Calculation of Medicare Fee-for-Service Actuarial Equivalent Cost Sharing for Contract Year 2012

1. Statutory / Regulatory Basis
    a. SSA 1854(a)(6)(A) The bid information to be submitted for an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, is described as follows:
        (i) The monthly aggregate bid amount for the provision of all items and services under the plan; and
        (ii) The proportions of such bid amounts that are attributable to-
            (a) the provision of benefits under the original Medicare fee-for-service program option (as defined in section 1852(a)(1)(B);
            (b) The provision of basic prescription drug coverage; and
            (c) The provision of supplemental care benefits.
    b. SSA 1852(a)(1)(B) (i) (as amended by the MMA) In General – For purposes of this part, the term "benefits under the original Medicare fee-for-service program option means those items and services (other than hospice care) for which benefits are available under Parts A and B to individuals entitled to benefits under part A and enrolled under Part B, with cost-sharing for those services as required under Parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.
    c. In the Preamble to Final rules (January 28, 2005), there were several alternative approaches to defining the actuarially equivalent amount of cost sharing for the basic A/B bid amount:
        (i) localized uniform dollar amount;
        (ii) plan-specific approach; and
        (iii) proportional approach.
    d. Regulation Text, CFR 42, Section 422.254(b)(4) The bid amount is for plan payments only but must be based on plan assumptions about the amount of revenue required from enrollee cost sharing. The estimate of plan cost-sharing for the unadjusted MA statutory non-drug monthly bid amount for coverage of original Medicare benefits must reflect the requirement that the level of cost sharing (deductible, copayments, or coinsurance) charged to beneficiaries under the original Medicare program option. The actuarially equivalent level of cost sharing reflected in a regional plan's unadjusted MA statutory non-drug monthly bid amount does not include cost sharing for out-of-network Medicare benefits as described in section 422-101(d).

2. The methodology implemented by OACT is the proportional approach, based on Medicare fee-for-service (FFS) cost sharing proportions (that is, the proportion of enrollee cost sharing, excluding balance billing, to total allowed cost). These proportions were developed for the following service categories and service areas:
    a. inpatient for local areas;
    b. skilled nursing facility for local areas;
    c. home health, covered under both Part A and Part B – (the proportion is 0 percent for all areas since there is no cost sharing for home health in Medicare FFS); and

d. Part B services other than home health, a national proportion.
    (i) Note that the Part B cost sharing proportion was determined at the national level because it is difficult to get outpatient hospital cost sharing accurately at the local level due to great variation by area and service.

3. Primary data:
    a. Medicare FFS reimbursements and cost sharing tabulated from the 2009 100% National Claims History (NCH) files by state and county, separately for aged, disabled, and ESRD beneficiaries. The following adjustments were made to the data:
        (i) Included payments for disproportionate share hospitals (DSH);
        (ii) Excluded indirect medical education (IME); and
        (iii) Excluded portion of pass-through (estimated to be 90%) that pertains to direct graduate medical education (DGME).
    b. 2009 county-level HCC risk scores developed under the recalibrated HCC-70 model.
    c. 2009 Part A and Part B county-level enrollments. This file is consistent with the county-level enrollment published on the CMS website.
    d. Core based statistical area (CBSA) for each county, defined by the Office of Management and Budget, with updates through May 2010. These are the definitions used in the development of the final rule for the FY 2011 Inpatient Prospective Payment System (IPPS).
    e. Estimate of PMPM incurred allowed charges and cost sharing from latest CMS estimates (consistent with the baseline supporting the 2012 rate book development). These PMPM estimates exclude IME and DGME.

4. Consolidate county-level NCH claims data, FFS enrollment, and risk scores.
    a. A listing of unique county codes in NCH data was developed.
    b. Using the listing of the unique county codes, the following data was imported for each county code
        a. County name
        b. CBSA code and CBSA name
        c. 2009 FFS risk score
        d. 2009 aged & disabled FFS enrollment
        e. 2009 NCH reimbursement and cost sharing for inpatient, SNF, and Part B excluding home health. Net inpatient reimbursements were calculated as payments (which include IME) plus 10% of pass through minus IME.

5. Develop county-level CBSA code and set Final CBSA code and name
    a. Merge initial CBSA code and name, risk score, enrollment, payments, and cost sharing
    b. The final CBSA code was determined as follows:
        1. If Part A enrollment in initial CBSA >= 49,999.5 then final CBSA code equals the initial CBSA code; else

2. Final CBSA code equals state code.

c. Aggregated for each final CBSA code, the standardized reimbursement and cost sharing values calculated as the unadjusted value divided by risk score.

6. Determine growth factors for 2009 to 2012
   a. Growth factors by service category are determined by using the 2009 reimbursements and cost sharing by service category and the total standardized reimbursements along with 2012 reimbursements and cost sharing by service category from CMS' latest estimate.
   b. The 2012 reimbursements and cost sharing from CMS' latest estimate are completed for expected run-out whereas the 2009 reimbursements and cost sharing derived from the NCH files are not. Also, the 2012 reimbursements and cost sharing from CMS' latest estimate contain additional expenditures such as bad debt and HPSA bonuses. So the growth factors calculated incorporate trend, completion, and additional expenditures.

7. Development of CBSA-level actuarial equivalent factors for 2012.
   a. Count of FFS beneficiaries and aggregate reimbursement and cost sharing values for each CBSA calculated.
   b. PMPM standardized values for 2009 calculated as the aggregate values divided by FFS enrollment divided by 12.
   c. PMPM standardized values for 2012 calculated as the standardized values for 2009 times (1 + '12/'09 growth factor).

8. Calculation of 2012 claims non-DE# vs. total
   a. Determine relationship of 2012 allowed cost, and cost sharing for non- DE# beneficiaries compared to all Medicare beneficiaries.
   b. Data source: 2009 national claims history as reflected in the Medicare integrated data repository (IDR).
   c. 2009 PMPM values are summarized for all Medicare beneficiaries and non-DE# populations
   d. Non-DE# projected forward to 2012 using growth factors for all Medicare beneficiaries

9. Calculation of 2012 standardized values for non-DE# beneficiaries
   a. 2012 PMPM by CBSA allowed cost and cost sharing for non-DE# beneficiaries are calculated as the product of each CBSA value for all Medicare beneficiaries and the ratio of CY 2012 PMPM allowed cost, and cost sharing for non-DE# beneficiaries.
   b. The cost sharing percentages by CBSA are calculated as the relevant cost sharing PMPM divided by the allowed cost PMPM.

10. Input CBSA-level cost sharing factors and allowed costs for non-DE# beneficiaries into BPT rates sheet.