparable harms, they did not slash benefits and enrollment grew by 7.1%.[18]

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

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

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

[15] *See, e.g*., MedPAC, "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" (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/.

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

[17] *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" (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" (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/.

[18] Bob Herman, "Medicare Advantage enrollment races past 33 million" (February 16, 2024), https://www.statnews.com/2024/02/16/medicare-advantage-enrollment/.

Industry claims that they cannot provide a competitive product without being overpaid is again either a startling admission of their own inefficiencies, a ploy to pad profits, or both. CMS cannot prevent plans from ceasing to offer heavily marketed supplemental benefits, the government should not pay a ransom for them either.

Therefore, we again ask CMS to center beneficiary needs by doing even more to rein in high and unnecessary MA costs. We also reiterate our calls for CMS to provide more robust oversight of MA and Part D plans to ensure they are meeting their contractual and civic duties. CMS must hold plans accountable for compliance with existing rules and guidelines and pay them accurately and appropriately. We recognize this may require additional CMS staff and resources, which we urge the agency to request and Congress to fund.

MA payment should strike a balance between encouraging insurers to enter and remain in the market and providing value for beneficiaries, taxpayers, and Medicare. Currently, the needle has swung too far to encourage plan entry as plans proliferate and are rewarded with high profits, while beneficiaries struggle to make informed enrollment decisions and obtain affordable care.[19] To the extent that CMS can promote a more reasonable, consumer-oriented system, the agency must do so.

Attachment II. Changes in the Part C Payment Methodology

Section G. CMS-HCC Risk Adjustment Model for CY 2024: We strongly support CMS's planned implementation of the recently revised risk adjustment model. Finalized last year, these updates make modest but important changes to MA payment methodology.[20]

We ask CMS to continue modernizing risk adjustment by reducing the impact that factors disconnected from plan costs can have on plan payments. CMS could further curtail plan gaming by identifying additional codes that are used disproportionately by MA plans, limiting them as appropriate to prevent risk score distortions and corresponding overpayments.

MedPAC recommends completely removing health risk assessments (HRAs) from risk adjustment.[21] We concur and support guardrails on the inclusion of chart reviews as well. As noted by MedPAC, the HHS Office of the Inspector General, and confirmed by independent researchers, these tools are easily manipulated.[22] In our experience, bad actors often assign diagnoses that are unsupported by the enrollee's medical record and that do not result in additional treatment. This not only allows individual

[19] Meredith Freed, *et al.*, "Medicare Advantage 2024 Spotlight: First Look" (November 1, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.
[20] CMS, "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" (March 31, 2023), https://www.cms.gov/files/document/2024-announcement-pdf.pdf.
[21] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.
[22] *See, e.g.,* HHS OIG, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments" (September 20, 2021), https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2023), https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/ and Richard Kronick, "Projected Coding Intensity in Medicare Advantage Could Increase Medicare Spending by $200 Billion Over Ten Years" (February 2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0768.

plans to receive extra money without providing extra care,[23] but also reduces payment accuracy system-wide by making the MA enrollee population appear sicker and costlier than they are.[24]

Ultimately, these upcoding abuses—which account for about half of excess payments to MA plans[25]—lead to billions of dollars in wasteful spending and jeopardize Medicare's financial footing.[26] They also hurt the health and economic well-being of all Medicare beneficiaries by driving up Part B premiums and undermining the extent to which the MA payment system can hold plans accountable for delivering high quality and equitable care, such as through the MA quality bonus program.[27]

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 overpayments.[28] 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 OM, funneling an extra $12 billion to plans and clearly exposing the inadequacy of a 5.9% adjustment.[29] By 2021, the scores and payments had jumped to 11% and $17 billion, respectively.[30] In 2024, coding intensity in MA is expected be 20.1% higher than OM, resulting in $54 billion in overpayments.[31]

We appreciate CMS's recognition of the need to minimize rampant MA plan upcoding. We strongly encourage CMS to do so more completely, by finalizing an approach that meaningfully accounts for coding differences between OM and MA. Since the coding intensity adjustment is a blunt instrument, applying to all plans regardless of their behavior, a more sufficient rate may adversely affect the relatively small number of plans that are not gaming the system. We urge CMS to investigate ways to hold these better actors harmless. However, we reiterate that such reforms are nevertheless necessary:

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[23] *Id.*

[24] *See, e.g.,* MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2023), https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/ and Juliette Cubanski, *et al.*, "FAQs on Medicare Financing and Trust Fund Solvency" (June 17, 2022), https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/.

[25] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

[26] *See, e.g.,* MedPAC, "Report to the Congress: Medicare Payment Policy" (March 2023), https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/ and Juliette Cubanski, *et al.*, "FAQs on Medicare Financing and Trust Fund Solvency" (June 17, 2022), https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/.

[27] MedPAC, "Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part 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.

[28] *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.

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

[30] Luis Serna, *et al.*, "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.

[31] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

The vast majority of beneficiaries are in plans that overcode.[32] Barring swift and extensive payment changes that precisely target those bad actors, blanket changes are required.

Section K. Normalization Factors: CMS proposes to use a new methodology to determine the 2025 OM normalization factor, to address the impacts of the COVID-19 pandemic more accurately without deleting data years. Previous and alternative methodologies failed to account for growth in spending while appropriately handling the anomalous pandemic years that temporarily disrupted cost trends. We support the outlined approach but note that severing the connection between OM spending and MA payment would better respond to increasing distortions in the underlying data set as healthier beneficiaries switch into MA and costlier beneficiaries remain in OM.[33] We urge CMS to consider such revisions in the future. In the interim, while MA payment remains tethered to OM costs, any projection must be as accurate and rational a reflection of OM costs as possible, in order to minimize further harms to beneficiary and program finances.

Conclusion

We welcome CMS's efforts to refine MA payment methodology and support further action to improve costs and the beneficiary experience, program wide.

Absent systemic reforms, including simplifying the MA choice landscape, enhancing consumer protections and affordability, and strengthening plan transparency, oversight, and accountability, taxpayers, beneficiaries, and Medicare will pay an ever-higher price.

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 at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi

Fred Riccardi
President
Medicare Rights Center

[32] *Id.*

[33] Steven M. Lieberman, *et al.*, "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments" (June 13, 2023), https://healthpolicy.usc.edu/research/ma-enrolls-lower-spending-people-leading-to-large-overpayments.