MILLIMAN WHITE PAPER

What health plans need to know about Medicare Advantage financial reconciliation

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Health plans must reconcile their Bid Pricing Tool (BPT) values against auditable material such as corporate financials or bid-level operational detail[1]. This paper discusses key considerations that can factor into this required reconciliation for Medicare Advantage (MA) and Medicare Part D (PD) plans filing bids with the Centers for Medicare and Medicaid Services (CMS).

When plans file their bids with CMS, they must enter values into their BPTs to support their financial projections. Among these values are reporting lines for their base period experience. It is easy to come into the financial reconciliation process expecting the values in a health plan's financials to naturally match the values in its BPTs, making the reconciliation a mere formality.

However, in practice it is typical for a plan's BPT values and financials to differ, sometimes substantially. Indeed, CMS's requirements take variation into account; as they state in their BPT instructions, BPT data "must reconcile in an auditable manner to the MAO's audited financial statements." This is not a demand for an exact match, but rather is a demand for evidence that differences between financials and BPT values are explainable and appropriate. Or to put it another way, CMS wants to see close matches between the financials and BPTs, after applying adjustments for known and appropriate differences.

Drivers of variation between financials and BPT values

There are many possible drivers of such differences between financials and BPT values. One common driver is claims completion, where runout and availability of supplemental data can vary between the time that financials are estimated and the time when relevant data for bid submission is provided.

For instance, claims runout will nearly always vary from what was estimated in the financials; accruals for incurred but not paid (IBNP) claims are, after all, estimates. In some cases, retroactive changes in membership can also impact capitation rates paid to providers. For example, subsequent Monthly Membership Report (MMR) files can add or subtract members and/or change the risk scores; this will then add or subtract plan revenue, which aligns with MMR data. Plans can also see bid impacts from the beneficiary-level files released by CMS (typically in April), if they base bid values on beneficiary-level file data instead of MMR data.

Structural differences between bid and financial data

Different plans can have different financial documents and different underlying data. Consider the example of two plans ("Plan A" and "Plan B") which have identical claims experience, membership data, and cash flows. However, the two plans organize their financials substantially differently.

In this case, Plan A's financials are primarily organized on an accrual / incurred basis, and Plan B's financials are primarily organized on a cash flow / paid basis. Even though their claims experience is the same, the relevant calculations and cited values in the plan financials (as well as those documented in the financial reconciliation) may look substantially different. Please note that for simplicity, the below example assumes that financials were filed as of December 2020.

FIGURE 1: RUNOUT EXAMPLE

	Plan A	Plan B
Claims Paid in 2020	n/a	$10,500,000
Claims Paid in 2020 for Earlier Dates	n/a	$1,500,000
Claims Paid and Incurred in 2020	$9,000,000	$9,000,000
Estimated Runout	$1,000,000	$1,000,000
Estimated Incurred	$10,000,000	$10,000,000

[1] Final CMS BPT Instructions can be downloaded from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Forms-Instructions

Note that Plan B's actual financials may be more complex than our example represents. For instance, if Plan B instead displayed monthly values of paid amounts along with a monthly value for change in outstanding claims to be paid, additional work would be needed to calculate the correct $1,000,000 total runout for 2020 claims value in the figure above.

Capitations and other risk-sharing values can also have material impacts on financials. We discuss those in later sections of the paper.

Impact of runout and completion

As noted previously, it is common for claims runout to drive differences between financials and BPT values. Consider Figure 2 below.

As Figure 2 shows, by April, there is much less completion remaining as compared to when the financials were set in January. While a 6% difference due to changes in runout and estimated completion may be larger than typically expected, it remains normal to see differences due to runout, sometimes even material differences. Explicitly accounting for these differences allows CMS and its reviewers to validate that BPT values are appropriate despite the large difference from the original financials.

Impact of paid date tracking in claims data

In addition to understanding how changes in runout and completion can shift values in the reconciliation, it is important to ensure that claims are handled consistently between the financials and the BPTs.

Consider a similar situation to the one described above: the numbers in Figure 3 appear to be the same as in Figure 2. However, this time a single $600,000 claim, originally paid in October 2020, was restated as being paid in February 2021 (perhaps due to a reversal and subsequent reinstatement).

FIGURE 2: RUNOUT EXAMPLE

	Financial Estimate	BPT Values
Claims Paid Through	January 2021	April 2021
Net Claims Paid	$9,000,000	$10,500,000
Estimated Completion	$1,000,000	$100,000
Estimated Incurred	$10,000,000	$10,600,000
Percent Difference From Financials	n/a	+6%
Estimated Claims Paid After January 2021	$1,000,000	$1,600,000
Adjustment to Financials to Match BPT Values	$600,000	n/a
Final Values to Reconcile	$10,600,000	$10,600,000
Remaining Difference From Financials	n/a	+0%

FIGURE 3: PAID DATE TRACKING EXAMPLE

	Financial Estimate (apparent)	BPT Values (apparent)	Financial Estimate (correct)	BPT Values (correct)
Claims Paid Through	Jan-21	Apr-21	Jan-21	Apr-21
Net Claims Paid	$9,000,000	$10,500,000	$9,000,000	$10,500,000
Estimated Completion	$1,000,000	$100,000	$1,000,000	$100,000
Estimated Incurred	$10,000,000	$10,600,000	$10,000,000	$10,600,000
Percent Difference From Financials	n/a	6%	n/a	6%
Estimated Claims Paid After January 2021	$1,000,000	$1,600,000	$1,000,000	$1,000,000
Adjustment to Financials to Match BPT Values	$600,000	n/a	$0	n/a
Final Values to Reconcile	$10,600,000	$10,600,000	$10,000,000	$10,600,000
Remaining Difference From Financials	n/a	0%	n/a	6%

Note the parallels between Figures 2 and 3; in Figure 2, adjusting the data due to apparent runout differences correctly aligns the claims and financials. In Figure 3, however, following the same approach also aligns the claims and financials, but it should not actually do so. Once the reconciliation is properly adjusted to reflect the $600,000 claim moving paid dates from 2020 to 2021, it is clear the 2020 claims data in the BPT reflects an extra $600,000 of claims paid through January 2021 as compared to the financials. Further work is required to explain this difference.

It may not be common to see restatements of this scale, but it is not unusual for claims files to reflect some shifts in paid dates between the claims costs used in the financials and the claims costs used in the BPTs. It is important to identify whether material paid date restatements exist, and whether they materially affect the reconciliation.

Differences in definitions of claims and membership

Plan financials are often presented on a different basis than the values reported in BPT files. For example, plan financials may incorporate certain items as medical expenses that CMS mandates be treated as non-benefit expenses. Reinsurance recoveries, quality improvement expenses, and other similar items must be counted as non-benefit expenses in bid preparation and reporting.

Another common difference is end-stage renal disease (ESRD) and hospice beneficiaries. CMS requires plans to create bids for Part C focusing on the non-ESRD, non-hospice (NENH) population. Worksheet 1 requires plans to report total values for both the NENH population as well as the ESRD and hospice populations, but as plans typically focus on the NENH data, it is important to ensure that the ESRD and hospice data do not cause material differences.

Adjustments to underlying claims data for capitation, completion, and supplemental benefits should be handled appropriately on the ESRD and hospice populations as well, particularly because plan financials will not likely split out ESRD and hospice. For instance, a capitation across all members should be counted for ESRD and hospice members, while a capitation that excludes these members should not be counted.

Other types of differences can exist as well. During claims processing and grouping, some claims may be dropped due to various reasons such as: lacking associated member IDs; having invalid dates, procedure, or diagnosis codes; or having invalid dollar amounts (e.g., claims without billed amounts).

Claims may also be adjusted when the allowed amount does not tie to the paid amount plus member cost sharing (plus coordination of benefits amounts where relevant); such adjustments, where they exist, may differ from financial data.

If any of these above issues drive differences between financials and BPT values, appropriate adjustments should be identified, estimated, and explained. If such differences persist over multiple years (particularly if they are material) then it may make sense to evaluate whether changes should be made to either the financials or the bid calculations.

Impact of Part B Rx

It is typical for some or all of a plan's Part B Rx claims to be reflected in a plan's financials as Part D or "drug" or "pharmacy" expenses. such instances could simply be the Part B Rx expenses from pharmacies or an additional portion of Part B Rx claims.

If the plan's financials include such costs under Part D rather than Part B, an adjustment must be made to the financials to reduce Part D and increase Part B claims to match what is reflected in the BPTs.

It is also important to adjust appropriately for the portion of rebates that affect Part B drugs. If plan financials do not break out rebates between B and D, the values from the financials must be adjusted to treat rebates consistently with the bids. Note also that rebates may be subject to runout differences between financials and bid values, much like incurred medical claims data.

Impact of CMS settlements

CMS provides annual Part D settlements for federal reinsurance subsidy, low-income cost sharing (LICS) subsidy, the Coverage Gap Discount Program (CGDP), and Part D risk sharing (also known as the "risk corridor"). It is important to understand how these settlements are reflected in the plan's financials.

Two particularly important considerations are risk corridors and prior year settlements:

RISK CORRIDORS

CMS guidance states that risk corridor payments (whether actual or accrued) should not be counted in the BPTs. This means any such payments or accruals must be backed out of the financials in the reconciliation.

Accruals for CMS settlements for reinsurance, LICS, and CGDP may be appropriate to include in the bid values, so long as they are reflected consistently with the CMS calculations in the BPTs. Note that final settlements for the base period will not be known as of bid submission, so some form of estimate or accrual will be necessary.

PRIOR YEAR SETTLEMENTS

A plan's annual financial statements are typically finalized and filed in the first few months of the subsequent year, well before CMS issues the final Part D settlement for that plan year (typically in the fall of the subsequent year). If the plan's final 2019 settlement (paid in fall of 2020) differs from the originally estimated accrual for that settlement, the 2020 financials may include this difference as an additional revenue or expense item (or both).

Any such items included in the 2020 financials are not truly incurred in 2020 and should be properly adjusted out of the financials during the reconciliation process.

The 2020 financials could also reflect the full value of 2019 reconciliations. For instance, a plan might do this if they are using cash flow statements in their provided financial values instead of income statements or accruals. In that case, appropriate adjustments should be made to back out the 2019 values and add in appropriate accruals for the 2020 values (except that, as noted above, risk corridor settlements should be excluded from the BPT values and reconciliations).

CMS related party rules

On October 30, 2020, CMS released Part 2 of the CY2022 Advance Notice.[2] They subsequently released additional guidance as part of the agenda for a November 12, 2020 actuarial user group call.[3] Among the items discussed was consideration of substantially changing the related party bid process for the CY2023 bid cycle. The discussed changes could have material impacts on future bid cycle processes.

For CY2022, however, the related party requirements should be substantially the same as in recent years, as they relate to the financial reconciliation process. It is therefore important to appropriately handle related party issues where applicable, including in financial reconciliations. Depending on the nature of such arrangements, this could materially change the reconciliation process or have essentially no impact.

CMS requires plans to document and price all related party arrangements in one of four allowable methods (Method 3 and Method 4 are only applicable to Part C benefit expenses). Depending on which method is used, plans may be required to adjust their BPT and Financial values to match the requirements of the selected method. We illustrate these adjustments by method in Figure 4.

FIGURE 4: RELATED PARTY ADJUSTMENTS

	Adjustments to Expenses in BPTs	Adjustments to Financials
Method 1 Actual Cost	Change to match actual related party expenses	Consistent with BPT
Method 2 Market Comparison	None	None
Method 3 Comparable to FFS	None	None
Method 4 FFS Proxy	Change to 100% FFS	Consistent with BPT

For example, a plan using Method 2 (Market Comparison) for related party testing treats its related parties equivalently to unrelated parties. As such, CMS allows the plan to file without needing to adjust its projections or reconciliations for the existence of a related party. Similarly, a plan using Method 3 for Part C claims—Comparable to Fee-for-Service (FFS)—can also avoid such adjustments to its financials.

The other two methods, however, can have different requirements. A plan using Method 1 (Actual Costs) would have BPT values reflect the actual cost of the benefit or non-benefit expenses. If the plan financials reflect contracted rates, then the financials would need to be adjusted to account for that difference in the reconciliation. Similarly, if a plan uses Method 4 for Part C claims (FFS Proxy), but the plan's financials reflect contracted rates, then the plan must also adjust the financials accordingly.

Consider the following illustrative example. A plan pays related providers a capitation amount equivalent to 100% Medicare on a projected basis. Should the actual experience diverge from projections by 5% or more, then the plan may be required to represent its base period experience using not the actual capitation payments, but rather a 100% of Medicare reimbursement basis using its encounter claims. The plan would then file its base period experience using Method 4 (FFS Proxy), while the plan's financials will reflect the actual payments made to related providers. This difference must then be accounted for in the financial reconciliation process.

[2] https://www.cms.gov/files/document/2022-advance-notice-part-ii.pdf

[3] https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf

Revenue and risk score runout adjustments

Plans often use CMS beneficiary-level files to estimate the final base year risk scores for their members, as they contain additional risk score runout relative to the MMR file data.

When financials are filed before the release of beneficiary-level files, they will not be able to account for the values from the beneficiary-level files. Plans may elect to hold an accrual reflecting expected future risk-adjusted revenue, or they may not hold any such accrual. In either case, however, the final BPT values, driven by beneficiary-level file risk scores with more complete coding, will differ from the financials. These differences should be understood and accounted for in the reconciliation.

Capitation and other risk-sharing arrangements

Membership and risk score data used in the BPTs can differ from what is used in the financials. Such differences can also affect capitation values, whether they are calculated as a percentage of revenue or a per member per month (PMPM) value. Capitation values may need to be adjusted in parallel with the adjustments applied to revenue values in plan reconciliations.

Other risk sharing arrangements may have similar considerations, depending on the contractual details. If risk-sharing settlements are not final and known as of the date the financials are finalized, appropriate adjustments should be made to reflect these risk-sharing settlements in the reconciliation.

Note that there may be additional impacts on various provider incentives such as quality payments; if additional data is available as of the BPT filing, such data should also be reflected in the financial reconciliations.

Conclusion

Understanding and correctly explaining the differences between bid and financial values can help health plans ensure their bid values are correct and appropriate. This will also prepare plans to answer CMS desk review questions efficiently, as well as address bid and financial audit questions as they arise.

Caveats

The findings reflect the research of the authors. Milliman does not endorse any product or organization. The authors of this paper are members of the American Academy of Actuaries, and meet its qualification standards to provide this analysis.

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