Federal government turns to fresher data to rein in Medicare Advantage upcoding

The data implies insurers code a lot of chronic diseases, but patients don't get follow-up care

By Bob Herman – STAT News
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The health insurance industry was caught off guard by the federal government's recent proposal to keep next year's payments to Medicare Advantage plans mostly flat, and to change a controversial coding practice. But another equally significant change has flown under the radar — and is a major reason why some insurers may face big hits to revenue.

The Centers for Medicare and Medicaid Services is proposing to use newer data when paying Medicare Advantage plans in 2027. And that data implies people with chronic health problems are not seeing their doctors nearly as much as their health profiles suggest they should.

As a result, CMS is ratcheting down payments to Medicare Advantage plans for enrollees who have common chronic diseases, such as diabetes, morbid obesity, and lung disease, a STAT analysis shows. The agency also is reducing payments tied to enrollees' ages and slashing add-on payments that plans receive if people have five or more diseases. Overall, Medicare is proposing to decrease payments for two-thirds of codes for the typical Medicare Advantage enrollee, STAT's analysis found.

Jason Jobes, a senior vice president at Norwood Solutions, a consulting firm that helps hospitals and health plans with their coding, said these "reweightings" indicate that actual spending among Medicare patients for those conditions is lower than what Medicare Advantage plans are getting paid to manage them. This could especially be the case if insurers

are submitting diagnosis codes from home visits, which do not always lead to follow-up care.

Medicare's proposal to use up-to-date data would better reflect actual spending patterns, but it could also raise pressure for insurers and providers to dig more for every condition that patients may have.

"If you thought you were doing a good job at capturing this 90% of the time, you probably have to make up for it by capturing it 95% of the time," Jobes said. "It increases your emphasis of getting this right every patient, every time."

The news isn't all grim for insurers: Medicare Advantage plans would receive a lot more money for people who have other conditions, including pressure ulcers and other skin problems. But experts warn this could lead to unnecessarily high payments to insurers, as federal investigators have found widespread improper spending on skin substitutes by providers.

Medicare Advantage insurers would still get an estimated $17 billion more next year than they are getting this year, which would result in roughly $650 billion in total funding — a little less than Walmart's annual revenue. But this shift is another example of the government cracking down on how insurers overuse diagnosis codes, especially in cases where people may not be getting much, or any, care for those conditions.

"CMS is no longer rewarding for that diagnosis capture and grab," said Melissa James, a risk adjustment consultant at Wolters Kluwer. "It has to mean something."

These changes are part of the Medicare Advantage risk adjustment system. Health insurers calculate "risk scores" for their members. These scores are a proxy for how sick someone is and are supposed to reflect the costs of their expected care. Someone's age, whether they live at home, the number of health conditions they have, and other factors all get rolled up into the number.

The goal of this system is to compensate insurers for covering people who may require a lot of care — and to prevent insurers from avoiding

sick patients completely. Insurers are paid prospectively, based on past data, and not based on how much care each individual actually gets. This arrangement has led to longtime allegations and settlements related to fraudulent or inappropriate behavior.

Each disease and demographic detail carries a different weight. Someone who has hemophilia or brain cancer will have a much higher risk score than someone who has diabetes because those conditions require a lot more treatment. Older Medicare enrollees, and those who live in nursing homes, also carry bigger weights because they are expected to need more care.

The more conditions someone has, the more money they bring in for an insurance company. For example, a 67-year-old woman who has no major health conditions would result in $4,000 for the Medicare Advantage plan in 2027. But a 76-year-old man who has diabetes, multiple sclerosis, depression, and ulcerative colitis would fetch almost $23,000. The baseline Medicare Advantage enrollee is worth about $12,900 annually. Overall, health insurers spend the majority of this money on patients' medical care.

STAT analyzed the proposed weights of all the disease categories and demographic data that go into Medicare Advantage members' risk scores. These values are based on 2023 spending data — which Lucretia Hydell and Jackson Hall, actuaries at Wakely, said is more pertinent and accurate to today — whereas the current risk adjustment system is based on 2018 spending data.

STAT's analysis focused on people who are older than 65 and do not qualify for Medicaid, which represents roughly 70% of the Medicare Advantage population.

Medicare is proposing to lower payments for 98 of the 150 codes and variables that factor into someone's risk score, the analysis shows. The largest cut is a 78% decrease for people who have pancreas transplant status. The code for stage three chronic kidney disease would go down by 50%. Drug and alcohol use disorders would get paid anywhere from 24% to 47% less.

Almost all age ranges would be cut. CMS also is decreasing the weights of "interaction" variables. For example, if a Medicare Advantage enrollee has heart failure and chronic kidney disease, insurers get an extra bump solely because the enrollee has both of those conditions. The extra payment for someone who has both heart failure and kidney disease would be cut by more than 53%, according to the analysis.

The cuts that will have a greater impact involve codes for chronic diseases, which are more prevalent. Payments will be lower for morbid obesity (19%), chronic obstructive pulmonary disease (19%), rheumatoid arthritis (17%), depression (14%), heart failure (11%), and diabetes (7%), among others, STAT's analysis shows.

A minority of risk score codes would get pay bumps. CMS is planning to more than double payments to Medicare Advantage plans that insure people with myasthenia gravis, an autoimmune disorder. Spending on the drug that treats the condition, Vyvgart, has gone up precipitously since it was approved in late 2021 and is expected to reach $6 billion this year. James of Wolters Kluwer said it makes sense to pay more for complex conditions, especially if the costs of treating those patients are going up.

The more important pay hikes would go toward codes that cover pressure ulcers. Payments for those conditions would increase between 15% and 77%, depending on the severity, according to the analysis.

HHS' Office of Inspector General has flagged spending on "skin substitutes," which treat pressure ulcers, as potentially fraudulent. CMS has already slashed reimbursement on skin substitutes starting this year in response. But that data has not made its way into Medicare Advantage risk adjustment, which is raising concerns.

"I think that's the next gaming of the system," Jobes said of the pressure ulcer codes. "The organizations that have succeeded in Medicare Advantage by risk score maximization — by playing the game — know the rules better than anybody else."

Medicare has the power to remove anomalous spending patterns from Medicare Advantage payments. For 2027, it proposed pulling out

spending for questionable billing of urinary catheters from its data, but does not appear to have done so for skin substitutes.

Insurers that cover people who qualify for both Medicare and Medicaid, known as dual eligibles, will not be hurt as much by the proposal — and in fact are in line for bigger payments for many health conditions. Analysts at the investment research firm Capstone found that two-thirds of medical codes for dual eligibles had “less punitive” adjustments than there are for traditional Medicare Advantage enrollees.

For example, while Medicare is cutting payment for diabetes codes by 7% for traditional Medicare Advantage members, diabetes codes for dual eligibles would go up 13%, according to Capstone.