Medicare Advantage Boot Camp for Health Actuaries

Presenters:
Daniel Bailey, FSA, MAAA
Kevin Pedlow, ASA, MAAA, FCA

2017 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
- Significant Accounting Policies – Information Concerning Parents, Subsidiaries & Affiliates (Generally Item #10 or #11)

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 – increased from $32 in previous years)

- Limit is adjusted for Technical and for Payment reasons:
  - Technical – change in OOPC software
  - Payment – changes to county benchmarks or quality bonus percentages

- Essentially a game of competing against yourself (avoiding "bait and switch")

Susquehanna
Actuarial Consulting Inc.

Base Period Medical Reconciliation

Components of Medical Costs

- Medical Claims
- Capitation
- Off-System

Common Off-System Expenses:

- Newsletter,
- Nurse Hotline,
- Part B Rx from PBM,
- etc.

Susquehanna
Actuarial Consulting Inc.

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

Susquehanna
Actuarial Consulting Inc.

Base Period Medical Reconciliation
(continued)

Reconciliations

- Amounts must be followed from bid entries to Financial Statements
- Common to tie GL to FS, then bid items to the 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 or 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
- Related-Party Medical Expenses – Adjustments to bid expenses will created reconciling items

Support for Trend Factors

General Trends

- 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

Combining Plans (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)
- D-SNP plans must be within -5% to +1% 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)

Bid Instructions Definition:

The related-party requirements apply to all MAOs that enter into any type of arrangement with or receive services from an entity that is associated with the MAO by any form of common, privately held ownership, control, or investment. This includes any arrangement where the MAO does business with a related party through one or more unrelated parties.

Review all company Legal Entities (Statutory FS – Schedule Y and Significant Accounting Policies: Concerning Parents, Subsidiaries and Affiliates)

State Waiver for reporting on Schedule Y does not alleviate CMS disclosure

Related-Party Expenses
(Disclosures)

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

Disclosure #2 – Details of agreement

- Declare every related party arrangement
- Disclose all services provided by each arrangement
- Explain the relationship and the common ownership, control or investment
- Summarize the contractual terms, including services and payments
- Disclose the Method used in preparing the bids
- Provide qualitative and quantitative summary for Actual Cost Method
- Show fee associated with the related-party arrangement are within 5% or $2 PMPM ($2 PMPM rule is only for Medical expenses) for Market Comparison Methods
- Provide signed attestation from related-party for Market Comparison Methods that come from the related-party perspective

Related-Party Expenses
(Administrative Services Methods)

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

Method #2 Market Comparison – comparable fees paid by unrelated parties

- from the perspective of the plan sponsor, or
- from the perspective of the related-party

Also,

- comparison contracts with unrelated parties have sufficient cost to be valid contracts
- Fees to related-party is less than the greater of 5% difference from unrelated party

Related-Party Expenses
(Medical Expense Methods)

Method #1 Actual Cost – Consistent with not recognizing the independence of the entity (for medical expense this can be extremely difficult)

Method #2 Market Comparison – comparable fees paid by unrelated parties

- from the perspective of the plan sponsor, or
- from the perspective of the related-party

Also,

- comparison contracts with unrelated parties have sufficient cost to be valid contracts
- Fees to related-party is less than the greater of 5% diff from unrelated party or $2 PMPM

Related-Party Expenses

(Medical Expense Methods - continued)

Method #3 Comparison to FFS – actual fees paid are less than the greater of 5% diff from Medicare FFS or $2 PMPM

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

- Must demonstrate at bid submission that it is not possible to comply with Methods 1, 2 or 3

Medicare as Secondary Payer (MSP)

CMS Direct Subsidies Pay at 17.3%

Instructions provide mathematics and examples for the calculation by evaluating member costs uniquely for MSP and Non-MSP

The use of CY2016 MMRs

- Consistent with base period medical expense
- True MSP membership is better identified (early 2017 MSP identified members have not been fully evaluated by the plan sponsor confirming their status as MSP)