# 2013 SOA BOOT CAMP

## MEDICARE ADVANTAGE PRICING, DOCUMENTATION AND AUDIT

Susquehanna
Actuarial Consulting Inc.

Kevin Pedlow ASA, MAAA, FCA

# Agenda



- Documentation
- General Comments
- OOPC & TBC
- Base Period Medical Expense Reconciliation
- Trend Factor Support
- Gain/Loss Rules
- Administrative Costs
- Related Parties
- Medicare as Secondary Payer

# Documentation



- Audit = Documentation

- ASOP# 41 *Actuarial Communications*

Section 3.2 Actuarial Report

"In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report."

- Documentation = Work (Work Plan and Work Management Tool)

# General Comments – Bid Development vs. Audit



- Bid Development is extremely complex, with many inter-related components
- Keeping all moving parts connected during the hectic bid development process is almost impossible
- It is far easier to go in after the fact to search and find discrepancies than it is to keep all items in order for bid submission

# General Comments – Purpose of Audit



- Review current bids with results intended to improve the next year's bid submissions

- All Findings & Observations must be stated in the next year's bid documentation with the initial submission – along with specifics on how the bid addresses these issues

- CMS OACT uses the results of these audits to help improve the bid instructions for future years

# General Comments – Orange Blank



- Page 7 – reported medical expense and administrative expense
- Page 11 – medical expense by product and incurred time-frame
- Exhibit of Premiums and Enrollment – membership by quarter (without retro-activity)
- Schedule Y – Related Parties & Transactions

# Out-Of-Pocket-Cost (OOPC) Differentials



- Meaningful differences ($20 PMPM)
- SAS Model made available by CMS

# Total-Beneficiary-Cost (TBC) Changes



- Limit year-over-year changes ($34 PMPM)
- Limit is adjusted for benchmarks (region & star rating)
- Essentially a game of competing against yourself (avoiding "bait and switch")

# Base Period Medical Reconciliation



## Components of Medical Costs

- Medical Claims
- Capitation
- Off-System

  common: Newsletter, Nurse Hotline, Part B Rx from PBM, Medical Management, etc.

# Base Period Medical Reconciliation (continued)



## Purpose of Reconciliation

- Ensure data accuracy
- Confirm all components of medical expense are included
- IBNR is explicit and is required to exclude provisions for adverse deviation

# Base Period Medical Reconciliation (continued)



Reconciliations

- Amounts must be followed from bid entries to Financial Statements
- Common to tie GL to FS, then other items to GL
- Capitation to GL
  - This is usually a direct tie, as "paid" and "incurred" timing is typically the same
- Off-System to GL
  - This is usually a direct tie, as "paid" and "incurred" timing is typically the same
- Medical claims to GL
  - Bid includes DOS of base period, run-out through Feb, Mar?
  - GL tied to FS show paid during base year, regardless of DOS
  - medical claims triangles connect the bid data to the GL amounts
- IBNR – best estimate for run-out past date of data (no margins)
- Provider Incentives – to be included in base period medical costs

# Support for Trend Factors



## General

- Historical trends
- Benchmark Trends
- Forecast trend selection (in and amongst historical and benchmarks, with explanation of the choice – notes and/or meeting notes)

# Support for Trend Factors (continued)



## Provider Payment Change

- Underlying Fees Schedule Changes (Medicare FFS reimbursement)
- Contract Changes (compiled over provider/contract level volume)

# Support for Trend Factors (continued)



Population Change

- Geographic Shifts (county level costs)
- Risk Score Changes
- Other

# Support for Trend Factors (continued)



## Other Factors

- MSP (Changes to the factor/membership or changes to the implemented identification process)

- Other

# Gain/(Loss) Rules



- Different Purposes (Aggregate Support and Negative Margins)
- Aggregate Support (Individual & I/C SNP Plans - MA)
  - Select Plan, Organization or Parent Org. Level
  - Accumulated gains at this level must be within 1.5% of pricing gains for non-Medicare LOBs (alt rules if <10% is priced at plan's discretion)
  - Each plan bid must be "reasonable" and be without anti-competitive practices (Product Pairings may be required to confirm this)
  - EGWP plans must be within -5% to +1.5% of Indiv & I/C SNP
  - D-SNP plans must be within -5% to +1.5% of Indiv & I/C SNP
- Negative Margins (Product Pairings)
  - May Pair a Negative Margin plan with other plans
    - Identical service areas
    - Local Plans or RPPO or PFFS
    - Non-SNP or same SNP Type
    - Combine to Positive Margin
  - Or Must file Business plan to achieve profitability

# Base Period Administrative Costs



- GL or TB – With tie to Financial Statements (FS are audited and considered to be accurate)

- Cost Allocations of expenses by Account, Department or Cost Center tied to GL or TB (allocated to Medicare, MA vs. PD, and to Bid Entries)

- Documentation – should show a mapping of all costs from bid entries to the Financial Statements

- Audit – Review the documentation trail from FS to bid entries, select allocations of a few Accounts, Departments or Cost Centers for reasonable allocation methodologies

- User Fees – include as Direct Administrative Expenses

# Contract Period Administrative Costs



- Projected from base period expenses or current budget (if from budget, tie to base period must be shown and available for validation)
- Similar modeling to base period is helpful for review – and easier for Reviewer/Auditor to understand
- Forecast assumptions documented and supported
- Clear mappings to bid entries (PMPM)

# Related-Party Expenses



## Definition of Related Party

- Review all company Legal Entities
- State Waiver for reporting on Schedule Y does not alleviate CMS disclosure

# Related-Party Expenses (continued)



Disclosure

•Disclosure #1 – Statement of Related Parties (even if there are none)

•Disclosure #2 – Details of agreement (relationship, services provided, financial considerations)

# Related-Party Expenses (continued)



Administrative Services

•Method #1 – consistent with not recognizing the independence of the entity (i.e., cost allocations)

•Method #2 – comparable fees paid as what the related party receives for these services form unrelated parties

# Related-Party Expenses (continued)



## Medical Expenses

- Method #1 – Included in the bid as cost

- Method #2 – actual fees paid and shown to be comparable to what the related party receives for these services from unrelated parties (+/- 5%)

- Method #3 – actual fees paid and shown to be comparable to what the related party receives for these services from Medicare FFS (+/- 5%)

- Method #4 – replace actual provider payments with 100% of Medicare FFS provider reimbursements

# Medicare as Secondary Payer (MSP)



- General
  - Pay 17.4% of normal payment (17.3% for 2013 & 2014)
- Working Files
  - list each member that is identified as MSP providing Other Insurer
  - Plan Sponsor can research and provide updates to CMS
- MMRs
  - Show payment levels for MSP members
  - Details for calculating current MSP reductions to total payments