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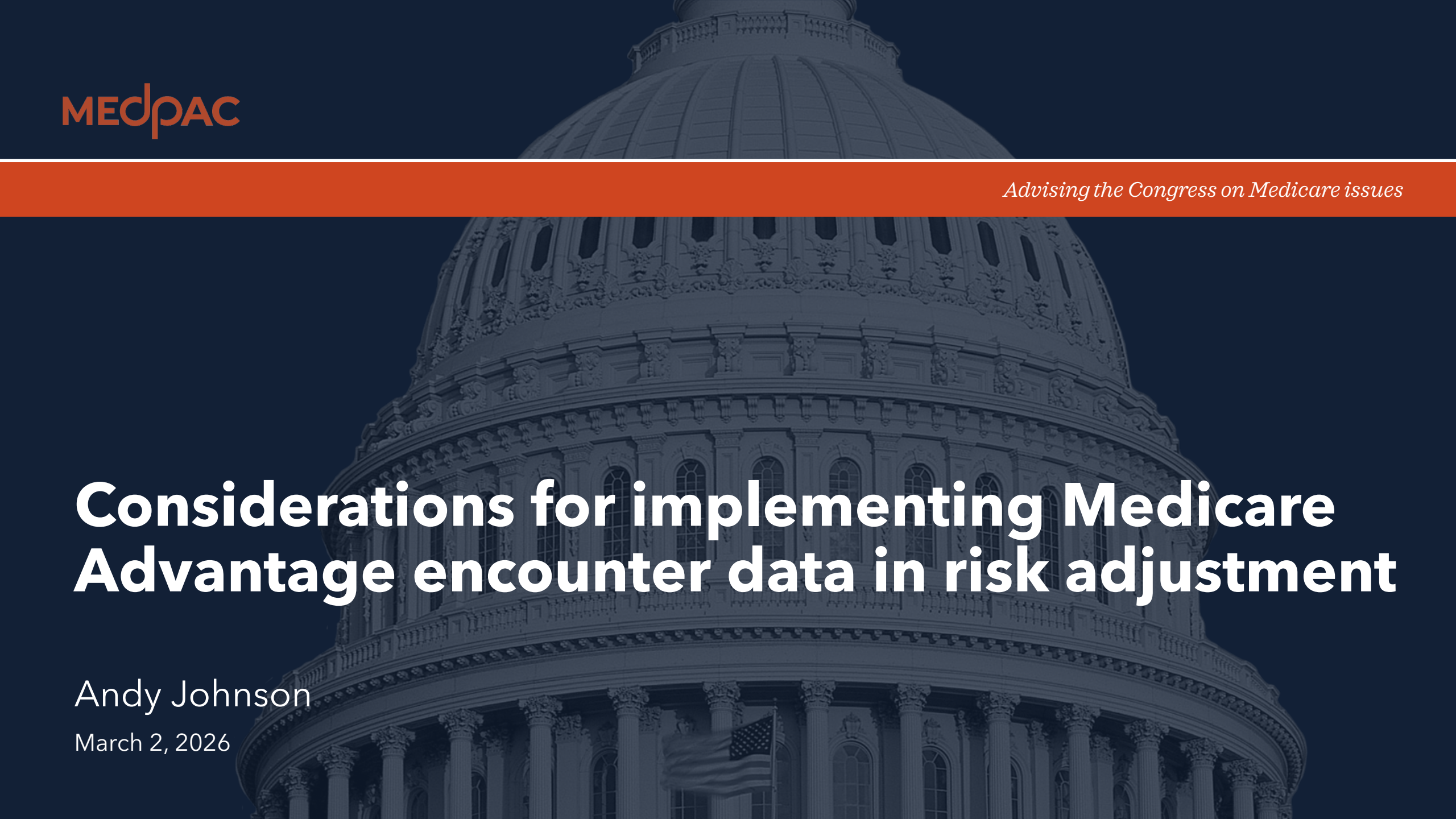

Considerations for implementing Medicare Advantage encounter data in risk adjustment

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Presentation roadmap

1. How risk adjustment affects payments to MA plans
2. Calibrating a risk-adjustment model and technical considerations
3. Key policy decisions for implementing an MA-based risk model
4. Potential implications of key policy decisions
5. Discussion

CMS: MA encounter-based model could better align with MA costs and care patterns

- Statute* requires an adjustment for coding pattern differences until risk adjustment uses "Medicare Advantage diagnostic, cost, and use data"
- MedPAC discussed implementation challenges for an MA-based risk model (MedPAC 2016)
- CMS has been developing an MA-based risk model (CMS 2024)
  - Reports that stakeholders generally support moving to an MA-based risk-adjustment model
- CMS announced that the agency could start phasing in an MA-based risk model as early as 2027 (CMS 2025)
  - An MA-based model was not proposed for the 2027 payment year

Notes: FFS (fee-for-service), MA (Medicare Advantage). * SSA section 1853(a)(1)(c)(ii)(IV)

Sources: Medicare Payment Advisory Commission. 2016. Using encounter data for risk adjustment in Medicare Advantage: https://www.medpac.gov/wp-content/uploads/2016/04/MA-Encounter-Apr-2016-Public.pdf

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Discuss important issues that could arise if implementing MA encounter data in risk adjustment

- The Commission has not taken a position on using MA encounter data for calibrating a risk model
- We are not planning a chapter in 2026, but we could return to the topic in the future depending on commissioner interest

Note: MA (Medicare Advantage).

How risk adjustment affects payments to MA plans

Medicare's payments to MA plans are risk adjusted to account for expected medical spending

- Payments to MA plans are based on a bid relative to a county-level benchmark, plus a rebate*
  - A bid is the amount each plan expects it will cost to cover Part A and B services
  - Benchmarks are based on CMS projections of FFS spending that are standardized to reflect a beneficiary with average medical spending
  - The rebate is a percentage of the difference between the bid and benchmark

Payment to plan = Plan bid + {[(Plan risk score × Standard Benchmark) – Plan bid] × Rebate percentage}

- Risk scores affect MA payments in two ways
  - Increase or decrease an MA plan's benchmark to determine rebate amount
  - Standardize FFS spending estimates used for benchmarks

Note: MA (Medicare Advantage). FFS (fee-for-service).
* If bid is greater than the benchmark, Medicare pays the benchmark, and the enrollee pays a premium to make up the difference. However, this scenario is rare.

Illustrative example of payment to an MA plan for a single county

MA plan data (illustrative)			
Plan bid (PMPM)	$900	Plan risk score	**1.100**
Plan risk score after 5.9% coding adjustment			**1.035**

FFS data for a county (illustrative)			
Average spending	$1,000	Average risk score	**1.000**
Standard benchmark* ($1,000 / **1.000**) =		**$1,000**	

Payment to plan = Plan bid + {[(Plan risk score × Standard Benchmark) – Plan bid] × Rebate percentage}

Payment to plan = $900 + {[(1.035 × $1,000) – $900] × 65% }

Payment to plan = $900 (base payment) + $88 (rebate amount) = $988 total payment

Notes: MA (Medicare Advantage). FFS (fee-for-service). PMPM (per member per month).
*Illustrative example is for a county in a 100% benchmark quartile and for a plan with 3.5-star rating, which does not provide the plan with a quality bonus increase to the plan benchmark and provides the plan with a rebate percentage of 65%.

Medicare's current risk-adjustment model is estimated using FFS claims data

- Risk scores are a beneficiary-specific index of expected spending relative to national average FFS spending (a 1.0 risk score)
  - Based on demographic characteristics and diagnoses
- The current risk-adjustment model is developed using spending and diagnostic data for FFS beneficiaries
  - Risk scores reflect relationships between diagnostic coding patterns and spending in FFS

Note: MA (Medicare Advantage). FFS (fee-for-service).

Issues with relying on FFS data for Medicare's payments to MA plans

- Risk scores reflect the relative costs of health conditions for the FFS population, generating two payment accuracy issues
  - Higher MA coding intensity
  - Favorable selection of beneficiaries into MA plans
- Both of these issues increase payments to MA plans relative to what FFS would have spent for the same beneficiaries

Note: MA (Medicare Advantage). FFS (fee-for-service).

Issues with relying on FFS data for Medicare's payments to MA plans: Coding intensity

- Diagnoses are not coded with the same frequency in MA and FFS
  - Higher MA coding intensity leads to higher average payments to MA plans; advantages plans that code more than plans coding less

Note: MA (Medicare Advantage). FFS (fee-for-service).

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Issues with relying on FFS data for Medicare's payments to MA plans: Favorable selection

- Risk scores do not reflect spending for MA enrollees as accurately as they do for FFS beneficiaries (on average)
  - Risk scores systematically overpredict spending for MA enrollees, leading to higher average payments to MA plans relative to FFS spending
  - FFS spending used for benchmarks allows for favorable selection to affect payments to MA plans

Note: MA (Medicare Advantage). FFS (fee-for-service).

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Pelech, D., R. Ding, J. Guo, et al. 2025. Favorable selection among dually enrolled beneficiaries in private Medicare plans. *Health Affairs* 44, no. 10 (October): 1256–1265.
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Calibrating a risk-adjustment model and technical considerations

Risk-adjustment models are developed from a beneficiary-level regression

- Models the association between
  - Outcome variable: Annual spending for Medicare services
  - Explanatory variables: Medical conditions (groups of diagnoses) and demographic characteristics
- The regression outputs are coefficients (β's), one for each explanatory variable

Annual spending = β_m × (medical conditions) + β_d × (demographic characteristics)

- Dollar-based coefficients are converted to risk score units by dividing by average annual spending (outcome variable)
  - Establishes a risk score of 1.0 for a beneficiary with average annual spending

β_m for HCC38 = $1,727 / $10,402 national average = 0.166 risk score coefficient

  - A beneficiary coded with HCC 38 is expected to have spending associated with that condition equal to 16.6% of national average spending

Note: FFS (fee-for-service), MA (Medicare Advantage), HCC (Hierarchical condition category). HCC 38 represents Diabetes with Glycemic, Unspecified, or No Complications.

MA-based model would be calibrated using spending and diagnostic information from encounter data

Data	Current FFS-based model	MA-based model
Beneficiary annual spending	FFS claims	MA encounters
Medical conditions (diagnoses)	FFS claims	MA encounters
Demographic characteristics	Medicare enrollment data for FFS beneficiaries	Medicare enrollment data for MA enrollees
	⬇	⬇
Reflects relationship between	FFS population spending and medical conditions / demographic characteristics	MA population spending and medical conditions / demographic characteristics
Coefficients may differ	β_m for HCC38 = 0.166	β 's may be higher or lower than 0.166

- Coefficients could change for a variety of reasons, including differences in efficiency of providing care in MA and FFS or differences in the average severity of disease among beneficiaries coded with a condition

Note: FFS (fee-for-service), MA (Medicare Advantage).

Technical considerations: Calculating MA enrollee spending for calibrating an MA-based risk model

- Would payments or standardized prices be used to calculate beneficiary annual spending from encounter data?
  - Plans report payments to providers made on a fee-for-service basis, but do not report capitated payment amounts
  - CMS could apply standardized FFS prices to encounter data
- Does incompleteness of MA encounter data meaningfully affect model accuracy?
  - Would an adjustment to encounter data be needed to address missing encounters
- Should encounters for denied claims or out-of-network care be excluded when calculating spending?

Note: FFS (fee-for-service), MA (Medicare Advantage). This slide represents only some possible considerations for calculating annual MA enrollee spending.

Key policy decisions

Three key policy decisions for implementing an MA-based risk model when using FFS-based benchmarks

- How would any coding intensity differences be addressed under an MA-based risk model?
- Would a single MA-based risk model also be used to standardize FFS spending for benchmarks?
  - Or would a separate FFS-based risk model continue to be used for standardizing FFS spending for benchmarks?
- If using separate MA and FFS risk models, would additional normalization factors be used to account for differences between the two populations?

Note: FFS (fee-for-service), MA (Medicare Advantage).

How would any coding intensity differences be addressed under an MA-based risk model?

- CMS currently reduces MA risk scores by 5.9% to account for coding pattern differences
  - MedPAC has found this adjustment to be insufficient; in 2026, MA risk scores after adjustment are projected to be 4% higher than for similar FFS beneficiaries
- Under some ways of implementing an MA-based model, coding intensity would still affect payments to MA plans
  - CMS indicated they do not intend to apply an adjustment under encounter-based model (CMS 2024)
- Policymakers could contemplate approaches to address effects of any coding differences under an MA-based risk model

Note: FFS (fee-for-service), MA (Medicare Advantage).
Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Report to Congress: Risk adjustment in Medicare Advantage. Baltimore, MD: CMS. https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2024.pdf

Would a single MA-based risk model also be used to standardize FFS spending for benchmarks?

- Risk scores affect MA payments in two ways
  - MA risk scores adjust benchmarks to determine rebate amounts
  - FFS risk scores standardize the FFS spending estimates used for benchmarks
- FFS spending estimates for MA benchmarks are standardized using FFS beneficiary risk scores; could be derived from either
  - The same MA-based risk model used for MA enrollees (single model)
  - A separate FFS-based risk model used only for FFS beneficiaries (separate models)

Note: FFS (fee-for-service), MA (Medicare Advantage).

Would additional normalization factors be used to account for differences between the two populations?

- If using separate MA and FFS risk models, risk scores produced by the two models could reflect different levels of absolute spending risk
  - May need to consider how to align MA and FFS risk models in a way that reflects population differences
  - Setting average MA and FFS risk scores to be equal would eliminate population-based differences in MA and FFS spending
- Normalizing the MA and FFS populations separately for sub-populations could account for some differences
  - Risk scores could be separately normalized for different demographic groups, for example by Medicaid eligibility or institutional status

Note: FFS (fee-for-service), MA (Medicare Advantage).

Illustrating the implications of key policy decisions

Illustrative scenarios partially or fully delinking MA payments from FFS data

- Partial delinking would use an MA-based risk model with benchmarks based on FFS spending
  - Scenario 1 uses an MA-based risk model for all Medicare beneficiaries
  - Scenario 2 uses separate MA-based and FFS-based risk models
- Full delinking would use an MA-based risk model with base payment that does not rely on FFS data
  - Scenario 3 uses an MA-based risk model with MA spending-based benchmarks
- For each scenario, assess whether coding intensity, inaccuracy due to population differences, or favorable selection could affect payments to MA plans

Illustrative scenarios for applying an MA-based risk model with FFS-based benchmarks (partial delinking)

Policy decisions	Current policy	Scenario 1	Scenario 2
Source of spending data for benchmarks	*FFS-based*	*FFS-based*	*FFS-based*
Risk model to standardize benchmarks	*FFS-based*	*MA-based*	*FFS-based*
Risk model to calculate MA enrollee risk scores	*FFS-based*	*MA-based*	*MA-based*

- Benchmarks continue to be based on FFS spending data
- A wide range of policies are possible; these two scenarios highlight the range of implications for applying an MA-based risk model

Note: FFS (fee-for-service), MA (Medicare Advantage).

Scenario 1: MA and FFS risk scores are calculated from an MA-based risk model

MA plan (illustrative)			
Plan bid (PMPM)	$900	Plan risk score	1.000
No coding adjustment applied to plan risk score			

FFS data for a county (illustrative)			
Average spending	$1,000	Average risk score	0.909
Standard benchmark* ($1,000 / 0.909) =		$1,100	

- Using an MA-based risk model that is normalized (1.0 risk score) to the average MA enrollee, both MA and FFS risk scores would be lower
  - Offsetting effects on risk-adjusted benchmark:

Current MA payment (FFS-based risk model) = $900 + [(1.035 × $1,000) - $900] × 65% = $998

Scenario 1 payment (MA-based risk model) = $900 + [(1.000 × $1,100) - $900] × 65% = $1,030

Notes: MA (Medicare Advantage). FFS (fee-for-service). PMPM (per member per month).
*Illustrative example is for a county in a 100% benchmark quartile and for a plan with 3.5-star rating, which does not provide the plan with a quality bonus increase to the plan benchmark and provides the plan with a rebate percentage of 65%. The only reason payment is higher under scenario 1 is because the coding adjustment (5.9% reduction to MA risk scores) is applied under current policy but is not applied under scenario 1.

Scenario 1: Using a single MA-based risk model, coding intensity would continue to affect average MA payments

- Effect on payments to MA plans is uncertain
  - Lower average MA risk scores could be offset by an increase to standardized benchmarks (caused by lower FFS risk scores in the denominator)
- Coding incentives for MA plans would remain, diagnoses would continue to be coded less frequently for FFS beneficiaries
  - Difference between MA and FFS risk scores remains, but size of difference may change depending on how the coefficients change under an MA-based model
  - If CMS no longer applies a coding adjustment to MA risk scores, differences in coding intensity would continue to affect risk scores and payments to MA plans
- Policymakers would still need to consider how to address differences in coding intensity

Note: FFS (fee-for-service), MA (Medicare Advantage).

Scenario 2: MA and FFS risk scores are calculated from separate MA-based and FFS-based risk models

MA plan data (illustrative)			
Plan bid (PMPM)	$900	Plan risk score	1.000
No coding adjustment applied to plan risk score			

FFS data for a county (illustrative)			
Average spending	$1,000	Average risk score	1.00
Standard benchmark* ($1,000 / 1.000) =		$1,000	

- Separate MA-based and FFS-based risk models would be separately normalized (1.0 risk score) to the average of their own population
  - Risk-adjusted benchmark is lower:

Current MA payment (FFS-based risk model) = $900 + [(1.035 × $1,000) – $900] × 65% = $988

Scenario 2 payment (Separate risk models) = $900 + [(1.000 × $1,000) – $900] × 65% = $965

Notes: MA (Medicare Advantage). FFS (fee-for-service). PMPM (per member per month).
*Illustrative example is for a county in a 100% benchmark quartile and for a plan with 3.5-star rating, which does not provide the plan with a quality bonus increase to the plan benchmark and provides the plan with a rebate percentage of 65%.

Scenario 2: Using separate risk models would eliminate the effect of coding intensity on average MA payments

- Overall differences in coding between MA and FFS would no longer affect MA payments, on average
- Variation in coding intensity within MA would still be an issue
  - Plans that code more intensively receive higher risk scores and greater payment than plans that code diagnoses less intensively

Note: FFS (fee-for-service), MA (Medicare Advantage).

Scenario 2: Using separate risk models could introduce a new source of inaccuracy in MA payments

- Using separate risk models implicitly assumes that the average risk of the MA population equals the average risk of the FFS population
  - However, a 1.0 MA risk score may not be equal to a 1.0 FFS risk score
  - Differences in age or true disease incidence between the MA and FFS populations would no longer affect average payments to MA plans
- If average risk differs between MA and FFS, average payments to MA plans could be higher or lower than intended

Note: FFS (fee-for-service), MA (Medicare Advantage).

Scenario 2: Using separate risk models presents a tradeoff for payment accuracy

- Available evidence suggests that inaccuracy due to equating average MA and FFS risk would be small in the short term
  - We estimate that very little of the difference in MA and FFS risk scores has been driven by factors other than coding intensity, such as population differences
  - Separately normalizing risk scores for different demographic groups (e.g., Medicaid eligibility or institutional status) could reduce the extent of any inaccuracy
  - Inaccuracy from using separate risk models may erode payment accuracy over time if MA and FFS populations become more different
- Tradeoff: Eliminating overall effects of higher MA coding intensity and potentially introducing inaccuracy from population differences

Note: FFS (fee-for-service), MA (Medicare Advantage).

An MA-based model with FFS benchmarks would not resolve all risk-adjustment issues

Policy decisions / Payment issues	Current policy	Scenario 1	Scenario 2
Source of spending data for benchmarks	*FFS-based*	*FFS-based*	*FFS-based*
Risk model to standardize benchmarks	*FFS-based*	*MA-based*	*FFS-based*
Risk model to calculate MA enrollee risk scores	*FFS-based*	*MA-based*	*MA-based*
Coding intensity affects MA payments	Yes	Yes	No
Inaccuracy due to equating MA and FFS populations	-	-	Potentially
Favorable selection affects MA payments	Yes	Yes	Potentially

- Scenario 1: Using a single MA-based risk model would not eliminate the effects of coding intensity, magnitude of effects may differ
- Scenario 2: Using separate MA-based and FFS-based risk models introduces tradeoff; eliminate effects of coding intensity but potentially introduce new source of payment inaccuracy
- Partially delinking MA payments from FFS data: inaccuracy due to population differences and favorable selection still have the potential to affect payments to MA plans

Note: FFS (fee-for-service), MA (Medicare Advantage).

Policymakers could also contemplate fully delinking MA payment from FFS data

- Fully delinking MA payments from FFS data: Using MA data to develop a risk model and a method for determining a base payment amount
- The Commission previously discussed options for reducing or removing FFS data from use in MA benchmarks (June 2023):
  - Replacing FFS spending estimates with combined MA and FFS spending estimates when calculating benchmarks
  - Competitive bidding to determine benchmark amount
  - Applying an administratively-set growth rate for benchmarks
- The Commission did not reach consensus on any of the three options, but raised concern about the continued use of FFS data for benchmarks

Note: FFS (fee-for-service), MA (Medicare Advantage).
Source: See Chapter 4: Medicare Payment Advisory Commission. June 2023. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

Scenario 3: Using MA-based risk model and benchmarks would fully delink MA payments from FFS data

- Illustrative scenario 3 retains the bid, benchmark, and rebate structure of the current MA payment system, except
  - Applies an MA-based risk model
  - Uses benchmarks based on MA spending
- Preserves the existing nature of competition among MA plans and incentives for plans to lower bids
  - Allow plans to offer more rebate-funded supplemental benefits

Note: FFS (fee-for-service), MA (Medicare Advantage).

Scenario 3: MA spending-based benchmarks can be calculated from existing MA data sources

- MA spending estimates could include amounts for medical spending, plan administration costs and profit, and rebate add-on for supplemental benefits
- Payments to MA plans could be higher or lower than current law depending on policy choices
  - E.g., how to account for plan administrative costs and profit and determine a rebate add-on amount

Note: FFS (fee-for-service), MA (Medicare Advantage).
Source: See Chapter 4: Medicare Payment Advisory Commission. June 2023. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC.

An MA-based risk model and benchmarks based on MA spending would fully delink MA payments from FFS data

Policy decisions / Payment issues	Current Policy	Scenario 1	Scenario 2	Scenario 3
Source of spending data for benchmarks	*FFS-based*	*FFS-based*	*FFS-based*	*MA-based*
Risk model to standardize benchmarks	*FFS-based*	*MA-based*	*FFS-based*	*MA-based*
Risk model to calculate MA enrollee risk scores	*FFS-based*	*MA-based*	*MA-based*	*MA-based*
Coding intensity affects MA payments	Yes	Yes	No	No
Inaccuracy due to equating MA and FFS populations	-	-	Potentially	-
Favorable selection affects MA payments	Yes	Yes	Potentially	No

- Scenario 3 tradeoff
  - Eliminate the effects of coding intensity and favorable selection
  - Introduce technical challenges to fully delinking MA payment system from FFS data

Source: Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system, Chapter 4*. Washington, DC: MedPAC.

Summary of encounter-based risk model approaches

- The current risk-adjustment system has issues affecting payment accuracy, including the effects of coding intensity and favorable selection
- Different ways of partially or fully delinking MA payments from FFS data have varied limitations and tradeoffs

Note: FFS (fee-for-service), MA (Medicare Advantage).

Discussion

- Questions about material
- Feedback

- We are not planning a chapter in 2026, but we could return to the topic in the future depending on commissioner interest

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