

CY2013 Actuarial Bid Training

Updated April 2012

Presentation: Points of Emphasis for Medicare Advantage and Part D Bids in CY2013

Slides and Script prepared by CMS Office of the Actuary

[Slide 1] Title

Welcome to the training session “Points of Emphasis for Medicare Advantage and Part D Bids in CY2013”.

[Slide 2] In this session . . .

In this session, we will review key changes to the Medicare Advantage and Part D bid pricing tools and discuss changes and clarifications made to the MA and Part D bid instructions, as well as other areas of emphasis from the instructions.

Note that MA bid instructions also cover MSA and ESRD-only SNPs. The addition of ESRD-only SNPs is new for CY2013. Changes for these plans are similar but not discussed in this presentation.

We’ll begin with discussing some of the key changes common to MA and PD. It may be helpful to have the MA and PD bid pricing tools open in front of you while watching this presentation.

[Slide 3] Medical Loss Ratio (MLR)

Although MLR rules and regulations for CY2014 have not been finalized, we are collecting information on CY2013 bid forms. This will ease the transition for bid preparers, and allow CMS to obtain feedback from industry.

[Slide 4] Quality Initiatives, Taxes and Fees, Adjusted MLR

Fields for Quality Initiatives, and Taxes and Fees have been added to MA and PD Worksheet 1 and MA Worksheet 4 and PD Worksheet 2. These fields will be used in the calculation of adjusted MLR. Note that Quality Initiatives are a subset of non-benefit expenses, whereas Taxes and Fees are a subset of non-benefit expenses and/or gain loss. For example, the annual fee on health insurance providers required by the Affordable Care Act and administrative expenses for chronic care management are both subsets of non-benefit expenses and a portion of income taxes is a subset of gain/loss margin. A description field has been added to Section IIC of MA Worksheet 4 and Section VII of PD Worksheet 2 for listing specific items included in the Quality Initiatives and Taxes and Fees. Included in this field should be the name of the supporting documentation file that contains a description of each item. The supporting documentation should explain why you believe each item should be included in the quality initiatives or taxes and fees category. CMS will consider this information in developing the Medicare MLR regulation for the implementation and data collection required by the Affordable Care Act.

[Slide 5] Overall Gain/Loss Margin

In MA Worksheet 4, section IIC, line z4 and PD Worksheet 3, section IV, are new fields used to designate the level of aggregation used to meet the gain/loss margin requirements. In the drop down list, plans must select the chosen level of aggregation of gain/loss by contract, organization or parent organization; however, EGWP plans are defaulted to contract level in the MA field. For plans that choose to rollup margin at the organizational level, a list of each contract number included must be submitted in the initial supporting documentation.

[Slide 6] Overall Gain/Loss Margin (Cont.)

The most significant change to the aggregate-level gain/loss margin pricing consideration is the requirement that the DE-SNP margin be within a range of minus 5% and plus 1% of the General Enrollment and Institutional and Chronic SNP margin. We also clarified the consistency of margin for General Enrollment and Institutional Chronic SNP and all non-Medicare health insurance, as well as projected and actual margins over the long term.

Accordingly, requirements for supporting documentation for MA and Part D were updated to reflect these changes and now must include a statement concerning what business comprises non-Medicare health insurance.

[Slide 7] Bid-Level Gain/Loss Margin

The definition of the kinds of plans eligible for product pairings used to determine exceptions to the business plan requirement for a negative bid margin has been clarified to be all LCCP, all RPPO or all PFFS, and the same SNP type or all non-SNP. The other criteria remain in place. We also remind you to include a list of paired plans in the initial upload of supporting documentation. There is additional guidance on gain/loss in the presentation for Non-Benefit Expenses and Gain/loss Margin.

[Slide 8] Risk Score

The CMS-HCC and the Part D RX HCC risk adjustment models are recalibrated for CY2013. The Part D model reflects the reduction in cost sharing for non-LIS beneficiaries purchasing non-applicable (generic) and applicable (brand name) drugs in the coverage gap. Additional information on the CMS-HCC model, including the 2013 normalization factor, is contained in the 2013 payment notice.

[Slide 9] Support for Related Parties

We have clarified the definition of and the required support for Related Parties for CY2013. All Plan sponsors must provide written disclosure of whether or not they have Related-Party agreements. Further, those with Related-Party agreements must summarize the contractual terms for each related party, as well as the approach used to report gain/loss margin and non-benefit expenses of the Related-Party organization.

[Slide 10] Other Topics

As a reminder, the CMS credibility guidelines were developed for projecting allowed costs. Use of this formula in other contexts, such as risk scores, may not be appropriate and must be fully explained and supported.

We also remind you to read the bid instructions in their entirety for other clarifications and updates. For example, two MA supporting documentation items have been moved from “On Request” to being required during bid submission. These are support for the development of DE# and non-DE# values and the MSP adjustment.

[Slide 11] MA Medicare Secondary Payer

Next we will discuss topics specific to MA. The MSP adjustment in the MA bid pricing tool must be calculated appropriately. Keep in mind, when grossing up MSP payments to determine the bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare, use MSP-specific data, that is, risk adjusted payments for MSP enrollees; do not estimate MSP payments based on combined data for MSP and non-MSP enrollees.

[Slide 12] MA Worksheet 1

A new column has been added to the base period data section of MA Worksheet 1 to capture the number of unique “Utilizers” of each service category. Each beneficiary that utilizes a service should be counted only once, even if there are multiple instances where the service was used by a beneficiary.

As a reminder, only plans that are undergoing an official crosswalk are to be entered in the “Plans in Base” section of Worksheet 1. Plans must be entered as Contract-Plan or Contract-Plan-Segment if the segment is “01” or greater. If more than eight plans are cross-walked into the plan, the supporting documentation must provide the member months for each plan in the data. Also note that data entered in Worksheet 1 should include data for out-of-area members.

[Slide 13] MA Worksheet 3

There are no substantial changes on MA Worksheet 2. Moving on to MA Worksheet 3, columns H and M, rows 25 through 64, where cost sharing descriptions can be entered, are now for use by bid preparers for internal purposes only and will be deleted from the finalized BPT.

Section IV has been added to Worksheet 3 which displays a pre-populated mapping of PBP categories to BPT service categories. The PBP categories must be overwritten to reflect any deviations from the default mapping and replaces the supporting documentation requirement for deviations from the suggested mapping in Appendix F.

[Slide 14] MA Worksheet 4

There are a number of changes as to how ESRD is handled on Worksheet 4. In Section IIC, the percent of revenue calculations have been revised to include the PMPM impact of the ESRD subsidy. In Section III, the Out-of-Area (OOA) member months have been added and are included in the ESRD subsidy calculations. Lastly, the ESRD member months line is now a calculated field equal to the amount entered on Worksheet 5.

[Slide 15] MA Worksheet 5

In Worksheet 5, Section V, the calculation for rebate percentage in line 3 has been revised for the following two changes. The pre-ACA 75% rebate level is now weighted $\frac{1}{3}$ and the post-ACA rebate level is weighted $\frac{2}{3}$. The second change is that low enrollment contracts are no longer given a rebate exception. The rebate level for low enrollment contracts is based on the QBP rating.

Also, Section VIII was added to capture and summarize the various components of member months: ESRD, hospice, out-of-area, and all other.

[Slide 16] Part D Changes

The last topic pertains to changes in Part D coverage in the gap.

For non-applicable (generic) drugs in the gap, beneficiary cost sharing has been reduced to 79 percent. The sponsor's liability is now 21 percent.

For applicable (brand) drugs in the gap, beneficiary cost sharing is 47.5 percent of the negotiated price, dispensing fee, and vaccine administration. The Part D sponsor's liability is 2.5 percent of the negotiated price plus 52.5 percent of the dispensing fee and vaccine administration.

[Slide 17] Questions?

For more details on the information contained in this presentation, please refer to the CY2013 MA and Part D bid instructions. In particular, the "Bidding Resources" section of the Introduction contains links to various bidding guidance. This concludes the presentation on "Points of Emphasis for MA and Part D Bids in CY2013".