Calculation of Medicare Fee-for-Service Actuarial Equivalent Cost Sharing for Contract Year 2009

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 2006 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. 2006 county-level HCC risk scores developed under the recalibrated HCC-70 model.
    c. 2006 Part A and Part B county-level enrollments. This file is consistent with the county-level enrollment published on the CMS website.
    d. Metropolitan and Micropolitan statistical areas, as defined by the Office of Management and Budget, December 2006.
    e. Estimate of PMPM incurred allowed charges and cost sharing from latest CMS estimates (consistent with the baseline supporting the 2009 rate book development). These PMPM estimates exclude IME and DGME.

4. The claims data (Inpatient, SNF, Outpatient, Physician, DME M, and DME O), risk scores, enrollment data, and MSA codes were merged using a State/County code field.
    a. In the process of merging tables, any data records with state/county codes not contained in the MSA codes table were excluded.
    b. Data were combined for aged and disabled beneficiaries.
    c. Data were excluded for beneficiaries in ESRD status (defined as enrollees in MSC code 11, 21, and 31).
    d. Hospice costs were not included in the calculation since MA plans don't provide hospice services. However, Hospice enrollees were included, resulting in the FFS county-level costs displayed in the table to be understated.
    e. Home Health costs were not included in the calculation since there is no cost sharing for Home Health in Medicare FFS.

5. Cost sharing for the Inpatient, SNF, and Part B (Outpatient, Physician, DME M and DME O combined) service categories for each state/county code was calculated, where cost sharing equals:
    a. Inpatient: deductible plus coinsurance
    b. SNF: coinsurance
    c. Outpatient: deductible plus copayments
    d. Physician, DME Medical, DME Other: allowed charges minus reimbursements

6. Reimbursements for the Inpatient, SNF, and Part B service categories for each state/county code were calculated, where reimbursements equal:
    a. Inpatient: payments – IME + .1 x pass-through
    b. SNF: payments
    c. Outpatient, Physician, DME Medical, DME Other: payments

7. Reimbursements, cost sharing, and allowed costs (sum of reimbursements and cost sharing) were standardized by county, taking the county nominal amounts divided by the county average risk score.

8. Reimbursements and cost sharing were projected from 2006 to 2009 using the growth in FFS USPCCs reimbursements and cost sharing by service category based on the latest CMS estimates.
    a. The reimbursements and cost sharing from the latest CMS estimates are completed for expected run-out whereas the 2006 reimbursements and cost sharing derived from the NCH files are not.
    b. The reimbursements and cost sharing from the latest CMS estimates contain additional expenditures such as bad debt and HPSA bonuses.
    c. Operating IME and DGME were removed from the reimbursements in the latest CMS estimates to be comparable to the reimbursements derived from the NCH files.
    d. The approach taken in determining the growth factors, comparing the 2006 standardized reimbursements and cost sharing from the NCH files to the 2009 reimbursements and cost sharing from the latest CMS estimates, results in growth factors incorporating trend, completion, and additional expenditures.
    e. Separate growth factors were obtained for reimbursements and cost sharing.

9. Trended reimbursements, cost sharing, allowed costs, and cost sharing proportions were developed at the MSA-level:
    a. Counties were mapped to an MSA or non-MSA in the state based on the MSA codes table.
    b. Any MSA with less than 50,000 enrollees was re-coded with the non-PMSA in the state.
    c. The FFS cost sharing proportions were calculated as the trended cost sharing divided by trended allowed costs.
    d. FFS PMPM allowed costs were calculated by dividing the standardized trended allowed costs by the corresponding aggregate enrollment (Inpatient and SNF by Part A enrollment, Part B services by Part B enrollment) divided by 12.

10. The MSA-level cost sharing proportions and FFS PMPM allowed costs were then mapped back to county based on the MSA codes table.
    a. Modifications made: Guam counties were mapped to non-MSA Puerto Rico.