MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

*payment***basics**

Revised: October 2019

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 34 percent of beneficiaries enrolled in MA plans in 2019. These payments amounted to $233 billion in 2018.

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 products 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 here is presented as the bid to cover an average, or standard, beneficiary. The bid will include plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and 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 rate for that county for the year, with the quartile assignment depending on the relative FFS expenditure levels among counties during the preceding year. If a county changes its quartile position from one year to the next, the percentage of FFS amount determining the county benchmark will be the average of the two percentages in each of the different years. The benchmark will also vary 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 expenditure levels and historically high Medicare managed care enrollment—plans with high star rankings can have their benchmark bonuses doubled. (Employer-group waiver

This document does not reflect proposed legislation or regulatory actions.

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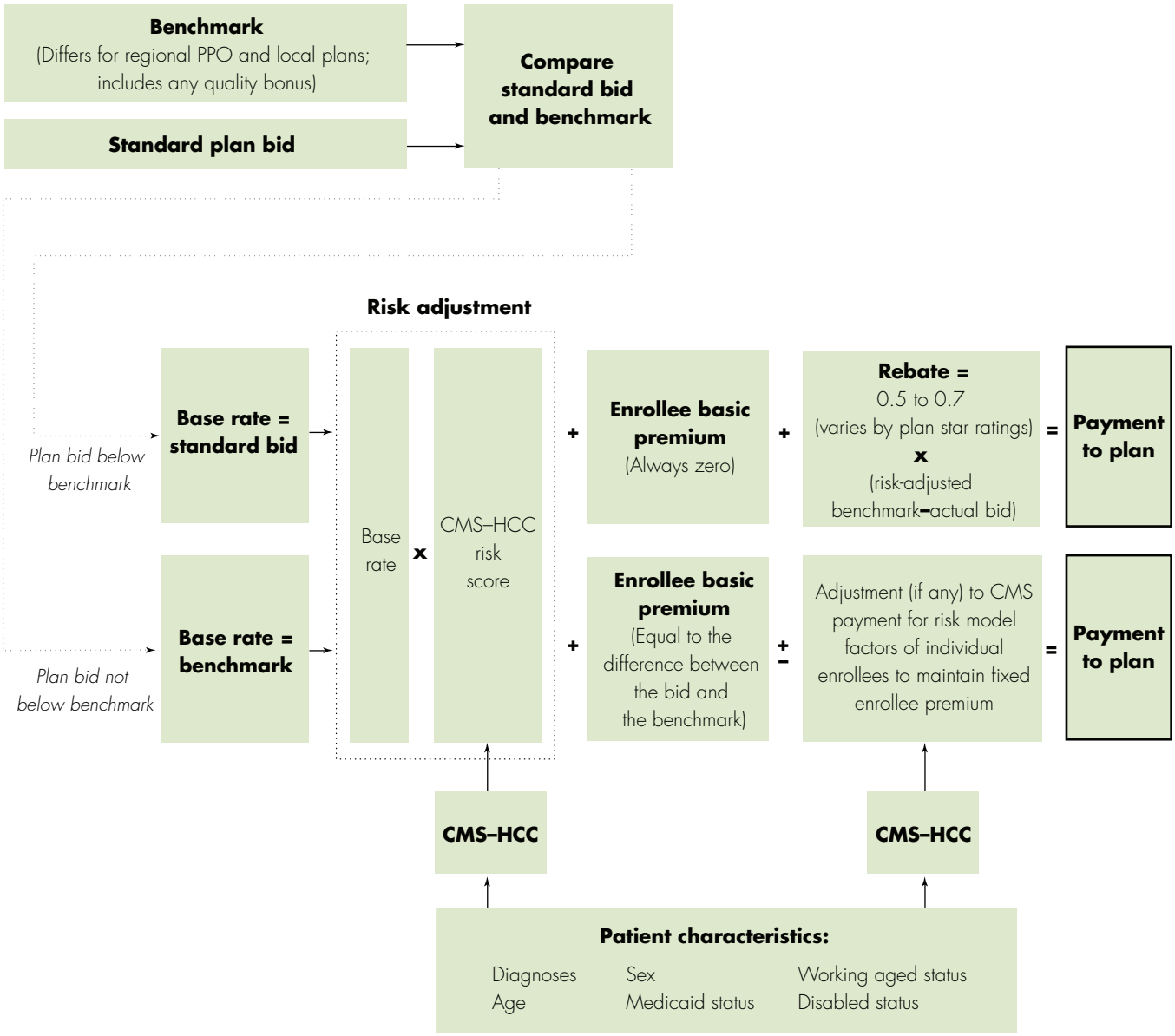
Figure 1 Medicare Advantage payment system for nondrug benefits, 2020



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.

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-PPACA rules.

Regional benchmarks are based on the local benchmarks and are discussed in detail later in this document. Benchmarks for dialysis and kidney transplant patients are based on average FFS spending per Medicare dialysis patient at the state level.

If a plan's standard bid is above the benchmark, then the plan receives a base rate equal to the benchmark and the enrollees have to pay a basic premium that equals the difference between the bid and the benchmark. The base rate for a plan bidding at the benchmark is the benchmark. If a plan bid falls below the benchmark, the plan receives a base rate equal to its standard bid.

Medicare payments are also based on 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. The payment for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's risk measure, also referred to as a risk score.

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. For beneficiaries with end-stage renal disease (ESRD), a separate risk adjustment model is applied that incorporates treatment status (dialysis, kidney transplantation, or post-transplantation).

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. Once the rebate dollars are determined, the plan must then 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.

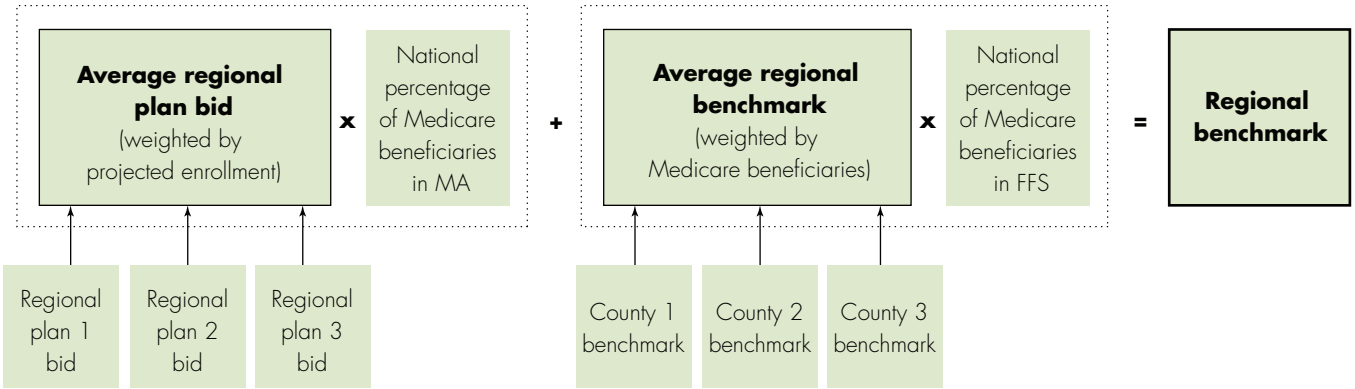
For plans bidding at or above the benchmark, there are no rebates. If a plan bids above the benchmark, the enrollee pays a premium equal to the difference between the standardized benchmark and the standardized bid. Medicare's payment to the plan is the risk-adjusted benchmark. For plans with a case 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.

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).

Figure 2 Setting a benchmark for regional PPOs



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

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 rate and the average plan bid. As directed by law, CMS computes the average county rate as the individual county rates weighted by the number of Medicare beneficiaries who live in each county. The average plan bid is each plan's 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. ■