



# Reimagining the Medicare Advantage Risk Adjustment Program

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*May 2023 (updated May 23, 2023)*

**As Medicare Advantage (MA) enrollment grows, encompassing half of the Medicare population, managing payment to MA plans is increasingly important for the financial health of the Medicare program. Researchers and regulators have long noted that MA plans are overpaid, particularly via the risk adjustment system. The Urban Institute convened two workshops with experts on MA and risk adjustment to discuss potential reforms to MA risk adjustment and the MA payment system. This brief summarizes the key proposals discussed by the expert panelists, including potential benefits, drawbacks, and areas for further research.**

Over half of Medicare beneficiaries are enrolled in a MA plan (Biniek et al. 2023). These private plans offer lower cost-sharing than the traditional Medicare (TM) program and are often combined with prescription drug coverage and supplemental benefits. MA plans have shown they can offer Part A and B services for less than TM in many parts of the country. However, the savings generated accrue primarily to MA plans and their enrollees, not to the Medicare program. The Affordable Care Act included provisions to reduce MA payments, but a wide range of evidence indicates that MA plans, on average, continue to be overpaid, particularly via the risk adjustment system. Some evidence suggests overpayment is getting worse over time (Kronick 2017).<sup>1</sup>

The MA payment system is complex. MA plans submit bids to offer Part A and B services, and those bids are compared to a predetermined benchmark based on TM spending in a local area. If plans bid below the benchmark, which most do, they keep a portion of the difference between their bid and the benchmark as a rebate. These rebates can be used to lower cost-sharing, reduce

premiums, offer more affordable Part D coverage bundled with the MA plan, or offer supplemental benefits like dental and vision coverage. In some counties where TM spending is low, benchmarks for MA plans are set up to 15 percent above TM spending in the county. In high-spending counties, MA benchmarks are set at 95 percent of TM spending. In 2022, MA payment averaged 100 percent of TM, not including risk adjustment payments (MedPAC 2022a).

After initial MA payment rates are calculated based on their bids and rebates, they are adjusted up or down based on the estimated risk of enrollees in their plan. Plans with an average risk score above 1.0 receive additional payments from Medicare. Those with an average risk score below 1.0 pay back a portion of their initial payment (we refer to these payments as risk adjustment charges). The risk adjustment system is designed to pay plans appropriately for the risk of the beneficiaries they enroll. Payments are reconciled when final risk scores are available. Risk adjustment payments to MA plans are not budget-neutral (i.e., positive and negative adjustments for risk do not balance out to zero). Because risk scores across all MA plans average to more than 1.0, MA plans as a whole receive positive net payment adjustments from the Medicare program. Without appropriate risk adjustment, MA plans have an incentive to avoid potentially high-cost enrollees. Evidence suggests that the risk adjustment system has reduced favorable selection into MA (McGuire and Newhouse 2018; McWilliams, Hsu, and Newhouse 2012).

However, the current MA risk adjustment system has significant downsides. The Centers for Medicare and Medicaid Services Hierarchical Condition Category (CMS HCC) risk adjustment system incentivizes MA plans to code as many diagnoses as possible, at the highest severity possible, to maximize payments. Moreover, the current risk adjustment system is calibrated with TM data, and TM has no equivalent incentives to vigorously code diagnoses. The Medicare Payment Advisory Commission (MedPAC) estimates that, after accounting for the high level of diagnostic coding in MA relative to TM, MA plans receive 104 percent of what would be spent in TM on an equivalent group of enrollees (MedPAC 2022a). This finding is not new. As MedPAC has stated, “The MA program has been expected to reduce Medicare spending since its inception—under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of [fee-for-service] payments—but private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed” (MedPAC 2022a).

To correct for this disparity in coding, CMS reduces MA risk scores by a “coding intensity adjustment” of 5.9 percent. However, MedPAC found that, in 2021, MA coding was 10.8 percent higher than in TM on average (MedPAC 2023). The coding intensity adjustment has remained at 5.9 percent since 2018, even as the extent of coding intensity has continued to grow (Kronick 2017).<sup>2</sup> Given the size of the MA program, even small overpayments can significantly reduce the sustainability of the Medicare program while increasing MA plan profitability. Total overpayments in 2023 are estimated to be \$23.1 billion.<sup>3</sup> In response to concerns about overpayment, CMS tightened risk adjustment audit rules for 2023, which they expect will result in a recovery of \$4.7 billion from plans between 2023 and 2032.<sup>4</sup> In addition, CMS has proposed changes to the risk adjustment

model for 2024, including removing several diagnoses subject to discretionary coding.<sup>5</sup> These changes are expected to reduce plan payments by 3.1 percent in 2024, or over \$11 billion in net savings.<sup>6</sup> However, overall MA payment is expected to increase by 1.0 percent in 2024.<sup>7</sup>

Given the critical importance of MA to Medicare solvency and sustainability and MedPAC's continued concerns about the effects of coding intensity on the risk adjustment system, the Urban Institute, with support from Arnold Ventures, hosted a series of two workgroups with experts on MA risk adjustment (box 1). The workgroups aimed to identify current problems in the MA risk adjustment system, on-the-table reforms, and outside-the-box solutions to inform the research environment.

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#### BOX 1

##### **The Panel**

The Urban Institute held a series of two virtual workgroups titled Reimagining the Medicare Advantage Risk Adjustment and Payment System. The panelists included 12 experts in MA and risk adjustment:

- Robert Berenson, the Urban Institute
- John Bertko, Covered California (retired)
- Gretchen Jacobson, the Commonwealth Fund
- Andy Johnson, MedPAC
- Richard Kronick, University of California San Diego
- Timothy Layton, Harvard University
- Thomas McGuire, Harvard University (retired)
- David Meyers, Brown University
- Amol Navathe, University of Pennsylvania
- Eric Roberts, University of Pittsburgh
- Cori Uccello, American Academy of Actuaries
- Richard van Kleef, Erasmus University, the Netherlands

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This brief describes key areas of concern about the MA risk adjustment system and ideas for reform discussed by the expert panel, including current problems in MA risk adjustment, reforms that could be made within the current system, and potential new approaches to risk adjustment.

# What Are the Current Problems in MA Risk Adjustment?

The panel discussed several current problems in MA, including risk selection, differential diagnostic coding, and the MA payment system (table 1).

TABLE 1

**Identified Problems in the MA Risk Adjustment System**

Problem	Description
Risk selection	While the risk adjustment system has significantly reduced the incentives to risk select, it is possible that selection still occurs for small, high-need groups of beneficiaries. Such selection is difficult to detect <sup>8</sup> and may be obscured by differences in coding between MA and TM.
Differential coding	Differential coding between MA and TM leads to overpayment of MA plans via risk adjustment. The current MA coding intensity adjustment of 5.9 percent is too low to fully adjust for the differences in coding.
MA payment system	The MA payment system, including rebates, risk adjustment payments, and quality bonuses, creates an unlevel playing field between MA and TM. This makes it difficult for value-based programs within TM, like Accountable Care Organizations, to compete with MA.

**Source:** Urban Institute synthesis of panelist discussion at two risk adjustment workshops.

**Note:** This list is not intended to be comprehensive but instead reflects the problems in MA risk adjustment that generated the most discussion among panelists. MA = Medicare Advantage; TM = traditional Medicare.

## Risk Selection

The panelists largely agreed that the MA risk adjustment system has significantly reduced incentives for plans to selectively enroll healthier beneficiaries. Estimating the degree of selection (both into MA relative to TM and within MA across plans) is complicated by the difficulty of detecting risk selection activities and differences in diagnostic coding between MA and TM. Studies that use other data sources to evaluate the relative risk of MA and TM enrollees overall show degrees of favorable selection that have fallen over time. Favorable selection into MA earlier in the program’s history was substantially reduced after the current HCC approach was fully phased in as of 2007 (McWilliams, Hsu, and Newhouse 2012). Based on comparably measured prescription drug utilization data, Jacobs and Kronick (2018) found that MA enrollees remained at lower risk than TM enrollees from the 2008 to 2015 period, but with the difference in risk narrowing over time. More recent analysis indicates that MA and fee-for-service populations are fairly balanced based on demographic characteristics, dual Medicaid/Medicare status, and institutional status through 2018/2019 depending on the data source (Kronick and Chua 2021). One panelist noted that remaining selection into MA may be driven more by structural issues rather than plan actions, including the cost and limitations of Medigap coverage.

Several experts noted that selection issues may remain for small groups of beneficiaries (Kim et al., 2022). While it is important to identify these groups through research, it is unlikely that any remaining selection incentives can be addressed by augmenting the current risk adjustment model.

As one panelist explained, adding and removing variables from the model has done little to improve model performance and predictive power.

## Differential Diagnostic Coding

The panelists agreed that the primary problem with MA risk adjustment stems from differences in diagnostic coding between MA and TM. To maximize risk adjustment payments, MA plans have incentives to find and document every possible diagnosis for their enrollees (Kronick and Chua 2021). TM, conversely, does not pay based on diagnoses or the time spent coding. As such, physicians, practices, and health systems have little incentive to engage in complete coding when billing TM. Because the risk adjustment model is calibrated with (i.e., statistically fit to) TM data, MA coding intensity leads to significant overpayment of MA plans (Kronick and Chua 2021). CMS has made changes to the risk adjustment audit program and has proposed changes to the risk adjustment model to try to reduce discretionary coding,<sup>9</sup> but the effects of these changes are not yet clear.

The incentive to code all possible diagnoses at the highest possible severity level leads MA plans to engage in what several panelists called “socially unproductive effort,” meaning activities that do not produce value for the Medicare program or beneficiaries. MA plans have developed policies and practices like in-home health risk assessments and chart reviews to maximize risk adjustment payments (MedPAC 2016b). For example, brokers selling MA plans can earn additional income by conducting health risk assessments of beneficiaries during enrollment.<sup>10</sup> Panelists noted that these efforts might not improve beneficiary health or the efficiency of the Medicare program, particularly when plans focus on increasing diagnostic severity,<sup>11</sup> and that beneficiaries would be better served if plans directed their efforts elsewhere.

CMS already adjusts MA risk scores downward by 5.9 percentage points to account for differences in coding intensity between MA and TM. Consistent with MedPAC’s findings, panelists agreed that this level of adjustment is insufficient to recapture overpayment. Additionally, several experts noted that coding is not consistent across plans. A flat coding intensity adjustment may only serve to reward those plans making the most effort to upcode or overcode, while penalizing those plans that do not emphasize this activity.

Medicare’s Hospital Insurance (HI) trust fund partly funds the MA program. Accordingly, overpayment to MA plans directly reduces the trust fund’s reserves, which are expected to be exhausted within the next eight years. The latest Medicare trustees’ report projects that the HI trust fund that pays for Part A services will be insolvent sometime around 2031 (Medicare Trustees 2023). The Congressional Budget Office recently revised its expected date of HI insolvency to 2033 from its estimate of 2030 a year ago.<sup>12</sup> While it seems the date of insolvency for HI has been postponed, there is uncertainty in the timing, and estimates have been sensitive to assumptions and economic conditions.

## The MA Payment System

Many aspects of the MA payment system, including rebates, quality bonuses, and risk adjustment, make MA highly profitable and more attractive to beneficiaries than TM. MA can offer lower cost-sharing, supplemental benefits, and integrated Part D coverage, all with low or no additional premiums. TM is limited to the statutorily-defined benefit and cost-sharing package. However, the costs of MA's enhanced benefits package are not fully financed by MA plan efficiencies. They are subsidized by Medicare (and therefore taxpayers and beneficiaries through higher Part B premiums) in three ways:

- MA benchmarks exceed TM costs in many counties.
- Quality bonuses to benchmarks and rebates are not offset by penalties.
- Risk adjustment payments are not budget neutral.

On net, the Medicare program provides extra payments to MA through the risk adjustment system because the average MA risk score is above 1.0. In addition, risk adjustment payments are not required to be spent on improving care for high-need beneficiaries. The unlevel playing field between the benefits and cost-sharing in MA and TM makes it difficult for TM to compete for enrollment with MA. Panelists also noted that it is unclear what value beneficiaries derive from taxpayer-subsidized supplemental benefits, how often they are used, or whether those benefits are provided efficiently.

## Potential Reforms within the Current System

Researchers and policy analysts have proposed several reforms to the MA risk adjustment system, including increasing the coding intensity adjustment, making changes to risk adjustment data sources, and introducing a two-sided reinsurance program (see table 2 on page 7). Our panelists discussed these proposals and the use of constrained regression to achieve specific payment goals using the current risk adjustment model.

TABLE 2

**Proposed Reforms to the MA Risk Adjustment Program**

Category	Reform proposal	Source
<b>Increase or refine the coding intensity adjustment</b>	Increase the coding intensity adjustment. <sup>13</sup>	MedPAC 2016b, Kronick and Chua 2021
	Implement a tiered coding adjustment so contracts that code more intensely face a larger adjustment. <sup>14</sup>	MedPAC 2016b, CMS 2009 (not implemented)
<b>Make changes to risk adjustment data sources</b>	Exclude diagnoses gathered only from health risk assessments.	MedPAC 2016b
	Exclude diagnoses gathered only from chart reviews.	OIG 2021, MedPAC 2021
	Use two years of prospective diagnostic data in risk adjustment.	MedPAC 2016b
	Remove diagnoses that may be subject to discretionary coding from the risk adjustment model.	CMS 2023
<b>Improve the risk adjustment model</b>	Add two-sided reinsurance to the MA payment system and/or trim outliers from model calibration data.	McGuire, Schillo, and Van Kleeef 2020, MedPAC 2022b (not an official recommendation)
	Use constrained regression to adjust payments to meet policy goals.	McGuire, Zink, and Rose 2021; Van Kleeef et al. 2020; Van Kleeef et al. 2019.
	Use AI/machine learning to predict costs instead of the current OLS regression model.	McGuire, Zink, and Rose 2021; Rose 2016

**Source:** Urban Institute synthesis of panelist discussion at two risk adjustment workshops.

**Notes:** This is a partial list and includes only those proposals that generated substantial expert discussion during the workshops. MA = Medicare Advantage.

**Increase or Refine the Coding Intensity Adjustment**

MA risk scores were approximately 10.8 percent higher than risk scores for comparable TM enrollees in 2021 (MedPAC 2023). MedPAC has consistently recommended increasing the coding intensity adjustment to reflect the full scope of the coding gap. However, CMS has continued implementing the coding intensity adjustment at 5.9 percent (the amount minimally required by statute). Our panelists were not opposed to an increase in the coding intensity adjustment, but they noted it would not reduce the incentive for plans to aggressively code diagnoses. In addition, several panelists were concerned that a larger across-the-board adjustment would punish the MA plans that do not put as much emphasis on coding. Two panelists noted that more research would be needed to determine the appropriate level of coding intensity adjustment.

One panelist suggested tiered or contract-specific coding intensity adjustments to address concerns about differences in plan coding approaches (MedPAC 2016b; CMS 2009).<sup>15</sup> These approaches would apply different coding intensity adjustments to different contracts based on their tier or specific coding history and average out to reflect the full coding difference. The panel agreed

this policy is worthy of further study but requires research into the feasibility of developing contract-specific adjustments and/or evidence-based approaches for placing contracts into tiers.

## **Make Changes to Risk Adjustment Data Sources**

MedPAC has recommended that CMS exclude diagnoses gathered from health risk assessments from risk adjustment. The HHS Office of Inspector General (OIG) has similarly noted that MA plans use health risk assessments as well as chart reviews to maximize payments, a practice they called “inappropriate” (OIG 2021). In 2022, based on OIG’s findings, MedPAC estimated that almost two-thirds of the difference between TM and MA coding intensity may be because of health risk assessments and chart reviews (MedPAC 2022a). Similarly, the Government Accountability Office (GAO) has recommended improving CMS oversight and audits to reduce diagnosis-related overpayments to MA plans (GAO 2016). Panelists supported excluding diagnoses from health risk assessments and chart reviews from risk adjustment. One panelist noted that disallowing these diagnoses could discourage plans from focusing on socially unproductive efforts to find diagnoses and boost risk scores. Further research could help determine the potential impact of eliminating HRA diagnoses on risk scores and coding incentives.

Panelists also suggested that CMS could remove diagnoses from the risk adjustment model that may be subject to gaming. However, panelists noted that this approach alone would likely have only a small, short-term effect on coding intensity and overpayment. For the 2024 payment year, CMS has proposed removing several diagnoses it found were subject to discretionary coding from the risk adjustment model.<sup>16</sup> MA plans have strongly objected to this change,<sup>17</sup> but they have been able to quickly adjust to previous changes in the HCC model by optimizing their coding in other ways, so it remains to be seen how much these adjustments affect MA payment.<sup>18</sup>

Finally, panelists noted that MedPAC previously discussed blending prospective and concurrent data into a model (MedPAC 2014). This proposal could improve the correspondence between MA payment and enrollee risk, but there was concern it could also affect MA plans’ incentives to hold down costs.

## **Improve the MA Risk Adjustment Model**

Several methods have been proposed to improve the fit of the MA risk adjustment model, including adding reinsurance and using machine learning rather than OLS regression to predict costs. In addition, constrained regression has been proposed as an approach to achieve policy goals with minimal disruption to model fit.

### **ADD REINSURANCE TO THE MA PAYMENT SYSTEM**

Under two-sided reinsurance, MA plans would receive payments for beneficiaries when their spending substantially exceeded that predicted by the risk adjustment model. Plans would have to pay reimbursements for beneficiaries when their spending was substantially lower than predicted.



This approach would set reinsurance payments equal to reimbursements to ensure the system would not cost the Medicare program additional money. Research has found that this approach could substantially improve the accuracy of the MA risk adjustment model (McGuire et al. 2020).

In March 2022, MedPAC explored the possibility of limiting the influence of outliers in the risk adjustment model calibration, a procedure adapted from McGuire et al. (2020) (MedPAC 2022b). MedPAC found that trimming outliers during model calibration would similarly improve the model fit more than any recent changes to MA risk adjustment.<sup>19</sup>

Panelists largely supported adding a small, budget-neutral reinsurance program to the MA payment system. Similar mechanisms already exist in TM, such as the outlier policy of the inpatient prospective payment system for acute care hospitals.<sup>20</sup> They noted it would improve the accuracy of the payment model for high-risk beneficiaries at a low cost. One panelist strongly opposed the use of reinsurance in MA, however, noting that reinsurance in Part D has led to significant increases in Medicare spending. For example, in 2021, reinsurance payments to Part D plans accounted for nearly half of all Part D spending, compared to just 14 percent in 2006.<sup>21</sup> While some other panelists agreed that reinsurance could, in theory, encourage plans to overspend, they suggested a small reinsurance program that required MA plans to pay for a share of the costs above an attachment point could potentially blunt these incentives. However, research is needed to determine the likely effects of reinsurance on MA plan behavior. An outlier-trimming approach such as that discussed by MedPAC would likely not affect MA plans' incentives to reduce costs. Panelists also suggested further research into the Part D experience to help develop policies for MA that would avoid creating incentives to overspend.

Panelists raised several technical issues with reinsurance. For example, the current MA encounter data does not include costs for all encounters,<sup>22</sup> making it difficult for CMS to calculate total spending per beneficiary. One panelist also noted that policymakers would have to decide whether to include spending on supplemental benefits in the reinsurance calculation.

Overall, panelists suggested that adding a reinsurance program to MA was worthy of further study and modeling to help support policy development. However, this approach would not address incentives to code more diagnoses and would need to be combined with other reforms to risk adjustment.

#### **USE MACHINE LEARNING IN RISK ADJUSTMENT**

One panelist noted the increased interest in using machine learning (ML) in risk adjustment to replace standard OLS regression models with more advanced predictive modeling. A study found that machine learning approaches can dramatically reduce the number of HCCs needed in the model while maintaining or improving overall model fit, potentially reducing plan incentives to aggressively code diagnoses (Rose 2016). To alleviate concerns about complexity and lack of transparency in applying machine learning, other research has considered methods that adopt ML variable selection techniques while remaining in a transparent regression framework for risk adjustment (Kan et al.

2019). An earlier yet transparent ML method, classification and regression trees modeling, has been used by CMS to create case-mix groups for Medicare’s inpatient rehabilitation facility prospective payment system (Carter et al. 2002). However, one panelist noted that introducing machine learning approaches to MA risk adjustment would not likely alter plan behavior. Although this topic did not generate much discussion among panelists, the topic could be explored more, given the growing literature on these approaches.

#### **USE CONSTRAINED REGRESSION TO ADJUST PAYMENTS TO MEET POLICY GOALS**

The current MA risk adjustments are derived from regression equations that estimate the effects of demographic and diagnostic variables on enrollee costs within the next year. These regressions are then estimated to fit the data in TM as well as possible—the better the fit, the more accurate the payments to MA plans for their enrollees’ health risks, and the lower the incentive for plans to enroll healthier individuals. However, if goodness-of-fit has been adequately satisfied in the risk adjustment payment model, policymakers may consider constraining regression coefficients to exploit the predictive value of variables that are not appropriate to be included in the risk adjustment model, either because they are too vulnerable to gaming (Van Kleeef et al. 2017) or because they are not available for the full population (Van Kleeef et al. 2020). Used in this way, constrained regression could be a valuable tool to modify risk adjustment payments to reduce incentives to risk-select or to meet well-defined policy goals (McGuire et al. 2021; Van Kleeef et al. 2017; Van Kleeef et al. 2020). The constrained regression function would systematically adjust the coefficients on the risk adjustment variables upward or downward to ensure a policy goal is met while maximizing goodness-of-fit subject to the constraint of satisfying the specified goal. For example, constrained regression could be used to increase risk adjustment payments for enrollees facing social risks without adding social risk factors to the model, which could have unintended consequences (McWilliams et al. 2023). Research has suggested that constraining the regression coefficients can achieve policy goals with little cost to overall model fit (Van Kleeef et al. 2020).

Panelists noted that constrained regression could be useful for diagnoses or other beneficiary needs that cannot easily be added to the risk adjustment model because of concerns about gaming or altering MA plan incentives. For example, prior-year spending is highly predictive of current-year spending, but it is not used as a variable in risk adjustment because it creates incentives for plans to overspend. Prior-year spending may also not accurately reflect the health needs of populations with poor access to care. Constrained regression could be used to ensure higher payments for enrollees with high prior-year spending without changing the variables in the risk adjustment model. Policymakers could also introduce constraints that ensure additional payment for groups with historically poor access to care. One complication of using this approach for MA plans is that CMS does not directly observe enrollee spending. CMS could estimate prior-year MA enrollee spending, however, using encounter data.

Panelists discussed whether constrained regression could be used to ensure equitable MA payments by race and ethnicity. Panelists noted that adding race and ethnicity data to the risk adjustment model would be controversial and could result in negative coefficients because of lack of

access to care, further perpetuating structural biases (McWilliams et al. 2023). Introducing a constraint into the regression model to ensure equitable payments could solve this problem. However, panelists were split on the usefulness of this approach. One panelist noted that health equity in Medicare must first be addressed at the system level before adjusting payments. Others noted that increasing payments for marginalized populations through the risk adjustment system assumes that plans have ways to address inequities and will spend the extra funds on those approaches. Oversight would be needed to ensure that MA plans use additional funds to improve care for the target beneficiaries (American Academy of Actuaries, 2022).

Several panelists suggested further research into constrained regression, including modeling scenarios with specific policy goals in the Medicare context. This research could help illuminate winners and losers from constrained regression and suggest use cases for policymakers.

## Potential New Approaches

The panel also discussed several broader or more novel approaches to MA risk adjustment reform (table 3). For each of these ideas, the panel offered suggested areas for research to help determine feasibility.

TABLE 3

**Potential New Approaches to Risk Adjustment in MA Discussed by the Workgroup**

Reform idea	Benefits	Drawbacks
Use survey data in risk adjustment	Using self-reported health status in risk adjustment would be less subject to gaming and coding intensity than diagnosis-based risk adjustment and would better capture patient needs.	Biases in survey response, as well as limits in the current sampling frame of the CAHPS, would need to be addressed. For example, CAHPS does not currently sample institutionalized beneficiaries.
Make MA risk adjustment zero-sum within MA	MA risk adjustment payments would equal charges, meaning MA risk adjustment would no longer be subsidized by the Medicare program.	This approach would not reduce incentives to code and could lead to transfers from more integrated plans to broader-network plans.
Introduce competitive contracting in MA	Medicare could contract with three plans per region and use its purchasing power to lower costs and improve benefits in MA. This would reduce the importance of risk adjustment. Fewer choices may also make it easier for beneficiaries to choose plans.	It isn't clear how much more Medicare could extract from MA contracts under this scenario, as changing plans frequently would disrupt beneficiaries' access to stable provider networks. This proposal involves more fundamental changes to the program design that could face many political obstacles.

**Source:** Urban Institute synthesis of panelist discussion at two risk adjustment workshops.

**Notes:** This list is not intended to be comprehensive and includes only those proposals that generated significant discussion among panelists. CAHPS = Consumer Assessment of Healthcare Providers and Systems; MA = Medicare Advantage.

## Using Survey Data in Risk Adjustment

Many panelists were interested in the possibility of using Consumer Assessment of Healthcare Providers and Systems (CAHPS) data or other survey data in risk adjustment. The CAHPS survey is already administered to MA enrollees for calculating quality star ratings measures, and it includes questions about self-reported health status and mental health status.<sup>23</sup> To support this approach, panelists noted that the CAHPS could be expanded to include more detailed questions about health to support risk adjustment.

The panel discussed several benefits of using CAHPS or survey data in risk adjustment. First, survey data can provide a very useful tool for assessing the performance of risk adjustment models (Van Kleef et al. 2019). For example, CAHPS data could be used to determine whether risk adjustment is paying adequately for enrollees with poor self-reported health. Second, the panel generally agreed that survey data is less subject to gaming by plans and could blunt incentives to engage in socially unproductive efforts to code diagnoses and boost risk scores.

However, panelists noted several complex problems that need to be addressed before adjusting payment based on survey data. While survey data could potentially replace diagnoses for common conditions, it would likely need to be supplemented by diagnostic data for rare but expensive conditions like HIV. Many panelists also noted that CMS would need to address nonresponse bias and differential response patterns by race and ethnicity prior to using survey data to adjust payment. Additionally, CMS would need to find a way to survey patients in long-term care institutions to ensure adequate payment for vulnerable beneficiaries (see box 2 on page 14). Some panelists also expressed concern that using CAHPS in risk adjustment could incentivize plans to interfere with CAHPS administration.

Overall, the panel supported further research into using CAHPS or other survey data in risk adjustment, such as the Health Outcomes Survey used in Medicare's quality bonus payments program. This approach could be pursued alongside easier-to-implement solutions like reinsurance and limiting the use of health risk assessments and chart reviews. The key research questions the panelists raised included the following:

- Who does CAHPS (or other new or existing surveys proposed for use by CMS for risk adjustment) miss and how could CMS capture comparable survey data for those respondents?
- How much do responses to CAHPS differ by race and ethnicity? By socio-economic status? By disability status? By caregiver proxy responses versus responses directly from the beneficiary selected for the survey?
- Does CAHPS have sufficient data to identify risks, or would questions need to be added to support risk adjustment? Would survey data supplement or replace diagnostic information, particularly for rare conditions?

## Making MA Risk Adjustment Zero-Sum

In the health insurance Marketplaces, which offer private, nongroup plans to nonelderly enrollees, total risk adjustment payments are equal to total risk adjustment charges. That is, the Marketplace risk adjustment system is zero-sum across plans and does not require public funding (Holahan et al. 2018). In MA, because risk adjustment is tied to TM, more plans have above-average risk scores than below-average risk scores, leading to substantial net transfers of Medicare funds to plans via risk adjustment (MedPAC 2022a). In short, MA risk adjustment is subsidized by Medicare.

The panel discussed the advantages and disadvantages of moving MA risk adjustment to a zero-sum model among MA plans similar to the Marketplaces. Overall, panelists agreed that this approach would save the Medicare program money and align it with other risk adjustment systems. However, it would not address MA plans' incentives to aggressively code, and it would exacerbate the negative effects on plans that do not attempt to game the risk adjustment system.

Several panelists raised concerns about new incentives a zero-sum risk adjustment system might create. For example, this approach could blunt incentives for plans to improve the value of care relative to TM, as MA's lower costs would be reflected in the risk adjustment system's coefficient weights. One panelist also noted that, in the Marketplaces, broad-network plans tend to be net recipients of risk adjustment payments while narrow-network, integrated plans tend to be net payers of risk adjustment charges.<sup>24</sup> If more integrated plans provide more coordinated care, they should be encouraged via MA payment policy rather than penalized.

Panelists also raised technical issues with making MA risk adjustment zero-sum among plans. For example, CMS would have to develop an average spending amount for a beneficiary with a risk score of 1.0 in MA that would be used to calculate payments and charges so they would net out to zero.

The panel identified several promising areas for further research. First, researchers could explore whether coding incentives are smaller and whether coding practices are more consistent in zero-sum systems like the Marketplaces or the Diagnosis Related Group (DRG) payment system. Second, panelists suggested simulation modeling to determine how zero-sum risk adjustment would affect MA plans and payments. Such modeling could also help to refine policy objectives. To the extent that zero-sum risk adjustment reduces MA revenue, research could also explore how it may affect MA benefits.

## Introducing Competitive Contracting in MA

Under a competitive contracting model, CMS would select just two or three insurers per region to offer MA.<sup>25</sup> MA plans would compete to be granted a regional oligopoly in exchange for concessions on pricing and benefits. Employer-sponsored insurance often operates on this model, with employers negotiating benefit packages with a few insurers instead of offering their employees an unfettered choice of plans. While the MA system is currently highly concentrated, competitive

contracting would still dramatically reduce the choice of insurers and plan designs available to beneficiaries. When combined with default enrollment policies, this approach could reduce the role of patient selection in driving insurer spending, thereby minimizing the need for risk adjustment and its attendant problems.

Overall, panelists emphasized that competitive contracting would radically change the MA system. However, they noted that the approach would have several positive features for the Medicare program and beneficiaries. First, the government could use its market power to extract more savings from the MA program, though these would need to be shared with beneficiaries for the MA program to continue to be attractive. Second, seniors would have an easier time making enrollment choices with fewer available plans.<sup>26</sup> Finally, if combined with autoenrollment or enrollment defaults, this approach could eliminate the need for a complex risk adjustment system and sidestep many associated problems, such as coding incentives.

However, many panelists felt the negatives of competitive contracting outweighed the positives. Several panelists noted that a competitive bidding demonstration in Medicare+Choice had failed in the 1990s because of beneficiaries' fears of losing plan choice and access to supplemental benefits.<sup>27</sup> These panelists felt that competitive contracting would likely not fare better among beneficiaries and members of Congress and would be very difficult politically. Other panelists noted that it would be difficult for CMS to change the insurers it contracts with as that could result in changes to networks and plan design for beneficiaries. Therefore, the government's leverage to extract concessions from MA plans, such as lower costs or more benefits, could diminish over time. Additionally, MA currently has many boutique plans designed for specific populations and integrated plans like Kaiser Permanente that may not be competitive under this approach (see box 2). Finally, one panelist noted that the contracting processes within CMS differ greatly from typical contracting processes to procure employer-sponsored insurance and may not yield the most value for beneficiaries and the Medicare program.

Overall, panelists suggested that competitive contracting could be worth further study but that other reform approaches should take precedence. Some potential areas for research included studying competitive contracting systems like TriCare and Medicaid to determine whether the approach could be a fit for Medicare, and exploring how employer-sponsored MA plans deal with changes to networks and benefits. Overall, however, panelists viewed this option as too significant a departure from the current system to be adopted soon.

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## BOX 2

### **Considerations for Dual-Eligibles and Other High-Need Beneficiaries**

With the growth of special needs plans, many dual-eligibles and other high-need beneficiaries are now enrolled in MA. The care integration provided by fully integrated special needs plans (FIDE-SNPs), an MA option designed specifically for the dual-eligible population, helps improve beneficiary health and creates care and cost efficiencies. The panel noted that dual-eligibles and other high-

need populations require special consideration when weighing changes to the MA risk adjustment system. The panelists raised the following examples:

- Two-sided reinsurance could be formulated to specifically target high-need beneficiaries based on prior year costs or other measures of need. This approach would reduce incentives to select against these beneficiaries while improving payment accuracy.
- Adding survey data to risk adjustment would require enhancing survey frames to ensure inclusion of beneficiaries in long-term care institutions. Additionally, research is needed to determine how proxy responses (such as by a caregiver) differ from beneficiary responses, particularly for beneficiaries with significant health care needs.
- Any competitive contracting approach would need to account for FIDE-SNPs and other MA special-needs plans that provide integrated care to high-need beneficiaries. Separate contracting processes may be needed to serve the dual-eligible population and those with significant health care needs.

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## Conclusion

Across the two working groups, panelists consistently expressed that although the risk adjustment system has succeeded in largely reducing incentives for plans to selectively enroll healthier beneficiaries, it creates incentives for MA plans to direct resources toward coding intensity and related efforts not aimed at producing value for enrollees or program efficiency, and ultimately results in overspending. Overall, panelists noted that short-term fixes to risk adjustment, like increasing the coding intensity adjustment, remain valuable. While these approaches might not solve all problems with risk adjustment, they can nudge the system in the right direction while researchers and policymakers work toward longer-term solutions.

The panel also discussed several longer-term approaches to improving MA risk adjustment. This brief described the approaches that generated the most discussion among panelists. Overall, panelists were most supportive of three longer-term solutions: two-sided reinsurance, using CAHPS or other survey data in risk adjustment, and making risk adjustment zero-sum among MA plans. These three approaches preserve the general structure of risk adjustment while improving payment accuracy (reinsurance), reducing incentives to code (survey data), and reducing the effects of coding intensity on Medicare's finances (zero-sum risk adjustment). As these three approaches target different problems with the MA payment system, they could be combined for maximum effectiveness. The panel suggested continued research into each of these solutions while shorter-term solutions are implemented, with a particular emphasis on how these changes might affect dual-eligibles and other high-need beneficiaries. Several panelists also suggested additional research into constrained regression and an overall evaluation of the performance of the current risk adjustment system to assess strengths, weaknesses, and potential paths forward.

The panel had several overarching recommendations for future research. First, panelists suggested research into the three most appealing approaches to the future of risk adjustment, including two-sided reinsurance, using CAHPS or other survey data in risk adjustment, and making risk adjustment zero-sum among MA plans. Second, panelists emphasized the importance of simulation modeling in assessing the potential winners and losers of risk adjustment reforms and illuminating unintended changes to incentives. Third, beyond the technical research questions already raised, panelists suggested a broader body of research into the drivers of unmet needs and disparities in the Medicare program. Such research is a critical first step to identifying policies that could address health equity.

## Notes

- <sup>1</sup> MedPAC (Medicare Payment Advisory Commission), “The Medicare Advantage Program: Status Report,” January 12, 2023.
- <sup>2</sup> MedPAC, “The Medicare Advantage Program: Status Report.”
- <sup>3</sup> MedPAC, “The Medicare Advantage Program.”
- <sup>4</sup> Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 88 Fed. Reg. 6643 (Feb. 1, 2023).
- <sup>5</sup> Meena Seshamani (director, Center for Medicare), note to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties, regarding “Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,” February 1, 2023.
- <sup>6</sup> Seshamani, “Advance Notice of Methodological Changes.”
- <sup>7</sup> CMS (Centers for Medicare and Medicaid Services), “2024 Medicare Advantage and Part D Advance Notice Fact Sheet,” February 1, 2023.
- <sup>8</sup> For example, risk selection does not require direct actions to reduce enrollment by unprofitable beneficiaries. MA plans could gain favorable selection by choosing not to contract with high-performing providers who serve high-need beneficiaries or by not designing benefit packages to attract these enrollees.
- <sup>9</sup> Medicare and Medicaid Programs, 88 Fed. Reg. 6643, and Seshamani, “Advance Notice of Methodological Changes.”
- <sup>10</sup> Faith Leonard, Gretchen Jacobson, Michael Perry, Sean Dryden, and Naomi Mulligan Kolb, “The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents,” Commonwealth Fund (blog), October 17, 2022.
- <sup>11</sup> Efforts to document all diagnoses, to the extent that important diagnoses are missing from patient records, could support better care coordination.
- <sup>12</sup> See CBO (Congressional Budget Office), “May 2022 Baseline Projections,” 2022, and CBO, “Budget and Economic Data,” 10-Year Trust Fund Projections, February 2023.
- <sup>13</sup> Hostetter, Martha, and Sarah Klein, “Taking Stock of Medicare Advantage: Risk Adjustment,” New York: NY. Commonwealth Fund, February 2022.
- <sup>14</sup> Hostetter and Klein, “Taking Stock of Medicare Advantage: Risk Adjustment.”
- <sup>15</sup> Hostetter and Klein, “Taking Stock.”
- <sup>16</sup> Seshamani, “Advance Notice.”



- <sup>17</sup> Mary Beth Donahue, “RE: Advanced Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.” (Washington, DC: Better Medicare Alliance, March 2023).
- <sup>18</sup> MedPAC. “The Medicare Advantage Program: Status Report.”
- <sup>19</sup> MedPAC found that limiting the influence of outliers during risk model calibration increased the R2 (a measure of goodness of fit) of the CMS HCC model from 0.13 to 0.19. See MedPAC (2022b).
- <sup>20</sup> CMS (Centers for Medicare and Medicaid Services), “Outlier Payments,” December 1, 2021.
- <sup>21</sup> “An Overview of the Medicare Part D Prescription Drug Benefit,” KFF (Kaiser Family Foundation), October 19, 2022.
- <sup>22</sup> Sean Creighton, Robin Duddy-Tenbrunsel, and James Michel, “The Promise and Pitfalls of Medicare Advantage Encounter Data,” *Health Affairs Forefront*, February 25, 2019.
- <sup>23</sup> “Current Data Collection Materials,” Medicare Advantage and Prescription Drug Plan CAHPS® Survey, February 21, 2022.
- <sup>24</sup> CMS (Centers for Medicare and Medicaid Services), “Summary Report on Permanent Risk Adjustment Transfers for the 2021 Benefit Year,” July 19, 2022.
- <sup>25</sup> Panelists did not discuss whether these regions would represent individual counties, combinations of counties, or larger geographic areas. The size of individual regions will directly affect several important factors including the number of potential beneficiaries served and the number of potential providers with which plans may need to coordinate.
- <sup>26</sup> Nancy Ochieng, Juliette Cubanski, Meredith Freed, and Tricia Neuman Follow, “A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment,” KFF, November 1, 2022.
- <sup>27</sup> Len Nichols, “Lessons from the Competitive Pricing Advisory Committee Experience for the Medicare + Choice Program and Long Term Reform: Statement before the United States’ Senate Committee on Finance,” Urban Institute, April 03, 2001.

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## Authors' Note

This brief was updated on May 23, 2023, to correct some terminology in the acknowledgments.

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# Acknowledgments

This brief was supported by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at [urban.org/fundingprinciples](https://urban.org/fundingprinciples).

The authors thank each of the panelists for their time, comments, and review of this report. The authors also thank Stephen Zuckerman for his review and comments and thank Sarah LaCorte and Lauren Lastowka for editing.



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