February 22, 2023

Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-2023-0010

Comments of Health Services, Law, and Policy Researchers on the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear CMS Officials,

We are pleased to submit these comments in response to the public comment period for the CY2024 Medicare Advantage Advance Notice. We are economics and legal scholars specializing in health law and policy issues. We have extensively researched payment policies and quality measurement in the Medicare Advantage (MA) program and offer our comments and suggestions in response to the Advanced Notice.

Comment 1: The expected change in revenue should not be regarded as a "Medicare Cut" and these overall payment changes are unlikely to substantially change plan behavior.

As detailed in the Advanced Notice and corresponding Fact Sheet, CMS is anticipating a 1.03% increase in revenue for MA plans for 2024 after accounting for a 1.24% reduction in revenue anticipated from star rating changes and a 3.12% reduction in revenue anticipated from risk model revision and normalization. Various advocacy organizations working on behalf of Medicare Advantage plans have argued that this is in effect a payment cut and have funded research that argues that plans will reduce benefits or increase premiums as a result. However, based on our collective research and interpretation of the academic literature, we do not agree with that characterization and believe that these changes are reasonable due to well documented overpayments to MA plans, and unlikely to substantively affect the generosity of MA plan benefits.

There is little evidence that modest MA payment reductions result in benefit cuts or higher premiums or cost sharing for beneficiaries. The few studies we are aware of are largely based on data that predate massive changes to the MA program under the ACA.[1] The most recent study on the topic finds that using data from 2007–2011, MA plans pass through only 1/8th of increased payments to beneficiaries through reduced premiums and increased benefits.[2]

[1] Marika Cabral, Michael Geruso & Neale Mahoney, *Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage*, 108 Am. Econ. Rev. 2048 (2018), https://doi.org/10.1257/aer.20151362; Mark Duggan, Amanda Starc & Boris Vabson, *Who Benefits When the Government Pays More? Pass-Through in the Medicare Advantage Program*, J. Pub. Econ., Sept. 2016, at 50, https://doi.org/10.1016/j.jpubeco.2016.07.003.
[2] Duggan, Starc & Vabson, *supra* note 1.

However, given the age of the data, and the growth of the MA program over time, that is likely to be an upper bound. Although one study found that MA plans reduced less-salient benefits following the ACA's dramatic cuts, premiums remained unchanged.[3] In our own research, we have also found that modest changes to plan payments have no effect on benefits offered to enrollees. In reality, there are likely to be stronger incentives for plans to continue to offer similar levels of benefits and premiums to maintain or grow enrollment. Prior work has found that beneficiary choice of plans is very sensitive to changes in premiums, and for plans that are seeking to increase their market share, increasing premiums may lose them enrollment.[4] Further, for plans that already offer a zero dollar premium, there are strong incentives not to increase greater than $0 and sacrifice the subsidy plans receive for bidding below the benchmark.

In forthcoming work in press, we find that discontinuities in plan payments that lead some plans to receive more or less payment in a year lead to no differences in the benefits offered. Given how small the payment reductions to plans are (so small that in fact plans will have increased revenue in 2024), and how competitive the MA market is for attracting new enrollees, our read of the literature is that there are not likely to be substantial changes to benefits and premiums offered to beneficiaries, and decisions made around payments to plans in CY2024 should not be driven by such concerns.

Comment 2: Changes to the HCC Formula are sensible, however more modifications may be warranted.

In Attachment II, Section G of the Advanced Notice, CMS has proposed making several key changes to the calculation of HCC scores. These largely include (1) restructuring HCCs based on ICD-10,[5] (2) updating the HCC estimation to reflect FFS 2018 and 2019 expenditures,[6] (3) constraining the HCC coefficients for several conditions to represent the same value at different severity levels,[7] (4) removing several conditions where coding may be discretionary,[8] and (5) expanding the total number of available HCCs.[9] Overall we support these changes as reasonable, and we offer several comments and suggestions to strengthen these changes.

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[3] Daria Pelech & Zirui Song, Pricing and Pass-Through in Response to Subsidies and Competition: Evidence from Medicare Advantage Before and After the Affordable Care Act (Oct. 19, 2018), https://www.hcp.med.harvard.edu/sites/default/files/Pricing_Pass-through_MA_10-19-2018_HCP.pdf.

[4] David J. Meyers et al., *Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries*, 179 JAMA Internal Med. 524 (2019), https://doi.org/10.1001/jamainternmed.2018.7639; Rachel O. Reid et al., *The Roles of Cost and Quality Information in Medicare Advantage Plan Enrollment Decisions: An Observational Study*, 31 J. Gen. Internal Med. 234 (2016), https://doi.org/10.1007/s11606-015-3467-3.

[5] Ctrs. for Medicare & Medicaid Servs., Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, at 46 (February 1, 2023), https://www.cms.gov/files/document/2024-advance-notice.pdf [hereinafter 2024 Advance Notice].

[6] *Id.* at 45.

[7] *Id.* at 48–49.

[8] *Id.*

[9] *Id.* at 46–47, 50–56.

Restructuring based on ICD10: Given that most healthcare claims are now recorded in ICD10, we agree that it is sensible to move the HCC system to fully be in an ICD10 environment. Our concern however is that in our experience, mapping chronic conditions from ICD9 to ICD10 even using established crosswalks can often result in a very different picture of the chronic disease burden in a population. We recommend that CMS make this update carefully and perform analysis to see how differently the ICD9 and ICD10 models capture chronic conditions within the same individual to ensure that there are not substantial differences in coding due to ICD coding format alone. We also recommend that CMS expands Risk Adjustment Data Validation (RADV) audits in the aftermath of this change to ensure MA plan compliance with risk coding and documentation requirements.

Updating the HCC estimate to more recent years: We agree with this change that more recent years of data should be used when estimating the coefficients for the HCC models. One consideration with this shift however is that MA penetration has expanded substantially from 2014/2015 to 2018/2019. With this growth, our research has established that beneficiaries with greater health needs leave the MA program at higher rates, so FFS beneficiaries may be a less healthy population who may have higher health costs in general.[10] Our research also suggests Medicare beneficiaries are unobservably sicker in counties with higher Medicare Advantage penetration, resulting in inflated benchmarks and payments to plans. As a result, CMS should model if the changing case mix of FFS beneficiaries between the two measurement periods leads to substantial differences in the performance of the HCC algorithm. In addition, given the recent availability of claims data from the Medicare Advantage encounter file, CMS could estimate coefficients for HCC models by incorporating data from Medicare Advantage beneficiaries (rather than extrapolating from the Traditional Medicare population only).

Removing several conditions where coding may be discretionary: We agree with CMS's decision in line with Principle 10 to remove protein-calorie malnutrition, angina pectoris, and atherosclerosis of arteries of the extremities from HCC calculation due to their minimal value in capturing costs.[11] While the removal of these conditions is a positive move, analysis from OIG and others has identified other conditions such as depressive conditions, obesity, and drug dependency where coding may be highly variable across contracts and largely added via chart reviews.[12] We recommend that CMS closely evaluate whether there are other codes that are discretionary in nature and may lead to distortions in risk adjustment payment.

Comment 3: To fully address issues in coding intensity, the coding intensity adjuster should be increased above the minimum 5.9%.

[10] Meyers et al., *supra* note 4.
[11] 2024 Advance Notice at 47–49.
[12] Suzanne Murrin, U.S. Dep't of Health & Hum. Servs. Off. of Inspector Gen., *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments*, OEI-03-17-00474 (2021), https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf.

While the changes to the HCC calculation are likely to improve the performance of HCCs as a risk adjuster, these changes don't go far enough to ensure the validity of risk adjustment in Medicare Advantage. CMS should consider other moves not considered in the Advanced Notice to better address these issues.

Notably, CMS currently applies a 5.9% coding intensity adjustment to plan payment. This assumes that, for the same patient, risk coding is 5.9% higher in Medicare Advantage that it would be in Traditional Medicare. CMS has chosen not to exceed this statutory floor despite its clear regulatory authority to do so. Based on the preponderance of evidence, this threshold is likely to be far too low, as overpayments due to variations in coding intensity are estimated to range from 6 to 20% depending on the data sources used and the setting.[13] Further, there is likely substantial variation across contracts in extent to which coded risk exceeds that of Traditional Medicare. Including a single flat "haircut" when adjusting overpayments will reward some plans while harming others and provide little incentive for plans to improve the accuracy of risk coding.[14] CMS should consider increasing this threshold for all contracts and consider using its statutory authority to vary the coding intensity adjustment by contract.[15] Additionally, CMS should consider further strategies for accounting for variation across contracts. For instance, CMS could offer to keep the coding intensity adjuster at 5.9% for Medicare Advantage plans that opt in to a demonstration program to adhere to coding best practices, increased audits, data quality monitoring, and financial penalties for unsupported coding. Plans that do not participate in the demonstration would be subject to a higher coding intensity adjuster.

Comment 4: Changes to the 5-Star Rating System are welcome, but more needs to be done to address underreporting and equity.

In general, we are supportive of the suggested changes to measure inclusion in the CY2024 star rating calculation as outlined in Attachment IV of the Advanced Notice. We have several additional suggestions that we believe should be accounted for in future iterations of the star ratings as well:

Inaccuracies in HEDIS reporting: HEDIS data include a range of quality indicators that are directly reported by plans to CMS. These data are important as they make up many of the measures that go into MA star rating calculation and serve as an important source of quality

[13] Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy (2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v3_SEC.pdf; Richard Kronick & F. Michael Chua, *Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity* (Nov. 11, 2021), https://dx.doi.org/10.2139/ssrn.3959446; Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*, 128 J. Pol. Econ. 984 (2020), https://doi.org/10.1086/704756.

[14] David J. Meyers & Amal N. Trivedi, *Medicare Advantage Chart Reviews Are Associated with Billions in Additional Payments for Some Plans*, 59 Med. Care 96 (2021), https://doi.org/10.1097/MLR.0000000000001412.

[15] *See* 42 U.S.C. § 1395w–23(a)(1), (3) (demonstrating that CMS's statutory requirement to apply a risk adjustment methodology uniformly across nearly all contracts confines the agency's authority to establish variable risk adjustment factors but not its authority to apply variable coding intensity adjustments across different contracts).

information to consumers, researchers, and policymakers. However, in our team's previous work, we've found that plans appear to underreport negative outcomes in their HEDIS data submissions. For example, we found that when comparing HEDIS hospital readmission rates to other sources, MA plans underreported index hospitalizations that resulted in a readmission.[16] If HEDIS measures are to continue to be used in quality performance measurement, it would be important for CMS to continually validate and audit what plans report for HEDIS data, perhaps against other files like the encounter records.

Exclusion of beneficiaries with higher needs from star ratings: An additional concern about the current star rating calculation is whether these ratings actually reflect how beneficiaries with heterogeneous needs actually experience the quality of the plan, or if they reflect healthier beneficiaries with fewer needs. For example, we've found that beneficiaries with dementia are disproportionately excluded from CAHPS data for performance measurement purposes.[17] As a result, it is unclear if a higher rated plan would actually be of the same benefit to beneficiaries with dementia. This is likely to be a concern for beneficiaries with other conditions that may be related to lower response rates in the CAHPS surveys. While adding an email based modality to fill out the CAHPS is a sensible move, without targeted sampling of beneficiaries with higher health needs, many needs may remain unmet.

Star ratings and equity: In recent work, we reproduced the MA star ratings at the contract level stratifying by beneficiary SES and race/ethnicity.[18] We found that there are substantial disparities in outcomes between High and Low SES individuals, and between White and Black and White and Hispanic beneficiaries. Of substantial concern, we found that as a plan's official star rating increased, the disparities in outcomes actually grew, indicating that the current star ratings may not adequately reflect the experience of historically marginalized populations enrolled in plans. In order to ensure that plans are actually incentivized to address equity issues, CMS may consider several approaches. First, it may be beneficial for CMS to create stratified ratings that beneficiaries can use to help make more informed decisions about which plan may be optimal for someone with their lived experiences. While the office for minority health does report some stratified measures by race/ethnicity, these data are not easy for consumers to find, are not incorporated into the plan finder tool, and do not reflect all dimensions of quality. Second, CMS may consider directly incentivizing equity measurement into star rating performance. CMS currently measures improvements in physical and mental health for

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[16] Orestis A. Panagiotou et al., *Hospital Readmission Rates in Medicare Advantage and Traditional Medicare: A Retrospective Population-Based Analysis*, 171 Annals of Internal Med. 99 (2019), https://doi.org/10.7326/M18-1795; Daeho Kim et al., *Assessment of Completeness of Hospital Readmission Rates Reported in Medicare Advantage Contracts' Healthcare Effectiveness Data and Information Set*, JAMA Network Open, Apr. 2020, https://doi.org/10.1001/jamanetworkopen.2020.3555.

[17] David J. Meyers et al., *Comparing the Care Experiences of Medicare Advantage Beneficiaries with and Without Alzheimer's Disease and Related Dementias*, 70 J. Am. Geriatrics Soc'y 2,344 (2022), https://doi.org/10.1111/jgs.17817.

[18] David J. Meyers et al., *Association of Medicare Advantage Star Ratings With Racial, Ethnic, and Socioeconomic Disparities in Quality of Care*, JAMA Health F., June 2021, https://doi.org/10.1001/jamahealthforum.2021.0793.

beneficiaries and includes those measures in star ratings. A similar measure could be produced to better reward plans that do well in reducing disparities in outcomes over time.

Moving to Budget Neutrality: We further agree with the assessment by MedPAC that the quality bonus program may be better suited as a budget neutral program, with a set amount of bonus payments available to be divided across all plans as under the current program there is largely no upward limit on the amount that CMS could be required to pay under current rules.

Accounting for kidney care: Now that beneficiaries with ESRD may enroll in Medicare Advantage plans, it will be essential to measure the performance of contracts in addressing the care needs of this high-need population. In recent work, our team has found that MA networks may have limited access to dialysis facilities.[19] Measures should be developed and incorporated to make sure that plans are equipped to care for this population.

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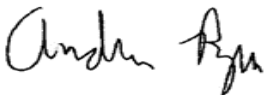
Thank you for considering these comments and recommendations. Each of the signatories below is signing in our personal capacities as researchers in the fields of health economics, law, and policy, and the views expressed in these comments do not necessarily reflect those of our institutions or employers.

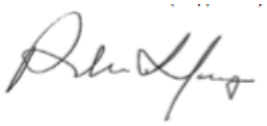
David J. Meyers PhD, MPH
Assistant Professor of Health Services, Policy, and Practice
Brown University School of Public Health

Erin C. Fuse Brown, J.D., M.P.H.
Catherine C. Henson Professor of Law
Director, Center for Law, Health & Society
Georgia State University College of Law



Andrew Ryan, Ph.D.
Professor of Health Services, Policy, and Practice
Director of the Center for the Study of Healthcare
Brown University School of Public Health

[19] Eunhae Grace Oh et al., *Narrow Dialysis Networks In Medicare Advantage: Exposure By Race, Ethnicity, And Dual Eligibility*, 42 Health Affs. 252 (2023), https://doi.org/10.1377/hlthaff.2022.01044.



Roslyn Murray, MPP
PhD Candidate | Health Services Organization & Policy
The University of Michigan, School of Public Health

Travis Williams
J.D. & M.P.H. Candidate | Health Management & Policy
Georgia State University College of Law & School of Public Health