

Actuarial Bid Training

Presentation: MA Pricing Considerations for Dual-Eligible Beneficiaries

Slides and Script prepared by CMS Office of the Actuary

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[Slide 1] Title

Welcome to the training session on MA Pricing Considerations for Dual-Eligible Beneficiaries.

[Slide 2] In this session. . .

In this session, we will discuss the background and definition of “d e pound”, Bid Pricing Tool data entry, and data sources. We recommend that you open a bid pricing tool from HPMS or have the hard copy in front of you because this presentation does not include screen shots.

[Slide 3] Dual-Eligible Cost Sharing

Beneficiaries who are eligible for Medicare and Medicaid are called dual eligible.

Some dual-eligible beneficiaries receive benefits in the form of reduced or eliminated cost sharing. For these beneficiaries, the pricing methodology recognizes Medicaid level cost sharing, and reflects the reduced or eliminated cost-sharing liability in the development of Medicare-covered medical costs. For all other beneficiaries, other duals and those not eligible for Medicaid, the pricing methodology applies Fee for Service Actuarial Equivalent Cost Sharing factors to develop the total Medicare covered medical costs.

[Slide 4] Definitions

For Bid Pricing Tool purposes, the plan population is categorized as DE# and non-DE# as follows:

DE# beneficiaries are dually eligible for Medicare and Medicaid and are exempt from paying full Medicare cost sharing.

Non-DE# beneficiaries are either dually eligible for Medicare and Medicaid and are liable for full Medicare cost-sharing or they are not eligible for Medicaid

[Slide 5] Definitions (cont.)

Per Federal statute, Qualified Medicare Beneficiaries, known as QMBs, are dually eligible for Medicare and Medicaid, and are not liable for Medicare cost sharing. Therefore, they are always considered to be DE# beneficiaries. It is the responsibility of the certifying actuary to determine which other categories of Medicaid beneficiaries are DE# based on his/her knowledge of the Medicaid cost-sharing policy for the states or territories in which the plan operates.

For example, if the state pays only the Part B premium for a dual-eligible beneficiary, then he or she would be included in the non-DE# category.

[Slide 6] Definitions (cont.)

There is a “safe harbor” for defining DE# beneficiaries. In a situation where the dual population is less than 10% of the total plan population, certifying actuaries may assume that the DE# membership is equal to the QMB and QMB+ members only. In all other cases, the certifying actuary must determine which categories of duals, in addition to QMB and QMB+, are DE# based on the state Medicaid cost sharing policy.

Next we will discuss DE# pricing considerations and bid pricing tool data entry.

[Slide 7] Worksheet 1: Base Period

On Worksheet 1, base period member months must be reported separately for the total population and for non-DE# members. The bid pricing tool will calculate the corresponding DE# member months. Base period risk score must be reported separately for the total population, the DE# population, and the non-DE# population.

All other data on Worksheet 1 are to be reported on a combined basis.

[Slide 8] Worksheet 2: Projected Allowed

On Worksheet 2, total projected allowed costs in column “o” are a blend of projected experience rates and manual rates for the total population. Note that the CMS credibility guideline is applied to the total member months.

[Slide 9] Worksheet 2: Projected Allowed (cont.)

Starting with column “p” in Worksheet 2, there are options for entering data depending upon the size of the projected DE# member months relative to the total projected member months. The options are presented on the next slide.

[Slide 10] Worksheet 2: Projected Allowed (cont.)

Projected allowed costs in columns p and q of Worksheet 2 must be calculated and entered separately for DE# and non-DE# members.

However, if the projected DE# membership represents less than 10%, or greater than 90%, of the total projected plan membership, then the certifying actuary may, in these limited cases, set both DE# and non-DE# projected allowed costs equal to the projected allowed costs for the total population. In this case, all three values are equal.

Note that both DE# and non-DE# projected allowed costs must be entered on the BPT, even if there are no members in one of the categories.

[Slide 11] Worksheet 3: Cost Sharing

The Cost Sharing information on Worksheet 3 must always be based on the benefits outlined in the Plan Benefit Package (PBP).

[Slide 12] Worksheet 3: Cost Sharing (cont.)

In-network cost-sharing utilization factors on Worksheet 3 apply to the non-DE# population with two exceptions.

First, if DE# and non-DE# projected allowed costs are set equal on Worksheet 2, then in-network cost-sharing utilization may be based on experience for the non-DE# or the total population.

Second, if plan population is projected to be 100% DE#, then cost sharing utilization must be based on total plan experience.

[Slide 13] Worksheet 4: Overview of Section II

On worksheet 4, the Medicare-covered cost-sharing amount is developed differently for each beneficiary category. Section IIA addresses non-DE# beneficiaries for whom the BPT pricing methodology applies the Fee-for-Service Actuarial Equivalent cost-sharing factors.

Section IIB addresses the DE# beneficiaries for whom the Medicaid level of cost-sharing is applied and reflects the reduced or eliminated cost-sharing liability.

Section IIC shows a weighted average of the medical expense PMPM from Sections IIA and IIB for all beneficiaries. The certifying actuary adds non-benefit expenses and gain/(loss) margin to calculate the total revenue requirement in Section IIC.

[Slide 14] Worksheet 4: Section IIB Detail (cont.)

The next few slides discuss in more detail the methodology used on Worksheet 4 in Section IIB to separate medical costs into Medicare-covered benefits and mandatory supplemental benefits.

In Column f – The BPT calculates plan cost sharing based on the cost sharing entered in the PBP. It is calculated using the relationship between cost sharing and allowed cost from Worksheet 4 Section IIA and the DE# allowed cost from Worksheet 2.

Column f may be overwritten at the discretion of the certifying actuary.

In Column g – Actual Cost Sharing is calculated based on the minimum of the plan-level cost sharing and the cost sharing required by the state, if any.

[Slide 15] Worksheet 4: Section IIB Detail (cont.)

In Column k, the certifying actuary enters the State Medicaid Required Beneficiary Cost Sharing PMPM. The PMPM is \$0 if the state or territory does not require the enrollee to pay cost sharing. If the state extends cost sharing aid to additional categories of duals beyond QMB and QMB+ it may require some limited amount of cost-sharing from these enrollees. The state required cost sharing must be calculated as the weighted average of the PMPM cost sharing for all DE# members. The certifying actuary may enter the PMPM as \$0 if the DE# population is less than 10% of the total population and the projected allowed costs entered on Worksheet 2 are equal for Total, DE#, and non-DE# members.

[Slide 16] Worksheet 4: Section IIB Detail

The plan pays the provider the Allowed Cost less the PBP cost sharing. The actual cost sharing is the lesser of the state required Medicaid cost sharing or what is entered on the PBP. Thus, for Medicare-covered services, the net PMPM in Column o reflects what the plan pays the provider plus the actual cost sharing less the state Medicaid cost sharing.

[Slide 17] Worksheet 4: Section IIB Detail (cont.)

The A/B mandatory supplemental benefits in column r, are the sum of the net PMPM for additional services in column p plus the reduction in A/B cost sharing in column q.

However, the PMPM value of the reduction in A/B cost sharing reflects the Medicaid level of cost sharing less the actual cost sharing in Section IIB.

[Slide 18] Worksheet 4: Section V – Medicaid Data

Worksheet 4 Section V collects information regarding agreements with the state or territory. All benefits that are funded under a state or territory agreement must be reflected in this section.

The benefit expense and non-benefit expense that together make up the cost of the plan sponsor to provide these Medicaid benefits are entered separately in this section. These expenses may include the cost of providing prescription drug benefits required for the Platino Program in Puerto Rico that are not included in the Part D bid.

Entries must be on a Per Member Per Month basis. Note that the per member calculation is based on the total plan membership and not the DE# membership.

[Slide 19] Worksheet 5: MA Benchmark

On Worksheet 5, the BPT aggregates total projected member months and risk scores that are entered by county. The non-DE# projected member months and risk scores must be entered regardless of the proportion of DE# enrollees. The BPT will calculate the DE# information from the Total and Non-DE# data, but the risk score may be overwritten by the certifying actuary. Do not round the Non-DE# member months to 0% or 100%.

[Slide 20] Worksheet 5: MA Benchmark (cont.)

If there are DE# members in the base period, then CMS expects non-zero DE# projected member months.

The DE# projected member months may equal zero only if—

All of the existing DE# members terminate and the probability of enrolling new DE# members is zero; and

The certifying actuary adequately explains why the DE# projected membership is zero; and

Projected member months and risk score are the same for non-DE# as for the total population.

[Slide 21] Worksheet 5: MA Benchmark – Risk Factors

The development of DE# and Non-DE# projected risk scores depends on how DE# and Non-DE# projected allowed costs are reported.

If the projected allowed costs are set equal, then DE# and non-DE# risk scores must also be equal. If the certifying actuary calculates distinct DE# and non-DE# projected allowed costs, then the projected risk scores must be calculated separately as well.

[Slide 22] Medicaid Data

One of the Appendices in the MA bid instructions summarizes the types of Medicaid data provided by CMS to aid the certifying actuary in determining the DE# and non-DE# populations.

The Appendix also outlines the conditions and options for determining DE# and non-DE# bid pricing tool values in a chart format.

The next few slides illustrate the data summarized in the Appendix.

[Slide 23] Medicaid Data (cont.)

This slide shows the Medicaid categories for dual-eligible beneficiaries. For further details please see the CMS webpage referenced at the end of this presentation.

[Slide 24] Medicaid Data (cont.)

This slide shows the Medicaid State-Reported Codes that correspond to the Medicaid Categories. Note that there is no code seven.

[Slide 25] Medicaid Data (cont.)

This table shows the Medicaid Grouping indicator that CMS provides to help the certifying actuary determine which beneficiaries are DE#.

As you can see on this slide, beneficiaries in the QMB or QMB+ status will have a Medicaid Indicator of A. Recall that this population is never liable for Medicare cost sharing and is therefore, always defined as DE#.

All other Medicaid beneficiaries will have a Medicaid indicator of B, and, again, it is the responsibility of the certifying actuary to know the Medicaid cost-sharing policy for the states or territories in the plan's service area and determine which Medicaid beneficiaries with a Medicaid indicator of B are DE#. All non-Medicaid beneficiaries will have a Medicaid indicator of C.

[Slide 26] References

The last slide lists sources for more bid development information.

This concludes the presentation.