

# Actuarial Bid Training

## MA Pricing Considerations for Dual-Eligible Beneficiaries



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CMS Office of the Actuary  
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## In this session ...

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- Definition of DE#
- Bid Pricing Tool (BPT) Data Entry
- Data Sources



# Dual-Eligible Cost Sharing

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- Some beneficiaries dually eligible for Medicare and Medicaid receive benefits in the form of reduced or eliminated cost sharing, others pay full cost sharing
  - Pay reduced or no cost sharing:
    - The BPT reflects reduced or eliminated cost-sharing liability in the development of Medicare-covered costs
  - Pay full cost sharing:
    - The BPT reflects FFS Actuarial Equivalent cost-sharing factors in the development of Medicare-covered costs



# Definitions

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- DE#
  - Dually eligible for Medicare and Medicaid and liable for reduced or eliminated Medicare cost sharing
- Non-DE#
  - Dually eligible for Medicare and Medicaid and liable for **full** Medicare cost sharing
  - Not eligible for Medicaid



## Definitions (cont.)

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- Qualified Medicare Beneficiaries (QMB and QMB+) are always DE#
- The certifying actuary must determine which other beneficiaries are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan's service area
  - Example: If the state pays only the Part B premium for a dual-eligible beneficiary, this beneficiary is categorized as non-DE#



## Definitions (cont.)

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- There is a “safe harbor”, which is determined based on proportion of Dual population
  - If dual population  $< 10\%$  of total plan population, the plan may consider DE# membership to equal QMB and QMB+ members only
  - If dual population  $\geq 10\%$  of total plan population, the plan must determine which duals in addition to QMB and QMB+ are DE# based on state Medicaid cost-sharing policy



# Worksheet 1: Base Period

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- Member Months
  - Report Total and Non-DE# values
    - BPT calculates DE# member months
- Risk Score
  - Report Total, non-DE# and DE# values separately
- Base Period Data and Projection Assumptions
  - Report non-DE# and DE# on a combined basis



## Worksheet 2: Projected Allowed

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- Total Allowed PMPM (column o)
  - Blended projected experience rate and manual rate for total population
- CMS credibility guideline applies to total (DE# plus non-DE#) member months





## Worksheet 2: Projected Allowed (cont.)

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- Starting with Worksheet 2, column p:
  - There are options for entering data depending on relative size of DE# population
  - That is, DE# projected member months versus total projected member months



## Worksheet 2: Projected Allowed (cont.)

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- Non-DE# and DE# Allowed PMPM
  - Calculated and entered separately (columns p and q)
  - If  $DE\# < 10\%$  or  $DE\# > 90\%$  of total projected plan population,
    - Then certifying actuary may set non-DE#, DE# and Total Allowed PMPM equal
  - Must enter data even if membership is zero



## Worksheet 3: Cost Sharing

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- Cost Sharing must always be based on the benefits outlined in the Plan Benefit Package (PBP)



## Worksheet 3: Cost Sharing (cont.)

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- In-network cost-sharing utilization factors apply to the non-DE# population
- Exceptions
  - If Non-DE# and DE# projected allowed costs were set equal on Worksheet 2
    - In-network cost-sharing utilization may be based on non-DE# or total experience
  - If plan population is projected to be 100% DE#
    - Cost-sharing utilization must be based on total plan experience



## Worksheet 4: Overview of Section II

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### Medicare-covered cost-sharing development

- Section IIA: non-DE# Beneficiaries
  - FFS actuarially equivalent cost-sharing factors applied
- Section IIB: DE# Beneficiaries
  - Medicaid level of cost sharing is applied
  - Takes into account reduced or eliminated cost-sharing liability
- Section IIC: All Beneficiaries
  - Is a weighted average of Sections IIA and IIB
  - Total revenue requirement calculated



## Worksheet 4: Section IIB Detail (cont.)

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- Plan Cost Sharing (column f)
  - The BPT calculates what the plan cost sharing would be if the beneficiary paid plan-level (PBP) cost sharing
  - This column may be overwritten at the discretion of the certifying actuary
- Actual Cost Sharing (column g)
  - The BPT calculates the actual cost sharing based on the minimum of the plan-level cost sharing and the cost sharing required by the state, if any



## Worksheet 4: Section IIB Detail (cont.)

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- State Medicaid Required Beneficiary Cost Sharing (column k)
  - \$0 PMPM if the state or territory does not require enrollee to pay cost sharing
  - Some nominal amount per state requirement, especially if the state offers partial cost-sharing relief to more than the QMB/QMB+ enrollees
  - Calculated as the weighted average of the PMPM cost sharing for all DE# members
  - PMPM may be \$0 if DE# population < 10% and projected allowed costs on WS2 are all equal.



## Worksheet 4: Section IIB Detail

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- Medicare-Covered Net PMPM (column o)
  - The plan pays the provider the Allowed Cost less the PBP cost sharing
  - Actual cost sharing is the lesser of the PBP cost sharing and the state Medicaid required cost sharing
  - Medicare-covered net PMPM reflects what the plan pays the provider for Medicare-covered services plus actual cost sharing for Medicare-covered services less state Medicaid cost sharing for Medicare-covered services





## Worksheet 4: Section IIB Detail (cont.)

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- A/B Mandatory Supplementary Benefits PMPM (column r) are the sum of:
  - Net PMPM for Additional Services (column p)
  - Reduction for A/B Cost Sharing PMPM (column q)
    - Reflects Medicaid level of cost sharing less actual cost sharing in Section IIB



## Worksheet 4: Section V - Medicaid Data

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- Complete if the plan has an agreement with the state or territory
- Projected Medicaid benefits
  - Reflect the cost of benefits
  - Include non-benefit expenses
  - May include prescription drug benefits required for Platino Program in Puerto Rico
- Entries must be on a per member per month basis
  - Use total plan membership, not DE# membership



## Worksheet 5: MA Benchmark

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- BPT aggregates total member month and risk score information from county-level detail
- Non-DE# projected member months and risk scores must be entered regardless of the proportion of DE# enrollees
- DE# projected member months and risk score are calculated by the BPT, but the risk score may be overwritten by the certifying actuary
- Do not round the Non-DE# projected member months to 0% or 100%



## Worksheet 5: MA Benchmark (cont.)

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- If base period DE# member months  $> 0$ :
  - CMS expects DE# projected MM  $> 0$
- Conditions for zero DE# member months
  - Existing DE# members terminated,
  - Zero probability of enrolling DE# members,
  - Adequate explanation, and
  - Same projected MM and risk score for non-DE# and total population



## Worksheet 5: Risk Scores

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- If actuary sets projected allowed costs equal ( $DE\# < 10\%$  or  $DE\# > 90\%$ )
  - Then,  $DE\#$ , non- $DE\#$  and total projected risk scores (WS5, Sect.II) must be equal
- If actuary sets distinct non- $DE\#$  and  $DE\#$  projected allowed costs
  - Then projected risk scores must be distinct



# Medicaid Data

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- See Appendices to MA Bid Instructions for:
  - Information for classifying dual eligibles
    - Medicaid status codes (01, 02, ...99, blank)
    - Medicaid groupings: A (DE#), B (DE# or Non-DE#) and C (non-DE#)
  - Conditions and options for determining BPT values based on—
    - DE# percentage of total member months
    - Presentation of projected allowed costs



## Medicaid Data (cont.)

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- Qualified Medicare Beneficiary (QMB and QMB+)
- Specified Low-income Medicare Beneficiary (SLMB and SLMB+)
- Qualified Individual (QI)
- Qualified Disabled and Working Individual (QDWI)
- Full benefit duals, non QMB, non-SLMB, non-QI, and non-QDWI



## Medicaid Data (cont.)

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- Beneficiary-Level Data

Medicaid Category	State-Reported Code
QMB	01
QMB+	02
SLMB	03
SLMB+	04
QDWI	05
QI	06
Full Benefit Duals	08
Other Title XIX	09
Unknown, Plan reported, and territories	99
Non-Medicaid	Blank





## Medicaid Data (cont.)

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- Plan-Level Data Posted in HPMS
  - Expanded to include a Medicaid indicator

Medicaid Indicator	Category Definition	State-Reported Code
A	QMB & QMB+	01, 02
B	All Other Medicaid	03, 04, 05, 06, 08, 09, 99*
C	Non Medicaid	
Total		* Note there is no code = 07



# References

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- Dual-Eligible Information
  - [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare\\_beneficiaries\\_dual\\_eligibles\\_at\\_a\\_glance.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf)
- MA BPT Instructions
- HPMS Technical Instructions
- Risk Score Technical Notes