



Comparing MA Payments to FFS Spending during Risk-Model Transitions

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The Medicare Payment Advisory Commission's (MedPAC) comparison of Medicare Advantage (MA) payments to traditional Medicare fee-for-service (FFS) spending shows parity when measuring MA payments from plan bids and quality bonus payments (described in Analysis 1 below). However, BRG's analysis finds that MedPAC's approach does not reflect expected reductions in payments to MA plans as a result of the transition to the new Centers for Medicare and Medicaid Services (CMS) Hierarchical Condition Categories (HCC) risk adjustment model (v28) from 2024 to 2026. MedPAC applies the same risk-adjustment factor when calculating MA payments and FFS spending. As a result, risk-adjustment policies that change payment to MA plans have no effect on MedPAC's ratio.

To show how v28 leads to relatively lower payments to MA plans, BRG professionals created an alternative model (Analysis 2) that compares payment to MA plans under v28 to FFS spending trended forward using CMS estimates. Under Analysis 2, BRG estimates the MA:FFS ratio would be 97% in 2024 and may decline to 91% in 2026.

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Introduction

Each year MedPAC compares aggregate Medicare payments to MA plans to what spending for MA beneficiaries would be if they were enrolled in FFS. Its analysis adjusts the FFS population to create equivalent populations in both MA and FFS using diagnostic risk coding and enrollment patterns and calculates a spending ratio of MA to FFS. Focusing on this MA:FFS spending ratio alone, however, will not capture absolute changes in MA plan payments during a risk-adjustment-model transition.

BRG finds that MedPAC's MA:FFS spending ratio shows parity between MA and FFS but does not reflect how CMS-HCC risk adjustment model (v28) will reduce MA payments from 2024 to 2026. MedPAC's approach assumes that revised risk scores would translate directly to lower FFS spending, despite CMS estimates that show growing FFS spending from 2024 to 2026.

This paper describes how MedPAC's MA:FFS spending ratio is calculated, identifies potential drawbacks to focusing on this ratio during a risk-adjustment-model transition, and offers an alternate analysis that models FFS spending based on projected growth.

Analysis 1: Equivalent Risk Adjustment

MedPAC's MA:FFS spending ratio is a comparison of per-beneficiary MA payments to per-beneficiary FFS spending for an equivalent population. Its analysis evaluates MA and FFS parity by determining the ratio of the cost for MA enrollees to an estimated equivalent of the cost for those MA enrollees if they were in FFS. MedPAC has performed this analysis since 2007.¹ Payment for MA enrollees is the total risk-adjusted payments made to MA plans, including rebates. The FFS equivalent is based on FFS spending used to calculate MA benchmarks, adjusted by MA risk scores and enrollment patterns.

Figure 1. Illustrative Example: in Analysis 1, risk score affects spending levels, but not the MA:FFS spending ratio

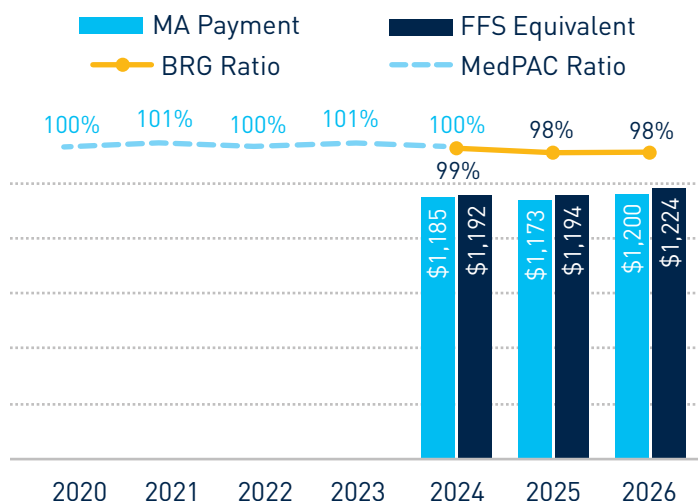
RA Model	MA Payments (PMPM)			÷	FFS Equivalent (PMPM)			=	MA:FFS Ratio
	MA Payment	× MA Risk Score	= Total Payment		FFS Equivalent	× MA Risk Score	= Total Spending		
v24	\$1,500	1.2	\$1,800		\$1,500	1.2	\$1,800		100%
v28	\$1,500	1.0	\$1,500		\$1,500	1.0	\$1,500		100%

A key feature of the MA:FFS spending ratio is that it applies the same risk-score factor used to calculate the numerator (MA payment) when calculating the denominator (the FFS equivalent) (Figure 1). On the one hand, it is necessary to carry over the risk, or expected health, of the population when calculating an equivalent spending estimate under a different payment program. On the other hand, it creates a scenario where risk-score changes are not—and cannot be—reflected in the MA:FFS spending ratio, as they will always cancel each other out. This includes ongoing changes to update the CMS-HCC risk-adjustment model to v28, which began to go into effect in 2024. While CMS estimates a raw risk adjustment payment impact of -4.4% in 2025 due to the phase-in of v28,² the v28 payment reductions do not show up as changes in MedPAC's MA:FFS spending ratio.

Since 2017, MedPAC has estimated a base MA:FFS spending ratio of 100% or 101% (shown since 2020). Using the same base MA:FFS spending ratio calculation, BRG projects a slight decline in the ratio from 2024 to 2026, from 99% to 98% (Figure 2).³ MedPAC makes additional adjustments to the MA:FFS spending ratio to reflect different coding patterns in MA and estimates of favorable selection that are not included here.

As noted above, risk-score changes due to v28 reduce the rate of growth in MA payment and the FFS equivalent from 2024 to 2026, effectively canceling each other out for the purposes of calculating the MA:FFS spending ratio. The slight decline in the MA:FFS spending ratio is instead driven primarily by two factors: MA plan bids and star ratings bonus payments. MA plan bids have been decreasing relative to FFS spending in recent years, and BRG's model assumes that trend will continue. Bonus payments will be lower due to lower star ratings in 2024-2025, and BRG projects they will not significantly rebound in 2026.

Figure 2. Analysis 1: MA:FFS Spending Ratio



1 MedPAC, *Report to the Congress: Medicare Payment Policy*, chapter 4, "Update on Medicare private plans" (March 2007).

2 CMS, "Advance Notice of Methodological Changes for Calendar Year [CY] 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" (January 2024).

3 BRG's 2024 estimate is <1% lower than MedPAC's 2024 estimate. MA payment and MA risk scores are modeled using BRG's MA model, described in the Methodology section below.

Analysis 2: FFS Trend Projection

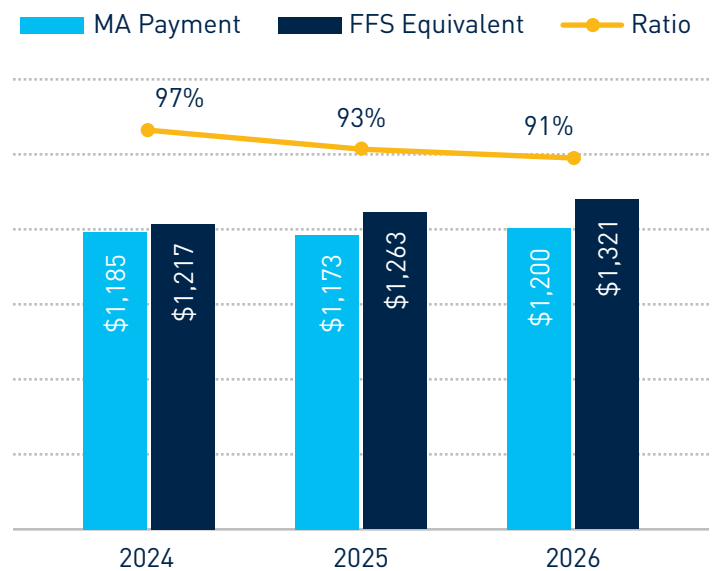
As noted above, the MA:FFS spending ratio in Analysis 1 does not change even when MA risk scores change due to a new CMS-HCC risk model. To show the effects of v28's risk-model changes on the MA:FFS ratio between MA payments and FFS spending, this alternate analysis estimates an FFS equivalent using CMS's projected FFS spending growth from 2024 to 2026.

To create equivalent populations, BRG projects MA payments using BRG's MA model, as in Analysis 1. MA payment for 2024 to 2026 remains the same: relatively flat, reflecting a net combination of effective growth rates, star ratings, risk adjustment, normalization factors, and other components of annual changes to MA payments.

BRG projects the FFS equivalent by first adjusting 2023 FFS spending by 2023 MA risk scores. 2023 is the last year before the v28 risk model is phased in. For 2024 to 2026, FFS spending for the same period grows about 4% annually on average, based on CMS projections for FFS US Per Capita Cost (USPCC) growth, a projection of actual experience of paid FFS claims.⁴

As FFS spending grows more quickly than MA payments, the Analysis 2 ratio of MA spending to FFS spending declines. Analysis 2 finds that MA payments are 97% of FFS spending in 2024 and would decline to 91% in 2026 (Figure 3).

Figure 3. Analysis 2: MA:FFS Ratio



Implications for Policymakers

This paper highlights how focusing on the MA:FFS spending ratio can have drawbacks when evaluating how payments to MA plans change during a risk-model revision. For 2025, CMS estimated the raw risk adjustment payment impact of phasing in v28 at -4.4%, but even if CMS estimated the impact to be -50% lower payments, the MA:FFS spending ratio would remain unchanged when calculated under the Analysis 1 approach. Other changes to risk scores—for example, from an increase in the adjustment for coding pattern differences—also would leave the MA:FFS ratio unchanged. In contrast, MA plans will likely experience v28's lower payments the way they are described in Analysis 2 while FFS spend likely increases as projected by CMS. Policymakers should think of MedPAC's MA:FFS spending ratio as a metric that highlights annual trends in star ratings and MA plan bids relative to benchmarks, not risk adjustment.

⁴ CMS (2024).



Methodology

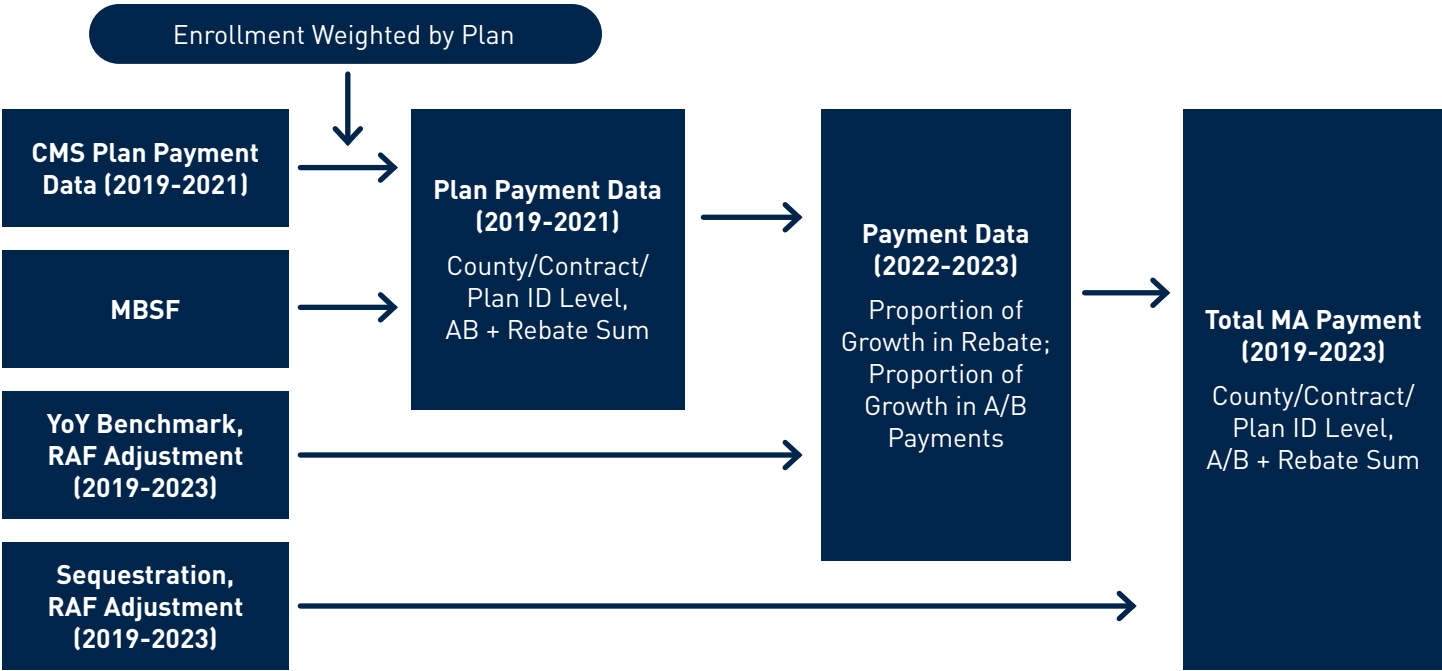
BRG projected MA payments for the period from 2024 to 2026 with a proprietary MA model that uses inputs from CMS and analysis of MA encounter and FFS claims data. More information about the model can be found [here](#). Our national estimates for spending and enrollment growth align closely with the Office of the Actuary at CMS, and our rebate estimates align with MedPAC and CMS Plan Payment data.

To replicate MedPAC’s analysis, BRG followed the approach detailed in MedPAC’s March 2023 *Report to the Congress*.⁵ FFS spending is derived from CMS’s estimate of county-level per-beneficiary spending that is produced to calculate MA benchmarks and published annually in the MA rate book. Projected FFS spending for 2025 and 2026 is based on CMS’s estimates of FFS USPCC growth rates published in the 2025 Advance Notice.⁶ National average FFS spending is enrollment weighted based on MA enrollment and risk adjusted based on MA risk scores. Employer group plans are included in the national-average MA payment estimates. BRG did not replicate or include MedPAC’s estimate of favorable selection or coding intensity beyond the statutorily required coding-intensity adjustment.

Limitations

MA payments and FFS spending could vary from projections due to changes in healthcare utilization or Medicare prices. MA plan behavior could increase or decrease payments relative to BRG and CMS projections, including bidding, star ratings, and/or reactions to v28.

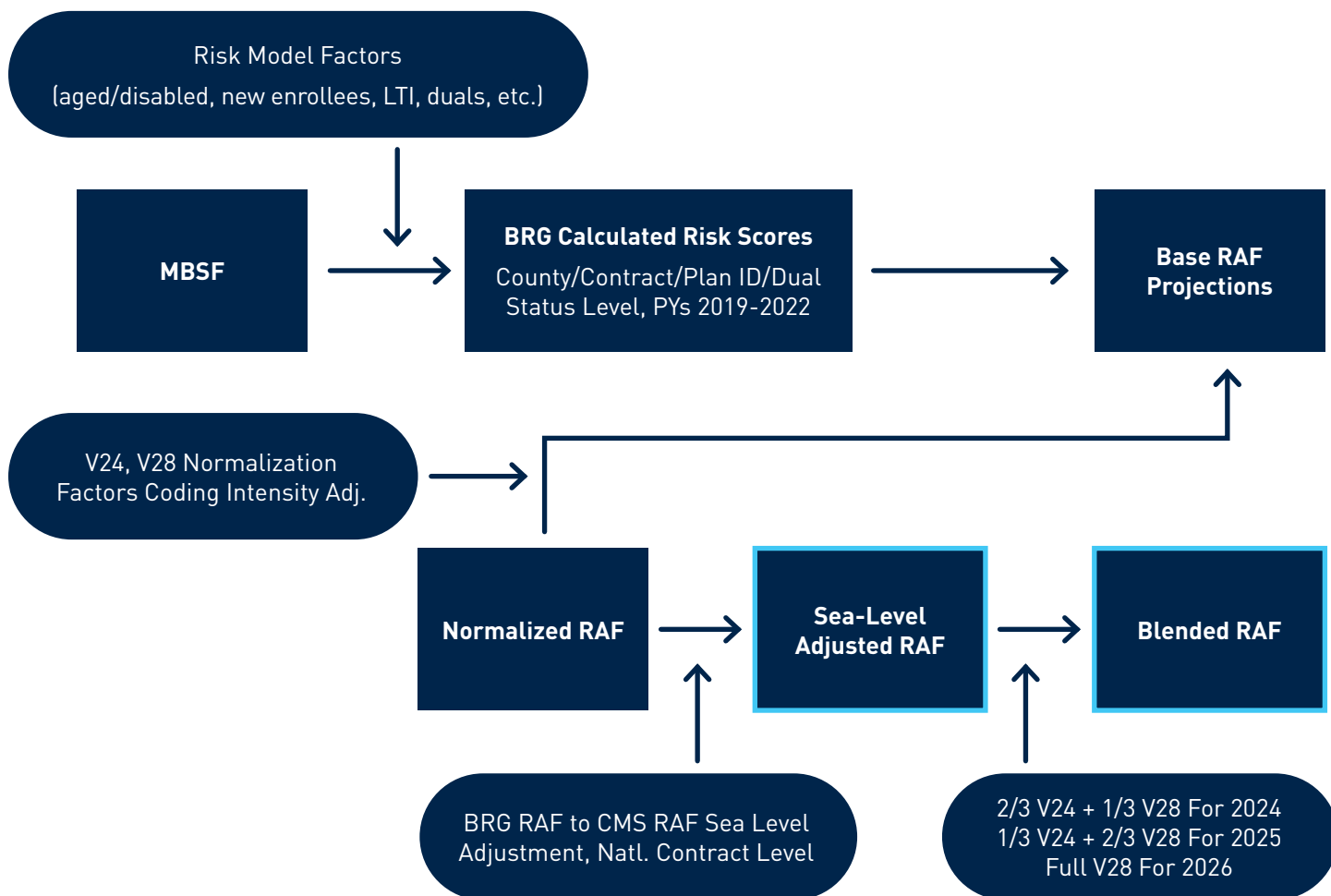
Figure 4. BRG MA Payment Model Methodology



5 MedPAC, *Report to the Congress, Medicare Payment Policy*, chapter 11, “The Medicare Advantage program: Status report” (March 2023).

6 CMS (2024), Table I-5.

Figure 5. Risk-Score Methodology



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