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INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOL

AND

THE MEDICAL SAVINGS ACCOUNT BID PRICING TOOL

FOR CONTRACT YEAR 2010

April 10, 2009

TABLE OF CONTENTS

Table of Contents 2

I. Introduction 4
- Background 4
- Document Overview 4
- New for Contract Year (CY) 2010 5
- Bidding Resources 8

II. Pricing Considerations 10
- Bidding/Pricing Approach 10
- Specific Topics 10

III. Data Entry and Formulas 30
- Medicare Advantage 30
- Medical Savings Account 30
- Data Entry 30

MA Worksheet 1 - MA Base Period Experience and Projection Assumptions 31
- Section I – General Information 31
- Section II – Base Period Background Information 33
- Section III – Base Period Data (At Plan's non-ESRD Risk Factor) 35
- Section IV – Projection Assumptions 36
- Section V – Description of Other Utilization Factor and Additive Values 37

MA Worksheet 2 – MA Projected Allowed Costs PMPM 38
- Section I – General Information 38
- Section II – Projected Allowed Costs 38

MA Worksheet 3 – MA Projected Cost Sharing PMPM 41
- Section I - General Information 41
- Section II – Maximum Cost Sharing Per Member Per Year 41
- Section III – Development of Contract Year Cost Sharing PMPM (Plan's non-ESRD Risk Factor) 42

MA Worksheet 4 – MA Projected Revenue Requirement PMPM 47
- Section I – General Information 47
- Section II – Development of Projected Revenue Requirement 47
- Section III – Development of Projected Contract Year ESRD "Subsidy" 53
- Section IV – For Employer Bid Use Only 54
- Section V – Projected Medicaid Data for DE# Beneficiaries 54

MA Worksheet 5 – MA Benchmark PMPM 56
- Section I - General Information 56
- Section II – Benchmark and Bid Development 56
- Section III – Savings/Basic Member Premium Development 57
- Section IV – Standardized A/B Benchmark – Regional Plans Only 57
- Section V – County Level Detail and Service Area Summary (excluding ESRD) 58
- Section VI – Other Medicare Information 60

MA Worksheet 6 – MA Bid Summary 62
Section I - General Information 62
Section II – Other Information 62
Section III – Plan A/B Bid Summary 62
Section C – Development of Estimated Plan Premium 64
Section IV – Contact Information and Date Prepared 66
Section V – Working Model Text Box 66
MA Worksheet 7 – Optional Supplemental Benefits 67
Section I - General Information 67
Section II – Optional Supplemental Packages 67
Section III - Comments 69
MA TWO-YEAR LOOK-BACK FORM 70
IV. Appendices 74
Appendix A - Actuarial Certification 74
Appendix B - Supporting Documentation 77
General 77
Submitting Supporting Documentation 78
MA Checklist for Required Supporting Documentation 84
SAMPLE Cover Sheet – Submitted with initial bid upload in June 86
SAMPLE Cover Sheet – Submitted as a subsequent substantiation upload 87
Sample Sormat for Reliance on Information Supplied by Others 87
Appendix C – PART B-Only Enrollees 88
Appendix D – Medicare Advantage Products Available to Groups 89
Appendix E – Rebate Reallocation and Premium Rounding 92
I. Rebate Reallocation Rules by Plan Type 92
II. Rebate Reallocation Rules and Examples 93
III. Additional Rebate Reallocation Guidance 98
IV. Rules for Rounding Premiums 100
V. Summary of Considerations for Rebate Reallocation Resubmissions 103
Appendix F – Suggested Mapping of MA PBP Categories to BPT Categories 105
Appendix G – Medical Savings Account BPT 108
Worksheet 1 - MSA Base Period Experience and Projection Assumptions (Corresponding to MA Worksheet 1) 108
Section I - General Information 108
Sections II, III, IV, and V 108
Worksheet 2 – MSA Total Projected Allowed Costs PMPM (Corresponding to MA Worksheet 2) 108
Section II – Projected Allowed Costs 108
Worksheet 3 – MSA Benchmark PMPM (Corresponding to MA Worksheet 5) 109
Worksheet 4 – Enrollee Deposit and Plan Payment (No corresponding MA Worksheet). 109
Section II – Development of Claim Information Intervals 109
Section III – Development of Summary Information 110
Worksheet 5 – Optional Supplemental Benefits (Corresponding to MA Worksheet 7) 110

I. INTRODUCTION

BACKGROUND

Medicare Advantage organizations (MAOs) must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each plan that they intend to offer under the Medicare Advantage program, including Medicare Advantage (MA) plans, Medical Savings Account (MSA) plans, and MSA Demonstration (MSA Demo) plans. For plans with service area segments, a separate bid must be submitted for each segment.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format – the MA Bid Pricing Tool (BPT) or the MSA BPT. The Two-Year Look-Back (2YRLB) Form must also be completed for contracts with enrollment in the Monthly Membership Report (MMR) in July 2008. The MA BPT is not to be completed for Section 1876 Cost plans, Section 1833 Cost plans, or PACE (Programs of All-Inclusive Care for the Elderly) plans. An actuarial certification and supporting documentation must be submitted for each bid as described in Appendix A and Appendix B, respectively.

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

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

DOCUMENT OVERVIEW

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

- Section I: The Introduction contains background information, a list of key changes from the CY2009 BPT, and provides sources of additional information regarding the bidding process.
- Section II: Pricing Considerations includes guidance for the overall approach to pricing in the BPT and topic-specific issues for bidders to consider. The section topics are arranged alphabetically.
- Section III: Data Entry and Formulas contains line-by-line instructions on each data entry field and describes the formulas for calculated cells.
- Section IV: Appendices A through G contain information on Actuarial Certification, Supporting Documentation, Part-B Only Enrollees, MA Products Available to Groups, Rebate Reallocation and Premium Rounding, Suggested Mapping of MA Plan Benefit Package (PBP) Categories to BPT Categories, and the MSA BPT.

NEW FOR CONTRACT YEAR (CY) 2010

Key features that are new for the CY2010 BPTs, and changes from the CY2009 BPTs, are listed below. The changes improve the usability and functionality of the BPT, and reflect updated regulatory guidance. The revisions are grouped by worksheet.

Many changes for CY2010 relate to the group of Medicare beneficiaries who are dually eligible for Medicare and Medicaid benefits without full Medicare cost-sharing liability. These beneficiaries are referred to in the BPT and in these instructions as the "DE#" (*d · e · pound*) population. All other beneficiaries are referred to as the non-DE# population, which includes non-dual eligible beneficiaries and dual-eligible beneficiaries with full Medicare cost-sharing liability. Changes attributable to DE#s are marked accordingly in the list below. See the "Pricing Considerations" and "Data Entry and Formulas" sections of these instructions for details on how to complete the BPT for the DE#, non-DE# and total populations.

MA Bid Pricing Tool

- Worksheet 1
  - (DE# change) In Section I, line 14, "Percentage of CY Dual Eligible" was removed. This line was also removed from the "General Information" section of all other worksheets.
  - (DE# change) In Section II, lines 2 and 3, base period "Member Months (excluding ESRD)" and "Non-ESRD Risk Score" must be entered separately for the "Total" and "Non-DE#" populations, and the BPT calculates the values for the DE#s.
- Worksheet 2
  - In Section II, column h, the "Projected Experience Allowed PMPM" formulas no longer explicitly reference the "Utilization/1000 Additive Adjustment" (Worksheet 1 Section IV column o). Users can still produce the same projected result in Worksheet 2 by modifying the additive adjustment factors entered on Worksheet 1, columns o and p.
  - In Section II, cell L39, the BPT calculates the credibility percentage using the CMS credibility guideline in these instructions and the base period member months entered on Worksheet 1. This may be used by the bid preparer and reviewer to compare the CMS calculated credibility percentage and the credibility being used to price the bid.
  - In Section II, cells L38 and L40, the "Experience Credibility Percentage" weighted averages use "Projected Experience Rate Allowed PMPM" (column h) as weights; prior BPTs used "Blended Allowed PMPM" (column o) as the weights.
  - (DE# change) Lines 1 and 2 (cells O13:Q14) were added to Section II to display the projected member months and the projected risk scores separately for the total, non-DE#, and DE# populations.
  - (DE# change) Two new columns were inserted in Section II to accommodate data entry of separate allowed PMPM rates for the non-DE# (column p) and DE# (column q) populations. Note that column q contains formulas. These may be overwritten at the discretion of the certifying actuary. However, user entries

must satisfy validations such that the total allowed PMPM (column o) is approximately equal to the weighted average of the non-DE# and DE# entries (in columns p and q), using the projected member months as weights.

- Worksheet 3
  - In order to enter the "In network," "Out of network," and "Combined" out-of-pocket (OOP) maximums, the user must answer "YES" to the question, "Is there a plan-level OOP maximum?" using a drop-down box for each maximum. For guidance on completing the OOP max entries consistently with the Plan Benefit Package (PBP), see the Pricing Considerations and Data Entry and Formulas sections of these instructions.
- Worksheet 4
  - (DE# change) Section II, "Development of Projected Revenue Requirement," has been divided into subsections A, B, and C to accommodate non-DE#s, DE#s, and all beneficiaries, respectively.
    - In subsection A, formulas for non-DE#s are similar to formulas from the CY2009 BPT. Note that an extra column has been inserted to the right of column f to accommodate fields in subsection B.
    - Subsection B is a new section for the DE# population. Note that column f contains formulas that may be overwritten at the discretion of the certifying actuary. The Pricing Considerations section of these instructions contains guidance on completing this subsection.
    - In subsection C, the total medical expenses are calculated as the weighted average of the DE# and non-DE# benefit expenses; non-benefit expenses and gain/loss margin are entered directly in this section.
  - (DE# change) Section V was added to capture projected Medicaid data for DE# beneficiaries. Entries for revenue and benefits must be reported on a per-DE#-member-per-month basis. The Pricing Considerations section of these instructions contains guidance on completing this section.
- Worksheet 5
  - (DE# change) Users must enter "Projected Member Months" and "Weighted Average Risk Factor" values for the non-DE# population in Section II, on lines 1 and 4, respectively. The BPT automatically calculates these values for the DE# and the total populations.
  - (DE# change) Section IV was relocated due to spacing needed for new fields in Section II; it is now located in cells I13:N19.
- Worksheet 6
  - In Section IIA, lines 2 and 3 have been removed. These lines summarized the maximum Part A premium for Part B-only plan beneficiaries.
  - Section IIB was relocated due to the removal of Section IIA, lines 2 and 3. Section IIB is now located in cells F12:L16.
  - (DE# change) In Section IIIA, line 1 and line 2 for "Allowed medical cost" and "Cost sharing" have been removed; the remaining lines were re-numbered 1 through 8.

  - A "Working Model Text Box" has been added in Section V. It contains multiple cells that may be used by bid preparers to enter internal notes. For example, it may be used to facilitate communication between BPT and PBP preparers or to track internal version schemes. This section will be deleted from the finalized file and therefore will not be uploaded to HPMS. Therefore, CMS will not have access to the information entered in this section. This section will not be deleted from the working BPT file and the backup file during finalization.
- Worksheet 7
  - Optional Supplemental benefit packages must now be entered in numerical order. The ID number is pre-populated by the BPT (packages 1 through 5); the user no longer enters the package ID number.
- The following technical changes were implemented:
  - Excel's "formula auditing" functions are now available; to use them, click the "Enable Protected Excel Functions" button. Clicking this button also accesses the "Change Links" function.
  - The BPT "save" logic was changed to be in a similar manner as that of other Excel files. That is, the BPT will now prompt users when they attempt to close a BPT that has been changed since the last save.
  - The BPT will be re-calculated during finalization.
  - The BPT technical instructions contain additional information regarding technical changes (including Excel 2007 information).
  - Two new MA BPT critical validations were implemented that will prevent finalization:
    - If member months are entered in Worksheet 5, then a corresponding county code and risk score must be entered. Similarly, if a risk score is entered, a corresponding county code must be entered.
    - In Worksheet 2, line s, "Total Medical Expenses," the allowed PMPM rate for the "Total" population (column o) must be within $0.50 of the weighted average of the non-DE# rate (column p) and the DE# rate (column q).
  - The following formulas were revised slightly for technical reasons. The BPT computations should not be impacted:
    - Worksheet 1, cell P17 (total member month percentage for "Plans in Base")
    - Worksheet 1, cells O5:O7 ("Region Name")
    - Worksheet 3, cells K25:K64 ("In-Network PMPM" cost sharing after deductible and OOP max)
    - Worksheet 4, cell O106 ("Plan A/B Bid") rounded
    - Worksheet 5, cell M16 ("Statutory Component" of regional benchmark)
    - Worksheet 6, cell L16 ("Full/Partial/No reduction" to Part B premium)

MSA Bid Pricing Tool

- Worksheet 2
  - The "Experience Credibility Percentage" weighted average in cell L32 uses "Projected Experience Rate Allowed PMPM" values (column h) as weights; prior BPTs used "Total Allowed PMPM" (column o) values as weights.
  - In Section II, column h, the "Projected Experience Allowed PMPM" formulas no longer explicitly reference the "Utilization/1000 Additive Adjustment" component (Worksheet 1 column o). Users can still produce the same projected result in Worksheet 2 by modifying the additive adjustment factors entered on Worksheet 1, columns o and p.
  - In Section II, cell L33, the BPT calculates the credibility percentage using the CMS credibility guideline and the base period member months entered on Worksheet 1. This may be used by the bid preparer and reviewer to compare the CMS calculated credibility percentage and the credibility being used to price the bid.
- Worksheet 5
  - Optional Supplemental benefit packages must now be entered in numerical order. The ID number is pre-populated by the BPT (packages 1 through 5); the user no longer enters the package ID number.
- The following technical changes were implemented:
  - Excel's formula auditing functions are now available; to use them, click the "Enable Protected Excel Functions" button. Clicking this button also accesses the "Change Links" function.
  - The BPT "save" logic was changed to be in a similar manner to that of other Excel files. That is, the BPT will now prompt users when they attempt to close a file that has been changed since the last save.
  - The BPT will be re-calculated during finalization.
  - The BPT technical instructions contain additional information regarding technical changes (including Excel 2007 information).
  - One new MSA BPT critical validation was implemented that will prevent finalization:
    - If member months are entered in Worksheet 3, then a corresponding county code and risk score must be entered. Similarly, if a risk score is entered, a corresponding county code must be entered.

BIDDING RESOURCES

In addition to these instructions, the following resources provide information on CY2010 bidding:

- The CY2010 Call Letter may be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/
- The CY2010 Advance Notice may be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2010.pdf

- The CY2010 Payment Notice may be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf
- The CY2010 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at http://www.cms.hhs.gov/apps/events/event.asp?id=550 and http://www.cms.hhs.gov/apps/events/event.asp?id=552.
- For questions about the bid form, 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 CY2010 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. The call-in information is as follows:
    - Every Thursday from April 16 through May 28, 2009
    - 11:00am – 12:30pm ET
    - Dial-In Number: 1-800-857-3437
    - Passcode: Rebate
    - Call Leader: Paul Spitalnic
- For technical questions about the BPT, HPMS, or the upload process, refer to the following resources:
    - The Technical Instructions are located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2010 > Documentation > BPT Technical Instructions
    - The *Bid Submission User's Manual*, also available in HPMS
    - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

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

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the bid level if the plan existed in CY2008, 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

Bad Debt

For Private Fee-for-Service (PFFS) plans that match Medicare fee-for-service (FFS) payment rates, bad debt for uncollected enrollee cost sharing for inpatient hospital and skilled nursing facility are to be included in medical costs. Other plans types are prohibited from directly paying for member cost sharing, but may adjust fee schedules to account for any projected uncollected cost sharing.

Base Period Experience

CMS generally expects experience data to be based on claims incurred in calendar year 2008 with at least 30 days of paid run-out; 2 - 3 months of paid claim run-out is preferable.

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

- Be submitted in Worksheet 1 at the bid level for all plans with experience data in 2008, regardless of the level of enrollment.
- Be provided for plans acquired by the Plan sponsor.
- Reconcile in an auditable manner to financial data.
- Be reported without adjustment in Section III. Adjustments may be made in Section IV to accommodate population, benefit design, or other changes between the base period and the projection period.
- Not be used to aggregate data from a number of plans in order to achieve credibility. Credibility is addressed on Worksheet 2.
- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).

- Include any provider incentive payments.
- Include total services (in-network and out-of-network, Medicare-covered, and mandatory supplemental).
- Be reported on an allowable basis before any reduction for reinsurance recoveries or cost sharing.
- Reflect the full level of plan cost sharing in the plan benefit PBP for all enrollees, including the DE# beneficiaries. See the pricing consideration for dual-eligible beneficiaries for more information about DE# beneficiaries.
- Include capitation amounts allocated to the appropriate service category line on a reasonable basis. See the pricing consideration for capitated arrangements for medical services.
- Exclude claim experience for hospice enrollees for the time period that an enrollee is in hospice status. See the pricing consideration for hospice enrollees,
- Exclude End-Stage Renal Disease (ESRD) claim experience for the time period that an enrollee is in ESRD status based on CMS eligibility records.
- Exclude claims experience for optional supplemental benefits. Such experience must be uploaded as supporting documentation with the initial June bid submission.

Plan Terminations and Enrollment Shifts

Base period experience may be reported in Worksheet 1 aggregated for a number of plans (or segments) only when a plan is dissolved, (that is, terminated) and the retained members are mapped (or "cross-walked") into ongoing plans. The terminating plan's base period experience—

- Must be reported in whole at the bid level for every contract-plan ID-segment 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 the mapping of enrollment.

Each contract-plan ID-segment ID must be identified in Worksheet 1, Section II, line 5.

Capitated Arrangements for Medical Services

Base Period Data

If medical services are provided under a capitated arrangement, then the utilization rates entered on Worksheet 1 must be based on claims or encounter data for the plan whether or not a related party is involved.

The requirements for the "Allowed PMPM" entered on Worksheet 1 depend on whether or not a related party is involved.

- If a non-related party provides medical services under a capitated arrangement, the allowed cost is the capitation amount plus any related cost sharing.
- If a related party provides medical services under a capitated agreement, an adjustment to the allowed cost (and cost sharing) may be needed.

- Similar to the requirements for related-party administrative agreements in the non-benefit pricing consideration, if the capitation paid to a related party exceeds the average cost that the related party would charge a non-related party for such services, only the average cost is included in the allowed cost. (The excess is considered gain/loss margin.)
- In determining such average cost, if the related party does not have an agreement with a non-related party on which to base the average cost, FFS data may be used to estimate this amount.

Projected Allowed Costs

Similar to the requirements for related-party administrative agreements in the non-benefit pricing consideration, the "Blended Rate, Total Allowed PMPM" in Worksheet 2 must reflect only the average cost that the related party would charge a non-related party for such services. The excess (that is, the difference between the capitation and the average cost) is considered gain/loss margin.

COB/Subrogation

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

Cost Sharing

The cost-sharing information entered in the BPT must tie to data in the PBP and, as such, must contain enough descriptive information to be easily cross-checked by CMS. Note that, although there are not individual entries for each cost-sharing item listed in the PBP, the value of all cost-sharing items must be reflected in the total PMPM amount in Worksheet 3. Further, the description entered in each line of Worksheet 3 must identify all plan cost sharing associated with the PMPM amount on that line.

The cost sharing descriptions in Worksheet 3 are to be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits priced in the BPT are consistent with the benefits in the PBP, as part of the quality control process for bid submissions. CMS recommends that the actuary include the PBP service categories (description of the cost-sharing amounts and the corresponding PBP line numbers) that are priced in each row of Worksheet 3. However, any PBP line numbers must be shown in addition to, and not in lieu of, a description of the cost-sharing amounts.

For plan cost sharing designed to match Medicare FFS cost sharing (an approach used by some employer-only or union-only group waiver Plan sponsors), users must enter "Medicare FFS cost sharing" (or similar wording) in the cost-sharing description for each applicable category. This is needed because the final cost-sharing dollar amounts will not be known when the bid is initially submitted. Note that this approach applies for the BPT but not the PBP. The actuary may use the actuarial equivalent cost-sharing factors shown in Worksheet 4 to estimate the PMPM amount for these benefits. In this case, the user may enter the entire value of cost sharing in columns i and j.

We expect that the cost sharing for travel benefits (obtained outside the plan's service area) will be entered as out-of-network (OON) cost sharing in Worksheet 3 (columns m and n). Further, if the plan applies different cost sharing for travel benefits than for "local" benefits (obtained within the service area), then this must be specified in the OON cost-sharing description in column m. However, if the travel benefit is provided in-network — that is, within the network established by the MAO or its affiliate for other health plans in other service areas —, then the plan sponsor may enter the cost sharing for the travel benefit as in-network (Worksheet 3, columns e through j). If the plan applies different cost sharing for travel benefits than for "local" benefits (obtained within the service area), then this must be specified in the in-network cost-sharing description in column h.

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

Credibility

Based on an application of classical credibility theory to Medicare FFS experience, CMS has established a guideline for full credibility for MA plans of 24,000 base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. This formula is a guideline; actuaries must consider the quality of the base period experience when calculating credibility. Plan sponsors may use a different credibility methodology only if the alternate method is consistently applied and is deemed acceptable by CMS.

The credibility assumption for projected allowed costs may vary—

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

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

When considering the credibility of plan experience, actuaries must consider ASOP No. 8, *Regulatory Filings for Health Plan Entities*, paying particular attention to the section "Use of Past Experience to Project Future Results" (3.2.4) and ASOP No. 23, *Data Quality*, particularly the section titled "Selection of Data" (3.2).

Disease Management

Disease management (DM) expenses are to be treated as medical expenses, non-benefit expenses, or both. DM services provided in a clinical setting by approved providers are to be treated as medical expenses. The cost of durable medical equipment (DME) associated with DM activities is typically classified as supplemental medical expenses. Absent other CMS guidance, other DM and care coordination efforts—such as costs incurred during recruitment,

enrollment, and general program communications—are to be classified as non-benefit, or administrative, expenses. In all cases, the classification of DM expenses in the bid must be explained in the supporting documentation for projected allowed costs and non-benefit expenses.

Dual-Eligible Beneficiaries

Dual-eligible (DE) beneficiaries are individuals who are eligible for both Medicare and Medicaid benefits under Titles XVIII and XIX of the Social Security Act, respectively. There are several categories of DE beneficiaries, such as Qualified Medicare Beneficiaries (QMBs), with different benefits based on income and other qualifying circumstances. Some DE beneficiaries receive benefits in the form of reduced or eliminated Medicare cost sharing. For descriptions of the dual eligible beneficiary categories, and the type of Medicaid benefits they are entitled to, see http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp.

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

Definition of DE#

In the BPT and these instructions, the term "DE#" (*d-e-pound*) refers to dual-eligible beneficiaries without full Medicare cost-sharing liability. Per federal statute, QMBs and QMB+ are not liable for Medicare cost sharing; therefore, these beneficiaries are always considered to be DE# beneficiaries. The certifying actuary must determine which additional beneficiaries are DE# based on Medicaid cost-sharing policy for the states or territories in the plan's service area.

All other beneficiaries are referred to as the non-DE# population. This population includes dual-eligible beneficiaries with full Medicare cost-sharing liability and beneficiaries who are not eligible for Medicaid (non-duals).

Bidding

The BPT must reflect data and costs for the DE# and non-DE# populations separately as explained below.

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

  Users must enter base period member months and risk scores separately for the total and non-DE# populations. The BPT calculates base period member months and risk scores for the DE# population based on the user-entered values for the total and non-DE# populations. All other data on Worksheet 1 is to be entered for the total population.

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

  The BPT calculates blended allowed costs for the total population (column o) based on the projected experience rate and manual rate. Separate projected allowed costs must be shown for non-DE#s and DE#s (columns p and q) as follows:

- The user must enter projected allowed costs for the non-DE# beneficiaries in column p.
- If DE# projected member months are less than 10 percent, or greater than 90 percent of the total projected member months (excluding ESRD), then the user may enter projected allowed costs for non-DE# beneficiaries (column p) equal to the projected allowed costs for the total population (column o), at the discretion of the certifying actuary. (The BPT will automatically calculate the projected allowed costs for DE# beneficiaries to be equal to the values for the total and the non-DE# populations, if the actuary has not overwritten the default formulas in column q.)
- If the projected member months for the DE# population are equal to zero, then the user must enter projected allowed costs for the non-DE# beneficiaries (column p) equal to the projected allowed costs for the total population (column o).
- The BPT automatically calculates blended allowed costs for DE#s (column q) using total and non-DE# allowed costs (columns o and p), and the projected enrollment (entered in Worksheet 5).
- The certifying actuary may overwrite the BPT-calculated values by directly entering allowed costs for DE#s.

Worksheet 2 column p must be completed "per non-DE# member per month" and column q must be completed on a "per DE# member per month" basis".

✓ **Worksheet 3 – Cost Sharing**

The cost sharing in Worksheet 3 must be based on the benefits outlined in the PBP.

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

- If (i) DE# projected member months are less than 10 percent, or greater than 90 percent of total projected member months (excluding ESRD), and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, may apply to either the total population or to the non-DE# population, at the discretion of the certifying actuary.
- In all other cases, the in-network utilization and PMPM value of cost sharing apply to the non-DE# population.

✓ **Worksheet 4 – Projected Required Revenue**

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

- In subsection A (non-DE#s), net medical expenses for Medicare-covered benefits (column o) are calculated based on Fee-for-Service (FFS) actuarially equivalent cost sharing proportions (column k) as in prior years.

- In subsection B (DE#s), comparable medical expenses are calculated for DE# beneficiaries based on state or territory Medicaid cost sharing (column k).
- In subsection C (all beneficiaries), the BPT weights the non-DE# and DE# costs by their respective projected member months (from Worksheet 5) to calculate costs for all beneficiaries. Users enter total non-benefit expenses and gain/loss margin for all beneficiaries.

Considerations for developing data for DE# beneficiaries include the following:

- Plan cost sharing (subsection B, column f) reflects the cost sharing that would be paid if the beneficiary actually paid the plan cost sharing.
  - This amount is calculated automatically based on DE# allowed costs in Worksheet 2 and the ratio of non-DE# plan cost sharing and allowed costs in subsection A.
  - However, the default formulas may be overwritten at the discretion of the certifying actuary.
- All values must be calculated on a "per DE# member per month" basis.
- In column k, users enter cost-sharing amounts required by state or territory Medicaid programs.
  - The state or territory Medicaid level of beneficiary cost sharing (column k) is an input item. The user must –
    - Calculate this cost sharing based on the state or territory eligibility rules for subsidized cost sharing for DE# beneficiaries in the plan's service area.
    - Calculate this cost sharing on a "per DE# member per month" basis as a weighted average of the PMPM cost sharing for all DE# members.
    - Enter data in all cases. The cells may not be left blank.

When the Plan sponsor has a separate contract with a state or territory for Medicaid services, the user must enter (on a per-DE#-member-per-month basis) projected Medicaid revenue and Medicaid benefits not otherwise reflected in the bid in Section V.

✓ **Worksheet 5 – Benchmark**

The user must enter county-specific projected member months and projected risk factors for the total population in Section V (column e).

In Section II, the BPT automatically calculates total member months and average risk factor for the total population based on the county-level information. Projected member months and projected risk factor for the non-DE# and the DE# populations are determined as follows:

- The user must enter values for the non-DE# population.
- Values for the DE# population are calculated automatically from the values for the total and the non-DE# populations.

- If the projected member months for the DE# population are equal to zero, then the user must enter projected member months and projected risk factor for the non-DE# equal to the values for the total population.

Employer-only or Union-only Group Waiver Plans (EGWPs)

Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year and the expected underwriting assumptions for all groups, in aggregate. In addition, projected enrollment within the plan's service area must be consistent with the location of employer groups. See Appendix D, MA Products Available to Groups, for more information.

End-Stage Renal Disease (ESRD)

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status based on CMS eligibility records, with the exception of Worksheet 4 Section III, as described below.

ESRD Subsidy

The benchmarks calculated in the MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan, including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In an effort to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, Worksheet 4 allows for an adjustment to A/B mandatory supplemental benefits. This adjustment is split into two sections: basic benefits and supplemental benefits, as explained in the instructions for Section III of Worksheet 4.

All Plan sponsors must enter the projected CY ESRD member months in the ESRD Subsidy section of Worksheet 4. Do not leave this field blank.

Gain/Loss Margin

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

When Medicare benefits are funded by an outside source (such as a state Medicaid program or an employer group), the gain/loss margin must be consistent for the Medicare Advantage bid and the other funding source (s).

General Enrollment Plans and Institutional/Chronic Care SNPs:

Overall Medicare margin levels for general enrollment and institutional/chronic care SNP plans are to be consistent with the Plan sponsor's corporate requirement. Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level.

The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range, not to exceed plus or minus 1.5 percent of other lines of

business. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE), the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business must take into account the degree of risk or surplus requirements of the business.

The overall margin level expectations are to be consistent on a year-by-year basis. Actual organization returns are expected to vary year to year, in practice, but to achieve the organization's requirement over a longer term period (for example, 3 to 5 years).

The overall margin levels included in the MA and Part D (PD) components of MA-PD bids must be within a reasonable range of each other, not to exceed plus or minus 1.5 percent, with any variation reflecting the different levels of financial risk for the two components. The individual Part D margin of an MA-PD bid can either be the same for all plans or may vary by plan in relation to the MA margin.

There is flexibility in setting gain/loss margin at the plan level, including the allowance for negative margin, provided that the overall margin meets CMS requirements, anti-competitive practices are not used, and the plan offers benefit value in relation to the margin level. For plans with negative margins, the Plan sponsor must develop and follow a business plan to achieve profitability. Exceptions to the business plan requirement are cases in which MA products are paired in a given service area and the pricing reflects implicit "subsidies" across benefit or service area offerings— for example, a low benefit plan with a positive margin is paired with a rich benefit plan with a negative margin such that the combined gain/loss margin is positive and satisfies the guidance in this subsection. Similarly, there may be significant variation in the gain/loss margin for an MA-only and an MA-PD plan with the same MA benefits as long as the combined margin for these plans is positive and satisfies the guidance in this subsection.

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

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

The foundation for the claim and administrative costs for EGWPs must be based on appropriate EGWP experience. The margin requirements for EGWPs depend upon whether or not corresponding general enrollment plans are offered.

- If corresponding general enrollment plans are offered, the assumptions used for general enrollment plans must be the basis for the margin requirements for EGWPs. The difference in the margin level between EGWP and general enrollment plans must not exceed 1 percent, calculated at the contract level.
- If corresponding general enrollment plans are not offered, then the margin guidance for general enrollment plans applies to the EGWP margin pricing.
    - Overall EGWP margin levels are to be consistent with the organization's margin requirement.

- Overall EGWP margin levels are to be within a reasonable range, not to exceed plus or minus 1.5 percent, of the margin for other similar lines of business.

Special Needs Plans Serving Dual-Eligibles (DE-SNPs):

The foundation for the claim and administrative costs for DE-SNPs must be based on appropriate experience. The margin assumptions used for DE-SNP plans depend upon whether or not corresponding general enrollment plans are offered.

- If corresponding general enrollment plans are offered, the assumptions used for general enrollment plans must be the basis for the margin requirements for DE-SNPs.
  - Organizations may choose to use the overall margin levels for general enrollment plans at a contract level or at a more aggregate level as the basis for the group plan margin assumptions, or they may rely on the margins used in comparable general enrollment plans.
  - There may be a small difference (that is, up to 1percent) in the margin level between DE-SNPs and general enrollment plans.
- If corresponding general enrollment plans are not offered, then the margin guidance for general enrollment plans applies to the DE-SNP margin pricing.
  - Overall DE-SNP margin levels are to be consistent with the organization's margin requirement.
  - Overall DE-SNP margin levels are to be within a reasonable range, not to exceed plus or minus 1.5 percent, of the margin for other similar lines of business.

Relationship of Margin Requirements and Non-Benefit Expenses:

The development of the margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

Hospice Enrollees

When a Medicare Advantage enrollee goes into hospice status, original Medicare assumes responsibility for Part A and Part B services, and the MA plan continues to cover supplemental benefits. Since the Plan sponsor is not liable for Medicare-covered benefits when the MA enrollee goes into hospice status, base period member months, base period risk scores, projected member months and projected risk scores must exclude enrollees in hospice status for the time period that they are in that status. The Monthly Membership Report (MMR) data includes hospice status.

However, since hospice enrollees continue to receive mandatory supplemental benefits from the MA plan, the projected allowed cost PMPM may reflect claim costs for hospice enrollees for mandatory supplemental benefits, at the discretion of the certifying actuary— for example, for a dental benefit or another additional benefit.

Inpatient Hospital Non-Covered Days

CMS developed a 1.2 percent factor based on FFS data that can be used as a "safe harbor" for determining the proportion of inpatient days that are non-covered. If the non-covered hospital pricing is based on an assumption other than the safe harbor, support for the data and methodology used in its development is required.

Manual Rating

Manual Rating with FFS Data

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

FFS Costs Used for the Actuarial Equivalent Cost Sharing Factors

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

Medicare Secondary Payer (MSP) Adjustment

CMS adjusts MA payments for the lower expected claim costs for enrollees who are working aged and working disabled. The BPT includes a Medicare Secondary Payer (MSP) adjustment factor in the conversion factor that is used to calculate the Plan A/B benchmark from the standardized A/B benchmark. Beginning for payment year 2010, CMS will adjust for MSP status at the beneficiary level. For more information, see the CY2010 Payment Notice found under the "Medicare Advantage Rates and Statistics" page of the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

Non-Benefit Expenses

Non-benefit expenses are all administrative costs of operating the Medicare Advantage plan, other than medical, DME/supplies, prescription drugs, and other benefits.

The worksheet distributes the non-benefit expenses proportionately between Medicare-covered and A/B mandatory supplemental (excluding the PMPM impact of the ESRD subsidy). Non-benefit expenses are also distributed within A/B mandatory supplemental benefits between "Additional Services" and "Reduction of A/B Cost Sharing."

The non-benefit expenses must be entered separately on the bid pricing tool for the following categories:

- Marketing & Sales (for example, the cost of marketing materials, commissions, enrollment packages, identification cards, the salaries of sales and marketing staff).
- Direct Administration (for example, functions that are directly related to the administration of the Medicare Advantage program). Examples of direct administration functions are as follows:
    - Customer service.
    - Billing and enrollment.
    - Medical management.
    - Claims administration.
    - Medicare user fees, which are estimated to be $0.33 PMPM on a national basis for CY2010.
    - Uncollected enrollee premium.
    - Disease management functions (such as patient education and disease monitoring).
- Indirect Administration (for example, functions that may be considered "corporate services," such as CEO, accounting operations, actuarial services, legal services, human resources, etc.).
- 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 (marketing and sales) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

Costs not pertaining to administrative activities, including goodwill amortization, income taxes, changes in statutory surplus, and investment expenses, must be excluded from non-benefit expenses. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid.

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

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

Non-benefit expenses that are common to offering an MA-PD plan must be allocated proportionately between the Medicare Advantage and Part D BPTs.

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

Related-Party Agreements

The level of disclosure of related-party agreements must demonstrate that the operating results and financial positions for organizations participating in such agreements are not significantly different from the operating and financial arrangements that would have been achieved in the absence of the relationships. This level of disclosure is comparable to the level required by GAAP.

The plan sponsor is required to demonstrate that the above is true, and that fees associated with these transactions are based on appropriately allocated, actual costs that are comparable with those experienced by unrelated organizations of similar size and market position.

To satisfy proprietary concerns, CMS can initiate separate contact with the sponsor and the subcontracted related party when addressing related-party issues in the bid. Plan sponsors interested in this level of discussion must request it and identify a point of contact at the related party at the time of bid submission.

These requirements for related-party agreements apply to a plan sponsor that enters into a service agreement involving a parent company and subsidiary, or between subsidiaries of a common parent.

A plan sponsor in a related-party agreement with an organization that supports only the MA organization must directly or indirectly, or through agreement with the subcontracted party do the following:

- Prepare the bid pricing tool in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the bid pricing tool, the bid sponsor must consider the gain/loss and non-benefit expense of the related- party to be those of the sponsor. The sponsor cannot allocate all administrative costs in the related party agreement to non-benefit expense.
- Develop the gain/loss and non-benefit expense of the related-party subcontractor in accord with the instructions for completing the bid pricing tool.
- Support the development of the gain/loss and the actual costs associated with the non-benefit expense as required by these instructions.
- Subcontracted related party agreements for all parties represented in the bid must be disclosed in accord with the instructions for completing the bid pricing tool.

Non-Covered Limited Benefits

For non-covered limited benefits with no cost sharing, the amounts over the limit must not be included as allowed costs in the bid form.

> **Example:** The PBP contains a hearing aid benefit with a $500 annual cost limit and no cost sharing. If the average cost of a hearing aid is $2,500, the allowed PMPM must be based on the $500 maximum benefit, not on a $2,500 cost offset by a cost-sharing entry in Worksheet 3 for the $2,000 paid by the beneficiary.

Part B Premium and Buydown

Section 1839 of the Social Security Act, as amended by Section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and Section 5111 of the 2005 Deficit Reduction Act, provides for an income-related reduction in the government subsidy of the Medicare Part B premium. Under this provision, for those beneficiaries meeting specified income thresholds, a monthly adjustment amount will be added to the standard Part B premium. We use the term "standard" to mean the premium amount excluding any income-based adjustments (as well as excluding other adjustments, such as late enrollment penalties).

Generally, effective 2007, the standard Part B premium amount becomes the lowest Part B premium a beneficiary would pay, with higher-income beneficiaries paying greater premiums. (The only beneficiaries who pay less than the standard Part B premium are those whose premium increase is limited by the increase in their Social Security check (the "hold harmless" provision) and those for whom the state or another third party pays for the Part B premium).

The addition of monthly adjustment amounts to the Part B premium obligation of higher-income beneficiaries will be phased in over 3 years, beginning in 2007. Given the MA requirement that benefits must be uniform within an MA plan, the effect of this provision on MA plans is that the lowest Part B premium a plan can offer is the estimated standard amount net of rebates. MA enrollees are required to pay the standard Part B premium, but it may be reduced by the MA organization through the use of rebate dollars.

The amount pre-populated in the BPT is the CMS estimated value of the standard Part B premium for the contract year at the time that the bid form is released.

CMS will consider allowing plans the ability to fully reduce the standard 2009 Part B premium. The bid pricing tool and instructions are released annually in April, but the standard Part B premium is not released by CMS for the upcoming contract year until several months later. Therefore, plans must use the CMS pre-populated premium estimate in the bid form to determine the level of rebates to allocate.

For plans that (i) have allocated Part B rebates equal to the estimated CY standard Part B premium pre-populated at the time that the bid form is released, and (ii) intend to fully reduce the standard CY Part B premium, (that is, plans that have allocated rebates equal to the CMS, pre-populated estimate and have entered "Yes" in line 3 of Worksheet 6, Section II.B.), CMS will release further guidance directly to the Plan sponsors on how to meet their intention, once the final Part B premium is announced by CMS, if it is determined by CMS that the full reduction is feasible for CY2010.

Plan Premiums, Rebate Reallocation, and Rounding

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

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

When the bid is initially submitted in June, the Part D basic premium entered in the MA BPT is an estimated value. The actual premium will be calculated by CMS following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional PPO benchmarks (typically in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2010.

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

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

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

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

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

Plan Intention for Target Part D Basic Premium

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

The target Part D basic premium is the Part D basic premium net of any MA rebate dollars that were applied to reduce (buy down) the premium, and does not include the Part D supplemental premium or the MA premium. Similarly, the low-income premium subsidy amount applies to the Part D basic premium and does not cover the cost of Part D supplemental benefits. The Part D bid instructions may contain further information regarding the target Part D premium options.

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

Point-of-Service (POS)

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

Preventive Services Incentives

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

When an incentive program incurs a cost, then this cost must be priced in the bid. The projected PMPM cost of incentives must be combined with the cost of other non-covered benefits and entered in line q of the MA BPT. Note that combining the costs with "Other Non-Covered" does not change the nature of incentives, which cannot be "benefits" as explained in the CY2010 Call Letter. Supporting documentation is required with the initial June bid submission.

Regional Preferred Provider Organizations (RPPO)

Intra-Service Area Rate (ISAR) Factors

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

Rebate Allocations

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

- The fifth column of Worksheet 6, Section IIIB shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum. Note that if the maximum value is negative (such as a negative Part D basic premium before rebates), then the rebate allocation must be blank or zero.
- The total rebates allocated must equal the total rebates available. Plans are not permitted to under- or over-allocate rebates in total. This rule applies to all bids, including 800-series EGWP bids.
- No rebate allocations may be negative.
- Rebate allocations for "Reduce A/B Cost Sharing" and "Other A/B Mandatory Supplemental Benefits" must be rounded to two decimals.
- The rebate allocations for standard Part B premium, Part D basic premium, and Part D supplemental premium are rounded by the BPT to one decimal (that is, the nearest dime) due to withhold system requirements.
- Employer-only group bids (that is, "800-series" plans) cannot allocate rebates to Part D.
- MA-only bids cannot allocate rebates to Part D.
- Rebates allocated to buy down the estimated standard Part B premium are subject to the maximum amount shown on Worksheet 6. This maximum is the estimated CY2010 standard Part B premium at the time when the bid form is released by CMS. See the "Part B Premium and Buydown" pricing consideration for and the instructions for Worksheet 6, Section II, for further information about rebates applied to the standard Part B premium.

Risk Score Development for CY2010

The projected CY2010 risk score must:

- Be based on the CMS HCC risk model used in payment years 2009 and 2010.
- Reflect appropriate projection factors, including, but not limited to, the plan's aggregate coding trend.
- Include a frailty factor, if applicable.
- Be adjusted for FFS normalization.
- Include the appropriate MA coding pattern differences adjustment factor.
- Be consistent with the development of projected medical expenses.

Risk Score Definitions and Information Sources

HCC-Risk Model

The CMS-HCC risk model was calibrated in 2007 to use for MA payments in CY2009 and CY2010. Additional information on the CMS-HCC Model, including the 2010 normalization factor, is contained in the 2010 MA payment notice.

Normalization

At time of payment, the risk scores for each plan enrollee will be divided by a factor, known as the FFS normalization factor for 2010. This adjustment accounts for the expectation of higher intensity in the aggregate risk scores for the contract year versus

the model denominator year (2007). Accordingly, the projected risk scores in the CY2010 bids must reflect the normalization factor of 1.041.

MA Coding Pattern Differences Adjustment Factor

In addition to normalization, the projected risk scores in the CY2010 bids must reflect the MA coding pattern differences adjustment factor, which is 3.41%. To apply this adjustment, multiply the projected CY2010 normalized risk scores by .9659.

Risk Adjustment Information Sources

The following materials can be found under the "Medicare Advantage Rates and Statistics" page of the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/:

- The 2009 MA ratebook announcement.
- The 2010 MA advance payment notice
- The 2010 MA ratebook announcement.

See the links under "Risk Adjustment", "Announcements & Documents", and "Ratebooks & Supporting Data".

Additional information on the risk adjustment process can be found under http://www.csscoperations.com/new/usergroup/traininginfo.html

Risk Score Calculation Approaches

Preferred Experienced-Based Approach

The preferred method for projecting the 2010 risk scores for plans with credible risk score data is use of the CMS-HCC risk scores for the 2008 enrollee cohort. Plan-specific risk score data that may be used as the basis for projecting CY2010 risk scores are available in HPMS under the "Risk Adjustment" link from the HPMS Home page. (Note: You must have HPMS user access to view this information. The HPMS weblink is either https://32.90.191.19/hpms/secure/home.asp or https://gateway.cms.hhs.gov, depending on your firm's connection method.) The risk score data posted in HPMS are accompanied by technical notes to assist actuaries with understanding the material presented.

There are several advantages to using the 2008 cohort HCC risk scores in the projection of the CY2010 risk score:

- They are consistent with the base-period medical expenses.
- They are based on a mid-year cohort and require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2007 dates of service submitted through January 31, 2009, which is the final reporting deadline for this period.
- They are based on the latest risk model.
- The risk score data posted on HPMS are disaggregated by Medicaid status.

The projection of scores from 2008 to 2010 must reflect relevant projection factors, which include, but are not limited to, the plan's aggregate coding trend, and changes in plan population. Please note that the HPMS reported scores are based on a mid-year cohort with nearly complete run-out of data and require no explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. Finally, the projected risk scores must be normalized by dividing by the 2010 FFS normalization factor and by adjusting for MA coding pattern differences.

Preferred Alternate Experienced-Based Approach

For plans with credible risk score data, the preferred alternate approach to forecasting the CY2010 MA risk scores is to use the CMS-HCC model to generate scores for the expected plan enrollment. Plans must follow the requirements for appropriate diagnostic data sources for the CMS-HCC risk adjustment model, which can be found at http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf.

The starting risk score is to be trended to CY2010 with explicit adjustment for the following factors, as appropriate:

- The plan's aggregate coding trend;
- Impact of lagged versus non-lagged diagnosis data;
- Run-out of diagnosis data;
- Seasonality;
- Population changes; and
- Other appropriate factors.

Once projected to CY2010, the projected scores must be normalized by dividing by the 2010 FFS normalization factor and by adjusting for the MA coding pattern differences adjustment factor. Note that, if you are normalizing a nominal or actual risk score associated with a different model calibration year, the contract year 2010 FFS normalization factor is not the appropriate normalization factor.

Manual Rating Approach

Plans without appropriate base period experience or without credible risk score data must estimate risk scores based on the expected medical expenses for their projected enrollees. Further, the risk scores for new plans must be developed in a manner consistent with the CMS-HCC model.

Other Approaches

If the method used to develop projected risk scores is not one of the approaches described above, then supporting documentation that clearly demonstrates consistency with these approaches is required.

Service Categories

Following are the three types of service categories:

- Services that can only be Medicare-covered.

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

See Appendix F for a suggested mapping of BPT and PBP service categories. For more information on benefits and service categories, see the Medicare Managed Care Manual, Chapter 4 – "Benefits and Beneficiary Protections" at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326

Skilled Nursing Facility

MA regulation 42 CFR 422.101(c) states that "MA organizations may elect to furnish, as part of their Medicare covered benefits, coverage of post hospital SNF care…in the absence of prior qualifying hospital stay that would otherwise be required for coverage of this care." When the PBP reflects the waiver of prior hospitalization requirement as a mandatory supplemental benefit, you do not need to reflect the cost of this "additional benefit" as a supplemental benefit in the bid pricing tool. It may be priced as a Medicare-covered benefit instead. Further, certifying actuaries do not need to qualify their actuarial opinions to reflect this PBP-to-BPT difference.

Supporting Documentation

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

III. DATA ENTRY AND FORMULAS

This section contains line-by-line instructions for completing the MA BPT, the MSA BPT, and the MA Two-Year Look-Back form. It also describes the formulas for calculated cells.

MEDICARE ADVANTAGE

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

The MA bid form is organized as outlined below:

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

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

In addition, each organization must complete the Two-Year Look-Back form, unless it did not have any Medicare experience in 2008 (that is, if the organization did not file any CY2008 MA BPTs or did not have any enrollment in July 2008 for the contract).

MEDICAL SAVINGS ACCOUNT

Appendix G provides additional guidance in completing the MSA Bid Pricing Tool for Medical Savings Account (MSA) and Medical Savings Account Demonstration (MSA Demo) plans. Appendix G highlights only the differences between the MSA BPT and the MA BPT.

DATA ENTRY

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

MA WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

The purpose of Worksheet 1 is to capture bid-specific experience for the base period, regardless of the level of enrollment and credibility, and to summarize the key assumptions used to project allowed costs to the contract period. Section I contains general plan information that will be displayed on all MA BPT worksheets. Section II captures base period background information. Section III summarizes the base period data for the plan. Section IV captures the factors used to project the base period data to the contract period. Section V contains a text field used to describe other utilization factors and/or additive factors used in Section IV.

Section I must be fully completed for all bids (note that some fields may be pre-populated by the Plan Benefit Package (PBP) software). Sections II through V must be completed for all plans with experience data for 2008 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, certain numeric fields, such as Plan ID, Segment ID and Region Number, must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros.

Line 1 – Contract Number

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

Line 2 – Plan ID

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

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

Line 3 – Segment ID

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

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – Plan Name

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

Line 7 – Plan Type

Enter the type of MA plan. The valid options are listed in the table below. The MA bid form is not completed for MSA, Cost, and PACE plans. There is a separate MSA Bid Pricing Tool.

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

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 HMOPOS
HMO with a (POS) Option	HMOPOS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
Regional Coordinated Care Plans:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Employer/Union Direct Contract Private Fee-for-Service Plan:	
Employer/Union Direct Contract Private Fee-for-Service	ED PFFS
Demonstration Plan:	
Continuing Care Retirement Community (CCRC)	CCRC

Line 8 – MA-PD Indicator

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

Line 9 – Enrollee Type

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

Line 10 – MA Region

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

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

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

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

Line 11 – Actuarial Swap or Equivalences

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

Line 12 – SNP Indicator

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

Line 13 – Region Name

No user input is required. This field contains the region name, based on the region number previously entered in this section.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

CMS generally expects experience data to be based on claims incurred in calendar year 2008 with at least 30 days of paid run-out; 2 - 3 months of paid claim run-out is preferable. See the "Pricing Considerations" section of these instructions for more information.

Enter the incurral 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 payment information through February 2009, then the "paid through" date is 2/28/2009.

Line 2 – Member Months (excluding ESRD)

Enter the total member months represented in the base period experience, excluding ESRD enrollees for the time period that enrollees are in ESRD status based on CMS eligibility records.

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

Line 3 – Non-ESRD Risk Score

Enter the risk score for the population represented in the base period data using the CMS-HCC risk model risk score for non-ESRD members. The risk score must be normalized for CY2008 and must reflect both a mid-year cohort (or be adjusted for seasonality) and non-lagged diagnosis data with full run-out.

Then enter the risk score for the non-DE# subset. The DE# subset will be calculated based on the total and non-DE# amounts entered.

Line 4 – Completion Factor

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

For example, assume the following:

Incurred Date	1/1/2008 – 12/31/2008
Paid Through Date	2/28/2009
Capitation Payments	$100
PTD Claims Requiring Completion	$400
Estimate of Unpaid 2008 Claims as of 2/28/2009	$30
Total Incurred Claims for 2008	$530

The Completion Factor would be calculated as:
Completion Factor = (400 + 30) ÷ 400 = 1.075

Line 5 – Plan/Segments Included in Base Period Data

Enter the contract number and plan ID (in the format H9999-999) of the plan for the base period data. If the segment is "01" or greater, include the segment ID (H9999-999-01). CMS expects that the contract number, plan ID, and segment ID, if applicable, for the base period data will be the same as that shown in Section I, except for plan ID changes and plan mergers. In the second column, input each plan's percentage of total member months reported in line 2.

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

5. Plans in Base	Contract-Plan ID	% of Member Months
	a. H9999-032	90%
	b. H8888-004-02	10%
	c.	
	d.	

If, for some reason, more than four plans comprise the base period data, then the plan sponsor must submit supporting documentation that provides the percentage of base period member months for each plan included in the data. In this situation, Plan sponsors may enter "All Other" for the contract number/plan ID indicated in Line 5d.

Line 6 – Base Period Description

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

SECTION III – BASE PERIOD DATA (AT PLAN'S NON-ESRD RISK FACTOR)

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

In lines a through r:

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

The benefit service categories are displayed in column c. See Appendix F for a suggested mapping of BPT and PBP service categories. For more information on benefits and service categories, see the *Medicare Managed Care Manual*, Chapter 4 – "Benefits and Beneficiary Protections," at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326

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

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

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

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

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

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

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

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

  See Appendix B for information regarding supporting documentation for the allocation of allowed PMPM by service category.

Line s – Total Medical Expenses

Calculated automatically as the sum of lines a through r.

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS

Section IV contains the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The factors in columns j through n are the total adjustment factor from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2008 and that the contract year is 2010. If the utilization trend is 5 percent from 2008 to 2009 and 6 percent for projecting 2009 to 2010, then enter "1.113" in column j (1.05 x 1.06).

In lines a through r:

- ✓ **Column j – Util/1000 Trend**

  Enter the total utilization trend factor from the base period to the contract period by service category. Entering 1.000 would indicate 0% trend. Do not leave blank. Do not enter zero (0).

- ✓ **Column k – Benefit Plan Change**

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

- ✓ **Column l – Population Change**

  Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the contract period. The population change adjustment entered in column l of Section IV must be consistent with the development of the CY2010 risk score. Entering 1.000 would indicate 0% change. Do not leave blank. Do not enter zero (0).

✓ **Column m – Other Factor**

Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. An example of the use of this factor is to adjust the base period service area to the contract year service area. Entering 1.000 would indicate 0 % adjustment. Do not leave blank. Do not enter zero (0).

✓ **Column n – Unit Cost/Intensity Trend**

Enter the unit cost/intensity trend by service category. This factor must reflect the anticipated unit cost/intensity trend from the base period to the contract period. Entering 1.000 would indicate 0 % trend. Do not leave blank. Do not enter zero (0).

✓ **Columns o and p – Additive Adjustments**

Use these columns to reflect adjustments that are additive; adjustments in columns j through n are multiplicative factors. For example, a benefit that is no longer being offered, but is included in the base period data, might need to be deleted/removed. In this case, enter the adjustment as a negative number in column p. For benefits that need to be added, if they are not included in the base period experience data but will be offered in the contract period, utilize the manual rates section of Worksheet 2.

Describe the reason for any additive adjustments in Section V.

SECTION V – DESCRIPTION OF OTHER UTILIZATION FACTOR AND ADDITIVE VALUES

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

MA WORKSHEET 2 – MA PROJECTED ALLOWED COSTS PMPM

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

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTED ALLOWED COSTS

Lines 1 and 2.

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

In lines a through r:

✓ **Column e – Utilization Type**

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

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

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

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

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

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

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

✓ **Column i – Utilization**

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

✓ **Column j – Average Cost**

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

✓ **Column k – Allowed PMPM**

Enter PMPM amounts in column k.

✓ **Line r – COB/Subrogation**

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

✓ **Column l – Experience Credibility Percentage**

Enter the experience credibility percentage by service category in column l. This percentage must be between 0% and 99% if the plan is using a manual rate in the projection.

Between lines s and t of column l, the BPT displays the credibility percentage that is calculated based on CMS guidance and the base period member months entered on Worksheet 1.

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

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

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

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

Note that column q contains formulas that may be overwritten by the user.

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

- For each service category, the PMPM value for the total population must be within $0.05 (5 cents) of the weighted average of the non-DE# and DE# PMPMs.
- The BPT will finalize only if the total PMPM for all enrollees is within $0.50 (50 cents) of the weighted average of the non-DE# and DE# PMPMs.

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

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

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

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

Line s – Total Medical Expenses

Calculated automatically as the sum of lines a through r.

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k.

Line u – Manual Rate Description

Use the text box to describe the general approach to manual rating, including a description of the source of the manual rate. This description is in addition to the required supporting documentation (see Appendix B).

MA WORKSHEET 3 – MA PROJECTED COST SHARING PMPM

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

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

SECTION I - GENERAL INFORMATION

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

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

For network plans, the response to the plan-level OOP maximum drop-down questions must be "No" if the corresponding in-network, out-of-network, or combined Plan Level Maximum Enrollee Out-of-Pocket Cost is blank in Section D of the PBP. However, if an in-network, out-of-network, or combined Plan Level Maximum Enrollee Out-of-Pocket Cost is entered in Section D of the PBP, the corresponding response on the BPT must be "Yes," and the amount entered on the PBP must be entered in the corresponding amount field on the BPT.

For non-network plans, if a Maximum Enrollee Out-of-Pocket Cost is entered in Section D of the PBP, the combined plan-level OOP maximum response on the BPT must be "Yes" and the amount entered on the PBP must be entered in the amount field on the BPT. Further, the in-network and out-of-network plan-level OOP maximum responses should be "No".

When the response to the OOP maximum drop-down question is "Yes", the entry in the OOP maximum amount field must be numeric and greater than 0.

Any service-level category OOP maximums must be described in column h and must not be considered plan level in Section II of the BPT.

Line 1 – In-Network

In the first field, select "Yes" or "No" to the question "Is there a plan-level in-network OOP maximum?" If the answer is "Yes", then enter in the second field, the maximum total dollar amount that a member could pay for in-network cost sharing for the contract year.

Line 2 – Out-of-Network

In the first field, select "Yes" or "No" to the question "Is there a plan-level out-of-network OOP maximum?" If the answer is "Yes", then enter in the second field, the maximum total dollar amount that a member could pay for out-of-network cost sharing for the contract year.

Line 3 – Combined

In the first field, select "Yes" or "No" to the question "Is there a plan-level combined OOP maximum?" If the answer is "Yes", then enter in the second field, the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network. The answer is "Yes" only if the plan has a combined in-network and out-of-network OOP maximum. Do not sum separate in-network and out-of-network OOP maximums.

Line 4 – Maximum Cost-Sharing Description

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

SECTION III – DEVELOPMENT OF CONTRACT YEAR COST SHARING PMPM (PLAN'S NON-ESRD RISK FACTOR)

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

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

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

Option A:

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

Option B:

Column d	Column g	Column j	Column k
Line a1 – Acute	2,000	$100.00	$16.67
Total	2,000	$100.00	$16.67

Example 2: The PBP has in-network professional copays of $10 for PCP, $20 for specialists excluding mental health (MH) services, $20 copay for MH group sessions, and $40 copay for individual MH sessions. There is no in-network maximum cost sharing. Assume that in-network office visit utilization is distributed as follows:

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

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

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

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

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

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

Line - Description	Col g	Col h	Col j	Col k
Line i1 – PCP	5,000	$10 per visit	$ 10.00	$ 4.17
Line i2 – Specialist excluding Mental Health	2,900	$20 per visit	$ 20.00	$ 4.83
Line i3 – Mental Health	100	$20/visit for group MH sessions, $40/visit for individual MH	$ 30.00	$ .25
Total	8,000		$ 13.88	$ 9.25

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

Line - Description	Col g	Col h	Col j	Col k
Line i6	8,000	$10/visit PCP $20/visit non-MH specialist $20/visit for group MH $40/visit for individual MH	$ 13.88	$ 9.25
Total	8,000		$ 13.88	$ 9.25

Column c – Service Category

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

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

- Transportation (Non-covered)
- Dental (Non-covered)
- Vision (Non-covered)
- Hearing (Non-covered)
- Health & Education (Non-covered)
- Other Non-covered

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

Column d – Service Category Description

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

Column e – Measurement Unit Code

For each cost-sharing line, enter the appropriate measurement unit from the list below. The valid utilization types vary by service category.

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

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

If there is an in-network plan-level deductible, you must enter the effective amount of the deductible on each service category line affected. For each service that is subject to the plan-level deductible, enter an amount such that the sum total represents the effective PMPM value of the deductible. Enter the actual in-network plan-level deductible amount (for example, $500) in the footnote.

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

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

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

Enter the projected in-network utilization/1000, or PMPM value in the case of coinsurance, after the plan-level deductible has been satisfied and including the impact of the OOP maximum.

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

Enter a description of the in-network cost sharing for each service category including any benefit limits. This is a text field.

This BPT field must provide descriptions of all plan cost sharing contained in the PBP, including descriptions of all PBP benefits priced together within each BPT service category. These details are necessary since each BPT category may map to several PBP benefit categories.

All descriptions entered must be easily matched back to the PBP.

Plan sponsors are required to use this field to describe all in-network benefits priced in the BPT. Even if there is no cost sharing for a particular service category, you must enter a comment indicating the zero cost-sharing arrangement (that is, $0.00 copay or 0% coinsurance). Do not leave this column blank.

Following are some examples:

- "(4a) $50/visit, (4b) $25/visit"
- "$150 days 1 - 5, $0 after day 5, unlimited coverage".
- "$100 eye exam every 2 years"
- "Medicare FFS cost sharing"

✓ **Column i – Effective Copay/Coinsurance before OOP Max**

Enter the projected effective in-network cost-sharing amount after the plan-level deductible has been satisfied and before the impact of the OOP max. This amount must represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g). Note that this cell is not used to calculate the in-network PMPM in column k.

✓ **Column j – Effective Copay/Coinsurance after OOP Max**

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

Enter the PMPM pricing impact of the in-network OOP maximum in the second footnote in column k. This value must reflect the PMPM difference in pricing for cost sharing before the OOP max and after the OOP max has been applied.

✓ **Column k – In-Network PMPM**

These cells are calculated automatically and reflect the projected cost-sharing value PMPM for in-network services, excluding the effective in-network plan-level deductible

and including the impact of the OOP maximum. The formula uses the utilization or PMPM amounts in column g and the effective copay or coinsurance in column j.

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

✓ **Column l – Total In-Network Cost Sharing PMPM**

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

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

Enter a description for the out-of-network cost sharing of each service category. This is a text field. See the instructions for in-network cost sharing in line h for additional information.

Plan sponsors are required to use this field to describe all out-of-network benefits priced in the BPT. Even if there is no cost sharing for a particular service category, the user must enter a comment indicating the zero cost-sharing arrangement (that is, $0.00 copay or 0% coinsurance). For plans that have out-of-network benefits this field must not be left blank.

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

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

Enter the actual out-of-network plan-level deductible in the footnote. Enter the pricing impact of the out-of-network OOP maximum in the second footnote. This value must reflect the PMPM difference in pricing for out-of-network cost sharing both before and after the OOP maximum has been applied.

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

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

MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

This worksheet uses the allowed costs (Worksheet 2) and cost sharing (Worksheet 3) to determine net medical costs in Section II. Section II contains three subsections: subsection A "Non-DE# (Non-Dual Eligible Beneficiaries AND Dual-Eligible Beneficiaries with full Medicare cost sharing liability)", subsection B "DE# (Dual-Eligible Beneficiaries without full Medicare cost sharing liability)" and subsection C "All Beneficiaries." Subsection C is the weighted average total of subsections A and B.

Non-benefit expenses and gain/loss margin are entered in Section IIC to establish the plan's revenue requirements for the contract year. Values are allocated between Medicare-covered benefits and A/B mandatory supplemental benefits and reflect the plan's non-ESRD risk factor for the contract period. The allocation of values between Medicare-covered benefits and A/B mandatory supplemental benefits must be consistent with the benefit type classification in the PBP.

In Section III, the plan sponsor must enter the projected member months for ESRD enrollees and may enter the projected ESRD "subsidy." ESRD enrollees must be excluded from all other sections of the BPT.

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

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

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

In lines a through r:

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

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

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

  The total in-network and out-of-network cost sharing PMPMs are obtained from column o of Worksheet 3 (except for line r). No user inputs are necessary.

✓ **Column g – N/A**

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

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

The Net PMPM is calculated automatically as column e less column f.

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

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

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

Example:

The plan sponsor estimates that 99.9% of the allowed PMPM in column e for outpatient facility emergency services is for Medicare-covered services and 0.1% is for A/B mandatory supplemental benefits, whereas 98.0% of the cost sharing PMPM in column f is for Medicare-covered services and 2.0% of the cost sharing is for A/B Mandatory supplemental benefits. The entries in columns i and j would be as follows:

(c)	(i)	(j)
	% for Cov. Svcs	
Service Category	Allowed	Cost Sharing
f. OP Facility – Emergency	99.9%	98.0%

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

For the Medicare-covered service categories, lines a through k, the values entered in columns i and j must generate appropriate pricing for mandatory supplemental benefits in columns p through r, consistent with the PBP. In addition, the relationship of the PBP benefits and the BPT pricing is to be consistent with the suggested mappings contained in Appendix F. Any deviations from the suggested mappings must be documented in supporting exhibits. For example, if a plan covers additional inpatient hospital days, then, absent supporting documentation that identifies a different mapping, the PMPM pricing for the non-covered inpatient services is to be represented in line a, column p, "Net PMPM for Additional Services."

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

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

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

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

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

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

✓ **Column m – Medicare-covered Allowed PMPM**

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

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

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

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

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

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

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

These amounts reflect the net costs (that is, allowed costs less enrollee cost sharing) for non-covered benefits. This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing for non-covered benefits (column f minus column l).

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

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

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

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

Line s – Total Medical Expenses

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

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

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

In lines a through r:

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

  Calculated automatically as the sum of columns g and h.

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

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

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

  Calculated automatically as the minimum of columns f and k.

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

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

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

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

- ✓ **Column k – State Medicaid Level of Beneficiary Cost Sharing**

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

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

  Calculated automatically as column g times column j.

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

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

  - ✓ **Column m – Medicare-covered Allowed PMPM**

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

  - ✓ **Column n – Medicaid Cost Sharing**

    Calculated automatically as column k times column j.

  - ✓ **Column o – Net PMPM**

    Calculated as column m minus column n.

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

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

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

This column is calculated automatically as the allowed costs for non-covered benefits (column e minus column m) less the cost sharing (column g minus column l).

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

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

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

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

Line s – Total Medical Expenses

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

Subsection C – All Beneficiaries

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

In lines a through q and t:

✓ **Columns e through g – N/A**

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

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

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

✓ **Columns i through n – N/A**

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

✓ **Columns o – Net PMPM for Medicare-covered Benefits**

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

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

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

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

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

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

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

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

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

Line r – ESRD

This line is populated based on Section III.

Line s – Additional Benefits (employer bids only)

This line is populated based on Section IV.

Line u – Total Medical Expenses

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

Line v – Non-Benefit Expenses

Enter the non-benefit expense information for total MA benefits in column h for the four categories described below.

- Marketing & Sales
- Direct Administration
- Indirect Administration
- Net Cost of Private Reinsurance

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

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

Lines v1 through v4 – Non-Benefit Expenses

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

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

Enter the PMPM by category.

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

  These values are calculated as column h minus column r.

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

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

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

The sum of lines v1 through v4.

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

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

Line w – Gain/Loss Margin

Enter the projected PMPM for the gain/loss in column h for total MA services.

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

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

Line x – Total Revenue Requirement

The sum of lines u (medical expense), v5 (non-benefit expense), and w (gain/loss margin). The value in column o is the total revenue requirement of the "Plan A/B Bid."

Line y – Percent of Revenue Ratios (excluding ESRD)

These lines calculate the ratio of net medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue. These ratios exclude the PMPM impact of the ESRD subsidy.

SECTION III – DEVELOPMENT OF PROJECTED CONTRACT YEAR ESRD "SUBSIDY"

Section III allows for an adjustment to A/B mandatory supplemental benefits in line r of Section II. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits.

Non-ESRD CY Member Months

This value is obtained from Worksheet 5.

ESRD CY Member Months

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

Basic Benefits

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

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

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

Supplemental Benefits

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

The BPT will calculate the incremental cost of supplemental benefits for ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD).

SECTION IV – FOR EMPLOYER BID USE ONLY

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

See Appendix D for further information on group bids.

Line 1. PMPM for Additional (Unspecified) Mandatory Supplemental Benefits

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

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

SECTION V – PROJECTED MEDICAID DATA FOR DE# BENEFICIARIES

This section contains two input cells: Line 1 "Medicaid Projected Revenue" and Line 2 "Medicaid Projected Benefits (not in bid)." Entries must be reported on a "per DE# Member

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

MA WORKSHEET 5 – MA BENCHMARK PMPM

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

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

- Section I – Displays the general information entered on Worksheet 1.
- Section II – Summarizes the development of the benchmark and the bid.
- Section III – Summarizes the development of the savings or basic member premium.
- Section IV – Development of regional A/B benchmark (including the statutory component of regional benchmark). Applies to RPPO plan types only.
- Section V – Projected plan-specific information for counties within the service area.
- Section VI – Other Medicare information (populated based on the enrollment projection).

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

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

SECTION I - GENERAL INFORMATION

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

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Projected Member Months (excluding ESRD)

The total projected member months (excluding ESRD) is obtained from Section V. Users must enter the projected non-DE# member months. The DE# member months is calculated as the difference between the total and the non-DE# amounts. See the "Pricing Considerations" section of these instructions for more guidance.

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

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

Line 3 – Medicare Secondary Payer (MSP) Adjustment

User input is required. Do not leave this field blank. If zero percent is the projected value, enter a zero (0) in this field.

Line 4 – Weighted Average Risk Factor (excl ESRD)

This value is obtained from Section V for total members. Users must enter the projected non-DE# value. The DE# value is calculated based on the total and the non-DE# amounts. See the "Pricing Considerations" section of these instructions for more guidance.

Line 5 – Conversion Factor

Calculated as (1.000 minus line 3) times line 4.

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

Calculated as line 2 times line 5.

Line 7 – Plan A/B Bid

This value is obtained from Worksheet 4, then rounded to two decimals.

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

Calculation is line 7 divided by line 5, then rounded to two decimals.

SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 – Savings

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

Line 2 – Rebate

Calculated as 75% of the savings (in line 1). This value is rounded to two decimals.

Line 3 – Basic Member Premium

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

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

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

Line 1 – Statutory Component

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

Line 2 – Plan Bid Component

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

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

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

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

Line 3 – Standardized A/B Benchmark – Regional Plans

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

SECTION V – COUNTY LEVEL DETAIL AND SERVICE AREA SUMMARY (EXCLUDING ESRD)

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

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

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

Line 1 – Use of Plan-Provided ISAR Factors

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

Line 2 – Total or Weighted Average for the Service Area

The county-level data are summarized in this line, weighted by projected member months.

Line 3 – County-Level Detail

✓ **Column b – State-County Code**

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

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

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

✓ **Column c – State**

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

✓ **Column d – County Name**

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

✓ **Column e – Projected Member Months (excluding ESRD)**

Enter the projected contract year member months for each county in the service area. The projected member months —

- Must include both aged and disabled members, and both DE# and non-DE# members, but must exclude ESRD members.
- Are to be developed using data on members enrolled in the plan as of early 2009.
- For MA-PD plans, must equal Part D member months less ESRD and hospice member months.

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

✓ **Column f – Non-ESRD Projected Risk Factor**

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

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

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

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

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

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

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

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

✓ **Column j – ISAR Scale**

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

✓ **Column k – ISAR-Adjusted Bid**

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

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

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

SECTION VI – OTHER MEDICARE INFORMATION

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

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

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

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

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

Columns t through u – FFS Equivalent Cost Sharing

These columns are populated based on the enrollment projections.

Columns v through w – Metropolitan Statistical Area (MSA)

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

MA WORKSHEET 6 – MA BID SUMMARY

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

SECTION I - GENERAL INFORMATION

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

SECTION II – OTHER INFORMATION

Section A – Part B Information

See the "Pricing Considerations" section for further information regarding the CMS estimate of the "standard" Part B premium and allocating rebates to buy down this premium.

Line 1 – CMS Estimate of "Standard" Contract Year (CY) Part B Premium

This value is pre-populated by CMS and is the CMS estimated value of the standard Part B premium for the contract year at the time that the bid form is released.

Section B – Rebate Allocation for CY Standard Part B Premium

Line 1 – PMPM Rebate Allocation for Standard CY Part B Premium

Enter the PMPM amount of rebates to reduce the standard Part B premium.

Line 2 – Rounded Part B Rebate Allocation

The PMPM amount entered in line 1 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements.

Line 3 – Does the plan sponsor intend to reduce the entire CY standard Part B premium using rebates?

If a plan (i) has allocated Part B rebates (in Section IIB, line 2) equal to the estimated CY standard Part B premium pre-populated at the time that the bid form is released (in Section IIA, line 1), and (ii) intends to fully reduce the standard CY Part B premium (that is, reduce the standard Part B premium to $0.00), then enter "Yes" in this line. (Technical note: Do not enter "Y" in this field; enter the entire word "Yes.")

Once the final Part B premium is determined, CMS will release further guidance directly to the Plan sponsors of those plans that meet these criteria (that is, plans that have allocated rebates equal to the CMS pre-populated estimate and have entered "Yes" in this line), if it is determined by CMS that the full reduction is feasible for CY2010.

SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the bid pricing tool information in three sections. Section A is an overview of the plan A/B bid and the costs of A/B mandatory supplemental benefits, and it

also contains some benchmark and risk score information from Worksheet 5. Section B contains the MA rebate allocation. Section C develops the MA premium and requires the input of the Part D premium information. Consistent with previous worksheets, any optional supplemental benefits/premiums are to be excluded.

Section A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Net Medical Cost

These amounts are obtained from Worksheet 4.

Line 2 – Non-Benefit Expenses

These amounts are obtained from Worksheet 4.

Line 3 – Gain/Loss Margin

These amounts reflect the estimated net gain/loss for the plan, including the amount of risk margin desired. These amounts are obtained from Worksheet 4.

Line 4 – Total Revenue Requirement

The sum of lines 1 through 3. These amounts are the required revenue at the plan's non-ESRD risk factor and are calculated prior to any rebate allocation.

Line 5 – Standardized A/B Benchmark

This amount is obtained from Worksheet 5.

Line 6 – Plan A/B Benchmark (or Regional A/B Benchmark for RPPO Plans)

This amount is obtained from Worksheet 5.

Line 7 – Non-ESRD Risk Factor

This amount is obtained from Worksheet 5.

Line 8 – Conversion Factor

This amount is obtained from Worksheet 5.

Section B – MA Rebate Allocation

This section captures how the plan intends to apply rebates to the following various options:

- Reduce A/B cost sharing.
- Other A/B mandatory supplemental benefits.
- Part B premium buydown.
- Part D basic premium buydown.
- Part D supplemental premium buydown.

Plan sponsors may choose which category, or categories, in which to allocate rebates.

See Appendix E for information regarding the reallocation of rebates (permitted for certain plans) after the publication of the Part D and MA regional benchmarks.

Line 1 – MA Rebate Available

This amount is obtained from Worksheet 5.

Lines 2 through 6 – Rebate Allocations by Category

In the fourth column, enter the portion of the total MA rebate that is allocated to each of the A/B rebate options. Note that the rebate allocations for Part B and Part D premiums are actually entered in separate sections of this worksheet, to ensure that the rebate allocations are rounded to comply with withhold system requirements.

The first three columns distribute the allocated rebate among medical expenses, non-benefit expenses, and gain/loss in the same proportion as used in Worksheet 4. The fifth column contains the maximum value that may be entered for each rebate category. See the "Pricing Considerations" section of these instructions for more information on rebate allocation.

Line 7 – Total Rebate Allocated

The sum of lines 2 through 6. This amount must equal the amount in line 1. If there are any "unallocated" rebates shown, including pennies, these amounts must be distributed among the categories available.

SECTION C – DEVELOPMENT OF ESTIMATED PLAN PREMIUM

Line 1 – A/B Mandatory Supplemental Revenue Requirements

This amount is obtained from Section IIIA.

Line 2 – Less Rebate Allocations

These amounts are obtained from Section IIIB, lines 2 and 3.

Line 3 – A/B Mandatory Supplemental Premium

The sum of lines 1 and 2.

Line 4 – Basic MA Premium

This amount is obtained from Worksheet 5.

Line 5 – Total MA Premium (excluding Optional Supplemental)

The sum of lines 3 and 4.

Line 6 – Rounded MA Premium (excluding Optional Supplemental)

The total MA premium from line 5 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements.

Line 7 – Part D Basic Premium

✓ **Line 7a - Prior to Rebates**

Enter the Part D basic premium prior to rebates after rounding (found on the separate Part D bid form). This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D basic premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy-down the Part D basic premium. MA-only plans and EGWP plans must leave this field blank.

✓ **Lines 7b and 7c – A/B Rebates Allocated to the Part D Basic Premium**

Enter the rebates that the Plan sponsor wishes to allocate to the Part D basic premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 7c), to comply with withhold system requirements.

✓ **Line 7d - Part D Basic Premium**

The estimated Part D basic premium net of rebates is calculated automatically as line 7a minus line 7c.

The Part D basic premium in the MA BPT is an estimate when the bid is initially submitted in June. The actual plan premium will be calculated by CMS, outside the BPT, when the Part D national average monthly bid amount is determined (typically in August).

Note that the Part D basic premium prior to rebates is permitted to be a negative number.

Line 8 – Part D Supplemental Premium

✓ **Line 8a - Prior to Rebates**

Enter the Part D supplemental premium prior to rebates (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D supplemental premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D supplemental premium. MA-only plans and EGWP plans must leave this field blank.

✓ **Lines 8b and 8c – A/B Rebates Allocated to the Part D Supplemental Premium**

Enter the rebates that the Plan sponsor wishes to allocate to the Part D Supplemental premium. The Part D rebate allocation must be rounded to one decimal. If is not done, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements.

✓ **Line 8d - Part D Supplemental Premium**

Calculates the Part D supplemental premium net of rebates. Line 8d equals line 8a minus line 8c.

Line 9 – Total Estimated Plan Premium

The sum of the rounded MA, Part D basic, and Part D supplemental premiums after rebates. This amount excludes any optional supplemental MA premiums, which are calculated on Worksheet 7.

Line 10 – Plan Intention for Target Part D Basic Premium

For MA-PD plans, this field contains a drop-down menu with two options: "Premium amount displayed in line 7d" or "Low Income Premium Subsidy Amount." MA-PD Plan sponsors must choose one of these two options for the target Part D basic premium the initial June bid submission and cannot change the chosen target in a subsequent resubmission. CMS will consider only the option chosen in June as the plan's intention.

For MA-only plans and EGWPs, the target Part D basic premium is not applicable.

See the "Pricing Considerations" section of these instructions for more information on the target Part D basic premium.

SECTION IV – CONTACT INFORMATION AND DATE PREPARED

In this section, enter the name, phone number, and e-mail information for the plan contact, the MA certifying actuary, and an additional MA BPT contact in the event that the certifying actuary is not available. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

The persons named in this section must be available for any actuarial questions and issues that arise during the review of the bid by CMS.

Section IV also contains a field labeled "Date Prepared." This field must contain the date that the BPT was prepared. If the BPT is revised and resubmitted during the bid review process, then this field must be updated accordingly.

SECTION V – WORKING MODEL TEXT BOX

This section contains multiple cells that may be used by bid preparers to enter internal notes. For example, this section may be used to facilitate communication between BPT and PBP preparers, or to track internal version schemes.

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

MA WORKSHEET 7 – OPTIONAL SUPPLEMENTAL BENEFITS

Worksheet 7 contains the actuarial pricing elements for any optional supplemental benefit packages to be offered during the contract year, up to a maximum of five.

For each of the five packages, the worksheet contains 20 category lines. If additional category lines are needed, then provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. Do not insert any additional rows into the form.

SECTION I - GENERAL INFORMATION

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

SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

Column b – Package ID

Displays the identification (ID) number to signify which package of optional supplemental benefits is being priced. The number "1" is used to identify the first package. Sequential numbers (that is, 2, 3) identify additional packages of optional supplemental benefits. The package IDs must correspond to the packages enumerated and described in the PBP.

Column c – Service Category

Enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

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

Column d – Benefit Category/Pricing Component

Enter a description of the benefit category/pricing component.

Column e – Allowed Medical Expense: Utilization Type

Enter the appropriate measurement unit from the list used for column e of Worksheet 2.

Column f – Allowed Medical Expense: Annual Utilization/1000

Enter the projected contract year annual utilization per thousand enrollees for allowed medical expenses for each benefit category.

Column g – Allowed Medical Expense: Average Annual Cost

Enter the projected contract year average annual cost for allowed medical expenses for each benefit category.

Column h – Allowed Medical Expense: PMPM

Column h is calculated automatically using the utilization reported in column f and the average cost information reported in column g.

Column i – Enrollee Cost Sharing: Measurement Unit Code

Enter the appropriate cost-sharing measurement unit using the codes provided for column e of Worksheet 3.

Column j – Enrollee Cost Sharing: Utilization/1000 or PMPM

Enter the projected contract year utilization per thousand enrollees or the PMPM value in the case of coinsurance.

Column k – Enrollee Cost Sharing: Average Cost Sharing

Enter the projected contract year average per-service cost-sharing amount or coinsurance percentage.

Column l – Enrollee Cost Sharing: PMPM

Column l is calculated automatically using the utilization (or PMPM) reported in column j and the average cost (or coinsurance percentage) reported in column k.

Column m – Net PMPM Value

Column m is calculated automatically as the allowed PMPM (column h) minus the cost sharing PMPM (column l).

Column n – Non-Benefit Expense

Enter the total projected contract year non-benefit expense for each optional supplemental package offered.

Column o – Gain/(Loss) Margin

Enter the total projected contract year gain/loss margin for each optional supplemental package offered.

Column p – Premium

The sum of columns m (medical expenses), n (non-benefit expenses), and o (gain/loss margin). The premiums are rounded to one decimal to comply with premium withhold system requirements.

Column q - Projected Member Months

Enter the total projected contract year member months for each optional supplemental package offered.

SECTION III - COMMENTS

Enter any comments needed to describe the optional benefit packages.

MA TWO-YEAR LOOK-BACK FORM

The Two-Year Look-Back Form provides CMS with data aggregated at the contract level, rather than at the bid level. It also provides a summary of costs separated by individual-market versus employer/union-only (that is, EGWP) group market. This information assists CMS in evaluating the consistency between bids and recent historical experience.

The form requires the user to input actual incurred revenue and expense information for the calendar year 2 years prior to the contract year being priced. In contract year 2010, the experience year is 2008.

The projected figures (to be reported in columns f through h) are based on the CY2008 bid submissions for the contract. CMS provides this information for plan use in HPMS, as described in the instructions below.

You must submit a Two-Year Look-Back Form for CY2010 for all contracts for which there is a CY2008 MA BPT and for which there is enrollment in the MMR for July 2008. In other words, if data are posted in HPMS for the contract, then a 2YRLB form must be uploaded.

The Two-Year Look-Back Form must be completed at the contract level (that is, H#), not at the plan level as is the case with BPTs. This worksheet must be completed in "per member per month" values (PMPMs).

The data reported must include or exclude experience for hospice enrollees consistent with the exclusion or inclusion of such experience in the 2008 Medicare Advantage (MA) BPTs. Data for ESRD enrollees must be excluded.

The data reported on the 2YRLB must exclude optional supplemental benefits.

Contract Number

Enter the contract number.

Organization Name

Enter the organization name.

Contract Year

Displays the contract year.

Experience Year

Displays the experience year, which is two years prior to the contract year.

Line 1 - Revenue

Complete columns f and g (original projection) using information from CMS, which is described in the section, "Source of original projection data from CMS." Column h is the weighted average of columns f and g. You must enter data on actual incurred experience into columns j and k. Column l is the weighted average of columns j and k. Columns n, o, and p calculate the ratio of actual-to-projected and do not require any user input.

✓ **Line 1a – CMS revenue**

Enter bid-based MA payments and accruals from CMS plus rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits. The payment accrual must account for the final risk adjustment reconciliation payment for CY2008, which will be received in mid-2009. Do not include rebates applied to Parts B and D premium buydowns. Also, report the CMS revenues gross of user fee reductions.

✓ **Line 1b - Premium**

Enter member premium for basic A/B benefits and mandatory supplemental benefits in line 1b.

Line 2 - Net Medical Expenses

Complete columns f and g using information from CMS. Column h is the weighted average of columns f and g. Columns j and k refer to data entered in footnote 2. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

The net medical expenses are to be reported on a calendar year 2008 incurred period.

✓ **Line 3 - Non-Benefit Expenses**

Columns f and g must be completed using information from CMS. Column h is the weighted average of columns f and g. Enter data in columns j and k. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input. Reinsurance information is entered in footnote 3.

Line 4 - Profit/Loss before Taxes and Investment Income

All columns are calculated automatically as revenue (line 1c) less medical expenses (line 2d) and non-benefit expenses (line 3e).

Line 5 - Key Statistics

✓ **Line 5a - Member Months**

Complete columns f and g using information from CMS, which was calculated as the July 2008 MMR enrollment times 12. Enter data from company financial records in columns j and k.

✓ **Line 5b - Non-ESRD Risk Factor**

Complete columns f and g using information from CMS. Enter the actual 2008 non-ESRD risk factor for the contract in columns j and k.

✓ **Lines 5c, 5d, and 5e**

These fields are calculated automatically. No user input is required.

Original Projection

The source of the data for columns f and g, except for member months, is the 2008 Medicare Advantage (MA) BPTs for the contract. CMS provides this information in HPMS at the following location: HPMS Home > Plan Bids > Bid Submission > CY2010> Download >

2-Year Lookback Projection Data. The data posted at this link must be manually entered into the Two-Year Look-Back Form.

Each line of data provided by CMS represents the average of the BPT values, weighted by actual enrollment as reported in the July 2008 MMR. Following are the specific MA BPT elements used in the calculation of each field (with their CY2008 BPT cell references):

1a CMS Revenue: Sum of —

(1) Lesser of plan A/B bid (Worksheet 5, cell E18) and plan A/B benchmark (BPT Worksheet 5, cell E17); and

(2) MA rebates to reduce A/B cost sharing (BPT Worksheet 6, cell L25); and

(3) MA rebates applied to other A/B mandatory supplemental benefits (BPT Worksheet 6, cell L26).

1b. Premium: Sum of basic member premium and mandatory supplemental premium, rounded (BPT Worksheet 6, cell R31).

1c. Total: Sum of 1a and 1b.

2a. Covered Benefits (excluding Risk Sharing): BPT Worksheet 4, cell N41.

2b. A/B Mandatory Supplemental Benefits: BPT Worksheet 4, cell Q41.

2c. Regional PPO Risk Sharing Paid/(Received): Total risk-sharing payment adjustment from RPPO risk-sharing reconciliation worksheet.

2d. Total: sum of 2a, 2b, and 2c.

3a. Marketing & Sales: BPT Worksheet 4, cell G43.

3b. Direct Administration: BPT Worksheet 4, cell G44.

3c. Indirect Administration: BPT Worksheet 4, cell G45.

3d. Net Cost of Private Reinsurance: BPT Worksheet 4, cell G46.

3e. Total: sum of 3a, 3b, 3c, and 3d.

4. Profit/Loss before Taxes and Investment Income: 1c minus 2d minus 3e.

5a. Member Months (excluding ESRD): members on July 2008 MMR times 12.

5b. Non-ESRD Risk Factor: BPT Worksheet 5, cell E16.

Footnote 2

Incurred in Experience Year and Paid Through. Enter the "paid through" date.

Net Medical Expenses.

Covered Benefits (excluding risk share). After you enter data in the first two columns, the total weighted average will be calculated automatically in the third column. After you enter data in the next two columns for Claim Reserves, a total weighted average will be calculated automatically.

A/B Mandatory Supplemental Benefits. After you enter data in the first two columns, the total weighted average will be calculated automatically in the third column. After you enter data in the next two columns for Claim Reserves, a total weighted average will be calculated automatically.

Regional PPO Risk Share Paid/(Received). After you enter data in the first two columns, the total weighted average will be calculated automatically in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated automatically.

Total. The sum of lines a through c.

Footnote 3

Actual Incurred Components of Net Reinsurance.

a. Private Reinsurance Premium. Enter data in the first two columns.

b. Private Reinsurance Recoveries. Enter data in the first two columns.

c. Net Reinsurance Cost. The sum of lines a and b.

IV. APPENDICES

APPENDIX A - ACTUARIAL CERTIFICATION

CMS requires an actuarial certification to accompany every bid submitted to HPMS. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater responsibility on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

Actuarial Standards of Practice and Other Considerations

In preparing the actuarial certification, the actuary must consider whether the actuarial work supporting the bid conforms to the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, *Incurred Health and Disability Claims*.
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*. Particular focus is placed on the following sections: "Use of Business Plans to Project Future Results" (3.2.3), "Use of Past Experience to Project Future Results" (3.2.4), "Recognition of Plan Provisions" (3.2.5), "New Plans or Benefits" (3.2.6), "Regulatory Benchmark" (3.2.8), and "Reasonableness of Assumptions" (3.2.9).
- ASOP No. 23, *Data Quality*. Particular focus is placed on the following sections: "Selection of Data" (3.2), "Reliance on Data Supplied by Others" (3.3), "Reliance on Other Information Relevant to the Use of Data" (3.4), "Review of Data" (3.5), "Use of Data"(3.7), and "Communications and Disclosures" (Section 4).
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*.
- ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*. Particular focus is placed on the following section: "Extent of Documentation" (3.2).
- ASOP No. 41, *Actuarial Communications*. Particular focus is placed on the following sections: "Reliance on Other Sources" (3.1.6) and "Actuarial Report" (3.3.3).

The certifying actuary must also consider whether the actuarial work supporting the bid complies with applicable laws, rules, CY2010 bid instructions, and current CMS guidance. In addition, he/she must consider whether the actuarial work supporting the bid is consistent and reasonable with the plan benefit package and the organization's current business plan.

Certification Module

The certification module contains the following features:

- Standardized required language (the required elements are described in the next section of this appendix).
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids.

- Links to additional information regarding the bid package (such as the PBP, BPT, substantiation, etc.).
- 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.

As was instructed in previous contract years, material changes to the certification language (after the initial June certification submission) are not allowed without prior written permission from the CMS Office of the Actuary.

Plan sponsors may have multiple actuaries assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

Every MA BPT requires a certification. Likewise, every PD BPT requires a certification. Since Part D BPTs are not submitted for "800-series" EGWP employer bids, a Part D actuarial certification is not required. However, a certification is still required for the MA portion of "800-series" employer bids.

Required Certification Elements

The certification module contains the following information, as part of the standardized language:

- The certifying actuary's name/user ID and the date, "stamped" when the certification is submitted.
- Attestation that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy's qualification standards for doing so.
- The specific contract, plan ID, and segment ID of the bid associated with the certification.
- The contract year of the bid contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Part D bid, or both.

- Attestation that the certification complies with the applicable laws,[1] rules,[2] CY2010 bid instructions, and current CMS guidance.
- Attestation that, in accordance with federal law, the bid is based on the "average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile."
- Attestation that the data and assumptions used in the development of the bid are reasonable for the plan's benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid are consistent with the organization's current business plan.
- Attestation that the bid was prepared based on the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the bid complies with the appropriate ASOPs.
- A statement that, in accordance with ASOP 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency, and that supporting documentation for the reliance on information provided by others is uploaded with the bid.

Please refer to ASOP No. 23, *Data Quality*, and ASOP No. 41, *Actuarial Communications*, for additional details regarding reliances. Also, see Appendix B for information regarding supporting documentation required for reliances.

If you have any questions regarding the CY2010 certification instructions, please contact the CMS Office of the Actuary at actuarial-bids@cms.hhs.gov.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2010 certification module were released via an HPMS memo dated March 9, 2009.

[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.

APPENDIX B - SUPPORTING DOCUMENTATION

GENERAL

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

Unless otherwise noted, Plan sponsors must upload all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation must be made available to CMS reviewers upon request, and within 48 hours of the request, as required by these instructions.

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the Plan sponsor or a third party. If the actuary relied upon others for certain bid data and/or assumptions, those individuals are subject to the same documentation requirements. The actuary must be prepared to produce all substantiation pertaining to the bid, even if it was prepared by others or is based on a reliance.

In preparing supporting documentation, the actuary must consider ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*. In accordance with Section 3.2, "Extent of Documentation", the materials provided must be written "with sufficient clarity that another actuary practicing in the same field could make an objective evaluation of the reasonableness of the work product."

All data submitted as part of the bid process are subject to review and audit by CMS, or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation must –

- Be clearly labeled and easily understood by CMS reviewers.
- Include quantitative support and details, rather than just narrative descriptions of assumptions.
- Describe plan–specific variations in addition to an overall description of a pricing assumption or methodology.
- Tie to the values entered in the BPT.
- Include working formulas in Excel spreadsheets.
- 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 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.

Acceptable forms of supporting documentation include, but are not limited to, the following items:

- Meeting minutes from discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources – for example, a report's official name/title, file name, date obtained, source file, etc.

- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- A reference to the supporting documentation for another plan such as "the same as for plan Hxxxx-xxx" and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is "professional judgment," with no additional explanation, reasoning, supporting factors, studies, etc.
- "Living worksheets" that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of prior bid filings.

SUBMITTING SUPPORTING DOCUMENTATION

Supporting materials must be in electronic format (Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, which compress multiple files into one (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload to multiple plans materials specific to a Part D plan, MA plan or certain contract ID. That is, do not upload support to contracts/plans for which the substantiation does not apply.

Cover Sheet

To expedite the bid review process, Plan sponsors must upload a cover sheet document that lists all of the supporting documentation that is uploaded (or is provided on the bid form). The filename must include the phrase "cover sheet." A cover sheet is required for each upload of substantiation.

The cover sheet must include detailed information for each support item, such as the filename and the location within the file, if applicable. The cover sheet must clearly identify the bid IDs and whether the substantiation is related to MA, Part D or both.

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements will 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 for a subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of bid

IDs (such as "plans 001 – 030", or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (that is, the cover sheet must not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact bid IDs, rather than a "range" of bid IDs.

Sample check lists and cover sheets for the initial June bid submission, and for subsequent substantiation uploads, are provided at the end of this appendix.

Timing

Plan sponsors and certifying actuaries must prepare all supporting documentation and upload required documentation into HPMS at the time of the initial June bid submission. These items are described in the "Initial June Bid Submission" section below.

Moreover, CMS recommends that other supporting documentation materials be uploaded with the initial June bid submission, though this is not required. However, these materials must be prepared at that time in order to be readily available to CMS reviewers upon request. See the "Upon Request by CMS Reviewers" section of this appendix for more information. When additional substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit.

Initial June Bid Submission

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

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review. For Dual Eligible SNPs, include a statement indicating how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management, and margins.
- Support for the credibility assumptions (Worksheet 2), including –
    - The credibility methodology used and a statement of whether or not it differs from the CMS guideline described in these instructions
    - The method for blending differences in the credibility for utilization and unit cost into a composite PMPM credibility factor. Justification for any variation in the credibility approach by line of business.
    - An explanation for a zero credibility percentage for a service category with credible data.
- A mapping of cost-sharing information from categories used in pricing to the BPT service categories (Worksheet 3).
- Support for non-benefit expense assumptions (Worksheet 4). The required elements include –

  - A summary of the non-benefit expenses by category of expense or by line item.
  - An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other experience.
  - 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.
- Justification of the gain/loss margin (Worksheet 4). The required elements include –
  - Support for overall margin levels, including a description of the methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.
  - Support for bids with negative margins – that is, a business plan that illustrates profitability within a few years.
  - A comparison of the gain/loss margin to the original business plan for plans with negative margins in prior years. This comparison includes details and source of deviation from prior years' business plans (Worksheet 4).
  - Justification of the margin for bids with relatively large projected overall gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other supporting documentation. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.
  - If applicable, further analysis of the organization's ROI/ROE and distinctions between recouping start-up costs versus ongoing organizational gain/loss.
- Detailed support for the development of projected risk scores (Worksheet 5). The required elements include–
  - A detailed description, and corresponding numerical demonstration, of the methodology used to develop projected CY MA risk scores.
  - A description of the source data for the development of the projected CY MA risk scores.
  - A description of all projection factors and the basis for the factors.
  - A demonstration that the development of the projected risk scores is consistent with the development of projected medical expenses, if the plan pricing is based on manual rates.

Documentation requirements that apply to <u>all bids that contain the following</u> specified assumptions:

- Detailed support for base period experience and projections (Worksheet 1). This documentation, which is based on regulatory authority for the review of materials that pertain to any aspect of services provided, is also required in cases where medical services are provided under a capitated arrangement. The required elements include–
  - A description of the allocation of allowed costs by service category when the allocation method is not based on plan experience data.

    - The development of the projection assumptions.
    - Information regarding the base period member month distribution, if for some reason more than four plans comprise the base period data (see Worksheet 1, Section II, line 5).
- Support for the pricing, including utilization and unit cost, of preventive services incentive programs (Worksheets 1 and 2, line k).
- Support for claim costs for hospice enrollees for mandatory supplemental benefits when these costs are included in the projected allowed cost PMPM.
- Detailed support for the manual rate development (Worksheet 2), including a description/illustration of the underlying data source(s) and data/methodology used in the development of the manual rates, if manual rate are used. The required elements include–
    - A description of the source data, including the data's relevance to the MA plan and the precise name of any published tables used.
    - Credibility standards applied to the data and corresponding adjustments, if applicable.
    - Consideration of any adjustments made for annual volatility of the source data.
    - Any applicable adjustments to the source data, such as–
        - Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data;
        - Addition of Medicare-covered benefits not reflected in the source data;
        - Exclusion of non-covered benefits reflected in the source data;
        - Techniques and factors used to reflect differences between the underlying population and that expected of the MA plan;
        - Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the MA plan; and
        - Methodology and data used to gross up reimbursements to an allowed-cost basis.
    - Data and methodology used to project the data from base period to CY2010.
    - A description of the source of data for the development of corresponding CMS-HCC model risk scores, and how it compares to the risk profile of the population underlying the manual rate source data.
    - The reasonableness of allowed costs and projection factors for costs based on capitated payments to related parties.
    - The allocation of projected allowed costs by service categories.
    - All other applicable factors and/or adjustments.
- Support, at the benefit level, for non-covered services (Worksheet 2, lines l through r, column o), if any, including a break-down of the PMPM value shown in the BPT. (Detailed support for the pricing of each additional benefit is available upon request.) For example, a $4.00 PMPM in column o of row p, "Health and Education," is to be shown in the supporting documentation as $1.50 PMPM for a smoking cessation program and $2.50 PMPM for nutritional counseling.

- Support for non-DE# projected allowed costs (Worksheet 2).
- A detailed description of the process used for adjusting cost sharing due to maximum OOP limits (Worksheet 3).

- A mapping of PBP benefit categories and BPT pricing categories for any deviations from the suggested mappings in Appendix F. (Worksheet 4).
- Disclosure of related-party administrative service agreements (Worksheet 4).
    - The required elements include—
        - The identity of the related-party organization.
        - A description of the business arrangement and services provided.
        - The financial terms.
        - A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
        - A demonstration that the operating and financial results of the participating organizations are not significantly different from those that would have been achieved by the plan in the absence of the related party relationships as outlined in the "Pricing Considerations" section of these instructions.
    - The required elements for a plan sponsor in a related-party administrative agreement with an organization that is providing services to unrelated parties must directly or indirectly, or through agreement with the subcontracted party include—
        - A written summary outlining the terms of actual contracts between the subcontractor and the comparable, unrelated parties for similar services. The support must demonstrate that the financial arrangements between related parties are not significantly different from those that would have been achieved by the plan sponsor in the absence of the related-party relationships.
        - An explanation of the disparities in the financial arrangements between related parties and unrelated parties. The explanation must fully address the advantaged or disadvantaged positions and, overall, must demonstrate that the financial arrangements are not significantly different from those that would have been achieved by the plan sponsor in the absence of the related-party relationships.
- Support for the development of the contract year ESRD "subsidy" (Worksheet 4). This documentation includes the following:
    - Base period (for example, 2008) revenues and medical expenditures for Medicare-covered benefits provided to enrollees in ESRD status.
    - The source for, and the development process of, any manual rates used.
    - Relevant base-to-contract year trend factors.
    - A short narrative on the credibility approach applied to the ESRD experience.

- Support for the development of plan-provided ISAR factors (Worksheet 5), if used (applies to RPPOs only). A description of the methodology and data source(s) used to calculate the ISAR scale(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (that is, non-benefit expense and gain/loss margin) that were assumed in the development of the factors.
- Aggregate contract-level optional supplemental experience for CY2008 (Worksheet 7).
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, when used (indicated in the General Information section of Worksheet 1).
- An explanation of the consistency between the pricing in the bid and the expected underwriting assumptions for all groups, in aggregate. This documentation includes, but is not limited to a description of the underwriting methodology.
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of how CY2009 bid audit findings and observations were addressed in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that —
    - Identifies the source(s) of the information – for example, name, position, company, date;
    - Identifies the information relied upon;
    - States the extent of the reliance – for example, states whether or not checks as to reasonableness have been applied; and
    - Indicates to which plan(s) the reliance information applies.

See the sample format at the end of this appendix.

Upon Request by CMS Reviewers

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request. If substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit:

- Support for the following items when the formulas provided in the BPT are overwritten at the discretion of the certifying actuary:
    - DE# allowed PMPM (Worksheet 2, column q).
    - DE# plan cost sharing (Worksheet 4, Section II.B., column f).
- Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.

- Support for the pricing of the non-covered services, including utilization and unit cost, (Worksheet 2, lines l through r, column o). (Support at the benefit level is required in the initial June bid submission.)
- Support for cost-sharing utilization assumptions and plan-level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-covered and A/B mandatory supplemental benefits (Worksheet 4).
- Copies of related-party administrative agreements for a plan sponsor in a related party agreement with an organization that is providing services to unrelated parties.
- Support for variation in the gain/loss margin that accounts for the difference in risks between products for EGWPs and DE-SNPs (Worksheet 4).
- Support for the allocation of enrollment between DE# and non-DE# beneficiaries (Worksheet 5).
- Support for the benefit, non-benefit expenses and gain/loss margins for specific optional supplemental benefit packages (Worksheet 7).
- Justification for significant differences in the assumptions between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark). See Appendix D for more information.
- Additional level of detail regarding the two-year look-back information–, for example, to separate SNP and non-SNP bids (Two-Year Look-Back Form).
- A letter supporting any information upon which the certifying actuary relied. The letter must be signed by the person (source) who provided the information.
- Communication between CMS reviewers and the organization throughout the bid review process (that is, e-mail communication).
- Additional information not specified in this list may be requested by CMS reviewers at any point during the bid desk review process, as needed.

MA CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission - Required for All Bids
Cover sheet
Product narrative
Credibility assumption
Cost-sharing category mapping
Non-benefit expenses
Gain/loss margin (include comparison of gain/loss margin to original business plan for plans with negative margins in prior years)
Projected risk scores

Initial June Bid Submission - Required for All Bids with Specified Assumptions
Base period experience and projections
Preventive services incentive programs
Hospice claims costs for mandatory supplemental
Manual rate development
Non-covered services benefit-level summary
Non-DE# projected allowed costs
Adjustment to cost sharing for OOP maximum
Mapping of PBP and BPT service categories
Disclosure of related-party agreements
ESRD "subsidy"
ISAR factors
Optional Supplemental Experience for 2008
Actuarial swaps/equivalences
EGWP comparison of bid pricing and expected underwriting assumptions
Input sheet for pricing model
Bid audit results
Reliance information

Upon Request by CMS Reviewers
Override of formulas for DE# allowed PMPM and/or cost sharing
Reconciliation of base period experience with company financial data
Non-covered services pricing details
Cost-sharing utilization and plan-level deductible
Allocation of allowed costs/cost sharing to Medicare–covered and non-covered
Related party agreements
Gain/loss margin for EGWPs and DE-SNPs
Enrollment allocation between DE# and non-DE#
Optional supplemental benefit packages
Differences in EGWP and general market pricing assumptions
Two-year look-back data
Reliance letter
Bid review communications
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD IN JUNE

Supporting Documentation Cover Sheet #1

CY2010 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: June 1, 2009

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if Applicable)	Applies to: MA, PD, or Both
Cover sheet	All bids	Cover Sheet 6-1-09.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-1-09.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-1-09.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-1-09.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet 1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet 2	both
Risk scores	All bids	Risk CY10.xls	MA-Sheet 1 PD-Sheet 2	both
Manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD

Supporting Documentation Cover Sheet #2

CY2010 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: July 16, 2009

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if Applicable)	Applies to: MA, PD, or Both
Cover sheet	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0 H9999-001-0 S9999-001-0	Cover Sheet 7-16-09.doc	n/a	both
E-mail communication with CMS bid reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	Email1.doc	n/a	MA
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email2.doc	n/a	PD
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	Email3.doc	n/a	PD

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid ID	MA or PD or Both	Source (Name, Position, Company)	Type of Information	Comments
H1234-002-00	MA and PD	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
H1234-002-00	MA and PD	Jane Doe, Medicare Analyst, ABC Health Plan	Claim modeling, risk score	I have not performed any independent audit or otherwise verified the accuracy of these data or information.

APPENDIX C – PART B-ONLY ENROLLEES

Medicare beneficiaries with Medicare coverage only under Part B have not been allowed to elect an MA plan since December 31, 1998 unless they were members of employer or union groups.

However, Medicare beneficiaries (with Part B coverage under Medicare) who were Medicare enrollees of a Section 1876 contractor on December 31, 1998 were considered to be enrolled with that organization on January 1, 1999 if the organization had an MA contract for providing benefits on the latter date. Health benefit coverage that MA organizations provide to such remaining Part B-only enrollees constitutes a separate MA plan (which requires a separate bid submission).

CMS encourages MA organizations to submit as few plans as possible for their pre-1999 Part B-only members, rather than duplicating each of their A/B plans. In fact, an MA organization can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if the plan is offering the pre-1999 Part B-only members the same benefits at the same price as those offered to A/B members (that is, members eligible for both Part A and Part B of Medicare), the plan sponsor is not required to submit a separate bid for the Part B-only members.

On the other hand, MAOs that enroll Medicare beneficiaries with Part B-only coverage in an employer-only group plan must prepare a separate Part B-only bid. If a separate Part B-only plan is not created, the CMS managed care payment system will reject any enrollments submitted on behalf of individuals without Part A.

MAOs are to prepare Part B-only bids in much the same way as those prepared for Part A/B members.

In completing the bids for Part B-only plans, MA organizations must give special consideration to allocating the portion of services that are considered to be Medicare-covered (Worksheet 4, Section II, columns i and j):

- The Medicare-covered proportion of inpatient services (line a) must equal zero (0) percent.
- While the majority of Medicare expenditures for skilled nursing facilities (SNFs) are covered under Part A (Hospital Insurance), in certain circumstances benefits are covered under Part B (Supplementary Medical Insurance). Guidance on these covered services can be found in Section 70 of Chapter 8 of the *Medicare Benefit Policy Manual* at http://www.cms.hhs.gov/manuals/iom . We estimate that for calendar year 2010, about 5 percent of Medicare expenditures for SNFs will be covered under Part B.
- Also, as is stated in Section 60.3 of Chapter 7 of the *Medicare Benefit Policy Manual*, if a beneficiary is enrolled only in Part B and is qualified for the Medicare home health benefit, then all of the home health services are financed under Part B. Thus, for most Part B-only plans, the Medicare-covered proportion of home health services (line c) will be 100 percent.

APPENDIX D – MEDICARE ADVANTAGE PRODUCTS AVAILABLE TO GROUPS

(EMPLOYER GROUPS AND UNION GROUPS)

Organizations have two options for offering Medicare Advantage products to members of employer and union groups: individual-market plans and Employer-Only or Union-Only Group Waiver Plans (that is, EGWP or "800-series" plans).

Individual-Market Plans ("mixed enrollment" plans)

Essentially, MAOs may either offer their individual-market products without modification or they may tailor the products to specific employer and union groups through two types of allowable customization: "actuarial swapping" or "actuarial equivalence."

Actuarial Swaps

If you are requesting the actuarial swapping category of customization, identify in the supporting documentation both the benefits that might be swapped during negotiations with employers and/or unions and the MA plan covering those benefits. Only supplemental benefits not covered under original Medicare are eligible for actuarial swapping, and only those benefits in your bids that are candidates for swaps need be identified. When you make specific swaps in negotiations with employers or unions, you can do so in the context of the CMS general approval of your candidates, without obtaining further approval from CMS for the actual swaps.

Actuarial Equivalence

If you request the actuarial equivalence category of customization allowable for employer and union groups, provide the following information as supporting documentation:

- The cost-sharing amounts you intend to change and the MA plan containing the cost sharing.
- Any modification to the premium you will charge.
- Any improvement in the benefit related to the changed cost sharing.

Unlike the actuarial swapping flexibility, this customization can apply to both Medicare-covered and non-covered benefits.

Please retain in your files a package of documents with computations supporting the proposed changes under these two types of allowable customization. Do not include those packages of documents in the backup material that you submit to CMS.

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

The MMA gives employers and unions a number of options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the MMA, those options include making special arrangements with MA organizations to purchase customized benefits

for their active employees and retirees or contracting directly with CMS to sponsor a Medicare Advantage plan.

Under sections 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for the kinds of arrangements that "hinder the design of, the offering of, or the enrollment in" these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of MA plan entities: (i) MA organizations that offer or administer employer/union-only sponsored group waiver plans ("EGWPs" or "employer-only group plans"); and (ii) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan ("Direct Contract" EGWPs).

CMS has issued guidance waiving or modifying a number of requirements for these entities. CMS waiver guidance is located at http://cms.hhs.gov/EmpGrpWaivers .

Also see Chapter 9 of the *Medicare Managed Care Manual* (MMCM), which can be found at:

http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326 .

As described in Chapter 9 of the MMCM, organizations may offer Medicare Advantage plans that are available only to employer and union groups. These plans must follow all Medicare Advantage bidding requirements, except those that are specifically waived per Chapter 9 of the MMCM.

Following are some of the key features to be reflected in employer-only group bids:

- The pricing in the bid must reflect the expected underwriting assumptions for all groups, in aggregate.
    - Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year. These characteristics include, but are not limited to, the following: risk scores, geographical distribution of enrollees, non-benefit expenses, and gain/loss margins.
    - Projected enrollment within the plan's service area must be consistent with the location of employer groups.
- The cost sharing priced in Worksheet 3 must correspond to that contained in the Plan Benefit Package (PBP). The PBP can be prepared using either the expected composite benefit plan or the Medicare fee-for-service benefit provisions.
- Generally, CMS expects that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience. Organizations must provide documentation in support of differences in actuarial/financial assumptions between the corresponding products.
- There is no requirement to charge the filed MA basic and supplemental premium to each employer or union group that enrolls in the plan. However, the average premium charged, weighted by enrollees, across all groups enrolled in the plan must correspond to (that is, be consistent with) the filed premium. This rule on premiums does not apply

when the Medicare fee-for-service bidding approach is utilized, since these filed plans, and resulting premiums, are not an accurate depiction of what is actually being offered to employer/union groups.

- Following are the guidelines for rebates:
  - Similar to CMS' payment on behalf of beneficiaries enrolled in individual-market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an employer-only group plan.
  - The allocation of rebates may vary from employer to employer within the employer-only group plan. (The bid form contains one allocation.)
  - Employer-only group bids cannot reflect an allocation of rebates to the Part D basic premium or the Part D supplemental premium. However, plans may, in fact, allocate rebates to the Part D premium when negotiating with employer/union groups.
  - Part B premium buydowns (that is, rebate allocation) must be the same for all enrollees within the same employer-only group plan.
  - Consistent with individual-market bids, rebates allocated to reduce members' Part B premium will be transferred to the Social Security Administration, not the MA organization.
  - All groups enrolled in an employer-only plan with supplemental A/B rebates (both reduction in A/B cost sharing and additional benefits) must receive supplemental benefits equal to the amount of the A/B rebate allocation. However, A/B supplemental benefits provided to each employer may be customized. Further, MA organizations may use the field in Worksheet 4, Section IV, Line 1, "PMPM for additional/unspecified MS benefits," to account for A/B supplemental benefits that are likely to be customized.
  - All rebates must be accounted for and must be used only for the purposes provided for in law. Documentation that supports the use of all of the rebates on a detailed basis must be retained by the employer-only group plan.

For regional PPO EGWP plans, the initial June bid submission contains an estimated MA premium. The actual MA premium will not be known until August, when the regional benchmarks are calculated by CMS. Note that after the MA regional benchmarks are released by CMS, all regional MA Plan sponsors will be required to resubmit the MA BPTs in order to reflect the actual plan bid component (in Worksheet 5, cell M17). Regional MA plans may need to re-allocate rebates accordingly. Note that this requirement also applies to EGWP regional MA plans (that is, all EGWP RPPOs will be required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

The CY2010 Call Letter may contain additional guidance regarding employer-only group bidding.

Please refer to the announcement released via HPMS on February 28, 2007 regarding the Part D EGWP bidding policy. Another announcement was released via HPMS on April 3, 2007 to clarify the bidding requirements for EGWP bids.

APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING

Organizations may resubmit bids in order to reallocate MA rebate dollars for certain plan bids after CMS publishes the Part D national average monthly bid amount national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks.

Rebate reallocation is required for some MA plans, is permitted (but not required) for others, and is not permitted for certain plans, as indicated in this appendix. The rebate reallocation guidance applies to plans with all types of pricing arrangements, including risk sharing and global capitation, and to pricing assumptions that were developed as a percent of revenue.

The rebate reallocation period is approximately five to seven business days. CMS will announce the exact dates of the rebate reallocation period when the Part D and MA benchmarks are released.

This appendix also provides premium rounding rules and describes what premium rounding is permissible during rebate reallocation.

I. REBATE REALLOCATION RULES BY PLAN TYPE

MA-PD plan sponsors may resubmit bids to reallocate rebates in order to return to the target Part D basic premium. Some MA-PD plans are required to reallocate rebates.

The target premium is communicated to CMS in the MA BPT in the initial June bid submission. The target may not be changed after the initial June bid submission.

MA-PD Plan sponsors have two options for the target premium: they can set it equal to—

- The basic Part D premium net of rebates (that is, the amount displayed in line 7d of Worksheet 6), or
- The Low Income Premium Subsidy Amount (LIPSA).

This choice is designated on line 10 of Worksheet 6; it is called the "Plan Intention for target Part D basic premium."

Target Part D basic premium concepts do not apply to MA-only plans or EGWP plans since these plans do not submit a Part D BPT.

All RPPO plans, including EGWPs, must resubmit during the rebate reallocation period, to reflect the published RPPO benchmarks within their bids.

The following tables summarize bid resubmission rules that apply during the rebate reallocation period for various plan types and rebate scenarios and show where examples can be found in this appendix. Additionally, the tables indicate if premium rounding is permitted during rebate reallocation.

MA-PD Plans with MA Rebate Dollars in the Initial June Bid Submission

Type of Plan	Rebate Scenario*	Rebate Reallocation Rules	Premium Rounding Rules	Example
Local (excluding EGWP)	Premium decreases below $0	Required	Permitted	1
Local (excluding EGWP)	Premium decreases but is greater than $0	Permitted	Permitted	2
Local (excluding EGWP)	Premium increases	Permitted	Permitted	3
RPPO		Required, to reflect the published MA regional benchmarks	Permitted	4

* Impact on the Part D basic premium net of rebates (line 7D of Worksheet 6) of reflecting the CMS published benchmarks.

MA-PD Plans with No MA Rebate Dollars in the Initial June Bid Submission

Type of Plan	Rebate Reallocation Rules	Premium Rounding Rules	Example
Local	Not applicable	Permitted (excluding EGWP)	None
RPPO	Required, to reflect the published MA regional benchmarks	Permitted	None

MA-Only Plans

Type of Plan	Rebate Reallocation Rule	Premium Rounding Rule	Example
Local	Not permitted; these plans are not affected by the Part D and MA regional benchmarks	Not permitted; premiums must reflect rounding from the initial June bid submission	None
RPPO	Required, to reflect the published MA regional benchmarks	Permitted	None

II. REBATE REALLOCATION RULES AND EXAMPLES

A. Return to the Target Premium

When rebates are reallocated, the Part D basic premium net of rebate must returned to the target premium indicated in the initial June bid submission. CMS will not accept a partial return to the target premium, except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

B. Negative Part D Basic Premium net of rebate after Part D Benchmark Announcement

If after reflecting announced Part D benchmarks, the Part D basic premium net of rebate is less than zero, rebate reallocation is required.

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if the premium resulting from application of the national average monthly bid amount and the base beneficiary premium is negative, then the

"excess" rebate allocated to buy down the Part D basic premium must be reallocated to buy down the other premiums (the A/B mandatory supplemental premium, the Part D supplemental premium, or the estimated Part B standard premium).

Example 1.

MA BPT Worksheet 6, Section IIIC.	**Initial June bid submission**	**After Release of Benchmark**	**Rebate reallocation Resubmission**
Line 7a. Part D basic premium prior to rebates (rounded)	$36	$34	$34
Line 7c. A/B rebates allocated to art D basic premium (rounded)	$36	$36	$34
Line 7d. Part D basic premium	$0	-$2	$0
Line 10. Plan Intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable

The required change is the shift from a $36 to a $34 rebate allocation to the Part D basic premium in order to return to the target premium of $0. The "excess" $2 is allocated to buy down other premiums.

C. Part D Basic Premium net of rebate after Part D Benchmark Announcement is less than Target Part D Basic Premium, but not less than zero

Rebate reallocation to reduce the premium for A/B mandatory supplemental or Part D supplemental benefits is optional if the Part D basic premium net of rebate is lower than the target Part D basic premium, but not less than zero. The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate in order to return to the target Part D basic premium. The rebates may be reallocated to reduce beneficiary premiums for the A/B mandatory supplemental and Part D supplemental benefits.

Note: If the MA organization elects to allocate the "excess" rebate dollars to the other benefits, the final Part D basic premium must be the target premium. That is, a partial return to the target premium will not be accepted.

Example 2.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June bid submission	After Release of Benchmark	Rebate reallocation Option 1	Rebate reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$35	$30	$30	$30
7c. A/B rebates allocated to Part D basic premium (rounded)	$15	$15	$15	$10
7d. Part D basic premium	$20	$15	$15	$20
10. Plan Intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has the following two options for rebate allocation:

- No rebate reallocation; leave the target Part D basic premium at the post Part D benchmark announcement basic premium of $15. Resubmission is not necessary.
- Reallocate $5 of rebates to other benefits in order to return to the target Part D basic premium of $20.

Note: If the MA organization does not want to maintain the post Part D benchmark announcement premium of $15, only a return to $20 is acceptable, not a partial return of (for example) $18.

D. Part D Basic Premium net of rebate after Part D Benchmark Announcement is greater than Target Part D Basic Premium

Rebate reallocation from the A/B mandatory supplemental or Part D supplemental premiums to the Part D basic premium in order to meet the target Part D basic premium is optional if the Part D basic beneficiary premium net of rebate is higher than the target premium, (that is, "insufficient" rebates). The MA organization has the following two options for rebate allocation:

- Leave the final Part D basic premium net of rebate unchanged (that is, at the level resulting from application of the national average monthly bid amount and the base beneficiary premium), or
- Reallocate rebate that had been applied to the reduction of A/B mandatory supplemental and Part D supplemental premiums or the estimated Part B standard premium toward the Part D basic premium, in order to return to the target D basic premium. If the MA organization does elect to reallocate additional rebate dollars from other benefits, the final Part D basic premium must be the target premium except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

Example 3.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June bid submission	After Release of Benchmark	Rebate reallocation Option 1	Rebate reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$35	$40	$40	$40
7c. A/B rebates allocated to Part D basic premium (rounded)	$15	$15	$15	$20
7d. Part D basic premium	$20	$25	$25	$20
10. Plan Intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has the following two options for rebate allocation:

- No rebate reallocation; leave the target Part D basic premium at the post Part D benchmark announcement Part D basic premium of $25. Resubmission is not necessary.
- Reallocate $5 of rebates from other benefits in order to return to the target Part D basic premium of $20.

Note: If the MA organization does not want to leave the post Part D benchmark announcement premium at $25, only a return to $20 is acceptable and not a partial return of, for example, $23, unless $23 is the result of allocating all rebates to the Part D basic premium.

E. Increase or Decrease in RPPO Total Rebate Dollars

Once CMS announces the MA regional benchmarks, there may be an increase or decrease in the total rebate dollars in a regional plan bid. The allocation of rebate dollars must be revised to reflect the new total rebate dollars.

Example 4.

MA BPT Worksheet 6.	Initial June bid submission	After Release of Benchmark	Rebate reallocation Option 1	Rebate reallocation Option 2
III.B., line 1. Total MA rebate	$55	$53	$53	$53
III.B., lines 2-4 and 6. MA rebates allocated to benefits other than Part D basic premium	$40	$40	$38	$43
III.B., Line 5. A/B rebates allocated to Part D basic premium (rounded)	$15	$15	$15	$10
III.B., line 7. Total rebates allocated	$55	$55	$53	$53
Unallocated rebates	$0	-$2	$0	$0
III.C., Line 7a. Part D basic premium prior to rebates (rounded)	$35	$30	$30	$30
III.C., Line 7d. Part D basic premium net of rebates	$20	$15	$15	$20
III.C., Line 10. Plan Intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

The MA organization has the following two options for rebate allocation:

- Leave basic Part D premium net of rebate at the post Part D benchmark announcement premium of $15. Subtract $2 of rebates that were allocated to other benefits such that the total rebates allocated equal the total rebates available.
- Reduce the rebate allocation for basic Part D premium by $5 in order to return to the target Part D basic premium of $20. Reallocate $3 of rebates to other benefits in order to return to the target Part D basic premium of $20.

F. Every plan bid must allocate the exact amount of the plan's total rebate.

The exact amount of the plan's total rebate must be allocated among the various options described above. MA organizations must account for all rebate dollars in a plan's bid. Moreover, the amount of rebate allocated to A/B mandatory supplemental benefits or the Part B standard premium reduction must not exceed the value of that benefit. For example, if the Part D supplemental premium is $50, an MA organization may not allocate more than $50 to buy down that premium. Rebate allocations to the standard Part B premium cannot exceed the estimated amount provided by CMS in the bid pricing tool.

G. MA-PD Plans with no, or insufficient, MA rebates and Target Part D Basic Premium equals LIPSA

If an MA-PD plan has no, or insufficient, MA rebates and specified that the plan intention for the target Part D basic premium is the low-income premium subsidy amount, but the plan's

Part D basic premium is above the low-income premium subsidy amount after the application of the national average monthly bid amount and the base beneficiary premium, then the plan cannot return to the target premium. The plan cannot have a final Part D premium that is zero for the full-subsidy low-income beneficiaries.

H. First-time allocation of rebate dollars to Part D basic premium during the rebate reallocation period.

In the June bid submission, an MA-PD plan with MA rebate dollars may have opted to not allocate any of the rebate to buying down the Part D basic premium For these bids, if the Part D basic premium after application of the Part D national average monthly bid amount and the base beneficiary premium were to be higher than the target premium, CMS would allow a return to the plan's target premium.

Example 5.

MA BPT Worksheet 6, Section IIIC, Line —	Initial June bid submission	After Release of Benchmark	Rebate reallocation Option 1	Rebate reallocation Option 2
7a. Part D basic premium prior to rebates (rounded)	$10	$15	$15	$15
7c. A/B rebates allocated to Part D basic premium (rounded)	$0	$0	$0	$5
7d. Part D basic premium	$10	$15	$15	$10
10. Plan Intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

III. ADDITIONAL REBATE REALLOCATION GUIDANCE

Changes Allowed to Funding of the Part D Basic and Supplemental Benefits

During the rebate reallocation period, rebate dollars that are not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. However, no modifications are allowed to the benefit design or pricing of the Part D basic benefit or the supplemental benefit offered under the "enhanced alternative" design. Specifically, this prohibition includes that no changes are permitted to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits.

Changes Allowed to Funding of the MA Mandatory Supplemental Benefits

The A/B mandatory supplemental benefit includes additional items and services not covered by Original Medicare and reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under Original Medicare. CMS will not allow MA organizations to substantially redesign A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during the rebate reallocation period; CMS will evaluate material differences.

The value of the added or eliminated A/B mandatory supplemental benefit is required to match the amount of rebate that must be shifted to return to the Part D target premium. For a regional

plan, the value of added benefits is required to match the net shift in total Part C rebate dollars due to an increase or decrease in those total rebate dollars after application of the regional benchmark and/or return to the Part D target premium.

When the Part D basic premium net of rebate is lower than the target Part D basic premium after the Part D benchmark announcement, the MA organization could—

- Further buy down the initial A/B mandatory supplemental premium.
- Add new non-drug benefits (for example, vision) to the A/B mandatory supplemental benefit package and then buy down the new A/B mandatory supplemental premium to the initial level.

For plans with excess rebate, we will not allow the MA organization to eliminate one additional benefit and add another additional benefit.

Example 6.

After application of the national average monthly bid amount and the base beneficiary premium, an MA-PD organization's Part D basic premium net of rebates shifts from $0 to -$3. The MA organization is required to reallocate $3 of rebates and may decide to buy down the cost of a benefit in the A/B mandatory supplemental package.

However, CMS will not allow the MA organization to accomplish rebate reallocation by moving $15 out of A/B cost-sharing reductions and moving $18 into an additional benefit. We would consider this to be a substantial redesign of the A/B mandatory supplemental benefit.

To return an MA-PD plan with "insufficient" rebate to the target Part D basic premium, the MA organization could eliminate an A/B mandatory supplemental benefit. To return a regional plan with a decrease in the total amount of rebate to the original premium, the MA organization could, for example, eliminate from the A/B mandatory supplemental benefit package the coverage of a non-Medicare covered item or service.

See the CY2010 Call Letter for additional guidance regarding benefit changes during rebate reallocation.

Changes Allowed to the Standard Part B Premium Reduction

One use of rebate dollars allowed under 42 CFR §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars may be shifted into or away from funding a reduction in the estimated standard Part B premium, under the reallocation rules described in other sections. Note that the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount of the estimated standard Part B premium released by CMS in the BPT.

Plans Required to Include Prescription Drug Coverage

MA organizations must meet the 42 CFR §423.104(f) requirement on type of drug coverage offered by certain plans and must reallocate the rebate, if necessary, to meet this requirement.

In accordance with 42 CFR §423.104(f), MA organizations may not offer an MA coordinated care plan in an area unless that plan (or another MA plan offered by the same MA organization in the same service area) includes required prescription drug coverage.

Required prescription drug coverage is defined by 42 CFR §423.100 as MA-PD plan coverage of Part D drugs that is either —

- Basic prescription drug coverage (that is, defined standard coverage, actuarially equivalent standard coverage, or basic alternative coverage); or
- Enhanced alternative coverage with no beneficiary premium for the Part D supplemental benefit. An MA-PD plan must apply rebate dollars to reduce to zero the beneficiary premium for the Part D supplemental benefit.

MA organizations are required to comply with this rule. If necessary, MA organizations must reallocate rebate dollars from other benefits to achieve the required Part D supplemental benefit in the plan.

To restate: MA organizations offering coordinated care plans must offer in an area either (a) a basic-only Part D plan or (b) a basic plus supplemental Part D plan for which the supplemental premium (net of rebates) equals zero. Failure to meet this requirement will result in the organization's inability to offer a Part D benefit. In addition, MA organizations offering coordinated care plans, and that fail to offer a Part D benefit in an area will be unable to offer a Part C benefit as well, under the rules of 42 C.F.R. §422.4(c).

Administrative Costs and Gain/Loss Margins

If the value of A/B mandatory supplemental benefits is changed as a result of reallocating rebate, there will be changes in the supplemental administrative costs and the gain/loss margin that reflect the new level of the benefit. Administrative costs and the gain/loss margin are allocated proportionately in the BPT. Therefore, CMS will allow only the resulting minor changes to administrative costs and margin.

This guidance applies to all types of pricing arrangements, including risk sharing and global capitation, and to pricing assumptions that were developed as a percent of revenue.

Local MA Plan Segments

The above rules on rebate reallocation apply to bids for local plan segments, with the following clarifications.

The plan's health care benefit package must be the same across plan segments, though the MA package can be priced differently. MA basic and mandatory supplemental premiums and cost-sharing may differ across the service areas for the segments.

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; thus it may not vary across segments. The amount of rebate allocated to buy-down Part D premiums, the initial target Part D basic premium, and the final Part D basic beneficiary premium must be identical across the entire service areas.

IV. RULES FOR ROUNDING PREMIUMS

Rule 1 – Premiums and Rebates

To comply with premium withhold system requirements, the BPTs round the following premiums to one decimal (that is, to the nearest dime): MA (the sum of basic plus mandatory supplemental), Part D basic, and Part D supplemental. No pennies are allowed.

Rebate dollars allocated to reduce the Part B standard and Part D premiums are rounded to one decimal.

Rebate dollars allocated to reduce the A/B mandatory supplemental premium are rounded to two decimal places.

Note: Prescription Drug Plans (PDPs) express their intention to round the Part D premium in the initial June bid submission, because the rebate reallocation period does not apply to PDPs. In the Part D bid pricing tool, PDPs are permitted to round their premiums to either the nearest $0.10 or the nearest $0.50.

Rule 2 – Local MA-Only Plans

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final premium, as these bids are not affected by the Part D national average calculation or the MA regional plan benchmark calculations. Local MA-only plans will not be given an opportunity to round the premiums after the initial June bid submission. If a local MA-only Plan sponsor wishes to offer a "whole-dollar" premium, the initial June bid submission must reflect a total premium that is rounded to the nearest dollar. The bid assumptions (such as gain/loss margin) must support the desired plan premium and the desired level of premium rounding.

Rule 3 – Local MA-PD plans (excluding EGWPs) and RPPOs

Regional plans and local MA-PD plans (excluding local EGWPs) may participate in the rebate reallocation process. During rebate reallocation, MA organizations may round the total plan premium to the nearest dollar (up or down) by increasing or reducing the gain/loss margin for Part A/B benefits, as long as there is an offsetting reduction of no more than $0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of some combination of the MA basic and mandatory supplemental premiums and the Part D basic and supplemental premiums.)

If the plan has rebate dollars, the Part A/B gain/loss margin can be changed to result in an increase or decrease of $0.50 of rebate dollars. Note that in order to account for the 25 percent of savings retained by the Medicare for plans with bids below benchmarks, the margin can be changed up to a maximum of $0.67 since this will result in a change of up to $0.50 in rebates ($0.67 x 75% = $.50).

If the plan A/B bid is equal to or greater than the A/B benchmark, the Part A/B gain/loss margin can be slightly changed to result in a premium increase or decrease of up to $0.50.

Examples of rounding.

> **Example (a).** An MA-PD plan has no premium for A/B basic or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if: (1) the bid equals the benchmark and no A/B mandatory supplemental benefits are offered, or (2) the bid is less than the benchmark, and the plan has A/B mandatory supplemental benefits and applies rebates to reduce the A/B mandatory supplemental premium to zero). If the post Part D benchmark announcement total plan premium is $30.42, the MA organization could round the plan premium to $30.00 by generating $0.42 of additional rebates to allocate to the basic Part D premium

by slightly reducing the gain/loss margin for Part A/B benefits. (The gain/loss margin for Part D benefits may not change.)

Example (b). An MA-PD plan has no premium for A/B benefits or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if: (1) the bid equals the benchmark and no A/B supplemental benefits are offered, or (2) the plan applies rebates to reduce the A/B mandatory supplemental premium to zero). If the post Part D benchmark announcement bid results in a total plan premium of $32.42, the MA organization could opt to generate $0.42 of additional rebates to allocate to the basic Part D premium by making a slight reduction in the gain/loss margin for A/B benefits that would result in a premium of $32.00.

The MA organization could not use the rounding rules to adjust the premium to anything lower than $32. For example, the organization could not round to a combined premium of $30 by reducing the gain/loss margin to result in a premium change of $2.42. To return to the premium of $30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

Example (c). An MA-PD plan has no rebates and an initial total plan premium of $25. The post Part D benchmark announcement total plan premium is $26.52. The MA organization could round the premium to the nearest dollar (that is, $27.00), by increasing the gain/loss margin to generate a $0.48 MA premium.

Example (d). The target Part D basic premium is the low income premium subsidy amount. After the Part D national average monthly bid amount is calculated, the Part D basic premium is $32.00, and the low-income premium subsidy amount is $31.60. The plan has the following three options:

> ***Option 1.*** The plan can maintain its Part D basic premium of $32.00. The plan's beneficiaries eligible for the full subsidy will pay a Part D basic premium of $0.40.
>
> ***Option 2.*** The MA-PD plan can reallocate $.40 of the rebates that were allocated to the A/B mandatory supplemental premium to its Part D basic premium, thus reducing the premium to the low-income premium subsidy amount of $31.60. To account for the reduction in rebates applied to A/B mandatory supplemental premium, the MA-PD plan may either increase its A/B mandatory supplemental premium by $.40 or reduce its gain/loss margin appropriately to eliminate the premium increase. Enrollees not eligible for the low-income subsidy would pay a Part D basic premium of $31.60.
>
> ***Option 3.*** In order to be able to offer a rounded Part D basic premium to enrollees not eligible for the low-income subsidy, MA-PD plans are permitted in this situation to reallocate A/B mandatory supplemental rebates to reduce their Part D basic premium to the nearest whole-dollar amount below the regional low-income premium subsidy amount. Therefore, the MA-PD plan can reallocate $1.00 of its A/B mandatory supplemental rebates to its Part D basic premium, reducing the Part D basic premium to $31.00, which is the nearest

whole dollar amount below the regional low-income premium subsidy amount of $31.60. To account for the reduction in A/B mandatory supplemental rebates applied to MA, the MA-PD plan must increase its A/B mandatory supplemental premium by $1.00. Please note that in this option, the MA-PD plan forgoes $.60 in potential low-income premium subsidy dollars per full subsidy eligible beneficiary.

Example (e). The target Part D basic premium is the low income premium subsidy amount (LIPSA). After the Part D national average monthly bid amount is calculated, the low-income premium subsidy amount is $31.76. Since Part D premiums must be rounded to the nearest dime, (that is, one decimal), it is acceptable for the plan to round the Part D basic premium to $31.70 or to $31.80 as follows:

Option 1. If the plan rounds the Part D basic premium to $31.70, then they would receive $31.70 as the 100% subsidy. The plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the premium is lower than the LIPSA.

Option 2. If the plan rounds the Part D basic premium to $31.80, then they would receive $31.80 as the 100% subsidy. In this case, the plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the $0.04 difference (that is, $31.80 less $31.76) rounds to zero when the premiums are rounded to one decimal.

Example (f). An MA-PD plan has three segments, with MA premiums of $51, $76, and $110. The Part D basic premium after the benchmark announcement is $37.90. To ultimately achieve whole-dollar total plan premiums, the MA organization could increase the MA gain/loss margin requirements to increase each MA premium by $0.10. When added to the $37.90 Part D premium, the total plan premium for each segment becomes a whole dollar amount: $89, $114, and $148.

Example (g). The initial June bid submission for a local MA-only plan includes a $0 basic MA premium and a $61.30 mandatory supplemental MA premium. The Plan sponsor would like to offer a "whole-dollar" premium to their enrollees. Before submitting the initial BPT to CMS (via HPMS upload), the actuary would slightly revise the gain/loss margin to accomplish the rounded premium. Plan sponsors are not allowed to make significant changes to the BPT in order to round premiums. For example, the actuary could reduce the gain/loss margin by $0.30 to achieve the $61.00 rounded premium. This adjustment must be completed before the BPT is submitted to CMS in early June. Local MA-only plans do not participate in rebate reallocation.

V. SUMMARY OF CONSIDERATIONS FOR REBATE REALLOCATION RESUBMISSIONS

When preparing resubmissions during the rebate reallocation period, plans should review the following considerations:

- All RPPOs (including EGWPs) must resubmit during the rebate reallocation period, in order to reflect the published regional MA benchmarks.

- If the national average monthly bid amount (NAMBA) and Base Beneficiary premium (BBP) result in a Part D basic premium that is lower than the rebates allocated to Part D Basic, then the bid must be resubmitted.
- When resubmitting bids during the rebate reallocation period, are the NAMBA and BBP updated in the Part D BPT?
- Is the Part D bid unchanged?
- Is the Part D basic premium net of rebates equal to the target?
- If targeting the LIPSA, is the resubmitted Part D basic premium net of rebates equal to the plan's LIPSA (rounded to the nearest dime or rounded down to the nearest dollar)?
- Is the "plan's intention for the target premium" unchanged in the MA BPT?
- Are changes to MA pricing assumptions (benefit/non-benefit /gain/loss) consistent with the instructions in this appendix?

APPENDIX F – SUGGESTED MAPPING OF MA PBP CATEGORIES TO BPT CATEGORIES

The Medicare Advantage Bid Pricing Tool contains benefit categories that do not correlate line-by-line with the MA Plan Benefit Package (PBP). The BPT was developed to include a reasonable number of benefit categories for pricing purposes and to provide benefit groupings that are consistent with organizations' accounting and claims systems.

The chart below provides a suggested mapping of the PBP and BPT benefit categories. This mapping is not intended to represent the only method of reporting benefits in the BPT; rather, it contains one suggested method that may be used. Other reasonable mappings may also be used at the actuary's discretion, though supporting documentation is required for mappings different from the one in this appendix (see Appendix B for more details). The cost sharing reported on Worksheet 3 must clearly identify which PBP benefit service categories are priced in each of the BPT service categories (see Worksheet 3 instructions for more details).

HPMS contains a "Medicare Benefit Description Report" with further information regarding the PBP service categories. In addition, the *Medicare Managed Care Manual* may be a helpful resource regarding benefit design.

PBP line #	**PBP Service Category**	**BPT line #**	**Corresponding BPT Category (Worksheet 3)**
1a	Inpatient Hospital - Acute	a1	Inpatient Facility: Acute
1b	Inpatient Psychiatric Hospital/Facility	a2	Inpatient Facility: Mental Health
2	Skilled Nursing Services	b	Skilled Nursing Facility
3	Comprehensive Outpatient Rehabilitation Facility (CORF)	h5	Outpatient Facility - Other: Other
4a	Emergency Care/Post Stabilization Care	f	Outpatient Facility – Emergency
4b	Urgently Needed Services	f	Outpatient Facility – Emergency
5	Partial Hospitalization	h3 h5	OP Facility - Other: Observation or OP Facility - Other: Other
6	Home Health Services	c	Home Health
7a	Primary Care Physician Services	i1	Professional: PCP
7b	Chiropractic Services	i2 i6	Professional: Specialist excl. MH; or Professional: Other
7c	Independent Occupational Therapy Services	i4	Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Excluding Psychiatric Services (exclude Radiology)	i2 i6	Professional: Specialist excl. MH or Professional: Other
7d	Physician Specialist Services Excluding Psychiatric (Radiology only)	i5	Professional: Radiology
7e	Mental Health Specialty Services - Non-Physician	i3	Professional: Mental Health
7f	Podiatry Services	i2 i6	Professional: Specialist excluding. MH or Professional: Other
7g	Other Health Care Professional Services	i2 i6	Professional: Specialist excluding MH or Professional: Other

PBP line #	PBP Service Category	BPT line #	Corresponding BPT Category (Worksheet 3)
7h	Psychiatric Services	i3	Professional: Mental Health
7i	Physical/Speech Therapy	i4	Professional: Therapy (PT/OT/ST)
8a	OP Diagnostic Procedures and tests and Lab Services	h1	OP Facility - Other: Lab
8b	OP Diagnostic and Therapeutic Radiological Services	h2	OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g or h	OP Facility - Surgery or OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center (ASC) Services	g	OP Facility - Surgery
9c	Outpatient Substance Abuse Services	h5	OP Facility - Other: Other
9d	Cardiac Rehabilitation Services	h5	OP Facility - Other: Other
10a	Ambulance	d	Ambulance
10b	Transportation	l	Transportation (Non-covered)
11a	Durable Medical Equipment (DME)	e1	DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Monitoring Supplies	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
12	Renal Dialysis	h5	OP Facility - Other: Renal Dialysis
13a	Blood	k	Other Medicare Part B
13b	Acupuncture	r	Other Non-covered
13c	Over-the-counter Rx	r	Other Non-covered
13d	Meal Benefit	r	Other Non-covered
13e	Other	r	Other Non-covered
14a	Health Education/Wellness Programs	q or k	Health & Education (Non-covered) or Other Medicare Part B
14b	Immunizations	i1	Professional: PCP
14c	(Routine) Physical Exams	i1	Professional: PCP
14d	Pap Smears and Pelvic Exams Screening	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14e	Prostate Cancer Screening		
14f	Colorectal Screening		
14g	Bone Mass Measurement		
14h	Mammography Screening		
14i	Diabetes Monitoring		
14j	Nutritional Training (diabetes and renal disease)		
15	Medicare Part B Drugs	j	Part B Rx
16a	Preventive Services (Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays, Oral Exams)	m	Dental (Non-covered)

PBP line #	PBP Service Category	BPT line #	Corresponding BPT Category (Worksheet 3)
16b	Comprehensive Services (Emergency, Diagnostic, Restorative, Endodontics/Periodontics /Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	m	Dental (Non-covered)
17a	Eye Exams	n1	Vision (Non-covered): Professional
17b	Eye Wear	n2	Vision (Non-covered): Hardware
18a	Hearing Exams	o1	Hearing (Non-covered): Professional
18b	Hearing Aids	o2	Hearing (Non-covered): Hardware

APPENDIX G – MEDICAL SAVINGS ACCOUNT BPT

This appendix provides guidance in completing the Medical Savings Account Bid Pricing Tool for Medical Savings Account (MSA) and Medical Savings Account Demonstration (MSA Demo) plans offered to Medicare beneficiaries. Any reference to MSA plans also pertains to MSA Demo plans unless otherwise noted. This appendix will highlight only the differences between the MSA BPT and the MA BPT.

The MSA bid form is organized as outlined below:

Worksheet 1 - MSA Base Period Experience and Projection Assumptions
Worksheet 2 - MSA Total Projected Allowed Costs PMPM
Worksheet 3 - MSA Benchmark PMPM
Worksheet 4 - Enrollee Deposit and Plan Payment PMPM
Worksheet 5 - Optional Supplemental Benefits

WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS (CORRESPONDING TO MA WORKSHEET 1)

SECTION I - GENERAL INFORMATION

Line 7 – Plan Type

Enter either MSA or MSA Demo.

Line 8 – Deductible Amount

Enter the deductible amount that each beneficiary will pay for Medicare-covered benefits. The maximum deductible for CY2010 for both MSA and MSA Demo plans is $10,600. The minimum deductible amounts for CY2010 for MSA and MSA Demo plans are $0 and $2,200, respectively.

Line 9 – Enrollee Type

This cell is pre-populated with "A/B."

SECTIONS II, III, IV, AND V

Base period data in Sections II, III, IV, and V must include only Medicare-covered medical expenses.

WORKSHEET 2 – MSA TOTAL PROJECTED ALLOWED COSTS PMPM (CORRESPONDING TO MA WORKSHEET 2)

SECTION II – PROJECTED ALLOWED COSTS

Data in Section II must include only Medicare-covered medical expenses.

WORKSHEET 3 – MSA BENCHMARK PMPM (CORRESPONDING TO MA WORKSHEET 5)

Follow the instructions for MA Worksheets 5 and 6 for the appropriate inputs.

WORKSHEET 4 – ENROLLEE DEPOSIT AND PLAN PAYMENT (NO CORRESPONDING MA WORKSHEET)

This worksheet calculates the MSA monthly plan revenue requirement and enrollee deposit.

Consistent with other worksheets, information provided on Worksheet 4 must exclude ESRD enrollees.

SECTION II – DEVELOPMENT OF CLAIM INFORMATION INTERVALS

Column c – Annual Projected Claim Interval

The column is pre-populated with annual projected claim intervals.

Column d – Annual Average Claim Amount

Enter the annual average claim amount paid in each claim interval.

Column e – Percentage of Member Months (Use Only the Highest Claim Interval)

Allocate the total projected member months to the highest claim interval expected by percentage.

For example, if 20% of the member months are expected to incur annual claims of $11,500, and 10% are expected to incur annual claims of $4,400, then put 20% only in the interval containing $11,500 and 10% only in the interval containing $4,400. The sum of column e must equal 100%.

Column f – Gross Claims (PMPM)

This column calculates total allowed Medicare-covered claims on a PMPM basis for each claim interval. No entry is required. The sum of column f must equal the total Medicare-covered medical expenses shown in column o of Worksheet 2.

Column g – Gross Claims over Deductible (PMPM)

Enter the total allowed Medicare-covered claims on a PMPM basis over the deductible for each claim interval expected to be paid by the MSA plan. Enter zero (0) for claim intervals below the deductible.

Cell G32 (MSA Demo Only) – Services Covered within the Deductible

Input the PMPM value of services that the plan is expected to cover within the deductible.

Cell G33 (MSA Demo Only) – Cost Sharing Offset over the Deductible

Input the PMPM value of beneficiary cost sharing over the deductible.

SECTION III – DEVELOPMENT OF SUMMARY INFORMATION

Line a – Medicare-Covered Medical Expenses PMPM

This cell displays the sum of column g of Section II.

Line b – Non-Benefit Expenses

Enter the non-benefit expense information. Please refer to the "Pricing Considerations" sections of these instructions for further guidance.

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

Line c – Gain/Loss Margin

Input the projected PMPM for the gain/loss for Medicare-covered services provided. Please refer to the "Pricing Considerations" section of these instructions for further guidance.

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

Line d – Total Plan Revenue Requirement

This cell is calculated automatically as the sum of projected Medicare-covered medical expense, non-benefit expense, and gain/loss margin.

Line e – Projected Plan Benchmark

This cell displays the value from Section III, column h, line 1 of Worksheet 3 — the weighted average for the service area of the risk-adjusted ratebook values.

Line f – Projected Monthly Enrollee Deposit

This cell calculates the monthly enrollee deposit by subtracting the total plan revenue requirement from the projected plan benchmark. For CY2010, the deductible must exceed, by at least $1,000, the annual deposit into the enrollee's savings account (MSA Demo only).

Line g – Percent of Plan Revenue Ratios

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

Line h – Standardized Plan Benchmark

This cell displays the value from Section III column g line 1 of Worksheet 3 - the weighted average for the service area of the unadjusted ratebook values.

WORKSHEET 5 – OPTIONAL SUPPLEMENTAL BENEFITS (CORRESPONDING TO MA WORKSHEET 7)

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

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 5 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.