Alliance of Specialty Medicine

25TH ANNIVERSARY

Sound Policy. Quality Care.

July 2, 2025

The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Jeff Merkley
United States Senate
531 Hart Senate Office Building
Washington, DC 20510

RE: Support of S. 1105, the *No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act*

Dear Senators Cassidy and Merkley:

As the Alliance of Specialty Medicine ("the Alliance"), our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care. As patient and physician advocates, the Alliance writes in support of your legislation, **S. 1105, the *No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act.*** The *No UPCODE Act* takes long-overdue steps to address the widespread and well-documented distortions in the Medicare Advantage risk adjustment system by requiring the Centers for Medicare and Medicaid Services (CMS) to base Medicare Advantage (MA) risk adjustment on two years of diagnostic data, exclude diagnoses from chart reviews and health risk assessments, and, after implementing these changes, fully account for any residual coding differences between MA and traditional Medicare.

Although MA was originally created to reduce costs through private-sector efficiency, the program now costs substantially more than traditional Medicare. According to the March 2025 *Report to the Congress* from the Medicare Payment Advisory Commission (MedPAC), Medicare will spend approximately 20 percent more per enrollee in 2025 than it would for a comparable beneficiary in traditional fee-for-service Medicare—translating to an estimated $84 billion in excess payments this year alone. Roughly half of this difference is due to coding intensity, as Medicare Advantage plans have a financial incentive to report as many diagnoses as possible—even if not actively treated—because each one inflates the patient's risk score and increases Medicare's payment to the plan.[1]

Investigative reporting by *The Wall Street Journal* and *The New York Times* describe the use of coding tactics by Medicare Advantage plans to increase payments and the resulting scrutiny from the Office of

[1] The majority of the remainder of this difference in spending is due to favorable selection, where plans enroll healthier beneficiaries who cost less to treat.

Inspector General, Congress and the Administration, including through recent legal filings. *The Wall Street Journal* further reported that Optum, a UnitedHealth Group subsidiary, employed its own physicians to retrospectively add diagnoses to patient charts—sometimes offering financial incentives based on the number of diagnoses added—to increase Medicare Advantage payments.

This systemic overpayment has had harmful consequences for specialty physicians, particularly in fields such as rheumatology and ophthalmology—especially among retina specialists—who have experienced increased administrative burden and payment pressures due to MA plan practices. Plans have dramatically increased the volume of chart reviews targeting network physicians—not to evaluate quality of care, but to extract additional diagnoses to inflate risk scores. Alliance members report that some specialty practices have been asked to produce as many as 1,800 charts for a single coding audit—often presented as CMS-mandated Risk Adjustment and Data Validation (RADV) audits—diverting limited administrative resources and distracting clinical staff from patient care. In addition, Alliance members report that some MA plans employ financial "carrots and sticks" to influence physician behavior—offering bonuses to those who document more diagnoses, while penalizing others through lower payment rates or exclusion from networks. In some cases, MA contracts even include provisions granting plans access to electronic health records (EHRs) to conduct their own "code-mining" operations.

The *No UPCODE Act* would help restore program integrity by modernizing the risk adjustment system, preventing the use of unrelated or outdated diagnoses, and ensuring that payment more accurately reflects patients' actual clinical needs. These changes would help align plan incentives with patient care and bring much-needed parity between traditional Medicare and Medicare Advantage. Importantly, the savings realized by addressing the widespread "upcoding" within Medicare Advantage could be reinvested to strengthen the broader Medicare program, including extending the solvency of the Medicare trust fund and advancing a long-overdue payment update for physicians who serve Medicare beneficiaries.

For these reasons, ***the Alliance strongly supports the No UPCODE Act and applauds your bipartisan leadership in advancing reforms that protect Medicare, its beneficiaries, and taxpayers.***

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology