

## Unpacking the Controversy Over Medicare Advantage

**Larry Levitt:** Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. Roughly once a month, we dive into timely and complex health policy topics with experts from a variety of perspectives. Today's installment certainly lives up to the wonk shop name as we unpack the debate over Medicare Advantage. Be prepared for a spirited discussion of benchmarks, rebates, and risk adjustment. Medicare Advantage, or what wonks call "MA," is the private plan alternative to traditional Medicare. Enrollment has grown rapidly with about half of all beneficiaries now covered by these private plans. There's been ongoing controversy for years over federal payments to Medicare Advantage plans with the Medicare Payment Advisory Commission estimating that the government pays plans about 6% more than it would've paid for equivalent beneficiaries in traditional Medicare. A recent proposal from the Biden administration would make some changes to MA payments, and it has received substantial pushback from the insurance industry and some Republicans in Congress who have called it a cut to Medicare.

We're joined today by three experts to sort all this out. Jeannie Fuglesten Biniek is associate director of KFF's Medicare Policy Program. Tom Kornfield is the senior consultant at Avalare Health and was previously at CMS and America's Health Insurance Plans. And Rick Kronick is a professor at UC San Diego and held senior positions at HHS. If you have questions, please submit them at any time through the Q&A button in Zoom, and we'll get to as many of them as we can. Also note that the session is being recorded and an archive version should be available later today. Jeannie, let's start with you. Give us a really quick, really quick summary of how Medicare Advantage plans are paid and what that means for enrollees to set the context for the conversation.

**Jeannie Fuglesten Biniek:** Sure. So, unlike traditional Medicare, which pays providers on a fee for service basis, Medicare Advantage plans receive a per capita payment every month from CMS. This payment is set in advance, and it doesn't vary depending on utilization of enrollees. So there are several steps that go into setting the payment. First, CMS determines the maximum amount they're willing to pay in a geographic area based on spending of traditional Medicare beneficiaries in that area. This is the benchmark. Benchmarks are adjusted up for plans that receive at least a four star quality rating. Second, plans submit their estimate of what it will cost to cover traditional Medicare benefits to CMS. This is known as the bid. When the bid is below the benchmark, which it almost always is, plans retain some of that difference, and this is known as the rebate. The rebate has to be used to lower cost sharing, provide extra benefits such as vision, dental, or hearing, or to reduce the Part B or Part D premium. And finally, relevant for this discussion, especially today, is that these payments are all risk adjusted, meaning that plans get higher payments for enrollees that are higher cost and lower payments for enrollees who are lower cost.

**Larry Levitt:** Well, as I promised, we got right into benchmarks, rebates, and risk adjustment. So Jeannie, this proposal from CMS in the Biden Administration is, you know, part of the annual payment notice that always gets proposed, but also some changes to how MA plans get paid. Quickly, kind of summarize what those changes are.

**Jeannie Fuglesten Biniek:** Yeah, sure. So most of the content of the advanced notice speaks to the elements of the payment system that I just described. So it includes updates to reflect changes in the economy, as well as Medicare spending trends. Those feed into the benchmarks, or the maximum amount CMS will pay Medicare Advantage plans this year. CMS is also proposing changes to star ratings as well as changes to the risk model. That's what's gotten a lot of attention. And the risk model is important because this is how CMS evaluates whether particular enrollees are expected to cost more or cost less on average, and how they adjust their payments to plans based on that. So the changes to the risk model include first transitioning to ICD 10, which is the system in place in clinical settings today to document diagnoses.

It also would move to a more recent year of data to calibrate the model. And then finally, they're proposing changes to how diagnoses codes feed into particular condition categories that are then used to estimate expected spending. So those changes include eliminating some diagnoses altogether from the model, remapping the diagnoses so there will be more condition categories, and then the contents of those categories will be different. And then finally, a handful of the condition categories will be constrained, meaning what were this year, and in the current model, distinct condition categories will effectively be combined so that they have the same estimated effect on spending. The example for that is diabetes. So a diabetes with acute complications, diabetes with chronic complications, and diabetes with no complications this year has three distinct effects on the expected spending. And the proposal would constrain those to be just a single effect. In that CMS predicts that, or estimates the effects would actually increase spending per enrollee by 1% relative to what plans received this year. And that's all of the policies and all of the other things that affect Medicare advantage spending, taking all of that into account on average.

**Larry Levitt:** We will definitely come back to these risk adjustment changes. Rick, let me turn to you. So, as I mentioned, you know, MedPAC estimates that the federal government overpays or pays Medicare Advantage plans 6% more than it would for these beneficiaries in traditional Medicare. How far does this proposal from CMS go to reduce that overpayment?

**Richard Kronick:** It makes a good beginning. I applaud CMS for proposing to begin to address the overpayments that Medicare has been making to Medicare Advantage plans for 15 or more years now. The average risk score, and Jeannie did a great job of trying to simplify what's a very complicated system. The average risk score and the risk score is the score that's used to determine payment to Medicare Advantage plans. The average risk score for Medicare Advantage members in 2020 was about 20% higher than the average risk score for a fee-for-service beneficiary. And as far as we know, Medicare Advantage members are no sicker and are probably somewhat healthier than fee-for-service beneficiaries on average. MedPAC did an analysis recently where they're suggesting 9% or 10% or 11% favorable selection.

There's some debate about how much favorable selection is left in Medicare Advantage, but almost all analysts would agree I think that Medicare Advantage members are no sicker and are probably somewhat healthier than fee for service beneficiaries. Despite that fact, the average risk score is 20% higher in MA than in fee-for-service, which indicates that plans are getting paid as if their members were 20% sicker when they are not. CMS and Congress requires what's called a coding intensity adjustment. That adjustment is currently at 5.9%. CMS has the authority to increase the adjustment above 5.9%, but has never, not yet done so. So the difference between the 20% difference in risk score and the 5.9% coding intensity adjustment is at least 14%. And if there's favorable selection, which there almost certainly is, it should actually be bigger than that.

The changes that CMS is proposing for 2024 are projected to reduce payments to MA by about 3% in and of themselves. As Jeannie said, there are a lot of other things going on and net payments are expected to go up by about a percent, but the particular changes CMS is proposing around risk adjustment are negative three. That negative three is a pretty small part of the plus 14, or probably even more than plus 14 if we included favorable selection that exists. So a beginning step, but, a kind of baby step.

**Larry Levitt:** So, so Rick, let me I wanna get to Tom, but let me follow up. So just so the audience is clear, you said that the evidence suggests that Medicare Advantage enrollees are healthier on average than traditional Medicare enrollees, yet their risk scores are 20% higher. So how does this happen?

**Richard Kronick:** It happens because Medicare Advantage plans report many more diagnoses on a given beneficiary than would be reported if she were in fee-for-service. Vascular disease is reported for about 15% of fee-for-service beneficiaries, and about 30% of Medicare Advantage beneficiaries. Morbid obesity is reported for more than twice as many Medicare Advantage beneficiaries as fee-for-service. Drug and alcohol dependence, more than twice as much in MA as in fee-for-service. There is no reason to think that Medicare Advantage beneficiaries, that a larger fraction of them are actually morbidly obese or actually have drug and alcohol disease or actually have vascular disease, but they're reporting more diagnoses. And while some of this may be fraud and there's work and the Department of Justice is involved, much of it is probably legitimate reporting. Many of these diagnoses there's under-reporting in fee-for-service, but even so, risk scores end up being 20% higher for the same person. Is that helpful or still too confusing?

**Larry Levitt:** No, that's great. We'll definitely come back to this. So Tom, I wanna bring you in and I wanna you to talk about your analysis. But first just following up on Rick's comments. Do you agree with that assessment of the risk adjustment system that Medicare Advantage enrollees are healthier than traditional Medicare enrollees, but that the risk scores end up higher?

**Tom Kornfield:** Well, <laugh>, I think it depends on how you do the analysis as a starting point is what I would say. So you know, Rick noted that, you know, they're coding more, the codes are accurate, but somehow that's problematic. Now, I want to talk a little bit about the changes that CMS has proposed and the analysis that we did just to sort of level set for everybody. So as Jeannie pointed out, there's something called the rebate, which is additional funds because the plans are more efficient than traditional Medicare, at least based in terms of how they bid for services that they provide to their members. They're able to use those rebate dollars, in many cases, to provide additional benefits to enrollees. So that includes dental vision hearing, that can also include transportation, food, nutrition. There's been a very wide expansion of what I guess could be seen as non-medical benefits such as I mentioned transportation and food, that we've seen in recent years and there have been studies that have shown that. If you're going to make a change, such as the one that CMS is proposing the analysis that we had done showed that there's a real possibility that those rebates that I mentioned could be lower by, you know, an order of, I think about \$45, on average. And that would vary a lot depending on what part of the country you're in and also can vary based on what plan you're in. I wanna make two other points here. One is, we talked about, there's this, there's a lot of, I think, confusion about this, you know, 1% overall growth. That's a number that CMS arrived at by saying, when you take everything together, including the risk model change, and then you account for excess coding, which they believe is

3.3% and not 20%, as Rick had pointed out. They then believe that, you know, when you get to the end of all that, the 3.3%, including this, you know, increased coding for MA versus fee-for-service, that's where you get to the 1%. Now, what I would say is, it's not clear to me how you can change the model, change the incentives for coding, and then say that the increase in coding for MA versus fee-for-service will be exactly the same trend as what you had said in the previous year, which is basically what CMS is saying. So, you know, it's either it reduces coding, or coding stays the same, but it's not clear to me how you can make this change and say that coding would, you know, if coding is going to increase in the same way, then, then I don't understand the purpose of making this change.

Second point I would make is that the impacts are very much disproportionate for people that are dual eligible. So we've seen in Puerto Rico, there's been analyses that have shown impacts of, you know, 9-10%, in price changes to the risk score. There are increases for people that don't have any diseases under the old model, but there are decreases for people that had multiple diseases under the old model. So particularly true of vascular disease. Now, you know, I guess the notion is that these folks don't actually cost more and, you know, they're, you know, as such, they should be taken out of the model, but I just, I don't think it's a good policy if your concern is around coding intensity to address it through changes to the risk adjustment model. As Rick mentioned, there's a coding intensity adjustment that can be applied. There's also the possibility of estimating the model on Medicare Advantage data itself. And CMS has been collecting that data for 10 some odd years, but hasn't talked about what their plans are to estimate the model on it and presumably that would address any differential because you would no longer have a differential since the model would be estimated on Medicare Advantage enrollees and their claims.

**Larry Levitt:** So, Tom, we definitely wanna come back to these risk adjustment issues, <laugh>, but let me ask, so the analysis you did, sort of assume that this reduction would flow through into benefits, is that correct?

**Tom Kornfield:** Yes, it would either be a reduction in the benefits that they offer, or it would be an increase in the premiums that the plans would have to charge. That the plan bids don't change -- that was, you know, part of the assumption that we made.

**Larry Levitt:** Sure, sure. So Rick, as I said, I wanna come back to these risk adjustment questions. But let me get your perspective on the Medicare Advantage market. And Tom's conclusion that these reduced rebates would then result in lower benefits or higher premiums.

**Tom Kornfield:** Could result.

**Larry Levitt:** Yeah.

**Richard Kronick:** You know, there is uncertainty, some uncertainty about how plans will respond. We do have some evidence from previous changes. So in 2014 to 2016, CMS made changes in the risk adjustment model that resulted in about a two to two and a half percent decrease in the rate of growth of MA payments. Very similar, a little smaller than the 3% that they're proposing now, but, you know, similar in magnitude. Rebates and enrollments in MA increased a lot after that. I'm not arguing that they increased because of those reductions, but there were many other changes going on. Those reductions

did not seem to have, you know, much of any effect, or certainly didn't reduce rebates that plans offered. MedPAC has done some work looking at the effects - what plans do when, they change quality bonus positions, if they lose money because they're their star rating goes down. They tend not to reduce rebates. They kind of take that out, either a profit or provider payment, but they make some other changes. There's some evidence that suggests that maybe a third of changes in payment might flow through to beneficiaries with the other two-thirds being absorbed by plans or being passed on to providers. You know, that evidence about the one-third, two-thirds is not, I'm not sure I'd go to the bank on that. It's really hard to figure out empirically what has gone on. But to the extent that people have tried to figure it out, it looks like, you know, a lot of the results of these kinds of changes will not flow through to beneficiaries, although some small part would. If I could make a couple other comments, Tom said the 3% and sort of juxtapose that to the 20% I was talking about. The 20% is an accumulation of many years of 3%, so there are very different kinds of things. And Tom, to your point that, you know, with these changes, will risk scores still increase by 3%? Oh, maybe they'll increase by 2.8%. You know, a little, maybe a little bit less. But you know, we've seen the difference between the fraction of MA patients who are morbidly obese and fee-for-service patients who are morbidly obese has increased over the last 10 years. And it's likely to continue to increase. And that's likely to be true for, you know, many of the other diagnoses where we see disproportionate numbers of MA beneficiaries coded with those diagnoses. And, I would, and the last thing I'd say, while I have the floor, Tom, I'd like to go back and ask you, I don't think I understood your response to Larry's first question, which is, is there anything wrong in your view with the analysis that I put forward, that the average risk score of MA beneficiaries is 20% higher than the average risk score of fee-for-service beneficiaries?

**Tom Kornfield:** I can't comment on an analysis that I've never seen written or do it in a specific way. So that's my answer.

**Richard Kronick:** I'll send you the link to that again. I mean, it's been out on the web for a year or something.

**Tom Kornfield:** I'm sorry, but I haven't read it. And you know, from CMS's own estimates, the the year over year growth, they believe to be about 3%.

**Richard Kronick:** Oh, I totally agree. The year over year is about 3%, and then when you add it up over many years, it gets to about 20%, or has gotten to 20% by 2020.

**Tom Kornfield:** Okay. But this is, but this is an annual rate notice that looks at year over year impacts. And I feel like you're adding a data point that's a little bit misleading here. If we're talking about how revenue is going to change from one year to the next.

**Richard Kronick:** I was not, I'm sorry. I was responding to Larry's first question.

**Tom Kornfield:** And that's what our analysis focused on.

**Richard Kronick:** Yeah.

**Tom Kornfield:** Plans have flexibility. I do think that these changes are, you know, I was at CMS when those changes were made in 1415. The, you know, these changes are, let's put into perspective, they're removing about 20% of the diagnosis codes that are, that were in the model currently for this year. And that includes a number of codes, as you know, vascular disease also includes some blood disorders. It includes some mental health disorders and perhaps some substance abuse disorders among others. So I just wanna put that in perspective. That's 20% of the codes that are being removed. That's not trivial. And if the, if the goal is for plans to code accurately and, you know, be paid based on the health status of their enrollees, then I'm concerned that these changes, which are meant to get at the coding intensity question could have the potential to do more harm than good given sort of how the impacts could play out. That's, that's all I would say on that.

**Larry Levitt:** So, Tom, let me, let me ask you about Rick's point that, you know, if there is a reduction in rebates to plans, some of it could flow through in reduced benefits, some could flow through in, you know, reduced profits for plans. What's your sense of that split?

**Tom Kornfield:** I don't know that I have a definitive answer on what that split is. I mean, I don't know that there's, you know, MedPAC has done work, but I would say that when MedPAC does their work, there tends to be, I'm not sure if, if other analysts from an objective perspective would reach that same conclusion as MedPAC would when it comes to, you know, how the dollars kind of flow. And I'm also not sure that the way they're doing the analysis is sort of indicative of what's actually happening. Yes, plans have some flexibility. I don't think there's any way to to know exactly what percent you know, of the dollars would be, would be in one area versus another. If there's small impacts, then I agree there's potentially a little bit more ability for plans to weather that.

What I would point out though is that, again, there's analyses not done by me, done by, by Milliman, by Wakely, you know, these are actuarial firms that have looked at it and have shown, you know, impacts for plans that are much greater than 3%. I think, you know, as I mentioned, the Puerto Rico case cuz there's a specific paper in Puerto Rico, it's around 9%. The, some of the dual eligible plans, I think I've seen that at, you know, 8%. So I don't know where the 3% comes from. CMS actually, there's a technical adjustment they make, which I don't really wanna get into here, which is called normalization, which is a way they adjust for differences between when they estimate the model, when the model is - the payment year of the model. But they combined that impact with the risk model impact and they said it's three something percent, but, you know, they didn't really show their math. So I think it's, it's a little hard to know exactly how CMS did their calculation. But I would say that the impacts that CMS has stated seem to be much not as great as what you know, we've seen from, from estimates, from Millman and Wakeley based on data that CMS had provided to the plans from their other risk scores.

**Larry Levitt:** So, I wanna get to audience questions as well and we have lots of them. Jeannie, let me step back a little bit. And, you know, we've talked about these rebates, these extra benefits, the effects on premiums for beneficiaries. You know, give us a sense of what this market looks like now. How much extra benefits are there? What are the premiums the beneficiaries typically face in Medicare Advantage?

**Jeannie Fuglesten Biniek:** Yeah, so for this plan year 2023, the average Medicare beneficiary had 43 plans to choose from, which is a lot. And that's actually twice as many plans as the average beneficiary



had in 2018. So we've seen a lot of growth in terms of the options, and participation and what insurers are offering in this market. Virtually every Medicare Advantage and enrollee is in a plan that has some coverage of dental, vision, hearing. Increasingly over-the-counter drugs and other types of health supplies are also a benefit. So even if there are some changes, there will still most likely be dozens of plans available that will all, or there will be an option for plans that offer these extra benefits. And just speaking about rebates, since 2018, the rebate portion of that payment, which funds these extra benefits has doubled.

So this year plans on average get about \$2,300 per person during the year to pay for these extra benefits, or reduce cost sharing. So there's a lot of cushion there that they have. These plans are also, you know, doing relatively well compared to their performance in other health insurance markets like the individual market or the group market. So in terms of how they may respond, there's a choice to reduce administrative costs, marketing, profits, and there's reason to believe that they may have more ability to absorb it in the Medicare Advantage market than maybe they would somewhere else.

**Larry Levitt:** So we have a question from the audience that really gets at this question. He points to a comment from Humana's CEO saying that these changes will benefit Humana which is a company that actually recently announced it's leaving the employer market and focusing on Medicare and Medicaid. That Humana said it would benefit the company cuz it could grab market share from any other Medicare advantage plan that decides to reduce benefits. So his question is isn't that a check? Isn't this competition among plans a check on the idea that that plans will reduce benefits? So Tom, let me just start with you sort of how you react to that.

**Tom Kornfield:** I'm sorry, there was a lot in what you just said, Larry, can you [inaudible].

**Larry Levitt:** Oh, sure. So, the idea I think what the questioner is getting at is the idea that there is, you know, competition in this market, and as Jeannie said, there are a lot of plans to choose from. If a plan tried to reduce benefits based on this payment, these payment changes, what other plans, you know, grab market share from that plan by not reducing benefits?

**Tom Kornfield:** They certainly could. I mean, there's certainly a risk in being the only plan that that does that, right? If you're a plan that goes out and decides, okay, I'm, and one thing we didn't talk about is a lot of plans are able to provide these benefits at, at \$0 premium. So they don't charge a premium. So if you're a plan that decides, well, you know what, we're gonna now charge a a \$5 premium, and the other plans decide, oh, we're going to, you know, continue to charge a \$0 premium and maybe make some other slight reductions in the benefits there's a real risk, that plans face. And it's, you know, it's a competitive market and from that perspective, there, there's a lot of, I mean I'm no game theory expert by interest of the imagination, but, you know, I suspect there's a certain element of that here where, you know, plans are going to have to anticipate how other plans will respond and react and act accordingly. And there is a risk, you know, if you make a [inaudible], you know, or if you drop a certain provider group or if, you know, reduce a benefit, you know, that's popular, you know, among seniors only your enrollee that there's a real possibility you'll lose members. And that's something that needs to be considered by plans.

**Larry Levitt:** Rick, what's your reaction to that question, how plans do - I dunno if you're a game theory expert either - but, how would plans react to this change? And is there an opportunity for plans to maybe take advantage of it and grab market share?

**Richard Kronick:** I'm sure there is. I mean, I think that Tom, I would agree with Tom's answer or the, that, you know, this market is not perfectly competitive, but it is competitive and plans work very hard to maintain and increase their enrollment and, will, I think, be very reluctant to take actions that will threaten that enrollment. And I think, you know, the evidence we have from similar sorts of changes that have occurred in the past, is that plans largely absorb the changes and don't pass them, largely do not pass them, on to beneficiaries. You know, a hundred percent? I can't be a hundred percent sure. They're probably, you know, might be some small changes that beneficiaries will see, but likely to be small and plans certainly are working to maintain and increase market share and will be very anxious about doing anything to threaten them.

**Larry Levitt:** So. And Rick, staying with you, we had a number of questions about this question of favorable selection, which you mentioned. And, you know, just so everyone in the audience is clear, favorable selection is the idea that MA plans may attract a healthier than average population of beneficiaries. So one question was about, you know, someone with chronic conditions, an MA plan would turn them down that, that is not possible. MA plans have to take everyone. But what, how do you think this favorable selection, what causes it? How does this happen?

**Richard Kronick:** There are, I think, two main dynamics, and by far the biggest one is that a beneficiary who's receiving a lot of healthcare and has a lot of healthcare problems is going to be more reluctant, understandably, to move from fee-for-service into Medicare advantage out of concern that his or her delivery system will be disrupted. You know, it's hard to, to make medical care system work if, if you're a patient, and if you've been able to figure out how to make it work, you're reluctant to disrupt that. A beneficiary who's not using very much healthcare, doesn't have very many needs, is gonna be more willing to move and be attracted by the extra benefits that Tom and Jeannie have been talking about. And so on the way in, you know, as people are choosing whether to join Medicare Advantage, it makes sense that healthier people are gonna be more likely to join than sicker people.

And that's the biggest part of the favorable selection dynamic. There's another part, and there's good evidence that that's what happens. A second part of that dynamic is that sicker people are somewhat more likely to exit Medicare Advantage. This is a smaller part of the dynamic. Dis-enrollment is relatively low but the people who do dis-enroll are more likely to be people with high levels of healthcare need seeking, apparently, the, the greater freedom, the lack of network restrictions in fee-for-service Medicare. And there has been, you know, evidence for many, many years about this selection. So, you know, the mortality rate of MA beneficiaries in their first year of enrollment in MA is 70% of the mortality rate of someone of the same age, gender, Medicaid status in fee-for-service. And maybe it's that in that first year, the Medicare Advantage plan has done something miraculous to lower mortality by 30%, but that seems pretty unlikely. Most of that is probably selection. And then the longer the Medicare Advantage beneficiary has enrolled, those mortality rates get closer together, you know, again suggesting this is largely selection and not that the MA plans are keeping people alive.

**Larry Levitt:** So Jeannie, there was an similar question around other differences between MA plans and traditional Medicare, namely prior authorization. And you've done some work recently on this. Explain



that difference. How do Medicare Advantage plans approach prior authorization differently? And there have also been some recent proposals to regulate that more strictly.

**Jeannie Fuglesten Biniek:** Yeah. So, Medicare Advantage plans are allowed to use utilization management tools, one of which is prior authorization, meaning they can require providers or their enrollees to get approval before certain services are authorized, so before they actually are able to obtain them. In 2021, there were 35 million of these requests submitted to Medicare Advantage plans. The denial rate is actually pretty low. It's about 6%. Though, when people decide to appeal, the vast majority of denials that are appealed are overturned. Some of the things that require prior authorization are skilled nursing facility stays. And so this is one area where there has been some concern that Medicare Advantage plans are using the prior authorization to require people to, instead of being discharged to a skilled nursing facility when their their doctor says that's where they they should go, they are looking at that recommendation and saying, no, we think that you can actually get the care you need at home.

CMS is seeking to clarify that that is not permitted, because skilled nursing facility stays are a covered benefit. If the provider at the hospital says this is the level of care you need, that they would in fact have to approve that stay. Some other things that have come up when the Office of the Inspector General has audited some prior authorization claims is that Medicare Advantage plans sometimes require their enrollees to get a lower sort of intensity service first. So, an x-ray before approving an MRI. This also is something that CMS has said should not be permitted and so they're seeking to clarify that they cannot require sort of lower intensity settings when the requested service is in fact a covered benefit and they do meet the clinical criteria to qualify for that service. They're also seeking to increase the transparency around these decisions, cuz that's a big complaint from patients and providers is the criteria used to say that this is not medically necessary is sometimes based on their own proprietary sort of decision making. And so CMS is seeking to say it has to be based on widely accepted, publicly available studies that have been conducted by people who are in this field and have the expertise to make those decisions.

**Larry Levitt:** We also have a number of questions about this idea that both Tom and Rick had had talked about, you know, the, the coding of diagnoses in Medicare Advantage versus traditional Medicare. And one person asked, you know, is it possible that the diagnoses are undercoded in traditional Medicare because traditional Medicare is unmanaged unlike, Medicare Advantage? Tom, you know, what's your sense of why this disparity?

**Tom Kornfield:** Well, the incentives are very different. I mean, in, in fee-for-service, you get paid per service. And in Medicare Advantage you get paid on a capitated basis. So from that perspective, there are, you know, stronger incentives for you to code accurately with Medicare Advantage. But again, I would, we haven't talked a lot about, and I know we can't talk about every topic that there is to talk about with Medicare Advantage, but you know, one piece that I do find a bit disappointing in terms of how CMS is talking about risk adjustment is let's say that there is a differential and, you know, we can, you know, we could always argue about the level of the differential, but let's say that there is a differential between Medicare Advantage and traditional Medicare in terms of [inaudible] code.

Well, one way to address that is to estimate the risk adjustment model on Medicare Advantage data itself, which by the way was the original intent back in the day, you know, if you go back to sort of the early two thousands and before, the intent had been to estimate the model on encounter data, but that didn't happen for a variety of reasons. But anyway, we're at a point where CMS has been collecting

these data for a number of years. They could use those data, estimate the model that would, by its very nature because it's based on Medicare Advantage claims, Medicare Advantage enrollees, you would no longer have an issue of, you know, does Medicare advantage code more than fee-for-service? Because we built into the model.

And I do hope that CMS starts to think about this a bit more, particularly as more enrollees are, are in Medicare advantage than traditional Medicare. In some parts of the country, it's well over 60%. And so from that perspective, I feel as if there's a problem that we'll always have where the coding is different between traditional Medicare and Medicare Advantage. It's built into the model that could be creating some issues that we're talking about here and there are ways to address it, but I don't hear a lot from CMS or even MedPAC about sort of a pathway to get to that encounter data-based model, which could be one way to address the coding differential problem.

**Larry Levitt:** So, and you Tom actually hit, we had a question from the audience that just came in about this exact question. So you, so you think that encounter based approach to estimating the model would address the coding intensity?

**Tom Kornfield:** I think it would certainly address differentials between Medicare Advantage and traditional Medicare because you would no longer have traditional Medicare as a basis on which you would estimate the model.

**Richard Kronick:** Larry can I [inaudible]?

**Larry Levitt:** Yeah, please, Rick.

**Richard Kronick:** I can jump in. First, you know, Tom's answer to your first question of why is there differential coding? I agree with that answer completely. There are differences in incentives. You know, in fee-for-service, if you look at a group of people who are coded with quadriplegia in a given 12 month period, 40% of them don't have quadriplegia show up on any claim in the next 12 months. They probably still mostly have quadriplegia, tends not to be cured, but there's no reason for the physician to write down quadriplegia. The patient comes for urinary tract infection or pneumonia, and UTI or pneumonia gets coded. In MA, there's a big incentive to write down quadriplegia as a contributing cause. And those differences in incentives is what drives the 20% difference in risk scores that we see between MA and fee-for service.

And Tom, I still hope someday you'll address that. I've sent in the chat, the work that that has led to that, which I think I've shared with you in prior times. But, to Tom's point about the value of estimating a model using the encounter data, I agree that it would probably be better in principle to have a model estimated with encounter data. There are many problems in getting there, but they are probably likely can be overcome, but that would not solve this differential coding problem because there still would be the need to figure out if the benchmark in, a county is \$12,000, is that benchmark for a person with a risk score of 1.0 or is it for a person with a risk score of 0.8?

Because we're still gonna see that, you know, the risk scores for the MA beneficiaries are close to 20% higher than the risk scores for fee-for-service beneficiaries. So there'll still be a need to calibrate MA to fee-for-service. Now, if the industry, if you in the industry, were happy to say, hey, if the benchmark is \$12,000 that that's, you know, for a 1.0 person, then sure. I think you're exactly right. Estimating a

model based on the counter data would solve this problem. I kind of doubt the industry is going to take that position. There's still gonna be the need to, how do you deal with the differential coding problem?

**Larry Levitt:** So we may be getting wonkier than is [inaudible], but Tom, I just wanted give you a chance to respond to that.

**Tom Kornfield:** Yeah, I think there are aspects of this that would need to be worked out. I agree with Rick, that there's a path and there are pieces and you know, the issue about how the rates are calculated at the county level and that those are fee-for-service costs and how you appropriately adjust for that and account for that. I think that's a piece to be measured, but I do, you know, again, I do worry that, you know, an encounter database model no longer has this issue of, you know, MA codes vascular disease more so that's problem so we're going to get rid of it, which is basically what they're doing with this new model. There's an entire HTC that's being dropped or practically. Yes, Rick, I mean, 2000 plus codes are being dropped.

So again, what I would say is if, if the purpose of risk adjustment is to pay based on health status based on expected healthcare costs and you have a model that's paying less, considerably less, for your sickest enrollees, I see that as problematic. An MA encounter database model would start to get at some of, you know, get at looking at what, you know, what the actual relative differences are in MA and then if there are issues around, you know, differences with fee-for-service, that's something I agree that could be addressed, you know, through the rate book in some fashion. But I just think that using model changes, and by the way, MedPAC years ago had said that they didn't agree with making these kinds of changes to the model. If you look, I think it's their 2015 or 2014 comments on the model changes that Rick had described. They've changed their tune more recently, but back then they had said that they didn't believe that that making changes to the HTCs was the appropriate way to address coding intensity.

**Jeannie Fuglesten Biniek:** I think I would add there are other options outside of using Medicare Advantage encounter data that could potentially improve the risk score model. So using two years of data, not using codes that are collected as part of home visits or as part of chart reviews. So those are other things that are done that are short of, you know, changing and using Medicare Advantage encounter data.

**Tom Kornfield:** Tiers of data doesn't make things better, it makes it worse. And MedPAC's done analysis showed that it makes it, it's less accurate.

**Jeannie Fuglesten Biniek:** They recommend actually doing that.

**Tom Kornfield:** I know they recommend doing it, but their analysis shows, if you look at their analysis, it shows that people with the sickest enrollees, the predictive ratios are less, meaning that it's less accurate than the one year model. They then said that they believed it was appropriate because of an appropriate adjustment because of concerns around coding. But from a model accuracy perspective, it was not shown to be better.

**Jeannie Fuglesten Biniek:** So the, the other point I wanted to say was the 2000 codes, this is coming from switching from ICD 9 to ICD 10, so we're vastly increasing the universe of codes that are there. And then you're taking 2000 out. So...

**Tom Kornfield:** No, it's already been [inaudible].

**Jeannie Fuglesten Biniek:** It's not that it's not a lot of codes, but there's some context there that I think is important to keep in mind.

**Tom Kornfield:** I think that's an inaccurate statement. I think CMS, they, it's not like they went from ICD 9 to ICD 10 all of a sudden. They had been mapping ICD 9 codes to ICD 10 codes which they had been using in the model. So when I say the 2000 codes, I'm talking about the ICD 10 codes that are in use for the model in 2023.

**Jeannie Fuglesten Biniek:** But it's still. Those are way more precise.

**Tom Kornfield:** There also is a model that they develop, by the way, there's, they have the V 28 model, which is the one that they're doing today versus the V 24 model. So there's several versions that they developed but didn't share with the public. There's a V 27 model that they produced risk scores on that didn't have all these coding changes. They provided that information to the plans, from what I understand, cause it was an HPMS memo. So I don't think it's completely accurate to say yes, ICD 9, ICD 10 are different, however, they had already taken a step of mapping the ICD 9 codes to the ICD 10 codes and then mapping those to the HCCs. And then 2000 codes are being removed from the set of codes that they had being used for payment for 2023.

**Richard Kronick:** And what CMS has written in frequently asked questions document is that much of the reason that codes were excluded is because they were not predictive of spending. [inaudible] It is what they said. [inaudible]

**Tom Kornfield:** No it is not. I have the rate notice right here. Can I read it to you?

**Richard Kronick:** I was reading from the frequently asked questions document, Tom.

**Tom Kornfield:** But, I'm talking about the rate notice and what they did in the rate notice.

**Richard Kronick:** And then they subsequently tried to clarify in the FAQ document [inaudible].

**Tom Kornfield:** But the rate notice is what people have an opportunity to respond to, not an FAQ document. So from the rate notice, they said they were looking at codes that were coded in MA versus fee-for-service. Rick, you yourselves talked about vascular disease being coded more. That was one of the ones that was targeted and it was targeted for that reason. It seems fairly clear.

**Richard Kronick:** In the rate notice, what they say is they are excluding angina pectoris and two other HTCs entirely for the reasons of disproportionate coding. But that the other, many of the other changes they made or attempts to simply improve the predictive ability of the model just as when the model was first developed. You know, there are thousands and thousands of ICD 9 codes that were not included in the payment model because they weren't predictive of spending. And CMS is now doing the similar kind of work with the ICD 10 codes.

**Tom Kornfield:** There is literally a sentence in here [inaudible].

**Richard Kronick:** Larry, you may want to [inaudible].

**Larry Levitt:** I'm gonna stop you all here cause we've gone down a risk adjustment rabbit hole, <laugh>, and are also [inaudible].

**Tom Kornfield:** Bottom of page 47 meters. Please look at it in the rate notice it, it says what I'm saying here.

**Larry Levitt:** Thanks, Tom. And we're also over time now, but I think this met expectations of a wonky discussion of Medicare Advantage and, and spirited - I appreciate that. So just one final question for each of you. And just, you know, really quick and starting with Tom, what would you recommend be done to you know, in this payment notice for this next year? What are the changes that you think should be made?

**Tom Kornfield:** Well, I think from the perspective of least disruption to beneficiaries, which is kind of what I'm going by, I believe that the model should implement, the model implementation should be delayed. I know others [inaudible] differently, notably Rick. But that would be what I would say. I also think there's a real need to, for CMS to start a true conversation around what an encounter data based model could be. How that could, you know, what that could look like, how that could interact with the rate book to deal with some of the issues that Rick mentioned. I think t's problematic to develop this kind of a, a change to the model and then only give plans a, you know, a short window to respond. Of course that that's me saying what I think could happen or should happen from the perspective of least disruption to the beneficiaries. So I just want to caveat that.

**Larry Levitt:** And Rick, how about you? What do you think should happen in this next year's payment?

**Richard Kronick:** I think CMS should finalize the changes that they proposed. I don't think that they are particularly large changes to the model, relatively small effect on payment 3% when the overpayment is at least 15% and probably greater. Too late to do now because it was not in the proposal, but the point that Jeannie made echoing recommendations for MedPAC, I do think in the future that CMS should exclude diagnoses from home-based health risk assessments and from chart reviews, which would help solve a part of the problem and make the payment system much fairer by affecting the plans that have done the most to code and not having so much effect on plans that have done relatively little coding.

**Larry Levitt:** So we at KFF don't make recommendations, so I won't ask Jeannie the same.

**Jeannie Fuglesten Biniek:** Oh, I was gonna add something though if you came that opportunity. So I think sort of at the heart of all of this is a question of whether we're overpaying Medicare Advantage plans. And I think that's a really hard question to answer because we don't have good information on how beneficiaries experience compares in Medicare advantage versus traditional Medicare. And so I wanted to take a step back and point that out because I think that really at the end of the day informs what we think of a lot of these changes and what the impact is on federal spending.

**Larry Levitt:** Terrific. Well, Tom, Rick, Jeannie, I wanna thank you for a great and wonky discussion. And thank the audience for participating and great questions. We got to only a fraction of them, so we may have to return to this discussion again. So as I said, this is being recorded and should be available later today. And please join us for the next wonk shop as well. Thank you all.

*KFF transcripts are created on a rush deadline. This text may not be in its final form and may be updated or revised in the future. Accuracy and availability may vary. The authoritative record of KFF programming is the video recording.*