

**WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS**

Note: See bid instructions for ESRD and hospice exclusions.

MA-2018.1

OMB Approved # 0938-0944 (Expires: TBD)

<b>I. General Information</b>			
1. Contract Number:		5. Organization Name:	
2. Plan ID:		6. Plan Name:	
3. Segment ID:		7. Plan Type:	
4. Contract Year:	2018	8. MA-PD:	
9. Enrollee Type:		10. MA Region:	N/A
11. Act. Swap/Equiv Apply:		12. SNP:	
13. Region Name:	N/A		
14. SNP Type:	N/A		
15. VBID:	N		

<b>II. Base Period Background Information</b>				<b>Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability</b>			
1. Time Period Definition	Incurred from: 01/01/2016 Incurred to: 12/31/2016 Paid through:		2. Member Months	3. Risk Score	4. Completion Factor	5. Bids In Base	6. Bids In Base
			Total	Non-DE#	DE#	Contr-Plan-Seg ID	Member Months
			0		0		
					0.0000		
6. Describe the source of the base period experience data							

<b>Base Period Data (at Plan's Risk Factor) for 1/1/2016-12/31/2016</b>										<b>IV. Projection Assumptions</b>						
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	
Service Category	Utilizers	Net PMPM	Cost Sharing	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments		
					Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Provider Payment Change	Other Factor	Util/1000	PMPM	
Inpatient Facility			\$0.00			\$0.00										
Skilled Nursing Facility			0.00			0.00										
Home Health			0.00			0.00										
Ambulance			0.00			0.00										
DME/Prosthetics/Diabetes			0.00			0.00										
OP Facility - Emergency			0.00			0.00										
OP Facility - Surgery			0.00			0.00										
OP Facility - Other			0.00			0.00										
Professional			0.00			0.00										
Part B Rx			0.00			0.00										
Other Medicare Part B			0.00			0.00										
Transportation (Non-Covered)			0.00			0.00										
Dental (Non-Covered)			0.00			0.00										
Vision (Non-Covered)			0.00			0.00										
Hearing (Non-Covered)			0.00			0.00										
Suppl. Ben. Chpt 4 (Non-Covered)			0.00			0.00										
Other Non-Covered			0.00			0.00										
COB/Subrg. (outside claim system)		0.00	0.00													
<b>Total Medical Expenses</b>		<b>\$0.00</b>	<b>\$0.00</b>					<b>\$0.00</b>								
Subtotal Medicare-covered service categories								\$0.00								

**V. Description of Other Utilization Adjustment Factor, Other Unit Cost Adjustment Factor, and Additive Adjustments**

<b>Base Period Summary for 1/1/2016-12/31/2016 (excludes Optional Supplemental)</b>									
	ESRD	Hospice	All Other	Total					
CMS Revenue				\$0	Non-Benefit Expenses:		8. Gain/(Loss) Margin	\$0	
Premium Revenue				\$0	7a. Sales & Marketing				
Total Revenue	\$0	\$0	\$0	\$0	7b. Direct Administration		Percentage of Revenue:		
					7c. Indirect Administration		9a. Net Medical Expenses	0.0%	
Net Medical Expenses				\$0	7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses	0.0%	
					7e. Insurer Fees		9c. Gain/(Loss) Margin	0.0%	
Member Months			0	0	7f. Total Non-Benefit Expenses	\$0			
Ms:							10a. Medicaid Revenue		
Revenue PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b. Medicaid Cost	\$0	
Net Medical PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b1. Benefit expenses		
Non-Benefit PMPM				\$0.00			10b2. Non-benefit expenses		
Gain/(Loss) Margin PMPM				\$0.00					

**WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID: N
4. Contract Year: 2018	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Projected Allowed Costs**

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

Contract Year Allowed Costs at Plan's Risk Factor:											Total	Non-DE#	DE#		
											1. Projected member months	0	0	0	
											2. Projected risk factor	0.0000	0.0000	0.0000	
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	
Service Category	Util Type	Projected Experience Rate			Manual Rate			Credibility	Blended Rate					% of svcs provided OON	
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM		
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00				
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00				
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00				
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00				
e. DME/Prosthetics/Diabetes		0	0.00	0.00		0.00			0	0.00	0.00				
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00				
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00				
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00				
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00				
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00				
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00				
l. Transportation (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
m. Dental (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
n. Vision (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
o. Hearing (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
p. Suppl. Ben. Chpt 4 (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
q. Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00				
r. COB/Subrg. (outside claim system)				0.00							0.00				
s. Total Medical Expenses				\$0.00				\$0.00	0%		\$0.00	\$0.00	\$0.00		
t. Subtotal Medicare-covered service categories				\$0.00				\$0.00	0%	CMS Guideline Credibility	\$0.00	\$0.00	\$0.00		
u. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable															

**WORKSHEET 3 - MA PROJECTED COST SHARING PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract No:	5. Org Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv		15. VBID: N
4. Contract Year: 2018	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Maximum Cost Sharing Per Member Per Year**

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network	NO	2. Out of Network	NO	3. Combined	NO
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4. Briefly explain the methodology for reflecting the impact of maximum cost sharing in Section III

**III. Development of Contract Year Cost Sharing PMPM (Plan's Risk Factor)**

(c) Service Category	(d) Description	(e) Measurement Unit Code	(f) In-Network Effective Deductible PMPM*	(g) In-Network Cost Sharing After Deductible				(i) Effective Copay / Coin Before OOP Max	(j) **Effective Copay / Coin After OOP Max	(k) In-Network PMPM	(l) Total In-Network Cost Share PMPM	(m) Out-of-Network Description of Cost Sharing / ... Benefit Limits****	(n) Out-of-Network Cost Sharing PMPM***	(o) Grand Total Cost Share PMPM (INN+OON)
				In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****									
a.1. Inpatient Facility	Acute								\$0.00	\$0.00			\$0.00	
a.2. Inpatient Facility	Mental Health								0.00	0.00			0.00	
b. Skilled Nursing Facility									0.00	0.00			0.00	
c. Home Health									0.00	0.00			0.00	
d. Ambulance									0.00	0.00			0.00	
e.1. DME/Prosthetics/Diabetes	DME								0.00	0.00			0.00	
e.2. DME/Prosthetics/Diabetes	Prosthetics/Diabetes								0.00	0.00			0.00	
f. OP Facility - Emergency									0.00	0.00			0.00	
g. OP Facility - Surgery									0.00	0.00			0.00	
h.1. OP Facility - Other	Lab								0.00	0.00			0.00	
h.2. OP Facility - Other	Radiology								0.00	0.00			0.00	
h.3. OP Facility - Other	Mental Health								0.00	0.00			0.00	
h.4. OP Facility - Other	Renal Dialysis								0.00	0.00			0.00	
h.5. OP Facility - Other	Other								0.00	0.00			0.00	
i.1. Professional	PCP								0.00	0.00			0.00	
i.2. Professional	Specialist excl. MH								0.00	0.00			0.00	
i.3. Professional	Mental Health (MH)								0.00	0.00			0.00	
i.4. Professional	Therapy (PT/OT/ST)								0.00	0.00			0.00	
i.5. Professional	Radiology								0.00	0.00			0.00	
i.6. Professional	Other								0.00	0.00			0.00	
j. Part B Rx									0.00	0.00			0.00	
k. Other Medicare Part B									0.00	0.00			0.00	
l. Transportation (Non-Covered)									0.00	0.00			0.00	
m. Dental (Non-Covered)									0.00	0.00			0.00	
n.1. Vision (Non-Covered)	Professional								0.00	0.00			0.00	
n.2. Vision (Non-Covered)	Hardware								0.00	0.00			0.00	
o.1. Hearing (Non-Covered)	Professional								0.00	0.00			0.00	
o.2. Hearing (Non-Covered)	Hardware								0.00	0.00			0.00	
p. Suppl. Ben. Chpt 4 (Non-Covered)									0.00	0.00			0.00	
q. Other Non-Covered									0.00	0.00			0.00	
s. Total			\$0.00						\$0.00	\$0.00		\$0.00	\$0.00	

t. Actual combined plan deductible: \_\_\_\_\_ \*Actual in-network plan deductible: \_\_\_\_\_ \*\*\*Actual OON plan deductible: \_\_\_\_\_

u. \*\* PMPM impact of in-network OOP max: \_\_\_\_\_ \*\*\*PMPM impact of OON OOP max: \_\_\_\_\_

\*\*\*\*NOTE: Cells H25:H64 and cells M25:M64 can be used at the discretion of the Plan sponsor. The contents are NOT uploaded in the bid submission, and will be deleted during finalization. See instructions for details.

**IV. Mapping of PBP service categories to BPT**

PBP line	BPT category
1a	a1
1b	a2
2	b
3	h5
4a	f
4b	f
4c	f
5	h5
6	c
7a	i1, i5
7b	i6
7c	i4
7d	i2, i6
7e	i3
7f	i6
7g	i6
7h	i3
7i	i4
8a	h1
8b	h2
9a	h5, g
9b	g
9c	h5
9d	k
10a	d
10b	l
11a	e1
11b	e2
11c	e2
12	h4
13a	q
13b	q
13c	q
13d, 13e, 13f	q
13g, 13h	q
14a	i1
14b	i1
14c	p
14d	i6
14e	i6
15	j
16a	m
16b	m
17a	n1
17b	n2
18a	o1
18b	o2
19a	
19b	

**WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID: N
4. Contract Year: 2018	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Development of Projected Revenue Requirement**

**A. Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability)**

Cost and Required Revenue PMPM at Plan's Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits			(g) % for Cov. Svcs		(k) FFS Medicare Actl. Equiv. cost sharing	(l) Plan cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/AE cost sh.)			(p) A/B Mand Suppl (MS) Benefits			
	(e) Allowed PMPM	(f) Plan Cost Sharing	(g) Net PMPM	(h) Allowed	(i) Cost Sharing			(m) Allowed PMPM	(n) FFS AE Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) Total	
a. Inpatient Facility	\$0.00	\$0.00	\$0.00			0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Diabetes	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00	0.00		0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Total Medical Expenses	\$0.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

**B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)**

Cost and Required Revenue PMPM at Plan's Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits			(g) % for Cov. Svcs		(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/Medicaid cost sh.)			(p) A/B Mand Suppl (MS) Benefits			
	(e) Reimb + Actual Cost Sh.	(f) Plan Cost Sharing	(g) Actual Cost Sharing	(h) Plan Reimb	(i) Allowed			(j) Cost Sharing	(m) Allowed PMPM	(n) Medicaid Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) Total
a. Inpatient Facility	\$0.00	\$0.00	\$0.00				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Diabetes	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00	0.00		0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Total Medical Expenses	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

**C. All Beneficiaries**

Cost and Required Revenue PMPM at Plan's Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits			(h) Net PMPM	(i) % for Cov. Svcs	(j) Cost Sharing	(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare-covered svcs.	(m) Medicare Covered		(p) A/B Mand Suppl (MS) Benefits		
	(e) Reimb + Actual Cost Sh.	(f) Plan Cost Sharing	(g) Actual Cost Sharing						(m) Allowed PMPM	(n) Medicaid Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.

**WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID: N
4. Contract Year: 2018	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Development of Projected Revenue Requirement**

a. Inpatient Facility		\$0.00				\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility		0.00				0.00	0.00	0.00	0.00
c. Home Health		0.00				0.00	0.00	0.00	0.00
d. Ambulance		0.00				0.00	0.00	0.00	0.00
e. DME/Prosthetics/Diabetes		0.00				0.00	0.00	0.00	0.00
f. OP Facility - Emergency		0.00				0.00	0.00	0.00	0.00
g. OP Facility - Surgery		0.00				0.00	0.00	0.00	0.00
h. OP Facility - Other		0.00				0.00	0.00	0.00	0.00
i. Professional		0.00				0.00	0.00	0.00	0.00
j. Part B Rx		0.00				0.00	0.00	0.00	0.00
k. Other Medicare Part B		0.00				0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)		0.00				0.00	0.00	0.00	0.00
m. Dental (Non-Covered)		0.00				0.00	0.00	0.00	0.00
n. Vision (Non-Covered)		0.00				0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)		0.00				0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (Non-Covered)		0.00				0.00	0.00	0.00	0.00
q. Other Non-Covered		0.00				0.00	0.00	0.00	0.00
r. ESRD		0.00				0.00	0.00	0.00	0.00
s.									
t. COB/Subrg. (outside claim system)		0.00				0.00	0.00	0.00	0.00
u. Total Medical Expenses		\$0.00				\$0.00	\$0.00	\$0.00	\$0.00
v. Non-Benefit Expense:									
1. Sales & Marketing			z1. Corporate Margin Requirement % of Rev.			\$0.00			\$0.00
2. Direct Administration			z2. Corporate Margin Basis			0.00			0.00
3. Indirect Administration			z3. Overall Gain/(Loss) Margin Level			0.00			0.00
4. Net Cost of Private Reinsurance						0.00			0.00
5. Insurer Fees			z4. Is this bid part of a valid product pairing?			0.00			0.00
6. Total Non-Benefit Expense		\$0.00	z5. Bids in Product Pairing			\$0.00	0.00	0.00	\$0.00
w. Gain/(Loss) Margin						\$0.00	0.00	0.00	\$0.00
x. Total Revenue Requirement		\$0.00				\$0.00	0.00	0.00	\$0.00
y1. Net Medical Expense % of Revenue		0.0%				0.0%			0.0%
y2. Non-Benefit % of Revenue		0.0%				0.0%			0.0%
y3. Gain/(Loss) Margin % of Revenue		0.0%				0.0%			0.0%

**III. Development of Projected Contract Year ESRD "Subsidy"**

CY member months entered by county	0		
CY ESRD member months	0		
CY Out-of-Area (OOA) member months	0		
Basic benefits (user entries must be reported as "per ESRD member per month")			
Supplemental Benefits			
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	\$0.00
		Non-ESRD CY additional benefits	\$0.00
CY Medical Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Non-Benefit Expenses for Basic Services		ESRD CY additional benefits	
CY Margin Requirement for Basic Services	\$0.00		
CY Gain/(Loss) Margin for Basic Services	\$0.00		
Cost for CY basic benefits allocated to plan members	\$0.00	Incremental CY cost of cost sharing reductions	\$0.00
		Incremental CY cost of additional benefits	\$0.00
		Total CY ESRD "subsidy" = \$0.00	

**IV. Projected Medicaid Data**

Entries must be reported as "Per Member Per Month" (PMPM).

1. Medicaid Projected Revenue	
2. Medicaid Projected Cost (not in bid)	\$0.00
2a. Benefit expenses	
2b. Non-benefit expenses	



**WORKSHEET 6 - MA BID SUMMARY**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID: N
4. Contract Year: 2018	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Other Information**

<b>A. Part B Information</b>	<b>B. Rebate Allocation for Part B Premium</b>	<b>C. Rebate Allocations</b>
1. Maximum Pt B premium buydown amt., per CMS \$109.00	1. PMPM Rebate Allocation for Part B premium (maximum value=\$109.00) <span style="background-color: yellow; border: 1px solid black; padding: 2px;"> </span>	1. Reduce A/B Cost Sharing (max. value=\$0.00) <span style="background-color: yellow; border: 1px solid black; padding: 2px;"> </span>
	2. Part B Rebate Allocation, rounded to one decimal (see instructions) \$0.00	2. Other A/B Mand Suppl Benefits (max. value=\$0.00) <span style="background-color: yellow; border: 1px solid black; padding: 2px;"> </span>

**III. Plan A/B Bid Summary**

<b>A. Overview</b>	<b>B. MA Rebate Allocation</b>	<b>C. Development of Estimated Plan Premium</b>																																																																																																																													
<table border="1" style="width: 100%;"> <thead> <tr> <th></th> <th>Medicare-covered</th> <th>A/B Mandatory Supplemental</th> </tr> </thead> <tbody> <tr> <td>1. Net medical cost</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>2. Non-benefit expense</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Gain / loss margin</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Total revenue requirement</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>5. Standardized A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>6. Plan A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>7. Risk Factor</td> <td>0.0000</td> <td></td> </tr> <tr> <td>8. Conversion Factor</td> <td>0.0000</td> <td></td> </tr> </tbody> </table>		Medicare-covered	A/B Mandatory Supplemental	1. Net medical cost	\$0.00	\$0.00	2. Non-benefit expense	\$0.00	\$0.00	3. Gain / loss margin	0.00	0.00	4. Total revenue requirement	\$0.00	\$0.00	5. Standardized A/B Benchmark	\$0.00		6. Plan A/B Benchmark	\$0.00		7. Risk Factor	0.0000		8. Conversion Factor	0.0000		<table border="1" style="width: 100%;"> <thead> <tr> <th rowspan="2"></th> <th colspan="4">Rebate PMPM Allocation</th> <th rowspan="2">Maximum Value</th> </tr> <tr> <th>Medical</th> <th>Non-Benefit</th> <th>Gain / (Loss)</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>1. MA Rebate</td> <td>n/a</td> <td>n/a</td> <td>n/a</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>2. Reduce A/B Cost Sharing</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Other A/B Mand Suppl Benefits</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Pt B Premium Buydown</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>109.00</td> </tr> <tr> <td>5. Pt D Premium Buydown Basic</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>6. 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**IV. Contact Information**

<b>MA Plan Bid Contact:</b>	
Name, Position	
Phone Number	
Email Address	
<b>MA Certifying Actuary:</b>	
Name, Credentials	
Phone Number	
Email Address	
<b>MA Additional BPT Actuarial Contact:</b>	
Name, Position	
Phone Number	
Email Address	
<b>Date Prepared</b>	

**V. Working Model Text Box**

<p>This section can be used at the discretion of the Plan sponsor. The contents are NOT uploaded in the bid submission, and will be deleted during finalization. See instructions for details.</p> <div style="background-color: yellow; height: 150px; width: 100%;"></div>
--

\* The premiums shown in lines 7 and 9 are estimates. Actual plan premiums will be calculated by CMS when the Part D National Average is determined by CMS. The premiums shown in lines 7 and 9 may not be final.

Note: Premiums are rounded to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements. See instructions for more information.

**WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract ID:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment:	7. Plan Type:	11. Act. Swap/Equip:		15. VBID: N
4. Contract 2018:	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

**II. Optional Supplemental Packages**

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

**III. Comments**

--

**IV. Base Period Summary for 1/1/2016-12/31/2016 (Note: This section must be reported at the contract level.)**

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
1. Total \$: for all OSB packages combined			\$0		
2. PMPM (based on OSB membership)	\$0.00	\$0.00	\$0.00	\$0.00	



**WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS**

Note: See bid instructions for ESRD and hospice exclusions.

MSA-2018.1

OMB Approved # 0938-0944

**I. General Information**

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:			
3. Segment ID:		7. Plan Type:	MSA		
4. Contract Year:	2018	8. Deductible Amount:			

**II. Base Period Background Information**

1. Time Period Definition	2. Member Months	5. Bids In Base	Contr-Plan-Seg ID	% of MMs
Incurred from: 01/01/2016			a.	
Incurred to: 12/31/2016	3. Risk Score		b.	
Paid through:	4. Completion Factor		c.	
6. Describe the source of the base period experience data			d.	

**III. Base Period Data (at Plan's Risk Factor)**

**IV. Projection Assumptions**

Service Category	Utilizers	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost/ Intensity	Additive Adjustments		
			Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Trend	Util/1000	PMPM
a. Inpatient Facility				\$0.00									
b. Skilled Nursing Facility				0.00									
c. Home Health				0.00									
d. Ambulance				0.00									
e. DME/Prosthetics/Diabetes				0.00									
f. OP Facility - Emergency				0.00									
g. OP Facility - Surgery				0.00									
h. OP Facility - Other				0.00									
i. Professional				0.00									
j. Part B Rx				0.00									
k. Other Medicare Part B				0.00									
l. COB/Subrg. (outside claim system)													
m. Total Medicare Covered Medical Expenses					\$0.00								

**V. Description of Other Utilization Factor and Additive Values**

--

**WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:	6. Plan Name:		
3. Segment ID:	7. Plan Type:	MSA	
4. Contract Year: 2018	8. Deductible Amount:		

**II. Projected Allowed Costs**

Contract Year Allowed Costs at Plan's Risk Factor:													
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	
Service Category	Util Type	Projected Experience Rate			Manual Rate			Exper. Cred. %	Contract Year Rate			% of svcs provided OON	
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	Allowed PMPM		
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00		
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00		
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00		
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00		
e. DME/Prosthetics/Diabetes		0	0.00	0.00		0.00			0	0.00	0.00		
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00		
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00		
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00		
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00		
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00		
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00		
l. COB/Subrg. (outside claim system)				0.00							0.00		
<b>m. Total Medicare Covered Medical Expenses</b>				<b>\$0.00</b>				<b>\$0.00</b>	<b>0%</b>		<b>\$0.00</b>		
								0%	CMS Guideline Credibility				
<b>n. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable</b>													

**WORKSHEET 3 - MSA BENCHMARK PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:	6. Plan Name:	
3. Segment ID:	7. Plan Type: MSA	
4. Contract Year: 2018	8. Deductible Amount:	

**II. Contact Information**

**MSA Plan Contact Person:**

Name, Position  
Phone Number  
Email Address

**MSA Certifying Actuary:**

Name, Credentials  
Phone Number  
Email Address

**MSA Additional BPT Actuarial Contact:**

Name, Position  
Phone Number  
Email Address

Date Prepared (MM/DD/YYYY)

**IV. Quality Bonus Rating**

1. Quality Bonus Rating	
2. New/low indicator (per CMS)	Not applicable

**III: County Level Detail and Service Area Summary**

(b)	(c)	(d)	(e)	(f)	(g)	(h)	
State/County Code	State	County Name	Projected Member Months	Projected Risk Factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	
1. Total or Weighted Average for Service Area:			0	0	\$0.00	\$0.00	Plan Benchmark
2. County Level Detail:							
<b>Out of Area</b>							

**WORKSHEET 4 - MSA ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:	6. Plan Name:	
3. Segment ID:	7. Plan Type: MSA	
4. Contract Year: 2018	8. Deductible Amount:	

**II. Development of Claim Information Intervals (Plan's Risk Factor and Exclude Services Covered Within the Deductible)**

	(c)	(d)	(e)	(f)	(g)
	Annual Projected Claim Interval	Annual Average Claim Amount	Percentage of Member Months (Only Use Highest Claim Interval)	Gross Claims (PMPM)	Gross Claims Over Deductible (PMPM)
1.	\$0-\$250			\$0.00	
2.	\$251-\$2,000			0.00	
3.	\$2001-\$4,000			0.00	
4.	\$4001-\$6,000			0.00	
5.	\$6001-\$8,000			0.00	
6.	\$8001-\$10,000			0.00	
7.	\$10,001-\$12,000			0.00	
8.	\$12,001-\$15,000			0.00	
9.	\$15,001-\$20,000			0.00	
10.	\$20,001-\$30,000			0.00	
11.	\$30,001-\$50,000			0.00	
12.	\$50,001-\$70,000			0.00	
13.	over \$70,000			0.00	
	<b>Total</b>		<b>0.00%</b>	<b>\$0.00</b>	<b>\$0.00</b>

**III. Development of Summary Information (Plan's Risk Factor)**

a. Plan Medical Expenses	\$0.00	Part A	Part B
b. Non-Benefit Expense:			
1. Sales & Marketing			
2. Direct Administration			
3. Indirect Administration			
4. Net cost of private reinsurance			
5. Insurer Fees			
6. Total Non-Benefit Expense	\$0.00		
c. Gain/(Loss) Margin			
d. Total Plan Revenue Requirement	\$0.00		
e. Projected Plan Benchmark	\$0.00		
f. Projected Monthly Enrollee Deposit	\$0.00	\$0.00	\$0.00
g. Percent of Plan Revenue			
1. Medical Expenses	0.0%		
2. Non-Benefit Expense	0.0%		
3. Gain/(Loss) Margin	0.0%		
h. Standardized Plan Benchmark	\$0.00	\$0.00	\$0.00
i. Corporate Margin Requirement % of Rev.			
j. Corporate Margin Basis			
k. Overall Gain/(Loss) Margin Level			

**WORKSHEET 5 - MSA OPTIONAL SUPPLEMENTAL BENEFITS**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:	6. Plan Name:		
3. Segment ID:	7. Plan Type:	MSA	
4. Contract Year: 2018	8. Deductible Amount:		

**II. Optional Supplemental Packages**

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

**III. Comments**

**IV. Base Period Summary for 1/1/2015-12/31/2015 (Note: This section must be reported at the contract level.)**

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
1 Total \$: for all OSB packages combined			\$0		
2 PMPM (based on OSB membership)	\$0.00	\$0.00	\$0.00	\$0.00	

**WORKSHEET 1**

**ESRD Plan Bid Submission  
Enrollment and PMPM Revenue Projection**

**ESRD-2018.1**  
**OMB Approved # 0938-0944**  
**CMS - 10142 (4/30/2017)**

**III. ESRD MSP Adjustment Factors for CY (from April Rate Announcement)**

1. Functioning Graft (i.e., postgraft) "F"	0.173
2. Dialysis / transplant ("D" / "T")	0.215

**I. General Information**

1. Contract Year:	2018	6. Contract #:	
2. Contract-Plan-Segment:		7. Plan ID:	
3. Organization Name:		8. Segment ID:	
4. Service Area:			
5. Plan type:	ESRD SNP		

**IV. Summary Data**

1. Part C Mandatory Monthly Enrollee Premium	\$0.00
2. Part C Monthly Plan Revenue	\$0.00
3. Part D Premium (basic + supplemental) net of reductions	\$0.00
4. Plan intention for target Part D basic Premium	0
5. Quality Bonus Rating (per CMS)	
6. New/low indicator (per CMS)	Not applicable

**II. Service Area Summary**

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
State/County Code	State	County Name (Func Graft)	ESRD Status D / T / F	Projected Member Months Jan.- Dec. 2018	Proj. Risk Score	CY 2018 State or County Rate	Percentage of MSP Mem. Months	Projected CMS Monthly Capitation
1. Total or Weighted Average for Service Area:				-	-	\$0.00	n/a	\$0.00
						-		
						-		
						-		

**WORKSHEET 2**  
**ESRD Plan Bid Submission**

**Projection of Revenue Requirement PMPM**

<b>I. General Information</b>		6. Contract #:	0
1. Contract Year:	2018	7. Plan ID:	000
2. Contract-Plan-Segment:	0_000_00	8. Segment ID:	00
3. Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

Section II Projection of Revenue Requirement PMPM				Mandatory Supplemental Benefits			
Service category	Allowed cost	Enrollee cost sharing	Net PMPM	Medicare AE cost sharing proportion	Medicare AE cost sharing value	Cost sharing enhancements	
Inpatient hospital			\$0.00	6.4%	\$0.00		\$0.00
Skilled nursing facility			\$0.00	19.3%	0.00		0.00
Home health			\$0.00	0.0%	0.00		0.00
Outpatient hospital / ASC			\$0.00	20.1%	0.00		0.00
Emergency Room			\$0.00	20.1%	0.00		0.00
Dialysis			\$0.00	20.1%	0.00		0.00
Primary care physician			\$0.00	20.1%	0.00		0.00
Nephrologist			\$0.00	20.1%	0.00		0.00
Physician specialist (o/t nephrologist)			\$0.00	20.1%	0.00		0.00
Other professional			\$0.00	20.1%	0.00		0.00
Radiology / pathology			\$0.00	20.1%	0.00		0.00
Ambulance / transportation			\$0.00	20.1%	0.00		0.00
DME / Diabetes			\$0.00	20.1%	0.00		0.00
Part B Rx: Medicare-covered			\$0.00	20.1%	0.00		0.00
Other Part B services			\$0.00	20.1%	0.00		0.00
Coordination of benefits			\$0.00				0.00
Sub-total: Medicare-covered services	\$0.00	\$0.00	\$0.00		\$0.00		\$0.00
Other: Part B premium reduction			0.00				0.00
Other: Part D Basic premium reduction			0.00				0.00
Other: Part D Supp premium reduction			0.00				0.00
Additional services			0.00				0.00
Sub-total: premium reductions + add'l services net PMPM			\$0.00		Sub-total: prem reduct + add'l srvs net PMPM		\$0.00
<b>Total benefit cost</b>			<b>\$0.00</b>		<b>Total benefit cost - mand. supplemental</b>		<b>\$0.00</b>
<b>Non-benefit Expenses (NBE) and Gain Loss Margin (GLM)</b>							
Sales & Marketing				Corporate Margin Requirement % of Revenue			
Direct Administration				Corporate Margin Basis			
Indirect Administration				Overall Gain/(Loss) Margin Level			
Net Cost of Private Reinsurance							
Insurer Fees				Total Benefit Cost % of Revenue			\$0.00
Sub-total non-benefit expenses			\$0.00	Total Non-Benefit Expense % of Revenue			\$0.00
Gain / loss margin				Gain/ loss margin % of Revenue			\$0.00
<b>Total NBE + GLM</b>			<b>\$0.00</b>	<b>Total NBE + GLM % of Revenue</b>			<b>\$0.00</b>
<b>Total Revenue Requirement</b>			<b>\$0.00</b>				
CMS capitation			\$0.00				
Part C mandatory enrollee premium			\$0.00				
<b>Summary of Total Revenue Requirement</b>							
Medicare-covered benefits	\$0.00	\$0.00	\$0.00				
Cost sharing enhancements	\$0.00	\$0.00	\$0.00				
Additional services	\$0.00	\$0.00	\$0.00				
Part B premium reduction	\$0.00	\$0.00	\$0.00				
Part D Basic premium reduction	\$0.00	\$0.00	\$0.00				
Part D Supp premium reduction	\$0.00	\$0.00	\$0.00				
Mandatory supplemental benefits	\$0.00	\$0.00	\$0.00				
Medicare covered and mand. supplemental benef	\$0.00	\$0.00	\$0.00				

Section III Development of Estimated Plan Premium		"Excess Funds"	\$0.00
		Funds for Part B & Part D premium reductions	\$0.00
<b>Part B Premium Reduction</b>			
1. PMPM reduction for Part B premium			
2. Part B Premium Reduction, rounded to one decimal (see instructions)			\$0.00
3. Total MA Enrollee Premium (excl. Opt. Suppl.)			0.00
<b>4. Rounded MA Premium (excl. Opt. Suppl.)</b>			<b>\$0.00</b>
<b>5. Part D Basic Premium</b>			
5a. Prior to reductions (rounded value from Rx BPT)			
5b. Part D Basic Premium reduction			
5c. Part D Basic Premium reduction (rounded)			\$0.00
<b>5d. Part D Basic Premium*</b>			<b>\$0.00</b>
<b>6. Part D Supplemental Premium</b>			
6a. Prior to reductions (rounded value from Rx BPT)			
6b. Part D Suppl Premium reduction			
6c. Part D Suppl Premium reduction (rounded)			\$0.00
<b>6d. Part D Supplemental Premium</b>			<b>\$0.00</b>
<b>7. Total estimated plan premium*</b>			<b>\$0.00</b>
<b>8. Plan Intention for target PD basic premium</b>			

\* The premiums shown in lines 5 and 7 are estimates. Actual plan premiums will be calculated by CMS when the Part D National Average is determined by CMS. The premiums shown in lines 5 and 7 may not be final.

Note: Premiums are rounded to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements. See instructions for more information.

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