MILLIMAN WHITE PAPER

# Estimated Financial Impact of Removing In Home Health Risk Assessments (HRA) Diagnoses for MA Risk Adjustment

Commissioned by UnitedHealth Group, Inc.

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## Summary

UnitedHealth Group commissioned Milliman to estimate what the reduction in federal expenditures to Medicare Advantage Organizations (MAO) would be if the Centers for Medicare & Medicaid Services (CMS) were to no longer include diagnosis submissions from in-home health risk assessments (HRA) in the Medicare Advantage (MA) risk adjustment calculations.

The Congressional Budget Office (CBO) has previously analyzed the impact to federal expenditures of removing diagnoses captured through in-home HRAs for risk adjustment purposes, as one of their various published analyses regarding options to reduce the federal deficit.[1] CBO's analysis did not model the financial impact of removing in-home health risk assessments in isolation, though; its analysis also included the estimated impact of using two years of diagnosis data within the risk adjustment model. The Office of Inspector General (OIG) and Committee for a Responsible Federal Budget (CRFB) have also analyzed similar proposals.[2] Milliman performed our analysis over the 10-year period of 2026 through 2035. This white paper describes the findings of our analysis.

- We estimate federal savings over the 10-year period from 2026 through 2035 of $57 billion, or $13 per member per month (PMPM).
- Estimated Year 1 savings would be $4.2 billion in 2026, growing to $7.3 billion in calendar year 2035.

We assume that MAOs would maintain current gain / loss margin levels and allocate the entire revenue reduction to beneficiaries in the form of increased cost sharing, removal of supplemental benefits, and / or increases in beneficiary premiums (i.e., 100% of reduced revenue will be offset by reduced beneficiary benefits). Alternatively, if MAOs decreased margin levels, this would result in greater federal savings.

## Background

In Medicare Advantage, MAOs receive a monthly capitation rate from CMS, for all members enrolled in their plans. The monthly capitation covers the cost of providing benefits, including the benefit cost, administrative cost, and any margin or profit. to manage the medical expense for their enrolled population. This capitation rate is adjusted for each beneficiary's risk score to reflect the illness burden or morbidity of its population relative to the entire Medicare population. Medicare risk scores are developed based on each beneficiary's current year demographic factors and prior year medical diagnosis documentation and submissions. Because the payments MAOs receive from the federal government are adjusted based on these risk scores, MAOs have a financial incentive to properly document and submit diagnoses for all beneficiaries to ensure they are appropriately compensated for the morbidity of the beneficiaries enrolled in their MA plans. As such, it is likely for the same population to have a higher average risk score in MA compared to traditional Medicare (Medicare Fee-for-Serve or FFS), even if the underlying morbidity level is the same because this financial incentive does not exist for the FFS population.

Many organizations, including the Medicare Payment Advisory Commission (MedPAC) and the OIG, have long advocated for addressing the higher MA coding level relative to FFS. In 2024, the OIG released a report where they analyzed the use of health risk

[1] https://www.cbo.gov/budget-options/60907
[2] https://www.crfb.org/blogs/cbos-medicare-savings-options

assessments and estimated financial impacts for payment year 2023.[3] Given that MA plans utilize these types of services at a higher proportion relative to FFS, removing diagnosis submissions related to these events will result in a greater reduction to MA risk scores relative to FFS risk score. All else equal, these reductions will lower the final risk adjusted payments provided by the federal government to MA plans.

# Results

We estimate that removing in-home HRA diagnoses for MA risk adjustment purposes would decrease federal expenditures by approximately $57 billion during the 10-year period from 2026 through 2035. We assume MAOs would maintain the same profit margins that they currently have and would allocate the full revenue reduction to beneficiaries.

Figure 1 displays additional details on estimated federal savings if this proposal is implemented. Results are shown for Year 1 (2026), Year 10 (2035), and the 10-year total in terms of total dollars and PMPM.

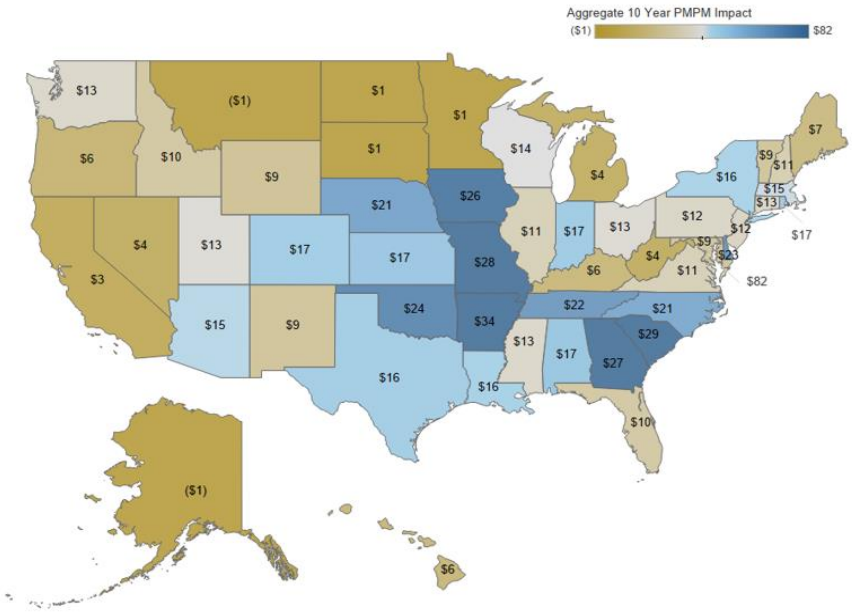
**FIGURE 1: ESTIMATED FEDERAL SAVINGS FROM REMOVING IN-HOME HRA DIAGNOSES FROM RISK ADJUSTMENT**

| | TOTAL DOLLARS ($B) | PMPM IMPACT |
|---|---|---|
| **Year 1 (2026)** | $4.2 | $11 |
| **Year 10 (2035)** | $7.3 | $15 |
| **Total 10 Year** | $56.9 | $13 |

To maintain the same profit levels they currently have, we assumed that MAOs would maintain the same Bid PMPM amount they currently have. Maintaining the same Bid PMPM increases the revenue received from the federal government, relative to decreasing the Bid PMPM. Alternatively, if MAOs decreased margin levels, this would reduce the Bid PMPM, resulting in more federal savings.

When analyzing these impacts by state, there is wide variation in terms of total dollars and on a PMPM basis. Figure 2 displays the estimated aggregate 10-year PMPM impact by state.

**FIGURE 2: ESTIMATED AGGREGATE 2026-2035 FEDERAL SAVINGS PMPM**




[3] https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf

Washington, D.C. experiences by far the greatest impact of this change at $82 PMPM. The state with the second highest estimated impact is Arkansas, which experiences a $34 PMPM impact. This indicates that a significant portion of diagnoses for MA beneficiaries residing in Washington D.C. are captured through the in-home HRA process. Among the three states with the largest enrollment, Texas experiences a high PMPM impact, about 30% higher than the nationwide average ($16 PMPM compared to $13 PMPM). California and Florida experience much lower impacts of about $3 PMPM and $10 PMPM, respectively, though the total dollar impacts in these states are still expected to be high because both states have a large number of MA beneficiaries.

There is wide variation in impact by state, which brings up a few key observations:

- Certain states have essentially no impact, such as Minnesota, North Dakota, and South Dakota. This indicates that few diagnoses in aggregate are captured from in-home HRAs. These states are more rural, which could be a reason that they have fewer in-home assessments in aggregate.
- Montana and Alaska are expected to experience a slightly negative impact, which indicates that the rate at which diagnoses are captured by MAOs through in-home HRAs in these states is less than nationwide average of beneficiaries who are enrolled in FFS Medicare. This implies that an extremely small amount of diagnoses in aggregate are captured through in-home HRAs in Alaska and Montana.
- In terms of total dollars, Texas experiences by far the highest impact from the change even though California and Florida have significantly more Medicare beneficiaries enrolled in MA plans (40% and 15% more MA beneficiaries in these states, respectively, compared to Texas). This indicates that MAOs in Texas capture significantly more diagnoses through in-home HRAs on a per member basis relative to California and Florida.

Additional details on the impact by state and county can be found in the accompanying appendix.

If the removal of in-home HRAs proposal is implemented and MAOs were to maintain the same profit margins as they had in 2025, we estimate that over the next 10 years MAOs would need to reduce benefits (increased beneficiary cost sharing or decreased non-Medicare covered supplemental benefits) or increase beneficiary premiums between $11 to $15 per month.

If MAOs intend to maintain current profit margins, there are several mechanisms available to help absorb revenue reductions. In addition to changes to benefits and premiums, MAOs could consider the following items to help offset the lower federal revenue:

- Adjust provider contracting strategies – MAOs may review their provider contracting arrangements and potentially reduce provider reimbursements in some situations. For example, this could hypothetically be in situations where providers are reimbursed above 100% of the Medicare fee schedule and MAOs may decrease the reimbursement to better align with the fee schedule. MAOs may also engage in additional risk sharing deals, requesting that providers take downside risk if claims are above an agreed upon amount.
- Increase focus on care management and utilization management – MAOs may look for opportunities to improve clinical outcomes, reduce complications, and eliminate waste through additional care management and utilization management programs.
- Improve risk score coding practices – Capturing diagnoses from in-home HRAs is just one mechanism that MAOs have to ensure all diagnoses are appropriately captured. If this method of capturing diagnoses were no longer permitted, MAOs would likely not accept lower risk scores, and would instead attempt to use other mechanisms to capture beneficiaries diagnoses to ensure that the risk-adjusted payments received from the federal government correctly reflect the illness burdens of their enrolled population.

The magnitude of federal savings depends on how much MAOs would adjust margin versus the various levers mentioned above as a result of this change. Greater reductions in margin would result in greater federal savings, though MAOs are unlikely to be able to absorb much of the cost through margin.

While OIG recommends restricting the use of diagnoses solely reported through in-home HRAs or chart reviews linked to in-home HRAs for MA risk adjustment calculation purposes, CMS has expressed that the following items are considerations in analyzing in-home HRAs:

- Diagnosis submissions from in-home HRAs cannot be deemed as inaccurate without conducting medical record reviews of those encounters.
- The E&M codes employed by the OIG for in-home HRA identification encompasses a broad range of services.
  - It is challenging to discern the specific intent behind an in-home HRA, whether it is aimed at coding assessment or treatment
  - It is essential to address and reduce any disincentives that might prevent MA plans from delivering suitable home-based services.

# Methodology and Assumptions

In conducting this analysis, we relied on the following CMS data sources: 2025 Rate Announcement, 2024 Medicare Trustees Report, 2021 & 2022 MA encounter data, through our access to the 100% CMS Research Identifiable Files (RIFs), September 2024 MA enrollment files, and 2024 Star Ratings (released October 2023; used in 2025 MA bids).

Identifying in-home HRAs can be challenging based on MAOs latitude in reporting said encounters. For this analysis, we identified in-home HRAs as encounters meeting the following criteria:

- HCPCS codes related to “E&M – Residence” OR “Preventive”
- Place of Service code equal to Home Residence

We sensitivity tested slight variations of this criteria but did not observe any material impacts to our final estimates.

We summarized enrollment, risk scores, benchmark, bid-to-benchmark (B2B) ratios, and star rating information. We summarized the information first from a plan-level and then aggregated to county and state level. Once aggregating all information at a county-level, we projected CMS revenue each year at the county and state levels from 2026 to 2035. Our modeling includes HMO, HMO-POS, LPPO, RPPO, and EGWP plan types, which account for nearly 100% of all MA enrollment.

We modeled the impact of removing in-home HRAs across both the FFS and MA population. All financial results we summarized are based on the net impact to MA risk scores above and beyond the impact to the nationwide FFS risk scores. We calculate the net impact because the risk score normalization factor that is used to calculate the payment risk scores each year is based on the estimated risk score trend for the nationwide FFS population, so we adjust for the change in FFS risk scores if this proposal were to be implemented. If CMS chose to not adjust the FFS risk adjustment data for the removal of in-home HRAs, then the negative revenue impact to MAOs would be even greater than the values in this report.

We apply the projected MA enrollment trends from the 2024 Trustees Report and applied the equivalent percentage for any year for the MA market. Our modeling assumed 387 million MA member months in 2026 and 489 million member months in 2035. Each year, we calculate the CMS Revenue = Bid PMPM + Rebate Retention % x [MA benchmark PMPM – Bid PMPM]).

In projecting results, we applied MA benchmark trends based on historical averages; however, we did not adjust the 2025 starting star ratings levels for potential future impacts. Specifically, while we anticipate star ratings will vary materially at the plan level, excluding the impact of potential star rating changes best isolates the projected impacts of this potential legislative change.

# Caveats, Limitations, and Qualifications

The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the American Academy of Actuaries to perform the analysis supporting this report.

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Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate what the federal expenditure impact would be if in-home Health Risk Assessment diagnoses would no longer be included in MA risk adjustment. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We relied upon certain data and information from CMS and UnitedHealth Group for this purpose and accepted it without audit. To the extent the data and information relied upon is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, output, and this report, may not be appropriate and should not be used for any other purpose.

Future healthcare costs are highly uncertain and will likely vary from our current summaries and will depend on the demographic characteristics and health statuses of enrolled beneficiaries, a plan’s geography, and other factors.

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