Elevance Health | Public Policy Institute

Understanding the Medicare Advantage Program

October 2023

Contents

Key Takeaways

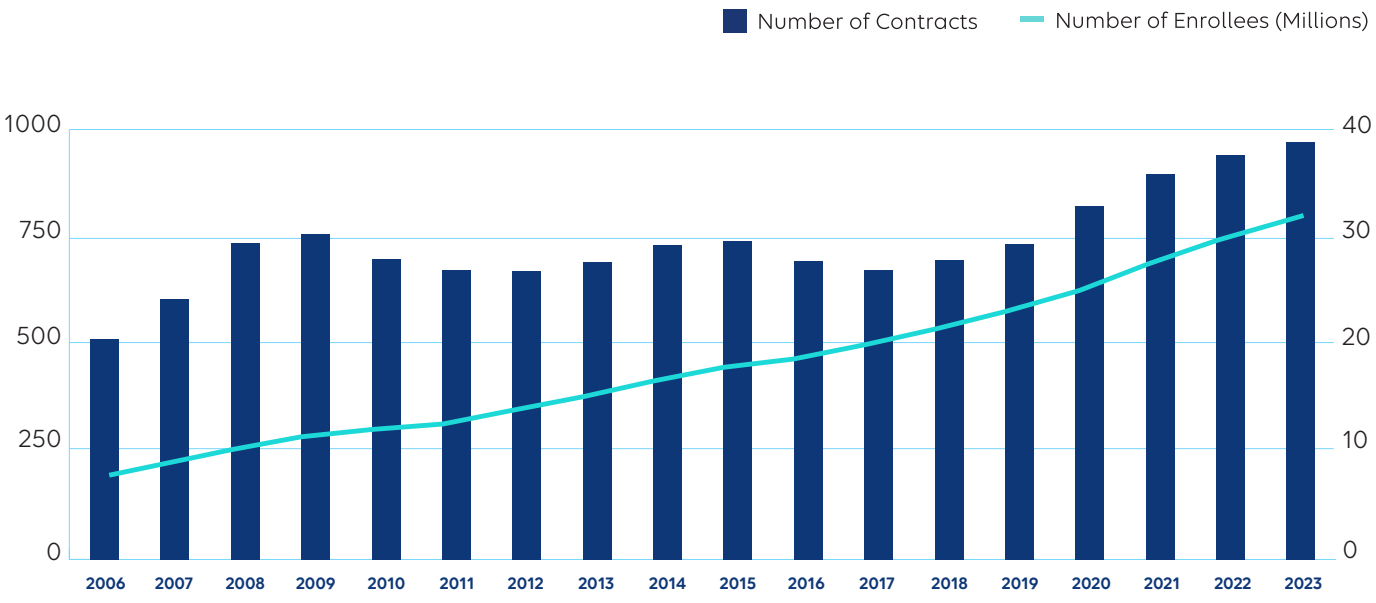
- Medicare fee-for-service (FFS) and Medicare Advantage (MA) plans both provide all Medicare benefits, but MA is a notably different model than FFS offering care coordination, disease management, out-of-pocket cost protections, and often additional benefits.
- Unlike FFS, which pays providers based on the services performed, MA plans receive a capitated payment under which they bear the full risk for providing all Medicare benefits to enrollees, giving plans an incentive to prioritize value of care over volume.
- As MA enrollment continues to increase, there are "spillover effects" onto FFS that lead to improvements in service utilization and lower costs for the Medicare program overall.

Overview

Medicare covers people who are 65 or older, certain people with disabilities, and people with end-stage renal disease. Of those eligible for Medicare, 51 percent—roughly 30.8 million beneficiaries—access their benefits through a Medicare Advantage (MA) plan in 2023.[1]

MA plans are private plans that provide Medicare benefits as an alternative to traditional Medicare, also known as Medicare fee-for-service (FFS). Unlike FFS, MA plans provide care coordination and disease management programs, and usually offer Medicare beneficiaries additional benefits to supplement their coverage. Most MA plans also provide prescription drug coverage in combination with medical coverage. MA plans deliver a more coordinated approach to care compared to the fragmented coverage generally received via traditional FFS.

Figure 1
Number of MA Contracts and Enrollees by Year, 2006-2023



Source. Centers for Medicare & Medicaid Services. (2023, March 20). Medicare Advantage/Part D Contract and Enrollment Data. Retrieved August 21, 2023, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata.

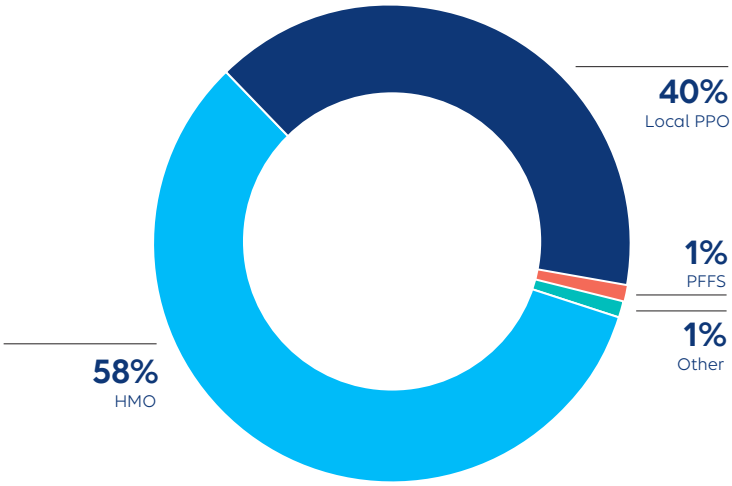
Note. Values for 2006-2022 are as of December of that year. Values for 2023 are from August 2023. MA = Medicare Advantage.

Types of MA Plans

There are several different types of MA plans that beneficiaries can choose from when selecting coverage. (Figure 2) The two most common are health maintenance organizations (HMOs) and local preferred provider organizations (PPOs).

- **HMOs** generally only cover care provided by in-network doctors, hospitals, and other health providers. While they are still the most common type of plan, their availability has declined from 71 percent of all plans in 2017 to 58 percent in 2023.[2]
- **Local PPOs,** which offer access to out-of-network providers but at a higher cost than in-network providers, have grown steadily in recent years from 24 percent in 2017 to 40 percent in 2023.[3]
- **Other types of MA plans** include regional PPOs—which work similarly to local PPOs but are required by the Centers for Medicare & Medicaid Services (CMS) to be offered in an entire state(s) as opposed to serving a single county or group of counties—and private-fee-for-service (PFFS) plans, which are now only offered in rural areas with limited provider networks.

Figure 2
MA Plans, by Plan Type, 2023



Source. Freed, M., et al. (2022, November 10). Medicare Advantage 2023 Spotlight: First Look. Kaiser Family Foundation. Retrieved August 15, 2023, from https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.

Note.
MA = Medicare Advantage;
HMO = Health Maintenance Organization;
PPO = Preferred Provider Organization;
PFFS = Private Fee-for-Service; N= 3,998 plans.

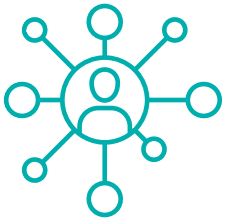
Special Needs Plans (SNPs) offer more specialized coverage for beneficiaries and can limit enrollment to certain categories of beneficiaries with specific needs. They include:

1. Dual Eligible SNPs (D-SNPs) for beneficiaries who are dually eligible for Medicare and Medicaid (known as "dual eligibles").

2. Institutional SNPs (I-SNPs) for beneficiaries who reside in long-term care institutions or would otherwise require an institutional level of care.

3. Chronic Condition SNPs (C-SNPs) for beneficiaries with certain specified chronic or disabling conditions.

Finally, MA employer group waiver plans (EGWPs) limit enrollment to the employer group and provide the standard Medicare benefit but allow employers to supplement those benefits or reduce cost sharing for their retirees. EGWPs may be HMOs, PPOs, or PFFS plans.



Virtually all Medicare beneficiaries have access to an MA plan option.

Access to MA Plans

As of 2023, virtually all (99.7%) Medicare beneficiaries have access to an MA plan option, including at least one plan with $0 premium and drug coverage.[4] Further, beneficiaries have an average of 43 plans in their area to choose from when selecting MA coverage, which is more than double the number from 2018.[5]

Comparing MA Plans and Medicare FFS

The structure of MA payment and financial incentives are significantly different than Medicare FFS.

MA plans receive a capitated payment from CMS each month for each enrollee, in addition to any other required beneficiary premiums, for providing the Medicare Part A and Part B benefits and a separate payment for the Part D benefit if provided through an integrated plan. MA plans bear the full risk of providing Parts A and B, along with any mandatory supplemental benefits, within the capitated payment; they do not get paid more if their costs exceed their payments.

The FFS system pays providers based on the number of services they perform, regardless of the relative appropriateness or quality of those services. This creates a system that rewards providers that may perform low value or unnecessary tests or services and penalizes those that provide fewer services even when that is high value, clinically appropriate care. Though Medicare FFS now offers providers a monthly fee if they deliver care coordination services to their FFS patients, and demonstration models under the Center for Medicare and Medicaid Innovation (CMMI) incentivize FFS providers to take on more risk for patient outcomes, the system still inherently rewards quantity of care over quality.

In contrast, the capitated payment model under which MA plans are paid, incentivizes plans to coordinate and effectively manage their enrollees' care, keep members healthy, prevent avoidable complications of chronic disease, and prioritize value and effectiveness over volume.

At the same time, there are program requirements in place to ensure that plans do not have unintended incentives to withhold care. First, plans are held to requirements that govern the minimum amount of their capitation payments that must be spent on medical care and improving quality of care, also known as minimum Medical Loss Ratio (MLR). (Figure 3) Under this requirement, plans must spend at least 85 percent of their premium payments on medical care and quality improvement. This also means that plans can use no more than 15 percent of their payments for administrative functions and profit.

While plans do not get paid more if costs exceed their payments, if they do not meet the minimum MLR requirements, they must remit to CMS the difference between their actual MLR and the minimum MLR. If a plan fails to meet the MLR requirements for three consecutive years, it may not be allowed to enroll new beneficiaries; if it does not meet the requirements for five consecutive years, the plan may be terminated.

Figure 3
Medical Loss Ratio Calculation

$$\text{Medical Loss Ratio (MLR)} = \frac{\text{Health Care Claims} + \text{Quality Improvement Expenses}}{\text{Premiums} - \text{Taxes, Licensing, and Regulatory Fees}}$$

As required by the Affordable Care Act (ACA), MA plans must submit data on the proportion of premium revenues spent on clinical services and quality improvement activities. This proportion is called the MLR.

Plans are also held to rigorous quality standards which assess member experience, how well plans keep members healthy and manage members' chronic conditions, and plans' compliance with CMS standards such as call center wait times and customer satisfaction ratings, among other factors. Plans that fail to achieve and maintain minimum levels of performance on these quality metrics are at risk of termination from the MA program.

Plans' scores are available on the Medicare Plan Finder, an online plan shopping website operated by CMS, to help beneficiaries compare and select plans based on quality. Notably, CMS does not measure or report on FFS quality scores the way it does for MA plans. As a result, Medicare enrollees have no way of directly comparing the quality of traditional FFS to available MA plan options.

Some examples of MA quality measures include:[6]

- Breast cancer screening
- Colorectal cancer screening
- Annual flu vaccine
- Monitoring physical activity
- Diabetes care

MA outperforms FFS in healthcare utilization and cost outcomes, even while MA and FFS beneficiaries have comparable health statuses.

As described previously, because of the capitated payment structure, MA plans bear full risk for the cost of providing Medicare benefits to their members. As a result, the incentives for plans are different than those for FFS providers. MA plans are successful if they identify conditions earlier, ensure that members' chronic conditions are well managed, and generally keep members healthy. To do this, plans use various tools such as care coordination programs, medication management that is integrated with the medical benefit, and newer services and health technologies like remote monitoring systems and telehealth. In other words, beneficiaries generally fare better in MA than FFS because plans are financially incentivized to engage members in their health and wellbeing and proactively manage chronic conditions to avoid unnecessary and resource-intensive provider encounters.

Several studies have validated MA's better healthcare utilization and cost outcomes, even while MA and Medicare FFS serve similar populations with comparable health statuses and levels of chronic illness.[7] In comparison to FFS beneficiaries, those enrolled in MA had lower rates of hospital stays, emergency department visits, and 30-day readmissions.[8] Consistent with these findings, another study saw lower hospital-level readmission rates and lower odds of 30-day readmission for MA beneficiaries compared to FFS beneficiaries within the same hospital.[9]

Post-acute care use is also more favorable under MA than FFS. MA beneficiaries, in comparison to FFS beneficiaries discharged from the same hospital, had lower intensity of post-acute care for lower extremity joint replacement, stroke, and heart failure.[10] Similarly, a study of over one million inpatient rehabilitation facility admissions found that MA beneficiaries had a shorter mean length of stay and a greater likelihood of returning to the community than FFS beneficiaries.[11] This greater likelihood of returning to the community, coupled with lower readmission rates among MA beneficiaries, suggest that the reductions in post-acute care and post-acute care intensity do not compromise patient health in reducing healthcare costs.

Value of MA

MA plans provide significant value and benefits to members. While MA plans must offer at least the traditional Medicare benefits, there are many additional ways that MA plans offer beneficiaries a more valuable option for Medicare coverage.

Care coordination. MA plans focus on coordinating care so that members get the care they need and avoid harmful or unnecessary duplicative care. MA plans also take a holistic view of members' healthcare needs and can connect members to care managers and disease management programs which can help them further navigate the healthcare system and better manage chronic conditions. As a result, recent studies document that MA plans can reduce inappropriate use of services and can improve members' quality of care and health outcomes.[12,13]

Supplemental benefits. Efficiencies unique to the MA care model generate savings that can be invested by the plan into supplemental benefits. These benefits fall into four categories:

Enhanced Coverage of Parts A and B

Some plans may lower the standard deductible or other cost sharing for members.

Enhanced Part D

This may mean a reduction in member cost sharing for Part D or broader formulary.

Buying Down Part B Premium

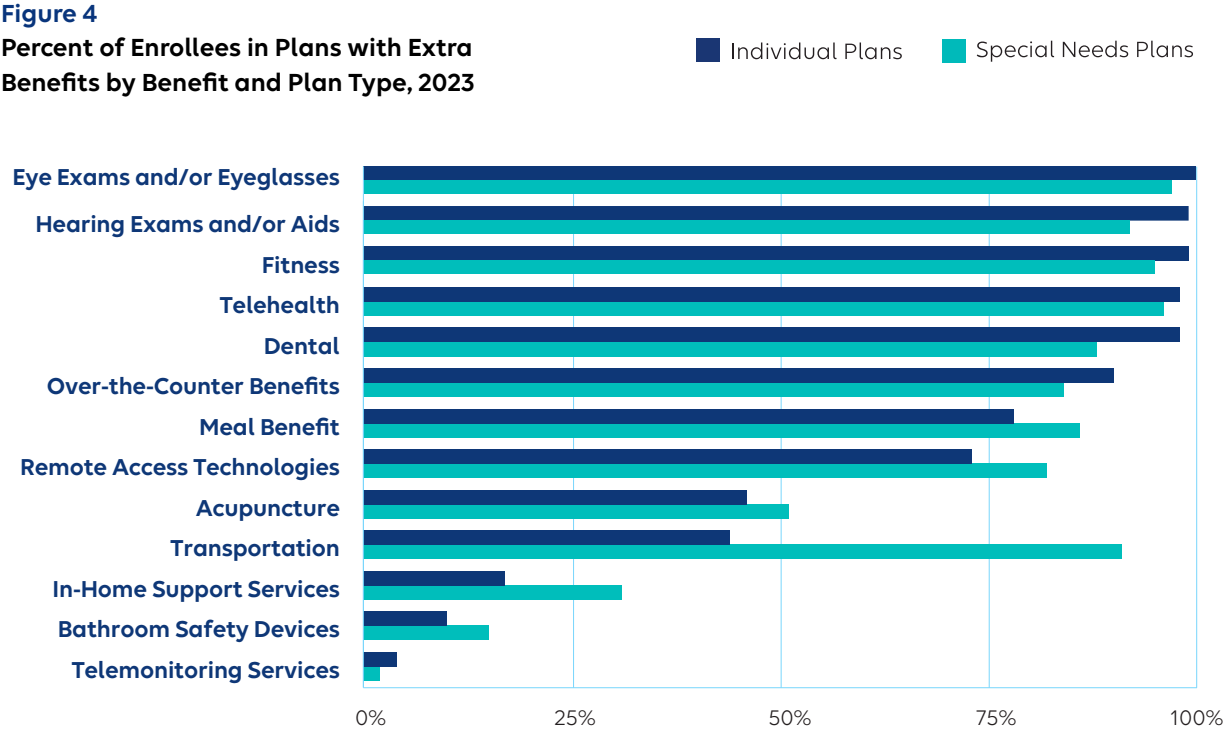
Buying down the standard Part B premium for enrollees, which is typically deducted from their social security check, reduces enrollees' out of pocket cost burden further.

Benefits Not Covered by Traditional Medicare

Plans may offer additional benefits outside of what is covered by traditional Medicare.

Under benefits not covered by traditional Medicare, almost all MA plans offer some combination of vision, dental, and hearing benefits. Plans are also increasingly offering other supports to improve member health, such as transportation to doctor's appointments, 24-hour nurse help hotlines, and home-delivered healthy meals. (Figure 4)

Figure 4
Percent of Enrollees in Plans with Extra Benefits by Benefit and Plan Type, 2023



Source. Ochieng, N., et al. (2023, August 9). Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. Kaiser Family Foundation. Retrieved August 29, 2023, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

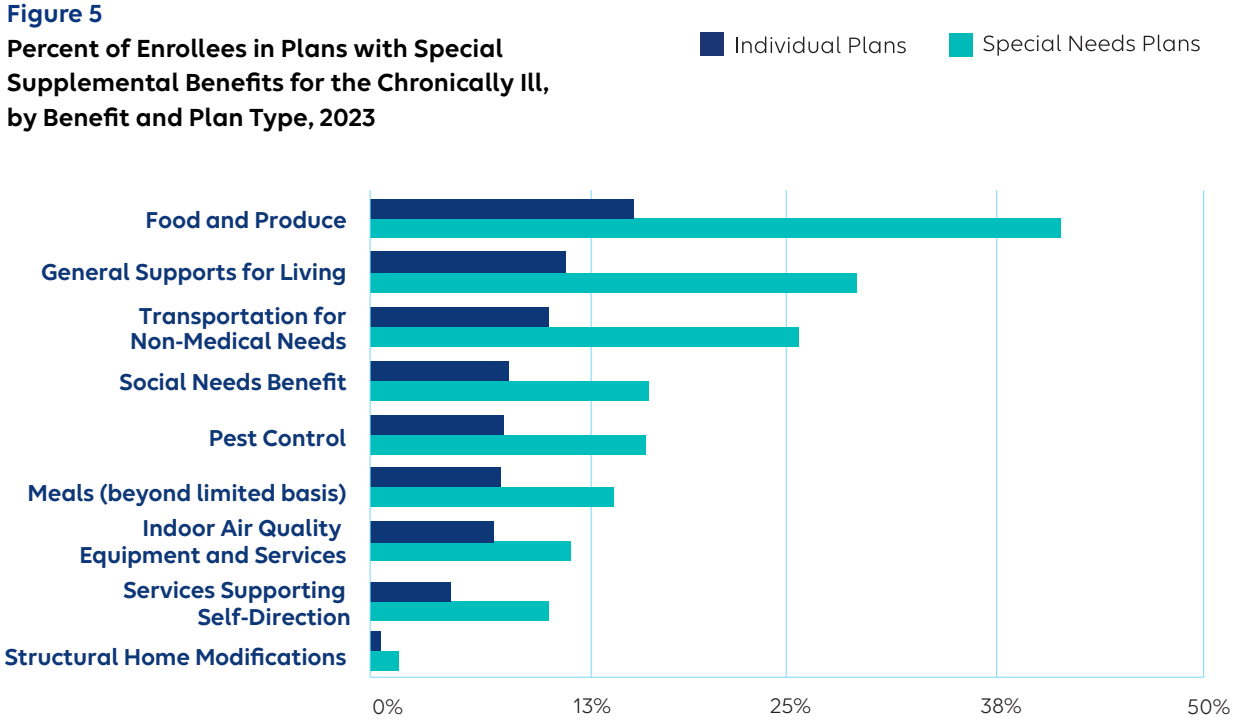
Note. N = 19.6 million in individual plans; N = 5.7 million in Special Needs Plans.

For MA enrollees who experience chronic illness, MA plans are able to offer Special Supplemental Benefits for the Chronically Ill (SSBCI), which were established under the CHRONIC Care Act.[14] These SSBCI can include non-medical services, such as home modifications, transportation for non-medical needs, and more robust meal services. (Figure 5) In 2020, the year SSBCI were first offered, only 267 MA plans offered SSBCI to their chronically ill enrollees; as of 2023, this number has grown to 1,451 plans.[15]

Supplemental benefits are key to advancing health equity, and many MA enrollees rely on them to address their health-related social needs (HRSN), which may include food insecurity and lack of reliable and accessible transportation. A recent study found that the vast majority of MA members use the supplemental benefits offered to them. Further, supplemental benefit users were more likely to live in food deserts and areas with low socioeconomic status, suggesting these members have higher HRSN than non-users.[16]

Figure 5

Percent of Enrollees in Plans with Special Supplemental Benefits for the Chronically Ill, by Benefit and Plan Type, 2023



Source. Ochieng, N., et al. (2023, August 9). Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. Kaiser Family Foundation. Retrieved August 29, 2023, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

Note. N = 19.6 million in individual plans; N = 5.7 million in Special Needs Plans.

Out-of-pocket (OOP) cost protections. Federal law requires MA plans to have a maximum OOP limit that protects members from incurring high OOP costs for necessary care. Many MA plans have chosen to have even lower limits to further protect members. Medicare FFS does not include this protection.

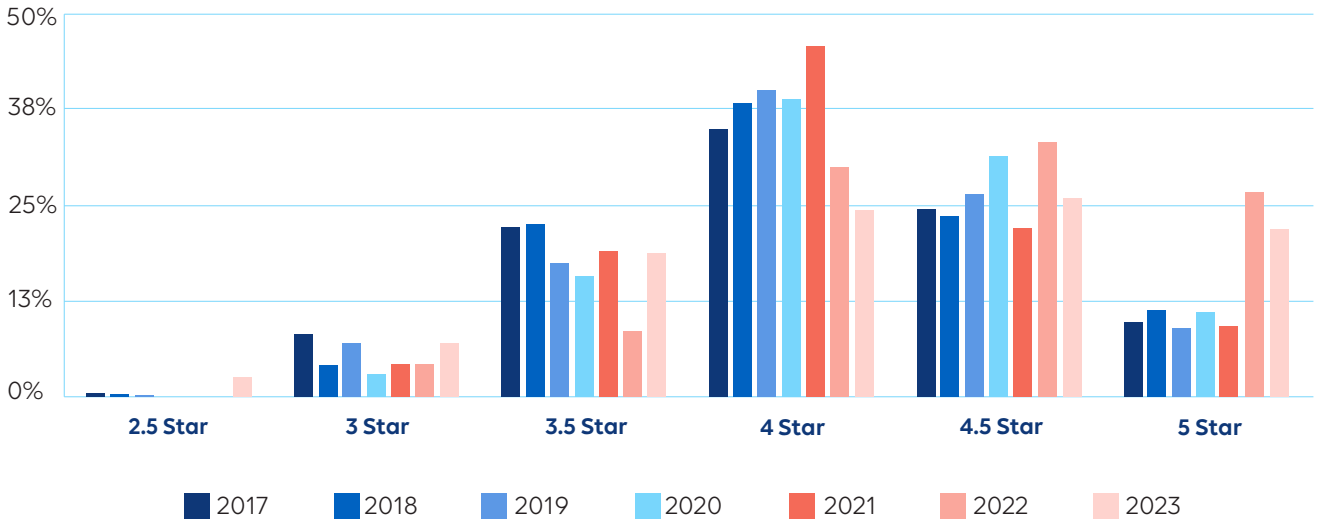
Integrated drug benefit. Most MA plans offer the Medicare prescription drug benefit (Part D) with their MA benefit (known as MA-PD plans). This allows greater coordination of medical and drug coverage and allows plans to promote medication adherence more effectively. Many plans also elect to enhance the drug benefit beyond the standard Part D design.

High-quality care. MA plans are evaluated on quality across a variety of performance measures, including measures on prescription drug coverage for plans that provide the Part D benefit. As of 2023, there are 40 different (28 in Part C, 12 in Part D) quality measure scores,[17] which are then combined into an overall score known as the MA Star Rating. The overall scores range from 1 to 5 stars with 4 or 5 stars representing higher quality plans. The MA payment system incorporates quality performance and rewards higher performing plans with increased payments.

In addition, CMS established a Health Equity Index (HEI) reward factor in April 2023. The HEI more explicitly factors health equity into the MA Star Ratings formula, rewarding eligible MA and Medicare Part D plans for providing excellent, culturally competent care for historically underserved populations. Plans are required to take coordinated, proactive actions to address their members' HRSN, including providing materials in alternate formats and languages to improve equitable access to care.[18] The first rating to include the HEI will be in 2027, measuring performance years 2024 and 2025.[19]

Most MA enrollees are in high performing plans; in 2023, 7 in 10 MA enrollees are in plans with a rating of 4 or more stars.[20] Approximately 51 percent of MA-PDs (260 contracts) earned four stars or higher for their 2023 overall rating.[21] This percentage is even higher (72%) when weighted by enrollment. (Figure 6)

Figure 6
Overall Star Rating Distribution for MA-PD Contracts, Weighted by Enrollment, 2017-2023



Source. Centers for Medicare & Medicaid Services. (2022, October 6). 2023 Medicare Advantage and Part D Star Ratings. Retrieved August 28, 2023, from https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings.

Note. MA-PD = Medicare Advantage Prescription Drug.

MA has positive "spillover effects," including improved healthcare utilization and a slowdown in overall Medicare spending.

Value-based payment arrangements. MA plans may engage providers in value-based payment arrangements, which often center on collaborations with providers designed to support them in providing more personalized, coordinated care that emphasizes the value of care over the volume of care delivered. These arrangements can include medical homes, bundled payments, and/or accountable care organizations with shared savings opportunities. In designing value-based payment arrangements, plans may:

- **Redesign payments** to align financial incentives with quality and cost goals;
- **Provide compensation** for important clinical interventions that occur outside of traditional patient encounters (e.g., email, remote monitoring);
- **Support care management efforts** through data sharing, reporting, and technology;
- **Share meaningful information** regarding patients that goes beyond the information captured in the physicians' medical record (e.g., hospitalizations, prescription drug fills); and
- **Provide physicians** with the information and tools to succeed under new payment models, along with support services and information exchange to transform the way they deliver care.

There is evidence to support that these collaborations with providers can improve health outcomes. When looking at Elevance Health affiliated MA plan members in value-based programs versus those who are not, as of 2022, those in value-based programs had 12.5 percent more annual planned visits, 4.6 percent more colorectal cancer screenings, 0.6 percent fewer plan all-cause readmissions, and greater blood pressure control and diabetes blood sugar control.[22]

MA "spillover effects." Several studies have noted "spillover effects" associated with MA, such as improved healthcare service utilization and a slowdown in overall Medicare spending.[23] This could be in part due to the MA program's efforts to improve care, such as through improved care coordination and focus on HRSN, influencing the way providers deliver care to both patients enrolled in MA plans and patients in Medicare FFS.

For instance, increased MA plan enrollment is associated with a decrease in hospital costs for all Medicare beneficiaries and for commercially insured younger populations,[24] as well as a decrease in avoidable hospitalizations (as compared to expected hospitalizations) for both MA and FFS beneficiaries.[25] Further, a 1 percent increase in county-level MA penetration results in a $64 reduction in standardized per-enrollee FFS spending.[26]

In addition, MA plans' adoption of strategies for care management and coordination offer CMS insights into which approaches might work best, which the agency can then apply in Medicare FFS. For example, Accountable Care Organizations (ACOs), including the Medicare Shared Savings Program, were established to ensure that coordinated, high-quality care is delivered to the Medicare FFS beneficiaries they serve. Similar to the role of managed care, these ACOs are a single entity responsible, and sometimes bearing financial risk, for providing better quality care while spending healthcare dollars more efficiently.

Positive impact on health equity. MA is uniquely positioned to advance health equity and reduce health disparities. For one, the MA program serves a more diverse and medically complex population than Medicare FFS. Over one-third of MA beneficiaries identify as a racial or ethnic minority and over half have annual incomes less than $25,000, as compared to 16 percent and 38 percent of FFS beneficiaries respectively.[27] MA beneficiaries are also more likely to self-report having three or more chronic conditions,[28] and have higher HRSN such as food insecurity.[29]

In recent years, there has been an increasing number of studies on the impact of MA on health equity, including a report from CMS showing favorable trends in addressing racial, ethnic, gender, and rural-urban inequities among MA enrollees.[30] Further, studies have shown that Latino and Black MA beneficiaries, when compared to Medicare FFS beneficiaries, have greater cost savings and increased use of preventive services. Latino and Black MA beneficiaries save an average of $1,421 and $1,104, respectively, each year compared to Medicare FFS beneficiaries.[31] They are also more likely to report receiving routine healthcare services, including mammograms, flu shots, blood pressure screenings, and cholesterol checks, when enrolled in MA as compared to Medicare FFS.[32]

Understanding MA Plan Payment

Plans receive a capitated payment to cover all Parts A and B Medicare services, as well as supplemental benefits, for their enrollees. Plans then contract with physicians, hospitals, skilled nursing facilities, pharmacies, and a range of other providers to deliver care and services to their members.

Plans also use a portion of their payments for important activities such as care coordination and disease management programs, customer service, quality improvement programs, and efforts to deter fraud, waste, and abuse. Plan payments are established through a bidding process that is based on administratively set benchmarks; plan quality performance also factors into plan payments.

Determining Plans' Payments

MA plans' payments are based on administratively set, county-specific payment rates known as "benchmarks." MA benchmarks are calculated using Medicare FFS spending in each county. Counties are divided into quartiles based on the level of their FFS costs, and the benchmarks are calculated as a percent of the county FFS costs based on the quartile assignment. (Table 1) Higher performing plans—those with four or more stars—are eligible for higher county benchmarks.

Table 1
MA Benchmarks Based on County Quartile Assignment

County Quartile Assignment	Benchmark Amount
1st Quartile (Lowest FFS)	115% FFS
2nd Quartile	107.5% FFS
3rd Quartile	100% FFS
4th Quartile (Highest FFS)	95% FFS

Note. MA = Medicare Advantage; FFS = Fee-For-Service.

MA plans determine which counties to offer coverage in and then submit bids based on their estimated costs per enrollee for providing the Medicare Parts A and B benefits. The submitted MA plan bids are then compared to the benchmarks for those counties. If a plan bids below the benchmark, it retains a portion of the difference between its bid and the benchmark, which is known as a rebate. Rebates must be used to benefit the members, such as to provide supplemental benefits or reduce cost sharing. The remaining portion of the difference is returned to the government as savings. If a plan bids above the benchmark, it must charge a premium to the enrollee for the amount above the benchmark.

Finally, plans' payments are adjusted to account for the health status, or "risk level" of each enrollee. Risk adjustment helps ensure that plans are paid appropriately for the health status of the beneficiaries enrolled in the plan.

The current approach to determining the county benchmarks was set by the Affordable Care Act (ACA) with the intent of better aligning plan payments with FFS costs. While benchmarks range from 95 percent to 115 percent of FFS costs, on average, MA plans' payments are about equal to 100 percent of FFS costs.[33] The higher (relative to FFS) benchmarks in the lowest quartiles help promote plan participation in rural areas, or other areas of low FFS spending. They are offset by lower benchmarks in the higher spending areas, such that on average, across the entire program, MA plans are paid on par with FFS.[34]

While the current payment structure does not cost the government any more, on average, for an MA enrollee compared to FFS, there is evidence that quality and outcomes may be better in MA.[35] Further, MA enrollees are getting a more robust benefit package than FFS for the same average spending. There is evidence suggesting that average payments to MA plans are 7 percent less than FFS spending, saving billions of dollars a year.[36]

Incentives for Quality

There are also payment incentives for high quality performance by MA plans, as plans are rewarded based on their MA Star Rating.

Plans with 4 to 5 stars receive an increase in their county benchmarks equal to 5 percent of the county's underlying FFS costs (e.g., a 4-star plan in a county with a benchmark set at 95 percent of FFS costs would have a benchmark set at 100 percent of FFS costs). This means that plans bid against a higher amount, giving them greater rebate opportunity if they bid below the benchmark, which in turn means the ability to offer a more robust set of supplemental benefits to enrollees.

In some counties, known as "double bonus counties," the benchmark is increased by 10 percent of underlying FFS costs. However, because the ACA limited benchmarks to no more than they would have been prior to the ACA, in some counties where the "benchmark cap" limits the quality bonus amount, it prevents plans from receiving the full amount of the quality bonus they earned.

MA Star Ratings also determine the rebates that plans receive when they bid below the benchmarks. The ACA created a tiered system for rebate amounts based on the Star Ratings, with the highest performing plans retaining the largest portion of the difference. (Table 2)

Table 2
MA Plan Quality Bonus Payment and Rebate Percentages

Plan Star Rating	Quality Bonus Payment	Rebate Percentage
4.5 and 5 stars	5% (10% in double bonus counties)	70%
4 stars	5% (10% in double bonus counties)	65%
New plans	3.5%	65%
3.5 stars	None	65%
3 stars or fewer	None	50%

Note. MA = Medicare Advantage

Risk Adjustment

There are multiple reasons that capturing accurate and complete data about MA members' clinical conditions is critical to MA organizations. For one, this ensures that MA plans can enroll their members in appropriate care management programs and collaborate with providers to promote better healthcare outcomes. Secondarily, having good data supports accurate risk adjustment, which ensures that plans are paid correctly and appropriately for the members they serve.

Paying plans appropriately for the risk profile of their members allows them to invest in innovative benefit designs and care management.

Risk adjustment helps ensure robust participation among MA plans by mitigating the effects of adverse selection in the market. Adverse selection occurs when the sickest patients, or those patients likely to be most costly, disproportionately enroll in certain plans, such as those with more generous benefits or more robust coverage of certain providers or drugs to treat chronic conditions.

If plans are not paid accurately for costs associated with higher risk enrollees, then plans may try to avoid enrolling sicker patients. That is, concerns about adverse selection could lead plans to compete based on risk avoidance rather than on the value of the benefits offered to enrollees. In contrast, if plans are paid accurately for the risk profile of their enrollees, they can invest in innovative benefit designs and care management that address their needs.

Therefore, risk adjustment is used to determine the expected costliness of individuals based on their risk scores, and payments are adjusted up or down in accordance with those risk levels, relative to an "average" Medicare beneficiary. This ensures that plans with higher risk enrollees who are expected to cost more receive higher payments than plans with lower risk enrollees who are not expected to be as costly.

The amount by which payments are adjusted is based on information about the member's health conditions and their demographics (e.g., age and gender). Health plans capture information about members' health conditions through claims submissions, medical charts, and health risk assessments. Historically, plans submitted to CMS only the diagnosis information from these sources to be used for risk score calculations. CMS now relies solely on the diagnosis information it extracts from encounter data that plans submit and uses this information for risk score calculations.

CMS uses a set of risk adjustment models to predict the expected relative costliness of certain conditions and demographic characteristics compared to others. These relative values are used to assign an MA risk score to each member. The risk score is the total of all the relative values associated with the condition and demographic factors applicable to the individual.

This risk score is then used to adjust the capitated payment that the health plan receives for that beneficiary. For example, if the per member per month (PMPM) payment for 1.0 risk beneficiaries (i.e., the average risk beneficiary) is $1,000, the PMPM payment for 1.5 risk beneficiaries is $1,500, or 1.5 times that for 1.0 risk beneficiaries.

To prevent overpayment to MA organizations, CMS monitors plans' risk adjustment data through a process known as Risk Adjustment Data Validation (RADV) audits. During these RADV audits, CMS confirms that any diagnoses submitted by the MA organization are supported in the enrollee's medical record.

The coding intensity adjustment accounts for "coding pattern differences" between FFS and MA.

Coding Intensity and Other Adjustments

In calculating plans' risk scores, CMS makes some adjustments to the scores. One such adjustment, required by law, is known as the coding intensity adjustment, which accounts for so-called "coding pattern differences" between Medicare FFS and MA. This adjustment reduces MA plans' risk-adjusted payments.

The coding intensity adjustment is made because the risk adjustment model that CMS uses for MA plans is calibrated with Medicare FFS data, and as a result, the model reflects the relative costs for conditions under the FFS program, but not necessarily those under MA. The adjustment is intended to make up for greater growth in risk scores in MA relative to those in FFS (i.e., "coding intensity").

These differences are driven by the fact that diagnosis codes on Medicare FFS claims have historically been less complete than coding in MA since procedure codes, rather than diagnoses, form the basis for how providers are reimbursed in Medicare FFS. Therefore, FFS providers have less incentive to capture all diagnoses that might be present or that were addressed in a visit. In contrast, MA plans' risk adjustment—as well as their ability to appropriately manage members' chronic conditions and other health needs—relies on the complete and accurate capture of diagnoses for their members. Thus, MA plans work with providers to improve the accuracy of their coding practices and engage in their own efforts to ensure that members' conditions are identified and treated.

Since 2018, the coding intensity adjustment has been a 5.91 percent reduction to risk scores as required by the ACA; this figure remains for 2023. The same adjustment applies to all MA plans, regardless of the level of care they provide or the severity of health conditions of the populations they serve.

Additionally, since CMS only recalibrates the risk adjustment model every few years (i.e., updates the model using new years of Medicare FFS data), CMS also adjusts plans' risk scores for changes in FFS risk levels over time, to keep the average MA risk score at 1.0 each year. This adjustment is known as the fee-for-service normalization factor. This adjustment often reduces plans' risk scores because of changes in FFS risk levels.

Conclusion

The MA program is a popular and valuable option for tens of millions of older adults and individuals with disabilities, offering a coordinated, whole health alternative to the more fragmented care found in Medicare FFS.

Most MA plans offer prescription drug coverage, which means MA members have the convenience of getting hospital, medical, and prescription drug coverage in a single plan. Unlike Medicare FFS, MA plans also offer OOP cost protections and often cover additional benefits, many of which are used to address the HRSN of the diverse, clinically complex population the MA program typically serves.[37]

MA also supports better health outcomes and more efficient spending, as MA plans use strategies for care management and coordination, which not only result in better health outcomes among MA members but have been found to have "spillover effects" to all Medicare beneficiaries. These care management and coordination strategies are also increasingly being tested in traditional Medicare, demonstrating MA's innovation and ability to support the long-term viability of the Medicare program at large.

Endnotes

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