CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

February 26, 2024

Deputy Administrator, Dr. Meena Seshamini
Director of Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**RE: Comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (CMS-2024-0006)**

Dear Deputy Administrator Seshamini:

The Brown University Center for Advancing Health Policy through Research (CAHPR) is an evidence-based, nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in healthcare delivery in the US. Our Center's investigators have been conducting research to develop potential legislative and regulatory solutions to improve the effectiveness, realize cost savings, and offer long-term budget stability in the Medicare Advantage (MA) program.

Thank you for the opportunity to comment on the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. This public comment represents the views of faculty members affiliated with CAHPR at the Brown University School of Public Health. As a team of health economists, health services researchers, and lawyers, we hope our comments are helpful as you implement the Advance Notice of Methodological Changes for CY 2025 for MA Capitation Rates and Part C and Part D Payment Policies.

CAHPR's responses to the Advance Notice are below. In general, we believe the steps taken in the Advance Notice are in the right direction to continue improving how the MA program functions. Based on findings from our research, additional opportunities exist to address larger issues in MA payment, including increasing the Coding Pattern Adjustment, rigorous enforcement of Risk Adjustment Data Validation (RADV) audits, and regulatory changes to the star ratings program to make it more difficult to obtain.

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**Risk Adjustment**

In the CY 2025 advance notice, CMS proposed to continue the phase-in of the new risk adjustment model announced in last year's CY 2024 advance notice and also proposed keeping the MA Coding Pattern Adjustment at the 5.9% statutory minimum. Overall, we believe that CMS's efforts to cut back on unnecessary risk coding that distorts payments in the MA program are essential to ensure the program's long-term sustainability. It has been well identified in the academic literature and in reports by MedPAC that MA plans differentially code more intensely than coding in the Traditional Medicare program. Based on the current state of the scientific literature on this topic,[3,6,10] CMS should consider changes to the new risk coding model. However, there are several additional changes that we believe may be called for, given the current knowledge on the topic:

Modifying the MA Coding Pattern Adjustment: Since the passage of the Deficit Reduction Act of 2005, the Centers for Medicare and Medicaid Services (CMS) has had the authority to apply a coding intensity adjustment to MA risk-coding. Following that, the Affordable Care Act and the American Taxpayer Relief Act established a schedule of minimum adjustments starting at 4.9% in 2014 and standing at 5.9% today[1]. To this day, CMS has stayed within the statutory floor of 5.9%. In the 2025 Advance Notice, the year-to-year percentage change in payment for the MA Coding Pattern Adjustment is 0%[2] from the 2024 Rate Announcement, which means that the coding intensity adjustment will remain at the statutory minimum of 5.9% for 2025.

While including this adjustment is essential, based on the scientific literature, the Coding Pattern Adjustment should be higher. Current literature estimates that using tools such as health risk assessments, chart reviews, and general coding behavior, MA coding is 6-16% higher scores than Traditional Medicare (TM), costing $10.2 billion in annual overpayments.[3] CMS should consider increasing the coding intensity adjuster beyond the statutory minimum of 5.9% to decrease substantial overpayments and enable recovery of overpayments from heightened coding. While CMS suggests that these levels are justified based on their internal analysis, which is required by statute,[4] as far as we are aware, these analyses have never been released to the public. CMS should consider releasing these analyses and their methods so that the public can validate whether the approach successfully captures increased coding.

To address this issue, CMS could consider increasing the adjustment overall or could instead implement a tiered adjuster that adjusts risk scores to a greater degree for plans that are documented to code more intensively and to apply a more minor coding pattern adjustment to plans that have not engaged in aggressive coding behavior. CMS could also reduce the ability for plans to add extensive coding through chart reviews or health risk assessments.[1] Our work and that of MedPAC and others find that plans differentially use these risk-coding methods, which can lead to unsupported risk coding.[5,6,7,8] Thus, CMS should consider limiting health risk assessments and chart reviews to reduce overpayment to plans nationally. Research from CAHPR and others has found that the estimated savings impact could range from $10.2 billion annually to $66.67 billion annually.[9,10]

**RADV Audits**

CMS could increase activities to correct and recoup overpayments due to erroneous risk coding. CMS could expand the scope of RADV audits through (1) increased investment in audit and enforcement activities and (2) efforts to streamline the RADV appeals process.

CMS possesses substantial regulatory authority to increase the scope and investment of the agency's risk adjustment data validation (RADV) audits of MA plans' coding practices. For instance, we support the agency's 2023 rule allowing CMS to extrapolate the error rate of the audited sample to the entire MA contract starting with payment year 2018, which CMS estimates will recoup an estimated $4.7 billion in overpayments over the next decade.[11] In addition, we support the proposed CY 2025 Policy and Technical Changes to the Medicare Advantage Program,[12] which would require MA organizations to complete appeals of medical record reviews before beginning payment calculation error appeals in an effort to streamline RADV appeals.[13] However, we think more can be done to increase the scale of recoupments under the RADV program and to simplify the appeals process.[1,9]

To increase resources for recoupment of overpayments, CMS could request more funding from Congress to conduct RADV audits and process appeals. Further, CMS could expand resources for RADV audits by partnering with Recovery Audit Contractors (RACs) to conduct MA audits as they do for fee-for-service Medicare.[14] In addition, CMS could devote more fraud and abuse enforcement resources to investigating violations of the Overpayment Rule in Medicare Advantage. The 2014 Overpayment Rule provides that any overpayment identified by a Medicare Advantage plan (whether through an RADV audit or during its course of business) must be returned to Medicare within 60 days or constitute a false claim under the federal False Claims Act.[15]

To scale the RADV program effectively, CMS could improve the unwieldy and protracted appeals process by streamlining the settlement of appeals. In recent years, similar measures have led to an 88 percent reduction in the substantial fee-for-service Medicare appeal backlog.[26] Considering the billions of dollars the agency is leaving on the table, substantially increasing funding for the RADV audit and appeals program would produce an excellent return on investment. Furthermore, CMS should limit the time period for resolving RADV appeals, which is currently unlimited.[9] Time limits would expedite the process and assist the agency in implementing the Affordable Care Act's mandate to expand the fee-for-service Medicare Recovery Audit Contractor (RAC) program to MA, something it has not done to date.[16] RACs have hesitated to participate in MA, partly citing the unpredictability of unlimited time frames for RADV appeals.[16] Improving the timeliness and predictability of the appeals process would thus remove a major barrier to RAC participation in MA.

RADV audits are CMS's "main corrective action for overpayments" in Medicare Advantage.[17] A more robust and streamlined RADV audit program would be a powerful strategy to reduce plans' incentive to upcode. With increased enforcement of the Overpayment Rule, deploying RADV audits more expansively presents a sizable opportunity for recouping billions of dollars in Medicare Advantage overpayments.

**FFS Risk Score Normalization**

CMS calculates risk-adjusted payments in Medicare Advantage relative to Traditional Medicare each year. Since there is risk growth over time between when the risk score models are calculated and when FFS data is used for setting payments, CMS applies a normalization factor to account for this growth in risk. In this Advance Notice, CMS noted that due to the COVID-19 pandemic, the standard normalization approach that they have previously used did not appear to work as expected since during COVID, beneficiaries received less care, which led to a lower amount of risk being coded. In the Advanced Notice, CMS proposed a new strategy involving a linear regression that adjusted for the COVID-19 effect. Based on CMS's data, this new approach will lead to a normalization factor similar to what's been used in prior years.

We agree with CMS that it is essential to account for the COVID pandemic when predicting Traditional Medicare risk. In the future, CMS should consider using beneficiary-level information from the likely population of Traditional Medicare beneficiaries in a given calendar year. Using estimates of historical changes in risk based on demographic, clinical, and market factors, including MA penetration, CMS could predict changes in risk at the beneficiary level, before aggregating nationally. By taking advantage of rich beneficiary information – as opposed to national averages – this approach would be more robust and less likely to require annual tweaks. In addition, recent work on favorable selection suggests that the Traditional Medicare population is unobservably healthier than the MA population, leading to large overpayments to MA plans.[27,28] Estimates of favorable selection in Medicare Advantage could be used to increase the fee-for-service normalization factor further.

**MA Quality Bonus Payment Program**

The MA Quality Bonus Payment Program (QBP) awards bonuses to plans that achieve at least a four-star rating based on clinical processes, health outcomes, and health plan performance. Research from MedPAC[18] and CAHPR[19] have found that the MA QBP has yet to improve claims-based quality performance and that nearly 80% of MA beneficiaries are in plans receiving ratings of 4 or higher.

To address this issue, CMS could continue to strengthen QBP criteria to raise quality standards, making the quality bonuses more difficult to achieve and motivating plans to improve their quality of service. As currently calculated, the five-star rating system may not be useful to beneficiaries, given that so many plans are highly rated, there needs to be more useful information in the ratings to help differentiate plans. The ratings may also not be useful in promoting plan quality through financial incentives since most plans currently receive financial benefits. Based on our research and current reading of the academic literature, we propose several updates to the star rating system.

First, CMS should consider recalculating the ratings to enforce a normal distribution, as CMS does with other rating systems, such as in Nursing Homes. This would ensure that plans that are truly high performing will be recognized with less noise coming from the majority of plans being over 4 stars.

Second, CMS initially increased the weight given to patient-reported measures such as those from CAHPS, but then decreased these weights in the last year. In the advanced notice, CMS states that it plans to keep the weights on patient-reported measures low and assign higher weights to quality measures, such as those from HEDIS. However, our work has found that HEDIS measurements can be manipulated by plans more easily than patient-reported measures and may not be an accurate measure of plan quality.[20] We recommend that CMS increase the weights given to patient-reported outcomes because they more meaningfully capture patient experiences with plans and may be less subject to manipulation by MA plans than the HEDIS measures.

Third, CMS currently includes a measure that captures if a beneficiary chooses to leave their plan. We propose that CMS increase the weight on this measure, as disenrollment is likely to be the strongest measure of if a plan is meeting a beneficiary's needs. We have found that beneficiaries with greater health needs disenroll at substantially higher rates, raising concerns about plan performance for high need beneficiaries.[21,22,23,24,25] In other recent work, we've also found that by five years after enrollment, nearly 50% of beneficiaries have left their initial plan, which raises concerns that plans lack incentives to invest in the healthcare outcomes of their beneficiaries over the long term. CMS may consider including additional measurements that capture disenrollment over a longer time window.

**Conclusions**

We appreciate the opportunity to provide feedback as you consider next steps. Should you have any questions about our comments, please contact me at david_meyers@brown.edu or Jared Perkins, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.

Sincerely,

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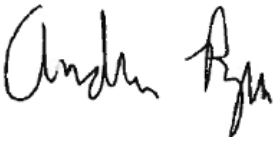

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