MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

*payment***basics**

Revised: October 2024

The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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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 they may pay additional premiums for them. Medicare pays plans a capitated rate for beneficiaries enrolled in MA plans, which in 2024 is 54 percent of all eligible beneficiaries. These payments amounted to $453 billion in 2023.

Available MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, medical savings account (MSA), and special needs plans (SNPs).[1] 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 1 of the 26 regions established by CMS. Each region comprises one or more entire states.

Defining the Medicare Advantage care that Medicare buys

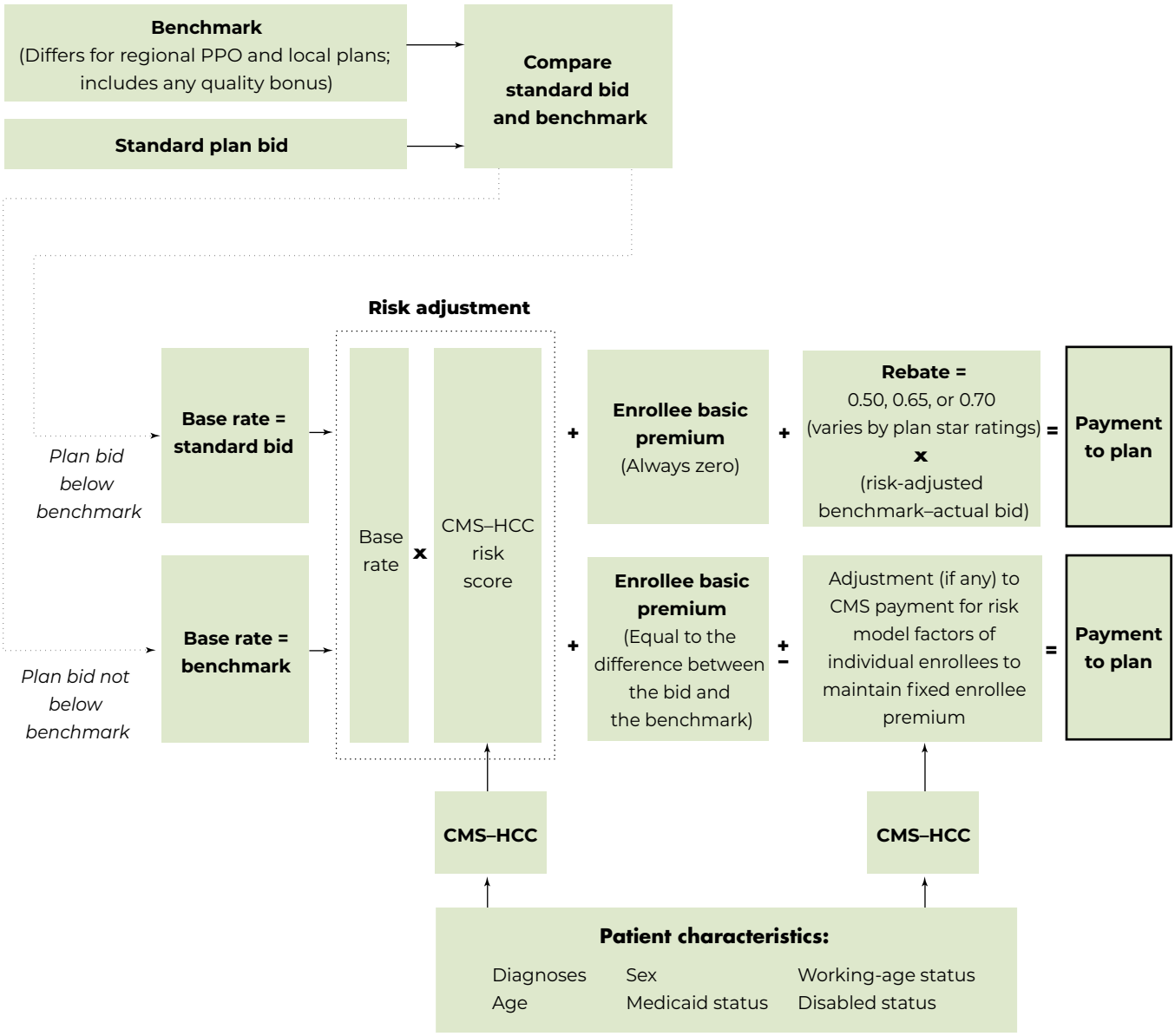
Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS and MSA plans, must also offer an option that includes the Part D drug benefit. Plans may limit enrollees' choices of providers more narrowly than the traditional FFS program and apply utilization management tools such as prior authorization. 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).[2] Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is handled separately). 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 to quartiles with a lower applicable percentage.) 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

Figure 1 Medicare Advantage payment system for nondrug benefits, 2025



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. For Medicare Advantage enrollees who elect hospice, Medicare pays providers directly for Part A– and Part B–covered services and continues to pay the rebate to the plan to provide extra benefits.

FFS spending levels and historically high Medicare managed care enrollment—plans with high star rankings can have their bonus amounts doubled.

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 a blend of regional plan bids and 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. If a plan bid is at or below the benchmark, the plan receives a monthly base payment equal to its standard bid.

A plan's monthly base payment is adjusted to reflect each enrolled beneficiary's demographic and health risk characteristics. Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS hierarchical condition categories (CMS-HCCs)—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 percent, 65 percent, and 70 percent, depending on a plan's star rating. A plan that receives a rebate must allocate its rebate dollars toward providing extra benefits that are divided into five categories: supplemental benefits not covered by Part A or Part B, reduced cost sharing for Part A and Part B services, reduced cost sharing for Part D benefits, lower Part B premium, or lower Part D premium. Plans may choose to offer a package of extra benefits valued higher than the plan's rebate, but the plan must charge enrollees a premium to cover the difference.

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.

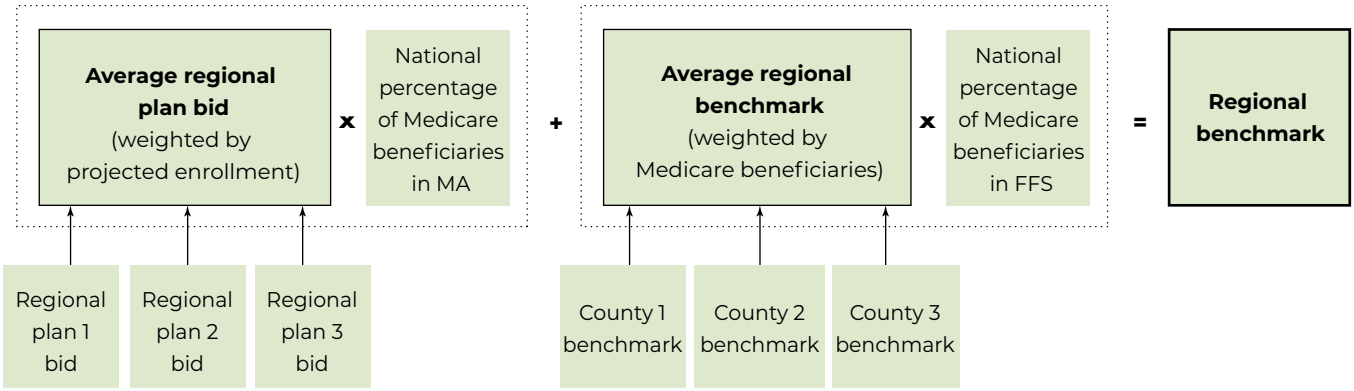
The above system relates to Medicare payments for Part A and Part B services. When a plan offers Part D prescription drug benefits as part of its package, it submits a separate bid for the Part D portion. Payment for the Part D prescription drug portion of the plan benefits is calculated separately, 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 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

Figure 2 Setting a benchmark for regional PPOs, 2025



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

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

Payments for MA enrollees with end-stage renal disease (ESRD) are not based on the bid and benchmark framework used to pay plans for other enrollees. Instead, payments for MA enrollees with ESRD are set equal to a base capitation rate multiplied by a beneficiary-level risk score. For payment purposes, MA enrollees with ESRD are identified as receiving dialysis, receiving a kidney transplant, or in posttransplant functioning graft status. The base capitation rate for MA enrollees receiving dialysis or a transplant is equal to the average FFS spending per Medicare dialysis patient in each state and for MA enrollees in functioning graft status is equal to the average FFS spending per Medicare beneficiary without ESRD in each county. CMS adjusts those base capitation rates using separate risk models for MA enrollees receiving dialysis, receiving a transplant, or in functioning graft status.

MA enrollees with ESRD receive the same benefit package as other enrollees in a plan, including any additional benefits or the requirement to pay a plan premium. Because plans bid only for enrollees without ESRD, a plan's funding for additional benefits (i.e., the rebate) is based only on non-ESRD enrollees. If there is a difference between a plan's projected payment for their ESRD enrollees and their projected cost of providing the basic Medicare benefit for enrollees with ESRD, 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. ■

1 Some private plans, including 1833 cost, 1876 cost, and Medicare–Medicaid plans, and contracts under the Program of All-Inclusive Care for the Elderly operate outside of the MA program and have separate payment rules.

2 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 (nongroup) 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.