Business Better (Season 3, Episode 7): 2024 Advance Notice: Proposed Changes to the Medicare Advantage Risk Adjustment Model

Speakers: Philip Legendy and Alexander Oliphant

Steve Burkhart:

Welcome to Business Better, a podcast designed to help businesses navigate the new normal. I'm your host, Steve Burkhart. After a long career at global consumer products company BIC – where I served as Vice President of Administration, General Counsel, and Secretary – I'm now Special Counsel in the Litigation Department at Ballard Spahr, a law firm with clients across industries and throughout the country.

In this episode, we discuss the Centers for Medicare and Medicaid Services' proposed changes to the Medicare Advantage risk adjustment payment model, which will take effect in 2024 if finalized. We're joined by special guest Alex Oliphant, Director of Berkeley Research Group's Health Analytics practice, who has extensive experience in the workings of the Medicare Advantage payment model. Speaking with Mr. Oliphant is my Ballard Spahr colleague Phil Legendy, Of Counsel in Ballard's New York office and a member of our Health Care practice group. So now, let's turn the discussion over to Phil.

Philip Legendy:

Welcome to our listeners. I'm Phil Legendy. I'm Of Counsel in Ballard Spahr's health care practice. And I'm joined today by Alex Oliphant. Alex is director in Berkeley Research Group's Health Analytics practice. Welcome, Alex. Great to be with you.

Alexander Oliphant:

Thanks, Phil. Great to be here.

Philip Legendy:

We're here to talk about the 2024 Advance Notice of Methodological Changes as it relates to Medicare Advantage payment policies. CMS generally publishes a proposed Advance Notice every year in February, and it finalizes it in early April. To get us started, generally, what information do these Advance Notices contain?

Alexander Oliphant:

Yeah, Phil, the Advance Notice is really the mechanism for CMS to inform Medicare Advantage plans of proposed updates that they would like to make to the key operational components of the MA program. So that can include a few different things. We see most commonly in the Advance Notice is information about the Fee-for-Service benchmarks that are used in the bid process. The bid process is a complicated issue that we're not going to tackle today. Instead, I think what we want to talk about and what is relevant in this Advance Notice is plans are notified by CMS of any changes that they make to payments specifically around what is called the CMS-HCC model. Not every year, but periodically CMS will make adjustments to the fundamental way that they determine how to pay plans. And then it also contains some more operationally-focused items such as the Fee-for-Service normalization adjustment and the coding intensity adjustment that will be applicable for the calendar year.

So, to summarize, the Advance Notice has a lot of good key information about what CMS intends to do in the upcoming year.

Philip Legendy:

One of the core concepts in Medicare Advantage is that CMS compensates health plans at a higher rate to provide coverage of sicker patients than it does to provide coverage for healthier ones. The idea being, that CMS wants to tailor payments to the cost of providing coverage to individual beneficiaries

Today, how does the model to determine those payment amounts work?

Alexander Oliphant:

Sure. The the way that the model works is it will evaluate the relationship between demographic information and diagnosis information in the Medicare Fee-for-Service world and use that information to determine which health conditions are good predictors of cost in the next year. So, CMS collects demographic information from the plans and will collect diagnosis code information from the plans and will use that information to predict what a member's cost would be in the subsequent year. So, that's an important thing to note about the CMS model. It takes information in year X and it predicts costs in year X plus one.

So, the way the model works in practicality is, plans submit diagnosis-code information to CMS. CMS collects that information, runs it through what it calls the CMS-HCC model, which determines the incremental normalized cost of each condition shown to have a good predictor, predicting value of payment in the next year. So it will aggregate all that information about the diseases and it will aggregate the information about the demographics and it will produce what's called a risk-adjustment factor or a risk score. And that risk score, for each beneficiary, is essentially a multiplier of the standard bid rate or the the amount that a plan will tell the government it will need to take care of an average patient. This risk score is a multiplier of that average amount, and sicker patients have higher risk scores. So that base amount will increase, and ultimately, the government will pay the plans more for those beneficiaries if they're sicker. And if the risk score is lower than the average, then the amount that the government will pay the plans is decreased.

This model has been in use since 2004 and has undergone some revisions along the way. Not every year, but every couple of years CMS reevaluates the model, such as which underlying diagnosis codes are good predictors of costs and should be included in the model, and what relative weights or what incremental costs associated with those conditions should be factored into the risk score. So, this model has been in play for a while. And what I think we're going to get into the details of is, there's a new model that they are proposing to use that has some significant revisions that I think are worth understanding.

Philip Legendy:

So, let's dive right in. What are the key changes in the new model that CMS is proposing?

Alexander Oliphant:

The key revisions in the model are a few significant ones. CMS is redesigning or re-categorizing specific diagnosis codes into the categories of conditions that it uses to determine if there should be incremental payment associated with that condition, and those categories are called Hierarchical Condition Categories or HCCs. One of the biggest updates to the model is that, historically, CMS has used ICD-9 diagnosis codes to group together into these categories of conditions or HCCs. In this newly-revised model, or newly-proposed revised model, the categories of conditions would be determined based off ICD-10 diagnosis codes as opposed to ICD-9 diagnosis codes. And as our listeners probably know, ICD-10 codes have a much more granular level of specificity than ICD-9 codes, so mapping the conditions together would look different under ICD-10 and likely is more precise than trying to use conditions formulated from ICD-9 codes but then applied with mapping to ICD-10 codes. So, that's one of the major updates.

Some of the other updates include, CMS specifically mentioned that they were going to remove conditions that it views as discretionary from the model. And what do I mean by discretionary? Discretionary codes are described by CMS as those that are not consistently coded or may experience variability in the coding pattern. Said another way, the patient might have it, but one doctor may diagnose the condition and one doctor may not diagnose the condition just based off their different experiences and training. So, CMS decided that it was going to identify the conditions that it views as discretionary and remove them from the model, but said another way, which is to not have incremental payment associated with these discretionary conditions.

And then lastly, along the lines of limiting the discretionary coding, CMS determined that it would constrain or make the incremental values associated with diabetes and congestive heart failure to all have the same coefficient or value in the risk score.

Philip Legendy:

Let's unpack each of those points. Starting with the remapping of the HCCs, you mentioned that one of the things going on is that CMS is now fully converting from ICD-9 to ICD-10. What's happening there?

Alexander Oliphant:

There is a lot of nuance and complexity with the CMS-HCC model in terms of assigning which diagnosis codes should be grouped together into HCCs and then, obviously, determining if those HCCs would be good predictors of cost in the subsequent year. If we're looking at the proposed model compared to the model that is in play for the current payment year, which is called the V24 model, the new proposed model called the V28 model has 115 HCCs or different groupings of conditions that CMS views would be good predictors of cost in the subsequent year. So, these HCCs would have positive value in the risk score that we talked about.

And to provide a little bit of context for that 115 number, the V24 model or the older model, the one that is in play today, only has 86 HCCs. So there's more groupings, arguably more granularity because CMS is using ICD-10 diagnosis codes to make the connections between different conditions. So there's more HCCs, but what's interesting is, when we examine the list of diagnosis codes that map to those HCCs or that translate to those HCCs, there's actually a fair amount fewer codes that risk adjust or that trigger that 115 HCC grouping compared to the old model that map to the 86 HCCs. So, to throw out some numbers here, for the V24 model in play, there was roughly 10,000 codes or 9,797 individual ICD-10 diagnosis codes that would map to an HCC. In the newer model, there's only 7,770 codes. So, CMS has, in its proposed model, removed many diagnosis codes that risk adjust.

And some of the examples that we found that were really interesting related to those diagnosis codes include peripheral vascular disease, unspecified. That code is more commonly coded in the MA world. We looked at the prevalence of that condition in the Fee-for-Service world, and it's about 6%, so not a uncommon condition that is being removed from the model.

Some other interesting conditions that we saw fall out of the model or be removed to where they no longer risk adjust would be some of the major depressive disorder conditions. Not all of them. So the more severe conditions still would map to an HCC and lead to incremental payment, but major depressive disorder, mild, or major depressive disorder, in partial remission or in full remission no longer would map to an HCC and no longer would, if diagnosed, lead to incremental payment in the subsequent year.

And then a few other ones that I personally found in this interesting, sacroiliitis was one that I saw that would no longer risk adjust, and then kwashiorkor, which isn't a very common condition and had been subject to some scrutiny a while back, is no longer in the model, as well.

Philip Legendy:

A related concept is, you mentioned CMS is dropping what it calls discretionary codes. And I think the way you describe those codes is essentially ones where reasonable minds can disagree as to whether that condition is present. What can you tell us about the changes that are going on in that category of codes?

Alexander Oliphant:

It's interesting to observe which codes that CMS views as discretionary. They explicitly call out in the Advance Notice three different HCCs, and those HCCs are protein-calorie malnutrition, angina pectoris, and atherosclerosis of the arteries of the extremities with intermittent claudication. So, following CMS's logic, as you put so well, Phil, the reasonable minds could differ on if it is appropriate in certain situations to code these conditions. So, what must be underlying this decision is some type of analysis that CMS has done to determine that the coding of these conditions is variable and is not consistent across the

industry. So their justification for removing these is that these conditions aren't very good predictors of incremental cost in the next year because they aren't consistently being coded across the industry.

Philip Legendy:

I think the last major category of changes you identified is that CMS is proposing to constrain the coefficients for certain health conditions. Can you go into a little bit of detail on what's going on there?

Alexander Oliphant:

Sure. This one is really interesting to me, especially the diabetes aspect of it. In the Advance Notice, CMS states that as part of its efforts to remove the effects of discretionary coding, they're going to keep diabetes and congestive heart failure in the HCC model but they're going to put some constraints on the incremental value of those HCCs, presumably to help mitigate against any discretionary coding patterns.

So, talking about diabetes first, if we think back to how the model has historically been used, there are differentiating factors for more severe types of diabetes. For example, there are three different diabetes HCCs in the V24 model: acute diabetes, diabetes with chronic complications, and diabetes without complication. And those relative factors for those HCCs or the amount that the HCC contributes to the overall risk score differs pretty significantly between acute diabetes and diabetes with chronic complications versus diabetes without complications. To throw out an example, if we're thinking about the coefficient associated with a community, non-disabled or non-dual member, the coefficients for acute diabetes and diabetes with chronic complications is 0.302, or, if you're thinking about this, about a third of what would factor into an average risk score of 1.0. So, that 0.302 is compared to diabetes without complications of 0.105, and that's a pretty significant spread between the two, almost three times the contribution to the risk score.

So, plans have been in tuned with this and ensure, I would imagine, through their policies and procedures that they are coding accurately and completely to ensure that if patients do have more severe manifestations or more severe versions of diabetes, that that information is correctly picked up, sent to CMS, and that CMS will factor that into the risk score and pay the plan the appropriate amount.

It is very interesting to see in the proposed model that CMS is eliminating the difference between coding diabetes with acute complications or with chronic complications or with no complications. All of those coefficients, or relative risk factors, or contribution to the risk score, however you want to think about it, is constrained to be the same. So, what does that mean? That means if a patient is coded with acute complications with diabetes, or if they're coded with chronic complications with diabetes, or if they're coded with no complications of diabetes, all three scenarios would produce the same incremental payment.

And when you examine the relative difference between the coefficients, there's a pretty big impact. If you had a decent-size population of members with chronic complications, you would be receiving about 0.3 of a contribution to the risk score for them. Under the proposed model, since the coefficients are all constrained, they're constrained at a lower level, lower than diabetes with chronic complications in the old model but higher than diabetes without complications, it is 0.166. So it is higher than the old model but for diabetes without complications, but when comparing with chronic complications or acute diabetes, it's a significant haircut. So, plans, I think, need to be in tune of how the constraints of this condition will affect its risk scores and plan appropriately.

In terms of congestive heart failure, it's a similar concept, although there's a little bit of a nuance here. In the old model for congestive heart failure, there was only one HCC. In the new model, there are a few HCCs. They are congestive heart failure, acute-on-chronic heart failure, acute heart failure, and heart failure except end-stage and acute. All of those conditions are constrained to have the same coefficient similar to diabetes, and so plans will not get any incremental benefit for a patient having a more severe manifestation of CHF. They're going to get paid the same regardless how severe the CHF diagnosis is.

Philip Legendy:

There's a lot that is changing with this proposal. We are changing the number of HCCs in the model. We're also changing the numbering that is assigned to each HCC, which I'm sure will be confusing. We're changing from ICD-9 to ICD-10. We're

dropping certain codes. And we are changing the dynamics associated with the different levels of severity for some of the common risk-adjusting conditions, like the ones we just talked about, diabetes and congestive heart failure. It's obviously a very detailed document that CMS has put out, we're just covering the highlights. But if we put this all together, who is affected, and what do you expect the effect of these changes will be?

Alexander Oliphant:

That's a great question, Phil. I think we'll start off with the most obvious party, which would be the health plans, the Medicare Advantage plans. CMS, in its Advance Notice, estimates that the impact of implementing this new proposed HCC model would decrease revenue by -3.12%. So that's a pretty substantial hit to the industry. That's about $11 billion of revenue that is taken out of the system solely attributable to updates to the HCC model.

For individual plans, that number may change, depending on their member makeup and the coding patterns and what other programs that they have in place. So, it will certainly affect plans, but providers may be impacted, too. I'm thinking specifically about providers that participate in risk-sharing arrangements, where they will share risk with health plans but also share the portion of revenue. So, if the overall revenue is decreasing for a plan, then providers that participate in risk sharing will presumably experience some revenue drop, as well, likely dependent on the contractual arrangements that the plan has with the providers.

And then finally, there could also be an impact on the Medicare Advantage beneficiaries. Plans are digesting this information about what this new risk-adjustment model will do to their business, and perhaps plans would make decisions on their standard bid rates or on the suite of benefits that they would offer in their plans and may make adjustments. They may increase bid rates to account for the loss of revenue, and that could increase premiums that plans have to pay. Typically, MA members don't have to pay premiums, but some do, depending on the plan's bid rate relative to the benchmark. And I'm also thinking, aside from the premium impact, plans could decide to reduce their benefit offering to help mitigate the loss in revenue. And having updates to plan offerings could impact the members. They may have less benefits available to them or reduced benefits available to them.

Philip Legendy:

Right, because when plans bid to offer insurance under Medicare Advantage, when they are able to bid low, they can use the difference between their bid and the benchmark which is set by CMS to offer additional benefits to their beneficiaries. And if they're not able to bid as low, then the amount left over for those benefits could decrease.

You previewed... It's a proposal. We're going to be releasing this podcast shortly before the final version of the payment model is announced. But assuming that the final version mostly mirrors the proposal, what should the affected parties, which I think for our purposes, in terms of those who can actually react today, would be health plans and providers, what should they do?

Alexander Oliphant:

That's a great question. I think plans and providers should get their arms around what the new proposed clinical HCC model will do to their payments specifically. What do I mean by that? CMS has estimated the overall impact across the industry, but, as I mentioned earlier, plans may experience varying effects of the model depending on their patient population and how they run their business. So, if I were a plan or a provider group, I would start analyzing my own specific patient population using the information available from CMS to recalculate what risk scores would be and ensure that information is being utilized in preparing for bids in the upcoming season. Plans, presumably, can do this with their own data. CMS also releases... or is planning to release reports that would do this analysis for them. However, it will not be customizable, and plans, without doing this analysis on their own, wouldn't be able to drill into areas that could experience more variation. So, if I were a plan, I'd be thinking about "How heavy is my dual population," because a -3% overall impact on the industry may look a lot different if you have a highly-concentrated population of duals relative to the industry.

The other thing I would be thinking about, too, as a plan is, "What does my provider arrangements look like? How many providers are at risk? Or how many do I pay... absent sharing the revenue that comes from CMS?" And I would look to ensure that for providers that are under risk-sharing agreements, I want to engage with them so that they understand the impacts of

the model, and to ensure that both the provider and the plan are thinking for compliance reasons or for a compliance perspective to ensure that this new proposed model doesn't create unexplainable variations in coding.

From a provider perspective, I think I would certainly understand if I was taking on risk, how my payments would be impacted. Presumably many providers' arrangements won't experience the full impact of the revenue reduction because that would be shared somewhat with the plan. But I would be cognizant to plan for what my predicted risk scores would be under the new model, how the proposed increase or decrease, depending on the patient population, would play out under the contractual arrangements with the plan, and then make adjustments as necessary. If I'm a provider managing care, then think through ways that the new model will affect reimbursement and ensure that you have compliant programs in place to capture all appropriate coding.

Philip Legendy:

I know a lot of plans have programs that are focused on the accuracy of the coding sets that they're submitting to CMS for reimbursement. Are there any takeaways for those initiatives based on the information that's available in this proposal?

Alexander Oliphant:

That's a great point, Phil. Plans use different programs to help ensure that they are capturing complete and accurate coding information. And some of those programs include retrospective-chart-review program, where coders will reopen charts and review those charts to determine if the codes that were submitted are complete and accurate. And if there were codes that were supported or conditions supported in the medical record that were not documented, then those codes can be added. And then if there are conditions that were originally reported that are not substantiated in the medical record, those would be removed. So, as a plan, if you have a retrospective-chart-review program, there's a lot of time and thought spent into what charts should be picked up. And plans should incorporate the information from the new model in that targeting process in determining which charts to pick up in a compliant fashion so that the plans are experiencing the best outcomes in its chart-review program.

Some of the other programs that plans can use to ensure complete and accurate coding include prospective programs, where plans will coordinate with providers about conditions that members may have but are not reported. And so those analytics that are used to help identify prospective opportunities with providers should obviously be re-calibrated for the new HCC model, not only the new mappings between the conditions in the HCCs but also the details of the components or the value of each HCC.

Philip Legendy:

You mentioned compliance, which is something I know many plans are very focused on. From that perspective, are there any issues you see based on the proposed notice that you think folks should be paying attention to?

Alexander Oliphant:

Yeah. I think plans and risk-sharing providers should be on the lookout for variations in the underlying coding patterns that may present on future dates of service. Plans and providers can assess the coding trends by running comparative analytics that examine coding behavior over time, and can drill down on any coding anomaly's that present. And, for example, there's a parallel to the last major clinical update to the CMS HCC model, which was in 2014. That update added certain conditions to the risk-adjustment model for the first time, and we've seen that for some of these conditions there were changes in prevalence rates before and after the model update.

The increase in prevalence alone does not necessarily mean that there is inaccurate coding. But, applying what we've learned from the 2014 exercise, if I were running a compliance program I would want to deploy certain data analytics to assess general coding trends, to understand changes in coding patterns, and to drill-down on the driving factors of any coding anomaly's and to make sure that those are understood, and that ultimately that the diagnosing coding for a plan or provider aligns with their compliance priorities.

Philip Legendy:

This is complicated material, and these changes are obviously being made to a very detailed program that few people understand as well as you do. So, thank you for helping us to make sense of it. Obviously we'll all be watching to see what's in the final notice. And if there are changes from what's been proposed, I hope we'll be able to have you back to review them.

We'll leave it there for now. Thank you so much for being here with us.

Alexander Oliphant:

Of course. Thank you for having me.

Steve Burkhart:

Thanks again to Phil Legendy and Alex Oliphant. Make sure to visit our website, www.ballardspahr.com where you can find the latest news and guidance from our attorneys. Subscribe to the show in Apple Podcasts, Google Play, Spotify, or your favorite podcast platform. If you have any questions or suggestions for the show, please email podcast@ballardspahr.com. Stay tuned for a new episode coming soon. Thank you for listening.