Overview of Medicare Advantage Payment and Accountability Measures

RECOMMENDATIONS TO STRENGTHEN AND SUSTAIN THE PROGRAM FOR BENEFICIARIES

BETTER MEDICARE ALLIANCE

Contents

Introduction

Medicare Advantage is the choice of more than 33 million seniors and people with disabilities for high-quality, affordable health care. As the program grows, however, misconceptions about how Medicare Advantage works are also on the rise. This document explains how Medicare Advantage is set up to deliver better health outcomes at a lower cost for beneficiaries than Fee-for-Service Medicare, with accountability and transparency measures built directly into the program to ensure taxpayer dollars are being spent efficiently.

Medicare Overview

Medicare is a federal health care program for qualified individuals and administered by the Centers for Medicare & Medicaid Services (CMS). Medicare differs from Medicaid, which provides health coverage to low-income individuals and other qualified individuals and administered at the state level with federal oversight. Individuals can be eligible for both Medicare and Medicaid and are called dual eligible beneficiaries, as they are dually eligible for both programs. Medicare beneficiaries have two options for receiving their Medicare benefits – Fee-for-Service (FFS) Medicare and Medicare Advantage (MA).

Medicare Eligibility Criteria

- People aged 65 and over
- Certain people with disabilities who are under 65, after receiving disability benefits for 25 months
    - People with Amyotrophic Lateral Sclerosis (ALS) who have Social Security Disability Insurance are immediately eligible
- People of any age living with End-Stage Renal Disease, which is a condition of permanent kidney failure requiring dialysis or a kidney transplant

Medicare is Comprised of Four Parts

- Part A: Hospital insurance / inpatient services and care
- Part B: Medical insurance / outpatient services and care
    - Covers items such as physicians' services and preventive services
- Part C: Medicare Advantage
- Part D: Prescription drug coverage
    - Optional coverage that is available to both FFS and MA beneficiaries

Pathways to Receive Medicare Benefits

There are two pathways for beneficiaries to receive their Medicare benefits – FFS Medicare and Medicare Advantage.

FFS Medicare includes coverage for Parts A and B services, with optional Part D prescription drug coverage and is administered by the federal government, specifically CMS.

- CMS pays participating providers directly for the health care cost of services and care delivered to beneficiaries.
- Beneficiaries may see any provider who accepts Medicare.
- There is no out-of-pocket cost limit for beneficiaries.

- Beneficiaries may separately purchase Medigap policies to reduce out-of-pocket costs.

Medicare Advantage, also known as Part C, includes all Parts A and B services provided in FFS Medicare and may include additional benefits in the form of lower cost sharing and premium buy-downs and extra supplemental benefits. Medicare Advantage is the managed care option in Medicare and is a public-private partnership, meaning approved benefits are offered and administered by a private health plan that contracts with CMS.

- Most MA plans include integrated Part D prescription drug coverage (MA-PD plans).
- Health plans may have preferred provider networks or more restrictive provider networks.
- Cost sharing may be above or below FFS Medicare but must be actuarially equivalent to it.
- There are out-of-pocket cost limits for beneficiaries.

Payment Overview

FFS Medicare

Generally, FFS Medicare pays physicians, hospitals, and other health care providers and facilities for services and care delivered to beneficiaries based on a series of established service lists and annual payment rates. The payment rates are prospectively set through regulation each year for each qualified service, procedure, or episode of care.[1] For example, payment rates for physician services are set in the Physician Fee Schedule (PFS), and payment rates for most acute care hospitals are set in the inpatient prospective payment system (IPPS). As beneficiaries receive services and care, the physician or other health care provider or facility bills CMS for the service provided. Thus, FFS Medicare is based on retrospective payment, or reimbursement, for care already delivered to beneficiaries. This is the primary distinction with payment in Medicare Advantage, which is prospective.[2]

Medicare Advantage

Medicare Advantage plans are paid a prospective, monthly capitated rate per beneficiary enrolled in the health plan for anticipated health care costs. The payment is based, in part, on a county benchmark, which is based on average spending in FFS Medicare in that county for an average health beneficiary.[3]

Each year, health plans bid against the county benchmark. If a health plan submits a bid that is *above* the benchmark, beneficiaries will pay a premium for the difference between the plan bid and the benchmark. If a health plan submits a bid that is *below* the benchmark, the plan receives a percentage of the savings in the form of a rebate.[4] The rebate must be used to offer additional supplemental benefits, lower beneficiary cost sharing, and/or reduce premiums.

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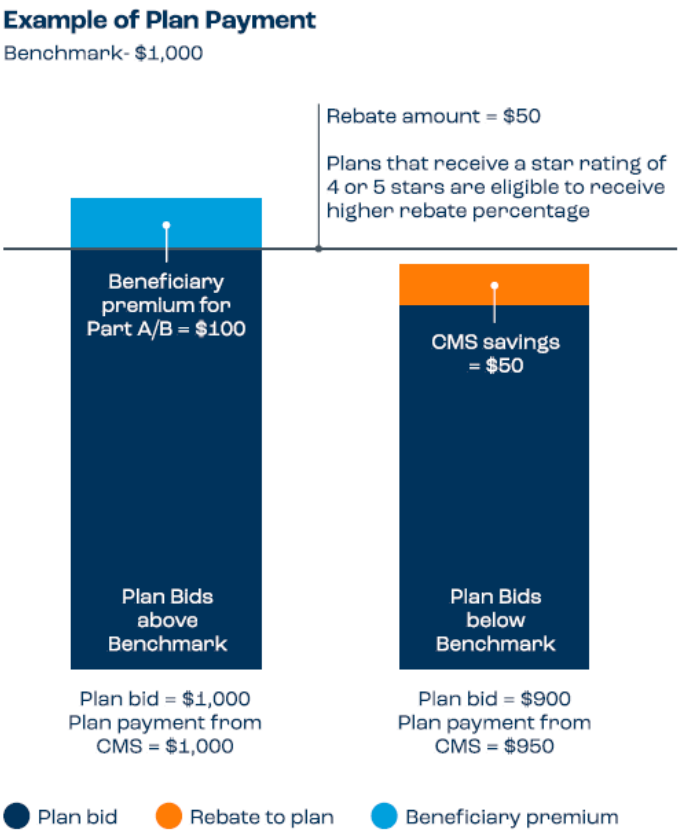
[1] Centers for Medicare & Medicaid Services, "Medicare Fee-for-Service Payment Regulations," 2023. Available here.
[2] Congressional Research Service, Medicare Primer, May 21, 2020. Available here.
[3] MedPAC, Medicare Advantage Program Payment System, October 2023. Available here.
[4] Rebates vary by health plan and are dependent on the plan's quality rating, with higher quality plans receiving a higher percentage of the rebate. Rebates vary from 50% to 70% of the difference between a plan's bid and the benchmark.



Through the annual bid process, a base rate is determined for each Medicare Advantage plan in the county. The base rate is then adjusted for each enrollee based on a risk score, which encompasses their demographics (e.g., age, sex, dual status, disability status) and individual health conditions (e.g., clinical diagnoses). CMS then pays health plans based on the risk adjusted base rate, applicable rebates for each enrollee in a health plan, and other standard adjustments.

Risk Adjustment Overview

Risk adjustment is the process of changing the base rate a health plan is paid for each enrollee based on the health status of the beneficiary. Risk adjustment ensures that payment in the Medicare Advantage program is adequate to cover the true cost of beneficiaries' care.

For the risk adjustment process to work properly, it is important to collect data on the health of all Medicare Advantage beneficiaries each year. Accurate documentation of diagnoses is a critical component of the risk adjustment process. It provides the opportunity to fully assess a beneficiary's clinical and social needs and communicate those needs to other clinicians caring for the individual and address risks that may not have been identified as requiring attention. Additionally, it supports care management and high-quality services for beneficiaries based on their conditions. 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.

Beneficiary health status is the primary factor in calculating the risk score used to adjust the capitated payments to health plans. The risk score is calculated by CMS using individual diagnoses and demographic data submitted by health plans. Each diagnosis code is attributed to broader diagnostic groups, further combined into Hierarchical Condition Categories (HCCs). HCCs and the beneficiary's demographic factors are used to more accurately predict future health care costs for each beneficiary. Moreover, risk scores are developed to account for the variation in health needs across the Medicare population.

Additional adjustments to the capitated payment include a coding adjustment to reflect the differences in coding practices in Medicare Advantage and FFS Medicare, as well as a quality performance adjustment discussed above in the form of a rebate.

Coding Practices and Adjustments

Coding practices differ in Medicare Advantage and FFS Medicare due to the different payment systems and care model. As noted, Medicare Advantage relies on diagnoses and health plan bids to determine prospective capitated payments for each enrollee. Health plans take on financial risk that the payment received from CMS will be adequate to cover the total cost of beneficiary care each month for the upcoming plan year. Unlike Medicare Advantage, FFS Medicare reimburses providers for each service, procedure, or episode of care provided to beneficiaries, meaning FFS Medicare operates on a retrospective payment system.

Coding intensity refers to the difference in diagnostic coding practices between Medicare Advantage and FFS Medicare. The Medicare Advantage risk adjustment model is based on FFS Medicare diagnosis codes. Because diagnosis coding practice is different between the two programs, CMS reduces Medicare Advantage risk scores by an annual percentage to align Medicare Advantage coding with FFS Medicare coding patterns.

Under current law, CMS must apply a coding intensity adjustment to Medicare Advantage risk scores to account for this difference, resulting in annual uniform reductions to Medicare Advantage risk scores, and subsequently, payments. Per statute, the coding intensity adjustment increased from a 3.41% reduction in 2010 to a 5.9% reduction in 2018. The adjustment currently remains at 5.9% and for subsequent years.[5] CMS has the authority to determine a reduction above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by statute. In the CY 2025 Final Rate Announcement, CMS found the "minimum adjustment is sufficient to reflect differences in coding patterns between [Medicare Advantage] plans and providers under FFS Parts A and B. CMS continues to believe that applying a uniform adjustment is an appropriate approach."[6]

Tools to Better Understand Beneficiary Health

It is necessary for health plans to have a comprehensive understanding of their enrollees through complete diagnostic information and risk assessments in order to effectively manage their population's clinical care. 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 Medicare Advantage beneficiaries.

There are a number of tools health plans utilize to collect information on beneficiaries' health status, including physical, social, and emotional health in an effort to fully comprehend the population and ensure proper clinical documentation. Two primary tools are health risk assessments (HRAs) and chart reviews.

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[5] 42 USC § 1395w-23(a)(1)(C)(ii)
[6] Centers for Medicare & Medicaid Services, Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, April 1, 2024. Available here.

Health Risk Assessments

HRAs are an established component of the Medicare Advantage program. CMS covers an initial health assessment for beneficiaries in FFS Medicare and in Medicare Advantage within 90 days of the effective date of Medicare enrollment. This can be accomplished through a FFS Medicare initial preventive visit (i.e. Welcome to Medicare visit), an Annual Wellness Visit, or in Medicare Advantage, a health risk assessment.[7]

Per CMS guidance, Medicare Advantage plans must make a best effort to conduct a health assessment annually to ensure coordinated and continuous patient care.[8] Within Medicare Advantage, CMS requires health plans that offer a Special Needs Plan (SNP) to conduct a comprehensive HRA at time of enrollment and annually thereafter, and recent regulations standardize some of the information collected, including questions on beneficiary social risk factors.[9]

HRAs are an objective evaluation tool that identify gaps in care and collect critical beneficiary information that informs a beneficiary's care plan to improve health. Information may include:[10]

- Health status
- Demographics
- Health risk factors, including physical, psychosocial, and behavioral risks
- Social determinants of health
- Functions of daily living

As an integral part of Medicare Advantage's care coordination model, these evaluations are primarily used for preventative care and to assess the overall health of beneficiaries, document diagnoses, and identify gaps in care and unmet needs based on the information collection.

HRAs are provided through two key modalities:

1. **Survey-based HRAs** – identify critical beneficiary information on a variety of health status and social risk factors and inform care plans and next best clinical actions
2. **In-home HRAs** – comprehensive clinical care models where a qualified health professional provides a clinical primary care visit, identifies and addresses gaps in care, and works to eliminate social needs and risk factors

As an integral part of Medicare Advantage's care coordination model, in-home HRAs are an important opportunity for health plans to deliver clinical care and holistically address beneficiary needs. These evaluations are primarily used for preventative care and to assess the overall health of beneficiaries, document diagnoses, and identify gaps in care and unmet needs based on the information collected. In-home HRAs provide a unique opportunity to gain additional insight into the overall environment that impacts an individual's health. For example, some physical and social needs like fall hazards may only be identified while in the home, leading to a more holistic understanding of the beneficiary and their needs.

[7] 42 CFR § 410.15
[8] 42 CFR § 422.112(b)(4)(i)
[9] 42 CFR § 422.101(f)(1)(i); Centers for Medicare & Medicaid Services, Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program, 87 Fed. Reg. 27,704 (May 9, 2022).
[10] 42 CFR § 410.15(a) ("health risk assessments")

Health Risk Assessments and Risk Adjustment

For an HRA to be used for risk adjustment purposes, it must be conducted in-person by a qualified health profession, which includes physicians, nurse practitioners, physician assistants, and clinical nurse specialists under CMS guidance and regulation.[11] HRAs, and specifically in-home HRAs, help improve the beneficiary care journey through the following activities that take place by administering an HRA:

- Care coordination and management
- Medication management and remediation
- Identification of high-risk individuals and those with chronic conditions
- Address risk factors in the home such as nutrition, safety, and isolation
- Enrollment in disease management or case management programs
- Schedule appointments with appropriate providers and coordinate other follow-up care
- Make referrals to appropriate community resources for health and social services
- Share information with beneficiary's providers
- Development of personalized comprehensive care plans

Chart Reviews

Chart reviews are one of two types of records Medicare Advantage plans submit to CMS, along with encounter data records. Health plans typically use chart reviews to edit or correct diagnostic information previously submitted in encounter records and include additional clinical information after careful review of the beneficiary's medical record. Chart reviews are a helpful tool to ensure comprehensive records of beneficiary clinical information and their complete health status are maintained.[12]

Mechanisms for Accuracy and Transparency

HHS Program Integrity

Ensuring Medicare program integrity is fundamental to safeguarding the future of Medicare and the ability to provide sustainable, high-quality, and affordable care to seniors and people with disabilities. The Department of Health and Human Services (HHS) and CMS conducts program integrity activities to prevent fraud, waste, and abuse and promote accuracy and transparency in the Medicare program. These activities include reviews of claims paid by Medicare, as well as audit activities in Medicare Advantage. Because Medicare Advantage plans are paid on prospective, per-enrollee bids, HHS and CMS conduct different program integrity activities in Medicare Advantage than in FFS Medicare. Nonetheless, a comparison of the relative error, as measured by overpayments and underpayments, is important context for understanding current oversight programs and the role of risk adjustment data validation (RADV) audits.

[11] 42 CFR § 410.15(a) ("health professional"); Centers for Medicare & Medicaid Services, Medicare Managed Care Manual, Chapter 7-40. Available here.

[12] MedPAC, Report to the Congress: Medicare and the Health Care Delivery System – Ensuring the Accuracy and Completeness of Medicare Advantage Encounter Data, June 2010. Available here.

CMS monitors payment error[13] across 13 programs designated by HHS and the Office of Management and Budget (OMB) as "risk susceptible,"[14] including FFS Medicare, Medicare Advantage, and Medicare Part D to identify overpayments and underpayments. In Medicare Advantage, CMS conducts a RADV audit of medical records for a set of diagnoses across health plans. As shown in Table 1 below, the Medicare Advantage overpayment rate for FY 2023 is noticeably lower than the FFS Medicare overpayment rate, 5.32% and 7.14%, respectively. In addition, the net overpayment rate, which is the overpayment less the underpayment rate, is lower in Medicare Advantage than in FFS Medicare, 4.63% and 6.90%, respectively.

Table 1: Estimated Improper Payments by Program, Fiscal Year 2023

	Overpayments		Underpayments		Technically Improper	
Program	**Dollars (in millions)**	**Percent**	**Dollars (in millions)**	**Percent**	**Dollars (in millions)**	**Percent**
FFS Medicare	$30,213.46	7.14%	$ 1,015.34	0.24%	$ -	0.00%
Medicare Advantage	$14,648.72	5.32%	$ 1,902.04	0.69%	$ -	0.00%
Medicare Part D	$ 2,334.94	2.59%	$ 1,019.84	1.13%	$ -	0.00%
Medicaid	$48,820.01	8.32%	$ 336.21	0.06%	$ 1,175.84	0.20%
CHIP	$ 2,121.52	12.73%	$ 0.97	0.01%	$ 13.09	0.08%

Source: Department of Health and Human Services, Agency Financial Report – Fiscal Year 2023. Available here.

Similarly, the Government Accountability Office (GAO) monitors improper payments across federal departments and programs, including HHS and the Medicare and Medicaid programs. GAO defines improper payments to include overpayments and underpayments or payments that should not have been made at all. Based on HHS and CMS data, GAO found FFS Medicare and Medicare Advantage improper payments and rates to be in line with the FY 2023 HHS Financial Report. In Table 2 below, the Medicare Advantage improper payment rate for FY 2023 is noticeably lower than the FFS improper payment rate, 6.0% and 7.4%, respectively. In addition, GAO examined improper payment amounts and rates over time. Rates for Medicare Advantage in FY 2018-2022 are unavailable due to a methodology change by CMS that renders comparison from prior years ineffective. However, the estimated payments and differences between Medicare Advantage and FFS Medicare are generally consistent year over year.

[13] Both overpayments and underpayments are included in CMS' payment error.
[14] Risk susceptible is defined as monetary loss estimates greater than $100 million in a fiscal year.

Table 2: Estimated Improper Payments for the Medicare Program, Fiscal Years 2018-2023

	2018		2019		2020		2021		2022		2023	
Program	**Dollars (in billions)**	**Percent**	**Dollars (in billions)**	**Percent**	**Dollars (in billions)**	**Percent**	**Dollars (in billions)**	**Percent**	**Dollars (in billions)**	**Percent**	**Dollars (in billions)**	**Percent**
FFS Medicare	$31.6	8.1%	$28.9	7.3%	$25.7	6.3%	$25.0	6.3%	$31.5	7.5%	$31.2	7.4%
Medicare Advantage	$15.6	*	$16.7	*	$16.3	*	$23.2	*	$13.9	5.4%	$16.6	6.0%
Medicare Part D	$1.3	**	$0.6	**	$0.9	**	$1.4	**	$1.4	**	$3.4	3.7%

Source: Government Accountability Office, Medicare and Medicaid: Additional Actions Needed to Enhance Program Integrity and Save Billions, April 2024 (GAO-24-107487). Available here.

***** According to CMS, the agency refined its Medicare Advantage improper payment rate methodology for FY 2022, and, as a result, those data should not be compared to prior years.

****** According to CMS, the agency refined its prescription drug benefit improper payment rate methodology for FY 2023, and, as a result, those data should not be compared to prior years.

RADV Audits

CMS employs RADV audits to ensure Medicare Advantage payment integrity. Under RADV, CMS selects a subset of health plans to audit. CMS then generates a small random sample of enrollees (typically 201 enrollees) for each selected Medicare Advantage contract and conducts medical record reviews to determine whether diagnoses submitted by the health plan from provider claims and medical records for risk adjustment purposes are supported by medical record documentation. CMS uses this information to validate enrollees' risk scores and payments to the health plan. Any difference between the actual paid amount (based on the health plans' submitted diagnoses) and the amount that would have been paid based on the RADV-validated diagnoses is known as the payment error. The error rate of the sampled enrollees is then extrapolated to the entire health plan membership.

In recent years, CMS has made several changes to the RADV audit process, with the most recent regulatory action occurring in 2023, with CMS releasing the final Medicare Advantage RADV rule on January 30, 2023. The final rule codified changes to Medicare Advantage RADV methodology, including:[15]

1. Finalizing CMS' authority to use any statistically valid auditing methodology and giving CMS and the HHS Office of Inspector General (OIG) flexibility in sampling and extrapolation methodology
2. Allowing for extrapolation of audit results to the plan population level starting in payment year 2018
3. Excluding the FFS Adjuster in any RADV recoveries

[15] Centers for Medicare & Medicaid Services, Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 87 Fed. Reg. 6,643 (February 1, 2023).

RADV audits remain the primary mechanism to ensure payments made to Medicare Advantage plans are appropriate and accurate. Following the finalization of the RADV rule in 2023, CMS resumed RADV audits, and according to GAO, initiated automated reviews in February 2024.[16]

Updating the CMS Risk Adjustment Model

CMS adjusts Medicare Advantage payments based on the HCC risk adjustment model that is updated from time to time with more current data, including payment and clinical data. In 2023, CMS finalized the update to the V28 model with clinical reclassifications of the HCCs using ICD-10-CM codes. After assessing conditions that are coded with more frequency in Medicare Advantage than FFS Medicare, CMS added additional constraints and removed several HCCs and diagnosis codes to reduce the impact of coding intensity on risk scores. The model update is being phased in, beginning in CY 2024 and complete phase-in occurring in 2026. Updating the risk adjustment model is another mechanism to improve the accuracy of payments to health plans via the diagnostic coding information used.[17]

Revising Diagnostic Information

In addition to CMS, there are mechanisms for Medicare Advantage plans to improve the accuracy of payments and completeness of data submitted to CMS for risk adjustment purposes. For example, health plans are able to edit or correct diagnostic information previously submitted to CMS, including the removal and addition of information following careful review.[18] Editing and correcting diagnostic information further improves the accuracy of building a beneficiary's health status and risk score and subsequent payments to deliver care and services.

Recommended Measures for Continued Improvement

Codify Best Practices for In-Home Health Risk Assessments

In-home HRAs have long been an important tool to understand and address the comprehensive social, emotional, and physical health needs of beneficiaries. At the same time, policymakers have expressed concern over the appropriate use of in-home HRAs and the connection to risk adjusted payments in Medicare Advantage despite wide recognition that in-home HRAs are an invaluable tool to fully understand beneficiary health status and support care coordination. For example, CMS requires that SNPs conduct an HRA for beneficiaries as part of the SNP model of care.[19]

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[16] Government Accountability Office, Medicare and Medicaid: Additional Actions Needed to Enhance Program Integrity and Save Billions, April 2024 (GAO-24-107487). Available here.
[17] Centers for Medicare & Medicaid Services, Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 31, 2023. Available here.
[18] MedPAC, Report to the Congress: Medicare and the Health Care Delivery System – Ensuring the Accuracy and Completeness of Medicare Advantage Encounter Data, June 2010. Available here.
[19] Centers for Medicare & Medicaid Services, Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program, 86 Fed. Reg. 5,864 (January 19, 2021); Centers for Medicare & Medicaid Services, Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 27,704 (May 9, 2022).

Better Medicare Alliance has long supported codifying best practices for in-home HRAS, as we recognize the role HRAs play in assessing beneficiary needs and addressing urgent and developing concerns.

CMS implemented mechanisms to increase oversight through the CY 2022 Medicare Advantage and Part D Final Rule, which requires that SNPs include questions in HRAs that address social drivers of health, beginning in CY 2024.[20] BMA encourages CMS to take additional steps to ensure in-home HRAs are available as a tool for health plans to assess the overall social, emotional, and physical health of beneficiaries, document diagnoses, and identify gaps in care.

To strengthen the value of in-home HRAs, policymakers should expand and codify in-home HRA best practices and assess whether health plans act in accordance with the best practices. In the CY 2016 Final Call Letter, CMS provided and encouraged health plans to implement best practices for conducting an in-home HRA[21] and issued further guidance in 2016, including implementing procedures to make a "best effort" that health plans conduct HRAs annually.[22] Best practices include:

1. All components of the annual wellness visit, including a health risk assessment such as the model health risk assessment developed by the Centers for Disease Control and Prevention (CDC)
2. Medication review and reconciliation
3. Scheduling appointments with appropriate providers and making referrals and/or connections for the beneficiary to appropriate community resources
4. Conducting an environmental scan of the beneficiary's home for safety risks, and need for adaptive equipment
5. A process to verify that needed follow-up care is provide
6. A process to verify that information obtained during the assessment is provided to the appropriate health plan provider(s)
7. Provision to the beneficiary of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources
8. Enrollment of assessed beneficiaries into the health plan's disease management/case management programs, as appropriate

To ensure transparency and accountability for in-home HRA best practices, CMS should mandate annual reporting from health plans that could include the following metrics:

- The organization's in-home HRAs are compliant with CMS guidelines, including the specified components of the HRA (e.g., contain questions on housing, transport, and food)
- Key metrics, including the number of:
    - In-home HRAs conducted
    - Medication reviews conducted

[20] Centers for Medicare & Medicaid Services, Contract Year 2022 Policy and Technical Changes.
[21] Centers for Medicare & Medicaid Services, Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Available here.
[22] Centers for Medicare & Medicaid Services, Medicare Managed Care Manual, Chapter 4-110.6. Available here.

- Appointments scheduled as a result of an in-home HRA
- In-home HRA reports delivered to beneficiary's primary care provider (PCP) or conducted by the beneficiary's PCP
- Beneficiaries receiving an in-home HRA that are enrolled in disease or case management programs

Encourage Health Plans to Incorporate Questions Related to Health Equity into All HRAs

In 2024, SNPs are required to include specific questions related to health equity, focusing specifically on food, housing, and transportation needs of beneficiaries on their HRAs. Questions related to beneficiary social needs and other drivers of health should be required for all HRAs and not exclusive to SNPs. The information collected could be leveraged by providers, health plans, and community partners to address the whole health of beneficiaries, for example, through accessing and utilizing supplemental benefits and identifying z-codes specific to social drivers of health.

Audit Every Medicare Advantage Plan Annually

CMS should conduct RADV audits of all Medicare Advantage plans annually to increase program oversight so that subjective decisions about which contracts are audited do not disproportionately impact some organizations more than others. CMS' current approach to RADV audits targets a subset of contracts annually and the criteria CMS uses to select contracts for audit are not available to the public. Thus, some contracts have a higher risk of exposure to audit than others. Under the current RADV audit process, contracts have an unknowable probability of being included in an audit, causing uncertainty in bidding, accounting, and financial reporting. By auditing every health plan annually, the current approach would be improved and increase confidence in CMS' program integrity efforts.