Risk Adjustment in Medicare Advantage

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BETTER MEDICARE ALLIANCE

Key Facts

- Medicare Advantage plans are paid a capitated amount based on average payments in FFS Medicare. Medicare Advantage payments are risk adjusted for each individual enrollees' health status and demographic information.
- Beneficiary health status is the primary factor in calculating the risk score used to adjust the capitated payments to health plans. These risk scores depend on accurate diagnosis coding and beneficiary demographics.
- Medicare Advantage depends on the accurate risk adjustment of each beneficiary to ensure there are adequate resources to provide high-quality care and services, particularly for beneficiaries with multiple chronic conditions.

BMA's Perspective

- Adequate resources create opportunities in Medicare Advantage to coordinate, manage, and deliver patient care in affordable, high-quality, and innovative ways. Accurate risk adjustment benefits the millions of beneficiaries that choose Medicare Advantage through early intervention and more personalized care, leading to improved health outcomes.

In Medicare Advantage, health plans are paid a capitated, or fixed, prospective amount to cover all care for enrollees. The capitated payments are determined annually by the Centers for Medicare & Medicaid Services (CMS) and based on a county-level benchmark rate that is adjusted for each Medicare Advantage beneficiary's health status and demographics.

The Risk Adjustment Process in Medicare Advantage

- CMS establishes an annual county-level benchmark based on average payments in Fee-for-Service (FFS) Medicare for that county. The benchmark is the basis for payment in Medicare Advantage and used to determine a health plan's payment rate through the annual prospective bid process. Each plan's base payment rate is then adjusted for each beneficiary's risk score, which measures how costly a beneficiary would be if enrolled in FFS Medicare and relative to the average beneficiary.
- The risk score is calculated by CMS using the beneficiary's diagnoses and demographic data submitted by health plans. Each diagnosis code is attributed to broader diagnosis groups, further combined into Hierarchical Condition Categories (HCCs). HCCs, along with the beneficiary's demographic factors (e.g., age, gender), are used to more accurately predict health care costs for each beneficiary.
- Medicare Advantage relies on risk scores to estimate the anticipated health care costs for Medicare Advantage enrollees and is done to account for the variation in health needs across the Medicare population.
- Base payment rates are adjusted with each beneficiary risk score through a process called risk adjustment, resulting in the monthly capitated payment made to health plans.
- Additional adjustments to the capitated payment include a coding intensity adjustment to reflect the differences in coding practices between Medicare Advantage and FFS Medicare and Star rating quality performance adjustment.

The Importance of Accurate Risk Adjustment

The Medicare Advantage care delivery model depends on understanding the population served and providing care for their health needs. Accurate risk adjustment facilitates predictable and stable payments, ensuring health plans receive adequate resources to provide comprehensive care for both anticipated and unexpected beneficiary health care needs.