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CENTERS for MEDICARE & MEDICAID SERVICES

OFFICE OF THE ACTUARY

To: Medicare Advantage & Prescription Drug Plan Sponsors and Certifying Actuaries

From: Paul Spitalnic, Director, Parts C & D Actuarial Group

Date: December 16, 2008

Subject: Revision to the Proposed CY2010 MA Bid Pricing Tool Changes regarding Dual Eligible Beneficiaries

Introduction

This is the second release of the draft contract year (CY) 2010 MA bid pricing tool (BPT) with proposed modifications to explicitly reflect the reduced cost-sharing levels for dual eligible beneficiaries. The initial HPMS Announcement released on November 3, 2008 included a link to the draft BPT and invited industry comments. This second release is in response to the comments we received.

A few common themes emerged from the comments as follows, with further details in Appendix 2 of this notice:

- Multiple comments were received related to the requirement to reflect $0 cost sharing for dual eligible beneficiaries in the MA BPT. These concerns have been addressed through changes in Worksheet 4 and clarification that these proposed changes will not directly affect the member cost sharing requirements reflected in the plan benefit package (PBP).
- Several comments were received requesting further clarification and guidance for the projected Medicaid data entered in Section V of Worksheet 4, and how that information will be used. As described in Appendix 2, these data are for informational purpose only, and do not directly affect the bid, rebate, or enrollee premium. However, consistent with CY 2009 bid instructions, all State funding that is "passed through" to providers must be netted from plan reimbursements.
- Several comments were received about the means and effort required to capture and project data specific to dual eligible beneficiaries. This concern has been addressed through clarification of the data and projection "flexibilities" presented in Appendix 1. For example, plans whose dual eligible enrollment amounts to less than 10 percent, or greater than 90 percent, of total projected plan enrollment are not required to explicitly project the dual eligible pricing.

(Please note that the majority of 2008 MA plans have less than 10 percent or greater than 90 percent dual eligible beneficiaries.) Also, we have clarified that reasonable "actuarial judgment" may be used in the development of dual eligible experience for base year 2008.

- We received several sample BPTs and other numerical demonstrations that illustrated the potential impact of the proposed changes on approved bids. In recognition of these concerns, we have developed five illustrative BPTs that are posted at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/09_Bid_Forms_and_Instructions.asp. (Note that changes from the CY2009 MA BPT are formatted in orange shading.) Appendix 3 provides an overview of the sample BPTs.

The remainder of this memo contains User Group Call information, an outline of the changes from the first draft MA BPT released by CMS, additional bid instructions regarding the dual eligible changes, responses to industry comments received, and an overview of the sample BPTs posted.

User Group Call Information

There will be an actuarial user group call to discuss the dual eligible BPT changes and give plan actuaries the opportunity to ask questions. The call details are as follows:

- Friday December 19, 2008
- 11:00AM - 12:30PM ET
- Dial-In Number: 1-800-857-3437
- Password: Actuary
- Call Leader: Paul Spitalnic

Changes from the Draft 1 release

Worksheet 1 Section II

1. Dual Eligible member months and risk scores are calculated via formula, based on the total and non-dual member months and risk scores entered.

Worksheet 2 Section II

1. A new section has been added to display the projected member months and risk scores for total, non-dual eligible and dual eligible populations. This information is obtained from Worksheet 5 Section II.

2. Additional flexibility has been added regarding the reporting of Dual Eligible Allowed PMPM in Column Q. In the first draft, this column contained formulas. In the second draft, the formulas remain, but now users are permitted to manually overwrite the formula to enter a different value. Please note that the weighted average PMPM (of the dual eligible and non-dual eligible values) must be within $0.05 of the PMPM in column O for each service category, as indicated by red-circle validation. Also, in total, the weighted average medical expense PMPM must be within $0.50 of the total in column O, or the BPT will not finalize.

3. The draft BPT contains an instruction section at the top of the worksheet. This will be removed in the final CY2010 MA BPT, scheduled to be released in April 2009.

Worksheet 3

1. The draft BPT contains an instruction section at the top of the worksheet. This will be removed in the final CY2010 MA BPT.

Worksheet 4 Section II Subsection A (Non-Dual Eligible Beneficiaries)

1. The risk factor for non-dual beneficiaries is displayed above column h. It is obtained from Worksheet 5 Section II.

2. A new column has been added after Column F. It is not used in this subsection.

Worksheet 4 Section II Subsection B (Dual Eligible Beneficiaries)

1. The risk factor for dual beneficiaries is displayed above column h. It is obtained from Worksheet 5 Section II.

2. Column E now reflects the reimbursement paid to providers plus any actual cost sharing paid by the beneficiary.

3. Column F reflects the cost sharing that would be paid if the beneficiary paid the plan level cost sharing. This amount is estimated based on the plan cost sharing from Section IIA of Worksheet 4. Note that users may also overwrite the formulas to enter values.

4. Column G reflects the minimum of column F (plan level cost sharing for duals) and column K (State Medicaid level of beneficiary cost sharing). Please note that the cost sharing for dual eligible members is no longer assumed to be $0.

5. Column H still reflects the plan's reimbursement to providers PMPM, but it is now calculated from the Allowed Cost for the dual population (Worksheet 2, column Q) less the estimated plan level of cost sharing (column F of this section).

6. Column K is now a user input reflecting the State Medicaid level of beneficiary cost sharing PMPM. We anticipate that for most plans, this will be zero or a nominal amount.

7. Column L reflects the actual cost sharing for Medicare-Covered services, calculated as column G (Actual Cost Sharing) times column J (% Cost Sharing for Covered Services).

8. Column N reflects Medicaid Cost Sharing, calculated as column K (State Medicaid level of beneficiary cost sharing PMPM) times column J (% Cost Sharing for Covered Services).

9. Column P reflects the Net PMPM for Additional Services, calculated based on actual cost sharing from column G rather than plan cost sharing in column F.

<u>Worksheet 4 Section II Subsection C (Dual and Non-Dual Eligible Beneficiaries)</u>

1. Many of the columns are grey and have no input/formula. Since the nature of the information for the dual and non-dual populations in some of the columns in Subsections A and B are not consistent, a combination of the two in Subsection C is not possible. Instead, the Total Benefit Net PMPM, Medicare Covered Net PMPM, Net PMPM for Additional Services, Reduction of A/B Cost Sharing PMPM, and the Total A/B Mandatory Supplemental Benefit PMPM are calculated.

<u>Worksheet 5 Section II</u>

1. Projected member months for dual eligible members is now calculated, based on total and non-dual member months.

2. The weighted average risk factor (excl ESRD) for dual eligible members is now calculated, based on the total and non-dual risk factors.

Worksheet 6 Section III Subsection A

1. The "Allowed medical cost" line for Medicare Covered and A/B Mandatory Supplemental has been removed.

2. The "Less cost sharing" line for Medicare Covered and A/B Mandatory Supplemental has been removed.

Appendix 1 – Additional Bid Instructions Regarding Dual Eligible Pricing

A – Reporting Requirements

If the plan's dual eligible population is greater than or equal to 10 percent, or less than or equal to 90 percent, then the BPT must be completed for both the dual and non-dual populations. Otherwise:

i. If the plan's dual eligible population is less than 10 percent of the total population (excluding ESRD), then the BPT may be completed for the total population.

ii. If the plan's dual eligible population is greater than 90 percent of the total population (excluding ESRD), then the BPT may be completed for the total population.

More specifically for situations i and ii above:

i. Total and non-dual enrollment information will be required on Worksheet 5, and if applicable, on Worksheet 1.

ii. Columns P and Q may be set equal to column O on Worksheet 2.

iii. Worksheet 3 may be completed to reflect either the total population or the non-dual population at the discretion of the plan actuary. Except if Worksheet 2 columns P and Q differ from column O, then Worksheet 3 must be completed for the non-dual population only.

iv. Worksheet 4 Section V must be completed if the plan sponsor has a separate contract with the state for Medicaid services or cost sharing. Otherwise, it may be left blank.

B – Enrollment

Beginning in mid-2008, the Monthly Membership Detail Report (MMR) includes Field #40 named "Current Medicaid Status". This is a one character field in position 171. This field indicates that a beneficiary was reported to have Medicaid in either one or two months prior to the current payment month (CPM). The field indicators are defined as follows:

'1' = Beneficiary was determined to be Medicaid eligible as of CPM-2 or CPM-1

'0' = Beneficiary was not determined to be Medicaid eligible as of CPM-2 or CPM-1

For contract year 2010, CMS will permit actuarial judgment in the determination of Medicaid eligibility for the first half of 2008.

C – Risk Scores

CMS will publish risk scores based on the July 2008 cohort, separately for the dual and non-dual eligible populations as represented by the Current Medicaid Status field in the MMR.

D – Credibility

Credibility will be determined based upon total member months.

E – Base Period Information

The base period data and projection assumptions on Worksheet 1 are to be reported for the total population. No distinction between dual and non-dual eligible members is being requested.

Appendix 2 - Responses to comments received via email

Proposed CY2010 MA Bid Pricing Tool Changes Regarding Dual Eligible Beneficiaries Feedback Common Themes

$0 Cost Sharing

Multiple comments were received related to the requirement to reflect $0 cost sharing for dual eligible beneficiaries on the Bid Pricing Tool (BPT). Concerns were expressed regarding the inappropriateness of the resulting net plan liability. Another stated concern was that showing $0 cost sharing might nullify state requirements to pay cost sharing for dual eligible beneficiaries. The revised changes take these comments into consideration such that the plan's net liability is appropriately reflected on Worksheet 4 of the BPT as Total Allowed less Plan (PBP) Cost Sharing. Additionally, the changes made to Worksheet 4 result in reductions in cost sharing being derived from a comparison of plan cost sharing to the state Medicaid cost sharing requirements rather than simply setting the cost sharing for dual eligible beneficiaries equal to $0.

Enrollee Premium

Some comments stated that the proposed approach results in higher enrollee premiums. With the revised changes, circumstances where enrollee premiums increase should be limited and gain/loss margin flexibility may be used to avoid significant premium increases. Please refer to the examples provided by CMS to see that the enrollee premium is unchanged in the example where plan cost sharing is equivalent to Medicare FFS cost sharing. In the example where plan cost sharing is lower than Medicare FFS cost sharing, the bid increases but the need to buy down cost sharing decreases; and hence enrollee premium decreases.

Worksheet 4 Section V

Several comments were received requesting further clarification and guidance for the projected Medicaid data entered in Section V of Worksheet 4 and how that information is used. The information requested in this section is for informational purposes only; it is not used in any BPT calculations. CMS is requesting this information to better understand the revenues and benefits provided to dual eligible beneficiaries that are not already reflected in the BPT. This section will be completed for plans where there is a separate contract with the state for Medicaid services. Revenues should reflect capitation, or other payments, received by the MA plan sponsor from the state for benefits provided for dual eligible beneficiaries. Likewise, benefits should reflect the per dual-eligible member per month value of benefits provided by the plan sponsor for dual eligible beneficiaries that are not contained in the PBP.

For example, if the plan sponsor receives a capitation from the state for dual eligible beneficiaries for the same dental benefit that is offered by the plan (i.e., the plan dental benefit in the PBP which is provided to all plan enrollees), Section V revenue would reflect the capitation amount, and benefits would be $0 since the value of the benefit is already reflected on the BPT. If the state pays the plan sponsor a capitation for dual

eligible beneficiary cost sharing, and the plan sponsor passes this amount to providers to compensate for the dual eligible cost sharing, then this capitation amount would be entered in Section V as revenue and entered as benefits per dual-eligible member per month.

Identification of Enrollment and Costs for Non Dual Eligible and Dual Eligible Beneficiaries

Several comments were received regarding how to identify dual eligible beneficiaries, in particular, using MMR data. Further, a few plan sponsors expressed concerns about the additional work involved in developing and entering data separately for non-dual eligible and dual eligible beneficiaries. See the additional bid instructions section of this memo for guidance on developing these values. Also note that input items were replaced by formulas where feasible. Based on the guidance contained in the instruction section of this memo, only about 25% of plans will be required to enter split data (dual eligible vs non-dual eligible) in the BPT as 65% of plans have <10% duals and 9% of plans have 90%+ duals as of October 2008.

Appendix 3 - Sample Bid Pricing Tools

Note that the sample BPTs are for illustrative purposes only. Input cell labels are not always aligned with the appropriate cell.

- Sample 1: *Current BPT w FFS CS.xls*
  - Current BPT (CY 2009) with Medicare fee-for-service (FFS) equivalent cost sharing.
  - Key results PMPM (assuming that projected and actual risk scores are equal)
    - Plan A/B bid = $1,246.63
    - Rebate = $137.78
    - Enrollee premium = $0.00
    - Total plan revenues = $1,384.41

- Sample 2: *Proposed BPT w FFS CS w DE.xls*
  - Proposed BPT with Medicare FFS equivalent cost sharing and 50 percent of projected enrollment assumed to be dual eligible.
  - State's Medicaid level of beneficiary cost sharing is $0.
  - Key results PMPM (assuming that projected and actual risk scores are equal)
    - Plan A/B bid = $1,246.63
    - Rebate = $137.78
    - Enrollee premium = $0.00
    - Total plan revenues = $1,384.41
  - Conclusion: proposed and current approaches generate same financial results.

- Sample 3: *Proposed BPT w FFS CS wo DE.xls*
  - Proposed BPT with Medicare FFS equivalent cost sharing and 0 percent of projected enrollment assumed to be dual eligible.
  - State's Medicaid level of beneficiary cost sharing is $0.
  - Key results PMPM (assuming that projected and actual risk scores are equal)
    - Plan A/B bid = $1,246.63
    - Rebate = $137.78
    - Enrollee premium = $0.00
    - Total plan revenues = $1,384.41
  - Conclusion: proposed and current approaches generate same financial results.

- Sample 4: *Current BPT w reduced CS.xls*
  - Current BPT (CY 2009) with plan cost sharing that is less than Medicare FFS equivalent.
  - Key results PMPM (assuming that projected and actual risk scores are equal)
    - Plan A/B bid = $1,224.45
    - Rebate = $154.42
    - Enrollee premium = $103.00
    - Total plan revenues = $1,481.87

- Sample 5: *Proposed BPT w reduced CS w DE.xls*
  - Proposed BPT (CY 2009) with plan cost sharing that is less than Medicare FFS equivalent with 50 percent of projected enrollment assumed to be dual eligible.
  - State's Medicaid level of beneficiary cost sharing is $0.
  - Key results PMPM (assuming that projected and actual risk scores are equal)
    - Plan A/B bid = $1,287.41
    - Rebate = $107.20
    - Enrollee premium = $87.30
    - Total plan revenues = $1,481.91
  - Conclusion: proposed and current approaches generate same net revenue to plan sponsor. Enrollee premium is lower under proposed approach.