JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

March 6, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-2023-0010
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

Re: CMS-2023-0010: Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Justice in Aging appreciates the opportunity to comment on the above-referenced Advance Notice of Methodological Changes (the "Advance Notice").

Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports (LTSS) and the particular needs of those dually eligible for Medicare and Medicaid coverage. Our advocacy focuses on populations of older adults who have historically faced discrimination, including women, LGBTQ+ people, people of color, people who have limited English proficiency (LEP), and people with disabilities. Therefore, ensuring that programs and services fully and fairly serve these communities in an equitable manner is at the heart of our work.

We advocate for culturally competent, person-centered care in programs like Medicare and Medicaid to meet the diverse needs of seniors with limited incomes and resources across the country. Every day, we work with a network of advocates and professionals serving older adults who benefit from the programs at issue in this rulemaking, yet are also harmed by the unfair and inequitable practices that these proposed rules aim to remedy.

Justice in Aging strongly supports the direction of the changes proposed in the Advance Notice. Many of the changes are highly technical and we will not comment on them in detail, but we appreciate that together they hold Medicare Advantage (MA) plans) more accountable for the quality of their services to enrollees and that they continue to address long-standing concerns about plan overpayment. With half of people with Medicare now enrolled in MA plans, the need to reform MA payments has increased in urgency.

Overpayments: As advocates for low-income older adults enrolled in Medicare, our concern is that these individuals have access to high quality affordable care, whether they choose to enroll in a Medicare Advantage plan or in Original Medicare. As documented repeatedly by the Medicare Payment Advisory Committee (MedPAC), CMS has been overpaying MA plans compared to payments for

individuals in Original Medicare for many years.[1] The overpayments have fueled rapid growth in MA plans, including Dual-eligible Special Needs Plans (D-SNPs), which have almost doubled in number in the last five years.[2] Most recently MedPAC found that Medicare spends four percent more for MA enrollees than it would spend if they were enrolled in Original Medicare.[3] These overpayments mean that Medicare enrollees in Original Medicare and, in the case of many low-income individuals, state Medicaid programs, are subsidizing MA plans. We appreciate that the proposed methodological changes for 2024 continue CMS' ongoing efforts to address these gaps and do so in a careful and thoughtful way that will not disrupt care delivery to individuals with Medicare Advantage.

Supplemental benefits: Individuals in Original Medicare do not have access to the supplemental benefits that MA plans offer. Yet, by subsidizing MA overpayments, they are indirectly paying for them. Many of these services, such as dental and vision services, are essential to good health but not available to individuals enrolled in Original Medicare. Instead of a payment design where individuals in Original Medicare bear the cost of additional services only available to MA enrollees, we urge CMS to level the payment structure and look to ways to improve the core Part A and B benefits so that the entire Medicare program better addresses the health care needs of all Medicare beneficiaries. This is especially important for low income individuals who simply cannot afford to pay for non-covered services. This approach to improving core Medicare benefits for all people with Medicare would also help ensure the quality of what are now supplemental benefits. While many MA plans offer benefits like dental to attract enrollees, the services covered are typically inadequate and may even be persuading people with Medicare to choose an MA plan that does not meet their needs while giving up provider choice under Original Medicare. We believe that rationalizing Medicare Advantage payments is an important foundational element in not only making access to services in Medicare more equitable but also in strengthening the services themselves.

Diagnosis codes: We particularly appreciate the steps that CMS is proposing in the Advance Notice to address the epidemic of upcoding, an issue that was highlighted both by MedPAC and the HHS Office of the Inspector General,[4] and confirmed by independent researchers.[5] Low income older adults, on average, are sicker and have more chronic conditions that other Medicare beneficiaries. While we most certainly want these individuals to be carefully diagnosed, we do not believe that plans should receive increased payments for diagnosing conditions that they do not manage or treat. We hear, for example,

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[1] See, e.g., For the record: MedPAC's response to AHIP's recent "Correcting the Record" blog post – MedPAC (Fig. 1); A. Johnson and L. Sema Balancing efficiency with equity in Medicare Advantage benchmark policy (Mar. 4, 2021), available at Sample title here (medpac.gov)

[2] Kaiser Family Found., Medicare Advantage 2023 Spotlight: First Look (Nov. 10, 2022), available at Medicare Advantage 2023 Spotlight: First Look | KFF.

[3] MedPAC, Report to the Congress: Medicare Payment Policy (Mar. 2022), p. 411, available at MedPAC March 2022 Report to the Congress.

[4] HHS Office of Inspector General, Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns (Dec. 2019), available at Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns (OEI-03-17-00470; 12/19) (hhs.gov)

[5] R. Kronick, Projected Coding Intensity in Medicare Advantage Could Increase Medicare Spending by $200 Billion Over Ten Years (Health Affairs, Feb. 2017), available at Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years | Health Affairs

from advocates for dually eligible individuals that D-SNPs, which serve the highest need populations, often have narrower networks. Advocates report that many enrollees, once they have a serious health condition, decide to disenroll from their D-SNP because the D-SNP does not offer the care they need, primarily because of network inadequacy.

The Advance Notice proposes to modernize claims data and reduce the impact of certain diagnosis codes that are discretionary and not connected to claims or care that the MA plan paid for. We appreciate that CMS is continuing its efforts to address inflated risk adjustment payments, a problem that has been challenging to fix.[6] We believe that this approach is an important and necessary response to upcoding and also offers the potential to incentivize more comprehensive care.

Quality bonuses: Last year, almost 70 percent of MA plans received star ratings of 4 or more, with attendant quality bonuses. For enrollees, this means two things. First, star ratings are of limited use in making plan selection when 70 percent are given a rank that should indicate above average performance. Second, it means that plans are being paid extra for performance that does not merit it and are paid in a way that does not result in better care.

Complexity of Payment Calculations: As CMS moves forward, we urge the agency to work to simplify and make more transparent the criteria by which it pays plans. The more complex the system is, the greater the opportunities for plans to game the system and the greater the barriers for advocates and other stakeholders to provide meaningful feedback. We have particular concerns about contract level quality measures, as well as the option for options for sponsors to create plan segments. These contracting models particularly lend themselves to manipulation. Each plan should be judged based on its performance serving all of the members of that plan. It should be that simple and currently it is not.

Thank you again for the opportunity to comment on the Advance Notice. If any questions arise concerning this submission, please contact Georgia Burke, gburke@justiceinaging.org.

Sincerely,

Georgia Burke

Georgia Burke
Director, Medicare Advocacy

[6] See, e.g., C. Miller and J. Sung, Improving Medicare Advantage Payment Policy While Focusing on Implications for Consumers (AARP, Feb. 2023), pp. 7-8, available at Improving Medicare Advantage Payment Policy While Focusing on Implications for Consumers - AARP Spotlight.