Medicare Advantage coding intensity during the first year of the V28 risk model implementation

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BACKGROUND

Medicare Advantage (MA) plans are paid a capitated amount that is risk adjusted to reflect beneficiary expected spending. Many studies have found that payments to MA plans are higher than they otherwise would be due to higher diagnostic coding intensity, and that coding intensity varies meaningfully across MA organizations (MAOs).

The V28 risk model aims to reduce differences in MA and Medicare fee-for-service (FFS) diagnostic coding by removing conditions or constraining condition coefficients. The model was introduced in 2024 and is fully phased in for 2026 payments.

RESEARCH OBJECTIVE

We analyze risk scores from 2024 to estimate diagnostic coding intensity in the MA program under the V28 risk model relative to the prior V24 risk model. We assess whether the V28 risk model has a greater effect on coding intensity for MAOs with higher coding intensity under V24.

We present a preliminary analysis of how diagnosis codes excluded or included in the V28 model affect overall diagnostic coding rates.

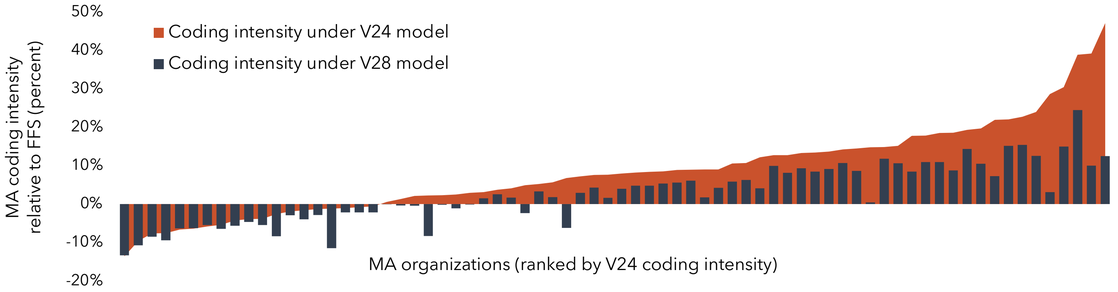
METHODS

We used MedPAC's demographic estimate of coding intensity (DECI) method to estimate how much 2024 risk scores differ between the MA and FFS populations after adjusting for differences in age, sex, Medicaid eligibility, and institutional status. We compared DECI estimates for V24 and V28 risk scores overall and by MAO, ranking organizations by their V24 coding intensity.

We derived 2024 risk scores from 2023 MA encounter and FFS claims data, allowing us to identify the diagnostic codes used to support each condition in the V24 and V28 risk models. We then assessed which conditions were most affected by excluded diagnosis codes and which conditions continue to contribute to coding differences under the V28 model.

PRINCIPAL FINDINGS

Lower coding intensity under V28, larger effects for MAOs with higher V24 coding intensity[1]



V28 effect was larger for MAOs with higher V24 coding intensity[1]

V24 coding intensity level	Share of enrollee years among MAOs	Average difference in coding intensity (V28 – V24 estimate)
<–10%	0.2%	0.3%
–10 to 0%	4.8	–1.6
0 to 5%	9.1	–7.9
5 to 10%	4.2	–5.0
10 to 15%	19.3	–5.5
15 to 20%	30.8	–8.5
20 to 25%	20.0	–11.5
>25%	1.5	–23.3

V28 removed some diagnoses contributing to MA and FFS coding differences[2]

Among the 10 conditions contributing the most to MA and FFS coding intensity differences under the V24 model:

- Diagnosis codes excluded from the V28 model reduced total differences in coding rates by 30% primarily affecting: vascular disease, mental health, hematological disorders, and immunity disorders. 14 excluded diagnosis codes accounted for 23% of total coding rate differences.
- Of the diagnosis codes included in the V28 model, 70% of total differences in coding rates remain, primarily affecting: diabetes, congestive heart failure, chronic obstructive pulmonary disorder, and morbid obesity. 29 included diagnosis codes accounted for 52% of total coding rate differences.

Note: [1]MA (Medicare Advantage), MAO (MA organization), FFS (fee-for-service). Analysis of MA organizations compares coding intensity for V24 and V28 risk scores and does not reflect the blending of the two risk models used to pay MA plans in 2024. Coding intensity estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico, enrolled in a chronic-condition special-needs plan, or with end-stage renal disease (ESRD) are excluded from the analysis, as well as organizations with fewer than 25,000 enrollees.
[2]Analysis of international classification of diseases, 10th revision (ICD–10) diagnosis codes for condition groups with the largest differences in MA and FFS coding rates (accounting for age, sex, and Medicaid status), excludes enrollees with institutional status or with ESRD. Coding differences by ICD–10 code account for MA and FFS enrollment, but not demographic differences.

Source: MedPAC analysis of CMS enrollment (2023, 2024), risk score (2024), FFS claims (2023), and MA encounter data (2023) files.

CONCLUSIONS

In the first year of implementation, the V28 risk model reduced estimated overall coding intensity and differences in coding intensity across MAOs. In 2024, MA risk scores were 18% higher than scores for similar FFS beneficiaries under the V24 model and 9% higher under the V28 model, a difference of 8.8 percentage points. MAOs with higher V24 coding intensity generally had a larger V28 effect than organizations with lower V24 coding intensity.

The V28 model excludes some diagnoses that contributed to MA and FFS coding differences. A small number of diagnosis codes continues to drive a large share of total coding differences.

IMPLICATIONS FOR POLICY AND PRACTICE

Our estimates suggest that V28 is having the intended effect of reducing the impact of differences in MA and FFS diagnosis coding on payments. MA payments in 2024 were adjusted using a blend of two-thirds V24 and one-third V28 risk models. We estimate that payments to MA plans in 2024 would have been $10 billion higher if payment was based solely on the V24 risk model. At the same time, average MA plan rebates remain stable, and enrollment continues to grow.

LIMITATIONS

Coding intensity under the V28 model may differ in future years as MA organizations adapt to the new risk model. The DECI method attributes higher demographic-adjusted MA risk scores relative to FFS to higher MA coding intensity rather than worse health acuity or complexity among MA enrollees than FFS beneficiaries.

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REFERENCES

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