



March 1, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC, 20201

RE: CMS-2023-0010

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled “Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,” published on February 2, 2023. We appreciate your staff’s work on the notice, particularly considering the competing demands on the agency.

Our comments focus on the following provisions:

- Technical update to medical education payments in the non-end-stage renal disease United States per capita cost baseline
- MA end-stage renal disease rates
- CMS hierarchical condition category risk adjustment model for calendar year 2024
- MA coding pattern difference adjustment
- Updates for Part C and Part D star ratings

Technical update to medical education payments in the non-end-stage renal disease (ESRD) United States per capita cost (USPCC) baseline

Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by the MA plan bid—which is intended to represent the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.¹

¹ If a plan’s bid is above the benchmark, the plan’s MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. If a plan’s bid is below the benchmark, its base payment rate is its bid plus a share of the difference between the plan’s bid and the benchmark.

MA benchmarks are based on fee-for-service (FFS) spending in each county and are established in the April prior to a given payment year so that MA plan sponsors have the information to prepare bids. Therefore, the county-level FFS spending estimates used in MA benchmarks are projections of FFS spending in each county for the payment year. These county-level FFS spending estimates used for MA benchmarks are the product of two factors: the national FFS per capita cost, also called the USPCC, and a county-level geographic index called the average geographic adjustment.

The USPCC includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs, which are not covered by plans) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs. The USPCC is projected for the payment year based on the most recent program experience and accounts for various trends, including unit cost changes; utilization and intensity of services; changes in population mix; and changes in Medicare coverage due to legislation, regulation, or national coverage decisions. CMS pays hospitals directly for indirect medical education (IME) and direct graduate medical education (DGME) costs on behalf of MA enrollees, so IME and DGME payments made on behalf of FFS beneficiaries are removed from the FFS spending estimates used for MA benchmarks.

There are separate payment rates for enrollees with ESRD and without ESRD, and so there are separate FFS spending estimates for each group. CMS notes that, historically, the hospital cost data supporting the modeling of the non-ESRD FFS USPCC did not separately identify payments made on behalf of FFS enrollees from payments made on behalf of MA enrollees, so the non-ESRD FFS USPCC has included both IME and DGME costs paid to inpatient facilities on behalf of MA enrollees. The inclusion of spending on behalf of MA enrollees in the FFS USPCC means that MA organizations effectively have been paid (in error) for MA-related IME and DGME costs. However, CMS is now able to separate these payments on behalf of MA enrollees and FFS beneficiaries and can identify the historical and projected costs of IME and DGME paid to inpatient facilities by CMS associated with services furnished to MA enrollees.

CMS is proposing to remove these MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs beginning with CY 2024.

Comment

MedPAC supports CMS's proposal to remove MA-related IME and DGME payments from the non-ESRD FFS USPCC estimates. Removing such payments will make payments to MA organizations more accurate in future years. We appreciate CMS's ongoing efforts to improve the processes through which the agency calculates plan payment rates and the transparency in this advance notice offered about these efforts at improvement.

MA end-stage renal disease (ESRD) rates

For enrollees with ESRD, CMS pays MA plans a payment rate for each state based on the spending for Medicare Part A and Part B services for FFS ESRD beneficiaries. These state dialysis rates are established based on a national growth trend and a state-based index.

Last year, CMS conducted an analysis calculating separate rates for each core-based statistical area (CBSA) (either metropolitan or micropolitan statistical area) within a state and for the non-CBSA, or rural, parts of each state. In that analysis, CMS standardized the CBSA-based rates so that overall payments would be the same as when using the state-based payments. CMS found that average rural rates would decrease by 2.6 percent, while average urban rates would increase by 0.5 percent. CMS noted some concern that rates for some medically-underserved urban areas would decline.

This year, building on the prior analysis, CMS assessed the changes in payment rates that would occur if using the CBSA-based rates instead of the state-based rates relative to county area deprivation index (ADI) values. A low ADI indicates a low level of socioeconomic deprivation and is associated with positive health outcomes for beneficiaries in a county, while a high ADI indicates a high level of socioeconomic deprivation and is associated with negative health outcomes. CMS found that, on average, using CBSA-based rates would increase the payment rates for areas with a relatively low ADI, whereas the payment rates would decrease for areas with a relatively high ADI. Given these findings, CMS proposed to continue using the existing state-based rates for CY 2024.

Comment

MedPAC shares CMS's concern about the resources available to providers in medically underserved areas and is sensitive to the adverse implications that policy changes may have for vulnerable populations such as those living in areas with higher levels of socioeconomic deprivation or in areas with higher rates of negative health outcomes. We assert that those providers and beneficiaries would be best served through policies or additional resources that are directly targeted to fulfill their unmet medical and social needs.

However, the state-based dialysis rates reflect both the per capita costs for FFS beneficiaries using dialysis and the geographic distribution of those FFS beneficiaries across the counties in each state, which often differs from the geographic distribution of MA enrollees using dialysis in the same state. The state dialysis rates would be more accurate if they reflected geographic distribution of MA dialysis patients. For example, CMS could develop state rates by aggregating county-level per capita costs for FFS dialysis patients weighted by county-level MA dialysis patient enrollment. Critically, CMS should not subsequently restandardize the MA-weighted state rates, constraining them to be equal to the existing state rates. If a greater share of MA dialysis patients in a state (compared to FFS dialysis patients) resides in counties with higher FFS per capita costs, then the state dialysis rate should be higher than the current rate to better reflect the FFS costs that exist in the counties where the MA dialysis patients reside. Such a method would continue to align MA payment rates with per capita FFS costs, but it would also pay MA plans more fairly, based on the geographic distribution of MA dialysis patients.

CMS hierarchical condition category risk adjustment model for CY 2024

Medicare payments to MA plans are adjusted to account for differences in enrollees' expected medical costs. The purpose of risk adjustment is to ensure that plans are adequately and fairly

compensated for treating all categories of enrollees—those with high medical costs as well as those likely to incur fewer costs. The CMS–hierarchical condition category (CMS–HCC) risk adjustment model uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses to calculate a risk score for each enrollee. Diagnoses associated with similar medical conditions and with similar treatment costs are grouped into HCCs. Some closely related HCCs are grouped into hierarchies based on condition severity.

Each demographic and HCC component in the risk adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated using FFS Medicare claims data such that all Medicare spending in a year is distributed among the model components. The sum of these dollar value coefficients is normalized into an index, called a risk score. Normalization, applied to all risk scores for FFS and MA enrollees, establishes a 1.0 risk score for a beneficiary with average FFS Medicare spending. Higher risk scores generate higher payments because beneficiaries with high risk scores are expected to have higher expenditures and vice versa.

For 2024, CMS proposes to introduce a new risk adjustment model version (v28) that is based on more recent data. The model would use a new International Classification of Diseases, 10th Revision (ICD–10) diagnosis code-to-HCC mapping and an updated list of HCCs. ICD–10 diagnosis codes have been required in FFS Medicare since October 1, 2015. This new model would replace the risk model version used in 2023, which is based on 2014 diagnostic data and 2015 spending, and uses an ICD–9 diagnosis code-to-HCC mapping combined with an ICD–9-to-ICD–10 crosswalk. Revising the model with more recent data years and a new diagnosis-to-HCC mapping will reflect more recent utilization, cost, and diagnostic patterns.

In the new (v28) risk adjustment model, CMS also proposes to eliminate or constrain the coefficients of certain HCCs that CMS has identified to be subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans or providers. CMS identified the conditions in the model where coding in MA was highest relative to FFS and reviewed those conditions with clinical experts to evaluate whether the coding differential indicates that the coding variation may be due to differences in diagnostic discretion. CMS proposes to remove HCCs for protein-calorie malnutrition, angina pectoris, and atherosclerosis of arteries of the extremities with intermittent claudication. At the same time, CMS proposes to eliminate the levels of severity for two 3-HCC hierarchies, effectively combining each set of three HCCs into single group with the same coefficient. CMS proposes to apply this hierarchy constraint to diabetes (with glycemic, unspecified, or no complications; with chronic complications; and with severe acute complications) and congestive heart failure (heart failure, except end-stage and acute; acute heart failure (excludes acute on chronic); and acute on chronic heart failure).²

² We interpret this proposal as an indication that CMS’s analysis found that coding of the higher-severity HCCs in these hierarchies (rather than coding of *any* HCC in each hierarchy) was greater in MA relative to FFS. We also note that the three congestive heart failure HCCs are the lower three severity levels of a 6-HCC hierarchy that also includes heart failure with heart assist device/artificial heart; end-stage heart failure; and heart transplant status/complications.

CMS estimates that implementing the proposed risk model, which incorporates a renormalization of FFS risk scores relative to the prior year, will reduce payments to MA plans by 3.12 percent. CMS also estimates that MA payments will increase by 3.30 percent due to coding trends, and that plan payments overall, net of all trend factors and policy adjustments, will rise by about 1 percent.

Comment

MedPAC supports CMS's proposal to use the new (v28) risk adjustment model for 2024 payment to MA plans. Basing 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.

In particular, we support CMS's efforts to reduce the extent of coding differences between MA plans and FFS Medicare providers. When diagnostic discretion, intentional or unintentional, leads to large differences in the coding rates between MA and FFS and across MA plans, it diminishes the accuracy of risk-adjusted payments to MA plans and increases the excess payments that MA plans receive due to higher coding intensity. Eliminating HCCs and constraining the coefficients of HCCs that are found to have excessive discretionary coding variation is sound strategy to improve payment accuracy and reduce overall MA coding intensity relative to FFS.

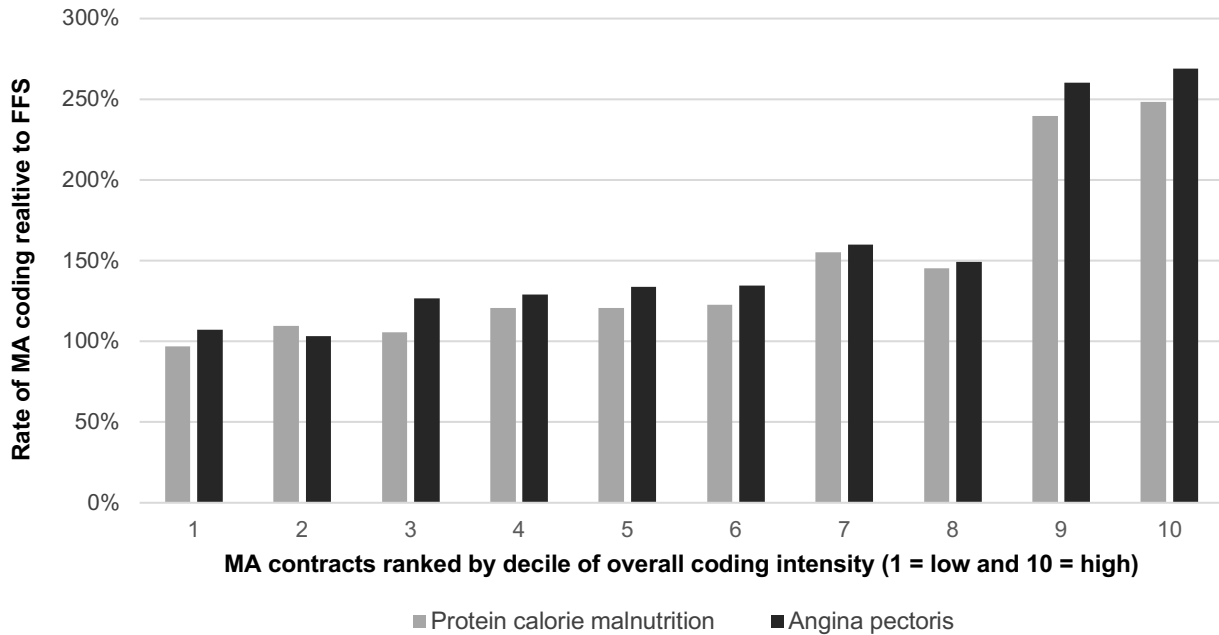
It is clear that CMS's proposal to eliminate or constrain the coefficients of certain HCCs will reduce coding intensity overall, but the distributional effect on plans by their level of coding intensity is also important. Currently, higher-coding plans receive a large share of the excess payments due to coding intensity, while other plans receive little or no coding-related excess payment.³ Therefore, to assess the effect of these HCC changes for plans with different levels of coding intensity, we compared rates of MA coding for each HCC relative to the rates of coding in FFS Medicare, accounting for differences in age, sex, and Medicaid eligibility status. We found that, after controlling for these variables, there was wide heterogeneity across plans in the use of the targeted codes, suggesting that it is plausible that these codes may be driving inappropriate variation in payment across plans.

We identified plans with high versus low overall coding intensity based on trends in risk scores for continuously enrolled members. For two of the three HCCs that CMS proposes to eliminate, we found that MA plans with lower overall coding intensity (in the lower deciles in Figure 1) code at rates similar to providers in FFS Medicare, while MA plans with high overall coding intensity (in the highest two deciles in Figure 1) code these HCCs 2.5 times more frequently than providers in FFS Medicare (Figure 1), after accounting for age, gender, and dual status.⁴

³ See Figure 6 and Figure 7 in this comment letter for information about the extent of coding intensity variation across MA contracts and across MA organizations.

⁴ We could not evaluate the third HCC (atherosclerosis of arteries of the extremities, with intermittent claudication) that CMS proposes to eliminate from the v28 model because there is not an equivalent HCC in the prior, v24 risk adjustment model.

Figure 1. MA plans with high overall coding intensity coded two HCCs proposed for elimination about 2.5 times as frequently as FFS Medicare providers



Note: FFS (fee-for-service), HCC (hierarchical condition category), MA (Medicare Advantage). MA contracts (which include one or more MA plans) were ranked from lowest to highest based on 2021 coding intensity and then grouped into deciles of roughly equal MA enrollment. This analysis evaluates HCC 21 (protein-calorie malnutrition) and HCC 88 (angina pectoris) in the v24 model used for 2021 risk scores, which are similar to HCC 47 (protein-calorie malnutrition) and HCC 230 (angina pectoris) in the proposed v28 model. The unit of analysis is rate of MA coding relative to the rate in FFS Medicare, where 100 percent indicates an MA coding rate that is the same as in FFS Medicare. The analysis accounts for differences in age, sex, and Medicaid eligibility status.

Source: MedPAC analysis of Medicare enrollment and 2021 risk score files.

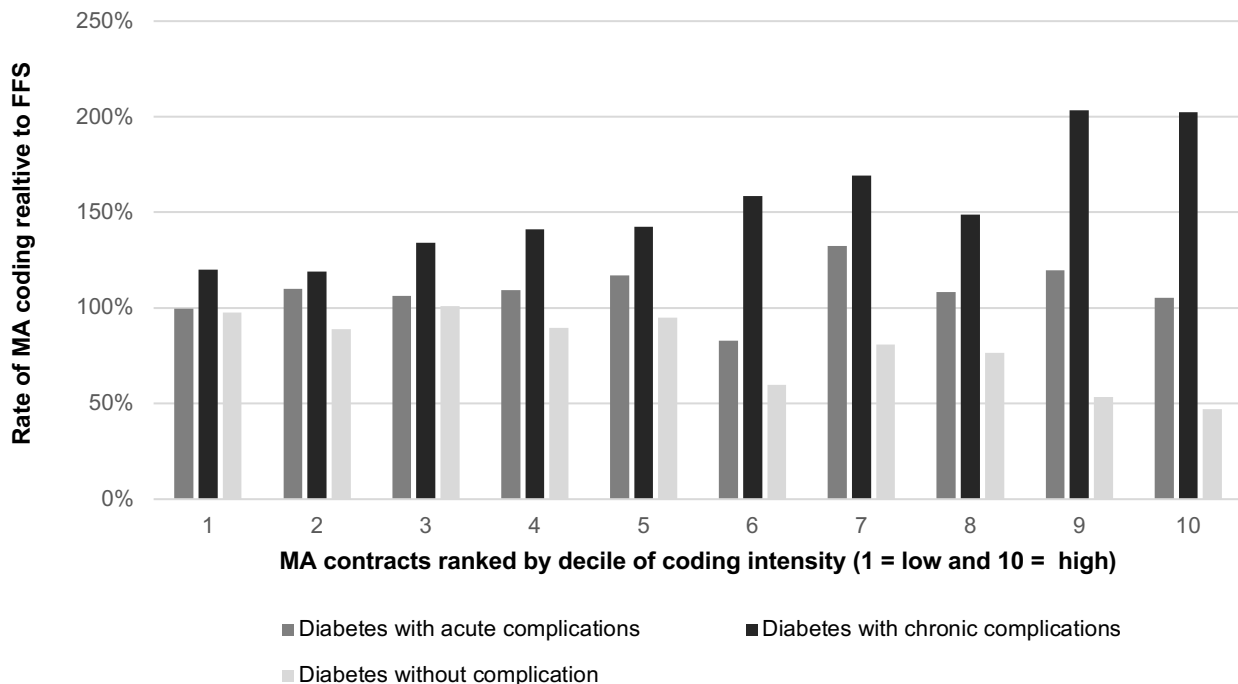
The amount of variation in coding these HCCs across MA plans suggests evidence of discretionary or inappropriate coding by health plans or providers. In the lower eight deciles, there is some correlation between higher overall coding intensity and higher coding rates for these two HCCs, but the coding practices of the MA plans and providers in the highest two deciles greatly exceed both those of providers in FFS Medicare and those of other MA plans. Thus, while plan-level variation in the severity of enrolled beneficiaries may contribute to observed coding differences, the magnitude of the increase between deciles 8 and 9 is concerning.

We found a similar pattern for the HCCs that CMS proposes to constrain (i.e., to hold the coefficients of the HCCs equal to each other such that each HCC carries the same weight). One set of three HCCs that CMS proposes to constrain is diabetes without complication, diabetes with chronic complications, and diabetes with acute complications. In the current (v24) model, the HCCs for diabetes with chronic or acute complications have a coefficient that is about three times larger than the HCC for diabetes without complication. Therefore, plans and providers in MA have an incentive to code any of the diabetes HCCs more frequently and, further, have an incentive to

shift coding beneficiaries with diabetes without complication (with a smaller coefficient) to diabetes with chronic or acute complications (with a larger coefficient) when possible.

MA plans with low overall coding intensity (in the lower deciles in Figure 2) tend to code these three HCCs similarly to providers in FFS Medicare, but providers with higher overall coding intensity (in the highest two deciles in Figure 2) code diabetes with chronic complications about two times more frequently than providers in FFS Medicare and code diabetes without complication about half as frequently as providers in FFS Medicare.

Figure 2. MA plans with high overall coding intensity coded diabetes with chronic complications about two times as frequently as FFS Medicare providers, and diabetes without complication about half as frequently as FFS Medicare providers



Note: FFS (fee-for-service), HCC (hierarchical condition category), MA (Medicare Advantage). MA contracts (which include one or more plans) were ranked from lowest to highest coding based on 2021 coding intensity and then grouped into deciles of roughly equal MA enrollment. This analysis evaluates HCC 17 (diabetes with acute complications), HCC 18 (diabetes with chronic complications), and HCC 19 (diabetes without complication) in the v24 model used for 2021 risk scores, which are similar to HCC 36 (diabetes with severe acute complications), HCC 37 (diabetes with chronic complications), and HCC 38 (diabetes with glycemic, unspecified, or no complications) in the proposed v28 model. The unit of analysis is rate of MA coding relative to the rate in FFS Medicare, where 100 percent indicates an MA coding rate that is the same as in FFS Medicare. The analysis accounts for differences in age, sex, and Medicaid eligibility status.

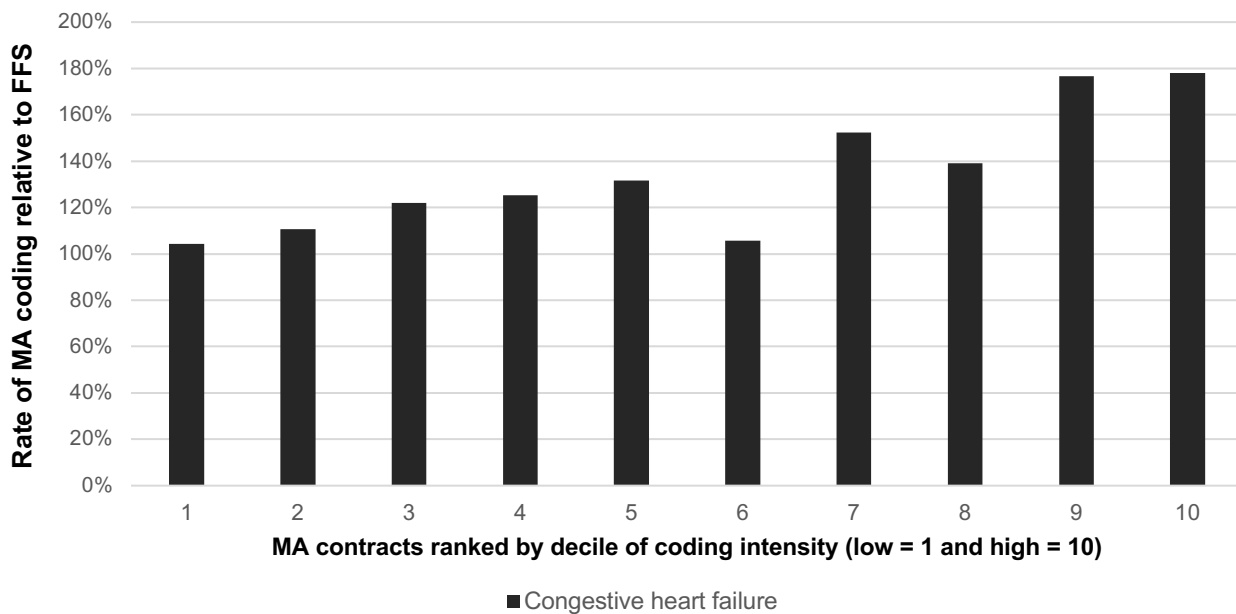
Source: MedPAC analysis of Medicare enrollment and 2021 risk score files.

Constraining the three diabetes HCCs to have the same coefficient would address the discretionary coding that leads to differential rates of coding of diabetes with chronic complications and diabetes

without complication. However, MA plans in the highest two deciles also code any of the three diabetes HCCs about 1.6 times more frequently than providers in FFS Medicare (data not shown). Constraining the three diabetes HCCs to have the same coefficient would not address this more frequent coding of diabetes (through any of the three HCCs).

The other set of three HCCs that CMS proposes to constrain is related to congestive heart failure (acute on chronic, acute (excluding acute on chronic), and heart failure (except end stage and acute)). In the current (v24) model, there is only one HCC for congestive heart failure, so we are not able to assess whether there is upcoding in the proposed v28 model from HCCs with lower coefficients to HCCs with higher coefficients. However, we do find that MA plans with low overall coding intensity code congestive heart failure at about the same rate as providers in FFS Medicare, while plans with high overall coding intensity code congestive heart failure about 1.8 times as frequently as providers in FFS Medicare (Figure 3).

Figure 3. MA plans with high overall coding intensity coded congestive heart failure nearly 1.8 times as frequently as FFS Medicare providers



Note: FFS (fee-for-service) HCC (hierarchical condition category), MA (Medicare Advantage). MA contracts (which include one or more MA plans) were ranked from lowest to highest coding based on 2021 coding intensity and then grouped into deciles of roughly equal MA enrollment. This analysis evaluates HCCs 85 (congestive heart failure) in the v24 model used for 2021 risk scores, which are similar to HCCs 224 (Acute on chronic heart failure), 225 (acute heart failure (excludes acute on chronic)), and 226 (heart failure, except end stage and acute) in the proposed v28 model. The unit of analysis is rate of MA coding relative to the rate in FFS Medicare, where 100 percent indicates a coding rate that is the same as in FFS Medicare. The analysis accounts for differences in age, sex, and Medicaid eligibility status.

Source: MedPAC analysis of Medicare enrollment and 2021 risk score files.

As with the diabetes HCCs, constraining the three congestive heart failure HCCs in the v28 model would mitigate the incentive to upcode among the three HCCs but would not address the more frequent coding of congestive heart failure (through any of the three HCCs) in MA relative to FFS Medicare.

We note that CMS previously implemented a similar strategy to reduce MA and FFS coding differences in the risk adjustment model introduced in 2014, where HCCs for chronic kidney disease (CKD) stage 3, CKD stages 1-2, or unspecified; unspecified renal failure; and nephritis were removed from the model (a conforming change was made to the renal disease / congestive heart failure interaction HCC) and subgroups of diagnoses associated with the HCC for polyneuropathy were either removed from the model or moved to another HCC. That risk adjustment model was phased in between 2014 and 2016. We estimated that the 2014 risk model, when fully phased-in in 2016, reduced MA and FFS coding differences by between 2 percentage points and 2.5 percentage points.⁵ Based on the information in the advance notice about the relative plan revenue changes related to the new risk adjustment model and the normalization factor, it appears that the current proposal to eliminate or constrain certain HCCs will have an effect on overall MA and FFS coding differences similar to the 2014 model.

The Commission notes that it is important for the risk adjustment model to accurately compensate plans that serve sicker beneficiaries. It is the Commission's understanding that the changes to the risk model proposed by CMS do not have a meaningfully adverse effect on the predictive power (or "fit") of the model, particularly across patients with different health status. CMS should continue to monitor those effects to confirm that resulting payments do not lead to unintended consequences for beneficiaries.

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.

MA coding pattern difference adjustment

As noted above, Medicare payments to MA plans are adjusted to account for differences in enrollees' expected medical costs using the CMS-HCC risk adjustment model. The model uses FFS Medicare claims data to estimate the model coefficients. Therefore, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported on physician and hospital outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses

⁵ Compared to the model used before 2014, we estimate that MA and FFS coding differences were about 20 percent to 25 percent lower under the 2014 model.

for FFS beneficiaries. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, including the coefficients for age and sex categories.

For MA payments to be accurate, diagnoses must be coded with the same intensity in both FFS Medicare and MA. When MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS. Because MA plans have significant financial incentives to code as many diagnoses as possible, coding intensity is higher in MA than in FFS Medicare and payments to MA plans are thus higher than intended.

Since 2010, CMS has had a mandate to adjust MA risk scores to address the impact of MA and FFS Medicare coding differences. An adjustment reducing MA risk scores by 3.41 percent was applied from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to a minimum adjustment of about 5.9 percent in 2018, where it will remain until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.⁶

To date, the Secretary has reduced MA risk scores by the minimum amount required by law and has not produced another study of the impact of coding intensity. For 2024, CMS proposes once again to apply the minimum required adjustment of 5.9 percent.

Comment

We understand the agency's inclination to proceed cautiously in making large changes to Medicare payments—whether provider payments under FFS, or payments to health plans under Medicare Advantage—in order to ensure that beneficiary access is not compromised. However, 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.⁷

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.

⁶ Section 1853 (a)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395w-23(a)(1)(C)(ii)].

⁷ Many Medicare beneficiaries and state Medicaid agencies help fund the Medicare program through Part B premiums.

CMS's adjustment does not fully account for coding differences, inflating payments to MA plans by more than \$124 billion between 2007 and 2023

Over the past several years, a growing body of research has demonstrated that the impact of MA and FFS coding differences are far larger than the minimum adjustment that the Secretary has routinely applied. At least eight independent studies, using a variety of methods and data sources, corroborate our findings that the impact of plan coding intensity has always been larger than the adjustment that CMS applied in any given year.^{8,9,10,11,12,13,14,15} One of these analyses found that coding intensity could result in MA risk scores being 20 percent above FFS risk scores in 2019.⁵

The Commission has estimated the magnitude of MA coding intensity relative to Medicare's payment adjustment for each year from 2007 to 2021 (the first year the CMS–HCC was fully implemented to the most recent year of available data (Figure 4)). The percentages at the top of each bar in Figure 4 show our estimate of the impact of coding intensity for each year. The black portion of each column shows the coding adjustment that CMS applied in each year and the gray portion shows the level of uncorrected coding intensity resulting in inflated payments to MA plans. Without intervention (such as the one-time events in 2014, 2016, and 2017), MA coding intensity increases by about 1 percentage point per year.¹⁶

⁸ Kronick, R., and F. M. Chua, Department of Health and Human Services. 2021. *Industry-wide and sponsor-specific estimates of Medicare Advantage coding intensity*. November 11. <https://ssrn.com/abstract=3959446>.

⁹ Jacobs P. D., and R. Kronick. 2018. Getting what we pay for: How do risk-based payments to Medicare advantage plans compare with alternative measures of beneficiary health risk? *Health Services Research*. 53(6): 4997–5015.

¹⁰ Hayford, T. B., and A. L. Burns. 2018. Medicare Advantage enrollment and beneficiary risk scores: Difference-in-differences analyses show increases for all enrollees on account of market-wide changes. *Inquiry* 55 (January–December): 46958018788640.

¹¹ Congressional Budget Office. 2017. *Effects of Medicare Advantage enrollment on beneficiary risk scores*. Working paper 2017–08. Washington, DC: CBO.

¹² Geruso, M., and T. Layton. 2015. *Upcoding: Evidence from Medicare on squishy risk adjustment*. NBER working paper no. 21222. Cambridge, MA: National Bureau of Economic Research.

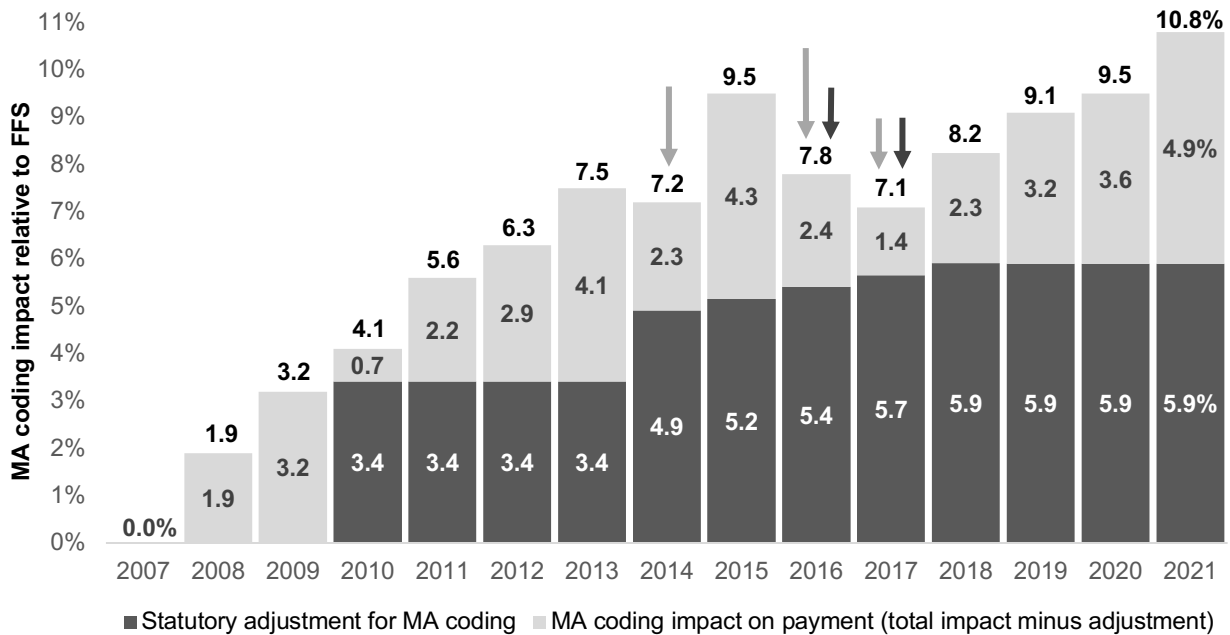
¹³ Kronick, R., and W. P. Welch. 2014. Measuring coding intensity in the Medicare Advantage program. *Medicare & Medicaid Research Review* 4, no. 2.

¹⁴ Government Accountability Office. 2013. *Medicare Advantage: Substantial excess payments underscore need for CMS to improve accuracy of risk score adjustments*. GAO–13–206. Washington, DC: GAO.

¹⁵ Government Accountability Office. 2012. *Medicare Advantage: CMS should improve the accuracy of risk score adjustments for diagnostic coding practices*. GAO–12–51. Washington, DC: GAO

¹⁶ MA coding intensity fell in 2014, 2016, and 2017 due to the introduction of model versions that were less susceptible to MA and FFS diagnostic coding differences. In 2016 and 2017, MA risk scores grew at about the same rate as in prior years, but FFS risk scores grew at a faster rate, likely caused by Medicare's transition from using International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes in October 2015.

Figure 4. The impact of coding intensity on MA risk scores was larger than the adjustment for coding pattern differences, 2007–2021



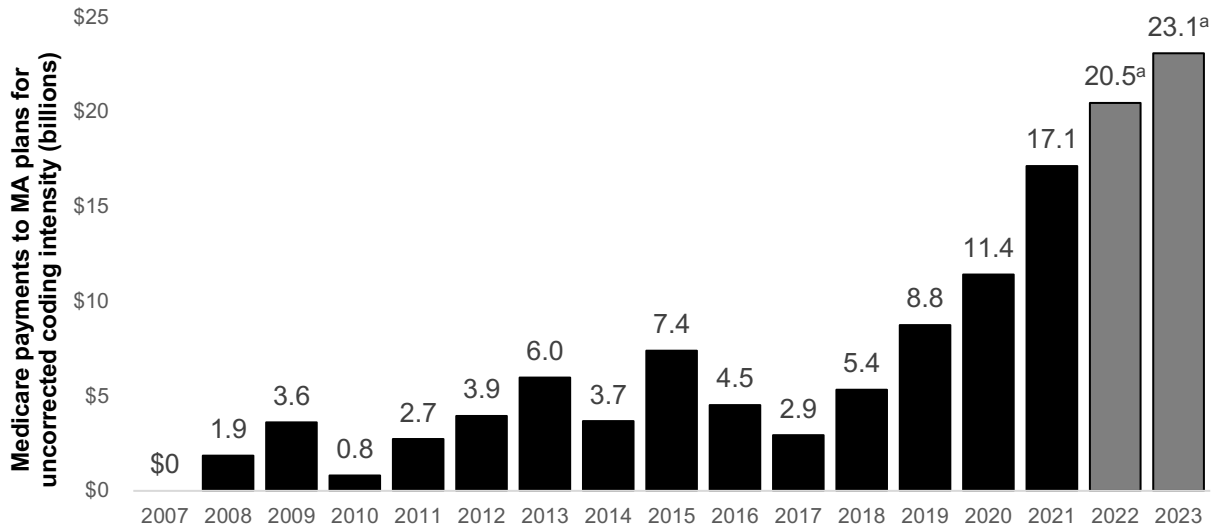
*MA coding intensity increased MA risk scores by 1 percentage point annually but was offset by new risk-adjustment model versions in 2014, 2016, and 2017 (gray arrows) and by increased FFS coding in 2016 and 2017 (black arrows).

Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age and sex between MA and FFS populations. Annual adjustment for MA coding began in 2010. MA coding intensity increased MA risk scores by about 1 percentage point annually, but was offset by new risk adjustment model versions in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017.

Source: MedPAC analysis of CMS enrollment and risk score files.

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.

Figure 5. Uncorrected MA coding intensity has generated \$124 billion in payments to plans since 2007, including nearly \$44 billion more in the last two years alone



Note: MA (Medicare Advantage). Estimates for 2007 through 2021 are based on MedPAC’s estimate of uncorrected coding intensity and Medicare spending for MA plans from the Medicare Trustees’ Reports.

^a The 2022 and 2023 estimates incorporate the conservative assumption that uncorrected coding intensity will be the same as in 2021 (4.9 percent, although all evidence suggests that it will be larger) and are based on projected Medicare spending for MA plans from the 2022 Medicare Trustees’ Report.

Source: MedPAC analysis of CMS enrollment and risk score files, and Medicare Trustee’s Reports, 2017 and 2022.

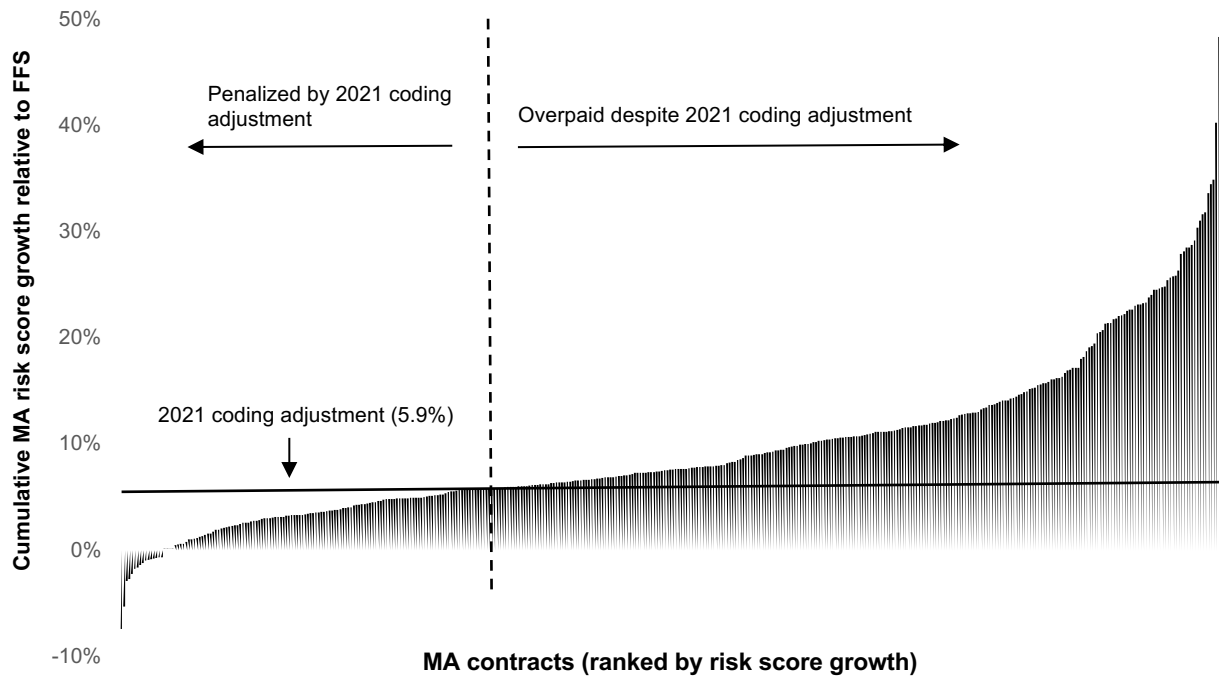
To consider the impact of MA coding intensity on 2024 payments, we start with our 2021 estimate of coding intensity and assume that coding intensity would continue to grow at a rate of about 1 percentage point per year, resulting in MA risk scores that would be between 13 percent and 14 percent above FFS levels, before accounting for the HCC eliminations and constraints in the proposed risk adjustment model. After accounting for those HCC adjustments, which we assume will offset about 2 percentage points to 2.5 percentage points of MA coding intensity, we expect MA coding in 2024 to be at roughly the same level as in 2021. If 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.¹⁷

¹⁷ The 2024 excess payments due to uncorrected coding intensity is an increase over 2023 due to increasing MA enrollment and spending. We applied the same level of uncorrected coding intensity as in 2021, 4.9 percent, to the Medicare Trustees’ estimate of spending on MA for 2024, \$519.4 billion.

Applying an across-the-board adjustment generates payment inequity across MA contracts and organizations

Each year, we break down our overall estimate of coding intensity impact relative to the statutory minimum coding adjustment and to FFS Medicare at the MA contract level (contracts may include one or more plans from the organization).

Figure 6. Cumulative MA risk score growth varied across contracts relative to local FFS, 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and contracts with enrollment below 2,500. Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007.

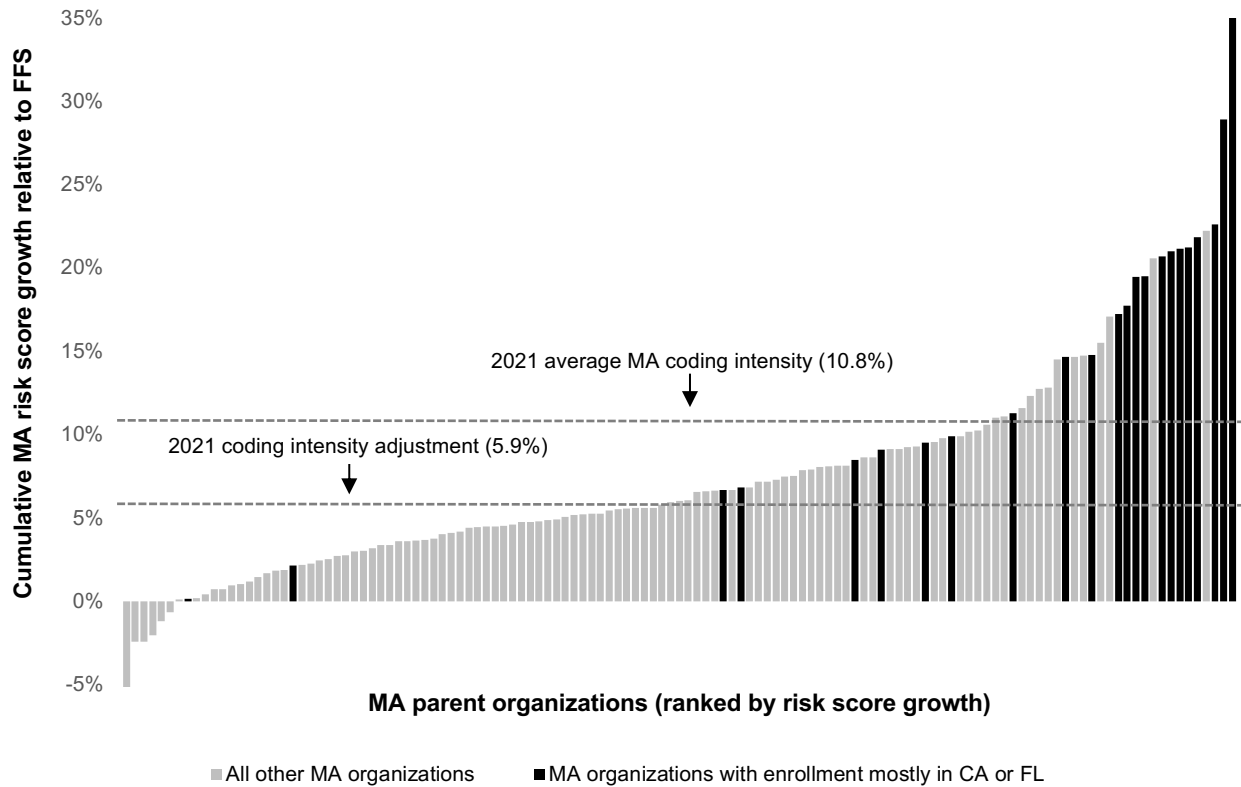
Source: MedPAC analysis of CMS enrollment and risk score files.

The substantial variation in coding intensity illustrated in Figure 6 highlights the second problem with CMS’s approach to addressing coding intensity: The across-the-board adjustment generates inequity across plans, with plans that code diagnoses most aggressively continuing to financially benefit from that coding, while plans that code more similarly to FFS Medicare are penalized. These payment differences are substantial.

This year, we aggregated our contract-level coding intensity estimates by MA organization, and in the course of reviewing these results, we found that several organizations with the highest diagnostic coding relative to FFS are located in California or Florida. We identified 23 MA organizations offering plans primarily in California and Florida (i.e., organizations with majority enrollment in California or Florida) and found that many have among the highest levels of coding

intensity of all MA organizations. Twelve of the 14 organizations with the highest coding intensity offer plans primarily in California and Florida (Figure 7).

Figure 7. MA organizations offering plans primarily in CA or FL account for many of the organizations with the highest coding intensity



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and parent organizations with enrollment below 2,500. Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007.

Source: MedPAC analysis of CMS enrollment and risk score files.

To address why these California- and Florida-focused organizations account for so many of the highest-coding organizations, we considered that health plans in California and (to a somewhat lesser extent) Florida have long participated in a form of capitated payment for providers known as the “delegated model.” Under the delegated model, the responsibility for health care delivery and associated financial risk are delegated by the plan to a medical group or an independent physician association. Typically, a plan pays a medical group a risk-adjusted sum per enrollee which is often calculated as a share of a plan’s total Medicare revenue. Because a plan’s revenue increases when more diagnoses are documented, the capitated payments to providers (determined as a percentage of the plan’s revenue) increase proportionately. In these arrangements, the financial incentive to document more diagnoses is passed on to the medical group, which has direct access to an

enrollee’s medical records and diagnostic information. Based on our results, it appears that some capitated providers in California and Florida have responded to financial incentives and dramatically increased risk scores for MA plan enrollees.

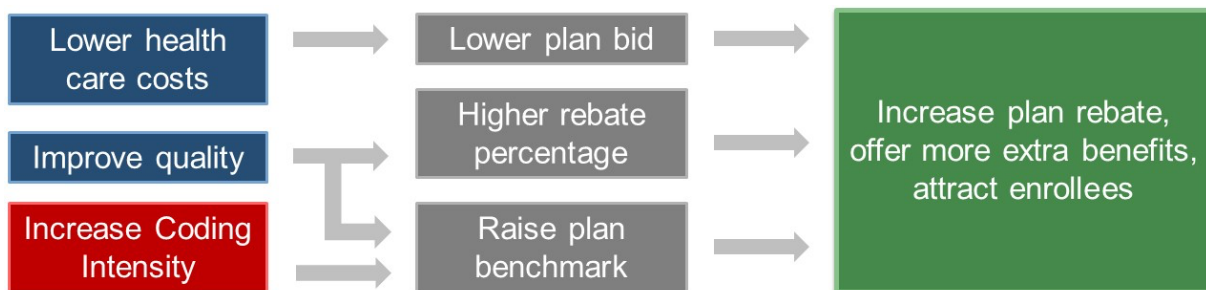
Although we could not confirm that the plans offered by the 12 highest-coding California and Florida organizations use the delegated model, we found that for the five organizations with the highest coding intensity, provider payments were almost entirely capitated, and use of capitation among the other California or Florida organizations was generally correlated with their level of coding intensity. Finally, we recognize the alignment of clinical and financial accountability under the delegated model theoretically provides incentives to constrain costs, avoid low-value care, and coordinate care. Despite these potential benefits, excess payments due to coding intensity are not warranted. As noted in the prior comment, high-coding MA organizations tend to use the HCCs that CMS proposes to eliminate or constrain in the new (v28) risk model to increase their overall coding intensity, and we support CMS’s proposal to eliminate or constrain these HCCs, thereby reducing excess payments due to coding intensity.

CMS’s approach does not address the underlying causes of coding intensity, allowing coding intensity to undermine the goal of plans competing on the basis of quality and costs

Incentives to improve quality and reduce health care costs are driven by the policy determining MA plan rebates. Rebates are one of the primary ways that MA plans compete because rebates fund the extra benefits (e.g., reduced cost sharing and premiums, supplemental health benefits) that attract more enrollees.

A plan’s rebate is calculated as the difference between a plan’s benchmark and bid, multiplied by a rebate percentage (which varies by the plan’s quality star rating). As shown in Figure 8, lowering health care costs reduces a plan’s bid, while improving quality can increase both a plan’s rebate percentage and its benchmark. Either strategy results in a larger rebate and more extra benefits offered to enrollees.

Figure 8. MA coding intensity undermines the goal of plans competing on the basis of improving quality and reducing costs



Note: Rebates are only available for plans bidding below their benchmark, which is nearly all plans in 2023.

Source: MedPAC public meeting presentation, January 2022.

However, increasing coding intensity also raises a plan's benchmark, leading to a higher rebate and the ability to offer more extra benefits. Increasing coding intensity therefore may generate a competitive advantage for a plan. At the very least, both the size of plan rebates and plan competition for more enrollees are based on a combination of all three strategies: lowering health care costs, improving quality, and increasing coding intensity.

Although 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. For 2023, annual extra benefits in MA average more than \$2,350 (a historic high for the seventh straight year) and account for about 17 percent of payments to MA plans. Extra benefits such as reduced cost sharing are financially beneficial to MA enrollees, but policy makers do not have reliable information about the extent to which beneficiaries use other benefits, thereby making it impossible to assess inefficiencies and actual value to beneficiaries.¹⁸ Though the Commission acknowledges some of these supplemental benefits may be valuable to beneficiaries, funding supplemental benefits through MA plan rebates is inefficient (because some of the rebate funds plans' administrative costs and profit, and plans may have the incentive to pick benefits that have high marketing value but may be of less value to beneficiaries) and requires beneficiaries to accept the restrictions associated with MA (e.g., more limited provider networks, utilization management) to access these benefits. Moreover, 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.¹⁹

MedPAC's approach to addressing coding intensity

The Commission strongly believes that Medicare should share in the savings associated with MA, the same standard we apply when making recommendations about payment rate updates in FFS Medicare. Furthermore, the Commission has recognized the wide variation of coding intensity within MA, and noted the undue competitive advantage that some MA organizations gain from higher coding intensity relative to others. In March 2016, we recommended a multipronged approach that would address overpayments to MA plans, improve the equity of payments net of the coding intensity adjustment across MA contracts, and encourage competition based on improving quality and reducing costs. The recommendation, which would replace the existing mandatory minimum coding intensity adjustment, has three parts:

- Develop a risk adjustment model that uses two years of FFS and MA diagnostic data,

¹⁸ The most commonly offered supplemental benefits in 2021 were: worldwide emergency care; routine eye exam; worldwide urgent care; fitness benefit; annual physical exam; routine hearing exam; eyewear, contacts; worldwide emergency care transportation; dental, preventive cleaning and oral exam; and eyewear, lenses and frames. See Chapter 1 ("Rebalancing Medicare Advantage benchmark policy") of the Commission's June 2021 report for more information.

¹⁹ See Table 3-3 of MedPAC's June 2020 report. (Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.)

- Exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- Apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

MedPAC's overall strategy is to first address the underlying causes of coding intensity. Two primary sources of coding intensity are inconsistent coding across years in FFS Medicare and MA plans' use of health risk assessments.

Most diagnoses used to set the weights in the CMS–HCC risk adjustment model come from physician or outpatient claims, which, in FFS Medicare, are paid based on procedure codes. Diagnoses that appear on these claims reflect the condition with which the patient is presenting at the time of service, and thus the provider's expectation of what they will be paid by Medicare for treating a patient with that condition. Under FFS, providers have little financial incentive to add diagnoses to the claim if they were not addressed by the provider during the encounter that is the basis for the claim. In contrast, MA plans have a significant financial incentive to code as many diagnoses during an encounter as possible and to develop the institutional infrastructure to collect and maintain these codes over time. Research has shown that many plans have responded to this incentive by pursuing multiple approaches to collect diagnoses (e.g., in-home health risk assessments, chart reviews, provider pay-for-coding incentives) and document all possible codes in each year. For MA payments to be accurate, diagnoses must be coded with the same intensity and clinical relevance in both FFS Medicare and MA.

MA plans' use of health risk assessments also contributes to coding intensity. Beneficiaries in both MA and FFS may have health risk assessments. (In FFS, most health risk assessments are provided as part of an annual wellness visit.) However, during these assessments, MA plans are far more likely to document diagnoses that are not being actively treated. We reported in 2016 that about 30 percent of the HCCs documented through health risk assessments for MA enrollees were not treated during the year, compared with about 6 percent of diagnoses that were documented through these assessments for FFS enrollees.²⁰ Further, our analysis and a study by the Office of Inspector General (OIG) found that use of health risk assessments varies significantly across MA contracts.²¹

A third source of coding intensity—which we did not address in our 2016 recommendation because the data were not available at the time—is the use of chart reviews in MA. A recent analysis from OIG indicates that use of chart reviews is a significant driver of both MA coding intensity and the variation in coding intensity across MA contracts.²²

²⁰ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

²¹ Office of Inspector General, Department of Health and Human Services. 2020. *Billions in estimated Medicare Advantage payments from diagnoses reported only on health risk assessments raise concerns*. OEI–03–17–00471. Washington, DC: OIG.

²² Office of Inspector General, Department of Health and Human Services. 2019. *Billions in estimated Medicare Advantage payments from chart reviews raise concerns*. OEI–03–17–00470. Washington, DC: OIG.

In 2017, OIG found that health risk assessments and chart reviews combined accounted for \$9.6 billion in payments to MA plans.²³ Based on OIG’s findings, we estimate that in 2017 health risk assessments and chart reviews were responsible for about two-thirds of the greater coding intensity in MA, generating 4.6 percent of total payments to MA plans that year.²⁴

Using two years of diagnostic data would improve the accuracy of both FFS and MA diagnostic information and would reduce year-to-year variation in documentation. We note that the 21st Century Cures Act (the Cures Act) codifies the Secretary’s authority to use two years of diagnostic data in MA risk adjustment, stating that, for 2019 and subsequent years, “the Secretary may use at least two years of diagnosis data.” However, CMS did not take this step in any of the rulemaking that implemented the Cures Act provisions.

At the same time, excluding diagnoses documented only through health risk assessments from risk adjustment calculations would ensure that only diagnoses that were both documented on an assessment and associated with medical treatment would count toward risk adjustment. We note that MA plans could still conduct health risk assessments and document diagnoses as a way to identify conditions, coordinate care, and improve outcomes. Though it was not part of our 2016 recommendations, eliminating chart reviews as a source of diagnostic data for risk adjustment would be consistent with our overall approach.

After addressing the underlying causes of coding intensity to the maximum extent possible (by using two years of FFS and MA diagnostic data in MA risk adjustment and by eliminating from risk adjustment calculations any FFS and MA diagnoses collected during health risk assessments and chart reviews that did not lead to treatment), CMS should adjust for any remaining coding intensity differences. Addressing remaining coding differences could be accomplished with an across-the-board adjustment (which is likely to be much smaller than the current adjustment), or by using a tiered approach that would group contracts into tiers of high, medium, and low coding intensity, and then apply a coding intensity adjustment based on each tier’s average level of coding intensity. A tiered approach would further limit the competitive advantage that some MA organizations achieve through higher coding intensity relative to others, and would support the integrity of the Medicare’s risk-based payments to MA plans.

²³ Office of Inspector General, Department of Health and Human Services. 2021. *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments*. Washington, DC: OIG.

²⁴ We estimate that MA coding intensity accounted for about 7.1 percent, or \$14.8 billion, of the \$209 billion Medicare paid MA plans in 2017.

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 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.

Changes to Part C and D star ratings measures in future years

CMS operates more than 20 quality reporting, rating, and value-based care programs that focus on health insurers, various health care providers, and accountable care organizations. Across these programs, where applicable, CMS is considering including a "Universal Foundation" of quality measures, which is a core set of measures that are aligned across federal programs and private payers. This "Universal Foundation" is a building block to which programs will add additional aligned or program-specific measures. As a start, CMS is reviewing each of the quality programs and considering which measures included in the "Universal Foundation" measure set are not currently in those programs and the steps to add them over time, if appropriate.

CMS has created a preliminary set of 10 measures focused on quality of care for adult populations. Seven of these measures are currently scored in the Part C and D star ratings or displayed on Medicare Plan Finder (e.g., colorectal cancer screening, controlling high blood pressure, readmissions). The other measures include adult immunization status, screening for depression and follow-up, and screening and referral to services for social needs. CMS is soliciting feedback on the Universal Foundation approach.

Comment

The Commission supports CMS's intention to select a small set of quality measures that are aligned across programs and payers, where applicable. This approach is consistent with the Commission's principle that Medicare quality programs should include a small set of measures tied to clinical outcomes, patient experience, and value.²⁵ Providers have the flexibility to choose to use more granular measures to manage their own quality improvement.

²⁵ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the healthcare delivery system*. Washington, DC: MedPAC.

Over the past several years, the Commission has outlined the flaws of the MA quality bonus program (QBP), which bases MA plan bonus payments on the star rating system.^{26,27} We argue that the number of measures in the current QBP, especially those tracking “insurance functions,” administration, and clinical processes, are excessive and weakly correlated with health outcomes.

In our June 2020 report to the Congress, the Commission recommended that the Congress replace the QBP with a MA value incentive program (MA–VIP). The MA–VIP design would score a small set of population-based measures tied to clinical outcomes as well as patient experience. Our illustrative MA–VIP measure set generally aligns with the adult Universal Foundation measure set CMS is proposing. Both sets include measures of readmissions, patient experience, wellness and prevention, and managing long-term conditions. The illustrative MA–VIP measure set also includes measures of ambulatory-care-sensitive hospital use, and patient-reported outcomes, which are measures that are patient oriented and encourage coordination across providers and time. We encourage CMS to use their Universal Foundation approach as the basis for reviewing the current QBP measure set, and removing those that are not tied to clinical outcomes and patient experience.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact James E. Mathews, MedPAC’s Executive Director, at 202-220-3700.

Sincerely,



Michael Chernew, Ph.D.
Chair

MC/aj/lt

²⁶ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the healthcare delivery system*. Washington, DC: MedPAC.

²⁷ Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the healthcare delivery system*. Washington, DC: MedPAC.