



Medicare Advantage

What Changes Did the Centers for Medicare & Medicaid Services (CMS) Propose in the 2021 Advance Notice?

What Is Medicare Advantage?

More than 23 million seniors and people with disabilities choose Medicare Advantage (MA) because it delivers better services, better value, and better access to care. MA delivers affordable coverage by limiting out-of-pocket costs and offering additional benefits that the government-run traditional Medicare doesn't cover – such as integrated vision, hearing, dental, and wellness programs. MA has strong bipartisan support, because it is a prime example of the private sector and government working together to deliver lower costs, more choices, and better outcomes for the American people.

- Research shows that MA plans achieve [better health outcomes](#) than the traditional Medicare program.
- Average payments to MA plans are [equivalent to traditional Medicare costs](#).
- Many doctors and hospitals are adopting MA plan practices for their patients on traditional Medicare. As a result, the improved care and reduced costs “[spill over](#)” to benefit traditional Medicare patients, too.

What Is the Advance Notice?

The Advance Notice lays out the proposed policies governing MA plan payment for 2021. The 2021 Advance Notice was released in two parts – CMS released [Part I](#) on January 6, 2020, and [Part II](#) on February 5. Stakeholders have until March 6 to comment on the Advance Notice prior to CMS issuing a Final Notice on April 6. MA bids are due to CMS on June 1.

What Did CMS Propose to Do?

Growth Rate

CMS is proposing to increase county benchmark rates by 2.57%. These rates are used in the bidding process to determine MA plan premiums and supplemental benefit amounts. In December, CMS released an early preview of the growth rate that estimated it would be 4.46%. If finalized, the 2021 growth rate would not only be nearly 2 percentage points lower than this recent estimate, but it would be the lowest rate in the past 6 years.

Normalization

Each year, CMS applies a “normalization” factor to risk scores to account for trends in traditional Medicare coding and a person’s health status. This factor ensures bids and county benchmarks can be compared on the same basis. CMS proposed a 2.54% reduction in MA funding to account for increases in the risk scores for traditional Medicare enrollees.

MEDICARE ADVANTAGE BY THE NUMBERS

23 million+ enrollees

35% of people eligible for Medicare choose MA for their coverage

403 members of Congress

Nearly 8 out of 10 – signed a bipartisan letter in support of MA

93%

MA enrollees satisfied with coverage

Year-over-Year Impact	2021 Advance Notice
Effective growth rate	2.99%
Star ratings	0.23%
Risk model revision	0.25%
Change to MA coding intensity	0%
FFS normalization	-2.54%
Encounter data transition	0%
Expected Average Change in Revenue	0.93%

Risk Adjustment and Encounter Data

Last year, CMS began phasing in changes to how it adjusts payments to MA plans based on health status – also known as risk adjustment – to account for the number of a patient’s clinical conditions. For 2021, CMS is proposing to blend the new model at 75% and the old model at 25% (compared to a 50/50 blend in 2020). By law, CMS must fully phase in the new model by 2022.

The new model is based entirely on encounter data, which are detailed claims data for MA enrollees that plans have been submitting to CMS since 2012. CMS began to adjust risk scores in 2016 based on diagnoses from encounter data. For 2021, CMS has proposed to increase the proportion of risk scores based on encounter data from 50% to 75%.

Although CMS now believes the ongoing transition to encounter data will be budget neutral, the Medicare Payment Advisory Commission (MedPAC) has found that [encounter data risk scores](#) are lower than under the legacy system – meaning payments based on encounter data are lower – and raised concerns that encounter data are not complete. Furthermore, CMS has yet to resolve persistent operational issues in using these data to calculate MA payments.

Coding Intensity

For 2021, CMS proposes to make the statutory minimum coding intensity adjustment, consistent with 2020. This adjustment reduces MA plan risk scores by 5.9% and accounts for more complete diagnosis coding in the MA program than traditional Medicare. It is separate from normalization.

What CMS Did Not Do

Fully Address ESRD Payment Inadequacy

Per the 21st Century Cures Act (Cures Act), beginning in 2021, people eligible for Medicare with end-stage renal disease (ESRD) will be able to enroll in an MA plan without restrictions. Currently, those with ESRD can only enroll under limited circumstances. The Cures Act also requires that traditional Medicare cover the cost of kidney acquisition for transplant, and as a result excludes these costs from the MA benchmark rates beginning in 2021. This change will cause many counties to see large reductions in their benchmark rates, with the greatest impact in Puerto Rico.

Despite this significant programmatic change, CMS proposed no updates to the methodology for determining payments to MA plans serving this population. People with ESRD represent less than 1% of the total Medicare population but 7% of spending. The actuarial firm Wakely estimates that under current rules the average MA plan

has a [medical loss ratio of 112%](#) for their members with ESRD, meaning that plans spent 12% more than the payments they received from CMS on medical care alone. Without significant policy changes, a large influx of people with ESRD into the MA program could increase premiums – making coverage less affordable for everyone – or lead to fewer supplemental benefits.

In order to take into account this ESRD enrollment change, CMS proposed to partially increase inpatient hospital cost-sharing and the maximum annual limit plans could set for an enrollee’s out-of-pocket spending. This proposal is necessary but insufficient to address underlying payment inadequacy. In a [separate proposed rule](#) on MA and Part D policy changes for 2021-2022, CMS further proposed to increase plans’ ability to reduce dialysis costs by allowing more flexibility to manage dialysis provider networks – unlike changes to beneficiary out-of-pocket spending limits, this proposal has the potential to impact the competitive landscape for dialysis services and meaningfully reduce spending.

Fix the Benchmark Calculation

In 2017, [MedPAC recommended](#) that CMS calculate county benchmark rates used to set MA payments by using only costs for people who are eligible to enroll in MA: those who have both Parts A and B coverage. The current approach includes people with only Part A – who cost less than people with Parts A and B – and creates artificially low benchmarks. In fact, analyses have estimated that [over 60% of counties](#) would see a more than a 5% increase in benchmark rates if CMS fixed the calculation. The [CMS Innovation Center has proposed to make such an adjustment](#) in setting payment rates under its Direct Contracting model. This change should be implemented in the broader MA program.

What Should CMS Do?

To ensure MA funding levels are stable and continue to support high-quality care and comprehensive benefits in 2021, CMS should:

- Ensure the growth rate was calculated correctly and provide greater transparency on the methodology.
- Ensure adequate funding for people with ESRD, and allow plans more flexibility to manage dialysis provider networks.
- Explore options that would limit the cut from the “normalization” factor increase.
- Resolve ongoing operational issues with the use of encounter data for payment purposes.
- Base the calculation of county benchmark rates only on beneficiaries eligible for MA.