

Key Facts

- CMS adjusts Medicare Advantage plan payments to account for cost differences associated with health status and demographic factors through a process called risk adjustment.
- Risk adjustment ensures predictable and actuarially sound payments to Medicare Advantage plans.
- Accurate risk adjustment is essential for Medicare Advantage plans to ensure adequate resources to care for patients with complex conditions.
- CMS recently made changes to the risk adjustment system to better account for dual-eligible beneficiaries. Challenges remain in accounting for other high-need beneficiaries with multiple, serious chronic conditions.

Risk adjustment is used in insurance to ensure that the payment is adequate to meet the expected costs of care for beneficiaries based on their health status. Medicare Advantage plans receive a capitated payment for each individual and accept financial responsibility for covering all services guaranteed under Medicare Part A and B.

What Is Risk Adjustment?

- Risk adjustment is an essential mechanism in the determination of payment in health insurance programs to account for the health status and expected medical costs of each individual beneficiary.
- Risk is determined by clinical documentation of health status by diagnoses, as well as demographic characteristics.
- There is a wide variation in health status within the Medicare population, including beneficiaries with complex diseases and multiple chronic conditions.

Why is Risk Adjustment Important to Medicare Advantage?

- The Federal government pays Medicare Advantage plans a fixed, per person (“capitated”) monthly amount to provide Medicare guaranteed health benefits to that individual.
- The Centers for Medicare & Medicaid Services (CMS) adjusts these payments to reflect the specific characteristics and anticipated cost of providing care to each beneficiary.

How Does Risk Adjustment Work in Medicare Advantage?

- Beneficiary diagnoses and other information, including beneficiary demographic data, are documented for each beneficiary using diagnosis codes and other data.
- CMS uses this information to calculate an individual risk adjustment factor, known as a “risk score,” for each beneficiary using the CMS Hierarchical Condition Categories (HCCs) risk adjustment system.
- CMS then uses the risk score to adjust the Medicare Advantage county benchmark rate for each beneficiary to determine the monthly capitated payment for that individual.
- CMS performs Risk Adjustment Data Validation (RADV) audits to ensure diagnoses are supported by information in patient medical records.

How has Risk Adjustment in Medicare Advantage Changed in Recent Years?

- CMS has made several changes to the CMS-HCC risk adjustment model during the past several years. For 2017, CMS modified the model to improve payment accuracy for low-income beneficiaries who are dually eligible for Medicare and Medicaid.
- Evidence shows that the risk adjustment model also does not adequately account for the cost of treating beneficiaries with multiple, complex chronic conditions.

Policy Recommendation

Accurate risk adjustment is essential to ensuring that Medicare Advantage plans and providers have the resources necessary to provide innovative, affordable, high quality care to all beneficiaries. CMS should work with Medicare Advantage stakeholders to ensure accurate risk adjustment and adequate payment for all enrollees, including those who are dually eligible for Medicare and Medicaid and those with multiple chronic conditions.