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Meena Seshamani, M.D., Ph.D.  
Director, Center for Medicare  
Centers for Medicare & Medicaid Services, Department of Health and Human Services,  
Attention: CMS-2023-0010  
7500 Security Boulevard  
Baltimore, MD 21244-1850

March 6, 2023

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

Dear Director Seshamani,

The Robert J. Margolis, MD Center for Health Policy at Duke University (Duke-Margolis Center) appreciates this opportunity to comment on the Center for Medicare's (CM) Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, hence forth known as the Advance Notice.

**About The Duke-Margolis Center**

Established with a founding gift through the Robert and Lisa Margolis Family Foundation, the Duke-Margolis Center brings together capabilities that generate and analyze evidence across the spectrum of policy to practice, supporting the triple aim of health care—improving the experience of care, the health of populations and reducing the per capita cost. The Duke-Margolis Center's activities reflect its broad multidisciplinary capabilities, fueled by Duke University's entrepreneurial culture. It is a university-wide program with staff and offices in both Durham, North Carolina, and Washington, DC, and collaborates with experts on health care policy and practice from across the country and around the world.

The mission of the Duke-Margolis Center is to improve health and the value of health care through practical, innovative, and evidence-based policy solutions. The Center's work includes identifying effective delivery and payment reform approaches that support the transition to value-based care and collaborating with expert stakeholders to identify pathways to increase the value of biomedical innovation to patients – both through better health outcomes and lower overall health care spending. A key focus area of Duke-Margolis's work is to accelerate the adoption of accountable care reforms that support whole person, comprehensive care through rigorous policy analysis, consensus building through stakeholder convenings, and evidence generation. Our recent work in developing policy recommendations to create a [pathway for safety net providers](#) to adopt value-based payments highlights the importance of a fair risk adjustment system that supports and promotes value-based payment reforms by ensuring payments are appropriately calibrated across populations.

## About CareJourney

CareJourney helps healthcare organizations move successfully towards value-based care by empowering them with actionable data derived from our expansive population claims datasets primarily across the Medicare, Medicare Advantage, and Medicaid populations. Our insights help them find impactful opportunities to deliver high-value care, reduce care gaps, and improve care coordination efforts. Our mission is to empower individuals and organizations they trust with open, clinically-relevant analytics and insights in the pursuit of the optimal healthcare journey. We are committed to using our vast data resources to highlight areas of inequity, help our customers identify underserved populations, and ultimately provide better, equitable care for all.

## Introduction

The Centers for Medicare and Medicaid Services (CMS or the Agency) has been at the forefront of improving value in our nation's health system. The meaningful steps the Agency has taken to accelerate adoption of coordinated, longitudinal models of care, and that support earlier, more accurate diagnosis of health conditions and interventions to prevent further disease progression, is transforming health care. Financial alignment in CMS payment models is key to this impact. Along with the Shared Savings Program (SSP) in Traditional Medicare, Medicare Advantage (MA) is central to Medicare's ambitious goal of supporting all Medicare beneficiaries in accountable, longitudinal coordinated care by 2030. In turn, risk adjustment is a critical design element in all these person-focused payment arrangements, so that Medicare payments to providers and plans create aligned incentives and supports for early diagnosis and effective treatment for beneficiaries at higher risk. This includes attention to beneficiaries less likely to have adequate access to care due to social barriers associated with economic status, race, and ethnicity. Medicare's risk adjustment policies not only have increasingly large consequences for Medicare spending. They also are fundamental to enabling the transition to more person-centered health care, especially for beneficiaries with serious chronic conditions or risk factors and those who have historically been underserved under fee-for-service – particularly in terms of early diagnosis and treatment to prevent further disease complications.

Keeping in mind the central importance of risk adjustment both for Medicare spending and for CMS care transformation goals, we appreciate CMS' attention to its risk adjustment principles in its proposed reforms in Medicare Advantage risk adjustment. Principle 10, which states that "discretionary" diagnostic categories that are subject to discretionary coding variation or that are not clinically important or associated with future cost variation should be excluded. However, without further analysis, we are concerned that CMS' proposed risk adjustment reforms may not be fully consistent with other risk adjustment principles. This includes principles 1 and 2 (clinically meaningful and predicting expenditures), and principle 5 (encouraging specific coding).

No policy reforms are perfect. A reform that substantially addresses issues of aggressive coding by plans may also have collateral effects on reducing payments and thus incentives and supports for plans to diagnose patients early and treat them effectively. While we support the Agency's goal in correcting risk adjustment in a manner that addresses increased and discretionary spending that is not clinically or empirically valid, we also believe there is some evidence that the proposed reforms will have consequences for beneficiaries facing real health risks, particularly for conditions like diabetes and depression that are common and often undertreated in fee-for-service medicine, particularly among lower-income and underserved beneficiaries.

Moreover, while the proposed reforms have short-term fiscal benefits, they are likely to work against CMS' critical long-term goal of aligning risk adjustment methodologies across its accountable care

programs and with the increasingly sophisticated and reliable electronic clinical data that are used to support care management and coordination for effective, whole-person care. Several organizations, including [Duke-Margolis](#), [National Quality Forum](#), and [CareJourney](#), have outlined a longer term path to accomplish these risk adjustment reforms. The current proposed reforms create an opportunity to begin this risk adjustment transition, which would have a much more fundamental impact on eliminating current incentives for many plans to invest in infrastructure for coding rather than in infrastructure for true clinical care improvement in appropriate diagnosis and treatment.

Our comments and recommendations for risk adjustment are three-fold:

- The risk adjustment reforms as proposed have significant impact on lower-income beneficiaries and racial and ethnic minorities, who are more likely to have the conditions and complications involved in the reforms, and on the plans who disproportionately serve such beneficiaries;
- CMS should conduct further beneficiary impact analyses to better understand these impacts and potentially support alternative policies to mitigate them, and should incorporate such analyses in proposed risk adjustment reforms in future advance notices;
- CMS should use this opportunity to seek public input and begin the transition to a more sustainable risk adjustment strategy – one that, in contrast to current approaches, diminishes incentives for investment in increasing administrative risk adjustment scores, and increases investments in electronic data systems to support early diagnosis and needed clinical interventions.

In addition to these important efforts on improving risk adjustment, we also appreciate CMS’ efforts in this AN and in a recent New England Journal of Medicine [article](#) to allow stakeholders to provide feedback on efforts to align measures across its programs. We believe this a critical step to increasing participation in value-based programs and look forward to providing feedback on these efforts in the future.

## Overview of proposed CMS-HCC risk adjustment reforms for CY 2024 including technical adjustments

In this annual Advance Notice, CMS proposes to implement a revised version of the CMS-HCC risk adjustment model. The new version of the model, V28, includes: (1) updated data years used for model calibration, (2) updated denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, and (3) a clinical reclassification of the hierarchical condition categories (HCCs) using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. As part of this clinical reclassification, CMS conducted an assessment on conditions that are coded more frequently in MA relative to FFS relative to Principle 10 of CMS’s longstanding model principles. This assessment included review by expert clinicians and cost analyses that resulted in “additional constraints and the removal of several HCCs in order to reduce the impact on risk scores of MA coding variation from FFS.” Specifically, changes in reclassification result in:

- Removing HCC 230 Angina Pectoris and HCC 265 Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication from the HCC model,

- Constraining all HCC Diabetes (HCC 36, 37, and 38) and HCCs related to Congestive Heart Failure (HCC 224, 225, and 226) so coefficients in each category will be equal to each other so that they carry the same weight in the risk score.

The sum of these changes results in more than 2,000 diagnostic codes no longer mapping in MA’s HCC model, and a 3.12% reduction in payments associated with the risk adjustment methodology. This is estimated to lead to a savings of over \$10 billion to the Medicare Trust Fund.

**We support the goal of reducing the sensitivity of the HCC to “discretionary coding” that may bias the model in predicting the true costs of beneficiaries, and the complementary goals of addressing overpayment in MA and improving the accuracy of risk adjustment methodologies. While the proposed changes appear to make significant progress on this goal, they also appear to have some unintended consequences for beneficiaries more likely to have the conditions involved, including more serious or complex forms of these conditions that are more costly to manage, creating offsetting reductions in the accuracy of risk adjustment.** CMS should take steps to better understand and address these unintended potential impacts on risk adjustment accuracy especially for traditionally underserved beneficiaries, including publishing a [proactive equity assessment](#) subject to notice and comment, and analysis and discussion on how complementary policy reforms such as social risk adjustment may mitigate some of these unintended consequences. These steps should help assure that the proposed risk adjustment changes do not [disproportionately impact disadvantaged and higher risk beneficiaries and do not offset CMS initiatives to address underdiagnosis](#) and undertreatment especially in high-risk populations. These steps would also help ensure alignment with the Administration’s broader [blueprint to protect the American people in an age of automated systems](#), including protecting Medicare beneficiaries from even unintentional algorithmic discrimination.

In particular, the reported diagnoses affected by the risk adjustment reforms are diagnoses are highly plausible for plans to code more aggressively without implementing commensurate improvements in care, as noted in a [recent Inspector General Report](#). At the same time, there is also [substantial evidence that these conditions](#) – including atherosclerotic disease, hypertension, depression and diabetes – are both [more prevalent](#) and [more severe](#) among beneficiaries from more vulnerable socioeconomic backgrounds, beneficiaries who are dually eligible for Medicare and Medicaid, and beneficiaries who are racial and ethnic minorities. Additionally, there is also evidence showing that some chronic conditions, [especially diabetes](#), may in fact be disproportionately underdiagnosed in racial and ethnic minorities.

Further, it is important to note that growth of MA and of alternative payment models in Traditional Medicare that similarly shift payment from traditional FFS to value-based or accountable care are an increasingly difficult fit with risk adjustment methodologies based on FFS administrative claims and care. Accountable payment and care systems aim to reduce the underdiagnosis and undertreatment of common and potentially serious chronic conditions like these that contribute significantly to health burdens and costly preventable complications in the Medicare population, particularly in underserved communities. Indeed, because a key goal of the shift to accountable care reforms is to improve diagnosis and treatment for these conditions, these conditions represent key parts of MA and SSP quality payments.

Finally, these proposed reforms do not address two important goals for the long-term sustainability and accuracy of MA risk adjustment:

- Increase investments in clinical risk detection and management systems: While the proposed reforms may have a marginal effect on incentives for investments in risk factor coding, they do

not encourage investments in clinical programs to detect these conditions earlier and manage their complications

- Align beneficiary payments with costs in accountable care delivery systems: The reforms do not make progress in moving away from beneficiary-level costs observed in FFS care systems and claims, even though these conditions are detected and managed differently in accountable care systems designed for earlier diagnosis and intervention.

### Rapid analysis of proposed reforms

Rapid analysis<sup>1</sup> performed by CareJourney, in collaboration with Duke-Margolis, is consistent with CMS' overall estimates of reduced beneficiary risk scores with consequences for payment differentials in moving from HCC V24 to HCC V28; however, that impact is relatively larger for beneficiaries from higher-risk groups (Table 1). Accounting for normalization, we estimate that risk scores decrease approximately 1.64 percentage points more than for white beneficiaries – a nearly 1.67 percentage point decrease overall. Dual-eligible beneficiaries experience an approximate 2.06 percentage point larger decrease compared to non-dual-eligible beneficiaries, and an approximate 1.81 percentage point decrease overall. Finally, we find an approximate 0.55 percentage point larger decline for beneficiaries from zip codes that are more “distressed,” defined as an individual residing in a distressed community by the Distressed Community Index in quintile 4 or 5. We note that with more recent data, as will actually be employed if the proposed reform is finalized, the differential impacts will likely be incrementally larger.

**Table 1: Overall risk score differences attributable to policy changes under Advance Notice**

<i>Risk Score Version</i>	<i>Beneficiaries</i>	<i>Raw V.24</i>	<i>Raw V.28</i>	<i>Percent Difference, Raw</i>	<i>Normalized v.24</i>	<i>Normalized v.28</i>	<i>Percent Difference</i>
<i>All Benes</i>	26,731,363	1.29	1.14	-11.79%	1.13	1.13	-0.42
<i>White</i>	20,022,632	1.27	1.13	-11.46%	1.11	1.12	-0.03
<i>Minority</i>	6,193,457	1.38	1.21	-12.91	1.21	1.19	-1.67
<i>Race Unknown</i>	515,274	0.95	0.85	-9.73	0.83	0.84	1.92
<i>Dual</i>	6,100,815	1.81	1.57	-13.03	1.58	1.55	-1.81
<i>Not Dual</i>	20,630,548	1.15	1.02	-11.21	1.00	1.00	0.25
<i>Distressed</i>	8,972,686	1.39	1.23	-11.96	1.22	1.21	-0.60
<i>Not Distressed</i>	16,543,119	1.23	1.09	-11.46	1.07	1.07	-0.03
<i>Distressed Unknown</i>	1,215,558	1.46	1.25	-14.42	1.28	1.23	-3.38

Notes: Distressed means an individual residing in a distressed community as defined by the Distressed Communities Index (<https://eig.org/distressed-communities/>), quintile - and "Distressed" = quintile 4 and 5.

Based on this rapid analysis, much of the differential impact of the proposed reforms appears to be driven by twenty diagnosis codes. In Table 2, we have ranked these by an index of magnitude of impact for beneficiaries with the condition – that is, number of beneficiaries affected times percentage point reduction after normalization, divided by 1000. Codes associated with many common conditions,

<sup>1</sup> These analyses are preliminary and may change with further analysis and refine to our methods given the rapid nature of these complex and manual computations.

including atherosclerotic disease, depression, and diabetes-related conditions (particularly diagnoses for more serious forms) saw substantial reductions in v28 compared to v24. As we noted above, these chronic conditions are significantly more prevalent and severe in racial and ethnic minorities and low-income populations.

*Analyses of administrative encounter data do not enable distinguishing true differences from reported differences in the presence and the severity of these common conditions, and it is likely that some and perhaps most of the differences reflect coding. However, the strong clinical evidence on diagnosis and severity of these common conditions across populations also mean that some of the differences represent a larger reduction in payment support for beneficiaries with higher true prevalence and severity of conditions that are underdiagnosed and undertreated.* For example, imaging studies to document aortic calcification can increase payment for more complex atherosclerosis, but are unlikely to materially change patient care. On the other hand, risk adjustment for depression and diabetes, and larger risk adjusted payments for beneficiaries with more severe forms of these conditions, plausibly helps sustain clinical care improvement initiatives by health plans to address underdiagnosis and undertreatment to prevent further complications of these conditions, particularly in underserved populations where they are more prevalent.

**Table 2: Distributional impact of risk score changes by ICD-10 cd differences attributable to policy changes under Advance Notice**

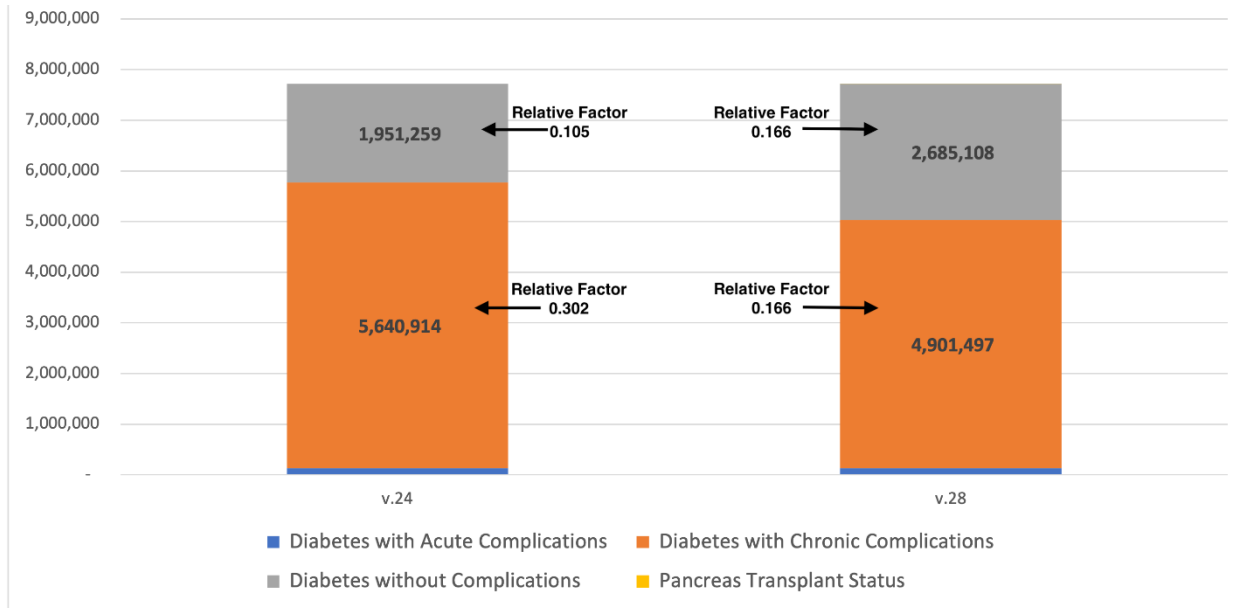
ICD Code	Description	Beneficiary Count	Avg. HCC Score Difference (V24 – v28)	RA Reform Impact Index (see text)	Norm v24 HCC Score	Norm v28 HCC score	Percentage Difference v.24 - v.28 HCC Score
I739	Peripheral vascular disease, unspecified	2,359,356	-0.491	-1157.7	2.132	1.924	-9.77
I700	Atherosclerosis of aorta	2,320,174	-0.498	-1155.8	1.931	1.689	-12.52
N179	Acute kidney failure, unspecified	1,108,980	-0.685	-759.5	3.302	3.054	-7.53
E1151	Type2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	1,146,787	-0.600	-688.1	2.577	2.319	-10.03
F330	Major depressive disorder, recurrent, mild	669,866	-0.528	-353.5	1.995	1.732	-13.16
D696	Thrombocytopenia, unspecified	633,876	-0.513	-325.4	2.636	2.470	-6.28
D692	Other nonthrombocytopenic purpura	209,258	-0.628	-319.7	2.038	1.683	-17.44
F339	Major depressive disorder, recurrent, unspecified	586,605	-0.478	-280.4	2.209	2.023	-8.41



I25119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	512,362	-0.488	-249.9	2.345	2.167	-7.58
I209	Angina pectoris, unspecified	451,153	-0.495	-223.4	2.161	1.952	-9.67
G63	Polyneuropathy in diseases classified elsewhere	242,749	-0.918	-222.8	2.419	1.828	-24.46
E46	Unspecified protein calorie malnutrition	235,168	-0.896	-210.7	3.565	3.142	-11.86
M461	Sacroiliitis, not elsewhere classified	335,816	-0.625	-209.8	1.844	1.466	-20.48
F320	Major depressive disorder, single episode, mild	357,966	-0.551	-197.4	1.950	1.658	-14.96
N2581	Secondary hyperparathyroidism of renal origin	408,801	-0.466	-190.5	2.666	2.551	-4.31
D709	Neutropenia, unspecified	186,395	-0.928	-173.1	3.283	2.792	-14.96
I25118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	361,162	-0.475	-171.5	2.246	2.068	-7.92
I70203	Unspecified atherosclerosis of native arteries of extremities, bilateral legs	321,371	-0.528	-169.7	2.365	2.150	-9.09
J181	Lobar pneumonia, unspecified organism	337,122	-0.489	-164.7	3.147	3.072	-2.39

Using diabetes as an illustrative example, our analysis finds significant shifts in beneficiaries based on ICD-10 codes (Figure 1). Specifically, approximately 739,000 MA beneficiaries are no longer attributed to “diabetes with chronic complications,” which is 13% drop by moving from v24 to v28. This is a multi-billion dollar reduction in total payments to plans associated with diabetes. In addition to correcting overpayments to some plans, this reduction will also likely alter the care related to diabetes diagnosis and management that patients receive as well as reduce the incentive to bid in areas with a high prevalence of diabetes, especially more complex diabetes. We surmise other areas have similar impacts. For example, with the proposed changes, approximately half of all ICD-10 codes for mental health conditions will not be associated with any differences in plan payment. Many of these conditions are undertreated and associated with significant costs for screening, initial treatment, and ongoing management.

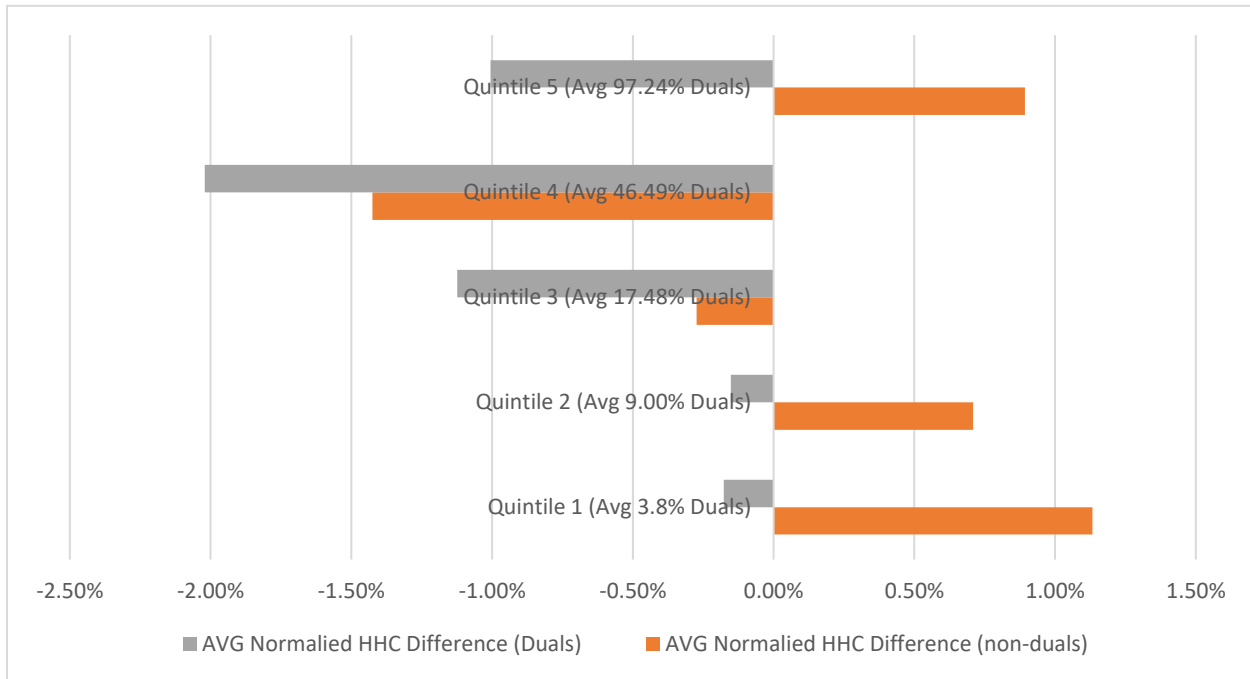
**Figure 1. Diabetes population distribution HCC model v24 vs v28**



In addition, and not surprisingly given these results, our rapid analysis indicates that these proposed risk adjustment reforms not only disproportionately affect plans with high overall use rates of these codes; they also disproportionately affect MA plans that have enrolled more high-risk beneficiaries. Figure 2 shows impact across plans grouped in quintiles based on percentage of dual-eligible beneficiaries enrolled, showing that normalized HHC impacts were noticeably larger across each quintile based on share of dual-eligible enrollees in the plan. These differential impacts by plan type have been noted by others (e.g., [Milliman](#)); our finding is that at least some of these plan effects appear to be associated with differences in beneficiary composition (and likely disease burden) not just plan coding.



Figure 2: Difference in HCC Risk Scores by plan type



Notes: Analysis of 585 MA plans with both dual and non-duals products

Eliminating inappropriate payments that add to Medicare costs is a critical goal, but so is assuring that Medicare payments are aligned with the core CMS goal of advancing coordinated, whole-person care for all beneficiaries regardless of their health needs, while improving equity. **These differential impacts underscore the potential importance of assessing whether the proposed reforms have significant impacts on higher-risk beneficiaries and whether CMS can better address Principle 10 without adverse consequences for Principles 1 and 2.**

To address this, we propose an alternative approach, one that aligns with further encouragement of accountable care and engaging more beneficiaries in coordinated care models, especially for vulnerable beneficiaries.

### Short-Term Recommendations

**Based on our analysis, our short-term recommendations are:**

- Conduct more thorough impact analysis of the proposed changes, including further assessments building on the analyses from stakeholders provided in comments.** In particular, CMS should assess differential impact on subgroups of beneficiaries that differ by neighborhood vulnerability, dual-eligibility status, and demographics. Additionally, analyses should attempt to determine whether plan-level variations in intensity of use of these codes is associated with differences in beneficiary composition (e.g., having a greater share of low-income or otherwise underserved beneficiaries) versus a systematic plan “coding effect” – for example, by including plan fixed or random effects in the model described above. Such further analyses could help CMS assess how these two components—impacts on subgroups and across different plans—may be correlated, and whether mitigating the impacts to certain plans that disproportionately serve higher-risk beneficiaries may also mitigate the impacts to those beneficiaries. This will better inform the Agency’s determination that particular codes are truly “overcoded” by some

plans, and are not the result of real differences in underlying beneficiary health status and severity that should receive additional payment (i.e., the codes that are strongly associated with “plan effects,” not with differences in beneficiary composition).

- **Consider a phased-in approach that minimizes impacts to the most disadvantaged.** Based on the analysis above, CMS should focus on reforms for codes that not only differ between TM and MA, but that more clearly reflect systematic differences in plan coding practices, not potential differences in underlying health status and complication risk and that are undertreated in TM and among traditionally underserved beneficiaries. Based on the analyses above, depression, diabetes, some of the atherosclerosis codes, and acute kidney disease are examples of codes where steps to mitigate potential impacts on vulnerable beneficiaries may be needed.
- **Implement routine administrative steps to conduct enhanced analysis of differential impacts on subgroups of beneficiaries— especially differential impacts that may impact health equity.** This should include standardized evaluation methodologies that are consistently used as CMS does with other regulatory actions. Indeed, with continued growth in MA, now approaching half of all fully-enrolled Medicare beneficiaries, the CM advance notice carries as much or more economic and clinical impact as any of the other major CMS rules, such as for inpatient payment or physician payment in Traditional Medicare. While some plans may be more aggressive in coding any one condition, that does not make the consequences of risk adjustment reform any less real or impactful for the millions of beneficiaries who actually have these conditions, especially in their more severe and costly forms. To prevent unintended consequences for so many beneficiaries, the same level of attention to assessing impact and transparency is needed for the MA advance notice payment changes as for CMS regulations that go through more intensive notice and comment rulemaking. For example, while CMS did release HCC Risk Adjustment Model Software, it was not until 17 days after the AN had been promulgated. Limited time and information to help assess impacts significantly reduces stakeholder ability to analyze the proposed policies. To improve transparency, CMS should provide stakeholders the full model specifications at the time the AN is published, and present a standard set of beneficiary impact assessments, to ensure feedback is actionable and well-informed for CMS to adjust its policies, and help plans and other stakeholders better understand the economic implications and clinical implications of the proposed changes.

### Proposed Transition to a Better, More Accurate Risk Adjustment Methodology

Through its proposed reforms, CMS has brought much-needed attention to shortcomings in its current risk adjustment methodology. We strongly encourage CMS to use this opportunity for stakeholder engagement to take further steps beyond short term patches to its methodology, especially since these patches appear to complicate moving to an accurate, clinically-based risk adjustment methodology. We have previously recommended steps to transition from the current risk adjustment system, based on FFS administrative data and FFS care practices that often fail to diagnose and intervene to prevent disease progression and complications, to one based on electronic clinical data systems, especially systems subject to Cures Act requirements which have resulted in further progress toward standardized, meaningful, and interoperable clinical data that can both improve care and support more accurate payment. This kind of risk adjustment reform would shift current investments in administrative RAF maximization systems to investments in electronic clinical data infrastructure for early diagnosis and

effective treatment of common, high-burden conditions like cardiovascular disease and diabetes that are key targets of CMS quality improvement and equity initiatives.

Such a modernized risk adjustment system should be aligned across Traditional Medicare and MA, with the goal of creating a level playing field across all Medicare programs to compete on improving clinical care. This is especially critical given that the proposed reform, even if implemented in a phased-in or multi-step approach, will cause risk scores in fee-for-service MA plans to increase and may trigger SSP participants to hit their risk cap prematurely. This impacts saving rates for the value-based entities and underscores the need to redesign the risk cap in MSSP to align with MA risk adjustment reforms. The relative increase in payments to MA fee-for-service plans compared to other types of MA plans may also impact CMS' policy goal of advancing coordinated care. For all these reasons, it is time to begin a transition to a more up-to-date risk adjustment system.

Key steps in this policy transformation include:

- **Propose a transition to HCC diagnosis determinations based on electronic data systems used to support clinical care improvements and care coordination, starting with key diagnosis codes in this proposal – diagnoses that are often overcoded but also reflect real disease conditions that are common, clinically and economically significant, often undertreated in FFS Medicare, and subject to health disparities.** In particular, CMS should propose and seek stakeholder input on implementing automated, auditable electronic submissions based on beneficiary-level clinical information mapped to the [United States Core Data for Interoperability](#) (“USCDI”), as available on certified electronic health records in 2023. This approach would align with similar efforts underway to access and use USCDI for digital quality measures, and existing CMS regulatory requirements on Medicare Advantage plans to offer USCDI via a Patient Access API when collected by plans. CMS could engage stakeholders already developing FHIR-based applications capable of auditing clinical information in an automated fashion. This approach would require reweighting, potentially by using estimates derived from SSP and MA plans that continue to use FFS billing in part (e.g., LAN category 3 models) rather than continuing to rely on claims from FFS providers. Unlike the current CMS reform proposal, this approach would reduce administrative and compliance burdens associated with the current administrative “encounter” approach to risk adjustment. Instead, it would leverage existing investments in certified electronic health records systems that improve diagnosis and care, and enable alignment of STARS quality and risk adjustment payment strategies (e.g., the denominator for quality measures for depression should come from the same electronic clinical data systems as the numerator and denominator for STARS measures related to depression).
- **Identify and incorporate social risk adjusters in conjunction with clinical risk adjusters.** Our rapid analysis highlights how diagnoses and diagnostic severity in risk adjustment policies have implications for CMS goals around improving equity and reducing disparities related to race, ethnicity, and socioeconomic status. It is possible that some of the potential adverse consequences identified here could be addressed by “social risk adjusters” rather than clinical risk adjusters alone. But to do so, CMS needs to build on its initial steps to develop social risk adjustment to implement a more systematic approach to including both types of risk adjusters in its consideration and assessment of risk adjustment reforms.

## Changes to Existing Star Ratings Measures for the 2023 Measurement Year and Beyond

In the AN, CMS notes it is “considering including what CMS is calling a “Universal Foundation” of quality measures which is a core set of measures that are aligned across programs.” CMS provides a list of measures in Table IV-4 for the AN.

**Duke-Margolis and Care Journey appreciate CMS’ commitment to aligning a core set of measures across all its programs (MA, SSP, and MIPS) and are supportive of efforts to develop and implement at “universal foundation” of quality metrics.** We believe this will reduce participation burden and allow for improved comparability across programs. This quality measurement strategy should not only enable more effective support for quality improvement across programs; it also aligns well with our proposed transition to the use of electronic clinical data systems rather than administrative claims data. If CMS could enable the same electronic data systems can be used both to provide clinically accurate risk adjustment information and “denominator” data for quality measures, the Agency could both substantially reduce administrative burdens and enable data infrastructure investments to go much further in supporting care improvement.

### Conclusion

We appreciate this opportunity provide feedback to CM on this Advance Notice. Improving risk adjustment is a critical step in achieving CMS’ ambitious goals for coordinated, high-quality longitudinal care for all beneficiaries by 2030. Our recommendations can enable CMS to address its concerns about coding accuracy while advancing its 2030 goals. Please let us know if you have any questions about our feedback and we would be happy to discussion.

Best Regards,

Mark McClellan, MD, PhD, Director  
Duke-Margolis Center for Health Policy

Frank McStay, MPA, Assistant Research Director for Medicare  
Transformation and Delivery System Implementation  
Duke-Margolis Center for Health Policy

Aneesh Chopra, MPP, President  
CareJourney

Erica Everart, JD, Head of Thought Leadership  
CareJourney

Nate Smith, PhD, Principal Researcher  
CareJourney

Sarah Grace, Manager, Member Services  
CareJourney

Ming Zhang, SVP Customer Engineering  
CareJourney