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INSTRUCTIONS FOR COMPLETING THE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2023

Final April 8, 2022

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I. INTRODUCTION

BACKGROUND

Part D sponsors, that is, Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs), must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each prescription drug plan that they intend to offer Medicare beneficiaries. This requirement includes Part D plans without a corresponding Medicare Advantage (MA) plan, such as Section 1876 cost plans, Section 1833 cost plans, and Programs of All-Inclusive Care for the Elderly (PACE) plans.

Note that a Medicare Advantage Organization (MAO) may offer private fee-for-service (PFFS) and Religious Fraternal Benefit PFFS plans without Part D coverage. However, if an MAO offers, in a given MA service area, at least one benefit plan of any other plan type, at least one benefit plan in such service area must include Part D coverage.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format—the Prescription Drug Bid Pricing Tool (BPT).

Each bid submission must include an actuarial certification and supporting documentation 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.

These bid instructions provide details on the bid submission elements required by 42 CFR 423.265.

DOCUMENT OVERVIEW

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

- Section I, “Introduction”: contains a list of key changes from the CY2022 BPT and provides sources of information that can be accessed for assistance during the bid submission process.
- Section II, “Pricing Considerations”: contains guidance for preparing bids and presenting pricing results in the BPT.
- Section III, “Data Entry and Formulas”: contains directions for completing the eight worksheets in the BPT and explains the formulas for calculated cells.
- Section IV, Appendices A through G: contains requirements for Actuarial Certification (Appendix A), Supporting Documentation (Appendix B), Employer/Union-Only Group Waiver Plans (Appendix C), Calculation of the National Average Monthly Bid Amount (Appendix D), Calculation of the Low-Income Benchmark Premium Amounts

(Appendix E), Health Care Reform (Appendix F) and Trending Risk Scores (Appendix G).

NEW FOR CONTACT YEAR 2023 (CY2023)

The key changes between the CY2022 and CY2023 Part D BPT are listed below. The changes improve the usability and functionality of the BPT and reflect updated guidance.

- The insurer fee inputs have been removed from the base period.
- The corporate margin requirement inputs have been removed from Worksheet 3.

BIDDING RESOURCES

The following resources provide information on CY2023 bidding:

- The CY2023 Advance Notices and Announcement are available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.
- The Actuarial Bid Training is available at https://www.cms.gov/medicare/medicare-advantage-rates-statistics/actuarial-bid-training. For questions about the BPT, e-mail the CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov.
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2023 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. For call-in information, see the OACT memorandum with the subject line "Actuarial User Group Calls" released via HPMS.
- For technical questions about the BPT, BPT Batch Tools, HPMS, or the upload process, refer to the following resources:
  - The BPT Technical Instructions, located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2023 > Documentation > BPT Technical Instructions.
  - The *Bid Submission User's Manual*, also available in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2023 > Documentation > Bid User's Manual.
  - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov.
- For information about benefits, see the *Medicare Prescription Drug Benefit Manual* located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050485.html.

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

By statute, the bid must represent the revenue requirement of the expected population. Therefore, in most circumstances, Part D sponsors must use credible bid-specific experience in the development of projected allowed costs. This approach does not preclude Part D sponsors from reaching specific benefit and premium goals; the gain/loss margin guidance allows sufficient flexibility to achieve pricing targets provided that the overall gain/loss 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 plan level if the plan existed in CY2021, 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

Actuarial Equivalence

Actuarial equivalence must be demonstrated for plan benefit types other than Defined Standard (DS).

When the plan benefit type is Actuarially Equivalent (AE), three tests must be satisfied on Worksheet 4, Section IV, lines 16 through 18 to demonstrate actuarial equivalence:

- The average coinsurance percentage for amounts between the deductible and the initial coverage limit (ICL) must be actuarially equivalent to 25 percent.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

When the plan benefit type is Basic Alternative (BA) or Enhanced Alternative (EA), six tests must be satisfied to demonstrate actuarial equivalence on Worksheet 5, Section VI, lines 1 through 6:

- The value of total coverage is at least actuarially equivalent to DS coverage.
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage.
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL.
- The deductible is not greater than the DS deductible.
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

Base Period Experience

The experience data must be based on a calendar year 2021 incurred period with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable. Further, the enrollment data for the Part D bid in an MA-PD plan must reflect the same underlying population as that for the corresponding MA bid.

Worksheet 1 must be completed with data for the plan ID. Note that these data—

- Must be submitted in Worksheet 1 for any plans with experience data for 2021, regardless of the level of enrollment.
- Must reconcile in an auditable manner to the plan-level Prescription Drug Event (PDE) data submitted to CMS for payment and reconciliation and the Part D sponsor's audited financial statements.
- Must include accepted PDEs, rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan (P2P) transactions and, if appropriate, transfer of over-the-counter (OTC) drug data from the base period experience to the non-benefit expense component. The impacts of each of these considerations must be quantifiable and must not be included in the completion factor.
- Must be reported without adjustment. Adjustments may be made in Worksheet 2, Sections II and III to accommodate population, benefit design or other changes from the base period to the contract period.
- May be reported in aggregate for a number of plans only when there are enrollment changes associated with the dissolution of a plan and the retained members are crosswalked into existing plans in the same contract or across contracts. Each contract-plan-segment ID must be identified in Section II, line 5.
- Must be provided for plans acquired by the Part D sponsor.
- May not be used to aggregate data from a number of plans in order to achieve credibility.
- Must be reported in total at the plan level for every contract-plan ID when plans are aggregated; do not include partial plan experience on Worksheet 1.

- May be reported on more than one bid when plans are aggregated, depending upon how enrollment changes are processed.

Data Aggregation

The requirements for reporting base period data for crosswalks and enrollment shifts depend on—

- How enrollment changes are processed.
  - In these Instructions, the term "formal crosswalk" refers to the crosswalk process submitted in HPMS for plan consolidations (that is, consolidated renewals), whereby members are automatically moved from one plan to another (that is, to one plan only). 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.
  - Medicare Advantage and Prescription Drug (MARx) enrollment transactions are used to automatically move members from one plan to more than one plan, for example, when the service area of one or more plans is redefined.
  - For more information about crosswalks, see the May 18, 2016 memorandum released via HPMS titled "Process for Requesting an HPMS Crosswalk Exception for Contract Year (CY 2018)."

The requirements for reporting base period data for crosswalks and enrollment shifts are described below.

✓ **Rule 1 – Crosswalks**

Base period data for more than one CY2021 contract number-plan ID 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.

Rule 1 applies when members are crosswalked within the same contract and when members are crosswalked between contracts in accord with limited exceptions described in CMS annual renewal and non-renewal guidance.

✓ **Rule 2 – Enrollment Shifts**

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

- When an existing member chooses to enroll in different plans.
- When enrollment changes do not involve a crosswalk whether or not a plan is terminated.

✓ **Rule 3 – Partial Experience**

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

✓ **Rule 4 – Two-Year Perspective**

Members may be crosswalked each contract year. For BPT reporting purposes, the actuary must consider the crosswalks from the base period to the contract year (that is, from CY2021 to CY2022 and from CY2022 to CY2023).

Example 1: Formal Crosswalk

A Part D sponsor offers plans 001, 002 and 003 in CY2021 and CY2022 and offers plans 002 and 003 in CY2023. Plan 001 is consolidated and the membership is formally crosswalked into plan 003 for CY2023 in accord with the limited exceptions described in CMS annual renewal and non-renewal guidance. Base period experience must be reported on Worksheet 1 of the CY2023 BPT as follows:

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

Example 2: Formal Crosswalk and Enrollment Shift

A Part D sponsor offers plans 001, 002 and 003 in CY2021 and CY2022 and offers plan 003 and new plan 004 in CY2023. Plan 001 is consolidated and the membership is formally crosswalked into plan 003 for CY2023 as submitted in HPMS. Plan 002 is terminated for CY2023 and the certifying actuary expects the membership in plan 002 to enroll evenly between plans 003 and 004; however, there is no formal crosswalk or approved crosswalk exception in place. Base period experience must be reported on Worksheet 1 of the CY2023 BPT as follows:

- For plan 003, report base period experience for plans 001 and 003 (Rule 1 and Rule 3).
- For plan 004, do not report base period experience (Rule 2). Data aggregation is not allowed.

Example 3: Crosswalks in Successive Years

A Part D sponsor offers plan 001 with 100 beneficiaries and plan 002 in CY2021. In CY2022, 50 beneficiaries stayed in plan 001 and 50 beneficiaries were crosswalked into plan 002 via MARx enrollment transactions. In CY2023, 25 beneficiaries stayed in plan 001 and 25 beneficiaries were crosswalked into plan 002 via MARx enrollment transactions. Base period experience must be reported on Worksheet 1 of the CY2023 BPT as follows:

- For plan 001, report base period experience for plan 001 (Rule 3).
- For plan 002, report base period experience for plans 001 and 002 (Rule 1, Rule 3, and Rule 4).

PDE Mapping

A mapping of PDE fields to required BPT inputs is provided in the following table.

Mapping of Prescription Drug Events to Part D Claims Experience in Worksheet 1, Section III

Column	Field Name	PDE Reference Information
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee) >= Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee)
(i)	Average Paid Amount per Member	Σ [Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP) + Low-Income Cost Sharing (LICS)] ÷ Members
(j)	Average Cost Sharing per Member	Σ [Patient Pay Amount + Other TrOOP Amount + Reported Gap Discount + Patient Liability Reduction due to other Payer Amount (PLRO)] / Members
(k)	Supplemental Cost-Share Reduction per Member	Σ [Non-Covered Plan Paid Amount (NPP)] ÷ Members
(l)	Reimbursement for LIS per Member	Σ [Low-Income Cost Share (LICS)] / Members
(m)	Reimbursement for Federal Reinsurance per Member	Σ {[Gross Drug Cost above Out-of-Pocket Threshold (GDCA) with Catastrophic Coverage Codes A or C]× 0.8} ÷ Members

When using PDE data, actuaries must be familiar with the process by which the PDE transactions are developed from claims data and with the timing of the adjustment and deletion processes to ensure that the final transaction is accurately summarized. This process includes, but is not limited to, consideration of rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan transactions and, if appropriate, transfer of over-the-counter drug data from the base period experience to the non-benefit expense component. It is important to note that a PDE maps to one script throughout the BPT regardless of the number of days for which the prescription is dispensed.

Coverage in the Gap

Medicare Coverage Gap Discount Program (CGDP)

The following guidelines apply to all Part D bids:

- Applicable drugs under the Medicare CGDP are defined as those that are on the plan's formulary or are treated as if on formulary through the exceptions process and are approved based on a new drug application (NDA) under Section 505(b)

of the Federal Food, Drug and Cosmetic Act or, in the case of a biologic, are licensed under Section 351 of the Public Health Service Act. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.

- Only those applicable Part D drugs covered by a manufacturer discount agreement are eligible for coverage under the program.
- In CY2023, beneficiary cost sharing for applicable drugs is 25 percent of the negotiated price plus 25 percent of the dispensing and vaccine administration fees, if any; the Part D sponsor's liability is 5 percent of the negotiated price plus 75 percent of the dispensing fee and vaccine administration, if any. For applicable drugs, 95 percent of the negotiated price and 25 percent of the dispensing fee and vaccine administration fee, if any, must be reported as beneficiary cost sharing in the bid.
- Coverage gap discounts begin when the beneficiary exceeds the plan-specific ICL.
- The administrative costs associated with administering the program must be included in the non-benefit expense component of the bid.
- The manufacturer discount amounts received under this program are not direct and indirect remuneration because they do not decrease the drug costs incurred by the Part D sponsor. Therefore, the manufacturer discounts must not be reported as rebate amounts in the bid.
- Applicable drugs must be reported as brand drugs in the bid.

Generic Drugs

The following guidelines apply to all Part D bids:

- In the coverage gap and throughout the BPT, a drug is considered a generic drug, or non-applicable drug, if it is not defined as an applicable drug under the Medicare CGDP. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.
- In CY2023, beneficiary cost sharing is 25 percent and the Part D sponsor's liability is 75 percent.
- Generic (non-applicable) drug coverage in the gap begins when the beneficiary exceeds the plan-specific ICL.
- Non-applicable drugs must be reported as generic drugs in the bid.

Pricing Considerations

Part D sponsors must model the impact of coverage in the gap on the DS benefit and alternative benefit (AE, BA or EA), if applicable.

- While coverage in the gap does not change the True out-of-pocket (TrOOP) threshold, it will affect the point at which the beneficiary reaches the TrOOP threshold for catastrophic coverage.
- The changes to projected average allowed amounts from the base period to the contract year that are expected to occur as a result of reduced beneficiary cost sharing must be reflected in the "Other Change" components of utilization and unit cost trend factors on Worksheet 2.

- The impact on the Federal Reinsurance "per-member-per-month" PMPM must be reflected in line 5, column m of Worksheet 3.
- The following guideline applies when the type of coverage is AE, BA or EA:
  - When an alternative coverage is modeled, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spending may be different because of the impact of the alternative benefits.
- The following guideline applies when the type of coverage is EA:
  - When an EA plan offers coverage in the gap that exceeds the DS coverage:
    - Report the drugs on the "enhanced" tiers based on the plan-specific formulary.
    - Report all other drugs based on the definition of applicable and non-applicable drugs.

Credibility

CMS does not permit adjustments to the credibility percentages on Worksheet 2 for the purpose of modifying the manual rate. For example, do not adjust the credibility percentages in the BPT as an equivalent alternative to removing the base period experience from the manual rate development.

The following credibility guidance in this section is provided as a resource to certifying actuaries, not as a requirement.

Information on the development of the CMS guidelines for full credibility can be found on the "Medicare Advantage Rates & Statistics" page of the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BidGuidance.html.

Claims Credibility

This section pertains to the credibility percentages on Worksheet 2.

CMS has established Part D credibility guidelines as summarized in the following table:

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Allowed Costs	56,000 member months	$\sqrt{\frac{\text{member months}}{56{,}000}}$

Risk Score Credibility

This section pertains to the credibility of risk scores based on the CMS preferred methodology. CMS has not developed credibility guidelines for risk scores based on alternate approaches.

CMS has established Part D credibility guidelines as summarized in the following table:

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Estimated Part D risk scores for development of 2023 bids as posted on HPMS	125 beneficiaries	$\sqrt{\frac{\text{number of beneficiaries}}{125}}$
Beneficiary-level file to support 2023 Part D bids as distributed by CMS	1,500 member months	$\sqrt{\frac{\text{member months}}{1{,}500}}$

Overriding the CMS Formulas for Partial Credibility

The following guideline is applicable only to the CMS claims and risk score credibility formulas presented above; such guideline may not be suitable for any alternative credibility formula. If the CMS formula for partial credibility is applied and the resulting credibility is—

- Less than or equal to 20 percent, then the actuary may override the computed credibility with 0 percent credibility.
- Greater than or equal to 90 percent, then the actuary may override the computed credibility with 100 percent credibility.

Decreased Initial Coverage Limit

Part D sponsors that are decreasing the ICL must modify the pricing of the benefit in the BPT. Specifically:

Worksheet 6, column k, lines 1 through 8 and 19 through 26

Enter the total cost sharing for allowed costs up to the DS ICL of $4,660 by point-of-sale (retail or mail order as defined by the Plan Benefit Package (PBP) and type of drug for each line. Total cost sharing is the sum of (i) the amounts calculated based on the cost-sharing structure of the alternative coverage up to the decreased ICL and (ii) 25 percent of the allowed costs of non-applicable (generic) drugs and 95 percent of the negotiated price of applicable (brand) drugs plus 25 percent of dispensing fees and vaccine administration, if any, for applicable (brand) drugs between the decreased ICL and standard ICL.

Direct and Indirect Remuneration (DIR)

Part D sponsors must include all expected amounts that will be reported as DIR under "Rebate" in the BPT. The DIR reported under "Rebate" represents the Part D sponsors' best estimate of all DIR categories and amounts that they expect to report under the Part D payment reconciliation process for the respective contract year. The development of the DIR amounts must be consistent with the development of projected costs.

Definition of Direct and Indirect Remuneration

Per 42 CFR Section 423.308, direct and indirect remuneration (DIR) comprises any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, charge-backs, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits. DIR does not include the manufacturer discount amounts received under the Medicare CGDP.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmacy benefit managers (PBMs), even if the price concessions are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the PBM receives from the sponsor for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, Part D sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk around the cost of the drug as reflected on claims data. Any gains or losses that the Part D sponsor may experience as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments, and any adjustments to generic dispensing incentive payments made to pharmacies after the point-of-sale dispensing event, are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point-of-sale are part of the dispensing fee reported on the PDE record and therefore are not included in the "DIR Report for Payment Reconciliation".

Enrollment

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

Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirement beyond benefit expenses and non-benefit expenses.

By statute, the bid must represent the revenue requirement of the expected population; therefore, the gain/loss margin requirements must be met with the gain/loss margin entered in the BPT.

Do not combine the gain/loss margins for the Medicare Advantage (MA) and Part D components of MA-PD bids to satisfy these Instructions.

Do not combine the gain/loss margins for bids in segmented plans to satisfy these Instructions.

See the "Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2023" for gain/loss margin requirements that are specific to MA bids.

The gain/loss margin entered in the BPT must be determined in connection with other CMS instructions such as Total Beneficiary Cost (TBC). If there is a conflict between satisfying gain/loss margin requirements and other CMS instructions, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the other CMS instructions. Such conflicts with the gain/loss margin requirements must be disclosed, fully explained and supported. An exception must be approved by CMS.

Gain/loss margin requirements apply at two levels—the bid level and an aggregate level; and both sets of requirements must be met in the initial bid submission and upon bid resubmission or withdrawal.

Definitions

In the BPT and these Instructions, the term—

- "Plan Category" refers to the following groupings of Part D bids:
  - Part D plans that are part of an MA-PD plan, that is, Part D BPTs that have a corresponding MA BPT; and
  - Part D plans that are not part of an MA-PD plan, that is, Part D BPTs with the following Plan Type Codes: PDP, PACE, 1876 Cost, and 1833 Cost.
- "Aggregate Part D gain/loss margin" refers to the projected enrollment-weighted average BPT PMPM gain/loss margin for the applicable plan category.

Bid-Level Requirements

The gain/loss margin entered in the BPT is allocated to basic coverage and supplemental coverage based on the distribution of total prescription drug costs between these two types of coverage.

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

- The bid offers benefit value in relation to the gain/loss margin level;
- Anti-competitive practices are not used; and
- All aggregate-level gain/loss margin requirements described below are met.

The bid-level requirements below do not apply to Part D BPTs that have a corresponding MA BPT: rather, these requirements apply only to Part D BPTs with the following Plan Type Codes: PDP, PACE, 1876 Cost, and 1833 Cost.

✓ **Benefit Value**

The bid must provide benefit value in relation to the gain/loss margin level.

For a bid with a high gain/loss margin, consideration must be given to premium changes that can be made in CY2023 to reduce gain/loss margin.

✓ **Anti-Competitive Practices**

Anti-competitive practices will not be accepted. For example, significantly low or negative gain/loss margin for plans that have substantial enrollment and stable

experience, or "bait and switch" approaches to specific plan gain/loss margin buildup, will be rejected, absent sufficient support that such pricing is consistent with these Instructions.

Aggregate-Level Requirements

The aggregate-level requirements are applied separately to each plan category.

See the "MA-PD Gain/Loss Margin Requirements" section below for the requirements for Part D plans that are part of an MA-PD plan.

✓ **Year-to-Year Consistency**

Although actual gain/loss margin may vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate Part D gain/loss margin over the long term is consistent with (that is, follow) the gain/loss margin assumptions used for pricing. That is, actual aggregate Part D gain/loss margin is to be consistent with the aggregate Part D gain/loss margin used in pricing, as a percentage of revenue.

✓ **Requirements for Part D Plans without Corresponding MA Plans**

This requirement applies only to Part D BPTs with the following Plan Type Codes: PDP, PACE, 1876 Cost, and 1833 Cost.

For Part D sponsors, the aggregate Part D gain/loss margin must be calculated at the parent organization level as a percentage of revenue and it must be disclosed. If such margin is less than 0 percent or greater than 5.5 percent, then this condition must be fully explained and supported, and it must be approved by CMS for CY2023.

MA-PD Gain/Loss Margin Requirements

The MA-PD gain/loss margin requirements are separate from the aggregate-level requirements above. There are two options for setting the Part D gain/loss margin of MA-PD bids:

Option A: Set the gain/loss margins at the bid level. Specifically, an MA-PD sponsor must—

- Set the Part D gain/loss margin for a plan as a percentage of revenue within 1.5 percent of the gain/loss margin for the MA component of the same MA-PD bid: and
- Apply this method consistently for all MA-PD bids submitted by the Medicare Advantage Organization.

Option B: Set the Part D gain/loss margins consistent with the aggregate MA gain/loss margin for all MA-PD bids. Specifically,—

- The MA-PD sponsor must set the Part D gain/loss margins equal for all plans.
- The Part D gain/loss margin as a percentage of revenue must be within 1.5 percent of the aggregate MA gain/loss margin for all MA-PD bids.

Exclusions

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.

Health Care Reform

See Appendix F for information concerning the provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, known collectively as the Affordable Care Act.

Non-Benefit Expenses

Non-benefit expenses consist of all of the bid-specific administrative and other non-benefit costs incurred in the operation of the Medicare Prescription Drug Plan. Therefore, any allocation of non-benefit expenses to the Part D bid (whether performed at the bid level or at a broader level) must take into consideration both the differences between the Part D bid and other bids and the impact on the non-benefit costs of the Part D bid.

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

- Sales & Marketing
  - Examples include, but are not limited to the cost of—
    - Marketing materials.
    - Commissions.
    - Enrollment packages.
    - Identification cards.
    - Salaries of sales and marketing staff.
- Direct Administration
  - Examples include, but are not limited to—
    - Customer service.
    - Billing and enrollment.
    - Claims administration.
    - True out-of-pocket (TrOOP) administration.
    - Pharmacy benefit management administration, which includes all of the costs for performing call center, claims, formulary management, network development and rebate management functions incurred by the plan or through a subcontractor.
    - Medicare CGDP administration.
    - Medicare Part D user fees, which are $1.05 per-member per-year (PMPY) or $0.087 (PMPM) on a national basis for CY2023. The COB user fee will be collected at a monthly rate of $0.1166 PMPM for the first 9 months of the coverage year.
    - Part D 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. Part D sponsors may use the CMS estimate, which is the monthly rate of $0.04 PMPM on a national basis for CY2023, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Part D sponsor's historical amount relative to the CMS annual national estimate.
        - Uncollected enrollee premium.
        - Uncollected cost sharing, which includes plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions.
        - Medication therapy management programs.
        - Disease management functions such as patient education and disease monitoring.
        - Over-the-counter drugs.
- Indirect Administration
    - Examples include, but are not limited to, functions that may be considered "corporate services," such as—
        - The position of CEO.
        - Accounting operations.
        - Actuarial services.
        - Legal services.
        - 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 is 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 income taxes, changes in statutory surplus, investment expenses and the cost of lobbying activities. See the "Gain/Loss Margin" subsection of Section II, "Pricing Considerations" for more information.

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 solely attributable to MA or Part D must be reported only on the corresponding MA or Part D BPT.

Non-benefit expenses that are common to the MA and Part D components of MA-PD bids 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, non-benefit expenses must be allocated proportionately between the Medicare revenue and the other revenue source.

PBM Pricing

For CY2023, Part D sponsors must develop their Part D bids using the pass-through price or negotiated amount paid to the dispensing provider at the point-of-sale as the basis for drug costs. For Part D sponsors that are contracted with a PBM, the following provisions apply: (i) when contracted under a lock-in pricing approach, the administrative expense component of the bid must reflect the expected difference between the lock-in price, or amount negotiated with the PBM, and the pass-through price (this difference is referred to as the risk premium or PBM spread); and (ii) when the PBM retains a portion of the rebates, the administrative expense component of the bid must include these costs.

Related-Party Arrangements

Benefit costs and non-benefit expenses for related parties must be reported in the BPT consistent with the contractual arrangement with the related party.

The related-party requirements apply to all Part D sponsors entering into any type of arrangement with or receiving services from, an entity that has a different tax identification number than that of the Part D sponsor but is associated with the Part D sponsor by any form of common, privately held ownership, control or investment, including any arrangement in which the Part D sponsor does business with a related-party entity through a contract with one or more unrelated parties, such as a pharmacy benefit manager.

The related-party pricing consideration does not apply to Part D sponsors' arrangements with parties within the Part D sponsors' own tax identification number. When a Part D sponsor has an arrangement for benefit services within their tax ID number, they may 1) submit PDE data that matches the reporting of these internal transactions in their financial statements, 2) establish the pharmacy under a new tax identification number and follow the related-party instructions, or 3) submit supporting documentation, like that for the related-party actual cost method, that explains and compares how these costs are reflected in the bid versus the Part D sponsor's financial statements.

The objective of the requirements for related-party arrangements is to ensure that financial arrangements between the Part D sponsor and related parties (i) are not significantly different from the financial arrangements that would have been achieved in the absence of the relationship and (ii) do not provide the opportunity to over- or under- subsidize the bid.

CMS requires all Part D sponsors to disclose whether or not they are in a business arrangement with a related party. Part D sponsors in such an arrangement must disclose and support each and every related-party arrangement at the time of the initial bid submission and must prepare the bid and documentation for each identified related party in accord with the requirements in this section and Appendix B.

Risk Score Development for CY2023

The projected CY2023 risk score must—

- Be based on the data sources and their respective weights, as specified in the resources listed below in the Risk Adjustment Information Sources section.
- Reflect the expected risk score trend at the bid level.
- Be appropriate for the expected population.
- Be adjusted for CY2023 normalization.

Risk Score Calculation Approaches

There are two methods for calculating the projected risk score: the preferred approach and the alternate approach.

- The preferred approach is to start with either the beneficiary or plan-level data files provided by CMS, which contain the calculated risk scores using the CY2023 payment model on 12 months of 2021 membership or the July 2021 enrollees, respectively.
- The alternate approach allows new plans or plans with significant population changes to use a different starting point for estimating their contract year risk score.

For both approaches, explicit adjustments for the following factors are required:

- Run-out of diagnosis data from all sources, including differences in the final cut-off date for data submission.
- Bid-specific coding trend.
- Changes in bid population.
- Impact of any improvements to operational and submission process for diagnosis data sources.
- Other appropriate factors.

For an alternate approach, Part D sponsors must consider the following additional adjustments:

- Conversion to risk model-specific unblended risk scores.
  - If the starting risk scores are blended scores, then Part D sponsors must produce unblended risk scores before the conversion to raw risk scores.
- Conversion to a raw risk score.
  - When starting from a data source with normalized risk scores, such as the MMR, Part D sponsors must consider a conversion to raw (not normalized) scores before making other adjustments.
- Impact of lagged versus non-lagged diagnosis data.
  - If the starting risk scores are based on lagged diagnosis data, as is the case for initial risk scores, Part D sponsors must transition the scores from lagged to non-lagged risk scores.

- Seasonality.
  - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then Part D sponsors must make an adjustment for enrollment seasonality.
- Risk model change.
  - This includes the use of a different model in the data source versus the projection year and differences in the diagnoses included in each model.
- Impact of changes to diagnosis data sources and weights between the time period of the data source and the contract year. Examples of the use of this factor include adjustments for—
  - The transition of starting risk scores based on MMR data from incomplete to final diagnosis data.
  - An estimate of the impact of the final risk score reconciliation.

Once projected to the contract year, the risk scores must reflect the CY2023 Part D normalization factor. Note that if a raw (not normalized) risk score associated with a different model calibration year is being normalized, the CY2023 Part D normalization factor is not the appropriate normalization factor.

Risk Adjustment Information Sources

The following resources provide information on the development of projected CY2023 risk scores:

- The CY2023 Advance Notices and Announcement found through the "Announcements & Documents" link on the "Medicare Advantage Rates and Statistics" page of the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.
- Bid-level data and technical notes available after the publication of the CY2023 Announcement through the "Risk Adjustment" link on the HPMS Home page.
- Beneficiary-level files and technical notes sent to MAOs electronically after the publication of the CY2023 Announcement.
- Additional information found—
  - Under the "Risk Adjustment" and "Ratebooks & Supporting Data" links at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.
  - At https://www.csscoperations.com/, including slides from Risk Adjustment User Group Calls.

Other Considerations

See the "Credibility" pricing consideration for more information about the projection of risk scores.

See Appendix G for more information about trending MA and Part D risk scores.

Sequestration

Pricing assumptions must consistently reflect the effect of sequestration.

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.

Types of Part D-Covered Drugs

Brand Drugs

Brand drugs consist of (i) single-source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA) and (ii) innovator multi-source drugs that were originally marketed under an original NDA and that now have generic equivalents.

Preferred/Non-Preferred Brand Drugs

Brand drugs that are placed in the most favorable position on the formulary in comparison to other similar brand drugs should be allocated to the preferred brand drug category. Brand drugs that are positioned in a less favorable position on the formulary should be allocated to the non-preferred brand category in the BPT.

Generic Drugs

Non-innovator multi-source drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately only when a plan utilizes designated Specialty tiering in the formulary and PBP in accord with CMS guidelines. The CMS guidelines require that cost sharing associated with that tier be limited to 25 percent in the initial coverage range when the plan has the standard deductible, which is $505 for CY2023. When the plan has a decreased deductible or no deductible, then actuarially equivalent coinsurance is permitted.

When designated Specialty tiering is used, all drugs classified as specialty-tier drugs on the plan formulary must be reported by point-of-sale (retail or mail order as defined by the PBP) in Worksheets 2, 6 and 6A of the BPT. The drugs in the Specialty tiers must not be sorted by type of drug status and must not be reported as a component of the generic, preferred brand and non-preferred brand drugs in the non-Specialty tiers.

When designated Specialty drug tiering is not used in the formulary and PBP, Specialty drugs must be sorted by generic, preferred brand and non-preferred brand status and must be reported in these categories by point-of-sale (retail or mail order as defined by the PBP). In this situation, the Specialty categories in Worksheets 2, 6 and 6A are not completed.

III. DATA ENTRY AND FORMULAS

This section includes line-by-line instructions for completing the Part D BPT. It also describes the formulas for calculated cells.

PRESCRIPTION DRUG

To complete the Part D bid form, Part D sponsors must provide a series of data entries on the appropriate BPT worksheets. The number of inputs depends on the type of plan being offered and the length of time it has had a contract with CMS, among other factors.

The Part D bid form is organized as outlined below:

- Worksheet 1 – Rx Base Period Experience
- Worksheet 2 – PDP Projection of Allowed/Non-Benefit
- Worksheet 3 – Rx Contract Period Projection for Defined Standard Coverage
- Worksheet 4 – Rx Standard Coverage with Actuarially Equivalent Cost Sharing
- Worksheet 5 – Rx Alternative Coverage
- Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage
- Worksheet 6A – Coverage in the Gap
- Worksheet 7 – Summary of Key Bid Elements

All Part D sponsors must complete Section I of Worksheet 1; completion of subsequent sections of the BPT is based on the plan benefit type being offered. The worksheets and sections that must be completed for each plan benefit type are defined below.

Defined Standard Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2021, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2021, complete Sections II and III; column O of Section IV; and Sections V and VII. For plans with partially credible claims experience in CY2021, complete all sections. For new plans in CY2022 and CY2023, complete Sections IV, V and VI.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete columns f, g, and h of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete columns f, g, and h of Section II for all plans.

- ✓ **Worksheet 7**

  Complete all sections for all plans.

Actuarially Equivalent Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2021, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2021, complete Sections II and III; column o of Section IV; and Sections V and VII. For plans with partially credible claims experience in CY2021, complete all sections. For new plans in CY2022 and CY2023, complete Sections IV, V and VI.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 4**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 7**

  Complete all sections for all plans.

Basic and Enhanced Alternative Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2021, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2021, complete Sections II, III, IV Column O, V and VI; for plans with partially credible claims experience in CY2021, complete all sections. For new plans for CY2022 and CY2023, complete Sections IV, V and VI.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 5**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete all columns of Section II for all plans

- ✓ **Worksheet 7**

  Complete all sections for all plans.

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.

PD WORKSHEET 1 – RX BASE PERIOD EXPERIENCE

Worksheet 1 contains general information about the plan and summarizes the base period Rx experience. Specifically, Section I collects general information about the plan that is displayed on all Part D BPT worksheets; Section II collects base period background information; Section III summarizes the base period Rx experience; Sections IV and V summarize components of the base period non-benefit expense and premium revenue, respectively; and Section VI is an Income Statement Summary.

Section I must be fully completed for all plans. (Note that some fields may be pre-populated by the PBP software.) Sections II through VI must be completed for all plans with experience data for 2021 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the "General" format in Excel to support the link functionality to other 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 zeroes.

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 S (Prescription Drug Plan) and includes four Arabic numerals (for example, H9999, R9999, S9999). Include all leading zeroes (for example, H0001).

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the PBP being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input and must include any leading zeroes.

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 and must include any leading zeroes.

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – SNP

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

Line 7 – Plan Name

Enter the name of the PBP. This information also appears in HPMS.

Line 8 – Plan Type

Enter the type of Part D plan. The valid options are listed in the table below.

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMO POS
HMO with a POS Option	HMO POS
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
Regional Coordinated Care Plan:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Prescription Drug Plans:	
Medicare Prescription Drug Plan (PDP)	PDP
Fallback Plan	Fallback
Demonstration Plans:	
National PACE	PACE
Cost Plans:	
1876 Cost	1876 Cost
1833 Cost	1833 Cost

Line 9 – Enrollee Type

If the plan covers enrollees eligible for both Part A and Part B of Medicare, enter "A/B". If the plan covers enrollees eligible for Part B only, enter "Part B Only". When the plan type is "PDP" or "Fallback," then the enrollee type cell is white and locked; no input is required.

Line 10 – VBID

If the plan is participating in the Value-Based Insurance Design (VBID) Demonstration, enter "Y". Otherwise, enter "N".

Line 11 – MTM

If the plan participated in the Medication Therapy Management (MTM) Demonstration in CY2021, enter "Y". Otherwise enter "N".

Line 12 – ESRD-SNP

Enter "Y" if the plan is part of an ESRD-SNP MA-PD. Otherwise enter "N".

Line 13 – PD Region

When the plan type is "PDP," enter the region number of the region the plan will cover. This field must be entered as a text input and must include any leading zeroes.

The valid entries are shown in the following table:

Region	Description	Region	Description
01	Maine and New Hampshire	21	Louisiana
02	Connecticut, Massachusetts, Rhode Island and Vermont	22	Texas
03	New York	23	Oklahoma
04	New Jersey	24	Kansas
05	Delaware, District of Columbia and Maryland	25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming
06	Pennsylvania and West Virginia	26	New Mexico
07	Virginia	27	Colorado
08	North Carolina	28	Arizona
09	South Carolina	29	Nevada
10	Georgia	30	Oregon and Washington
11	Florida	31	Idaho and Utah
12	Alabama and Tennessee	32	California
13	Michigan	33	Hawaii
14	Ohio	34	Alaska
15	Indiana and Kentucky	35	American Samoa
16	Wisconsin	36	Guam
17	Illinois	37	Northern Mariana Islands
18	Missouri	38	Puerto Rico
19	Arkansas	39	Virgin Islands
20	Mississippi		

Line 14 – Plan Benefit Type

Enter the plan benefit type that identifies the type of coverage in the PBP. The valid options are "DS" for Defined Standard, "AE" for Actuarially Equivalent, "BA" for Basic Alternative and "EA" for Enhanced Alternative.

Line 15 – SNP Type

If the plan is a SNP as indicated by "Y" on line 6, then enter the type of SNP. The valid options are "Institutional," "Dual-Eligible" and "Chronic or Disabling Condition." The selection must agree with the option identified in the MA BPT.

Line 16 – Payment Modernization Model

If the plan is participating in the Part D Payment Modernization Model (PMM), enter "Y". Otherwise enter "N".

Line 17 – Senior Savings Model

If the plan is participating in the Senior Savings Model (SSM), enter "Y". Otherwise enter "N".

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

Enter the incurred dates of the base period data on the first two lines and the paid through date on the third line. For example, if the data reflect claims paid through February 2022, then the paid through date is 2/28/2022.

Line 2a – Total Member Months

The value is calculated automatically in the BPT from line 6 column e.

Line 2b – LIS Member Months

Enter the number of low-income subsidy (LIS) member months represented in the base period experience based on CMS eligibility records.

Line 3 – Risk Score

Enter the final average risk score for the population represented in the base period data using the Part D risk model that was used for payment year 2021. This risk score must incorporate the normalization factors and an estimate of the final reconciliation.

Actuaries may use as a starting point risk scores calculated with the model used for 2021, which are included in the beneficiary-level files sent to Part D sponsors electronically after the publication of the CY2023 Announcement.

Line 4 – Completion Factor

Enter the 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.

Line 5 – Mapping

Enter in the first column the contract-plan-segment ID (in the format H####-###-###) of each plan for which base period data is required by these Instructions to be reported in Section III. Cell K12 is automatically populated with the contract number, plan, and segment ID in cells D5 and D6; the contract-plan-segment ID in cell K12 can be overwritten if there is no base period data for that plan. When base period data for more than eight plans is entered in Section III, (i) enter in cells K12:K15 and M12:M14 the contract-plan-segment IDs of the plans with the greatest number of member months; (ii) enter "all other" in cell M15 and (iii) list in supporting documentation the contract-plan-segment IDs and member months of all plans in the "all other" category.

Enter the corresponding number of member months in the second column.

SECTION III – PART D CLAIMS EXPERIENCE

Lines 1 through 11 include experience relating to Part D-covered drugs only. Lines 12 through 14 include experience for drugs that are covered by the plan but are not Part D-covered drugs at the time they are dispensed.

Lines 1 through 5:

- ✓ **Column d – Number of Members**

  Enter for each line the number of members with total allowed costs in the defined standard allowed costs interval. For example, if 7,000 members had total allowed costs between $445 and $4,130, then enter "7,000" in line 3, column d. The "Total Covered Part D Spending at OOP Threshold for Non-Applicable Beneficiaries" and "Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries" for CY2021 must be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.

- ✓ **Column e – Member Months**

  Enter for each line the number of member months associated with the number of members in column d.

- ✓ **Column f – Total Number of Scripts**

  Enter for each line the number of prescriptions filled for Part D-covered drugs for the members in column d.

- ✓ **Column g – Total Allowed Dollars**

  Enter for each line the total allowed dollars for the prescriptions filled for the members in column d. Total allowed dollars are defined as ingredient cost plus dispensing fee, plus sales tax where applicable, plus the vaccine administration fees, prior to the application of any rebates recovered after the point-of-sale.

- ✓ **Column h – Average Allowed Amount per Member**

  The value is calculated automatically in the BPT as column g divided by column d for each line.

- ✓ **Column i – Average Paid Amount per Member**

  Enter the result of dividing the total dollars paid by the plan for the members in column d by the number of members in column d. Total paid dollars are defined as basic and supplemental payments for Part D-covered drugs and are not net of rebates, low-income subsidy payments or federal reinsurance.

- ✓ **Column j – Average Cost Sharing per Member**

  Enter for each line the average cost sharing per member for Part D-covered drugs for the members in column d.

- ✓ **Column k – Supplemental Cost-Sharing Reduction per Member**

  Enter for each line the average value of supplemental cost sharing per member for Part D-covered drugs for members in column d.

- ✓ **Column l – Reimbursement for Low-Income Cost-Sharing Subsidy per Member**

  Enter for each line the average low-income cost-sharing subsidy amount received and receivable for the members in column d.

- ✓ **Column m – Reimbursement for Federal Reinsurance per Member**

  Enter for each line the average federal reinsurance amount received and receivable for the members in column d.

- ✓ **Column n – Net Plan Responsibility per Member**

  The value is calculated automatically in the BPT as column i minus the sum of columns k through m for each line.

Line 6, columns d through n – Subtotal

The values are calculated automatically in the BPT as the sum of lines 1 through 5 for columns d through g and as the weighted average based on the number of members in column d of lines 1 through 5 for columns h through n.

Line 7 – Percentage OON

- ✓ **Column g**

  Enter in line 6 the percentage of total allowed dollars for prescriptions filled at out-of-network (OON) pharmacies.

- ✓ **Column i**

  Enter in line 6 the percentage of average paid dollars for prescriptions filled at OON pharmacies.

- ✓ **Column j**

  Enter in line 6 the percentage of average cost sharing per member for prescriptions filled at OON pharmacies.

Line 8, column i and columns k through n – PMPM Values

These values are calculated automatically by the BPT as the result of the subtotal of the column in line 6 divided by the number of member months in column d.

Line 9 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates received as of the "Paid through" date in Section I and expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column m**

  Enter the amount of rebates attributable to the federal reinsurance amount in line 6.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column i minus column m.

Line 10 – Plus Part D as Secondary

- ✓ **Column g**

  Enter the total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer. The term "total plan liability" is defined as CPP (Covered Plan Paid Amount) plus NPP (Non-Covered Plan Paid Amount) minus 80 percent of either GDCA (Gross Drug Cost above Out-of-Pocket Threshold) or GDCA minus PLRO (Patient Liability Reduction due to Other Payer Amount) as appropriate.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column i minus the sum of columns k through m.

Line 11, columns i and k through n – Net Average Paid Amount PMPM

The values are calculated automatically in the BPT as line 8 minus line 9 plus line 10.

Line 12 – Non-Covered Supplemental Drugs

- ✓ **Column g**

  Enter the total plan paid amount for prescription drugs that are covered by the plan but are not Part D-covered drugs.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

Line 13, column i – Rebates on Supplemental Drugs

Enter the total amount of rebates received as of the "Paid through" date in Section I and expected to be received for the claims in line 12. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must

be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

Line 14, columns I and n – Net PMPM on Supplemental Drugs

The value in column i is calculated automatically in the BPT as line 40 minus line 41 and is carried to column n.

SECTION IV – PMPM NON-BENEFIT EXPENSES

Section IV summarizes all administrative expenses associated with the operation of the prescription drug plan in the base period, including any expenses that were offset by direct or indirect remuneration.

Lines 1 through 4, column g – Total

Enter the sales and marketing, direct administration, indirect administration and net cost of private reinsurance average PMPM amounts for total coverage in lines 1 through 4, respectively. Include uncollected enrollee premium, uncollected cost sharing and OTC drugs in direct administration.

Line 5, column g – Total Non-Benefit Expenses

The value is calculated automatically in the BPT as the sum of lines 1 through 4.

SECTION V – PMPM PREMIUM REVENUE

Section V summarizes the components of premium revenue of the prescription drug plan for the base period.

Lines 1 through 4, column e – Basic

Enter the CMS Part D direct subsidy payment, low-income premium subsidy and member premium average PMPM amounts for basic coverage in lines 1 through 3, respectively. The direct subsidy amount must account for the final risk-adjusted reconciliation payment for CY2021, which will be received in mid-2022, and include the impact of sequestration and PACE add-on, if applicable.

Line 3, column f – Supplemental

Enter in line 3 the member premium average pmpm amount for supplemental coverage.

Lines 1 through 4, column g and line 5 – Total Premium

The values are calculated automatically in the BPT as the sums of columns e and f.

SECTION VI – PMPM INCOME STATEMENT SUMMARY

Section VI is a summary of the prescription drug plan's income, including the amount of MA rebate allocable to Part D when applicable, for the base period.

Lines 1 through 9, column m

Enter in line 4 the average PMPM amount of the MA rebate dollars, including the impact of sequestration, used to buy down the Part D premium. The values in lines 1 through 3 and lines 5 through 9 are carried from other sections in Worksheet 1 or are calculated automatically in the BPT as sums or differences in column m.

Total Non-LI Brand Discount Amount

Enter in cell M60 the total non-LI brand discount amount received or expected to be received for the base period and reported in the "Reported Gap Discount" field on the PDEs.

PD WORKSHEET 2 – RX PDP PROJECTION OF ALLOWED/NON-BENEFIT

Worksheet 2 projects the base period experience to the contract year, blending with a manual rate when the base period experience is not fully credible, by point-of-sale (retail or mail order as defined by the PBP) and type of drug. Specifically, Section I displays general information about the plan; Sections II and III summarize the base period and contract period utilization per 1,000 members and allowed costs per script, as well as the components of utilization and cost trends; Section IV blends the projected allowed costs with a manual rate based on the plan's credibility; Section V summarizes the components of non-benefit expenses in the base and contract periods; and Section VI calculates the ratios of claims, non-benefit expenses and gain/loss margin to the total basic bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – UTILIZATION FOR COVERED PART D DRUGS

Lines 1 through 8 – Base Period

- ✓ **Column e – Number of Scripts/1000**

  Enter for each line the number of prescriptions that were filled in the base period, expressed as annual prescriptions per 1,000 members, by point-of-sale (retail or mail order as defined by the PBP) and type of drug (generic, preferred brand, non-preferred brand or Specialty).

- ✓ **Column f – Allowed per Script**

  Enter the average allowed amount per script by type of script filled in the base period for each line. The term "allowed amount" is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable, plus the vaccine administration fee, prior to the application of any rebates recovered after the point-of-sale.

- ✓ **Column g – PMPM**

  The value is calculated automatically in the BPT as column e times column f divided by 12,000 for each line.

Lines 1 through 8 – Components of Utilization Change

- ✓ **Column h – Trend in Scripts/1,000**

  Enter the utilization trend factor by type of script to project scripts/1,000 to the contract period for each line.

- ✓ **Column i – Formulary Change**

  Enter the factor that represents the impact on utilization of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

- ✓ **Column j – Risk Change**

  Enter the factor that represents the impact on utilization of the covered population's change in risk from the base period to the contract period by type of script for each line.

- ✓ **Column k – Induced Utilization**

  Enter the factor that adjusts for the utilization difference between the base period type of benefit plan (AE, BA or EA) and a DS plan by type of script for each line.

- ✓ **Column l – Other Change**

  Enter the factor that represents the impact on utilization of any differences between the base period and contract period not included in the other components of utilization change, columns h through k, by type of script for each line.

- ✓ **Column m – Total Utilization Change**

  The value is calculated automatically in the BPT as the product of columns h through l for each line.

Lines 1 through 8, column n – Projected Scripts/1000

The value is calculated automatically in the BPT as the product of columns e and m for each line.

Lines 1 through 8, column o – Covariance

The value is calculated automatically in the BPT as projected allowed PMPM divided by the product of base period allowed PMPM times total utilization change times total unit cost change for each line.

Lines 9 through 14, columns e through o

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION III – COST FOR COVERED PART D DRUGS

Lines 1 through 8 – Components of Unit Cost Change

- ✓ **Column e – Inflation Trend**

  Enter the factor that represents the impact on cost between the base period and contract period because of changes in drug prices by type of script for each line.

- ✓ **Column f – Discount Change**

  Enter the factor that represents the impact on cost between the base period and contract period because of changes in point-of-sale network pricing, including

discounts off of average wholesale price (AWP) and dispensing fees, by type of script for each line.

- ✓ **Column g – Formulary Change**

  Enter the factor that represents the impact on cost because of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

- ✓ **Column h – Other Change**

  Enter the factor that represents the impact on cost of any differences between the base period and contract period not included in the other components of unit cost change, columns e through j, by type of script for each line.

- ✓ **Column i – Total Unit Cost Change**

  The value is calculated automatically in the BPT as the product of columns e through h by type of script for each line.

Lines 1 through 8, column j – Projected Unit Cost

The value is calculated automatically in the BPT as the product of base period allowed per script times total unit cost change for each line.

Lines 1 through 8, column k – Projected Allowed PMPM

The value is calculated automatically in the BPT as scripts/1,000 times projected unit cost divided by 12,000 for each line.

Lines 9 through 14, columns e through k

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION IV – PROJECTED ALLOWED PMPM

Lines 1 through 8

- ✓ **Column l – Manual Utilization/1,000**

  When the base period experience is not fully credible, enter the projected utilization per 1,000 members, based on a manual rate, by type of script for each line.

- ✓ **Column m – Manual Unit Cost**

  When the base period experience is not fully credible, enter the projected unit cost per script, based on a manual rate, by type of script for each line.

- ✓ **Column n – Manual Rate PMPM**

  The value is calculated automatically in the BPT as column l times column m divided by 12,000 by type of script for each line.

- ✓ **Column o – Credibility**

  Enter the credibility percentage by point-of-sale and type of drug that is applied to the projected PMPM allowed amount in Section IV and blended with the PMPM manual rate to calculate the blended PMPM allowed amount for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

- ✓ **Column p – Blended Allowed PMPM**

  The value is calculated automatically in the BPT as the sum of (column o times column k) and [(1 minus column o) times column n] for each line.

Lines 9 through 14, columns l through p

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column. Cell O57, "CMS Guideline Credibility" is calculated automatically in the BPT as the square root of total member months from Worksheet 1 divided by 56,000, not to exceed 100 percent.

SECTION V – PMPM NON-BENEFIT EXPENSES

Section V summarizes the components of non-benefit expenses in the projection period.

Lines 1 through 4

- ✓ **Column e – Projected Expenses**

  Enter the projected non-benefit expense by component for each line.

Line 5, column e – Total Non-Benefit Expenses

The values are calculated automatically in the BPT using information entered on lines 1 through 4.

SECTION VI – PERCENTAGE OF REVENUE

Section VI summarizes the components of the total basic bid amount and calculates the ratios of claims, non-benefit expenses and gain/loss margin to the total basic bid.

Lines 1 through 3, column j

The values are carried from Worksheets 3 through 5.

Line 4, column j

The value is calculated automatically in the BPT as the sum of lines 1 through 3.

Lines 5a through 5c, column j

The values are calculated automatically in the BPT as percentages of the total basic bid.

PD WORKSHEET 3 – RX CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

Worksheet 3 develops the defined standard bid amount. Specifically, Section I displays general information about the plan; Section II collects contract period information; Section III summarizes the contract period Rx experience; and Sections IV and V summarize components of the contract period non-benefit expenses and gain/loss margin and components of the defined standard bid amount, respectively.

Sections II through V must be completed by all plans.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

Line 1 – Projected Member Months

The value is carried from Section III, line 6, column e. For an MA-PD, Part D projected member months are the sum of projected member months for MA, ESRD and hospice members.

Line 2 – Projected Average Risk Score

Enter the estimated average Rx risk score for the population expected to enroll in the contract period. Refer to the topic "Risk Score Development for CY2023" in the "Pricing Considerations" section of the Instructions for more information.

Line 3 – Projected Low-Income Subsidy (LIS) Member Months

Enter the estimated number of member months for enrollees who will qualify for and obtain LIS status in the contract period.

Line 4 – Projected non-LIS Member Months

The value is calculated automatically in the BPT as projected member months minus projected low-income subsidy member months.

SECTION III – PART D COVERED DRUG CLAIMS

The projection of contract period Rx experience must reflect the risk score entered in Section II, line 2.

Lines 1 through 5

- ✓ **Column d – Number of Members**

  Enter the number of members expected to have total allowed claims in the allowed claim interval defined for each line. For CY2023, the "Total Covered Part D Spending at OOP Threshold for Non-Applicable Beneficiaries" of

$10,516.25 and "Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries" of $11,206.28 must be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.

- ✓ **Column e – Member Months**

  Enter the number of member months that are expected in the contract period that are associated with the number of members in column d for each line.

- ✓ **Column h – Average Amount Allowed PMPM**

  The value is calculated automatically in the BPT as column g divided by projected member months for each line.

- ✓ **Column n – Plan Liability PMPM**

  The value is calculated automatically in the BPT as column h minus the sum of columns j through m for each line.

Lines 2 through 5

- ✓ **Column f – Number of Scripts**

  Enter the estimated total number of prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line.

- ✓ **Column g – Projected Allowed Amount**

  Enter the estimated total allowed dollars for prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line. Total allowed dollars must reflect the price paid to the dispensing provider at the point-of-sale and must be net of point-of-sale rebates and price concessions.

- ✓ **Column i – Cost Sharing**

  The value is calculated automatically in the BPT as the sum of columns j through l for each line.

- ✓ **Column k – PMPM Deductible**

  Enter the projected PMPM value of the deductible for the members in column d for each line.

- ✓ **Column l – Other Cost Sharing PMPM**

  Enter the projected PMPM value of the 25 percent cost sharing between the deductible and ICL and the catastrophic coinsurance above the catastrophic limit for the members in column d for each line.

- ✓ **Column o – Federal LIS Cost Sharing PMPM**

  Enter the projected amount of low-income cost sharing subsidy that will be received for the members in column d who are LIS-eligible divided by the total projected member months entered in Section II, line 1 for each line.

Lines 4 through 5, column j – GAP PMPM

Enter the projected PMPM value corresponding to amounts between the ICL and catastrophic limit for members in column d for each line. Reflect the impact of gap coverage in this amount.

Line 5, column m – Federal Reinsurance PMPM

Enter the projected amount of federal reinsurance that will be received for the members in column d divided by the total projected member months entered in Section II, line 1 for each line. Reflect the impact of gap coverage in this amount.

Line 6 – Subtotal

The value is calculated automatically in the BPT as the sum of lines 1 through 5 for each column.

Line 7 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Point-of-sale rebates reported in "Column g – Projected Allowed Amount" are not reported here. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates and all other types of DIR must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

- ✓ **Column h**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Columns m and n**

  The value in column h is allocated automatically to columns m and n in the BPT based on the relative amount of federal reinsurance to the total allowed amount.

Line 8 – Plus Part D as Secondary

- ✓ **Column g**

  Enter, as a positive value, the projected total plan cost (Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP)) for Part D-covered drugs for which the Part D plan is the secondary payer.

- ✓ **Column h**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column m**

  Enter, as a positive value, the projected PMPM plan liability for Part D-covered drugs attributable to federal reinsurance for which the Part D plan is the secondary payer.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column h minus column m.

Line 9 – Projected Percentage Out-of-Network (OON) Allowed

Enter the percentage of line 6, of column g projected allowed dollars for prescriptions that will be filled OON.

Line 10 – Projected Percentage Out-of-Network (OON) Plan Liability

Enter the percentage of line 6, of column n projected Part D plan liability for prescriptions that will be filled OON.

Line 11, columns g through o – Total

The values are automatically calculated in the BPT as line 6 minus line 7 minus line 8 plus line 9 for each column.

SECTION IV – PMPM NON-BENEFIT EXPENSE AND GAIN/LOSS MARGIN

Section IV summarizes components of the contract period non-benefit expenses and gain/loss margin.

Lines 1 through 5

The values are carried from other worksheets or are calculated automatically in the BPT.

Line 6 – Total Gain/loss Margin

Enter the estimated PMPM amount of gain or loss projected during the contract period.

Line 7 – Related-Party Allowed Cost PMPM

Enter the best estimate of the plan sponsor's total allowed PMPM cost for the sum of the following:

1) All related-party pharmacy services in the bid, and

2) Services that are provided by entities with the same tax identification number and that are reported in the bid.

This entry must reflect the expected allowed costs consistent with actual contracts, capitation and risk arrangements, and financial reporting.

Line 8 – Related-Party Non-Benefit Expense PMPM

Enter the best estimate of the plan sponsor's total PMPM cost for all related-party non-benefit expenses reported in the bid. This entry must reflect the expected non-benefit expenses for all related parties, consistent with actual contracts and financial reporting.

SECTION V – DEFINED STANDARD COVERAGE BID DEVELOPMENT

Section V summarizes the components of the defined standard bid amount.

Lines 1 through 5, columns i and j

The values are carried from other sections in Worksheet 3 or are calculated automatically in the BPT as sums or quotients.

PD WORKSHEET 4 – RX STANDARD COVERAGE WITH ACTUARIALLY EQUIVALENT COST SHARING

Worksheet 4 must be completed when the plan benefit type is Actuarially Equivalent (AE). The three tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The average coinsurance percentage for amounts between the deductible and the ICL must be actuarially equivalent to 25 percent.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

CONSIDERATIONS FOR ACTUARIALLY EQUIVALENT COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for an AE plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, AE plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the AE benefit and the DS benefit by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS AND TESTS FOR ACTUARIAL EQUIVALENCE

Lines 1 through 8, columns e, g, i, and l

The values are carried from other worksheets in the BPT.

Line 9 – Coinsurance Percentage

- ✓ **Columns e, g, i, and l**

  The values are carried from other worksheets in the BPT.

Lines 10 through 14, columns e, g, i, and l

The values are carried from other worksheets in the BPT.

Line 15 – Rebates

- ✓ **Column l**

  Enter the estimated total amount of rebates expected to be received by the plan.

- ✓ **Column i**

  The value is calculated automatically in the BPT and is prorated for reinsurance.

Lines 16 through 18 – Tests for Actuarial Equivalence

The three actuarial equivalence tests are applied to certain values in Section IV to determine whether the proposed benefit plan qualifies as standard coverage with actuarially equivalent cost sharing.

SECTION V – STANDARD COVERAGE BID DEVELOPMENT WITH ACTUARIALLY EQUIVALENT COST SHARING

Lines 1 through 5

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 6 – LIS

Enter the projected average low-income cost-sharing PMPM subsidy for the risk score of the expected population.

PD WORKSHEET 5 – RX ALTERNATIVE COVERAGE

Worksheet 5 must be completed when the plan benefit type is Basic Alternative (BA) or Enhanced Alternative (EA). The six tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The value of total coverage is at least actuarially equivalent to DS coverage.
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage.
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL.
- The deductible is not greater than the DS deductible.
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

CONSIDERATIONS FOR BASIC ALTERNATIVE AND ENHANCED ALTERNATIVE COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for a BA and less than or equal to 25 percent for an EA plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, BA and EA plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the BA or EA benefit and the DS benefit by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

BA and EA plans may reduce the value of the deductible. Since the value of coverage up to the ICL must remain the same relative to the DS, a supplemental premium will result unless the cost of the additional coverage is offset by savings in catastrophic coverage.

EA plans may provide additional coverage in the gap. Additional coverage in the gap can delay the point at which a beneficiary reaches catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, cause induced utilization and increase the risk profile of the group. Members with extremely high spending will not benefit as much as those with moderate amounts of spending.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS

Lines 1 through 3

- ✓ **Columns f, g and m**

  The values are carried from Worksheet 3 in the BPT.

- ✓ **Columns i and o**

  The values are calculated automatically in the BPT as column f plus column g.

Type of Deductible

Select in cell I33 the type of deductible consistent with the description in the PBP for the alternative coverage. The valid options are: "no deductible", "applies to all tiers" or "applies to some tiers".

Alternative Coverage Deductible Amount

Enter in cell I34 the alternative coverage deductible amount consistent with the amount in the PBP. Plans with a non-uniform deductible must also enter their deductible amount in this cell.

Type of Gap Coverage

Select in cell M33 the type of gap coverage consistent with the description in the PBP for the alternative coverage. The options are "DS ICL and cost sharing," "increased ICL and DS cost sharing," "all drugs covered in full," and "reduced cost sharing on some drugs".

Plans that are participating in the Senior Savings Model (SSM) must select either "all drugs covered in full" or "reduced cost sharing on some drugs." This entry may or may not align with entries in the PBP, depending on the benefits offered.

Alternative Coverage ICL

Enter in cell M34 the ICL consistent with the description in the PBP for the alternative coverage.

Lines 4 through 24

The values in columns d through o include Part D-covered drugs only; the values in column q include non-Part D-covered drugs only. The values are carried from other worksheets or are calculated automatically in the BPT, with the exception of the following, which must be entered:

- ✓ **Line 6, columns f and g– Value of Defined Standard Deductible**

  The values are calculated from other worksheets in the BPT.

- ✓ **Line 7, columns f and g – Value of Proposed Deductible**

  The values are calculated from other worksheets in the BPT.

- ✓ **Line 11, column f – Coinsurance Percentage**

  The values are calculated from other worksheets in the BPT.

- ✓ **Line 11, column g – Coinsurance Percentage**

  The values are calculated from other worksheets in the BPT.

- ✓ **Line 17, column o – Minus Rebates**

  Enter the estimated total rebates PMPM expected to be received for Part D-covered drugs.

- ✓ **Line 17, column q – Minus Rebates**

  Enter the estimated total rebates PMPM expected to be received for non-Part D-covered drugs.

- ✓ **Line 19, columns m, o, and q – Plus Part D as Secondary**

  Enter, as a positive value, the projected plan liability PMPM for which the Part D plan is the secondary payer for reinsurance-eligible Part D-covered drugs, Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

SECTION V – DEVELOPMENT OF ACTUARIAL EQUIVALENCE TEST

Lines 1 through 8

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 9 – LIS

Enter the projected average low-income cost-sharing PMPM subsidy for the risk score of the expected population.

SECTION VI – TESTS FOR ALTERNATIVE COVERAGE

This section applies the six actuarial equivalence tests to certain values in Sections III through V to determine whether the proposed benefit plan qualifies as alternative coverage.

SECTION VII – DEVELOPMENT OF SUPPLEMENTAL PREMIUM

Lines 1 through 5 and 8

The values are calculated automatically in the BPT from values in Worksheet 5.

Line 6 – Additional Non-Benefit Expenses

The value is carried from Worksheet 3.

Line 7 – Additional Gain/loss Margin

The value is carried from Worksheet 3.

SECTION VIII – DEVELOPMENT OF INDUCED UTILIZATION ADJUSTMENT

This section summarizes the additional costs of DS coverage with respect to the enhanced alternative plan with supplemental benefits and is used to adjust allowable costs for risk corridor payments.

Line 2 – Impact of Alternative Utilization on Standard Benefit

Enter the additional costs for Part D-covered drugs under a DS plan in the first column if the utilization of the EA plan was used to price the DS coverage in the bid. The adjustment applies to the EA plan type only and must be a positive value.

PD WORKSHEET 6 – SCRIPT PROJECTIONS FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6 summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in different distributions of drug spending. In addition, Worksheet 6 illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid. Part D sponsors must model the impact of the alternative benefit compared to the DS by making adjustments in utilization and average script pricing in Worksheet 6. The distributions must be based on the intervals defined for DS coverage. For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 9 must reflect the utilization for the AE, BA or EA plan for members expected to have less than the DS ICL of $4,660 in CY2023. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.

Refer to the "Pricing Considerations" section of the Instructions for information on modeling the impact of coverage in the gap, and decreased ICL.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTIONS FOR EQUIVALENCE TESTS

Data are collected for four levels of allowed costs on lines 1 through 36. The distribution of the population and Part D covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the deductible, coverage gap and LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 8 – Population Not Exceeding Allowed Costs of $4,660 with Standard Coverage

All utilization for members with projected total allowed costs of less than $4,660 must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost-sharing structure of the DS plan by point-of-sale and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. Exclude claims subject to the deductible, which are reported in line 10.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage. Exclude claims subject to the deductible, which are reported in line 10.

Line 9, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 1 through 8 for each column.

Line 10, columns f, g, i and j – Claims Subject to Deductible (<$4,660)

For the population not exceeding allowed costs of $4,660, enter the number of scripts that are subject to the deductible in columns f and i.

For the population not exceeding allowed costs of $4,660, enter allowed costs that are subject to the deductible in columns g and j.

Lines 11 through 18 – Population Exceeding Allowed Costs of $4,660 with Standard Coverage

All utilization for members with projected total allowed costs greater than or equal to $4,660 must be reported on these lines.

- ✓ **Columns f and g – Defined Standard Coverage**

  Enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f and g, respectively, for each line. Exclude claims subject to the deductible, which are reported in line 20.

- ✓ **Columns i and j – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage. Exclude claims subject to the deductible, which are reported in line 20.

Line 19, columns f, g, i and j – Total

The values are calculated automatically in the BPT as the sum of lines 10 through 17 for each column.

Line 20, columns f, g, i and j – Claims Subject to Deductible (>$4,660)

For the population exceeding allowed costs of $4,660, enter the number of scripts that are subject to the deductible in columns f and i.

For the population exceeding allowed costs of $4,660, enter allowed costs that are subject to the deductible in columns g and j.

Lines 21 through 28 – Population Exceeding $4,660 with Standard Coverage Amounts Allocated up to ICL

All utilization for total allowed costs up to $4,660 for members with projected total allowed costs greater than or equal to $4,660 must be reported on these lines. These amounts are a subset of the amounts reported in lines 10 through 18; amounts in the gap are intentionally excluded.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts allocated up to the ICL of $4,660in CY2023, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. Exclude claims subject to the deductible, which are reported in line 20.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts allocated up to the ICL, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage. Exclude claims subject to the deductible, which are reported in line 20.

Line 29, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 21 through 28 for each column.

Lines 30 through 37, columns f through k – Amounts Allocated over Catastrophic Coverage

The amounts in these lines are a subset of the amounts reported in lines 11 through 18.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 38, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 30 through 37 for each column.

Line 39, columns i through k – Non-Part D-Covered Drugs All Spending

When the plan benefit type is EA and the plan covers non-Part D drugs, enter the projected total number of scripts, total allowed dollars and total cost sharing, for the population identified in Worksheet 3, Section III, using the cost-sharing structure of the EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line.

Network Pricing

Enter the projected average percentage discount off of AWP and the projected average dispensing fees for generic, brand and Specialty drugs dispensed at retail and mail.

The values in this section must be based on the network pricing contracts that will be effective in CY2023 and on the projected weighted utilization by pharmacy of the population identified in Worksheet 3.

PD WORKSHEET 6A – COVERAGE IN THE GAP FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6A summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in the coverage gap. As a continuation of Worksheet 6, Worksheet 6A illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5 and calculates the plan-specific prospective brand discount amount payment. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – SPENDING IN THE COVERAGE GAP

Data are collected for allowed costs in the coverage gap on lines 1 through 33. The distribution of the population and Part D-covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 11, columns f through k – Amounts Allocated between $4,660 and Catastrophic

The values are calculated automatically in the BPT.

Lines 12 through 21 – Low-Income Population Amounts Allocated between $4,660 and Catastrophic

All utilization for LIS members with projected total allowed costs greater than $4,660 and less than the catastrophic limit must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 22, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 11 through 21 for each column.

Lines 23 through 32 – Non-Low-Income Population Amounts Allocated between $4,660 and Catastrophic

All utilization for non-LIS members with projected total allowed costs greater than $4,660 and less than the catastrophic limit must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 33, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 23 through 32 for each column.

Non-LI Generics in Gap PMPM

The value is calculated automatically in the BPT.

Non-LI Brand Discount Amount PMPM

For plans participating in SSM, this value is an input and plans must enter their best estimate of the expected amount of brand discount.

For plans not participating in this model, the value is calculated automatically in the BPT.

PD WORKSHEET 7 – SUMMARY OF KEY BID ELEMENTS

Worksheet 7 summarizes key payment-related components of the bid and the Part D sponsor's estimate of the national average monthly bid amount and calculates premiums.

SECTION I – GENERAL INFORMATION

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

SECTION II – 2023 DEFINED STANDARD BENEFIT PARAMETERS

Line 1 – Deductible

The cell is pre-populated with the deductible for the DS plan benefit type.

Line 2 – Initial Coverage Limit

The cell is pre-populated with the ICL for the DS plan benefit type.

Line 3 – Out-of-Pocket Limit

The cell is pre-populated with the OOP for the DS plan benefit type.

SECTION III – SUMMARY OF KEY BID ELEMENTS

Line 1 – Standardized Part D Bid

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 2 – National Average Monthly Bid Amount (NAMBA)

Enter the Part D sponsor's estimate of the NAMBA at the time of bid submission. The final NAMBA for CY2023 will be calculated and published by CMS in early August 2022.

Line 3 – Base Beneficiary Premium (BBP)

Enter the Part D sponsor's estimate of the BBP. The NAMBA, basic Part D A/B rebate allocation reported on the MA BPT for MA plans and BBP will determine the plan's basic Part D target premium.

Line 4 – Medication Therapy Management (MTM) Performance Payment

For standalone PDP plans that are participating in the MTM demonstration, this input cell will account for the performance payment that the plan is to receive in its CY2023 payments. All plans must enter "0" for this amount in their initial bid submission on the first Monday in June. Plans that qualify for this performance payment will be given an opportunity to resubmit their bid after they have been informed of the amount.

Lines 5 and 6 – Basic Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT. Line 4 is calculated as line 1 minus line 2 plus line 3 minus line 4. Line 6 reflects the value of the basic Part D premium from line 5 after the rounding rule selected on line 9 of this section has been applied. If the basic Part D premium is negative and the plan benefit type is DS, AE or BA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP. If the plan benefit type is EA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP or fully offset the negative basic premium with a supplemental Part D premium. The basic Part D premium, before and after the rounding rule is applied, will be updated based on the final NAMBA and BBP that are calculated and published by CMS in early August.

Lines 7 and 8 – Supplemental Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT when supplemental benefits are offered. Line 6 is carried from Worksheet 5 of the BPT. Line 7 reflects the value of the supplemental Part D premium from line 6 after the rounding rule selected on line 12 of this section has been applied.

Line 9 – Prospective Federal Reinsurance (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 10 – Prospective Low-income Cost-Sharing Subsidy (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 11 – Target Adjustment (Allowed Costs as a Ratio of Bid)

The target adjustment is the allowed costs percentage of the bid and it is used in calculating the target amount for risk corridor payments. The value is calculated as—

[(1.00 – administration cost percentage) X (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount)]

Line 12 – Prospective Brand Discount Amount

The value is carried from Worksheet 6A of the BPT.

Line 13 – Rounding Rule

Select the option from the drop-down box that corresponds to the preferred method for rounding the Part D premium. The valid options are $0.10 and $0.50. MA-PD plans are required to round to the nearest $0.10; Part D plans are permitted to round to either the nearest $0.10 or the nearest $0.50.

SECTION IV – PART D BID PRICING TOOL CONTACTS AND DATE PREPARED

Part D sponsors must identify three persons as plan bid contact, Part D certifying actuary and Part D additional actuarial BPT contact. However, the Part D sponsor may designate a centralized mailbox as the e-mail for any of the three contacts.

The Part D certifying actuary and Part D additional actuarial BPT 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; 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 is populated with a date/time stamp during the BPT finalization.

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 the backup file during finalization.

IV. APPENDICES

APPENDIX A – ACTUARIAL CERTIFICATION

GENERAL

CMS requires an actuarial certification to accompany every bid submitted to HPMS. If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval. Every Part D BPT requires a certification. Likewise, every MA BPT requires a certification.

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 that person accountable for the reasonableness of the assumptions and projections.

Certification Module

The certification module contains the following features:

- Standardized required language.
- 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.

Multiple actuaries may be 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 certifying actuaries.

Additional information regarding the actuarial certification process (including technical instructions for completing the HPMS certification module) will be included in an initial actuarial certification deadline memorandum released via HPMS.

Detailed instructions regarding how to apply for access to the certification module are released via an HPMS memorandum regarding consultant access or electronic signature access to HPMS.

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 completed.
- Declaration 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 number, plan ID and segment ID of the bid(s) being certified.
- The contract year of the bid(s) contained in the certification.
- Indication of whether the certification applies to the MA bid(s), the PD (Part D) bid(s) or both.
- Attestation that the bid(s) are in compliance with the applicable laws,[1] rules,[2] CY2023 bid instructions and current CMS guidance.
- Attestation that, in accordance with Federal law, the bid(s) are 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(s) are reasonable for the plan's benefit package (PBP).
- Attestation that the bid(s) were prepared in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries.[3]

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[1] Social Security Act sections 1851 through 1859; and Social Security Act sections 1860D-1 through 1860D-42.

[2] 42 CFR Parts 400, 403, 411, 417, 422, and 423

[3] Emphasis is placed on, but not limited to, the following Actuarial Standards of Practice (ASOPs):

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits (Revised)*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures*
- ASOP No. 41, *Actuarial Communications*
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*

APPENDIX B – SUPPORTING DOCUMENTATION

GENERAL

In addition to the BPT and actuarial certification, Part D sponsors must provide CMS with supporting documentation for every bid, as described in these Instructions.

Unless otherwise noted, Part D sponsors must upload to HPMS all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation must be made available to CMS auditors and reviewers upon request, and for CMS reviewers, within 48 hours of the request, as required by these Instructions. Part D sponsors must upload supporting documentation consistent with the final certified bid.

Additional information not listed by number in this appendix may be requested by CMS reviewers and auditors at any point during bid desk review or a CMS audit.

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the Part D 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 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 and additional Part D BPT actuarial contacts must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation must—

- Be clearly labeled and easily understood by CMS reviewers.
- Explain the rationale for the assumptions, including quantitative support and details, rather than just provide narrative descriptions of assumptions.
- Describe bid-specific variations in addition to the overall pricing assumption or methodology.
- Match the values entered in the current BPT and tie to the PBP.
- Include Excel spreadsheets with working formulas, rather than pdf files, and a narrative explanation of the inputs and the calculations and their components.
- Clearly identify if it is related to MA, Part D or both.
- Clearly identify the bid(s) relating to the support. 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.
- Include a hard-coded date.

- Include the contract-plan ID (or organization name) and brief description in the beginning of the file name.

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.
- A complete description of data sources–for example, a report's official name/title, file name, date obtained, source file, the precise name of any published tables used, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services arrangements.
- 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 are accessible 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 bid must be self-contained.
- Excel spreadsheets with a vague explanation or no explanation of the bid-specific inputs and calculations.
- PDF files with the "copy" function disabled.
- 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 bid filings in previous years.

SUBMITTING SUPPORTING DOCUMENTATION

Supporting materials must be in electronic format (for example, 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 note that although one file can be uploaded to multiple plans in HPMS, documentation must not be uploaded to plans to which it does not pertain. Similarly, it is not acceptable to upload to multiple plans materials specific to a Part D plan, an MA bid or another contract number.

More requirements about the upload of substantiation files are located in HPMS in the "Notes" section, under HPMS Home > (Plan Bids) Bid Submission > CY2023 > (Upload) Substantiation > Next.

Cover Sheet

To expedite the bid review process, Part D sponsors must upload a cover sheet that lists all of the supporting documentation that is uploaded or provided with 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 bids for which such support item applies 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 contract number-plan IDs (such as "plans 001 – 030" or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact contract number-plan IDs (contract/plan) 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 contract number-plan IDs rather than a "range" of contract number-plan 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

Part D sponsors and certifying actuaries must prepare all supporting documentation at the time of the initial June bid submission so that it is immediately available to CMS and reviewers at initial bid submission or readily available upon request as explained below.

- The "Initial June Bid Submission" section of Appendix B describes supporting documentation materials that Part D sponsors must upload to HPMS with the initial June bid submission.
- The "Upon Request by CMS Reviewers" section of Appendix B describes materials that Part D sponsors and certifying actuaries must provide within 48 hours of request by CMS reviewers and upload to HPMS prior to the final actuarial certification.
- When a BPT is resubmitted, the Part D 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 resubmitted at the same time, the supporting documentation must include a mapping of specific bid changes and contract number-plan IDs.
    - Sample BPTs are not to be uploaded to HPMS.

- Prior to the final actuarial certification—
  - Part D sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid. This includes additional information or materials provided during bid review to support the bid.
  - CMS expects revised supporting documentation to have the same file name as the original substantiation file except for a different date or a word such as "revised."

Initial June Bid Submission

The following documentation requirements apply to all bids (as all bids contain these assumptions):

1. A cover sheet outlining the documentation files, as described above.
2. A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.
3. A document titled "Related-Party Declaration" that states whether or not the Part D sponsor is in a related-party arrangement in the base period and/or the projection period.
4. Support for the effect of sequestration on the bid, including a detailed qualitative and quantitative description of how sequestration is reflected in pricing assumptions.
5. Support for the claims credibility assumptions (Worksheet 2), including—
   5.1. A statement of the credibility methodology used—for example, the CMS guidelines.
   5.2. An actuarial report of the credibility procedure used if it varies from the CMS guidelines.
6. A quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories used in pricing (Worksheets 2, 6 and 6A). The required elements include—
   6.1. The PBP description of the deductible and copay/coinsurance structure by days supply, point-of-sale and claims interval.
   6.2. Allowed costs, effective cost sharing and script counts by formulary tier within each claims interval based on the cost-sharing structure specified in the PBP, including days supply and point-of-sale.
   6.3. A quantitative description of the distribution of the allowed costs, effective cost sharing and script counts by formulary tier to each of the categories on Worksheets 6 and 6A.
7. Support for non-benefit expense assumptions (Worksheet 2). The required elements include—
   7.1. A reconciliation of the base period non-benefit expenses reported in Worksheet 1 of the BPT to auditable material such as corporate financials and plan-level operational data.
   7.2. A description of the expenses included in each non-benefit expense category in the BPT.

7.2.1. For the "Net Cost of Private Reinsurance" category, the required elements include the type of reinsurance and applicable benefits, attachments points, maximums, and other information pertinent to the reinsurance coverage.

7.3. Detailed support for the development of projected non-benefit expenses. The required elements include—

7.3.1. A description of the methodology used to develop non-benefit expenses.

7.3.2. An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.

7.3.3. A description of the relationship between the non-benefit expense line items reported in the BPT and auditable material such as corporate financials and plan-level operational data.

8. Justification of the Part D gain/loss margin (Worksheet 2). The required elements include—

8.1. For a Part D plan without a corresponding Medicare Advantage plan, disclosure of the aggregate Part D gain/loss margin at the time of the initial bid submission.

8.2. For a Part D plan without a corresponding Medicare Advantage plan, support for the aggregate Part D gain/loss margin if the aggregate Part D gain/loss margin is below 0% or above 5.5%. The required elements include—

8.2.1. A description of the reasons supporting aggregate Part D gain/loss margin.

8.2.2. An aggregate-margin numeric (non-PDF) business plan showing the current bid submission and next year. The required elements include—

a. Projected member months, risk scores, CMS revenue, Part D premium, claims expense, non-benefit expenses, and gain/loss margin.

b. Projected gain/loss margin as a percentage of revenue from the previous year's business plan(s), if applicable.

8.3. A demonstration of consistency between the projected aggregate Part D gain/loss margins and the actual aggregate Part D gain/loss margins over the long term at the applicable plan–category level, including—

8.3.1. An explanation of how that knowledge was incorporated into the current bid submission, if the gain/loss margins have been inconsistent historically.

8.4. A detailed justification of the need for flexibility in the gain/loss margin requirements in order to satisfy other CMS instructions such as Total Beneficiary Cost (TBC).

8.5. For a Part D plan without corresponding Medicare Advantage plans, support for how the aggregate Part D gain/loss margin does not jeopardize financial solvency, if the aggregate Part D gain/loss margin is negative.

8.6. For a Part D plan without a corresponding Medicare Advantage plan, justification of benefit value in relation to the gain/loss margin, if the gain/loss margin at the bid level is greater than 11.5% of revenue. The required elements include—

8.6.1. An explanation of how the PBP provides benefit value in relation to the gain/loss margin.

8.6.2. A description of premium changes made for CY2023.

8.7 For an MA-PD plan, a description of the approach for setting the Part D gain/loss margin in relation to the MA gain/loss margin.

9. Detailed support for the development of projected risk scores (Worksheet 3). The required elements include—
   - 9.1. A detailed description and corresponding numerical demonstration of the methodology used to develop projected CY2023 Part D risk scores, including the impact of the assumed mix between low-income subsidy (LIS) and non-LIS populations.
   - 9.2. A description of, and the rationale for choosing, the source data for the development of the projected CY2023 Part D risk scores, including—
     - 9.2.1. Identification of the source of the starting risk score and, if the CMS-provided risk scores were not used, an explanation of why the alternative source was appropriate.
     - 9.2.2. For an alternative approach, identification of the years used, the population incorporated and any data points used as a basis for developing the CY2023 risk score.
   - 9.3. A description of the methodology used to derive each projection factor, including—
     - 9.3.1. A summary of the consideration for using or not using the projection factor; a description of and the rationale for choosing the source data; and the data points used in the derivation of the projection factor.
     - 9.3.2. For the bid-specific coding trend, a statement about the risk score years utilized, the number of years used and whether the scores are normalized or raw.
   - 9.4. A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected prescription drug expenses.
   - 9.5. For an alternate approach, a demonstration that the method used is consistent with the preferred development approach in these Instructions, including an explanation of why such method is more appropriate than the CMS preferred approach.
   - 9.6. A statement of the credibility approach used—for example, the CMS guidelines.
   - 9.7. A description of the credibility methodology used if it varies from the CMS guidelines.

The following documentation requirements apply to all bids that contain these specified assumptions:

10. Support for the development of the base period data (Worksheet 1).
    - 10.1. Detailed qualitative and quantitative support for the development of the base period experience, including allowed cost, GAP discount and LICS. The required elements include—
      - 10.1.1. Description of the source data, such as a list of the CMS return files that were used in the compilation of the PDEs
      - 10.1.2. Information regarding the base period member months, if more than eight bids constitute the base period experience
      - 10.1.3. Any applicable adjustments, stated as absolute values or percentages, to the source data, including considerations for—
        a. Accepted PDEs.
        b. Rejected PDEs expected to be accepted by CMS upon resubmission.

c. P2P transactions.
d. Transfer of OTC drug data from the base period experience to the non-benefit expense component.

10.2. Reconciliation of base period experience to the Part D sponsor's 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 an accounting period, the data need not be based on an audited GAAP financial basis.

10.3. Crosswalk information regarding data aggregation (Worksheet 1). The required elements include—

10.3.1. A list of all bids that are involved in approved crosswalks for CY2022 and proposed crosswalks for CY2023 and that are considered for base period data aggregation.

10.3.2. A statement of the intention to submit a crosswalk exception for CY2023, if applicable.

10.4. Detailed qualitative and quantitative support for the development of the rebates and all other types of direct and indirect remuneration (DIR) (Worksheets 1 and 3).

11. Detailed qualitative and quantitative support of the development of each trend projection factor (Worksheet 2). The required elements include—

11.1. A description of the source data, including the data's relevance to the Part D plan and the mix between LIS and non-LIS populations.

11.2. A summary of the Part D sponsor's historical trends including—

11.2.1. The percentage trends.

11.2.2. A description of the methodology used to analyze the data.

11.2.3. The numeric calculations.

11.3. Any applicable adjustments to the source data, such as considerations for—

11.3.1. The Part D sponsor's experience.

11.3.2. PBM reports and contracts.

11.3.3. Industry and/or internal studies.

11.3.4. Formulary analysis.

11.3.5. Benefit design analysis.

11.3.6. Bid-specific circumstances.

11.3.7. LIS and non-LIS populations.

12. 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—

12.1. A description of the source data, including, but not limited to, the data's relevance to the Part D bid, incurred dates, and the exposure (expressed in member months) that was used to develop the manual rate.

12.2. An analysis justifying the reasonableness of the Part D manual rate, if the manual rate is based on experience of less than 56,000 member months of exposure.

12.3. Any applicable adjustments to the source data, such as—

12.3.1. Techniques and factors used to reflect differences between the underlying population and that expected of the Part D plan;

12.3.2. Techniques and factors used to adjust for differences in plan design between the source data and the Part D plan; and

12.3.3. Approach and factors applied to account for incomplete claim run-out, formulary differences and/or expenditures that are not reflected in the source data.

12.4. Data and methodology used to project the data from the incurred period to CY2023.

12.5. All other applicable factors and/or adjustments.

13. A Part D sponsor in a related-party arrangement must provide the following:

13.1. Declaration of every related-party arrangement in the base period and projection period.

13.2. Disclosure of all services provided in every related-party arrangement in the base period and projection period.

13.3. A summary that explains the relationship of the parties involved and common ownership, control and investment in the base period and projection period.

13.4. If the ratio of the related-party expenses on Worksheet 3 (cell D50 plus cell D51) to total blended allowed PMPM on Worksheet 2 (cell P56) plus total non-benefit expenses Worksheet 2 (cell E67) is greater than 10%, provide a summary of the contractual terms for the five largest related parties declared in the projection period, including a description of the services provided and money exchanged in the projection period. The five largest related-party relationships are to be determined by their share in the total related-party expenses on Worksheet 3 (cell D50 plus cell D51).

13.5. If the ratio of the related-party expenses on Worksheet 3 (cell D50 plus cell D51) to total blended allowed PMPM on Worksheet 2 (cell P56) plus total non-benefit expenses Worksheet 2 (cell E67) is greater than 10%, provide items 13.5.1 and 13.5.2 for the five largest related parties declared in the projection period. The five largest related-party relationships are to be determined by their share in the total related-party expenses on Worksheet 3 (cell D50 plus cell D51)

13.5.1. The PMPM cost of services or benefits consistent with the contractual arrangement and the number of beneficiaries affected by the contract, and

13.5.2. A comparison for each contractual arrangement to the cost of the services or benefits in the absence of a related party or to actual cost. Acceptable forms of comparison are as follows:

a. <u>Actual Cost Method for Administrative Services</u>

Show the actual cost of the non-benefit services provided by the related party excluding the gain/loss margin of the related party and provide a qualitative and quantitative summary of the development of the related party's expenses to provide the administrative services.

b. <u>Actual Cost for Benefit Costs</u>

Show the actual cost of the related party to provide the benefit services excluding the gain/loss margin of the related party and provide a qualitative and quantitative summary of the development of the related party's expenses to provide the benefit services.

c. <u>Market Comparison through Part D Sponsor Method</u>

Demonstrate through analysis and contract terms, that the fee associated with the benefit or administrative services from the Part D sponsor's related-party arrangement is comparable to the fee for providing the same service to a Medicare population in an arrangement between the Part D Sponsor and an unrelated entity.

d. Market Comparison through Related-Party Method

Demonstrate through analysis and contract terms, that the fee associated with the benefit or administrative services from the Part D sponsor's related-party arrangement is comparable to the fee for providing the same service to a Medicare population in an arrangement between the Part D sponsor's related party and an unrelated entity.

e. Alternative Comparison

If the Part D sponsor is not able to meet the requirements of 13.5.2a through 13.5.2d, the Part D sponsor must show a comparison for administrative services or benefit costs as outlined in 13.8 or 13.9 even if the fees associated with the arrangement are not within 5 percent of the comparison.

13.6. A Part D sponsor that chooses the Actual Cost Method for Administrative Services must provide a qualitative and quantitative summary of the development of the expenses for the related party to provide the administrative services, excluding the gain/loss margin of the related party, compared to the cost in the bid.

13.7. A Part D sponsor that chooses the Actual Cost Method for Benefit Costs must—

13.7.1. Provide a qualitative and quantitative analysis of the development of the related party's gain/loss margin reflected in the benefit costs, in which the related party's gain/loss margin is defined as the allowed amount of the related party entered in the BPT less the cost of purchasing pharmaceuticals and dispensing prescriptions. The gain/loss margin must be reconcilable to the related party's audited financial statements.

13.7.2. Provide the related party's gain/loss margin as i) the allowed amount of the related party entered in the BPT less the cost of purchasing pharmaceuticals and dispensing prescriptions divided by the total member months in the BPT and (ii) the allowed amount of the related party entered in the BPT less the cost of pharmaceuticals and dispensing prescriptions divided by the allowed amount of the related party.

13.8. A Part D sponsor that chooses the Market Comparison through Part D Sponsor Method must—

13.8.1. Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from those that are achieved in the absence of the related-party relationship.

13.8.2. Show that results of pricing at least two quarters of the Part D plan's experience through the related-party and unrelated-party contracts are within plus or minus 5 percent.

13.8.3. Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

13.9. A Part D sponsor that chooses the Market Comparison through Related-Party Method must—

13.9.1. Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from those that are achieved in the absence of the related-party relationship.

13.9.2. Show that results of pricing at least two quarters of the Part D plan's experience through the related-party and unrelated-party contracts are within plus or minus 5 percent.

13.9.3. Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

13.9.4. Provide a signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.

13.10. The following requirements apply to support for a related party:

13.10.1. Benefit and administrative services must be supported in a separate and independent demonstration for all methods used.

13.10.2. Only one method may be used to support the benefit or administrative component of each related-party arrangement.

13.10.3. Two arrangements under comparison are recognized as comparable when the terms are identical.

13.10.4. When demonstrating that the fees for each service for a related-party and unrelated-party arrangement are within 5 percent, all of the services in the related-party arrangement must also be included in the unrelated-party arrangement. The unrelated-party arrangement may also include services that are not in the related-party arrangement but that are similar to those services.

13.10.5. When demonstrating that results from the same utilization priced through a related party and unrelated-party arrangement are comparable, all of the services in the related-party arrangement must also be included in the unrelated-party arrangement. The unrelated-party arrangement may also include services that are not in the related-party arrangement but that are similar to those services.

14. The input sheet(s) for the pricing model used in the development of the bid.

15. An explanation of and detailed support for how CY2022 bid audit findings and compliance issues 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.

16. Support for reliance on information supplied by others that—

16.1. Identifies the source(s) of the information—for example, name, position, company, date;

16.2. Identifies the information relied upon;

16.3. States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and

16.4. Indicates to which plan(s) the reliance information applies.

See the sample format at the end of this appendix.

17. Detailed qualitative and quantitative support for the development of the components of pricing assumptions pertaining to the Part D sponsor's participation in the Medicare Advantage Value-Based Insurance Design (MA-VBID) model or Medication Therapy

Management (MTM) model, including an explanation for and a demonstration of elements that affect projected costs.

18. Detailed quantitative support for the development of the induced utilization factor (Worksheet 5).
19. – 33. For future use

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 by the certifying actuary or additional Part D BPT contact within 48 hours. These materials will be reviewed at audit:

34. Support for how the pricing of the bid is not anti-competitive, including a comparison of the bid benefits and premium to the benefits and premium of competitors.
35. Copies of related-party contracts
36. 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.
37. An explanation of how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.
38. For a Part D plan without a corresponding Medicare Advantage plan, justification of benefit value in relation to the gain/loss margin, if the gain/loss margin is less than or equal to 11.5 percent of revenue. The required elements include the information required in 8.6.
39. For the projected bid values listed below, an analysis of the relationship between bid level actual and projected experience for CY2019, CY2020 and CY2021, including an explanation of how that knowledge was incorporated into the current bid submission.
    39.1. Total Non-Benefit Expenses, Worksheet 2, cell E67.
    39.2. Projected Average Risk Score, Worksheet 3, cell H11.
    39.3. Total Blended Allowed Cost, Worksheet 2, cell P56.
40. For an MA-PD plan, if the MA and Part D enrollment differ after taking into account hospice and ESRD enrollees, justification that base period and projected enrollment in the corresponding MA and Part D bids reflect the same underlying population. (Worksheets 1 and 3)
41. A detailed breakout of "Claims subject to the deductible" listed in line 10 and line 20 of Worksheet 6. This documentation should include the details underlying all values in lines 10 and 20, and be set up similarly to the way in which the breakouts for "Claims Not Subject to the Deductible" are set up in rows 1-8 and 11-18.

PART D CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Related-party declaration
Sequestration assumptions
Claims credibility assumption
Mapping of allowed costs, script counts and cost sharing in formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and projections
Trend projection factor development
Manual rate development
Related-party arrangements
Input sheet(s) for pricing model
Bid audit results and compliance issues
Reliance information
VBID Model
Induced utilization factor development

Upon Request by CMS Reviewers
Related-party contracts
Reliance letter
OFM audit results
Actual to Projected
MA-PD enrollment

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD

Supporting Documentation Cover Sheet

CY2023 Bid Submission

Organization Name: Health One

Contract(s): Hxxxx, Hyyyy and Szzzz

Date: June 6, 2022

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, Part D, or Both
Cover sheet	All bids	Cover Sheet 6-6-22.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-6-22.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-6-22.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-6-22.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xlsx	Sheet1	both
Gain/loss margin	All bids	AdminProfit.xlsx	Sheet2	both
Risk scores	All bids	Risk CY22.xlsx	MA-Sheet 1 PD-Sheet 2	both
Related-party declaration	All bids	Cover Sheet 6-6-22.pdf	Page 7	both
Sequestration	All bids	Cover Sheet 6-6-22.pdf	Page 7	both
Manual rates	Hxxxx-003 Syyyy-001	Manual.xlsx	Section II	PD
ESRD subsidy	Hxxxx-001 Hxxxx-004	Manual.xlsx	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD

Supporting Documentation Cover Sheet #2

CY2023 Bid Submission

Organization Name: Health One

Contract(s): Hxxxx, Hyyyy, and Szzzz

Date: July 14, 2022

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, Part D, or Both
Cover sheet	Hxxxx-001 Hxxxx-003 Hxxxx-004 Hxxxx-801 Hyyyy-001 Hzzzz-001	Cover Sheet 6-6-22.doc	n/a	both

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid	MA or Part D or Both	Source (Name, Position, Company)	Type of Information	Comments
Hxxxx-002	both	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
Hxxxx-002	both	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 – EMPLOYER/UNION-ONLY GROUP (EGWP) REQUIREMENTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives employers and unions a number of options for providing prescription drug coverage to their retirees. Employers and unions may–

- Provide coverage at least as good as Medicare's Part D DS benefit and receive a retiree subsidy of 28 percent of a retiree's drug costs between $505 and $10,350;
- Purchase customized benefits from a PDP or MA-PD pursuant to CMS waivers; or
- Contract directly with CMS to become a PDP and provide customized benefits pursuant to CMS waivers.

Under Sections 1860D-22(b) and 1857(i) of the Social Security Act (SSA), CMS may waive or modify Part D requirements that hinder the design of, offering of, or enrollment in an employer or union Part D retiree plan. The waiver authority applies to PDPs and MA-PDs that offer employer/union-only group plans and to employer/union-only groups that contract directly with CMS to become a PDP.

For CY2006, CMS issued guidance that waives or modifies many of the requirements for these entities. All of the standard Part D bidding guidelines apply, with the exception of those specifically waived.

For CY2023, CMS does not require a Part D BPT for employer/union-only group plans.

APPENDIX D – CALCULATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT

For CY2006, the NAMBA was calculated using equal weighting applied to all PDP sponsors, and MA-PD plans were assigned a weight based upon prior enrollment. New MA-PD plans were assigned a zero weight. This approach was used because no PDP enrollment data existed for 2005.

For CY2007 and CY2008, the NAMBA was calculated according to the guidelines established by the "Medicare Demonstration to Limit Annual Changes in Part D Premiums due to Beneficiary Choice of Low-Cost Plans." Specifically, 80 percent of the calculation for CY2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average, and 20 percent was based on an enrollment-weighted average. For CY2008, 40 percent of the calculation was based on the uniform-weighting average and 60 percent was based on an enrollment-weighted average. The demonstration was no longer in effect for CY2009 and the benchmarks were based on the 2008 enrollments applied to the 2009 bids. The CY2023 benchmarks will be based on the 2022 enrollments applied to the 2023 bids.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2021 and February 2022. Recall that the 2022 benchmark was calculated as 100 percent of the enrollment-weighted approach.

The same values are presented based on the February 2022 enrollment. Since the 2023 benchmarks will be based on 2022 enrollment, these values may be useful for estimating the 2023 benchmarks. The left section of the table shows the actual 2022 benchmarks, which were calculated based on June 2021 enrollment. The right section, titled "February 2022 Enrollment," indicates how the 2022 benchmarks would have been calculated based on more current enrollment data.

	Enrollment Weighted Approach	
	June 2021 Enrollment	**February 2022 Enrollment**
National average monthly bid amount	**$38.18**	**$36.18**
Base beneficiary premium	**$33.37**	**$31.88**
Direct subsidy	**$4.81**	**$4.30**

This illustrative recalculation of the 2022 benchmarks is provided for the purpose of assisting Part D sponsors in developing the projected 2023 national average monthly bid amount and base beneficiary premium, which will be used in the calculation of the plan's target premium. The final 2023 benchmarks will be based on the 2022 enrollments applied to the 2023 bids.

APPENDIX E – CALCULATION OF LOW-INCOME BENCHMARK PREMIUM AMOUNTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to use a weighted average to calculate the regional low-income benchmark premium amounts used in the determination of the low-income premium subsidy amounts. In determining the CY2006 low-income benchmark premium amounts, PDPs were weighted equally, MA-PDs were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PDs were assigned a zero weight. For CY2007, under the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006.

For CY2008, CMS implemented a transition to the statutorily required weighting such that the regional low-income benchmark premiums would experience a smaller decrease. CMS calculated the 2008 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average), as described below:

- The first component, the simple average, was the same as the 2006 weighting methodology for the regional low-income benchmark premium amount. The PDP organization premium amounts for basic prescription drug coverage in each region were weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, were weighted based upon prior enrollment.
- The second component was a weighted average of the premium amounts for each PDP and MA-PD with a weighting based on each plan's prior enrollment as a percentage of all beneficiaries enrolled in those plans.

For CY2008, the regional low-income benchmark amount was based on 50 percent of the first component and 50 percent of the second component, as described above.

For CY2009, the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries" and the de minimis policy were not in effect. The regional low-income benchmark amounts were calculated based on 100 percent of the weighted LIS enrollments.

For CY2010, the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" established that the regional low-income benchmark amounts, based on 100 percent of the weighted LIS enrollments, would be calculated using the Part D premiums for MA-PD plans before they were reduced by any applicable MA A/B rebates.

For CY2011 and subsequent years, in accord with the codification of the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation", the weighted average premium amounts are to be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable Part A/B rebates.

The following table illustrates the impact of calculating the regional low-income benchmark amounts based on 100 percent of the weighted LIS enrollments for two enrollment periods, June 2021 and February 2022.

PD Region	State(s)	Enrollment Weighted Approach	
		June 2021 Enrollment	February 2022 Enrollment
1	NH, ME	$30.53	$30.45
2	CT, MA, RI, VT	$36.27	$36.48
3	NY	$42.43	$42.84
4	NJ	$37.07	$37.28
5	DE, DC, MD	$36.96	$37.05
6	PA, WV	$40.74	$40.61
7	VA	$35.11	$35.85
8	NC	$35.82	$36.13
9	SC	$31.12	$33.54
10	GA	$32.38	$33.41
11	FL	$34.32	$35.28
12	AL, TN	$32.72	$33.10
13	MI	$31.49	$31.35
14	OH	$33.54	$33.84
15	IN, KY	$29.65	$30.04
16	WI	$42.29	$42.65
17	IL	$29.05	$29.16
18	MO	$33.42	$35.07
19	AR	$26.72	$29.91
20	MS	$29.22	$29.75
21	LA	$36.35	$36.79
22	TX	$25.10	$25.61
23	OK	$30.90	$31.27
24	KS	$32.92	$33.36
25	IA, MN, MT, ND, NE, SD, WY	$38.88	$38.90
26	NM	$34.31	$34.45
27	CO	$39.81	$39.20
28	AZ	$40.04	$40.33
29	NV	$31.68	$31.67
30	OR, WA	$40.48	$40.63
31	ID, UT	$42.93	$41.98
32	CA	$33.16	$31.99
33	HI	$35.98	$36.57
34	AK	$32.63	$32.09

APPENDIX F – HEALTH CARE REFORM

PROVISIONS

The following provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 apply to Part D bids for CY2023.

Coverage in the Gap

In CY2023, beneficiary cost sharing is 25 percent for non-applicable (generic) drugs; the Part D sponsor's liability for DS coverage is 75 percent. Beneficiary cost sharing remains (i) 25 percent of the negotiated price for applicable (brand) drugs, defined for purposes of the coverage gap discount program as the gross drug cost minus the dispensing fee and vaccine administration fee, if any, under Section 1860D-14A(g)(6) of the SSA, and (ii) 25 percent of the dispensing fee and vaccine administration fee, if any. Pharmaceutical manufacturers will provide a 70 percent discount off of the Part D sponsor's negotiated price of the brand-name drug at the point-of-sale. Ninety-five percent of the negotiated price of the drug and 25 percent of the dispensing fee and vaccine administration fee, if any, will count toward the beneficiary's TrOOP; the Part D sponsor's liability is 5 percent plus 75 percent of the dispensing fee and vaccine administration, if any. Applicable drugs are defined in Section 1860D-14A(g)(2) of the statute and consist of covered Part D drugs that either are approved based on a new drug application (NDA) under Section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, are licensed under Section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of Section 351) using a biologics license application (BLA). Non-applicable drugs consist of covered Part D drugs that do not meet the definition of an applicable drug.

These coverages apply to beneficiaries who, on the date of dispensing a covered Part D drug, are enrolled in an MA-PD or a PDP plan, are not enrolled in a qualified retiree prescription drug plan, are not entitled to the low-income subsidy, have reached or exceeded the ICL and have not exceeded the TrOOP threshold.

Low-Income Premium Subsidy Amounts

The approach to determine the low-income premium subsidy amounts that was established in the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" and approved on August 11, 2009 was codified. Therefore, the weighted average premium amounts will be calculated for MA-PD plans using the Part D premiums before they have been reduced by any applicable MA A/B rebates.

Income-Related Part D Premium

Similar to Medicare Part B, an income-related premium is established for Part D beneficiaries with modified gross income greater than specified income thresholds. The income thresholds for CY2022 are $91,000 per individual and $182,000 per couple. The CY2023 income thresholds will be indexed to the August 2022 CPI, which will be released in September 2022. The Part D income-related monthly adjustment amounts will be collected by the federal government and will have no impact on the direct subsidy payments received by Part D sponsors.

APPENDIX G – TRENDING RISK SCORES

This appendix includes the following considerations for developing trends for coding and population changes to project CY2023 risk scores.

- Include the most recent annual consecutive calendar risk scores that are available.
- Use raw risk scores that are not normalized.
- Reflect the same amount of paid claims run-out for each year's risk scores.
- Use final risk scores from each year or apply a completion factor to the last set of scores to approximate a final score.
- Use the same cohort for each year (for example, the July cohort).
- Use the same model to estimate all payment year scores. If possible, use the risk adjustment model for the upcoming payment year or apply a conversion factor to each payment year's risk scores to convert to a single risk model.
    - The model conversion factor should be bid-specific. It can be generated from the risk scores that CMS sends to Part D sponsors to support bidding; however, Part D sponsors should also consider whether other years in their trends have a different conversion factor (for example, when the population mix differs).
    - The conversion factor can be derived by calculating risk scores from a year under two different models. The factor can be a ratio of the scores under each model.
- When a Part D sponsor is converting risk scores from one model to another, a conversion between denominator years is, more than likely, occurring also. The risk scores in the conversion factor should be raw if the factor will be applied to an old model raw risk score, which is then projected to the payment year.
- If Part D sponsor compares scores within a single cohort, and the risk adjustment models do not have the same denominator year, the raw risk scores should be normalized to the same year. Otherwise, some portion of the ratio between the models will be attributed to the more recent denominator rather than to a difference in predicted risk.
- Divide cohorts into meaningful subgroups using the same considerations that are used to determine allowed costs and project enrollment in each subgroup to the payment year.
    - Weight subgroup risk scores by enrollment in each subgroup per year to determine annual risk scores for trending.
- Compare year over year risk scores to obtain a trend factor. Unless the Part D sponsor is anticipating changes in coding efforts or population characteristics, more than 2 years of risk scores will help minimize the effect of random changes in coding patterns and enrolled population. If deviations from the previous trend are expected in the payment year, provide justification for such changes in the supporting documentation.
    - If starting with base year risk scores that are blended, Plan sponsors are to assess whether there are bid-specific risk score trends unique to each model and adjust their overall trend accordingly.
    - Use this trend factor to project from base period risk scores to payment (contract) year raw risk scores.

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 12 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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