March 3, 2023

Honorable Xavier Becerra  
Secretary of Health and Human Services  
Washington, DC

Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare and Medicaid Services  
Washington, DC

Dear Secretary Becerra and Administrator Brooks-LaSure:

The policy changes for Medicare Advantage payment proposed by CMS in the “Calendar Year 2024 Advance Notice with Proposed Payment Updates for the Medicare Advantage and Part D Prescription Drug Program” constitute important advances. These improvements are long overdue and badly needed to assure appropriate financial payments and stewardship for MA funds, fair payments to enable excellent care for sicker patients, sustainability of the overall Medicare program, and security for all beneficiaries. We support CMS’s finalizing these proposed MA payment changes.

MedPAC has estimated that in 2023 there will be $27 billion in excessive and unwarranted payments to MA Plans. Others have projected these overpayments will cost taxpayers $600 billion over the next 8 years. Beneficiaries will ultimately directly shoulder approximately 14% of this, almost $90 billion in increased Part B premiums.

The primary mechanism by which MA plans harvest these profits is by increasing the number of diagnoses recorded for their beneficiaries. Problems with the current CMS Hierarchical Conditions Category (HCC) system have been well documented for years. Under the coding rules, CMS pays plans more for beneficiaries with many diagnostic codes that have little or no real connection to patients’ health conditions and needs, costs of their proper care, or true illness severity. Some of the codes overused by MA plans identify asymptomatic disease that may represent future risk but are not contributors to current year expenses. Because the financial value of each HCC is based on Traditional Fee-for-Service Medicare, in which fewer codes are submitted, every additional code drives excess payments.

The hunt for more codes is distorting the actual delivery of care. It is not primarily a case of bad actors or fraud. It is a broken system that rewards questionable behavior like house calls to do lots of screening exams looking for asymptomatic diseases. While it is possible that these exams may occasionally pick up an unknown problem that needs treatment, the motivating factor is disease coding not preventive care. Furthermore, if an MA Plan does not participate in the game of adding more codes, they suffer in the marketplace as their products become uncompetitive because they have less revenue to support more generous benefits.
CMS now proposes to decrease the coding revenue opportunities by eliminating some HCC’s that have been abused and standardizing the prices associated with categories of codes to avoid upcoding for some conditions. The net result is projected to be a 1% increase in payments in 2024. In practice, the changes will be concentrated among MA plans and providers that are using the eliminated codes or adding more codes per patient. The proposed changes will leave the MA Plans, in aggregate, in a strong financial position while penalizing those who game the risk adjustment system. Efficient, ethical, and cost-effective providers will continue to be adequately reimbursed to deliver high quality care.

Continued overpayment to MA Plans represents a fiscally unsustainable long-term policy. Stakeholders should support CMS in these proposed reforms. The best answer is for MA plans, themselves, to become constructive partners in major coding and payment reforms.

Sincerely,

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