

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



**MEDICARE DRUG BENEFIT AND C & D DATA GROUP**

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**CORRECTIVE ACTION PLAN REQUEST**

May 21, 2014

Contract IDs: H3923, H3962, S8067

Deborah Ziegler  
Medicare Compliance Officer  
Capital BlueCross  
2500 Elmerton Avenue  
Harrisburg, Pennsylvania 17177

*Delivered via email to Deborah Ziegler at [Deborah.Ziegler@capbluecross.com](mailto:Deborah.Ziegler@capbluecross.com)*

**RE: Actuarial Compliance Issues**

Dear Ms. Ziegler,

The Centers for Medicare & Medicaid Services (CMS) is issuing a request for a Corrective Action Plan (CAP) to Capital Blue Cross (hereinafter "Capital"), which operates the Medicare Advantage (MA) and Prescription Drug Plan (PDP) sponsor contracts listed above through its subsidiaries, because it failed to meet one or more actuarial standards in submitting its 2014 Medicare Advantage and/or Part D bids. The actuarial standards were set forth in the 2014 Instructions for Completing the Medicare Advantage Bid Pricing Tool and the 2014 Instructions for Completing the Prescription Drug Plan Bid Pricing Tool issued by CMS on April 5, 2013, through the Health Plan Management System (HPMS).

Pursuant to 42 CFR §§ 422.254(b) and 423.265(c), each potential MA and Part D sponsor must submit a bid and supplemental information in a format to be specified by CMS for each MA and Part D plan it offers. Specifically, the regulation states that the bid must be prepared in accordance with CMS actuarial guidelines based on generally accepted actuarial principles. A qualified actuary must certify the plan's actuarial valuation (which may be prepared by others under his or her direction or review), and must be a member of the American Academy of Actuaries to be deemed qualified. Applicants may use qualified actuaries from outside their organization to prepare their bids.

As stated in CMS' bid instructions, MA and Part D bids are comprised of two basic components, the plan benefit package (or, PBP - a set of benefits for a defined Medicare Advantage or PDP service area) and BPT (a financial proposal for the health or prescription drug plan that a sponsor

intends to offer Medicare beneficiaries in a format required by CMS). The CMS Office of the Actuary (OACT) reviews the BPT to make sure that it conforms to actuarial standards.

CMS has determined that Capital's 2014 bid submissions were out of compliance with the following CMS actuarial requirements stated in the CY2014 Bid Instructions and CMS Bidder Trainings:

1. *The following documentation requirements apply to all bids (as all bids contain these assumptions): A quantitative mapping in a spreadsheet format of the values for allowed costs, effective cost sharing and script counts from the formulary tiers to the categories of type-of-drug and point-of-sale (retail or mail order as defined by the PBP) used in pricing (Worksheets 2, 6 and 6A). (Appendix B – Supporting Documentation of the 2014 Part D bid instructions) Capital did not provide proper mapping to calculate effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories used for pricing at bid submission.*
2. *Organizations must conduct adequate peer review to avoid errors and carelessness. Peer review and documentation are paramount to compliance. (Industry Training, Points of Emphasis for MA and PD CY2014 Slide 17). CMS identified the following errors during our review of Capital's bid submissions.*
  - a. *The base risk score reflected July 2012 and was based on the 2014 model when it should have reflected the 2012 model. (Page 33 of the Part D bid instructions direct organizations to enter the normalized risk score, estimated to three decimal places, for the population represented in the base period data using the Part D RxHCC risk model that was in place for the payment year.)*
  - b. *In completing the projected risk development, Capital used an erroneous starting risk score which directly caused the projected risk to be inaccurate. (Page 23 of the Part D bid instructions states that the preferred method for projecting the CY2014 risk scores is to start with the Part D RxHCC risk scores that are provided by CMS in the plan-level data for the July 2012 enrollee cohort with retroactive enrollment and status adjustments; or the beneficiary-level file containing 12 months of 2012 membership with retroactive enrollment adjustments and status adjustments.)*
  - c. *The cost sharing figure in the gap per-member-per-month (PMPM) reflected in Worksheet 5, cell K49, did not reflect the value derived from Worksheet 6a, cell H21 divided by the projected member months as required. (Page 64 of the Part D bid instructions instructs organizations to enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.)*
  - d. *The values in cell H25 on the "Standard Coverage" tab and cell P56 of "Projection of Allowed-Admin" were not within +/- of \$1.00 of each other. Capital was made aware of this same issue for CY2013 regarding H3962. An adjustment in All Other Utilization and Unit Cost trend was made, but this was*

not in accordance with CMS guidance. *(Page 40 of the Part D bid instructions directs organizations to enter the factor that represents the impact on utilization of any differences between the base period and contract period not included in the other components of utilization change, columns h through k, by type of script for each line.)* Page 41 states, *“Enter the factor that represents the impact on cost of any differences between the base period and contract period not included in the other components of unit cost change, columns e through j, by type of script for each line.”*)

- e. The mail order specialty cost sharing in the gap for non-LIS beneficiaries incorrectly reflected 100% cost sharing under the alternate plan when it should have been less due to dispensing/vaccine fees. *(Page 64 of the Part D bid instructions states that when the plan benefit type is Actuarially Equivalent (AE), Basic Alternative (BA) or Enhanced Alternative (EA), organizations are to enter the projected total number of scripts, total allowed dollars and total cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Organizations must calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between defined standard (DS) coverage and the proposed alternative coverage).*

CMS requests that your organization take corrective action to come into compliance. The first opportunity for Capital to demonstrate that it has taken the necessary corrective action will be the 2015 bid cycle. Therefore, CMS requests that Capital address these areas of noncompliance in the spring of 2014 leading up to the 2015 bid cycle. CMS will rely on Capital's 2015 bid submission to determine whether the corrective action plan has been successfully implemented. CMS will consider the CAP closed once OACT has determined that Capital's 2015 bid submission demonstrates that it has effectively resolved the issues described above.

We appreciate your prompt attention to this matter. In the event your organization does not successfully complete its CAP, CMS will consider additional compliance and enforcement actions, including imposition of intermediate sanctions (*e.g.*, the suspension of marketing and enrollment activities).

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. This letter is considered a Part C and D issue without beneficiary impact for past performance purposes. CMS notes that we are issuing this compliance notice based exclusively on information that we obtained from sources other than the sponsor's own self-disclosure.

If you have any questions, please contact Michael Neuman at (410) 786-7069 or email [Michael.Neuman@cms.hhs.gov](mailto:Michael.Neuman@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Amy Larrick", is written over a horizontal line. The signature is cursive and extends slightly above and below the line.

Amy Larrick  
Acting Director  
Medicare Drug Benefit and C & D Data Group

CC via email:

Linda Anders, CMS  
Scott Nelson, CMS  
Michael Neuman, CMS  
Rose Babilino, CMS