
INSTRUCTIONS FOR COMPLETING
THE MEDICARE ADVANTAGE
BID PRICING TOOLS
FOR CONTRACT YEAR 2015

April 11, 2014

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I. INTRODUCTION

BACKGROUND

Medicare Advantage (MA) organizations must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each plan that they intend to offer under the Medicare Advantage program, including MA plans, Medical Savings Account (MSA) plans and End-Stage Renal Disease-only special needs plans (ESRD-SNPs). For plans with service area segments, a separate bid must be submitted for each segment. In these Instructions, the term “bid ID” refers to: (i) the contract and plan number combination for non-segmented plans, and (ii) the contract, plan, and segment number combination for segmented plans.

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

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

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

DOCUMENT OVERVIEW

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

- Section I, “Introduction”: contains background information and a list of key changes from CY2014, and provides sources of additional information regarding the bidding process.
- Section II, “Pricing Considerations”: includes guidance for the overall approach to pricing in the BPT and topic-specific issues for bidders to consider. The section topics are arranged alphabetically.
- Section III, “Data Entry and Formulas”: contains line-by-line instructions on each data entry field and describes the formulas for calculated cells.
- Section IV, Appendices: contain information on Actuarial Certification, Supporting Documentation, Part B-Only Enrollees, MA Products Available to Groups, Rebate Reallocation and Premium Rounding, Suggested Mapping of MA Plan Benefit Package (PBP) Categories to BPT Categories, DE#, Related-Party Requirements, the MSA BPT, the ESRD-SNP BPT, and Trending Risk Scores.

NEW FOR CONTRACT YEAR 2015 (CY2015)

Some of the key features that are new or changed for the CY2015 BPT are listed below. The changes improve the usability and functionality of the BPT and reflect current guidance.

- Technical
 - The add-in file (BPT2015.xlam) must be saved under C:\BPT\BPT2015\.
See the BPT technical instructions for more information.
- MA Worksheet 1
 - In Section VI, line 7e “Insurer Fees” has been added.
 - In Section VI, line 7e “Total Non-Benefit expenses” has been renumbered line f “Total Non-Benefit expenses” and the calculation now includes insurer fees.
 - In Section VI, three lines have been removed.
 - Line 10a “NBE Quality Initiatives”
 - Line 10b “Taxes and Fees”
 - Line 10c “Insurer Fees (subset of Taxes and Fees)”
 - In Section VI, six lines have been moved up 4 rows renumbered from 11a, 11b, 11b1, 11b1, and to—
 - Line 10a “Medicaid Revenue”
 - line 10b “Medicaid Cost”
 - Line 10b1 “Benefit Expenses”
 - Line 10b2 “Non-benefit expenses”
 - Line 10c “Adjusted GLM”
- MA Worksheet 3
 - In Section IV, PBP line 4c has been moved between PBP line 4b and PBP line 5.
- MA Worksheet 4
 - In Section IIC, line v5 “Insurer Fees” has been added. In columns o and r, calculations are added to proportionately distribute the insurer fees between “Medicare Covered” and A/B Mand Suppl (MS) Benefits”.
 - In Section IIC, line v5 “Total Non-Benefit expenses” has been renumbered line v6 and the calculation includes insurer fees.
 - In Section IIC, four lines have been deleted:
 - Line y4 “BPT MLR”
 - Line z1 “NBE Quality Initiatives”
 - Line z2 “Taxes and Fees”
 - Line z3 “Insurer Fees (subset of Taxes and Fees)”
- MA Worksheet 5
 - In Section V, the Rebate % in cell L26 has been revised to assign a 65% rebate percentage to low enrollment contracts.

- In Section VI, an out-of-area line has been added in row 38:
 - Cell B38 “Out of Area”
 - Cell E38 is an input field for out-of-area projected member months.
 - Cell F38 is an input field for out-of-area projected risk factors.
 - Cell H38, calculations are added for out-of-area “MA Risk Ratebook Unadjusted”.
 - Cell I38, calculations are added for out-of-area “MA Risk Ratebook Risk-Adjusted”.
 - In Section VI, row 36, calculations are revised to reflect out-of-area in the weighted-average calculation of —
 - In column e, “Projected Member Months”
 - In column h, “MA Risk Ratebook Unadjusted”.
 - In column i, “MA Risk Ratebook Risk-Adjusted”.
 - In Section VI, row 36, calculations are revised to subtract out-of-area member months in the denominator of the weighted-average calculation for—
 - In column j, “ISAR scale”
 - In column k, “ISAR-Adjusted Bid”.
 - In Section VII, cell T37 has been revised to subtract out-of-area member months in the denominator
 - In Section VIII, the calculation for—
 - Line 1 “Member Months by County (Sect VI.)” has been revised to subtract out-of-area member months.
 - Line 4 “Out-of-Area (OOA) member months” is no longer an input cell, it is now a calculated field.
- MA Worksheet 7
 - In Section II, all service category detail lines have been removed from each package.
 - In column c, “Service Category” is deleted and replaced with “Description”.
 - In Section II, seven columns have been deleted:
 - Column d “Benefit category or pricing component”.
 - Allowed medical expense data in columns e through g.
 - Enrollee cost sharing data in columns i through k.
 - In Section II, package total values for—
 - “Allowed Medical Expense PMPM” and “Enrollee Cost Sharing PMPM” are no longer calculated fields, they are now input cells.
 - “Net PMPM value” is now calculated as the difference between “Allowed Medical Expense PMPM” and “Enrollee Cost Sharing PMPM” from the same package total row.
 - In Section II, a “Weighted Avg. Total” line has been added to calculate weighted-average values for all 5 packages with weights equal to projected membership for—,
 - Column d “Allowed Medical Expense PMPM”
 - Column e “Enrollee Cost Sharing PMPM”
 - Column f “Net PMPM Value”
 - Column g “Non-Benefit Expense”

- Column h “Gain(Loss) Margin”
 - Column i “Premium”.
 - In Section II, column j a “Weighted Avg. Total” line has been added to sum “Projected Member Months” for all packages.
 - In Section III, the size of the comment box has been reduced.
- MSA Worksheet 3
 - In Section III, an out-of-area line has been added in row 38:
 - Cell B38 “Out of Area”
 - Cell E38 is an input field for out-of-area projected member months.
 - Cell F38 is an input field for out-of-area projected risk factors.
 - Cell G38, calculations are added for out-of-area “MA Risk Ratebook Unadjusted”.
 - Cell H38, calculations are added for out-of-area “MA Risk Ratebook Risk-Adjusted”.
 - In Section III, row 36, calculations are revised to reflect out-of-area in the weighted-average calculation of —
 - In column e, “Projected Member Months”
 - In column g, “MA Risk Ratebook Unadjusted”.
 - In column h, “MA Risk Ratebook Risk-Adjusted”.
 - In Section IV, a new/low indicator has been added to Cell I12.
- MSA Worksheet 4
 - In Section III, line 5 “Insurer Fees” has been added.
 - In Section III, line 5 “Total Non-Benefit expenses” has been renumbered line 6 and the calculation includes insurer fees.
 - In Section III, four lines have been deleted:
 - Line i “BPT MLR”
 - Line j “NBE Quality Initiatives”
 - Line k “Taxes and Fees”
 - Line l “Insurer Fees (subset of Taxes and Fees)”
- MSA Worksheet 5
 - Changes are consistent with those made for MA Worksheet 7
- ESRD-SNP Worksheet 2
 - In Section II, “Insurer Fees” has been added to the “Non-benefit components”.
 - In Section II, four lines have been deleted:
 - “BPT MLR”
 - “NBE Quality Initiatives”
 - “Taxes and Fees”
 - “Insurer Fees (subset of Taxes and Fees)”
- ESRD-SNP Worksheet 4
 - Changes are consistent with those made for MA Worksheet 7

BIDDING RESOURCES

In addition to these Instructions, the following resources provide information on CY2015 bidding:

- The CY2015 Advance Notice and draft CY2015 Call Letter may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf>.
- The CY2015 Rate Announcement and CY2015 Call Letter may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf>.
- The CY2015 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/bidTraining2015.html> and <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTrainingIntro.html>.
- Medicare fee-for-service trends may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html>.
- 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 CY2015 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 17, through May 29, 2014
 - 11:00am – 12:00pm ET
 - See HPMS announcement for call details
- For technical questions about the BPT, BPT Batch Tools, HPMS, or the upload process, refer to the following resources:
 - The Technical BPT Instructions located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2015 > Documentation > BPT Technical Instructions
 - The *Bid Submission User's Manual*, also available in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2015 > Documentation > Bid User's Manual
 - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov
- For information about benefits and service categories, see—
 - Chapter 4 of the *Medicare Managed Care Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>
 - The CY2015 PBP/SB Software List of Changes located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2015 > Documentation > PBP – SB List of Changes

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

By Part C statute, the bid must represent the revenue requirement of the expected population. Therefore, the revenue requirement in the MA bid pricing tool (BPT) must reflect the costs for providing MA services; it must not include the cost for non-MA services (such as Part D).

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

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the bid ID level if the plan existed in CY2013, 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

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Affordable Care Act

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

The contract-level ratings for the CY2015 QBP can be found at the following path in HPMS: HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating > 2015.

Low-Enrollment Contract

A low-enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because it lacked a sufficient number of enrollees to reliably measure the performance of the health plan. For 2015, a "low" enrollment contract receives a QBP percentage of 3.5% and a rebate percentage of 65%.

New Contract under New Parent Organization

A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, until the contract has enough data to calculate a star rating. For 2015, a "new contract under new parent org" receives a QBP percentage of 3.5% and a rebate percentage of 65%.

New Contract under Existing Parent Organization

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

The following table outlines the QBP percentage and rebate percentage for various QBP star ratings in CY2015.

QBP star rating	CY2015 QBP Percentage	CY2015 Rebate Percentage
4.5+	5.0%	70%
4.0	5.0%	65%
3.5	0.0%, except for: 3.5% for "new contract under new parent org" 3.5% for "low enrollment contract"	65%
3.0	0.0%	50%, except for: 65% Employer/Union Direct PFFS (ED PFFS) contract
< 3.0	0.0%	50%

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The CY2015 Advance Notice and Rate Announcement contain additional information regarding the ACA provisions and the Quality Bonus Payment.

Bad Debt

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

Base Period Experience

The base experience must be based on claims incurred in calendar year 2013 with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

Worksheet 1 must be completed with data at the bid level, that is, for the bid ID. Note that these data must—

- Be reported without adjustment in Section III except as noted in the pricing considerations for capitated arrangements for medical services and related-party arrangements (medical and non-benefit). (Adjustments may be made in Section IV to accommodate population, benefit design, or other changes between the base period and the projection period.)
- Be submitted in Worksheet 1 at the bid level for all bid IDs with experience data in 2013, regardless of the level of enrollment.
- Reconcile in an auditable manner to the Plan sponsor's audited financial statements.
- Be provided for plans acquired by the Plan sponsor.
- Not be used to aggregate data from multiple plans in order to achieve credibility. Credibility is addressed on Worksheet 2.
- Must be reported in total at the bid level for every bid ID if base period experience is aggregated; do not include partial plan experience on Worksheet 1.
- May be reported on more than one bid when plans are aggregated, depending how enrollment changes are processed.

The medical expenses in Section III must—

- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Be reported on an allowable basis (before any reduction for reinsurance recoveries or cost sharing) and on a net basis.
- Include any provider incentive payments.
- For Employer-only or union-only group waiver plans (EGWPs), reflect the actual cost sharing provided to groups enrolled. For other plans, reflect the full level of plan cost sharing in the plan benefit package (PBP) for all enrollees including the DE# beneficiaries. See the pricing consideration for dual-eligible beneficiaries for more information about DE# beneficiaries.
- Include claim experience for out-of area enrollees.

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- Include or exclude claim experience for hospice enrollees for the time period that an enrollee is in hospice status consistent with the development of projected allowed costs. See the pricing consideration for hospice enrollees.
- Exclude end-stage renal disease (ESRD) claim experience for the time period that an enrollee is in ESRD status based on CMS eligibility records.
- Exclude claims experience for optional supplemental benefits.
- Exclude incurred claims for Medicaid benefits.

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

Data Aggregation

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

- How enrollment changes are processed.
 - In these Instructions, the term “formal crosswalk” refers to the crosswalk process submitted in HPMS for plan consolidations (that is consolidated renewals), whereby members are automatically moved from one bid ID to another (that is, to one bid ID only). Without an HPMS crosswalk in place, members are dis-enrolled from the terminating bid ID and must actively select to enroll in a new bid ID of their choosing.
 - MARx enrollment transactions are used to automatically move members from one bid ID to more than one bid ID, for example, when the service area of one or more segments is redefined. Note that in some cases, an approved crosswalk is required, for example, when the service area of one or more non-segmented plans is redefined. In this situation, without an approved crosswalk in place, members in the affected counties must actively select to enroll in a bid ID of their choosing.
 - For more information about MA organization renewals and crosswalks see section 140 in Chapter 4 of the *Medicare Managed Care Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>.
- Whether or not enrollment changes that are processed via MARx enrollment transactions apply to a significant percentage of members in the bid ID from which the members are moving, as determined by the certifying actuary.

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

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

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

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- When two or more plans are consolidated and the members are crosswalked into an existing or new plan under a formal crosswalk.
- When a significant proportion of members in a bid ID (as determined by the certifying actuary) are crosswalked into existing or new plans through MARx enrollment transactions.

Note the following:

- Members may be crosswalked each contract year. For BPT reporting purposes, the actuary must consider the crosswalks from the base period to the contract period (that is, two years of crosswalks, from CY2013 to CY2014, and then from CY2014 to CY2015).
- This rule applies when members are crosswalked within the same contract and when members are crosswalked between contracts in accord with the limited exceptions described in CMS annual renewal and non-renewal guidance.

✓ **Rule 2 – Enrollment Shifts**

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

- When an existing member chooses to enroll in a different plan.
- When an insignificant proportion of members in a bid ID (as determined by the certifying actuary) are crosswalked into existing or new plans through MARx enrollment transactions.
- When enrollment changes do not involve a crosswalk whether or not a bid ID is terminated.

✓ **Rule 3 – Partial Experience**

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

Example 1:

An MA organization offers non-segmented plans H1234-001 and H5678-002 in CY2013 and non-segmented plan H5678-002 and new non-segmented plan H5678-003 in CY2015. Plan H1234-001 is consolidated and the membership is formally crosswalked into H5678-003 for CY2015 in accord with the limited exceptions described in CMS annual renewal and non-renewal guidance. Base period experience must be reported on Worksheet 1 of the CY2015 BPTs as follows:

- For H5678-002, report aggregate base period experience for H5678-002 (Rule 1 and Rule 3).
- For H5678-003, report base period experience for H1234-001 (Rule 1 and Rule 3).

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Example 2:

An MA organization offers non-segmented plans 001, 002, and 003 in CY2013 and non-segmented plan 003 and new non-segmented plan 004 in CY2014. Plan 001 is consolidated and the membership is formally crosswalked to plan 004 for CY2015 as submitted in HPMS. Plan 002 is terminated for CY2015 and the certifying actuary expects the membership in such plan to enroll evenly between plan 003 and plan 004; however, there is neither formal crosswalk nor an approved crosswalk exception in place. Base period experience must be reported on Worksheet 1 of the CY2015 BPTs as follows:

- For plan 003, report base period experience for plan 003 (Rule 2 and Rule 3). Do not report base period experience for plan 002 (Rule 2).
- For plan 004, report base period experience for plan 001 (Rule 1). Do not report base period experience for plan 002 (Rule 2).

Example 3:

An MA organization offers non-segmented plans 001 and 002 in CY2013 and plan 002 in CY2015. Plan 001 is consolidated and the membership is formally crosswalked to plan 002 for CY2014. For CY2015, the service area for plan 002 is reduced to remove most of the counties formerly in plan 001 and an insignificant proportion of the members that were formerly in plan 001 remain. Base period experience must be reported on Worksheet 1 of the CY2015 BPTs as follows:

- For plan 002, report aggregate base period experience for plan 001 (Rule 1 and Rule 3) and plan 002. Do not exclude plan 001 data for enrollment shifts in CY2015.

Example 4:

An MA organization offers non-segmented plans 001, 002, 003, and 004 in CY2013 and plans 003 and 004 in CY2015. Plan 001 is consolidated and the membership is formally crosswalked to plan 002 for CY2014. Plan 002 is consolidated and the membership is formally crosswalked to plan 003 for CY2015. Base period experience must be reported on Worksheet 1 of the CY2015 BPT as follows:

- For plan 003, report aggregate base period experience for plans 001, 002, and 003 (Rule 1 and Rule 3).
- For plan 004, report base period experience for plan 004.

Example 5:

An MA organization offers PFFS non-network plan H1234-001 and PFFS full network plan H5678-001 in both CY2013 and CY2015. However for CY2015, county A in H1234-001 is reclassified from non-network to full network and is moved from the service area of H1234-001 to the service area of H5678-001. A significant percentage of members in plan H1234-001 are in county A and are

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moved to H5678-001 through MARx enrollment transactions under an approved crosswalk exception.

Also for CY2015, county B in H5678-001 is reclassified from full network to non-network and is moved from the service area of H5678-001 to the service area of H1234-001. In this case, an insignificant percentage of members in H5678-001 are in county B and are moved to H1234-001 through MARx enrollment transactions under an approved crosswalk exception. Base period experience must be reported on Worksheet 1 of the CY2015 BPTs as follows:

- For H1234-001, report base period experience for H1234-001. Do not report base period experience for H5678-001 (Rule 2).
- For H5678-001, report aggregate base period experience for plans H1234-001 and H5678-001 (Rule 1 and Rule 3).

Example 6:

An MA organization offers segmented plan 001 with segments 01, 02, 03, 04, and 05 for CY2013 and segments 02, 03, 04 for CY2015. For CY2014, segments 01 and 05 are terminated with crosswalks summarized below and the service areas for segments 02, 03 and 04 are redefined as summarized below.

- Segment 01 is terminated and the membership is crosswalked into segments 02 and 04 through MARx enrollment transactions.
- For segment 02, counties are added to the service area, but no counties are removed.
- For segment 03 and 04, counties are added to the service area of each segment. Counties are also removed from the service area of each of these segments and members in the affected counties are moved to other segments through MARx enrollment transactions (see table below).
- Segment 05 is consolidated and the membership is formally crosswalked into segment 04.

H1234-001 Segment	Total Members 12/31/2013	% Members Automatically Moved	Segment Cross-walked to
01	20,000	85% (17,000)	04
01	20,000	15% (3,000)	02
02	10,000	N/A	N/A
03	30,000	40% (12,000)	04
03	30,000	15% (4,500)	02
04	40,000	55% (20,000)	03

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H1234-001 Segment	Total Members 12/31/2013	% Members Automatically Moved	Segment Cross-walked to
04	40,000	45% (18,000)	02
05	5,000	100% (5,000)	04

The certifying actuary determines that 40% is a significant percentage of members in a bid ID to be crosswalked into another bid ID through MARx enrollment transactions; therefore, Worksheet 1 of the CY2015 BPTs for segments in H1234-001 must include the following base period experience:

- For segment 02, aggregated data for segment 04 (Rule 1 and Rule 3) and segment 02. Do not report base period experience for segments 01 and 03 (Rule 2).
- For segment 03, report aggregated data for segment 04 (Rule 1 and Rule 3) and segment 03.
- For segment 04, report aggregated data for segments 01, 03, 05 (Rule 1 and Rule 3), and segment 04.

Benefits and Service Categories

Benefits are defined in Chapter 4 of the *Medicare Managed Care Manual* (MMCM) as Medicare-covered, mandatory supplemental, or optional supplemental benefits. Mandatory supplemental benefits are priced in the BPT as benefit expenses (not non-benefit expenses), for example, smoking cessation programs and gym memberships.

The user must generally enter input items related to medical expenses separately for each service category displayed in the BPT. See Appendix F for a suggested mapping of BPT and PBP service categories.

The certifying actuary must include in non-benefit expenses, the cost of rewards and incentives that do not qualify as benefits and are marketing tools covered under CMS Marketing Guidelines.

For more information on benefits, service categories, and segmented bids see:

- Chapter 3 “Medicare Marketing Guidelines” and Chapter 4 Benefits and Beneficiary Protections” of the *Medicare Managed Care Manual* (Publication #100-16) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLSort=0&DLSortDir=ascending>.
- Medicare Marketing Guidelines at <http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>
- Call Letter (included in the Advance Notice) at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>
- PBP/SB Software List of Changes located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY20XX > Documentation > PBP – SB List of Changes.

Disease Management

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

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

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

Medicare-Covered and Non-Covered

Following are the three types of service categories:

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

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

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

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

Inpatient Hospital Additional Days

CMS developed a 1.2-percent factor based on FFS data that can be used as a “safe harbor” for the proportion of inpatient days that are non-covered. If the non-covered

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

Non-Covered Limited Benefits

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

Skilled Nursing Facility (SNF)

If the PBP provides skilled nursing facility (SNF) benefits without a three-day prior in-patient hospital stay, the certifying actuary may price the waiver of the prior hospitalization requirement as a Medicare-covered benefit.

However, the certifying actuary must allocate the projected allowed cost of SNF mandatory supplemental benefits (that is, additional days or stays in a SNF that is not approved for Medicare stays) to non-covered.

Capitated Arrangements for Medical Services

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

✓ Annual Utilization Per 1,000

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

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

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

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

Global Capitation and Risk-Sharing Arrangements

This subsection contains additional requirements for costs associated with global capitation and risk-sharing arrangements as described below.

- It is not appropriate to provide risk protection for PD through MA or vice-versa. Therefore, the MA BPT must not include the portion (determined based on net allowed costs of services included in the global capitation contract) of global capitation payments attributable to Part D—the Part D BPT must include such amount.
- The BPT must reflect the benefit costs in the service categories included in the global capitation contract. If the certifying actuary projects a payment adjustment at the end of the contract year, such adjustment must be allocated to service category based on net medical costs under the global capitation arrangement prior to such adjustment. Specifically, the adjustment for a particular service category is based on the ratio of: (i) net medical costs in such service category, and (ii) total net medical costs of the service categories included in the global capitation contract.

The cost sharing PMPM in Worksheet 3, Section III, column i must be based on benefits outlined in the PBP. Therefore, in order for the BPT to reflect the appropriate projected allowed costs and net medical expenses, the effective coinsurance percentage in column i may not match the coinsurance percentage in the PBP. See the cost sharing pricing consideration for more information about the calculation of the effective coinsurance percentage.

Coordination of Benefits (COB)/Subrogation

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

Cost Sharing

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

Coinsurance

The cost sharing PMPM in Worksheet 3, Section III, column i must be based on benefits outlined in the PBP. Therefore, in order for the BPT to reflect the appropriate projected allowed costs and net medical expenses, the effective coinsurance percentage in column i may not match the coinsurance percentage in the PBP. Examples include, but are not limited to, adjustments to projected allowed costs and /or net medical expenses for related-party arrangements under Method 1 Actual Costs, sequestration, global capitation, and risk sharing arrangements.

Following is an example:

Example: The PBP contains in-network cost sharing of 20%. \$3 PMPM of projected allowed costs must be shifted from medical expense to non-benefit expense and gain/loss margin in order to satisfy the related party requirements.

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BPT values before related-party requirements are taken into account would be as follows:

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

BPT values that do not recognize the independence of the subcontracted related party are as follows:

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

Consistency with PBP

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

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

Medicare FFS Cost Sharing

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

However, the effective copay/coinsurance after MOOP in Worksheet 3, column j must reflect the expected impact of the OOP max (which is a required PBP entry). Note that if Worksheet 3 is completed for the total population and the total population includes non-DE# members, then the effective copay/coinsurance values before and after MOOP (Worksheet 3 columns i and j) may not be equal.

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

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These approaches do not apply for other levels of cost sharing or for local preferred provider organization (PPO) plans and regional PPO plans with an annual deductible.

Visitor/Travel Benefits

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

Credibility

Claims Credibility

This section pertains to the experience credibility percentages in Worksheet 2.

Based on an application of classical credibility theory to Medicare FFS experience, CMS has established a credibility guideline for projected allowed costs of full credibility for MA plans of 24,000 base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. This formula is a guideline; actuaries may use a different credibility methodology. However, any method used must be consistently applied among all bids in the contract.

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

- If the CMS formula for partial credibility is applied to base period members months and the resulting credibility is—
 - Less than or equal to 20 percent (that is, 960 or fewer MA member months), then the actuary may override the computed credibility with 0 percent credibility.
 - Greater than or equal to 90 percent (that is, 19,440 or more MA member months), then the actuary may override the computed credibility with 100 percent credibility.
- The override is applicable only to the CMS credibility formula; it is not applicable to any alternative credibility formula. If the certifying actuary overrides the CMS credibility, then the override option must be applied consistently among all bids and cannot be applied selectively to certain bids.

The credibility assumption for projected allowed costs may vary—

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

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

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Credibility for Medicare Secondary Payor (MSP)

This section pertains to the application of credibility in developing the MSP adjustment on Worksheet 5. If the conditions in the manually-rated bids subsection of the MSP adjustment pricing consideration are met, the MSP adjustment is zero. In other situations, the manual rate for projected allowed costs and the projected experience rate must consistently reflect the MSP assumption for the expected bid population and a credibility factor is not applicable.

Risk Score Credibility

This section pertains to the application of credibility in developing projected risk scores. The use of the CMS claims credibility guideline above is not permitted for risk scores. The certifying actuary must use actuarial judgment in developing a credibility guideline for risk scores. CMS has not developed a separate credibility guideline for risk scores.

Dual-Eligible Beneficiaries

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

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

Medicaid Revenue and Costs

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

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

Worksheet 1 collects the Medicaid data (in total dollars) of revenue and costs in the base period (Section VI, lines 10a and 10b). These items are defined in the same manner as for the projection period.

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

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

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

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

Definition of DE#

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

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

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

- Consider the 2013 membership data posted in HPMS for the contract plan-ID segment(s) listed in Worksheet 1 for the base period.
- Consider the membership in the QMB and QMB+ categories to represent the entire DE# population only if the percentage of total dual-eligible beneficiaries (who comprise all dual-eligible categories and not just the QMB and QMB+ categories) is less than 10 percent of total beneficiaries.
- If the percentage of total dual-eligible beneficiaries is greater than or equal to 10 percent of total beneficiaries, then determine which dual-eligible beneficiaries, in addition to QMB and QMB+ beneficiaries, are DE# based on the Medicaid cost-sharing policy for the states or territories in the plan’s service area.

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

Bid Values

The BPT must reflect data and costs for the DE# and non-DE# populations separately, as explained in this section and summarized in Appendix G. Note that the distinct data and costs for both the DE# and non-DE# populations must reflect the impact of out-of-area members.

✓ **Worksheet 1 – Base Period Data**

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

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

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

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

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

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

- Enter projected allowed costs for the non-DE# beneficiaries in column p and projected allowed costs for the DE# beneficiaries in column q.
- If DE# projected member months are between 10 percent and 90 percent inclusive of the total projected member months, then enter distinct DE# and non-DE# projected allowed costs (columns p and q).
- If DE# projected member months are less than 10 percent or greater than 90 percent of the total projected member months, then the user may, at the discretion of the certifying actuary, enter—
 - Non-DE# projected allowed costs (column p) equal to the projected allowed costs for the total population (column o); and
 - DE# projected allowed costs (column q) equal to the projected allowed costs for the total population (column o).
- If the projected member months for the DE# population or for the non-DE# population are equal to zero, then enter projected allowed costs for the non-DE# beneficiaries (column p) and for the DE# beneficiaries (column q) equal to the projected allowed costs for the total population (column o). Do not enter zero for these costs.
- Complete Worksheet 2, column p on a “per non-DE# member per month” basis, and complete column q on a “per DE# member per month” basis.

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✓ **Worksheet 3 – Cost Sharing**

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

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

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

✓ **Worksheet 4 – Projected Required Revenue**

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

- In subsection A (non-DE#s), net medical expenses for Medicare-covered benefits (column o) are calculated based on FFS actuarially equivalent cost-sharing proportions (column k).
- In subsection B (DE#s), comparable medical expenses are calculated for DE# beneficiaries, taking into account the reduced or eliminated cost-sharing liability of dual-eligible beneficiaries, including the state or territory Medicaid cost sharing (column k). Specifically, the Medicare-covered net PMPM reflects—
 - What the plan pays the provider for Medicare-covered services; plus
 - The actual cost sharing for Medicare-covered services; less
 - The state or territory Medicaid cost sharing for Medicare-covered services.
- In subsection C (all beneficiaries), the BPT weights the non-DE# and DE# costs by their respective projected member months (from Worksheet 5) to calculate costs for all beneficiaries. The user must enter total non-benefit expenses and the gain/loss margin for all beneficiaries.

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

- All values must be calculated on a “per DE# member per month” basis.

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

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

✓ **Worksheet 5 – Benchmark**

The user must enter—

- Distinct projected member months and projected risk factor for the non-DE# population, (including out-of-area members) in Section II (lines 1 and 4).
- Projected member months and projected risk factors for out-of-area members (DE# plus non-DE#) in Section VI (line 38, columns e and f).
- County-specific projected member months and projected risk factors for the total (DE# plus non-DE#) population, excluding out-of-area members, in Section VI (columns e and f) beginning in line 39).

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

Considerations for developing projected member months include the following:

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

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

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

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

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

See the enrollment pricing consideration for information about entering enrollment in the BPT by county and Appendix D, "MA Products Available to Groups", for group-specific information.

End-Stage Renal Disease (ESRD)

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

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status based on CMS eligibility

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records, with the exception of Worksheet 1 Section VI, Worksheet 4 Section III, and Worksheet 5 Section VIII. Note that all Plan sponsors must enter the projected CY ESRD member months in Worksheet 5.

ESRD Subsidy

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

✓ Basic Benefits

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

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

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

✓ Supplemental Benefits

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

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

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

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

Enrollment

The projected enrollment for the MA bid must be consistent with that for the corresponding Part D bid and must reflect the same underlying population. Therefore, if the projected enrollment in a particular county is zero, the user is to enter for the county code zero (0) projected member months and not another number such as one (1) or a fraction between zero and one. There is no requirement to enter member months greater than zero in order to generate a county-level payment rate.

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

The pricing considerations for hospice and out-of-area explain which BPT entries must include the impact of out-of-area and hospice members.

Gain/Loss Margin

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

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

When setting gain/loss margins separately for MA and Part D bids, the Plan sponsor must take into account other CMS requirements such as Total Beneficiary Cost (TBC) or Medicare Medical Loss Ratio (MLR). CMS expects that the gain/loss margin will be set with appropriate consideration for the need to remit funds to CMS if the Plan sponsor's actual claims experience fails to meet the minimum Medicare MLR requirement. Further, if there is a conflict between satisfying gain/loss margin requirements and other CMS requirements, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the other CMS requirements. Such modifications to the gain/loss margin requirements must be fully explained and supported.

The gain/loss margin requirements are designed to ensure that gain/loss margins are reasonable and that an MA organization's MA business is not used to subsidize its other insurance lines of business. When some benefits offered by a Plan sponsor are funded by an outside source (such as an employer group), the gain/loss margin must be consistent between the Medicare benefits and benefits funded by other sources. Further, if the Plan sponsor has a separate contract with a state or territory for Medicaid services, then the gain/loss margin used to satisfy the gain/loss margin requirements in these Instructions depends upon the type of program offered.

- For the Platino program, the Plan sponsor has the option to use one of the following amounts to satisfy all gain/loss margin requirements:
 - The gain/loss margin for the bid in Worksheet 4 Section II, or
 - The adjusted gain/loss margin for the bid calculated in Worksheet 4 Section V.

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- For other programs, the Plan sponsor must use the adjusted gain/loss margin for the bid calculated in Worksheet 4 Section V to satisfy all gain/loss margin requirements.

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

Bid (PBP)-Level Requirements

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

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

✓ Benefit Value

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

✓ Anti-competitive Practices

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

✓ Bids with Negative Margin

If the projected gain/loss margin in the BPT is negative, the Plan sponsor must develop, submit, and follow a bid-specific business plan that is to achieve profitability within 5 years. Exceptions to the 5-year period for unique situations must be fully explained and supported. CMS expects that in subsequent years, MA projected gain/loss margins will meet or exceed the year-by-year MA gain/loss margins contained in the original business plan or in subsequent business plans, if any.

Exceptions to the business plan requirement are cases in which MA products are “paired” and the pricing reflects implicit “subsidies” across benefit or service area offerings as described below.

- The bid IDs in the product pairing must—
 - Have identical service areas;
 - All be local coordinated care plans or all be RPPOs or all be PFFS plans;
 - All be of the same SNP type or all be non-SNPs;
 - All be EGWPs or all be non-EGWPs; and
 - Have a positive combined MA gain/loss margin for CY2015.

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

Aggregate-Level Requirements (Overall Margins)

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

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

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

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

In these Instructions, “non-Medicare business” refers to all health insurance business that is not Medicare Advantage or Part D. Non-Medicare business, includes, but is not limited to, the following lines of business: Medicare-Medicaid, Medicare supplement, Medicaid, and commercial.

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

- The aggregate MA margin must be consistent from year to year.
- The aggregate MA margin must be consistent with the Plan sponsor’s corporate requirement, as explained below. This requirement depends upon the volume of the Plan sponsor’s non-Medicare business and whether or not the Plan sponsor offers general enrollment plans and I/C SNPs, if D-SNPs are offered.
 - If the volume of the Plan sponsor’s non-Medicare business for which it has discretion in rate setting is greater than or equal to 10% of the Plan sponsor’s total non-Medicare business, then—
 - For general enrollment plans and I/C SNPs, the aggregate MA margin, as measured by a percentage of revenue, must be within 1.5 percent of the Plan sponsor’s margin for all non-Medicare business.
 - For D-SNPs (if general enrollment plans and I/C SNPs are not offered), the aggregate MA margin, as measured by a percentage of revenue, must

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- be no more than 1.5 percent higher and no less than 5 percent lower than the Plan sponsor's margin for all non-Medicare business.
- For EGWPs (if general enrollment plans and I/C SNPs are not offered), the aggregate margin as measured by a percentage of revenue, must be within 1.5 percent of the Plan sponsor's margin for all non-Medicare business.
 - If: (i) the volume of the Plan sponsor's non-Medicare business for which it has discretion in rate setting is less than 10% of the Plan sponsor's total non-Medicare business, or (ii) the plan sponsor has no non-Medicare business; then, the aggregate MA margin must be set by taking into account the degree of risk and capital and surplus requirements of the business.
 - Although actual aggregate MA margins may vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate returns over the long term are consistent with the margin assumptions used for pricing.

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

- The aggregate MA margin must be consistent from year to year.
- The aggregate MA margin as a percentage of revenue is to be no more than 1 percent higher and no less than 5 percent lower than the aggregate margin for general enrollment plans and I/C SNPs.
 - Exceptions for unique situations must be fully explained and supported.
 - Although actual MA aggregate margins will vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate returns over the long term are consistent with the margin assumptions used for pricing.

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

- The aggregate margin must be consistent from year to year.
- The aggregate margin as a percentage of revenue must be no more than 1 percent higher and no less than 5 percent lower than the aggregate MA margin for general enrollment plans and I/C SNPs.
 - Although actual aggregate margins will vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate returns over the long term are consistent with the margin assumptions used for pricing.

For bids participating in the Minnesota Senior Health Options program, additional aggregate-level margin requirements may be found at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf>

MA-PD Margin Requirements

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

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

Exclusions

Non-insurance revenues pertaining to investments and fee-based activities designed to influence state or federal legislation such as the cost of lobbying activities cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009.

Hospice Enrollees

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

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

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

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

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

Manual Rating

Manual Rating with FFS Data

Special considerations, and corresponding documentation, are required when using Medicare FFS data as a manual rating source. Many of the available FFS data are not directly applicable and/or detailed enough to be used as the sole source for projection of medical expenses. For example, it is inappropriate to tabulate claims data using Medicare Public Use Files (PUFs) without making adjustments for corresponding demographic, health, and geographic profiles of the claimants and to account for the non-claimants. Similarly, since the FFS data published in the BPT and/or the MA rate

book development files are not split by benefit type, another appropriate source must be used to allocate the data to all of the BPT service categories. Further, as is the case with use of all manual rating sources, adjustments must be made to account for claim expenses that are not reflected in the FFS data, such as claim run-out, inclusion of expenses excluded from the data, and adjustments for medical education expenses.

FFS Costs Used for the Actuarial Equivalent Cost-Sharing Factors

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

Medicare Secondary Payer (MSP) Adjustment

The bid reflects lower claim amounts for enrollees whose primary coverage is not Medicare (that is, enrollees with Medicare Secondary Payer (MSP) status of aged/disabled MSP or ESRD MSP) and MA organizations receive reduced payments for such enrollees. Accordingly, the BPT uses the MSP adjustment, in conjunction with the projected risk score and the standardized A/B benchmark, to produce a plan A/B benchmark consistent with the plan A/B bid; therefore, the projected MSP adjustment represents the average payment reduction for the expected bid population due to MSP enrollees (with the limited exception described in the Manually Rated Bids subsection in this section). Although CMS reduces payments for MSP status at the beneficiary level, the BPT applies the MSP adjustment at the bid level. The projected MSP adjustment must be bid specific.

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

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

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

- Data described in the following sections of Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) and Appendices, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelppdesk/Plan_Communications_User_Guide.html:
 - 5.1 Part C Payments: describes the calculation of MA payments.
 - 5.1.5 Part C Payments When Medicare Secondary Payer (MSP) Status Applies: describes the payment reduction based on MSP status.
 - F.26 “Monthly MSP Information Data File”: provides specific information regarding the primary coverage for beneficiaries enrolled in the plan, whose

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payments were adjusted for MSP that month. It allows Plan sponsors to reconcile beneficiary payments.

- The following data in the Monthly Membership Detail Report (MMR):
 - MSP adjustment factor (field 82).
 - Related fields that provide the payment MSP reduction amount due to MSP for Part A (field 83) and Part B (field 84).
- Rolled-up MSP member counts for the month in the Monthly Membership Summary Data File.
- MSP factors shown in the April Rate Announcement for the applicable payment year.

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

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

Note that MSP adjustment must reflect changes from the source data payment year to the contract year that impact the relative payment dollars for MSP and non-MSP beneficiaries. Examples include, but are not limited to, a change in the MSP factor or a change in the distinct risk characteristics of MSP beneficiaries as compared to non-MSP beneficiaries.

Example:

The source data to project the CY2015 MSP adjustment for H1234-001 is March 2014 MMR data for H1234-001. There is no change in the distinct risk characteristics of MSP beneficiaries as compared to non-MSP beneficiaries from CY2014 to CY2015.

Step 1: Calculate the CY2014 bid portion of payment reflecting reduced payments for MSP beneficiaries (X^{2014}).

\$12,000,000 = “Total MA Payment” for the plan from a 2014 MMR file. This field includes all rebates except rebates for reduction of Part B premium and Part D basic premium and excludes part C basic premium, if any.

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

$$X^{2014} = \$12,000,000 - \$2,253,975 = \$9,746,025.$$

Step 2: Separate the CY2014 bid portion of payment reflecting reduced payments for MSP beneficiaries (X^{2014}) into payments for non-MSP enrollees and MSP enrollees based on MSP status.

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\$9,692,896 = CY2014 bid portion of payment for non-MSP enrollees

\$53,129 = CY2014 bid portion of payment for MSP enrollees

$$X^{2014} = \$9,746,025 = \$9,692,896 + \$53,129$$

Step 3: Calculate the CY2015 bid portion of payment reflecting reduced payments for MSP beneficiaries (X)

\$9,692,896 = CY2015 bid portion of payment for non-MSP enrollees

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

.173 = CY2015 “MSP factor” for working aged and working disabled

\$53,129 = (.173 / .173) * \$53,129 = CY2015 bid portion of payment for MSP enrollees

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

Step 4: Calculate the projected CY2015 bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare (Y).

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

Step 4: Calculate the projected CY2015 MSP adjustment to enter into the BPT.

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

Manually Rated Bids

If the following conditions are met, the actuary does not need to estimate an explicit MSP adjustment for 100% manually-rated bids and must enter zero (0) in the MSP adjustment field in Worksheet 5:

- The basis for both projected allowed costs and projected risk scores is FFS data that are reduced for MSP.
- The projected proportion of MSP members is the same as the proportion of MSP enrollees in the FFS data.

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

- Rate calculation data zip files (for example, “risk_scores 2008-2012 Non-PACE.csv” from the CY2015 MA Ratebook).
- Limited Data Sets (or “CMS 5% sample”).
- FFS Data zip files (for example “FFS data 20XX”).

Non-Benefit Expenses

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

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

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

- Sales & Marketing
 - This category includes all direct and indirect sales and marketing expenses for the MA plan.
 - Examples include, but are not limited to the costs of—
 - Marketing materials;
 - Commissions;
 - Enrollment packages;
 - Identification cards; and
 - Salaries of sales and marketing staff.
- Direct Administration
 - This category includes all expenses for all functions that are directly related to the administration of the MA program.
 - Examples include, but are not limited to—
 - Customer service.
 - Billing and enrollment.
 - Medical management.
 - Claims administration.
 - Part C National Medicare Education Campaign (NMEC) user fees. CMS collects NMEC user fees based on a percentage of revenue; however, the BPT entry is a PMPM equivalent value consistent with the calculation of other BPT values. Plan sponsors may use the CMS estimate, which amounts to \$0.28 PMPM on a national basis for CY2015, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Plan sponsor’s historical amount relative to the CMS annual national estimate.
 - Uncollected enrollee premium.
 - Certain disease management functions. See the “Disease Management” pricing consideration.
- Indirect Administration
 - This category includes expenses for functions that may be considered “corporate services,” such as the position of CEO, accounting operations, actuarial services, legal services, and human resources.
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).
- Insurer Fees.

All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that is consistent with the organization’s standard accounting practices, if not subject to GAAP). Also, acquisition expenses (sales and marketing) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards is promulgated by the Financial Accounting Standards Board

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(FASB). Of particular applicability is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

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

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

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

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

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

Optional Supplemental Benefits

See the CY2015 Call Letter at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf> for the following requirements regarding the total value of all optional supplemental benefits offered to non-EGWP plans under each contract:

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

Out-Of-Area Enrollees

The BPT must reflect the impact of out-of-area members in the base period experience and in the projected values for the contract year, including the calculation of the ESRD subsidy.

Enrollees are classified as out-of-area based on the classification used for MA payment.

The user must enter distinct projected member months and projected risk scores for out-of-area members in Worksheet 4, Section VI, row 38.

The DE pricing consideration explains that out-of-area members are attributable to the DE# and non-DE# populations in Worksheet 5, Section II.

Part B Premium and Buydown

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

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

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

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

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

Plan Premiums, Rebate Reallocation, and Premium Rounding

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

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

When the bid is initially submitted in June, the Part D basic premium entered in the MA BPT is an estimated value. The actual premium will be calculated by CMS following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional preferred provider organization (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 CY2015.

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.

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

MA-PD plans and regional MA-only Plan sponsors have the opportunity to reallocate rebates after the release of the Part D national average bid amount and regional PPO benchmarks.

Appendix E contains information about rebate reallocation and rounding rules, including the following:

- A description of the rebate reallocation period.
- A summary of the circumstances under which rebate allocation is required, permitted, or not permitted.
- Specific rules for returning to the target Part D basic premium.
- Limitations on benefit changes that are permitted during the rebate reallocation period.
- Limitations on changes in pricing assumptions that are permitted during the rebate reallocation period, including a small change in gain/loss margin in order to satisfy Total Beneficiary Cost (TBC) requirements.
- Limitations on significant changes to the BPT when rounding premiums.
- 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 PPO 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." There is no option to target and reallocate rebates to return to Total Plan Premium.

The target Part D basic premium is the Part D basic premium net of any MA rebate dollars that were applied to reduce (buy down) the premium; it does not include the Part D supplemental premium or the MA premium. Similarly, the low-income premium subsidy amount (LIPSA) applies to the Part D basic premium and does not cover the cost of Part D supplemental benefits.

CMS expects a consistent estimate of the LIPSA among bids in the same region.

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

Point-of-Service (POS)

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

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

Rebate Allocations

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

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

Regional Preferred Provider Organizations (RPPOs)

An RPPO plan must cover only enrollees eligible for both Part A and Part B of Medicare. See Chapter 1 of the *Medicare Managed Care Manual* (MMCM), which can be found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c01.pdf>.

Intra-Service Area Rate (ISAR) Factors

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

Related-Party Arrangements (Medical and Non-Benefit)

The related-party requirements apply to all Plan sponsors that enter into any type of arrangement with or receive services from an entity that is associated with the Plan sponsor by any form of common, privately held ownership, control, or investment. This includes any arrangement where the Plan sponsor does business with a related party through one or more unrelated parties. The requirements apply to all related-party arrangements supporting the bid which are in effect during the base period and/or contract year.

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

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

The Plan sponsor may have one or more of the following options for entering in the BPT costs associated with related-party arrangements, as explained in this pricing consideration and summarized in Appendix H.

- Enter the actual costs of the related party as those of the Plan sponsor when preparing the BPT (Method 1, Actual Cost).
- Show that the arrangement with the related party is comparable to other arrangements and enter all fees paid by the Plan sponsor to the related party as non-benefit or benefit expenses (Method 2, Market Comparison and Method 3, Comparable to FFS).
- Use 100 percent FFS costs as a proxy for benefit expenses (Method 4, FFS Proxy).

Comparable rate demonstrations must be based on actual contracts which must be available for review upon request by CMS. Further, when supporting comparable rates through the related party, such demonstration must be accompanied by a signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.

The next two sections describe additional requirements for reflecting in the BPT the cost of administrative and medical services provided under a related party arrangement for each available option listed above.

Administrative Related-Party Arrangements

✓ Method 1 Actual Costs for Administrative Services

A Plan sponsor using the actual costs for administrative services method must—

- Prepare the BPT in a manner that does not recognize the independence of the related party by entering the costs of the related party as those of the Plan sponsor. Specifically, the Plan sponsor must—
 - Enter the non-benefit expense and gain/loss margin of the related party as the non-benefit expense and gain/loss margin, respectively, of the Plan sponsor.

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- Provide supporting documentation for the development of the actual cost method with the initial bid submission as required by these Instructions.

✓ **Method 2 Market Comparison for Administrative Services**

A Plan sponsor using the market comparison for administrative services method must—

- Demonstrate through analysis and contract terms, how the fees associated with the Plan sponsor's related-party arrangement are comparable to the fees for similar services in administrative arrangements between the following entities:
 - The Plan sponsor and unrelated parties, or
 - The related-party organization and unrelated parties.

In order to meet this requirement, the Plan sponsor must demonstrate at the time of bid submission that—

- The contracts with unrelated parties are associated with sufficient costs of services to be considered valid contracts.
- The fees associated with such arrangements are within 5 percent or \$2 PMPM— whichever is greater.
- Prepare the BPT in a manner that recognizes the independence of the related party by entering all costs in the related-party arrangement as non-benefit expense.

Medical Related-Party Arrangements

✓ **Method 1 Actual Costs for Medical Services**

A Plan sponsor using the actual cost method for administrative services must—

- Prepare the BPT in a manner that does not recognize the independence of the related party by entering the costs of the related party as those of the Plan sponsor. Specifically, the Plan sponsor must—
 - Enter the benefit expense, non-benefit expense, and gain/loss margin of the related-party as the benefit expense, non-benefit expense and gain/loss margin, respectively, of the Plan sponsor.
- Provide supporting documentation for the development of the actual cost method with the initial bid submission as required by these Instructions.

See the cost sharing pricing consideration for information regarding the cost sharing PMPM for coinsurance under related-party Method 1.

✓ **Method 2 Market Comparison for Medical Services**

A Plan sponsor using the market comparison for medical services method must—

- Demonstrate through analysis and contract terms, how the fees associated with the Plan sponsor's related-party arrangement are comparable to the fees for providing similar services to a Medicare population in medical arrangements between the following entities:
 - The Plan sponsor and unrelated parties in the bid's service area, or
 - The related-party organization and unrelated MA organizations.

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In order to meet this requirement, the Plan sponsor must demonstrate at the time of bid submission that—

- The contracts with unrelated parties are associated with sufficient costs of services to be considered valid contracts.
- The fees associated with such arrangements are within 5 percent or \$2 PMPM—whichever is greater.
- Prepare the BPT in a manner that recognizes the independence of the related party by entering all costs in the related-party arrangement as net medical expenses.

✓ **Method 3 Comparable to FFS**

A Plan sponsor using the comparable to FFS method must—

- Demonstrate at the time of bid submission that it is not possible to comply with Method 1 Actual Costs as required by these Instructions.
- Demonstrate at the time of bid submission that the fees associated with the related-party arrangement are comparable to 100% FFS costs, that is, within 5 percent or \$2 PMPM—whichever is greater.
- Prepare the BPT in a manner that recognizes the independence of the related party by entering all costs in the related-party arrangement as net medical expenses.

✓ **Method 4 FFS Proxy**

A Plan sponsor using the FFS proxy method must—

- Demonstrate at the time of bid submission that it is not possible to comply with each of the following related-party methods as required by these Instructions—
 - Method 1 Actual Costs.
 - Method 2 Actual Costs Market Comparison.
 - Method 3 Comparable to FFS. In order to meet this requirement, the Plan sponsor must demonstrate that the fees associated with the Plan sponsor's related-party arrangement are not comparable to 100% FFS costs for similar services.
- Prepare the BPT in a manner that recognizes the independence of the related party by entering 100 percent FFS costs in the BPT as net medical expenses.

Risk Score Development for CY2015

The projected CY2015 risk score must—

- Be based on the methodology for calculating CY2015 risk scores, as discussed in the CY2015 Rate Announcement.
 - The CY2015 risk scores will be calculated by blending the normalized risk scores calculated under the CY2013 risk model and the CY2014 risk model. The CY2013 model risk scores will be weighted at 67% and the CY2014 model risk scores will be weighted at 33%.
 - The blended CY2015 risk scores developed for bids are to be based on risk scores calculated using each of the CY2013 and CY2014 models, separately projected to CY2015 and adjusted with that model's normalization factor, and then blended.

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- Reflect plan-specific coding trend.
- Be appropriate for the expected population.
- Include the appropriate MA coding adjustment factor.
- Be adjusted for FFS normalization.
- For Fully Integrated Dual Eligible (FIDE) SNPs, include a frailty factor, if applicable.

Risk Score Definitions and Information Sources

✓ Member Weighted Versus Member/Payment Weighted

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

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

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

CY2015 risk scores will be calculated using the same approach used for CY2014, by blending the normalized risk scores calculated under the CY2013 model (weighted at 67%) and the normalized risk scores calculated under the CY2014 model (weighted at 33%).

Additional information on the CMS-HCC model, including the CY2015 normalization factors, is contained in the CY2015 Rate Announcement. Information on the CY2013 and CY2014 models can be found in the CY2013 and CY2014 Rate Announcements, respectively.

✓ Normalization Factors

The risk scores calculated for each plan enrollee will be divided by the appropriate FFS normalization factor. This adjustment accounts for the underlying trend in risk scores and the effect of that trend on average risk scores between the model denominator year and the payment year (CY2015), and is designed to bring the average risk score back to 1.0. Since CMS will be blending the risk scores from the CY2013 and the CY2014 risk models, the projected risk scores in the CY2015 bids must incorporate the following two CY2015 normalization factors:

- 0.992 for the CY2013 risk model.
- 0.978 for the CY2014 risk model.

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✓ **MA Coding Adjustment Factor**

In addition to normalization, the projected risk scores in the CY2015 bids must reflect the MA coding adjustment factor. This adjustment accounts for the difference in diagnostic coding pattern differences between MA and FFS. The CY2015 MA coding adjustment is 5.16 percent. Accordingly, the projected CY2015 normalized risk scores must each be multiplied by 0.9484 (which is $1 - 0.0516$).

✓ **Risk Adjustment Information Sources**

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

- “Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” (2015 Announcement);
- “Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies” (2014 Announcement); and
- “Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Draft Call Letter” (2015 Advance Notice).

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

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

Risk Score Calculation Approaches

✓ **Preferred Methodology**

The preferred method for projecting the CY2015 risk scores is to start with the CMS-HCC risk scores that are provided by CMS in—

- The plan-level data for the July 2013 enrollee cohort with retroactive enrollment and status adjustments; or
- The beneficiary-level file containing twelve months of 2013 membership with retroactive enrollment adjustments and status adjustments.

The plan-level data will be available after the publication of the 2015 Rate Announcement under the “Risk Adjustment” link on the HPMS Home page. The risk score data posted in HPMS are calculated using the risk model used for 2015 payment and are accompanied by technical notes to assist actuaries with understanding the material presented. The beneficiary-level data provide the 2013 risk scores calculated using both the risk model used for 2013 payment and the models to be used for 2015 payment. This data is sent electronically to plan sponsors around the same time.

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There are several advantages to using these 2013 CMS-HCC risk scores in the projection of the CY2015 blended risk score:

- They are consistent with the base-period medical expenses as they include data for out-of-area members.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2012 dates of service submitted through January 31, 2014, which is the final reporting deadline for this period.
- They require no adjustment for risk model changes.
- Both the beneficiary-level file and the plan-level data will provide the 2013 scores using both the 2013 and the 2014 models.

Please note that, since the HPMS plan-level risk scores are based on a mid-year cohort using full calendar-year data with nearly complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete run-out of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2013 to 2015 with explicit adjustment for the following factors:

- Plan-specific coding trend.
- Changes in plan population.
- Missing diagnosis adjustment. The risk scores provided using the CY2014 model may be missing diagnosis data depending on whether the Plan sponsor filters for model diagnoses when submitting RAPS data.
 - If the MA organization does not filter diagnoses for model diagnoses when submitting RAPS data, then the risk scores calculated using the CY2014 CMS-HCC model and therefore the risk scores used for 2015 payment may be complete (diagnoses from FFS are complete and CMS uses all MA diagnoses submitted by the MA organization).
 - If the MA organization does filter diagnoses when submitting RAPS data, then the risk scores are not complete. CMS will provide “missing diagnosis” adjustment factors in the technical notes for the risk scores. These “missing diagnosis” adjustment factors were derived from FFS data, and are offered to MA organizations to assist them in determining how to adjust the risk scores under the CY2014 model. The actual adjustment will depend on where the MA organization’s 2013 enrollees were enrolled in 2012 (that is, one of the MA organization’s plans, FFS, or a plan with another MA organization).
- Other appropriate factors.

Finally, the projected risk scores must be normalized by dividing by the appropriate CY2015 FFS normalization factors and by applying the CY2015 MA coding adjustment factor.

✓ Alternate Approaches

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2014, if there was limited enrollment in 2013, or if there

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were significant changes in plan or enrollment characteristics between 2013 and 2014.

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

- Conversion to a raw risk score.
 - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized, not adjusted for MA coding) risk score before making other adjustments.
 - Note that conversion from 2014 MMR data must adjust for the MA coding adjustment factor and the normalization factors for both 2013 and 2014. Before removing the effect of the MA coding adjustment factor and the normalization factors, the certifying actuary may consider disaggregating the two underlying risk scores. This may entail calculating one or both of the risk scores.
- Impact of lagged versus non-lagged diagnosis data.
 - If the starting risk score is based on lagged diagnosis data, as it is when the initial risk scores are used, then an adjustment is required to transition the scores from lagged to non-lagged. An example is a starting point of March 2014 MMR data, which contain risk scores based on the July 2012 to June 2013 diagnosis data.
- Run-out of diagnosis data.
 - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is diagnosis data and will be when the starting point is MMR data, then an adjustment factor is required to transition the scores from incomplete to complete diagnosis data. Starting risk scores from MMR data do not reflect the final reconciliation.
- Seasonality.
 - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
 - If the starting risk scores are calculated using a risk model (or models) other than those to be used for CY2015 payments, then an adjustment for the risk model change must be made.
 - The beneficiary-level file provided by CMS for CY2015 bid development includes risk scores based on: (i) the CY2013 risk model, and (ii) the two models that will be used to calculate blended risk scores for payment year CY2015, that is, the CY2013 model and the CY2014 model.
- Missing diagnosis adjustment.
- Plan-specific coding trend. Plan-specific coding trends may differ when risk scores are calculated using different models. Therefore, when

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starting with base year risk scores that are already blended, CMS recommends that plan sponsors assess whether blended scores are to be disaggregated and trended separately, based on expected bid-specific trend experiences under each model.

- Population changes.
 - If the starting risk score is based on a population with different risk characteristics than the expected population, then an adjustment for population changes must be made.
 - Other appropriate factors.

Once projected to CY2015, the scores must be: (i) normalized by dividing by the appropriate CY2015 FFS normalization factors, and (ii) adjusted by the MA coding adjustment factor. Note that, if a raw (not normalized) risk score associated with a different model calibration year is being normalized, the contract year 2015 FFS normalization factors are not appropriate and must be adjusted.

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

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

Considerations for Trending Risk Scores

See Appendix K for considerations for trending Part C and Part D risk scores.

Sequestration

To the extent that sequestration is assumed to occur during the projection period, net medical expenses must reflect the expected impact of sequestration on provider payments. Cost sharing is not reduced under sequestration; therefore, for purposes of completing the BPT, net medical expenses are not reduced, cost sharing is unaffected, and total allowed costs are reduced to equal the sum of net medical expenses and cost sharing. Similar modifications must be made to base period data to the extent that sequestration affected actual provider payments.

Some calculations in the BPT may be affected by the modifications listed above and are to be handled as follows:

- In the case of coinsurance, the effective cost sharing entered in Worksheet 3 may not match the cost-sharing percentage in the PBP. In this case, the Plan sponsor must adequately justify such difference. See the cost sharing pricing consideration for more information about the calculation of the effective coinsurance percentage.
- In the case of the actuarial equivalent cost sharing test (failing “red circle” validations) on Worksheet 4, the Plan sponsor must adequately demonstrate the requirement that the plan cost sharing for Medicare-covered benefits entered in the PBP is not greater than FFS cost sharing.

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CMS recognizes that under sequestration the gain/loss margin entered in the BPT is not the gain/loss margin that the Plan sponsor will actually achieve; however, margin requirements must be met with the gain/loss margin entered in the BPT.

Service Area Changes

Segmented Service Areas

See the uniformity of benefit requirements in Chapter 4 “Benefit and Beneficiary Protections” of the *Medicare Managed Care Manual* for information on non-RPPO bids with segmented service areas at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLSort=0&DLSortDir=ascending>.

Pending Service Area Changes

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

Supporting Documentation

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

III. DATA ENTRY AND FORMULAS

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

MEDICARE ADVANTAGE

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

The MA bid form is organized as outlined below:

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

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

MEDICAL SAVINGS ACCOUNT

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

ESRD-SNP

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

DATA ENTRY

Do not leave a field blank to indicate a zero amount. If zero is the intended value, then enter zero (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 that describes other utilization factors and/or additive factors used in Section IV.
- Section VI contains a summary of the base period revenue and expenses.

Section I must be fully completed for all bids. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2013 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

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

Line 1 – Contract Number

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

Line 2 – Plan ID

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

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

Line 3 – Segment ID

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

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – Plan Name

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

Line 7 – Plan Type

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

Note that an MA organization may offer private-fee-for-service (PFFS) plans in a service area without Part D coverage. However, for other plan types shown below, an MA organization must offer at least one benefit plan (of any plan type) that includes Part D coverage for each service area.

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 Plan:	
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 PFFS	ED PFFS
Employer/Union Direct Contract LPPO	ED LPPO

Line 8 – MA-PD

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

Line 9 – Enrollee Type

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

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

Line 10 – MA Region

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

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

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

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

Line 11 – Actuarial Swap or Equivalences Apply

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

Line 12 – SNP

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

Line 13 – Region Name

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

Line 14 – SNP Type

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

Line 15 – EGWP

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

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

CMS requires base experience data to be based on claims incurred in calendar year 2013 and generally expects at least 30 days of paid claims run-out; 2 - 3 months of paid claim run-out is preferable. See the “Pricing Considerations” section of these instructions for more information.

The incurred dates are pre-populated on the first two lines, as 1/1 through 12/31 for the 2 years prior to the contract year. Enter the “paid through” date on the third line. For example, if the data reflect payment information through February 2014, then the “paid through” date is 2/28/2014.

Line 2 – Member Months

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

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

Line 3 – Risk Score

Enter the final risk score for the non-ESRD and non-hospice members of the population represented in the base period data using the CMS-HCC risk model for payment in CY2013. This factor must include the appropriate MA coding pattern difference adjustment factor and FFS normalization factor for payment in CY2013.

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

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

Line 4 – Completion Factor

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

For example, assume the following:

Incurred Date	1/1/2013 – 12/31/2013
Paid Through Date (PTD)	2/28/2014
Capitation Payments	\$100
PTD Claims Requiring Completion	\$400
<u>Estimate of Unpaid 2013 Claims as of 2/28/2014</u>	<u>\$30</u>
Total Incurred Claims for 2013	\$530
The Completion Factor would be calculated as:	
Completion Factor = $(400 + 30) \div 400 = 1.075$	

Line 5 – Plan/Segments Included in Base Period Data

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

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

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

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

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

Line 6 – Base Period Description

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

SECTION III – BASE PERIOD DATA (AT PLAN’S RISK FACTOR) FOR 1/1/2013 – 12/31/2013

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

In lines a through r:

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

The benefit service categories are displayed in column b.

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

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

This field must reflect the number of members that incurred a service in the specified category in the base period. The basis for the determination that a service was used by a beneficiary must be consistent with the utilization types displayed in column f and the annualized utilization per thousand entered in column g.

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

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

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

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

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

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

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

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

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

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

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

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

Line s – Total Medical Expenses

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

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS

Section IV contains the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The values in columns j through n are the total adjustment factors from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2013 and that the contract year is 2015. If the utilization trend is 5 percent from 2013 to 2014 and 6 percent for projecting 2014 to 2015, then enter “1.113” in column j (1.05×1.06).

In lines a through r:

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

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

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

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

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

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

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

Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. An example of the use of this factor is to reflect the impact on utilization of a change in the service area from the base period to the contract year.

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

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

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

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

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

Enter any other factors for unit cost adjustments by service category. An example of this type of change is a change in unit cost due to intensity of service trend or the impact on unit costs of the covered population's change in risk from the base period to the contract period. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Entering 1.000 would indicate 0 percent adjustment. Do not leave blank. Do not enter zero (0).

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

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

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

Describe the reason for any additive adjustments in Section V.

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

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

SECTION VI – BASE PERIOD SUMMARY FOR 1/1/2013 – 12/31/2013 (EXCLUDES OPTIONAL SUPPLEMENTAL)

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

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

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

Section VI must not include optional supplemental benefits.

This section must not be left blank.

Line 1 – CMS Revenue

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

- Include rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits.
- Include an estimate of the final risk-adjustment reconciliation payment for CY2013, which will be received in mid-2014, such as the final risk-adjustment reconciliation payment for the prior year, if appropriate.
- Do not include rebates applied to Parts B and D premium buydowns.
- Report the CMS revenues gross of user fee reductions and net of sequestration reductions.

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

Line 2 – Premium Revenue

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

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

Line 3 – Total Revenue

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

Line 4 – Net Medical Expenses

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

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

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

Line 5 – Member Months

Enter the base period member months.

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

Line 6 – PMPMs

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

Line 7 – Non-Benefit Expenses

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

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

Line 8 – Gain/Loss Margin

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

Line 9 – Percentage of Revenue

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

Lines 10a, 10b and 10c – Medicaid Revenue, Medicaid Cost, and Adjusted GLM

See the “Pricing Considerations” section of these Instructions.

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

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 – Projected Member Months and Projected Risk Factor

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

In lines a through r:

✓ Column e – Utilization Type

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

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

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

✓ Columns f through h – Projected Experience Rate

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

✓ Columns i through k – Manual Rate

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

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

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

✓ **Column j – Average Cost**

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

✓ **Column k – Allowed PMPM**

Enter PMPM amounts in column k.

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

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

✓ **Column l – Experience Credibility Percentage**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line s – Total Medical Expenses

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

Line t – Subtotal Medicare-Covered Service Categories

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

Line u – Manual Rate Description

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

MA WORKSHEET 3 – MA PROJECTED COST SHARING PMPM

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

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

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

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

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

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

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

Line 1 – In-Network

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

Line 2 – Out-of-Network

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

Line 3 – Combined

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

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

Line 4 – Maximum Cost-Sharing Description

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

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

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

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

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

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

Option A:

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

Option B:

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

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

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

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

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

WORKSHEET 3

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

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

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

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

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

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

Column c – Service Category

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

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

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

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

Column d – Service Category Description

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

Column e – Measurement Unit Code

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

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

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

For each cost-sharing line, enter—

- The effective PMPM cost of the in-network plan deductible, plan deductible, or annual deductible contained in Section D of the PBP as summarized below by type of plan:
 - For local PPO and regional PPO plans, if the PBP contains an annual plan deductible that is applied to in-network benefits, enter the effective PMPM cost of such deductible.
 - For non-network PFFS plans, enter a portion of the effective PMPM cost of the plan deductible, at the discretion of the certifying actuary.

- For other plan types, if the PBP contains an in-network plan deductible and/or a combined plan deductible that is applied to in-network benefits, enter the effective PMPM cost of such deductible(s).
- A PMPM cost such that the sum total represents the effective PMPM cost of the deductible(s) that is attributable to in-network benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

Note that in certain cases, the effective coinsurance percentage in column i may not match the coinsurance percentage in the PBP. See the cost sharing pricing consideration for more information about the calculation of the effective coinsurance percentage.

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

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

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

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

✓ **Column k – In-Network PMPM**

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

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

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

Column l – Total In-Network Cost Share PMPM

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

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

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

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

Column n – Out-of-Network Cost Sharing PMPM

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

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

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

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

Footnotes

The footnotes for columns h, k and n are used to enter plan deductible dollar amounts contained in Section D of the PBP and to answer questions about the applicability of plan deductibles to Part B-Only services, as explained below.

If the PBP indicates that the cost sharing is designed to match Medicare FFS cost sharing, enter the amount of the plan-level deductible as “Medicare FFS”. Do not enter an estimate of the actual Part B deductible for 2015 or leave the field blank. Specifically,—

- If the PBP indicates that the in-network, out-of-network, or combined plan deductible is “the Medicare-defined Part B Deductible amount”, enter in the BPT the amount of the corresponding in-network, out-of-network, or combined plan-level deductible as “Medicare FFS”.
- If the PBP indicates that the annual deductible is “the Medicare-defined Part A Deductible amount”, “the Medicare-defined Part B Deductible amount”, or “the Medicare-defined Part A and B Deductible amount”, enter “Medicare FFS” as the in-network, out-of-network, or combined plan-level deductible, as explained below.

Otherwise, enter the actual amount, for example, “\$500”.

✓ **Column h**

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

- For local PPO and regional PPO plans, the annual deductible always applies to Medicare-covered out-of-network benefits. Therefore,—
 - If the PBP indicates that the annual deductible amount applies to in-network benefits, the annual deductible functions like a combined deductible. In this case, enter the annual deductible amount in the first footnote.
 - If the PBP indicates that the annual deductible does not apply to in-network benefits, leave the first footnote blank.
- For non-network PFFS plans, enter the plan deductible amount
- For other plan types, enter the combined plan deductible amount.

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

✓ **Column k**

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

- For local PPO and regional PPO plans, an annual deductible always applies to Medicare-covered out-of-network benefits; therefore, if the PBP indicates that the

annual deductible amount also applies to in-network benefits, the annual deductible functions like a combined deductible. In this case, leave the first footnote blank.

- For other plan types, enter the in-network plan deductible amount.

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

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

✓ **Column n**

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

- For local PPO and regional PPO plans, the annual deductible always applies to Medicare-covered out-of-network benefits. Therefore,—
 - If the PBP indicates that the annual deductible amount also applies to in-network benefits, the annual deductible functions like a combined deductible. In this case, leave the first footnote blank.
 - If the PBP indicates that the annual deductible does not apply to in-network benefits, enter the annual deductible amount in the first footnote.
- For other plan types, enter the out-of-network plan deductible amount.

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

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

SECTION IV – MAPPING OF PBP SERVICE CATEGORIES TO BPT

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

MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

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

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

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

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

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

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

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

In lines a through r:

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

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

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

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

✓ **Column g – N/A**

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

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

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

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

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

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

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

Example:

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

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

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

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

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

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

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

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

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

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

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

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

✓ **Column m – Allowed PMPM**

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

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

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

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

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

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

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

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

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

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

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

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

Line s – Total Medical Expenses

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

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

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

In lines a through r:

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

Calculated automatically as the sum of columns g and h.

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

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

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

Calculated automatically as the minimum of columns f and k.

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

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

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

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

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

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

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

Calculated automatically as column g times column j.

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

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

✓ **Column m – Allowed PMPM**

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

✓ **Column n – Medicaid Cost Sharing**

Calculated automatically as column k times column j.

✓ **Column o – Net PMPM**

Calculated as column m minus column n.

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

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

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

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

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

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

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

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

Line s – Total Medical Expenses

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

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

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

In lines a through q and t:

✓ **Columns e through g – N/A**

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

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

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

✓ **Columns i through n – N/A**

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

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

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

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

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

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

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

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

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

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

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

Line r – ESRD

This line is populated based on Section III.

Line s – Additional Benefits (employer bids only)

This line is populated based on Section IV.

Line u – Total Medical Expenses

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

Line v – Non-Benefit Expenses

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

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

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

Lines v1 through v5 – Non-Benefit Expenses

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

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

Enter the PMPM by category. Lines v1, v2, v3, and v5 must be greater than or equal to zero.

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

These values are calculated as column h minus column r.

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

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

Line v6, columns h, o, and r – Total Non-Benefit Expense

The sum of lines v1 through v5. The value must be greater than or equal to zero.

Line v6, columns p and q – Total Non-Benefit Expense for Additional Services and Reduction of A/B Cost Sharing

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

Line w – Gain/Loss Margin

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

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

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

Line x – Total Revenue Requirement

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

Lines y1, y2 and y3 – Percentage of Revenue

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

Line z – Overall Gain/(Loss) Margin Level

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

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

Do not leave this field blank.

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

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

CY Member Months (entered by county)

This value is obtained from Worksheet 5.

CY ESRD Member Months

This value is obtained from Worksheet 5.

CY Out-of-Area (OOA) Member Months

This value is obtained from Worksheet 5.

Basic Benefits

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

Supplemental Benefits

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

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

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

See Appendix D for further information on group bids.

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

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

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

SECTION V – PROJECTED MEDICAID DATA

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

MA WORKSHEET 5 – MA BENCHMARK PMPM

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

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

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

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Member Months (from Section VI)

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

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

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

Line 3 – Medicare Secondary Payer (MSP) Adjustment

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

Line 4 – Weighted Average Risk Factor

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

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

Line 5 – Conversion Factor

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

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

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

Line 7 – Plan A/B Bid

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

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

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

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

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

Line 2 – Rebate

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

Line 3 – Basic Member Premium

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

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

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

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

Line 1 – Statutory Component for Region

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

Line 2 – Plan Bid Component

The plan bid component of the MA regional PPO benchmark 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 monthly bid amount is announced (typically in August).

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

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

Line 3 – Standardized A/B Benchmark

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

SECTION V – QUALITY RATING

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

Line 1 – Quality Bonus Rating (per CMS)

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

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

Line 2 – New/Low Indicator (per CMS)

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

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

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

Line 3 – Rebate Percentage

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

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

SECTION VI – COUNTY-LEVEL DETAIL AND SERVICE AREA SUMMARY

This section contains detailed data by county and develops plan-specific county-level MA payment rates. For most plans, the only user inputs are the state-county codes (column b), projected member months (column e), projected risk factors (column f) by county, and out-of-area enrollment data. Entries must reflect bid-specific non-ESRD non-hospice enrollment projections for each county within the service area, including the case in which member months are projected to be zero. There is no requirement to enter member months greater than zero in order to generate a county level payment rate.

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

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

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

Line 1 – Use of Plan-Provided ISAR Factors

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

Line 2 – Total or Weighted Average for the Service Area

The county-level data are summarized in this line, weighted by projected member months (including out-of-area in row 38). The projected risk factors are also weighted by MA ratebook rates.

Line 3 – County-Level Detail

✓ **Column b – State-County Code**

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

- Each state-county code must be entered as a text input (that is, must include a preceding apostrophe) and must include all leading zeroes (for example, '01000). This field is formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (that is, using a preceding apostrophe) and must include any leading zeros.
- If the service area has more than one county, do not leave any blank rows between the first and last state-county code entered. Also, do not leave blank rows before the first county code entered.
- Do not enter the same state-county code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area county, "99999" in rows 39 through 9999. Out-of-area enrollees must be captured in row 38.
- The county codes entered in the BPT must match the service area defined in HPMS by the MA organization. Any service area discrepancies between the BPT and HPMS may result in delays during bid review and could affect the approval timeline of the bid.

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

✓ **Column c – State**

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

✓ **Column d – County Name**

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

✓ **Column e – Projected Member Months**

Enter the projected contract year member months for each county in the service area. The projected member months must include both aged and disabled members, and DE# and non-DE# members, but exclude ESRD and hospice members. Out-of-area projected member months must be entered in row 38.

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

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

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

✓ **Column f – Projected Risk Factors**

Enter the risk factors for the projected non-ESRD non-hospice membership by county. The risk factors for out-of-area members must be entered in row 38.

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

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

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

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

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

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

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

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

✓ **Column j – ISAR Scale**

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

✓ **Column k – ISAR-Adjusted Bid**

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

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

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

SECTION VII – OTHER MEDICARE INFORMATION

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

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

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

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

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

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

Columns t through u – Metropolitan Statistical Area (MSA)

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

SECTION VIII – PROJECTED CY MEMBER MONTHS

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

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

This value is obtained from Section VI.

Line 2 – ESRD Member Months

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

This amount is used on Worksheet 4 Section III.

Line 3 – Hospice Member Months

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

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

This value is obtained from Section VI.

Line 5 – Total Member Months

Calculated as the sum of line 1 through 4.

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

MA WORKSHEET 6 – MA BID SUMMARY

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

SECTION I – GENERAL INFORMATION

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

SECTION II – OTHER INFORMATION

Section A – Part B Information

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

Line 1 – Maximum Part B Premium Buydown Amount, per CMS

This value is pre-populated by CMS at the time that the bid form is released.

Section B – Rebate Allocation for Part B Premium

Line 1 – PMPM Rebate Allocation for Part B Premium

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

Line 2 – Rounded Part B Rebate Allocation

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

Section C – Rebate Allocations

Line 1 – Reduce A/B Cost Sharing

Enter the PMPM amount of rebates to reduce A/B cost sharing.

Line 2 – Other A/B Mandatory Supplemental Benefits

Enter the PMPM amount of rebates to apply toward other A/B mandatory supplemental benefits.

SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the bid pricing tool information in three sections.

- Section A is an overview of the plan A/B bid and the costs of A/B mandatory supplemental benefits, and it also displays some benchmark and risk score information from Worksheet 5.
- Section B contains the MA rebate allocation.

- Section C develops the MA premium and requires the input of the Part D premium information. Consistent with previous worksheets, any optional supplemental benefits/premiums are to be excluded.

Section A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Net Medical Cost

These amounts are obtained from Worksheet 4.

Line 2 – Non-Benefit Expenses

These amounts are obtained from Worksheet 4.

Line 3 – Gain/Loss Margin

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

Line 4 – Total Revenue Requirement

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

Line 5 – Standardized A/B Benchmark

This amount is obtained from Worksheet 5.

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

This amount is obtained from Worksheet 5.

Line 7 – Risk Factor

This amount is obtained from Worksheet 5.

Line 8 – Conversion Factor

This amount is obtained from Worksheet 5.

Section B – MA Rebate Allocation

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

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

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

Line 1 – MA Rebate

This amount is obtained from Worksheet 5.

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

Lines 2 through 6 – Rebate Allocations by Category

The fourth column displays the portion of the total MA rebate that is allocated to each of the rebate options. Note that the rebate allocations are actually entered in separate sections of this worksheet, to ensure that the rebate allocations are rounded to comply with withhold system requirements.

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

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

Line 7 – Total Rebate Allocated

The sum of lines 2 through 6. This amount must equal the amount in line 1.

If there are any “unallocated” rebates shown, including pennies, these amounts must be distributed among the categories available. The BPT will not finalize if there are any invalid values (such as “#N/A”, “#DIV/0!”, “#REF!”, “#NAME?”, etc.) in this field.

Section C – Development of Estimated Plan Premium

Line 1 – A/B Mandatory Supplemental Revenue Requirements

This amount is obtained from Section IIIA.

Line 2 – Less Rebate Allocations

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

Line 3 – A/B Mandatory Supplemental Premium

The sum of lines 1 and 2.

Line 4 – Basic MA Premium

This amount is obtained from Worksheet 5.

Line 5 – Total MA Premium (excluding Optional Supplemental)

The sum of lines 3 and 4.

Line 6 – Rounded MA Premium (excluding Optional Supplemental)

The total MA premium from line 5 is rounded to one decimal (that is, the nearest dime) to comply with withhold system requirements. Value must be greater than or equal to zero.

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

Line 7 – Part D Basic Premium

✓ **Line 7a – Prior to Rebates**

Enter the Part D basic premium prior to rebates after rounding (found on the separate Part D bid form). This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D basic premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D basic premium. This field is not applicable to MA-only plans and EGWP plans.

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

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

✓ **Line 7d – Part D Basic Premium**

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

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

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

This field is not applicable to MA-only plans and EGWP plans (that is, it must be equal to zero).

If the plan intention for the target premium (cell R47) equals “Low Income Premium Subsidy Amount” and the plan enters Part D basic rebates (cell R36) greater than zero, then the Part D basic premium after rebates (cell R37) must be greater than zero.

Line 8 – Part D Supplemental Premium

✓ **Line 8a – Prior to Rebates**

Enter the Part D supplemental premium prior to rebates (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (that is, the amount prior to application of any MA rebates). Note: The Part D supplemental premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy down the Part D supplemental premium. This field is not applicable to MA-only plans and EGWP plans.

Note that if the Part D basic premium is negative, then the Part D supplemental premium must offset the negative amount. That is, the sum of the Part D basic and supplemental premiums must be greater than or equal to zero.

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

Enter the rebates that the Plan sponsor wishes to allocate to the Part D supplemental premium. The Part D rebate allocation must be rounded to one decimal. If this is not done, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements. This field is not applicable to MA-only plans and EGWP plans.

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

Calculates the Part D supplemental premium net of rebates. Line 8d equals line 8a minus line 8c. The value must be greater than or equal to zero. This field is not applicable to MA-only plans and EGWP plans (that is, it must be equal to zero in these cases).

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

Line 9 – Total Estimated Plan Premium

The sum of the rounded MA, Part D basic, and Part D supplemental premiums after rebates. This amount excludes any optional supplemental MA premiums, which are calculated on Worksheet 7. The value must be greater than or equal to zero.

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

Line 10 – Plan Intention for Target Part D Basic Premium

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

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

See the “Pricing Considerations” section of these Instructions for more information on the target Part D basic premium.

SECTION IV – CONTACT INFORMATION AND DATE PREPARED

Plan sponsors must identify three persons as MA plan bid contact, MA certifying actuary, and additional MA BPT actuarial contact. The MA certifying actuary and additional MA BPT actuarial contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number, and e-mail information for all three contacts; in addition, credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

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

SECTION V – WORKING MODEL TEXT BOX

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

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

MA WORKSHEET 7 – OPTIONAL SUPPLEMENTAL BENEFITS

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

The PBP packages must be entered in the same order as they are entered in the PBP, and the package name/description must match the PBP.

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 – Description

For each package, enter a description of the OSB package. This description must match the description/package name entered in the PBP for each package. Examples: “Enhanced Dental”, “Gold Package”, etc. The description field must not be left blank when there is an optional supplemental package entered.

Column d – Allowed Medical Expense: PMPM

Enter the projected contract year allowed medical expense PMPM for each package.

Column e – Enrollee Cost Sharing: PMPM

Enter the projected enrollee cost sharing PMPM for each package.

Column f – Net PMPM Value

Column f is calculated automatically as the allowed PMPM (column d) minus the cost sharing PMPM (column e).

Column g – Non-Benefit Expense

Enter the total projected contract year non-benefit expense PMPM for each OSB package offered.

Column h – Gain/Loss Margin

Enter the total projected contract year gain/loss margin PMPM for each OSB package offered.

Column i – Premium

The sum of columns f (medical expenses), g (non-benefit expenses), and h (gain/loss margin). The premiums are automatically rounded to one decimal to comply with premium withhold system requirements. Premium values must be greater than zero if an OSB package is offered and must be equal to zero if an OSB package is not offered.

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

Column j – Projected Member Months

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

SECTION III – COMMENTS

Enter any comments needed to describe the OSB packages.

SECTION IV – BASE PERIOD SUMMARY (ENTERED AT THE CONTRACT LEVEL)

This section contains a summary of the actual contract-level base period revenue and expenses.

Note that Section IV must be completed in total dollars (not PMPMs), and it must include all optional supplemental benefit packages that were provided in the base period.

IV. APPENDICES

APPENDIX A – ACTUARIAL CERTIFICATION

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

Actuarial Standards of Practice and Other Considerations

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

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

The certifying actuary must also certify that the actuarial work supporting the bid complies with applicable laws, rules, CY2015 bid instructions, and current CMS guidance. The actuarial work supporting the bid must be consistent and reasonable with respect to the plan benefit package.

Certification Module

The certification module contains the following features:

- Standardized required language. (The required elements are described in a subsequent section of this appendix.)
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids.
- Links to additional information regarding the bid package such as the PBP, BPT, and supporting documentation.
- The ability to certify multiple bids/contracts.
- The ability to print and save the submitted certification.

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is, pending CMS approval) via the certification module in August following the CMS publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but they may do so if they wish.

Note that in the event that the PBP changes after the “final” bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

Material changes to the certification language (after the initial June certification submission) are not allowed without prior written permission from the CMS Office of the Actuary.

Plan sponsors may have multiple actuaries assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. The instructions contained in this appendix must be followed by all actuaries who will be certifying CY2015 bids.

If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

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

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

Required Certification Elements

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

- The certifying actuary’s name/user ID and the date, “stamped” when 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 CY2015 bid instructions, and current CMS guidance.

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 A

- 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 bid was prepared in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the bid complies with the appropriate ASOPs.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2015 certification module are released via an HPMS memorandum regarding consultant access or electronic signature access to HPMS.

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, if requested, must be made available to CMS reviewers within 48 hours, as required by these Instructions. Plan sponsors must upload supporting documentation consistent with the final certified bid.

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

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.2, “Actuarial Report,” the materials provided must be written “with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”

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

Supporting documentation must be easily understood by CMS reviewers and must include the following:

- The rationale for the assumption, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Plan-specific variations in addition to the overall pricing assumption or methodology.
- Values that match entries in the current BPT and tie to the PBP.
- Excel spreadsheets with working formulas, rather than pdf files, accompanied by a narrative explanation of the inputs and the calculations and their components.

Supporting documentation must be clearly labeled and include the following information:

- The bid ID. At a minimum, the contract number and organization name must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart, or as an attachment.
- A reference to MA, Part D, or both.
- A hard-coded date.
- Contract/Plan number or organization name and topic in the beginning of the file name.
- The word “revised”, if any information in the file is revised or appended during bid review.

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

- Meeting minutes that include comprehensive documentation of discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources—for example, a report’s official name/title, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

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

- Materials that can be accessed only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as “the same as for plan Hxxxx-xxx,” and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- Excel spreadsheets with no or a vague explanation of the bid-specific inputs and calculations.
- A statement that the source of a pricing assumption is “professional judgment” with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies, or public information.
- “Living worksheets” that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of prior bid filings.

SUBMITTING SUPPORTING DOCUMENTATION

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

Cover Sheet

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

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

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a bid’s projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must not refer to a “range” of bid IDs (such as “plans 001 – 030” or “all plans under contract Hxxxx”). For these items, the cover sheet must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

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

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

Timing

Plan sponsors and certifying actuaries must prepare all supporting documentation at the time of the initial June bid submission in order to be immediately available to CMS and reviewers at that time or be readily available upon request as explained below.

- The “Initial June Bid Submission” section in this appendix describes supporting documentation items that Plan sponsors must upload to HPMS with the initial June bid submission.
- The “Upon Request by CMS Reviewers” section of this appendix describes materials that Plan sponsors and certifying actuaries must provide within 48 hours of request by CMS reviewers and upload to HPMS prior to bid approval.
- When a BPT is resubmitted, the Plan sponsor must upload a summary of changes, including the cause and effect of each revision, authorized by CMS or CMS reviewers. If multiple BPTs are submitted at the same time, the supporting documentation must include a mapping of specific bid changes and bid IDs.
- Prior to bid approval,—
 - Plan sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid. Note that the upload of e-mail correspondence to HPMS alone does not satisfy this requirement.
 - Plan sponsors must upload revised supporting documentation and e-mail correspondence supporting bid resubmissions to HPMS.

Initial June Bid Submission

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

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, service area changes, type of coverage, contractual arrangements, marketing approach, and any other pertinent information that would help expedite the bid review. For dual-eligible SNPs, include a statement indicating how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management, and margins.
- A document titled “Related Party Declaration,” which states whether or not the Plan sponsor is in a related-party arrangement (Worksheets 1 and 4).
- Support for sequestration’s effect on the bid, including a detailed description of how it is reflected in pricing assumptions.
- Support for the claims credibility assumptions (Worksheet 2), including—
 - A statement of the credibility approach used—for example, the CMS guideline or the CMS override.
 - A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
 - The method for blending differences between the credibility for utilization and that for unit cost into a composite PMPM credibility factor.
 - Justification for any variation in the credibility approach by line of business.
 - An explanation for a zero credibility percentage for a service category with credible data.
- A detailed description of the process used for adjusting cost sharing due to maximum OOP limits, including how the PMPM impact of the maximum OOP was determined. (Worksheet 3).
- Support for non-benefit expense assumptions. The required elements include—
 - A reconciliation of the base period non-benefit expenses reported in the BPT and auditable material such as corporate financials and plan-level operational data (Worksheet 1).
 - A description of the expenses included in each non-benefit expense category in the BPT. (Worksheet 4)
 - Detailed support for the development of projected non-benefit expenses (Worksheet 4). The required elements include—
 - A description of the methodology used to develop projected non-benefit expenses.
 - A description of the data source and its relationship to the base period non-benefit expenses reported in the BPT.
 - An explanation for significant differences between actual and expected non-benefit expenses for CY2011, CY2012 and CY2013, including a description of how that knowledge was incorporated into the CY projection.

- ▶ A demonstration of the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other projections.
- Justification of the gain/loss margin (Worksheet 4). The required elements include—
 - Support for overall MA margin levels including—
 - ▶ The Plan sponsor’s margin requirement for all non-Medicare business, including any change in such requirement in the prior two years, and identification of these lines of business.
 - ▶ A description of the methodology used to develop the gain/loss margin assumption and the level at which the aggregate margins are determined.
 - ▶ For Plan sponsors that choose to satisfy aggregate-level gain/loss requirements at the organization level, a list of the MA contract numbers offered by the organization.
 - ▶ A demonstration of consistency of projected margins from year to year.
 - ▶ A demonstration of consistency between the aggregate margin for general enrollment plans & I/C SNPs (or for other gain/loss margin categories, if applicable) and the applicable measure of the Plan sponsor’s margin requirement, that is, (i) the Plan sponsor’s margin requirement for all non-Medicare business, or (ii) the Plan sponsor’s capital and surplus requirement. Acceptable support for scenario (ii) includes, but is not limited to, a demonstration of risk-based capital needs or an illustration of return on investment or equity requirements.
 - ▶ A demonstration of consistency between the aggregate margin for general enrollment plans & I/C SNPs and other gain/loss margin categories, if applicable.
 - ▶ A detailed justification for unique situations, in which the aggregate margin for D-SNPs is outside of the stated range of the aggregate margin for general enrollment plans & I/C SNPs combined, including—
 - A description of extenuating circumstances supporting an exception.
 - Evidence of the absence of anti-competitive practices and solvency issues.
 - Actions taken to bring the margin differential into compliance with these Instructions.
 - ▶ A demonstration of consistency between (projected) aggregate margins and actual aggregate returns over the long term. If historically these items have been inconsistent, provide an explanation for how this is addressed in the current bid submission, for example, how pricing assumptions have been set to make the projected margin more consistent with actual returns.
 - ▶ Justification for bids with relatively large projected overall gain/loss margin, including an explanation of how the PBP offers benefit value in relation to the margin level.
 - ▶ Support for a bid with a high margin that is not in a valid product pairing, including one of the following items:
 - An explanation of a need for a contingency margin that correlates to the “risk” to the plan sponsor, low credibility, and/or significant claims variability from year to year.

- A demonstration of incremental benefit and premium changes being made over time to reduce margin while maintaining stability, including a justification that the PBP is providing all possible benefits that the expected population can utilize.
- Support for bids with negative margins, including one of the following items:
 - For a new bid ID, or a bid ID with a zero or positive projected gain/loss margin for the prior contract year, a bid-specific, year-by-year, numeric business plan that demonstrates profitability within 5 years.
 - For a bid ID with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the gain/loss margin to the MA margin in the original business plan. The required elements include—
 - Details and sources of deviation from the original business plan.
 - An explanation and demonstration as to how the targeted margin in the original business plan will be met, if the bid ID is progressing towards a positive margin less rapidly than projected in the original business plan, including—
 - A revised business plan demonstrating that the bid will reach profitability within 5 years of the original business plan.
 - A description of benefits reductions or premium increases for CY2015.
 - The year the bid reaches profitability or becomes part of a valid product pairing.
 - A copy of the original business plan uploaded to HPMS in a separate file.
 - A description of the MA product pairing, which includes the gain/loss margin for each bid ID and shows that such bids—
 - Have identical service areas,
 - Are all local coordinated care plans, or all RPPOs, or all PFFS plans,
 - Have the same SNP type (or are all non-SNPs),
 - Are all EGWPs or all non-EGWPs, and
 - Have a positive combined gain/loss margin.
- A detailed justification for unique situations, in which a business a plan does not achieve profitability within 5 years, including—
 - A description of extenuating circumstances supporting an exception.
 - Evidence of the absence of anti-competitive practices and solvency issues.
 - Actions taken to bring the margin differential into compliance with these Instructions.
- For MA-PD plans, a description of the approach for setting the Part D margin in relation to the MA margin.
- For bids in the Platino program, a statement as to which BPT margin was used to satisfy all gain/loss margin requirements.
- A detailed explanation of the need for flexibility in the gain/loss margin requirements in order to satisfy other CMS requirements.
- 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 CY2015MA risk scores.
- A description of the source data for the development of the projected CY2015 MA risk scores.
- A description of all projection factors and the basis for the factors.
- A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected medical expenses.
- A demonstration that the method used is consistent with the preferred development approach in these Instructions, including an explanation for using an alternate approach, if applicable.
- Justification for and a description of the credibility assumption for actual plan risk scores.

The following documentation requirements apply to all bids for which the below elements pertain:

- Detailed support for the development of base period experience (Worksheet 1). This documentation, which is based on regulatory authority for the review of materials that pertain to any aspect of services provided, is also required in cases in which medical services are provided under a capitated arrangement. The required elements include—
 - A description of the allocation of allowed costs by service category when the allocation method is not based on plan experience data (Worksheet 1).
 - Information regarding the base period member months, if for some reason more than eight plans constitute the base period data (see Worksheet 1, Section II, line 5).
 - Reconciliation of base period experience with the audited financial statements and bid-level operational data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including claims paid, unloaded claim reserves, non-benefit expenses, and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
 - Justification for the lack of encounter data for services provided under capitated arrangements including—
 - An explanation for the deficiency.
 - A detailed description of the steps that the Plan sponsor has taken or is taking to obtain encounter data for subsequent year's bid submissions.
 - A description of the data source for utilization per 1,000 and the basis for any adjustments.
- Detailed qualitative and quantitative support for the development of each projection factor (Worksheet 1). The required elements include—
 - A description of the source data, including the data's relevance to the MA plan.
 - A summary of the Plan sponsor's historical trends including—
 - The percentage trends.
 - A description of the methodology used to analyze the data.
 - The numeric calculations.
 - Any applicable adjustments to the source data, such as considerations for—

- Plan sponsor's experience, including an explanation for significant differences between actual and expected claims for CY2011, CY2012 and CY2013, and a description of how that knowledge was incorporated into the projection factors.
 - Industry and/or internal studies.
 - Benefit design analysis.
 - A change in the mix of services, including the rationale for the type of projection factor used to reflect such change.
 - A change in the mix of provider arrangements such as capitated and risk sharing arrangements.
- Justification for combining data for multiple service categories.
- Support for the allocation of enrollment between DE# and non-DE# beneficiaries including the basis for classifying dual-eligible enrollees as DE# (Worksheets 1 and 5).
- Support for claim costs for hospice enrollees for mandatory supplemental benefits when these costs are included in the projected allowed cost PMPM.
- Detailed support for the data and methodology used in the development of appropriate manual rates for the expected population (Worksheet 2). The required elements include—
 - A description of the source data, including the data's relevance to the MA plan and the precise name of any published tables used.
 - Credibility standards applied to the data and corresponding adjustments, if applicable.
 - Consideration of any adjustments made for annual volatility of the source data.
 - Any applicable adjustments to the source data, such as—
 - Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data.
 - Addition of Medicare-covered benefits not reflected in the source data.
 - Exclusion of non-covered benefits reflected in the source data.
 - Techniques and factors used to reflect differences between the underlying population and that expected of the MA plan.
 - Factors to reflect lower claims for expected MSP enrollees in the projected population.
 - Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the MA plan.
 - Methodology and data used to gross up reimbursements to an allowed-cost basis.
 - Data and methodology used to project the data from base period to CY2015.
 - The reasonableness of allowed costs and projection factors for costs based on capitated payments to related parties.
 - The allocation of projected allowed costs by service categories.
 - All other applicable factors and/or adjustments.
- Support for non-DE# projected allowed costs (Worksheet 2).

- The rationale for projecting a zero cost of a benefit that is included in the PBP whether or not the cost of the benefit in the base period data or in the manual rate source data is zero or insignificant. Indicate which \$0 cost benefits each PBP includes.
- Support, at the benefit level, for non-covered services (Worksheet 2, lines l through q, column o), if any, including a breakdown of the PMPM value shown in the BPT. For example, a \$4.00 PMPM in column o of row p, “Health and Education,” is to be shown in the supporting documentation as \$1.50 PMPM for a smoking cessation program and \$2.50 PMPM for nutritional counseling. (Detailed support for the pricing of each additional benefit is available upon request.)
- Detailed support for related-party medical and administrative service arrangements (Worksheets 1 and 4).
 - A Plan sponsor in a related-party arrangement must provide the following:
 - Declaration of every related-party arrangement.
 - Disclosure of all services provided in every related-party arrangement.
 - A summary that explains the relationship of the parties involved and common ownership, control and investment.
 - A summary of the contractual terms of each relationship that includes a description of the services provided and money exchanged.
 - Disclosure of the method used in preparing the bid for each arrangement. The options are Actual Cost Method (for Administrative Services and for Medical Services), Market Comparison Method for Administrative Services (through Plan sponsor or through related party), Market Comparison for Medical Services (through Plan sponsor or through related party), Comparable to FFS Method, and FFS Proxy Method.
 - Supporting documentation for each arrangement, as outlined below.
 - A Plan sponsor that chooses the Actual Cost Method must provide a qualitative and quantitative summary of the development of the actual costs associated with the non-benefit expense, gain/loss margin, and medical expense, if applicable.
 - A Plan sponsor that chooses the Market Comparison Method for Administrative Services or for Medical Services must provide the following support:
 - A demonstration that the contracts with the unrelated parties or unrelated MA organizations are associated with sufficient costs to be considered valid contracts.
 - For related-party administrative arrangements between the Plan sponsor and unrelated parties, a demonstration that the fees associated with such arrangements are within 5 percent or \$2 PMPM, whichever is greater.
 - For related-party administrative arrangements between the related-party organization and unrelated parties,—
 - A demonstration that the fees associated with such arrangements are within 5 percent or \$2 PMPM, whichever is greater.
 - A signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.
 - For related-party medical arrangements between the Plan sponsor and unrelated parties in the bid’s service area, a demonstration that the fees

associated with such arrangements are within 5 percent or \$2 PMPM, whichever is greater.

- ▶ For related-party medical arrangements between the related-party organization and unrelated MA organizations,—
 - A demonstration that the fees associated with such arrangements are within 5 percent or \$2 PMPM, whichever is greater.
 - A signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.
- A Plan sponsor that chooses the Comparable to FFS Method must—
 - ▶ Provide written evidence of a good-faith, but unsuccessful, effort to obtain the actual costs of the related party to provide medical services to the Plan sponsor under the related-party arrangement.
 - ▶ Demonstrate that the fees associated with the related party arrangement are comparable to 100% FFS for similar services, that is, within 5 percent or \$2 PMPM, whichever is greater.
- A Plan sponsor that chooses the FFS Proxy Method must—
 - ▶ Provide written evidence of a good-faith, but unsuccessful, effort to obtain the actual costs of the related party to provide medical services to the Plan sponsor under the related-party arrangement.
 - ▶ Demonstrate that the fees associated with the related party arrangement are not comparable to 100% FFS for similar services, that is, within 5 percent or \$2 PMPM, whichever is greater.
 - ▶ Provide one of the following elements:
 - A declaration that: (i) the related-party organization does not have an arrangement to provide similar services with an unrelated party, or (ii) the Plan sponsor does not have an arrangement to provide similar services with unrelated providers in the bid's service area.
 - Evidence of a good-faith, but unsuccessful, effort to obtain sufficient information about fees for similar services in medical arrangements between: (i) the related-party organization and unrelated parties, or (ii) the Plan sponsor and unrelated providers in the bid's service area.
 - A demonstration that fees for similar services are not comparable between: (i) the related-party organization and unrelated parties, or (ii) the Plan sponsor and unrelated providers in the bid's service area.
- A detailed demonstration that coinsurance or copayment amounts for which CMS does not have an established amount (such as coinsurance for inpatient or SNF, or copayment for durable medical equipment) satisfies CMS service category requirements (Worksheet 3).
- Support for a global capitation arrangement or risk sharing arrangement. The required elements include—
 - A description of the arrangement.
 - A demonstration of the methodology used to allocate the impact of the arrangement to BPT service categories (including the allocation to the MA and PD BPTs, if the arrangement applies to Part D services)

- Support for the development of the contract year ESRD subsidy (Worksheet 4). This required documentation includes the following:
 - Base period (for example, 2013) revenues and medical expenditures for Medicare-covered benefits provided to enrollees in ESRD status.
 - The source for, and the development process of, any manual rates used.
 - Relevant base-to-contract year trend factors.
 - A short narrative on the credibility approach applied to the ESRD experience.
- Detailed support for the MSP adjustment, including justification for a zero amount. (Worksheet 5).
- Support for zero projected DE# member months when there are DE# members in the base period (Worksheet 5).
- Support for the development of plan-provided ISAR factors (Worksheet 5), if used. (This requirement applies to RPPOs only.) A description of the methodology and data source(s) used to calculate the ISAR factor(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (that is, non-benefit expense and gain/loss margin) that were assumed in the development of the factors.
- Support for the projected medical expense, projected non-benefit expense, and projected gain/loss margin for specific OSB packages (Worksheet 7).
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, when used (that is, when indicated in the “General Information” section of Worksheet 1).
- For EGWPs, an explanation of the consistency between the pricing in the bid and the expected underwriting assumptions for all groups, in aggregate. This documentation includes, but is not limited to, a description of the underwriting methodology.
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of and detailed support for how CY2014 bid audit findings and observations and compliance issues were corrected in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that—
 - Identifies the source(s) of the information—for example, name, position, company, date;
 - Identifies the information relied upon;
 - States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and
 - Indicates to which plan(s) the reliance information applies.

See the sample format at the end of Appendix B.

Upon Request by CMS Reviewers

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request.

If substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit:

- Support for the pricing of the non-covered services, including utilization and unit cost (Worksheet 2, lines l through r, column o). (Support at the benefit level is required in the initial June bid submission.)
- Detailed support for cost-sharing utilization assumptions and plan-level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-covered and A/B mandatory supplemental benefits (Worksheet 4).
- Support for when the formulas provided in the BPT for DE# plan cost sharing (Worksheet 4, Section IIB, column f) are overwritten at the discretion of the certifying actuary.
- Copies of related-party contracts.
- Support for the calculation of the “Medicaid Cost Sharing” in column k, including cost sharing required by state or territory Medicaid programs in the plan’s service area based on the eligibility rules for subsidized cost sharing for DE# beneficiaries (Worksheet 4).
- Justification for significant differences between the assumptions of corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark). See Appendix D for more information.
- A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.
- Communication between CMS reviewers and the Plan sponsor throughout the bid review process (that is, e-mail communication) that was not uploaded to HPMS during bid review.
- An explanation as to how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

MA CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Related-party declaration
Sequestration
Claims credibility assumption
Adjustment to cost sharing for maximum OOP limit
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and reconciliation
Projection factors
Enrollment allocation (DE#/non-DE#)
Hospice claims costs for mandatory supplemental
Manual rate development
Non-DE# projected allowed costs
Zero cost benefit
Non-covered services benefit-level summary
Related-party arrangements
Coinsurance/copay satisfies service category requirements
Global capitation or risk sharing arrangement
ESRD "subsidy"
MSP adjustment
Projected zero DE# member months
ISAR factors
Optional supplemental benefit (OSB) packages pricing assumptions
Actuarial swaps/equivalences
EGWP comparison of bid pricing and expected underwriting assumptions
Input sheets for pricing model
Bid audit results and compliance issues
Reliance information

Upon Request by CMS Reviewers
Non-covered services pricing
Cost-sharing utilization and plan-level deductible
Allocation of allowed costs/cost sharing to Medicare-covered and non-covered
Override of formulas for DE# plan cost sharing
Related-party contracts
State and territory cost sharing requirements
Differences in EGWP and general market pricing assumptions
Reliance letter
Bid review communications
OFM audit results
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD IN JUNE

Supporting Documentation Cover Sheet #1

CY2015 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: June 2, 2014

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 6-1-2014.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-1-2014.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-1-2014.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-1-2014.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 CY2015.xls	MA-Sheet 1 PD-Sheet 2	both
Related-Party declaration	All bids	Cover Sheet 6-1-2014.pdf	Page 7	both
Sequestration	All bids	Cover Sheet 6-1-2014.pdf	Page 7	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****CY2015 Bid Submission****Organization Name:** Health One**Contract(s):** H1234, H9999, and S9999**Date:** July 16, 2014

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 7-16-2014.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.

SAMPLE FORMAT FOR AGGREGATE GAIN/LOSS MARGIN SUPPORT

Note that a numerical summary of aggregate gain/loss margins is a component of required aggregate gain/loss supporting documentation, and does not, in itself, fully satisfy such requirements.

Overall Gain (Loss) Margin Level Designated in BPT: Organization

Organization Name: Health One

Aggregate Grouping	MA Bid IDs	Adjusted Gain/Loss Margin PMPM	Adjusted Gain /Loss Margin %	Comparison	Difference
Corporate Requirement	N/A	N/A		N/A	N/A
MA General Enrollment and I/C SNP ("GE")	H1234-001-00, H1234-002-00, H5678-001-00, H5678-001-00			MA "GE" – Corporate	
MA D-SNP	H1234-003-00, H1234-004-00			MA "GE" – MA D-SNP	
EGWP	H1234-801-00, H1234-802-00			MA "GE" – EGWP	
EGWP	H5678-801-00, H5678-802-00			MA "GE" – EGWP	
MA-PD General Enrollment and I/C SNPs	H1234-001-00, H1234-002-00, H5678-001-00, H5678-001-00			MA "GE" – PD "GE" ¹	
MA-PD D-SNPs	H1234-003-00, H1234-004-00, H5678-003-00, H5678-004-00			MA D-SNP – Part D D-SNP ²	

¹ The Part D margin for each bid is within 1.5 percent of the margin in the MA component of the same MA-PD.

² The Part D margin for each bid is within 1.5 percent of the margin in the MA component of the same MA-PD.

SAMPLE FORMAT FOR SUMMARY OF NEGATIVE-MARGIN BIDS

MA Bid ID	CY2015 MA Gain/Loss Margin PMPM	CY2015 MA Gain /Loss Margin %	1st First Year of Negative Projected G/L Margin	1st Year Profita ble	1st Year Bid is in a Valid Product Pairing	Bids in the Valid Product Pairing
H4444-003-00			2014	2019	N/A	N/A
H7777-002-00			2013	N/A	2017	H7777-001-00, H7777-002-00, H7777-003-00
H7777-003-00			2013	2016	2017 ¹	H7777-001-00, H7777-002-00, H7777-003-00 ²

SAMPLE FORMAT FOR PRODUCT PAIRING SUPPORTING DOCUMENTATION

Service Area	MA Bid ID	Plan Type	SNP Type	MA Projected Member Months	CY2015 MA Gain /Loss Margin %
55010	H5555-001-01	LPPO	N/A		
55010	H5555-002-01	LPPO	N/A		
55010	H5555-003-01	LPPO	N/A		
Average					
55020	H5555-001-02	LPPO	N/A		
55020	H5555-002-02	LPPO	N/A		
55020	H5555-003-02	LPPO	N/A		
Average					

¹ Note that it is acceptable to omit the date the bid becomes part of a valid product pairing because the bid becomes profitable in an earlier year.

² Note that it is acceptable to omit the bid IDs for the valid product pairing because the bid becomes profitable in an earlier year.

APPENDIX C – PART B-ONLY ENROLLEES

This appendix includes bid requirements for plans that cover only enrollees eligible for Medicare Part B. An RPPO plan must cover enrollees eligible for both Medicare Part A and Part B.

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

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

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

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

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

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

- The Medicare-covered proportion of inpatient services (line a) must equal zero (0) percent.
- While the majority of Medicare expenditures for skilled nursing facilities (SNFs) are covered under Part A (Hospital Insurance), in certain circumstances benefits are covered under Part B (Supplementary Medical Insurance). Guidance on these covered services can be found in Section 70 of Chapter 8 of the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c08.pdf>. We estimate that for calendar year 2015, 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 (MA) products to members of employer and union groups: individual-market plans and employer-only or union-only group waiver plans (that is, EGWP or “800-series” plans).

Individual-Market Plans (“Mixed Enrollment” plans)

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

Actuarial Swaps

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

Actuarial Equivalence

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

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

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

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

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

The MMA gives employers and unions multiple options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), those options include making special

arrangements with MA organizations to purchase customized benefits for their active employees and retirees or contracting directly with CMS to sponsor a MA plan.

Under section 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for the kinds of arrangements that “hinder the design of, the offering of, or the enrollment in” these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of employer/union-only sponsored group waiver plans (EGWPs): (i) MA organizations that offer or administer employer/union-only sponsored group waiver plans (that is, “800-series plans” in an “H” or “R” contract); and (ii) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan (that is, Employer/Union “Direct Contract” PPO or PFFS plans).

Chapter 9 of the *Medicare Managed Care Manual* (MMCM), which can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c09.pdf>, describes the offering of these EGWPs that are available only to employer and union groups. These plans must follow all MA bidding requirements, except those that are specifically waived per Chapter 9 of the MMCM.

Below are some of the key features to be reflected in EGWP bids. The term “group” refers to employer and union groups.

- Base period data must reflect actual experience for all group members enrolled in the EGWP, across all groups.
- Total projected allowed costs for Medicare-covered services must reflect the composite characteristics of the individuals expected to enroll in the EGWP for the contract year, across all groups.
- The pricing in the bid must reflect the expected underwriting assumptions for all groups, in aggregate, that is,—
 - Each EGWP bid must reflect the composite characteristics of the individuals expected to enroll in the EGWP for the contract year, across all groups. These characteristics include, but are not limited to, the following: risk scores, geographical distribution of enrollees, non-benefit expenses, and gain/loss margins.
 - Projected enrollment within the plan’s service area must be consistent with the location of employer groups.
- The cost sharing priced in Worksheet 3 must correspond to that contained in the PBP.
 - The PBP can be prepared using either the expected composite benefit plan or the Medicare fee-for-service benefit provisions with the required maximum out-of-pocket limit (MOOP).
 - If the PBP reflects Medicare fee-for-service benefits with a MOOP and an MA rebate is generated, then the user must enter the PMPM value of the medical costs associated with these additional “unspecified” benefits in Worksheet 4, Section IV.
- Generally, CMS expects that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience.

Organizations must provide documentation in support of differences in actuarial/financial assumptions between the corresponding products.

- There is no requirement to charge the filed MA basic and supplemental premium to each group that enrolls in the EGWP. However, if the PBP reflects the expected composite benefit plan, then the average premium charged, weighted by all members enrolled in the EGWP across all groups, must correspond to (that is, be consistent with) the filed premium.
- Following are the guidelines for rebates:
 - Similar to CMS' payment on behalf of beneficiaries enrolled in individual-market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an EGWP.
 - The allocation of rebates may vary from group to group within the EGWP subject to the requirements listed below. (The bid form contains one allocation.)
 - ▶ The total rebate must be uniform for all members enrolled in the EGWP.
 - ▶ MA organizations may allocate rebates to the Part D premium when negotiating with specific groups; however, EGWP bids cannot reflect an allocation of rebates to the Part D basic premium or the Part D supplemental premium in the bid form.
 - ▶ The Part B premium buydown rebate allocation in the bid form applies for all members enrolled in the EGWP.
 - ▶ All group members enrolled in an EGWP with supplemental A/B rebates (both reduction in A/B cost sharing and additional benefits) must receive supplemental benefits equal to the amount of the A/B rebate allocation. However, A/B supplemental benefits provided to each group may be customized. Further, MA organizations may use the field in Worksheet 4, Section IV, line 1, "PMPM for additional/unspecified MS benefits," to account for A/B supplemental benefits that are likely to be customized.
 - Consistent with individual-market bids, rebates allocated to reduce members' Part B premium will be transferred to the Social Security Administration, not the MA organization.
 - All rebates must be accounted for and must be used only for the purposes provided for in law. Documentation that supports the use of all of the rebates on a detailed basis must be retained by the MA organization.

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

APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING

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

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

CMS will announce the exact dates of the rebate reallocation period when the Part D and MA benchmarks are released.

In addition to reallocation guidance, this appendix provides premium rounding rules and describes the premium rounding that is permissible during rebate reallocation.

Note that in order to satisfy all CMS rebate reallocation requirements, it may not be possible for the Plan sponsor to reach the total plan premium prior to rebate reallocation. Rebate reallocation is only an opportunity to get back to the target Part D basic premium.

I. REBATE REALLOCATION PERMISSIBILITY BY PLAN TYPE

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

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

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

- The basic Part D premium net of rebates (that is, the amount displayed in line 7d of Worksheet 6, Section IIIC), or
- The low income premium subsidy amount.

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

The target Part D basic premium concept does not apply to MA-only plans and EGWP plans, since these plans do not submit a Part D BPT.

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

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

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

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

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

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

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted	Permitted (excluding EGWP)
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

MA-Only Plans

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted; these plans are not affected by the Part D and MA regional benchmarks	Not permitted; premiums must reflect desired rounding in the initial June bid submission
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

II. REBATE REALLOCATION RULES AND EXAMPLES**A. Return to the Target Premium**

When rebates are reallocated, the Part D basic premium net of rebate must be returned to the target Part D basic premium indicated in the initial June bid submission; there is no option to target and reallocate rebates to return to Total Plan Premium.

CMS will not accept a partial return to the target premium, except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

B. Negative Part D Basic Premium Net of Rebate after Part D Benchmark Announcement

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

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if the premium resulting from application of the national average monthly bid amount and the base beneficiary premium is negative, then the “excess” rebate allocated to buy down the Part D basic premium must be reallocated to buy down the other premiums (the A/B mandatory supplemental premium, the Part D supplemental premium, and/or the Part B premium).

Example 1.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Resubmission
7a. Part D basic premium prior to rebates (rounded)	\$36	\$34	\$34
7c. MA rebates allocated to Part D basic premium (rounded)	\$36	\$36	\$34
7d. Part D basic premium	\$0	–\$2	\$0
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable

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

C. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than Target Part D Basic Premium, but Not Less than Zero

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

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

Note: If the MA organization elects to allocate the “excess” rebate dollars to the other premiums, then the final Part D basic premium must equal the target premium. In other words, a partial return to the target premium will not be accepted.

Example 2.

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. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$15	\$10
7d. Part D basic premium	\$20	\$15	\$15	\$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

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

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

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

D. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than Target Part D Basic Premium

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

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

Example 3.

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. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$15	\$20
7d. Part D basic premium	\$20	\$25	\$25	\$20
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable

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

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

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

E. Increase or Decrease in RPPO Total Rebate Dollars

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

Example 4.

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2	Rebate Reallocation Option 3
Total MA rebate (IIIB, line 1)	\$55	\$53	\$53	\$53	\$53
MA rebates allocated to benefits other than Part D basic premium (IIIB, lines 2-4 and 6)	\$40	\$40	\$38	\$43	\$38
MA rebates allocated to Part D basic premium (rounded) (IIIB, line 5)	\$15	\$15	\$15	\$10	\$15
Total rebates allocated (IIIB, line 7)	\$55	\$55	\$53	\$53	\$53
Unallocated rebates	\$0	-\$2	\$0	\$0	\$0
A/B Supp premium prior to rebates (IIIC, line 1)	\$50	\$50	\$50	\$50	\$48

APPENDIX E

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2	Rebate Reallocation Option 3
A/B Supp premium net of rebates (rounded) (IIIC, line 3)	\$10	\$10	\$12	\$7	\$10
Part D basic premium prior to rebates (rounded) (IIIC, line 7a)	\$35	\$30	\$30	\$30	\$30
Part D basic premium net of rebates (IIIC, line 7d)	\$20	\$15	\$15	\$20	\$15
Total MA-PD premium (IIIC, line 9)	\$30	\$25	\$27	\$27	\$25
Plan intention for target Part D basic premium (IIIC, line 10)	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable	Not applicable

The MA organization has one of the following three options for rebate allocation:

- Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of \$15. Subtract \$2 of rebates that were allocated to other premiums such that the total rebates allocated equal the total rebates available.
- Reduce the rebate allocation for the basic Part D premium by \$5 in order to return to the target Part D basic premium of \$20. Reallocate \$3 of rebates to other premiums such that the total rebates allocated equal the total rebates available.
- Make a change to A/B supplemental benefits as discussed in the section III in Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits. Reduce the rebate allocation to benefits other than the Part D basic premium by \$2 such that the total rebates allocated equal the total rebates available. Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of \$15.

F. Every Plan Bid Must Allocate the Exact Amount of the Plan's Total Rebate

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

G. Examples in which Target Part D Basic Premium Is the Low-Income Premium Subsidy Amount (LIPSA) (and the Plan Desires to Return to the Target)

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than LIPSA

If the Part D basic premium net of rebate is lower than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the MA organization may increase

the Part D basic premium in order to reach the target LIPSA by either (i) reallocating rebates to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental), or (ii) adding A/B mandatory supplemental benefits, in accordance with this appendix, and reallocating rebates to reduce the premium for the newly added benefits.

Note: The final Part D basic premium must equal the target premium unless all of the rebates are allocated to the Part D basic premium and it is still less than the LIPSA.

Example 5a.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	\$35	\$30	\$30
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$12
7d. Part D basic premium	\$20	\$15	\$18
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$18	\$18

The LIPSA is less than expected, and the Part D basic premium post-benchmark is less than the LIPSA. To return to the target LIPSA, the only option that the MA organization has is to reallocate rebates to other benefits/premiums.

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA

If the Part D basic premium net of rebate post-benchmark is greater than the LIPSA, then the MA organization may lower the Part D basic premium to the target LIPSA by reallocating the rebate to the Part D basic premium that was applied to buy down other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental). If the MA organization chooses to reallocate additional rebate dollars from other premiums, the final Part D basic premium must equal the LIPSA except in the following situation: the Plan sponsor intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the LIPSA.

Example 5b. (Similar to Example 3)

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	\$35	\$40	\$40
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$25
7d. Part D basic premium	\$20	\$25	\$15
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$15	\$15

The LIPSA is less than expected, and the Part D basic premium post-benchmark is greater than the LIPSA. To return to the target LIPSA, the only option the MA organization has is to reallocate rebates from other benefits/premiums to the Part D basic premium.

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA - De Minimis Election

The Part D basic premium post-benchmark is greater than the LIPSA and LIPSA is designated as the target Part D basic premium. If (i) the MA organization has no rebates or has allocated all of the MA rebates to the Part D basic premium, and (ii) the difference between the Part D basic premium post-benchmark and the LIPSA is between \$0 and the de minimis amount published by CMS, the MA organization may volunteer to waive the portion of the Part D basic premium equal to this difference.

Conversely, if the difference between the Part D basic premium post-benchmark and the LIPSA is greater than the de minimis amount published by CMS, the MA organization cannot volunteer to waive the de minimis amount.

Example 5c (MA rebates allocated to Part D basic premium equal total MA rebates)

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	\$35	\$40	\$40
7c. MA rebates allocated to Part D basic premium (rounded)	\$15	\$15	\$23
7d. Part D basic premium	\$20	\$25	\$17
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	\$15	\$15

The difference between the \$17 Part D basic premium post-benchmark and the \$15 LIPSA is \$2. The MA organization may volunteer to waive \$2 of the \$17 Part D basic premium to reach the target LIPSA only if CMS publishes a de minimis amount greater

than or equal to \$2. If CMS publishes a de minimis amount less than \$2, the MA organization may not participate in the de minimis program or waive any portion of the \$17 Part D basic premium.

Note that the de minimis amounts in this example are hypothetical and do not reflect CMS' de minimis policy for CY2015.

H. First-Time Allocation of Rebate Dollars to Part D Basic Premium during the Rebate Reallocation Period.

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

Example 6.

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

III. ADDITIONAL REBATE REALLOCATION GUIDANCE

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

During the rebate reallocation period, rebate dollars that are not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. However, no modifications are allowed to the benefit design or pricing of the Part D basic benefit or the supplemental benefit offered under the “enhanced alternative” design. That is, this prohibition includes that no changes are permitted to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits. (Note that in the rare case, in which the basic Part D premium is negative after the release of the national average and base beneficiary premium, limited changes may be allowed to enhance the Part D benefits in order to create a Part D supplemental premium that offsets the Part D basic premium.)

Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits

The A/B mandatory supplemental benefit includes reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under original Medicare and additional items and services not covered by original Medicare. CMS will not allow MA

organizations to substantially redesign A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during this period and will evaluate material differences.

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

- The net shift in (i) total MA rebate dollars due to an increase or decrease in those dollars after application of the regional benchmark, and (ii) a shift in rebates dollars allocated to Part D basic premium to return to the Part D target premium.
- The shift in total MA rebate dollars due to an increase or decrease in those dollars after application of the regional PPO benchmark.

CMS will not allow the MA organization to eliminate one additional benefit and then add another additional benefit.

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

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

Example 7.

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

However, CMS will not allow the MA organization to accomplish rebate reallocation by changing the value of benefits by more than \$3, for example, by moving \$15 out of A/B cost-sharing reductions and moving \$18 into an additional benefit. We would consider this to be a substantial redesign of the A/B mandatory supplemental benefit.

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

- Buy down less of the A/B mandatory supplemental premium; or
- Eliminate or reduce an A/B mandatory supplemental benefit (for example, provide an eye exam less frequently), and then buy down the new A/B mandatory supplemental premium to the initial level.

Similarly, to return a regional plan with a decrease in the total amount of rebate to the original premium, the MA organization could, for example, eliminate from the A/B mandatory supplemental benefit package the coverage of a non-Medicare covered item or service.

The CY2010 Call Letter included the following guidance regarding benefit changes during rebate reallocation (page 22):

“III. Bidding

Rebate Re-allocation

. . . In situations when MA-PD plans are allowed to re-allocate Part C rebate dollars in order to return to the Target Part D basic premium (due to “insufficient allocation” resulting in a Part D basic premium larger than the target premium or due to a reduction in the total amount of rebate for a regional plan), MAOs should make re-allocations that reflect the following priorities. Specifically, there may not be any reduction of rebate allocated to priority (3) unless reductions have first been made to priority (1), then priority (2) noted below.

1. Reduce or remove non-Medicare covered benefits;
2. Increase cost sharing for widely-used services such as primary care visits; and
3. As a last resort, increase cost sharing for more limited-use services such as inpatient, skilled nursing facility (SNF), and home health care.

MAOs that do not adhere to this guidance may be asked to resubmit.”

Changes Allowed to the Part B Premium Reduction

One use of rebate dollars allowed under 42 CFR §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars allocated for this purpose may be increased or decreased. However, the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount pre-populated by CMS in the BPT.

Plans Required to Include Prescription Drug Coverage

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

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

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

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

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

To restate: MA organizations offering coordinated care plans must offer in an area either (i) a basic-only Part D plan or (ii) a basic plus supplemental Part D plan for which the supplemental premium (net of rebates) equals zero. Failure to meet this requirement will result in the

organization's inability to offer a Part D benefit. In addition, MA organizations that offer coordinated care plans but that fail to offer a Part D benefit in an area will be unable to offer an MA benefit as well, under the rules of 42 C.F.R. §422.4(c).

MA Pricing

CMS will allow only minor changes to the BPT as explained below, that is, the PMPM value of each pricing assumption is essentially fixed prior to rebate reallocation. This guidance applies to all pricing arrangements and methodologies, including percent of revenue, risk sharing, and global capitation.

Changes to A/B Mandatory Supplemental

CMS will allow only the following minor changes to non-benefit expenses and the gain/loss margin as a result of rebate reallocation:

- A change, if any, in non-benefit expenses related to the incremental change of A/B mandatory supplemental benefits.
- A small change in the gain/loss margin related to premium rounding (see premium rounding rules in Appendix E).
- A small change resulting from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.
- A small change in gain/loss margin in order for the bid to satisfy CMS Total Beneficiary Cost (TBC) requirements.

CMS will also allow a small change in the ESRD subsidy due to the automatic (that is, calculated by formula) impact of changes in mandatory supplemental benefits, non-benefit expenses and gain/loss margin as a result of rebate reallocation and rounding.

Changes to Medicare-Covered

CMS will allow only the minor modifications specified below to the pricing of Medicare-covered benefits as a result of rebate reallocation; that is, the PMPM value of allowed costs, non-benefit expenses, and the gain/loss margin may not change except for—

- A small change, if any, in allowed costs directly related to a change in utilization due to the change in A/B mandatory supplemental benefits.
- A small change in non-benefit expenses and the gain/loss margin resulting solely from the proportional allocation of non-benefit expenses and the gain/loss margin in the BPT.
- A small change in gain/loss margin in order for the bid to satisfy CMS TBC requirements.

Total Beneficiary Cost

If the Plan sponsor chooses to modify the PBP as a result of rebate reallocation, CMS will allow a minor change in gain/loss margin in order to satisfy CMS TBC requirements as explained below. Such adjustment is separate from other small changes

in gain/loss margin allowed in these Instructions, for example, a small change in margin in order to round premium.

- Step 1: Before reallocating rebates, adjust gain/loss margin only to the extent necessary to satisfy TBC requirements based on the pre-rebate reallocation change in TBC, (that is, the change in TBC resulting solely from the premium changes associated with the national average and base beneficiary premium, and prior to any changes to benefits), then
- Step 2: Participate in rebate reallocation making benefit changes while complying with TBC requirements.

Local MA Plan Segments

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

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; it may not vary across segments. Therefore, prior to the allocation of rebates to buy down the premium, the Part D basic and supplemental premium must be the same across segments. However, the amount of rebates allocated to buy down Part D basic and supplemental premiums may differ by segment.

See Chapters 1 and 4 of the *Medicare Managed Care Manual* for requirements for MA plan segments.

IV. RULES FOR ROUNDING PREMIUMS

This section describes system requirements for rounded premiums and the circumstances in which the Plan sponsor may round premiums in order to reach plan premium goals.

Rule 1 – System Requirements Regarding Premiums and Rebates

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

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

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

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

Rule 2 – Local MA-Only Plans

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final premium, as these bids are not affected by the Part D national average calculation or the MA regional plan benchmark calculations. Local MA-only plans will not be given an opportunity to round the premiums after the initial June bid submission. If a local

MA-only Plan sponsor wishes to offer a “whole-dollar” premium, the initial June bid submission must reflect a total premium that is rounded to the nearest dollar. The bid assumptions (such as gain/loss margin) must support the desired plan premium and the desired level of premium rounding.

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

Regional plans and local MA-PD plans (excluding local EGWPs) may participate in the rebate reallocation process. During rebate reallocation, MA organizations may round the total plan premium to the nearest dollar (up or down) by slightly increasing or reducing the gain/loss margin in the MA bid, as long as the change in margin results in a total plan premium change of less than \$0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of the combination of the MA basic and mandatory supplemental premiums and the Part D basic and supplemental premiums.)

If the plan has rebate dollars, then the MA organization may make a small change in the gain/loss margin to result in an increase or decrease in rebate dollars of no more than \$0.50. Note that, in order to account for the proportional allocation of the total gain/loss margin to Medicare-covered and A/B mandatory supplemental in the BPT, and also to account for the savings retained by Medicare, the total margin may change by slightly more than \$0.50. Specifically, the Medicare-covered margin (Worksheet 4, cell O107) would be limited to:

- At the 70% rebate level: limited to a \$0.71 Medicare-covered margin change, to result in a \$0.50 change in rebates ($\$0.71 \times 70\% = \0.50).
- At the 65% rebate level: limited to a \$0.77 Medicare-covered margin change, to result in a \$0.50 change in rebates ($\$0.77 \times 65\% = \0.50).
- At the 50% rebate level: limited to a \$1.00 Medicare-covered margin change, to result in a \$0.50 change in rebates ($\$1.00 \times 50\% = \0.50).

If the plan A/B bid is equal to or greater than the A/B benchmark, the MA organization may make a small change in the gain/loss margin resulting in a premium increase or decrease of up to \$0.50.

Note that this rule applies separately from, and after, all other bid adjustments CMS allows during rebate reallocation are made, for example, a small change in gain/loss margin in order to satisfy TBC requirements.

Examples of rounding.

Example (a). An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This situation could occur if (i) the bid equals the benchmark, and no A/B mandatory supplemental benefits are offered, or (ii) the bid is less than the benchmark, and the plan has A/B mandatory supplemental benefits and applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement total plan premium is \$30.42, the MA organization could round the plan premium to \$30.00 by generating \$0.42 of additional rebates to allocate to the basic Part D premium by slightly reducing the gain/loss margin for MA benefits. (The gain/loss margin for Part D benefits must not change.)

Example (b1). An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This situation could occur if (i) the bid equals the benchmark, and no A/B supplemental benefits are offered, or (ii) the plan applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement bid results in a total plan premium of \$32.42, the MA organization could opt to generate \$0.42 of additional rebates to allocate to the basic Part D premium by making a slight reduction in the gain/loss margin for MA benefits that would result in a premium of \$32.00.

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

Example (b2). An MA-PD plan has A/B mandatory supplemental benefits, an initial basic Part D premium (target premium) of \$30, and a total plan premium of \$70.00. If the post-Part D benchmark announcement bid results in a basic Part D premium of \$28.55 and a total plan premium of \$68.55, the MA organization could opt to make a slight change in the gain/loss margin for MA benefits in order to achieve a \$0.45 increase in premium for A/B mandatory supplemental benefits, resulting in a total plan premium of \$69.00.

The MA organization could not use the rounding rules to adjust the premium to anything higher than \$69. For example, the organization could not round to a combined premium of \$70 by increasing the gain/loss margin to result in a premium change of \$1.45. To return to the target premium of \$30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

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

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

Option 1. The plan can maintain its Part D basic premium of \$32.00. The plan's beneficiaries eligible for the full subsidy will pay a Part D basic premium of \$0.40.

Option 2. The MA-PD plan can reallocate \$.40 of the rebates that were allocated to the A/B mandatory supplemental premium to its Part D basic premium, thus reducing the premium to the low-income premium subsidy amount of \$31.60. To account for the reduction in rebates applied to the A/B mandatory

supplemental premium, the MA-PD plan may either increase its A/B mandatory supplemental premium by \$0.40 or reduce its gain/loss margin appropriately to eliminate the premium increase. Enrollees not eligible for the low-income subsidy would pay a Part D basic premium of \$31.60.

Option 3. In order to be able to offer a rounded Part D basic premium to enrollees not eligible for the low-income subsidy, MA-PD plans are permitted in this situation to reallocate A/B mandatory supplemental rebates to reduce their Part D basic premium to the nearest whole-dollar amount below the regional low-income premium subsidy amount. Therefore, the MA-PD plan can reallocate \$1.00 of its A/B mandatory supplemental rebates to its Part D basic premium, reducing the Part D basic premium to \$31.00, which is the nearest whole-dollar amount below the regional low-income premium subsidy of \$31.60. To account for the reduction in A/B mandatory supplemental rebates applied to MA, the MA-PD plan must increase its A/B mandatory supplemental premium by \$1.00 and cannot offset the reduction by a change in the gain/loss margin. Please note that in this option, the MA-PD plan forgoes \$0.60 in potential low-income premium subsidy dollars per each beneficiary eligible for the full subsidy.

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

Option 1. If the plan were to round the Part D basic premium to \$31.70, then it would receive \$31.70 as the low-income premium subsidy. The plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since such premium is lower than the LIPSA.

Option 2. If the plan were to round the Part D basic premium to \$31.80, then it would receive \$31.80 as the low-income premium subsidy as if the LIPSA were \$31.80. In this case, the plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the \$0.04 difference between the Part D basic premium and the LIPSA (that is, \$31.80 less \$31.76) rounds to zero when such premiums are rounded to one decimal.

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

Example (g). The initial June bid submission for a local MA-only plan includes a \$0 basic MA premium and a \$61.30 mandatory supplemental MA premium. The Plan sponsor would like to offer a whole-dollar premium to the plan's enrollees. Before submitting the initial BPT to CMS (via HPMS upload), the actuary would slightly revise the gain/loss margin to accomplish the rounded premium. For example, the actuary could reduce the gain/loss margin by \$0.30 to achieve the \$61.00 rounded

premium. This adjustment must be completed before the BPT is submitted to CMS in early June. Note that Plan sponsors are not allowed to make significant changes to the BPT in order to round premiums. Local MA-only plans do not participate in rebate reallocation.

V. SUMMARY OF CONSIDERATIONS FOR REBATE REALLOCATION RESUBMISSIONS

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

- All RPPOs (including EGWPs) must resubmit during the rebate reallocation period, in order to reflect the published regional MA benchmarks.
- If the national average monthly bid amount (NAMBA) and base beneficiary premium (BBP) result in a Part D basic premium that is lower than the rebates allocated to Part D basic, then the bid must be resubmitted.
- When resubmitting bids during the rebate reallocation period, plans must update the NAMBA and BBP in the Part D BPT.
- The Part D bid must be unchanged.
- The Part D basic premium net of rebates must equal the target.
- If the LIPSA is targeted, the resubmitted Part D basic premium net of rebates must be equal to the plan's LIPSA (rounded to the nearest dime or rounded down to the nearest dollar).
- The "plan's intention for the target premium" in the MA BPT must be unchanged.
- Changes to MA pricing assumptions (benefit/non-benefit /gain/loss) must be consistent with these Instructions.

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

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

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

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

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

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PBP line #	PBP Category	BPT line #	Corresponding BPT Category: Description/Note (Worksheet 3)
7i	Physical Therapy and Speech Language Pathology Services	i4	Professional: Therapy (PT/OT/ST)
8a	Outpatient Diagnostic Procedures/Tests/Lab Services	h1	OP Facility - Other: Lab
8b	Outpatient Diagnostic/Therapeutic Radiological Services	h2	OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g or h	OP Facility - Surgery; or OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center (ASC) Services	g	OP Facility - Surgery
9c	Outpatient Substance Abuse	h5	OP Facility - Other: Other
9d	Outpatient Blood Services	h5 or k	OP Facility - Other: Other or Other Medicare Part B
10a	Ambulance Services	d	Ambulance
10b	Transportation Services	l	Transportation (Non-Covered)
11a	Durable Medical Equipment (DME)	e1	DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Supplies and Services	e2	DME/Prosthetics/Supplies: Prosthetics/Supplies
12	End-Stage Renal Disease	h4	OP Facility - Other: Renal Dialysis
13a	Acupuncture and Other Alternative Therapies	q	Other Non-Covered
13b	OTC Items	q	Other Non-Covered
13c	Meal Benefit	q	Other Non-Covered
13d	Other 1	q	Other Non-Covered
13e	Other 2	q	Other Non-Covered
13f	Other 3	q	Other Non-Covered
13g	Dual Eligible SNPs with Highly Integrated Services	q	Other Non-Covered
13h	Medicare-Medicaid Plan	q	Other Non-Covered
14a	Medicare-covered Preventive Services	k, i1, i2 or i6	Other Medicare Part B; Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14b	Annual Physical Exam	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14c	Eligible Supplemental Benefits as Defined in Chapter 4	p	Health & Education (Non-Covered)
14d	Kidney Disease Education Services	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14e	Diabetes Self-Management Training	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
15	Medicare Part B Rx Drugs (includes Part D home infusion drugs included in bundled services)	j	Part B Rx

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PBP line #	PBP Category	BPT line #	Corresponding BPT Category: Description/Note (Worksheet 3)
16a	Preventive Dental	m	Dental (Non-Covered)
16b	Comprehensive Dental	m	Dental (Non-Covered)
17a	Eye Exams	n1	Vision (Non-Covered): Professional
17b	Eye Wear	n2	Vision (Non-Covered): Hardware
18a	Hearing Exams	o1	Hearing (Non-Covered): Professional
18b	Hearing Aids	o2	Hearing (Non-Covered): Hardware

APPENDIX G – DE# SUMMARY

Medicaid Eligibility Data

The Medicaid status codes in the beneficiary-level file provided by CMS indicate the Medicaid eligibility status of the beneficiary as reported by the respective state Medicaid agency. These codes are shown in the table below. For descriptions of the dual-eligible beneficiary categories, and of the types of Medicaid benefits to which these beneficiaries are entitled, see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf.

Medicaid Status Code	Medicaid State-Reported Code (Dual-Eligible Category)
01	QMB only
02	QMB + full Medicaid benefits
03	SLMB only
04	SLMB + full Medicaid benefits
05	QDWI (Qualified Disabled and Working Individual)
06	QI (Qualified Individual)
08	Full-benefit dual-eligible beneficiaries who do not have QMB or SLMB status
09	Other dual-eligible beneficiaries without full Medicaid benefits—for example, those in Pharmacy Plus and 1115 drug-only demonstrations
99	Unknown, including Medicaid-eligible beneficiaries reported by plans and territories
Blank	Non-Medicaid

Classifying Dual-Eligible Data

The HPMS plan-level data also include a Medicaid grouping indicator as shown in the table below. This table illustrates how the data for dual-eligible beneficiaries are classified as DE# or non-DE#. The certifying actuary must consider the Medicaid cost-sharing policy for the states or territories in the plan's service area when determining which beneficiaries in Medicaid grouping B are in the DE# population.

Medicaid Grouping	Dual Eligible	Category of Dual Eligible	Medicaid Status Code	Medicare Cost-Sharing Liability	DE# Status
A	Dual	QMB and QMB+	01, 02	None	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Reduced (as determined by the certifying actuary)	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Full (as determined by the certifying actuary)	Non-DE#
C	Non-dual	Non-Medicaid	Blank	Full	Non-DE#

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The following table outlines the requirements for classifying dual-eligible beneficiaries that are not QMB or QMB+ (that is, Medicaid Indicator B: Other Medicaid) as DE# or non-DE#. The percentages in the table below represent the number of total dual-eligible beneficiaries relative to total members per the HPMS plan-level data.

Medicaid Grouping/Status Code	Condition	DE# Determination for Base Period Data
A: 01, 02	None	DE#
B: 03, 04, 05, 06, 08, 09, 99	<10% total dual-eligible beneficiaries	May consider as non-DE# or determine actual classification
B: 03, 04, 05, 06, 08, 09, 99	10% to 100% total dual-eligible beneficiaries	Must determine actual classification
C: Blank	None	Non-DE#

BPT Values

The following table outlines the determination of certain BPT values when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2.

BPT Area	Input Item	<10% DE#	>90% DE#	10% to 90% DE#
WS3	Utilization and PMPM values	Enter non-DE# or total values	Enter non-DE# or total values ¹	N/A
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Enter zero or appropriate values ²	Enter appropriate values ³	N/A
WS5 II	Non-DE# risk factor	Enter total values	Enter total values	N/A

¹ Enter total values if DE# projected member months equal total projected member months.

² Plus plan cost sharing for non-covered, non-Medicaid benefits.

³ Plus plan cost sharing for non-covered, non-Medicaid benefits.

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The next table summarizes the determination of certain BPT values when (i) the value for the DE# projected member months is less than 10 percent, or greater than 90 percent, of the total projected member months and the certifying actuary chooses to separately calculate DE# and non-DE# projected allowed costs; or (ii) the value for the DE# projected member months is between 10 percent and 90 percent inclusive of the total projected member months.

BPT Area	Input Item	Determination of BPT Values
WS3	Utilization and PMPM values	Enter non-DE# values
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Determine appropriate values (including zero) ¹
WS5 II	Non-DE# risk factor	Determine distinct non-DE# and DE# values

The table below outlines the determination of BPT values in which the requirements are the same for all bids regardless of the percentage of DE# members.

BPT Area	Input Item	Determination of BPT Values
WS3	Cost-sharing values and description	Reflect PBP package
WS4 IIB	Plan cost sharing (column f)	Default to non-DE# ratio of plan cost sharing or override formulas
WS5 II	Non-DE# member months	Determine distinct non-DE# and DE# values

¹ Plus plan cost sharing for non-covered, non-Medicaid benefits.

APPENDIX H – RELATED-PARTY ADMINISTRATIVE AND MEDICAL SERVICE ARRANGEMENTS

This appendix outlines some of the requirements for each of the methods used to reflect in the BPT costs associated with related-party administrative services arrangements.

Summary of MA Related-Party (RP) Requirements - Administrative Services Arrangements

See the pricing consideration for related-party arrangements for a complete explanation of the requirements.

Method	Availability	Unrelated Party	Criteria	NBE in BPT
Method 1 Actual Cost	Always available	N/A	<ul style="list-style-type: none"> Support method 	Actual cost of RP
Method 2 Market Comparison – through Plan sponsor	Alternative to Method 1	Provides similar services	<ul style="list-style-type: none"> Compare to contracts with sufficient costs of services Show fees within 5% or \$2 PMPM—whichever is greater 	Fees paid by Plan sponsor
Method 2 Market Comparison – through Related Party				

Summary of MA Related-Party Requirements – Medical Services Arrangements

See the pricing consideration for related-party arrangements for a complete explanation of the requirements.

Method	Availability	Unrelated Party	Criteria	Net Medical in BPT
Method 1 Actual Cost	Always available	N/A	<ul style="list-style-type: none"> Support method 	Actual cost of RP
Method 2 Market Comparison – through Plan sponsor	Alternative to Method 1	<ul style="list-style-type: none"> Similar services Medicare population Bid’s service area 	<ul style="list-style-type: none"> Compare to contracts with sufficient costs of services Fees within 5% or \$2 PMPM—whichever is greater 	Fees paid by Plan sponsor
Method 2 Market Comparison – through Related Party		<ul style="list-style-type: none"> MA organization Similar services Medicare population Attest to contract availability 		
Method 3 Comparable to FFS	Cannot satisfy Method 1	N/A	<ul style="list-style-type: none"> Demonstrate Method 1 not possible Fees within 5% of 100% FFS or \$2 PMPM—whichever is greater 	
Method 4 FFS Proxy	Cannot satisfy Method 1, or Method 2, or Method 3	N/A	<ul style="list-style-type: none"> Show Method 1, 2, or 3 not possible Show fees NOT comparable to 100% FFS 	100% FFS

APPENDIX I – MEDICAL SAVINGS ACCOUNT BPT

This appendix provides guidance for completing the Medical Savings Account Bid Pricing Tool for Medical Savings Account (MSA) plans offered to Medicare beneficiaries. This appendix highlights only the differences between the MSA BPT and the MA BPT.

The MSA bid form is organized as outlined below:

Worksheet 1 – MSA Base Period Experience and Projection Assumptions

Worksheet 2 – MSA Total Projected Allowed Costs PMPM

Worksheet 3 – MSA Benchmark PMPM

Worksheet 4 – MSA Enrollee Deposit and Plan Payment PMPM

Worksheet 5 – MSA Optional Supplemental Benefits

WORKSHEET 1 – MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS (CORRESPONDING TO MA WORKSHEET 1)

SECTION I – GENERAL INFORMATION

Line 7 – Plan Type

MSA is the only valid plan type.

Line 8 – Deductible Amount

Enter the deductible amount that each beneficiary will pay for Medicare-covered benefits. The maximum deductible for CY2015 for MSA plans is \$10,750.

Line 9 – Enrollee Type

This cell is pre-populated with “A/B”.

SECTIONS II, III, IV, AND V

Base period data in Sections II, III, IV, and V must include only Medicare-covered medical expenses.

WORKSHEET 2 – MSA TOTAL PROJECTED ALLOWED COSTS PMPM (CORRESPONDING TO MA WORKSHEET 2)

SECTION II – PROJECTED ALLOWED COSTS

Data in Section II must include only Medicare-covered medical expenses.

WORKSHEET 3 – MSA BENCHMARK PMPM (CORRESPONDING TO MA WORKSHEET 5)

Follow the instructions for MA Worksheets 5 and 6 for the appropriate inputs.

WORKSHEET 4 – MSA ENROLLEE DEPOSIT AND PLAN PAYMENT (NO CORRESPONDING MA WORKSHEET)

This worksheet calculates the MSA monthly plan revenue requirement and enrollee deposit. Consistent with other MSA worksheets, information provided on Worksheet 4 must exclude ESRD enrollees.

SECTION II – DEVELOPMENT OF CLAIM INFORMATION INTERVALS (PLAN’S RISK FACTOR AND EXCLUDE SERVICES COVERED WITHIN THE DEDUCTIBLE)

Column c – Annual Projected Claim Interval

The column is pre-populated with annual projected claim intervals.

Column d – Annual Average Claim Amount

Enter the annual average claim amount paid in each claim interval.

Column e – Percentage of Member Months (Use Only the Highest Claim Interval)

Allocate total projected member months to the highest claim interval expected by members and enter the allocation as a percentage.

For example, if projected member months for members expected to incur annual claims of \$11,500 represent 20 percent of total projected member months, and projected member months for members expected to incur annual claims of \$4,400 represent 10 percent of total projected member months, then enter 20 percent only in the interval containing \$11,500 and 10 percent only in the interval containing \$4,400. The sum of column e must equal 100 percent.

Column f – Gross Claims (PMPM)

This column calculates total allowed Medicare-covered claims on a PMPM basis for each claim interval. No entry is required. The sum of column f must equal the total Medicare-covered medical expenses shown in column o of Worksheet 2.

Column g – Gross Claims over Deductible (PMPM)

Enter the total allowed Medicare-covered claims on a PMPM basis over the deductible for each claim interval expected to be paid by the MSA plan. Enter zero (0) for claim intervals below the deductible.

SECTION III – DEVELOPMENT OF SUMMARY INFORMATION (PLAN’S RISK FACTOR)

Line a – Medicare-Covered Plan Medical Expenses PMPM

This cell displays the sum of column g of Section II.

Line b – Non-Benefit Expenses

Enter the non-benefit expense information. Please refer to the “Pricing Considerations” section of these Instructions for further guidance.

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

Line c – Gain/Loss Margin

Input the projected PMPM for the gain/loss margin for Medicare-covered services provided. Please refer to the “Pricing Considerations” section of these Instructions for further guidance.

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

Line d – Total Plan Revenue Requirement

This cell is calculated automatically as the sum of projected Medicare-covered medical expense, non-benefit expense, and gain/loss margin.

Line e – Projected Plan Benchmark

This cell displays the value from Section III, column h, line 1 of Worksheet 3—the weighted average for the service area of the risk-adjusted ratebook values.

Line f – Projected Monthly Enrollee Deposit

This cell calculates the monthly enrollee deposit by subtracting the total plan revenue requirement from the projected plan benchmark.

Line g – Percent of Plan Revenue Ratios

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

Line h – Standardized Plan Benchmark

This cell displays the value from Section III, column g, line 1 of Worksheet 3—the weighted average for the service area of the unadjusted ratebook values.

WORKSHEET 5 – MSA OPTIONAL SUPPLEMENTAL BENEFITS (CORRESPONDING TO MA WORKSHEET 7)

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

APPENDIX J – END-STAGE RENAL DISEASE-ONLY SPECIAL NEEDS PLANS BPT

This appendix provides guidance for completing the ESRD-SNP BPT for ESRD-SNP plans offered to Medicare beneficiaries. This appendix highlights only the differences between the ESRD-SNP BPT and the MA BPT.

The ESRD-SNP bid form is organized as outlined below:

Worksheet 1 – Enrollment and PMPM Revenue Projection

Worksheet 2 – Projection of benefit cost, non-benefit expenses, and gain/loss margin PMPM

Worksheet 3 – Program Experience for Calendar Year 2013

Worksheet 4 – Optional Supplemental Benefits

WORKSHEET 1 – ENROLLMENT AND PMPM REVENUE PROJECTION

SECTION I – GENERAL INFORMATION

Follow the instructions for MA Worksheet 1 for the appropriate inputs.

Line 2 – Contract-Plan-Segment

This field concatenates the contract ID, plan ID and segment ID.

Line 4 – Service Area

Enter a brief description of the service area.

Line 5 – Plan Type

“ESRD SNP” is pre-populated.

SECTION II – SERVICE AREA SUMMARY

Follow the instructions for MA Worksheet 5 for the appropriate inputs.

✓ Column a – State/County Code

Similar to MA BPT Worksheet 5, enter the county codes associated with the plan’s service area.

Technical note regarding the ESRD-SNP BPT: the rates populated in column (g) are “state-wide” rates for dialysis and transplant statuses. Therefore, plans may enter one county code (example: entering 05430 for California) and report the dialysis member months and risk scores for the state in that row. Similarly, one county code may be entered for the state-wide transplant information. In other words, the dialysis and transplant member months and risk scores do not need to be reported at the county level. Functioning graft rates are “county-specific”, and therefore member months and risk scores must be reported at the county level for functioning graft status.

✓ **Column d – ESRD Status (D /T /F)**

Enter the ESRD status: “D” for dialysis, “T” for transplant, or “F” for functioning graft (that is, postgraft).

✓ **Column f – Projected Risk Score**

Projected risk scores must:

- Be based on the CMS-HCC ESRD Model.
- Reflect appropriate projection factors.
- Be adjusted for FFS normalization.
- Reflect the MA coding adjustment factor as follows: postgraft risk scores must reflect the MA coding adjustment factor in the Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Dialysis risk scores and transplant factors should not incorporate the MA coding adjustment.

✓ **Column h – Percentage of MSP Member Months**

Enter the percentage of Medicare Secondary Payer (MSP) member months applicable for the ESRD status and county/state indicated.

✓ **Column i – Projected CMS Monthly Capitation**

This field is calculated automatically.

SECTION III – ESRD MSP ADJUSTMENT FACTORS FOR CY (FROM APRIL RATE ANNOUNCEMENT)

This section contains the MSP adjustment factors released by CMS in the Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Line 1 contains the MSP factor for functioning graft, and line 2 contains the MSP factor for dialysis/transplant.

SECTION IV – SUMMARY DATA

Line 1 – Part C Mandatory Monthly Enrollee Premium

This amount is obtained from Worksheet 2.

Line 2 – Part C Monthly Plan Revenue

This field is calculated automatically.

Line 3 – Part D Premium (Basic plus Supplemental) Net of Reductions

This information is obtained from Worksheet 2.

Line 4 – Plan Intention for Target Part D Basic Premium

This information is obtained from Worksheet 2.

Line 5 – Quality Bonus Rating (per CMS)

Follow the instructions for MA Worksheet 5.

Line 6 – New/low indicator (per CMS)

Follow the instructions for MA Worksheet 5.

WORKSHEET 2 – PROJECTION OF BENEFIT COST, NON-BENEFIT EXPENSES, AND GAIN/LOSS MARGIN PMPM

SECTION II – PROJECTION OF PLAN COSTS

The medical expense projection is to be consistent with the population reflected in the revenue projections on Worksheet 1. The medical expense projections may be based on a blend of trended plan experience and other data sources.

The allowed costs in rows 16-31 must include only Medicare-covered services. Additional services such as inpatient coverage beyond lifetime reserve days and preventive services not covered by original Medicare must be reflected in additional services on row 37.

The supplemental benefits columns are calculated automatically and reflect cost sharing enhancements to the Medicare-covered benefit package.

For guidance on reporting non-benefit expenses, gain/loss margin and related parties, see the “Pricing Considerations” section and MA Worksheet 4 section of these Instructions.

SECTION III – DEVELOPMENT OF ESTIMATED PLAN PREMIUM AND REDUCTIONS

Follow the instructions for MA Worksheet 6.

In this appendix, the term “excess funds” refers to the difference between the CMS capitation payment and the Plan sponsor’s cost to provide Medicare-covered benefits. Regarding the rebate reallocation period and the ESRD-SNP BPT, note that—

- After CMS publishes the Part D national average monthly bid amount, the Part D base beneficiary premium, and the Part D regional low-income premium subsidy amounts, the Plan sponsor may return to the target Part D basic premium by reallocating “excess funds” allocated in the initial submission to the supplemental benefit items in rows 56 through 60 of Worksheet 2.
- Generally, the rules in effect for other MA-PD plans for changes to the funding of benefits during the rebate reallocation period apply to reallocation of excess funds. For more information about rebate reallocation see Appendix E of these Instructions.

WORKSHEET 3 – PROGRAM EXPERIENCE FOR CALENDAR YEAR 2013

SECTION II – CONTACT INFORMATION

Follow the instructions for MA Worksheet 6.

SECTION III – REVENUES

Enter member months, CMS payments (on a PMPM basis), and enrollee premium (on a PMPM basis) for CY2013. All revenues are to be reported on an earned basis, including retroactive adjustments. Revenues for 2013 are to include an estimate of the final risk adjustment settlement to be received in mid-2014.

SECTION IV – MEDICAL BENEFITS (PMPM)

Enter claims incurred in CY2013 and paid through March 31, 2014. Medical benefits are to be reported net of enrollee cost sharing.

Claim reserves as of March 31, 2014 are to be reported for 2013. Organizations may allocate claim reserves to appropriate categories in situations where reserves are developed at a consolidated level.

For “Utilizers” column, follow the instructions for MA Worksheet 1.

For guidance on reporting non-benefit expenses and gain/loss margin, see the “Pricing Considerations” section of these Instructions.

WORKSHEET 4 – OPTIONAL SUPPLEMENTAL BENEFITS

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

SUPPORTING DOCUMENTATION FOR ESRD-SNP BPTs

See Appendix B for supporting documentation requirements.

APPENDIX K – TRENDING RISK SCORES

This appendix includes the following considerations for trending Part C and Part D risk scores.

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

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