FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

March 1, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

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

Dear Administrator Brooks-LaSure,

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to 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* (i.e., 2025 Advance Rate Notice). Central to Families USA's mission is a commitment to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage and care that improves overall health – which includes ensuring that our nation's seniors and all those who rely on Medicare for their health care have access to high-quality care and coverage options.

Medicare Advantage (MA) is a coverage option within the Medicare Program, which allows Medicare beneficiaries to receive Part A and Part B coverage benefits from private plans rather than from Traditional fee-for-service (FFS) Medicare.[1] The MA program has rapidly increased its enrollment over time and now provides coverage for more than half (51%) of all eligible Medicare beneficiaries in 2023, compared to less than a quarter (19%) in 2007.[2] Notably, this significant growth in MA enrollment is expected to continue, with the Congressional Budget Office projecting that 62% of all Medicare beneficiaries will be enrolled in a Medicare Advantage plan by 2033.[3]

As enrollment in MA continues to rapidly increase, it is critical that policymakers ensure the MA program is providing access to high-quality, affordable, and equitable care that Medicare beneficiaries deserve and can count on. Yet too often MA organizations and plans engage in harmful business practices and corporate abuses that negatively impact Medicare beneficiaries and taxpayers alike. These practices include predatory and deceptive marketing schemes to prospective enrollees[4,5] and systematic upcoding of patient diagnoses that do not reflect the actual care that enrollees are receiving, among other abuses.[6] Ultimately, these practices are driving tens of billions of dollars in overpayments and undermining healthy competition within

and across the MA program, raising concerns about accountability for MA plans to deliver high-quality, high-value, and equitable care.[7]

Families USA applauds much of what the administration and the Centers for Medicare and Medicaid Services (CMS) have done to date to rein in the harmful business practices and corporate abuses in the MA program, such as strengthening protections against unfair and deceptive marking schemes and ensuring MA plans cover basic benefits to the same extent as Traditional Medicare, among other critical reforms.[8] **Families USA also recognizes that additional action is desperately needed and urges the administration and CMS to go further towards reining in the harmful practices of MA plans, particularly around systematic upcoding and overpayments. Specifically, in the short term, we urge CMS to enact a higher coding adjustment factor for MA, and in the longer term we urge CMS to pursue more fundamental changes to the CMS-HCC risk adjustment model that prevent industry gaming and help to drive the delivery of high-quality and equitable health care.**

In the 2025 Advance Rate Notice, there are two CMS proposals that Families USA believes are particularly important and relevant to reining in systematic upcoding in the MA Program and the related harms that upcoding has on beneficiaries and taxpayers, alike. They include two overlapping areas under Attachment II: Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2025 – Section G. CMS-HCC Risk Adjustment Model for CY 2025 and Section J. Medicare Advantage Coding Pattern Difference Adjustment.[9] These proposals are the focus of our comments and are outlined further below, along with our detailed recommendations thereafter:

<u>Attachment II. Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2025:</u>

a. <u>Section G. CMS-HCC Risk Adjustmen Model for CY 2025</u>
b. <u>Section J. Medicare Advantage Coding Pattern Difference Adjustment</u>

Attachment II. Section G. CMS-HCC Risk Adjustmen Model for CY 2025

Under Attachment II. Section G., CMS proposes to continue to implement the 2024 updated risk adjustment model that helps calculate payments to MA organizations and plans, otherwise known as the 2024 CMS-HCC risk adjustment model, over a three-year phase in period, with full implementation of the updated model starting from CY2026.[10,11] This updated model was finalized as part of the 2024 Rate Announcement and includes a number of important changes that seek to promote more accurate payments to MA organizations and plans, helping to ensure that MA payments truly reflect and account for the expected costs of each enrolled patient.[12] Ultimately, risk adjustment within the MA program is designed to help guarantee that MA plans are equally incentivized to enroll and cover both healthy and sick patients alike, including those with complex conditions and other characteristics associated with higher treatment costs.[13] This approach is intended to prevent adverse or favorable selection of enrollees.

Notable changes to the risk adjustment model include:

(1) Using an updated list of diagnosis codes and definitions (i.e., International Classification of Diseases, 10th Revision);
(2) Modifications to how diagnoses associated with similar medical conditions and treatment costs were grouped together (i.e., grouped into hierarchical condition categories, or HCCs) and the extent to which certain groups of medical diagnoses result in relatively higher or lower payments for MA plans caring for individuals with those particular diagnoses; and
(3) Using more recent FFS data to estimate treatment costs associated with each diagnosis in the model, moving from 2014 and 2015 FFS data to 2018 and 2019 FFS data to better reflect more recent cost, treatment, and utilization patterns associated with each diagnosis, among other technical changes.

Importantly, CMS is taking the opportunity to make adjustments to the risk adjustment model that would help rein in systematic upcoding by MA plans. Specifically, CMS takes into consideration which HCCs, and the diagnoses therein, were found to disproportionately drive systematic upcoding and overpayments across the MA program as compared to Traditional Medicare.[14] Among those HCCs and diagnoses found to be associated with upcoding, CMS reduced or eliminated the extent to which they would result in inappropriate payments to MA plans.[15] For example, CMS decreased the extent to which a diabetes diagnosis (with chronic or acute complications) would impact an enrollee's risk score and result in higher risk-adjusted payments to MA plans.[16] This is an important step as MA plans have been found to improperly bill and upcode diabetes diagnoses to a considerable degree compared to providers in Traditional Medicare, contributing to billions of dollars in inappropriate overpayments to MA plans. In fact, according to the Medicare Payment Advisory Commission (MedPAC), MA plans code diabetes with chronic complications up to two times more frequently than providers in Traditional Medicare, despite serving a healthier enrollee population overall.[17]

Families USA applauds CMS' changes to the CMS-HCC Risk Adjustment Model as part of the 2024 Rate Announcement and its proposed continued phase-in of that updated model in the current 2025 Advance Rate Notice. Families USA also urges the administration to go further and in the longer term pursue more fundamental changes to the CMS-HCC risk adjustment model that prevent industry gaming and help to drive the delivery of high-quality and equitable health care.

Attachment II. Section J. Medicare Advantage Coding Pattern Difference Adjustment

Under Attachment II. Section J., CMS proposes to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent to beneficiary risk scores across all MA plans.[18,19] Like the modifications to the CMS-HCC Risk Adjustment model outlined above, the MA coding pattern difference adjustment is designed to help rein in overpayments to MA plans by accounting for differences in coding intensity and upcoding between MA and Traditional Medicare. Specifically, this adjustment factor decreases beneficiary risk scores across all MA

plans by 5.9 percent after risk scores are initially calculated using the risk adjustment model.[20] Since these beneficiary risk scores are systematically inflated due to MA plan upcoding and are used to inform final MA plan payments, this adjustment helps to rein in overpayments associated with MA plan upcoding and coding intensity.[21] The particular adjustment level of 5.9 percent was put into place by Congress starting in 2019; however, it is important to note that CMS has the statutory authority to implement a coding pattern adjustment above and beyond the minimally required 5.9 percent, but has never done so.[22]

Families USA appreciates the steps CMS has taken in the Advanced Notice and elsewhere to rein in upcoding and overpayments to MA, however we are disappointed CMS chose to only apply the coding pattern adjustment at the minimum 5.9 percent. We urge the administration to go further and to institute a higher coding pattern adjustment above and beyond the minimum 5.9 percent.

Continued Abuses in MA Demand Further Administrative Action

Combined with the relatively modest improvements to the risk adjustment model, the coding pattern adjustment does not fully address nor rein in the differences in MA coding intensity and upcoding relative to Traditional Medicare, nor does it mitigate the resulting harms to Medicare benificiaries and taxpayers. According to MedPAC, the updated risk model (i.e., 2024 CMS-HCC risk adjustment model) is estimated to reduce MA and Traditional Medicare coding differences between approximately 2 and 2.5 percentage points per year.[23] Combined with the 5.9 percent statutory minimum MA coding pattern difference adjustment, this is significantly less than the current and projected upcoding by MA plans. In fact, MedPAC estimates that coding intensity in MA will be 14.2 percentage points higher than Traditional Medicare, resulting in $54 billion dollars in overpayments in 2024 alone.[24]

By definition, MA payments are intended to represent and cover the expected health care costs of the enrollee population of MA plans. These payments are risk-adjusted based on the characteristics and health status (i.e. diagnoses) of each enrolled patient to help account for differences in health care costs between healthier and sicker enrollees and ensure plans are equally incentivized to cover enrollees regardless of health status.[25] These characteristics and diagnoses are assigned a value – based on associated historical health care spending in Traditional FFS Medicare – which is then used to help calculate MA payments for each enrollee.[26] Systematic upcoding undermines the integrity of the MA payment system and the accuracy of those risk adjusted payments,[27] making the MA enrollee population appear sicker and costlier despite the fact that those enrollees tend to be healthier and less costly than those in Traditional Medicare (whose historical health care costs, importantly, end up informing the MA risk adjustment model and MA payments).[28] Most concerningly, MA plans have gone so far as to upcode and assign erroneous patient diagnoses – through sham chart reviews and health risk assessments (HRAs) – that are not medically supported (i.e., not supported by the patient's medical record) or do not result in any additional medically necessary treatment or care.[29] This is a national scandal. MA plans have engaged in these coding abuses in order to increase their

payments, and ultimately maximize their revenues and profits, with little regard to what they mean for the health and financial well-being of Medicare beneficiaries.

This behavior negatively impacts those who rely on Medicare for health coverage and taxpayers in five important ways:

1. MA plans' systematic upcoding results in significant overpayments which directly harms the financial sustainability of the Medicare program as well as the financial wellbeing of Medicare beneficiaries and taxpayers. According to MedPAC, between 2007 and 2023, MA upcoding and coding intensity led to nearly $124 billion in excess payments to MA plans.[30] Notably, about one-third of these overpayments – $44 billion – will be paid to plans in 2022 and 2023, highlighting that upcoding and resulting overpayments continue to grow worse over time, especially as the MA program experiences record enrollment[31] Since the MA program is funded through a combination of the Medicare Part A Trust Fund and the Supplementary Medical Insurance (Part B) Trust Fund – which are primarily financed by a mix of general tax revenue and payroll taxes[32] – heightened spending and overpayments associated with the MA program worsens Medicare's financial position and financial sustainability. This is especially urgent as Medicare's trustees estimate that without changes to current law, the Part A Trust Fund will become insolvent by 2028.[33] Moreover, overpayments in MA hurt Medicare beneficiaries' financial wellbeing directly by contributing to increases in Part B spending and Part B premiums that are borne by Medicare beneficiaries across the Medicare Program as well as state Medicaid agencies who help pay for Part B premiums for select beneficiaries[34] In fact, MedPAC estimates that Part B premiums will increase by $13 billion in 2024 due to MA plan overpayments.[35]
2. MA plans' systematic upcoding undermines competition within and across the MA program and the extent that MA plans are held accountable to delivering high quality, affordable, and equitable care. In addition to increasing plans' monthly payments, MA plans' systematic upcoding increases the rebates that over 99 percent of MA plans receive.[36] Rebates are additional Medicare payments that complement MA plans' base payments, which can then be used by plans to offer supplemental benefits to their enrollees, such as reduced cost sharing or vision or dental coverage.[37] Importantly, these rebates are designed to incentivize plans to compete with each other on the basis of health care quality and value while lowering costs.[38] In return for improving care quality or lowering costs, MA plans receive increased rebates that they can then use to offer supplemental benefits in order to attract additional enrollees overtime.[39] However, as noted above, MA plans can *also* increase their rebates by upcoding (i.e., increasing their coding intensity) since rebates are in part calculated using a formula that relies on risk adjustment and enrollee risk scores.[40] In the context of systematic upcoding across the MA program, this loophole to achieving higher rebates undermines competition between MA plans and the extent to which MA plans are incentivized to improve their health care quality or costs. For instance, consider two MA plans that cover the same set of enrollees with the same expected health costs and deliver the same health care quality, but Plan A engages in aggressive upcoding while Plan B does not.[41] As a result, Plan A will receive a higher rebate and be more competitive by offering additional supplemental benefits to attract additional enrollees while Plan B does

not – creating an unfair advantage in favor of Plan A. Worse, according to a scenario calculated by MedPAC, Plan B could even achieve higher quality scores, but Plan A (through upcoding) still earns a higher rebate.[42] Ultimately, the present and growing disincentive among MA plans to deliver high quality, affordable, and equitable care for their enrollees puts those very enrollees' health and financial security directly at risk. For instance, it can jeopardize a patient getting the proper care coordination they need or the preventive checkup that saves their life.

3. A number of additional factors compound concerns that MA plans are not held accountable to delivering high quality, affordable, and equitable care, including a lack of transparency into health care utilization and patient outcomes among MA plans, an ineffective MA quality program, and growing evidence of adverse selection where healthier beneficiaries are more likely to enroll into a MA plan compared to Traditional Medicare while sicker and more marginalized beneficiaries largely stay segregated in Traditional Medicare. For instance, according to the Government Accountability Office, the information CMS collects and reports on supplemental benefits offered by MA plans is severely limited.[43] There is limited information on the extent to which MA enrollees are using supplemental benefits, the characteristics of enrollees who are most likely to use them, and whether supplemental benefits are having a truly positive impact on health care quality.[44] Overall, this lack of transparency makes it increasingly difficult to evaluate the quality of care that MA plans deliver, including their impact on health equity, and creates significant barriers to holding them accountable.[45]
4. Further, the MA quality bonus program is largely ineffective at incentivizing high quality and equitable care delivery, further incentivizing MA plans to focus on upcoding rather than improving quality or outcomes. Numerous studies have found that quality bonus payments were not associated with consistent improvements in plan quality.[46] One study even found that certain types of bonus payments tended to be delivered in a racially inequitable way, where counties with higher proportions of Black beneficiaries were less likely to receive bonus payments.[47] Other studies have observed that MA plans that cover the highest need and most vulnerable beneficiaries tended to receive the lowest bonus payments while plans serving higher-income beneficiaries tended to receive the highest bonus payments.[48] These findings collectively raise a number of significant concerns about the effectiveness of the MA quality bonus program and its ability to hold MA plans accountable to delivering high quality and equitable care. They also raise concerns about the ability of MA plans to appropriately serve vulnerable beneficiaries and the extent to which the quality measures used to evaluate MA plan quality and the underlying risk adjustment model account for social risk factors; the latter concern was similarly raised by MedPAC and others when reviewing the MA quality bonus program.[49] Moreover, MA plans' systematic upcoding- poses a direct barrier to evaluating MA plans on the basis of quality as many quality measures, including those used in the MA quality bonus program, are risk-adjusted and therefore prone to gaming.[50]
5. Lastly, there is growing evidence of favorable selection in the MA program, where healthier beneficiaries are more likely to enroll into a MA plan compared to Traditional Medicare, while sicker and more marginalized beneficiaries largely stay segregated to Traditional Medicare.[51] In addition to further driving overpayments to MA plans as compared to

Traditional Medicare, this raises a particular concern about the extent to which the MA program can play a positive role in driving health equity and the ability of MA plans to adequality serve marginalized populations. This also raises concerns regarding whether the risk adjustment model used in MA is adequately working to ensure that MA plans are equally incentivized to enroll beneficiaries with higher treatment costs associated with social risk factors as compared to healthier and more privileged enrollees. For instance, according to MedPAC, there is growing evidence that Medicare beneficiaries who are chronically ill, costly, or nearing the end of life were more likely to leave MA after initially enrolling.[52]

In short, systematic upcoding by MA plans negatively impacts those who rely on Medicare for health care and taxpayers in a number of important and substantive ways, including by threatening the financial sustainability and wellbeing of the Medicare program and individual Medicare beneficiaries respectively. Combined with a lack of meaningful transparency, an ineffective quality program, and growing evidence of adverse selection, there is growing urgency towards reining in the harmful business practices of MA plans and fully addressing the systematic upcoding and overpayments as well as strengthening the MA risk adjustment model to further improve payment accuracy and in turn hold MA plans truly accountable to the health and wellbeing of consumers and their families.

Families USA Recommendations to Further Rein in MA Abuses

We strongly urge the Administration and CMS to go further in reining in the systematic upcoding and overpayments observed in the Medicare Advantage Program by 1) applying a higher coding adjustment factor in the short term, and 2) enacting more fundamental changes to the CMS-HCC Risk Adjustment model that prevent industry gaming and help to drive the delivery of high-quality and equitable health care in the long term.

Specifically, we recommend CMS enact the following changes in its 2025 Rate Announcement.

- Apply a higher coding adjustment factor above and beyond what is minimally required in statute to fully account for intensive coding by MA plans, using a tiered approach that targets MA plans who engage in upcoding to the greatest extent in order to remove their unfair advantage as compared to other MA plans.
- Exclude information exclusively collected via in-home health risk assessments (HRAs) or chart reviews as a source of diagnoses for Medicare Advantage risk adjustment scores and payments, which are easily abused and represent a significant driver of coding intensity and upcoding as noted by MedPAC and HHS OIG.[53]
- Use two years of traditional Medicare and MA diagnostic data for calculating MA risk adjusted payments to avoid allowing erroneous diagnoses, such as those due to errors or inappropriate coding from one particular year, drive upcoding and overpayments in MA.[54]

- Initiate longer term reforms of the CMS-HCC Risk Adjustment Model that drive towards a health care system that promotes health equity and social and economic wellbeing and delivers whole-person and patient-centered care:
    - Explore alternative sources of data for MA risk adjustment that cannot be easily gamed by industry
    - Incorporate additional measures of health-related social needs to more accurately account for expected health care costs among socially vulnerable and marginalized populations and drive towards equity and improved protections against adverse selection.

Conclusion

Families USA applauds CMS and the Biden administration for taking meaningful steps towards reining in the harmful business practices and corporate abuses in the MA program. As the MA program continues to experience record enrollment and now provides health care coverage to over half of all Medicare beneficiaries, it is critical CMS continues to hold MA plans accountable to delivering high quality, affordable, and equitable care. Families USA stands ready to work with you to ensure our nation's seniors and all those who rely on Medicare for their health care have access to the high-quality care and coverage options they deserve.

Thank you again for the opportunity to provide comment. Please contact Aaron Plotke (APlotke@familiesusa.org), Senior Policy Analyst at Families USA, with any questions.

Sincerely,

Yael Lehmann
Interim Executive Director

[1] MedPAC, The Medicare Advantage program: Status Report, March 2023.
[2] KFF, *Medicare Advantage in 2023: Enrollment Update and Key Trends, August 9, 2023.* https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[3] Ibid.

[4] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022). "In 2020, we received a total of 15,497 complaints related to marketing. In 2021, excluding December, the total was 39,617."

[5] US Senate Committee on Finance (Majority Staff), *Deceptive Marketing Practices Flourish in Medicare Advantage.* https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf

[6] HHS OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments,* September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp

[7] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023; MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf

[8] 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

[9] See Attachment II, Section G & Section J of Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2025-advance-notice.pdf

[10] See Attachment II, Section G of Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2025-advance-notice.pdf

[11] CMS's proposal to continue its three-year phase in of the updated risk adjustment is as follows: For CY2024, risk scores will be calculated as the sum of 33% of the risk score calculated using the updated 2024 CMS-HCC risk adjustment model with 67% of the risk score calculated using the current 2020 CMS-HCC risk adjustment model. For CY2025, risk scores will be calculated as the sum of 67% of the risk score calculated using the updated 2024 CMS-HCC risk adjustment model with 33% of the risk score calculated using the current 2020 CMS-HCC risk adjustment model. For CY2026, 100% risk scores will be calculated using the updated 2024 CMS-HCC risk adjustment model.

[12] Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2024-announcement-pdf.pdf

[13] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.

[14] Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2024-announcement-pdf.pdf

[15] Ibid.

[16] Ibid.

[17] MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf;

[18] See Section II, Section J of Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. https://www.cms.gov/files/document/2025-advance-notice.pdf.

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

[20] MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf

[21] Ibid.

[22] Section 1853 (a)(1)(C)(ii) of the Social Security Act [42 U.S.C. 1395w–23(a)(1)(C)(ii)].
[23] MedPAC, Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf
[24] MedPAC: Medicare Advantage Status Report Presentation, January 12, 2024.
[25] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.
[26] Ibid.
[27] Ibid.
[28] Ibid; HHS OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments,* September 20, 2021. OEI-03-17-00474.
[29] HHS OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments,* September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023.
[30] Ibid.
[31] Ibid; according to MedPAC, MA coding intensity relative to Traditional Medicare has increased by 1 percentage point per year.
[32] Juliette Cubanski & Tricia Neuman, *FAQs on Medicare Financing and Trust Fund Solvency*, June 17, 2022. https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/
[33] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2022. 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Washington, DC: Boards of Trustees.
[34] MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf; Tricia Neuman, Juliette Cubanski, & Meredith Freed, *Monthly Part B Premiums and Annual Percentage Increases,* January 12, 2022. https://www.kff.org/medicare/slide/monthly-part-b-premiums-and-annual-percentage-increases/; CMS, *Medicare Savings Programs*, https://www.medicare.gov/basics/costs/help/medicare-savings-programs
[35] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See page 265 of MedPAC, January 2024 Public Meeting Transcript.
[36] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; MedPAC, Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf
[37] Ibid; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.
[38] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023; See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023; MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Mar2023_MA_C_AND_D_CY-2024_MedPAC_COMMENT_v2_SEC.pdf
[39] Ibid.
[40] Ibid.
[41] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023
[42] Ibid.
[43] Government Accountability Office, *Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization,* January 2023. https://www.gao.gov/assets/gao-23-105527.pdf
[44] Ibid; Jeannie Fuglesten Biniek, Meredith Freed, & Tricia Nueman, *Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries,* Kaiser Family Foundation, April 25, 2023. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/

[45] Among the research that does attempt to evaluate quality of care in the MA program, the results are largely mixed, with most studies comparing hospital readmissions, mortality, and patient experience measures not showing a consistent pattern of better or worse performance between MA plans and Traditional Medicare. For more information, see MedPAC, The Medicare Advantage program: Status Report, March 2023.
[46] Markovitz, A. A., Ayanian, J. Z., Warrier, A., & Ryan, A. M. (2021). Medicare Advantage plan double bonuses drive racial disparity in payments, yield no quality or enrollment improvements. *Health Affairs*, *40*(9), 1411–1419. https://doi.org/10.1377/hlthaff.2021.00349; Markovitz, A. A., Ayanian, J. Z., Sukul, D., & Ryan, A. M. (2021). The Medicare Advantage Quality Bonus program has not improved plan quality. *Health Affairs*, *40*(12), 1918–1925. https://doi.org/10.1377/hlthaff.2021.00606
[47] Ibid.
[48] Laura Skopec & Robert Berenson, *The Medicare Advantage Quality Bonus Program,* June 2023. https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf
[49] Jeannie Fuglesten Biniek, Anthony Damico, & Tricia Neuman, *Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least $12.8 Billion in 2023*, Kaiser Family Foundation, August 9, 2023; Laura Skopec & Robert Berenson, *The Medicare Advantage Quality Bonus Program,* June 2023. https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf; See Chapter 3, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf
[50] See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023
[51] See Chapter 4, MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, June 2023.
[52] Ibid.
[53] HHS OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments,* September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; See Chapter 12, MedPAC, Report to the Congress: Medicare Payment Policy, March 2016.; See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023
[54] See Chapter 12, MedPAC, Report to the Congress: Medicare Payment Policy, March 2016