

TOPIC: CODING INTENSITY AND FAVORABLE SELECTION

Background

Risk adjustment is designed to ensure that Medicare Advantage (MA) plans receive sufficient payment for beneficiaries regardless of differences in health status. The Centers for Medicare & Medicaid Services (CMS) risk adjusts MA plan payments to account for variations in cost based on enrollee health status and demographic factors. This ensures that, on average, plans are paid less for healthier beneficiaries and more for sicker beneficiaries relative to what they would be paid for beneficiaries with an

Key Points

- Risk adjustment is necessary to ensure that payments to MA plans account for the higher health care costs for sicker beneficiaries. Despite risk adjustment, favorable selection remains when plans disproportionately enroll or retain beneficiaries whose costs are low relative to the payments received.
- Fraud, waste, and abuse (FWA) risks arise when MA organizations use inappropriate coding intensity strategies to make enrollees appear sicker and thereby increase their payments from Medicare. Risks also arise when MA organizations use inappropriate strategies to enroll or retain lower-cost beneficiaries or discourage enrollment or encourage disenrollment among higher-cost beneficiaries.
- Policy-based mitigation strategies include:
 - eliminating chart review diagnoses from risk adjustment,
 - eliminating health risk assessment (HRA)-only diagnoses from risk adjustment,
 - using 2 years of diagnosis data for risk adjustment,
 - refining the coding intensity adjustment factor,
 - refining or redesigning the risk adjustment approach,
 - introducing a reinsurance policy,
 - limiting contractual arrangements that incentivize providers to capture more diagnosis codes,
 - introducing competitive bidding,
 - setting benchmarks administratively,
 - limiting MA marketing tactics,
 - introducing multiyear MA plans,
 - auto-enrolling beneficiaries in MA plans, and
 - requiring broader provider networks.
- Oversight-based mitigation strategies include:
 - increasing the number of and improving the timeliness of risk adjustment data validation (RADV) audits,
 - extrapolating results from RADV audits,
 - targeting audits and monitoring based on HRAs and chart reviews,
 - financing audits through MA plan user fees,
 - increasing financial or enrollment penalties,
 - improving calculation of coding intensity for RADV purposes,
 - focusing audits on the plans most likely to have high rates of improper payments,
 - introducing prepayment reviews, and
 - improving oversight of favorable selection.

average health risk profile. “Coding intensity” refers to the extent to which conditions are diagnosed and the severity of the conditions diagnosed. MA plans with higher coding intensity receive higher risk-adjusted payments for a given beneficiary.

The original intent of risk adjusting MA plan payments was to reduce the incentive for MA organizations to enroll healthier-than-average beneficiaries and avoid the sickest beneficiaries, a phenomenon known as “favorable selection.” Despite risk adjustment, favorable selection can still occur within a cohort—for example, the selection of beneficiaries who use fewer services than other individuals with similar risk scores and demographics. This means that favorable selection can happen at any risk score level if actual spending is lower than predicted spending. When favorable selection occurs in MA, it can create adverse selection, or enrollment of beneficiaries who are more costly than average in Traditional Medicare (TM). This favorable selection into MA and adverse selection into TM results in lower costs for MA plans and distorts risk adjustment calibration and benchmarks that are based on TM spending, particularly in counties with high MA penetration, and further increases payments to MA plans.¹

The design of the risk adjustment model and the rules related to data that can be included in risk adjustment should help to ensure fair and accurate payment. The Secretary of Health and Human Services (HHS) has broad discretion to determine how to adjust for health status, with some specifics defined in legislation (e.g., with requirements to consider the number of conditions, the level of dual eligible benefits, as well as substance use disorder, mental health, and chronic kidney disease).² The current risk adjustment model uses data from TM beneficiaries to estimate costs associated with each risk factor (e.g., an age group or a diagnosis), which are converted to relative weights and used to adjust MA payments relative to the average predicted cost for a TM beneficiary.³ CMS uses the diagnosis data that MA organizations submit to the Encounter Data System to determine payment according to the risk adjustment model. A diagnosis can only be used for risk adjustment if it is from an acceptable provider type (i.e., hospital inpatient, hospital outpatient, or professional); coded in accordance with the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding guidelines; results from a face-to-face visit; and is documented in a medical record.^{4,5} CMS has established the inpatient and outpatient facilities and professional encounters that are acceptable for risk adjustment, as well as the methodologies to identify diagnoses to be used for payment purposes. CMS groups diagnoses into 266 Hierarchical Condition Categories (HCCs) and uses just a subset of the HCCs to ensure that diagnoses included in the model are specific, are not discretionary in treatment or coding, and are medically significant, enduring, and predictive of costs.⁶ The risk adjustment model is prospective—that is, diagnoses and demographics (age, sex, Medicaid dual eligibility, disability status) from 1 year are used to predict costs for the following year.

CMS continues to refine MA risk adjustment to improve its ability to predict costs. For example, the new CMS-HCC model 2024 (version 28) includes updated diagnosis and spending data, ICD-10 rather than ICD-9 diagnosis codes, and clinically informed revisions to ensure that conditions included in the model are more stable predictors of costs.⁷ CMS has also removed or constrained payments associated with conditions where diagnosis and coding patterns vary across plans and providers.⁸ This is expected to reduce the reward for coding intensity without meaningfully increasing favorable selection.⁹ The new risk adjustment model is also expected to help reduce overpayments due to coding practices, with the most impact expected on MA plans that code most intensively.^{10,11,12}

CMS conducts oversight of MA payments and the risk adjustment system through various mechanisms, including tracking attestations and compliance with data submission requirements, rerunning prior years' data to determine whether plans received overpayments as a result of diagnoses that were later deleted, and conducting risk adjustment data validation (RADV) audits.^{13,14} For the audits, CMS first selects risk-based samples of MA organizations and enrollees within their plans for audit, then MA organizations and their providers identify and share with CMS applicable medical records for those enrollees from the audit year, and CMS assesses the documentation to determine whether it appropriately supports the diagnoses submitted for those enrollees.^{15,16} CMS can then request repayments from the MA organizations, and MA organizations may appeal if they disagree with the audit findings.¹⁷ RADV audits are designed to detect improper payments, including overpayments due to both errors (which can contribute to waste and abuse) and fraud.

Potential for FWA

It is appropriate for MA organizations to add diagnoses and receive higher payment if the resulting risk scores reflect the cost of caring for an enrollee. However, on average, the current system results in higher risk scores in MA than for comparable beneficiaries in TM.^{18,19} As a result, CMS applies a "coding intensity adjustment" that reduces the risk scores for all MA plans by 5.9% (the statutory minimum).²⁰ Even after the coding intensity adjustment and recent improvements to the risk adjustment approach, coding intensity still results in overpayments to MA relative to TM. The Medicare Payment Advisory Commission (MedPAC) estimated that coding intensity would result in payments that are \$22 billion (4%) higher for MA beneficiaries than if the beneficiaries were enrolled in TM in 2026.²¹ CMS estimated that coding intensity would have resulted in MA payments between 1.5% and 2% higher than TM if the latest risk adjustment approach had been applied in 2022.²² The CMS estimate is lower because it used data from a different year and did not take into account the growth over time in coding intensity.²³ In addition, because the coding intensity adjustment is the same for all plans, it rewards MA organizations that code more intensively by maintaining their higher revenue

relative to other plans; that additional revenue may provide greater opportunities to increase market share through marketing or more generous plan designs.²⁴

Coding intensity that results from more thorough capture of diagnoses in MA may contribute to waste. In TM, diagnosis coding may be incomplete because physicians are generally paid for services rendered and thus have less incentive to document all diagnoses each year. Greater coding intensity in MA distorts payments because the risk adjustment model is built on potentially under-coded diagnoses from TM. In addition, CMS currently uses diagnoses from a single year of data both to calibrate the risk adjustment model based on TM claims and to determine payments based on MA plans' encounter data.²⁵ This single-year approach may exacerbate the differences in coding between MA and TM because, without incentives to code diagnoses, providers in TM may not always list all diagnoses on claims, resulting in some beneficiaries with a chronic condition having no record of that diagnosis in some years.²⁶ These coding intensity incentives may contribute to waste in the form of MA organizations diverting resources to identifying and documenting diagnoses each year rather than delivering patient care.

Coding intensity can also present risks of fraud and abuse. For example, submitting intentionally inaccurate diagnoses could be fraud, and recording a diagnosis for a condition that does not require treatment based on professionally recognized standards could be abuse. In addition, MA organizations have faced legal challenges based on various coding intensity practices including:

- Submitting unsupported diagnoses, where diagnoses lack appropriate medical record documentation;^{27,28,29,30}
- Instructing providers to use improper diagnosis codes or to add diagnoses retrospectively to increase payment;^{31,32}
- Editing medical records to add diagnoses;³³
- Conducting “one-way” chart reviews, which involve reviewing medical records to identify unrecorded diagnoses and submitting them for additional payment without checking for inaccurate diagnosis codes that should be deleted and therefore require repayment;^{34,35} and
- Conducting in-home health risk assessments (HRAs) to collect diagnoses without proper diagnostic testing or imaging, treatment, or supporting documentation from other health care providers.³⁶

Some MA organizations conduct chart reviews and HRAs to capture additional diagnoses. Chart reviews are used to identify conditions that health care providers may have missed or submitted incorrectly in encounter data records.^{37,38} HRAs involve gathering diagnostic

information directly from enrollees as part of an initial or annual wellness visit or during a standalone home visit expressly for the purpose of the assessment. The impact of these activities is significant. In 2023, the HHS Office of Inspector General (OIG) found that chart reviews and HRA-only diagnoses resulted in \$7.5 billion in risk-adjusted payments.³⁹ A *Wall Street Journal* analysis found that Medicare paid \$50 billion for diagnoses added by MA organizations in the 3 years to 2021.⁴⁰ A study of 2019 data found that risk scores increased among 9.5% of beneficiaries who received HRAs due to diagnoses that were not recorded on other encounters and that their risk scores increased by 12.8% on average.⁴¹ Similarly, a study of 2015 data found that risk scores changed among 4.5% of beneficiaries due to chart reviews and that their risk scores increased by 4.1% on average.⁴² Because payment is generally based on utilization of specific services rather than diagnoses, providers in TM have less incentive to use chart reviews and rely on HRAs in a more limited way, resulting in fewer opportunities to capture diagnoses.⁴³ MA organizations that use chart reviews and HRAs have higher coding intensity relative to TM and to MA organizations that pursue these strategies less aggressively.

HRA and chart review practices can create risks of fraud, waste, and abuse. HRAs are rarely conducted by the patient's primary care provider, and those administering the assessments may be unable to conduct the appropriate tests to confirm a diagnosis.^{44,45} Risks of unsubstantiated diagnoses may be even greater when MA organizations use chart reviews of information gathered during HRAs—also known as HRA-linked chart reviews—to identify additional diagnoses because enrollees' providers are not involved in either process.⁴⁶ Indeed, there is evidence that these practices have led to many instances of diagnoses that patients do not have either because they are impossible (e.g., cataracts in patients that have already received cataract surgery), highly unlikely (e.g., HIV diagnoses in patients not receiving antiretroviral treatment), diagnosed at unusually high rates, or otherwise confirmed as nonexistent following subsequent physician confirmation.^{47,48} These practices also present risks to beneficiaries, who may be pressured or offered financial incentives to agree to participate in home HRAs, and who may be denied needed care if the MA organizations do not provide appropriate follow-up care for legitimate diagnoses identified during HRAs.⁴⁹

Risks of improper upcoding—that is, using diagnosis codes for a more serious condition than actually exists—may be greater for vertically integrated MA plans and for other situations where MA organizations can exert more control over providers' coding practices and have greater access to the data needed to design profitable risk coding programs (see chapter on vertical integration). For example, risk score payments have been found to increase 25% in the first 2 years and 35% in the first 5 years after primary care physicians are employed by practices that are integrated with MA organizations.⁵⁰ Providers also may be incentivized or encouraged to increase coding intensity through such arrangements as receiving payments for submitting more diagnostic codes, requirements to use artificial intelligence (AI) tools or prompts to

identify additional diagnoses, sharing a percentage of the MA premium, or MA organizations directing their provider organization employees to identify more diagnoses.^{51,52,53,54} These practices may increase the risk of fraud and abuse and create conflicts of interest for providers.

Risks of FWA are exacerbated by challenges with the RADV system audit processes and by legal challenges to CMS's audit authority. The HHS OIG conducted audits similar to RADV and found in November 2023 that among a group of high-risk diagnoses, 90% of diagnoses contained errors, indicating a significant need for oversight.⁵⁵ However, CMS is several years behind on audits,⁵⁶ faces legal challenges to proposed changes in audit methods (e.g., extrapolating audit findings beyond the sample of audited enrollees) that could increase penalties for inappropriate coding,⁵⁷ and must navigate a lengthy appeals processes.⁵⁸ As a result, CMS has recouped only a fraction of the estimated improper payments.⁵⁹ A September 2025 ruling vacated the 2023 RADV final rule, creating questions regarding the extent of CMS' audit authority that are unlikely to be resolved without additional Congressional or rulemaking activity.⁶⁰ The audit system thus is less effective in deterring fraud and errors, and there is greater waste because CMS audits are not recouping a majority of the improper overpayments. In addition, the RADV program's effectiveness is threatened by increasing vertical integration between payers and providers because it creates less distance between the encounter and the medical record.

Favorable selection also contributes to overpayments. For example, in 2026, MedPAC predicts that Medicare will spend \$57 billion more on MA beneficiaries than it would if those same beneficiaries were enrolled in TM due to favorable selection; this is in addition to the higher payments that would result from coding intensity described above.⁶¹ Although there are disagreements about both how to measure favorable selection and to what extent it is a problem,^{62,63} there is general agreement that some favorable selection still exists in MA.

The incentives for favorable selection may lead to behaviors that constitute fraud, waste, or abuse. Drivers of favorable selection include proactive MA plan strategies, including marketing, benefit designs, utilization management, and the structure of provider networks and care management systems; and consumer behavior, including preferences for certain benefits and higher disenrollment rates among high-need enrollees.^{64,65,66} Despite risk adjustment, MA plans can still benefit from favorable selection if they can attract healthier, lower-cost individuals to enroll *among those with similar risk profiles*. Problematic behaviors include incentivizing insurance agents and brokers to identify and enroll beneficiaries with lower health care utilization and avoiding beneficiaries who are expected to be more expensive (see the chapter on enrollment, agents, and brokers). Additionally, enrolling beneficiaries like veterans, who may receive most of their health care from another payer, can contribute to waste (see the chapter on cost shifting to the Veterans Affairs). Similarly, plans can nudge beneficiaries to disenroll

when their health status declines or their health care utilization increases.⁶⁷ Problematic plan behaviors include creating ghost networks or narrow specialty networks and using prior authorization to make it difficult to seek care for expensive conditions and drive selective disenrollment (see the chapters on network adequacy and misrepresentation of provider networks and prior authorization and other utilization management approaches). Benign behaviors can also contribute to favorable selection—for example, when MA plans deliver less of the low-value care that might contribute to higher utilization among beneficiaries with a given risk score in TM.⁶⁸

In the next two sections, we describe approaches for mitigating the FWA risks associated with coding intensity and favorable selection through policy and oversight. Policy approaches generally include reducing incentives and opportunities for FWA, while oversight approaches include deterring, identifying, and holding plans accountable for inappropriate coding intensity and favorable selection.

Mitigation Approaches: Policy

Eliminate chart reviews from risk adjustment. One option raised by several stakeholders is for CMS or Congress to eliminate from risk adjustment any diagnoses documented only in chart reviews (also known as unlinked chart reviews),^{69,70,71,72,73} or to limit how much risk scores could increase as a result of chart reviews.⁷⁴ Consistent with this approach, CMS announced that, as of 2027, it will exclude diagnoses obtained from unlinked chart review records from risk adjustment calculations, except for beneficiaries who switch to a plan with a different MA organization.⁷⁵ Studies have estimated that chart reviews account for around one-third of coding intensity overpayments^{76,77} and that eliminating chart reviews as a source of diagnoses for risk adjustment would reduce MA payments by roughly \$7 billion annually.^{78,79} The new CMS policy is more limited in that it only excludes diagnoses from chart reviews if they are not also identified in another health care encounter. However, implementing this option should still help reduce risks of fraudulent upcoding, waste of resources due to unnecessary chart reviews, and abuse in cases where beneficiaries do not receive treatment based on additional diagnoses.⁸⁰ In addition, the impact will be greatest on those plans that use chart reviews most aggressively.⁸¹

There are potential challenges and limitations associated with removing chart reviews as a source of diagnoses for risk adjustment. As with other policy options to reduce overall MA payments, some contend that MA organizations will respond by using more stringent utilization management processes or other methods to encourage providers to deliver less care.⁸² This policy could also increase favorable selection because reduced pay-offs for coding intensity (or higher costs) could increase the incentive for MA plans to avoid beneficiaries who are expected

to have higher costs relative to payments.⁸³ An industry group argued that Dual Eligible Special Needs Plans (D-SNPs) should be excluded from policies prohibiting the use of chart reviews to capture diagnoses for risk adjustment because safety-net providers used by D-SNP enrollees often lack proficiency in optimal documentation and coding and chart reviews can help to ensure accurate diagnoses.⁸⁴ Studies have estimated that excluding diagnoses obtained through chart reviews would still leave plans that code most intensively with substantially higher risk scores than other plans, suggesting that additional policies will be required to address the discrepancies.⁸⁵ There may also be a trade-off with accuracy in terms of the risk adjustment model's ability to predict utilization.⁸⁶ Finally, the reduction in coding intensity from this option may be temporary because MA organizations have other options to capture diagnoses, such as through office-based encounters.⁸⁷

Eliminate HRA-only diagnoses from risk adjustment. CMS or Congress could eliminate from risk adjustment any diagnoses documented only in HRAs (also known as unlinked HRAs) or in a subset of HRAs such as in-home HRAs or HRA-linked chart reviews, or limit how much risk scores could increase as a result of HRAs.^{88,89,90,91,92,93,94,95,96} Studies have estimated that diagnoses from HRAs account for around one-sixth of coding intensity overpayments, and removing HRA diagnoses from risk adjustment could similarly reduce overpayments significantly.^{97,98} This policy could reduce FWA associated with inappropriate use of HRAs, and the impact would be greatest on those plans that use HRAs most aggressively.⁹⁹

CMS has considered this policy, including in a 2014 proposal to exclude from risk adjustment any diagnoses from home HRAs that were not confirmed by a subsequent clinical encounter.¹⁰⁰ However, it elected not to implement the policy after opposition from many commenters and instead opted for further study using new data.¹⁰¹ Some commenters argued that diagnoses obtained from home HRAs should be considered legitimate depending on the nature of the visit, the provider, or the enrollee. As of 2024, CMS has continued to study the feasibility of excluding diagnoses obtained during home visits and has described outstanding challenges including difficulties in distinguishing visits for diagnostic versus treatment purposes, potential disincentives for MA organizations to provide home-based care, and the risk of missing timely home HRA diagnoses that are subsequently treated.¹⁰²

There are some challenges with implementing this policy. For example, there is no definitive method to identify whether and for what purpose HRAs are conducted in beneficiaries' homes.^{103,104} There are also concerns that removing HRA-derived diagnoses from risk adjustment could reduce MA organization incentives to encourage preventive screenings and associated care and instead incentivize unnecessary visits with health care providers to confirm diagnoses, which could increase utilization and costs.¹⁰⁵ Other potential challenges with this policy mirror those associated with removing chart reviews from risk adjustment. Namely, MA

organizations may respond by using more stringent utilization management processes or other methods to encourage providers to deliver less care;¹⁰⁶ the policy could increase favorable selection;¹⁰⁷ the risk adjustment model may be slightly less accurate in predicting utilization;¹⁰⁸ if used in isolation, the policy would be insufficient to bring the plans with the most intense coding practices in line with other plans;¹⁰⁹ and D-SNPs may be disproportionately affected by the policy because their safety-net providers code incompletely and D-SNPs can use HRAs for care management and to connect beneficiaries with needed care.¹¹⁰

A related option is for CMS to require that MA organizations provide (or make efforts to provide) follow-up treatment or care coordination for any new diagnoses identified in HRAs or that they only include diagnoses for risk adjustment if they are actively managed.^{111,112,113,114} This is similar to proposals that would only allow diagnoses from chart reviews or HRAs if they also appear in another health care encounter record. Although this would reduce the incentive to use HRAs solely to collect diagnoses and ensure that patients are receiving necessary care, it may also require countermeasures to address the potential for induced overutilization.

Finally, the HHS OIG has recommended audit and monitoring activities related to diagnoses from HRAs. It recommended that CMS conduct audits to validate diagnoses reported on in-home HRAs and chart review-linked HRAs.¹¹⁵ OIG also recommended that CMS conduct monitoring to identify MA organizations that receive a disproportionate share of payments from diagnoses identified through HRAs or chart reviews and determine whether specific diagnoses associated with a large share of payments from in-home HRAs and HRA-linked chart reviews are a particular risk for inappropriate or highly variable coding.¹¹⁶ CMS concurred with these recommendations and indicated that it has plans to consider targeting diagnoses from HRAs in audits and noted that the new version of the risk adjustment model (version 28) excludes or limits diagnoses that are most susceptible to coding variations.¹¹⁷

Use 2 years of diagnosis data for risk adjustment. MedPAC, the sponsors of a Senate bill, and others have proposed that CMS use 2 years of diagnostic data for risk adjustment.^{118,119,120,121,122} The Congressional Budget Office has estimated that using 2 years of diagnostic data and eliminating home HRAs from risk adjustment would save \$124 billion between 2027 and 2034.¹²³ Proponents argue that this approach could reduce differences in coding intensity between MA and TM; improve the risk adjustment model's ability to predict MA costs, particularly for enrollees with multiple chronic conditions; and reduce MA overpayments.^{124,125,126,127,128} In theory, more diagnoses would be captured for TM beneficiaries, thereby making risk scores more similar between MA and TM, reducing the incremental payments that MA plans receive for each diagnosis, and ultimately reducing overpayments.¹²⁹ MA organizations would still have a strong incentive to capture all diagnoses, meaning that this change would have little or no impact on coding-related fraud or abuse, while

the impact on favorable selection is unclear. However, this approach could reduce reliance on collecting diagnoses annually and potentially reduce slightly the waste associated with using resources to identify and document diagnoses. It may also benefit MA organizations that invest less in activities designed to maximize diagnosis capture.¹³⁰

There are also significant challenges to using 2 years of diagnostic data for risk adjustment calculations. Implementation challenges include managing with smaller sample sizes, particularly for smaller subgroups, because it would exclude beneficiaries who have less than 24 months of data; assessing the validity of older diagnoses, such as for conditions that may be inactive; and dealing with an additional year's delay before beneficiaries are assigned a risk score.¹³¹ Further, this option could incorrectly reduce payments for D-SNPs and other MA plans with higher proportions of enrollees who are new or have multiple chronic conditions.^{132,133} In addition, based on preliminary findings, CMS has found that using 2 years of diagnostic data would not improve the accuracy of model payments.¹³⁴

Refine the coding intensity adjustment factor. Several stakeholders have proposed that CMS increase the coding intensity adjustment factor and evaluate and set the factor annually to fully account for coding differences between TM and MA.^{135,136,137} The Congressional Budget Office has estimated that, between 2027 and 2034, increasing the minimum adjustment to 8% across all plans would reduce payments by \$159 billion while increasing the adjustment to 20% would reduce payments by more than \$1 trillion.¹³⁸ However, it is possible that the adjustment factor provides implicit permission and an incentive for MA organizations to increase coding intensity to stay ahead of the adjustment.¹³⁹ Other potential impacts of a large increase in the coding intensity adjustment include a reduction in less profitable plans, increased MA cost sharing, reduced supplemental benefits, reduced MA and Part B premiums, and other actions by MA organizations to reduce costs.^{140,141} In addition, uncertainty about the impact of the HCC version 28 model in reducing coding intensity^{142,143} will make it difficult to reach consensus on changes to the adjustment until the impact is clear. The potential impact on favorable selection is also unclear.

An increase in the adjustment factor for all plans is unlikely to reduce FWA because the adjustment would continue to reward MA organizations that code more intensively.^{144,145,146} To improve fairness and remove the competitive advantage gained by MA organizations that code most intensively, CMS could introduce coding adjustments tailored to each MA organization's (or plan's) level of coding intensity or assign plans to tiers for coding adjustments.^{147,148,149,150} A graduated approach is more likely than a single coding adjustment to reduce FWA associated with intensive coding. The impact on competition is also a factor. For example, it has been reported that representatives from some small and regional plans prefer approaches that would target adjustments by coding intensity, rather than a blanket increase in the adjustment

factor, which they believe would further penalize them unfairly and drive some plans out of business.¹⁵¹ The implementation of a tiered approach would be contentious because assigning plans to tiers with different adjustments would introduce cliff effects, where small differences near coding intensity thresholds could result in large financial impacts for MA organizations. Assuming that implementation is technically feasible, plan-level coding adjustments would both improve fairness and reduce the potential for gaming or appeals from MA organizations attempting to move to a more favorable tier.

Changes to the coding intensity adjustment would face several challenges. Some industry stakeholders favor retaining the current coding intensity adjustment, contending that it will achieve stable, predictable, and adequate payments and ensure that MA organizations and providers have the data needed for early intervention and care management.¹⁵² There are also concerns that tailored coding adjustments would continue to leave some plans relatively overpaid or underpaid and would not eliminate incentives to maximize payment.¹⁵³ Other considerations include the extent to which changes would lead to higher premiums, fewer benefits, slower enrollment growth, or reduced profits to MA organizations; whether a sufficient TM comparison group is available to determine a coding intensity benchmark for D-SNPs in smaller geographic areas; and whether D-SNPs and similar plans could be penalized inadvertently for having sicker enrollees.^{154,155}

Refine or redesign the risk adjustment approach. Many risk adjustment refinements have been proposed to predict MA costs more accurately and reduce the potential for gaming. Because risk adjustment is intended to reduce the incentive for favorable selection by paying appropriately for higher-cost enrollees, some changes to the risk adjustment approach could both reduce coding intensity and further reduce the incentive for favorable selection. Other changes may inadvertently increase the incentive for favorable selection. For example, approaches that predict costs more accurately may reduce coding intensity; however, because the current approach likely overestimates costs for groups with historically low utilization, a more accurate model could reduce payments for these enrollees and therefore disincentivize enrolling beneficiaries from these groups.¹⁵⁶

As signaled in a November 2025 Request for Information, CMS is considering new risk adjustment approaches. Approaches range from minor changes to the existing risk adjustment model to more significant changes such as a “next generation” risk adjustment approach, including possible CMS Innovation Center model tests, which could help to ensure effectiveness and feasibility before widespread implementation.¹⁵⁷ CMS could implement most changes to risk adjustment under existing authority, but legislative changes may be needed in some cases. For example, if CMS were to introduce a revised risk adjustment approach that resulted in

significantly less intensive coding, Congress may need to repeal the requirement for coding intensity adjustments. Possible refinements to risk adjustment include the following:

- **Updating the model regularly.** The version 28 update to the risk adjustment model involved “recalibrating,” that is, using more recent claims data to determine the payment weights. Along with other changes such as limiting the impact of diagnoses that are easily gamed, this change is expected to reduce coding intensity and overpayments significantly relative to the previous version of the model.^{158,159} An additional recalibration proposed for 2027 (using data from 2023 and 2024 rather than 2018 and 2019) was anticipated to improve payment accuracy and result in further savings;¹⁶⁰ however, it was not implemented to allow MA organizations more time to adjust to the v28 model.¹⁶¹ A regular schedule of updates, such as every 2–3 years, could help reduce the difference between data used to determine payments and current costs (including current coding practices), thereby increasing model accuracy and reducing the payoff for coding intensity. The likely impact on favorable selection is not clear.
- **Using diagnostic and cost data from encounter data submissions to develop a risk adjustment model based exclusively on MA data** rather than using TM data to predict costs.¹⁶² CMS is investigating this option and is considering methodological challenges, such as how to select beneficiary samples and predict costs and the potential downstream market effects.¹⁶³ This approach could somewhat reduce the coding intensity incentive if the payoff for additional diagnoses were lower.¹⁶⁴ However, it could continue to reward MA organizations that code more aggressively.^{165,166} In addition, because this approach could reduce payment weights for some conditions, it could increase the incentive to avoid the more expensive patients with those conditions (favorable selection) and reduce the payoff for managing chronic conditions more efficiently than would occur in TM.¹⁶⁷ Current law requires that CMS implement a coding intensity adjustment only until it starts using MA diagnostic, cost, and use data, so this option would likely end the adjustment.¹⁶⁸ There is a risk that switching to the use of encounter data while removing the coding intensity adjustment could result in a net increase in payments to MA plans. To reduce this risk, Congress could enact a law change to de-link the use of encounter data and the coding intensity adjustment, allowing CMS to use both policy levers if needed.
- **Incorporating utilization data from prescriptions and electronic health records into risk adjustment.**¹⁶⁹ Although this approach should reduce the incentive to code intensively, it could encourage more prescriptions, overutilization of medications or services, and over-testing, particularly for diagnoses that could result in more profitable payments.¹⁷⁰ If prescription drug utilization data are used in isolation, there is also a risk of missing diagnoses not treated by prescription drugs, and this approach is estimated to be inferior to the standard HCC model in predicting utilization.¹⁷¹ This approach could reduce the

incentive for favorable selection to the extent that the additional payment for a given service added to the model matches the cost of delivering that service.^{172,173} Conversely, there could be new risks of favorable or adverse selection if service costs are much higher or lower than the associated marginal payments for beneficiaries with certain conditions or risk factors.

- ***Building a risk adjustment model using data that MA organizations and providers cannot influence***, such as area-level measures of upstream drivers of health, patient-reported health status or outcome measures, biometric information, or survey-reported measures of chronic condition prevalence that can be collected from beneficiaries independently from MA organizations.^{174,175,176,177} Survey data could also be combined with HCC data in various ways. One study found that combining Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data and HCC data after removing eight HCCs that are prone to inflated coding was the best of nine options at predicting next-year utilization, and that other combined CAHPS-HCC options also predicted utilization better than HCCs alone.¹⁷⁸ With any survey-based approach, CMS would need to address issues arising from survey response biases and sampling frame limits if using existing surveys (e.g., the existing MA CAHPS survey excludes beneficiaries in institutions).¹⁷⁹ Surveys may need to be expanded to collect more information about health status and utilization and supplemented with other data sources, such as for rare and expensive conditions.^{180,181} While potentially costly, such data collection may cost less than MA organizations currently spend on diagnosis capture and thus could potentially reduce waste, and the data could be used for population health monitoring.¹⁸² This approach would reduce or remove coding intensity incentives potentially without increasing the incentive for favorable selection.¹⁸³
- ***Building a risk adjustment model based on diagnoses inferred from an aggregate population***.¹⁸⁴ This would involve using population-level data on diagnoses and utilization and potentially upstream drivers of health along with individual-level data to assign risk scores to beneficiaries.¹⁸⁵ Inferred risk scores would be accurate at a group level; reduce coding intensity incentives and wasted resources to capture diagnoses; and improve fairness across plans.¹⁸⁶ This approach could potentially reduce the use of prior authorization or increase utilization generally if plans or providers expect the greater utilization to result in payments that offset the cost of that utilization.^{187,188} There is a risk that this approach could entrench lower payments where there has been historical underutilization (e.g., rural areas), thereby penalizing MA plans serving those beneficiaries¹⁸⁹ or creating an incentive to avoid those beneficiaries. Some strategies could mitigate these limitations, such as using data for risk adjustment that are less prone to influence from MA organizations and adjusting risk score calculations to accurately reflect health status in areas with low spending.¹⁹⁰ Other challenges include data availability and

accuracy at this scale, statistical noise for smaller plans, and the risk of new gaming incentives that require further exploration before implementing this approach. CMS is developing and plans to test AI-inferred risk adjustment in a new value-based payment model,¹⁹¹ with initial results available in 2028 that could also inform the approach in MA.

- ***Using AI or machine learning to predict costs more accurately.***¹⁹² A machine learning algorithm named “Franklin” that is based on age, sex, and diagnosis codes from traditional Medicare claims data was three times more accurate than the current approach at predicting costs, and accuracy gains were greatest among beneficiaries with zero or one HCCs, a group that has some of the greatest overpayments.¹⁹³ Franklin was also estimated to reduce overpayments due to favorable selection by 21%.¹⁹⁴ Although this or a similar approach may improve payment accuracy, it is not clear whether it would change MA organization behavior in terms of coding intensity. A model like Franklin that is based on all diagnosis codes could reduce coding intensity or make it more difficult to execute, whereas a model that used the same diagnosis codes as the HCC model could instead increase incentives to over code.^{195,196} There is also a risk that such models could weaken incentives to avoid overutilization and entrench existing areas of underutilization.¹⁹⁷ Ensuring transparency about how a model predicts costs would be an important implementation challenge.^{198,199}
- ***Limiting the impact of diagnosis codes that are easily gamed.*** The existing risk adjustment approach uses a statistical technique called “constrained regression” that limits the impact of specific factors on payments, including diagnoses that are vulnerable to gaming.²⁰⁰ This approach could be expanded to improve the accuracy of payments while reducing incentives to code intensively.²⁰¹ For example, prior year spending predicts current-year spending, but including prior year spending in the risk adjustment model would incentivize increased utilization.²⁰² With constrained regression, CMS could ensure higher payments for beneficiaries with higher prior year spending without adding spending variables to the model that would encourage overutilization.²⁰³ A similar option would be to limit diagnoses used in risk adjustment based on disease severity or the setting of the patient encounter.²⁰⁴ In its version 28 model, CMS has removed or constrained payments associated with conditions where diagnosis and coding patterns vary across plans and providers and ensured that conditions included in the model are stable predictors of costs.²⁰⁵ These changes are expected to reduce coding intensity incentives without appreciable negative impact on favorable selection.²⁰⁶ However, there may be some small additional risk of favorable selection with this approach. For example, the HCC version 28 model forces payments to be equal across different severities of diabetes, which means costs for the most severe diabetes category are underpredicted.²⁰⁷ Although this reduces the incentive

to use more severe diabetes diagnosis codes, it may inadvertently introduce an incentive to avoid beneficiaries with more severe diabetes.

- ***Simplifying the HCC model.*** One study found that just 10 diagnoses accounted for almost all the difference in risk scores between TM and MA; excluding them from payment calculations would align risk scores between the two programs and remove most of the discrepancy among plans with different levels of coding intensity.²⁰⁸ MA organizations could shift their coding intensity efforts to the remaining diagnoses still used for risk adjustment, but these conditions may be less at risk of overcoding given that their prevalence is similar between MA and TM.²⁰⁹ However, with a simpler model, MA organizations could be incentivized to avoid beneficiaries with the excluded diagnoses or scale back efforts to manage these conditions because they would no longer receive additional payments for those beneficiaries.²¹⁰ The impact would be similar if machine learning or AI were used to identify a simpler model (that is, using fewer diagnoses for risk adjustment).^{211,212} Some of the risks of this approach could be mitigated if combined with a reinsurance policy, as described below.
- ***Adding social determinants of health metrics to the risk adjustment model.***²¹³ This approach could help predict spending and reduce the importance of diagnostic codes.²¹⁴ Given that individual-level indicators are not consistently collected and potentially can be gamed (e.g., incentives may emerge for physicians to over-report health-related social needs), CMS could investigate the use of area-level proxies (e.g., area indices, county designation, median income) or individual proxies (e.g., months of Medicaid enrollment in the last year) because these factors cannot be gamed by MA organizations.²¹⁵ It is unclear how this would work with the current risk adjustment approach, and there is no evidence regarding whether it would actually improve payment accuracy or reduce gaming behaviors. In addition, although this approach has been suggested to reduce favorable selection,²¹⁶ there is no evidence that that is the case, and it could introduce new risks of favorable selection based on social characteristics.
- ***Developing a hybrid model that involves concurrent risk adjustment*** (i.e., based on data during the payment year) for beneficiaries with chronic, costly, and easily verifiable conditions ***and prospective risk adjustment*** (i.e., based on data in the year prior to the payment year) for all other beneficiaries.^{217,218} This approach has the advantage of providing more immediate funding to plans for beneficiaries who develop high-cost conditions.²¹⁹ In theory, if plans were reimbursed based on current health status, predicted payments would track closer to actual costs and there would be less incentive to avoid enrollees who might become more expensive or to employ plan designs—such as limited provider networks or prior authorization processes—that could encourage enrollees to disenroll if they develop expensive conditions.²²⁰ Additionally, plans should have less

incentive to market selectively to individuals expected to have low utilization relative to their risk profiles.²²¹ However, one study found that this hybrid model was worse than CMS' prospective model at predicting costs, particularly in the base year.²²² This could *increase* the risk of favorable selection because MA organizations would have better information about costs in that year, and it could increase the incentive to code intensively.²²³

- ***Making risk adjustment zero sum.*** This would be similar to the risk adjustment approach used for Marketplace plans, where risk adjustment payments to plans with above-average risk scores are offset by charges to plans with below-average risk scores so that risk adjustment payments are zero sum across plans.²²⁴ Although this would reduce the impact of coding intensity on total costs to Medicare, it would not reduce coding intensity incentives and would maintain financial advantages for MA organizations that code most intensively.
- ***Developing separate risk adjustment models for specific complex, or high-cost, conditions,*** similar to how CMS currently handles end-stage renal disease.²²⁵ This option would enable more accurate cost predictions within the subset of beneficiaries with certain conditions and reduce the incentive for favorable selection among that subset.²²⁶ However, this option would only be possible for highly prevalent conditions where the sample is large enough to ensure accurate predictions; many of these conditions overlap, making this option difficult to implement.
- ***Adjusting MA rates to account for recent switchers to MA.***^{227,228} Beneficiaries who are new to Medicare and chose to enroll in MA are assigned a risk score based on demographics alone, while beneficiaries who switch from TM to MA are assigned a risk score based on the diagnoses they received the previous year in TM. This adjustment would address the phenomenon that new MA enrollees usually have lower actual costs than predicted by average MA rates for a given risk score.²²⁹ CMS would group beneficiaries by their risk scores, rank their historical expenditures into percentiles, and calculate their actual spending compared to averages.²³⁰ Using these ratios, payments to MA plans for recent switchers would be proportionally adjusted.²³¹ The policy would need to specify how long after beneficiaries switch to MA to implement the adjusted MA payment rates.²³² With risk adjustment based on TM spending for recent switchers, there would be less incentive for MA plans to recruit and enroll healthier, low-cost individuals as payments would align more closely with plan costs.²³³

Introduce a reinsurance policy. Part D Medicare and Marketplace plans have access to reinsurance that protects issuers from the financial risks of enrollees whose costs far exceed expectations. In Medicare Part D, for example, CMS covers either 20% or 40% of drug costs (depending on the drug) once a beneficiary reaches the catastrophic threshold.²³⁴ A similar

one-sided reinsurance policy for MA plans could increase costs to Medicare, incentivize overspending, and fail to reduce the incentive to code intensively,²³⁵ but it may have advantages for favorable selection.²³⁶ Variants of this approach have been proposed, including a budget-neutral, two-sided reinsurance approach that requires MA organizations to repay some amount to Medicare when the plan payments received far exceed plan spending on a beneficiary's care while also reimbursing MA organizations for high-cost outliers.^{237,238} If combined with an approach to optimize the risk adjustment model, proponents argue that reinsurance could reduce the influence of diagnoses where risk-adjusted payments exceed spending; further reduce the incentive to code intensively because unusually high costs would be covered regardless of HCC scores; and reduce the incentive for favorable selection.^{239,240,241} Related implementation challenges include reinsurance being operationally complex and the fact that the lack of comprehensive cost information in MA encounter data would necessitate the additional collection of more granular cost data.^{242,243} One potential disadvantage of reinsurance is that using actual spending to determine payments may increase incentives for greater utilization.^{244,245} In addition, coding intensity incentives would remain throughout most of the cost distribution, while reducing plans' responsibility for enrollees with the highest costs. Further, this policy does not fully eliminate the incentives for favorable selection, particularly among beneficiaries whose costs are high but fall below the point at which reinsurance would apply.²⁴⁶ MA plans already have the option to spread risk across enrollees, which is the most feasible for plans with large numbers of enrollees, or to purchase reinsurance privately. Government reinsurance may be most beneficial to those smaller local and regional plans that would experience a reduction in private reinsurance costs.²⁴⁷

A related option is to remove outliers from the risk adjustment model and to cover high-cost outliers through a high-cost pool.²⁴⁸ This approach could improve the accuracy of the risk adjustment model in predicting costs and would reduce the impact of high-cost outliers on plans.²⁴⁹ This approach could also be tailored by risk adjustment model segment. For example, plans could allow for different outlier thresholds for beneficiaries who are eligible for Medicare based on age versus disability. However, this option is unlikely to reduce FWA because it will not reduce the incentive to code intensively. In addition, it could create a new risk of FWA, namely unnecessarily increasing utilization or overreporting spending to move cases into the high-cost pool.

Limit contractual arrangements that incentivize providers to capture more diagnosis codes.

Limits on certain contractual arrangements such as paying providers to submit codes or to use tools that identify additional diagnoses could help reduce coding intensity.^{250,251} For example, Congress could enact a ban on using percentage of premium contracts, gainsharing contracts, and other arrangements that incentivize providers to assist MA organizations in increasing Medicare payments.²⁵² This could be achieved by treating such arrangements as kickbacks and

by prohibiting MA organizations from paying for them.²⁵³ Congress could consider imposing additional limits on payer-provider vertical integration to increase providers' independence or even outlaw payer ownership of providers as has been proposed in a recent bill.²⁵⁴ Implementation could be challenging given the high prevalence of vertical integration and the large number of provider contracts that could be affected.

Introduce competitive bidding. This approach would involve MA organizations bidding to set the benchmark price or competing for contracts to deliver MA plans.²⁵⁵ CMS might select two or three organizations, similar to the approach taken by many employers offering insurance benefits to employees, or limit the number of plans a MA organization can offer in an area.^{256,257} Benchmarks would be based on MA plan bids, such as using the second-lowest or average bid to determine the benchmark.^{258,259} This approach could be an alternative to or used in combination with a benchmark based on TM (similar to the current approach) to avoid increasing costs where competition is insufficient to ensure that bids are priced below TM spending.²⁶⁰ Competitive bidding would require benefit packages to be standardized (e.g., to specify cost-sharing levels and supplemental benefits in addition to required Part A, B, and D covered services) so that MA organizations compete on price and quality. This would be in contrast to the current approach, where CMS sets the prices and MA organizations compete on plan benefits and quality.²⁶¹ It would be a major change, likely requiring Congressional action to grant CMS the authority to implement competitive bidding through regulation.

Competitive bidding has pros and cons. It is generally proposed as an option to reduce government spending on MA because it would incentivize MA organizations to submit bids that are expected to be lower than the current benchmarks.²⁶² Competitive bidding could also reduce the payoff from coding intensity because higher coding intensity would affect how payments are distributed among MA organizations rather than increasing costs relative to TM.²⁶³ Payments would still be adjusted for risk based on health status, leaving a risk of favorable selection among beneficiaries with similar risk scores. The difference would be that MA organizations' approaches to favorable selection would improve their competitive advantage rather than increasing total costs to Medicare.²⁶⁴ Indeed, the plans with the greatest cost savings due to favorable selection may be able to submit lower bids, increasing downward pressure on benchmarks.²⁶⁵ Competitive bidding would reduce stakeholder pressure on CMS and Congress to change benchmark rates.²⁶⁶ However, competitive bidding could significantly reduce choice, which could simplify enrollment decisions but also remove valuable options for beneficiaries.^{267,268} It could also change plan designs, potentially reducing the generosity of supplemental benefits and increasing out-of-pocket costs for enrollees, and also reduce the flexibility to innovate.^{269,270,271} It is unclear to what extent, or for how long, savings could be maintained if competitive bidding were used to determine the benchmark, or whether it could ultimately lead to plan exits, reduced competition, and increased costs.^{272,273}

Set benchmarks administratively. Instead of using the current method for setting benchmarks, in which benchmarks are based on observed TM spending, there has been discussion of setting MA benchmarks administratively. Under this approach, benchmarks initially would be set to correct for coding intensity and favorable selection and updated annually based on a predetermined growth rate calculation, similar to some Medicare fee-for-service payment systems.²⁷⁴ Such an approach would require Congressional action to grant CMS the authority to implement the benchmarks. Rate updates could be based on a formula (e.g., linked to inflation and adjusted for improvements in provider productivity similar to the inpatient prospective payment system approach).²⁷⁵ This would minimize administrative discretion and the associated pressure on CMS and Congress if rate updates were viewed unfavorably.²⁷⁶ In addition, methodology changes could be designed to ensure budget neutrality.²⁷⁷ However, setting the initial rate would be contentious, and, if based on either TM or MA spending, would entrench existing distortions.²⁷⁸ Although this approach may initially correct for coding intensity, coding incentives are likely to persist to the extent that payments are still risk adjusted. Administrative benchmarks could also put downward pressure on payments, reducing the incentive and resources for—but not completely eliminating—favorable selection.

Limit MA marketing tactics. In 2022, the Senate Committee on Finance uncovered evidence that Medicare beneficiaries were being targeted with aggressive MA marketing and other tactics that could contribute to favorable selection.²⁷⁹ Although such marketing is not inherently problematic, the large proportion of MA advertising depicting healthy, active people, and the fact that there was none depicting people with disabilities or other visible health challenges, suggests that marketing is designed to appeal to healthier beneficiaries.²⁸⁰ Marketing could also contribute to favorable selection if it is targeted to beneficiaries who are likely to have lower MA costs (e.g., veterans who receive services from the Veterans Health Administration) or if its intent is to avoid enrolling beneficiaries who are expected to have higher MA costs relative to payments. For example, brokers and agents working on behalf of large MA organizations have allegedly avoided enrolling beneficiaries with disabilities in MA plans as those beneficiaries were expected to be less profitable.²⁸¹ The Senate Committee on Finance’s report called on CMS and Congress to take multiple corrective actions, including monitoring MA disenrollment patterns, using enforcement authority to hold bad actors accountable, requiring agents and brokers to follow best practices, strengthening regulations around MA marketing materials, and closing regulatory loopholes that allow sales-related cold calls to beneficiaries.²⁸² Limiting aggressive marketing or other tactics that are meant to attract or avoid beneficiaries who are likely to be more or less profitable could help reduce favorable selection.

Interventions targeted at agents and brokers could also reduce favorable selection. Agents, brokers, and third-party marketing organizations can identify and selectively market to

beneficiaries who are expected to have lower health care costs²⁸³ by using screening questions to request information on beneficiaries' prescriptions, health status, and health care utilization. Favorable selection could be reduced by increasing funding to impartial advisory sources such as State Health Insurance Assistance Programs (SHIPs) relative to agents and brokers, who are paid by MA organizations.²⁸⁴ Additionally, introducing restrictions on agents and brokers, such as limiting their ability to collect health-related information in some circumstances, could reduce favorable selection. Challenges with these approaches include insufficient capacity among alternative sources of enrollment advice (e.g., SHIPs) and the need for agents and brokers to use some beneficiary health information to identify appropriate plans.

Introduce multiyear MA plans. Increasing the time between enrollment periods is a policy option that could have implications for favorable selection. To reduce favorable selection, a “lock-in” policy was phased in for MA plans between 2007 and 2011. Under that policy, enrollees could no longer switch from MA to TM—often in response to changing health needs—at the end of any month. Instead, they could switch only during annual open enrollment, during a special enrollment period triggered by an event such as moving to a different county, or once per year to enroll in a 5-star plan.²⁸⁵ The lock-in policy reduced consumer behavior that contributed to favorable selection among MA beneficiaries.²⁸⁶

Expanding on the lock-in approach, multiyear enrollment in MA plans has been proposed as a way to reduce payments to agents and brokers,²⁸⁷ improve patient experience and reduce disenrollment or switching, and increase plans' incentives to invest in longer-term outcomes.²⁸⁸ Examples of investments in longer-term outcomes include preventive care, value-based provider contracts with longer measurement periods, upstream drivers of health, and treatments with high initial costs but longer-term benefits. CMS could test 3- to 5-year contract periods through an Innovation Center model or through regional demonstration projects to assess different aspects of multiyear enrollment.^{289,290}

Multiyear enrollment could reduce or increase favorable selection. One report suggested that such a policy could create *adverse* selection because, assuming that multiyear plans are optional alongside single-year plans, multiyear plans would be most attractive to beneficiaries with expensive long-term conditions.²⁹¹ This could be desirable from a program perspective, and any negative impact on MA organizations could be mitigated through mechanisms such as risk adjustment or risk corridors.²⁹² With fewer open enrollment periods, there would also be fewer opportunities for undesirable behaviors from agents and brokers that can contribute to favorable selection, and fewer opportunities for MA plans to encourage beneficiaries to disenroll during annual open enrollment. However, multiyear plans would have significant challenges, including the long lock-in period, which would reduce an important protection: beneficiaries' freedom to choose to disenroll if an MA plan is not meeting their needs.²⁹³ This

would be an even greater concern if enrollment in multiyear plans was mandatory, as proposed in a House bill.²⁹⁴ The bill also includes a provision to allow disenrollment due to a hardship event, including serious illness.²⁹⁵ This could increase the risk of MA organizations, agents, and/or brokers engaging in inappropriate behaviors to encourage beneficiaries to disenroll when they develop expensive conditions, thereby increasing the risk of favorable selection. This policy option would need robust oversight and appeals processes in place to ensure that beneficiaries who are “locked-in” are able to receive needed care. Furthermore, CMS might consider expanding the reasons for special enrollment periods for beneficiaries who are enrolled in multiyear plans.

Auto-enroll beneficiaries in MA plans. CMS leadership and a house bill recently raised the possibility of enrolling beneficiaries in MA plans rather than TM as the default when they first become eligible for Medicare,^{296,297} a policy that is likely to have implications for favorable selection. Congress could introduce legislation to implement such a change, or CMS could test the approach through an Innovation Center model or demonstration.²⁹⁸ Proponents of default enrollment into MA contend that it would improve outcomes because patients would be in an accountable care relationship,²⁹⁹ that it would ensure that these beneficiaries have access to the supplemental benefits and lower out-of-pocket costs that are a feature of MA plans,³⁰⁰ and that MA organizations would spend less on agents and brokers.³⁰¹ The impact on favorable selection is unclear. Such a policy could reduce favorable selection because a wider range of beneficiaries would be in MA plans; however, disproportionate opt-out (to TM) remains likely among beneficiaries who expect to have high health care costs and consider their MA plan’s networks or other policies to be barriers to receiving necessary care. It could also reduce MA organizations’ concerns that offering benefits that attract higher-cost enrollees could result in adverse selection.³⁰² Auto-enrollment in MA also carries significant challenges, such as the risk that it could increase total costs to Medicare, that beneficiaries could struggle to obtain Medigap policies when they disenroll, and that it could disrupt patient-provider relationships.^{303,304}

Require broader provider networks. Broader provider network requirements, particularly for specialty services, could reduce favorable selection by increasing enrollment among beneficiaries with chronic conditions and by reducing the number of beneficiaries who disenroll due to difficulty accessing specialty services.³⁰⁵ MA organizations design provider networks based on quality and costs, considering the impact on their plans’ Star Ratings, rebates, and financial positions.^{306,307} However, limited networks can discourage beneficiaries from enrolling if they require more costly services. For example, MA plans may limit the extent to which their networks include comprehensive cancer centers or other providers that patients with complex medical needs may require.³⁰⁸ Therefore, patients with higher-cost medical needs may avoid enrolling in MA plans or, if they enroll and have difficulty getting care, will be encouraged to

switch back to TM.^{309,310,311} Broader networks can appeal to and provide access to care for patients with complex and high-cost medical needs and reduce the extent to which they avoid or differentially disenroll from MA plans.^{312,313}

Mitigation Approaches: Oversight

Many of the policies discussed earlier would require significant changes to oversight approaches, such as auditing any utilization data used for payment purposes and monitoring and investigating impacts on favorable selection. The oversight approaches discussed in the sections that follow assume no changes or limited changes to the approach used to pay MA organizations.

Increase the number and timeliness of RADV audits. Ultimately, CMS would like to audit all MA plans annually.^{314,315} One option that could increase the number of audits is for CMS to implement a recovery audit contractor (RAC) program for MA that is consistent with the RAC program for TM.³¹⁶ Current law authorizes a RAC program for MA, and CMS has sought information on proposals for the MA RAC program.³¹⁷ However, CMS has not implemented the program because vendors do not consider the approach viable due to payment structures, narrow scope of errors, and unlimited appeal timelines.³¹⁸ CMS also indicated that it has been able to achieve the same goals through the use of other contractors who conduct medical record reviews, payment error calculations, and other RADV tasks.³¹⁹

In 2025, CMS again proposed auditing all MA plans each year and announced an ambitious plan to use advanced systems to flag errors, aggressively expand its team of medical coders to review flagged errors, and complete all audits for payment years 2018 through 2024 by early 2026.³²⁰ As of March 2026, CMS had initiated audits for payment years 2018 and 2019 and published a schedule for initiating audits for payment years 2020 through 2025 by April 2027.^{321,322,323} CMS has also selected increasing numbers of plans for audit, up from 30 in payment year 2013 to 58 in payment year 2018 and 355 in payment year 2019.^{324,325,326} This indicates that CMS has made progress toward improving timeliness and increasing the volume of audits. Regardless of whether CMS can audit all plans annually, the announcement of this intent and its progress to date may have a deterrent effect on coding behavior. For example, MA organizations may try to identify undocumented diagnoses (due to both errors and fraud) that were subject to audits of prior years and reconsider internal strategies for ensuring comprehensive documentation for future payment years.

The increased pace, number, and impact of audits will increase pressure on MA organizations to identify medical records selectively, submit them in a timely manner, and make corrections within shorter timelines.^{327,328} Providers may also receive increased requests for medical records, even for plans with which they have no current contracts, and in some cases may be

liable for some of the overpayments, depending on their contracts with MA organizations.^{329,330} However, there is also some industry support for auditing all plans each year because it would provide more certainty for bidding, accounting, and financial reporting and enable MA organizations to obtain medical records from providers more easily.³³¹

In addition to recommending an increase in the number and timeliness of audits, the U.S. Government Accountability Office (GAO) has recommended that CMS make several changes to improve the timeliness of RADV audits and appeals.³³²

CMS has implemented some of the proposed strategies, including eliminating the lag between audit notification and requesting beneficiary records and reducing the number of medical records submitted per diagnosis.³³³ CMS is still using the Centralized Data Abstraction Tool, which was associated with challenges in transferring medical records to CMS in earlier audits, but the reduction in the number of medical records permitted per diagnosis could reduce pressure on the system in the absence of other upgrades.^{334,335} Additional adjustments to improve the timeliness of the audit and appeals processes could reduce the lag time between overpayments and recoupments, which could also increase incentives for accurate coding because overpayment liabilities will occur earlier.

Extrapolate results from RADV audits. Following RADV audits through 2017 (the most recent year completed as of November 2025), CMS has sought recoupments only for the enrollees sampled for audit and found to have associated overpayments, which would be some proportion of the 201 enrollees sampled per contract.³³⁶ Consistent with audit extrapolation approaches used in TM and other programs, CMS finalized a method that would allow extrapolation of RADV findings from the sampled enrollees to all audit-relevant enrollees, starting with audits for the 2018 plan year.^{337,338} For example, if the audit focused on a cohort of enrollees with a specific set of diagnoses, any audit findings would be extrapolated to other enrollees with one of those same diagnoses in the applicable payment year.³³⁹ This would result in significantly larger recoupments and a greater disincentive for MA organizations to submit unsupported diagnoses, including some of those identified through coding intensity strategies. Although extrapolation may be applied to increase recoupments from previous years, any announcements regarding extrapolation will have an impact on future FWA by altering MA organization and provider coding behaviors for future payment years.

Stakeholders disagree about whether CMS should pursue extrapolation. Some believe the greater penalties resulting from extrapolation are necessary to ensure overpayments are returned to Medicare and to provide a sufficient disincentive against inaccurate and fraudulent overcoding.³⁴⁰ However, there is significant industry opposition to this approach, including criticism that it is unfair to change the recoupment policy years after MA organizations

submitted bids for the plan year in question, and concerns that it could adversely affect MA plan offerings.^{341,342} There is also a risk that recoupments from extrapolated audit findings could be delayed or not realized due to appeals and legal challenges.³⁴³ Indeed, a judge vacated the regulation enabling extrapolation in 2025.³⁴⁴ CMS has appealed the ruling and intends to continue the RADV program to the extent possible while complying with the court ruling.³⁴⁵ However, it will not be able to implement extrapolation without a favorable decision on the appeal, additional rulemaking, or Congressional action.³⁴⁶

An industry group has supported extrapolation set at the lower bound of the 99% confidence interval of the estimated overpayment point estimate.³⁴⁷ This method, proposed by CMS in 2012,³⁴⁸ would mean that many plans with an estimated overpayment would not be required to make any repayments and those that do would pay much less on average than their estimated overpayment,³⁴⁹ likely reducing the deterrent effect of the audits and extrapolations. CMS has since emphasized that it will use any appropriate and statistically valid extrapolation method and has proposed a less conservative approach of using the lower bound of the 90% confidence interval of the point estimate to determine recoupments for the 2018 and 2019 payment years.^{350,351,352} Using the lower bound of the 90% confidence interval to determine recoupments or risk score changes is consistent with the approaches used by the HHS OIG for MA audits and by CMS for Marketplace plans.^{353,354}

Target audits and monitoring based on HRAs and chart reviews. Several stakeholders have proposed that CMS should look to identify improper use of HRAs and chart reviews to obtain unsupported diagnoses. Methods could include validating through audits those diagnoses that are reported only through in-home HRAs, HRA-linked chart reviews, any chart reviews, or any chart reviews for beneficiaries with no records of health care encounters; targeting oversight to those MA organizations that receive the greatest portion of payments driven by in-home HRAs; or requiring that MA organizations flag in encounter data any HRAs they initiate.^{355,356,357} CMS indicated that diagnoses from chart reviews were one of its selection factors for RADV audits for the 2018 payment year.³⁵⁸ These targeted audits could incentivize MA organizations to use HRAs and chart reviews more carefully and could potentially reduce coding intensity resulting from unsupported diagnoses.

Finance audits through MA plan user fees. In the absence of extrapolation, the RADV program could have a negative return on investment, assuming the program's operating costs are \$51 million per year and that the expected recoupments without extrapolation are just \$41 million in total for payment years 2011–2017.³⁵⁹ A negative return on investment could threaten the viability of the RADV program to deter and identify fraud and abuse. Section 1893(h) of the Social Security Act indicates that MA RACs should be paid a portion of the overpayment amounts they recover through collections, consistent with payments for TM RACs. Such a

payment structure would help ensure that audit costs are covered. In the absence of MA RACs, audits could be financed by MA organizations through other mechanisms, potentially with larger audit fees for plans that have higher rates of unsupported diagnoses.³⁶⁰ This approach could help ensure that CMS and its contractors have the resources and capacity they need to conduct sufficient audits and allow the audit program to adapt to fluctuations in the number of MA plans.

Increase financial or enrollment penalties. Several options have been proposed to increase financial penalties for submitting unsupported diagnoses, mostly with the aim of recouping more overpayments. Such a policy could also deter fraud. Some options include recouping overpayments from all prior years, extrapolating error rates to recoup overpayments for all similar beneficiaries in the plan (see above), recouping overpayments from audits conducted by the HHS OIG as well as CMS, and levying fines for unsupported diagnoses independent of recoupment amounts.³⁶¹ Fines in particular could help with deterrence if they are more immediate than recoupments and less susceptible to delays from appeals and reconsiderations. For example, Congress could increase penalties or CMS could use its civil monetary penalties authority to penalize plans with high error rates. CMS could also exclude plans from MA if error rates remain high.³⁶² CMS recently suspended an MA organization's enrollment and beneficiary communication activities as sanctions for sustained noncompliance, including failure to report risk adjustment data appropriately, delete undocumented diagnosis codes, and report and return overpayments within 60 days.³⁶³ Financial penalties also could be greater for audit findings that lead to prosecution under the False Claims Act, but meeting the standard of proof required for such cases might be difficult.^{364,365}

Focus audits on the plans most likely to have high rates of improper payments. For its audits of 2007 and 2011 plan year data, CMS selected a sample that included plans with low, medium, and high coding intensity.³⁶⁶ The GAO has recommended strategies to focus on plans that are likely to have high rates of improper payments, which would increase repayments and the detection of fraudulent practices relative to the previous approach.³⁶⁷ Recommended strategies include the following:

- excluding plans with low coding intensity scores and selecting more plans with high coding intensity scores
- selecting plans that had high rates of unsupported diagnoses in previous audits
- in cases where a plan that had previously high rates of unsupported diagnoses is no longer operating, selecting another plan in that service area from the same parent organization
- selecting some high enrollment plans that have either high coding intensity or high rates of unsupported diagnoses in previous audits³⁶⁸

For its audits of plan year 2018 data, CMS announced it would select plans that, among other characteristics, scored in the top 10% in one of two improper payment prediction models.³⁶⁹ This is consistent with GAO recommendations and could help disincentivize fraud.

Improve calculation of coding intensity for RADV purposes. In earlier audits, CMS calculated and used a measure of coding intensity to classify plans as high, medium, or low coding intensity and selected plans from each group for audit.³⁷⁰ The GAO recommended that CMS make several adjustments to the calculation of coding intensity to improve its ability to predict which plans might have a high proportion of unsupported diagnoses and, therefore, efficiently identify and recoup overpayments.³⁷¹ Although audits can uncover both errors and fraud, focusing audits through a more informative measure of coding intensity could help CMS to identify a greater proportion of fraudulent coding and create a stronger disincentive against engaging in fraud.

Introduce prepayment reviews. Rather than relying exclusively on retrospective audits, CMS could review medical records for targeted diagnoses before making risk-adjusted payments to MA organizations.^{372,373} This approach could reduce the need for RADV audits and associated appeals that can delay recoupments and prevent some inaccurate or fraudulent payments, but such an approach would be costly to implement.³⁷⁴

Improve oversight of favorable selection. It may be possible for CMS to strengthen existing oversight to reduce the risk of inappropriate favorable selection. Regulations require that CMS reviews benefit designs for features that might “discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services” (42 CFR § 422.100 (f)(2)).³⁷⁵ CMS guidance also notes that MA organizations must not request or encourage a beneficiary to disenroll and must apply disenrollment policies consistently.³⁷⁶ It is unclear how CMS conducts oversight of these requirements, or how often plan applications are denied or other penalties issued for failure to meet these requirements. The HHS OIG or another independent party could review CMS oversight procedures, identify any important favorable selection risks that CMS may not be monitoring, and recommend approaches to improve oversight and reporting.

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