

CY2014 Actuarial Bid Training

Presentation: Points of Emphasis for Medicare Advantage and Part D Bids in CY2015

Slides and Script prepared by CMS Office of the Actuary

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[SLIDE #1] Title

Welcome to the training session “Points of Emphasis for Medicare Advantage and Part D Bids in Contract Year 2015.”

[SLIDE #2] In This Session . . .

In this session, we will cover key changes to the Medicare Advantage (MA) and Part D bid pricing tools and bid instructions, other areas of emphasis from the instructions, and our compliance initiatives, including goals, CY2014 results, CY2015 expectations, and tips.

[SLIDE #3] Clarifications and Updates

We continue to remind you to read the bid instructions in their entirety for all clarifications and updates noting for MA that parts of some pricing considerations have been moved around. Examples of clarifications and updates include new data aggregation examples in the MA bid instructions for network and non-network private-fee-for service plans and segmented bids. In addition, the enrollment pricing consideration now states explicitly that “there is no requirement to enter member months greater than zero in order to generate a county-level payment rate.” If the projected enrollment in a particular county is zero, we ask that you enter zero projected member months for that county on MA Worksheet 5, and not another number such as “1” or a fraction between zero and one.

[SLIDE #4] Bid Pricing Tool (BPT) Changes

The most significant changes in both the MA and Part D bid pricing tools (BPTs) apply to base period data and contract year projections. First, all input cells, formulas, and text boxes related to the BPT medical loss ratio (MLR) have been removed. Second, the user must enter insurer fees required by the Affordable Care Act in a separate input cell that is included in the calculation of total non-benefit expenses. Note that insurer fees are not a subset of any other non-benefit category.

For the MA BPT, the MA ratebook has been restructured to incorporate changes resulting from the termination of the Quality Bonus Payments (QBP) demonstration.

The Worksheet for optional supplemental benefits has been condensed such that the user enters allowed costs, enrollee cost sharing, and other data in total for each optional supplemental benefit package rather than entering data at the service-category level for each package.

[SLIDE #5] BPT Changes - MA

The requirements for entering data in the MA BPT for out-of-area (OOA) members no longer depend upon the significance of the difference in risk score or projected allowed costs for out-of-area members. All bid components must reflect costs for out-of-area members as explained in the new pricing consideration for out-of area enrollees. Specifically, the county-level detail section of Worksheet 5 now includes separate input cells for out-of-area projected member months and risk score. Further, such entries are used in the summary calculations in row 36, which in turn are used to calculate DE# and non-DE# values in Section II. Therefore, the projected non-DE# and/or DE# projected member months and risk score entries in Section II must take into account the appropriate portion of out-of-area members.

[SLIDE #6] BPT Changes – Part D

In addition to the changes to the Part D BPT previously discussed in this presentation, there have been three changes to Worksheet 1: (1) “SNP Type” and a drop-down box with three options – “Institutional,” “Dual-Eligible,” and “Chronic or Disabling Condition” – have been added in cells M7 and N7; (2) the inputs for “Basic” and “Supplemental” non-benefit expenses have been removed; and (3) the components of “total” non-benefit expenses have been changed to input elements in cells G48-G52.

[SLIDE #7] Gain/Loss Margin – High

Next we will cover several gain/loss margin requirements. Under the bid-level gain/loss margin requirements, the initial bid submission must provide “Justification for bids with relatively large projected overall gain/loss margin, including an explanation of how the plan benefit package (PBP) offers benefit value in relation to the margin level.” On the next slide, we’ll discuss how this requirement applies to supporting documentation for a bid with a high projected gain/loss margin.

[SLIDE #8] Gain/Loss Margin - High (cont.)

In reviewing the reasonableness of a bid with a relatively high projected gain/loss margin, CMS will consider factors described in supporting documentation, such as a need for a contingency margin that correlates to the “risk” to the plan sponsor, low credibility, or significant variability in claims from year to year. Absent these factors, supporting documentation must demonstrate that the plan sponsor is making incremental benefit and premium changes over time to reduce margin while maintaining stability and is providing all possible benefits, such as rebates applied to Part B premium buydown. For DE# enrollees, the plan sponsor must indicate if most supplemental benefits are already provided by the State.

[SLIDE #9] Gain/Loss Margin – High (cont.)

Pairing a high margin bid with another positive margin bid cannot be used to justify high margin, since this would not be a valid product pairing. A valid product pairing must include one bid with negative margin. Further, the purpose of a valid product pairing is to allow an exception to the business plan requirement for a negative margin bid.

For bids in a valid product pairing with relatively large projected overall gain/loss margin, CMS will consider the reasonableness of benefit relativities in order to assure that the excess margin for the high margin bid is commensurate with the difference in benefits and the other considerations covered in the previous slides.

[SLIDE #10] Gain/Loss Margin – D-SNPs

Next we will cover aggregate gain/loss margin requirements starting with D-SNPs. For the case in which the plan sponsor does not offer general enrollment and institutional-special needs plans or chronic care-special needs plans, the MA aggregate gain/loss margin requirement for D-SNPs has been revised to be no more than 5 percent below or no more than 1.5 percent above the plan sponsor's margin for non-Medicare health insurance lines of business.

[SLIDE #11] Gain/Loss Margin – Related Party

Another aspect of gain/loss margin we'd like to emphasize pertains to the situation in which bid elements are adjusted to reflect the actual costs of the plan sponsor's related party to provide services for the bid population. In this situation the adjusted gain/loss margin in the bid pricing tool is used to satisfy all margin requirements.

[SLIDE #12] Related-Party Arrangements

Also regarding related-party arrangements, we modified the definition of a related party based on what we learned from bid review and audit, and we may capture more relationships as a result. Key revisions to the methods for entering the cost of services provided under related-party arrangements include (1) an expanded definition of market comparison that may allow the plan sponsor to compare the related-party arrangement to arrangements the plan sponsor has with unrelated parties, (2) changes in the availability of each method for medical related-party arrangements, and (3) specifications for the handling of the actual cost and market comparison methods for Part D pharmacy costs. The “Related-Party Arrangements” presentation provides more information about these changes.

[SLIDE #13] Sequestration

A new pricing consideration for sequestration clarifies the handling of sequestration in the BPT. Plan sponsors have flexibility in setting gain/loss margin and may consider the effects of sequestration in setting the gain/loss margin in the BPT; however, gain/loss margin requirements are not modified due to sequestration.

To the extent that sequestration is assumed to occur during the projection period, MA projected net medical expenses must reflect the expected impact of sequestration on provider payments.

The MA bid instructions also explain that a coinsurance percentage entered in the BPT may need to be adjusted to produce the appropriate cost sharing per-member-per-month cost.

[SLIDE #14] Global Capitation

The “MA Capitated Arrangements for Medical Services” pricing consideration includes a new section for global capitation and risk-sharing arrangements. This section points out that it is not appropriate to provide risk protection for Part D through the MA bid or vice versa. The Part D bid instructions state that any gains or losses that the Part D sponsor experiences or expects to experience through the settlement process must be included in the Part D bid pricing tool as direct and indirect remuneration—that is, (DIR).

The requirement for the MA BPT is to reflect costs in all service categories included in the global capitation contract. Further, if the certifying actuary projects a payment adjustment at the end of the contract year, such adjustment must be allocated to the service category based on net medical costs under the global capitation contract prior to the adjustment being made.

[SLIDE #15] Credibility

The credibility pricing consideration reiterates that the CMS claims credibility guideline is not an acceptable basis for projected risk scores as it was developed as weights for blended projected allowed costs.

[SLIDE #16] Credibility - MA

The Medicare Secondary Payor (MSP) Adjustment entered in the MA BPT reflects the average payment reduction for the expected bid population due to MSP enrollees and the bid instructions provide an exception only for 100% manually-rated bids. It is not acceptable to calculate a blended MSP adjustment using the claims credibility guideline for bids with partially credible claims experience. Additionally, if the exception for 100% manual rating does not apply, both the manual rate and the projected experience rate must reflect the MSP assumption for the expected bid population.

This completes the discussion of the key changes to the bid pricing tools and bid instructions. We now turn to a discussion of OACT’s compliance initiative.

[SLIDE #17] Compliance Initiative

OACT's compliance initiative will continue for CY2015, as we have found this to be an effective means to provide constructive feedback to certifying actuaries. The over-arching goals of OACT's compliance initiative are to produce more accurate and transparent bids and to enable more efficient and effective bid reviews. When preparing MA and Part D bids for review by CMS, each actuary must ensure that his or her work complies with relevant professional standards; these include —the American Academy of Actuaries' Code of Professional Conduct, any applicable Actuarial Standards of Practice (ASOP); all applicable laws, and regulations; and any agency guidance, including the MA and Part D bid instructions, guidance promulgated by OACT during the User Group Calls, and notices released via the Health Plan Management System (or HPMS).

[SLIDE #18] Compliance Initiative (cont.)

Note that these standards apply not only to how actuaries prepare bids, but also to how they conduct themselves during bid review and bid audit. As always, we emphasize that adequate peer review and documentation are critical components of an efficient bid desk review. Therefore, the compliance process places great emphasis on CMS' supporting documentation requirements and considers numerous errors and resubmissions to be evidence of an inadequate peer review process.

[SLIDE #19] Compliance Initiative (cont.)

In cases in which certifying actuaries fail to comply with the standards outlined above, CMS may take action, including (but not limited to) an advisory e-mail; a formal compliance phone call or written warning to the certifying actuary to identify compliance issues and discuss their remedy; a notice of non-compliance or warning letter sent to the plan sponsor to alert it to the areas of non-compliance by its certifying actuary; a Corrective Action Plan to formalize a process to remedy issues arising from non-compliant actions; the placing of limitations on a plan's marketing and enrollment practices until the situation is remedied; and plan termination.

[SLIDE #20] Compliance Initiative (cont.)

After examining the comments from the bid review teams, OACT identified nine cases that warranted direct phone calls with actuaries to discuss compliance issues associated with CY 2014 bid submissions. Three of these cases were subsequently forwarded to the CMS compliance group to initiate compliance action with the plan sponsor. As part of a newly added component to the process for CY 2014, we reached out to an additional 32 certifying actuaries to inform them of concerns we noted during bid review. Our goal with this informal advisory communication was to provide constructive feedback to be used to improve future bid submissions.

It should be noted that the majority of certifying actuaries are highly supportive of the bid submission and review processes and *are* compliant with the requirements. So even though we addressed issues with only a small number of actuaries, OACT believes that everyone can benefit from a review of these cases as a reminder to avoid conduct that can result in unwanted action and significantly hinder submission of accurate bids.

[SLIDE #21] Compliance Initiative (cont.)

The main areas of concern resulting in compliance action by OACT for CY 2014 fell into two categories—peer review and documentation.

In some cases we noted a large number of errors in submissions and resubmissions, which demonstrate a lack of adequate peer review. Other cases contained supporting documentation that failed to meet the standard stated in ASOP 41 that “another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”

Bid instructions require an upload to HPMS with each resubmission summarizing the changes, including the cause and effect. Lack of such uploaded documentation was noted several times in the compliance initiative.

It should be noted that OACT did not take explicit action on every case reported by reviewers. OACT maintains historical feedback from reviewers and incorporates that feedback into the initiative as needed. Although compliance issues may not necessarily warrant OACT action in one year, continued non-compliance over several years is likely to result in OACT action. So if an actuary didn’t receive a compliance notice regarding the CY 2014 bid, that doesn’t mean there is no room for improvement.

[SLIDE #22] Compliance Initiative (cont.)

Compliance issues are treated like audit findings and observations, which means that 2014 issues must be remedied in 2015 bids, and a description of those remedies must be included in supporting documentation for the applicable bids. As with audit findings and observations, this requirement applies to ALL compliance issues, even those with which the certifying actuary disagreed.

[SLIDE #23] CY2015 Tips and Recommendations

We offer tips and recommendations taken from comments made by both internal and external bid reviewers. These are intended to help actuaries avoid the pitfalls that have constrained the bid process in the past. Of primary importance is the adequate and thorough documentation that meets the standards that “another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.” By definition, this documentation will prevent many reviewers’ questions and can significantly increase the efficiency of the review. Providing quantitative support and files with working formulas is a key component to meeting this requirement. Additionally, an accompanying narrative explaining the flow of, inputs to, and calculations in complex spreadsheets allows for easier understanding of the bid development. It is also important to provide clearly labeled supporting documentation files that include the contract number or organization name and topic in the file name.

CMS requires that plan sponsors develop and upload bid-specific information. Supporting documentation must include ALL the necessary information about that bid. The support must explain why the pricing assumption is appropriate for the circumstances of the bid, especially when data and studies are not available.

Plan sponsors must upload additional supporting documentation during bid review to explain any bid values that have been revised. Additionally, complete documentation in support of the final bid must be uploaded.

[SLIDE #24] CY2015 Tips and Recommendations (cont.)

Ensuring that the BPT is consistent with the PBP is another proactive way to lessen the burden of the bid review process and make it more efficient. For CY 2015, OACT is again providing a tool for plan sponsors to help them assess the consistency between the MA BPT and the PBP. The certifying actuary must check that the PBP to BPT mappings indicated on MA Worksheet 3 are consistent with where the benefits have been priced, noting that PBP category 4c has been inserted in its proper order on Worksheet 3. Additionally, the certifying actuary must follow the MA bid instructions for classification of maximum out-of-pocket (MOOP) amounts and deductibles as “combined”, “in-network”, and/or “out-of-network,” noting that the mapping for the LPPO/RPPO annual deductible has been changed. We also require that the certifying actuary include support for \$0 cost benefits, indicating why they have a \$0 cost and which \$0 cost benefits each PBP includes.

[SLIDE #25] CY2015 Tips and Recommendations (cont.)

The certifying actuary must check that each gain/loss margin requirement is met. OACT is supplying a tool to assist the certifying actuary in evaluating compliance with some of the gain/loss margin requirements for CY 2015. To avoid resubmissions, it is critical to pay attention to detail and build sufficient time in the process for adequate peer review. We recommend that plan sponsors and certifying actuaries review all flagged data validations and correct those that are in error; check the accuracy of every upload; and avoid carelessness (such as repeatedly uploading incorrect files and/or uploading files to the wrong bid).

[SLIDE #26] Planning Information

Since responsiveness is one of the evaluation categories in OACT's compliance initiative and we expect responses to desk review inquiries within 48 hours, we provide information on this slide to assist certifying actuaries in planning resource availability for bid review. OACT expects its contracted reviewers to send all initial correspondence by June 27. Additionally, OACT will conduct several reviews internally, including a review of red-circle validations and other data checks, MA BPT to PBP consistency, and optional supplemental pricing. These reviews will be conducted by different individuals. To the extent possible, OACT will attempt to consolidate correspondence on these areas of review. However, inquiries can be avoided through the due diligence described in this presentation—namely adequate peer review and thorough documentation.

[SLIDE #27] Questions?

For more details on the information contained in this presentation, please refer to the CY2015 MA and Part D Bid Instructions. In particular, the "Bidding Resources" section of the Introduction of the bid instructions contains links to various types of bidding guidance. This concludes the presentation on "Points of Emphasis for MA and Part D Bids in CY2015."