Coding Practices and Adjustments in Medicare Advantage

Fact Sheet JUNE 2022

BETTER MEDICARE ALLIANCE

Key Facts

- Medicare Advantage plans are paid a capitated amount based on average payments in FFS Medicare, which are risk adjusted for each individual enrollees' health status.
- The model used by CMS to calculate payments for Medicare Advantage uses diagnosis codes to measure health status. By contrast, FFS Medicare uses procedure codes or other clinical data for reimbursement.
- This adjustment is intended to account for the difference in coding patterns between Medicare Advantage and FFS Medicare, which is due in part to the differences in payment structures and care models.
- Statute requires CMS to reduce Medicare Advantage payments annually to account for coding differences between Medicare Advantage and FFS Medicare.
- This coding intensity adjustment is a 5.9% reduction per year in Medicare Advantage risk score payments

BMA's Perspective

- Policymakers should apply the current 5.9% coding intensity, which sufficiently accounts for the differences in coding patterns between Medicare Advantage and FFS Medicare. Any increase in the current coding intensity adjustment could increase premiums for Medicare Advantage beneficiaries or reduce benefits.

It is important that beneficiaries' complete diagnostic information is accurately captured so health plans can effectively manage their population's clinical care. Stable payments and risk adjustment calculations are needed to ensure that adequate resources are available to provide high-quality care and services to beneficiaries.

Payment Model in Medicare Advantage

- Medicare Advantage plans are paid a capitated, or fixed, prospective amount to cover care for enrollees. Medicare Advantage relies on risk scores to estimate the anticipated health care costs for enrollees based on individual health status each year.
- The risk score is calculated using the enrollees' diagnoses and demographic data. Medicare Advantage plans submit diagnosis codes to the Centers for Medicare & Medicaid Services (CMS), which are combined into diagnoses groups and further aggregated into Hierarchical Condition Categories (HCCs). CMS then adjusts the capitated payments to health plans for each enrollee based on their risk score.
- Health plans submit bids prospectively to CMS that include their projections of risk scores and expected costs for the subsequent payment year (e.g., plans submit bids in June 2022 for payment year 2023).

Coding Practice Differences

- Coding practices differ in Medicare Advantage and Fee-For-Service (FFS) Medicare, due to the different payment systems and care models.
- Medicare Advantage relies on diagnoses and plan bids to determine prospective, capitated payments for each enrollee. Plans take on the financial risk that the payment received will be adequate to cover the total cost of beneficiary care. Unlike Medicare Advantage, FFS Medicare reimburses providers for each service, procedure, or episode of care provided to beneficiaries.
- Medicare Advantage depends on beneficiary disease information for care management and early interventions, beneficiary engagement, clinical management, and management of social and emotional barriers. Such care coordination and management are not part of FFS Medicare.

Coding Intensity Adjustment in Medicare Advantage

- Coding intensity refers to the difference in diagnostic coding patterns between Medicare Advantage and FFS Medicare.
- The Medicare Advantage risk adjustment model is estimated based on FFS Medicare diagnosis codes. Since diagnosis coding practice is different between the two programs, CMS reduces Medicare Advantage risk scores by an annual percentage to bring Medicare Advantage coding in-line with FFS Medicare coding patterns.
- Under current law, CMS must apply a coding intensity adjustment to Medicare Advantage risk scores to account for this practice difference, resulting in annual across-the-board reductions in Medicare Advantage risk scores and payments.
- Per statute, the coding intensity adjustment increased from a 3.41% reduction in 2010 to a 5.9% reduction in 2018. The adjustment remains at an annual 5.9% reduction to risk scores for subsequent years. [1]
- 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.
- In the CY 2023 Final Rate Announcement, CMS found that the "minimum adjustment, as established and updated in statute over the years, sufficient to reflect the differences in coding patterns between MA plans and providers under Parts A and B that are indicated in our annual analysis." [2]

The Value of Accurate Coding in Medicare Advantage

The Medicare Advantage care delivery model depends on understanding the population served and their health needs. Accurate records of diagnoses support health plans in understanding their enrollees better by fully and more adequately capturing health status. When health plans better understand their population, they are able to intervene early and appropriately manage and coordinate care, leading to improved care delivery and overall better health outcomes for the millions of beneficiaries choosing Medicare Advantage.

1. 42 U.S.C. § 1395w-23(a)(1)(C)(ii).
2. Centers for Medicare & Medicare Services, Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (April 4, 2022). Available here: https://www.cms.gov/files/document/2023-announcement.pdf