

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 28, 2014

Contract IDs: H3907, H4279, H5533, H9670

John Cain  
Medicare Compliance Officer  
UPMC Health Plan, Inc.  
600 Grant Street  
Pittsburgh, Pennsylvania 15219

*Delivered via email to John Cain at [mccomplianceofficer@upmc.edu](mailto:mccomplianceofficer@upmc.edu)*

**RE: Actuarial Compliance Issues**

Dear Mr. Cain,

The Centers for Medicare & Medicaid Services (CMS) is issuing a request for a Corrective Action Plan (CAP) to UPMC Health System. (hereinafter "UPMC"), 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 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 UPMC'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. *Organizations must provide justification of the gain/loss margin (Worksheet 4). The required elements include - Support for overall MA margin levels including— The Plan sponsor's margin requirement for all non-Medicare health insurance lines of business, including any change in such requirement in the prior two years, and identification of these lines of business. (Appendix B – Supporting Documentation of the 2014 MA bid instructions)– Gain/loss documentation regarding identification of other insurance lines of business, year-over-year historical margins, and consistency of Medicare margin with other non-Medicare insurance margins was incomplete and lacked adequate documentation to support the bid review elements*
2. *Organizations must provide detailed support for the data and methodology used in the development of appropriate manual rates for the expected population (Worksheet 2). The required elements include— A description of the source data, including the data's relevance to the MA plan and the precise name of any published tables used, credibility standards applied to the data and corresponding adjustments if applicable, and consideration of any adjustments made for annual volatility of the source data (Appendix B – Supporting Documentation of the 2014 MA bid instructions) – Documentation for manual rates was incomplete or missing.*
3. *For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (that is, the cover sheet must not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact bid IDs rather than a "range" of bid IDs. (Appendix B – Supporting Documentation of the 2014 MA and PD bid instructions) - Bid substantiation and documentation of resubmissions was missing. All original bid substantiation was removed from HPMS and new documents were submitted on 6/10/2013 without a supplemental cover sheet or any indication of which documents were revised.*
4. *If general enrollment plans and I/C SNPs are offered, the following requirements apply to EGWPs - The aggregate margin must be consistent from year to year, the aggregate margin as a percentage of revenue must be no more than 1 percent higher and no less than 5 percent lower than the aggregate margin for general enrollment plans and I/C SNPs. (Although actual aggregate margins will vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate returns over the long term are consistent with the margin assumptions used for pricing.) (Appendix B – Supporting Documentation of the 2014 MA bid instructions) EGWP margins were not in compliance with CMS gain/loss guidance that requires them to be within the specified range of the general enrollment and I/C SNP margin.*
5. *Organizations are allowed to make changes to Funding of the Part D Basic and Supplemental Benefits during rebate reallocation. However, no modifications are allowed to the benefit design or pricing of the Part D basic benefit or the supplemental benefit offered under the "enhanced alternative" design. That is, this prohibition*

*includes that no changes are permitted to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits.* (Appendix E - Rebate Reallocation and Premium Rounding of the MA bid instructions) - UPMC's actions did not comply with CMS guidance. UPMC asserted that the need to abide by Total Beneficiary Cost (TBC) requirements was the reason for the non-compliance. However, bid values were well within the TBC requirements and should not have triggered any form of non-compliance. As a direct result, UPMC had to resubmit its bids to reverse the original rebate reallocation changes.

6. *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) The following errors could have been discovered with adequate peer review and resulted in the need for numerous resubmissions
  - a. An error in the calculation of the impact of the Out-Of-Pocket (OOP) Maximum cost sharing.
  - b. An error regarding the target premium intention with two bids.
  - c. Errors in the calculation of projection factors by service category and adjustments for provider contractual arrangements.
  - d. Errors in the calculations of plan specific coding adjustments to projected risk scores and application of the CMS coding pattern adjustment to base period risk scores.
  - e. Errors in the entry of completion factors in the base period.
  - f. A linking error that led to the incorrect projected Non-Benefit expense (NBE).
  - g. A linking error that led to a mismatch of member months on the MA and PD bid forms.
  - h. Errors in the allocation of the NBE between MA and PD.

In addition to the above-stated actuarial bid deficiencies, the following deficiencies that were present in UPMC's bid submissions from the previous year were once again present in its 2014 bid submissions:

7. *A MA sponsor in a related-party agreement must provide a disclosure of every related-party agreement with a sufficient level of detail as stated in the BPT instructions* (Page 105 of the 2014 MA bid instructions). UPMC's documentation of related parties was incomplete or missing. It did not contain a complete summary that explained the relationship in terms of the parties involved, common ownership, control, investment, the contractual terms of each relationship, a description of the services provided, money exchanged and the description of the approach used to report the medical expense in the bid. Only a high-level narrative was provided in bid substantiation.
8. *An organization must provide support for non-benefit expense assumptions. The required elements include— A demonstration of the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other projections. Supporting documentation must be easily understood by CMS reviewers and must include the following: Excel spreadsheets with working formulas . . .*

(Appendix B – Supporting Documentation of the 2014 MA bid instructions). There was an insufficient demonstration of the development of each NBE line item to support allocations to NBE categories. In addition, the bid substantiation contained hidden hard-coded allocation percentages in white type.

9. *An organization must provide detailed qualitative and quantitative support for the development of each projection factor (Worksheet 1). The required elements include— A description of the source data, including the data's relevance to the MA plan. Any applicable adjustments to the source data, such as considerations for— Plan sponsor's experience, including an explanation for significant differences between actual and expected claims for CY2010, CY2011 and CY2012, and a description of how that knowledge was incorporated into the projection factors . . .* (Appendix B – Supporting Documentation of the 2014 MA bid instructions). There was insufficient support for projection factors, missing or unclear rationale for assumptions, narrative descriptions of assumptions rather than quantitative support, missing explanations of plan specific variations, and an unclear connection between overall trends and methodology and the values in the BPTs.

CMS requests that your organization take corrective action to come into compliance. The first opportunity for UPMC to demonstrate that it has taken the necessary corrective action will be the 2015 bid cycle. Therefore, CMS requests that UPMC address these areas of noncompliance in the spring of 2014 leading up to the 2015 bid cycle. CMS will rely on UPMC'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 UPMC'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,



Amy K. Larrick  
Acting Director

Medicare Drug Benefit and C & D Data Group

CC via email:

Linda Anders, CMS

Scott Nelson, CMS

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Scott Beach, CMS