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Reasons to Reconcile

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Figure 1
Reconciliation Process

Financial reconciliation is critical to a successful Medicare Advantage (MA) bid. It can be a frustrating lesson to learn in May that a reconciliation is not balancing, as the pressure to complete the pricing increases while the days before the deadline tick down.

Alternatively, the frustration can be suffered later in the process as a bid or financial audit identifies discrepancies in the data. In this article, we assert that reconciling data early is extremely important and should be routinely revisited as new data or information is incorporated into bid pricing. We assume the reader has a good understanding of the MA bid process and a fair amount of the terminology surrounding it.

PREPARING TO RECONCILE

What does it mean to reconcile? According to Investopedia, "[r]econciliation is an accounting process that uses two sets of records to ensure figures are correct and in agreement."[1] For the MA bids, the data used in the pricing must match the financial statements. Again, according to Investopedia, "[f]inancial statements for businesses usually include income statements, balance sheets, statements of retained earnings and cash flows."[2] The "income statement covers a range of time, which is a year for annual financial statements" and "provides an overview of revenues, expenses, net income and earnings per share." Thus, the annual income statement for the base year should be the primary source that the data used in pricing should reconcile.

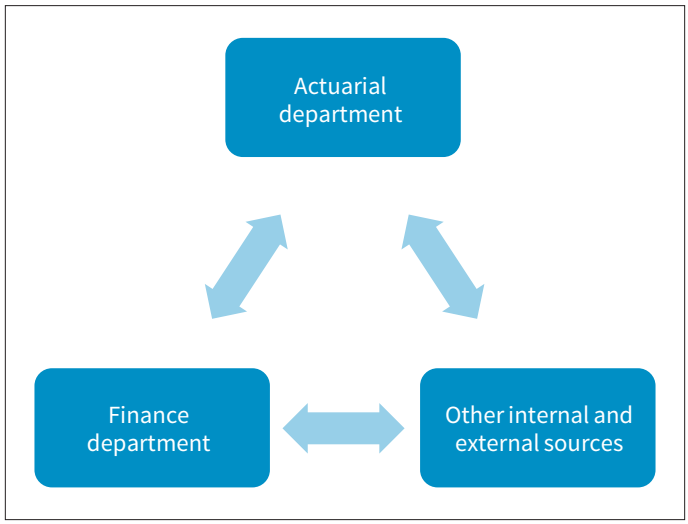
The first step in the reconciliation is to break out the MA line of business from the non-MA lines of business. Similarly, MA has a nuance that is not necessarily present in other lines of business, as end-stage renal disease (ESRD), hospice and employer group waiver plan (EGWP) members are excluded from certain elements of the pricing. It is important to be transparent in the development of the values that are assigned to each member grouping so that it will be easier to trace any discrepancies.

As actuaries, we may need help in understanding some of the finer details of the financial statements. We should not be intimidated by them and should lean on the finance department to help explain confusing parts, adjustments or notes. We are not accountants, and we are not required to be experts on every aspect of the financial statements. Nevertheless, as actuaries, we are required to understand the data and not just accept whatever comes across our desk without scrutiny. Communication with the internal departments is the key to feeling comfortable with the data (Figures 1 and 2). The other departments should also run some preliminary reconciliations and quality checks before providing data to the actuary. It is a good idea for the actuary to check consistency with prior years' information.

Actuarial Standards of Practice No. 23 deals with data quality and addresses reconciliation in three sections:[3]

- **2.1 Appropriate Data.** "For purposes of data quality, data are appropriate if they are suitable for the intended purpose of an analysis and relevant to the system or process being analyzed."
- **2.7 Review.** "An informal examination of the obvious characteristics of the selected data to determine if such data appear reasonable and consistent for purposes of the assignment. A review is not an audit of data."
- **3.5 Review of Data.** "A review of data may not always reveal existing defects. Nevertheless, whether the actuary prepared the data or received the data from others, the actuary should review the data for reasonableness and

Figure 2
Interacting With Others in Reconciliation



consistency, unless, in the actuary's professional judgment, such review is not necessary or not practical. In exercising such professional judgment, the actuary should take into account the extent of any checking, verification, or auditing that has already been performed on the data, the purpose and nature of the assignment, and relevant constraints."

The Centers for Medicare & Medicaid Services (CMS) oversees the MA bids and specifically notes two Part C areas where reconciliation is mandated:[4]

1. **Base period claims expenses** (Appendix B, Section 10.2). "Reconciliation of base period experience to the audited financial statements and bid-level operational data of the Medicare Advantage organizations (MAO). The data are to be reported on an incurred rather than an accounting or GAAP basis, including claims paid, unloaded claims reserves, non-benefit expenses, and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis."

2. **Non-benefit expenses** (Appendix B, Section 7.1). "A reconciliation of the base period non-benefit expenses reported in Worksheet 1 of the Bid Pricing Tool (BPT) to auditable material such as corporate financials and bid-level operational data."

While the reconciliation of base period revenue does not have a specific reference in Appendix B, CMS's desk review standards consistently treat revenue as a mandatory recon item. In particular, bid instructions require the following for Part C revenue entries:[5]

- Enter bid-based MA payments and accruals from CMS.
- Include rebates for the reduction of Part A/B cost sharing and other Part A/B mandatory supplemental benefits.
- Include an estimate of the final risk-adjustment reconciliation payment for calendar year (CY) 2016, which will be received in 2017.
- Do not include rebates applied to Parts B and D premium buy-downs.
- Report the CMS revenues gross of user fee reductions and net of sequestration reductions.

In addition to these requirements relating to base period expenses and revenue (found in the same locations in the corresponding Appendix B for Part D[6]), CMS offers these directives:

- The data "[m]ust reconcile in an auditable manner to the plan-level Prescription Drug Event (PDE) data submitted to CMS for payment and reconciliation and the Part D sponsor's audited financial statements."
- **Related-party arrangements** (Appendix B, Section 13.3.1). "The gain/loss margin must be reconcilable to the related party's audited financial statements."

Across all areas, it is important to be consistent from year to year. If the data is consistent from year to year, the actuary can take some comfort that the reconciliation process is starting on a good footing.

COMPLYING WITH CMS

In the next few sections, we look at the three mandated areas that CMS has addressed and note specific issues within each that the actuary should take into consideration.

Revenue

While the base period revenue shown on Worksheet 1 does not impact the pricing of the bids, it still must be reconciled to the financial statements. Revenue can be a tricky number to reconcile. The actuary should rely on the monthly membership reports (MMRs) and plan payment reports (PPRs) as the starting point. The plan should have its operations department compare these reports against internal membership and eligibility reports for consistency. Splitting the medical (Part C) from the prescription drug (Part D) revenue is the first step, because this could affect the allocation of non-benefit expenses based

on revenue. For Part C, the revenue consists of the sum of the risk rate, Medicare second payer (MSP) amounts, cost-sharing rebates, Part B rebates, mandatory supplemental rebates and any member premium. The risk rate is the county rate from the specific bid at a 1.000 risk score multiplied by each member's risk score. The county rate at a 1.000 risk score for each bid can be found on Worksheet 5 of the base period BPTs. In addition, the rebates and member premiums can be found on Worksheet 6 of the base period BPTs.

For Part D, the revenue is comprised of the direct subsidy, the low-income premium subsidy and the basic premium rebate and premium, along with any supplemental premium rebates and premium. The Part D basic and supplemental premium rebates and premiums actually come from Worksheet 6 of the Part C BPT. The direct subsidy is calculated by subtracting the basic premium from the basic bid, both shown on Worksheet 7 of the Part D BPT, multiplied by each member's risk score.

Other components of revenue come from additional sources besides the MMRs. The PPRs contain a summary of the revenue from CMS as well as the sequestration amounts, Part D settlements and user fees. While not required by the bid instructions, it is important for MAOs to reconcile the MMRs and PPRs to the bids. This reconciliation allows MAOs, especially the actuaries and finance, to confidently use the reports provided by CMS. Like any report, if the values do not make sense, it is important to notify internal users and CMS.

The Risk Adjustment Processing System (RAPS) and now the Encounter Data Processing System (EDPS) accruals need to be taken into account. RAPS/EDPS accruals are necessary to reflect the timing of the revenue paid by CMS. The magnitude of the payments and timing of the revenue are influenced by the diagnoses updates from CMS as well as MAO efforts to appropriately reflect member diagnoses. The timing of these accruals will be affected by an adjustment in August or September for the final settlement for the prior year (Figure 3). Another accrual to reconcile is the Part D risk corridor payments.

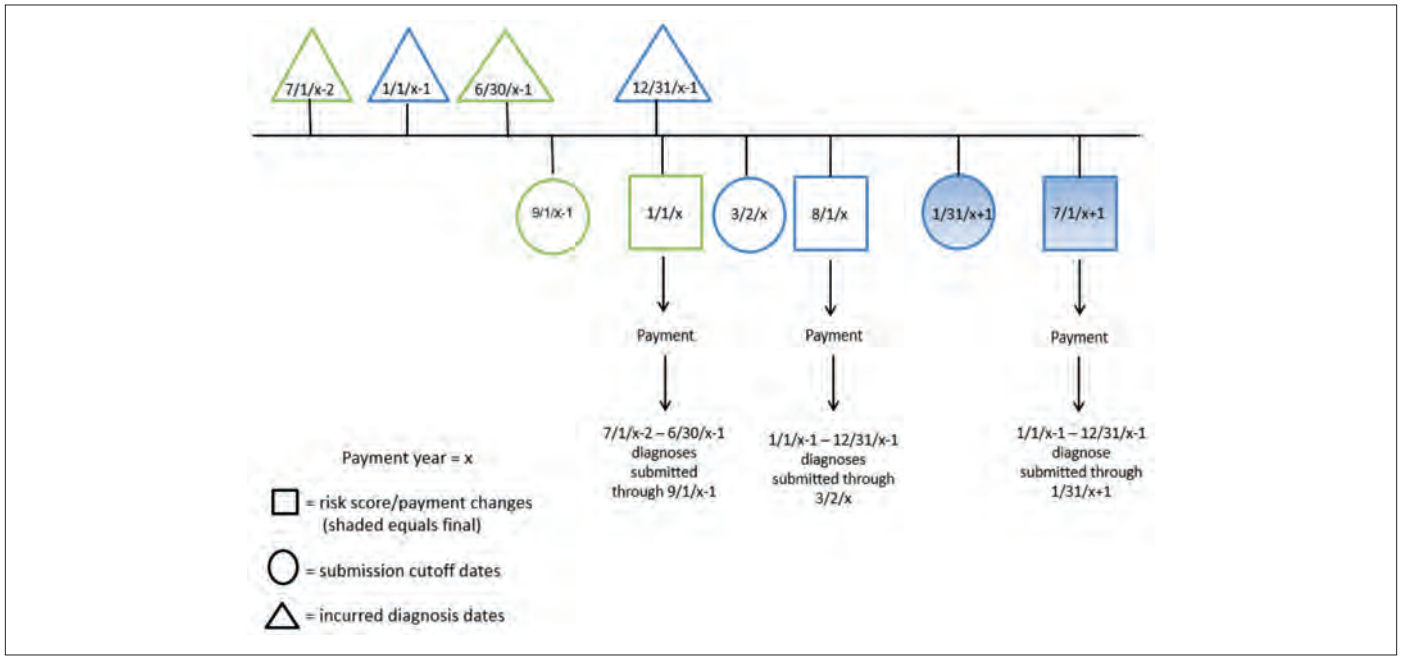
Other revenue components that should be considered are as follows:

- Prior period adjustments
- Bad debt
- Premiums from optional supplemental benefits
- Receivables for MSPs

These revenue items cannot be reflected in the bid, per CMS on page 31 of the Part C instructions:[7]

- Noninsurance revenues pertaining to investments
- Fee-based activities designed to influence state or federal legislation, such as the cost of lobbying activities
- Costs of value-added items and services (VAIS)

Figure 3
Timing of RAPS Submissions and Payments



Claims Costs

The reconciliation of the claims costs is the most important because the base period claims costs are the primary driver of the projected claims costs. As noted, the complications of the differing member statuses adds to the complication of the claims cost reconciliation process. Accounting for ESRD, hospice and EGWP, member claims can lead to inconsistencies in the reconciliation process.

While the format can vary by insurer, the basis of the Part C claims are the fee-for-service (FFS) claims plus the unpaid claims liability plus any capitation plus any other services outside the claims system (i.e., over-the-counter drugs as a medical benefit). For Part D, the PDE files capture the financial items necessary for reconciliation.

The actuary should take into account a number of items when reconciling claims costs:

- **Allowed versus paid dollars.** The bases for the bids are allowed amounts, so make sure to account for all member cost sharing so the paid amounts can be properly reconciled to the financial statements.
- **FFS costs.** Net of margin on incurred but not paid (IBNP) amounts—bids do not include margin on IBNP, while financial statements would.
- **Capitation**
  - Compare the actual paid versus what was contracted to be paid
  - Make sure there is no double-counting (i.e., including capitation along with the notional cost of the capitated encounters from the claims system)
  - Account for accruals that need to occur compared to what was reported in the financial statements
  - Reclassification to non-benefit expenses (NBE). Certain capitated services may be for administrative services. MAOs may report these in claims on the financial statements; however, they need to be reclassified to NBE for the bids.
- **Mapping issues**
  - Members changing plan benefit packages
  - Members changing counties, including out-of-area members
  - Member IDs that are incorrect
  - Eligibility issues like claims paid in a given month but with no corresponding member record in the MMR
- **Part B Rx and OTC drugs.** These are Part C benefits, but MAOs may report them in prescription drug costs along with Part D. Note that any Part D OTC that is not a medical benefit should be removed from Part D claims and added to Part D NBE.
- **Incentives and risk sharing.** Incentives can sometimes be reported in NBE in sales and marketing. Check the bid instructions or consult with CMS for clarification on specific situations.
- **Provider issues.** Voided checks and/or advance payments can come into play with the timing of claims payments for the base year.
- **Related parties**
  - Check the bid instructions or consult with CMS for compliance with one of the methodologies for handling medical related-party arrangement(s).
  - Depending on the situation and method for demonstrating compliance, this can create a difference between the reporting of claims for these services in the bids versus the financial statements, which requires further reconciliation steps.
- **Coordination of benefits and reinsurance recoveries**
  - These items are usually outside of the claims system.
  - Consider the timing of payments, which can lead to a long lag relative to the incurred year.
  - Make sure they are being allocated to either the Part C or Part D correctly.
- **Rebates for Part B Rx and Part D**
  - Part B Rx rebates are relatively new, occurring in the last couple of years.
  - The contract determines how rebates are paid, as some may be used to offset pharmacy benefit manager (PBM) administrative costs.
  - Part D requires 100 percent pass-through in bids, so all rebates must be reported as a reduction in claims costs. In particular, any rebates retained by the PBM should be included as an NBE.
  - Three to six months of lag time between the incurred year and payment of rebates must be allowed, so there is a need to include an accrual for rebates incurred but not paid. Make sure the methodology is reasonable for estimating future payments.
- **Optional supplemental claims.** Voluntary or optional services are reflected in the bids separately. Take them out of the Worksheet 1 reconciliation.

- **Patient liability reduction due to other payer.** EGWP plans with a supplemental wrap product. They should be considered with paid claims when reconciling Part D.
- **Prior period adjustments.** Should be taken out of the Worksheet 1 reconciliation. Include claims reserves.
- **Non-medical vendor data.** This could be reported in claims and should be reclassified as NBE.
- **Non-risk Part D items**
  - MAOs are not at risk for the Coverage Gap Discount Program, Low-Income Cost Sharing Subsidies or federal reinsurance.
  - Take careful consideration of how these items are reported in the financial statements.

There are many issues surrounding the inventory of claims items, so it is prudent to take action early to make sure everything is accounted for and on the finance department's radar.

Non-benefit Expenses

While the base period revenue is not directly used in the bids and base period claims costs are the primary driver of future claims costs in the bid, MAOs develop their projected NBEs using either a projection of base period NBE, a current budget for NBE or a combination of the two.

The NBE, or administrative costs, are typically a function of the finance department. As noted in CMS's CY 2018 Bid Tools and Instructions[8] for Part C on page 34, "[n]on-benefit expenses are all of the bid-specific administrative and other non-medical costs incurred in the operation of the MA bid." Along with the importance of allocating costs among the different lines of business and between Parts C and D, the actuary needs to be aware of expenses for services that are reclassified either from claims costs to administrative costs or vice versa.

Medical benefits are defined in Chapter 4 of the *Medicare Managed Care Manual* (*MMCM*) as Medicare-covered, mandatory supplemental or optional supplemental benefits.[9] Chapter 4 of the *MMCM*, along with Chapter 3 of the *Medicare Marketing Guidelines*,[10] should be referenced for clarification of what can and cannot be included as non-benefit expenses.

CONCLUSION

Reconcile early and often! The reconciliation process can be intricate, but if done early it will not take the focus and priority away from the ultimate goal of completing the pricing and documenting the bid. Do not wait until May to perform this part of the analysis when finalizing the supporting documentation for the bid submission. It can lead to unexpected changes in pricing, rushed judgment, incorrect conclusions and flat-out errors. Moreover, from the regulatory side, there can be repercussions from audits of the financial data that could lead to findings and/or observations that could have been avoided.

The best practice is to educate the varying departments to understand how the data are used and can affect the pricing of the MA bids. In addition, the departments should understand the regulatory risks and implications during an audit process. The earlier the education occurs, the more informed all parties will be, which should lead to a smoother reconciliation process. ■

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ENDNOTES

1 Reconciliation, Investopedia, *http://www.investopedia.com/terms/r/reconciliation.asp* (accessed October 26, 2017).

2 Financial Statements, Investopedia, *http://www.investopedia.com/terms/f/financial-statements.asp* (accessed October 26, 2017).

3 See the full standard at *http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop023_141.pdf*.

4 Centers for Medicare & Medicaid Services, Medicare Advantage Rates and Statistics: Details for Title: 2018, *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2018.html* (accessed October 26, 2017).

5 Ibid.

6 Ibid.

7 Ibid.

8 Ibid.

9 Centers for Medicare & Medicaid Services, Chapter 4: Benefits and Beneficiary Protections, in *Medicare Managed Care Manual*, April 22, 2016, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf* (accessed October 26, 2017).

10 Centers for Medicare & Medicaid Services, *Medicare Marketing Guidelines*, June 10, 2016, *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf* (accessed October 26, 2017).