



August 30, 2022

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to provide responses to the Centers for Medicare and Medicaid Services (CMS) on the “Medicare Program; Request for Information on Medicare”, referred to as CMS-4203-NC, which was published in the Federal Register on August 1, 2022.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work in the health care sector is driven by a recognition that the system costs too much and often fails to adequately meet the needs of the people it seeks to serve. Our work spans a wide range of issues including commercial-sector prices, provider payment incentives, prescription drug prices, clinical trials, Medicare sustainability, and complex care.

First, we want to thank the agency for its important work to improve the Medicare Advantage program, and for the opportunity to provide input. Our Medicare work to date is focused on improving the fiscal sustainability of the program and addressing the needs of the dual-eligible population. Before we provide responses, we want to be clear that we support Medicare Advantage as an option for Medicare beneficiaries. Medicare Advantage plans have demonstrated that they have the potential to provide care less expensively than fee-for-service Medicare.<sup>1</sup> And Medicare Advantage plans have greater ability to coordinate and organize delivery systems to improve care, particularly for the dual-eligible population. However, the Medicare Advantage program has never yielded aggregate savings to the Medicare program and taxpayers given the higher payments made to Medicare Advantage plans for similar beneficiaries.

Our responses focus on various aspects of the Medicare Advantage program that can be strengthened and improved so that the program better serves beneficiaries in alignment with CMS’ vision for advancing equity, expanding access, promoting person-centered care, and supporting the affordability and sustainability of Medicare. The table below summarizes our recommendations and what follows are more details regarding our feedback.

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<sup>1</sup> Medicare Payment Advisory Commission. Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans. March 2022.



RFI Topic	Summary of Recommendations
Advance Health Equity	<ul style="list-style-type: none"> <li>• Prioritize improvements and increased access to fully integrated special need plans (FIDE-SNPs) as a meaningful leverage point to address disparities.</li> <li>• Support D-SNPs by further limiting D-SNP look-alike plans.</li> </ul>
Expand Access: Coverage and Care	<ul style="list-style-type: none"> <li>• Prioritize improvement of the enrollment experience for the dual-eligible population specifically by (1) providing additional support at the time of enrollment; (2) better using disclaimers to notify people about their coverage selection; and (3) employing automatic enrollment strategies for FIDE-SNPs.</li> <li>• Create a standardized data collection methodology for supplemental benefits and require plans to operate it over the long-term.               <ul style="list-style-type: none"> <li>○ Provide more transparency on supplemental benefits in the near term through requiring plans to report more data on supplemental benefits including (1) the number of enrollees using supplemental benefits by category; (2) detailed, beneficiary-level data in the Medicare Advantage encounter data where data are available; and (3) data on how many of their enrollees purchase optional benefits that require beneficiaries to pay a separate premium.</li> </ul> </li> </ul>
Drive Innovation to Promote Person-Centered Care	<ul style="list-style-type: none"> <li>• Collect and report Medicare Advantage quality measures for plans at the local market level.</li> <li>• Calculate star ratings by plan.</li> <li>• Reduce the number of measures and place a greater emphasis on clinical outcome and beneficiary measures.</li> </ul>
Support Affordability and Sustainability	<ul style="list-style-type: none"> <li>• Reduce overpayments to Medicare Advantage plans in order to improve the fiscal sustainability of the Medicare program, including through changes to risk adjustment and the quality bonus program.</li> <li>• Contemplate making any bonus payments contingent on Medicare Advantage plans' compliance with other program requirements.</li> <li>• Design measures and performance thresholds that reduce spending on the quality bonus program.</li> <li>• Increase the coding intensity adjustment in the risk adjustment model beyond what is minimally required in statute.</li> <li>• Exclude health risk assessment (HRAs) and chart reviews as the sole source of diagnoses for the purposes of risk adjustment.</li> <li>• Contemplate larger scale reforms to CMS' approach to risk adjustment as part of a long-term vision.</li> <li>• Prioritize increasing transparency in Medicare Advantage by strengthening data collection requirements with respect to quality, access, and enrollment.</li> <li>• Collect and publish more information on (1) prior authorization denials and appeals, (2) disenrollment, and (3) supplemental benefits.</li> <li>• Include demographic data such as race/ethnicity in the monthly Medicare Advantage enrollment data.</li> <li>• Improve the accuracy and completeness of Medicare Advantage encounter data by holding plans accountable for data quality.</li> </ul>



## A. Advance Health Equity

1. What steps should CMS take to better ensure that all Medicare Advantage enrollees (including across race, ethnicity, sexual and gender orientation, health status, religion, and cultural beliefs, economic status, language, geographic location, etc.) receive the care they need?
2. What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

**We encourage CMS to continue to prioritize improvements and increased access to fully integrated special need plans (FIDE-SNPs) as a meaningful leverage point to address disparities.**

Few populations within the Medicare Advantage program are more diverse and possess as complex care needs than those eligible for both Medicare and Medicaid. Dual-eligible individuals are more likely than the average Medicare-only beneficiary to identify as a racial or ethnic minority, experience multiple functional limitations, be low-income, and experience food and housing insecurity.<sup>2,3</sup> Dual-eligible individuals also experience poorer outcomes compared to their Medicare-only counterparts. They are more likely to have an inpatient stay, an emergency room visit, or live in a long-term care facility than Medicare-only beneficiaries and are over three times as likely to self-report poor health.<sup>4,5</sup> Achieving equity within the Medicare Advantage program means addressing these disparities and improving the care and experience of this population.

The disparate outcomes between the dual-eligible and Medicare-only populations are driven in part by the need to navigate two distinct and non-aligned coverage systems. Integrating Medicare and Medicaid's care delivery, financing, and administration, offers a promising solution for achieving more equitable care for this population. CMS has taken important strides towards accomplishing this goal, most recently through "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs" (CMS-4192-F), which increased the level of integration and alignment offered through the FIDE-SNP. However, the model is far from perfect and almost 50 percent of dual-eligible individuals do not have access to an integrated model today. Recommendations for

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<sup>2</sup> Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. February, 2022.

<sup>3</sup> Association for Community Affiliated Plans. Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans. October 2020.

<sup>4</sup> Medicare Payment Advisory Commission. July 2020 Data Book, Section 4: Dual-Eligible Beneficiaries. July, 2020

<sup>5</sup> The Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. February, 2022.



improvements to the FIDE-SNP are outlined throughout this letter in response to the relevant questions and include:

- Further limit D-SNP look-alike plans.
- Make it easier for people to understand and enroll in the FIDE-SNP by improving Medicare Plan Finder, investing in additional educational support for beneficiaries, and employing automatic enrollment so long as adequate education and an opt-out are available.
- Employ standardized data collection of supplemental benefits and specifically study the utilization patterns of dual-eligible individuals, and the value of these benefits.
- Ensure sustainability by reducing excessive payments to Medicare Advantage plans.
- At a minimum, operate the star rating system at the plan level so that the quality of a D-SNP, specifically, is clear. However, we encourage CMS to require all D-SNPs, and FIDE-SNPs in particular, to operate on a separate contract to provide additional visibility into quality and financial outcomes for these plans.

While viewed as outside the scope of this letter, it is important that CMS and the Medicare Advantage program continue to recognize the important role that states play in the availability of the FIDE-SNP model. CMS should use all the tools at its disposal including its authority over the Medicare Advantage program and Medicaid and Medicaid managed care to require and support states in providing integrated care to all dual-eligible individuals residing in their states.

9. How are MA SNPs, including D-SNPs, C-SNPs, and I-SNPs tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted coordinated care for enrollees?

**We encourage CMS to support D-SNPs by further limiting D-SNP look-alike plans.**

The promise and value of D-SNPs is to integrate the Medicare and Medicaid programs. In the absence of integration, the value of a D-SNP model is an open question. As examples, integration includes aligned financing, a single set of benefits from the beneficiary and provider perspective, a single insurance card, and a medical review process that simultaneously accounts for both Medicare and Medicaid coverage. CMS has improved upon one form of the D-SNP—the FIDE-SNP model—in its “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs” (CMS-4192-F). Under these rules, a beneficiary enrolled in a FIDE-SNP will have access to the full range of Medicare and Medicaid services available under a single managed care organization, making it a premier option for dual-eligible beneficiaries seeking aligned care.



Unfortunately, many MA plans target the dual-eligible population without the ability to integrate their Medicare coverage with the Medicaid program. These so called “D-SNP look-alike” plans are confusing to beneficiaries and reduce enrollment in all D-SNPs, including FIDE-SNPs. CMS responded to this phenomenon in the “Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Programs, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly” (CMS-4190-F) by defining “look-alikes” as non-special needs plans with 80 percent or more enrollment of dual eligible individuals, refusing to renew or sign a new contract with any plan that meets this definition. While this change represents significant progress, we encourage CMS to go further and reduce the threshold from 80 to *at least* 50 percent.

When the Medicare Payment Advisory Commission (MedPAC) conducted its analysis of D-SNP look-alike plans, it found that most plans where at least 50 percent of its members were dually eligible were aimed at attracting people who are dual-eligible. “Most [were] being offered in situations... that [enabled] plan sponsors to circumvent restrictions on offering a D-SNP,” according to MedPAC.<sup>6</sup> Fifty-four plans were estimated to meet the enrollment threshold of 80 percent, while 95 plans would meet the 50 percent threshold in 2019.<sup>7</sup> Further, the 80 percent threshold would not prevent the problem in most states where look-alikes exist. There are only 13 states where look-alike plans' enrollment reached the 80 percent threshold, while 35 states have plans operating in their market that meet the 50 percent threshold.<sup>8</sup>

Additionally, we also are concerned with C-SNPs in particular being similarly leveraged to target the dual-eligible population since they are excluded from the D-SNP look-alike definition. We have heard anecdotally that this is a new strategy some plans are employing. States have no ability to regulate the availability of look-alikes within their market. As states implement the FIDE-SNP model in particular, CMS should protect these investments by further curbing D-SNP look-alikes.

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<sup>6</sup> Medicare Payment Advisory Commission. Chapter 12: Promoting Integration in Dual Eligible Special Needs Plans. June 2019.

<sup>7</sup> Medicare Payment Advisory Commission. Chapter 12: Promoting Integration in Dual Eligible Special Needs Plans. June 2019.

<sup>8</sup> Medicare Payment Advisory Commission. Chapter 12: Promoting Integration in Dual Eligible Special Needs Plans. June 2019.



## B. Expand Access: Coverage and Care

(1) What tools do beneficiaries generally, and beneficiaries with one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage and among different choices for MA plans? How can CMS ensure access to such tools?

(2) What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

There are multiple approaches CMS could take to improve the enrollment experience for Medicare Advantage enrollees. Our comments focus specifically on the dual-eligible population given the additional challenges this vulnerable and medically complex population face when making enrollment decisions.

**We encourage CMS to prioritize the improvement of the enrollment experience for the dual-eligible population specifically by (1) providing additional support at the time of enrollment (2) better using disclaimers to notify people about their coverage selection; and (3) employing automatic enrollment strategies for FIDE-SNPs.**

While the enrollment process is daunting for all Medicare Advantage beneficiaries, it is particularly challenging for the dual-eligible population, who must enroll in coverage for both Medicare and Medicaid. Dual eligible individuals can be faced with as many as 43 different combinations of Medicare and Medicaid coverage, not even accounting for the number of organizations providing the coverage.<sup>9</sup> Having to compare this many options, combined with confusing ads and mailers, impairs people's ability to clearly assess their options and to appreciate the value of integrated models. CMS' and states' investments in improving integrated care cannot be realized if people ultimately do not enroll.

AV recently released a report that outlines consumer advocate feedback regarding perceived challenges associated with integrated models. Advocates emphasized the shortcomings of the existing education and enrollment process as a barrier to the growth of these programs.<sup>10</sup> We recommend that CMS prioritize support for the dual-eligible population with the following strategies: (1) improve upon and increase the availability of enrollment assistance specifically for dual-eligible individuals; (2) use disclaimers in instances when people do not select integrated

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<sup>9</sup> Allison Rizer. Making Sense of Medicare-Medicaid Integration Models. ATI Advisory. June 11, 2020.

<sup>10</sup> Arnold Ventures. Findings from Arnold Ventures' Request for Information on the Dual-Eligible Experience. 2022.



care to raise awareness; and (3) use automatic enrollment into FIDE-SNPs paired with adequate resources including an opt-out option to simplify the enrollment process.

- **Improve upon and increase the availability of enrollment assistance:** Dual-eligible individuals benefit from a combination of online and in-person assistance to ensure they are making informed decisions about their coverage. We recommend that CMS make amendments to the Medicare Plan Finder website and its educational resources—potentially using My Care, My Choice as a template—to make the value of integrated models clearer. For example, make the value of an integrated model clearer and prioritize these models in the display of coverage options. This kind of information should be paired with in-person or, at a minimum, telephonic, unbiased support that can assist beneficiaries and their families with the decision-making process. While the State Health Insurance Program serves as this resource for many Medicare beneficiaries today, our understanding is that relatively few of these organizations are fully equipped to speak to integrated coverage options and the ways in which Medicare and Medicaid coverage can interact.
- **Use disclaimers in instances when people do not select integrated care to raise awareness:** Even with more comprehensive navigation supports, understanding when a coverage option is integrated can be difficult. We recommend that CMS notify dual-eligible enrollees when they select a model that does not integrate care if one is available to them, as well as require all non-integrated coverage options (including FFS) to notify dual-eligible beneficiaries through disclaimers in beneficiary-facing materials that their Medicaid coverage is provided elsewhere.
- **Use automatic enrollment into FIDE-SNPs paired with adequate resources including an opt-out to simplify the enrollment process:** Research suggests that automatic or “passive” enrollment was one of the most effective strategies for enrolling dual-eligible individuals in FAI demonstration models.<sup>11</sup> While similar enrollment strategies exist today for FIDE-SNPs, they are limited. Today, automatic enrollment is generally only available when an individual becomes newly eligible for Medicare and is enrolled in a Medicaid managed care plan (e.g., default enrollment), or when an individual’s plan leaves the market. Most notably, there is no automatic enrollment when a state launches a FIDE-SNP. Also, someone in the Medicare program that becomes newly eligible for Medicaid

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<sup>11</sup> Mathematica Policy Research. The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries. December 4, 2018.



would not be automatically enrolled in a FIDE-SNP, for example. We recommend that CMS expand the use of automatic enrollment into FIDE-SNPs, like the allowances afforded through the FAI demonstration. The use of automatic enrollment strategies more broadly must be coupled with significant education and outreach efforts, as well as a sufficiently long opt-out period. Adequate decision-making support is critical as it allows dual-eligible beneficiaries to recognize that enrollment in a FIDE-SNP is a choice, rather than something out of their control, while simplifying the process for them.

9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBI Model)?

**We recommend that CMS create a standardized data collection methodology for supplemental benefits and require plans to operate it.**

Supplemental benefits offered through Medicare Advantage plans are a growing component of the program, with the number of plans offering non-medical benefits having tripled over the last three years.<sup>12</sup> Plans that disproportionately serve the dual-eligible population, including D-SNPs, are particularly likely to make these benefits available because they do not have to use rebate dollars to reduce cost-sharing and premiums—states are largely responsible for paying these costs for dual-eligible beneficiaries. Despite the widespread availability of supplemental benefits, we know surprisingly little about the extent to which beneficiaries, including dual-eligible individuals, are receiving these services. Information on the utilization of these benefits and their impacts on health outcomes is important for understanding the value of the availability of these additional benefits that are funded through taxpayer dollars and for ensuring that beneficiaries are receiving high-quality whole-person care.

We recognize the challenge with developing a standardized approach to collecting supplemental benefit data given that data on non-medical benefits tend not to be collected like medical benefits, and the community-based organizations that provide non-medical services often do not document beneficiary utilization, or do not do so in a manner that is conducive to standardized reporting. Overcoming challenges with data collection on supplemental benefits will require a long-term plan, but we believe it is important for CMS to make these investments in the interest

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<sup>12</sup> Allison Rizer and Laura Benzing. Filling The Gaps: The Role and Value of Supplemental Benefits in Medicare Advantage. Health Affairs Forefront. August 2022.





of program integrity. Over the long term, CMS may wish to contemplate some level of standardization of supplemental benefits, similar to reforms that were made to Medigap benefits, to ensure the value of supplemental benefits to beneficiaries.

In the near term, there are several concrete steps that CMS can implement to advance the development of a standardized data collection methodology and to begin collecting data elements, where possible, including:

- **Require Medicare Advantage plans to report the number of enrollees using supplemental benefits by category.** Collecting utilization data would enable CMS to understand the number of beneficiaries using supplemental benefits and general trends in use. Collecting basic utilization data, even in aggregate, is an important step toward being able to evaluate the benefit of supplemental benefits. Because we currently know very little about what supplemental benefits Medicare Advantage plans are offering and have no understanding of what benefits beneficiaries actually use, we cannot ascertain the impact of these benefits on beneficiary health outcomes or their value. By linking utilization data with other available data on government spending and beneficiary outcomes, CMS could begin to contemplate whether the federal dollars being spent to make these benefits available are justified by the value they provide to beneficiaries and any resulting improvement in health outcomes.
- **Where data are available, require Medicare Advantage plans to submit detailed, beneficiary-level data in the Medicare Advantage encounter data for supplemental benefits.** CMS could start by requiring Medicare Advantage plans to report these data for dental and vision where data are already available and most similar to the data currently collected on medical services. Imposing this data collection requirement would align reporting in Medicare Advantage with reporting in commercial plans and would be useful for unpacking the use and value of supplemental benefits provided to beneficiaries.
- **Require Medicare Advantage plans to submit data on how many of their enrollees purchase optional benefits that require beneficiaries to pay a separate premium, such as optional dental coverage.** Collecting this information would support CMS in better understanding enrollee costs associated with supplemental benefits.

To support a long-term vision for standardized collection of all supplemental benefits, we encourage CMS to draw on learnings from CMS Innovation Center models that have laid the groundwork for a more robust data collection and reporting infrastructure. For example, the new



ACO REACH model encourages ACOs to report social determinants of health data in support of health equity goals, which may provide a starting point from which to build a system for standardized reporting on non-medical data elements in Medicare Advantage.<sup>13</sup>

### C. Drive Innovation to Promote Person-Centered Care

8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

**We recommend that CMS make the Star Ratings system more usable to beneficiaries through the following changes: (1) collect and report Medicare Advantage quality measures for plans at the local market level; (2) calculate star ratings by plan; (3) reduce the number of measures and place a greater emphasis on clinical outcome and beneficiary experience measures, and (4) contemplate making any bonus payments contingent on Medicare Advantage plans' compliance with other program requirements.**

The Medicare Advantage Star Ratings system is intended to provide information to beneficiaries about the quality of plans and enable them to make informed choices about their coverage options; however, the current system often falls short of achieving this goal. A key limitation with the current Star Ratings system is that quality scores are reported at the contract level, which may include large geographic areas that span multiple states. As a result, beneficiaries may select a plan based on quality scores that are not reflective of the quality of care in the market where they live, greatly reducing the relevance of such scores to beneficiaries. Contract-level reporting of quality scores also conceals variations across plan type. One contract may include a multitude of Medicare Advantage plan types that serve beneficiaries with different characteristics and needs. Measuring traditional Medicare Advantage plans against D-SNPs, for example, obscures individual plan performance and financial behavior, further complicating beneficiaries' ability to choose a plan based on the quality of care provided to people with similar characteristics. MedPAC has found that Medicare Advantage plan sponsors are strategically consolidating contracts to artificially boost star ratings.<sup>14</sup> The Bipartisan Budget Act of 2018 partly addressed this issue, but not fully.

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<sup>13</sup> William K. Blesser, Yolande Pokam Tchuisseu, Humphrey Shen, Andrea Thoumi, Chinmay Amin, Deborah R. Kaye, Mark B. McClellan, and Robert S. Saunders. ACO REACH And Advancing Equity Through Value-Based Payment, Part 2. Health Affairs Forefront. May 2022.

<sup>14</sup> Medicare Payment Advisory Commission. Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans. March 2022.



Furthermore, while the current Medicare Advantage Star Ratings system enables beneficiaries to rule out low-quality plans, it does not effectively enable beneficiaries to evaluate and distinguish between high-performing plans. This is partly due to quality scores being reported at the contract-level (as noted above) and also because of limited variation across plans. In 2022, three-quarters of all Medicare Advantage enrollees are in plans that received high quality ratings (4 or more stars), up from 55 percent in 2015.<sup>15</sup>

Our recommendation that CMS collect and report Medicare Advantage quality measures for plans at the local market level and to calculate Star Ratings by plan would address these key limitations in the current Star Ratings. Requiring reporting and calculation of Star Ratings by market area would improve the relevance of the quality ratings for beneficiaries.

Another limitation with the current Star Ratings is that its measures largely focus on process measures rather than ones that are more meaningful to beneficiaries like outcomes and beneficiary experiences. Collecting measures that are not meaningful to beneficiaries reduces the utility of the Star Ratings system and adds unnecessary costs to the program. For these reasons, we have suggested that CMS reduce the number of measures and place a greater emphasis on clinical outcome and beneficiary experience measures. In addition, CMS should contemplate making any bonus payments contingent on Medicare Advantage plans' compliance with other program requirements. For example, compliance requirements could include submitting high-quality encounter data and data on supplemental benefits.

#### D. Support Affordability and Sustainability

##### 1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

**We encourage CMS to alter the way MA plans are incentivized for delivering high quality care by designing measures and performance thresholds that reduce spending on the quality bonus program.** Medicare spending on bonus payments to Medicare Advantage plans exceeded \$11.5 billion in 2021.<sup>16</sup> Despite this magnitude of investment, the state of quality reporting in Medicare Advantage does not allow for a meaningful assessment of the quality of care in Medicare Advantage including how quality varies among Medicare Advantage plans and compares to

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<sup>15</sup> Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. Medicare Advantage in 2022: Enrollment Update and Key Trends. Kaiser Family Foundation. August 25, 2022.

<sup>16</sup> Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman. Medicare Advantage in 2021: Star Ratings and Bonuses. Kaiser Family Foundation. June 21, 2021.



Medicare fee-for-service. It is critical that CMS consider whether the program is adequately promoting high quality care for Medicare Advantage enrollees. Unfortunately, there is little evidence to suggest that the current quality bonus program has improved Medicare Advantage plan quality, and certain bonus payments may exacerbate racial inequities.<sup>17,18,19</sup> Furthermore, the quality bonus program is funded with additional program dollars, which is not only inefficient but also inconsistent with quality incentive programs in fee-for-service. Ultimately, the Medicare Advantage quality bonus program should be redesigned to be a budget neutral program in which bonuses and penalties are redistributed among plans. While some legislation is required to realize this vision, CMS can take steps to move the program closer to a budget neutral approach to better align it with fee-for-service and reduce spending.

2. What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

**We encourage CMS to contemplate larger scale reforms to its approach to risk adjustment, which will require the development of a long-term vision, while also taking several immediate steps to improve its current approach to risk adjustment.**

It is imperative that CMS' risk adjustment methodology accurately predicts variation in health risk and costs across plans to mitigate plan selection incentives and is designed in a way that limits the ability of plans to profit from intensive coding or gaming. Risk adjustment could also promote health equity by reallocating resources to better account for the care of beneficiaries with higher medical complexity and greater social risk, including those dually eligible for Medicare and Medicaid. Immediate steps that we encourage CMS to employ to improve its current approach to risk adjustment in the interim, include:

- **Increase the coding intensity adjustment in the risk adjustment model beyond what is minimally required in statute.** An analysis by MedPAC found that risk scores in Medicare Advantage were 9.5 percent higher than risk scores for similar beneficiaries in fee-for-

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<sup>17</sup> Medicare Payment Advisory Commission. Chapter 8: Redesigning the Medicare Advantage Quality Bonus Program. June 2019.

<sup>18</sup> Adam A. Markovitz, John Z. Ayanian, Devraj Sukul, and Andrew M. Ryan. The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality. *Health Affairs*, 40(12). December 2021.

<sup>19</sup> Adam A. Markovitz, John Z. Ayanian, Anupama Warriar, and Andrew M. Ryan. Medicare Advantage Plan Double Bonuses Drive Racial Disparity in Payments, Yield No Quality or Enrollment Improvements. *Health Affairs*, 40(9). September 2021.



service in 2020.<sup>20</sup> Even after accounting for CMS' current coding adjustment, this differential cost taxpayers \$12 billion in excess payments to Medicare Advantage plans in a single year. Other estimates suggest that risk scores in Medicare Advantage could be even higher, including estimates that risk scores were 20 percent higher than in fee-for-service in 2019 and that Medicare overpaid Medicare Advantage plans by more than \$106 billion from 2010 through 2019.<sup>21,22</sup> Notably, this problem is getting worse. The impact of Medicare Advantage plans' coding intensity has continued to grow over time but CMS' coding intensity adjustment has remained constant, leading to higher and higher overpayments annually.<sup>23</sup> Increasing the coding intensity adjustment would also improve the solvency of the Medicare Hospital Insurance Trust Fund, as nearly 45 percent of Medicare Advantage funding comes from the Hospital Insurance Trust Fund. While there is clear evidence that plans are engaging in intense coding, there is also evidence showing that there is substantial variation in coding behavior across Medicare Advantage plans, which enables some plans to have an unfair competitive advantage over others. The problem of coding intensity, however, must be rectified immediately to protect Medicare solvency. CMS should increase the adjustment beyond 5.9 percent while investigating alternative mechanisms to account for an individual plan or groups of plans propensity for engaging in upcoding.

- **Exclude health risk assessments (HRAs) and chart reviews as the sole source of diagnoses for the purposes of risk adjustment.** Upcoding is the product of the data sources and variables used to adjust for risk. Because the data can be directly influenced by plans and the coded diagnoses directly affect payment, there is ample opportunity and incentive for upcoding. Two sources of data that Medicare Advantage plans leverage to maximize their payments include chart reviews and HRAs. MedPAC estimates that about two-thirds of overpayments from coding intensity can be attributed to plans using chart reviews and HRAs as exclusive sources of diagnoses.<sup>24</sup> In 2017, diagnoses generated solely by chart reviews led to \$6.7 billion in overspending while HRA diagnoses resulted

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<sup>20</sup> Medicare Payment Advisory Commission. The Medicare Advantage Program: Status Report and Mandated Report on Dual-eligible Special Needs Plans. January 14, 2022.

<sup>21</sup> Kronick, Richard and Chua, F. Michael. Industry-Wide and Sponsor-Specific Estimates of Medicare Advantage Coding Intensity. November 11, 2021.

<sup>22</sup> Schulte, Fred. "Researcher: Medicare Advantage Plans Costing Billions More Than They Should." Kaiser Health News. November 11, 2021.

<sup>23</sup> Medicare Payment Advisory Commission. The Medicare Advantage Program: Status Report and Mandated Report on Dual-eligible Special Needs Plans. January 14, 2022.

<sup>24</sup> Medicare Payment Advisory Commission. Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans. March 2022.



in \$2.6 billion in overpayments to Medicare Advantage plans.<sup>25,26</sup> A relatively small number of Medicare Advantage plans are responsible for a large share of overpayments from chart reviews and HRAs. The OIG has recommended that CMS reassess the use of chart reviews and in-home HRAs for the purposes of risk adjustment and conduct targeted oversight of the Medicare Advantage plans driving a disproportionate share of overpayments from these tactics.<sup>27</sup> MedPAC has also recommended excluding diagnoses from HRAs from risk adjustment calculations.<sup>28</sup>

Emerging evidence on the use of more sophisticated approaches to risk adjustment, including more parsimonious models, suggests that other methods may yield more accurate risk scores while also reducing the potential for plan gaming.<sup>29</sup> MedPAC, for example, recently analyzed a modified risk adjustment model that incorporates the principles of reinsurance and repayment to address inaccuracies caused by outliers.<sup>30</sup> Alternate methods also point to how risk adjustment can be leveraged as a tool to improve the distribution of health care resources to better serve underserved beneficiaries and reduce selection bias, a strategy that aligns with CMS' health equity goals. In consideration of this emerging evidence, a long-term vision for CMS' risk adjustment should contemplate major changes to the methodological approach and data sources.

### 3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

**We encourage CMS to focus on (1) reducing overpayments to Medicare Advantage plans and (2) increasing transparency in Medicare Advantage by strengthening data collection requirements with respect to quality, access, and enrollment.**

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<sup>25</sup> U.S. Department of Health and Human Services Office of Inspector General. Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns (OEI-03-17-00470). December 2019.

<sup>26</sup> U.S. Department of Health and Human Services Office of Inspector General. Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns (OEI-03-17-00471). September 2020.

<sup>27</sup> U.S. Department of Health and Human Services Office of Inspector General. Testimony before the United States House Committee on Energy and Commerce Subcommittee on Oversight and Investigations. June 28, 2022.

<sup>28</sup> Medicare Payment Advisory Commission. Chapter 12: The Medicare Advantage Program: Status Report. March 2016.

<sup>29</sup> Sherri Rose. A Machine Learning Framework for Plan Payment Risk Adjustment. Health Services Research, 51(6). December 2016.

<sup>30</sup> Medicare Payment Advisory Commission. Chapter 5: Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS's risk-adjustment model. June 2022.



The Medicare Advantage program now accounts for nearly half of all Medicare enrollment, up from around one-quarter a decade ago, and Medicare Advantage’s market share is projected to continue rising in the coming years.<sup>31</sup> As Medicare Advantage’s market share grows—and that of Medicare fee-for-service shrinks—CMS will need to confront several emerging challenges. In response to these challenges, we encourage CMS to direct its focus on the following:

- **Reduce overpayments to Medicare Advantage plans in order to improve the fiscal sustainability of the Medicare program.** One challenge with growing enrollment in Medicare Advantage is its broader implications for spending in the Medicare program. Medicare has a long history of paying more for beneficiaries in Medicare Advantage than for beneficiaries in fee-for-service Medicare. Overpayments to Medicare Advantage plans put strain on Medicare’s fiscal sustainability and contribute to Medicare’s Hospital Insurance Trust Fund insolvency. As Medicare Advantage enrollment continues to rise, so too will its impacts on Medicare’s fiscal challenges. The Hospital Insurance Trust Fund is only six years away from insolvency, making it clear that the Medicare program cannot afford continued overpayments to Medicare Advantage plans.<sup>32</sup> Overpayments to Medicare Advantage plans currently result from several factors including coding intensity, the quality bonus program, and the way benchmarks are determined. Policies to more fully account for coding intensity in Medicare Advantage to address overpayments could reduce Medicare spending by as much as \$198 to \$355 billion over the next decade (2021-2030), with slightly over half of savings accruing to the Hospital Insurance Trust Fund, thereby extending solvency. These policies would also reduce premiums for Medicare beneficiaries by \$32 to \$57 billion.<sup>33</sup>
- **Prioritize increasing transparency in Medicare Advantage by strengthening data collection requirements with respect to quality, access, and enrollment.** We know less about the care and experiences of beneficiaries in Medicare Advantage relative to beneficiaries in traditional Medicare. As the Medicare Advantage program grows, we will have less transparency into the care that more and more beneficiaries are receiving. This will limit CMS’ ability to ensure beneficiaries are receiving high quality care and to conduct appropriate oversight of the program. CMS can take the following steps to increase transparency in Medicare Advantage:

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<sup>31</sup> Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. Medicare Advantage in 2022: Enrollment Update and Key Trends. Kaiser Family Foundation. August 25, 2022.

<sup>32</sup> The Centers for Medicare and Medicaid Services. 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Funds. June 2, 2022.

<sup>33</sup> Committee for a Responsible Federal Budget. Reducing Medicare Advantage Overpayments. February 23, 2021.





- **Collect and publish more information on prior authorization denials and appeals.** Specifically, CMS should collect data on the number of initial prior authorization denials (including partial and full), filed appeals, and final outcomes for the appeals (i.e., fully overturned, partially overturned, upheld) by beneficiary in Medicare Advantage so these data can be analyzed by race/ethnicity and dual-eligible status, for example. A recent OIG report found 13 percent of prior authorization denials in Medicare Advantage were for services that met Medicare coverage rules and likely would have been provided had the beneficiary been in traditional Medicare.<sup>34</sup> This signals the need for greater transparency and oversight. While some data on denials and appeals in Medicare Advantage are already available, there is a need for data that are complete and made fully available by CMS for research use. We also encourage CMS to consider ways to collect more details on service type for the appeals and denials, even if by broad category. In addition, we encourage CMS to contemplate including more data on denials and appeals into the Medicare Advantage Plan Finder to enable beneficiaries to consider these aspects of plan quality when making enrollment decisions.
- **Collect and publish more information on disenrollment.** Specifically, CMS should collect information on how many beneficiaries disenrolled from each contract or plan, the characteristics of the beneficiaries who disenrolled (e.g., race, age, dual-eligible status), and the characteristics of the plan from which they disenrolled (e.g., PPO/HMO, SNP, insurer, etc). Disenrolling in Medicare Advantage and switching to traditional Medicare can be a sign that some Medicare Advantage plans are not providing access to high quality care and providers, and disenrollment at the end-of-life drives up Medicare spending.<sup>35</sup> Complete information on disenrollment would enable CMS to better monitor quality and access issues in Medicare Advantage. As above, we also encourage CMS to contemplate including more information on disenrollment in the Medicare Advantage Plan Finder to enhance informed choice among beneficiaries when selecting Medicare coverage.

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<sup>34</sup> U.S. Department of Health and Human Services Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care (OEI-09-18-00260). April 2022.

<sup>35</sup> U.S. Government Accountability Office. Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending (GAO-21-482). June 2021.





- **Collect and publish more data on supplemental benefits.** Specifically, CMS should collect utilization data to understand the number of beneficiaries using supplemental benefits and utilization trends. This would serve as an important step toward being able to evaluate the benefit of supplemental benefits. In addition, where data are available, CMS should require Medicare Advantage plans to submit detailed, beneficiary-level data in the Medicare Advantage encounter data (i.e., dental and vision data). Lastly, CMS should require Medicare Advantage plans to submit data on how many of their enrollees purchase optional benefits that require beneficiaries to pay a separate premium, such as optional dental coverage. Collecting this information would support CMS in better understanding enrollee costs associated with supplemental benefits.
- **Include demographic data such as race/ethnicity in the monthly Medicare Advantage enrollment data.** Data on race/ethnicity is currently only available in files that have a two-to-three-year lag, and they are not available in the monthly enrollment reports. Having more up-to-date data on enrollment by race/ethnicity would enable a better understanding of enrollment trends by race/ethnicity and support CMS' health equity goals.
- **Improve the accuracy and completeness of Medicare Advantage encounter data by holding plans accountable for data quality.** Information from Medicare Advantage plans is necessary for assessing the quality of care provided by these plans compared to traditional Medicare and for determining if payments are appropriate. As more beneficiaries enroll in Medicare Advantage, it becomes even more important to ensure CMS can assess the value of the program and the quality of care provided by it. Medicare Advantage plans must be held more accountable for the accuracy and completeness of the data they submit to CMS to enhance oversight and enable a better assessment of quality and value in Medicare Advantage. We encourage CMS to contemplate developing a policy modeled after the process CMS uses to collect and assess data submitted by state Medicaid programs. This would entail 1) developing a set of measures that compare encounter data to external and plan-generated data sources to benchmark the accuracy and completeness of the encounter data, and 2) implementing a small payment withhold that could be returned to plans based on how they perform on the accuracy and completeness measures. This recommendation is consistent with actions the Government Accountability Office has urged CMS to adopt to verify if plan-submitted data are accurate including establishing benchmarks for completeness and accuracy and reviewing medical



records to verify data.<sup>36</sup> MedPAC has also made recommendations along these lines to enable CMS to obtain better information on the quality of care in Medicare Advantage, evaluate Medicare Advantage payments, and assess other aspects of the program.<sup>37</sup> We encourage CMS to take up these recommendations to overcome current barriers to understanding quality and value in Medicare Advantage.

We appreciate the Administration's commitment to strengthening the Medicare Advantage program. Again, we appreciate the opportunity to provide responses to this request for information. Please contact Mark Miller, Ph.D., Arnold Ventures' Executive Vice President of Health Care, at [mmiller@arnoldventures.org](mailto:mmiller@arnoldventures.org), Erica Socker at [esocker@arnoldventures.org](mailto:esocker@arnoldventures.org), or Arielle Mir at [amir@arnoldventures.org](mailto:amir@arnoldventures.org) with any questions.

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<sup>36</sup> U.S. Government Accountability Office. Testimony Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives: Medicare Advantage Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight (GAO-22-106026). June 28, 2022.

<sup>37</sup> Medicare Payment Advisory Commission. Testimony Before the Subcommittee on Oversight and Investigations Committee on Energy and Commerce U.S. House of Representatives: Improving the Medicare Advantage Program. June 28, 2022.