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Medicare Advantage Experience Data: Pitfalls and Concerns Beyond ASOP #23

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Medicare Advantage organizations (MAOs) face many challenges when preparing their Medicare Advantage (MA) bids for the upcoming year. In particular, when organizations assess their emerging claims experience or review a prior year's data, they may struggle with the quality of data available. MAOs must consider influences both internal and external to the claims adjudication process as they review and use their data. Is the claims experience consistent with the plan benefit package (PBP) and provider contracts? Does the claims experience seem reasonable compared to prior years and benchmarks? MAOs must evaluate these and other important questions as they prepare their historical data for bid development.

INTERNAL CONSIDERATIONS

MAOs must use appropriate data to price their bids, both in order to comply with required bid instructions and to increase accuracy of future projections; however, this task is not always a simple one. Depending on how many vendors they contract with, the complexity of provider contracts and how they store and perform quality assurance on their own data, MAOs can have many data-related concerns. These concerns may include items that are internal to the claims adjudication process, including the following topics.

Does the Data Contain the Required Elements?

MAOs must properly store and classify all relevant data for their covered members and benefits. This may include eligibility, fee-for-service (FFS) claims data, and capitated encounter and payment data received from all vendors that process this data. These vendors may include the MAO's third-party administrator as well as any specialized vendors (e.g., for a fitness or transportation benefit).

MAOs must compare the data they have to the benefits covered in that period to identify any missing elements. Once the MAO has collected data from all vendors, it must assess the quality of the data and address any deficiencies. MAOs will need to consider several potential areas of concern, such as these:

- **Missing information.** MAOs may struggle to obtain complete data at the level of detail required to perform bid pricing. For certain benefits, an MAO may have difficulty receiving claims data at the member level (i.e., the MAO may not have tracked the data at that level of detail or may not have ready access to it). There may also be instances when the MAO or its vendor did not track encounter data associated with capitation arrangements.

- **Aggregate data.** Some vendors may provide data for several services that are covered under their contract with the MAO but may not include enough detail to allow for an accurate allocation to the corresponding services. For instance, a vendor adjudicating a vision benefit may provide claims data for both hardware and exam services in the same data set, but might not provide enough information to distinguish between the two to correctly populate the Bid Pricing Tool (BPT).

- **Integration of benefits.** Some vendors may provide data for a service that integrates Medicare and Medicaid benefits. MAOs will need to be able to segregate the two benefits and use only the subset of data covered by Medicare.

- **Medicare- vs. non-Medicare-covered benefits.** Some service categories (such as vision and hearing) include services that are covered by traditional Medicare and other services that are covered only via supplemental benefits. If a supplemental benefit is offered, the MAO must be able to identify and separate claims for Medicare-covered vs. non-Medicare-covered services.

- **Incomplete data.** Depending on the vendor and benefit, there may be significant lags in the completion of the data. Additionally, if the MAO recently switched vendors or renegotiated contracts, it will need to ensure it is receiving complete information that reflects the terms of the contract in place at the time of service.

- **Eligibility.** MAOs must confirm that the claims and encounter records are consistent with the eligibility records. In general, beneficiaries with end-stage renal disease (ESRD) cannot join an MA plan. Thus, Part C data must exclude all claims for ESRD individuals. However, this will change in 2021 as Medicare beneficiaries with ESRD will be allowed to enroll in MA plans.

- **Utilization considerations.** MAOs will need to identify any claim records that could lead to over- or underreporting

utilization if handled incorrectly. Depending on the situation, this could include claim records with $0 paid, records that reflect adjustments or denials, utilization records for a benefit such as transportation that includes both an original and return trip, or instances where multiple visits (such as to a chiropractor) are included on one claim form. In addition, sufficient data must be collected in order to determine the unique number of utilizers for each service category to satisfy BPT reporting requirements.

- **Paid amount considerations.** MAOs must understand the contents of each dollar amount field to ensure data are used appropriately. For instance, capitated encounter data may include a "paid" amount field. However, this field may be purely informational, reflect the capitated payment or reflect a payment made in addition to the capitated payment. Additionally, the total payment to a provider may be in the form of multiple components (e.g., a capitated payment and an additional administrative fee). Also, some organizations track the paid amount both before and after a sequestration adjustment. The MAO should understand each source of paid data and confirm it has accurately captured all payments associated with a given service.

- **Classification.** MAOs will need to classify data into the categories the BPT and PBP require for bid pricing. This classification can be a complex process that incorporates numerous claim elements and decision-tree logic to ensure appropriate classification, account for denials or adjustments and assign various utilization metrics (e.g., days vs. admits). Consistent classification of claims also allows for meaningful benchmark testing and multiyear analyses.

Tools built around grouping software allow MAOs to efficiently perform such classification and provide a platform for consistent benchmarking. Milliman developed one such tool that sorts data into benefit service categories based on current medical code sets and can mitigate an MAO's expense associated with annual Centers for Medicare and Medicaid Services (CMS) PBP definition compliance.

There will be nuances associated with each benefit, and MAOs must understand those nuances to be able to identify errors and appropriately use the data for bid pricing.

Is Claims Experience Consistent With Benefit Parameters and Provider Contracts?

MAOs frequently work with many vendors to adjudicate each of the benefits covered by the plan. This can quickly lead to poor outcomes if the MAO does not periodically audit the data and correct discrepancies. When MAOs audit their data, they may be able to identify and stop adjudication errors concurrently, thereby reducing the amount they would have had to attempt to recover retroactively.

Identifying adjudication errors is important from both a financial standpoint and a bid preparation standpoint. MAOs will need to handle adjudication errors correctly when reporting data in the BPT, populating the financial reconciliation and determining the appropriate experience basis for bid pricing. MAOs should audit their data to identify claims that may be inconsistent with the PBP or provider contracts. Examples of this may include the following:

- **Capitated arrangements.** MAOs may contract with certain vendors under a capitated arrangement. MAOs should validate that the vendor is receiving the correct contracted amount and that they are covering services consistent with the PBP for eligible members only. Additionally, MAOs should confirm that the covered services are being paid only under the specified capitation arrangement and are not additionally being erroneously paid as FFS as well. This is especially important as plan sponsors reshape reimbursement arrangements with their providers, which may require significant modifications to existing claim-processing systems.

- **Member cost sharing.** MAOs should audit their data to confirm that vendors and providers are charging the plan's beneficiaries correct member cost sharing according to the PBP and CMS rules. It is possible for a vendor or provider to charge an erroneous copayment to a member (or no copayment at all), resulting in the MAO over- or underpaying for a benefit. Furthermore, CMS maintains specific cost-sharing limits for certain services, and all services are subject to a maximum effective member cost share of 50 percent of the negotiated reimbursement rate. MAOs should monitor data to ensure compliance with all CMS rules.

- **Benefit coverage.** MAOs should confirm providers and vendors are providing their beneficiaries with the correct coverage for each of their plans. MAOs likely vary their coverage across their product portfolio. As part of a periodic audit, MAOs should validate that each plan is being adjudicated and covered at the correct level for that particular plan.

The earlier plan sponsors detect these issues in emerging experience, the faster they can take corrective action and recoup any amounts owed to them.

Is Claims Experience Reasonable Compared to Internal Expectations?

After gathering, understanding and cleaning the data, the MAO should review experience and compare to what it expected for that book of business. This actual-to-expected comparison will help the MAO understand emerging financial results, identify new adjudication or contracting issues, identify areas of utilization management improvement and set assumptions for the upcoming bid year.

MAOs should perform this actual-to-expected review throughout the year, as well as during the year-end financial statement reporting process. Delaying this experience data review until early spring (when Medicare bids are typically prepared) may result in unexpected outcomes, late changes and avoidable discrepancies. MAOs can prepare for the upcoming bid cycle during the year-end financial statement reporting process by reviewing and reconciling claims, gathering certain settlement items and developing incurred but not reported (IBNR) completion factors.

EXTERNAL CONSIDERATIONS

As part of the MA bid development process, MAOs will also need to address several considerations external to the claims adjudication process. These items may be driven by competitive benchmarks or regulatory influences, including the following.

Is Claims Experience Reasonable Given External Benchmarks?

MAOs should compare their claims experience to both the plan's expected results and external benchmarks. External benchmarks should consider the plan's geographic area, covered benefits, risk score and level of utilization management. Through external benchmarking, the MAO will be able to identify opportunities for improvement and areas where it may be an outlier. It can react to this information by implementing changes or programs that will be reflected in the upcoming bid year.

Is Claims Experience Being Prepared to Comply with CMS Requirements for Bid Pricing?

To expedite bid pricing, MAOs should prepare their claims experience data in compliance with CMS requirements from the beginning. Some common problem areas and solutions are presented here.

- **Nonbenefit expenses.** Payments must be categorized as a nonbenefit expense or a medical claims expense consistent with CMS guidance. MAOs may pay an "administrative fee" to a vendor for adjudicating a certain benefit. The classification of this expense as nonbenefit expense or medical claims expense in the BPT may depend on how the *total* vendor payment is structured. Likewise, an MAO may consider certain internal expenses to be an "administrative expense" rather than a medical claims payment (e.g., for a nursing hotline benefit). The classification of these expenses in the

BPT must be consistent with the classification of these expenses in the PBP.

- **Capitation encounters.** CMS requires encounter data for all services to be incorporated into the BPT, including for those services that are provided under a capitation arrangement. If accurate encounter data are not available, plans are required to disclose the deficiency and develop a corrective action plan for future years.

- **Global payment allocation.** Global payments related to capitation or risk-sharing arrangements are required to be allocated proportionally to the net cost of services covered under the contract for Worksheet 1 reporting. MAOs must ensure appropriate classification of benefits and isolation of different provider contracts in order to accurately complete such an allocation.

MAOs must take care to comply with CMS guidance. This will minimize any potential issues during the desk review and audit processes and will similarly reduce the likelihood of having to resubmit bids to address deficiencies.

CONCLUSION

Collecting, reviewing and reacting to Medicare Advantage claims experience is crucial to the success of the plan. Successful data maintenance involves addressing data quality issues, rectifying adjudication errors, comparing to internal and external benchmarks and making the necessary adjustments to comply with CMS guidelines. Employing these controls will lead to optimal financial results and efficient processes. ■

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