
INSTRUCTIONS FOR COMPLETING THE
MEDICARE ADVANTAGE
BID PRICING TOOL
FOR CONTRACT YEAR 2008

April 6, 2007

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Introduction

Medicare Advantage organizations must submit a separate bid for each plan they offer to Medicare beneficiaries. In the case of a local plan with service area segments, a separate bid must be submitted for each segment.

The bid must be submitted to the Centers for Medicare & Medicaid Services (CMS) on the provided form – the Medicare Advantage (MA) Bid Pricing Tool (BPT). The MA bid form should not be completed for Medical Savings Account (MSA), Cost, and PACE plans. There is a separate MSA bid pricing tool required for MSA plans.

Additionally, MA organizations (MAO) must give CMS supporting documentation as described throughout these instructions and in the Supporting Documentation appendix. The submitted bids will be subject to review and negotiation by CMS. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

If the plan includes prescription drug benefits under the Medicare Part D program, then an *additional Rx bid pricing tool* must be completed and submitted.

To complete the MA bid form, organizations must provide a series of data entries on the appropriate form pages. The number of inputs depends on the type of plan and how long it has operated, among other factors.

Following are the most common steps that an MA organization with fully credible experience data must complete:

- Report the Medicare base period allowed costs.
- Enter the estimated adjustments needed to project the base period costs to the contract year (CY).
- Report the estimated cost sharing values for the contract year.
- Enter the projected CY non-benefit expenses and gain/loss margin.
- Enter the projected enrollment and risk scores by county.
- Allocate rebates (if any).

MA organizations that do not have base period costs, or do not have fully credible experience, must enter a manual rate that estimates the medical costs for the contract year.

MAOs must use the bid pricing tool to develop a pricing structure for each MA plan/segment. Organizations must submit the information in the CMS-approved electronic format via upload to the CMS Health Plan Management System (HPMS).

Appendix C contains further information regarding MA plans covering Part B-only enrollees. Appendix D provides information for “group bids” (i.e., employer groups and union groups). Appendix E contains additional guidance regarding MA plans covering Qualified Medicaid Beneficiaries (QMBs).

Note: Any data entries included in the bid form are for illustration purposes only.

Introduction

In addition to these instructions, information regarding CY2008 bidding may be found at the following resources:

- The **CY2008 Call Letter** contains information and guidance pertaining to CY2008 bidding, and may be found at: <http://www.cms.hhs.gov>
- CMS offered **CY2008 bidders training** as a web-based conference. The conference materials, including slides and streaming video downloads, are available at: http://www.cms.hhs.gov/apps/events/docs/Conference_ID_356/bidconference.html
The actuarial sessions of the conference are available under the “OACT Video Streaming/ Podcast” link.
- If there are any questions about the bid form, **e-mail** the Office of the Actuary (OACT) at: actuarial-bids@cms.hhs.gov .
- CMS Office of the Actuary will host weekly **actuarial technical user group calls** regarding actuarial aspects of the CY2008 bidding process. The conference calls will include live Question & Answer sessions for participants to speak with CMS actuaries. Call information:
 - Every Thursday, April 12 – May 31, 2007
 - 11:00AM - 12:30PM ET
 - Dial-In Number: 1-800-857-1286
 - Passcode: Bidders
 - Call Leader: Paul Spitalnic
- If there are any **technical questions** regarding the BPT, HPMS, or the upload process, refer to the following resources:
 - Appendices H and I of these instructions.
 - The “Bid Submission User’s Manual” (available in HPMS).
 - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov .

General Overview

These instructions provide guidance in completing the Medicare Advantage Bid Pricing Tool.

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 should be left blank.

In addition, each organization must complete the Two-Year Look-Back form, unless it did not have any Medicare experience in 2006 (i.e., if the organization did not file any CY2006 MA BPTs or did not have any 2006 enrollment).

If the plan includes prescription drug benefits under the Medicare Part D program, then an *additional Rx bid form* must be completed. The separate Rx bid pricing tool captures pricing information regarding any prescription drug benefits offered by the plan. While the supplemental benefits (either prescription drug or A/B) offered by the plan may be viewed as a single package, the two types of supplemental benefits are considered separately for bidding purposes.

The following sections explain how to complete the MA bid form and include line-by-line instructions with user inputs noted. In addition, there is a glossary to assist the user with unfamiliar terms. The Medicare Benefit Description Report available in HPMS may also be helpful.

Some of the material changes in the CY2008 bid form and instructions (as compared to CY2007) are highlighted below. These changes were a result of feedback received from industry and were made in an effort to increase the usability/functionality of the BPT.

- Part D Basic Premium prior to rebates (reported on MA BPT Worksheet 6 cell R34, but calculated in the Part D BPT) is permitted to be a negative number. In the CY2007 MA BPT, there was an erroneous validation such that negative Part D Basic premiums were prohibited. This has been corrected in the CY2008 MA BPT.
- Certain sections of the MA BPT were removed, as they were deemed no longer necessary. These sections include: MA BPT Worksheet 5 Sections VII and VIII (which contained demographic payment information for some demonstration plans in the CY2007 MA BPT) and MA BPT Worksheet 6 Sections V and VI (which contained RPPO risk sharing information in the CY2007 MA BPT). Also, the stabilization fund adjustment (in MA BPT Worksheet 5 Section IV) was removed.
- The target Part D premium (MA BPT Worksheet 6 cell R47) will be populated as “not applicable” for MA-only plans.

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- The Medicare FFS cost sharing categories on Worksheet 5 Section VI were consolidated from four categories into three: Inpatient, SNF, and Part B (excluding Home Health). See Worksheet 5 instructions for more information.
- The county-level information in Worksheet 5 (Sections V and VI) will be sorted in descending county-code order in the finalized MA BPT. That is, the finalization macro with sort these sections in the finalized BPT file.
- New Actuarial Certification process – See Appendix A for information regarding the actuarial certification process for CY2008. The certification process has significantly changed since CY2007. The certification upload process has been replaced by a new certification module within HPMS.
- Base period data must be entered in Section III of Worksheet 1 if there is a minimum of 1,500 member months or if experience data is used to calculate manual rates.
- See the non-benefit (previously referred to as non-medical) expenses section of the instructions for updated bidding guidance for CY2008. (See Worksheet 4 section.)
- See the gain/loss margin section of the instructions for updated bidding guidance for CY2008. (See Worksheet 4 section.)
- See the risk score section of the instructions for updated guidance for CY2008. (See Worksheet 5 section.) Important note: CMS has released plan-specific risk score data in HPMS that may be used as the basis for projecting CY2008 risk scores.
- Supporting documentation must include a cover sheet and a product narrative as outlined in Appendix B.
- Supporting documentation for the non-benefit expenses and gain/loss margin must be submitted with the initial June bid submission (as compared to “upon request” by CMS reviewers or during an audit).
- See Appendix B for updated guidance for CY2008 regarding supporting documentation. Appendix B contains more detailed descriptions regarding the substantiation requirements, including some examples of what is considered appropriate and inappropriate forms of documentation.

Rounding must not be used when entering data into the bid form, except for rebate allocations on Worksheet 6 (see instructions).

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

Note: Any data entries included in the bid form are for illustration purposes only.

Worksheet 1 - MA Base Period Experience and Projection Assumptions

Worksheet 1 summarizes the base period data and the key assumptions used to calculate the projected allowed costs for 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, and Section IV illustrates the factors used to project the base period data to the contract period.

Section I must be fully completed for all plans (note some fields may be pre-populated by the Plan Benefit Package (PBP) software). Completion of Sections II and III depends on the size of the population and whether or not experience data was used to develop the bid. Base period data and background information must be entered in Worksheet 1 when:

- Projected allowed costs are calculated directly from the base data; or
- Projected allowed costs are a blend of manual rates and projected base data; or
- Base period data was used in any manner to develop the manual rates. Note that the experience credibility percentages in Worksheet 2 may be entered as zero for any or all service categories; or
- The experience data is based on a minimum of 1,500 member months.

All information provided on Worksheet 1 must exclude ESRD enrollees, for the time period enrollees are in ESRD status based on CMS eligibility records.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- Information regarding the member month distribution if more than four plans comprise the base period data (see Section II line 5).
- A reconciliation of base period experience with company financial data.
- Support for projection assumptions.
- Information about “actuarial swapping” or the “actuarial equivalence” category of customization allowable for employer and union groups, as described in Appendix D.

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 (i.e., using a preceding apostrophe) and must include any leading zeros.

Line 1 – Contract Number. Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional PPO plan), or E (Employer/Union Direct Contract Private FFS plan) and includes four Arabic numerals (e.g., H9999, R9999, E9999). Be sure to include all leading zeros (e.g., H001, H0123).

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 (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '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. These plans may be referred to as an “800-series plan”, a “group plan”, an “employer/union-only group waiver plan (EGWP)”, or an “employer-only group plan”.

Line 3 – Segment ID. If the bid is for a “service area segment” of a local plan, enter the segment ID. This field must be entered as a text input (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '01).

Line 4 – Contract Year. This cell is pre-populated with the calendar year to which the contract applies.

Line 5 – Organization Name. Enter the organization’s legal entity name. This information also appears in HPMS and the PBP.

Line 6 – Plan Name. Enter the plan name of the plan benefit package that corresponds to the information contained in this bid pricing tool. 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 should not be completed for MSA, Cost, and PACE plans. There is a separate MSA Bid Pricing Tool.

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

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

Demonstration Plans:	
Continuing Care Retirement Community	CCRC
Minnesota Disability Health Options	MN DHO
Minnesota Senior Health Options	MN SHO
Wisconsin Partnership Program	WI PP
Massachusetts Health Senior Care Options	MA HSCO

Line 8 – MA-PD Indicator. If the plan is offering Part D benefits during the contract year (and therefore is submitting a separate Rx bid form for the same plan ID), enter “Y”. Otherwise, enter “N”.

Line 9 – Enrollee Type. If the bid prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, enter “A/B”. If the bid prices any type of plan covering enrollees eligible for Part B only, enter “Part B Only”. (See Appendix C for additional information regarding Part B only plans.)

Line 10 – MA Region. If the MA plan is a regional PPO (i.e., plan type of RPPO), then input the region number associated with the region that the plan will cover. This field must be entered as a text input (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '01).

For regional PPO plans, valid entries are as follows:

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

Line 12 – SNP Indicator. If the plan is a Special Needs Plan (SNP), enter “Y”. Otherwise, enter “N”.

Line 13 – Region Name. No user input is required. This field contains the region name, based on the region number entered previously in this section.

Line 14 – Percentage of Contract Year Enrollees that are Dually Eligible. Enter the percentage of projected enrollees that are dually eligible, i.e. eligible for both Medicare and Medicaid, during the contract period.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition. Enter the incurral dates of the base period data on the first two lines and the “paid through” date on the third line.

For example, if the incurral period is calendar year 2006, the “incurred from” date is 1/1/2006 and the “incurred to” date is 12/31/2006. If the data reflect payment information through February 2007, the “paid through” date is 2/28/2007.

While we generally expect the experience data to be based on a 12-month incurral period with at least 30 days paid run-out (preferably at least 2 - 3 months of paid claim run-out), we do not require that the base experience incurral period be a *calendar year*.

CMS recommends that plans should not rely solely on CY2007 year-to-date claims experience for the CY2008 projection. We also recommend that the experience data be sufficiently recent.

When selecting base period data, the certifying actuary should consider ASOP No. 8, with particular attention to the section *Use of Past Experience to Project Future Results*. The certifying actuary should also consider ASOP No. 23, with particular attention to the sections *Selection of Data* and *Use of Imperfect Data*.

Line 2 – Member Months (excluding ESRD). Enter the total member months represented in the base period experience, excluding ESRD enrollees for the time period enrollees are in ESRD status based on CMS eligibility records.

Line 3 – Non-ESRD Risk Score. Enter the risk score for the population represented in the base period data. The recalibrated 70 CMS-HCC risk model (hereafter referred to as recalibrated HCC) risk score for non-ESRD members must be used. The risk score should reflect a mid-year cohort (or be adjusted for seasonality) and reflect non-lagged diagnosis data with full run-out. The population change adjustment entered in column I in Section IV should be consistent with the development of the CY2008 risk score.

Line 4 – Completion Factor. Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the “paid through” date. The factor entered must be the amount to adjust only the portion of paid claims that requires completion (i.e., omit capitations from the calculation of this factor).

For example, assume:

Incurred Date	1/1/2006 – 12/31/2006
Paid Through Date	2/28/2007
Capitation Payments	\$100
PTD Claims Requiring Completion	\$400
Estimate of Unpaid 2006 Claims as of 2/28/2007	\$30
Total Incurred Claims for 2006	<u>\$530</u>

The Completion Factor would be calculated as:

$$\text{Completion Factor} = (400 + 30) \div 400 = 1.075$$

Line 5 – Plans Included in Base Period Data. Enter the contract number and plan ID (in the format H9999-999) of the plans that are included in the base period data. In the second column, input each plan’s percentage of the total member months reported in Line 2.

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

5. Plans in Base	<u>Contract-Plan ID</u>	<u>% of Member Months</u>
a.	H9999-032	44%
b.	H9999-001	37%
c.	H9999-002	19%
d.		

If more than four plans comprise the base period data, then the plan must submit supporting documentation that provides the percentage of base period member months for each plan included in the base period data. In this situation, plans may enter “All Other” for the Contract-Plan ID indicated in Line 5d.

Line 6 – Base Period Description. Use the text box provided to briefly describe the base period data. The base period data need not reflect the same benefit plan or service area as the contract year. Do not adjust base period data for credibility, as this issue is addressed on Worksheet 2 with manual rates. Following are examples of different base period data:

- Same benefit plan, but larger or smaller service area.
- Same benefit plan, but an entirely different service area.
- Similar benefit plan in same or different service area.
- Benefit plan with similar in-network benefits/cost sharing.

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

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

General Considerations.

CMS recommends that plans should not rely solely on CY2007 year-to-date claims experience for the CY2008 projection. We also recommend that the experience data be sufficiently recent.

While we generally expect the experience data to be based on a 12-month incurral period with at least 30 days paid run-out (preferably at least 2 - 3 months of paid claim run-out), we do not require that the base experience incurral period be a *calendar year*.

When selecting base period data, the actuary should consider ASOP No. 8, with particular attention to the section *Use of Past Experience to Project Future Results*. The actuary should also consider ASOP No. 23, with particular attention to the sections *Selection of Data* and *Use of Imperfect Data*.

The circumstances for when experience data must be reported in Worksheet 1 are listed in the beginning of the instructions for Worksheet 1.

Note that these data:

- Need *not* exactly match the benefit plan or service area for the bid (see Section II instructions). Section IV will address adjusting the base period data to the contract year benefit plan and service area. In addition, any adjustments for population differences should be reflected in the population change in Section IV, not in the data reported in Section III.
- Reflect either calendar year or other *annualized* experience.
- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Include any provider incentive payments.
- Include total services (both in-network and out-of-network, Medicare-Covered and additional services).
- Reflect costs before any reduction for member cost sharing and reinsurance recoveries (i.e., the experience data must be on an *allowable* basis).
- Include capitations allocated to the appropriate service category line on a reasonable basis.
- Exclude ESRD claim experience for the time period an enrollee is in ESRD status based on CMS eligibility records.
- Reflect the full level of plan cost sharing for Qualified Medicare Beneficiaries (QMB) even if a state Medicaid agency pays all or part of the cost sharing on behalf of the QMB. See Appendix E for information regarding QMBs.

Appendix G contains a suggested **mapping of benefit categories** between the PBP and the bid pricing tool. The Medicare Managed Care Manual may also be a helpful resource regarding benefit definitions:

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

Service category lines can be one of three types:

- Medicare-Covered services that may be supplemented, as an A/B Mandatory Supplemental Benefit, (e.g., the cost for additional days not covered by Medicare in line a, Inpatient Facility).
- Services that can only be Medicare-Covered.
- Services that can only be Non-Covered (e.g. line l, Transportation).

The benefit costs will be distributed between Medicare-Covered and Non-Covered benefits based on the percentages entered in Worksheet 4 columns h and i.

POS experience data may be included in the appropriate service category (in lines a through o and q through s), with nothing entered in the POS service category (line p). Alternatively, the plan may enter the POS experience in line p.

For **Non-Covered limited benefits with no cost sharing**, the amounts over the limit should not be included as allowed costs in the bid form.

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

The **COB/Subrogation** line (line s) is intended to include only those amounts settled outside the claim system. If an MAO pays claims for its estimated liability only (i.e., net of the amount that is the responsibility of another payer, such as an employer plan or auto policy), the MAO's net liability amount (before cost sharing reductions) may be entered on lines a through r. [This is a change from the ACR instructions, in which the detail service claims were to be reported at the full amount (i.e., including other payer liabilities) and the full COB amount used. Both methods result in the same total allowed cost across all service categories.]

See **Appendix B** for information regarding supporting documentation for base period data.

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

Column f, Lines a through r – Utilization type. The type of utilization *must* be entered in column f for each benefit category that contains PMPM costs. Do not leave this column blank. If the plan is not using base period experience data, but instead is using manual rates, entries in this column are still required.

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

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

Column g, Lines a through r – 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 entered in column f.

Column h, Lines a through r – Average Cost. These cells are calculated using the utilization provided in column g and allowed PMPM provided in column i.

Column i, Lines a through s – Allowed PMPM. Enter the allowed PMPM by service category for the base period. Note that line s will be *added* to total medical expenses; thus any COB/Subrogation offsets to costs must be input as a negative number.

Line t – Total Medical Expenses. Calculated as the sum of lines a through s.

Line u – Subtotal Medicare-Covered service categories. Calculated as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS (COLUMNS J THROUGH P)

Section IV presents the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The factors in columns j through n are the *total* adjustment factor from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2006 and that the contract year is 2008. If the utilization trend is 5% from 2006 to 2007 and 6% for projecting 2007 to 2008, then enter 1.113 in column j (1.05×1.06).

See Appendix B for information regarding supporting documentation for projection assumptions.

Column j, Lines a through s – Util/1000 Trend. Enter the total expected utilization trend factor from the base period to the contract period by service category. (Entering 1.000 would indicate 0%.) Do not leave blank.

Column k, Lines a through s – Benefit Plan Change. Enter the multiplicative adjustment factor for any benefit plan changes that affect the base period utilization by service category (e.g., increase in coverage level from base period to contract period). (Entering 1.000 would indicate 0%.) Do not leave blank.

Column l, Lines a through s – 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%.) Do not leave blank.

Column m, Lines a through s – Other Factor. Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Examples of the use of this factor are to adjust the base period service area to the contract year service area or to adjust consolidated base period experience to a specific plan option. (Entering 1.000 would indicate 0%.) Do not leave blank.

Column n, Lines a through s – Unit Cost/Intensity Trend. Enter the unit cost/intensity trend by service category. This factor must reflect the anticipated unit cost/intensity trend from the base period to the contract period. (Entering 1.000 would indicate 0%.) Do not leave blank.

Columns o and p, Lines a through s – Additive Adjustments. Use these columns to reflect adjustments that are additive (adjustments in columns j through n are multiplicative factors). For example, a benefit that is no longer being offered, but is included in the base period data, might need to be deleted/removed. In this case, enter the projected PMPM of the benefit being removed as a negative number in column p. For benefits that need to be added, if they are not included in the base period experience data but will be offered in the contract period, the plan should utilize the manual rates section of Worksheet 2.

Describe the reason for any additive adjustments in Section V.

SECTION V – DESCRIPTION OF OTHER UTILIZATION FACTOR AND ADDITIVE VALUES

Use this “text box” field to describe the reason for using a multiplicative factor other than 1.00 in column m and any additive adjustments entered in columns o and p.

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.

All information provided on Worksheet 2 must exclude ESRD enrollees, for the time period enrollees are in ESRD status based on CMS eligibility records.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The manual rate development.
- Significant projected allowed costs for Non-Covered services.
- A credibility approach different from the CMS guideline described in these instructions.

SECTION I - GENERAL INFORMATION

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

SECTION II – PROJECTED ALLOWED COSTS

Plan's non-ESRD Risk Factor (for the contract period) – The non-ESRD risk factor for the contract year is obtained from Worksheet 5.

Lines a through s.

Column e – Utilization type. Displays the utilization types entered on Worksheet 1. Utilization Types are required inputs on Worksheet 1, whether the pricing uses base experience data or manual rates.

Columns f through h – Projected Experience Rate. Columns f through h are calculated 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 the 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 (see instructions for Worksheet 1 regarding base period experience data and credibility), you must enter manual rate information for the contract period. You must provide a description of the source of the manual rate in line v. The general considerations listed for the Base Period Experience data also apply here (see Worksheet 1 instructions).

Utilization/1000 assumptions by service category must be entered in column i for lines a through r. The manual's utilization rates must be consistent with the "utilization type"

input on Worksheet 1. *If no base period data were entered on Worksheet 1, enter the manual rate's utilization types in Worksheet 1 column f.* The utilization type column must not be left blank. Average costs (column j) will be calculated based on the entries in columns i and k. Projected PMPM amounts must be entered in column k.

Line s will be *added* to total medical expenses; thus any COB/Subrogation offsets to costs must be entered as a negative number.

Supporting documentation for the development of the manual rate is required, including a description/illustration of the underlying data source(s) and data/methodology used in the development of the manual rates. The required elements for this documentation include:

- A description of the source data, including its 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 source data, such as:
 - Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data;
 - Addition of Medicare-covered benefits not reflected in the source data;
 - Exclusion of non-covered benefits reflected in the source data;
 - Techniques and factors used to reflect differences between the underlying population and that expected of the MA plan;
 - Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the MA plan;
 - Methodology and data used to gross-up reimbursements to an allowed-cost basis.
- Data and methodology used to project the data from base period to contract year (CY) 2008.
- A description of the source of data for the development of corresponding CY 2008 recalibrated CMS-HCC 70 model risk scores, and how it compares to the risk scores of the population underlying the manual rate source data.
- All other applicable factors and/or adjustments.

Column I – Experience Credibility Percentage. Enter the experience credibility percentage by service category in column I. This percentage must be between 0% and 99% if the plan is using a manual rate in the projection. The credibility assumption may vary by service category, especially when a subset of providers is reimbursed on a capitation basis or when a new benefit category is added using a manual rate.

Based on an application of classical credibility theory to Medicare Fee-for-Service experience, CMS has established a guideline for full credibility 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. Note that this formula is a guideline; organizations may use a different credibility approach if appropriate supporting materials are provided (see Appendix B).

For example, if the member months reflected in the experience period were to equal 6,000, then in the projection of contract year medical expenses, the weight given to actual trended experience would equal 50 percent [calculated as $(6,000/24,000)^{(1/2)}$]. Alternatively, 100% credibility weight would be given to actual trended experience if there were 30,000 member months during the experience period.

Worksheet 2

See instructions for Worksheet 1, Section II, line 1 (base period time definition) for additional guidance on the base period used.

Columns m through o – Contract Year Rate. Columns m through o calculate the blended contract year rate, based on the projected experience rate and the manual rate. The Contract Year Rate is included in the plan's contract year revenue requirements.

Supporting documentation is required for significant projected Non-Covered allowed costs (see Appendix B).

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

Line t – Total Medical Expenses. Calculated as the sum of lines a through s.

Line u – Subtotal Medicare-Covered service categories. Calculated as the sum of lines a through k.

Line v – Manual rate description. Use the text box to provide a description of the source of the manual rate, including trend assumptions.

Worksheet 3 - MA Projected Cost Sharing PMPM

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

All information provided on Worksheet 3 must exclude ESRD enrollees, for the time period enrollees are in ESRD status based on CMS eligibility records.

The cost sharing information entered on this worksheet must tie to the PBP and, as such, must contain enough detailed information to be easily cross-checked by CMS. A description of the cost sharing for each benefit category is required.

Note that although there are not individual entries for each cost sharing item listed in the PBP, the value of all cost sharing items must be reflected in the total PMPM amount on this worksheet.

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

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The process for adjusting cost sharing due to OOP limits.
- Support for cost sharing utilization assumptions and plan level deductible.

SECTION I - GENERAL INFORMATION

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

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

See Appendix B for information regarding required supporting documentation for out-of-pocket limits.

Line 1 - In-Network. Enter the maximum total dollar amount that a member could pay for in-network cost sharing for the contract year.

Line 2 – Out-of-Network. Enter the maximum total dollar amount that a member could pay for out-of-network cost sharing for the contract year.

Line 3 - Combined. Enter the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network.

Line 4 - Maximum Cost Sharing Description. In the text box provided, briefly explain the methodology used to reflect the impact of maximum cost sharing on the PMPM values entered in Section III.

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

Section III summarizes the cost sharing for all services included in the plan benefit package. The service categories are the same as presented in previous worksheets, except that line s (COB) has been omitted. Please note that for some service categories, (e.g., Inpatient Facility), there is more than one cost sharing line available. Multiple lines allow you to enter multiple cost sharing items in a service category to better match the PBP. In addition to the lines presented, the user 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.

If the plan's cost sharing is designed to match **Medicare fee-for-service (FFS) cost sharing**, e.g. for a **dual eligible SNP** plan or a demonstration plan, then the final cost sharing amounts will not be known when the bid is submitted. In order to charge actual Medicare FFS cost sharing, the cost sharing description entered for each applicable benefit category should read "Medicare FFS cost sharing" or similar wording. Note that this approach applies for the BPT and not the PBP. The actuary may use the actuarial equivalent cost sharing factors shown in Worksheet 4 to estimate these benefits.

In the case of a **Qualified Medicare Beneficiary (QMB)** where a state Medicaid agency pays all or part of the cost sharing on behalf of the QMB, the full level of plan cost sharing must be included in Section III. See Appendix E for information regarding QMBs.

We expect that the cost sharing for an out-of-service area **travel benefit** will be entered as out-of-network cost sharing in columns l and m with any differences from the out-of-network cost sharing within the service area clearly described. This applies whether or not the out-of-service area travel benefit is provided in-network, i.e., within the network established by the MAO or its affiliate for other health plans in other service areas. Alternatively, the plan may enter the cost sharing for the travel benefit as in-network.

See Appendix B for information regarding **supporting documentation** for cost sharing utilization assumptions and plan level deductible.

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

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

Option A:

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

Option B:

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

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

- PCP 5,000
- MH – Indiv. 50
- MH – 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 finest level of detail, with individual mental health in line i3 and group mental health in line i6.

	<u>col g</u>	<u>col i</u>	<u>col j</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 mental health copays.

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

	<u>col g</u>	<u>col h</u>	<u>col i</u>	<u>col j</u>
Line i1 – PCP	5,000	\$10 per visit	\$ 10.00	\$ 4.17
Line i2 – Specialist excl MH	2,900	\$20 per visit	\$ 20.00	\$ 4.83
Line i3 – Mental Health	<u>100</u>	\$20/visit for group MH sessions, \$40/visit for individual MH	<u>\$ 30.00</u>	<u>\$.25</u>
Total	8,000		\$ 13.88	\$ 9.25

Option C: Enter all services on one line (e.g., i6).

	<u>col g</u>	<u>col h</u>	<u>col i</u>	<u>col j</u>
Line i6	<u>8,000</u>	\$10/visit PCP \$20/visit non-MH specialist \$20/visit for group MH \$40/visit for individual 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
- 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)
- POS
- 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 (e.g., Inpatient Facility), the description is provided to help you provide detailed information that can easily be checked against the PBP. You may input a description if using a blank row at the bottom of the worksheet to enter additional cost sharing lines.

Column e – Measurement Unit Code. For each cost sharing line, enter the appropriate measurement unit from the list below. The valid utilization types vary by service category, consistent with previous worksheets.

- A - Admits
- D - Days
- BP - Benefit Period
- V - Visits

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

Column f – Effective In-Network Plan-Level Deductible PMPM. If there is an in-network plan-level deductible, you must enter the effective amount of the deductible on each service category line affected. For each service that is subject to the plan-level deductible, enter an amount such that the sum total represents the effective PMPM value of the deductible. Enter the actual in-network plan-level deductible amount (e.g., \$500) in the footnote.

Column g – In-Network Util/1000 or PMPM (after plan-level deductible has been satisfied, and includes the impact of the OOP maximum). Enter the projected in-network utilization/1000, or PMPM value in the case of coinsurance, after the plan-level deductible has been satisfied and including the impact of the OOP maximum.

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

Column h – In-Network Cost Sharing Description. Enter a description of the in-network cost sharing for each service category. Include any notes such as “for 1st 5 days”. This is a text field.

This BPT field must contain descriptions of *all* plan cost sharing included in the PBP. This includes descriptions of *all* PBP benefits priced within each BPT service category. Since each BPT category may map to several PBP benefit categories, this field must provide details on all benefits priced together within each BPT service category.

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

This field should be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits in the PBP are consistent with the benefits priced in the BPT, as part of the quality control for your bid submission. We recommend that the actuary include the PBP service categories (description of the cost sharing amounts and the corresponding PBP line #s) that are priced in each row of Worksheet 3.

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

Column i – In-Network Effective Copay/Coinsurance (after the plan-level deductible has been satisfied, and includes the impact of the OOP maximum). 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 should represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g).

Column j – In-Network PMPM. These cells are calculated and reflect the projected cost sharing value PMPM for in-network services, excluding the effective in-network plan-level deductible. The formula uses the utilization or PMPM amounts in column g and the effective copay or coinsurance in column i.

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

Column k – Total In-Network Cost Sharing PMPM. These cells are calculated as the sum of columns f and j. This column is the total projected cost sharing for in-network services.

Column l – Out-of-Network (OON) Cost Sharing Description. Enter a description for the out-of-network cost sharing of each service category. Include any notes such as “for 1st 5 days.” This is a text field.

This BPT field must contain descriptions of *all* plan cost sharing included in the PBP. This includes descriptions of *all* PBP benefits priced within each BPT service category. Since each BPT category may map to several PBP benefit categories, this field must provide details on all benefits priced together in each BPT service category.

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

This field should be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits in the PBP are consistent with the benefits priced in the BPT, as part of the quality control for your bid submission. We recommend that the actuary include the PBP service categories (description of the cost sharing amounts and the corresponding PBP line #s) that are priced in each row of Worksheet 3.

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

Column m – 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 OON plan-level deductible in the footnote. Enter the pricing impact of the OON OOP maximum in the second footnote. (This value should reflect the PMPM difference in pricing for OON cost sharing before the OOP max and after the OOP max has been applied.)

Column n – Grand Total Cost Sharing PMPM (In-Network and Out-of-Network). This column is calculated as the sum of the in-network cost sharing (column k) and the out-of-network cost sharing (column m).

Worksheet 4 - MA Projected Revenue Requirement PMPM

This worksheet uses the information from previous worksheets for the allowed costs (Worksheet 2) and cost sharing (Worksheet 3) to determine net medical costs. Non-benefit expenses and gain/loss margins are entered to establish the plan's revenue requirements for the contract year. Values are allocated between Medicare-Covered Benefits and A/B Mandatory Supplemental Benefits and reflect the plan's non-ESRD risk factor for the contract period. The allocation of values between Medicare-Covered Benefits and A/B Mandatory Supplemental Benefits must be consistent with the Benefit Type classification in the PBP.

In Section IV, the plan must enter the projected "subsidy" for ESRD enrollees. ESRD enrollees must be excluded from all other sections of the BPT.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- Non-benefit expense assumptions.
- Gain/loss margin.
- The cost sharing test in Section III if the plan does not fall within the allowable limit.
- ESRD information provided.
- The allocation of allowed costs and cost sharing between Medicare-Covered and A/B Mandatory Supplemental benefits.

SECTION I - GENERAL INFORMATION

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

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

Plan's non-ESRD Risk Factor (for the contract period) – The non-ESRD risk factor is obtained from Worksheet 5.

Lines a through r and line u.

Column e – Allowed PMPM for Total Benefits. The allowed PMPM is obtained from Worksheet 2 column O. No user inputs are necessary.

Column f – Cost Sharing for Total Benefits. The total in- and out-of-network cost sharing PMPMs are obtained from Worksheet 3 column N (except for lines s, t, and u). No user inputs are necessary.

Column g – Net PMPM for Total Benefits. The Net PMPM is calculated as column e less column f.

Columns h and i - Percentage for Covered Services. The PMPM amounts shown in columns e through g reflect *all* benefits covered by the MA plan. In columns h and i, you must enter the expected percentages of these benefits that represent

Medicare-Covered benefits. The percentages in column h are used to allocate allowed costs (column e) between Medicare-Covered (column l) and A/B Mandatory Supplemental Benefits. The percentages in column i are used to allocate the plan's cost sharing (column f) between Plan Cost Sharing for Medicare-Covered services (column k) and cost sharing for A/B Mandatory Supplemental Benefits.

For services that are Non-Covered as defined, the percentage is defaulted 0.0% (e.g. line l, Transportation Non-Covered). For all other services, the plan must estimate the percentage of Covered Services for both the allowed costs and the cost sharing. The user must enter these percentages in columns h and i. If the plan's benefit for a service is richer than that covered by FFS Medicare, the percentage entered should be less than 100%.

Example: The plan estimates that the Allowed PMPM in column e for Outpatient Facility Emergency services represents that 99.9% of those costs are for Medicare-Covered services and 0.1% of those costs are for A/B Mandatory Supplemental Benefits, whereas the cost sharing PMPM in column f represents that 98.0% of the cost sharing is for Medicare-Covered services and 2.0% of the cost sharing is for A/B Mandatory Supplemental Benefits. The entries in columns h and i would be as follows:

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

For “Part B Only” plans, the Medicare-Covered percentage for inpatient services (lines a and b) should equal 0.0%. Also, Home Health services (line c) should be approximately 50%, which represents the national average portion of Medicare-Covered Home Health provided under Part A.

See Appendix B for information regarding supporting documentation for the allocation of costs and cost sharing between Medicare-Covered and Mandatory Supplemental.

Column j – Fee-for-Service Medicare Actuarial Equivalent (AE) Cost Sharing Proportions. These values are populated based on the enrollment projections entered in Worksheet 5.

Column k – 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 i). This column is used to determine the Reduction of A/B Cost Sharing in column p.

Columns l through n – 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 l – Medicare-Covered Allowed PMPM. The Medicare-Covered Allowed costs are calculated based on the percentage of Medicare-Covered

benefits input by the plan in column h. Column l is calculated as column e times column h.

Column m – Fee-for-Service Medicare Actuarial Equivalent Cost Sharing. The FFS Medicare AE cost sharing PMPMs are based on the proportions in column j. Column m is calculated as column j times column l.

Column n – Net PMPM. Calculated as column l minus column m.

Columns o through q – 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 o – Net PMPM for Additional Services. These amounts reflect the net costs (i.e., allowed costs less enrollee cost sharing) for Non-Covered benefits. This column is calculated as the allowed costs for Non-Covered benefits (column e minus column l) less the cost sharing for Non-Covered benefits (column f minus column k).

Column p – Reduction of A/B Cost Sharing. This column is the difference between FFS actuarial equivalent cost sharing and the plan cost sharing for Medicare-Covered services, calculated as column m minus column k. This is sometimes referred to as the “FFS cost sharing buydown.”

Column q – Total A/B Mandatory Supplemental Benefits. This column is calculated as the sum of columns o and p.

Line s – ESRD. This line is populated based on Section IV.

Line t – Additional Benefits (employer bids only). This line is populated based on Section V.

Line v – Total Medical Expenses. The total medical expense is the sum of lines a through u, except for column j. The value in column n is the net medical cost included in the Plan A/B Bid. The value in column q is the net medical cost included in the A/B Mandatory Supplemental (MS) Premium.

Line w – Non-Benefit Expenses. The user must enter the non-benefit expense information for total MA benefits in column g for the four categories described below. (Note: In the CY2007 bid instructions, “non-benefit expenses” were referred to as “non-medical expenses”.) These data represent all administrative costs of operating the Medicare Advantage plan, other than medical, DME/supplies, prescription drugs, and other benefits.

The worksheet distributes the non-benefit expenses proportionately between Medicare-Covered (column n) and A/B Mandatory Supplemental (column q) for each category. Non-benefit expenses are also distributed within A/B Mandatory Supplemental benefits between Additional Services (column o) and Reduction of A/B Cost Sharing (column p). The proportions are described in these instructions and exclude the PMPM impact of the ESRD subsidy.

Supporting documentation for non-benefit expenses is required (see Appendix B). Such documentation must include:

- A summary of the non-benefit expenses by category of expense, or line item.
- An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.

Plans must be prepared to report on the contractual terms of administrative services, and to identify when the service is performed by the plan sponsor, by a related party, or by an unrelated party. Administrative service agreements with related parties must reflect a competitive cost for the contracted services, and be prepared to support this upon request. For example, a plan or the related party could demonstrate that the terms of related party agreement are comparable to those terms offered by a comparable and competitive unrelated party for performing a comparable service.

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

- Marketing & Sales (for example, the cost of marketing materials, commissions, enrollment packages, identification cards).
- Direct Administration (for example, functions that are directly related to the administration of the Medicare Advantage program). Examples of direct administration functions are as follows.
 - customer service
 - billing and enrollment
 - medical management
 - claims administration
 - Medicare user fees, which are estimated to be \$0.35 PMPM on a national basis for CY 2008.
 - Uncollected enrollee premium
 - Disease management functions (such as patient education and disease monitoring).
- Indirect Administration (for example, functions that may be considered “corporate services,” such as CEO, accounting operations, actuarial services, legal services, human resources, etc.).
- Net Cost of Private Reinsurance (i.e., reinsurance premium less projected reinsurance recoveries).

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

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

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

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

Costs that are common to offering a Medicare Advantage-Prescription Drug (MA-PD) plan must be allocated proportionately between the Medicare Advantage and Part D bid pricing tools based on total revenue.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a zero (\$0.00) in the cell.

Lines w1 through w4 - Non-Benefit Expense. Total non-benefit expenses are input in column g and allocated proportionately between Medicare-Covered (column n) and A/B Mandatory Supplemental (column q). Note that the same proportion is used for each line item. The allocation is based on the relative proportion of the plan's medical expenses requirements for Medicare-Covered ("bid") and A/B Mandatory Supplemental, excluding the PMPM impact of the ESRD subsidy.

Column g – Non-Benefit Expense PMPM for Total Benefits. Enter the PMPM by category.

Column n – Non-Benefit Expense PMPM for Medicare-Covered. These values are calculated as column g minus column q.

Column q – 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 w5, columns g, n, and q - Total Non-Benefit Expense. The sum of lines w1 through w4.

Line w5, columns o and p - Total Non-Benefit Expense for Additional Services and Reduction of A/B Cost Sharing. The total non-benefit expense for A/B MS benefits (column q) is allocated between Additional Services (column o) and Reduction of A/B Cost Sharing (column p). 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 x – Gain/Loss Margin.

Introduction

The user must input the projected PMPM for the gain or loss in column g for total MA services. Gain/loss margin refers to the additional revenue requirements above and beyond the requirements needed to cover medical expenses and non-benefit expenses.

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 expenses requirements for Medicare-Covered and A/B Mandatory Supplemental, excluding the PMPM impact of the ESRD subsidy.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a zero (\$0.00) in the cell.

Gain/Loss Margin Guidance

Individual-market plans (that is, non-EGWP & non-SNP):

Overall Medicare margin levels for individual-market plans are to be consistent with the plan sponsor's corporate requirement. Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level. The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range (for example, plus or minus 1% or 1.5%) of other lines of business. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE) bases, the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business should take into account the degree of risk or reserve levels of the business.

It is expected that the overall margin level expectations will be consistent on a year-by-year basis. Actual organization returns are expected to vary year-to-year in practice, but are expected to achieve the organization's requirement over a longer term period (for example, three to five years). Individual plan margins may vary from the overall organization level.

The overall margin levels included in the MA and Part D components of MA-PD bids must be within a reasonable range of each other (for example, plus or minus 1% or 1.5%) with any differences reflecting the different levels of risk underlying the two reimbursements. The individual Part D margin of an MA-PD bid may be allocated by applying the overall Part D margin requirement to each Part D bid of the MA-PD organization or alternatively, in similar relationships as the MA margins.

Plans with negative margins must develop and follow a business plan to get to profitability. An exception to the business plan requirement are cases where multiple MA products are offered in a given service area and the pricing reflects implicit "subsidies" to mitigate premium spirals.

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

Employer Group & Waiver Plans (EGWPs):

The foundation for the claim and administrative costs for EGWP plans should be based on appropriate EGWP experience. The margin assumptions used for individual plans should be the basis for the margin requirements for EGWP plans. Organizations may choose to use the overall margin levels for individual plans as the basis for the group plan margin assumptions or may rely on the margins used in comparable individual plans.

There may be small differences (that is, up to 1 percent) in the margin levels between EGWP and individual plans. If corresponding individual-market plans are not offered, then the margin guidance for individual-market plans applies to the EGWP margin pricing. That is, overall EGWP margin levels are to be consistent with the organizations margin requirement and this requirement is to be within a reasonable range (for example, plus or minus 1% or 1.5%) around a return-on-equity or return-on-investment type measure or comparable to other comparative lines of businesses.

Special Needs Plans serving Dual-Eligibles (DE-SNP):

The foundation for the claim and administrative costs for DE-SNPs should be based on appropriate experience. The margin assumptions used for individual plans should be the basis for the margin requirements for DE-SNP plans. There may be small differences (that is, up to 1 percent) in the margin levels between DE-SNP and individual plans.

If corresponding individual-market plans are not offered, then the margin guidance for individual-market plans applies to the DE-SNP margin pricing. That is, overall DE-SNP margin levels are to be consistent with the organization's margin requirement and this requirement is to be within a reasonable range (for example, plus or minus 1% or 1.5%) around a return-on-equity or return-on-investment type measure or comparable to other comparative lines of businesses.

Documentation requirements

Supporting documentation for the gain/loss margin is required (see Appendix B). This documentation must include the following:

- Support for overall margin levels, including description of methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.
- Support for bids with negative margins, i.e., a business plan that illustrates profitability within few years.
- Justification of the margin for bids with relatively large projected overall gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other supporting documentation. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.
- If applicable, further analysis of the organization's ROI / ROE and distinctions between recouping start-up costs versus ongoing organizational gain/loss.

Note that supporting documentation requirements are the same regardless of the source of the assumption: whether developed by the actuary, the plan sponsoring organization, or a third party.

Support for variation that accounts for the difference in risks between products for EGWPs and DE-SNPs must be available upon request.

In future years, comparisons to the original business plan are to be provided including details and source of deviation from prior years' plans.

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

Line y – Total Revenue Requirement. The sum of lines v (medical expense), w5 (non-benefit expense), and x (gain/loss margin). The value in column n is the total revenue requirement of the Plan A/B Bid.

Line z – Percent of Revenue Ratios (excluding ESRD). These lines calculate the ratio of net medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue. These ratios exclude the PMPM impact of the ESRD subsidy.

SECTION III – COMPARISON OF COST SHARING FOR COVERED SERVICES WITH FFS MEDICARE

This section computes whether the plan's cost sharing PMPM is within the allowable limit (i.e., does not exceed original Medicare cost sharing). No user inputs are required.

Line 1. Standardized FFS Cost Sharing for Medicare-Covered Services. This value is populated based on the enrollment projections entered in Worksheet 5. No user input is required.

Line 2. Standardized Plan Cost Sharing for Covered Services. Plan cost sharing PMPM from line v of column k, standardized to a 1.000 beneficiary. No user input is required.

The plan cost sharing includes both in-network and out-of-network. For Regional PPOs, per section 1852(a)(1)(B)(ii) of the Social Security Act, only in-network services provided by an RPPO are subject to this test. Thus, line 3 may display a "No" for an RPPO bid, and the plan's cost sharing requirements may still meet the statutory requirements. The supporting documentation submitted by the plan must support that the in-network cost sharing is within the allowable limit.

Line 3. Is Covered Cost Share Within FFS Medicare Limit? No user input is required. Displays either "Yes" or "No" based on lines 1 and 2.

If the plan's cost sharing (in line 2) is greater than the allowable limit (in line 1), a "No" is displayed and supporting documentation is required (see Appendix B).

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

The benchmarks calculated in the CY2008 MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan,

including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In an effort to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, Section IV allows for an adjustment. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits.

All plans *must* enter the projected CY ESRD member months. Do not leave this field blank. If the plan is expecting zero ESRD enrollees during the contract period, then enter a zero (0) in this field.

Bids that are based on a credible block of ESRD experience are expected to complete the ESRD fields for **Basic, or Medicare-Covered**, benefits based on their experience. (Obviously, due to the higher expected level of per-enrollee expenditures, the credibility thresholds for individuals in ESRD status will typically be lower than those based on non-ESRD populations.) 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 applicable fields to be completed 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 (e.g., 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.

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

The **Mandatory Supplemental** part of Section IV *must* be completed for all bids that reflect credible Medicare-Covered experience for enrollees in ESRD status. Bids that do not have credible Medicare-Covered experience are encouraged to reflect this incremental cost for supplemental A/B 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 form will calculate the incremental cost of Supplemental Benefits for ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD).

The ESRD subsidy calculated in this section is used in line s of Section II.

Supporting documentation for ESRD manual rates is required (see Appendix B). This documentation could include:

- Base period (e.g., 2006) revenues and medical expenditures for Medicare-Covered benefits provided to enrollees in ESRD status.
- The source for and 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.

SECTION V – FOR EMPLOYER/UNION-ONLY GROUP WAIVER PLAN (EGWP) BIDS ONLY (“800-SERIES” BIDS)

This section may be used by employer/union-only group waiver plan (EGWP) bids (“800-series” plan IDs) to provide CMS with the costs associated with additional “unspecified” benefits. This includes Employer/Union Direct Contract Private Fee-for-Service plans (i.e., plan type equal to “ED PFFS”).

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. Users may 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 t of Section II. Note that the non-benefit expenses and gain/loss margin will be proportionately allocated.

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.

All information provided on Worksheet 5 must exclude ESRD enrollees, for the time period enrollees are in ESRD status based on CMS eligibility records.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The development of projected risk factors.
- The development of plan-provided ISAR factors, if used (Regional PPO plans only).

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

- Section II – Summarizes the development of the benchmarks and bids.
- Section III – Summarizes the development of the Savings or Basic Member Premium.
- Section IV – Development of Regional A/B Benchmark (including the Statutory Component of Regional Benchmark).
- Section V - Projected plan-specific information for counties within the service area.
- Section VI – Other Medicare Information (populated based on the enrollment projection).

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

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

SECTION I - GENERAL INFORMATION

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

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Standardized A/B Benchmark (at 1.000 risk score). This value is obtained from Section IV for regional plans and from Section V for local plans.

Line 2 – Medicare Secondary Payer (MSP) Adjustment. User input is required. Do not leave this field blank. If zero percent is the projected value, enter a zero (0) in this field.

This entry can be calculated, using the Medicare Membership Report (MMR) data, as the ratio of total working aged adjustment dollars divided by total payments before reduction for user fees or working aged.

Line 3 – Weighted Average Risk Factor (excl ESRD). This value is obtained from Section V.

Line 4 – Conversion Factor. Calculated as $(1.000 \text{ minus line } 2) \times \text{line } 3$.

Line 5 – Plan (or Regional) A/B Benchmark. Calculated as $\text{line } 1 \times \text{line } 4$.

Line 6 – Plan A/B Bid. This value is obtained from Worksheet 4, then rounded to two decimals.

Line 7 – Standardized A/B Bid (@ 1.000). Calculation is $\text{line } 6 \text{ divided by line } 4$, then rounded to two decimals.

SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 – Savings. The difference between the Plan (or Regional) A/B Benchmark and the Plan A/B Bid, but not less than zero. This value is rounded to two decimals.

Line 2 – Rebate. Calculated as 75% of the Savings (in line 1). This value is rounded to two decimals.

Line 3 – Basic Member Premium. The Standardized A/B Bid less the Standardized A/B Benchmark, but not less than zero. This value is rounded to two decimals.

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

This section calculates the Standardized A/B Benchmark for Regional PPO plans.

Line 1 – Statutory Component. The PMPM amount, defined by region, is pre-populated by CMS. The weighting is also pre-determined by CMS and populated in the bid form.

Line 2 – Plan Bid Component. The plan bid component will be announced by CMS after the regional bids are submitted. It will likely be announced at the same time that the Part D National Average is announced (generally in August).

Plans may input an *estimated* average regional bid amount in their initial bid submission in June.

For bids that are submitted prior to the announcement of the RPPO averages, there are two options for completing this field: (i) leave the cell blank, in which case the submitted plan's standardized bid (Section II, line 7) is used as the Plan Bid Component, or (ii) input a reasonable estimate of the average RPPO bid for the region.

The RPPO announcement includes the weighted average MA RPPO bid for each region. Organizations will be instructed to submit revised RPPO MA BPTs (generally in August) with the applicable average bid amount entered in Line 2. Employer bids ("800-series" bids) are also required to resubmit at that time to reflect the RPPO average bids in Line 2. Any changes in rebates due to the actual plan bid component must be re-allocated at that time.

Line 3 – Standardized A/B Benchmark – Regional Plans. This line is calculated as the weighted average of lines 1 and 2 (if line 2 has a value entered). If line 2 does not have a value entered (i.e., for a pre-announcement bid submission for which the plan has not entered an estimate value), the amount from Section II, line 7 is used in the calculation.

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

This section contains detailed data by county and develops plan-specific county-level MA payment rates. For most plans, the only user inputs are the State-County code (column b), projected member months (column e), and projected risk factors (column f). Entries must reflect plan-specific enrollment projections for each county within the service area.

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

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. MA organizations that wish to propose plan-provided ISAR factors for regional plans must input such amounts in this section, as described below.

Line 1 – Use of Plan-Provided ISAR Factors. Regional plans that wish to use ISAR factors to develop their county payment rates must enter "Yes". (Technical note: Do not enter "Y" in this field – enter the entire word "Yes")

Line 2 – Total or Weighted Average for the Service Area. The county-level data are summarized in this line, weighted by projected member months.

Line 3 – County-Level Detail.

Column b – State-County Code. Enter the Social Security Administration (SSA) State-County codes that define the MA service area, in accordance with the following:

Worksheet 5

- Each State-County code must be entered as a text input (i.e. must include a preceding apostrophe) and include all leading zeroes (e.g., '01000). This field has been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (i.e., using a preceding apostrophe) including any leading zeros.
- If the service area has more than one county, do not leave any blank rows between the first and last State-County code entered. Also, do not leave blank rows before the first county code entered.
- Do not enter the same State-County code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area (OOA) county, "99999". OOA enrollees are not represented in the benchmark calculation.
- The county codes entered in the BPT must match the service area defined in HPMS by the MA organization.

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 technical instructions (Appendix H) for further information.

Column c – State. The worksheet 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 worksheet will display the applicable county name based on the corresponding code entered in column b. No user entry is required.

Column e – Projected Member Months (excluding ESRD). Enter the projected contract year member months for each county in the service area. The projected member months must include both aged and disabled members, but exclude ESRD members. The projected member months should be developed using data on members enrolled in the plan as of early 2007. (Technical note: The data will display as whole values, but can be entered with decimal places.)

Column f – Non-ESRD Projected Risk Factor. Enter the risk factors for the projected non-ESRD membership by county. In accordance with Appendix B, supporting documentation for the development of the projected risk scores is required.

Risk Score Development for CY 2008:

The CY 2008 risk score must be based on the recalibrated HCC risk model, be adjusted for normalization, and reflect appropriate projection factors. CMS implemented a recalibrated Medicare Advantage CMS-HCC 70 risk model, which is used for payments in CY2007 and CY2008. Projected risk scores for MA bids must be developed using this recalibrated HCC risk model. Additionally, as described below, different approaches are to be followed for plans with appropriate base period experience vs. plans without such experience.

At time of payment, the risk scores for each plan enrollee will be adjusted by a factor, know as the fee-for-service (FFS) normalization, which is 1.04 for 2008. This adjustment accounts for the expectation of higher intensity in the aggregate risk scores for the contract year vs. the model calibration year (2005). Accordingly, the 2008 bid projected

risk scores must reflect the 1.04 normalization factor. Additional information on the 2008 normalization factor is contained in the 2008 ratebook announcement:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage>

Acceptable approaches for the development of risk scores depends on whether or not the plan pricing is based on manual rates or actual plan experience. Plans that are priced using a manual rating approach must estimate risk scores based on the expected medical expenses for their projected enrollees. Further, the risk scores for new plans must be developed consistent with the recalibrated HCC model. Details of this model may be found at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>, under “risk adjustment”. Additional information on the risk adjustment process can be found at the web site: http://www.csscooperations.com/new/usergroup/july2006_reqtrn/raps-participant-guide_081606.pdf.

Use of the recalibrated HCC risk scores for the 2006 enrollee cohort is the preferred basis for the projecting the 2008 risk scores for experienced-rated plans. CMS has released plan-specific risk score data that may be used as the basis for projecting CY2008 risk scores. This information is available in HPMS under the “Risk Adjustment” link from the HPMS Home page. (Note: You must have HPMS user access to view this information. The HPMS weblink is either: <https://32.90.191.19/hpms/secure/home.asp> or <https://gateway.cms.hhs.gov>, depending on your firm’s connection method.) The risk score data posted in HPMS is accompanied by technical notes to assist actuaries with interpreting the data presented. There are several advantages to using the 2006 cohort recalibrated HCC risk scores in the projection of the CY 2008 risk score including: (i) consistency with the base-period medical expenses; (ii) they are based on a mid-year cohort and require no adjustment for seasonality; (iii) they reflect non-lagged diagnosis data; and (iv) they are based on the latest risk model.

The projection of scores from 2006 to 2008 must reflect relevant projection factors, which include, but are not limited to, coding intensity trend and changes in plan population. Please note that the reported scores are based on a mid-year cohort with nearly-complete run-out of data and require no explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. Finally, the projected “raw” scores must be normalized by dividing by the 2008 FFS normalization factor of 1.04.

An alternate approach to forecasting the CY 2008 MA risk scores for experience-rated plans is to use as the base scores from a 2007 Medicare Membership Report (MMR) file. This approach may be appropriate in situations where the plan was first offered in 2007, there was limited enrollment in 2006, or there were significant changes in plan or enrollment characteristics between 2006 and 2007.

The starting “raw” risk scores for this alternative approach are the average risk scores from one, or more, of the 2007 MMR files for non-adjustment records multiplied by 1.029 to remove the effect of the 2007 normalization factor. These scores are trended to 2008 with explicit adjustment for the following factors:

- Coding intensity;
- Impact of lagged vs. non-lagged diagnosis data;
- Run-out of diagnosis data;
- Seasonality
- Population changes.
- Other appropriate factors.

Finally, the projected “raw” scores must be normalized by dividing by the 2008 FFS normalization factor of 1.04.

Documentation requirements

Supporting documentation for the development of projected risk scores is required (see Appendix B). This documentation must include the following:

- A detailed description of the methodology used to develop projected 2008 MA risk scores.
- A description of the source data for the development of the projected 2008 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, if the plan pricing is based on manual rates.

Column g – Plan-Provided ISAR Factors. CMS may allow MA organizations, on a case-by-case basis, to request that regional plan payment rates be developed using plan-provided geographic 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 regional plan’s projected costs in its service area.

MA organizations that wish to propose plan-provided ISAR factors for regional plans must complete the following steps:

- (i) 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”.)
- (ii) Enter the plan-provided ISAR factors in column g of the county-level detailed table. Factors can be in the form of either PMPM values or a relative scale.
- (iii) Provide support for the development of the plan-provided ISAR factors in accordance with Appendix B.

Column h – MA Risk Ratebook: Unadjusted. The worksheet 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 is the Part B rate only.

Column i – MA Risk Ratebook: Risk-Adjusted. The worksheet 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 worksheet 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 worksheet will calculate the ISAR-adjusted bid based on the ISAR scale in column j and the Standardized A/B Bid in Section II. Note that the payment rates represent coverage for Medicare Part A and Part B (except for Part-B only plans). The values will then be separated into Part A and Part B payment rates in columns l and m.

Columns l through m – Risk Payment rates. These columns are calculated based on the ISAR-adjusted bid in column k and the Risk Ratebook proportions for Part A and Part B.

SECTION VI – OTHER MEDICARE INFORMATION

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

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. The costs for hospice services are excluded 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. In addition, experience for ESRD enrollees is excluded. For further details on the development of the cost sharing factors, such as the handling of IME, GME, and other costs, can be found at www.cms.hhs.gov under Medicare > Medicare Advantage Rates & Statistics > Ratebooks & Supporting Data.

Columns n through p – Original Medicare Cost Sharing Proportional Factors. These columns are populated based on the enrollment projections and are used in column j of Worksheet 4.

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 of Worksheet 5 Section VI.

Columns t through u – FFS Equivalent Cost Sharing. These columns are populated based on the enrollment projections and are used in Section III of Worksheet 4.

Columns v through w – Metropolitan Statistical Area (MSA). These columns are populated based on the enrollment projections. While not directly used in the BPT calculations, this information is helpful to CMS during bid reviews.

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.

All information provided on Worksheet 6 must exclude ESRD enrollees, for the time period enrollees are in ESRD status based on CMS eligibility records.

SECTION I - GENERAL INFORMATION

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

SECTION II – OTHER INFORMATION

Section A – Part B Information

Line 1 – CMS Estimate of “Standard” Contract Year Part B Premium. This value is pre-populated by CMS.

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

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

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

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

See Section IIB for further information regarding allocating rebates to the standard Part B premium.

Line 2 – Part B % of USPPC. This value is pre-populated by CMS. For “Part B Only” bids, this percentage is used to estimate the Part A portion of the plan benchmark, which is used in line 3.

Line 3 – Maximum for Part A Package on Part B Only Members. Lines a through c do not require any user inputs. These lines use bid information to calculate the maximum that can be charged to Part B Only members for Part A services. On line d, enter the amount for Part B Only members for Part A services. The amount entered in line d cannot be greater than the maximum value shown to the right. If the bid’s Enrollee Type is “A/B”, then this field should be left blank.

Note: the MA premium actually charged to all plan enrollees is calculated in Section IIIC, line 6.

Section B – Rebate Allocation for CY Standard Part B Premium

Line 1 – PMPM Rebate Allocation for Standard CY Part B Premium. Enter the PMPM amount of rebates that the plan wishes to use to reduce the standard Part B premium.

Line 2 – Rounded Part B Rebate Allocation. The PMPM amount entered in line 1 is rounded to one decimal (i.e., the nearest dime) to comply with withhold system requirements.

Line 3 – Does the plan intend to reduce the entire CY standard Part B premium using rebates? CMS is considering allowing plans the ability to fully reduce the standard Part B premium. The bid pricing tool and instructions are released annually in April, but the standard Part B premium is not released by CMS for the upcoming contract year until several months later. Therefore, plans must use the CMS pre-populated Part B premium *estimate* in the bid form (Section IIA line 1) to determine the level of rebates to allocate.

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

CMS will release further guidance directly to those plans that meet these criteria (i.e., have allocated rebates equal to the CMS pre-populated estimate and have entered “Yes” in this line), *if* it is determined by CMS that the full reduction is feasible for CY2008.

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. Section A also contains some benchmark and risk score information from Worksheet 5. Section B contains the MA Rebate Allocation. Section C develops the estimated plan premium. Consistent with previous worksheets, note that any optional supplemental benefits/premiums are excluded.

Section A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Allowed Medical Cost. The allowed PMPM at the plan's contract year non-ESRD risk factor. These amounts are obtained from Worksheet 4.

Line 2 – Less Cost Sharing. Values are obtained from Worksheet 4.

Line 3 – Net Medical Cost. The sum of lines 1 and 2.

Line 4 – Non-Benefit Expenses. These amounts are obtained from Worksheet 4.

Line 5 – 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 6 – Total Revenue Requirement. The sum of lines 3 through 5. These amounts are the required revenue at the plan's non-ESRD risk factor and are calculated prior to any rebate allocation.

Line 7 – Standardized A/B Benchmark. This amount is obtained from Worksheet 5.

Line 8 – Plan A/B Benchmark (or Regional A/B Benchmark for RPPO plans). This amount is obtained from Worksheet 5.

Line 9 – Non-ESRD Risk Factor. This amount is obtained from Worksheet 5.

Line 10 – Conversion Factor. This amount is obtained from Worksheet 5.

Section B – MA Rebate Allocation

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

- Reduce A/B Cost Sharing.
- Other A/B Mandatory Supplemental Benefits.
- Standard Part B Premium buydown.
- Part D Basic Premium buydown.
- Part D Supplemental Premium buydown.

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

See Appendix F for information regarding the re-allocation of rebates (permitted for certain plans) after the publication of the Part D National Average Bid Amount by CMS.

Line 1 – MA Rebate Available. This amount is obtained from Worksheet 5.

Lines 2 through 6 – Rebate Allocations by Category. In the fourth column, enter the portion of the total MA rebate that is allocated to each of the A/B rebate options. Note that the rebate allocations for Part B and Part D premiums are actually entered in separate

sections of this worksheet, to ensure that the rebate allocations are rounded consistently with withhold system requirements.

The first three columns distribute the allocated rebate among medical expenses, non-benefit expenses, and gain/loss in the same proportion as used in Worksheet 4. The fifth column contains the maximum value that may be entered for each rebate category.

The following rules apply for rebate allocations:

- The fifth column of this section shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum. Note that if the maximum value is negative (such as a negative Part D Basic premium before rebates), then the rebate allocation must be blank or zero.
- The total rebates allocated must equal the total rebates available. Plans are not permitted to under- or over-allocate rebates in total. This applies to all bids, including 800-series bids.
- No rebate allocations may be negative.
- Rebate allocations for “Reduce A/B Cost Sharing” and “Other A/B Mandatory Supplemental Benefits” must be rounded to two decimals.
- The rebate allocations for Standard Part B Premium, Part D Basic Premium, and Part D Supplemental Premium are rounded to one decimal (i.e., the nearest dime) due to withhold system requirements.
- Employer-only group bids (i.e., “800-series” plans) cannot allocate rebates to Part D.
- MA-only bids cannot allocate rebates to Part D.
- Rebates allocated to buy down the estimated standard Part B Premium are subject to the maximum amount shown on Worksheet 6. This maximum is the estimated CY2008 standard Part B premium at the time when the bid form is released by CMS. See the instructions for Section IIB for further information about rebates applied to the standard Part B premium.

Line 7 – Total Rebate Allocated. The sum of lines 2 through 6. This amount must equal the amount in line 1. If there are any “unallocated” rebates shown, including pennies, these amounts must be distributed among the categories available.

Section C – Development of Estimated Plan Premium

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

- Underscore the relationship of MA rebates and Part D premiums.
- Recognize the integrated relationship of the MA and Part D programs, which is often viewed as a single product with a single premium.
- Display the total estimated plan premium (sum of MA plus 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 when the Part D National Average Bid Amount is determined (generally in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2008.

For local MA-only plans, the premium shown on the MA BPT in the initial submission in June is the final actual premium (*not* an estimate) since they are not affected by the Part D National Average or Regional PPO benchmark calculations. Local MA-only plans *do not* have an opportunity to resubmit in August for rebate reallocations. The initial bid submission in June must reflect the desired plan premium.

If a local MA-only plan wishes to offer a “whole-dollar” premium, the 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. Local MA-only plans will not be given an opportunity to round the premiums after the initial June submission.

Example: After initially completing the BPT for a local MA-only plan, the BPT produced a \$0.00 Basic MA Premium (as Bid < Benchmark) and a \$61.30 Mandatory Supplemental MA premium. The plan would like to offer a “whole-dollar” premium to their enrollees. Before submitting the BPT to CMS (via HPMS upload), the actuary would *slightly* revise the bid assumptions, such as gain/loss margin, to accomplish the rounded premium. Plans should not make *significant* changes to the BPT in order to round premiums. For example, the actuary could reduce the gain/loss margin by 30 cents (\$0.30) to achieve the \$61.00 rounded premium. This should be completed before the BPT is submitted to CMS in early June.

MA-PD plans and regional MA-only plans do have an opportunity to reallocate rebates after the release of the Part D National Average Bid Amount and RPPO benchmarks. However, there are specific guidelines regarding what types of changes are permitted during the rebate reallocation period. Also, there are very specific rules regarding the *amount/level of rounding* permitted. Plans should not expect to make significant changes to the BPT in order to round premiums during the rebate reallocation period. Plans are also subject to the rules regarding the Part D target premium. See Appendix F for the premium and rounding rules that were released in the CY2007 Call Letter.

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 thereafter.

MA-PD plans must identify, in the MA BPT Worksheet 6 Section IIIC line 10, their intention for the Part D target premium *in their initial June bid submission*. See instructions for line 10 of this section for further information on the Part D target premium.

For regional PPO plans, the initial bid submission in June contains an estimated MA premium. The actual MA premium will not be known until August, when the regional benchmarks are calculated by CMS. Note that after the MA regional benchmarks are released by CMS, all regional MA plans are required to resubmit the MA BPTs in order to reflect the actual plan bid component (in Worksheet 5 cell K17). Regional MA plans may need to re-allocate rebates accordingly. Note that this requirement also applies to EGWP regional MA plans (i.e., all EGWP RPPOs are required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

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 (i.e., the nearest dime) to comply with withhold system requirements.

Line 7 – Part D Basic Premium. In line 7a, enter the Part D basic 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 (i.e., the amount prior to application of any MA rebates). Note: The Part D basic premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy-down the Part D basic premium. MA-only plans should leave this field blank. Also, EGWP plans should leave this field blank.

In line 7b, enter the rebates that the plan wishes to allocate to the Part D Basic premium. The Part D rebate allocation should be rounded to one decimal. If it is not rounded to one decimal, then the bid form will round these rebates to one decimal (in line 7c), to comply with withhold system requirements.

Line 7d calculates the estimated Part D Basic Premium net of rebates. Line 7d equals 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 when the Part D National Average Bid Amount is determined (generally in August).

Note that the Part D Basic Premium prior to rebates is permitted to be a negative number.

Line 8 – Part D Supplemental Premium. In line 8a, 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 (i.e., the amount prior to application of any MA rebates). Note: The Part D supplemental premium prior to rebates must be entered in the MA BPT, even if no MA rebates are allocated to buy-down the Part D supplemental premium. MA-only plans should leave this field blank. Also, EGWP plans should leave this field blank.

In line 8b, enter the rebates that the plan wishes to allocate to the Part D Supplemental premium. The Part D rebate allocation should be rounded to one decimal. If it is not rounded to one decimal, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements.

Line 8d calculates the Part D Supplemental Premium net of rebates. Line 8d equals line 8a minus line 8c.

Line 9 – Total Estimated Plan Premium. The sum of the rounded MA, Part D Basic, and Part D Supplemental premiums. This amount excludes any Optional Supplemental MA premiums (calculated on Worksheet 7).

Line 10 – Plan Intention for Part D Target Premium. When MA-PD bids are initially submitted in June, the Part D Basic premium in the bid forms is an *estimated* amount. The *actual* Part D Basic premium will not be known until CMS releases the Part D National Average Bid Amount. MA-PD plans can either “target” the estimated premium submitted in June or they can “target” the Low Income Premium Subsidy Amount (which is also not known until it is released later by CMS) as the Basic Part D premium amount. The Part D bid instructions may contain further information regarding the target Part D premium options.

For MA-PD plans, this field contains a drop-down menu with two options. MA-PD plans must choose one of the two options: “Premium amount displayed in line 7d” or “Low Income Premium Subsidy Amount”. When CMS later releases the Part D National Average Bid Amount and LIS amounts, MA-PD plans will have an opportunity to reallocate rebates to return to the target premium amount. Based on the option selected in this field, the plan will be able to return to the target chosen when it was initially submitted in June.

The plan intention for the Part D target premium is chosen in the initial June bid submission. The plan cannot change the chosen target in a subsequent resubmission. CMS will consider only the option chosen in the June bid submission as the chosen target.

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

SECTION IV – CONTACT INFORMATION AND “DATE BID PREPARED” IDENTIFIER

In this section, enter the name, phone number, and email information for the plan contact, as well as for the certifying actuary. For the phone number, enter all 10 digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

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

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

Worksheet 7 – Optional Supplemental Benefits

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

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

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- Contract-level MA optional supplemental experience for CY 2006, including:
 - Member months
 - Earned premiums
 - Incurred benefits
 - Non-benefit expenses
 - Gain-loss margin
- Further support on the benefit, non-benefit expenses and gain/loss margins for specific optional supplemental plans available for CY 2008.

SECTION I - GENERAL INFORMATION

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

SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

Column b – Package ID. Enter an identification (ID) number to signify which package of optional supplemental benefits is being priced. The number 001 is used to identify the first package. Whole numbers in sequence (i.e., 002, 003) identify additional packages of optional supplemental benefits. Enter the package IDs that correspond to the packages enumerated and described in the PBP.

Column c – Service Category. Enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery

- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-Covered)
- Dental (Non-Covered)
- Vision (Non-Covered)
- Hearing (Non-Covered)
- POS
- Health & Education (Non-Covered)
- Other Non-Covered

Column d – Benefit Category/Pricing Component. Enter a description of the benefit category/pricing component.

Column e – Allowed Medical Expense: Utilization Type. Enter the appropriate measurement unit from the list used for column f of Worksheet 1.

Column f – Allowed Medical Expense: Annual Utilization/1000. Enter the projected contract year annual utilization per thousand enrollees for allowed medical expenses for each benefit category.

Column g – Allowed Medical Expense: Average Cost. Enter the projected contract year average cost for allowed medical expenses for each benefit category.

Column h – Allowed Medical Expense: PMPM. Column h is calculated using the utilization reported in column f and the average cost information reported in column g.

Column i – Enrollee Cost Sharing: Measurement Unit Code. Enter the appropriate cost sharing measurement unit using the codes provided for column e of Worksheet 3.

Column j – Enrollee Cost Sharing: Utilization/1000 or PMPM. Enter the projected contract year utilization per thousand enrollees or the PMPM value in the case of coinsurance.

Column k – Enrollee Cost Sharing: Average Cost Sharing. Enter the projected contract year average per-service cost sharing amount or coinsurance percentage.

Column l – Enrollee Cost Sharing: PMPM. Column l is calculated using the utilization (or PMPM) reported in column j and the average cost (or coinsurance percentage) reported in column k.

Column m – Net PMPM Value. Column m is calculated as the Allowed PMPM (column h) minus the Cost Sharing PMPM (column l).

Column n – Non-Benefit Expense. Enter the total projected contract year non-benefit expense for each optional supplemental package offered. See Appendix B for information

regarding supporting documentation for Optional Supplemental Packages' non-benefit expenses.

Column o – Gain/(Loss) Margin. Enter the total projected contract year gain/loss margin for each optional supplemental package offered. See Appendix B for information regarding supporting documentation for Optional Supplemental Packages' gain/loss margin.

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

Column q - Projected Member Months. Enter the total projected contract year member months for each optional supplemental package offered (not average members).

SECTION III - COMMENTS

Enter any comments needed to describe the optional benefit packages.

Two-Year Look-Back Form

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

The form requires the user to input actual incurred revenue and expense information for the calendar year two years prior to the contract year being priced. For example, in contract year 2008, the experience year is 2006.

The projected figures (to be reported in columns f through h) are based on the CY2006 bid submissions for the contract. CMS provides this information for plan use, under the following location within HPMS:

HPMS Home > Plan Bids > Bid Submission > CY2008 > Download > 2-Year Lookback Projection Data
The data posted at this link must be manually entered into the two-year look-back form.

All contracts that submitted CY2006 MA BPT(s) and had enrollment in July 2006 must submit a two-year look-back form for CY2008. If data is posted at the above HPMS link for the contract, then a 2YRLB form is required to be uploaded.

The Two-Year Look-Back form must be completed at the contract-level (i.e., H#), not at the plan-level as BPTs are completed. This worksheet must be completed in “per member per month” values (PMPMs).

The data reported should include experience for Hospice enrollees, such that revenues consist of member supplemental premiums and benefits consist of supplemental claims for these enrollees. Data for ESRD enrollees should be excluded.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- Additional level of detail, for example: to separate SNP and non-SNP bids.

Contract Number. Displays the contract number.

Organization Name. Displays the organization name.

Contract Year. Displays the contract year.

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

Line 1. Revenue. Columns f and g (Original Projection) must be completed using information from CMS, which is described in the below section, *Source of Data from CMS*. Column h is the weighted average of columns f and g. The user must enter data on actual incurred experience into columns j and k. Column l is the weighted average of columns j and k. Columns n, o, and p calculate the ratio of actual-to-projected and do not require any user input.

The CMS revenue fields (a1) are to reflect bid-based MA payments from CMS plus rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits.

Two-Year Look-Back Form

Rebates applied to Parts B and D premium buydowns are not to be included. Accordingly, line d, MA Rebate applied to Part D, is to be filled with a value of zero. Also, the CMS revenues are to be reported gross of User Fee reductions.

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

The net medical expenses are to be reported on an experience (or incurred) basis, rather than GAAP (or accounting year) basis.

Line 3. Non-benefit Expenses. Columns f and g must be completed using information from CMS. Column h is the weighted average of columns f and g. The user must enter data in columns j and k. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

Line 4. Profit/(Loss) Before Taxes and Investment Income. All columns are calculated as revenue (line 1e) less medical expenses (line 2d) and non-benefit expenses (line 3e).

Line 5. Key Statistics.

Line 5a - Member Months. Columns f and g must be completed using information from CMS, which was calculated as the July 2006 MMR enrollment times 12. The user must also enter data from company financial records in columns j and k.

Line 5b - Non-ESRD Risk Factor. Columns f and g are to be left blank, or enter "n/a". The actual 2006 non-ESRD risk factor for the contract must be entered in columns j and k.

Lines 5c, 5d, and 5e. These fields are calculated fields. No user input is required.

Source of original projection data from CMS. The source of the data for columns f and g, is the 2006 Medicare Advantage (MA) bid pricing tools (BPTs). Each line of data provided by CMS represents the average of the BPT values, weighted by actual enrollment as reported on July 2006 Monthly Membership Report (MMR). Following are the specific MA BPT elements used in the calculation of each field:

1.a1 CMS Revenue (excl. bonuses): Sum of

a. Lesser of Plan A/B Bid (Worksheet 5, cell J18) and Plan A/B Benchmark (BPT worksheet 5, cell J17); and

b. MA rebates to reduce A/B cost sharing: BPT worksheet 6, cell L25; and

c. MA rebates applied to other A/B mandatory supplemental benefits: BPT worksheet 6, cell L26.

1.a2. Regional PPO Bonus Payments: not applicable; zero for all contracts.

1b. Member Premium: Basic: BPT Worksheet 5, cell J25.

1c. Member Premium – A/B Mandatory Supplemental: BPT worksheet 6, cell R26.

1d. MA Rebate applied to Part D: not applicable; zero for all contracts

1e. Total: sum of 1a1, 1a2, 1b, 1c, and 1d.

2a. Covered Benefits (excl. risk sharing): BPT worksheet 4, cell N39.

2b. A/B Mandatory Supplemental benefits: BPT worksheet 4, cell Q39.

Two-Year Look-Back Form

2c. Regional PPO Risk Sharing Paid/(Rec'd): not applicable; zero for all contracts.

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

3a. Marketing & sales: BPT worksheet 4, cell G41.

3b. Direct Administration: Sum of BPT worksheet 4 (cell G42, cell G45, and G46).

3c. Indirect Administration: BPT worksheet 4, cell G43.

3d. Net Cost of Private Reinsurance: BPT worksheet 4, cell G44.

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

4. Profit/(loss) Bef Taxes and Investment Income: 1e minus 2d minus 3e.

5a. Member months (excl ESRD): members on July 2006 MMR * 12.

5b. Non-ESRD risk factor: not applicable.

Footnote 2:

Incurred in Experience Year and Paid Through. The user must enter the "paid through" date.

Net Medical Expenses.

- a. **Covered Benefits (excluding risk share).** The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
- b. **A/B Mandatory Supplemental Benefits.** The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
- c. **Regional PPO Risk Share Paid/(Received).** The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
- d. **Total.** Calculates the sum of lines a through c.

Footnote 3:

Actual Incurred components of Net Reinsurance.

- a. **Private Reinsurance Premium.** The user must enter data in the first two columns.
- b. **Private Reinsurance Recoveries.** The user must enter data in the first two columns.
- c. **Net Reinsurance Cost.** The sum of lines a and b.

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 reliance on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

Actuarial Standards of Practice and Other Considerations

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

- ASOP No. 5, Incurred Health and Disability Claims.
- ASOP No. 8, Regulatory Filings for Health Plan Entities. Particular focus is placed on the sections dealing with the Use of Business Plans to Project Future Results (3.2.3), Use of Past Experience to Project Future Results (3.2.4), Recognition of Plan Provisions (3.2.5), New Plans or Benefits (3.2.6), Regulatory Benchmark (3.2.8), and Reasonableness of Assumptions (3.2.9).
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans.
- ASOP No. 23, Data Quality. Particular focus is placed on the following sections: Analysis of Issues and Recommended Practices (Section 3), Communications and Disclosures (Section 4).
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage.
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking. Particular focus is placed on the section dealing with the Extent of Documentation (3.2).
- ASOP No. 41, Actuarial Communications. Particular focus is placed on the section dealing with the Actuarial Report (3.3.3),

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

Background on previous certification process

In previous contract years (CY2006-2007), actuaries were required to prepare an actuarial certification document. These documents were uploaded to HPMS by the plan sponsor with the initial June bid submission.

During the bid review process, resubmissions may occur for a variety of reasons in order to revise the bid package (i.e., the bid pricing and/or benefits). In such circumstances, the initial certification submitted may become outdated. There was confusion among plan sponsors regarding when/if a certification needed to be re-uploaded for certain types of resubmissions.

In CY2007, CMS attempted to address these issues. In addition to the initial certification, plan sponsors were required to upload a “final” certification in late August. While no material changes were permitted to the certification language, actuaries were expected to update the certification document to contain certain HPMS references to the final bid that was pending CMS approval.

While this alleviated some of the certification issues, other concerns with the certification process still remained. Not all certifying actuaries had access to HPMS, which created several problems. First, actuaries could not view the uploaded Bid Pricing Tool, Plan Benefit Package, and certification to ensure that they were on a consistent basis. Secondly, CMS sometimes released bidding guidance through HPMS, which actuaries could not easily access. And lastly, when the final certifications were being prepared, actuaries had a difficult time obtaining the HPMS bid references to include in the final certification.

In addition to the HPMS access issues, the certification process itself was not efficient. Actuaries needed to prepare multiple free-form text documents (for each bid submitted). When the final certifications were submitted in August, CMS had little time to re-review these documents before the bid approval process was scheduled to begin. And there continued to be confusion among plans regarding when/if a revised certification was required for intermittent resubmissions.

New certification process for CY2008

CMS is striving to create a more efficient and effective certification process for CY2008.

As part of this new process, all CY2008 certifying actuaries are required to have user access to HPMS. Actuaries will have access to the bid package uploaded (BPT, PBP, substantiation, etc.) to ensure their consistency. Actuaries will have access to any guidance that may be released by CMS via HPMS. And most importantly, *the only way to certify a bid in CY2008 will be through a new certification module within HPMS.* (The previous process of uploading certification documents will be replaced by the new certification module.)

The new certification module will contain the following features:

- Standardized required language (the required elements are described below in a subsequent section)
- The ability to append free-form text language to the required standardized language
- A summary of key information from the submitted bids
- Links to additional information regarding the bid package (such as the PBP, BPT, substantiation, etc.)
- The ability to certify multiple bids/contracts
- The ability to print and save the submitted certification

The new module will eliminate the need for actuaries to prepare and upload separate certification documents to HPMS. The new certification module/process is similar to the Benefit Attestation module/process that plan sponsors currently complete in HPMS.

An initial actuarial certification must be submitted via the new certification module in June. And then in late August, the actuary must certify the final bid (that is pending CMS approval) via the new certification module. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but may do so if they choose to.

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

Applying for access to the new certification module

All certifying actuaries and plan sponsors must take action to gain access to the new certification module. This includes:

- All actuaries certifying the MA portion of a bid (i.e., MA BPT)
- All actuaries certifying the Part D portion of a bid (i.e., PD BPT)
- Consulting actuaries who will be certifying bids for a plan sponsor
- Health plan staff actuaries (i.e., actuaries employed by the plan sponsor) who will be certifying bids

Even actuaries with current HPMS access must still take action to gain access to the new certification module.

Detailed instructions on how to apply for access to the new certification module were released via HPMS on March 9, 2007. The memo was also e-mailed to the certifying actuaries on file from last year. Below contains instructions on how to apply for the module, based on that memo.

Step 1: All certifying actuaries who do not have current HPMS access must submit an application form. The application requirement applies to both consulting actuaries and health plan staff actuaries. If the certifying actuary already has user access to HPMS, then skip step 1 and proceed to step 2.

Complete the following:

Download the *Application for Access to CMS Computer Systems* form at: <http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf>

Complete the form as follows:

- a) Section 1 – Check “New” as the type of request.
- b) Section 2 – Check “Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only”.
- c) Section 3 – Enter the contract number(s) for which you will be submitting actuarial certifications for CY 2008.
- d) Section 4 – Check the first row beneath the “Default Non-CMS Employee” row (i.e., place a check in the Connect box of the third row). On the blank line beside your check mark, write “HPMS_P_CommlUser”.
- e) Section 5 – State briefly that you require HPMS access to submit the actuarial certification. Also indicate whether you are employed by the contracting organization or whether you are under contract as an actuarial consultant with the contract organization(s).

- f) Section 6 – Leave blank.
- g) Sign and date the Privacy Act Statement on page 3 of the form. Also enter your name and Social Security Number at the top of page 3. This step is critical to ensuring the successful processing of your request.

Common mistakes to avoid when completing the application form:

- You must include the contract number(s) in Section 3 for which you will be submitting an actuarial certification.
- You must always provide a Social Security Number. CMS will not process a request without this piece of information.
- You must complete the form in ink, not pencil.
- You must submit the original hardcopy form with an original signature and date.
- Photocopies and faxes are not acceptable.

Step 2: All certifying actuaries must submit an official letter from each plan sponsor that they intend to certify bids for in CY2008. The letter requirement applies to both consulting actuaries and health plan staff actuaries, and also applies to actuaries who have current HPMS access.

Letter requirements:

- The letter must specify the contract number(s) and type of functionality required by the certifying actuary:
 - Actuarial Certification Profile only
 - Actuarial certification submission functionality, and related PBP and BPT reports
 - Actuarial Certification Profile and Plan Profile
 - Actuarial certification submission functionality and related reports, as well as all other standard plan functionality, including bid upload, formulary upload, marketing submission, etc.
- The letter must be provided on the organization's official letterhead, with an original dated hardcopy signature of a senior official of the plan sponsoring organization.
- If the certifying actuary already has HPMS access (and has skipped step 1), then the official letter must include the HPMS user ID of the actuary and an explanation that the user already has HPMS access.

CMS recommends using the following sample language for the letter (to be prepared on the organization's letterhead):

(Date of Letter)

Ms. Sara Walters,
(Name of Organization) hereby requests that *(Name of Actuary)* with the firm of *(Name of Consulting Firm, if applicable)* requires HPMS access to submit actuarial certifications on our behalf. *(Name of Actuary)* requires access to the following contract number(s):
(list specific contract numbers).

(Name of Actuary) requires the following HPMS access (please check one box):

- Actuarial Certification Profile only (actuarial certification submission functionality and related PBP and BPT reports)

- Actuarial Certification Profile and Plan Profile (actuarial certification submission functionality as well as all other standard plan functionality, including bid upload, formulary upload, marketing submission, etc.)

[If the actuary currently has HPMS access, then add a sentence to indicate that the actuary already has HPMS access and to indicate what is their HPMS user ID.]

If you have any questions, please feel free to contact me at *(phone number)*.

Sincerely,
(Signature of Plan Sponsor senior official)
(Name and title of Plan Sponsor senior official)

Step 3: Consider the following:

If a certifying actuary is serving multiple plan sponsors (for ex., as a consulting actuary), only one application is required, but a letter must be provided from each plan sponsor for which the actuary will be serving as an agent in HPMS.

At least one letter from a plan sponsor must be included with the application in order for the HPMS access request to be processed. Please note that additional letter(s) from other plan sponsor(s) may be submitted following the initial submission for HPMS access.

If the certifying actuary already has HPMS access, they do not need to resubmit the application form (i.e., may skip step 1), but they still must submit the letter (see step 2).

Plan sponsors can have multiple actuaries assigned to one contract to perform the certification module. 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 Hxxxx-002. The instructions contained in this appendix should be followed by all actuaries who will be doing any certification(s) for CY2008 bid(s).

Step 4: Submit the letter(s), and any applications, to CMS as soon as possible:

Please submit the original (not a copy) application and the corresponding organization letter(s) via traceable carrier to:

Ms. Sara Walters
Re: Actuarial HPMS Access
7500 Security Blvd.
Location: C4-17-05 / Mailstop: C4-14-21
Baltimore, MD 21244

If you have any questions regarding the certification access instructions, please contact:
Sara Walters: 410-786-3330 or sara.walters@cms.hhs.gov.

Required Certification Elements

The certification module will contain the following information as part of the standardized language:

- When the certification is submitted, the certification will be “stamped” with the certifying actuary’s name/user ID and the date.
- 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(s), and segment ID(s) of the bids associated with the certification.
- The Contract Year of the bid(s) contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Prescription Drug bid, or both.
- Attestation that the certification complies with the applicable laws¹, rules², CY2008 bid instructions and current CMS guidance.
- Attestation that, in accordance with Federal law, the bid(s) 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(s) are reasonable for the plan’s benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid(s) are consistent with the organization’s current business plan.
- Attestation that the bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the bid complies with the appropriate ASOPs.
- Attestation that, in accordance with ASOP No. 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency.

If you have any questions regarding the CY2008 certification instructions, please contact CMS Office of the Actuary at actuarial-bids@cms.hhs.gov.

¹ Social Security Act Sections 1851 through 1859; and Social Security Act Sections 1860D-1 through 1860D-42.

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

Appendix B – Supporting Documentation

In addition to the bid form and actuarial certification, organizations must provide CMS with supporting material. All data submitted as part of the bid process are subject to review and audit by CMS, or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation requirements are the same regardless of the source of the assumption: whether developed by the actuary, the plan sponsoring organization, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, they are still subject to the same documentation requirements. The actuary may be asked for a list of materials that were relied on and a reliance letter. The actuary must be prepared to produce the substantiation, even if it was prepared based on a reliance.

Supporting documentation must be clearly labeled and easily understood by CMS reviewers. The substantiation should clearly identify if it is related to MA, Part D or both. The documentation for the bid must include quantitative support and details, rather than just narrative descriptions of assumptions, and identify all reliances applicable to the materials provided.

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

- Meeting minutes from any discussions related to bid development.
- Email correspondence related to bid development.
- A complete description of data sources, i.e., report name, 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 include, but are not limited to, the following items:

- A reference to the supporting documentation for another plan such as “the same as for plan Hxxxx-xxx” and not the documentation itself, i.e., the supporting documentation for a plan must be self-contained.
- A statement that the source of a pricing assumption is “professional judgment“, with no additional explanation, reasoning, supporting factors, studies, etc.
- “Living worksheets” that are overwritten with current data, (i.e. save the version of the worksheet that is used in bid preparation.)
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on inclusion in a bid 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 independently of prior bid filings.

The supporting documentation for a plan should be self-contained and not contain references such as “the same as for plan Hxxxx-xxx”.

Supporting materials must be in electronic format (i.e., 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, whereby multiple files are compressed into one file (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when selecting plans.

To expedite the bid review process, CMS requires plans to upload complete supporting documentation *with the initial June bid submission to HPMS*.

Required Documentation

Cover Sheet. Organizations often upload multiple documents that contain supporting documentation. To expedite the bid review process, organizations must upload a “cover sheet” that lists all of the supporting documentation that is uploaded or provided in the bid form.

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

Note that certain documentation requirements will apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements will only apply to bids that contain certain assumptions (for example, manual rate documentation would only apply if a bid’s projection is based on manual rates). For documentation categories that apply for a subset of bids that contain a specified assumption, the cover sheet should 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 should contain the exact bid IDs (contract/plan/segment) that the documentation applies to.

For subsequent substantiation uploads, the cover sheet should only summarize the *additional* documents uploaded at that time (i.e., the cover sheet should not be maintained as a cumulative list). The subsequent cover sheets should also contain the exact bid IDs, rather than a “range” of bid IDs.

Sample cover sheets for the initial bid submission, and for subsequent substantiation uploads, are provided at the end of Appendix B.

Initial June Bid Submission. CMS requires that the following supporting documentation be uploaded to HPMS *with the initial June bid submission*:

Documentation requirements that apply to all bids (as all bids contain the following assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that gives relevant information about plan design, the product positioning in the market (i.e., high/low), changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.
- Support for non-benefit expense assumptions (Worksheet 4). See the instructions for Worksheet 4 for a description of appropriate documentation.
- Justification of the gain/loss margin (Worksheet 4). See the instructions for Worksheet 4 for a description of appropriate documentation.
- Detailed support for the development of projected risk scores (Worksheet 5). See the instructions for Worksheet 5 for a description of appropriate documentation.

Documentation requirements that apply to all bids that contain the following specified assumptions:

- Information regarding the base period member month distribution, if more than four plans comprise the base period data (see Worksheet 1, Section II line 5).
- Support for the credibility assumptions (Worksheet 2), if the assumptions differ from the CMS guidelines included in these instructions.
- Support for the manual rate development (Worksheet 2), if a manual rate is used. See the instructions for Worksheet 2 for a detailed description of appropriate documentation for manual rates.
- Support, at the benefit level, for any significant projected allowed costs, (i.e., PMPM > \$5.00) for Non-Covered services (Worksheet 2, lines l through s, column o), if any.
- Detailed description of the process used for adjusting cost sharing due to maximum out-of-pocket limits (Worksheet 3).
- Support for the cost sharing test if a plan does not fall within the allowable limit (Worksheet 4, Section III).
- Support for the development of the Contract Year ESRD “subsidy” (Worksheet 4).
- Support for the development of plan-provided ISAR factors (Worksheet 5), if used (applies to RPPOs only). A description of the methodology and data source(s) used to calculate the ISAR scale(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (i.e., non-benefit expense and gain/loss margin) that were assumed in the development of the factors.
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, if used. (Indicated in the General Information section of Worksheet 1.)

Upon Request by CMS Reviewers. The following items are not required to be uploaded with the initial June bid submission, but must be prepared around that time in order to be readily available to provide to CMS reviewers upon request. If these materials are requested by CMS reviewers, the requested substantiation is expected to be provided within 48 hours. These materials will be reviewed at audit:

- Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
- Support for projection assumptions (Worksheet 1).
- 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).

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- Further support on the benefit, non-benefit expenses and gain/loss margins for specific Optional Supplemental Packages (Worksheet 7).
- Aggregate contract-level optional supplemental experience for CY2006 (Worksheet 7).
- Justification for significant differences in the assumptions between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark). See Appendix D for more information.
- Additional level of detail regarding the two-year look-back information, for example: to separate SNP and non-SNP bids (Two-Year Look-Back Form).
- If applicable, a list of materials that were relied on and an accompanying reliance letter.
- Communication between CMS reviewers and the organization throughout the bid review process (i.e., e-mail communication).
- Additional information (not specified in this list) may be requested by CMS reviewers, as needed.

Sample Cover Sheet – Submitted with initial bid upload**Supporting Documentation Cover Sheet
CY2008 Bid Submission****Organization Name:** Health One**Contract(s):** H1234, H9999, and S9999**Date:** June 1, 2007

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 6-1-07.doc	n/a	both
Product Narrative	All bids	Cover 6-1-07.doc	Pages 2+	both
MA and Part D Non-Benefit Expenses	All bids	AdminProfit.xls	Sheet1	both
MA and Part D Gain/Loss Margins	All bids	AdminProfit.xls	Sheet2	both
MA and Part D Risk Scores	All bids	Risk CY08.xls	MA-Sheet 1 PD-Sheet 2	both
MA and/or Part D Manual Rate Development, if projection(s) based on manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
MA Base period member month distribution (if >4 plans used)	H1234-002-0	N/A (contained in the MA BPT)	MA BPT Worksheet 1, Section II line 6 text box	MA
MA Credibility assumption if differs from CMS guidelines	N/A			
MA Significant Non-Covered allowed costs, if any	N/A			
MA Adjustment to cost sharing for OOP max	N/A			
MA Cost sharing test, if outside limits	N/A			
MA ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA
MA ISAR factors, if used	N/A			
MA Actuarial swaps/ equivalences, if used	N/A			
Part D rebate and discount assumptions	All bids	Manual.xls	Section III	PD
Part D credibility assumptions	All bids	PartD.xls	"Credibility" worksheet	PD
Part D base period experience development	H1234-001-0 H1234-002-0 H1234-004-0 H9999-001-0 S9999-001-0	PartD.xls	"Base" worksheet	PD

Sample Cover Sheet – Submitted with subsequent substantiation uploads

**Supporting Documentation Cover Sheet #2
CY2008 Bid Submission**

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: July 16, 2007

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 7-16-07.doc	n/a	both
Reliance Letter	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0	Reliance CY08.pdf	n/a	both
E-mail communication with CMS Bid Reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	E-mail1.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

Appendix C – Part B-Only Enrollees

Medicare beneficiaries with Medicare coverage only under Part B cannot elect an MA plan after December 31, 1998 unless they are 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 shall be 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 (i.e., members eligible for both Part A and Part B of Medicare), the plan is not required to submit a separate bid for the Part B-only members.

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

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

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/union-only group waiver plans (i.e., “800-series” plan IDs).

Individual-Market Plans (“mixed enrollment” plans)

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

Actuarial Swaps. If 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. You need to identify only those benefits in your bids that are candidates for swaps. When you make specific swaps in negotiations with employers or unions, in the context of the CMS general approval of your candidates, you can do so 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.

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 you send to CMS. Unlike the actuarial swapping flexibility, this customization can apply to both Medicare-Covered benefits and Non-Covered benefits.

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

The Medicare Modernization Act (MMA) provides employers and unions with a number of options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the MMA, those options include making special arrangements with MA organizations to purchase customized benefits for their active employees and retirees or contracting directly with CMS to sponsor a Medicare Advantage plan.

Under Sections 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for these kinds of arrangements that “hinder the design of, the offering of, or

the enrollment in” these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of MA plan entities: (1) MA organizations that offer or administer employer/union-only sponsored group waiver plans (“EGWPs” or “employer-only group plans”); and (2) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan (“Direct Contract” EGWPs).

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

CMS also has issued guidance on employer and union MA plans in Chapter 9 of the *Medicare Managed Care Manual*:

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

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

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

- Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year. These assumptions include, but are not limited to, the following: risk scores, geographical distribution of enrollees, non-benefit expenses, and gain/loss margins.
- The cost sharing priced in worksheet 3 must correspond to that contained in the Plan Benefit Package (PBP). The PBP can either be prepared using the expected composite benefit plan or may be based on the Medicare fee-for-service benefit provisions.
- Generally, CMS would expect that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience. Organizations must provide documentation in support of differences in actuarial/financial assumptions between the corresponding products.
- There is no requirement to charge the filed MA basic and supplemental premium to each employer or union group that enrolls in the plan. However, the average premium charged, weighted by enrollees, across all groups enrolled in the plan should correspond to (i.e., be consistent with) the filed premium. This rule on premiums will not apply when the Medicare fee-for-service bidding approach is utilized since these filed plans, and resulting premiums, are not an accurate depiction of what is actually being offered to employer/union groups.
- The following are the guidelines for rebates:
 - Similar to CMS’ payment on behalf of beneficiaries enrolled in individual market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an employer-only group plan.

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

For regional PPO plans, the initial bid submission in June contains an estimated MA premium. The actual MA premium will not be known until August, when the regional benchmarks are calculated by CMS. Note that after the MA regional benchmarks are released by CMS, all regional MA plans are required to resubmit the MA BPTs in order to reflect the actual plan bid component (in Worksheet 5 cell K17). Regional MA plans may need to re-allocate rebates accordingly. Note that this requirement also applies to EGWP regional MA plans (i.e., all EGWP RPPOs are required to resubmit the MA BPTs in August after the announcement of the regional MA benchmarks).

The CY2008 Call Letter may contain additional guidance regarding employer-only group bidding.

Please refer to the announcement released via HPMS on February 28, 2007 regarding the CY2008 Part D EGWP bidding policy. Another announcement was released via HPMS on April 3, 2007 to clarify the bidding requirements for EGWP bids.

Appendix E – Plans Serving Qualified Medicaid Beneficiaries (QMBs)

The following guidance was released in the CY2007 Call Letter regarding plans serving QMBs.

Bidding Instructions for Plans Serving Qualified Medicare Beneficiaries

The MA bidding rules specify that the development of contract year total allowed medical expenses, which are reflected on a per-member per-month (PMPM) basis, include the sum of projected plan reimbursements and enrollee cost sharing. The plan reimbursements reflected in the bid must reflect the actual projected plan payments to providers for health care services.

The basis of each category of enrollee cost sharing is the product of per-service requirements, as reflected in the plan benefit package (PBP), and expected utilization. MA plans subtract from total allowed medical expenses the PMPM value of fee-for-service Medicare actuarially equivalent cost sharing.

Section 1902(a)(10)(E)(i) of the Act requires State Medicaid Agencies to pay cost sharing amounts on behalf of Qualified Medicare Beneficiaries (QMBs). (The term QMB is defined in section 1905(p)(1) of the Act.) Paragraphs (n)(1) and (2) of section 1902 of the Act provide authority, when certain conditions are met, for State Medicaid agencies to reduce or eliminate cost sharing amounts on behalf of such beneficiaries through the State Medicaid Plan. In such cases paragraph (n)(3) exempts QMB beneficiaries from paying Medicare Advantage plan Medicare cost sharing (see section 1905(p)(3)) and requires providers to accept the sum of Medicare Part C payments and any amount paid (or reduced/eliminated) by the State Medicaid Agency as payment in full for the item or service in question.

The MA Organization determines what level of cost sharing it wishes to have for any given MA plan. This is true for all plans, including those that primarily serve QMBs. The MA Organization may determine the desired level of plan cost sharing irrespective of whether a state Medicaid agency will pay the plan or its providers some, all or none of this cost sharing for QMBs.

These instructions clarify that the cost sharing component of the bids filed on behalf of QMBs must reflect plan cost sharing, as reflected in the PBP. That is, the cost sharing component of allowed medical expenses will include all cost sharing charged by the plan, even though some or all of that cost sharing may not be paid to the plan or its providers because of the application of SSA Section 1902(n). In other words, regardless of whether a state Medicaid agency pays on behalf of a QMB some, all, or no cost sharing — either directly to the provider, or through a contractual arrangement with the MA Organization — the full level of plan cost sharing must be reflected in the development of allowed costs (MA bid Worksheet 2) and enrollee cost sharing requirements (MA bid Worksheet 3). Please note that this guidance is not intended to limit an MA Organization's flexibility to determine how much to pay its providers or how to determine projected payments to providers.

For example, an MA plan that charges cost sharing that is actuarially equivalent to full Medicare fee-for-service will include the PMPM equivalent of full Medicare fee-for-service

cost sharing in their allowed costs. Per SSA Section 1902(n), CMS will consider Medicaid payments made on behalf of any QMBs enrolled in this MA plan as meeting the cost sharing obligation of these individuals.

This guidance does not change the requirement that plan cost sharing in the PBP must be the same for all enrollees. Therefore, if an MA Organization offers a plan that serves both QMBs and non-QMBs and includes cost sharing that is less than that charged in Medicare fee-for-service, the cost sharing component of the plan's allowed costs must reflect this plan-level cost sharing for both QMBs and non-QMBs.

Reimbursements of QMB cost sharing by Medicaid State Agencies may take the form of a payment to either MA Organizations or the providers. The reimbursements reflected in the allowed cost component of each bid must reflect the projected payments from the MA Organization to the providers, less any projected payments from Medicaid agencies to the MA organization for cost-sharing. Payments made directly from Medicaid State Agencies to providers should not be netted from allowed costs. To the extent that the provider does not collect from the State Medicaid agency (either directly or through the MA Organization) the full amount of cost sharing, CMS does not consider the plan to be waiving the Part C cost sharing amounts.

These instructions are consistent with last year's QMB bidding instructions and there is no change intended.

Appendix F – Rebate Reallocation and Premium Rounding

The following guidance was released in the CY2007 Call Letter regarding the rebate reallocation period and premium rounding.

In addition, the CY2008 Call Letter may contain additional guidance regarding rebate reallocation.

Rebate Reallocation and Premium Rounding

This guidance is organized into five sections: Section I presents terminology. Section II discusses rules for rebate reallocation by plan type. Section III provides guidance for changes that can be made to funding of Part D and Part C benefits during the rebate reallocation period. Section IV covers several additional topics, and Section V discusses premium rounding rules.

I. Terminology

Rebate Reallocation Period. Following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks, MA organizations may reallocate Part C rebate dollars in the MA bid pricing tool for certain MA plan bids (BPT). Rebate reallocation is one aspect of the annual MA bid negotiation process that takes place in August. Rebate reallocation is required for some MA plans, is optional for others, and is not allowed for certain plans, as discussed in this guidance.

The rebate reallocation period is about five to seven business days. After changes to rebate allocation and/or premium rounding, the MA organization will re-submit the bid package via HPMS. CMS will announce the exact dates of the rebate reallocation period at the time we publish the Part D and MA regional plan amounts.

Target Part D basic premium. The target Part D basic premium is the Part D basic premium net of any Part C rebate dollars that were applied to reduce (buy down) the premium. MA organizations will provide the target Part D basic premium in the initial June bid submission via the bid pricing tools. Once CMS publishes the national average Part D bid and other amounts, CMS calculates each plans' actual Part D basic and actual total plan premium. MA organizations that are required, or that can opt, to reallocate rebate dollars to return to the target Part D basic premium can do so only during the rebate reallocation period.

Standard Part B premium. The standard Part B premium is the full-subsidy monthly Part B premium amount. Beginning in 2007, beneficiaries meeting specified income thresholds will have a monthly adjustment amount added to the full-subsidy amount. Given the MA requirement of uniform premiums within a plan, effective 2007, the lowest Part B premium an MA plan can offer is the estimated standard amount net of rebates. This may not result in a zero Part B premium for all enrollees. OACT will continue to provide the estimate of the standard Part B premium each year for bidding purposes.

II. Rebate Reallocation Rules – When Can Rebate Be Reallocated?

II.A. MA-only Plans.

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final CY premium, as these plans are not affected by calculations of the Part D national average bid or the MA regional plan benchmarks. Thus, the rebate reallocation period does not apply to local MA-only plans. That is, MA organizations will **not** have an opportunity during the rebate reallocation period to resubmit local MA-only plan bids to round their premiums. If an MA organization desires a “whole-dollar” premium, it should be submitted as such in the initial June submission.

II.B. Local and Regional MA-PD Plans with No Part C Rebate Dollars.

Local and regional MA-PD plans with no Part C rebate dollars would only participate in the Rebate Reallocation Period to round premiums in order to adjust the Part D basic premium resulting from application of the Part D national average bid. See Section III.B.4. for the case where the plan’s target Part D basic premium is the Low Income Premium Subsidy (LIPS) amount.

Regional MA-PD plans with no Part C rebate dollars in the initial June bid submission that end up with rebate dollars after comparison of the final MA regional benchmark to the plan bid must participate in rebate reallocation to apply those rebate dollars to fund reduction(s) in supplemental benefit premiums, a Part B premium reduction, and/or a return to the target Part D basic premium.

II.C. Local and Regional MA-PD plans that Allocated Excess or Insufficient Part C Rebate to the Part D Basic Premium

Organizations must provide in the MA BPT the target Part D basic premium. The MA organization has two options for specifying the target Part D basic premium: (1) The low-income premium subsidy benchmark for the region (i.e., whatever amount is equivalent to a zero premium for full subsidy low-income beneficiaries); or (2) a specific dollar amount net of Part C rebates (e.g., zero).

Once CMS has announced the national Part D Base Beneficiary Premium, the resulting Part D basic beneficiary premium may be higher or lower than the plan’s target premium. If more rebate dollars were allocated to achieve the plan’s target premium than are actually needed, this “excess” allocation results in premium lower than the target premium. This includes the possibility that the resulting premium is a negative number. Conversely, if none of the Part C rebate dollars were allocated to achieve the plan’s target Part D basic premium or if not enough rebate dollars were allocated to achieve the plan’s target premium, this “insufficient” allocation results in a premium is higher than intended.

Below are the rules for addressing excess and insufficient rebate allocation to the Part D basic premium.

II.C1. Rebate reallocation to adjust the Part D basic beneficiary premium (net of rebate) must return to the target premium provided in the initial June bid submission. We will not accept a partial return to the target premium except in the following situation: where the plan intends to return to the target premium and all of the rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

II.C2. If the Part D basic beneficiary 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 premium resulting from application of the National Average Monthly Bid Amount and the Base Beneficiary Premium is negative, the “excess” rebate allocated to buy-down the Part D basic premium must be reallocated to buy-down the Part C or Part D supplemental premiums or the estimated Part B standard premium, in order to return to the target premium.

Example II.C2: Required Rebate Reallocation, given “Excess” Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	\$36
	Identify target premium (post-rebate premium)	\$0
	Determine rebate amount to apply to pre-rebate D basic premium to “buy down” to target	\$36
August – Part D benchmarks published	Outcome of nat’l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	\$34 -\$2 [\$34-\$36]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	\$34 [\$34 – 0]
	Calculate “excess” rebate [June rebate – August rebate]	\$2 [\$36-\$34]
Rebate Reallocation Required	MA organization must reallocate \$2 of “excess” rebate to other benefits to return to target premium of \$0	

In example C2 above, 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.

II.C3. Rebate reallocation to reduce the premium for Part C or D supplemental benefits is optional if the Part D basic beneficiary premium (net of rebate) is lower than the target premium but not less than zero.

The MA organization has two options: leave the final Part D basic premium (net of rebate) unchanged (i.e., at the level resulting from application of the National Average Monthly Bid Amount and the Base Beneficiary Premium); or reallocate rebate to fund other portions of the plan benefit package in order to return to the target D basic premium. Rebate can be reallocated to reduce beneficiary premiums for the Part C and D supplemental benefits.

If the MA organization elects to allocate the “excess” rebate dollars to the other benefits, the final Part D basic premium must be the target premium. That is, we will not accept a partial return to the target premium (see rule C1). Thus, in example C3 below, if the MA organization does not want to maintain the August post-rebate premium of \$15, only a return to \$20 is acceptable, not \$18.

Example II.C3: Optional Rebate Reallocation, given “Excess” Initial Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	\$35
	Identify target premium (post-rebate premium)	\$20
	Determine rebate amount to apply to pre-rebate D basic premium to “buy down” to target premium	\$15
August – Part D benchmarks published	Outcome of nat’l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	\$30 \$15 [\$30-\$15]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	\$10 [\$30-\$20]
	Calculate “excess” rebate [June rebate – August rebate]	\$5 [\$15-\$10]
Rebate Reallocation Options	(a) No rebate reallocation; leave at post-rebate D basic premium of \$15.	
	(b) Reallocate \$5 of “excess” rebate to other benefits to return to target premium of \$20	

II.C4. Rebate reallocation from the Part C or D supplemental premiums to the Part D basic premium in order to meet the target premium is optional if the Part D basic beneficiary premium (net of rebate) is higher than the target premium.

The MA organization has two options: leave the final Part D basic premium (net of rebate) unchanged (i.e., 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 reduction of Part C and D supplemental premiums or the estimated Part B standard premium toward the Part D basic premium, in order to return to the target D basic premium.

If the MA organization does elect to reallocate additional rebate dollars from other benefits, the final Part D basic premium must be the target premium (see rule C1). Thus, in example C4 below, if the MA organization does not want to leave the August post-rebate premium of \$25, only a return to \$20 is acceptable, not \$23.

Example II.C4: Optional Rebate Reallocation, given “Insufficient” Initial Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	\$35
	Identify target premium (post-rebate premium)	\$20
	Determine rebate amount to apply to pre-rebate D basic premium to “buy down” to target premium.	\$15
August – Part D benchmarks published	Outcome of nat’l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	\$40 \$25 [\$40-\$15]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	\$20 [\$40-\$20]
	Calculate “insufficient” rebate [August rebate to achieve target premium – June rebate]	\$5 [\$20-\$15]
Rebate Reallocation Options	(a) No rebate reallocation; leave at post-rebate D basic premium of \$25.	
	(b) Reallocate \$5 of rebate from other benefits to the Part D basic premium to increase total rebate to \$20, thus buying the \$40 premium down to the target premium of \$20.	

II.C5. Regional MA plans also must adjust rebate allocation to account for any increase or decrease in total rebate dollars.

Once CMS has determined the MA regional benchmarks, there may be an increase or decrease in the total rebate dollars in a regional plan bid. The allocation of rebate dollars to fund the premium for Part C or Part D basic or supplemental benefits or the estimated Part B standard premium reduction must be revised to reflect the new total.

**Example II.C5: Regional Plan Decrease in Total Rebate combined with “Excess”
Initial Allocation to Part D Basic Premium**

June - initial bid submission	Estimate total rebate dollars	\$55
	Estimate pre-rebate D basic premium	\$35
	Identify target premium (post-rebate premium)	\$20
	Determine rebate amount to apply to pre-rebate D basic premium to “buy down” to target premium.	\$15
August – Part D and MA regional benchmarks published	Outcome of nat’l Part D average bid and base premium:	\$53 \$30
	Final total rebate dollars	\$15 [\$30-\$15]
	August pre-rebate D basic premium	
	August post-rebate premium, applying June rebate allocation	
	Identify change in amount of total rebate	-\$2
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	\$10 [\$30-\$20]
	Calculate “excess” rebate [June rebate – August rebate]	\$5 [\$15-\$10]
Reconcile reduced total rebate with “insufficient” D basic allocation	\$3 [\$5-\$2]	
Rebate Reallocation Options	(a) Leave D basic premium at post-rebate premium of \$15. Subtract \$2 of rebate from other benefits to adjust for reduced total rebate	
	(b).Return to target premium of \$20. Allocate \$3 of rebate to other benefits.	

Section III. How Can Rebate Be Reallocated: Changes Allowed to Funding of Benefits during Rebate Reallocation Period

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

During the rebate reallocation period, rebate dollars 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. Changing the Part D benefit design would affect projected reinsurance due to the change in induced demand for basic Part D benefits. This change in reinsurance has an impact on the pricing of basic Part D benefits and, in turn, affects both the National Average Monthly Bid Amount and the Base Beneficiary Premium. The National Average Monthly Bid Amount and the Base Beneficiary Premium can not be recalculated after being announced; thus, there can be no change in Part D benefit design.

Specifically, this prohibition includes the rule that no changes are allowed to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits.

III.B. Allowed to Funding of the Part C Supplemental Benefits

The Part C mandatory supplemental benefit includes additional items and services not covered by Medicare and reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under original Medicare. During the

rebate reallocation period, for a plan with “excess” rebate, an MA organization could further buy down the initial Part C supplemental premium or could add new non-drug benefits (e.g., a vision benefit) to the Part C supplemental package and then buy down the new Part C supplemental premium to the initial level. Significant changes to the Part C benefits will result in additional benefit reviews. No changes in Part D benefits or pricing will be accepted.

CMS will not allow MA organizations to substantially redesign Part C supplemental benefits during the rebate reallocation period. We expect only marginal adjustments during the rebate reallocation period, and we will evaluate reallocations for differences in materiality.

Example: acceptable change in supplemental cost sharing. After application of the National Average Monthly Bid Amount and the Base Beneficiary Premium, an MA-PD plan’s Part D basic premium shifts from \$0 to -\$3, which means it has credited \$3 of rebate where it is not needed. Rebate reallocation is required. The MA organization may decide to reallocate this \$3 to buy-down the cost of a benefit in the Part C mandatory supplemental package.

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

III.B1. Administrative costs and gain/loss margins.

If the value of non-drug additional benefits is being increased as a result of reallocating rebate, there will be changes in the supplemental administrative costs and the gain/loss margin that reflect the new level of the benefit. Administrative costs and the gain/loss margin are allocated proportionately. Therefore, we will allow only minor changes to administrative costs and margins.

III.B2. Elimination of a Part C supplemental benefit.

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

The value of the added or eliminated Part C supplemental benefit should match the amount of rebate that must be shifted to return to the Part D target premium. For a regional plan, the value of added benefits should match the net shift in total Part C rebate dollars due to an increase or decrease in those total rebate dollars after application of the regional benchmark and/or returning to the Part D target premium.

We reiterate that we will not allow substantive redesigning of the Part C supplemental package. For plans with excess rebate, we will not allow the MA organization to eliminate one additional benefit and add another additional benefit.

III.B3. First-time allocation of rebate dollars to the Part D basic premium during the rebate reallocation period.

Some MA-PD plans with Part C rebate dollars may have opted in the June bid submission to not allocate any of the rebate to buying down the Part D basic premium. For these plan bids, if the Part D basic premium after application of the National Average Monthly Bid Amount

and the Base Beneficiary Premium ends up lower or higher than the target premium, CMS would allow a return to the plan's target premium. No partial return would be allowed.

In the first situation where the Part D basic premium ends up lower than the target premium, the MA organization may return to the target premium by adding an additional benefit to the Part C supplemental package, including the appropriate level of administrative cost and gain/loss margin. This additional benefit must have a value equal to the difference between the Part D basic target premium and the post-national average Part D basic premium.

For example, if no Part C rebate dollars were allocated to buy-down the Part D basic premium, resulting in a target premium of \$25, but the plan's Part D basic premium ended up being \$23, the MA organization could add an additional benefit worth \$2 pmpm to the Part C supplemental benefit to return to the target premium.

III.B4. MA-PD Plans with no Part C rebate and LIPS as Target Part D Basic Premium

If an MA-PD plan, including a Special Needs Plan, has no Part C rebate and specified that the Low Income premium subsidy amount is the target premium, but ends up with a Part D basic premium above the Low Income subsidy amount after the application of the National Average Monthly Bid Amount and the Base Beneficiary Premium, the plan cannot return to the target premium. The plan cannot have a final Part D premium that is zero for the full subsidy Low Income beneficiaries.

III.C. Changes Allowed to the standard Part B premium reduction.

The other use of rebate dollars allowed under §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars may be shifted into or away from funding a reduction in the estimated standard Part B premium, under the reallocation rules described in other sections. Note that the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount of the estimated standard Part B premium. OACT will continue to provide the estimate of the standard Part B premium each year for bidding purposes.

Section IV — Miscellaneous Guidance

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

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

IV.B. MA organizations must meet the §423.104(f) requirement on type of drug coverage offered by certain plans, and must reallocate 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 either 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 (i.e., 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 requirement. If necessary, MA organizations must reallocate rebate dollars from other benefits to achieve the required Part D supplemental benefit in the plan.

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

IV.C. Local MA Plan Segments.

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

The plan's health care benefit package must be the same across plan segments. However, the Part C package can be priced differently across segments, e.g., basic and supplemental premiums and cost-sharing may differ across segments.

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

Section V. Rules for Rounding Premiums

1. The bid pricing tools round the following premiums to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements: Part C (the sum of basic + mandatory supplemental), Part D basic and Part D supplemental. No pennies are allowed.

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

Rebate dollars allocated to reduce the Part C mandatory supplemental premium are still 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.

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 they are not affected by the Part D National Average calculation or the MA regional plan benchmark calculations. Local MA-only plans will **not** have an opportunity to resubmit bids to round their premiums. Therefore, if an organization desires a “whole-dollar” premium, it should be submitted as such in the initial June submission.

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

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

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

The rebate reallocation period is not an opportunity to significantly change the benefit package or the bid. For example, one-half of one percent (0.5%) of revenue is considered by CMS to be a significant amount of the average gain/loss margin, and thus a significant change in the bid.

Examples of rounding.

Example (a): An MA-PD plan has no premium for A/B basic or supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This could happen if: (1) the bid equals the benchmark and no A/B supplemental benefits are offered; or (2) the bid is less than the benchmark, the plan has A/B mandatory supplemental benefits, and applies rebates to reduce the Part C supplemental premium to zero. If the post-national-average-drug-bid total plan premium is \$30.42, the MA organization could round the plan premium to \$30.00, and slightly reduce the gain/loss margin for Part A/B benefits to result in the \$0.42 premium reduction. (The gain/loss margin for Part D benefits may not change.)

Example (b). An MA-PD plan has no premium for A/B benefits or supplemental benefits, and an initial basic Part D premium (target premium) of \$30. (This could happen if the bid equals the benchmark and no A/B supplemental benefits are offered or if the plan applies rebates to reduce the Part C supplemental premium to zero). If the post-national average drug-bid results in a total plan premium of \$32.42, the MA organization could opt to make a slight reduction in the gain/loss margin for A/B benefits that would result in a \$0.42 premium reduction and a premium of \$32.00.

The MA organization could not round 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 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-national average drug-bid total plan premium is \$26.52. The MA organization can round the premium to the nearest dollar (i.e., \$27.00), up to a maximum change of \$0.50 by increasing the gain/loss margin accordingly.

Example (d). The target Part D basic premium for an MA-PD plan with A/B supplemental benefits is the Regional Low Income Premium Subsidy amount. After the Part D national average monthly bid amount is calculated, the MA-PD plan ends up with a Part D basic premium of \$32.00, which is 40 cents over the Regional Low Income Premium Subsidy Amount of \$31.60. The MA-PD plan has the following 3 options.

Option 1. The MA-PD plan can maintain its Part D basic premium of \$32.00. The plan's full subsidy eligible beneficiaries will pay a Part D basic premium of \$0.40.

Option 2. The MA-PD plan can reallocate 40 cents of the rebates that were allocated to the Part C supplemental premium to its Part D basic premium, thus reducing the premium to the Regional Low Income Premium Subsidy Amount of \$31.60. To account for the reduction in rebates applied to Part C mandatory supplemental premium, the MA-PD plan may either increase its Part C supplemental premium by 40 cents or reduce its gain/loss margin appropriately. Non-low income subsidy eligible enrollees 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 non-low-income-subsidy eligible enrollees, MA-PD plans are permitted in this situation to reallocate A/B 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 supplemental rebates to its Part D basic premium, reducing the Part D basic premium to \$31.00, the nearest whole dollar amount below the Regional Low Income Premium Subsidy Amount of \$31.60. To account for the reduction in A/B supplemental rebates applied to Part C, the MA-PD plan must increase its Part C supplemental premium by \$1.00. Please note that in this option, the MA-PD plan forgoes 60 cents in potential Low Income Premium Subsidy dollars per full subsidy eligible beneficiary.

Example (e). An MA-PD plan has 3 segments, with Part C premiums of \$51, \$76, \$110. The post-national-average-drug-bid Part D basic premium is \$37.90. To end up with whole-dollar total plan premiums, the MA organization could increase the MA gain/loss margin requirements to increase each Part C premiums by \$0.10. When added to the \$37.90 Part D premium, the total plan premium for each segment is a whole dollar amount - \$89, \$114, and \$148.

Appendix G – Suggested Mapping of MA PBP Categories to BPT Categories

The Medicare Advantage (MA) Bid Pricing Tool (BPT) contains benefit categories that do not correlate one-for-one 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. It was released on March 14, 2005 via HPMS.

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 which PBP benefit service categories are priced in each of the BPT service categories. See Worksheet 3 instructions for more details.

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

PBP line #	PBP Service Category	Corresponding BPT Category (Worksheet 3)
1a	Inpatient Hospital - Acute	a1. Inpatient Facility: Acute
1b	Inpatient Hospital - Psychiatric	a2. Inpatient Facility: Mental Health
2	Skilled Nursing Services	b. Skilled Nursing Facility
3	Rehab. Services (CORF)	h5. Outpatient Facility - Other: Other
4a	Emergency Care/Post Stabilization Care	f. Outpatient Facility - Emergency
4b	Urgently Needed Care/Urgent Care Centers	f. Outpatient Facility - Emergency
5	Partial Hospitalization	h3. OP Facility - Other: Observation; or h5. OP Facility - Other: Other
6	Home Health Services	c. Home Health
7a	Primary Care Physician Services	i1. Professional: PCP
7b	Chiropractic Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7c	Independent Occupational Therapy Services	i4. Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Except Psych (excl Radiology)	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7d	Physician Specialist Services Except Psych (Radiology)	i5. Professional: Radiology
7e	Mental Health Specialty Services - Non-Physician	i3. Professional: Mental Health
7f	Podiatry Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7g	Other Health Care Professional Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7h	Psychiatric Services	i3. Professional: Mental Health
7i	Physical/Speech Therapy	i4. Professional: Therapy (PT/OT/ST)
8a	OP Clinical/Diagnostic /Therapy Radiological Lab Services	h1. OP Facility - Other: Lab
8b	Outpatient X-Ray	h2. OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g. OP Facility - Surgery; or h. OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center Services	g. OP Facility - Surgery
9c	Outpatient Substance Abuse Services	h5. OP Facility - Other: Other

Appendix G

9d	Cardiac Rehabilitation Services	h5. OP Facility - Other: Other
10a	Ambulance	d. Ambulance
10b	Transportation	l. Transportation (Non-Covered)
11a	Durable Medical Equipment	e1. DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Monitoring Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
12	Renal Dialysis	h4. OP Facility - Other: Renal Dialysis
13a	Blood	k. Other Medicare Part B
13b	Acupuncture	r. Other Non-Covered
14a	Health Education/Wellness Programs	q. Health & Education (Non-Covered) or k. Other Medicare Part B
14b	Immunizations	i1. Professional: PCP
14c	Routine Physical Exams	i1. Professional: PCP
14d	Pap Smears and Pelvic Exams Screening	i1. Professional: PCP; i2. Professional: Specialist excl MH; or i6. Professional: Other
14e	Prostate Cancer Screening	
14f	Colorectal Screening	
14g	Bone Mass Measurement	
14h	Mammography Screening	
14i	Diabetes Monitoring	
15	Outpatient Drugs and Biologicals/Prescription Drug	j. Part B Rx
16a	Dental: Preventative Services	m. Dental (Non-Covered)
16b	Dental: Comprehensive Services	m. Dental (Non-Covered)
17a	Eye Exams	n1. Vision (Non-Covered): Professional
17b	Eye Wear	n2. Vision (Non-Covered): Hardware
18a	Hearing Exams	o1. Hearing (Non-Covered): Professional
18b	Hearing Aids	o2. Hearing (Non-Covered): Hardware
19	POS	p. POS

Appendix H - BPT Technical Instructions

CMS strongly encourages all BPT users and certifying actuaries to read the Technical Instructions before working with the CY2008 bid tools.

The CY2008 BPT Technical Instructions are located in HPMS under:
HPMS Home > Plan Bids > Bid Submission > CY2008 > Documentation > BPT Technical Instructions


If you have any technical questions regarding the Bid Pricing Tool workbooks, please contact the HPMS Help Desk at 1-800-220-2028, or via email at: hpms@cms.hhs.gov.


Appendix I – Red-Circle Validation Edits

The purpose of the “red-circle” validation rules in the bid pricing tool is:

- to highlight *some* of the fields that require data entry by the user (i.e., fields that cannot be left blank), and
- to highlight *some* data that may be invalid/ inaccurate.

In order to check for red-circle validation errors, you must click on the “Circle Invalid Data”

button  on the Standard Excel toolbar. Note: the validation edits will not be updated automatically as you enter BPT data – you must run the validation macro, to update the red circles, whenever you want to check for these types of errors. The validation macro will also be run each time the BPT is opened, and each time the BPT is saved.

There is also a report in the BPT that will list all of the cells that have red-circle validation errors. To run this report, click on the “Validation Report” button on the Standard Excel toolbar. 

This macro will create a new worksheet in the BPT that lists all of the BPT cells that currently have red-circle validation errors.

Each BPT cell that contains a validation rule has a “pop-up” box in the BPT that explains the validation rule. The following list contains brief descriptions of the validation rules of the MA Bid Pricing Tool. Towards the end of this list, there is a section that describes the “Critical Validation” errors of the MA BPT.

Worksheet 1

Section I - General Information

All fields require valid user entry in accordance with these bid instructions (i.e., the specified # of digits, capitalization and valid options). Note that three fields in this section – Plan ID, Segment ID and Region Number - must be entered as text (i.e., include a preceding apostrophe and any leading zeroes).

Section II

Line 1 – Time Period Definition

E14: Incurred From Date: valid date entry (i.e., M/D/YYYY).

E15: Incurred To Date: valid date entry after the ‘incurred from’ date.

E16: Paid through Date: valid date entry after the ‘incurred to’ date.

Line 5 – Plans in Base: Valid format of entries in first column (for ex., H9999-001). Line 5d can be entered as “All Other” if more than four plans are used as base period data. Percentage of member months in second column must total 100%.

Section III

column f : Utilization types cannot be left blank if annualized utilization/1000 and allowed PMPM are entered in columns g and i. Valid entries vary by service category as indicated in the validations’ pop-up messages.

Note that plans that use 100% manual rates must enter utilization types on Worksheet 1 for each service category that annualized utilization/1000 and allowed PMPM are entered in columns i and k of Worksheet 2.

Worksheet 2

column e: Utilization types cannot be blank if annualized utilization/1000 and allowed PMPM are entered in columns i and k. Utilization types must be entered on Worksheet 1 for all bids, including those that are using 100% manual rates.

K39: Manual Rate must be greater than zero if experience credibility (L39) is less than 100%.

column l: Experience Credibility must be 100% if projected base data (column h) is used and manual rates (column k) are not used.

column p: Percentage of Services Provided OON require valid user entry (i.e., between 0% and 100%).

line v: Manual rate description is required if manual rate is used.

Worksheet 3

column e: Measurement unit code requires user entry, for proper calculation of PMPM cost sharing values in column j. Valid entries vary by service category as indicated in the validations' pop-up messages.

column h: In-network cost sharing descriptions require user entry if in-network utilization/1000 (or PMPM) and effective copay/coinsurance are entered in columns g and i.

J67: Actual plan level in-network deductible is required if an effective in-network plan level deductible PMPM is entered in column f.

J68: Impact of in-network OOP max must be entered if there is an in-network OOP max in cell D12.

column l: Out-of-network cost sharing descriptions require user entry if out-of-network cost sharing PMPM is entered in column m.

M67: Actual plan level OON deductible is a required entry if plan type is LPPO or RPPO.

M68: Impact of out-of-network OOP max must be entered if there is an out-of-network OOP max in cell G12.

Worksheet 4

P13: Standardized plan cost sharing must be within the allowable limit (i.e., P12 must be less than or equal to P11).

columns h and i: Percentage Covered requires valid user entry (i.e., between 0% and 100%).

F41: Total cost sharing must equal the cost sharing total on Worksheet 3 cells N66.

G43, G44, G45: Non-benefit expense categories are required user entries and cannot be negative.

G47: Total non-benefit expenses cannot be negative

G48: Gain/Loss margin requires user entry (i.e., cannot be left blank).

F60: ESRD member months field requires user data entry (i.e., cannot be left blank).

Worksheet 5

E14: Medicare Secondary Payer adjustment requires valid user entry (i.e., between 0% and 100%).

column b: State/County Codes must be entered as text (i.e., include a preceding apostrophe and any leading zeroes).

G31: Use of Plan Provided ISAR cannot be “Yes” for plan types other than RPPO.

Worksheet 6

K16: Maximum premium for Part A package (for Part B Only) cannot exceed maximum value in cell L16.

Q16: If rebate allocation does not equal the CMS estimate in cell E14, then entry cannot equal “Yes”.

L30: Total rebates must not display “Incorrect Total”.

L25, L26, L27, L28, L29, L31: Rebate allocations – see critical validations list below.

R34, R40: Part D premiums – see critical validations list below.

R31, R43, R45: MA and Part D Supplemental premiums – see critical validations list below.

D39, D40, D41, D45, D46, D47, D49: Contact information fields and date prepared field require valid user entry (i.e., cannot be left blank). On critical validations list below.

R47: For MA-PD plans, the target Part D premium must be selected from drop-down menu options. For MA-only plans, the field is pre-populated with “N/A”. On critical validations list below.

Worksheet 7

column h: Package totals must be greater than zero, if package is offered.

column n: Administrative expenses must be greater than zero, if package is offered.

column q: Member months must be greater than zero, if package is offered.

Two-Year Look-Back

D6, D7: Contract number and organization name require user entry.

F57, G57: Entries cannot be negative.

J14, J15, J16, J17, J18, J29, J30, J31, J40, J41, J51, J52, J53: Require user entries and cannot be negative.

K14, K15, K16, K17, K18, K29, K30, K31, K40, K41, K51, K52, K53: Require user entries and cannot be negative.

K49: Paid Through Date must be a valid entry (M/D/YYYY).

N51, N52, N53, O51, O52, O53: Require user entries and cannot be negative.

Critical Validations for MA BPT Finalization and/or Upload:

Worksheet 6 Critical Validations

L25, L26: Rebate allocation cannot be negative and must be less than or equal to the maximum value in column m. MA rebate allocations must be rounded to two decimals.

L27: Rebate allocation (input in cell R13) cannot be negative and must be less than or equal to the maximum value in column m. Part B rebate allocation must be rounded to one decimal.

L28, L29: Rebate allocation (input in cells R35 and R41) cannot be negative and must be less than or equal to the maximum value in column m. Part D rebate allocation must be rounded to one decimal. Additionally, "800-series" plans and MA-only plans cannot allocate rebates to Part D.

L31: Unallocated rebates must equal zero.

R31, R43, R45: MA and Part D Supplemental premiums cannot be negative.

R34, R40: For MA-only plans, Part D premiums must be zero or blank.

D39:D41, D45:D47: Contact information must not be left blank.

R47: MA-PD plans must select a valid target Part D premium from the drop-down menu options. MA-only plans will have this cell pre-populated with "N/A".

Other critical validations for finalization and/or upload of the MA BPT:

If the Bid Pricing Tool is ever unprotected (via password), the finalization process of the BPT will not be possible. If the BPT is ever unprotected for any reason, the user may have to download a blank BPT and "start over" (i.e., transfer all BPT entries into a protected BPT).

The General Information section of Worksheet 1 will be compared to the corresponding PBP general info for consistency. If any fields are inconsistent, upload of the bid package will not be successful. Most of the BPT general information section input cells cannot be left blank.

The service area (counties) entered in MA BPT Worksheet 5 Section V will be validated against the service area defined by the plan in PBP/HPMS.

For MA-PD plans, the Part D premiums entered in Worksheet 6 of the MA BPT must match the premiums calculated in Worksheet 7 of the Part D BPT.

Glossary of Terms

The Medicare Advantage program uses a number of terms that have specialized meanings. Many of the terms have been used for several years (e.g., Plan Type) and are generally not included in this glossary. The terms included here are primarily those that came about as a direct result of the Medicare Modernization Act (MMA) or the development of the bid form.

A/B Mandatory Supplemental Benefits. Health care services not covered by traditional FFS Medicare (Parts A and B) that an MA enrollee must purchase as part of an MA plan. The benefits may include reductions in cost sharing for Medicare benefits, non-prescription drug benefits not covered by Medicare, and Part B and Part D premium buy-downs.

A/B Mandatory Supplemental Premium. The premium charged to an enrollee for A/B Mandatory Supplemental Benefits.

Allowed Costs. Medical costs before reduction for member cost sharing. This term is not uniquely associated with the MMA, but it has not previously been used in the Adjusted Community Rate (ACR) form.

Average 1.000 Risk Factor. Representation of an average Medicare beneficiary in terms of demographic and health status, as measured by CMS' risk adjustment models.

Basic Member Premium. The MA premium charged to an enrollee for A/B services, if the standardized bid is above the standardized benchmark.

Covered. An abbreviation for Medicare-Covered services.

EGWP. An abbreviation for Employer/Union-Only Group Waiver Plan (i.e., "800-series" plan). Also known as a group plan or employer-only group plan.

EGWP Supplemental Benefits. Benefits offered to employer/union-only groups that are above and beyond what is covered in the MA plan.

ISAR. An abbreviation for intra-service area rate. See Worksheet 5 instructions for more information about ISAR.

Local plan. An MA plan other than a Regional PPO plan type. Service areas are defined by county.

MA. An abbreviation for Medicare Advantage.

MAO. An abbreviation for Medicare Advantage Organization.

MA-PD plan. An MA plan that offers prescription drug coverage under Part D of the Social Security Act.

MA Rebate. An amount equal to 75% of Savings.

Manual Rates. Rates that are used when the base period experience data are deemed to be less than fully credible. In such cases, the projected experience rate is weighted with the

estimated costs developed under some other (fully credible) basis in the proportion to which the experience data are deemed credible. The term “manual rates” is not uniquely associated with the MMA, but it is not a term previously used in the Adjusted Community Rate (ACR) form.

Optional Supplemental Benefits. Health care services not covered by Medicare that an MA enrollee might choose to purchase as part of an MA plan.

Plan A/B Benchmark. The Standardized A/B Benchmark multiplied by the plan’s projected risk factor (for local plans).

Plan A/B Bid. The amount that the MAO estimates as its monthly required revenue to provide benefits for A/B services (at the plan’s projected risk factor).

Plan Benefit Package (PBP). The summary of benefits offered by the MA plan. Health plans fill out a separate form and submit the information to CMS.

Plan Bid Component. The weighted average of the Regional PPO A/B bids (at 1.000) based on projected enrollments.

Prescription Drug Plan (PDP). Prescription drug coverage that is offered under a policy, contract, or plan that has been approved as meeting CMS requirements and that is offered by an organization that has a contract with CMS.

Regional A/B Benchmark. The Standardized A/B Benchmark multiplied by the plan’s projected risk factor (for regional plans).

Regional Plan. A coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire MA regions, as defined by CMS. An MA regional plan (i) must have a network of contracting providers that have agreed to a specific reimbursement for the plan’s covered services, and (ii) must pay for all covered services whether provided in- or out-of-network. Service areas are defined by region.

Reinsurance. A term referring to two different concepts:
In the MA program for A/B services, reinsurance refers to the situation in which an MAO is ceding risk to commercial carriers. Also known as *private reinsurance*.
Under Medicare Part D, reinsurance refers to the Federal Government’s coverage of 80% of costs over the catastrophic coverage level.

Savings. The difference between the Plan (or Regional) A/B Benchmark and the Plan A/B Bid (not less than zero).

Special Needs Plan (SNP). Any type of MA coordinated care plan that exclusively enrolls special needs individuals.

Standardized A/B Benchmark. For local plans, the weighted average MA payment rate for the plan’s service area based on the plan’s projected enrollment. For regional plans, the benchmark is based on the Statutory Component and the Plan Bid Component. The term “standardized” indicates that the benchmark is based on a “1.000” average risk profile.

Standardized A/B Bid. The Plan A/B Bid divided by the plan’s projected risk factor (i.e., the bid at a 1.000 risk factor).

Statutory Component. The rate used in calculating the regional benchmark, based on regional rates weighted by Medicare-eligible beneficiaries.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
