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INSTRUCTIONS FOR COMPLETING  
THE MEDICARE ADVANTAGE  
BID PRICING TOOLS  
FOR CONTRACT YEAR 2014

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April 5, 2013

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## I. INTRODUCTION

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### BACKGROUND

Medicare Advantage (MA) organizations must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each plan that they intend to offer under the Medicare Advantage program, including MA plans, Medical Savings Account (MSA) plans and End-Stage Renal Disease-only special needs plans (ESRD-SNPs). For plans with service area segments, a separate bid must be submitted for each segment.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format—the MA Bid Pricing Tool (BPT), the MSA BPT or the ESRD-SNP BPT. The MA BPT is not to be completed for Section 1876 Cost plans, Section 1833 Cost plans, Programs of All-Inclusive Care for the Elderly (PACE) plans, and Medicare-Medicaid Plans offered through the Financial Alignment Demonstration. An actuarial certification and supporting documentation must be submitted for each bid as described in Appendix A and Appendix B, respectively.

The submitted bids will be subject to review and audit by CMS or by any person or organization that CMS designates. As part of the review and audit process, CMS or its representative may request additional documentation supporting the information contained in the BPT. Organizations must be prepared to provide this information in a timely manner.

If the MA plan includes prescription drug benefits under the Medicare Part D program (that is, an MA-PD plan), then an additional Part D BPT must also be completed and submitted to CMS. Prescription drug benefits under the Medicare Part D program are not allowed to be offered with an MSA plan.

### DOCUMENT OVERVIEW

This document contains general pricing considerations and detailed instructions for completing the BPT. Following are the contents of each section:

- Section I, “Introduction”: contains background information and a list of key changes from CY2013, and provides sources of additional information regarding the bidding process.
- Section II, “Pricing Considerations”: includes guidance for the overall approach to pricing in the BPT and topic-specific issues for bidders to consider. The section topics are arranged alphabetically.
- Section III, “Data Entry and Formulas”: contains line-by-line instructions on each data entry field and describes the formulas for calculated cells.
- Section IV, Appendices: contain information on Actuarial Certification, Supporting Documentation, Part B-Only Enrollees, MA Products Available to Groups, Rebate Reallocation and Premium Rounding, Suggested Mapping of MA Plan Benefit Package (PBP) Categories to BPT Categories, DE#, the MSA BPT, and the ESRD-SNP BPT.

### NEW FOR CONTRACT YEAR 2014 (CY2014)

Some of the key features that are new or changed for the CY2014 BPT are listed below. The changes improve the usability and functionality of the BPT and reflect current guidance.

- Technical
  - The add-in file (BPT2014.xlam) must be saved under C:\BPT\BPT2014\ See the BPT technical instructions for more information.
- MA Worksheet 1
  - In Section II, line 3, the “DE# Risk Score” default formula may now be over-written by the user.
  - In Section VI, six lines have been added:
    - line 10c “Insurer Fees (subset of Taxes and Fees)”
    - line 11a “Medicaid Revenue”
    - line 11b “Medicaid Cost”
    - Line 11b1 “Benefit Expenses”
    - Line 11b2 “Non-benefit expenses”
    - Line 11c “Adjusted GLM”
- MA Worksheet 3
  - In Section IV, PBP lines 4c and 13h have been added.
- MA Worksheet 4
  - In Section IIC, line z3 has been changed from a text box description field to now be an input field for “Insurer Fees (subset of Taxes and Fees)”
  - In Section IIC, the formula calculation in line y4 “BPT MLR” has been revised.
  - In Section V, label references to DE# have been removed. Data entry in this section is now on a PMPM basis, not a “per DE# member per month” basis.
  - In Section V, three lines have been added:
    - line 2a “Benefit expenses”
    - line 2b “Non-benefit expenses”
    - line 3 “Adjusted GLM”
  - In Section V, line 2 is no longer an input field, it is now a calculated field.
- MA Worksheet 5
  - In Section II, line 4, the “DE# Risk Factor” default formula may now be over-written by the user.
  - In Section V, the formula calculation in line 3 “Rebate %” has been revised.
- MA Worksheet 6
  - In Section IIA, line 1 “Maximum Part B premium buydown amount”, the amount has been updated to \$104.90.

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- MA Worksheet 7
  - New Section IV has been added.
- MSA Worksheet 4
  - In Section III, the text box description field has been removed, and line 1 “Insurer Fees (subset of Taxes and Fees)” has been added.
  - In Section III, the formula calculation in line i “BPT MLR” has been revised.
- MSA Worksheet 5
  - New Section IV has been added.
- ESRD-SNP Worksheet 1
  - In Section IV, the formula in line 1 “Part C premium” has been revised.
  - In Section IV, lines 3 and 4 are no longer input fields, they are now calculated fields.
  - In Section IV, lines 5 and 6 now have drop-down boxes.
- ESRD-SNP Worksheet 2
  - In Section II, the three fields for Part B and Part D premium reductions are no longer input fields, they are now calculated fields.
  - In Section II, the text box description field has been removed, and the “Insurer Fees (subset of Taxes and Fees)” line has been added.
  - In Section II, the formula calculation of the “BPT MLR” line has been revised.
  - New Section III has been added.
- ESRD-SNP Worksheet 3
  - In Sections III and IV, the BPT now collects data from the base period two years prior to the contract period. It no longer collects data from three years prior to the contract period.
  - In Sections III and IV, the BPT now collects data on a PMPM basis. It no longer collects data in aggregate/total dollars
  - In Section IV, the service category lines have been revised to be consistent with the service category lines on Worksheet 2.
- ESRD-SNP Worksheet 4
  - New Section IV has been added.

## BIDDING RESOURCES

In addition to these instructions, the following resources provide information on CY2014 bidding:

- The CY2014 Advance Notice and draft CY2014 Call Letter may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2014.pdf>.

## INTRODUCTION

- The CY2014 Rate Announcement and CY2014 Call Letter may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf>
- The CY2014 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTraining2014.html> and <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTrainingIntro.html>.
- For questions about the bid form, e-mail the CMS Office of the Actuary (OACT) at [actuarial-bids@cms.hhs.gov](mailto:actuarial-bids@cms.hhs.gov).
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2014 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. The call-in information is as follows:
  - Every Thursday
  - 11:00am – 12:00pm ET
  - See HPMS announcement for call details
- For technical questions about the BPT, HPMS, or the upload process, refer to the following resources:
  - The Technical BPT Instructions located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2014 > Documentation > BPT Technical Instructions
  - The *Bid Submission User's Manual*, also available in HPMS
  - HPMS Help Desk: 1-800-220-2028 or [hpms@cms.hhs.gov](mailto:hpms@cms.hhs.gov)
- For information about benefits and service categories, see—
  - Chapter 4 of the *Medicare Managed Care Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>
  - The CY2014 PBP/SB Software List of Changes located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2014 > Documentation > PBP – SB List of Changes

## II. PRICING CONSIDERATIONS

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### BIDDING/PRICING APPROACH

By statute, the bid must represent the revenue requirement of the expected population. Therefore, in most circumstances, Plan sponsors must use credible bid-specific experience in the development of projected allowed costs. This approach does not preclude Plan sponsors from reaching specific benefit and premium goals; the gain/loss margin guidance allows sufficient flexibility to achieve pricing targets provided that the overall margin meets the requirements in the guidance and that anti-competitive practices are not used.

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the bid level if the plan existed in CY2012, regardless of the level of enrollment. This experience must also be projected in Worksheet 2 and assigned an appropriate level of credibility by the certifying actuary. Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year.

### SPECIFIC TOPICS

Topic	Page	Topic	Page
Affordable Care Act and Quality Bonus Payment Demonstration	9	Hospice Enrollees	29
Bad Debt	10	Manual Rating	29
Base Period Experience	10	Medicare Secondary Payor (MSP) Adjustment	30
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BPT Medical Loss Ratio (MLR)	14	Optional Supplemental Benefits	34
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Cost Sharing	17	Point-of-Service (POS)	36
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End-Stage Renal Disease (ESRD)	24	Risk Score Development for CY2014	40
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## PRICING CONSIDERATIONS

### Affordable Care Act and Quality Bonus Payment Demonstration

The Affordable Care Act introduced quality bonus payments (QBPs) to MA organizations based on a five-star quality rating system. The Affordable Care Act also changed the share of savings that MA organizations must provide to enrollees as the beneficiary rebate, mandating that the level of rebate is tied to the level of the plan's QBP rating.

The contract-level ratings for the CY2014 QBP can be found at the following path in HPMS: HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating > 2014.

#### ***Low-Enrollment Contract***

A low-enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because it lacked a sufficient number of enrollees to reliably measure the performance of the health plan. For 2014, a "low" enrollment contract received three stars for QBP purposes.

#### ***New Contract under New Parent Organization***

A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, until the contract has enough data to calculate a star rating. For 2014, a "new contract under new parent org" received 3.5 stars for QBP purposes.

#### ***New Contract under Existing Parent Organization***

For a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization received a weighted average of the QBP star ratings earned by the parent organization's existing MA contracts (weighted by enrollment).

CMS announced a demonstration based on scaled bonuses; the higher a contract's star rating, the greater the QBP percentage. The following table outlines the QBP percentage and rebate percentage for various QBP star ratings in CY2014.

QBP star rating	CY2014 QBP %	CY2014 Rebate Percentage
4.5+	5.0%	70%
4.0	5.0%	65%
3.5	3.5%	65%
3.0	3.0%	50%, except for: 65% Employer/Union Direct Contract PFFS (ED PFFS) contract
< 3.0	0.0%	50%

The CY2014 Advance Notice and Rate Announcement contain additional information regarding the ACA provisions and the Quality Bonus Payment demonstration.

## PRICING CONSIDERATIONS

### Bad Debt

Bad debt for uncollected enrollee cost sharing for inpatient hospital and skilled nursing facility care is to be included in medical costs when paid for by the Plan sponsor in limited situations, such as when private fee-for-service (PFFS) plans have chosen to match this aspect of Medicare fee-for-service payment rules or when necessary for a plan to maintain access to a sole provider of a service.

### Base Period Experience

The base experience must be based on claims incurred in calendar year 2012 with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

Worksheet 1 must be completed with data at the bid level, that is, with a contract number, Plan ID, and segment combination for each bid. Note that these data must—

- Be reported without adjustment in Section III. (Adjustments may be made in Section IV to accommodate population, benefit design, or other changes between the base period and the projection period.)
- Be submitted in Worksheet 1 at the bid level for all plans with experience data in 2012, regardless of the level of enrollment.
- Reconcile in an auditable manner to the Plan sponsor's audited financial statements.
- Be provided for plans acquired by the Plan sponsor.
- Not be used to aggregate data from multiple plans in order to achieve credibility. Credibility is addressed on Worksheet 2.

The medical expenses in Section III must—

- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Be reported on an allowable basis (before any reduction for reinsurance recoveries or cost sharing) and on a net basis.
- Include any provider incentive payments.
- For Employer-only or union-only group waiver plans (EGWPs), reflect the actual cost sharing provided to groups enrolled. For other plans, reflect the full level of plan cost sharing in the plan benefit package (PBP) for all enrollees including the DE# beneficiaries. See the pricing consideration for dual-eligible beneficiaries for more information about DE# beneficiaries.
- Include or exclude claim experience for hospice enrollees for the time period that an enrollee is in hospice status consistent with the development of projected allowed costs. See the pricing consideration for hospice enrollees.
- Exclude end-stage renal disease (ESRD) claim experience for the time period that an enrollee is in ESRD status based on CMS eligibility records.
- Exclude claims experience for optional supplemental benefits.
- Exclude incurred claims for Medicaid benefits.

The net medical and non-benefit expenses and CMS and premium revenue in Section VI must include all enrollees (that is, include ESRD and hospice and out-of-area). Section VI excludes optional supplemental benefits. Section VI must be completed in total dollars (not PMPMs).

### ***Data Aggregation***

The requirements for reporting base period data for plan consolidations and enrollment shifts are described below. Such requirements also apply to consolidations and enrollment shifts between segments.

#### **✓ Rule 1 – Plan Consolidations (that is, Consolidated Renewals)**

Base period data for more than one plan must be aggregated and reported on Worksheet 1 of the plan into which the members are crosswalked only in the following circumstances:

- When two or more plans are consolidated and the members are crosswalked into an existing or new plan under a formal crosswalk. The term “formal crosswalk” refers to the crosswalk process submitted in HPMS whereby members are automatically moved from one plan to another. Without an HPMS crosswalk in place, members are dis-enrolled from the terminating plan and must actively select to enroll in a new plan of their choosing.
- When a significant proportion of members (as determined by the certifying actuary) in a plan are crosswalked into existing or new plans through MARx enrollment transactions.

Note the following:

- Plans can be crosswalked each contract year. For BPT reporting purposes, the actuary must consider the crosswalks from the base period to the contract period (that is, two years of crosswalks, from CY2012 to CY2013, and then from CY2013 to CY2014).
- This rule applies when members are crosswalked within the same contract and when members are crosswalked between contracts.

#### **✓ Rule 2 –Enrollment Shifts**

Base period data for more than one plan cannot be aggregated and reported on Worksheet 1 in the following circumstances:

- When an existing member chooses to enroll in a different plan.
- When an insignificant proportion of members (as determined by the certifying actuary) in a plan are crosswalked into existing or new plans through MARx enrollment transactions.

#### **✓ Rule 3 – Partial Experience**

Base period experience must be reported in total at the bid level for every contract-plan ID-segment ID; do not include partial plan experience on Worksheet 1.

#### **Example 1:**

An MA organization offers plans 001-00 and 002-00 in CY2012 and plans 002-00 and 003-00 in CY2014. Plan 001-00 is consolidated and the

## PRICING CONSIDERATIONS

membership is formally crosswalked into plan 003-00 for CY2014. Base period experience must be reported on Worksheet 1 of the CY2014 BPT as follows:

- For plan 002-00 BPT, report aggregate base period experience for plan 002-00 (Rule 1 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 001-00 (Rule 1 and Rule 3).

### Example 2:

An MA organization offers plans 001-00 and 002-00 in CY2012 and plans 002-00 and 003-00 in CY2014. Plan 001-00 is consolidated and the membership is formally crosswalked to plan 003-00 for CY2014 as submitted in HPMS. The certifying actuary expects most of the current membership in plan 002-00 to enroll in plan 003-00 for CY2014; however, plan 002-00 is still offered. Base period experience must be reported on Worksheet 1 of the CY2014 BPT as follows:

- For plan 002-00 BPT, report base period experience for plan 002-00 (Rule 2 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 001-00 (Rule 1).

### Example 3:

An MA organization offers plans 001-00, 002-00, and 003-00 in CY2012 and plans 002-00 and 003-00 in CY2014. Plan 001-00 is consolidated and the membership is formally crosswalked to plan 002-00 for CY2013. Base period experience must be reported on Worksheet 1 of the CY2014 BPT as follows:

- For plan 002-00 BPT, report base period experience for plans 001-00 and 002-00 (Rule 1 and Rule 3).
- For plan 003-00 BPT, report base period experience for plan 003-00.

### Example 4:

An MA organization offers plans 001-00, 002-00, and 003-00 in CY2012 and plan 003-00 in CY2014. Plan 001-00 is consolidated and the membership is formally crosswalked to plan 002-00 for CY2013. Plan 002-00 is consolidated and the membership is formally crosswalked to plan 003-00 for CY2014. Base period experience must be reported on Worksheet 1 of the CY2014 BPT as follows:

- For plan 003-00 BPT, report base period experience for plans 001-00, 002-00, and 003-00.

## Benefits and Service Categories

Input items related to medical expenses must generally be entered separately for each service category displayed in the BPT. See Appendix F for a suggested mapping of BPT and PBP service categories.

### ***Medicare-Covered and Non-Covered***

Following are the three types of service categories:

- Services that can be only Medicare-covered.
- Services that can be only non-covered (for example, transportation benefits in line 1, “Transportation (Non-Covered)”).
- Medicare-covered services that may be supplemented, as an A/B mandatory supplemental benefit (for example, the cost for additional days not covered by Medicare in line a, “Inpatient Facility”).

For the third type, values are allocated between Medicare-covered benefits and A/B mandatory supplemental benefits in Worksheet 4 as specified by the user. This allocation must be consistent with the benefit type classification in the PBP. For example:

- Out-of-network POS inpatient stays are A/B mandatory supplemental benefits.
- For non-SNPs, physical exams that provide services not included in the required Annual Wellness Visits are A/B mandatory supplemental benefits.
- For SNPs, assessments of enrollees are considered Medicare-covered benefits as explained in the CY2013 Call Letter.

To maintain consistency with the PBP, the cost to provide Medicaid benefits must be entered in Worksheet 4 Section V since these benefits are not entered in the PBP as A/B mandatory supplemental benefits.

For more information on benefits and service categories, see:

- Chapter 4 of the *Medicare Managed Care Manual*, “Benefits and Beneficiary Protections,” at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>
- Call Letter at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>
- CY2014 PBP/SB Software List of Changes located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2014 > Documentation > PBP – SB List of Changes.

### ***Inpatient Hospital Additional Days***

CMS developed a 1.2-percent factor based on FFS data that can be used as a “safe harbor” for the proportion of inpatient days that are non-covered. If the non-covered hospital pricing is based on an assumption other than the safe harbor, support for the data and methodology used in the development of that assumption is required. Note that if the cost sharing varies by day of hospital stay, the proportion of cost sharing for inpatient days that are non-covered will differ from the proportion of inpatient days that are non-covered. In such case, the actuary may use the “safe harbor” to calculate the inpatient cost sharing Medicare-covered percentages entered on Worksheet 4, but not enter 1.2-percent as such percentages.

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### ***Non-Covered Limited Benefits***

For non-covered limited benefits with no cost sharing, the value of benefits over the limit must be excluded from projected allowed costs. For example, if the PBP contains a hearing aid benefit with a \$500 annual cost limit, no cost sharing, and an average cost of a hearing aid is \$2,500, then the allowed PMPM must be based on the \$500 maximum benefit. Do not enter a \$2,500 cost offset by a cost-sharing entry in Worksheet 3 for the \$2,000 paid by the beneficiary.

### ***Preventive Services Incentives***

The CY2010 Call Letter outlined requirements for items or services that a plan offers conditional to an enrollee taking some action (for example, receiving a flu shot) or participating in some program (for example, a smoking cessation program).

When an incentive program incurs a cost, then this cost must be priced in the bid. For this purpose, the projected PMPM cost of incentives must be combined with the cost of other non-covered benefits and entered in line q of the MA BPT. Note that combining the costs with “Other Non-Covered” does not change the nature of incentives or benefits; incentives cannot be “benefits” as defined in MA regulation 42 CFR §422.2 and explained in the CY2010 Call Letter. Supporting documentation is required with the initial June bid submission.

### ***Skilled Nursing Facility***

MA regulation 42 CFR §422.101(c) states that “MA organizations may elect to furnish, as part of their Medicare covered benefits, coverage of post hospital SNF care . . . in the absence of prior qualifying hospital stay that would otherwise be required for coverage of this care.” The certifying actuary may price the waiver of the prior hospitalization requirement as a Medicare-covered benefit.

### **BPT Medical Loss Ratio (MLR)**

The BPT MLR included on Worksheet 4 will be used for bid review purposes. (See the pricing consideration for gain/loss margin for more information about MLR.) Note that a separate data submission will be needed to fulfill the Medicare MLR requirements.

The BPT MLR is based on the projected revenue requirement for Medicare-covered benefits, A/B mandatory supplemental benefits, and optional supplemental benefits (OSB). It is calculated in Worksheet 4, Section IIC (line y4) as the ratio of projected:

- Medical expenses (line u and Worksheet 7 and Part B rebate allocation) plus NBE quality initiatives (line z1), to
- Total revenue requirement (line x and Worksheet 7 and Part B rebate allocation) less taxes and fees (line z2).

The cost of NBE quality initiatives is the certifying actuary’s best estimate of non-benefit expenses for activities that are designed to improve healthcare quality. NBE quality initiatives are added to the medical expense (numerator) in the calculation of the BPT MLR. This includes activities that are designed to—

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- Improve health outcomes.
- Prevent hospital readmissions.
- Improve patient safety and reduce medical errors, lower infection and mortality rates.
- Increase wellness and promote health activities.
- Enhance the use of health care data to improve quality, transparency, and outcomes.

Accordingly, this cost is a subset of projected non-benefit expenses (line v).

Similarly, the cost of taxes and fees is the certifying actuary's best estimate of federal and state taxes and licensing and regulatory fees. Taxes and fees are subtracted from the revenue (denominator) in the calculation of the BPT MLR. This includes the health insurance providers fees required by Section 9010 of the Affordable Care Act; it is based on net premiums written during CY2013 and labeled "Insurer Fees" in the BPT.

Line z3 "Insurer Fees" is a subset of line z2 "Taxes and Fees", which in turn, is a subset of projected non-benefit expenses (line v) and/or gain/loss margin (line w).

Worksheet 1 collects the costs (in total dollars) of NBE quality initiatives, taxes and fees, and insurer fees incurred in the base period (Section VI, lines 10a, 10b and 10c). These items are defined in the same manner as for the projection period.

### Capitated Arrangements for Medical Services

The BPT must reflect base period data, projection factors and cost sharing for medical services provided under a capitated arrangement, as explained below. Note that each projection factor must be a blend of the corresponding change in non-capitated and capitated services allowed costs from the base period to the contract year.

#### ✓ Annual Utilization Per 1,000

Utilization rates entered on Worksheet 1 must be based on claims or encounter data for the plan/segment whether or not a related party is involved. However, if encounter data is not available for a certain service, supporting documentation must fully explain the extenuating circumstances and remedy for the deficiency.

#### ✓ Net PMPM, Allowed PMPM, Net Medical Expenses, and Non-Benefit Expenses

The requirements for the "Net PMPM", "Net Medical Expenses", "Non-Benefit Expenses", and "Allowed PMPM" entered on Worksheet 1 depend on whether or not a related party is involved. If the Plan sponsor purchased capitated services from—

- A non-related party, then the allowed cost is the capitation paid for medical services plus any related cost sharing.
- A related party, then the "Related Party Agreements" pricing consideration determines whether or not the net PMPM is the full capitation paid or an adjusted amount.

### Claims Credibility

Based on an application of classical credibility theory to Medicare FFS experience, CMS has established a credibility guideline for projected allowed costs of full credibility for MA plans of 24,000 base period member months. The formula for partial credibility is the square root of the

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result of base period member months divided by 24,000. This formula is a guideline; actuaries must consider the quality of the base period experience when calculating credibility. Actuaries may use a different credibility methodology only if the alternate method is consistently applied among all plans in the contract and is deemed acceptable by CMS.

The certifying actuary must adhere to the following rules of overriding the CMS credibility formula for partial credibility:

- If the CMS formula for partial credibility is applied to base period members months and the resulting credibility is—
  - Less than or equal to 20 percent (that is, 960 or fewer MA member months), then the actuary may override the computed credibility with 0 percent credibility.
  - Greater than or equal to 90 percent (that is, 19,440 or more MA member months), then the actuary may override the computed credibility with 100 percent credibility.

The override is applicable only to the CMS credibility formula; it is not applicable to any alternative credibility formula. If the certifying actuary overrides the CMS credibility, then the override option must be applied consistently among all bids and cannot be applied selectively to certain bids. If the certifying actuary proposes a variation to the override, then the alternate credibility method proposal and documentation requirements apply.

The credibility assumption for projected allowed costs may vary—

- By service category, which may be appropriate if a subset of providers is reimbursed on a capitation basis or if manual rates are being used for newly added benefits.
- By line of business within a contract—for example, special needs plans (SNPs) as compared to other plans.
- From the credibility method used for ESRD membership—which may reach full credibility at lower levels of member months due to the high amount of claims.

Credibility factors are applied to PMPM costs in the BPT. Therefore, actuaries who use different credibility factors for utilization than for unit costs must develop blended factors to use in the bid form.

When the base period experience is partially credible and included in experience used to develop the manual rate, the actuary must consider the extent to which the manual rate development double counts the base period experience. That is, is the manual rate developed relatively independent of the base period experience? (See “The Complement of Credibility” by Joseph A. Boor, *Proceedings of the Casualty Actuarial Society, May 1996, Volume LXXXIII*.) If the proposed manual rate lacks sufficient independence from the base period experience, then an alternative manual rate must be developed (by removing the base period experience from the manual rate development and/or by increasing the use of other, non-base period experience in the manual rate development). As an equivalent alternative to removing the base period experience from the manual rate development, CMS will allow the credibility percentage in the BPT to be adjusted such that the experience for the plan is assigned the appropriate credibility (based on the CMS standard formula), taking into consideration the proportion of the manual experience that is from the subject base plan.



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The manual rate used in a credibility-weighted projection must be based on a sufficient and credible volume of data and be an appropriate predictor of the plan's projected experience.

When assessing the credibility of plan experience, actuaries must consider ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages* and ASOP No. 8, *Regulatory Filings for Health Plan Entities*.

Note that the CMS credibility guideline was developed as weights for blended projected allowed costs. Use of this formula for other pricing assumptions, such as risk scores, must be fully explained and supported.

### **Coordination of Benefits (COB)/Subrogation**

The COB/Subrogation service category is intended to include only those amounts that are to be settled outside the claim system. If an MA organization pays claims for its estimated liability only (that is, net of the amount that is the responsibility of another payer, such as an employer plan or auto policy), the MA organization's net liability amount (before cost-sharing reductions) may be entered on Worksheet 1, Section III, lines a through q.

### **Cost Sharing**

Any member premium(s) and Part D cost sharing must be excluded from MA Worksheet 3.

#### ***Consistency with PBP***

The cost-sharing information entered in the BPT must tie to data in the PBP. Note that, although there are not individual entries for each cost-sharing item listed in the PBP, the value of all cost-sharing items must be reflected in the total per member per month (PMPM) amount in MA Worksheet 3. The PBP line numbers in Section IV of MA Worksheet 3 must be mapped to the BPT line numbers to identify all of the plan cost sharing.

The cost-sharing descriptions in Worksheet 3 may be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits priced in the BPT are consistent with those in the PBP, as part of the quality control process for bid submissions. These descriptions will be deleted from the finalized BPT and therefore will not be uploaded to HPMS for use by CMS or CMS reviewers.

#### ***Medicare FFS Cost Sharing***

For plan cost sharing designed to match Medicare fee-for-service cost sharing (an approach used by some employer-only or union-only group waiver Plan sponsors), the actuary may use the FFS actuarial equivalent cost-sharing PMPM shown in MA Worksheet 4 to estimate the PMPM amount for plan cost sharing. In this case, the user may enter the entire value of cost sharing in Worksheet 3, column i for the effective copay/coinsurance before MOOP.

However, the effective copay/coinsurance after MOOP in Worksheet 3, column j must reflect the expected impact of the OOP max (which is a required PBP entry). Note that if Worksheet 3 is completed for the total population and the total population includes

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non-DE# members, then the effective copay/coinsurance values before and after MOOP (Worksheet 3 columns i and j) may not be equal.

Further, the actuary may enter the effective copay/coinsurance before the MOOP (Worksheet 3 column i) for the DE# plan cost sharing in Worksheet 4, Section IIB, column f.

These approaches do not apply for other levels of cost sharing.

### ***Visitor/Travel Benefits***

In-network cost sharing in Worksheet 3 includes mandatory supplemental benefits offered under the Visitor/Travel Program (that is, Medicare-covered and non-covered services obtained outside the plan's service area).

### **Disease Management**

Disease management (DM) expenses are to be treated as medical expenses, non-benefit expenses, or both, depending upon the nature of the expense. For DM services furnished in a clinical setting by approved providers, costs are to be treated as medical expenses. The cost of durable medical equipment (DME) associated with DM activities is typically classified as a medical expense.

For care management services provided under a SNP model of care—for example, services provided by an interdisciplinary care team as mandated by Medicare Improvements for Patients and Providers Act (MIPPA) and addressed in a HPMS memorandum dated September 15, 2008—costs are treated as medical expenses. Should the team provide additional services, any added costs may be classified by the certifying actuary as medical expenses or as non-benefit expenses.

Absent additional CMS guidance, other DM and care coordination costs —such as those incurred during recruitment, enrollment, and general program communications—are to be classified as non-benefit, or administrative, expenses. In all cases, the classification of DM expenses in the bid must be explained in the supporting documentation for projected allowed costs and non-benefit expenses.

### **Dual-Eligible Beneficiaries**

Dual-eligible beneficiaries are individuals who are eligible for both Medicare and Medicaid benefits under Titles XVIII and XIX of the Social Security Act, respectively. There are several categories of dual-eligible beneficiaries, such as qualified Medicare beneficiaries (QMBs), with different benefits based on income and other qualifying circumstances. Some dual-eligible beneficiaries receive benefits in the form of reduced or eliminated Medicare cost sharing.

The BPT reflects the difference in cost-sharing liability for certain dual-eligible beneficiaries in the development of total medical costs.

### ***Medicaid Revenue and Costs***

In Worksheet 4 Section V, if the Plan sponsor has a separate contract with a state or territory for Medicaid services, then enter projected Medicaid revenue and cost for members of the MA plan.

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- The projected Medicaid cost—
  - Includes the cost to provide Medicaid benefits that the Plan sponsor has contracted to provide plan members under the state or territory Medicaid program.
  - Reflects the full cost, which includes benefit expenses and non-benefit expenses.
  - May include prescription drug benefits that the Commonwealth of Puerto Rico requires to be offered in order to participate in the Platino Program beyond what is submitted in the Part D bid.
- The projected Medicaid revenue is the corresponding revenue received from the state Medicaid program to provide the Medicaid benefits.
- The values must be on a per-member-per-month (PMPM) basis.

Worksheet 1 collects the Medicaid data (in total dollars) of revenue and costs in the base period (Section VI, lines 11a and 11b). These items are defined in the same manner as for the projection period.

The BPT uses this data to calculate an adjusted gain/loss margin in Worksheet 4, Section V (line 3) as:

- Total gain or loss margin (Worksheet 4, Section IIC, line w, column h), plus
- Medicaid Projected Revenue (Worksheet 4, Section V, line 1), less
- Medicaid Projected Cost (Worksheet 4, Section V, line 2).

The adjusted gain/loss margin will be taken into account in satisfying the gain/loss margin requirements. For more information on Medicaid benefits, see Chapter 4, Sections 10.3, 30.4 and 120, of the *Medicare Managed Care Manual* at:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>

### **Definition of DE#**

In the BPT and these instructions, the term “DE#” (*d-e-pound*) refers to dual-eligible beneficiaries without full Medicare cost-sharing liability. Included are dual-eligible beneficiaries who receive benefits in the form of reduced, as well as eliminated, Medicare cost sharing. The non-DE# population includes dual-eligible beneficiaries with full Medicare cost-sharing liability and beneficiaries who are not eligible for Medicaid (that is, non-dual eligible). The terms “total population” and “total beneficiaries” refer to the combined non-DE# and DE# population and beneficiaries, respectively.

Per federal statute, QMBs and qualified Medicare beneficiaries with full Medicaid benefits (QMB+) are not liable for Medicare cost sharing; therefore, these individuals are always considered to be DE# beneficiaries. The certifying actuary must determine which additional beneficiaries are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan’s service area.

The certifying actuary may use plan-specific enrollment data available in HPMS, under the “Risk Adjustment” link, to determine the DE# population as follows:

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- Consider the 2012 membership data posted in HPMS for the contract plan-ID segment(s) listed in Worksheet 1 for the base period.
- Consider the membership in the QMB and QMB+ categories to represent the entire DE# population only if the percentage of total dual-eligible beneficiaries (who comprise all dual-eligible categories and not just the QMB and QMB+ categories) is less than 10 percent of total beneficiaries.
- If the percentage of total dual-eligible beneficiaries is greater than or equal to 10 percent of total beneficiaries, then determine which dual-eligible beneficiaries, in addition to QMB and QMB+ beneficiaries, are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan's service area.

To learn more about the enrollment data posted in HPMS, see the pricing consideration for risk score definitions and information sources.

### ***Bid Values***

The BPT must reflect data and costs for the DE# and non-DE# populations separately, as explained in this section and summarized in Appendix G.

#### **✓ Worksheet 1 – Base Period Data**

The user must enter distinct base period member months and risk scores separately for the total and non-DE# populations regardless of the size of the actual and projected DE# populations. The BPT calculates base period member months and risk scores for the DE# population based on the user-entered values for the total and non-DE# populations. The DE# risk score default calculation may be overwritten by the user, for example, to take into account payments as well as member months.

All other data on Worksheet 1 are to be entered for the total population.

See the Medicaid Revenue and Costs subsection of this pricing consideration for information about entering Medicaid data in Worksheet 1.

#### **✓ Worksheet 2 – Projected Allowed Costs (Blended Rates)**

The BPT calculates blended allowed costs for the total population (column o) based on the projected experience rate and manual rate. The CMS credibility guideline applies to total (DE# plus non-DE#) member months.

The user must enter projected allowed costs for both the non-DE# and DE# populations (columns p and q) as follows:

- Enter projected allowed costs for the non-DE# beneficiaries in column p and projected allowed costs for the DE# beneficiaries in column q.
- If DE# projected member months are between 10 percent and 90 percent inclusive of the total projected member months, then enter distinct DE# and non-DE# projected allowed costs (columns p and q).
- If DE# projected member months are less than 10 percent or greater than 90 percent of the total projected member months, then the user may, at the discretion of the certifying actuary, enter—

## PRICING CONSIDERATIONS

- Non-DE# projected allowed costs (column p) equal to the projected allowed costs for the total population (column o); and
- DE# projected allowed costs (column q) equal to the projected allowed costs for the total population (column o).
- If the projected member months for the DE# population or for the non-DE# population are equal to zero, then enter projected allowed costs for the non-DE# beneficiaries (column p) and for the DE# beneficiaries (column q) equal to the projected allowed costs for the total population (column o). Do not enter zero for these costs.
- Complete Worksheet 2, column p on a “per non-DE# member per month” basis, and complete column q on a “per DE# member per month” basis.

### ✓ **Worksheet 3 – Cost Sharing**

The user must enter cost-sharing information in Worksheet 3 based on benefits outlined in the PBP, including the case when the number of projected non-DE# member months equals zero.

The values apply to the total population or to the non-DE# population as follows:

- If (i) DE# projected member months are less than 10 percent, or greater than 90 percent, but not equal to 100 percent of total projected member months, and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, may, at the discretion of the certifying actuary, apply to either—
  - The non-DE# population; or
  - The total population.
- If DE# projected member months are 100 percent of total projected member months, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, must apply to the total population.
- In all other cases, the utilization rates and PMPM value of cost sharing apply to the non-DE# population.

### ✓ **Worksheet 4 – Projected Required Revenue**

Total medical expenses are calculated separately for non-DE#s, DE#s, and all beneficiaries in subsections A, B, and C, respectively.

- In subsection A (non-DE#s), net medical expenses for Medicare-covered benefits (column o) are calculated based on FFS actuarially equivalent cost-sharing proportions (column k).
- In subsection B (DE#s), comparable medical expenses are calculated for DE# beneficiaries, taking into account the reduced or eliminated cost-sharing liability of dual-eligible beneficiaries, including the state or territory Medicaid cost sharing (column k). Specifically, the Medicare-covered net PMPM reflects—
  - What the plan pays the provider for Medicare-covered services; plus
  - The actual cost sharing for Medicare-covered services; less

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- The state or territory Medicaid cost sharing for Medicare-covered services.
- In subsection C (all beneficiaries), the BPT weights the non-DE# and DE# costs by their respective projected member months (from Worksheet 5) to calculate costs for all beneficiaries. The user must enter total non-benefit expenses and the gain/loss margin for all beneficiaries.

Considerations for developing data for DE# beneficiaries in subsection B include the following:

- All values must be calculated on a “per DE# member per month” basis.
- In column f, plan cost sharing reflects the cost sharing that would be paid if the beneficiary actually paid the plan cost sharing in the PBP.
  - This amount is calculated automatically based on DE# allowed costs in Worksheet 2 and the ratio of non-DE# plan cost sharing and allowed costs in subsection A.
  - However, the default formulas may be overwritten at the discretion of the certifying actuary.
- Also in column f, plan cost sharing must reflect the following:
  - If projected DE# member months is greater than zero, and non-DE# cost sharing (Worksheet 4 Section IIA col. f) is greater than zero, then DE# cost sharing (Worksheet 4 Section IIB col. f) must be greater than zero.
  - If projected DE# member months equal total member months (that is, 100% DE# plan), then DE# cost sharing (Worksheet 4 Section IIB col. f) must equal the cost sharing entered on Worksheet 3.
- In column k, the “Medicaid Cost Sharing” reflects the cost sharing that the beneficiary is liable to pay.
  - The “Medicaid Cost Sharing” includes the following:
    - Cost-sharing amounts required by state or territory Medicaid programs based on the eligibility rules for subsidized cost sharing for DE# beneficiaries in the plan’s service area.
    - Plan cost sharing for non-covered, non-Medicaid benefits.
  - The user must—
    - Calculate the “Medicaid Cost Sharing” as a weighted average of the PMPM cost sharing for all DE# members.
    - Enter data in all cases. The cells must not be left blank.
  - If (i) DE# projected member months are less than 10 percent of total projected member months, and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the user may, at the discretion of the certifying actuary, enter—
    - A zero amount; or
    - The state or territory Medicaid required level of beneficiary cost sharing, if any.

See the Medicaid Revenue and Costs subsection of this pricing consideration for information about entering Medicaid data in Worksheet 4.

✓ **Worksheet 5 – Benchmark**

The user must enter—

- County-specific projected member months and projected risk factors for the total (DE# plus non-DE#) population in Section VI (columns e and f).
- Distinct projected member months and projected risk factor for the non-DE# population in Section II (lines 1 and 4).

In Section II, the BPT displays the total member months and member/payment-weighted average risk factor for the total population based on the county-level information. Values for the DE# population are calculated automatically from the values for the total and the non-DE# populations. The DE# risk score default calculation may be overwritten by the user, for example, to take into account payments as well as member months.

Considerations for developing projected member months include the following:

- The user must not round projected non-DE# member months to 0 percent or 100 percent, even if non-DE# projected member months are less than 10 percent, or greater than 90 percent, of total projected member months.
- CMS expects non-zero DE# projected member months when there are DE# members in the base period. The DE# projected member months may be zero (that is, the user may enter non-DE# projected member months equal to the member months for the total population) only if—
  - All of the existing DE# members terminated and the probability of enrolling DE# members is zero;
  - The certifying actuary adequately explains why the DE# projected membership is zero; and
  - The user enters non-DE# projected member months and risk score equal to the corresponding values for the total population.

Non-DE# and DE# projected risk scores are determined as follows:

- If the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are not all equal, the user must enter a distinct non-DE# projected risk factor.
- If the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, the user must enter a projected risk factor for the non-DE# population equal to the projected risk factor for the total population.

**Employer-Only or Union-Only Group Waiver Plans (EGWPs)**

Each employer-only or union-only group waiver plan (EGWP) bid must reflect: (i) the composite characteristics of the individuals expected to enroll in the EGWP for the contract year; and (ii) the expected underwriting assumptions for all EGWP enrollees, in aggregate. In addition, projected enrollment within the plan's service area must be consistent with the location of employer or union groups.

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Note that the user must enter a county code in Worksheet 5 for each county in the plan's service area in order to generate a county-level payment rate, although the projected member months can be zero.

See Appendix D, "MA Products Available to Groups", for more information.

### **End-Stage Renal Disease (ESRD)**

This subsection applies to the MA BPT. See Appendix I for ESRD-SNPs.

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status based on CMS eligibility records, with the exception of Worksheet 1 Section VI, Worksheet 4 Section III, and Worksheet 5 Section VIII. Note that all Plan sponsors must enter the projected CY ESRD member months in Worksheet 5.

#### ***ESRD Subsidy***

The benchmarks calculated in the MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan, including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In order to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, the BPT allows for an adjustment that is allocated across ESRD and non-ESRD plan members (including out-of-area members). The adjustment is split into two sections, basic benefits and supplemental benefits, although the entire subsidy is added to A/B mandatory supplemental benefits.

#### **✓ Basic Benefits**

The inputs in the Medicare-covered section are (i) projected CMS capitation revenue, (ii) projected net medical expenses, and (iii) projected non-benefit expenses. The projected margin requirement is calculated based on the values for the non-ESRD bid. All fields in this section are to reflect Medicare levels of cost sharing (for example, 20 percent cost sharing for Part B services once the deductible has been met) and must be reported on a "per ESRD member per month" basis.

If the organization does not have fully credible ESRD experience, it may blend the experience with manual rates similar to what is done on Worksheet 2 for non-ESRD enrollees.

The BPT will automatically calculate the plan's costs for basic benefits of ESRD enrollees and will allocate these costs across ESRD and non-ESRD members.

#### **✓ Supplemental Benefits**

The inputs in this section are (i) the projected cost-sharing reduction PMPM for ESRD enrollees, and (ii) the projected PMPM cost of additional benefits for ESRD enrollees. Entries must be reported on a "per ESRD member per month" basis.



## PRICING CONSIDERATIONS

The BPT will calculate the incremental cost of supplemental benefits for ESRD enrollees, including a proportionate share of non-benefit expenses and gain/loss margin, and allocate such costs across ESRD and non-ESRD plan members.

If a zero incremental cost of Mandatory Supplemental (MS) is intended, then the user may either—

- Leave the MS input fields blank; or
- Set these costs equal to the projected cost-sharing reduction PMPM and cost of additional benefits PMPM for non-ESRD enrollees.

### Enrollment

The projected enrollment for the MA bid must be consistent with that for the corresponding Part D bid and must reflect the same underlying population.

ESRD and out-of-area projected member months are used in the calculation of the ESRD subsidy on Worksheet 4.

If the projected enrollment in a particular county in the plan's service area is zero, the user must enter the county code with zero projected member months in order to generate a county-level payment rate for that county.

If a member is assigned to more than one status at the same time, the priority for assigning status for bid development is: (1) hospice, (2) ESRD, (3) out-of area, and (4) all other statuses.

Projected allowed costs and projected risk scores must reflect the impact of out-of-area members as follows:

- If there is a significant difference between the projected allowed costs and/or the projected risk scores for out-of-area members and other members, as determined by the certifying actuary, then both projected allowed costs and projected risk scores must reflect the impact of out-of-area members.

### Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirement beyond medical expenses and non-benefit expenses. It is allocated to Medicare-covered services and A/B mandatory supplemental benefits based on the distribution of total medical expenses across these categories (excluding the impact of the ESRD subsidy).

MA statute requires the MA bid to represent the revenue requirement of the expected population; therefore, the combined margin for the MA and Part D components of MA-PDs is not a substitute for MA margin in these bid instructions. See the MA-PD Margin Requirements subsection and the Part D bid instructions for gain/loss margin requirements that are specific to Part D bids.

When setting gain/loss margins separately for MA and Part D bids, the Plan sponsor must take into account other CMS requirements such as Total Beneficiary Cost (TBC) or Medicare Medical Loss Ratio (MLR). While CMS will not automatically disapprove a bid containing an MA MLR that is less than 85%, CMS's expectation is that the gain/loss margin will be set with appropriate consideration for the need to remit funds to CMS if the Plan sponsor's actual claims experience fails to meet the minimum Medicare MLR requirement. Further, if there is a

conflict between satisfying gain/loss margin requirements and other CMS requirements, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the other CMS requirements. Such modifications to the gain/loss margin requirements must be fully explained and supported.

The gain/loss margin requirements are designed to ensure that gain/loss margins are reasonable and that an MA organization's MA business is not used to subsidize its other health insurance lines of business. Margins for MA business must take into account the degree of risk and surplus requirements of the business.

When some benefits offered by a Plan sponsor are funded by an outside source (such as a state Medicaid program or an employer group), the gain/loss margin must be consistent between the Medicare benefits and benefits funded by other sources. Further, if the Plan sponsor has a separate contract with a state or territory for Medicaid services, then the gain/loss margin used to satisfy all gain/loss margin requirements is the adjusted gain/loss margin for the bid calculated in Worksheet 4 Section V.

Gain/loss requirements apply at two levels—the bid (PBP) level and an aggregate level; both sets of requirements must be met.

### ***Bid (PBP)-Level Requirements***

There is flexibility in setting the gain/loss margin at the bid level provided that—

- The bid offers benefit value in relation to the margin level;
- Anti-competitive practices are not used;
- The bid margin is non-negative or the special rules for bids with negative margin outlined below are followed; and
- All aggregate-level margin requirements described below are met.

#### **✓ Benefit Value**

The bid must provide benefit value in relation to the margin level. For example, a significantly high margin for a bid that is not a valid product pairing will be rejected, absent sufficient support that it is not possible to provide additional benefits that the expected population can utilize.

#### **✓ Anti-competitive Practices**

Anti-competitive practices will not be accepted. For example, significantly low or negative margins for plans that have substantial enrollment and stable experience, or “bait and switch” approaches to specific plan margin buildup, will be rejected, absent sufficient support that such pricing is consistent with these instructions.

#### **✓ Bids with Negative Margin**

If the projected gain/loss margin in the BPT is negative, the Plan sponsor must develop, submit, and follow a bid-specific business plan that achieves profitability in 3 to 5 years. CMS expects that in subsequent years, MA projected gain/loss margins will meet or exceed the year-by-year MA gain/loss margins contained in the original business plan or in subsequent business plans, if any.

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Exceptions to the business plan requirement are cases in which MA products are “paired” and the pricing reflects implicit “subsidies” across benefit or service area offerings. The plans in the product pairing must—

- Have identical service areas;
- All be local coordinated care plans or all be RPPOs or all be PFFS plans;
- All be of the same SNP type or all be non-SNPs; and
- Have a positive combined gain/loss margin for CY2014.

Examples include a low-benefit plan with a positive margin paired with a rich-benefit plan with a negative margin, or an MA-only plan paired with the MA portion of an MA-PD plan.

### ***Aggregate-Level Requirements (Overall Margins)***

The aggregate-level requirements are applied separately to each of following MA plan categories—

- General enrollment plans and institutional/chronic care special needs plans (general enrollment plans & I/C SNPs),
- Dual-eligible special needs plans (D-SNPs), and
- Employer-only or union-only group waiver plans (EGWPs).

For EGWPs, the gain/loss margins entered in the BPTs must comply with the aggregate-level margin requirements at the contract level. (That is, the projected enrollment-weighted average margin for the contract must meet the requirements outlined below.)

For both general enrollment plans & I/C SNPs and D-SNPs, the gain/loss margins entered in the BPTs must comply with the aggregate-level margin requirements at one of the following three levels: contract level, organization level (that is, the legal entity that contracts with CMS to provide MA benefits), or parent-organization level. The Plan sponsor must enter the chosen level of aggregation in the BPT and it must be the same for all general enrollment plans & I/C SNPs and D-SNPs. The level of aggregation selected in the MA BPT must match the level selected in the PD BPT. See the instructions for Worksheet 4, Section IIC line z4.

The following requirements apply to general enrollment plans and I/C SNPs. If general enrollment plans and I/C SNPs are not offered, these requirements also apply, separately, to D-SNPs and EGWPs.

- The aggregate margin must be consistent from year to year.
- The aggregate margin must be consistent with the Plan sponsor’s corporate requirement as follows:
  - If the volume of the Plan sponsor’s non-Medicare health insurance business for which it has discretion in rate setting is greater than or equal to 10% of the Plan sponsor’s total non-Medicare health insurance business (including Medicaid), then the aggregate margin, as measured by a percentage of revenue, must be within 1.5 percent of the Plan sponsor’s margin for all non-Medicare health insurance lines of business.

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- If: (i) the volume of the Plan sponsor's non-Medicare health insurance business for which it has discretion in rate setting is less than 10% of the Plan sponsor's total non-Medicare health insurance business, or (ii) the plan sponsor has no non-Medicare health insurance business; then, the aggregate margin must be set by taking into account the degree of risk and capital and surplus requirements of the business.
- Although actual aggregate margins may 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.

If general enrollment plans and I/C SNPs are offered, the following requirements apply to D-SNPs.

- The aggregate margin must be consistent from year to year.
- The aggregate margin as a percentage of revenue is to 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.
  - Exceptions for unique situations must be fully explained and supported.
  - 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.

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.

### ***MA-PD Margin Requirements***

Plan sponsors have the following two options for setting the margin for the MA and Part D components of MA-PD bids:

- Set the Part D margin for a bid within 1.5 percent of the corresponding MA margin for the same bid. This method must be applied consistently for all bids submitted by the MA organization.
- Set Part D margins equal for all bids within an aggregate-level margin plan category (for example, general enrollment & I/C-SNPs or D-SNPs) at the level of aggregation chosen in the BPT. Within each plan category the Part D margin must be within 1.5 percent of the aggregate-level MA margin at the level of aggregation chosen in the BPT.

## PRICING CONSIDERATIONS

### ***Non-Benefit Expenses***

The gain/loss margin may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income. Non-insurance revenues pertaining to investments and fee-based activities designed to influence state or federal legislation such as the cost of lobbying activities cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009.

### **Hospice Enrollees**

When a Medicare Advantage enrollee goes into hospice status, original Medicare assumes responsibility for Part A and Part B services, and the MA plan continues to cover supplemental benefits. Since the Plan sponsor is not liable for Medicare-covered benefits, in this situation, the following data must exclude enrollees for the time period that they are in that status—

- Base period member months and base period risk scores in Worksheet 1, Sections II and III, and
- Projected member months (entered by county), and
- Projected risk scores.

However, base period data in Worksheet 1, Section VI must include hospice data.

On the other hand, since hospice enrollees continue to receive mandatory supplemental benefits from the MA plan, the projected allowed cost PMPM may reflect claim costs for these enrollees for mandatory supplemental benefits, at the discretion of the certifying actuary—for example, for a dental or another additional benefit. If the projected allowed costs for mandatory supplemental benefits include claims costs for hospice enrollees, then the mandatory supplemental medical expenses in Worksheet 1, Section III must include claims for hospice enrollees for the time period that they are in that status.

The “Monthly membership Report” (MMR) data include hospice status.

### **Manual Rating**

#### ***Manual Rating with FFS Data***

Special considerations, and corresponding documentation, are required when using Medicare FFS data as a manual rating source. Many of the available FFS data are not directly applicable and/or detailed enough to be used as the sole source for projection of medical expenses. For example, it is inappropriate to tabulate claims data using Medicare Public Use Files (PUFs) without making adjustments for corresponding demographic, health, and geographic profiles of the claimants and to account for the non-claimants. Similarly, since the FFS data published in the BPT and/or the MA rate book development files are not split by benefit type, another appropriate source must be used to allocate the data to all of the BPT service categories. Further, as is the case with use of all manual rating sources, adjustments must be made to account for claim expenses that are not reflected in the FFS data, such as claim run-out, inclusion of expenses excluded from the data, and adjustments for medical education expenses.

### ***FFS Costs Used for the Actuarial Equivalent Cost-Sharing Factors***

Please note that the FFS costs used for the actuarial equivalent cost sharing do not include home health care costs since there is no cost sharing for home health services in Medicare FFS. Experience for ESRD enrollees is excluded, as are the costs for hospice services, since MA enrollees do not receive Medicare-covered hospice services through the MA plan. However, hospice enrollees have not been excluded in calculating the PMPM FFS costs used to weight original Medicare FFS cost sharing on Worksheet 5. Further details on the development of the cost-sharing factors, such as the handling of Indirect Medical Education (IME), Graduate Medical Education (GME), and other costs, may be found at <http://www.cms.gov> under Medicare > Medicare Advantage Rates & Statistics > Ratebooks & Supporting Data.

### **Medicare Secondary Payer (MSP) Adjustment**

The bid reflects lower claim amounts for enrollees whose primary coverage is not Medicare (that is, enrollees with Medicare Secondary Payer (MSP) status of aged/disabled MSP or ESRD MSP) and MA organizations receive reduced payments for such enrollees. Accordingly, the BPT uses the MSP adjustment, in conjunction with the projected risk score and the standardized A/B benchmark, to produce a plan A/B benchmark consistent with the plan A/B bid. Although CMS reduces payments for MSP status at the beneficiary level, the BPT applies the MSP adjustment at the bid level. The projected MSP adjustment must be bid specific.

The user may enter a 0% Medicare Secondary Payer (MSP) adjustment in the BPT only if—

- The certifying actuary expects no MSP enrollees in the contract year, or
- The requirements in the Manually Rated Bids subsection of this section are met.

MSP data provided by CMS serve as the basis for projecting the MSP adjustment. This includes—

- Data described in the following sections of Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) and Appendices, which is available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan\\_Communications\\_User\\_Guide.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html):
  - 5.1 Part C Payments: describes the calculation of MA payments.
  - 5.1.5 Part C Payments When Medicare Secondary Payer (MSP) Status Applies: describes the payment reduction based on MSP status.
  - F.29 “Monthly MSP Information Data File”: provides specific information regarding the primary coverage for beneficiaries enrolled in the plan, whose payments were adjusted for MSP that month. It allows Plan sponsors to reconcile beneficiary payments.
- The following data in the Monthly Membership Detail Report (MMR):
  - MSP adjustment factor (field 82).
  - Related fields that provide the payment MSP reduction amount due to MSP for Part A (field 83) and Part B (field 84).
- Rolled-up MSP member counts for the month in the Monthly Membership Summary Data File.
- MSP factors shown in the April Rate Announcement for the applicable payment year.

## PRICING CONSIDERATIONS

The method to calculate the MSP adjustment is based on payment dollars as described below.

- $\text{MSP adjustment} = 1 - X/Y$ , where
  - X = Bid portion of payment reflecting reduced payments for MSP beneficiaries, which excludes MA rebates and basic MA premium, if any. as shown in the example below, and
  - Y = Bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare. This is determined by (i) grossing up the payments for MSP beneficiaries to the amount that would be paid if they did not have a payer that was primary to Medicare and (ii) adding these payments to the payments for non-MSP beneficiaries. The resulting value of Y explicitly takes into account the distinct risk characteristics of MSP beneficiaries as compared to non-MSP beneficiaries.

### Example:

The source data to project the CY2014 MSP adjustment for H1234-001 is March 2013 MMR data for H1234-001.

Step 1: Calculate the CY2013 bid portion of payment reflecting reduced payments for MSP beneficiaries (X).

\$12,000,000 = “Total MA Payment” for the plan from a 2013 MMR file. This field includes all rebates except rebates for reduction of Part B premium and Part D basic premium and excludes part C basic premium, if any.

\$2,253,975 = Sum of rebates for cost-sharing reduction, other mandatory supplemental benefits, and Part D supplemental benefits for the plan. See the PCUG for the applicable field names.

$$X = \$12,000,000 - \$2,253,975 = \$9,746,025.$$

Step 2: Separate the CY2013 bid portion of payment reflecting reduced payments for MSP beneficiaries (X) into payments for non-MSP enrollees and MSP enrollees based on MSP status.

\$9,692,896 = Bid portion of payment for non-MSP enrollees

\$53,129 = Bid portion of payment for MSP enrollees

$$X = \$9,746,025 = \$9,692,896 + \$53,129$$

Step 3: Calculate the projected CY2014 bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare (Y).

.173 = CY2014 “MSP factor” for working aged and working disabled

$$Y = \$9,692,896 + (\$53,129 / .173) = \$9,692,896 + \$307,104 = \$10,000,000.$$

Step 4: Calculate the MSP adjustment to enter into the BPT.

$$\text{MSP adjustment} = 1 - \$9,746,025 / \$10,000,000 = 0.0254 = 2.54\%.$$

### ***Manually Rated Bids***

If the following conditions are met, the actuary does not need to estimate an explicit MSP adjustment for 100% manually rated plans and must enter “0” in the MSP adjustment field in Worksheet 5:

- The basis for projected allowed costs and projected risk scores is FFS data that are reduced for MSP.
- Since the risk score is already reduced for MSP, no further adjustment is needed on Worksheet 5.
- The projected proportion of MSP members is the same as the proportion of MSP enrollees in the FFS data.

Examples of FFS data located on the CMS website that are reduced for MSP include—

- Rate calculation data zip files (for example, “risk\_scores 2003-2010 Non-PAVE.csv” from the CY2013 MA Ratebook).
- Limited Data Sets (or “CMS 5% sample”).
- FFS Data zip files (for example “FFS data 20XX”).

### **Non-Benefit Expenses**

Non-benefit expenses are all of the bid-level administrative and other non-medical costs incurred in the operation of the MA plan.

Worksheet 4 distributes the non-benefit expenses proportionately between Medicare-covered benefits and A/B mandatory supplemental benefits (excluding the PMPM impact of the ESRD subsidy). Non-benefit expenses are further distributed within A/B mandatory supplemental benefits between “Additional Services” and “Reduction of A/B Cost Sharing.”

The non-benefit expenses must be entered separately on the BPT for the following categories:

- Sales & Marketing
  - This category includes all direct and indirect sales and marketing expenses for the MA plan.
  - Examples include, but are not limited to the costs of—
    - Marketing materials;
    - Commissions;
    - Enrollment packages;
    - Identification cards; and
    - Salaries of sales and marketing staff.
- Direct Administration
  - This category includes all expenses for all functions that are directly related to the administration of the MA program.
  - Examples include, but are not limited to—
    - Customer service.
    - Billing and enrollment.
    - Medical management.



## PRICING CONSIDERATIONS

- ▶ Claims administration.
- ▶ Part C National Medicare Education Campaign (NMEC) user fees. CMS collects NMEC user fees based on a percentage of revenue; however, the BPT entry is a PMPM equivalent value consistent with the calculation of other BPT values. Plan sponsors may use the CMS estimate, which amounts to \$0.30 PMPM on a national basis for CY2014, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Plan sponsor’s historical amount relative to the CMS annual national estimate.
- ▶ Uncollected enrollee premium.
- ▶ Certain disease management functions. See the “Disease Management” pricing consideration.
- Indirect Administration
  - This category includes expenses for functions that may be considered “corporate services,” such as the position of CEO, accounting operations, actuarial services, legal services, and human resources.
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).

All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that is consistent with the organization’s standard accounting practices, if not subject to GAAP). Also, acquisition expenses (sales and marketing) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB’s Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes, changes in statutory surplus, investment expenses, and the costs of lobbying activities. See the gain/loss pricing consideration for more information about costs excluded from both non-benefit expenses and gain/loss margin.

Start-up costs that are not considered capital expenditures under GAAP are reported as follows:

- Expenditures for tangible assets (for example, a new computer system) must be capitalized and amortized according to relevant GAAP principles.
- Expenditures for non-tangible assets (for example, salaries and benefits) must be reported in a manner consistent with the organization’s internal accounting practices and the reporting of similar expenditures in other lines of business.

Non-benefit expenses that are common to the MA and Part D components of MA-PD plans must be allocated proportionately between the Medicare Advantage and Part D BPTs.

When Medicare benefits are funded by an outside source (such as a state Medicaid program or an employer group), the non-benefit expenses must be allocated proportionately between Medicare and the other revenue source.

### Optional Supplemental Benefits

See the CY2014 Call Letter at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf> for the following requirements for non-EGWP plans:

- The enrollment-weighted contract-level projected gain/loss margin, as measured by a percent of premium, cannot exceed 15%.
- The sum of the enrollment-weighted contract-level projected gain/loss margin and non-benefit expenses, as measured by a percent of premium, cannot exceed 30% of revenue.

### Part B Premium and Buydown

MA enrollees are required to pay the Part B premium, but it may be reduced by the MA organization through the use of MA rebate dollars.

Note that the Part B premium amount charged by CMS is not the same for all Medicare beneficiaries.

- Section 1839 of the Social Security Act, as amended by section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and section 5111 of the Deficit Reduction Act of 2005, provides for an income-related reduction in the government subsidy of the Medicare Part B premium. Under this provision, for those beneficiaries meeting specified income thresholds, a monthly adjustment amount is added to the Part B premium. The addition of monthly adjustment amounts to the Part B premium obligation of higher-income beneficiaries was phased in over 3 years, beginning in 2007.
- Certain beneficiaries' premium increase is limited by the increase in their Social Security checks (that is, the "hold harmless" provision).
- States, or another third party, may pay the Part B premium for certain beneficiaries.
- Certain beneficiaries may pay a late-enrollment penalty.

Given the MA requirement that benefits must be uniform within an MA plan, the amount of rebate dollars that can be applied to the Part B premium is limited to the amount pre-populated in the BPT by CMS at the time when the BPT is released.

The bid pricing tool and instructions are released annually in April, but the Part B premium is not announced by CMS for the upcoming contract year until several months later. Therefore, plans must use the CMS pre-populated amount in the bid form to determine the level of rebates to allocate to the Part B premium buydown.

### Plan Premiums, Rebate Reallocation, and Premium Rounding

The MA BPT calculates the plan's premium for services under the Medicare Advantage program. Estimated Part D premiums, calculated in the separate Part D BPT, are then entered in the MA BPT in order to—

- Underscore the relationship of MA rebates and Part D premiums.
- Recognize the integrated relationship of the MA and Part D programs, which are viewed by the enrollee as a single product with a single premium.
- Display the total estimated plan premium (sum of MA and Part D).

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When the bid is initially submitted in June, the Part D basic premium entered in the MA BPT is an estimated value. The actual premium will be calculated by CMS following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional preferred provider organization (RPPO) benchmarks (typically in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2014.

For local MA-only plans, the premium shown on the MA BPT in the initial June submission is the final actual premium (not an estimate), since these plans are not affected by the Part D national average monthly bid amount and regional PPO benchmark calculations. Local MA-only plans do not have an opportunity to resubmit in August for rebate reallocations. The initial June bid submission must reflect the desired plan premium.

For RPPO plans, the initial bid submission in June contains an estimated MA premium. The actual MA premium will not be known until August, when the regional PPO benchmarks are calculated by CMS. Note that after the MA regional PPO benchmarks are released by CMS, all regional MA Plan sponsors are required to resubmit the MA BPTs in order to reflect the actual plan bid component in Worksheet 5, and they may need to re-allocate rebates accordingly. This requirement also applies to EGWP regional MA plans (that is, all EGWP RPPOs are required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

MA-PD plans and regional MA-only Plan sponsors have the opportunity to reallocate rebates after the release of the Part D national average bid amount and regional PPO benchmarks. Appendix E contains rebate reallocation and rounding rules, including the following:

- A description of the rebate reallocation period.
- The types of benefit changes that are permitted during the rebate reallocation period.
- A summary of the circumstances under which rebate allocation is required, permitted, or not permitted.
- Limitations on significant changes to the BPT when rounding premiums.
- Specific rules for returning to the target Part D basic premium.
- Examples of rebate allocation and rounding.

It is important to note that for all plans, the initial June bid submission must reflect the desired level of premium rounding, since there are specific rules regarding the level of premium rounding permitted during the rebate reallocation period.

### **Plan Intention for Target Part D Basic Premium**

Following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks, MA organizations may reallocate MA rebate dollars in certain MA-PD bids in order to return to the target Part D basic premium. MA-PD Plan sponsors must choose one of the following two options for the target premium: "Premium amount displayed in line 7d" or "Low Income Premium Subsidy Amount."

The target Part D basic premium is the Part D basic premium net of any MA rebate dollars that were applied to reduce (buy down) the premium; it does not include the Part D supplemental

## PRICING CONSIDERATIONS

premium or the MA premium. Similarly, the low-income premium subsidy amount (LIPSA) applies to the Part D basic premium and does not cover the cost of Part D supplemental benefits.

MA-PD Plan sponsors must choose a plan intention for the target Part D basic premium option in the initial June bid submission and cannot change the chosen target in a subsequent resubmission. CMS will consider only the option selected in the initial June bid submission as the plan's intention.

### Point-of-Service (POS)

There is no separate service category for POS; therefore, POS base period experience data and projected allowed costs must be included in the appropriate service categories.

Section 422.105 of the Code of Federal Regulations and Chapter 4 of the *Medicare Managed Care Manual* allow HMOs to offer a POS option as a mandatory or optional supplemental benefit. Therefore, the projected allowed cost of all POS benefits must be allocated to A/B mandatory supplemental benefits or entered in Worksheet 7 consistent with the PBP. The Plan A/B Bid for Medicare-covered services may not include the cost of POS benefits.

### Rebate Allocations

The following rules apply for rebate allocations in the initial June bid submission:

- The fifth column of Worksheet 6, Section IIIB shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum. Note that if the maximum value is negative (such as a negative Part D basic premium before rebates), then the rebate allocation must be zero.
- The total rebates allocated must equal the total rebates available. Plans are not permitted to under- or over-allocate rebates in total. This rule applies to all bids, including 800-series EGWP bids.
- No rebate allocations may be negative.
- Rebate allocations for “Reduce A/B Cost Sharing” and “Other A/B Mandatory Supplemental Benefits” are rounded by the BPT to two decimals.
- The rebate allocations for Part B premium, Part D basic premium, and Part D supplemental premium are rounded by the BPT to one decimal (that is, the nearest dime) due to withhold system requirements.
- Employer-only group bids (that is, “800-series” plans) cannot allocate rebates to Part D.
- MA-only bids cannot allocate rebates to Part D.
- Rebates allocated to buy down the Part B premium are subject to the maximum amount shown on Worksheet 6 when the BPT is released by CMS. See the “Part B Premium and Buydown” pricing consideration and the instructions for Worksheet 6, Section II, for further information about rebates applied to the Part B premium.

### Regional Preferred Provider Organizations (RPPOs)

#### **Part B-Only RPPOs**

An RPPO plan must cover only enrollees eligible for both Part A and Part B of Medicare. See Chapter 1 of the *Medicare Managed Care Manual* (MMCM), which can

be found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c01.pdf>.

***Intra-Service Area Rate (ISAR) Factors***

In the event that the variation in the MA rates is not an accurate reflection of the variation in a plan's projected costs in its service area, CMS will consider allowing MA organizations, on a case-by-case basis, to request that payment rates for RPPOs be developed using plan-provided geographic intra-service area rate (ISAR) factors. See the instructions for Worksheet 5 for more details on ISAR factors.

**Related-Party Agreements (Medical and Non-Benefit)**

The objective of the requirements for related-party medical or service agreements is to assure that financial arrangements between the Plan sponsor and related parties (i) are negotiated at arm's length, and (ii) do not provide the opportunity to over- or under- subsidize the bid. In these instructions, the term "related party" refers to entities that are associated with the Plan sponsor by any form of common, privately held ownership, control, or investment.

CMS requires all Plan sponsors to disclose whether or not they are in a related-party agreement. Further, Plan sponsors in a related-party agreement must disclose and support all related-party agreements at the time of bid submission and prepare the bid in accord with the guidance below for each related-party agreement identified.

The level of disclosure of related-party medical and service agreements must demonstrate that the operating results and financial positions for organizations participating in such agreements are not significantly higher or lower than the operating and financial arrangements that would have been achieved in the absence of the relationships.

A Plan sponsor in a related-party agreement for administrative or medical services with an organization that has an agreement with an unrelated party must either (i) prepare the BPT in a manner that does not recognize the independence of the subcontracted related party, or (ii) demonstrate that fees associated with the sponsor's related-party transaction are comparable to the fees between the related-party organization and other unrelated parties of similar size and market position to the Plan sponsor.

To provide additional flexibility in presenting the terms of related party agreements in the bid, the next two subsections separately address the treatment of related-party administrative and medical services in the MA BPT.

***Administrative Related-Party Agreements***

The requirements for reflecting the cost of administrative services provided under a related party agreement in the BPT depend on whether or not the related party has an agreement to provide similar services to an unrelated party.

- A Plan sponsor in a related-party agreement for administrative services with an organization that does not have an agreement with an unrelated party must prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. A Plan sponsor in this type of agreement must—
  - Disclose the related-party agreement to CMS at the time of bid submission.

## PRICING CONSIDERATIONS

- Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, consider the gain/loss and non-benefit expense of the related party to be those of the sponsor.
- Develop the gain/loss and non-benefit expense of the related-party subcontractor in accord with these Instructions for completing the bid pricing tool.
- Support the development of the gain/loss and the actual costs associated with the non-benefit expense as required by these instructions for completing the bid pricing tool.
- A Plan sponsor in a related-party agreement for administrative services with an organization that has an agreement with an unrelated party must either (i) prepare the BPT in a manner that does not recognize the independence of the subcontracted related party, or (ii) demonstrate that fees associated with the sponsor's related-party transaction are comparable to the fees between the related-party organization and other unrelated parties of similar size and market position to the Plan sponsor.
  - If the Plan sponsor chooses to prepare the BPT in a manner that does not recognize the independence of the subcontracted related party, the Plan sponsor must—
    - Disclose the related-party agreement to CMS at the time of bid submission.
    - Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, the Plan sponsor must consider the gain/loss and non-benefit expense of the related party to be those of the sponsor.
    - Develop the, gain/loss and non-benefit expense of the related-party subcontractor in accord with these instructions for completing the bid pricing tool.
    - Support the development of the gain/loss and the actual costs associated with non-benefit expense as required by these instructions for completing the bid pricing tool.
  - If the Plan sponsor chooses to demonstrate that fees associated with a related-party transaction for administrative services are comparable to the fees between the related party and other unrelated parties of similar size and market position, the Plan sponsor must—
    - Disclose the related-party agreement to CMS at the time of bid submission.
    - Provide a written document at the time of bid submission fully explaining the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated parties and the fees associated with the related party transaction are comparable, (that is, within 5%).
    - Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all costs in the related-party agreement to non-benefit expense.

### ***Medical Related-Party Agreements***

A Plan sponsor in a related-party agreement for medical services—

- Always has the option to prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. A Plan sponsor in this type of agreement must—
  - Disclose the related-party agreement to CMS at the time of bid submission.
  - Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, consider the medical expense, gain/loss, and non-benefit expense of the related party to be those of the sponsor.
  - Develop the medical expense, gain/loss and non-benefit expense of the related-party subcontractor in accord with these Instructions for completing the bid pricing tool.
  - Support the development of the gain/loss and the actual costs associated with the medical and non-benefit expense as required by these instructions for completing the bid pricing tool.
- May have one of the following options for entering costs associated with such agreement in the BPT, as explained below: (i) allocate all costs in the related-party agreement to medical expenses, or (ii) enter 100% FFS as the net medical cost.
  - To demonstrate that fees associated with a related-party transaction for medical services are comparable to the fees between the related party and other unrelated MA organizations of similar size and market position, a Plan sponsor must—
    - Disclose the related-party agreement to CMS at the time of bid submission.
    - Provide a written document at the time of bid submission fully explaining the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated MA organizations and the fees associated with the related party transaction are comparable (that is, within 5 percent).
    - Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all costs in the related-party agreement to medical expenses.
  - If a Plan sponsor is unable to demonstrate that fees associated with a related-party transaction for medical services are comparable to the fees between the related party and other unrelated MA organizations of similar size and market position, then the Plan sponsor may use 100% FFS for the purpose of demonstrating that the fees associated with the related-party contract are comparable to what would be expected in the absence of the relationship, as long as the fees associated with the related party contract are within 5% of 100% FFS. In this situation a Plan sponsor must—
    - Disclose the related-party agreement to CMS at the time of bid submission.

## PRICING CONSIDERATIONS

- ▶ Provide a written document at the time of bid submission fully explaining that the fees associated with the related party contract are comparable to 100% FFS (within 5%).
- ▶ Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all costs in the related party agreement to medical expenses.
- If (i) a Plan sponsor is unable to demonstrate that fees associated with a related-party transaction for medical services are comparable to the fees between the related party and other unrelated MA organizations of similar size and market position, and (ii) the fees associated with the related party contract are not within 5 percent of 100% FFS, then the Plan sponsor must—
  - ▶ Disclose the related-party agreement to CMS at the time of bid submission.
  - ▶ Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by entering 100% FFS as the net medical cost in the MA BPT.

Regardless of the bidding approach, Plan sponsors must substantiate all information presented in the BPT pertaining to related-party agreements even when that information is held by the related party.

See the instructions for Worksheet 3, Section III, column i for information regarding the cost sharing PMPM for coinsurance under related parties.

### Risk Score Development for CY2014

The projected CY2014 risk score must—

- Be based on the methodology for calculating CY2014 risk scores, as discussed in the CY2014 Rate Announcement.
  - The CY2014 risk scores will be calculated by blending the normalized risk scores calculated under the CY2013 risk model and the CY2014 risk model. The CY2013 risk scores will be weighted at 25% and the CY2014 risk scores will be weighted at 75%.
  - The blended CY2014 risk scores developed for bids should be based on risk scores calculated using each of the CY2013 and CY2014 models, separately projected to CY2014 and adjusted with that model's normalization factor and the MA coding adjustment factor, and then blended.
- Reflect plan-specific coding trend.
- Be appropriate for the expected population.
- Include the appropriate MA coding adjustment factor.
- Be adjusted for FFS normalization.
- For Fully Integrated Dual Eligible (FIDE) SNPs, include a frailty factor, if applicable.



***Risk Score Definitions and Information Sources***

✓ **Member Weighted Versus Member/Payment Weighted**

In Worksheet 5, Section VI, line 2, column f, the BPT calculates a member/payment-weighted average projected risk score (“Total Weighted Average Risk Factor”) from the county-level projected risk factors. In Worksheet 5, Section II, line 4, the BPT captures risk scores for the DE# versus the non-DE# projected enrollment. The BPT contains a default calculation for the DE# risk score that is based on a member-weighted formula. The BPT also contains a default calculation for the DE# risk score entered in Worksheet 1, Section II, line 3 that is based on a member-weighted formula.

The certifying actuary may override the default DE# formulas in Worksheets 1 and 5, to enter member/payment weighted risk scores for DE#. The certifying actuary may choose to explain the relationship of the member-weighted and member/payment-weighted average projected risk scores for DE# in supporting documentation.

✓ **CMS Hierarchical Condition Categories (CMS-HCC) Risk Model**

The CMS-HCC risk model was recalibrated and clinically revised for CY2013. CY2014 risk scores will be calculated by blending the normalized risk scores calculated under the CY2014 model (weighted at 75%) and the normalized risk scores calculated under the CY2013 model (weighted at 25%). The disease groupings in the CY2014 model are updated and some differ from those in past models; in addition, the relative factors are different. For the CY2014 model, diagnoses from CY2010 were used to predict CY2011 expenditures; the denominator year is CY2014.

Additional information on the CY2014 CMS-HCC model, including the CY2014 normalization factors, is contained in the CY2014 Rate Announcement. Information on the CY2013 model can be found in the CY2013 Advance Notice and Rate Announcement.

✓ **Normalization Factors**

The risk scores calculated for each plan enrollee will be divided by the FFS normalization factor. This adjustment accounts for the underlying trend in risk scores and the effect of that trend on average risk scores between the model denominator year (CY2012) and the payment year (CY2014), and is designed to bring the average risk score back to 1.0. Since CMS will be blending the risk scores from the CY2013 and the CY2014 risk models, the projected risk scores in the CY2014 bids must incorporate the following two CY2014 normalization factors:

- 1.041 for the CY2013 risk model.
- 1.026 for the CY2014 risk model.

✓ **MA Coding Adjustment Factor**

In addition to normalization, the projected risk scores in the CY2014 bids must reflect the MA coding adjustment factor. This adjustment accounts for the

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difference in diagnostic coding pattern differences between MA and FFS. The CY2014 MA coding adjustment is 4.91 percent. Accordingly, the projected CY2014 normalized risk scores must each be multiplied by .9509 (which is  $1 - 0.0491$ ).

### ✓ Risk Adjustment Information Sources

The following materials can be found under the “Announcements & Documents” link on the “Medicare Advantage Rates and Statistics” page of the CMS website at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>:

- “Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter”
- “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies” and
- “Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Draft Call Letter”

Also see the links under “Risk Adjustment” and “Ratebooks & Supporting Data.”

Additional information on the risk adjustment process can be found at <http://www.csscooperations.com/>.

### ***Risk Score Calculation Approaches***

#### ✓ Preferred Methodology

The preferred method for projecting the CY2014 risk scores is to start with the CMS-HCC 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 twelve months of 2012 membership with retroactive enrollment adjustments and status adjustments.

These 2012 risk scores are calculated using the risk models that will be used to develop the blended risk scores for CY2014 payment. The plan-level data will be available in early April 2013 under the “Risk Adjustment” link on the HPMS Home page. The risk score data posted in HPMS will be accompanied by technical notes to assist actuaries with understanding the material presented.

There are several advantages to using the 2012 CMS-HCC risk scores provided by CMS in the projection of the CY2014 blended risk score:

- They are consistent with the base-period medical expenses as they include data for out-of-area members.
- They require no adjustment for seasonality.

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- They reflect the most complete MA diagnosis data for 2011 dates of service submitted through January 31, 2013, which is the final reporting deadline for this period.
- They require no adjustment for a risk model changes.

Please note that, since the HPMS plan-level risk scores are based on a mid-year cohort using full calendar-year data with nearly complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete run-out of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2012 to 2014 with explicit adjustment for the following factors:

- Plan-specific coding trend.
- Changes in plan population.
- Missing data adjustment. The risk scores provided using the CY2014 model may be missing diagnosis data depending on whether the Plan sponsor filters for model diagnoses when submitting RAPS data.
  - If the MA organization does not filter diagnoses for model diagnoses when submitting RAPS data, then the risk scores calculated using the CY2014 CMS-HCC model may be complete. (Diagnoses from FFS are complete and CMS uses all MA diagnoses submitted by the MA organization.)
  - If the MA organization does filter diagnoses when submitting RAPS data, then the risk scores are not complete. CMS will provide “missing data” adjustment factors in the technical notes for the risk scores. These “missing data” adjustment factors were derived from FFS data, and are offered to MA organizations to assist them in determining how to adjust the risk scores under the CY2014 model. The actual adjustment will depend on where the MA organization’s 2012 enrollees were enrolled in 2011 (that is, one of the MA organization’s plans, FFS, or a plan with another MA organization).
- Other appropriate factors.

Finally, the projected risk scores must be normalized by dividing by the appropriate CY2014 FFS normalization factors and by applying the CY2014 MA coding adjustment factor.

### ✓ Alternate Approaches

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2013, if there was limited enrollment in 2012, or if there were significant changes in plan or enrollment characteristics between 2012 and 2013.

If a Plan sponsor chooses to develop its risk score by using a methodology different from that preferred by CMS, then, depending on the starting point, the following adjustments must be considered:

- Conversion to a raw risk score.

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- If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized, not adjusted for MA coding) risk score before making other adjustments.
- Note that conversion from 2013 MMR data must adjust for both the normalization factors and the MA coding adjustment factor.
- Impact of lagged versus non-lagged diagnosis data.
  - If the starting risk score is based on lagged diagnosis data, as it is when the initial risk scores are used, then an adjustment is required to transition the scores from lagged to non-lagged. An example is a starting point of March 2013 MMR data, which contain risk scores based on the July 2010 to June 2012 diagnosis data.
- Run-out of diagnosis data.
  - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is diagnosis data and will be when the starting point is MMR data, then an adjustment factor is required to transition the scores from incomplete to complete diagnosis data. Starting risk scores from MMR data do not reflect the final reconciliation.
- Seasonality.
  - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
  - If the starting risk scores are calculated using a risk model (or models) other than those to be used for CY2014 payments, then an adjustment for the risk model change must be made.
  - The beneficiary-level file provided by CMS for CY2014 bid development includes risk scores based on: (i) the CY2012 risk model, and (ii) the two models that will be used to calculate blended risk scores for payment year CY2014, that is, the CY2013 model and the CY2014 model.
- Plan-specific coding trend.
- Population changes.
  - If the starting risk score is based on a population with different risk characteristics than the expected population, then an adjustment for population changes must be made.
- Other appropriate factors.
  - An example of the use of this factor is to assure consistency of projected allowed costs and projected risk scores when: (i) the impact of out-of-area members is significant, and (ii) the projected risk scores do not otherwise reflect the impact of out-of-area members.

Once projected to CY2014, the scores must be: (i) normalized by dividing by the appropriate CY2014 FFS normalization factors, and (ii) adjusted by the MA coding adjustment factor. Note that, if a raw (not normalized) risk score

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associated with a different model calibration year is being normalized, the contract year 2014 FFS normalization factors are not appropriate and must be adjusted.

Supporting documentation that clearly demonstrates consistency with the preferred approach is required.

### **Service Area Changes**

The initial bid submission must reflect pending service area expansions and changes. The user must enter county-level data on Worksheet 5 for each county in the proposed service area. If the pending request is later denied, then the Plan sponsor must resubmit a BPT that includes only the approved counties. The revised bid values must reflect only the change in the service area.

### **Supporting Documentation**

In addition to the BPT and actuarial certification, organizations must submit supporting documentation for every bid. See Appendix B for a description of the supporting documentation requirements, including content, quality, and timing.

### III. DATA ENTRY AND FORMULAS

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This section contains line-by-line instructions for completing the Medicare Advantage (MA) Bid Pricing Tool (BPT), the Medical Savings Account (MSA) BPT, and the ESRD-SNP BPT. It also describes the formulas for calculated cells.

#### MEDICARE ADVANTAGE

To complete the MA bid form, organizations must provide a series of data entries on the appropriate form pages.

The MA bid form is organized as outlined below:

- Worksheet 1 – MA Base Period Experience and Projection Assumptions
- Worksheet 2 – MA Projected Allowed Costs PMPM
- Worksheet 3 – MA Projected Cost Sharing PMPM
- Worksheet 4 – MA Projected Revenue Requirement PMPM
- Worksheet 5 – MA Benchmark PMPM
- Worksheet 6 – MA Bid Summary
- Worksheet 7 – Optional Supplemental Benefits

All worksheets must be completed, with the following exception: if the plan does not offer any optional supplemental benefit packages, then Worksheet 7 may be left blank.

#### MEDICAL SAVINGS ACCOUNT

Appendix H provides additional guidance in completing the MSA BPT for MSA plans, and highlights the differences between the MSA BPT and the MA BPT.

#### ESRD-SNP

Appendix I provides additional guidance in completing the ESRD-SNP BPT for ESRD-SNP plans, and highlights the differences between the ESRD-SNP BPT and the MA BPT.

#### DATA ENTRY

Do not leave a field blank to indicate a zero amount. If zero is the intended value, then enter a “0” in the cell.

## MA WORKSHEET 1 – MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

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The purpose of Worksheet 1 is to capture bid-specific experience for the base period, regardless of the level of enrollment and credibility, and to summarize the key assumptions used to project allowed costs to the contract period.

- Section I contains general plan information that will be displayed on all MA BPT worksheets.
- Section II captures base period background information.
- Section III summarizes the base period data for the plan.
- Section IV captures the factors used to project the base period data to the contract period.
- Section V contains a text field that describes other utilization factors and/or additive factors used in Section IV.
- Section VI contains a summary of the base period revenue and expenses.

Section I must be fully completed for all bids. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2012 regardless of the level of enrollment.

### SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the “General” format in Excel, in order to support the functionality to link spreadsheets. Therefore, certain numeric fields, such as Plan ID, Segment ID, and Region Number, must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros. All fields in Section I must be completed; none can be left blank.

#### Line 1 – Contract Number

Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional Preferred Provider Organization plan), or E (Employer/Union Direct Contract Preferred Provider Organization or Private Fee-for-Service) and includes four Arabic numerals (for example, H9999, R9999, E9999). Be sure to include all leading zeros (for example, H0001).

#### Line 2 – Plan ID

The Plan ID (accompanied by the corresponding contract number) forms a unique identifier for the plan benefit package being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, '001).

If the bid is for a plan that is offered only to employer or union groups, then the Plan ID will be 800 or higher. This plan may be referred to as an “800-series plan” or an “employer/union-only group waiver plan (EGWP).

**Line 3 – Segment ID**

If the bid is for a “service area segment” of a local plan, enter the segment ID. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, ‘01).

**Line 4 – Contract Year**

This cell is pre-populated with the calendar year to which the contract applies.

**Line 5 – Organization Name**

Enter the MA organization’s legal entity name. This information also appears in HPMS and the PBP.

**Line 6 – Plan Name**

Enter the plan name of the plan benefit package. This information also appears in HPMS and the PBP.

**Line 7 – Plan Type**

Enter the type of MA plan. The valid options are listed in the table below. The MA bid form is not completed for MSA, ESRD-SNP, Cost, PACE, and Medicare-Medicaid plans. There is a separate MSA BPT and a separate ESRD-SNP BPT.

Note that an MA organization must offer at least one benefit plan (of any plan type) that includes Part D coverage for each service area. This requirement does not apply to private-fee-for-service (PFFS) plans, which can be offered in a service area without Part D coverage.

Type of Plan	Plan Type Code
<b>Local Coordinated Care Plans:</b>	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMOPOS
HMO with a POS Option	HMOPOS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
<b>Regional Coordinated Care Plan:</b>	
Regional Preferred Provider Organization (RPPO)	RPPO
<b>Private Fee-for-Service Plans:</b>	
Private Fee-for-Service (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
<b>Employer/Union Direct Contract Private Fee-for-Service Plan:</b>	
Employer/Union Direct Contract PFFS	ED PFFS
Employer/Union Direct Contract LPPO	ED LPPO



**Line 8 – MA-PD**

If the plan is offering Part D benefits during the contract year (and is therefore submitting a separate Part D bid form for the same Plan ID), enter “Y”. Otherwise, enter “N”.

**Line 9 – Enrollee Type**

If the bid prices a plan covering enrollees eligible for both Part A and Part B of Medicare, enter “A/B”. If the bid prices a plan covering enrollees eligible for Part B only, enter “PART B ONLY”. (See Appendix C for additional information regarding Part B-only plans.)

If the plan type equals “RPPO”, then the enrollee type must equal “A/B”.

**Line 10 – MA Region**

If the MA plan is a regional PPO (that is, plan type equals RPPO), then input the region number associated with the region that the plan will cover. This field must be entered as a text input (that is, must include a preceding apostrophe) and must include any leading zeros (for example, ‘01).

For regional PPO plans, valid entries are shown in the following table:

Region	Description
01	Northern New England (New Hampshire and Maine)
02	Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont)
03	New York
04	New Jersey
05	Mid-Atlantic (Delaware, District of Columbia, and Maryland)
06	Pennsylvania and West Virginia
07	North Carolina and Virginia
08	Georgia and South Carolina
09	Florida
10	Alabama and Tennessee
11	Michigan
12	Ohio
13	Indiana and Kentucky
14	Illinois and Wisconsin

Region	Description
15	Arkansas and Missouri
16	Louisiana and Mississippi
17	Texas
18	Kansas and Oklahoma
19	Upper Midwest and Northern Plains (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming)
20	Colorado and New Mexico
21	Arizona
22	Nevada
23	Northwest (Idaho, Oregon, Utah, and Washington)
24	California
25	Hawaii
26	Alaska

**Line 11 – Actuarial Swap or Equivalences Apply**

If an individual-market plan will use actuarial swaps or equivalences for employer or union groups, enter “Y”. Otherwise, enter “N”. (See Appendix D for further information on using swaps or equivalences.)

**Line 12 – SNP**

If the plan is a Special Needs Plan (SNP), enter “Y”. Otherwise, enter “N”.

**Line 13 – Region Name**

No user input is required. This field displays the region name, based on the region number entered in line 10.

**Line 14 – SNP Type**

If the plan is a Special Needs Plan, enter the SNP type. Valid options are “Institutional”, “Dual-Eligible”, or “Chronic or Disabling Condition”. This entry must match the SNP type in the PBP.

**Line 15 – EGWP**

No user input is required. This field displays a yes/no indicator based on the plan ID entered in line 2.

**SECTION II – BASE PERIOD BACKGROUND INFORMATION****Line 1 – Time Period Definition**

CMS requires base experience data to be based on claims incurred in calendar year 2012 and generally expects at least 30 days of paid claims run-out; 2 - 3 months of paid claim run-out is preferable. See the “Pricing Considerations” section of these instructions for more information.

The incurred dates are pre-populated on the first two lines, as 1/1 through 12/31 for the 2 years prior to the contract year. Enter the “paid through” date on the third line. For example, if the data reflect payment information through February 2013, then the “paid through” date is 2/28/2013.

**Line 2 – Member Months**

This line is calculated as the sum of the member months entered in line 5. The total member months in line 2 represent the base period experience excluding ESRD enrollees for the time period that enrollees are in ESRD status based on CMS eligibility records and excluding hospice enrollees for the time period that the enrollees are in hospice status.

Enter the subset of member months that represents the non-DE# enrollees. The DE# subset will be calculated as the difference between the total and the non-DE# amounts entered.

**Line 3 – Risk Score**

Enter the final risk score for the non-ESRD and non-hospice members of the population represented in the base period data using the CMS-HCC risk model for payment in CY2012. This factor must include the appropriate MA coding pattern difference adjustment factor and FFS normalization factor for payment in CY2012.

Also enter the risk score for the non-DE# subset. The DE# subset will be calculated based on the total and non-DE# amounts entered. The DE# risk score default calculation may be overwritten by the user. See the “Pricing Considerations” section of these instructions for more guidance.

If DE# members equals zero, then the non-DE# risk score must equal the total risk score.

#### Line 4 – Completion Factor

Enter the multiplicative factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the “paid through” date. The factor entered must be the amount to adjust only the portion of paid claims that requires completion (that is, omit capitations from the calculation of this factor).

For example, assume the following:

Incurred Date	1/1/2012 – 12/31/2012
Paid Through Date (PTD)	2/28/2013
Capitation Payments	\$100
PTD Claims Requiring Completion	\$400
<u>Estimate of Unpaid 2012 Claims as of 2/28/2013</u>	<u>\$30</u>
Total Incurred Claims for 2012	\$530
The Completion Factor would be calculated as:	
Completion Factor = $(400 + 30) \div 400 = 1.075$	

#### Line 5 – Plan/Segments Included in Base Period Data

Enter the contract number and Plan ID (in the format H9999-999) of the plan for the base period data. If the segment is “01” or greater, include the segment ID (H9999-999-01). CMS expects that the contract number, Plan ID, and segment ID, if applicable, for the base period data will be the same as that shown in Section I, except for Plan ID changes and plan crosswalks. In the second column, input each plan’s member months. The sum of the member months entered in line 5 is displayed as the total member months in line 2.

Plan IDs are to be reported in descending order of member months, such that the plan with the largest member months is listed first. For example:

<b>5. Plans in Base</b>	<b><u>Contract-Plan ID</u></b>	<b><u>Member Months</u></b>
a.	H9999-032	5,000
b.	H8888-004-02	1,000
c.		
d.		

If members of more than eight plans are crosswalked into the Plan ID of the bid, then the Plan sponsor must submit supporting documentation that provides the base period member months for each plan included in the data. In this situation, Plan sponsors may enter “All Other” for the contract number/Plan ID indicated in the last line.

Data entered must be in the format of either: H#####-#### or H#####-####-## (with the first character being H, E or R). “All Other” is an acceptable entry in the eighth (that is, last) line.

#### Line 6 – Base Period Description

Use the text box provided to briefly describe changes in the benefit plan, service area, or contract number/Plan ID/segment ID from the base period to the contract year.

### SECTION III – BASE PERIOD DATA (AT PLAN’S RISK FACTOR) FOR 1/1/2012 – 12/31/2012

Section III summarizes the base period data by benefit service category.

In lines a through r:

✓ **Column b, lines a through r – Service Category**

The benefit service categories are displayed in column b.

✓ **Column c, lines a through q – Utilizers**

Enter the number of unique plan enrollees who used each of the service categories for the base period.

This field must reflect the number of members that incurred a service in the specified category in the base period. The determination that a service was used by a beneficiary must be reported consistently with the utilization types displayed in column f.

✓ **Column d, lines a through q – Net PMPM**

Enter the net medical PMPM for each of the benefit service categories for the base period. Note that line r, COB, is set equal to the allowed PMPM in column i by formula.

✓ **Column e, lines a through r – Cost Sharing**

These fields are calculated automatically, as the difference between column i (allowed PMPM) and column d (net PMPM). The values must be greater than or equal to zero. Note that line r, COB, is set equal to zero.

✓ **Column f, lines a through q – Utilization type**

Column f displays the utilization types entered on Worksheet 2. Utilization types are required inputs on Worksheet 2, whether the pricing is based on base period experience data or manual rates.

✓ **Column g, lines a through q – Annualized Utilization/1,000**

Enter the annualized utilization per thousand enrollees for each of the benefit service categories for the base period data. The utilization/1000 must be reported consistently with the utilization type displayed in column f.

✓ **Column h, lines a through q – Average Cost**

These cells are calculated automatically using the utilization provided in column g and allowed PMPM provided in column i.

✓ **Column i, lines a through r – Allowed PMPM**

Enter the allowed PMPM by service category for the base period. Input any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

#### Line s – Total Medical Expenses

Calculated automatically as the sum of lines a through r. Value should be greater than zero if base period member months are greater than zero.

**Line t – Subtotal Medicare-Covered Service Categories**

Calculated automatically as the sum of lines a through k.

**SECTION IV – PROJECTION ASSUMPTIONS**

Section IV contains the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The values in columns j through n are the total adjustment factors from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2012 and that the contract year is 2014. If the utilization trend is 5 percent from 2012 to 2013 and 6 percent for projecting 2013 to 2014, then enter “1.113” in column j ( $1.05 \times 1.06$ ).

**In lines a through r:**

✓ **Column j – Utilization Adjustment – Utilization/1,000 Trend**

Enter the utilization trend factor from the base period to the contract period by service category. An example of the use of this factor is to reflect the impact on utilization of changes in medical management. Entering 1.000 would indicate 0 percent trend. Do not leave blank. Do not enter zero (0).

✓ **Column k – Utilization Adjustment – Benefit Plan Change**

Enter the multiplicative adjustment factor for any benefit plan changes (for example, increase in coverage level from base period to contract period) that affect the base period utilization by service category. Entering 1.000 would indicate 0 percent change. Do not leave blank. Do not enter zero (0).

✓ **Column l – Utilization Adjustment – Population Change**

Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the contract period. Entering 1.000 would indicate 0 percent change. Do not leave blank. Do not enter zero (0).

✓ **Column m – Utilization Adjustment – Other Factor**

Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Examples of the use of this factor are to

- Adjust the base period service area to the contract year service area.
- Remove claims for out-of-area members, if the projected risk scores exclude data for out-of-area members and there are no significant differences between projected allowed costs and projected risk scores for out-of-area and other members.

Entering 1.000 would indicate 0 percent adjustment. Do not leave blank. Do not enter zero (0).

✓ **Column n – Unit Cost Adjustment – Provider Payment Change**

Enter the unit cost adjustments for expected changes in provider payments from the base period to the contract period by service category. Examples of this type of change include increases in provider reimbursement due to inflation, an indexing provision in

provider contracts, or changes in the capitation amount aside from those attributable to changes in utilization or benefit changes. Entering 1.000 would indicate 0 percent trend. Do not leave blank. Do not enter zero (0).

✓ **Column o – Unit Cost Adjustment – Other Factor**

Enter any other factors for unit cost adjustments by service category. An example of this type of change is a change in unit cost due to intensity of service trend. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Entering 1.000 would indicate 0 percent adjustment. Do not leave blank. Do not enter zero (0).

✓ **Columns p and q – Projected Additive Adjustments**

Use these columns to reflect adjustments that are additive; adjustments in columns j through o are multiplicative factors.

- For a benefit that is no longer being offered, but is included in the base period data, enter the projected value of such benefit as a negative number in column p and/or q.
- The adjustment for a new benefit in the contract year depends upon whether or not there is base period experience for other benefits in the same service category.
  - If there is no base period experience for other benefits in the same service category, then enter the projected value of the new benefit as—
    - A positive number in Worksheet 1, column p and/or q, or
    - A manual rate in Worksheet 2.
  - If the base period experience for other benefits in the same service category is 100% credible, then—
    - Enter the projected value of the new benefit as a positive number in Worksheet 1, column p and/or q.
    - Do not change the credibility percentage to 0%; do not enter a manual rate.
  - If the base period experience for other benefits in the same service category is less than 100% credible, then—
    - Enter the projected value of the new benefit as a positive number in Worksheet 1, column p and/or q.
    - Enter the appropriate experience credibility percentage for other benefits in the same service category in Worksheet 2; do not change the credibility percentage to 0%.
    - Enter the projected value of all benefits in the service category, including the new benefit, as a manual rate in Worksheet 2.

Describe the reason for any additive adjustments in Section V.

**SECTION V – DESCRIPTION OF OTHER UTILIZATION ADJUSTMENT FACTOR, OTHER UNIT COST ADJUSTMENT FACTOR, AND ADDITIVE ADJUSTMENTS**

Use this “text box” field to describe the reason for using a multiplicative factor other than 1.000 in columns m and o, and any additive adjustments entered in columns p and q.

## SECTION VI – BASE PERIOD SUMMARY FOR 1/1/2012 – 12/31/2012 (EXCLUDES OPTIONAL SUPPLEMENTAL)

Section VI contains a summary of the actual bid-level base period revenue and expenses. This section must be completed consistently with the “Plans in Base” bid ID information (reported in Section II line 5) and consistently with the information reported in Section III. See the “Pricing Considerations” section of these instructions for more information on reporting base period data.

Note that Section VI must be completed in total dollars, and it must include all beneficiaries (that is, ESRD, hospice, and all other, which includes out-of-area or OOA members). To reiterate: the revenue (line 3), net medical expenses (line 4), and non-benefit expenses (line 7e) must include ESRD and hospice beneficiaries in addition to all other beneficiaries (which include OOA members).

Section VI must not include amounts that are entered in Worksheet 1 of the Part D bid pricing tool. (For example, do not include MA rebates applied to Part D premiums.)

Section VI must not include optional supplemental benefits.

This section must not be left blank.

### Line 1 – CMS Revenue

This field captures MA revenue from CMS earned in the base period in total dollars. Enter bid-based MA payments and accruals from CMS.

- Include rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits.
- Include an estimate of the final risk-adjustment reconciliation payment for CY2012, which will be received in mid-2013, such as the final risk-adjustment reconciliation payment for the prior year, if appropriate.
- Do not include rebates applied to Parts B and D premium buydowns.
- Report the CMS revenues gross of user fee reductions.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees (including OOA members). The sum total is displayed in the fourth column. Values must be greater than or equal to zero.

### Line 2 – Premium Revenue

Enter the revenue from earned MA premiums for the base period in total dollars. Include premiums associated with Medicare-covered and all A/B mandatory supplemental benefits, including actual employer and employee premiums for EGWPs. Do not include premiums for optional supplemental benefits. Do not include Part D premiums.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees (including OOA members). The sum total is displayed in the fourth column. Values must be greater than or equal to zero.

**Line 3 – Total Revenue**

This line is calculated as the sum of lines 1 and 2. If base period data is entered in Section III, then this line total must be completed (that is, must be greater than zero).

**Line 4 – Net Medical Expenses**

Enter the net medical expenses for the base period in total dollars. Include net medical expenses associated with Medicare-covered and all A/B mandatory supplemental benefits, and COB/Subrogation offsets to medical costs. Do not include expenses for optional supplemental benefits, and do not include expenses for Part D benefits.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees (including OOA members).

The sum total is displayed in the fourth column. Values must be greater than or equal to zero. If base period data is entered in Section III, then this line total must be completed (that is, must be greater than zero).

**Line 5 – Member Months**

Enter the base period member months.

In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. The third column displays the amount applicable to all other enrollees (including OOA), which is equal to the member months entered in Section II. The sum total is displayed in the fourth column.

**Line 6 – PMPMs**

Lines 6a through 6d compute base period “per member per month” values for revenue, net medical expenses, non-benefit expenses, and gain/loss margin.

**Line 7 – Non-Benefit Expenses**

Enter the MA non-benefit expenses for the base period in total dollars by category. A total is computed. Values in lines 7a, 7b, and 7c must be greater than or equal to zero. If base period data is entered in Section III, then this line total must be completed (that is, must be greater than zero).

Uncollected premiums must be included in line 7b (“Direct Administration”).

**Line 8 – Gain/Loss Margin**

Calculated as MA revenue (line 3) less net medical expenses (line 4) less MA non-benefit expenses (line 7).

**Line 9 – Percentage of Revenue**

Lines 9a, 9b, and 9c compute the percentage of MA revenue for net medical expenses, non-benefit expenses, and gain/loss margin for the base period.



## WORKSHEET 1

### **Lines 10a, 10b and 10c – NBE Quality Initiatives, Taxes and Fees, and Insurer Fees**

See the “Pricing Considerations” section of these instructions.

The amounts entered in lines 10a, 10b and 10c are in total dollars (not PMPMs).

### **Lines 11a, 11b and 11c – Medicaid Revenue, Medicaid Cost, and Adjusted GLM**

See the “Pricing Considerations” section of these instructions.

The amounts in lines 11a, 11b and 11c are in total dollars (not PMPMs).

## **MA WORKSHEET 2 – MA PROJECTED ALLOWED COSTS PMPM**

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This worksheet calculates the projected allowed costs for the contract year. For plans without fully credible experience, it will be necessary to input manual rate information. The service category lines are the same as those on Worksheet 1.

### **SECTION I – GENERAL INFORMATION**

This section displays the information entered on Worksheet 1, Section I.

### **SECTION II – PROJECTED ALLOWED COSTS**

#### **Lines 1 and 2 – Projected Member Months and Projected Risk Factor**

The projected member months and projected risk factors are obtained from Worksheet 5 for total (non-DE# plus DE#), non-DE#, and DE# members.

**In lines a through r:**

#### **✓ Column e – Utilization Type**

Enter the type of utilization in column e for each benefit category that contains PMPM costs in column o. Do not leave this column blank. If manual rates are not used, entries in this column are still required and are displayed on Worksheet 1.

For each service category line, enter the appropriate utilization type that reflects the annualized utilization/1000 enrollees entered in columns f and i. The valid utilization types are listed below. Note that the valid utilization types vary by service category, as indicated in the BPT cell labels.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P – Procedures
- T – Trips
- S – Scripts
- O – Other

#### **✓ Columns f through h – Projected Experience Rate**

Columns f through h are calculated automatically using the information provided in Sections III and IV on Worksheet 1. No user inputs are needed. Column f calculates the projected utilization, column g is the expected average cost, and column h is allowed PMPM for the contract period, projected based on base period experience data.

#### **✓ Columns i through k – Manual Rate**

For a plan with less than fully credible experience or no experience, enter manual rate information for the contract period, and provide a description of the source of the manual rate in line u.

✓ **Column i – Annual Utilization/1,000**

Enter utilization/1000 assumptions by service category in column i for lines a through q. Do not leave the utilization type (column e) blank.

✓ **Column j – Average Cost**

Average cost will be calculated automatically based on the entries in columns i and k.

✓ **Column k – Allowed PMPM**

Enter PMPM amounts in column k.

✓ **Line r – COB/Subrogation (outside claim system)**

Enter any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

✓ **Column l – Experience Credibility Percentage**

Enter the experience credibility percentage by service category in column l.

The percentage entered must be between 0 percent and 100 percent. This percentage must be between 0 percent and 99 percent if the plan is using a manual rate in the projection. The percentage must equal 100 percent if a manual rate is not being used in the projection.

Between lines s and t of column l, the BPT displays the credibility percentage that is calculated based on CMS guidance and the base period member months entered on Worksheet 1. If the credibility entered by the plan does not equal the CMS credibility, then supporting documentation must be uploaded to HPMS.

✓ **Columns m through o – Blended Rate**

Columns m through o calculate the blended contract year rate, based on the projected experience rate, the manual rate, and the credibility percentage.

Note that, in column o, if the allowed PMPM is greater than zero and a utilization type is not entered, the BPT results in an error. A utilization type must be entered in column e for all service categories in which allowed PMPMs are projected.

PMPM values in column o must be greater than or equal to zero, with the exception of line r (COB/Subrg.), which may be negative.

✓ **Columns p and q – Non-DE# and DE# Allowed PMPMs**

Columns p and q capture the separate allowed PMPM costs for non-DE# and DE# enrollees. Column p must be entered on a “per non-DE# member per month” basis, and column q must be entered on a “per DE# member per month” basis. The amounts entered in columns p and q are used on Worksheet 4.

The BPT contains validations such that the total allowed PMPM in column o must be approximately equal to the weighted average of the non-DE# and DE# PMPMs.

- For each service category, the PMPM value for the total population must be within \$0.05 (5 cents) of the weighted average of the non-DE# and DE# PMPMs.

## WORKSHEET 2

- The BPT will finalize only if the total PMPM for all enrollees is within \$0.50 (50 cents) of the weighted average of the non-DE# and DE# PMPMs.

See the “Pricing Considerations” section of these instructions for more information on the reporting requirements of DE# pricing.

Enter any COB/Subrogation offsets to costs as a negative number, since line r will be added to total medical expenses.

PMPM values entered in columns p and q must be greater than or equal to zero, with the exception of line r (COB/Subrg.), which may be negative.

### ✓ **Column r – Percentage of Services Provided Out-of-Network**

Enter the percentage of total allowed costs that are expected to be provided out-of-network for each service line. Enter a 0 if zero percent is expected; do not leave the field blank to indicate 0 percent. The percentage entered must be between 0 percent and 100 percent.

If the plan has OON cost sharing PMPM on Worksheet 3, or is an RPPO plan type, then it is expected that the percentage of services provided out-of-network on Worksheet 2 will be greater than 0 percent.

### **Line s – Total Medical Expenses**

Calculated automatically as the sum of lines a through r. Values must be greater than or equal to zero.

### **Line t – Subtotal Medicare-Covered Service Categories**

Calculated automatically as the sum of lines a through k. Values must be greater than or equal to zero.

### **Line u – Manual Rate Description**

Use the text box to describe the general approach to manual rating, including a description of the source of the manual rate. This description is in addition to the required supporting documentation (see Appendix B). If the experience credibility used is less than 100 percent, then the manual rate description must not be left blank.

## MA WORKSHEET 3 – MA PROJECTED COST SHARING PMPM

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Worksheet 3 summarizes the projected MA cost sharing for the contract year and includes both in-network and out-of-network cost sharing.

See the “Pricing Considerations” section of these instructions for more information on cost sharing in general and the cost sharing for DE# beneficiaries.

### SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

### SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

The responses to the plan-level (out-of-pocket) OOP maximum drop-down questions depend on how Section D of the Plan Benefit Package (PBP) is completed and must be—

- “No” if the corresponding in-network, out-of-network, or combined plan-level maximum enrollee OOP cost is blank in the PBP or if the PBP field is not applicable.
- “Yes” if the corresponding in-network, out-of-network, or combined plan-level maximum enrollee OOP cost is entered in the PBP. The PBP amount must be entered in the corresponding amount field on the BPT.

The responses to the plan-level OOP maximum drop-down questions are summarized below by type of plan:

- For HMO plans and HMO with optional supplemental POS plans enter—
  - “Yes” for the plan-level in-network OOP maximum.
  - “No” for the plan-level out-of-network and combined OOP maximum.
- For HMO with mandatory supplemental POS plans enter—
  - “Yes” for the plan-level in-network OOP maximum in Section D.
  - “Yes” or “No” for the plan-level out-of-network OOP maximum in Section D of the PBP, consistent with the PBP. For example, if there are POS OOP maximums in Section C of the PBP for a sub-set of service categories, but no plan-level out-of-network (POS) OOP maximum in Section D, then enter “No” for this question.
  - “Yes” or “No” for the plan-level combined OOP maximum, consistent with the PBP.
- For local PPO and regional PPO plans enter—
  - “Yes” for the plan-level in-network OOP maximum.
  - “Yes” or “No” for the plan-level out-of-network OOP maximum, consistent with the PBP.
  - “Yes” for the plan-level combined OOP maximum.
- For full network PFFS and partial network PFFS plans enter—
  - “No” for the plan-level in-network and out-of-network OOP maximums.
  - “Yes” for the plan-level combined OOP maximum.

- For non-network PFFS plans enter—
  - “No” for the plan-level in-network and out-of-network plan-level OOP maximums.
  - “Yes” for the plan-level combined OOP maximum. Note that this question corresponds to the non-network maximum enrollee out-of-pocket cost amount entered on the PBP.

When the response to the OOP maximum drop-down question is “Yes”, the entry in the OOP maximum amount field must be numeric and greater than or equal to zero.

**Line 1 – In-Network**

In the first field, select “Yes” or “No” to the question “Is there a plan-level in-network OOP maximum?” If the answer is “Yes”, then enter in the second field the maximum total dollar amount that a member could pay for in-network cost sharing for the contract year. This dollar amount must match the dollar amount entered in the in-network maximum enrollee OOP cost field in Section D of the PBP.

**Line 2 – Out-of-Network**

In the first field, select “Yes” or “No” to the question “Is there a plan-level out-of-network OOP maximum?” If the answer is “Yes”, then enter in the second field the maximum total dollar amount that a member could pay for out-of-network cost sharing for the contract year. This dollar amount must match the dollar amount entered in the out-of-network maximum enrollee out-of-pocket cost field in Section D of the PBP.

**Line 3 – Combined**

In the first field, select “Yes” or “No” to the question “Is there a plan-level combined OOP maximum?” If the answer is “Yes”, then enter in the second field one of the following amounts:

- For non-network PFFS plans, the maximum total dollar amount that a member could pay in the contract year for cost sharing. This dollar amount must match the dollar amount entered in the non-network maximum enrollee out-of-pocket cost field in Section D of the PBP.
- For other plans, the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network. This dollar amount must match the dollar amount entered in the combined (in-network and out-of-network) maximum enrollee out-of-pocket cost field in Section D of the PBP. Do not sum separate in-network and out-of-network OOP maximums.

**Line 4 – Maximum Cost-Sharing Description**

In the text box provided, briefly explain the methodology used to reflect the impact of maximum cost sharing on the PMPM values entered in Section III.

**SECTION III – DEVELOPMENT OF CONTRACT YEAR COST SHARING PMPM (PLAN’S RISK FACTOR)**

Section III summarizes the cost sharing for all services included in the plan benefit package.

### WORKSHEET 3

The service categories are the same as presented in previous worksheets, except that line r (COB) has been omitted. Please note that for some service categories (for example, “Inpatient Facility”), there is more than one cost-sharing line available. A number of lines allow you to enter multiple cost-sharing items in a service category to better match the PBP. In addition to the lines presented, you may also use the ten blank lines at the bottom of the section to include additional cost-sharing items that do not fit into an already defined service category line item. Do not insert any additional rows.

The BPT allows for flexibility in entering cost-sharing information. Following are some examples:

**Example 1:** The PBP contains in-network inpatient cost sharing of \$100 per day for both acute and psychiatric stays with no service-specific cost sharing maximums. Assume that the total in-network inpatient utilization/1000 is 2,000 days, 1,900 of which are for acute and the remaining 100 for psychiatric. The projected impact of the plan-level in-network cost sharing maximum is \$0. These figures could be reflected in the bid form in either of the following ways:

**Option A:**

<u>Column d</u>	<u>Column g</u>	<u>Column j</u>	<u>Column k</u>
Line a1 – Acute	1,900	\$100.00	\$15.83
Line a2 – Mental Health	100	\$100.00	\$ 0.83
Total	2,000	\$100.00	\$16.67

**Option B:**

<u>Column d</u>	<u>Column g</u>	<u>Column j</u>	<u>Column k</u>
Line a1 – Acute	2,000	\$100.00	\$16.67
Total	2,000	\$100.00	\$16.67

**Example 2:** The PBP has in-network professional copays of \$10 for PCP, \$20 for specialists excluding mental health (MH) services, \$20 for MH group sessions, and \$40 for individual MH sessions with no service-specific cost sharing maximums. The projected impact of the plan-level in-network cost sharing maximum is \$0. Assume that in-network office visit utilization is distributed as follows:

<u>Type of Service</u>	<u>Utilization</u>
PCP	5,000
Mental Health – Individual	50
Mental Health – Group	50
Other Spec	2,900
Total	8,000

Following are some of the options that could be used to complete the bid form:

**Option A:** Use the finest level of detail, with individual MH in line i3 and group MH in line i6.

### WORKSHEET 3

<u>Line – Description</u>	<u>Column g</u>	<u>Column j</u>	<u>Column k</u>
Line i1 – PCP	5,000	\$10.00	\$4.17
Line i2 – Specialist excl MH	2,900	\$20.00	\$4.83
Line i3 – Mental Health	50	\$40.00	\$.17
Line i6 – Other	<u>50</u>	<u>\$20.00</u>	<u>\$.08</u>
Total	8,000	\$13.88	\$9.25

Note that one of the blank rows at the bottom of the form could also be used to enter one of the MH copays.

**Option B:** Same as Option A, but combine the individual and group MH copays onto line i3.

<u>Line – Description</u>	<u>Col g</u>	<u>Col h (not in finalized BPT)</u>	<u>Col j</u>	<u>Col k</u>
Line i1 – PCP	5,000	\$10 per visit	\$10.00	\$4.17
Line i2 – Specialist excl MH	2,900	\$20 per visit \$40/visit for indiv MH sessions,	\$20.00	\$4.83
Line i3 – MH	<u>100</u>	\$20/visit for group MH	<u>\$30.00</u>	<u>\$.25</u>
Total	8,000		\$13.88	\$9.25

**Option C:** Enter all services on one line (for example, i6).

<u>Line – Description</u>	<u>Col g</u>	<u>Col h (not in finalized BPT)</u>	<u>Col j</u>	<u>Col k</u>
		\$10/visit PCP		
		\$20/visit non-MH specialist		
		\$20/visit for group MH		
Line i6	<u>8,000</u>	\$40/visit for indiv MH	<u>\$13.88</u>	<u>\$9.25</u>
Total	8,000		\$13.88	\$9.25

#### Column c – Service Category

This column is pre-populated for most of the available rows. When the blank rows at the bottom of the worksheet are used to provide detailed cost-sharing information, the valid entries are as follows:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- Outpatient (OP) Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-covered)
- Dental (Non-covered)
- Vision (Non-covered)



- Hearing (Non-covered)
- Health & Education (Non-covered)
- Other Non-covered

Technical note: When the blank rows at the bottom of the worksheet are used, the service category entries must match those listed above exactly. If there is a typographical error in the entry, the BPT will not recognize the entered cost-sharing information on Worksheet 4.

**Column d – Service Category Description**

This column provides a description for many of the fixed-line cost-sharing items. For lines with multiple options (for example, “Inpatient Facility”), the description is intended to help you provide detailed information that can easily be checked against the PBP. You may input a description if you are using a blank row at the bottom of the worksheet to enter additional cost-sharing lines.

**Column e – Measurement Unit Code**

For each cost-sharing line, enter the appropriate measurement unit that reflects the projected utilization per 1,000 or PMPM value entered in column g. The valid utilization types are listed below. Note that the valid utilization types vary by service category, as indicated in the BPT cells.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P – Procedures
- T – Trips
- S – Scripts
- O – Other
- Coin – Coinsurance
- Ded – Deductible (used only for single-line items, such as per-benefit period deductibles; plan-level deductibles that apply to multiple service categories and the pricing impact are entered in the footnote and column f)

**Column f – In-Network Effective Plan-Level Deductible PMPM**

For each cost-sharing line, enter—

- The effective PMPM cost of certain plan-level deductibles contained in Section D of the PBP as summarized below by type of plan:
  - For local PPO and regional PPO plans, if the PBP contains an annual plan deductible that is applied to in-network benefits, enter the effective PMPM cost of such deductible.
  - For other plan types, if the PBP contains an in-network plan-level deductible and/or a combined plan-level deductible that is applied to in-network benefits, enter the effective PMPM cost of such deductible(s).

- A PMPM cost such that the sum total represents the effective PMPM cost of the deductible(s) that is attributable to in-network benefits.

If an effective cost of a plan-level deductible is entered in column f, then the amount of the plan-level deductible must be entered in the footnotes. See the instructions for the footnotes in columns h, k and n for information about plan-level deductible amounts and the applicability to Part B-Only services.

Note to include the effect of service-specific deductibles entered in Section B of the PBP in columns g through j.

### Columns g through k – In-Network Cost Sharing after Plan-Level Deductible

These fields pertain to the in-network cost sharing priced in the BPT.

#### ✓ Column g – In-Network Util/1000 or PMPM

Enter the projected in-network utilization/1000, or PMPM value in the case of coinsurance—

- For the time period for which the cost sharing applies.
- After the plan-level deductible has been satisfied.
- Before the impact of the OOP maximum.

#### ✓ Column h – In-Network Description of Cost Sharing/Additional Days/Benefit Limits

These cells are text fields that may be used by bid preparers to enter internal descriptions of in-network plan cost sharing contained in the PBP, including descriptions of all PBP benefits priced together within each BPT service category and any benefit limits. These details are useful since each BPT category may map to several PBP benefit categories.

The text in column h above the “Total” row will be deleted from the finalized file and therefore will not be uploaded to HPMS. Bid preparers must not enter information in this section meant to be communicated to CMS or to CMS reviewers, as CMS will not have access to it. This text will not be deleted from the working file or from the backup file during finalization.

Enter the actual combined plan-level deductible amount (if applicable) in the footnote.

#### ✓ Column i – In-Network Effective Copay/Coinsurance before OOP Max

Enter the projected effective in-network cost-sharing amount after the plan-level deductible has been satisfied and before the impact of the OOP max. This amount must represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g).

Note that this cell is not used to calculate the in-network PMPM in column k. However, if a value is entered in column j, then a corresponding value must be entered in column i for each service category.

Also note that, if a service is provided under an agreement between the Plan sponsor and a related party, the effective coinsurance percentage in column i may not match the coinsurance percentage in the PBP. Specifically, the related party pricing consideration may require a shift in projected allowed costs from medical expenses to non-benefit

### WORKSHEET 3

expenses and gain/loss margin, which affects the in-network PMPM in column g, but not the cost sharing paid by the member. Following is an example:

**Example:** The PBP contains in-network cost sharing of 20%. \$3 PMPM of projected allowed costs must be shifted from medical expense to non-benefit expense and gain/loss margin in order to satisfy the related party requirements. BPT values before related-party requirements are taken into account would be as follows:

(e) <u>Measurement Unit Code</u>	(g) <u>PMPM</u>	(i) <u>Effective Coin Before OOP Max</u>	(j) <u>Effective Coin After OOP Max</u>	(k) <u>In-Network PMPM</u>
Coin	25	.2000	.1900	4.75

BPT values that recognize the independence of the subcontracted related party are as follows:

(e) <u>Measurement Unit Code</u>	(g) <u>PMPM</u>	(i) <u>Effective Coin Before OOP Max</u>	(j) <u>Effective Coin After OOP Max</u>	(k) <u>In-Network PMPM</u>
Coin	22	.2273	.2159	4.75

#### ✓ **Column j – In-Network Effective Copay/Coinsurance after OOP Max**

Enter the projected effective in-network cost-sharing amount after the plan-level deductible has been satisfied and including the impact of the OOP max. This amount must represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g). This cell is used to calculate the in-network PMPM in column k. The values in column j must be less than or equal to the corresponding values in column i.

Enter the PMPM pricing impact of the in-network OOP maximum in the footnote.

#### ✓ **Column k – In-Network PMPM**

These cells are calculated automatically and reflect the projected cost-sharing value PMPM for in-network services, excluding the effective in-network plan-level deductible and including the impact of the OOP maximum. The formula uses the utilization or PMPM amounts in column g and the effective copay or coinsurance in column j.

- If the measurement unit is coinsurance (“Coin”), then the calculation is column g times column j.
- For measurement units other than coinsurance, the calculation is column g times column j divided by 12,000.

Enter the actual in-network plan-level deductible and the pricing impact of the in-network OOP maximum in the footnote.

**Column l – Total In-Network Cost Share PMPM**

These cells are calculated automatically as the sum of columns f and k. This column is the total projected cost sharing for in-network services.

Note that, in column l, if the cost sharing PMPM is greater than zero and a utilization type is not entered, the BPT result is an error. A utilization type must be entered in column e for all service categories into which cost sharing PMPMs are entered.

**Column m – Out-of-Network Description of Cost Sharing/Additional Days/Benefit Limits**

This column may be used to enter internal descriptions of the out-of-network cost sharing for each service category. This column will be deleted from the finalized file. See the instructions for in-network cost sharing in column h for additional information.

**Column n – Out-of-Network Cost Sharing PMPM**

Enter the effective value of cost sharing for out-of-network benefits for each service category. This column must reflect the total projected cost sharing for all out-of-network services.

Enter the actual out-of-network plan-level deductible and the pricing impact of the out-of-network OOP maximum in the footnote.

**Column o – Grand Total Cost Share PMPM (In-Network and Out-of-Network)**

This column is calculated automatically as the sum of the in-network cost sharing (column l) and the out-of-network cost sharing (column n).

**Footnotes**

The footnotes for columns h, k and n are used to enter plan-level deductible dollar amounts contained in Section D of the PBP and to answer questions about the applicability of plan deductibles to Part B-Only services, as explained below. If the PBP indicates that the cost sharing is designed to match Medicare FFS cost sharing, enter the amount of the plan-level deductible as “Medicare FFS”. Otherwise, enter the actual amount, for example, “\$500”.

✓ **Column h**

The first footnote contains the “Actual combined plan level deductible,” which includes a combined plan-level or annual deductible. Consistent with the PBP,—

- For local PPO and regional PPO plans, if the PBP indicates that the annual deductible amount applies to both in-network and out-of-network benefits, enter the annual deductible amount.
- For other plan types, enter the combined plan-level deductible amount, consistent with the PBP.

In the second footnote, consistent with the PBP, enter “Yes” or “No” to the question “Does the actual combined plan-level deductible apply to Part B-Only?”

✓ **Column k**

The first footnote contains the “Actual in-network plan-level deductible,” which includes an in-network plan-level or annual deductible. Consistent with the PBP,—

- For local PPO and regional PPO plans, if the PBP indicates that the annual deductible amount applies to in-network benefits, enter the annual deductible amount.
- For other plan types, enter the in-network plan-level deductible amount.

In the second footnote, consistent with the PBP, enter “Yes” or “No” to the question “Does the actual in-network plan-level deductible apply to Part B-Only?”

In the third footnote, enter the PMPM pricing impact of the in-network OOP maximum. This value must reflect the PMPM difference between the pricing for in-network cost sharing before and after the OOP maximum has been applied. This value must be greater than or equal to zero.

✓ **Column n**

The first footnote contains the “Actual out-of-network plan-level deductible,” which includes an out-of-network plan-level or annual deductible. Consistent with the PBP,—

- For local PPO and regional PPO plans, if the PBP indicates that the annual deductible amount applies to out-of-network benefits, enter the annual deductible amount.
- For other plan types, enter the out-of-network plan-level deductible amount.

In the second footnote, consistent with the PBP, enter “Yes” or “No” to the question “Does the actual out-of-network plan-level deductible apply to Part B-Only?”

In the third footnote, enter the PMPM pricing impact of the out-of-network OOP maximum. This value must reflect the PMPM difference between the pricing for out-of-network cost sharing before and after the OOP maximum has been applied. This value must be greater than or equal to zero.

## **SECTION IV – MAPPING OF PBP SERVICE CATEGORIES TO BPT**

Section IV captures the mapping of PBP benefit categories to BPT service categories for all benefits and services included in the plan benefit package. These cells are pre-populated based on the suggested mapping of PBP to BPT categories in Appendix F, but must be overwritten by the user to reflect the actual mapping used in developing PMPM amounts by service category in the BPT.

## MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

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This worksheet uses the allowed costs (Worksheet 2) and cost sharing (Worksheet 3) to determine net medical costs in Section II. Below are the subsections contained in Section II:

- Subsection A - “Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability).”
- Subsection B - “DE# (Dual-Eligible Beneficiaries without full Medicare cost sharing liability).”
- Subsection C - “All Beneficiaries.” (Total of subsections A and B)

Subsection C is the weighted average total of subsections A and B.

Non-benefit expenses and gain/loss margin are entered in Section IIC to establish the plan’s revenue requirements for the contract year. Values are allocated between Medicare-covered benefits and A/B mandatory supplemental benefits and reflect the plan’s risk factor for the contract period. In Section III, the Plan sponsor may enter the projected ESRD “subsidy”.

The Plan sponsor may use Section IV to provide the costs associated with additional “unspecified” benefits for employer/union-only group waiver plan (EGWP) bids. Section V captures projected Medicaid data.

See the “Pricing Considerations” section of these instructions for information on completing Worksheet 4 for DE# beneficiaries.

### SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

### SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

#### Subsection A – Non-Dual-Eligible Beneficiaries and Dual-Eligible Beneficiaries with Full Medicare Cost-Sharing Liability (Non-DE#)

The risk factor for non-DE# beneficiaries is obtained from Worksheet 5 and displayed at the top of this section.

**In lines a through r:**

✓ **Column e – Allowed PMPM for Total Benefits**

The allowed PMPM is obtained from column p of Worksheet 2.

✓ **Column f – Plan Cost Sharing for Total Benefits**

The total in-network and out-of-network cost sharing PMPMs are obtained from column o of Worksheet 3 for each service category (except for line r). If you enter additional cost-sharing lines on Worksheet 3, then you must verify that the total cost sharing on Worksheet 4 equals the total on Worksheet 3.

✓ **Column g – N/A**

This column is left intentionally blank; it is not applicable to this section.

✓ **Column h – Net PMPM for Total Benefits**

The net PMPM is calculated automatically as column e less column f. Values must be greater than or equal to zero.

✓ **Columns i and j – Percentage for Covered Services**

The PMPM amounts shown in columns e, f, and h reflect all benefits covered by the MA plan. In columns i and j, you must enter the expected percentages of these benefits that represent Medicare-covered. The percentages in column i are used to allocate allowed costs (column e) between Medicare-covered (column m) and A/B mandatory supplemental benefits. The percentages in column j are used to allocate the plan's cost sharing (column f) between plan cost sharing for Medicare-covered services (column l) and cost sharing for A/B mandatory supplemental benefits.

The percentage entered must be between 0 percent and 100 percent.

For services that are non-covered as defined, the percentage is defaulted to 0.0 percent (for example, line l, "Transportation Non-covered"). For all other services, the Plan sponsor must estimate the percentage of covered services for both the allowed costs and the cost sharing. Enter these percentages in columns i and j. If the plan's benefit for a service is richer than that under FFS Medicare or is classified as a mandatory supplemental benefit in the PBP such as a POS benefit, the percentage entered must be less than 100 percent.

**Example:**

The Plan sponsor estimates that 99.92 percent of the allowed PMPM in column e for outpatient facility emergency services is for Medicare-covered services and 0.08 percent is for A/B mandatory supplemental benefits, whereas 98.03 percent of the cost sharing PMPM in column f is for Medicare-covered services and 1.97 percent of the cost sharing is for A/B mandatory supplemental benefits. The entries in columns i and j would be as follows:

(c) Service Category	(j) % for Cov. Svcs	
	(i) Allowed	(j) Cost Sharing
f. OP Facility – Emergency	99.92%	98.03%

See Appendix C for instructions on completing columns i and j for Part B-only plans.

For the Medicare-covered service categories (lines a through k), the values entered in columns i and j must generate appropriate pricing for mandatory supplemental benefits in columns p through r, consistent with the PBP. In addition, the relationship of the PBP benefits and the BPT pricing is to be consistent with the mapping entered on Worksheet 3 Section IV. For example, if a plan covers additional inpatient hospital days, and the plan is using the suggested mapping from Appendix F, the PMPM pricing

for the non-covered inpatient services is to be represented in line a, column p, “Net PMPM for Additional Services.”

✓ **Column k – FFS Medicare Actuarial Equivalent (AE) Cost-Sharing Proportions**

These values are populated automatically based on the enrollment projections entered in Worksheet 5.

✓ **Column l – Plan Cost Sharing for Medicare-Covered Services**

This column calculates the portion of the plan’s cost sharing that is attributable to Medicare-covered benefits (calculated as column f times column j). This column is used to determine the reduction of A/B cost sharing in column q.

Plan cost sharing for Medicare-covered services is compared to Medicare FFS actuarially equivalent cost sharing in the BPT “red-circle” validations.

✓ **Columns m through o – Medicare-Covered using Actuarial Equivalent Cost Sharing**

These columns are calculated automatically and are the basis for the costs included in the “Plan A/B Bid.”

✓ **Column m – Allowed PMPM**

The Medicare-covered allowed costs are calculated automatically based on the percentage of Medicare-covered benefits input in column i. Column m is calculated as column e times column i.

✓ **Column n – Fee-for-Service Medicare Actuarial Equivalent (AE) Cost Sharing**

The FFS Medicare AE cost sharing PMPMs are based on the proportions in column k. Column n is calculated as column k times column m.

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

**Columns p through r – A/B Mandatory Supplemental (MS) Benefits**

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

✓ **Column p – Net PMPM for Additional Services**

These amounts reflect the net costs (that is, allowed costs less enrollee cost sharing) for non-covered benefits. This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing for non-covered benefits (column f minus column l). These values must be greater than or equal to zero (except line r, COB, which may be negative).

✓ **Column q – Reduction of A/B Cost Sharing**

This column is the difference between FFS AE cost sharing and the plan cost sharing for Medicare-covered services, calculated automatically as column n minus column l. This reduction is sometimes referred to as the “FFS cost-sharing buydown.”



✓ **Column r – Total A/B Mandatory Supplemental Benefits**

This column is calculated automatically as the sum of columns p and q.

**Line s – Total Medical Expenses**

The total medical expense is the sum of lines a through r, except for columns i, j, and k.

**Subsection B – Dual-Eligible Beneficiaries without Full Medicare Cost-Sharing Liability (DE#)**

The risk factor for DE# beneficiaries is obtained from Worksheet 5 and displayed at the top of this section.

**In lines a through r:**

✓ **Column e – Reimbursement plus Actual Cost Sharing for Total Benefits**

Calculated automatically as the sum of columns g and h.

✓ **Column f – Plan Cost Sharing for Total Benefits**

This column contains a formula that may be overwritten by the user. The default formula divides the non-DE# beneficiary cost sharing by the non-DE# allowed, and then multiplies by the DE# allowed from column q of Worksheet 2. See the “Pricing Considerations” section of these instructions for more guidance.

✓ **Column g – Actual Cost Sharing for Total Benefits**

Calculated automatically as the minimum of columns f and k.

✓ **Column h – Plan Reimbursement for Total Benefits**

Calculated automatically as column q from Worksheet 2 less column f.

✓ **Columns i and j – Percentage for Covered Services**

See instructions under Worksheet 4, subsection IIA, columns i and j.

✓ **Column k – State Medicaid Required Beneficiary Cost Sharing**

Enter values in accordance with the “Pricing Considerations” section of these instructions.

✓ **Column l – Actual Cost Sharing for Medicare-Covered Services**

Calculated automatically as column g times column j.

✓ **Columns m through o – Medicare-Covered using Medicaid Cost Sharing**

These columns are calculated automatically and are the basis for the costs included in the “Plan A/B Bid.”

✓ **Column m – Allowed PMPM**

The Medicare-covered allowed costs are calculated automatically based on the percentage of Medicare-covered benefits input in column i. Column m is calculated as column e times column i.

✓ **Column n – Medicaid Cost Sharing**

Calculated automatically as column k times column j.

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

**Columns p through r – A/B Mandatory Supplemental (MS) Benefits**

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

✓ **Column p – Net PMPM for Additional Services**

This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing (column g minus column l). These values must be greater than or equal to zero (except line r, COB, which may be negative).

✓ **Column q – Reduction of A/B Cost Sharing**

This column is calculated automatically as column n minus column l.

✓ **Column r – Total A/B Mandatory Supplemental Benefits**

This column is calculated automatically as the sum of columns p and q.

**Line s – Total Medical Expenses**

The total medical expense is the sum of lines a through r, except for columns i and j.

**Subsection C – All Beneficiaries (Total of Subsections A and B)**

The risk factor for total beneficiaries (non-DE# plus DE#) is obtained from Worksheet 5 and displayed at the top of this section.

**In lines a through q and t:**

✓ **Columns e through g – N/A**

These columns are left intentionally blank; they are not applicable to this section.

✓ **Column h – Net PMPM for Total Benefits**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

✓ **Columns i through n – N/A**

These columns are left intentionally blank; they are not applicable to this section.

✓ **Column o – Net PMPM for Medicare-Covered Benefits**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

**Columns p through r – A/B Mandatory Supplemental (MS) Benefits**

These columns are calculated automatically and are the basis for the costs included in the A/B mandatory supplemental premium.

✓ **Column p – Net PMPM for Additional Services**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

✓ **Column q – Reduction of A/B Cost Sharing**

The PMPM is calculated automatically as the weighted average of subsections A and B, based on projected enrollment in Worksheet 5.

✓ **Column r – Total A/B Mandatory Supplemental Benefits**

This column is calculated automatically as the sum of columns p and q.

**Line r – ESRD**

This line is populated based on Section III.

**Line s – Additional Benefits (employer bids only)**

This line is populated based on Section IV.

**Line u – Total Medical Expenses**

The total medical expense is the sum of lines a through t. The value in column o is the net medical cost included in the “Plan A/B Bid.” The value in column r is the net medical cost included in the A/B mandatory supplemental premium.

**Line v – Non-Benefit Expenses**

Enter the non-benefit expense information for total MA benefits in column h for each of the categories.

The worksheet distributes the non-benefit expenses proportionately between Medicare-covered (column o) and A/B mandatory supplemental (column r) for each category. Non-benefit expenses are also distributed within A/B mandatory supplemental benefits between “Additional Services” (column p) and “Reduction of A/B Cost Sharing” (column q).

See the “Pricing Considerations” section of these instructions for more information regarding non-benefit expenses.

**Lines v1 through v4 – Non-Benefit Expenses**

Total non-benefit expenses are input in column h and allocated proportionately between Medicare-covered (column o) and A/B mandatory supplemental (column r). Note that the same proportion is used for each line item. The allocation is based on the relative proportion of the plan’s medical expense requirements for Medicare-covered (“bid”) and A/B mandatory supplemental, excluding the PMPM impact of the ESRD subsidy.

✓ **Column h – Non-Benefit Expense PMPM for Total Benefits**

Enter the PMPM by category. Lines v1, v2, and v3 must be greater than or equal to zero.

✓ **Column o – Non-Benefit Expense PMPM for Medicare-Covered**

These values are calculated as column h minus column r.

✓ **Column r – Non-Benefit Expense PMPM for A/B Mandatory Supplemental**

These values are calculated based on the relative proportion of A/B mandatory supplemental, excluding the impact of the ESRD subsidy.

**Line v5, columns h, o, and r – Total Non-Benefit Expense**

The sum of lines v1 through v4. The value must be greater than or equal to zero.

**Line v5, columns p and q – Total Non-Benefit Expense for Additional Services and Reduction of A/B Cost Sharing**

The total non-benefit expense for A/B mandatory supplemental benefits (column r) is allocated between additional services (column p) and reduction of A/B cost sharing (column q). The allocation is based on the relative proportions of additional services and reduction of A/B cost sharing, excluding the impact of the ESRD subsidy.

**Line w – Gain/Loss Margin**

Enter the projected PMPM for the gain/loss in column h for total MA services. Do not leave this field blank.

The gain/loss margin is distributed proportionately between Medicare-covered and A/B mandatory supplemental. The allocation is based on the relative proportions of the medical expense requirements for Medicare-covered and A/B mandatory supplemental, excluding the PMPM impact of the ESRD subsidy.

See the “Pricing Considerations” section of these instructions for more information regarding gain/loss margin.

**Line x – Total Revenue Requirement**

The sum of lines u (medical expense), v (non-benefit expense), and w (gain/loss margin). The value in column o is the total revenue requirement of the “Plan A/B Bid.”

**Lines y1, y2 and y3 – Percentage of Revenue**

These lines calculate the ratio of net medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue.

**Line y4 – BPT MLR**

See the “Pricing Considerations” section of these instructions.

**Lines z1, z2 and z3 – NBE Quality Initiatives, Taxes and Fees, and Insurer Fees**

See the “Pricing Considerations” section of these instructions.

**Line z4 – Overall Gain/(Loss) Margin Level**

Enter the level at which the overall gain/loss margin requirements are met. See the “Pricing Considerations” section of these instructions for more information regarding gain/loss margin.

This line contains a drop-down menu with three options: “Contract”, “Organization” and “Parent-Organization”. EGWP plans are defaulted to the “Contract” option. The option selected in the MA BPT must match the option selected in the Part D BPT.

Do not leave this field blank.

**SECTION III – DEVELOPMENT OF PROJECTED CONTRACT YEAR ESRD “SUBSIDY”**

Section III allows for an adjustment to A/B mandatory supplemental benefits in line r of Section II. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits. Values entered in input cells must be greater than or equal to zero.

**CY Member Months (entered by county)**

This value is obtained from Worksheet 5.

**CY ESRD Member Months**

This value is obtained from Worksheet 5.

**CY Out-of-Area (OOA) Member Months**

This value is obtained from Worksheet 5.

**Basic Benefits**

See the “Pricing Considerations” section on ESRD for more information.

**Supplemental Benefits**

See “Pricing Considerations” section on ESRD for more information.

**SECTION IV – FOR EMPLOYER BID USE ONLY (“800-SERIES”)**

This section may be used for employer/union-only group waiver plan bids (“800-series” Plan IDs) and employer/union direct contract private fee-for-service plans (that is, plan type equal to “ED PFFS”) to provide CMS with the PMPM costs associated with additional “unspecified” benefits. These services may be funded by rebate dollars. Consistent with individual-market bids, all rebates available to the plan must be allocated on Worksheet 6.

See Appendix D for further information on group bids.

**Line 1 – PMPM for Additional (Unspecified) Mandatory Supplemental Benefits**

Enter the PMPM value of medical costs associated with additional “unspecified” benefits. The benefits represented by this value may be customized for each employer or union group that enrolls in the plan. See Appendix D for further guidance on the use of this field.

This value will be used in line s of Section IIC.

**SECTION V – PROJECTED MEDICAID DATA**

This section contains three input cells to capture Medicaid projected revenue and costs. Entries must be reported on a “per Member per Month” (PMPM) basis. Values must be greater than or equal to zero. See the “Pricing Considerations” section of these instructions for more guidance.

## MA WORKSHEET 5 – MA BENCHMARK PMPM

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This worksheet calculates the A/B benchmark and evaluates whether the plan realizes a savings or needs to charge a basic member premium.

Below is a brief description of the sections contained in this worksheet:

- Section I – General information entered on Worksheet 1.
- Section II – Summary of development of the benchmark and the bid.
- Section III – Summary of development of the savings or basic member premium.
- Section IV – Development of the regional A/B benchmark (including the statutory component of the regional benchmark). Applies to RPPO plan types only.
- Section V – Summary of Quality Bonus Rating information (from CMS).
- Section VI – Projected plan-specific information for counties within the service area.
- Section VII – Other Medicare information (populated based on the enrollment projection).
- Section VIII – Projected CY Member Months.

The A/B benchmark calculation is based on the following data elements:

- Service Area: Counties within the MA service area defined by their respective Social Security Administration (SSA) state-county codes.
- Projected Member Months (excluding ESRD and hospice): Projected non-ESRD non-hospice member months, reported by county of the plan's service area.
- Projected Risk Factor (excluding ESRD and hospice): Projected average risk factor for non-ESRD non-hospice enrollees, reported by county of the plan's service area.
- Medicare Secondary Payer Adjustment Factor: Factor relative to all payments.
- For RPPOs, the mix of Medicare beneficiaries (nationally) between original Medicare and Medicare Advantage (used to weight the statutory and plan bid components of the regional A/B benchmark).
- Quality Bonus Rating (from CMS).

### SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

### SECTION II – BENCHMARK AND BID DEVELOPMENT

#### Line 1 – Member Months (from Section VI)

The value for projected member months (excluding ESRD and hospice) is obtained from Section VI (entered by county of the plan's service area). You must enter the projected non-DE# member months. The value for DE# member months is calculated as the difference between the total and the non-DE# amounts. See the "Pricing Considerations" section of these instructions for more guidance.

**Line 2 – Standardized A/B Benchmark (at 1.000 Risk Score)**

This value is obtained from Section IV for regional plans and from Section VI for local plans.

**Line 3 – Medicare Secondary Payer (MSP) Adjustment**

User input is required. Note that this field is formatted as a percentage; therefore, if the value is 2.53 percent, enter “2.53” or “0.0253”. Do not leave this field blank. If zero percent is the projected value, then enter a “0” in this field. The value entered must be between 0 percent and 100 percent.

**Line 4 – Weighted Average Risk Factor**

This member/payment-weighted average value is obtained from Section VI. You must enter the projected non-DE# value. The DE# value is calculated based on the total and the non-DE# amounts. The DE# risk score default calculation may be overwritten by the user. See the “Pricing Considerations” section of these instructions for more guidance.

If the value for DE# members equals zero, then the non-DE# risk score must equal the total risk score.

**Line 5 – Conversion Factor**

Calculated as (1.000 minus line 3) times line 4. This is an intermediate step in the BPT calculations.

**Line 6 – Plan (or Regional) A/B Benchmark**

Calculated as line 2 times line 5. The BPT finalization process will verify that this value must be greater than zero.

**Line 7 – Plan A/B Bid**

This value is obtained from Worksheet 4, rounded to two decimals. The BPT finalization process will verify that this value must be greater than zero.

**Line 8 – Standardized A/B Bid (@ 1.000)**

Calculated as line 7 divided by line 5, and then rounded to two decimals.

**SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT****Line 1 – Savings**

Calculated as the difference between the plan (or regional) A/B benchmark and the plan A/B bid, but not less than zero. This value is rounded to two decimals.

**Line 2 – Rebate**

Calculated as Section III, line 1 (“Savings”) times Section V, line 3 (“Rebate %”). This value is rounded to two decimals.



**Line 3 – Basic Member Premium**

Calculated as the standardized A/B bid less the standardized A/B benchmark, but not less than zero. This value is rounded to two decimals.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**SECTION IV – STANDARDIZED A/B BENCHMARK – REGIONAL PLANS ONLY**

This section calculates the standardized A/B benchmark for regional PPO plans.

**Line 1 – Statutory Component for Region**

The PMPM amount, defined by region, is pre-populated by CMS. The weighting is also pre-populated in the bid form by CMS.

**Line 2 – Plan Bid Component**

The plan bid component will be announced by CMS after the bids are submitted. It will likely be announced at the same time that the Part D national average is announced (typically in August).

Plan sponsors may input an estimated average regional bid amount in their initial June bid submission.

For bids that are submitted prior to the announcement of the RPPO averages, there are two options for completing this field: (1) leave the cell blank, in which case the plan’s submitted standardized bid (Section II, line 8) is used as the plan bid component, or (2) input a reasonable estimate of the average RPPO bid for the region.

The RPPO announcement includes the weighted average MA RPPO bid for each region. Organizations will be instructed at the time of the announcement to submit revised RPPO MA BPTs with the applicable average bid amount entered in line 2. Regional employer bids (“800-series” bids) must also be resubmitted to reflect the RPPO average bids in line 2. Any changes in rebates due to the actual plan bid component must be re-allocated at the same time. Appendix E contains additional guidance regarding the rebate reallocation period.

**Line 3 – Standardized A/B Benchmark**

This line is calculated as the weighted average of lines 1 and 2 (if line 2 has a value entered). If line 2 does not have a value entered (that is, if the Plan sponsor has not entered an estimated value for a pre-announcement bid submission), the amount from Section II, line 8 is used in the calculation.

**SECTION V – QUALITY RATING**

This section captures quality rating information released by CMS. See the “Pricing Considerations” section of these instructions for more information.

**Line 1 – Quality Bonus Rating (per CMS)**

Enter the quality bonus rating (that is, QBP “star rating”) released by CMS for the contract. The rating is a numeric value from 1.0 through 5.0.

The value entered in the BPT will be validated upon upload. (That is, if the BPT value does not match the value released by CMS, the upload will be rejected.)

**Line 2 – New/Low Indicator (per CMS)**

Enter the new/low indicator released by CMS for the contract. The four valid options are as follows:

- New contract under existing parent org
- New contract under new parent org
- Low
- Not applicable

For plans where the new/low indicator is applicable, the text entered in the BPT will be validated upon upload. (That is, if the BPT text does not match the text released by CMS, the upload will be rejected.)

**Line 3 – Rebate Percentage**

The BPT computes the rebate percentage that is used in Section III, line 2.

See the “Pricing Considerations” section of these instructions for more information.

**SECTION VI – COUNTY-LEVEL DETAIL AND SERVICE AREA SUMMARY**

This section contains detailed data by county and develops plan-specific county-level MA payment rates. For most plans, the only user inputs are the state-county codes (column b), projected member months (column e), and projected risk factors (column f) by county. Entries must reflect plan-specific non-ESRD non-hospice enrollment projections for each county within the service area. Plans are permitted to project zero enrollment in a particular county in order to generate a county-level payment rate for that county.

As with all aspects of the projections for MA-PD plans, the enrollment and risk scores for the MA bid must be based on a population consistent with the corresponding Part D bid.

Payment rates for RPPOs may be developed using plan-provided geographic intra-service area rate (ISAR) factors on a case-by-case basis, as explained in the “Pricing Considerations” section of these instructions.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in Section VI.

**Line 1 – Use of Plan-Provided ISAR Factors**

Regional plans that wish to use ISAR factors to develop their county payment rates must enter “Yes”. (Technical note: Do not enter “Y” in this field; enter the entire word “Yes”.)

## Line 2 – Total or Weighted Average for the Service Area

The county-level data are summarized in this line, weighted by projected member months. The projected risk factors are also weighted by MA ratebook rates.

## Line 3 – County-Level Detail

### ✓ Column b – State-County Code

Enter the Social Security Administration (SSA) state-county codes that define the MA service area, in accordance with the following:

- Each state-county code must be entered as a text input (that is, must include a preceding apostrophe) and must include all leading zeroes (for example, '01000). This field is formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros.
- If the service area has more than one county, do not leave any blank rows between the first and last state-county code entered. Also, do not leave blank rows before the first county code entered.
- Do not enter the same state-county code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area (OOA) county, "99999". OOA enrollees are not explicitly represented in the benchmark calculation.
- The county codes entered in the BPT must match the service area defined in HPMS by the MA organization. Any service area discrepancies between the BPT and HPMS may result in delays during bid review and could affect the approval timeline of the bid.

Technical note: In the "finalized" MA BPT file, the county-level section will be sorted in a descending order, based on the county codes entered in column b. See the BPT technical instructions for further information.

### ✓ Column c – State

The BPT will display the applicable state name based on the corresponding code entered in column b. No user entry is required.

### ✓ Column d – County Name

The BPT will display the applicable county name based on the corresponding code entered in column b. No user entry is required.

### ✓ Column e – Projected Member Months

Enter the projected contract year member months for each county in the service area. The projected member months must include both aged and disabled members, and DE# and non-DE# members, but exclude ESRD and hospice members.

See the "Pricing Considerations" section of these instructions for more guidance.

Technical note: The data will display as whole values but can be entered with decimal places.

If member months are entered in a particular row of column e, then a corresponding county code and a risk score must be entered in columns b and f, respectively.

✓ **Column f – Projected Risk Factors**

Enter the risk factors for the projected non-ESRD non-hospice membership by county.

If a risk score is entered in a particular row of column f, then a corresponding county code must be entered in column b.

✓ **Column g – Plan-Provided ISAR Factors**

If the Plan sponsor has support for plan-specific ISAR factors for a regional PPO, then—

- Enter “Yes” in line 1, in response to the question “Use of plan-provided ISAR?” (Technical note: Do not enter “Y” in this field; enter the entire word “Yes”.)
- Enter the plan-provided ISAR factors in column g of the county-level section. Factors can be in the form of either PMPM values or a relative scale.

✓ **Column h – MA Risk Ratebook: Unadjusted**

The BPT will display the applicable published ratebook risk rates for the contract period. If enrollee type is “A/B,” the amounts shown are the total of Part A and Part B. If enrollee type is “Part B-Only”, the amount shown is the Part B rate.

✓ **Column i – MA Risk Ratebook: Risk-Adjusted**

The BPT will calculate the risk-adjusted rates based on the rates in column h and the risk scores entered in column f.

✓ **Column j – ISAR Scale**

The BPT will calculate the ISAR scale based on either the plan-provided ISAR factors in column g (if provided) or the ratebook rates in column h.

✓ **Column k – ISAR-Adjusted Bid**

The BPT will calculate the ISAR-adjusted bid based on the ISAR scale in column j and the standardized A/B bid in Section II. Note that the payment rates represent coverage for Medicare Part A and Part B (except for Part B-only plans). The values will then be separated into Part A and Part B payment rates in columns l and m.

✓ **Columns l through m – Risk Payment Rates**

These columns are calculated based on the ISAR-adjusted bid in column k and the risk ratebook proportions for Part A and Part B.

## **SECTION VII – OTHER MEDICARE INFORMATION**

This section contains county-level Medicare information used in the bid form and is populated based on the county codes input in column b and the projected member months entered in column e.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in Section VII.

**Columns n through p – Original Medicare Cost-Sharing Proportional Factors**

These columns are populated based on the enrollment projections and are used in column k of Worksheet 4, Section IIA.

**Columns q through s – FFS Costs Used to Weight Original Medicare Cost Sharing**

These columns are populated based on the enrollment projections and are used in the weighted averages (row 36) of columns n through p.

**Columns t through u – Metropolitan Statistical Area (MSA)**

These columns are populated based on the enrollment projections. The names shown are based on metropolitan and micropolitan statistical areas as defined by the Office of Management and Budget. Though this information is not directly used in the BPT calculations, it is used by CMS during bid reviews.

**SECTION VIII – PROJECTED CY MEMBER MONTHS**

This section captures and summarizes the various components of the plan's member months.

**Line 1 – Member Months entered by county (from Section VI)**

This value is obtained from Section VI.

**Line 2 – ESRD Member Months**

Enter the projected CY ESRD member months. Do not leave this field blank. If no ESRD enrollees are expected during the contract period, then enter a zero (0) in this field.

This amount is used on Worksheet 4 Section III.

**Line 3 – Hospice Member Months**

Enter the projected CY hospice member months. Do not leave this field blank. If no hospice enrollees are expected during the contract period, then enter a zero (0) in this field.

**Line 4 – Out-of-Area (OOA) Member Months**

Enter the projected CY OOA member months. Do not leave this field blank. If no OOA enrollees are expected during the contract period, then enter a zero (0) in this field.

This amount is used on Worksheet 4 Section III.

**Line 5 – Total Member Months**

Calculated as the sum of line 1 through 4.

The enrollment for the MA bid must be based on a population consistent with the corresponding Part D bid.

## MA WORKSHEET 6 – MA BID SUMMARY

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Worksheet 6 summarizes the results of the calculations of the bid form. In addition, some user inputs are required, as described below.

### SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

### SECTION II – OTHER INFORMATION

#### ***Section A – Part B Information***

See the “Pricing Considerations” section for further information regarding allocating rebates to buy down the Part B premium.

##### **Line 1 – Maximum Part B Premium Buydown Amount, per CMS**

This value is pre-populated by CMS at the time that the bid form is released.

#### ***Section B – Rebate Allocation for Part B Premium***

##### **Line 1 – PMPM Rebate Allocation for Part B Premium**

Enter the PMPM amount of rebates to reduce the Part B premium.

##### **Line 2 – Rounded Part B Rebate Allocation**

The PMPM amount entered in line 1 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements.

#### ***Section C – Rebate Allocations***

##### **Line 1 – Reduce A/B Cost Sharing**

Enter the PMPM amount of rebates to reduce A/B cost sharing.

##### **Line 2 – Other A/B Mandatory Supplemental Benefits**

Enter the PMPM amount of rebates to apply toward other A/B mandatory supplemental benefits.

### SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the bid pricing tool information in three sections.

- Section A is an overview of the plan A/B bid and the costs of A/B mandatory supplemental benefits, and it also displays some benchmark and risk score information from Worksheet 5.
- Section B contains the MA rebate allocation.

- Section C develops the MA premium and requires the input of the Part D premium information. Consistent with previous worksheets, any optional supplemental benefits/premiums are to be excluded.

### ***Section A – Overview***

This section summarizes information entered on previous worksheets.

#### **Line 1 – Net Medical Cost**

These amounts are obtained from Worksheet 4.

#### **Line 2 – Non-Benefit Expenses**

These amounts are obtained from Worksheet 4.

#### **Line 3 – Gain/Loss Margin**

These amounts reflect the estimated net gain/loss for the plan, including the amount of risk margin desired. These amounts are obtained from Worksheet 4.

#### **Line 4 – Total Revenue Requirement**

The sum of lines 1 through 3. These amounts are the required revenue at the plan's risk factor and are calculated prior to any rebate allocation.

#### **Line 5 – Standardized A/B Benchmark**

This amount is obtained from Worksheet 5.

#### **Line 6 – Plan A/B Benchmark (or Regional A/B Benchmark for RPPO Plans)**

This amount is obtained from Worksheet 5.

#### **Line 7 – Risk Factor**

This amount is obtained from Worksheet 5.

#### **Line 8 – Conversion Factor**

This amount is obtained from Worksheet 5.

### ***Section B – MA Rebate Allocation***

Plan sponsors may choose which of the following category, or categories, in which to allocate rebates.

- Reduce A/B cost sharing.
- Other A/B mandatory supplemental benefits.
- Part B premium buydown.
- Part D basic premium buydown.
- Part D supplemental premium buydown.

See Appendix E for information regarding the reallocation of rebates (permitted for certain plans) after the publication of the Part D and MA regional benchmarks.

**Line 1 – MA Rebate**

This amount is obtained from Worksheet 5.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**Lines 2 through 6 – Rebate Allocations by Category**

The fourth column displays the portion of the total MA rebate that is allocated to each of the rebate options. Note that the rebate allocations are actually entered in separate sections of this worksheet, to ensure that the rebate allocations are rounded to comply with withhold system requirements.

The first three columns distribute the allocated rebate among medical expenses, non-benefit expenses, and gain/loss in the same proportion as used in Worksheet 4. The fifth column contains the maximum value that applies to each rebate category. See the “Pricing Considerations” section of these instructions for more information on rebate allocation.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in these fields.

**Line 7 – Total Rebate Allocated**

The sum of lines 2 through 6. This amount must equal the amount in line 1.

If there are any “unallocated” rebates shown, including pennies, these amounts must be distributed among the categories available. The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

***Section C – Development of Estimated Plan Premium***

**Line 1 – A/B Mandatory Supplemental Revenue Requirements**

This amount is obtained from Section IIIA.

**Line 2 – Less Rebate Allocations**

These amounts are obtained from Section IIIB, lines 2 and 3.

**Line 3 – A/B Mandatory Supplemental Premium**

The sum of lines 1 and 2.

**Line 4 – Basic MA Premium**

This amount is obtained from Worksheet 5.

**Line 5 – Total MA Premium (excluding Optional Supplemental)**

The sum of lines 3 and 4.

**Line 6 – Rounded MA Premium (excluding Optional Supplemental)**

The total MA premium from line 5 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements. Value must be greater than or equal to zero.



The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**Line 7 – Part D Basic Premium**

✓ **Line 7a – Prior to Rebates**

Enter the Part D basic premium prior to rebates after rounding (found on the separate Part D bid form). This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D basic premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D basic premium. This field is not applicable to MA-only plans and EGWP plans.

✓ **Lines 7b and 7c – A/B Rebates Allocated to the Part D Basic Premium**

Enter the rebates that the Plan sponsor wishes to allocate to the Part D basic premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 7c), to comply with withhold system requirements. This field is not applicable to MA-only plans and EGWP plans.

✓ **Line 7d – Part D Basic Premium**

The estimated Part D basic premium net of rebates is calculated automatically as line 7a minus line 7c.

The Part D basic premium in the MA BPT is an estimate when the bid is initially submitted in June. The actual plan premium will be calculated by CMS, outside the BPT, when the Part D national average monthly bid amount is determined (typically in August).

Note that the Part D basic premium prior to rebates can be a negative number.

This field is not applicable to MA-only plans and EGWP plans (that is, it must be equal to zero).

If the plan intention for the target premium (cell R47) equals “Low Income Premium Subsidy Amount” and the plan enters Part D basic rebates (cell R36) greater than zero, then the Part D basic premium after rebates (cell R37) must be greater than zero.

**Line 8 – Part D Supplemental Premium**

✓ **Line 8a – Prior to Rebates**

Enter the Part D supplemental premium prior to rebates (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D supplemental premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D supplemental premium. This field is not applicable to MA-only plans and EGWP plans.

Note that if the Part D basic premium is negative, then the Part D supplemental premium must offset the negative amount. That is, the sum of the Part D basic and supplemental premiums must be greater than or equal to zero.

✓ **Lines 8b and 8c – A/B Rebates Allocated to the Part D Supplemental Premium**

Enter the rebates that the Plan sponsor wishes to allocate to the Part D supplemental premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements. This field is not applicable to MA-only plans and EGWP plans.

✓ **Line 8d – Part D Supplemental Premium**

Calculates the Part D supplemental premium net of rebates. Line 8d equals line 8a minus line 8c. The value must be greater than or equal to zero. This field is not applicable to MA-only plans and EGWP plans (that is, it must be equal to zero in these cases).

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**Line 9 – Total Estimated Plan Premium**

The sum of the rounded MA, Part D basic, and Part D supplemental premiums after rebates. This amount excludes any optional supplemental MA premiums, which are calculated on Worksheet 7. The value must be greater than or equal to zero.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**Line 10 – Plan Intention for Target Part D Basic Premium**

For MA-PD plans, this field contains a drop-down menu with two options: “Premium amount displayed in line 7d” or “Low Income Premium Subsidy Amount”. MA-PD Plan sponsors must choose one of these two options for the target Part D basic premium in the initial June bid submission and cannot change the chosen target in a subsequent resubmission. CMS will consider only the option chosen in June as the plan’s intention.

For MA-only plans and EGWPs, the target Part D basic premium is not applicable.

See the “Pricing Considerations” section of these instructions for more information on the target Part D basic premium.

**SECTION IV – CONTACT INFORMATION AND DATE PREPARED**

Plan sponsors must identify three persons as MA plan bid contact, MA certifying actuary, and additional MA BPT actuarial contact. The MA certifying actuary and additional MA BPT actuarial contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number, and e-mail information for all three contacts; in addition, credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

Section IV also contains a field labeled “Date Prepared”. This field must contain the date that the BPT was prepared. If the BPT is revised and resubmitted during the bid review process, then this field must be updated accordingly.

### **SECTION V – WORKING MODEL TEXT BOX**

This section contains multiple cells that may be used by bid preparers to enter internal notes—for example, to facilitate communication between BPT and PBP preparers or to track internal version schemes.

Section V will be deleted from the finalized file and therefore will not be uploaded to HPMS. Bid preparers must not enter information in this section meant to be communicated to CMS or to CMS reviewers, as CMS will not have access to it. Section V will not be deleted from the working file or from the backup file during finalization.

## MA WORKSHEET 7 – OPTIONAL SUPPLEMENTAL BENEFITS

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Worksheet 7 contains the actuarial pricing elements for any optional supplemental benefit (OSB) packages to be offered during the contract year, up to a maximum of five.

The PBP packages must be entered in the same order as they are entered in the PBP, and the package name/description must match the PBP.

For each of the five packages, the worksheet contains 20 category lines. If additional category lines are needed, then provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. Do not insert any additional rows into the form.

### SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

### SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

#### Column b – Package ID

Displays the identification (ID) number to signify which package of optional supplemental benefits is being priced. The number “1” is used to identify the first package. Sequential numbers (that is, 2, 3) identify additional packages of optional supplemental benefits. The package IDs must correspond to the packages enumerated and described in the PBP.

#### Column c – Service Category

On the first line for each package, enter a description of the OSB package. This description must match the description/package name entered in the PBP for each package. Examples: “Enhanced Dental”, “Gold Package”, etc. The description field must not be left blank when there is an optional supplemental package entered.

On each subsequent line, enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-covered)

- Dental (Non-covered)
- Vision (Non-covered)
- Hearing (Non-covered)
- Health & Education (Non-covered)
- Other Non-covered

**Column d – Benefit Category/Pricing Component**

Enter a description of the benefit category/pricing component.

**Column e – Allowed Medical Expense: Utilization Type**

Enter the appropriate measurement unit from the list used for column e of Worksheet 2.

**Column f – Allowed Medical Expense: Annual Utilization/1,000**

Enter the projected contract year annual utilization per thousand enrollees for allowed medical expenses for each benefit category.

**Column g – Allowed Medical Expense: Average Cost**

Enter the projected contract year average annual cost for allowed medical expenses for each benefit category.

**Column h – Allowed Medical Expense: PMPM**

Column h is calculated automatically using the utilization reported in column f and the average cost information reported in column g.

**Column i – Enrollee Cost Sharing: Measurement Unit Code**

Enter the appropriate cost-sharing measurement unit using the codes provided for column e of Worksheet 3.

**Column j – Enrollee Cost Sharing: Utilization/1000 or PMPM**

Enter the projected contract year utilization per thousand enrollees or the PMPM value in the case of coinsurance.

**Column k – Enrollee Cost Sharing: Average Cost Sharing**

Enter the projected contract year average per-service cost-sharing amount or coinsurance percentage.

**Column l – Enrollee Cost Sharing: PMPM**

Column l is calculated automatically using the utilization (or PMPM) reported in column j and the average cost (or coinsurance percentage) reported in column k.

**Column m – Net PMPM Value**

Column m is calculated automatically as the allowed PMPM (column h) minus the cost sharing PMPM (column l).

**Column n – Non-Benefit Expense**

Enter the total projected contract year non-benefit expense for each OSB package offered.

**Column o – Gain/Loss Margin**

Enter the total projected contract year gain/loss margin for each OSB package offered.

**Column p – Premium**

The sum of columns m (medical expenses), n (non-benefit expenses), and o (gain/loss margin). The premiums are automatically rounded to one decimal to comply with premium withhold system requirements. Premium values must be greater than zero if an OSB package is offered and must be equal to zero if an OSB package is not offered.

The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

**Column q – Projected Member Months**

Enter the total projected contract year member months for each OSB package offered.

**SECTION III – COMMENTS**

Enter any comments needed to describe the OSB packages.

**SECTION IV – BASE PERIOD SUMMARY (ENTERED AT THE CONTRACT LEVEL)**

This section contains a summary of the actual contract-level base period revenue and expenses.

Note that Section IV must be completed in total dollars (not PMPMs), and it must include all optional supplemental benefit packages that were provided in the base period.

## IV. APPENDICES

### APPENDIX A – ACTUARIAL CERTIFICATION

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CMS requires an actuarial certification to accompany every bid submitted to HPMS. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater responsibility on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

#### Actuarial Standards of Practice and Other Considerations

In the actuarial certification, the actuary must certify that the actuarial work supporting the bid conforms to the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, *Incurred Health and Disability Claims*.
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*.
- ASOP No. 23, *Data Quality*.
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*.
- ASOP No. 41, *Actuarial Communications*.
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*.

The certifying actuary must also certify that the actuarial work supporting the bid complies with applicable laws, rules, CY2014 bid instructions, and current CMS guidance. In addition, he/she must consider whether the actuarial work supporting the bid is consistent and reasonable with respect to the plan benefit package and the organization's current business plan.

#### Certification Module

The certification module contains the following features:

- Standardized required language. (The required elements are described in a subsequent section of this appendix.)
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids.
- Links to additional information regarding the bid package such as the PBP, BPT, and supporting documentation.
- The ability to certify multiple bids/contracts.
- The ability to print and save the submitted certification.

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is, pending CMS approval) via the certification module in August following the CMS publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but they may do so if they wish.

Note that in the event that the PBP changes after the “final” bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

Material changes to the certification language (after the initial June certification submission) are not allowed without prior written permission from the CMS Office of the Actuary.

Plan sponsors may have multiple actuaries assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. The instructions contained in this appendix must be followed by all actuaries who will be certifying CY2014 bids.

If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

Every MA BPT requires a certification. Likewise, every PD BPT requires a certification. Since Part D BPTs are not submitted for “800-series” EGWP employer bids, a Part D actuarial certification is not required for EGWPs. However, a certification is still required for the MA portion of “800-series” employer bids.

Additional information regarding the actuarial certification process (including technical instructions for completing the HPMS certification module) will be included in the initial actuarial certification deadline memorandum issued in June 2013.

### **Required Certification Elements**

The certification module contains the following information, as part of the standardized language:

- The certifying actuary’s name/user ID and the date, “stamped” when the certification is submitted.
- Attestation that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy’s qualification standards for doing so.
- The specific contract, Plan ID, and segment ID of the bid associated with the certification.
- The contract year of the bid contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Part D bid, or both.
- Attestation that the certification complies with the applicable laws,<sup>1</sup> rules,<sup>2</sup> CY2014 bid instructions, and current CMS guidance.

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<sup>1</sup> Social Security Act sections 1851 through 1859; and Social Security Act sections 1860D-1 through 1860D-42.

<sup>2</sup> 42 CFR Parts 400, 403, 411, 417, 422, and 423.



- Attestation that, in accordance with federal law, the bid is based on the “average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile.”
- Attestation that the data and assumptions used in the development of the bid are reasonable for the plan’s benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid are consistent with the organization’s current business plan.
- Attestation that the bid was prepared in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the bid complies with the appropriate ASOPs.
- A statement that, in compliance with ASOP No. 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency and that supporting documentation for the reliance on information provided by others is uploaded with the bid.

Please refer to ASOP No. 23, *Data Quality*, and ASOP No. 41, *Actuarial Communications*, for additional details regarding reliances.

**Certification Module Access**

Detailed instructions regarding how to apply for access to the CY2014 certification module were released via an HPMS memorandum about consultant access or electronic signature access to HPMS.

## APPENDIX B – SUPPORTING DOCUMENTATION

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### GENERAL

In addition to the BPT and actuarial certification, Plan sponsors must provide CMS with supporting documentation for every bid, as described in these instructions.

Unless otherwise noted, Plan sponsors must upload all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation, if requested, must be made available to CMS reviewers within 48 hours, as required by these instructions. Plan sponsors must upload supporting documentation consistent with the final certified bid.

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the Plan sponsor, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, those individuals are subject to the same documentation requirements. The actuary must be prepared to produce all substantiation pertaining to the bid, even if it was prepared by others or is based on a reliance.

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.2, “Actuarial Report,” the materials provided must be written “with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”

All data submitted as part of the bid process are subject to review and audit by CMS or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation must be easily understood by CMS reviewers and must include the following:

- The rationale for the assumption, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Plan-specific variations in addition to the overall pricing assumption or methodology.
- Values that match entries in the current BPT and tie to the PBP.
- Excel spreadsheets with working formulas, rather than pdf files.

Supporting documentation must be clearly labeled and include the following information:

- The bid ID. At a minimum, the contract number and organization name must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart, or as an attachment.
- A reference to MA, Part D, or both.
- A hard-coded date.
- Contract/Plan number and topic in the beginning of the file name.
- The word “revised”, if any information in the file is revised or appended during bid review.

Acceptable forms of supporting documentation include, but are not limited to, the following items:

- Meeting minutes that include comprehensive documentation of discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources—for example, a report’s official name/title, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- Materials that can be accessed only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as “the same as for plan Hxxxx-xxx,” and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is “professional judgment” with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies, or public information.
- “Living worksheets” that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of prior bid filings.

### **SUBMITTING SUPPORTING DOCUMENTATION**

Supporting materials must be in electronic format (Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using “zip” files, which compress multiple files into one (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload to multiple plans materials specific to a Part D plan, MA plan, or certain contract ID.

#### **Cover Sheet**

To expedite the bid review process, Plan sponsors must upload a cover sheet that lists all of the supporting documentation that is uploaded or provided on the bid form. The filename must include the phrase “cover sheet.” A cover sheet is required for each upload of substantiation.

The cover sheet must include detailed information for each support item—such as the filename and the location within the file, if applicable—and must clearly identify the bid IDs and whether the substantiation is related to MA, Part D, or both.

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a bid's projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of bid IDs (such as "plans 001 – 030" or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

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.

Sample check lists and cover sheets for the initial June bid submission, and for subsequent substantiation uploads, are provided at the end of this appendix.

### **Timing**

Plan sponsors and certifying actuaries must prepare all supporting documentation at the time of the initial June bid submission in order to be immediately available to CMS and reviewers at that time or be readily available upon request as explained below.

- The "Initial June Bid Submission" section in this appendix describes supporting documentation items that Plan sponsors must upload to HPMS with the initial June bid submission.
- The "Upon Request by CMS Reviewers" section of this appendix describes materials that Plan sponsors and certifying actuaries must provide within 48 hours of request by CMS reviewers and upload to HPMS prior to bid approval.
- When a BPT is resubmitted, the Plan sponsor must upload a summary of changes, including the cause and effect of each revision, authorized by CMS or CMS reviewers. If multiple BPTs are submitted at the same time, the supporting documentation must include a mapping of specific bid changes and bid IDs.
- Prior to bid approval,—
  - Plan sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid. Note that the upload of e-mail correspondence to HPMS alone does not satisfy this requirement.
  - Plan sponsors must upload revised supporting documentation and e-mail correspondence supporting bid resubmissions to HPMS.

### **Initial June Bid Submission**

The following documentation requirements apply to all bids (as all bids contain these assumptions):

- A cover sheet outlining the documentation files, as described above.

- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, service area changes, type of coverage, contractual arrangements, marketing approach, and any other pertinent information that would help expedite the bid review. For dual-eligible SNPs, include a statement indicating how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management, and margins.
- A document titled “Related Party Declaration,” which states whether or not the Plan sponsor is in a related-party agreement (Worksheets 1 and 4).
- Support for the claims credibility assumptions (Worksheet 2), including—
  - A statement of the credibility approach used—for example, the CMS guideline or the CMS override.
  - A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
  - The method for blending differences between the credibility for utilization and that for unit cost into a composite PMPM credibility factor.
  - Justification for any variation in the credibility approach by line of business.
  - An explanation for a zero credibility percentage for a service category with credible data.
- A detailed description of the process used for adjusting cost sharing due to maximum OOP limits, including how the PMPM impact of the maximum OOP was determined. (Worksheet 3).
- Support for non-benefit expense assumptions. The required elements include—
  - A reconciliation of the base period non-benefit expenses reported in the BPT and auditable material such as corporate financials and plan-level operational data (Worksheet 1).
  - A description of the expenses included in each non-benefit expense category in the BPT. (Worksheet 4)
  - Detailed support for the development of projected non-benefit expenses (Worksheet 4). The required elements include—
    - A description of the methodology used to develop projected non-benefit expenses.
    - A description of the data source and its relationship to the base period non-benefit expenses reported in the BPT.
    - An explanation for significant differences between actual and expected non-benefit expenses for CY2010, CY2011 and CY2012, including a description of how that knowledge was incorporated into the CY projection.
    - A demonstration of the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other projections.
- 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.

- ▶ A description of the methodology used to develop the gain/loss margin assumption and the level at which the aggregate margins are determined.
- ▶ For Plan sponsors that choose to satisfy aggregate-level gain/loss requirements at the organization level, a list of the MA contract numbers offered by the organization.
- ▶ A demonstration of consistency of projected margins from year to year.
- ▶ A demonstration of consistency between the aggregate margin for general enrollment plans & I/C SNPs (or for other gain/loss margin categories, if applicable) and the applicable measure of the Plan sponsor's margin requirement, that is, (i) the Plan sponsor's margin requirement for all non-Medicare health insurance lines of business, or (ii) the Plan sponsor's capital and surplus requirement.
- ▶ A demonstration of consistency between the aggregate margin for general enrollment plans & I/C SNPs and other gain/loss margin categories, if applicable.
- ▶ A detailed justification for unique situations, in which the aggregate margin for D-SNPs is outside of the stated range of the aggregate margin for general enrollment plans & I/C SNPs combined, including a description of extenuating circumstances supporting an exception, evidence of the absence of anti-competitive practices and solvency issues, and actions taken to bring the margin differential into compliance with bid instructions.
- ▶ A demonstration of consistency between (projected) aggregate margins and actual aggregate returns over the long term. If historically these items have been inconsistent, provide an explanation for how this is addressed in the current bid submission, for example, how pricing assumptions have been set to make the projected margin more consistent with actual returns.
- Justification for bids with relatively large projected overall gains/losses including an explanation of how the PBP offers benefit value in relation to the margin level.
- Support for bids with negative margins, including one of the following items:
  - ▶ For a new plan, or a plan with a zero or positive projected gain/loss margin for the prior contract year, a bid-specific, year-by-year, numeric business plan that demonstrates profitability within 3 to 5 years.
  - ▶ For a plan with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the gain/loss margin to the MA margin in the original business plan. The required elements include—
    - Details and sources of deviation from the original business plan.
    - An explanation and demonstration as to how the targeted margin in the original business plan will be met, if the plan is progressing towards a positive margin less rapidly than projected in the original business plan.
    - A copy of the original business plan uploaded to HPMS in a separate file.
  - ▶ A description of the MA product pairing, which includes the gain/loss margin for each plan and shows that the plans—
    - Have identical service areas,
    - Are all local coordinated care plans, or all RPPOs, or all PFFS plans,
    - Have the same SNP type (or are all non-SNPs), and

- Have a positive combined gain/loss margin.
  - For MA-PD plans, a description of the approach for setting the Part D margin in relation to the MA margin.
  - A detailed explanation of the need for flexibility in the gain/loss margin requirements in order to satisfy other CMS requirements.
- A detailed description of the items included in NBE quality initiatives and taxes and fees (Worksheet 4).
- Detailed support for the development of projected risk scores (Worksheet 5). The required elements include—
  - A detailed description, and corresponding numerical demonstration, of the methodology used to develop projected CY2014 MA risk scores.
  - A description of the source data for the development of the projected CY2014 MA risk scores.
  - A description of all projection factors and the basis for the factors.
  - A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected medical expenses.
  - A demonstration that the method used is consistent with the preferred development approach in these instructions, including an explanation for using an alternate approach, if applicable.
  - Justification for and a description of the credibility assumption for actual plan risk scores.

The following documentation requirements apply to all bids that contain the assumptions specified below:

- Detailed support for the development of base period experience (Worksheet 1). This documentation, which is based on regulatory authority for the review of materials that pertain to any aspect of services provided, is also required in cases in which medical services are provided under a capitated arrangement. The required elements include—
  - A description of the allocation of allowed costs by service category when the allocation method is not based on plan experience data (Worksheet 1).
  - Information regarding the base period member months, if for some reason more than eight plans constitute the base period data (see Worksheet 1, Section II, line 5).
  - Reconciliation of base period experience with the audited financial statements and bid-level operational data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including claims paid, unloaded claim reserves, non-benefit expenses, and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
  - Justification for the lack of encounter data for services provided under capitated arrangements including—
    - An explanation for the deficiency.
    - A detailed description of the steps that the Plan sponsor has taken or is taking to obtain encounter data for subsequent year's bid submissions.

- ▶ A description of the data source for utilization per 1,000 and the basis for any adjustments.
- 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.
  - A summary of the Plan sponsor's historical trends including—
    - ▶ The percentage trends.
    - ▶ A description of the methodology used to analyze the data.
    - ▶ The numeric calculations.
  - 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.
    - ▶ Industry and/or internal studies.
    - ▶ Benefit design analysis.
    - ▶ A change in the mix of services, including the rationale for the type of projection factor used to reflect such change.
    - ▶ A change in the mix of provider arrangements such as capitated and risk sharing arrangements.
  - Justification for combining data for multiple service categories.
- A detailed description of the NBE quality initiatives and taxes and fees reflected in base period data (Worksheet 1 Section VI).
- Support for the allocation of enrollment between DE# and non-DE# beneficiaries including the basis for classifying dual-eligible enrollees as DE# (Worksheets 1 and 5).
- Support for the pricing, including utilization and unit cost, of incentive programs for preventive services (Worksheets 1 and 2, line q).
- Support for claim costs for hospice enrollees for mandatory supplemental benefits when these costs are included in the projected allowed cost PMPM.
- 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.
  - Consideration of any adjustments made for annual volatility of the source data.
  - Any applicable adjustments to the source data, such as—
    - ▶ Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data.
    - ▶ Addition of Medicare-covered benefits not reflected in the source data.
    - ▶ Exclusion of non-covered benefits reflected in the source data.
    - ▶ Techniques and factors used to reflect differences between the underlying population and that expected of the MA plan.



- Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the MA plan.
  - Methodology and data used to gross up reimbursements to an allowed-cost basis.
- Data and methodology used to project the data from base period to CY2014.
- The reasonableness of allowed costs and projection factors for costs based on capitated payments to related parties.
- The allocation of projected allowed costs by service categories.
- All other applicable factors and/or adjustments.
- Support for non-DE# projected allowed costs (Worksheet 2).
- An explanation for a zero cost of a benefit that is included in the PBP.
- The rationale for including in non-benefit expenses the cost of a benefit that is included the PBP.
- Support, at the benefit level, for non-covered services (Worksheet 2, lines l through q, column o), if any, including a breakdown of the PMPM value shown in the BPT. For example, a \$4.00 PMPM in column o of row p, “Health and Education,” is to be shown in the supporting documentation as \$1.50 PMPM for a smoking cessation program and \$2.50 PMPM for nutritional counseling. (Detailed support for the pricing of each additional benefit is available upon request.)
- Disclosure of related-party medical and administrative service agreements (Worksheets 1 and 4).
  - A Plan sponsor in a related-party agreement must provide the following:
    - Disclosure of every related-party agreement.
    - A summary that explains the relationship in terms of the parties involved, and common ownership, control, or investment.
    - A summary of the contractual terms of each relationship, to include a description of the services provided, and money exchanged.
    - A description of the approach used to report the medical expense (if applicable), gain/loss margin, and non-benefit expense in the bid.
  - A Plan sponsor that chooses to demonstrate that the terms and fees associated with their administrative services agreement are comparable to those between the related party and unrelated parties of similar size and market position must—
    - Demonstrate and explain the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated parties and the fees associated with the related party transaction are comparable.
  - A Plan sponsor that chooses to demonstrate that the terms and fees associated with their medical services agreement are comparable to those between the related party and unrelated MA organizations of similar size and market position must either—
    - Demonstrate and explain the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated MA organizations and the fees associated with the related party transaction are comparable, or

- Demonstrate that the fees associated with the related party contract are comparable to 100% FFS.
- A Plan sponsor who chooses to enter 100% FFS cost in the BPT as net medical expenses must—
  - Document that: (i) it cannot demonstrate the fees associated with the related-party transaction are comparable to the fees between the related party and other unrelated MA organizations of similar size and market position, and (ii) the actual medical costs of the related party cannot be determined.
  - Demonstrate that fees associated with a related-party transaction for medical services are not comparable to 100% FFS costs.
- Support for the development of the contract year ESRD subsidy (Worksheet 4). This required documentation includes the following:
  - Base period (for example, 2012) revenues and medical expenditures for Medicare-covered benefits provided to enrollees in ESRD status.
  - The source for, and the development process of, any manual rates used.
  - Relevant base-to-contract year trend factors.
  - A short narrative on the credibility approach applied to the ESRD experience.
- Detailed support for the MSP adjustment (Worksheet 5).
- Support for zero projected DE# member months when there are DE# members in the base period (Worksheet 5).
- Support for the development of plan-provided ISAR factors (Worksheet 5), if used. (This requirement applies to RPPOs only.) A description of the methodology and data source(s) used to calculate the ISAR factor(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (that is, non-benefit expense and gain/loss margin) that were assumed in the development of the factors.
- Support for the benefit, projected non-benefit expense, and projected gain/loss margin for specific OSB packages (Worksheet 7).
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, when used (that is, when indicated in the “General Information” section of Worksheet 1).
- For EGWPs, an explanation of the consistency between the pricing in the bid and the expected underwriting assumptions for all groups, in aggregate. This documentation includes, but is not limited to, a description of the underwriting methodology.
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of and detailed support for how CY2013 bid audit findings and observations were corrected in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that—
  - Identifies the source(s) of the information—for example, name, position, company, date;
  - Identifies the information relied upon;

- States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and
- Indicates to which plan(s) the reliance information applies.

See the sample format at the end of Appendix B.

**Upon Request by CMS Reviewers**

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request. If substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit:

- Support for the pricing of the non-covered services, including utilization and unit cost (Worksheet 2, lines l through r, column o). (Support at the benefit level is required in the initial June bid submission.)
- Detailed support for cost-sharing utilization assumptions and plan-level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-covered and A/B mandatory supplemental benefits (Worksheet 4).
- Support for when the formulas provided in the BPT for DE# plan cost sharing (Worksheet 4, Section IIB, column f) are overwritten at the discretion of the certifying actuary.
- Copies of related-party agreements for a Plan sponsor who has entered into a related-party agreement with an organization that is providing services to unrelated parties.
- Support for the calculation of the “Medicaid Cost Sharing” in column k, including cost sharing required by state or territory Medicaid programs in the plan’s service area based on the eligibility rules for subsidized cost sharing for DE# beneficiaries (Worksheet 4).
- Justification for significant differences between the assumptions of corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark). See Appendix D for more information.
- A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.
- Communication between CMS reviewers and the Plan sponsor throughout the bid review process (that is, e-mail communication) that was not uploaded to HPMS during bid review.
- An explanation as to how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

**MA CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION**

<b>Initial June Bid Submission – Required for All Bids</b>
Cover sheet
Product narrative
Related-party declaration
Claims credibility assumption
Adjustment to cost sharing for maximum OOP limit
Non-benefit expenses
Gain/loss margin
Projected NBE quality initiatives and taxes and fees
Projected risk scores

<b>Initial June Bid Submission – Required for All Bids with Specified Assumptions</b>
Base period experience and reconciliation
Projection factors
Base period NBE quality initiatives and taxes and fees
Enrollment allocation (DE#/non-DE#)
Preventive services incentive programs
Hospice claims costs for mandatory supplemental
Manual rate development
Non-DE# projected allowed costs
Zero cost benefit
Cost of benefit included in non-benefit expenses
Non-covered services benefit-level summary
Disclosure of related-party agreements
ESRD "subsidy"
MSP adjustment
Projected zero DE# member months
ISAR factors
Optional supplemental benefit (OSB) packages pricing assumptions
Actuarial swaps/equivalences
EGWP comparison of bid pricing and expected underwriting assumptions
Input sheets for pricing model
Bid audit results
Reliance information

Upon Request by CMS Reviewers
Non-covered services pricing
Cost-sharing utilization and plan-level deductible
Allocation of allowed costs/cost sharing to Medicare-covered and non-covered
Override of formulas for DE# plan cost sharing
Related-party agreements
State and territory cost sharing requirements
Differences in EGWP and general market pricing assumptions
Reliance letter
Bid review communications
OFM audit results
Other

## SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD IN JUNE

### Supporting Documentation Cover Sheet #1

#### CY2014 Bid Submission

**Organization Name:** Health One

**Contract(s):** H1234, H9999, and S9999

**Date:** June 3, 2013

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if Applicable)	Applies to: MA, PD, or Both
Cover sheet	All bids	Cover Sheet 6-1-2013.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-1-2013.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-1-2013.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-1-2013.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet 1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet 2	both
Risk scores	All bids	Risk CY2014.xls	MA-Sheet 1 PD-Sheet 2	both
Manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA

**SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD****Supporting Documentation Cover Sheet #2****CY2014 Bid Submission****Organization Name:** Health One**Contract(s):** H1234, H9999, and S9999**Date:** July 16, 2013

<b>Documentation Requirement</b>	<b>Specific Bid ID(s) or N/A</b>	<b>File Name</b>	<b>Location within File (if Applicable)</b>	<b>Applies to: MA, PD, or Both</b>
Cover sheet	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0 H9999-001-0 S9999-001-0	Cover Sheet 7-16-2013.doc	n/a	both
E-mail communication with CMS bid reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	Email1.doc	n/a	MA
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email2.doc	n/a	PD
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email3.doc	n/a	PD

**SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS**

<b>Bid ID</b>	<b>MA or PD or Both</b>	<b>Source (Name, Position, Company)</b>	<b>Type of Information</b>	<b>Comments</b>
H1234-002-00	MA and PD	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
H1234-002-00	MA and PD	Jane Doe, Medicare Analyst, ABC Health Plan	Claim modeling, risk score	I have not performed any independent audit or otherwise verified the accuracy of these data or information.

## APPENDIX C – PART B-ONLY ENROLLEES

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This appendix includes bid requirements for plans that cover only enrollees eligible for Medicare Part B. An RPPO plan must cover enrollees eligible for both Medicare Part A and Part B.

Medicare beneficiaries with Medicare coverage only under Part B have not been allowed to elect an MA plan since December 31, 1998 unless they were members of employer or union groups.

However, Medicare beneficiaries (with Part B coverage under Medicare) who were Medicare enrollees of a Section 1876 contractor on December 31, 1998 were considered to be enrolled with that organization on January 1, 1999 if the organization had an MA contract for providing benefits on the latter date. Health benefit coverage that MA organizations provide to such remaining Part B-only enrollees constitutes a separate MA plan (which requires a separate bid submission).

CMS encourages MA organizations to submit as few plans as possible for their pre-1999 Part B-only members, rather than duplicating each of their A/B plans. In fact, an MA organization can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if the plan is offering the pre-1999 Part B-only members the same benefits at the same price as those offered to A/B members (that is, members eligible for both Part A and Part B of Medicare), the Plan sponsor is not required to submit a separate bid for the Part B-only members.

On the other hand, MA organizations that enroll Medicare beneficiaries with Part B-only coverage in an employer-only or union-only group waiver plan must prepare a separate Part B-only bid. If a separate Part B-only plan is not created, the CMS managed care payment system will reject any enrollments submitted on behalf of individuals without Part A.

MA organizations are to prepare Part B-only bids in much the same way as those prepared for Part A/B members.

In completing the bids for Part B-only plans, MA organizations must give special consideration to allocating the portion of services that are considered to be Medicare-covered (Worksheet 4, Section II, columns i and j):

- The Medicare-covered proportion of inpatient services (line a) must equal zero (0) percent.
- While the majority of Medicare expenditures for skilled nursing facilities (SNFs) are covered under Part A (Hospital Insurance), in certain circumstances benefits are covered under Part B (Supplementary Medical Insurance). Guidance on these covered services can be found in Section 70 of Chapter 8 of the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c08.pdf>. We estimate that for calendar year 2014, about 5 percent of Medicare expenditures for SNFs will be covered under Part B.
- Also, as is stated in Section 60.3 of Chapter 7 of the *Medicare Benefit Policy Manual*, if a beneficiary is enrolled only in Part B and is qualified for the Medicare home health benefit, then all of the home health services are financed under Part B. Thus, for most Part B-only plans, the Medicare-covered proportion of home health services (line c) will be 100 percent.

## APPENDIX D – MEDICARE ADVANTAGE PRODUCTS AVAILABLE TO GROUPS

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### (EMPLOYER GROUPS AND UNION GROUPS)

Organizations have two options for offering Medicare Advantage (MA) products to members of employer and union groups: individual-market plans and employer-only or union-only group waiver plans (that is, EGWP or “800-series” plans).

#### Individual-Market Plans (“Mixed Enrollment” plans)

Essentially, MA organizations may either offer their individual-market products without modification or they may tailor the products to specific employer and union groups through two types of allowable customization: “actuarial swapping” or “actuarial equivalence.”

##### ***Actuarial Swaps***

If you are requesting the actuarial swapping category of customization, identify in the supporting documentation both the benefits that might be swapped during negotiations with employers and/or unions and the MA plan covering those benefits. Only supplemental benefits not covered under original Medicare are eligible for actuarial swapping, and only those benefits in your bids that are candidates for swaps need to be identified. When you make specific swaps in negotiations with employers or unions, you can do so in the context of the CMS general approval of your candidates, without obtaining further approval from CMS for the actual swaps.

##### ***Actuarial Equivalence***

If you request the actuarial equivalence category of customization allowable for employer and union groups, provide the following information as supporting documentation:

- The cost-sharing amounts you intend to change and the MA plan containing the cost sharing.
- Any modification to the premium you will charge.
- Any improvement in the benefit related to the changed cost sharing.

Unlike the actuarial swapping flexibility, this customization can apply to both covered and non-covered Medicare benefits.

Please retain in your files a package of documents with computations supporting the proposed changes under these two types of allowable customization. Do not include those packages of documents in the backup material that you submit to CMS.

#### Employer-Only or Union-Only Group Waiver Plans (EGWPs)

The MMA gives employers and unions multiple options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), those options include making special



arrangements with MA organizations to purchase customized benefits for their active employees and retirees or contracting directly with CMS to sponsor a MA plan.

Under section 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for the kinds of arrangements that “hinder the design of, the offering of, or the enrollment in” these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of employer/union-only sponsored group waiver plans (EGWPs): (i) MA organizations that offer or administer employer/union-only sponsored group waiver plans (that is, “800-series plans” in an “H” or “R” contract; and (ii) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan (that is, Employer/Union “Direct Contract” PPO or PFFS plans).

Chapter 9 of the *Medicare Managed Care Manual* (MMCM), which can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c09.pdf> , describes the offering of these EGWPs that are available only to employer and union groups. These plans must follow all MA bidding requirements, except those that are specifically waived per Chapter 9 of the MMCM.

Below are some of the key features to be reflected in EGWP bids. The term “group” refers to employer and union groups.

- Base period data must reflect actual experience for all group members enrolled in the EGWP, across all groups.
- Total projected allowed costs for Medicare-covered services must reflect the composite characteristics of the individuals expected to enroll in the EGWP for the contract year, across all groups.
- The pricing in the bid must reflect the expected underwriting assumptions for all groups, in aggregate, that is,—
  - Each EGWP bid must reflect the composite characteristics of the individuals expected to enroll in the EGWP for the contract year, across all groups. These characteristics include, but are not limited to, the following: risk scores, geographical distribution of enrollees, non-benefit expenses, and gain/loss margins.
  - Projected enrollment within the plan’s service area must be consistent with the location of employer groups.
- The cost sharing priced in Worksheet 3 must correspond to that contained in the PBP.
  - The PBP can be prepared using either the expected composite benefit plan or the Medicare fee-for-service benefit provisions with the required maximum out-of-pocket limit (MOOP).
  - If the PBP reflects Medicare fee-for-service benefits with a MOOP and an MA rebate is generated, then the user must enter the PMPM value of the medical costs associated with these additional “unspecified” benefits in Worksheet 4, Section IV.
- Generally, CMS expects that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience.

Organizations must provide documentation in support of differences in actuarial/financial assumptions between the corresponding products.

- There is no requirement to charge the filed MA basic and supplemental premium to each group that enrolls in the EGWP. However, if the PBP reflects the expected composite benefit plan, then the average premium charged, weighted by all members enrolled in the EGWP across all groups, must correspond to (that is, be consistent with) the filed premium.
- Following are the guidelines for rebates:
  - Similar to CMS' payment on behalf of beneficiaries enrolled in individual-market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an EGWP.
  - The allocation of rebates may vary from group to group within the EGWP subject to the requirements listed below. (The bid form contains one allocation.)
    - ▶ The total rebate must be uniform for all members enrolled in the EGWP.
    - ▶ MA organizations may allocate rebates to the Part D premium when negotiating with specific groups; however, EGWP bids cannot reflect an allocation of rebates to the Part D basic premium or the Part D supplemental premium in the bid form.
    - ▶ The Part B premium buydown rebate allocation in the bid form applies for all members enrolled in the EGWP.
    - ▶ All group members enrolled in an EGWP with supplemental A/B rebates (both reduction in A/B cost sharing and additional benefits) must receive supplemental benefits equal to the amount of the A/B rebate allocation. However, A/B supplemental benefits provided to each group may be customized. Further, MA organizations may use the field in Worksheet 4, Section IV, line 1, "PMPM for additional/unspecified MS benefits," to account for A/B supplemental benefits that are likely to be customized.
  - Consistent with individual-market bids, rebates allocated to reduce members' Part B premium will be transferred to the Social Security Administration, not the MA organization.
  - All rebates must be accounted for and must be used only for the purposes provided for in law. Documentation that supports the use of all of the rebates on a detailed basis must be retained by the MA organization.

For RPPO EGWP plans, the initial June bid submission contains an estimated MA premium. The actual MA premium will not be known until August, when the regional benchmarks are calculated by CMS. Note that after the MA regional benchmarks are released by CMS, all regional MA Plan sponsors will be required to resubmit the MA BPTs in order to reflect the actual plan bid component (in Worksheet 5, cell M17). Regional MA plans may need to reallocate rebates accordingly. Note that this requirement also applies to EGWP regional MA plans (that is, all EGWP RPPOs will be required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

## APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING

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Organizations may resubmit bids in order to reallocate MA rebate dollars for certain plan bids after CMS publishes the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks.

Rebate reallocation is required for some MA plans, is permitted (but not required) for others, and is not permitted for certain plans, as indicated in this appendix. The rebate reallocation guidance applies to plans with all types of pricing arrangements, including risk sharing and global capitation, and to pricing assumptions that were developed as a percent of revenue.

CMS will announce the exact dates of the rebate reallocation period when the Part D and MA benchmarks are released.

In addition to reallocation guidance, this appendix provides premium rounding rules and describes the premium rounding that is permissible during rebate reallocation.

### I. REBATE REALLOCATION PERMISSIBILITY BY PLAN TYPE

MA-PD Plan sponsors may resubmit bids to reallocate rebates in order to return to the target Part D basic premium. Some MA-PD plans are required to reallocate rebates.

The target premium is communicated to CMS in the MA BPT in the initial June bid submission. The target may not be changed after initial submission.

MA-PD Plan sponsors have two options for the target premium. They can set it equal to—

- The basic Part D premium net of rebates (that is, the amount displayed in line 7d of Worksheet 6, Section IIIC), or
- The low income premium subsidy amount.

This choice is designated on line 10 of Worksheet 6 Section IIIC; it is called the “Plan Intention for target Part D basic premium.”

The target Part D basic premium concept does not apply to MA-only plans and EGWP plans, since these plans do not submit a Part D BPT.

All RPPO plans, including EGWPs, must resubmit during the rebate reallocation period, to reflect the published RPPO benchmarks within their bids.

The following tables summarize rebate reallocation permissibility during the rebate reallocation period for various plan types and rebate scenarios and show where examples can be found in this appendix. Additionally, the tables indicate if premium rounding is permitted during rebate reallocation.

**MA-PD Plans with MA Rebate Dollars in the Initial June Bid Submission**

Type of Plan	Rebate Scenario*	Rebate Reallocation	Premium Rounding	Example
Local (excluding EGWP)	Premium decreases below \$0	Required	Permitted	1
Local (excluding EGWP)	Premium decreases but is greater than \$0	Permitted	Permitted	2
Local (excluding EGWP)	Premium increases	Permitted	Permitted	3
RPPO		Required, to reflect the published MA regional benchmarks	Permitted	4

\* Impact on the Part D basic premium net of rebates (line 7D of Worksheet 6, Section IIIC) of reflecting the CMS published benchmarks.

**MA-PD Plans with No MA Rebate Dollars in the Initial June Bid Submission**

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted	Permitted (excluding EGWP)
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

**MA-Only Plans**

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted; these plans are not affected by the Part D and MA regional benchmarks	Not permitted; premiums must reflect desired rounding in the initial June bid submission
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

**II. REBATE REALLOCATION RULES AND EXAMPLES****A. Return to the Target Premium**

When rebates are reallocated, the Part D basic premium net of rebate must be returned to the target premium indicated in the initial June bid submission. CMS will not accept a partial return to the target premium, except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

**B. Negative Part D Basic Premium Net of Rebate after Part D Benchmark Announcement**

If, after reflecting announced Part D benchmarks, the Part D basic premium net of rebate is less than zero, rebate reallocation is required.

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if the premium resulting from application of the national average monthly bid amount and the base beneficiary premium is negative, then the “excess” rebate allocated to buy down the Part D basic premium must be reallocated to buy

down the other premiums (the A/B mandatory supplemental premium, the Part D supplemental premium, and/or the Part B premium).

**Example 1.**

<b>MA BPT Worksheet 6, Section IIIC, Line—</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation Resubmission</b>
7a. Part D basic premium prior to rebates (rounded)	\$36	\$34	\$34
7c. MA rebates allocated to Part D basic premium (rounded)	\$36	\$36	\$34
7d. Part D basic premium	\$0	–\$2	\$0
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable

The required change is the shift from a \$36 to a \$34 rebate allocation to the Part D basic premium in order to return to the target premium of \$0. The “excess” \$2 is allocated to buy down other premiums.

**C. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than Target Part D Basic Premium, but Not Less than Zero**

Rebate reallocation to reduce the other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) is optional if the Part D basic premium net of rebate is lower than the target Part D basic premium, but not less than zero. The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate in order to return to the target Part D basic premium. The rebate may be reallocated to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental).

Note: If the MA organization elects to allocate the “excess” rebate dollars to the other premiums, then the final Part D basic premium must equal the target premium. In other words, a partial return to the target premium will not be accepted.

**Example 2.**

<b>MA BPT Worksheet 6, Section IIIC, Line—</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation Option 1</b>	<b>Rebate Reallocation Option 2</b>
7a. Part D basic premium prior to rebates (rounded)	\$35	\$30	\$30	\$30
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$15	\$10
7d. Part D basic premium	\$20	\$15	\$15	\$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has one of the following two options for rebate allocation:

- No rebate reallocation; leave the Part D basic premium at the post-Part D benchmark announcement basic premium of \$15. Resubmission is not necessary.
- Reallocate \$5 of rebates to other premiums in order to return to the target Part D basic premium of \$20.

Note: If the MA organization does not want to leave the post-Part D benchmark announcement premium at \$15, only a return to \$20 is acceptable, not a partial return of, for example, \$18.

**D. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than Target Part D Basic Premium**

Rebate reallocation from other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) to the Part D basic premium in order to meet the target Part D basic premium is optional if the Part D basic beneficiary premium net of rebate is higher than the target premium (that is, the plan has insufficient rebates). The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate that had been applied to the reduction of other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental) toward the Part D basic premium, in order to return to the target D basic premium. If the MA organization does elect to reallocate additional rebate dollars from other benefits, the final Part D basic premium must be the target premium except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

**Example 3.**

<b>MA BPT Worksheet 6, Section IIIC, Line —</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation Option 1</b>	<b>Rebate Reallocation Option 2</b>
7a. Part D basic premium prior to rebates (rounded)	\$35	\$40	\$40	\$40
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$15	\$20
7d. Part D basic premium	\$20	\$25	\$25	\$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has one of the following two options for rebate allocation:

- No rebate reallocation; leave the Part D basic premium at the post-Part D benchmark announcement Part D basic premium of \$25. Resubmission is not necessary.
- Reallocate \$5 of rebates from other premiums in order to return to the target Part D basic premium of \$20.

Note: If the MA organization does not want to leave the post-Part D benchmark announcement premium at \$25, only a return to \$20 is acceptable, not a partial return, of, for example, \$23, unless \$23 is the result of allocating all rebates to the Part D basic premium.

**E. Increase or Decrease in RPPO Total Rebate Dollars**

Once CMS announces the MA regional benchmarks, there may be an increase or decrease in the total rebate dollars in a regional plan's bid. The allocation of rebate dollars must be revised to reflect the new total rebate dollars.

**Example 4.**

<b>MA BPT Worksheet 6</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation Option 1</b>	<b>Rebate Reallocation Option 2</b>	<b>Rebate Reallocation Option 3</b>
Total MA rebate (IIIB, line 1)	\$55	\$53	\$53	\$53	\$53
MA rebates allocated to benefits other than Part D basic premium (IIIB, lines 2-4 and 6)	\$40	\$40	\$38	\$43	\$38
MA rebates allocated to Part D basic premium (rounded) (IIIB, line 5)	\$15	\$15	\$15	\$10	\$15
Total rebates allocated (IIIB, line 7)	\$55	\$55	\$53	\$53	\$53
Unallocated rebates	\$0	-\$2	\$0	\$0	\$0
A/B Supp premium prior to rebates (IIIC, line 1)	\$50	\$50	\$50	\$50	\$48

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2	Rebate Reallocation Option 3
A/B Supp premium net of rebates (rounded) (IIC, line 3)	\$10	\$10	\$12	\$7	\$10
Part D basic premium prior to rebates (rounded) (IIC, line 7a)	\$35	\$30	\$30	\$30	\$30
Part D basic premium net of rebates (IIC, line 7d)	\$20	\$15	\$15	\$20	\$15
Total MA-PD premium (IIC, line 9)	\$30	\$25	\$27	\$27	\$25
Plan intention for target Part D basic premium (IIC, line 10)	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable	Not applicable

The MA organization has one of the following three options for rebate allocation:

- Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of \$15. Subtract \$2 of rebates that were allocated to other premiums such that the total rebates allocated equal the total rebates available.
- Reduce the rebate allocation for the basic Part D premium by \$5 in order to return to the target Part D basic premium of \$20. Reallocate \$3 of rebates to other premiums such that the total rebates allocated equal the total rebates available.
- Make a change to A/B supplemental benefits as discussed in the section III in Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits. Reduce the rebate allocation to benefits other than the Part D basic premium by \$2 such that the total rebates allocated equal the total rebates available. Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of \$15.

#### F. Every Plan Bid Must Allocate the Exact Amount of the Plan's Total Rebate

The exact amount of the plan's total rebate must be allocated among the various options described above. MA organizations must account for all rebate dollars in a plan's bid. Moreover, the amount of rebate allocated to each benefit (A/B mandatory supplemental, Part B, Part D) must not exceed the value of that benefit. For example, if the Part D supplemental premium is \$50, an MA organization may not allocate more than \$50 to buy down that premium. Rebate allocations to the Part B premium cannot exceed the amount provided by CMS that is pre-populated in the bid pricing tool.

#### G. Examples in which Target Part D Basic Premium Is the Low-Income Premium Subsidy Amount (LIPSA) (and the Plan Desires to Return to the Target)

##### ***Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than LIPSA***

If the Part D basic premium net of rebate is lower than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the MA organization may increase



the Part D basic premium in order to reach the target LIPSA by either (i) reallocating rebates to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental), or (ii) adding A/B mandatory supplemental benefits, in accordance with this appendix, and reallocating rebates to reduce the premium for the newly added benefits.

Note: The final Part D basic premium must equal the target premium unless all of the rebates are allocated to the Part D basic premium and it is still less than the LIPSA.

**Example 5a.**

<b>MA BPT Worksheet 6, Section IIIC, Line—</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation</b>
7a. Part D basic premium prior to rebates (rounded)	\$35	\$30	\$30
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$12
7d. Part D basic premium	\$20	\$15	\$18
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$18	\$18

The LIPSA is less than expected, and the Part D basic premium post-benchmark is less than the LIPSA. To return to the target LIPSA, the only option that the MA organization has is to reallocate rebates to other benefits/premiums.

***Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA***

If the Part D basic premium net of rebate post-benchmark is greater than the LIPSA, then the MA organization may lower the Part D basic premium to the target LIPSA by reallocating the rebate to the Part D basic premium that was applied to buy down other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental). If the MA organization chooses to reallocate additional rebate dollars from other premiums, the final Part D basic premium must equal the LIPSA except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the LIPSA.

**Example 5b. (Similar to Example 3)**

<b>MA BPT Worksheet 6, Section IIIC, Line—</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation</b>
7a. Part D basic premium prior to rebates (rounded)	\$35	\$40	\$40
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$25
7d. Part D basic premium	\$20	\$25	\$15
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$15	\$15

The LIPSA is less than expected, and the Part D basic premium post-benchmark is greater than the LIPSA. To return to the target LIPSA, the only option the MA organization has is to reallocate rebates from other benefits/premiums to the Part D basic premium.

***Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA - De Minimis Election***

The Part D basic premium post-benchmark is greater than the LIPSA and LIPSA is designated as the target Part D basic premium. If (i) the MA organization has no rebates or has allocated all of the MA rebates to the Part D basic premium, and (ii) the difference between the Part D basic premium post-benchmark and the LIPSA is between \$0 and the de minimis amount published by CMS, the MA organization may volunteer to waive the portion of the Part D basic premium equal to this difference.

Conversely, if the difference between the Part D basic premium post-benchmark and the LIPSA is greater than the de minimis amount published by CMS, the MA organization cannot volunteer to waive the de minimis amount.

**Example 5c (MA rebates allocated to Part D basic premium equal total MA rebates)**

<b>MA BPT Worksheet 6, Section IIIC, Line—</b>	<b>Initial June Bid Submission</b>	<b>After Release of Benchmark</b>	<b>Rebate Reallocation</b>
7a. Part D basic premium prior to rebates (rounded)	\$35	\$40	\$40
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$23
7d. Part D basic premium	\$20	\$25	\$17
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$15	\$15

The difference between the \$17 Part D basic premium post-benchmark and the \$15 LIPSA is \$2. The MA organization may volunteer to waive \$2 of the \$17 Part D basic premium to reach the target LIPSA only if CMS publishes a de minimis amount greater

than or equal to \$2. If CMS publishes a de minimis amount less than \$2, the MA organization may not participate in the de minimis program or waive any portion of the \$17 Part D basic premium.

Note that the de minimis amounts in this example are hypothetical and do not reflect CMS' de minimis policy for CY2014.

#### H. First-Time Allocation of Rebate Dollars to Part D Basic Premium during the Rebate Reallocation Period.

In the June bid submission, an MA-PD plan with MA rebate dollars may have opted not to allocate any of the rebate to buying down the Part D basic premium. For these bids, if the Part D basic premium after application of the Part D national average monthly bid amount and the base beneficiary premium were to be higher than the target premium, CMS would allow a return to the plan's target premium.

#### Example 6.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	\$10	\$15	\$15	\$15
7c. MA rebates allocated to Part D basic premium (rounded)	\$0	\$0	\$0	\$5
7d. Part D basic premium	\$10	\$15	\$15	\$10
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

### III. ADDITIONAL REBATE REALLOCATION GUIDANCE

#### Changes Allowed to Funding of the Part D Basic and Supplemental Benefits

During the rebate reallocation period, rebate dollars that are not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. 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.

#### Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits

The A/B mandatory supplemental benefit includes reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under original Medicare and additional items and services not covered by original Medicare. CMS will not allow MA organizations to substantially redesign A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during this period and will evaluate material differences.

The value of the added or eliminated A/B mandatory supplemental benefit is required to match the amount of rebate that must be shifted to return to the Part D target premium. For a regional PPO plan, the value of added or eliminated benefits is required to match one of the following amounts:

- The net shift in (i) total MA rebate dollars due to an increase or decrease in those dollars after application of the regional benchmark, and (ii) a shift in rebates dollars allocated to Part D basic premium to return to the Part D target premium.
- The shift in total MA rebate dollars due to an increase or decrease in those dollars after application of the regional PPO benchmark.

CMS will not allow the MA organization to eliminate one additional benefit and then add another additional benefit.

When the Part D basic premium net of rebate is lower than the target Part D basic premium after the Part D benchmark announcement, the MA organization could—

- Further buy down the initial A/B mandatory supplemental premium;
- Reduce plan cost sharing and then buy down the new A/B mandatory supplemental premium to the initial level; or
- Add new non-drug benefits (for example, vision) to the A/B mandatory supplemental benefit package and then buy down the new A/B mandatory supplemental premium to the initial level.

**Example 7.**

After application of the national average monthly bid amount and the base beneficiary premium, an MA-PD organization's Part D basic premium net of rebates shifts from \$0 to -\$3. The MA organization is required to reallocate \$3 of rebates and may decide to buy down the cost of a benefit in the A/B mandatory supplemental package.

However, CMS will not allow the MA organization to accomplish rebate reallocation by changing the value of benefits by more than \$3, for example, by moving \$15 out of A/B cost-sharing reductions and moving \$18 into an additional benefit. We would consider this to be a substantial redesign of the A/B mandatory supplemental benefit.

When the Part D basic premium net of rebate is greater than the target Part D basic premium after the Part D benchmark announcement, the MA organization could—

- Buy down less of the A/B mandatory supplemental premium; or
- Eliminate or reduce an A/B mandatory supplemental benefit (for example, provide an eye exam less frequently), and then buy down the new A/B mandatory supplemental premium to the initial level.

Similarly, to return a regional plan with a decrease in the total amount of rebate to the original premium, the MA organization could, for example, eliminate from the A/B mandatory supplemental benefit package the coverage of a non-Medicare covered item or service.

The CY2010 Call Letter included the following guidance regarding benefit changes during rebate reallocation (page 22):

### ***“III. Bidding***

#### **Rebate Re-allocation**

. . . In situations when MA-PD plans are allowed to re-allocate Part C rebate dollars in order to return to the Target Part D basic premium (due to “insufficient allocation” resulting in a Part D basic premium larger than the target premium or due to a reduction in the total amount of rebate for a regional plan), MAOs should make re-allocations that reflect the following priorities. Specifically, there may not be any reduction of rebate allocated to priority (3) unless reductions have first been made to priority (1), then priority (2) noted below.

1. Reduce or remove non-Medicare covered benefits;
2. Increase cost sharing for widely-used services such as primary care visits; and
3. As a last resort, increase cost sharing for more limited-use services such as inpatient, skilled nursing facility (SNF), and home health care.

MAOs that do not adhere to this guidance may be asked to resubmit.”

#### **Changes Allowed to the Part B Premium Reduction**

One use of rebate dollars allowed under 42 CFR §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars allocated for this purpose may be increased or decreased. However, the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount pre-populated by CMS in the BPT.

#### **Plans Required to Include Prescription Drug Coverage**

MA organizations must meet the 42 CFR §423.104(f) requirement on type of drug coverage offered by certain plans and must reallocate the rebate, if necessary, to meet this requirement.

In accordance with 42 CFR §423.104(f), MA organizations may not offer an MA coordinated care plan in an area unless that plan (or another MA plan offered by the same MA organization in the same service area) includes required prescription drug coverage.

Required prescription drug coverage is defined by 42 CFR §423.100 as MA-PD plan coverage of Part D drugs that is either—

- Basic prescription drug coverage (that is, defined standard coverage, actuarially equivalent standard coverage, or basic alternative coverage); or
- Enhanced alternative coverage with no beneficiary premium for the Part D supplemental benefit. An MA-PD plan must apply rebate dollars to reduce to zero the beneficiary premium for the Part D supplemental benefit.

MA organizations are required to comply with this rule. If necessary, MA organizations must reallocate rebate dollars from other benefits to achieve the required Part D supplemental benefit in the plan.

To restate: MA organizations offering coordinated care plans must offer in an area either (i) a basic-only Part D plan or (ii) a basic plus supplemental Part D plan for which the supplemental premium (net of rebates) equals zero. Failure to meet this requirement will result in the

organization's inability to offer a Part D benefit. In addition, MA organizations that offer coordinated care plans but that fail to offer a Part D benefit in an area will be unable to offer an MA benefit as well, under the rules of 42 C.F.R. §422.4(c).

## **MA Pricing**

This guidance applies to all pricing arrangements and methodologies, including percent of revenue, risk sharing, and global capitation.

### ***Changes to A/B Mandatory Supplemental***

CMS will allow only the following minor changes to non-benefit expenses and the gain/loss margin as a result of rebate reallocation:

- A change, if any, in non-benefit expenses related to the incremental change of A/B mandatory supplemental benefits.
- A small change in the gain/loss margin related to premium rounding (see premium rounding rules in Appendix E).
- A small change resulting from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.

CMS will also allow a small change in the ESRD subsidy due to the automatic (that is, calculated by formula) impact of changes in mandatory supplemental benefits, non-benefit expenses and gain/loss margin as a result of rebate reallocation and rounding.

### ***Changes to Medicare-Covered***

CMS will allow only the minor modifications specified below to the pricing of Medicare-covered benefits as a result of rebate reallocation; that is, the PMPM value of allowed costs, non-benefit expenses, and the gain/loss margin may not change except for—

- A small change, if any, in allowed costs directly related to a change in utilization due to the change in A/B mandatory supplemental benefits.
- A small change in non-benefit expenses and the gain/loss margin resulting solely from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.

## **Local MA Plan Segments**

The above rules on rebate reallocation apply to bids for local MA plan segments, with the following clarifications.

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; it may not vary across segments. Therefore, prior to the allocation of rebates to buy down the premium, the Part D basic and supplemental premium must be the same across segments. However, the amount of rebates allocated to buy down Part D basic and supplemental premiums may differ by segment.

See Chapters 1 and 4 of the *Medicare Managed Care Manual* for requirements for MA plan segments.

## IV. RULES FOR ROUNDING PREMIUMS

This section describes system requirements for rounded premiums and the circumstances in which the Plan sponsor may round premiums in order to reach plan premium goals.

### Rule 1 – System Requirements Regarding Premiums and Rebates

To comply with premium withhold system requirements, the BPTs round the following premiums to the nearest one decimal: MA (the sum of basic plus mandatory supplemental), Part D basic, and Part D supplemental. No pennies are allowed.

Rebate dollars allocated to reduce the Part B and Part D premiums are rounded to one decimal.

Rebate dollars allocated to reduce the A/B mandatory supplemental premium are rounded to two decimal places.

Note: Prescription Drug Plans (PDPs) express their intention to round the Part D premium in the initial June bid submission, because the rebate reallocation period does not apply to PDPs. In the Part D bid pricing tool, PDPs are permitted to round their premiums to either the nearest \$0.10 or the nearest \$0.50.

### Rule 2 – Local MA-Only Plans

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final premium, as these bids are not affected by the Part D national average calculation or the MA regional plan benchmark calculations. Local MA-only plans will not be given an opportunity to round the premiums after the initial June bid submission. If a local MA-only Plan sponsor wishes to offer a “whole-dollar” premium, the initial June bid submission must reflect a total premium that is rounded to the nearest dollar. The bid assumptions (such as gain/loss margin) must support the desired plan premium and the desired level of premium rounding.

### Rule 3 – Local MA-PD Plans (excluding EGWPs) and RPPOs

Regional plans and local MA-PD plans (excluding local EGWPs) may participate in the rebate reallocation process. During rebate reallocation, MA organizations may round the total plan premium to the nearest dollar (up or down) by slightly increasing or reducing the gain/loss margin in the MA bid, as long as the change in margin results in a total plan premium change of less than \$0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of the combination of the MA basic and mandatory supplemental premiums and the Part D basic and supplemental premiums.)

If the plan has rebate dollars, then the MA organization may make a small change in the gain/loss margin to result in an increase or decrease in rebate dollars of no more than \$0.50. Note that, in order to account for the proportional allocation of the total gain/loss margin to Medicare-covered and A/B mandatory supplemental in the BPT, and also to account for the savings retained by Medicare, the total margin may change by slightly more than \$0.50. Specifically, the Medicare-covered margin (Worksheet 4, cell O107) would be limited to:

- At the 70% rebate level: limited to a \$0.71 Medicare-covered margin change, to result in a \$0.50 change in rebates ( $\$0.71 \times 70\% = \$0.50$ ).

- At the 65% rebate level: limited to a \$0.77 Medicare-covered margin change, to result in a \$0.50 change in rebates ( $\$0.77 \times 65\% = \$0.50$ ).
- At the 50% rebate level: limited to a \$1.00 Medicare-covered margin change, to result in a \$0.50 change in rebates ( $\$1.00 \times 50\% = \$0.50$ ).

If the plan A/B bid is equal to or greater than the A/B benchmark, the MA organization may make a small change in the gain/loss margin resulting in a premium increase or decrease of up to \$0.50.

#### Examples of rounding.

**Example (a).** An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This situation could occur if (i) the bid equals the benchmark, and no A/B mandatory supplemental benefits are offered, or (ii) the bid is less than the benchmark, and the plan has A/B mandatory supplemental benefits and applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement total plan premium is \$30.42, the MA organization could round the plan premium to \$30.00 by generating \$0.42 of additional rebates to allocate to the basic Part D premium by slightly reducing the gain/loss margin for MA benefits. (The gain/loss margin for Part D benefits must not change.)

**Example (b1).** An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This situation could occur if (i) the bid equals the benchmark, and no A/B supplemental benefits are offered, or (ii) the plan applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement bid results in a total plan premium of \$32.42, the MA organization could opt to generate \$0.42 of additional rebates to allocate to the basic Part D premium by making a slight reduction in the gain/loss margin for MA benefits that would result in a premium of \$32.00.

The MA organization could not use the rounding rules to adjust the premium to anything lower than \$32. For example, the organization could not round to a combined premium of \$30 by reducing the gain/loss margin to result in a premium change of \$2.42. To return to the premium of \$30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

**Example (b2).** An MA-PD plan has A/B mandatory supplemental benefits, an initial basic Part D premium (target premium) of \$30, and a total plan premium of \$70.00. If the post-Part D benchmark announcement bid results in a basic Part D premium of \$28.55 and a total plan premium of \$68.55, the MA organization could opt to make a slight change in the gain/loss margin for MA benefits in order to achieve a \$0.45 increase in premium for A/B mandatory supplemental benefits, resulting in a total plan premium of \$69.00.

The MA organization could not use the rounding rules to adjust the premium to anything higher than \$69. For example, the organization could not round to a combined premium of \$70 by increasing the gain/loss margin to result in a premium change of



\$1.45. To return to the target premium of \$30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

**Example (c).** An MA-PD plan has no rebates and an initial total plan premium of \$25. The post-Part D benchmark announcement total plan premium is \$26.52. The MA organization could round the plan premium to the nearest dollar (that is, \$27.00) by increasing the gain/loss margin to generate a \$0.48 MA premium.

**Example (d).** The target Part D basic premium is the low-income premium subsidy amount. After the Part D national average monthly bid amount is calculated, the Part D basic premium is \$32.00, and the low-income premium subsidy amount is \$31.60. The plan has the following three options:

**Option 1.** The plan can maintain its Part D basic premium of \$32.00. The plan's beneficiaries eligible for the full subsidy will pay a Part D basic premium of \$0.40.

**Option 2.** The MA-PD plan can reallocate \$.40 of the rebates that were allocated to the A/B mandatory supplemental premium to its Part D basic premium, thus reducing the premium to the low-income premium subsidy amount of \$31.60. To account for the reduction in rebates applied to the A/B mandatory supplemental premium, the MA-PD plan may either increase its A/B mandatory supplemental premium by \$0.40 or reduce its gain/loss margin appropriately to eliminate the premium increase. Enrollees not eligible for the low-income subsidy would pay a Part D basic premium of \$31.60.

**Option 3.** In order to be able to offer a rounded Part D basic premium to enrollees not eligible for the low-income subsidy, MA-PD plans are permitted in this situation to reallocate A/B mandatory supplemental rebates to reduce their Part D basic premium to the nearest whole-dollar amount below the regional low-income premium subsidy amount. Therefore, the MA-PD plan can reallocate \$1.00 of its A/B mandatory supplemental rebates to its Part D basic premium, reducing the Part D basic premium to \$31.00, which is the nearest whole-dollar amount below the regional low-income premium subsidy of \$31.60. To account for the reduction in A/B mandatory supplemental rebates applied to MA, the MA-PD plan must increase its A/B mandatory supplemental premium by \$1.00 and cannot offset the reduction by a change in the gain/loss margin. Please note that in this option, the MA-PD plan forgoes \$0.60 in potential low-income premium subsidy dollars per each beneficiary eligible for the full subsidy.

**Example (e).** The target Part D basic premium is the LIPSA. After the Part D national average monthly bid amount is calculated, the low-income premium subsidy amount is \$31.76. Since Part D premiums must be rounded to one decimal, it is acceptable for the plan to round the Part D basic premium to \$31.70 or to \$31.80, as follows:

**Option 1.** If the plan were to round the Part D basic premium to \$31.70, then it would receive \$31.70 as the low-income premium subsidy. The plan's

beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since such premium is lower than the LIPSA.

**Option 2.** If the plan were to round the Part D basic premium to \$31.80, then it would receive \$31.80 as the low-income premium subsidy as if the LIPSA were \$31.80. In this case, the plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the \$0.04 difference between the Part D basic premium and the LIPSA (that is, \$31.80 less \$31.76) rounds to zero when such premiums are rounded to one decimal.

**Example (f).** An MA-PD plan has three segments, with MA premiums of \$51, \$76, and \$110. The Part D basic premium after the benchmark announcement is \$37.90. To ultimately achieve whole-dollar total plan premiums, the MA organization could increase the MA gain/loss margin requirements to increase each MA premium by \$0.10. When added to the \$37.90 Part D premium, the total plan premium for each segment becomes a whole-dollar amount: \$89, \$114, and \$148.

**Example (g).** The initial June bid submission for a local MA-only plan includes a \$0 basic MA premium and a \$61.30 mandatory supplemental MA premium. The Plan sponsor would like to offer a whole-dollar premium to the plan's enrollees. Before submitting the initial BPT to CMS (via HPMS upload), the actuary would slightly revise the gain/loss margin to accomplish the rounded premium. For example, the actuary could reduce the gain/loss margin by \$0.30 to achieve the \$61.00 rounded premium. This adjustment must be completed before the BPT is submitted to CMS in early June. Note that Plan sponsors are not allowed to make significant changes to the BPT in order to round premiums. Local MA-only plans do not participate in rebate reallocation.

## V. SUMMARY OF CONSIDERATIONS FOR REBATE REALLOCATION RESUBMISSIONS

When preparing resubmissions during the rebate reallocation period, plans should review the following considerations:

- All RPPOs (including EGWPs) must resubmit during the rebate reallocation period, in order to reflect the published regional MA benchmarks.
- If the national average monthly bid amount (NAMBA) and base beneficiary premium (BBP) result in a Part D basic premium that is lower than the rebates allocated to Part D basic, then the bid must be resubmitted.
- When resubmitting bids during the rebate reallocation period, plans must update the NAMBA and BBP in the Part D BPT.
- The Part D bid must be unchanged.
- The Part D basic premium net of rebates must equal the target.
- If the LIPSA is targeted, the resubmitted Part D basic premium net of rebates must be equal to the plan's LIPSA (rounded to the nearest dime or rounded down to the nearest dollar).
- The "plan's intention for the target premium" in the MA BPT must be unchanged.
- Changes to MA pricing assumptions (benefit/non-benefit /gain/loss) must be consistent with these instructions.

## APPENDIX F – SUGGESTED MAPPING OF MA PBP CATEGORIES TO BPT CATEGORIES

The Medicare Advantage (MA) Bid Pricing Tool (BPT) contains benefit categories that do not correlate line-by-line with the MA Plan Benefit Package (PBP). The BPT was developed to include a reasonable number of benefit categories for pricing purposes and to provide benefit groupings that are consistent with organizations' accounting and claims systems.

The chart below provides a suggested mapping of the PBP and BPT benefit categories. This mapping is not intended to represent the only method of reporting benefits in the BPT; rather, it contains one suggested method that may be used. Other reasonable mappings may also be used at the actuary's discretion. The cost sharing reported on Worksheet 3 must clearly identify where PBP benefit service categories are priced within the BPT service categories (see Worksheet 3 instructions for more details).

HPMS contains a "Medicare Benefit Description Report" with further information regarding the PBP service categories and a list of PBP/SB software changes. In addition, the *Medicare Managed Care Manual* may be a helpful resource regarding benefit design.

<b>PBP line #</b>	<b>PBP Category</b>	<b>BPT line #</b>	<b>Corresponding BPT Category: Description/Note (Worksheet 3)</b>
1a	Inpatient Hospital – Acute	a1	Inpatient Facility: Acute
1b	Inpatient Hospital - Psychiatric	a2	Inpatient Facility: Mental Health
2	Skilled Nursing Facility	b	Skilled Nursing Facility
3	Cardiac and Pulmonary Rehabilitation Services	h5	Outpatient Facility - Other: Other
4a	Emergency Care	f	Outpatient Facility - Emergency
4b	Urgently Needed Care	f	Outpatient Facility - Emergency
4c	Worldwide Coverage	f	Outpatient Facility - Emergency
5	Partial Hospitalization	h3 h5	OP Facility - Other: Mental Health; or OP Facility - Other: Other
6	Home Health Services	c	Home Health
7a	Primary Care Physician Services	i1	Professional: PCP
7b	Chiropractic Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7c	Occupational Therapy Services	i4	Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Excluding Psychiatric Services (exclude Radiology)	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7d	Physician Specialist Services Excluding Psychiatric (Radiology only)	i5	Professional: Radiology
7e	Mental Health Specialty Services – Non-Physician	i3	Professional: Mental Health
7f	Podiatry Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7g	Other Health Care Professional Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7h	Psychiatric Services	i3	Professional: Mental Health

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<b>PBP line #</b>	<b>PBP Category</b>	<b>BPT line #</b>	<b>Corresponding BPT Category: Description/Note (Worksheet 3)</b>
7i	Physical Therapy and Speech Language Pathology Services	i4	Professional: Therapy (PT/OT/ST)
8a	Outpatient Diagnostic Procedures/Tests/Lab Services	h1	OP Facility - Other: Lab
8b	Outpatient Diagnostic/Therapeutic Radiological Services	h2	OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g or h	OP Facility - Surgery; or OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center (ASC) Services	g	OP Facility - Surgery
9c	Outpatient Substance Abuse	h5	OP Facility - Other: Other
9d	Outpatient Blood Services	h5 or k	OP Facility - Other: Other or Other Medicare Part B
10a	Ambulance Services	d	Ambulance
10b	Transportation Services	l	Transportation (Non-Covered)
11a	Durable Medical Equipment (DME)	e1	DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Supplies and Services	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
12	End-Stage Renal Disease	h4	OP Facility - Other: Renal Dialysis
13a	Acupuncture and Other Alternative Therapies	q	Other Non-Covered
13b	OTC Items and Services	q	Other Non-Covered
13c	Meal Benefit	q	Other Non-Covered
13d	Other 1	q	Other Non-Covered
13e	Other 2	q	Other Non-Covered
13f	Other 3	q	Other Non-Covered
13g	Dual Eligible SNPs with Highly Integrated Services	q	Other Non-Covered
13h	Medicare-Medicaid Plan	q	Other Non-Covered
14a	Medicare-covered Preventive Services	k, i1, i2 or i6	Other Medicare Part B; Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14b	Annual Physical Exam	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14c	Supplemental Education/Health Management Programs	p	Health & Education (Non-Covered)
14d	Kidney Disease Education Services	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14e	Diabetes Self-Management Training	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
15	Medicare Part B Rx Drugs (includes Part D home infusion drugs included in bundled services)	j	Part B Rx

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<b>PBP line #</b>	<b>PBP Category</b>	<b>BPT line #</b>	<b>Corresponding BPT Category: Description/Note (Worksheet 3)</b>
16a	Preventive Dental	m	Dental (Non-Covered)
16b	Comprehensive Dental	m	Dental (Non-Covered)
17a	Eye Exams	n1	Vision (Non-Covered): Professional
17b	Eye Wear	n2	Vision (Non-Covered): Hardware
18a	Hearing Exams	o1	Hearing (Non-Covered): Professional
18b	Hearing Aids	o2	Hearing (Non-Covered): Hardware

## APPENDIX G – DE# SUMMARY

### Medicaid Eligibility Data

The Medicaid status codes in the beneficiary-level file provided by CMS indicate the Medicaid eligibility status of the beneficiary as reported by the respective state Medicaid agency. These codes are shown in the table below. For descriptions of the dual-eligible beneficiary categories, and of the types of Medicaid benefits to which these beneficiaries are entitled, see [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare\\_beneficiaries\\_dual\\_eligibles\\_at\\_a\\_glance.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf).

Medicaid Status Code	Medicaid State-Reported Code (Dual-Eligible Category)
01	QMB only
02	QMB + full Medicaid benefits
03	SLMB only
04	SLMB + full Medicaid benefits
05	QDWI (Qualified Disabled and Working Individual)
06	QI (Qualified Individual)
08	Full-benefit dual-eligible beneficiaries who do not have QMB or SLMB status
09	Other dual-eligible beneficiaries without full Medicaid benefits—for example, those in Pharmacy Plus and 1115 drug-only demonstrations
99	Unknown, including Medicaid-eligible beneficiaries reported by plans and territories
Blank	Non-Medicaid

### Classifying Dual-Eligible Data

The HPMS plan-level data also include a Medicaid grouping indicator as shown in the table below. This table illustrates how the data for dual-eligible beneficiaries are classified as DE# or non-DE#. The certifying actuary must consider the Medicaid cost-sharing policy for the states or territories in the plan's service area when determining which beneficiaries in Medicaid grouping B are in the DE# population.

Medicaid Grouping	Dual Eligible	Category of Dual Eligible	Medicaid Status Code	Medicare Cost-Sharing Liability	DE# Status
A	Dual	QMB and QMB+	01, 02	None	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Reduced (as determined by the certifying actuary)	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Full (as determined by the certifying actuary)	Non-DE#
C	Non-dual	Non-Medicaid	Blank	Full	Non-DE#

The following table outlines the requirements for classifying dual-eligible beneficiaries that are not QMB or QMB+ (that is, Medicaid Indicator B: Other Medicaid) as DE# or non-DE#. The percentages in the table below represent the number of total dual-eligible beneficiaries relative to total members per the HPMS plan-level data.

Medicaid Grouping/Status Code	Condition	DE# Determination for Base Period Data
A: 01, 02	None	DE#
B: 03, 04, 05, 06, 08, 09, 99	<10% total dual-eligible beneficiaries	May consider as non-DE# or determine actual classification
B: 03, 04, 05, 06, 08, 09, 99	10% to 100% total dual-eligible beneficiaries	Must determine actual classification
C: Blank	None	Non-DE#

### BPT Values

The following table outlines the determination of certain BPT values when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2.

BPT Area	Input Item	<10% DE#	>90% DE#	10% to 90% DE#
WS3	Utilization and PMPM values	Enter non-DE# or total values	Enter non-DE# or total values <sup>1</sup>	N/A
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Enter zero or appropriate values <sup>2</sup>	Enter appropriate values <sup>3</sup>	N/A
WS5 II	Non-DE# risk factor	Enter total values	Enter total values	N/A

<sup>1</sup> Enter total values if DE# projected member months equal total projected member months.

<sup>2</sup> Plus plan cost sharing for non-covered, non-Medicaid benefits.

<sup>3</sup> Plus plan cost sharing for non-covered, non-Medicaid benefits.

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The next table summarizes the determination of certain BPT values when (i) the value for the DE# projected member months is less than 10 percent, or greater than 90 percent, of the total projected member months and the certifying actuary chooses to separately calculate DE# and non-DE# projected allowed costs; or (ii) the value for the DE# projected member months is between 10 percent and 90 percent inclusive of the total projected member months.

<b>BPT Area</b>	<b>Input Item</b>	<b>Determination of BPT Values</b>
WS3	Utilization and PMPM values	Enter non-DE# values
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Determine appropriate values (including zero) <sup>4</sup>
WS5 II	Non-DE# risk factor	Determine distinct non-DE# and DE# values

The table below outlines the determination of BPT values in which the requirements are the same for all bids regardless of the percentage of DE# members.

<b>BPT Area</b>	<b>Input Item</b>	<b>Determination of BPT Values</b>
WS3	Cost-sharing values and description	Reflect PBP package
WS4 IIB	Plan cost sharing (column f)	Default to non-DE# ratio of plan cost sharing or override formulas
WS5 II	Non-DE# member months	Determine distinct non-DE# and DE# values

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<sup>4</sup> Plus plan cost sharing for non-covered, non-Medicaid benefits.



## APPENDIX H – MEDICAL SAVINGS ACCOUNT BPT

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This appendix provides guidance for completing the Medical Savings Account Bid Pricing Tool for Medical Savings Account (MSA) plans offered to Medicare beneficiaries. This appendix highlights only the differences between the MSA BPT and the MA BPT.

The MSA bid form is organized as outlined below:

Worksheet 1 – MSA Base Period Experience and Projection Assumptions

Worksheet 2 – MSA Total Projected Allowed Costs PMPM

Worksheet 3 – MSA Benchmark PMPM

Worksheet 4 – MSA Enrollee Deposit and Plan Payment PMPM

Worksheet 5 – MSA Optional Supplemental Benefits

### WORKSHEET 1 – MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS (CORRESPONDING TO MA WORKSHEET 1)

#### SECTION I – GENERAL INFORMATION

##### Line 7 – Plan Type

MSA is the only valid plan type.

##### Line 8 – Deductible Amount

Enter the deductible amount that each beneficiary will pay for Medicare-covered benefits. The maximum deductible for CY2014 for MSA plans is \$11,200.

##### Line 9 – Enrollee Type

This cell is pre-populated with “A/B”.

#### SECTIONS II, III, IV, AND V

Base period data in Sections II, III, IV, and V must include only Medicare-covered medical expenses.

### WORKSHEET 2 – MSA TOTAL PROJECTED ALLOWED COSTS PMPM (CORRESPONDING TO MA WORKSHEET 2)

#### SECTION II – PROJECTED ALLOWED COSTS

Data in Section II must include only Medicare-covered medical expenses.

### WORKSHEET 3 – MSA BENCHMARK PMPM (CORRESPONDING TO MA WORKSHEET 5)

Follow the instructions for MA Worksheets 5 and 6 for the appropriate inputs.

## **WORKSHEET 4 – MSA ENROLLEE DEPOSIT AND PLAN PAYMENT (NO CORRESPONDING MA WORKSHEET)**

This worksheet calculates the MSA monthly plan revenue requirement and enrollee deposit. Consistent with other MSA worksheets, information provided on Worksheet 4 must exclude ESRD enrollees.

### **SECTION II – DEVELOPMENT OF CLAIM INFORMATION INTERVALS (PLAN’S RISK FACTOR AND EXCLUDE SERVICES COVERED WITHIN THE DEDUCTIBLE)**

#### **Column c – Annual Projected Claim Interval**

The column is pre-populated with annual projected claim intervals.

#### **Column d – Annual Average Claim Amount**

Enter the annual average claim amount paid in each claim interval.

#### **Column e – Percentage of Member Months (Use Only the Highest Claim Interval)**

Allocate the total projected member months to the highest claim interval expected by percentage.

For example, if 20 percent of the member months are expected to incur annual claims of \$11,500, and 10 percent are expected to incur annual claims of \$4,400, then put 20 percent only in the interval containing \$11,500 and 10 percent only in the interval containing \$4,400. The sum of column e must equal 100 percent.

#### **Column f – Gross Claims (PMPM)**

This column calculates total allowed Medicare-covered claims on a PMPM basis for each claim interval. No entry is required. The sum of column f must equal the total Medicare-covered medical expenses shown in column o of Worksheet 2.

#### **Column g – Gross Claims over Deductible (PMPM)**

Enter the total allowed Medicare-covered claims on a PMPM basis over the deductible for each claim interval expected to be paid by the MSA plan. Enter zero (0) for claim intervals below the deductible.

### **SECTION III – DEVELOPMENT OF SUMMARY INFORMATION (PLAN’S RISK FACTOR)**

#### **Line a – Medicare-Covered Plan Medical Expenses PMPM**

This cell displays the sum of column g of Section II.

#### **Line b – Non-Benefit Expenses**

Enter the non-benefit expense information. Please refer to the “Pricing Considerations” section of these instructions for further guidance.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a 0 in the cell.

**Line c – Gain/Loss Margin**

Input the projected PMPM for the gain/loss margin for Medicare-covered services provided. Please refer to the “Pricing Considerations” section of these instructions for further guidance.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a 0 in the cell.

**Line d – Total Plan Revenue Requirement**

This cell is calculated automatically as the sum of projected Medicare-covered medical expense, non-benefit expense, and gain/loss margin.

**Line e – Projected Plan Benchmark**

This cell displays the value from Section III, column h, line 1 of Worksheet 3—the weighted average for the service area of the risk-adjusted ratebook values.

**Line f – Projected Monthly Enrollee Deposit**

This cell calculates the monthly enrollee deposit by subtracting the total plan revenue requirement from the projected plan benchmark.

**Line g – Percent of Plan Revenue Ratios**

These cells calculate the ratio of medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue.

**Line h – Standardized Plan Benchmark**

This cell displays the value from Section III, column g, line 1 of Worksheet 3—the weighted average for the service area of the unadjusted ratebook values.

**Lines i, j, k and l – BPT MLR fields**

Follow the instructions for MA Worksheet 4 for the appropriate inputs.

**WORKSHEET 5 – MSA OPTIONAL SUPPLEMENTAL BENEFITS (CORRESPONDING TO MA WORKSHEET 7)**

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

## APPENDIX I – END-STAGE RENAL DISEASE-ONLY SPECIAL NEEDS PLANS BPT

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This appendix provides guidance for completing the ESRD-SNP BPT for ESRD-SNP plans offered to Medicare beneficiaries. This appendix highlights only the differences between the ESRD-SNP BPT and the MA BPT.

The ESRD-SNP bid form is organized as outlined below:

Worksheet 1 – Enrollment and PMPM Revenue Projection

Worksheet 2 – Projection of benefit cost, non-benefit expenses, and gain/loss margin PMPM

Worksheet 3 – Program Experience for Calendar Year 2012

Worksheet 4 – Optional Supplemental Benefits

### WORKSHEET 1 – ENROLLMENT AND PMPM REVENUE PROJECTION

#### SECTION I – GENERAL INFORMATION

Follow the instructions for MA Worksheet 1 for the appropriate inputs.

##### Line 2 – Contract-Plan-Segment

This field concatenates the contract ID, plan ID and segment ID.

##### Line 4 – Service Area

Enter a brief description of the service area.

##### Line 5 – Plan Type

“ESRD SNP” is pre-populated.

#### SECTION II – SERVICE AREA SUMMARY

Follow the instructions for MA Worksheet 5 for the appropriate inputs.

##### ✓ Column a – State/County Code

Similar to MA BPT Worksheet 5, enter the county codes associated with the plan’s service area.

Technical note regarding the ESRD-SNP BPT: the rates populated in column (g) are “state-wide” rates for Dialysis and Transplant statuses. Therefore, plans may enter one county code (example: entering 05430 for California) and report the Dialysis member months and risk scores for the state in that row. Similarly, one county code may be entered for the state-wide Transplant information. In other words, the Dialysis and Transplant member months and risk scores do not need to be reported at the county level. Functioning Graft rates are “county-specific”, and therefore member months and risk scores must be reported at the county level for Functioning Graft status.

✓ **Column d – ESRD Status (D /T /F)**

Enter the ESRD status: “D” for dialysis, “T” for transplant, or “F” for functioning graft (that is, postgraft).

✓ **Column f – Projected Risk Score**

Projected risk scores must:

- Be based on the CMS-HCC ESRD Model.
- Reflect appropriate projection factors.
- Be adjusted for FFS normalization.
- Reflect the MA coding adjustment factor as follows: postgraft risk scores must reflect the MA coding adjustment factor in the Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Dialysis risk scores and transplant factors should not incorporate the MA coding adjustment.

✓ **Column h – Percentage of MSP Member Months**

Enter the percentage of Medicare Secondary Payer (MSP) member months applicable for the ESRD status and county/state indicated.

✓ **Column i – Projected CMS Monthly Capitation**

This field is calculated automatically.

### **SECTION III – ESRD MSP ADJUSTMENT FACTORS FOR CY (FROM APRIL RATE ANNOUNCEMENT)**

This section contains the adjustment factors released by CMS in the Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Line 1 contains the MSP factor for Functioning Graft, and line 2 contains the MSP factor for dialysis/transplant.

### **SECTION IV – SUMMARY DATA**

**Line 1 – Part C Mandatory Monthly Enrollee Premium**

This amount is obtained from Worksheet 2.

**Line 2 – Part C Monthly Plan Revenue**

This field is calculated automatically.

**Line 3 – Part D Premium (Basic + Supplemental) net of reductions**

This information is obtained from Worksheet 2.

**Line 4 – Plan intention for target Part D basic premium**

This information is obtained from Worksheet 2.

**Line 5 – Quality Bonus Rating (per CMS)**

Follow the instructions for MA Worksheet 5.

**Line 6 – New/low indicator (per CMS)**

Follow the instructions for MA Worksheet 5.

**WORKSHEET 2 – PROJECTION OF BENEFIT COST, NON-BENEFIT EXPENSES, AND GAIN/LOSS MARGIN PMPM**

**SECTION II – PROJECTION OF PLAN COSTS**

The medical expense projection is to be consistent with the population reflected in the revenue projections on Worksheet 1. The medical expense projections may be based on a blend of trended plan experience and other data sources.

The allowed costs in Rows 16-31 should include only Medicare-covered services. Additional services such as inpatient coverage beyond lifetime reserve days and preventive services not covered by original Medicare should be reflected in Additional Services on row 37.

The Supplemental Benefits columns are calculated automatically and reflect cost sharing enhancements to the Medicare-covered benefit package.

For guidance on reporting non-benefit expenses, gain/loss margin and related parties, see the “Pricing Considerations” section and MA Worksheet 4 section of these instructions.

For information on the BPT MLR fields, see the “Pricing Considerations” section and MA Worksheet 4 section of these instructions.

**SECTION III – DEVELOPMENT OF ESTIMATED PLAN PREMIUM AND REDUCTIONS**

Follow the instructions for MA Worksheet 6.

Note regarding the rebate reallocation period and the ESRD-SNP BPT: After CMS’ release of the Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, and the Part D Regional Low-Income Premium Subsidy Amounts, CMS will allow plans to return to their target Part D basic premium by reallocating “excess funds” allocated in the initial submission to the supplemental benefit items in rows 56 through 60 of Worksheet 2. Here, the term “excess funds” refers to the difference between the CMS capitation payment and the plan’s cost to provide Medicare-covered benefits. Generally, the rules in effect for other MA-PD plans for changes to the funding of benefits during the rebate reallocation period will apply to reallocation of excess funds (see Appendix E).

**WORKSHEET 3 – PROGRAM EXPERIENCE FOR CALENDAR YEAR 2012**

**SECTION II – CONTACT INFORMATION**

Follow the instructions for MA Worksheet 6.

### **SECTION III – REVENUES**

Enter member months, CMS payments (on a PMPM basis), and enrollee premium (on a PMPM basis) for CY2012. All revenues are to be reported on an earned basis, including retroactive adjustments. Revenues for 2012 are to include an estimate of the final risk adjustment settlement to be received in mid-2013.

### **SECTION IV – MEDICAL BENEFITS (PMPM)**

Enter claims incurred in CY2012 and paid through March 31, 2013. Medical benefits are to be reported net of enrollee cost sharing.

Claim reserves as of March 31, 2013 are to be reported for 2012. Organizations may allocate claim reserves to appropriate categories in situations where reserves are developed at a consolidated level.

For “Utilizers” column, follow the instructions for MA Worksheet 1.

For guidance on reporting non-benefit expenses and gain/loss margin, see the “Pricing Considerations” section of these instructions.

### **WORKSHEET 4 – OPTIONAL SUPPLEMENTAL BENEFITS**

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

### **SUPPORTING DOCUMENTATION FOR ESRD-SNP BPTs**

See Appendix B for supporting documentation requirements.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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