DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244

OFFICE OF THE ACTUARY

To: Medicare Advantage & Prescription Drug Plan Sponsors and Certifying Actuaries

From: Paul Spitalnic, Director, Parts C & D Actuarial Group

Date: November 3, 2008

Subject: Proposed CY2010 MA Bid Pricing Tool Changes regarding Dual Eligible Beneficiaries

Introduction

The MA bid pricing tool (BPT) was originally developed for the 2006 contract year. The tool was designed to capture the plan's revenue requirements, including the benefit cost sharing. The tool was not designed to explicitly recognize the different cost-sharing arrangements for dually eligible beneficiaries (that is, beneficiaries that are eligible for both Medicare and Medicaid[1]). To address these arrangements, CMS provided guidance regarding the development of the Plan Benefit Package (PBP). CMS is proposing that the CY2010 MA BPT be modified to explicitly reflect the reduced cost-sharing levels for dual eligible beneficiaries. The proposed changes would more accurately reflect an MA plan's revenue requirements and eliminate any PBP considerations that were based on the design of the BPT.

Background

Consistent with requirements of SSA 1854(a)(6), the MA bid pricing tool requires a representation of the cost sharing that plan members would be subject to if they were enrolled in the Traditional Part A/B Medicare fee-for-service (FFS) program. The Medicare FFS proportional factors used in the MA BPT for this purpose have been

[1] Per Federal statute, States are required to provide QMBs with full or partial reduction in cost sharing for Medicare covered services. Some States provide the same benefits to a broader category of dual eligibles. As referenced in this paper, the term "full dual eligible" refers to all beneficiaries who are entitled to reductions in Medicare cost sharing as a result of their Medicaid status.

widely accepted by industry, except with regard to their application to dual eligible beneficiaries.

As provided for in SSA Section 1902(n), State Medicaid agencies are required to reduce or eliminate cost sharing on behalf of dual eligible beneficiaries through the State Medicaid Plan. Thus, dual eligible beneficiaries enrolled in Medicare FFS may be exempt from paying cost sharing for Medicare-covered services

Dual eligible beneficiaries enrolled in MA plans may similarly be exempt from paying the plan's cost sharing for most services. In these situations, a provider treating a dual eligible enrollee will either bill the State for the "waived" cost sharing, or will accept the payment from the plan as payment in full. Our understanding is that due to the relative richness of MA reimbursements (versus Medicaid schedules), most of the cost sharing waived on behalf of MA dual eligibles is not reimbursed by the State Medicaid programs.

Also, some States directly pay, or capitate, plan sponsors for some or all of the waived cost sharing and other Medicaid supplemental benefits. Currently, the MA BPT does not reflect the receipt or usage of such state funding. This is an issue to the extent that benefits reflected in the Plan Benefit Package (PBP) overlap with the State Medicaid package. In such cases, these benefits may be funded twice – from the State and through the allocation of MA rebates.

Among the beneficiaries currently enrolled in MA Plans, approximately 15 percent are eligible for both Medicare and Medicaid. A mixture of dual eligible and non-dual eligible beneficiaries exists in all MA plans regardless of plan type or target population. Thus, the MA actuarial projections should accurately reflect the costs of both the dual eligible and non-dual populations. Further, the MA bidding process should appropriately address the benefit and revenue requirements unique to covering dual elgibles, and should not advantage nor disadvantage DE-SNPs relative to general enrollment plans.

The proposed changes to the CY2010 Medicare Advantage bid pricing tool allow for appropriate actuarial representation and transparency of the unique benefits and costs of the dual eligible and non-dual eligible populations. While some structural changes will be required under this bidding approach, the proposed changes should not be overly burdensome to plan sponsors and certifying actuaries. This should also eliminate any misunderstanding of the appropriate means to complete the MA BPT for dual eligible enrollees. In addition, plans will no longer be required to allocate rebates to buy down cost-sharing for dual eligible beneficiaries, as the BPT will recognize when no cost-sharing is required for these beneficiaries.

Proposed changes

Generally, the changes will concentrate on reporting and projecting the allowed cost, cost sharing, and consequential revenue requirement separately for the dual and non-dual eligible populations. A sample BPT including the proposed changes is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/09_Bid_Forms_and_Instructions.asp

(Note the proposed changes are formatted in orange shading.) A summary of the proposed changes is also provided at the end of this memo.

CMS requests that any comments regarding this proposed BPT change be submitted by November 14, 2008 via e-mail to actuarial-bids@cms.hhs.gov. Please use the phrase "Comments on Dual Eligible Pricing" in the e-mail subject line. There will be an actuarial user group call to discuss these changes, and plan actuaries will have the opportunity to ask questions. The call details are as follows:

- Thursday November 6, 2008
- 11:00AM - 12:30PM ET
- Dial-In Number: 1-800-857-3437
- Password: Actuary
- Call Leader: Paul Spitalnic

Summary of proposed BPT changes:

1. Report the base period membership and risk scores separately for the dual eligible and non-dual eligible populations. (worksheet 1)
2. Add an input column to the existing projection of allowed costs to identify the projected costs attributable to the non-dual population. (worksheet 2)
3. The actuarially equivalent cost sharing will only be calculated for the non-dual population. (worksheet 4)
4. The allowed cost calculation will be calculated for the non-dual and dual populations separately, and then combined to represent the aggregate plan bid. (worksheet 4)
5. Add a section for reporting of revenues from the State and supplemental Medicaid required benefits. (worksheet 4)
6. Add a section to reflect the projected member months, standardized A/B Benchmark, Medicare secondary payer (MSP) adjustment, weighted average risk factor, post MSP risk factor, Plan A/B benchmark, Plan A/B bid, and standardized bid for dual and non dual eligible beneficiaries separately. (worksheet 5)

   Note that only the projected member months and projected risk factor will be input items. The other items are calculated fields.