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U.S. Department of Health and Human Services
Baltimore, MD 21244-8016.

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Re CMS-2024-0360: Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Acting Administrator Stephanie Carlton,

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) 2026 Capitation Rates and Part C and Part D Payment Policies* (i.e., the CY 2026 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 health care that improves overall health – including our nation's seniors and people with disabilities who rely on Medicare for health insurance.

The high and rising cost of health care is a profound health problem and a significant economic burden on our nation's families, including for people who rely on Medicare, and Medicare Advantage (MA) in particular, for their health coverage.[1]

Insurers participating in MA – a program that gives people the option to receive their Medicare Part A and B benefits through private plans – too often engage in harmful business practices that drive low-value care and coverage for patients and wasteful spending in the Medicare program, which harms the health and financial wellbeing of beneficiaries.[2] These harmful practices include predatory and deceptive marketing schemes to prospective beneficiaries, overly aggressive and medically inappropriate care denials, and systematic upcoding of patient diagnoses that do not reflect the actual care that beneficiaries are receiving.[3] Collectively, these practices deprive beneficiaries of access to medically necessary care when they need it most, raise Part B premiums for everyone, and contribute to hundreds of billions of dollars in wasteful Medicare spending – putting the financial solvency of the Medicare trust fund at risk.[4]

The CY 2026 Advance Rate Notice includes significant payment and policy changes related to the financing of the MA program, with noteworthy implications for the health and health care coverage of the over 30 million people who rely on the program.[5] Families USA offers comments on two proposals that we believe are particularly important to ensuring our nation's

older adults have access to affordable and high-quality care and coverage. **Specifically, our comments focus on the urgent need for the Centers for Medicare and Medicaid Services (CMS) to end wasteful and inefficient spending in the MA program by reining in the ability of MA insurers to systematically upcode (i.e., increase coding intensity) patient diagnoses without evidence of improved patient care. These comments pertain to the following sections of this notice**:

- Attachment II., Section G. CMS-HCC Risk Adjustment Model for CY 2026
- Attachment II., Section J. Medicare Advantage Coding Pattern Difference Adjustment

Attachment II. Section G. CMS-HCC Risk Adjustment Model for CY2026

Under Attachment II. Section G., CMS proposes to fully implement the 2024 updated risk adjustment model (i.e., 2024 CMS-HCC risk adjustment model) to calculate Medicare payments to MA insurers.[6] Specifically, CMS proposes calculating 100% of all beneficiary risk scores using the 2024 CMS-HCC risk adjustment model, which would then be used to adjust Medicare's base payments to MA insurers starting in CY2026.[7]

In the Medicare Advantage program, CMS pays MA insurers a monthly capitated payment for each enrolled beneficiary. Those payments are designed to cover the expected health care costs of an MA insurer's enrollee population. These payments are then 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 to ensure plans are equally incentivized to cover enrollees regardless of health status.[8] Importantly, for the purposes of risk adjustment, these characteristics and diagnoses are assigned a value based on how much Medicare pays health care providers in Traditional fee-for-service (FFS) Medicare for services they provide to patients with those same characteristics and diagnoses.[9] Ultimately, risk adjustment serves as a critical patient safeguard within the MA program because it is designed to help guarantee that MA insurers enroll and cover both healthy and sick patients alike and to prevent insurers from engaging in discriminatory behavior such as adverse selection.[10]

However, MA insurers identified a loophole in this system that they have developed into a multibillion-dollar business tactic at the expense of our nation's seniors and at great risk to Medicare's solvency.[11] Providers in Traditional FFS Medicare are not incentivized to code every diagnosis for their patients because they are paid based on the volume of services they deliver and the type of procedure they perform and bill rather than a lump sum per beneficiary that is risk-adjusted based on the submission of medical diagnoses.[12] MA plans take advantage of the underreporting this disincentive creates by reporting more patient diagnoses than providers would in FFS.[13] These coding practices, often referred to as upcoding or increased coding intensity, make their enrollee populations *appear* sicker and more expensive than those in Medicare FFS, despite the fact that MA enrollees are actually healthier and less costly to cover overall than those in Traditional Medicare.[14] As a result, MA plans receive an additional $44

billion every year solely due to differences in diagnosis coding rates between MA and Traditional FFS Medicare.[15]

Concerningly, these inflated Medicare payments often do not result in additional medically necessary treatment or care. MA plans assign these additional patient diagnoses by reviewing medical charts and conducting health risk assessments (HRAs) to add new conditions to patients' charts that are not present in claims data.[16] These new conditions can be added to patient charts even when there is no documented medical evidence that these new conditions actually exist, and in cases where the conditions do exist, still does not usually result in any additional treatment or care for the patients.[17] In fact, *more than half* of the conditions discovered through these tactics, including chart reviews and HRAs, do not result in *any* additional treatment or care.[18]

Fundamentally, MA insurers' coding abuses undermine critical patient protections in the MA payment system, allowing MA insurers to receive higher payments without delivering additional care or coverage, even in the cases of patients with chronic diseases and comorbidities who need that additional care.

These coding abuses and the resulting overpayments directly harm the financial sustainability of the Medicare program and take money out of the pockets of all Medicare beneficiaries in the form of higher Part B premiums.[19] MA insurers' coding abuses drove Part B premiums to increase by a staggering $13 billion in 2024 alone.[20] And 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, heightened spending associated with MA insurers upcoding worsens Medicare's overall financial position and sustainability.[21] This is especially problematic as Medicare's trustees estimate the Part A Trust Fund will become insolvent by 2028.[22]

Over the past two years, CMS has worked to phase in an updated risk adjustment model which seeks to address some of the flaws in MA payment that lead to increased coding intensity and overpayments and instead aims to promote more accurate payments to MA insurers that better reflect the expected costs of each enrolled patient. CMS uses a risk adjustment model called the Hierarchical Condition Category (HCC) which includes sets of medical codes that are linked to specific clinical diagnoses and expected annual costs. This model calculates a risk score for each MA enrollee based on their demographic characteristics and diagnoses across 83 HCCs.[23] Importantly, while this model is used to calculate risk scores and payments for MA enrollees and plans, the data used in these calculations is actually based on Traditional Medicare cost and utilization data which uses beneficiaries' demographic characteristics and HCCs to project Traditional Medicare costs.

These risk scores based on Traditional Medicare enrollees are then used to calculate MA enrollee risk scores based on MA enrollees' demographic and HCC data. Higher risk scores result in higher payments to the MA plan. Effectively, this means that MA enrollee risk scores are assigned based on the treatment patterns of patients in Traditional Medicare who tend to be sicker than the MA population.[24] These risk scores are then used to calculate payments to

health care organizations for patients insured by Medicare Advantage and for patients receiving care through other types of value-based payment arrangements including the Medicare Shared Savings Program (MSSP), and certain Accountable Care Organization (ACO) models.

Under CMS's updated risk adjustment model, CMS is implementing a number of changes aimed at improving the accuracy of payments to MA plans. One of the changes being implemented focuses on identifying which HCCs disproportionately experience increased coding intensity by MA insurers across the MA program compared to Traditional Medicare.[25] Once those commonly upcoded HCCs and diagnoses are identified, CMS can then reduce or eliminate the extent to which these upcoded services result in additional risk-adjusted payments to MA insurers. They do this by more accurately adjusting the values of, or by removing entirely, those HCCs that are overly coded in MA as compared to Tradition FFS Medicare from the risk-adjustment model.[26] This update to the risk adjustment model is a significant step in beginning to rein in the wasteful and inefficient spending driven by MA insurers. If fully implemented in CY 2026, as is being proposed by CMS, this updated risk adjustment model has the potential to improve the value of care being delivered to seniors through MA and generate significant savings for the Medicare program.

As a result, **Families USA strongly supports CMS's proposal to fully phase-in the use of the 2024 CMS-HCC Risk Adjustment Model starting in CY2026 (i.e., use the 2024 CMS-HCC Risk Adjustment Model to calculate 100 percent of Medicare Advantage risk scores and risk adjusted payments).**

CMS also indicates in this notice that they "may be able to start phasing in an MA encounter data-based model as early as CY 2027."[27] This is an important step to improving the accuracy of CMS risk-adjusted payments to MA plans and would help to rein in the systematic upcoding observed across the MA program. As noted above, MA plans have an increased financial incentive to code all applicable diagnoses and increase coding intensity, while Traditional Medicare providers are not incentivized to completely capture all diagnoses on an annual basis. As a result, MA risk scores generally appear higher than those in Traditional Medicare, which results in a higher risk-adjusted payment for MA plans. Because MA encounter data more closely reflects MA costs and diagnoses patterns, recalibrating the risk adjustment model with encounter data rather than relying on Traditional Medicare claims data - which is easily gamed by MA plans - would help to achieve more accurate risk scores for certain populations and more accurate payments to MA plans.[28] As a result, **Families USA supports CMS's efforts to recalibrate the MA risk adjustment model with MA encounter data.**

However, Families USA strongly disagrees with CMS's claim in this notice that recalibrating the risk adjustment model using MA encounter data *alone* would eliminate the need for any coding intensity adjustments. While there are benefits to calibrating the risk adjustment model based on relative costs and use patterns within MA, it would still be necessary to adjust for coding differences between MA and Traditional Medicare because MA payments would continue to be

determined by Traditional Medicare-based benchmarks. In addition, coding pattern differences across plans in MA would still exist, and plans would continue to be incentivized to code aggressively to increase their enrollee risk scores and therefore their payments. **As a result, Families USA recommends that the proposed recalibration of the risk adjustment model based on MA encounter data, including the implications for payments, coding, and competition in the MA market, be carefully evaluated before proceeding with this proposed change.**

Finally, to support the recalibration of the MA risk adjustment model, it is critical that MA encounter data is accurate and complete. Despite federal requirements for MA plans to submit encounter records to CMS for each medical item or service to enrollees,[29] there is evidence that MA plans and organizations underreport care that is used by MA beneficiaries when submitting encounter data.[30] According to the Medicare Payment Advisory Commission (MedPAC), not a single MA organization had 100% complete encounter data when comparing that data to other reference datasets.[31] CMS has not proposed any specific additional requirement to address this issue in this year's CY 2026 Advance Notice. **Therefore, we urge CMS to use its existing authority to improve the accuracy and completeness of MA encounter data so it is a reliable and accurate source of risk adjustment data. Specifically, CMS should take concrete steps to:**[32]

- **Increase the extent to which it evaluates and audits the encounter data submitted by MA organizations;**
- **Establish more comprehensive performance metrics that specifically evaluate the completeness of MA encounter data; and**
- **Impose financial penalties, up to the withholding of a percentage of MA-related payments, for all MA organizations that do not meet such metrics.**

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 5.9 percent to beneficiary risk scores across all MA plans.[33] 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.[34] Since these beneficiary risk scores are systematically inflated due to MA plan upcoding (as discussed above) and are used to inform final MA plan payments, this adjustment helps to mitigate the impact of overpayments associated with increased coding intensity by MA plans across the board.[35] The particular adjustment level of 5.9 percent was put into place by Congress starting in 2019; however, it is important to note that while CMS has the statutory authority to implement a coding pattern adjustment above and beyond the minimally required 5.9 percent, it has never done so.[36]

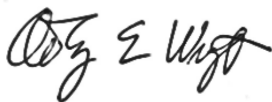
Importantly, careful and credible independent studies have concluded that the statutory minimum adjustment is inadequate.[37] Despite overwhelming evidence, CMS has yet to address those analyses or disclose any information about any analyses it may have conducted to justify its policy to only apply the minimum required coding adjustment. Further, CMS is required under federal law to conduct an annual analysis of coding pattern differences, yet the public has no insight into whether those analyses are conducted, or the methodology and approach CMS may be using in those analyses to conclude that the minimum coding adjustment is sufficient.[38] This lack of transparency, and lack of response to the evidence base, is deeply concerning and undermines efforts to advance meaningful policy solutions that address wasteful and inefficient spending of MA plans. As a result, **Families USA recommends that CMS confirm that it conducted an annual analysis of coding pattern differences and promptly release any such analysis along with all underlying data necessary to evaluate its conclusions. These steps would allow a more meaningful opportunity for public comment about targeted policy solutions that can address coding pattern differences in the Medicare program. Further, we strongly encourage CMS to apply a higher coding adjustment to more effectively control widespread overpayments driven by MA plans engaging in systematic coding intensity that threatens the solvency of the Medicare program.**

Conclusion

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 that CMS use all available and appropriate tools to ensure program integrity. That includes holding MA plans accountable for the fraud, waste, and abuse observed in the program – including upcoding.

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 health care and coverage options they need and 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,



Anthony Wright
Executive Director

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