Congress of the United States
Washington, DC 20515

March 4, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure,

Thank you for your consideration of public comments on the Calendar Year 2023 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. The current risk adjustment model leads to billions of Medicare dollars going into the pockets of private insurance companies, taking away taxpayer dollars that should be applied for urgently needed medical care for our seniors and people with disabilities. This is a complete diversion from the purpose and spirit of the Medicare program.

Given these concerns, we write to urge CMS to improve the risk adjustment model to correct overpayments to MA plans and ensure taxpayer dollars in the Medicare trust fund are disbursed equitably. Specifically, we ask that CMS use the Demographic Estimate of Coding Intensity (DECI) method with incorporation of public health measures such as the area deprivation and childhood opportunity indices to calculate the risk score coding intensity adjustment for 2023 and beyond.[1] Additionally, we urge you to implement this method at the individualized plan level to ensure that the specific social determinants of health in each area are considered.

Flaws in the current risk adjustment model

As you know, to ensure accurate payments from the Medicare program to MA plans for beneficiaries who may be sicker than the average patient, CMS calculates a risk score to adjust the payment made to the MA plan. CMS currently uses the Hierarchical Condition Category (HCC)

[1] Kronick, Richard and Chua, F. Michael, Estimating the Magnitude of Medicare Advantage Coding Intensity and of the Budgetary Effects of Fully Adjusting for Differential MA Coding (February 23, 2021).

method which uses a patient's diagnosis codes and other demographics to calculate a risk score. But despite mortality data, prescription drug claims, and demographic data demonstrating that MA beneficiaries are initially healthier than traditional Fee-for-Service (FFS) beneficiaries, the government paid $321 more per person to MA than it did to provide care for the sicker FFS beneficiaries.[2,3] Further, MA plans took in $2,256 more in premiums, on average, than they paid out in medical claims.[4] Despite claims by MA plans that these overpayments are used for patient care, only a small portion are used for care while the rest contributes to the skyrocketing profits MA insurance companies make.[5] These companies often defend their profits by claiming to adhere to a requirement to spend 85 percent of funds on medical care. However, increasing the payments they receive allows them to increase their profits while technically adhering to regulations. Additionally, MA plans have been cited recently for not adhering to regulations and spending too little revenue on seniors' medical care in pursuit of increased profits.[6]

Misaligned incentives in the risk adjustment model lead to risk score gaming

Overpayments to MA plans stem from misaligned incentives in the HCC model for MA plans to increase the diagnosis codes a beneficiary is assigned, thereby increasing the tax-payer dollars MA plans receive from Medicare. MA plans aggressively push doctors and medical professionals to increase the diagnosis codes assigned to a patient, also known as upcoding, by paying doctors more to use software for upcoding, conducting medically unnecessary home health visits, and even using artificial intelligence tools to mine beneficiaries' medical charts for additional codes. Importantly, when MA plans use these software tools, they are not looking for diagnoses to improve patient treatment, they use the findings to increase their payments from the government.

It is particularly important to note that the increased payments to MA plans do not result in better care.[7] In fact, the Health and Human Services Office of the Inspector General found in 2018 that MA plans inappropriately deny claims of millions of their beneficiaries per year.[8] Because, MA plans enroll larger populations of low-income seniors and seniors of color, it is critical for health

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[2] Reducing Medicare Advantage Overpayments. Committee for a Responsible Federal Budget (February 23, 2021).

[3] Biniek Jeannie, Cubanski Juliette, Neuman Tricia, Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges. Kaiser Family Foundation (August 17, 2021).

[4] McDermott Daneil, Stolyar Lina, Hinton Elizabeth, Ramirez Giorlando, Cox Cynthia, Biniek Jeannie. Health Insurer Financial Performance in 2020 Kaiser Family Foundation (May 3, 2021).

[5] Jacobs, PD, Kronick, R. The effects of coding intensity in Medicare Advantage on plan benefits and finances. *Health Serv Res*. 2021; 56: 178– 187.

[6] Snowbeck Christopher, Feds penalize United Healthcare for underspending premiums on medical care for seniors. Star Tribune. (September 15, 2021).

[7] Newhouse JP, Price M, McWilliams JM, Hsu J, Souza J, Landon BE. Adjusted Mortality Rates Are Lower for Medicare Advantage Than Traditional Medicare, But the Rates Converge Over Time. *Health Aff (Millwood)*. 2019;38(4):554-560. doi:10.1377/hlthaff.2018.05390

[8] Levinson Daniel, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. Health and Human Services Office of the Inspector General. (September 2018).

equity that they care for these beneficiaries appropriately.[9] Correction of the risk adjustment model will protect our most vulnerable seniors who are more often enrolled in these profit-driven MA plans.

Upcoding is so prevalent in the MA sector that the Medicare Payment Advisory Commission, the Congressional Budget Office, and the Government Accountability Office, and the Committee for a Responsible Federal Budget all incorporate it into their Medicare cost models.[10] CMS has also acknowledged this problem and attempted to fix it by using a coding intensity adjustment, a percentage by which payments to MA plans based on the HCC model are automatically decreased to account for upcoding. Unfortunately, CMS's proposal to use the statutory minimum coding intensity adjustment of 5.9 percent for 2023 is inadequate to keep up with the increased upcoding by MA plans. Researchers estimate that the true coding intensity adjustment should be over 15 percent.[11]

Incorporation of the DECI method of coding intensity adjustment improves accuracy of MA payments

Not only would using the DECI model correct for equity and other imbalances and ensure that more taxpayer dollars go to patient care, it would also save Medicare $355 billion over the next decade.[12] The DECI method assumes that after correcting for demographics MA beneficiaries are no sicker than FFS beneficiaries, an assumption backed up by the data discussed above,[13] and corrects for differences between diagnosis-related risk scores and demographic-related risk scores that are due to upcoding. Notably, previous corrections to the coding intensity adjustment have not resulted in decreased benefits or increased costs to seniors.[14] Instead of overpaying private MA insurance plans by billions of dollars while straining the finances of Medicare, the DECI method allows for equitable distribution of Medicare funds to all seniors.

Finally, as discussions continue about expanding Medicare to cover dental, vision, and hearing services and to provide care to those ages 60-65 years old, critics claim these proposals cost too much. In reality, taxpayers are already paying enough for Medicare to provide these benefits, but too much of those taxpayer dollars are being gamed to go to private insurance profits rather than providing the benefits that seniors desperately need and could be provided through traditional Medicare. Correcting the Medicare risk adjustment model could offset proposals to allow

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[9] Teigland Christie, Pulungan Zulkarnain, Shah Tanya, Schneider Eric, Bishop Shawn, As it grows, Medicare Advantage is enrolling more low-income and medically complex beneficiaries. Commonwealth Fund. (May 13 2020).

[10] Reducing Medicare Advantage Overpayments. Committee for a Responsible Federal Budget (February 23, 2021).

[11] Reducing Medicare Advantage Overpayments. Committee for a Responsible Federal Budget (February 23, 2021).

[12] Reducing Medicare Advantage Overpayments. Committee for a Responsible Federal Budget (February 23, 2021).

[13] Reducing Medicare Advantage Overpayments. Committee for a Responsible Federal Budget (February 23, 2021).

[14] Skopec Lauren, Aarons Joshua, Zuckerman Stephen. Did Medicare Advantage Payment Cuts Affect Beneficiary Access and Affordability? American Journal of Managed Care (August 30, 2019).

traditional Medicare to provide these benefits, which a majority of Americans and House Democrats support.[15,16]

We urge you to take aggressive action to increase the risk score coding intensity adjustment by using the DECI method, providing more accurate payments to MA plans while ensuring the solvency of the Medicare trust fund and the equitable distribution of Medicare benefits. We stand ready to work with you to enact this more accurate, equity-focused risk score adjustment model.

Sincerely,

Pramila Jayapal
Member of Congress

Bernard Sanders
U.S. Senator

Katie Porter
Member of Congress

Elizabeth Warren
U.S. Senator

Jamaal Bowman, Ed.D.
Member of Congress

[15] Jayapal Pramila, Sanders Bernie, Voters are Right: Its time to expand Medicare. Data for Progress (June 23 2021).
[16] Jayapal Pramila, Jayapal Leads 155 Lawmakers Urging Biden to Expand Medicare in American Families Plan (May 27 2021).