April 18, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) shares the Administration's commitment to payment integrity and the mitigation of fraud, waste and abuse in the Medicare Advantage (MA) program. MA is working for America's seniors, reaching 31 million beneficiaries and counting, and now represents more than half of all Medicare enrollment. To be most successful for consumers, it is imperative to target MA program integrity actions at health plans at highest risk for improper payments, reducing administrative burden on the majority of plans and leveling the competitive landscape for seniors to select the best coverage and care options for their individual circumstance. To protect the Medicare dollar and address improper payments, CMS should utilize program integrity tools, particularly the recently finalized RADV regulation, to appropriately target the most egregious coding violations.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care. ACHP member health companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans in 37 states and DC. This industry leadership allows ACHP to advocate for practical, bipartisan solutions that translate into high-value coverage and care for all.

One of CMS' critical responsibilities is ensuring accurate payment across the Medicare program and between Medicare Advantage plans to safeguard federal taxpayer dollars and protect seniors. On January 30, 2023, CMS finalized the risk adjustment data validation (RADV) rule. Studies done by CMS, the HHS Office of Inspector General (OIG), MedPAC and numerous independent stakeholders have shown significant variance in risk-adjustment coding practices generating large variances in potential instances when medical records may not support the diagnoses reported. CMS must be considerate of the selection of which MA plans to audit to be most effective at addressing improper payments and ensure the plans chosen are the ones most likely to employ risk adjustment coding practices that result in risk-adjustment not supported by medical records.

Unfortunately, the final RADV regulation lacked clarity and transparency regarding the sampling methodology for audits selected, the extrapolation calculation and the overpayment recoupment process. It is imperative that CMS provide clarity and transparency on this critical information. CMS has also failed to provide guidance on the selection process for audits.

To achieve the stated intent of protecting the Medicare dollar and addressing improper payments, CMS should utilize the RADV regulation to appropriately target the most egregious coding violations through

clear and simple criteria. ACHP proposes that CMS publicize audit selection criteria for contract-level screening that clearly establish an incentive for a health plan to be comprehensive, but not aggressive or inappropriate, in risk-adjustment, reduce burden and target outlier health plans at the highest risk of improper payment.

Criteria CMS should establish to be eligible for RADV audit selection include:

- **Minimum Number of Lives / Member Months –** MA contracts must have an enrollment threshold greater than or equal to the specified level of credibility as defined by CMS' guidelines for Full Credibility.
- **Normalized Risk Score –** MA contracts must have above a 1.0 normalized risk score. Further consideration should be given to contracts one or greater standard deviations above the mean normalized risk score.
- **Risk Score Growth –** MA contracts must have risk score annual growth above the industry average. Further consideration should be given to risk score growth trend over a multi-year period and to contracts with risk score growth one or greater standard deviations above the mean.

After applying these screening criteria, separately accounting for dual and non-dual plans for appropriate peer comparisons, CMS could then randomly select health plans to audit. Additional factors to consider include health plan demographics, population mix and significant changes in enrollment. Importantly, health plans with low risk of improper payments would be rewarded for their risk-adjustment practices and CMS would utilize its limited program integrity resources to target the most significant risks to the MA program and taxpayer dollar. Should CMS consider audits based on hierarchical condition categories (HCCs), we look forward to working with CMS to ensure those audits are appropriately targeted.

ACHP encourages the Administration to establish and publicize these criteria to strengthen the Medicare Advantage program through robust and targeted program integrity efforts. We appreciate the opportunity to share our ideas and look forward to continuing to collaborate with you and your team. Please contact Michael Bagel, Associate Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss our recommendations further.

Ceci Connolly, President & CEO

Cc:
Jon Blum, Principal Deputy Administrator and Chief Operating Officer
Dara Corrigan, Deputy Administrator and Director, Center for Program Integrity
George Mills, Jr., Deputy Center Director, Center for Program Integrity
Stacy Sanders, Counselor to the Secretary, HHS