Medicare Advantage Risk Adjustment

Current Issues, Evolution & Policy Recommendations

WHITE PAPER FEBRUARY 2018

Medicare Advantage, also called Part C, is an option within Medicare that allows Medicare-eligible seniors and beneficiaries with disabilities to receive their benefits through a private plan of their choice, instead of receiving coverage through Traditional Fee-For-Service (FFS) Medicare. Medicare Advantage plans are approved and regulated by the Centers for Medicare & Medicaid Services (CMS). The Federal government, through CMS, pays Medicare Advantage plans a fixed (or capitated) monthly amount per enrolled beneficiary to provide Medicare inpatient and outpatient benefits. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called "risk adjustment" to adjust payments based on the health status of enrollees. An accurate, stable risk adjustment model is a critical tool for ensuring adequate resources to care for enrollees in the Medicare Advantage program.

CMS has modified the risk adjustment model over the past several years in efforts to improve payment accuracy. Changes to the model, as well as improvements to the process used to implement model changes, could help enhance the overall stability and functionality of the market. The proposals outlined in this brief to improve CMS' risk adjustment policies would better ensure accuracy, enhance predictability, and promote transparency for stakeholders.

THIS WHITE PAPER:

- **Describes the Medicare Advantage risk adjustment model**
- **Discusses the purpose of risk adjustment**
- **Reviews changes to the risk model over time**
- **Evaluates potential challenges associated with the model development process**
- **Provides suggested improvements for model design and process.**

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Model Background and Evolution

Purpose of Risk Adjustment

As described in a previous Better Medicare Alliance (BMA) brief, risk adjustment is an essential mechanism used across health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan.[1] Adequate risk adjustment helps to ensure that payments are sufficient to meet the anticipated costs of enrollees.

CMS risk-adjusts the capitated payments to Medicare Advantage plans based on an enrollee's "risk score" – a measure of the expected costs associated with a person's care. An enrollee with a risk score of 1.0 is expected to incur costs equal to those of the average Medicare beneficiary. An enrollee with a risk score of 2.0 is expected to cost twice as much as the average beneficiary, whereas an enrollee with a risk score of 0.5 is expected to cost 50% less than average (see Figure 1).

FIGURE 1: INDIVIDUAL RISK SCORES

Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. An accurate risk adjustment model ensures that payments to Medicare Advantage plans adequately compensate for the costs of treating and managing both high- and low-cost individuals.[2] An effective and stable Medicare Advantage program depends on a viable, accurate, and well-functioning risk adjustment system.

In addition to providing stability to the market, risk adjustment affects plan payment in three important ways:

- First, Medicare Advantage plans bid against FFS Medicare county benchmarks to determine payment. CMS adjusts benchmarks based on the average FFS Medicare risk score in the county. These adjusted benchmarks represent the maximum amount CMS will pay to an individual plan.
- Second, CMS uses the difference between the county benchmarks (described above) and the plan's bid to determine the level of rebates, which are used by plans to provide additional benefits to beneficiaries.
- Third, after a benchmark is set, CMS adjusts the payments to health plans on an individual level based on the risk score.

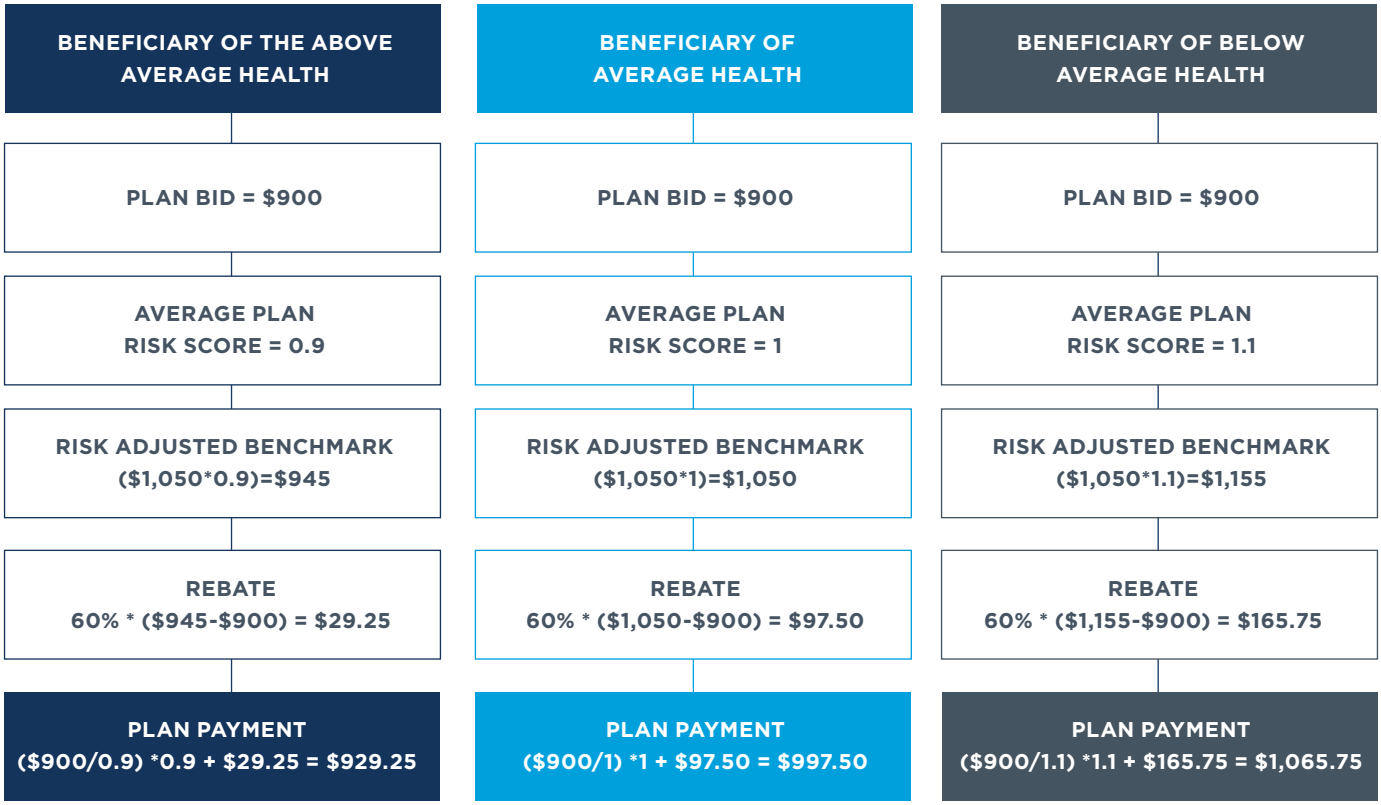
(See Figure 2) for an example of how risk scores affect plan payment.

Evolution of Risk Adjustment

The evolution of the current CMS risk adjustment model began in 1984 with the development of the Diagnostic Cost Group (DCG) models by researchers at Boston University and Brandeis in work sponsored by the Health Care Financing Administration (HCFA).[3] In the 1990s, research undertaken by HCFA identified that the demographic payment adjustment – based on age, gender, Medicaid, and institutional and working aged status – did not properly account for health care costs, resulting in overpayments to health plans. As a result, the Balanced Budget Act of 1997 required HCFA to risk-adjust payments to Medicare managed care plans beginning in 2000. HCFA evaluated various risk adjustment models and settled on DCG models to risk-adjust payments.[4]

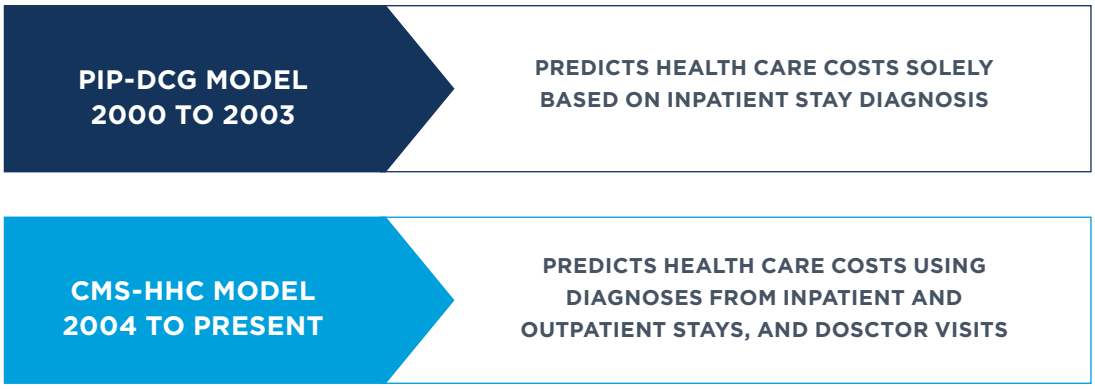
From 2000 to 2003, CMS used the Principal Inpatient Diagnostic Cost Group, or PIP-DCG model, which predicted health care costs using only the principal diagnosis from an inpatient stay. Since 2004, CMS has used the Hierarchical Condition Categories (CMS-HCC) model to risk-adjust payments to Medicare Advantage plans. In contrast to the PIP-DCG model, the CMS-HCC model uses diagnoses from inpatient, outpatient, and physician encounters, thereby more comprehensively accounting for the full range of patient spending (see Figure 3). Since 2004, CMS has made several updates to the CMS-HCC model, including changes in 2014 and 2017, discussed further below.

FIGURE 2: CMS ADJUSTS THE PAYMENTS TO MEDICARE ADVANTAGE PLANS ON AN INDIVIDUAL LEVEL BASED ON RISK SCORE



Note: (1) Assumes county benchmark rate of $1,050 and a 4-Star Plan. (2) In order to calculate plan payment in these examples, the beneficiary risk score is equal to the average plan risk score, although actual beneficiary risk scores vary.

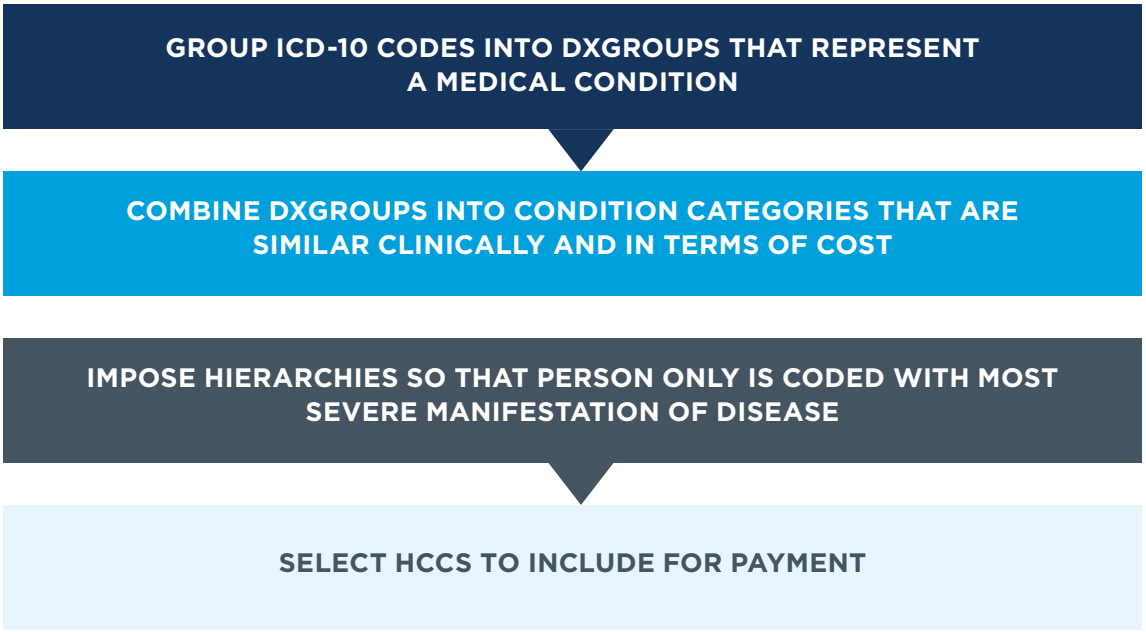
FIGURE 3: THE CMS-HCC RISK MODEL CAPTURES FULLER RANGE OF SPENDING ON AN INDIVIDUAL BASIS



About the CMS Model

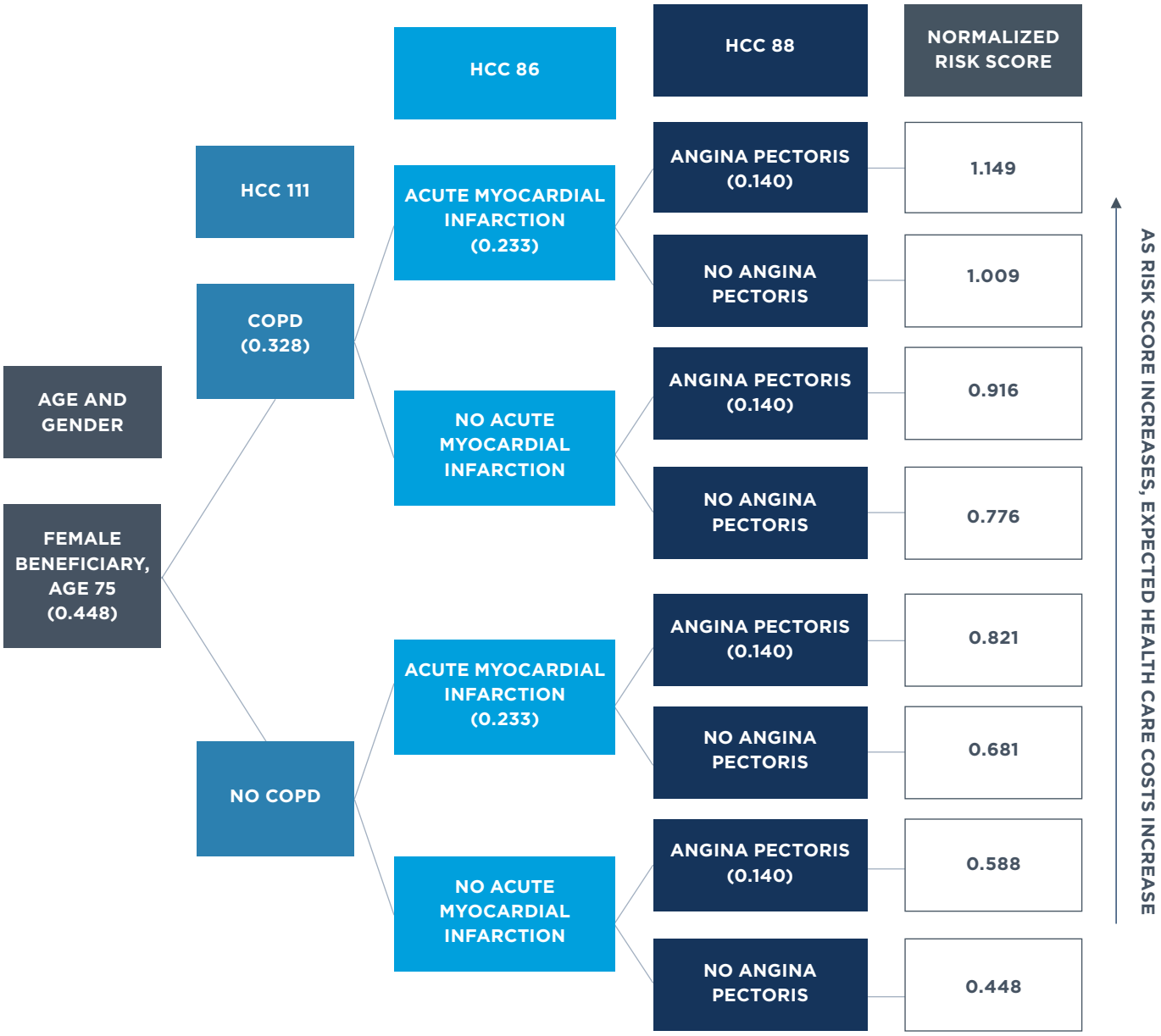
In the CMS-HCC model, CMS first groups all International Classification of Disease, Tenth Edition (ICD-10) codes into diagnostic groups called DxGroups. These groups include diagnosis codes that cover similar medical conditions. Second, CMS combines the DxGroups into Condition Categories (CCs) based on similar expected costs. Third, CMS imposes hierarchies on the model by dropping a less severe manifestation of the disease if a more severe manifestation is present. Finally, once the hierarchies are applied, CMS publishes the list of categories, or Hierarchical Condition Categories (HCCs), as part of the annual rate announcement, typically located in a table in a supplemental attachment. This process is illustrated in Figure 4 below.

FIGURE 4: MEDICARE ADVANTAGE RISK ADJUSTMENT PROCESS BEGINS BY GROUPING DISEASES AND ASSIGNING HCCS



Each HCC has an associated coefficient (or weight). The coefficients for each HCC are added, along with those for age and gender, to determine an enrollee's risk score, as shown in Figure 5.[5] CMS estimates the costs associated with different risk scores based on FFS Medicare spending and utilization data.

FIGURE 5: MEDICARE ADVANTAGE RISK ADJUSTMENT EXAMPLE



Accounting for Different Types of Beneficiaries in Risk Adjustment

CMS has three different risk models for different types of beneficiaries:

Risk Model	Population Served
New Enrollee	Beneficiary enrolled for less than 12 months in Medicare Parts A and B
Institutional	Beneficiary in a long-term institution
Community	All other beneficiaries, including dual-eligable beneficiaries

Adjusting for Dual-Eligible Beneficiaries in the Community Risk Model

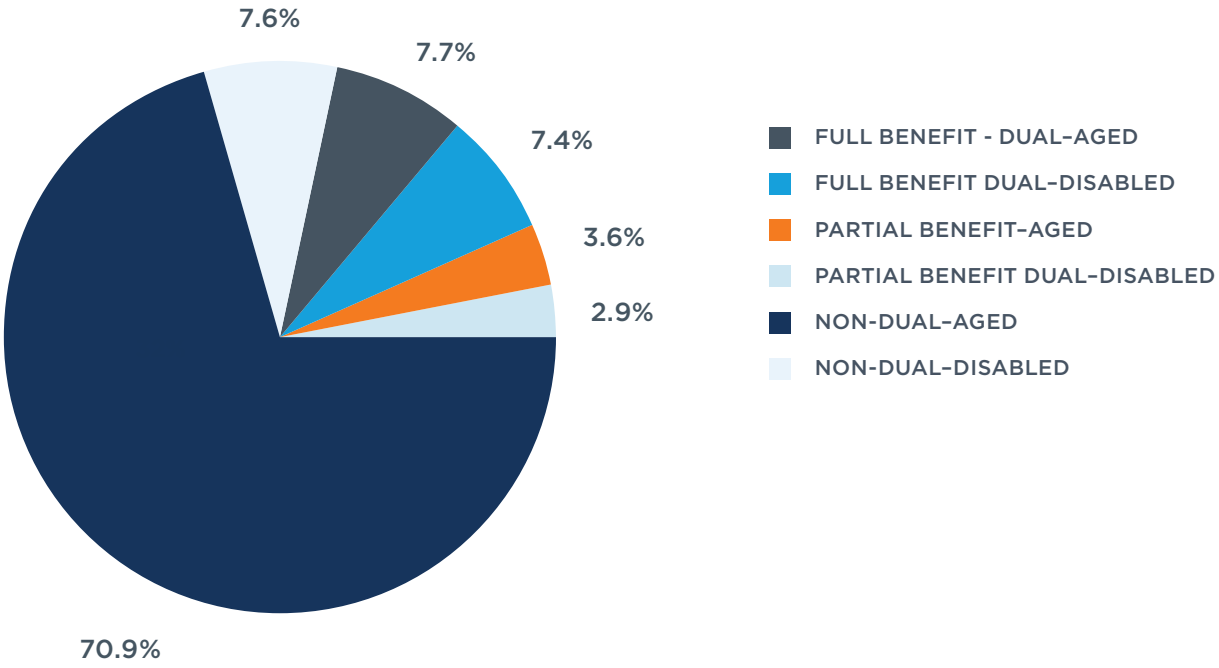
There are six main beneficiary subgroups in the community risk model (as shown in Figure 6), including individuals eligible for both Medicare and Medicaid, called dual-eligible beneficiaries. The current community risk model adjusts plan payment for dual-eligible beneficiaries. (CMS also calculates separate risk scores for individuals who are on, or have been on, chronic dialysis, but that model is not discussed here).

There are two types of dual-eligible beneficiaries – those receiving full Medicaid benefits and those receiving partial Medicaid benefits. Full-benefit dual-eligible beneficiaries receive cost sharing assistance and medical benefits from Medicaid not paid for by Medicare (e.g., dental, long-term care), while partial-benefit dual-eligible beneficiaries only receive cost-sharing assistance. Three-quarters of dual-eligible beneficiaries are enrolled in FFS Medicare and 20% are enrolled in Medicare Advantage; 5% of dual-eligible beneficiaries change enrollment between the two programs during a year.[6] As shown in Figure 6, more dual-eligible beneficiaries receive full Medicaid benefits than partial Medicaid benefits. A large majority of Medicare beneficiaries are not dually eligible for Medicaid.

Dual-eligible beneficiaries are among the highest-cost, highest-risk enrollees and require more specialized care and management. In recent years, CMS has found that the current risk model underpays Medicare Advantage plans for dual-eligible beneficiaries. The 2017 CMS-HCC risk model changes, described later in this brief, aim to address these underpayments.

FIGURE 6: CMS CALCULATES RISK SCORES FOR NEW ENROLLEES, INSTITUTIONALIZED INDIVIDUALS, AND COMMUNITY-BASED BENEFICIARIES

Percentage of Community Model Sample of the Six Subgroups (2012)



Source: CMS, Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017, October 28, 2015, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RiskAdj2017ProposedChanges.pdf

Adjusting for Coding Differences in Risk Adjustment: Coding Intensity Adjustment

Because CMS uses FFS Medicare data to estimate the Medicare Advantage model, it also adjusts Medicare Advantage payments to account for differences in coding between the two programs. These coding differences arise from structural, payment and care model differences between FFS Medicare and Medicare Advantage. Medicare Advantage utilizes diagnosis codes submitted by providers to risk adjust the prospective payment received from CMS, whereas FFS Medicare relies on procedure codes submitted by providers to process payments and does not require the same specificity in diagnosis coding. In addition, Medicare Advantage plans employ care management and disease-specific programs, and they depend on risk data to identify patients and actively intervene to facilitate patient engagement, adherence to clinical recommendations, slow disease progression, and address social or emotional impairments. These care management and intervention tools are not readily available in FFS Medicare. Because of these programmatic differences, risk scores estimated using FFS Medicare data may not accurately predict health care costs for Medicare Advantage enrollees. Since 2010, Congress has required CMS to reduce Medicare Advantage risk scores by a uniform, pre-determined factor, through an annual coding intensity adjustment, to account for this difference. CMS has the statutory authority to increase the annual coding intensity adjustment, but to date has not used that authority to apply reductions above the statutory minimum to plan payments.

Model Changes

CMS has modified the Medicare Advantage risk adjustment model in recent years. In 2014, CMS removed certain diagnosis codes from the model, and in 2017, the agency implemented a series of more substantive changes.

2014 Model Changes

The revised model for 2014 eliminated the risk adjustment payments for certain HCCs from the model: Chronic Kidney Disease (CKD) Stages 1, 2, and 3; and Diabetic Neuropathy. CMS referenced coding intensity concerns, and not clinical guidelines, when removing these codes, stating, “Medicare Advantage plans tend to code at higher rates those HCCs that experienced reductions in their relative value in this new model.”[7] Despite concerns that CMS was “double counting,” by both applying the coding intensity adjustment and removing HCCs from the risk model, these codes have not been added back to the model, inhibiting early clinical intervention.

2017 Model Changes

For 2017, CMS modified the model to account for concerns that the risk model under-predicted costs for lower-income beneficiaries. In response to these concerns, CMS evaluated how accurately the current community risk model predicted costs for full-benefit, partial-benefit, and non-dually eligible beneficiaries. CMS determined that the 2014 community model under-predicted costs for full-benefit dual-eligible beneficiaries by 9%, while over-predicting costs for partial-benefit dual-eligible beneficiaries by 9% and non-dually eligible beneficiaries by 1.5%. The 2017 model changes satisfy the 21st Century Cures Act requirement for CMS to provide separate adjustments for dual-eligible beneficiaries.[8]

Impact of Model Changes

As shown in Table 1, these changes to the model had notable impacts on the relative coefficients for each HCC. As mentioned above, coefficients for each HCCs are added together, along with those for age and gender, to determine the risk score and capitated payment for each enrollee.

The increases are most pronounced for full-benefit dual-eligible beneficiaries. Coefficients for 8 of the 10 most common HCCs increased for full-benefit dual-eligible beneficiaries under age 65. For the non-dually eligible aged beneficiaries (traditional Medicare beneficiaries over the age of 65), who comprise the largest category of individuals (71% of the total, according to Figure 6), coefficients decreased for 8 of the 10 most frequent HCCs (and therefore payments also decreased).

TABLE 1. PERCENT CHANGE IN HCC COEFFICIENTS UNDER THE 2017 MODEL, AS COMPARED TO THE 2014 MODEL, FOR 10 MOST COMMON HCCS

			Community						Institutional
HCC	HCC Description	Prevalence*	Non Dual, Aged	Non Dual, Disabled	FB Dual, Aged	FB Dual, Disabled	PB Dual, Disabled	PB Dual, Disabled	
019	Diabetes without complication	16.3%	-11.9%	8.5%	-17.8%	35.6%	-16.9%	15.3%	-12.1%
108	Vascular Disease	12.8%	-0.3%	11.4%	8.4%	6.7%	5.7%	9.0%	-12.1%
111	Chronic Obstructive Pulmonary Disease	12.8%	-5.2%	-24.3%	22.0%	2.3%	3.5%	-15.3%	-16.2%
096	Specified Heart Arrhythmias	12.5%	-9.2%	-3.7%	25.1%	27.8%	-4.1%	-12.5%	-14.5%
085	Congestive Heart Failure	10.3%	-12.2%	12.0%	-3.5%	12.8%	-13.0%	-0.3%	-16.6%
018	Diabetes with Chronic Complications	8.7%	-13.6%	0.8%	-6.0%	17.1%	-3.8%	14.9%	-7.0%
012	Breast, Prostate, and Other Cancers and Tumors	6.3%	-5.2%	31.2%	3.2%	23.4%	-1.3%	18.2%	0.5%
058	Major Depressive, Bipolar, and Paranoid Disorders	5.7%	19.7%	-36.7%	34.5%	-46.1%	25.2%	-50.6%	-12.9%
040	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	5.5%	13.1%	0.8%	-1.1%	-7.8%	4.3%	-22.5%	-6.3%
048	Coagulation Defects and Other Specified Hematological Disorders	3.7%	-12.3%	34.5%	6.3%	50.0%	-10.7%	51.6%	-7.9%

FB = Full-Benefit; PB = Partial-Benefit; Disabled – Under Age 65; Aged – 65 and Over
*Based on 2012-2013 5% Medicare FFS Limited Data Set.

While CMS did not make any specific changes to the institutional model for 2017, coefficients in the institutional model did change, perhaps due to spillover effects from the changes to the community model. Of note, the weights for 9 of the 10 most common HCCs decreased. These scores particularly affect institutional special needs plans (I-SNPs), a specialized type of Medicare Advantage plan that covers individuals who reside in a long-term care facility. Some plans have reported to CMS that the decrease in their institutional risk scores was unexpected. CMS responded by explaining that a reduction in costs for beneficiaries residing in institutions accounted for this difference.[9] However, this does not explain the change to disease weights in the model, because the value of any disease reflects the relative cost of the disease compared to other diseases, not the total cost.

Advantages and Disadvantages to Model Changes

The changes made by CMS in 2017 have benefits and drawbacks for different clinical groups of Medicare Advantage enrollees. For example, the modified model may increase risk scores for dual-eligible beneficiaries and beneficiaries with disabilities.

First, by increasing payments for full-benefit dual-eligible beneficiaries, the model changes could lead to improvements in benefits offered by dual-eligible Special Needs Plans (D-SNPs). D-SNPs have higher average risk scores under the new risk model. These higher risk scores can lead to higher rebates, which, as explained earlier, can be used to fund additional benefits for enrollees or to reduce cost sharing obligations.

Second, the changes in the model address differences in costs by age – namely, between individuals over age 65 and individuals with disabilities under age 65. Improvements in the risk scores for individuals with disabilities could lead to more accurate payments for plans enrolling these beneficiaries. As noted in Table 1, seven of the top 10 most frequent HCCs would see increases for the non-dually eligible disabled population. More accurate payments ensure that plans have the resources required to care for high-cost, high-need beneficiaries.

Third, the model changes ensure alignment of incentives regarding enrollment of partial-benefit and full-benefit dual-eligible beneficiaries. Under the 2014 model, risk scores were the same for partial- and full-benefit dual-eligible beneficiaries, all else being equal, even though full-benefit dual-eligible beneficiaries typically incurred higher health care costs. The 2017 model better predicts the higher costs incurred by full-benefit dual-eligible beneficiaries, ensuring plans have the resources required to care for them.

At the same time, the 2017 model has some potential drawbacks. First, the model may under-predict costs for individuals with specific and multiple chronic conditions, particularly for non-dually eligible aged beneficiaries over 65. As shown in Table 1, coefficients were reduced for eight the 10 most common conditions. The reductions in these coefficients would lead to reductions in the risk scores. The impacts could be larger for individuals with multiple chronic conditions versus those with single conditions, because the risk score is additive.

Second, beneficiaries residing in institutions could be harmed by reductions in benefits due to risk score decreases, especially those enrolled in I-SNPs. While the average risk scores are expected to increase for D-SNPs, risk scores may decrease for I-SNPs, which could lead to reductions in benefits as rebates would be lower due to lower risk scores, all else being equal.

In Part I of the CY 2019 Advance Notice, as required by the 21st Century Cures Act, CMS proposes a new risk adjustment model, the "Payment Condition Count Model," which accounts for the number of conditions that an MA enrollee has only among the conditions that are included in the payment model. CMS indicates that adding this count would improve the accuracy of predicted risk across deciles, but increase underprediction for beneficiaries with 5 or more chronic conditions. CMS also discusses an alternative model, the "All Condition Count model," which considers all an enrollee's conditions included and excluded from the payment model. While the All Condition Count model would improve predictive accuracy for beneficiaries with 5 or more chronic conditions, CMS believes this model would reduce predictive accuracy for enrollees with fewer than 5 chronic conditions, and result in less accuracy across nearly all deciles of predicted risk.

Looking Ahead: Increasing Stability and Making Risk Model Changes More Predictable

CMS has made some notable changes to the risk model in recent years. However, challenges remain both in terms of the model itself, as well as the process used to make changes. While changes in the model to improve accuracy are essential, the stability of the model is also critical. Any change to the risk adjustment model pose challenges for stakeholders, including clinicians, to understand, assess, and implement. Challenges are amplified when stakeholders have limited information regarding the impacts, consequences,

BMA RECOMMENDATIONS:

1. **Ensure a predictable and stable risk adjustment model;**
2. **Maintain coding intensity adjustment at the statutory minimum level;**
3. **Improve risk model accuracy for individuals with multiple chronic conditions;**
4. **Incorporate social determinants of health into the risk model;**
5. **Validate the Encounter Data System;**
6. **Implement the Encounter Data System at a slow and measured pace;**
7. **Consider impact of the Encounter Data System on the coding intensity adjustment; and**
8. **Guarantee a transparent process when modifying the risk adjustment model.**

or concerns about both the current model and proposed changes. Therefore, it is critical that CMS balance the potential benefit of changes to improve risk adjustment accuracy with the disruption such changes cause within the Medicare Advantage program.

1. Ensure a predictable and stable risk adjustment model

Risk adjustment is designed to encourage plans to compete on the basis of price and quality, not health status. A well-functioning risk adjustment program adequately compensates plans that enroll high-cost individuals and manage their care effectively. With millions of baby boomers aging into Medicare, it is essential that risk adjustment in Medicare Advantage create a level playing field for all beneficiaries and plans, ensuring the long-term sustainability of the program. **CMS should, to the greatest extend possible, limit the number and scope of changes to the risk adjustment model in any single year.**

2. Maintain Coding Intensity Adjustment at the Statutory Minimum Level

CMS uses FFS Medicare data to estimate the risk adjustment model used in Medicare Advantage. As explained above, differences between the two programs result in variations in coding practices. As such, risk scores estimated using FFS Medicare data may not accurately predict health care costs for Medicare Advantage enrollees. An annual coding intensity adjustment is applied to account for this difference, though it does not sufficiently capture the structural differences that drive coding variation. To achieve stability and adequacy for the prospective, capitated payment and enable plans and providers to gather the data necessary for early intervention and care management, **CMS should freeze the coding intensity adjustment at the current statutory minimum.**

3. Improve Risk Model Accuracy for Individuals with Multiple Chronic Conditions

Stakeholders continue to express concerns regarding the risk model's ability to accurately predict costs for individuals living with multiple chronic conditions. A recent Avalere analysis found that the current risk model does not accurately predict health care costs for these enrollees.[10] While CMS has not commented on this issue, the Senate Finance Committee's Bipartisan Chronic Care Working recommended changes to the risk model that would take into account the cumulative impact of a large number of chronic conditions, the interaction between behavioral/mental health conditions and physical health conditions, the differences in dual-eligible beneficiary costs given different eligibility pathways, and the potential for using more than one year of data to establish risk scores. Ensuring that the risk adjustment model accurately predicts costs for individuals with multiple chronic conditions is critical for the ongoing effectiveness of the program. **CMS should review published research and conduct an internal analysis to determine if the current risk model is resulting in inadequate payments to Medicare Advantage plans for patients with multiple chronic conditions, and correct deficiencies it identifies.**

4. Incorporate Social Determinants of Health into the Risk Model

More broadly, risk model accuracy may be improved by accounting for social determinants of health, as proposed and executed by CMS and the National Quality Forum (NQF) for quality measures in the Star Rating System. In 2014, the NQF announced that it would allow measures to adjust for patient socio-demographic factors, including poverty level, homelessness, health literacy, and other health determinants, for a two-year trial period.[12] With the trial underway, the NQF has endorsed several new and existing measures used in the Hospital Quality Star Rating program, adjusting for socioeconomic status and other demographic factors (e.g., insurance status). NQF stated it is committed to continuing to develop adjustments to achieve health equity for vulnerable populations.[13,14] CMS is working with NQF to study, specifically, the effect of socioeconomic status on quality measures and payment programs based on such measures, and will adjust its measures based on their findings.[15] As Medicare Advantage grows and beneficiaries become increasingly diverse, it will be critical to gain a better understanding of how social determinants of health affect costs, and adjust payments accordingly. **As part of its work to improve the accuracy for Star Rating measures, CMS should review trials of new measure and actively explore ways to account for social determinants of health in the risk adjustment model for Medicare Advantage plan payments.**

5. Validate the Encounter Data System

CMS is in the process of changing the system used to gather diagnosis codes used in risk adjustment and is currently using a blended version of two different systems. Through the Risk Adjustment Processing System (RAPS), Medicare Advantage plans filter diagnosis codes and submit them to CMS, where the files are reviewed and audited for accuracy. With the newer Encounter Data System (EDS), Medicare Advantage plans submit all unfiltered data directly to CMS, which then applies its own filtering logic to extract diagnosis codes from the data. Stakeholders have raised serious concerns about the transition to the EDS as the single source of enrollee diagnosis data used as the basis for risk scores. These concerns have been echoed by the Government Accountability Office, which concluded that limited progress has been made to validate the EDS, potentially resulting in inaccurate risk scores.[16] **CMS must validate the EDS to ensure accuracy of risk scores for Medicare Advantage enrollees before progressing with any further implementation.**

6. Implement Encounter Data System at a Slow and Measured Pace

In addition to validation issues, stakeholders, CMS, and providers are not yet ready for aggressive implementation of the EDS. In 2017, CMS acknowledged concerns about stability in payment and smooth implementation and dialed back use of encounter data from a proposed blend of 75% RAPS and 25% EDS to 85% RAPS and 15% EDS. **CMS should continue working with stakeholders to develop a strategy for addressing implementation issues while progressing at a slow and measured pace to adequately prepare all parties for the transition.**

7. Consider the Impact of the Encounter Data System on the Coding Intensity Adjustment

If CMS can guarantee the reliability and accuracy of encounter data to ultimately transition to use of the EDS for risk adjustments, CMS should carefully analyze what impact the transition will have on payments to Medicare Advantage. **CMS should take a measured approach to the EDS transition to ensure accurate and sufficient payments to Medicare Advantage.** Once this transition is complete, the coding intensity adjustment will no longer be used.[1]

8. Guarantee a transparent process when modifying the risk adjustment model

The Medicare Advantage risk adjustment model is likely to continue evolving. As future changes are considered, challenges associated with the model development process should be evaluated for improvement. Such changes should strive to improve accuracy and transparency.

Several actions would help achieve these goals. First, time for commenting on changes proposed in the "Advance Notice," released in February, may be insufficient given the complexity of the changes CMS may make. While Congress has given stakeholders more time to comment, the agency often does not have time to create new models in response to comments. Instead, the agency can either move forward with proposed changes or maintain the previous year's model. While CMS develops changes to the risk model before publishing, it does not make any of these discussions public. These challenges are compounded by the fact that CMS rarely conducts open door forums or listening sessions on the risk model. As a result, stakeholders are unaware of the issues CMS is considering until the Advance Notice is released. While recent changes have demonstrated progress, **CMS should continue to employ a transparent process that includes sharing impact analyses in a timely manner, holding multiple open-door forums, and meeting regularly with stakeholders throughout the year.**

In addition, while CMS does publish many comments associated with the Rate Announcement, the agency does not always publish all comments received. Additionally, the agency does not necessarily respond to each comment received. Commenters do not always know how CMS has addressed their comment, and the public also does not know which comments were considered and which ones were not addressed. If CMS published of the comments it receives, stakeholders will understand the panoply of issues that have been raised and the agency may be more likely to respond to each comment. **CMS should work to make public all stakeholder comments on proposals to modify the risk adjustment model.**

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[1] Since 2010, the Affordable Care Act (The Patient Protection and Affordable Care Act (Pub L. 111-148)) requires CMS to apply a coding intensity adjustment to Medicare Advantage risk scores to account differences between FFS Medicare risk scores, resulting in an annual across-the-board reduction in Medicare Advantage payments. Per statute, the coding intensity adjustment increased from a 3.41% reduction in 2010 to a 5.91% reduction in 2018. The adjustment remains at an annual 5.91% reduction to risk scores for subsequent years.

Conclusion

An accurate, stable risk adjustment model is a critical tool for Medicare Advantage. CMS has made notable changes to the risk model in the past several years, and the model will likely experience additional changes over time. While changes to the model to improve accuracy should occur, stability of the model and predictability of payments is critical. CMS must balance the potential of any proposed changes to improve risk adjustment accuracy with the disruption such changes cause within Medicare Advantage. The risk model improvements outlined in this brief would enhance the overall stability and functionality of Medicare Advantage without compromising the accuracy of payments. These proposed changes would also better ensure predictability and transparency for stakeholders, create a more accurate risk model, and strengthen Medicare Advantage.

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