

MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

payment**basics**

Revised:
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The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. Under some MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums for them. Medicare pays plans a capitated rate for the 46 percent of eligible beneficiaries enrolled in MA plans in 2021. These payments amounted to \$317 billion in 2020.

Available MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs). For payment purposes, there are two different categories of MA plans: local plans and regional plans. Local plans may be any of the available plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve all of one of the 26 regions established by the Centers for Medicare & Medicaid Services (CMS). Each region comprises one or more entire states.

Defining the Medicare Advantage care Medicare buys

Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit. Plans may limit enrollees' choices of providers more narrowly than under the traditional FFS program. Plans may supplement Medicare benefits by reducing cost-sharing

requirements or providing coverage of non-Medicare benefits. Plans may charge a premium for these benefits.

Determining Medicare payment for local MA plans

Plan bids partially determine the Medicare payments they receive (Figure 1). Plans bid to offer Parts A and B (Part D coverage is handled separately) coverage to Medicare beneficiaries. The bid is presented as the amount to cover an average, or standard, beneficiary. The bid includes plan administrative cost and profit. CMS bases the monthly payment it makes to each private plan for an enrolled beneficiary on the relationship between the plan's bid and its benchmark.

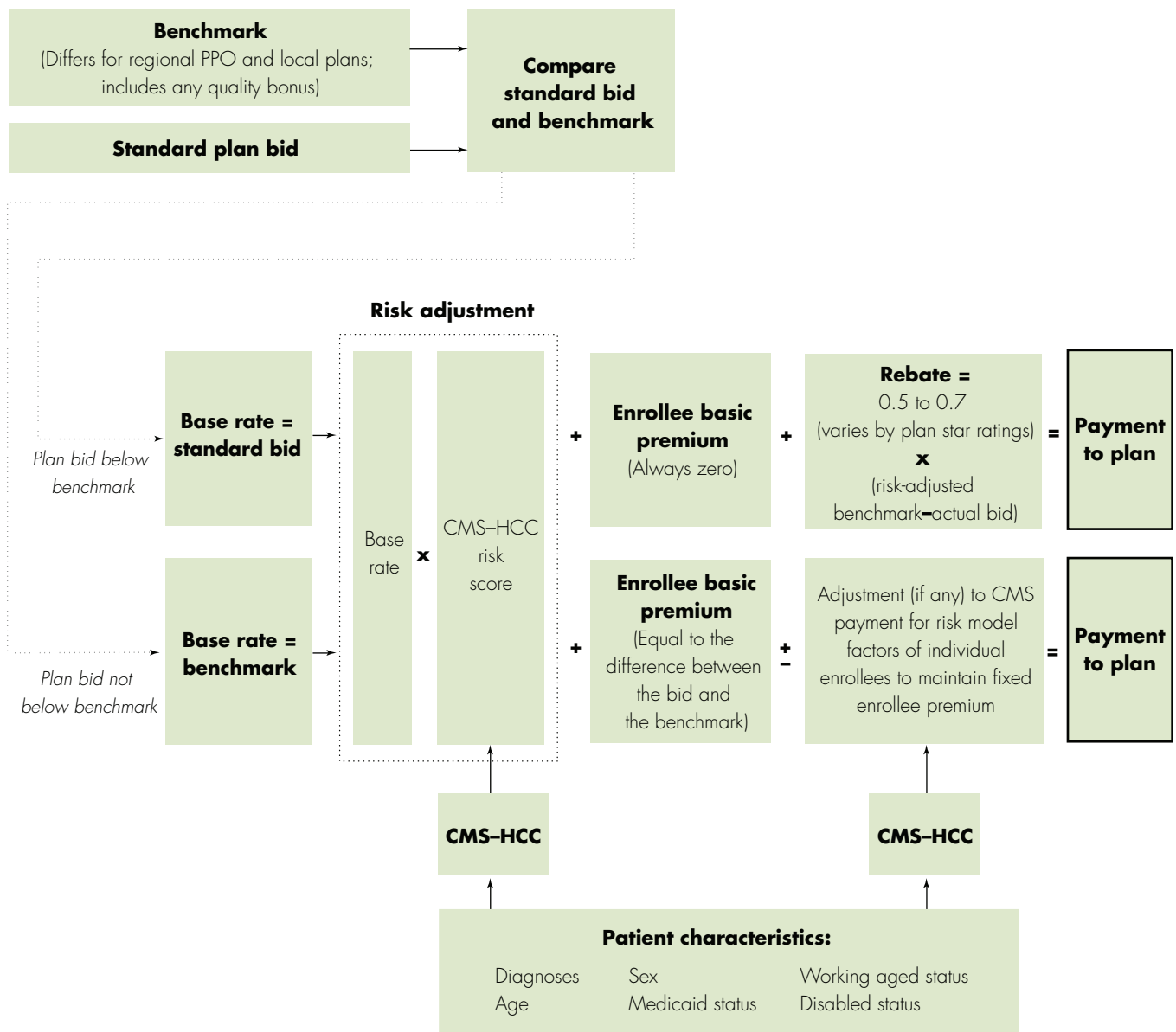
The benchmark is a bidding target. The local MA benchmarks are determined under statutory formulas whereby county-level rates vary depending on average FFS spending per Medicare beneficiary. County benchmarks are set at one of four quartile levels. The benchmark is 95, 100, 107.5 or 115 percent of the FFS projected spending for that county for the year, with the quartile assignment depending on the relative FFS spending levels among counties during the preceding year. (Counties with higher FFS spending levels are assigned lower benchmarks.) If a county changes its quartile position from one year to the next, the percentage of FFS spending determining the county benchmark is the average of the two percentages in each of the different years. The benchmark also varies from plan to plan depending on a plan's ranking in the CMS star system that measures the quality of care that plans provide. Plans with higher quality rankings will have bonus amounts added to benchmark levels. In certain counties—urban areas with low FFS spending levels and historically high

The policies discussed in this document were current as of October 15, 2021, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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Figure 1 Medicare Advantage payment system for nondrug benefits



Note: PPO (preferred provider organization), CMS-HCC (CMS-hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intra-service area adjustment based on the county of residence of the enrollee.

Medicare managed care enrollment—plans with high star rankings can have their benchmark bonuses doubled. (Employer-group waiver plans (EGWPs), which are MA plans that exclusively enroll employer- or union-sponsored retirees and eligible spouses, do not submit bids. Payments to

EGWPs are based on the bids of other MA plans available to individual (non-group) enrollees. EGWPs receive a payment that is a percentage of the area benchmark based on the bid-to-benchmark ratios of the bids of non-EGWP plans. EGWP plans can also receive quality bonus payments.)

There is also a statutory cap on the benchmark amount whereby it may not exceed the level of the benchmark amount determined under pre-Affordable Care Act rules. Regional benchmarks are based on the local benchmarks and are discussed in detail later in this document.

If a plan's standard bid is above the benchmark, then the plan receives a monthly base payment equal to the benchmark and its enrollees have to pay an additional premium. The monthly base rate for a plan bidding at the benchmark is the benchmark. If a plan bid falls below the benchmark, the plan receives a monthly base rate equal to its standard bid.

A plan's monthly base payment is adjusted to reflect each enrolled beneficiaries' demographics and health risk characteristics. Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS-hierarchical condition category (CMS-HCC)—to develop a measure of their expected relative risk for covered Medicare spending. In addition to demographic factors and prior health conditions, other factors are important in calculating the risk scores, including Medicaid, disability, or institutional status and whether a beneficiary is new to Medicare.

Plans that bid below the benchmark also receive payment from Medicare in the form of a "rebate." The law defines the rebate as a fixed percentage of the difference between the plan's actual bid (not standardized) and its risk-adjusted benchmark. The fixed percentages are 50, 65, and 70 percent, depending on a plan's star rating. A plan that receives a rebate must "return" the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits.

For plans bidding at or above the benchmark, there are no rebates. If a plan bids above the benchmark, the enrollee

pays a premium equal to the difference between the standardized benchmark and the standardized bid. Medicare's payment to the plan is the risk-adjusted benchmark. For plans with a case mix that is different from the average case mix (either less or more healthy than the case mix represented by the standardized bid), the Medicare payment is adjusted upwards or downwards to reflect the enrollee premium payments, which are fixed at the standardized amount for each enrollee.

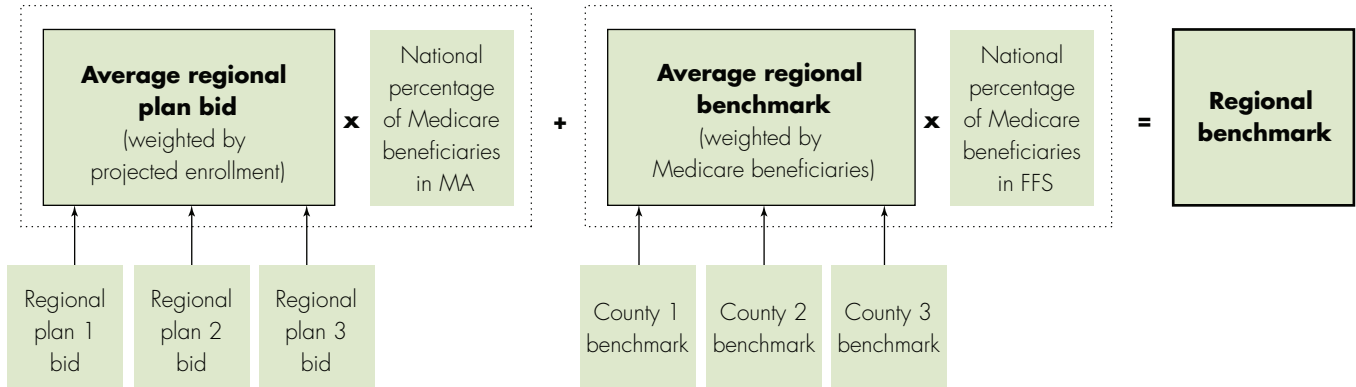
The above system relates to Medicare payments for Part A and Part B services. When a plan offers Part D prescription drug benefits as part of its package, it submits a separate bid for the Part D portion. Payment for the Part D prescription drug portion of the plan benefits is calculated separately, the same way as if the plan were offering a stand-alone prescription drug package. The *Part D Payment System* document in our "Payment Basics" series provides more information on this topic. The only difference from stand-alone prescription drug plans is that the MA plan may choose to apply some of its rebate payments to lower the Part D premium or cost sharing that enrollees would otherwise be required to pay, as noted above.

Determining Medicare payment for regional MA plans

Aside from a few special payment incentives, payment for regional MA plans is determined like payment for local plans, except that the benchmarks are calculated differently (Figure 2).

CMS determines the benchmarks for the MA regional plans by using a more complicated formula that incorporates the plan bids. A region's benchmark is a weighted average of the average county FFS spending per beneficiary and the average plan bid. As directed by law, CMS computes the average county FFS spending as the individual rates for each county weighted by the number of Medicare beneficiaries who live in each county. The average plan bid is each plan's

Figure 2 Setting a benchmark for regional PPOs



Note: PPO (preferred provider organization), MA (Medicare Advantage), FFS (fee-for-service).

bid weighted by each plan's projected number of enrollees. CMS then combines the average county rate and the average bid into an overall average. In calculating the overall average, the average bid is weighted by the number of enrollees in all private plans across the country, and the average county rate is weighted by the number of all Medicare beneficiaries who remain in FFS Medicare.

Payments for beneficiaries with end-stage renal disease (ESRD)

Payments for dialysis and kidney transplant patients are based on average

FFS spending per Medicare dialysis patient at the state level. If there is a difference between the payment and a plan's cost of covering dialysis and kidney transplant patients, plans have the option to apply the difference to the rebate amount (if applicable) by reducing the rebate amount if costs are greater than payments or by adding to the rebate amount if payments are greater than costs. To risk adjust plan payments for beneficiaries with ESRD, CMS applies a separate risk adjustment model that incorporates treatment status (dialysis, kidney transplantation, or post-transplantation). ■