# Coding and Payment in Medicare Advantage

**FACT SHEET** JANUARY 2021

BETTER MEDICARE ALLIANCE

## Key Facts

- Medicare Advantage plans are paid a capitated amount based on the average cost of FFS Medicare. That payment is risk adjusted for each enrollee based on health status.
- Medicare Advantage relies on diagnosis codes for payment. FFS Medicare relies on procedure codes for reimbursement.
- There are differences in coding patterns between Medicare Advantage and FFS Medicare, which are a function of the differences between the payment structure and care models.
- CMS reduces Medicare Advantage payments annually to account for coding differences between Medicare Advantage and FFS Medicare.
- The coding intensity adjustment is a 5.91% reduction per year in Medicare Advantage payments.

## Policy Recommendation

To achieve stability and predictability in payment to Medicare Advantage, ensure adequacy of prospective, capitated payment, and enable plans and providers to have the data necessary for early intervention and care management, CMS should freeze the coding intensity adjustment at the current statutory minimum.

**Medicare Advantage plans depend on stable payment and risk adjustment to ensure adequate resources are available to provide coverage for the care and treatment of enrollees.**

### Payment Model in Medicare Advantage

- In Medicare Advantage, health plans are paid a capitated, or fixed, prospective amount to cover care for enrollees. Medicare Advantage relies on risk scores to account for anticipated health costs for enrollees based on health status.
- Medicare Advantage plans submit diagnosis codes to the Center for Medicare & Medicaid (CMS). Then CMS adjusts capitated payments to plans for each enrollee based on his or her risk score. The risk score is calculated using patients' diagnoses and demographic data.

### Coding Pattern Differences

- There are different diagnostic coding practices in Medicare Advantage and Fee-For-Service (FFS) Medicare, due to the different payment systems and care models.
- Medicare Advantage relies on diagnosis coding to adjust the prospective, capitated payment for each enrollee. Plans then take on the financial risk that the payment will be adequate to cover costs of care. FFS Medicare reimburses providers for services, procedures, or episodes of care already provided.
- FFS Medicare payment does not rely on the same degree of specificity of diagnoses.
- Medicare Advantage depends on risk data to enable care management and early interventions, engage patients, follow-up on clinical recommendations, address social and emotional barriers, and slow disease progression. Such care management is not typically available in FFS Medicare.

### Coding Intensity Adjustment in Medicare Advantage

- Coding intensity refers to the difference in diagnostic coding patterns between Medicare Advantage and FFS Medicare.
- Medicare Advantage payment is based on FFS Medicare cost data. Since diagnosis coding practice is different between the two programs, CMS reduces Medicare Advantage payments by an annual percentage to bring Medicare Advantage coding in-line with FFS Medicare coding patterns.
- Since 2010, Congress requires CMS to apply a coding intensity adjustment to Medicare Advantage risk scores to account for this difference, resulting annual across-the-board reduction in Medicare Advantage payments.
- Per statute, the coding intensity adjustment increased from a 3.41% reduction in 2010 to a 5.91% reduction in 2018. The adjustment remains at an annual minimum 5.91% reduction to risk scores for subsequent years.
- CMS has the authority to determine a reduction above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by law.