**Advance Notice Template Comments for Organizations**

[Submission Date]

Centers for Medicare & Medicaid Services
Department of Health and Human 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**

[Organization name] appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Advance Notice of Methodological Changes for CY 2024 MA Capitation Rates and Part C and Part D Payment Policies. [Description of organization]

We strongly support the proposals in the Advance Notice (AN) that would improve MA payment accuracy and urge CMS to build upon these modest but important reforms to more fully correct the decades-long problem of MA overpayments.

Independent researchers and advisors have consistently found that overpayments to private MA plans are negatively impacting Medicare’s finances and long-term sustainability, as well as driving up beneficiary premiums and taxpayer costs.[[1]](#footnote-2) The AN is largely responsive to these findings, and to the concerns many current and future Medicare beneficiaries have about paying for care,[[2]](#footnote-3) rising Medicare costs,[[3]](#footnote-4) and the program’s future.[[4]](#footnote-5)

The amounts inappropriately paid to plans are significant and well documented. For example, the Government Accountability Office estimates that in 2013 alone, MA plans received an extra $14.1 billion,[[5]](#footnote-6) and the Medicare Payment Advisory Committee (MedPAC) has cataloged approximately $140 billion in MA overpayments over the past 12 years.[[6]](#footnote-7) In 2018, CMS identified an estimated $650 million in overpayments to 90 plans from 2011 through 2013; some analysts calculated overpayments of at least twice that much.[[7]](#footnote-8)

This inflation is the result of several factors, some of which—including the MA risk adjustment model and coding intensity—are addressed in the AN. 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—require policymaking that is beyond the scope of this AN but no less urgent.

Swift and comprehensive reforms are needed because MA costs will escalate as plan and enrollment numbers do. Relaxed regulations[[8]](#footnote-9) and burgeoning profits[[9]](#footnote-10) have led to an unduly cluttered MA marketplace. In 2023, beneficiaries had access to an average of 43 MA plans, over twice as many as in 2018.[[10]](#footnote-11) MA enrollment has also surged, more than doubling in the last decade.[[11]](#footnote-12) The Congressional Budget Office (CBO) projects the share of beneficiaries enrolled in MA, now 48%, will hit 61% by 2031.[[12]](#footnote-13)

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.[[13]](#footnote-14) Per person, Medicare spending is higher and growing faster for MA beneficiaries than for those with Original Medicare;[[14]](#footnote-15) MedPAC estimates payments to MA plans are about 104% of what Original Medicare would have spent on the same care for the same enrollee.[[15]](#footnote-16)

Given these realities, policymakers must use every opportunity to remedy MA financing flaws; we appreciate the AN provisions that would advance this goal. The risk adjustment updates in particular would make MA payment methodology more accurate and rates more rational, appropriately slowing MA payment growth while maintaining beneficiary access to a flourishing MA marketplace. We encourage CMS to finalize this proposal and to revise others, including by more forcefully addressing coding variances and abuses. Taken together, these and other changes in the AN would increase plan payments by 1% next year, on top of an 8.5% hike in 2023.

Reining in MA overpayments is long overdue. Troublingly, this move towards accuracyis causing some plans to consider, or at least to threaten, to scale back benefits, raise premiums, or both.[[16]](#footnote-17) In context, however, this risk appears overblown; beneficiaries would have the option to abandon or avoid such plans, blunting envisioned profits. These cuts 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.[[17]](#footnote-18) 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.[[18]](#footnote-19)

It also appears disingenuous. MA plans consistently report much larger profit margins than other insurers, indicating ample opportunity 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.[[19]](#footnote-20)

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 significantly impacting access or benefits, such as by reducing their disproportionately high profits or lowering their administrative costs.[[20]](#footnote-21) Past plan behaviors, including in response to the Affordable Care Act’s (ACA) comparatively severe payment reductions, prove this point. Despite fears that MA plans would reduce benefits or leave the market, the post ACA period was one of robust and sustained expansion.[[21]](#footnote-22)

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 by this rhetoric and to move forward with needed reforms; the current system is simply not sustainable. The 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.[[22]](#footnote-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.[[23]](#footnote-24)

As outlined below, the AN’s risk adjustment changes would begin to alter these entrenched patterns. We support those provisions and ask CMS to strengthen those that fall short, namely the agency’s application of the statutory minimum coding adjustment.

**Risk Adjustment**

CMS is legally required to update payments to MA plans each year to ensure they match expected enrollee health care costs. These determinations are made through a process known as “risk adjustment” and are based on diagnoses and demographic characteristics. CMS routinely revises the underlying model to improve payment accuracy.

This AN would do so in several commonsense ways. It would transition the model to a diagnostic classification system (known as ICD-10) that has been in place since 2015 and long-used by other programs, such as the Affordable Care Act market and Medicare Part D. It would also link the model to more recent data; it presently relies on cost, utilization, and demographic patterns that are nearly ten years old. In addition, it would disregard certain “discretionary” diagnoses that MA plans utilize but that are not connected to program spending. These modernizations “were constructed in close collaboration with expert clinicians to reflect how doctors and other health care providers diagnose and care for their patients.”[[24]](#footnote-25) If adopted, they would better align MA with standard practices and yield more accurate payments.

**MA Coding Pattern Adjustment**

As the Medicare Payment Advisory Commission (MedPAC) explains, payments to MA plans are inflated, in part “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.”

CMS has a crucial lever to help correct this, known as “coding intensity adjustment.” This is an annual, across-the-board payment reduction designed to account for the widespread plan practice of coding too intensely. The minimum statutory adjustment is 5.9%, though CMS can and should increase it.

MedPAC warns the fixed minimum adjustment is not keeping pace with MA coding intensity trendlines. As it falls ever short—and is applied to an ever-growing number of MA enrollees—overpayments will only rise.[[25]](#footnote-26) The Commission 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, resulting in $12 billion in excess plan payments and illustrating the inadequacy of a 5.9% adjustment.[[26]](#footnote-27)

Yet, CMS is again seeking to apply the statutory minimum for 2024. We strongly encourage CMS to reconsider this, and to instead pursue an adjustment level that more sufficiently accounts for the impact of coding differences between Original Medicare and MA.

**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 insurers to enter and remain in the market and providing 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 this opportunity to provide comment. For additional information, please contact [name and title (if other than yourself), e-mail, and phone number].

Sincerely,

[Name]
[Title]
[Organization]

1. *See, e.g*., Medicare Payment Advisory Commission, “The Medicare Advantage program: Status Report” (March 2019), <https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch13_sec.pdf>; and 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>. [↑](#footnote-ref-2)
2. *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/>. [↑](#footnote-ref-3)
3. 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/>. [↑](#footnote-ref-4)
4. 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>. [↑](#footnote-ref-5)
5. 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>. [↑](#footnote-ref-6)
6. 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/>. [↑](#footnote-ref-7)
7. 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/>. [↑](#footnote-ref-8)
8. 86 FR 16440, 16491. [↑](#footnote-ref-9)
9. *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/>. [↑](#footnote-ref-10)
10. 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/>. [↑](#footnote-ref-11)
11. *Id.* [↑](#footnote-ref-12)
12. Congressional Budget Office, “Baseline Projections” (May 2022), <https://www.cbo.gov/system/files?file=2022-05/51302-2022-05-medicare.pdf>. [↑](#footnote-ref-13)
13. 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/>. [↑](#footnote-ref-14)
14. 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/>. [↑](#footnote-ref-15)
15. 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/>. [↑](#footnote-ref-16)
16. 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/>. [↑](#footnote-ref-17)
17. 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/>. [↑](#footnote-ref-18)
18. 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>. [↑](#footnote-ref-19)
19. 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/>. [↑](#footnote-ref-20)
20. *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/>. [↑](#footnote-ref-21)
21. *Id.* [↑](#footnote-ref-22)
22. 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>. [↑](#footnote-ref-23)
23. *Id.* [↑](#footnote-ref-24)
24. U.S. Department of Health and Human Services, “Fact v. Fiction: Biden-Harris Administration is Strengthening Medicare; Private Industry Must Share Obligation to Deliver Quality Health Care for America’s Seniors” (February 17, 2023), <https://www.hhs.gov/about/news/2023/02/17/fact-v-fiction-biden-harris-administration-strengthening-medicare-private-industry-must-share-obligation-deliver-quality-health-care-for-americas-seniors.html>. [↑](#footnote-ref-25)
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26. Martha Hostetter and Sarah Klein, “Taking Stock of Medicare Advantage: Risk Adjustment” The Commonwealth Fund (February 17, 2022), <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-risk-adjustment>. [↑](#footnote-ref-27)