Funding Fundamentals

Milliman

Basics of Medicare Advantage Revenue

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Agenda

- Part C revenue
- Low-income member considerations
- Part D revenue
- Part D settlement
- Risk adjustment basics

Presenters

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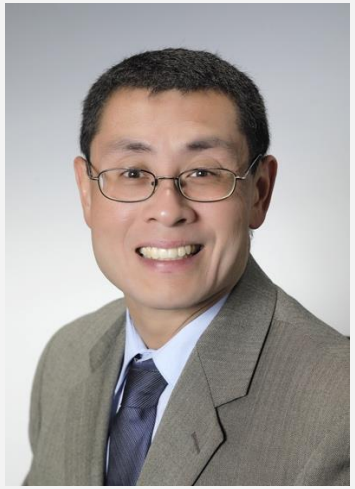

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Funding fundamentals:

Part C

Sources of funding for Part C

Medical and supplemental benefits

CMS benchmarks

- Main source of revenue
- Funds Medicare-covered medicals costs at standard Medicare cost sharing
- Funds reduced cost sharing below standard Medicare*
- Funds supplemental benefits *
- Can also be used to fund members Part D premium *
- Benchmarks are set at the county level
- Risk adjusted
- Quality component
- Rate announcement is released early in April each year

* Funding reduced by savings percentage tied to Stars

Member premiums or cost sharing

- Plans can charge members a monthly premium
  - Many plans with $0 member premium
  - Buy down Part D premium as well
  - Must charge all members same premium
- Cost sharing reduces plan liability for medical benefits
  - Typically collected by providers

Medicaid funding

- Members must be dual eligible for Medicare and Medicaid
- Medicaid pays or waives all cost sharing
  - Typically collected by providers
  - Most states have a “lesser of” policy
- Funds services not covered by Medicare
- Funds additional supplemental benefits
- Both D-SNP and general enrollment plans

CMS benchmarks

Part C benchmark calculation

Benchmark =

(FFS Costs excluding IME) * (Quartile % + Bonus %)

Quartile	Percentage of FFS costs
Highest cost quartile	95% of FFS costs
Second-highest cost quartile	100% of FFS costs
Third-highest cost quartile	107.5% of FFS costs
Lowest cost quartile	115% of FFS costs

County benchmarks

Ranking

Re-ranked annually

- Counties that change quartiles are transitioned for one year
  - Straight average of previous year multiplier and current year multiplier

Bonus percentage

Plans with 4.0 stars and above will receive 5% bonus (subject to caps)

- 10% for double bonus counties
  - Urban counties with high Medicare Advantage enrollment and high star ratings
- 3.5% for new and low enrollment contracts

Revenue and payment

- As of 2015, revenue (including quality bonus) cannot exceed benchmark under pre-ACA methodology
- Any potential reversals of the ACA or changes to the program may impact MA payment rates

Part C Bid – Revenue calculation

Benchmark for 3.5 Star Plan	$1,000	A
Projected plan risk score	1.100	B
Risk adjusted benchmark	$1,100	C = A * B
Bid: Projected plan costs for traditional Medicare @ 1.1 risk score	$950	D
Savings	$150	E = C - D
Rebate percentage for 3.5 Star Plan	65%	F
Rebates	$98	G = E * F
Plan revenue	$1,048	H = G + D

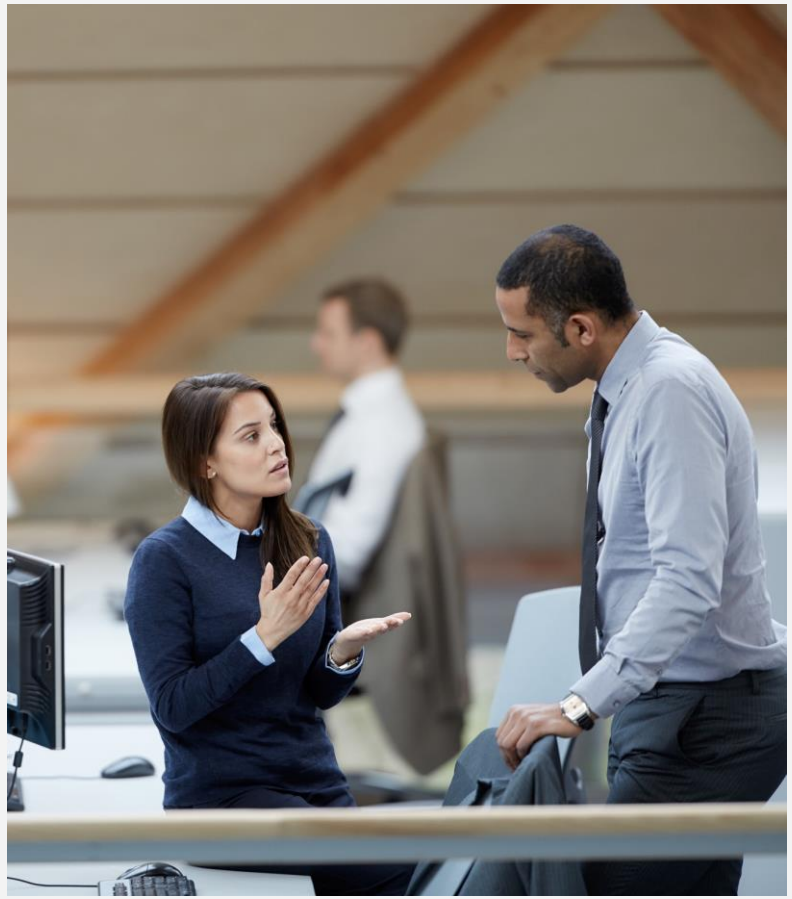
Savings and rebates

Share y% of savings with plan, CMS retains 1-y%

- Savings % depends on quality star rating
  - 4.5 or 5.0 = 70%
  - New, low enrollment, 3.5, or 4.0 = 65%
  - 3.0 or lower = 50%
- Plan must spend savings

Savings or rebate can be used to:

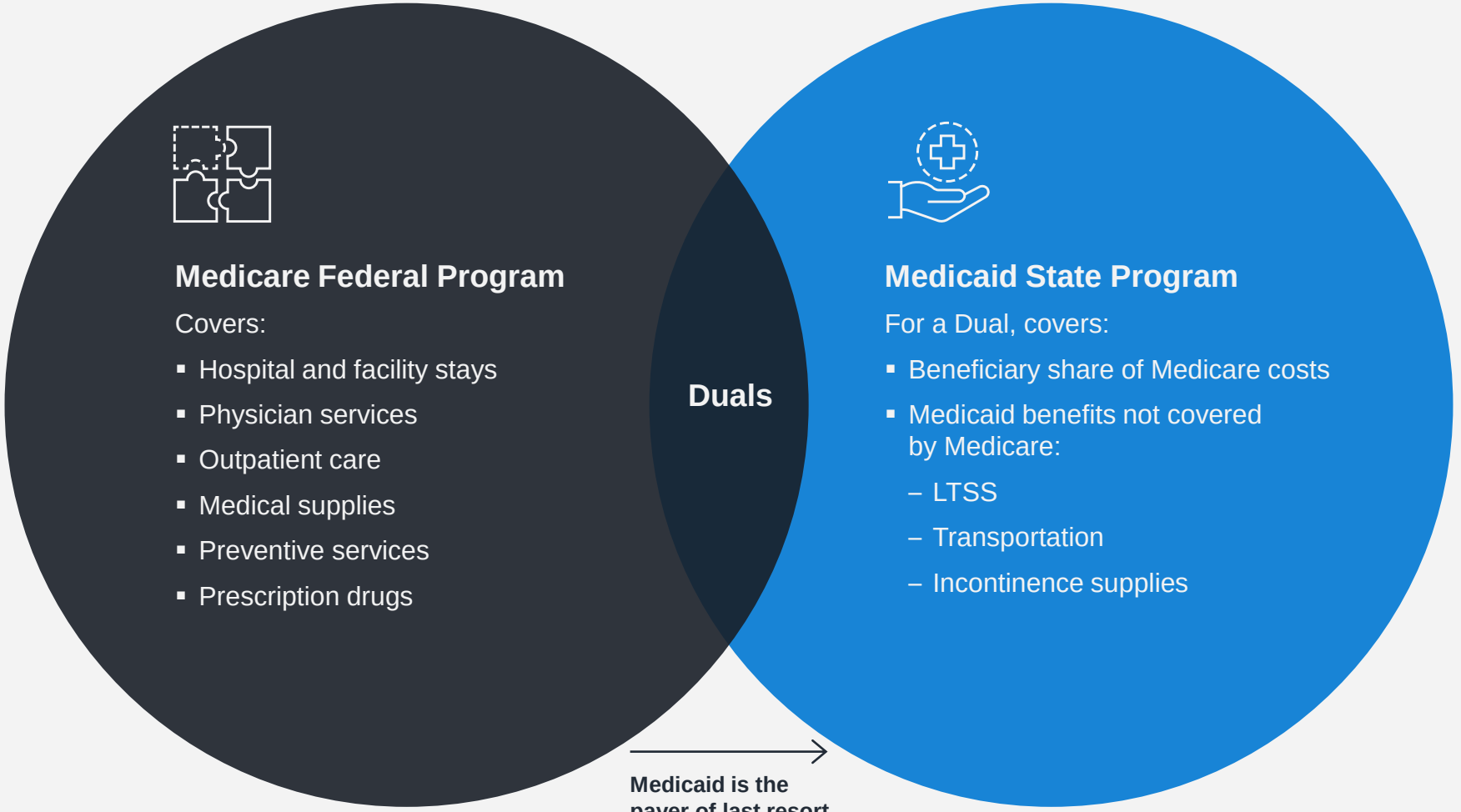
- Reduce cost sharing
- Pay for supplemental benefits
- Lower Part D member premium
- Lower member Part B premium
- All rebates must be used



Medicare & Medicaid

Eligibility:

- 65 and over
- Younger people with disabilities
- End-stage renal disease (ESRD)



Eligibility:

- Low income
- Aged
- Disabled
- Blind
- Pregnant
- Responsible for a child <21 y.o.
- Benefits and eligibility vary by state

Low Income Premium Subsidy Amount (LIPSA)

CMS subsidizes the monthly member premium

- LI members pay the difference between actual premium and LIPSA
- Important for D-SNPs and other plans targeting low-income membership to target LIPSA for premium
  - From a member's perspective the plan has $0 premium

Subsidizes basic member premium only

Calculation of LIPSA	
Member income	**Premium subsidy percentage**
<=135% FPL	100%
>135% and <= 140% FPL	75%
>140% FPL and <= 145% FPL	50%
>145 FPL and <150% FPL	25%
>=150% FPL (NLI)	0%

Low Income Benchmarks (LIBs)

- **Low Income Premium Subsidy Amount** (LIPSA) reflects what CMS subsidizes for low-income members
  - – LIBs may refer to bid amounts or premium amounts
  - – LIB Bid amount = LIPSA + Direct Subsidy at 1.0
- LIBs reflect the **weighted average basic bid** or **premium** in each region
  - – Like national average, unknown at initial bid submission
  - – Plans must estimate this amount as part of initial submission
  - – Usually published in late July / early August
  - – Weighted based on LI members, including SNPs and PDPs
- 34 PD regions cover 50 states + 5 PD regions for US territories

2023 Low Income Premium Subsidy amounts

Region	State(s)	Subsidy
1	NH, ME	31.10
2	CT, MA, RI, VT	36.27
3	NY	38.90
4	NJ	35.02
5	DE, DC, MD	39.22
6	PA, WV	41.08
7	VA	34.55
8	NC	38.38
9	SC	37.84
10	GA	37.30
11	FL	35.92
12	AL, TN	35.16
13	MI	32.65
14	OH	34.71
15	IN, KY	28.11
16	WI	43.10
17	IL	27.35

Funding fundamentals:

Part D

Part D benefit design – 2022 and 2023

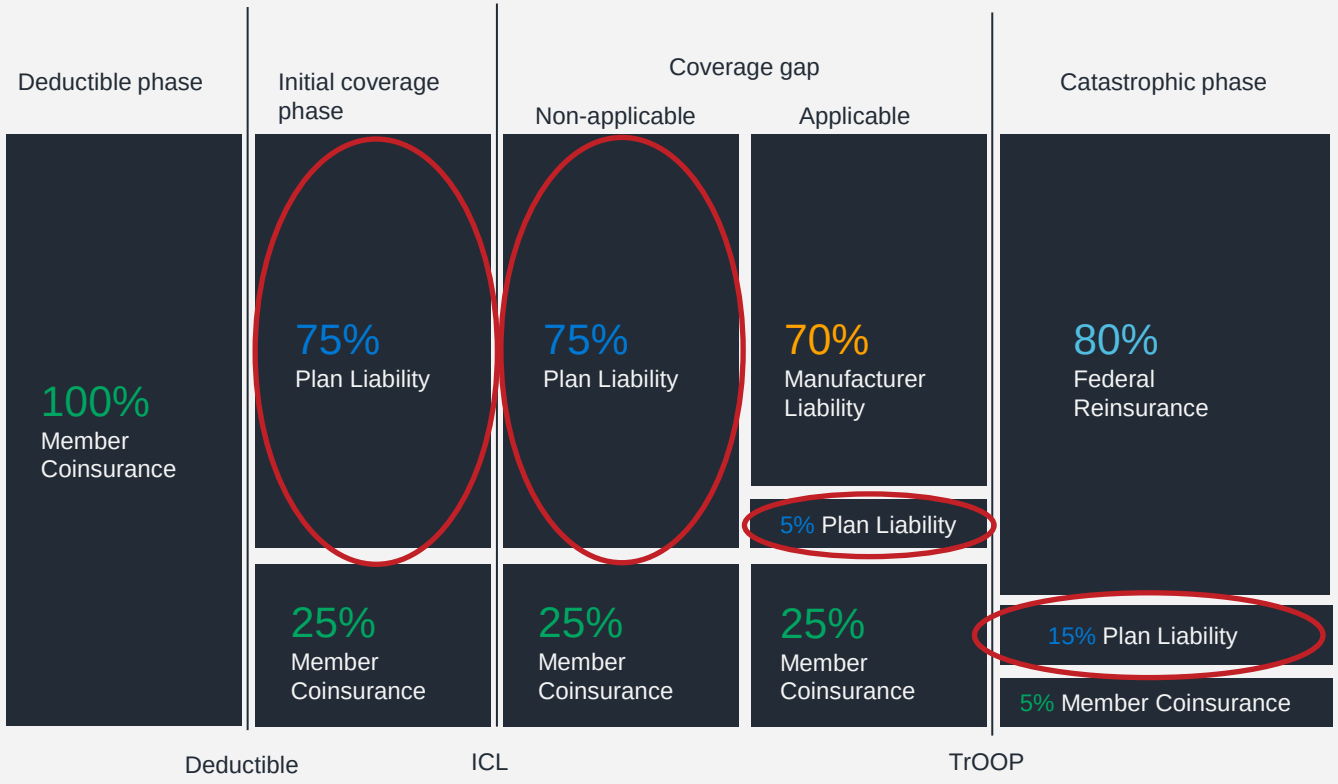
Total required revenue = net liability (for basic benefit) + administrative cost + required margin

Members

Pharma Manufacturers

Plan Sponsors

Federal Government



Note: Non-LI members only. LI members receive LI cost sharing subsidy (LICS) from CMS for remainder of expected cost sharing above nominal copays.

Part D revenue basics

Bid calculations

Total required revenue = net liability (for basic benefit) + administrative cost + required margin

- Also known as the bid amount

Total required revenue = direct subsidy + basic member premium

- **Basic member premium** = bid at 1.0 – direct subsidy at 1.0
  - Subsidized for LI members
- **Direct subsidy:** Paid by CMS to MAO, adjusted for risk score

Total member premium = basic premium + supplemental premium

- **Supplemental premium** is only for enhanced plans

Part D revenue basics

Actual revenue received

Risk-adjusted direct subsidy

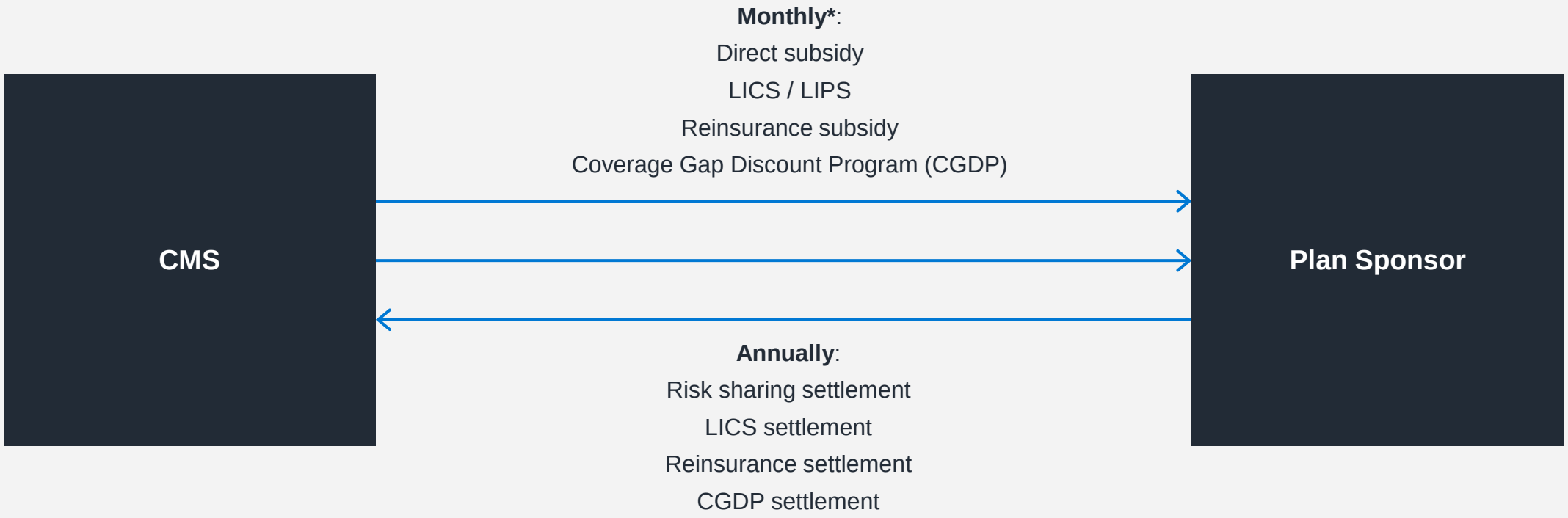
- = Basic bid at risk score – basic member premium
- = (Risk score * basic bid at 1.0) – basic member premium
- Amount is plan-specific and varies based on actual risk score

Member premium

- Basic member premium = basic bid at 1.0 – direct subsidy at 1.0
- Supplemental member premium if Enhanced Alternative plan
  - *No subsidy or risk corridors available for supplemental benefits*
- Can be partially or fully bought down by Part C rebates on MAPD plans
- Same for all plan members regardless of Part D risk score

Part D revenue basics

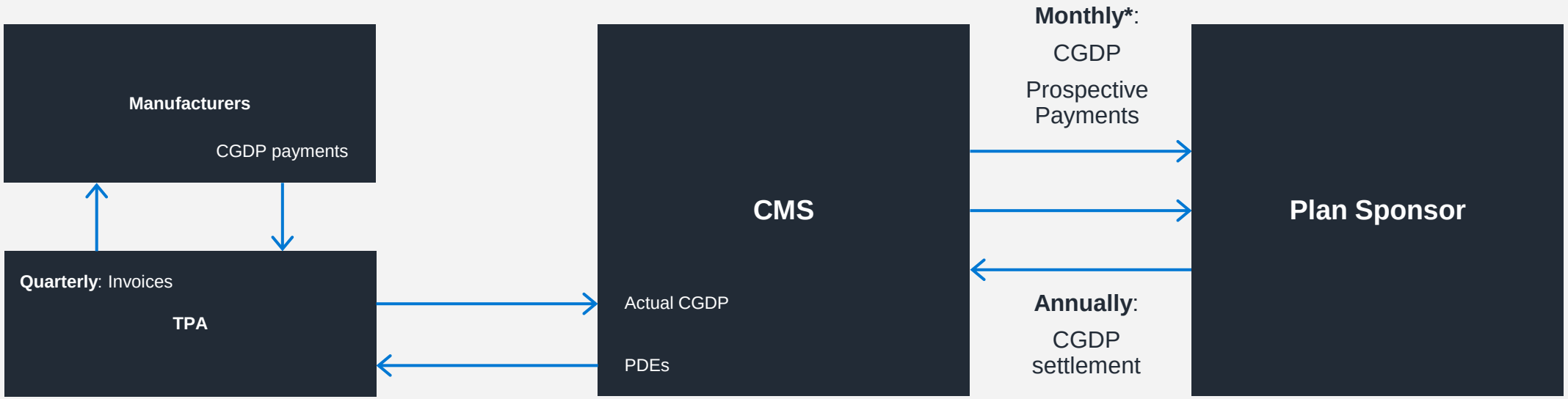
Revenue dynamics



*Estimated in bid, prospective payments

Part D revenue basics

Revenue dynamics



Source: https://www.tpadministrator.com/internet/tpaw3_files.nsf/F/TPASponsor_CGDP_Onboarding_Training_112022_v3.pdf/$FILE/Sponsor_CGDP_Onboarding_Training_112022_v3.pdf

Funding fundamentals:

Part D settlements

Part D settlement components

Reinsurance

- Subsidy estimated in the bid
  - Reinsurance in catastrophic phase less reinsurance DIR
- Subsidy paid to MAO each month
- Actual reinsurance calculated at year end
- Difference settled with CMS

LICS

Risk sharing

CGDP

Part D settlement components

Reinsurance – Settlement calculation

Reinsurance settlement = actual reinsurance – reinsurance subsidy revenue

- Actual reinsurance = allowable reinsurance costs x 0.80
- Allowable reinsurance costs = GDCA – reinsurance DIR
- Reinsurance DIR = DIR for covered drugs* x [GDCA / (GDCB + GDCA)]

Negative settlement = amount MAO owes back to CMS

Positive settlement = amount CMS owes to MAO

GDCB = Gross drug cost below out-of-pocket threshold
GDCA = Gross drug cost above out-of-pocket threshold
*DIR on Part D covered drugs. Excludes DIR on non-Part D drugs.

Part D settlement components

Reinsurance

- Subsidy estimated in the bid
  - Reinsurance in catastrophic phase less reinsurance DIR
- Subsidy paid to MAO each month
- Actual reinsurance calculated at year end
- Difference settled with CMS

LICS

- Low-income cost sharing subsidy
- Subsidy estimated in the bid
- Subsidy paid to MAO each month
- Actual LICS calculated at year end
- Difference settled with CMS

Risk sharing

CGDP

Part D settlement components

Low-income Cost Sharing Subsidy (LICS) – Settlement calculation

LICS settlement = LICS amounts from PDE – LICS revenue

- Inflation Reduction Act: Beginning January 1, 2024, partial subsidy eliminated, transitioned to full subsidy
  - Beneficiaries between 135% and 150% FPL now eligible for full subsidy (larger LICS)

Negative settlement = amount MAO owes back to CMS

Positive settlement = amount CMS owes to MAO

Part D settlement components

Reinsurance

- Subsidy estimated in the bid
  - Reinsurance in catastrophic phase less reinsurance DIR
- Subsidy paid to MAO each month
- Actual reinsurance calculated at year end
- Difference settled with CMS

LICS

- Low-income cost sharing subsidy
- Subsidy estimated in the bid
- Subsidy paid to MAO each month
- Actual LICS calculated at year end
- Difference settled with CMS

Risk sharing

- Also known as “risk corridor”
- When actual costs differ materially from bid projections
- Actual costs calculated at year end
- Amount settled with CMS

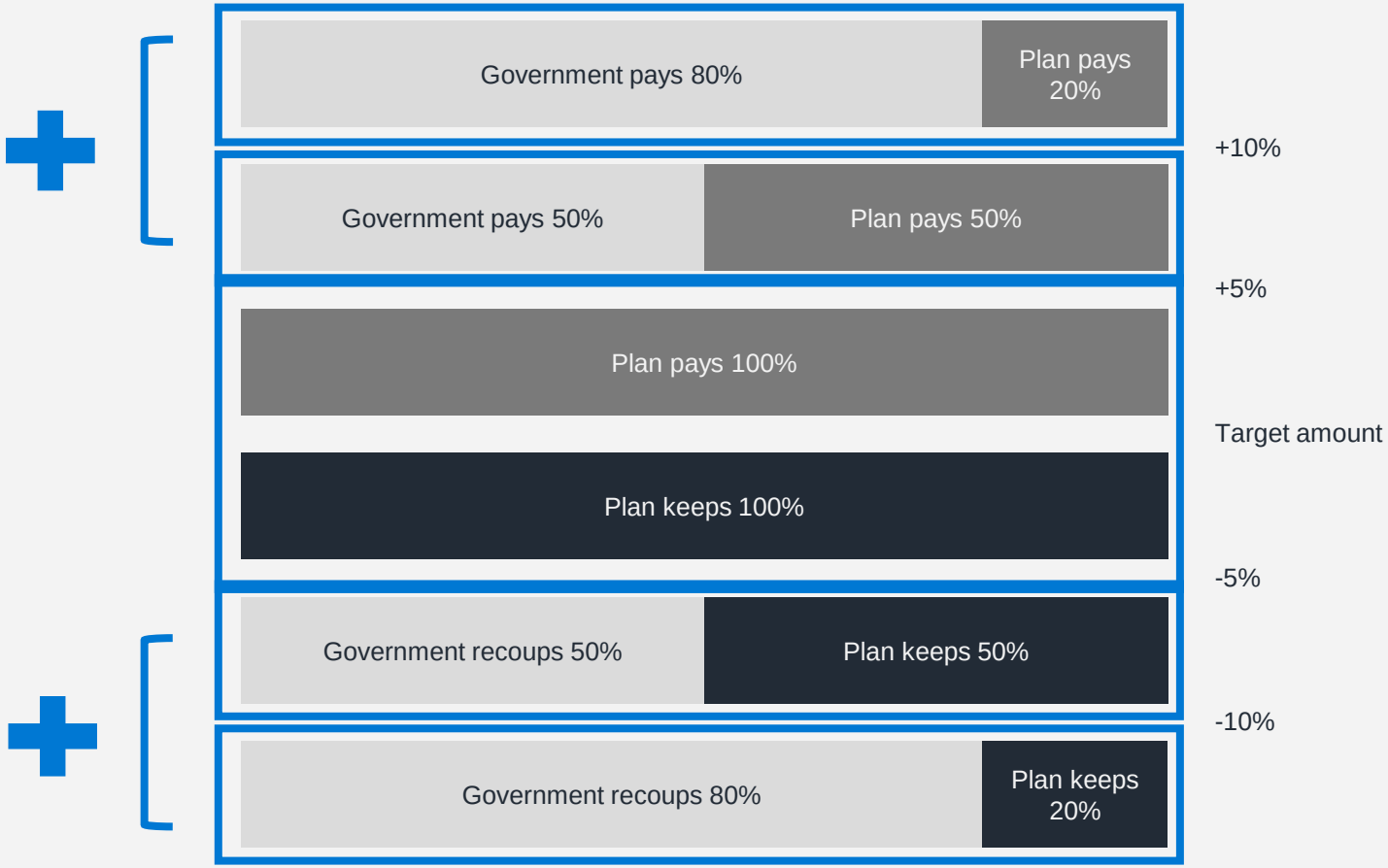
CGDP

Risk sharing

Settlement calculation

Risk sharing settlement based on allowable costs compared to target amount

- Within 5%: No payment
- Over 5% and under 10%: Sharing 50% / 50%
- Over 10%: Sharing 80% CMS / 20% MAO
  - Includes 50% sharing over 5% and under 10%



Source: https://www.medpac.gov/explainer-risk-sharing-mechanisms-in-part-d/#:~:text=Part%20D%20uses%20symmetric%20RISK,what%20the%20plan%20sponsor%20bid.

Part D settlement components

Risk sharing – Settlement calculation

Risk sharing settlement based on allowable costs compared to target amount

Target amount = (total direct subsidy payments + total basic premium) x (1 - administrative cost ratio from bid)

- Basic premium includes Part C rebate buy downs, low-income premium subsidies
- Administrative cost ratio = (total non-pharmacy expense + gain / loss) / total basic bid

Adjusted allowable risk corridor costs (AARCC) = (total CPP – reinsurance payments – DIR*) / induced utilization ratio from bid

CPP = Covered Part D plan paid amount, or net amount the plan paid for standard Part D benefits (if the plan is a standard Part D plan or an enhanced plan) or for basic alternative or actuarial equivalent benefits
*DIR on Part D covered drugs. Excludes DIR on non-Part D drugs.

Part D settlement components

Reinsurance

- Subsidy estimated in the bid
  - Reinsurance in catastrophic phase less reinsurance DIR
- Subsidy paid to MAO each month
- Actual reinsurance calculated at year end
- Difference settled with CMS

LICS

- Low-income cost sharing subsidy
- Subsidy estimated in the bid
- Subsidy paid to MAO each month
- Actual LICS calculated at year end
- Difference settled with CMS

Risk sharing

- Also known as “risk corridor”
- When actual costs differ materially from bid projections
- Actual costs calculated at year end
- Amount settled with CMS

CGDP

- Coverage gap discount program
- Payments estimated in the bid
- Prospectively paid to MAO each month
- Actual CGDP calculated at year end
- Difference settled with CMS

Part D settlement components

Coverage Gap Discount Program (CGDP) – Settlement calculation

CGDP settlement = CGDP amounts from PDE – CGDP revenue from MMR

- Inflation Reduction Act: Beginning January 1, 2025, CGDP eliminated
  - Replaced by Manufacturer Discount Program (MDP)

Negative settlement = amount MAO owes back to CMS

Positive settlement = amount CMS owes to MAO

Inflation Reduction Act Subsidy Amount (IRASA)

Expected settlement

For 2023 only

- Temporary retrospective subsidy
- For reduced cost sharing and deductibles for vaccines and insulins when not included in 2023 bids

Source: https://www.cms.gov/files/document/irasapdeguidance508g.pdf
ACIP = Advisory Committee on Immunization Practices

- Memo released by CMS on September 26, 2022
- IRASA defined as the “difference between the beneficiary cost sharing for the covered insulin, or ACIP-recommended vaccine, under the plan’s 2023 benefit design, and the applicable statutory maximum cost sharing ($35 for insulins and $0 for vaccines).”
- Examples of IRASA calculations included in memo

Funding fundamentals:

Risk adjustment

Risk score basics

CMS-HCC models

- New enrollee
  - Applies to members with less than 12 months of Part B enrollment during the diagnosis collection period
  - Factor based only on age / gender / Medicaid / originally disabled status
- Community
  - Applies to majority of Medicare Advantage members
  - Also includes Hierarchical Condition Categories (HCCs)
- Institutional (Same as Community model, but different coefficients)
  - Also includes Hierarchical Condition Categories (HCCs)
- ESRD / Graft
  - Similar to Community, but with different set of HCCs and coefficients

Calculation components

- CMS-HCC models
  - Demographics (age/gender/originally disabled)
  - HCCs including interactions
- FFS normalization
  - CMS adjustment to normalize total risk scores to 1.00
  - Varies by year and model
- MA coding pattern adjustment
  - Part C only
  - CMS adjustment to account for coding improvement over time
  - Varies by year (maybe)

Risk score basics

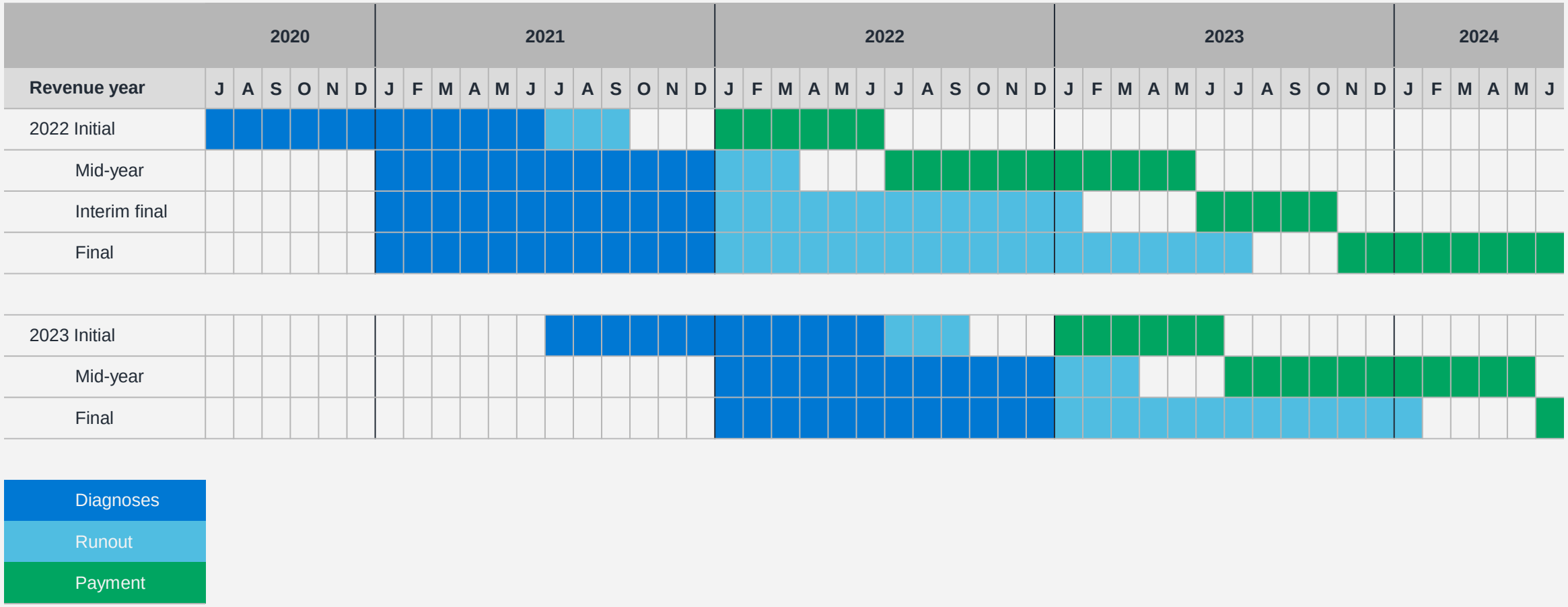
Medicare Advantage Risk Scores Are NOT ACA Risk Scores

Differences

- Prospective (diagnoses from the prior year are used to calculate risk scores in the current year)
- Condition categories more appropriate for Medicare population
- Risk scores directly affect payments to insurers (no transfer calculation)
- Payment is from government to insurers and not between insurers

Timing

When do I get paid?



Sample calculation

Raw

D.B.

Stats

- Female, 67 years old
- Aged in
- Not eligible for Medicaid

Diagnoses

- HCC001 (1/7/2022)
- HCC085 (5/9/2022)
- HCC001 (5/9/2022)
- HCC018 (5/9/2022)
- HCC019 (8/12/2022)
- HCC017 (12/4/2022)

Raw risk score

Calculation

Demographic coefficients

- 0.323

HCC coefficients

- 0.335
- 0.331
- n/a
- ~~0.302~~
- n/a
- 0.302
- 1.291

Sample calculation

Final

D.B.

Stats

- Female, 67 years old, Aged in, Not eligible for Medicaid

Diagnoses

- HCC001 (1/7/2022)
- HCC085 (5/9/2022)
- HCC001 (5/9/2022)
- HCC018 (5/9/2022)
- HCC019 (8/12/2022)
- HCC017 (12/4/2022)

Raw risk score

Other factors

- Normalization
- Coding Pattern Adjustment

Final risk score

Calculation

Demographic coefficients

- 0.323

HCC coefficients

- 0.335
- 0.331
- n/a
- ~~0.302~~
- n/a
- 0.302

= 0.323 + 0.335 + 0.331 + 0.302 = 1.291

Other factors

- 1.127
- 5.90%

= 1.291 / 1.127 * (1 – 5.90%) = 1.078

Bid risk score projection components

- Plan specific coding trend
  - Revenue only
- Population change
  - Should include a corresponding claims adjustment
- Expected CMS-HCC model changes

Sample calculation – The bid picture

Real world calculation

Bid calculation*			Actual calculation*		
1.0 Benchmark (from bid)	$1,000.00	A	Actual risk score	1.050	A
Risk Score (from bid)	1.020	B	1.0 bid	$600.00	B
Risk Adj Benchmark	$1,020.00	C = A x B	County ISAR (from bid)	1.02	C
			Risk revenue	$642.60	D = A x B x C
Bid	$612.00	D			
1.0 Bid	$600.00	E = D / B			
Savings	$408.00	F = C - D			
Rebate	$265.20	G = F * Rebate %			

* excludes MSP and sequestration

Sample calculation

What do I get paid?

Plan level payments

- January risk score as of January payment: 1.00
- January risk revenue PMPM as of January payment: $600.00
- Calculated risk score after “mid-year” update based on actual diagnoses: 1.03
- Accrual for January due to “mid-year” update: $18.00 PMPM (0.03 * $600 PMPM)
- Historical increase in risk scores due to “final” update: 2%
- Estimated final risk score: 1.03 * 1.02 = 1.0506
- Accrual for January due to “final” update: $12.36 PMPM (0.0206 * $600 PMPM)
- Total accrual if including “mid-year” and “final”: $30.36 PMPM

Other Part C revenue sources

- **Rebates allocated to MA**
- **Member premiums**
  - NOT risk adjusted

What's the big deal anyway?

Why this is all important, and how you can stay ahead of the game

Why this is important

- Re-sets every year
- Maintain competitive position
- Benefits
- Profitability

What you can do

- Monitor risk scores
- Concurrent review
  - "real time" review of members
- Retrospective review
  - Use historical medical and drug data to identify "suspects"
  - Identify dropped diagnoses (esp. chronic conditions)
  - Provider review

Methods for diagnosis collection

- Claims
- Chart reviews
- Home visits
- Health risk assessment forms

Q&A

Caveats, limitations, and qualifications

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