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INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOLS FOR CONTRACT YEAR 2018

As of September 6, 2016

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I. INTRODUCTION

DEFINITIONS

In these Instructions, the term "bid" refers to the Medicare Advantage (MA) Bid Pricing Tool (BPT) and/or the MA Plan Benefit Package (PBP) required for a contract number-plan ID-segment ID.

In the BPT and these Instructions,—

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

BACKGROUND

Medicare Advantage Organizations (MAOs) must submit a separate MA BPT to the Centers for Medicare & Medicaid Services (CMS) for each bid that they intend to offer under the MA program, including MA plans, Medical Savings Account (MSA) plans and End-Stage Renal Disease-only special needs plans (ESRD-SNPs). For plans with service area segments, a separate BPT must be submitted for each segment.

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

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

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

DOCUMENT OVERVIEW

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

- Section I, "Introduction": contains a list of key changes from the CY2017 BPT and provides sources of information that can be accessed for assistance during the bid submission process.
- Section II, "Pricing Considerations": contains guidance for preparing bids and presenting pricing results in the BPT.
- Section III, "Data Entry and Formulas": contains directions for completing the seven worksheets in the MA BPT and explains the formulas for calculated cells.
- Section IV, Appendices A through L: contain requirements for and information on Actuarial Certification, Supporting Documentation, Part B-Only Enrollees, MA Products Available to Groups, Rebate Reallocation and Premium Rounding, Suggested Mapping of MA PBP Categories to BPT Categories, DE#, Related-Party Requirements, the MSA BPT, the ESRD-SNP BPT, Trending Risk Scores, and Data Aggregation Examples.

NEW FOR CONTRACT YEAR 2018 (CY2018)

The key changes between the CY2017 and CY2018 MA, MSA and ESRD BPTs are listed below. The changes improve the usability and functionality of the BPTs and reflect updated guidance.

- Technical
  - The add-in file (BPT2018.xlam) must be saved under C:\BPT\BPT2018\.
  - See the BPT technical instructions for more information.

BIDDING RESOURCES

The following resources provide information on CY2018 bidding:

- The CY2018 Advance Notice and Announcement at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.
- The CY2018 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTraining2018.html.
- Medicare fee-for-service (FFS) trends can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html.
- For questions about the BPT, e-mail the CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov.
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2018 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. For call-in information, see the OACT memorandum with the subject line "Actuarial User Group Calls" released via HPMS.
- For technical questions about the BPT, BPT Batch Tools, HPMS, or the upload process, refer to the following resources:
  - The BPT Technical Instructions, located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2018 > Documentation > BPT Technical Instructions

- The Bid Submission User's Manual, also available in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2018 > Documentation > Bid User's Manual
- HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

- For information about benefits and service categories, see—
  - Chapter 4 of the *Medicare Managed Care Manual*, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.
  - A memorandum released via HPMS titled "The Contract Year 2018 Medicare Advantage Bid Review and Operations Guidance."

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

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

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

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the bid level if the bid existed in CY2016, regardless of the level of enrollment. This experience must also be projected in Worksheet 2 and assigned an appropriate level of credibility by the certifying actuary. Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year.

SPECIFIC TOPICS

Affordable Care Act

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

The contract-level quality bonus ratings for the CY2017 QBP can be found in HPMS, under HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating > 2017.

Low-Enrollment Contract

A low-enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because it lacked a sufficient number of enrollees to reliably measure the performance of the health plan. For 2017, the quality bonus rating on HPMS for a "low" enrollment contract is blank and the quality bonus rating on Worksheet 5, Section V, line 1 must be left blank.

New Contract under New Parent Organization

A new MA contract offered by a parent organization that has not had any MA contract(s) with the CMS in the previous three years is treated as a qualifying contract, per statute, until the contract has enough data to calculate a star rating. For 2017, the quality bonus rating on HPMS for a "new contract under new parent org" is blank and the quality bonus rating on Worksheet 5, Section V, line 1 must be left blank.

New Contract under Existing Parent Organization

For a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization received a weighted average of the QBP star ratings earned by the parent organization's existing MA contracts (weighted by enrollment). For 2017, the user must enter the quality bonus rating from HPMS as the quality bonus rating in Worksheet 5, Section V, line 1.

The table below outlines the QBP percentage and rebate percentage for various quality bonus ratings (that is, QBP star ratings) in CY2017.

QBP star rating	CY2017 QBP Percentage	CY2017 Rebate Percentage
4.5+	5.0%	70%
4.0	5.0%	65%
3.5	0.0%	65%
3.0	0.0%	50%
< 3.0	0.0%	50%
Blank	3.5%	65%

The CY2017 Advance Notice and CY2017 Call Letter and the CY2017 Rate Announcement contain additional information regarding the ACA provisions and the QBP.

Bad Debt

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

Base Period Experience

The experience data must be based on a calendar year 2016 incurred period with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

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

- Must be submitted on Worksheet 1 for a bid with experience data for 2016, regardless of the level of enrollment.
- Must reconcile in an auditable manner to the MAO's audited financial statements.
- Must be reported without adjustment in Section III except as noted in the pricing considerations for capitated arrangements for medical services and related-party arrangements (medical and non-benefit). Adjustments may be made in Section IV to accommodate population, benefit design, or other changes from the base period to the contract period.
- May be reported in aggregate for a number of bids only as allowed in the "Data Aggregation" section of this pricing consideration. Each contract number-plan ID-segment ID must be identified in Section II, line 5.
- Must be provided for plans acquired by the MAO.
- May not be used to aggregate data from a number of bids in order to achieve credibility.

The medical expenses in Section III must—

- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Be reported on an allowable basis (before any reduction for reinsurance recoveries or cost sharing) and on a net basis.
- Include any provider incentive payments.
- Reflect the full level of plan cost sharing in the PBP for all enrollees including the DE# beneficiaries. See the "Dual-Eligible Beneficiaries" pricing consideration for dual-eligible beneficiaries for more information about DE# beneficiaries. Include claim experience for out-of area enrollees.
- Include or exclude claim experience for hospice enrollees for the time period that an enrollee is in hospice status consistent with the development of projected allowed costs. See the "Hospice Enrollees" pricing consideration for more information about reporting base period experience.
- Exclude end-stage renal disease (ESRD) claim experience for the time period that an enrollee is in ESRD status based on CMS eligibility records.
- Exclude claims experience for optional supplemental benefits.
- Exclude incurred claims for Medicaid benefits.

The net medical and non-benefit expenses and CMS and premium revenue in Section VI must include all enrollees (that is, include ESRD and hospice and out-of-area). Section VI excludes

optional supplemental benefits. Section VI must be completed in total dollars (not per-member-per-month amounts).

Data Aggregation

The requirements for reporting on Worksheet 1 base period data for more than one bid due to cross-walks and enrollment shifts are described in Rules 1 through Rule 4 at the end of this section. These rules apply to cross-walk and enrollment shifts between segments and depend on the following factors:

- How enrollment changes are processed.
  - In these Instructions, the term "formal cross-walk" refers to the cross-walk process submitted in HPMS for non-segmented plan consolidations (that is consolidated renewals), whereby members are automatically moved from one bid to another (that is, one bid only). Without an HPMS cross-walk in place, members are dis-enrolled from the terminating plan and must actively select to enroll in a new plan of their choosing.
  - Medicare Advantage and Prescription Drug (MARx) enrollment transactions are used to automatically move members from one bid to more than one bid, for example, when the service area of one or more segments is redefined. Note that in some cases, an approved cross-walk is required, for example, when the service area of one or more non-segmented plans is redefined. In this situation, without an approved cross-walk in place, members in the affected counties must actively select to enroll in a bid of their choosing.
- Whether or not members cross-walked or moved to a bid via MARx transactions are dis-enrolled from such bid the following year via MARx transactions, that is, when to use Rule 4 – Two-Year Perspective. (Note that the dis-enrollment of members from a bid, in itself, is not a factor—a "dis-enrollment" must be preceded by a "cross walk" for the previous year.).
- Whether or not enrollment changes that are processed via MARx enrollment transactions apply to a significant proportion of members in the bid from which the members are moving, that is, when Rule 2 – Enrollment Shifts applies.

The threshold (that is, the level of significance) for determining the significance of the proportion of members in a bid that are cross-walked into existing or new plans via MARx enrollment transactions must be the same for each of the MAO's MA bids that an actuary certifies.

For more information about MA renewals and cross-walks, see Chapters 4 and 16 of the *Medicare Managed Care Manual* at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

✓ **Rule 1 – Cross-walks**

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

- When two or more plans are consolidated and the members are cross-walked into an existing or new plan under a formal cross-walk, but are not dis-enrolled

via MARx transactions the following year. If members are cross-walked one year and dis-enrolled the following year, then Rule 4 applies.

- When the proportion of members in a bid that are cross-walked into existing or new plans via MARx enrollment transactions, subject to Rule 4, is greater than or equal to the MA level of significance determined by the certifying actuary. That is, if members are cross-walked one year and dis-enrolled via MARx transactions the following year then such proportion must be reduced.

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

✓ **Rule 2 – Enrollment Shifts**

Base period data for more than one plan cannot be aggregated and reported on Worksheet 1 of the bid into which the members are moved or cross-walked to in the following circumstances:

- When an existing member chooses to enroll in a different plan.
- When the proportion of members in a bid that are cross-walked into existing or new plans via MARx enrollment transactions, subject to Rule 4, is less than the MA level of significance determined by the certifying actuary.
- When enrollment changes do not involve a cross-walk whether or not a bid is terminated.

✓ **Rule 3 – Partial Experience**

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

✓ **Rule 4 – Two-Year Perspective**

For BPT reporting purposes, the actuary must consider the cross-walks from the base period to the contract period (that is, two years of cross-walks, from CY2016 to CY2017, and then from CY2017 to CY2018) taking into account MARx dis-enrollment transactions, as explained below. That is, Rule 4 applies only if members are: (i) cross-walked both years, or (ii) cross-walked one year and dis-enrolled the following year.

- For a BPT, that is, "Bid Y," the MAO must report base period experience of another bid, that is, "Bid X," on Worksheet 1 of the Bid Y CY2017 BPT, if—
  - The proportion of Bid X members who are cross-walked or moved into Bid Y and who remain in Bid Y for CY2018, is greater than or equal to the level of significance determined by the certifying actuary.
- The calculation of the aforementioned proportion includes the following types of cross-walks and MARx enrollment and dis-enrollment transactions occurring over the course of the two year period:
  - A plan consolidation for CY2017 or a proposed consolidation for CY2018 that moves Bid X members to Bid Y under a formal cross-walk.

- A service area expansion (SAE) for CY2017 or a proposed SAE for the CY2018 that cross-walks or moves Bid X members to Bid Y via MARx enrollment transactions.
- A proposed service area reduction (SAR) for CY2018. However, the calculation pertains only to prior Bid X members (that is, Bid X members who were moved to Bid Y for CY2017) in the reduced portion of the service area of Bid Y who will be dis-enrolled from Bid Y via MARx transactions. Note that this type of transaction does not involve a cross-walk.

- A separate calculation is required for each Bid X from which members are cross-walked into Bid Y.

Benefits and Service Categories

Benefits are defined in Chapter 4 of the *Medicare Managed Care Manual* (MMCM) as Medicare-covered, mandatory supplemental, or optional supplemental benefits. Benefits must be priced in the BPT as benefit expenses, not non-benefit expenses. For example, remote access technologies (such as a nursing hotline), a fitness benefit, and other supplemental benefits as defined in Chapter 4 of the MMCM must all be priced as benefit expenses. The cost of value-added items and services must be excluded from the BPT.

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

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

- Chapter - 3 Marketing Guides Instructions and Chapter 4 - Benefits and Beneficiary Protections of the *Medicare Managed Care Manual* located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.
- Medicare Marketing Guidelines at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html.

Disease Management

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

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

Absent additional CMS guidance, other DM and care coordination costs —such as those incurred during recruitment, enrollment, and general program communications—are to be classified as non-benefit, or administrative, expenses. In all cases, the

classification of DM expenses in the BPT must be explained in the supporting documentation for projected allowed costs and non-benefit expenses.

Medicare-Covered and Non-Covered

Following are the three types of service categories:

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

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

- A Skilled Nursing Facility (SNF) waiver of a qualifying 3-day inpatient hospital stay and the associated SNF stay are Medicare-covered benefits.
- Out-of-network point-of-service inpatient stays are A/B mandatory supplemental benefits.
- For non-SNPs, physical exams that provide services not included in the required Annual Wellness Visits are A/B mandatory supplemental benefits.
- For SNPs, assessments of enrollees are considered Medicare-covered benefits as explained in the CY2013 Call Letter.

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

Inpatient Facility Additional Days

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

Further, the certifying actuary may use the inpatient facility "safe harbor" as a basis for determining the inpatient facility cost-sharing Medicare-covered percentages entered on Worksheet 4.

Non-Covered Limited Benefits

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

Capitated Arrangements for Medical Services

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

- ✓ **Annual Utilization Per 1,000**

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

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

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

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

  Global Capitation and Risk-Sharing Arrangements

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

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

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

Coordination of Benefits (COB)/Subrogation

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

Cost Sharing

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

Coinsurance

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

Following is an example:

Example: The PBP contains in-network cost sharing of 20%. $3 PMPM of projected allowed costs must be shifted from medical expense to non-benefit expense and gain/loss margin in order to satisfy the related-party requirements. BPT values before related-party requirements are taken into account would be as follows:

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

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

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

Consistency with PBP

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

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

Deductibles

The BPT must reflect in Worksheet 3, Section III, column f, "In-Network Effective Plan-Level Deductible PMPM," the in-network impact of the following deductibles, with exception of the pricing option described in the "Medicare FFS Cost Sharing" section of this pricing consideration:

- A local preferred provider organization (PPO) or a regional PPO deductible that applies to one or more in-network benefits.
- A plan-level in-network or combined deductible contained in Section D of the PBP.

Further, the BPT must reflect in Worksheet 3, Section III, columns g through k, "In-network Cost Sharing After Plan-Level Deductible," the impact of service-category specific deductibles included in Section B of the PBP.

Medicare Fee-For-Service (Medicare FFS) Cost Sharing

The Medicare FFS cost sharing pricing option involves the use of Medicare FFS actuarial equivalent cost sharing in Worksheet 4 to price certain plan cost sharing designed to match Medicare FFS cost sharing. This option applies to all inpatient facility services, and/or all SNF services, and/or all Medicare Part B services, as described below.

- For a local PPO or a regional PPO bid, the Medicare FFS cost sharing pricing option is available only to price the cost sharing all Medicare Part A and Part B services. Further, the plan cost sharing for such services must match Medicare FFS cost sharing and the deductible must be—
  - A "Medicare-Defined Part A and B Deductible amount combined as a single deductible."
  - "Differentially applied to Part A and Part B Medicare services, reflecting Original Medicare payment structure."
- For an health maintenance organization (HMO), an HMO with a point-of-service option (HMOPOS), or a non-network PFFS bid, plan cost sharing must align with Medicare FFS cost sharing for all inpatient facility services, and/or all SNF services, and/or all Part B services. That is, if this option is used for—
  - All inpatient facility services and/or all SNF services, the service–specific cost sharing for such services must be "Medicare-Defined Cost Shares."
  - All Part B services, the in-network plan deductible (HMO), or the combined plan deductible (HMOPOS), or the plan deductible (non-network PFFS) must be "Medicare-Defined Cost Shares."

If the criteria above are met, the certifying actuary has the option to use the FFS actuarial equivalent cost-sharing in Worksheet 4, to estimate the PMPM amount for

total plan cost sharing before the impact of the maximum out-of-pocket limit (MOOP). Further, if the certifying actuary chooses such option, the user must enter on Worksheet 3, Section III and Worksheet 4, Subsection IIB, DE# cost sharing as described below.

✓ **Worksheet 3 – Plan Cost Sharing**

For the applicable service categories, the user must—

- Enter in column f, zeroes (0) as the in-network cost of the plan deductible.
- Enter in column i, the in-network portion of total plan cost sharing as the in-network effective copay/coinsurance after the plan deductible has been satisfied and before the impact of the MOOP.

Further, the effective copay/coinsurance after MOOP in column j must reflect the expected impact of the MOOP. Note that, if Worksheet 3 is completed for the total population and such population includes non-DE# members, then the effective copay/coinsurance before and after MOOP (columns i and j, respectively) may not be equal. In this case, CMS expects the non-DE# reduction of A/B cost sharing calculated automatically in Worksheet 4 (Section II, Subsection A, column q) to reflect only: (i) the PMPM value of the MOOP; plus (ii) the impact of related-party and risk-sharing requirements, if the projected allowed costs used in the calculation of cost sharing differ from the allowed PMPMs on Worksheet 4.

✓ **Worksheet 4 – Cost Sharing**

DE# plan cost sharing in Worksheet 4, Section IIB, column f must be based on total plan cost sharing before MOOP, as estimated by the certifying actuary using the FFS actuarial equivalent cost-sharing in MA Worksheet 4.

The Medicare FFS cost sharing pricing option is intended to result in zero mandatory supplemental benefits for reduced cost sharing consistent with Medicare FFS cost sharing (aside from the impact of the MOOP). Therefore, cost sharing priced under this option may not be adjusted for sequestration, which would incorrectly produce a non-zero mandatory supplemental benefit for reduced cost sharing.

Visitor/Travel Benefits

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

Credibility

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

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

Claims Credibility

This section pertains to the credibility percentages on Worksheet 2 and to the ESRD subsidy on Worksheet 4.

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

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Non-ESRD Allowed Costs	24,000 member months	$\sqrt{\frac{\text{member months}}{24{,}000}}$
ESRD Allowed Costs	4,000 member months	$\sqrt{\frac{\text{member months}}{4{,}000}}$

Risk Score Credibility

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

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

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Estimated Part C risk scores for development of 2018 bids as posted on HPMS	300 beneficiaries	$\sqrt{\frac{\text{number of beneficiaries}}{300}}$
Beneficiary-level file to support 2018 Part C bids as distributed by CMS	3,600 member months	$\sqrt{\frac{\text{member months}}{3{,}600}}$

Overriding the CMS Formulas for Partial Credibility

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

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

Dual-Eligible Beneficiaries

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

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

Medicaid Revenue and Costs

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

- The projected Medicaid cost—
  - Includes the cost to provide Medicaid benefits that the MAO has contracted to provide bid members under the state or territory Medicaid program.
  - Reflects the full cost, which includes benefit expenses and non-benefit expenses.
  - May include prescription drug benefits that the Commonwealth of Puerto Rico requires to be offered in order to participate in the Platino Program beyond what is submitted in the Part D bid.
- The projected Medicaid revenue is the corresponding revenue received from the state Medicaid program to provide the Medicaid benefits.
- The values must be on a PMPM basis.
- Worksheet 1 collects the Medicaid data (in total dollars) of revenue and costs in the base period (Section VI, lines 10a and 10b1, and 10b2). These items are defined in the same manner as for the projection period.

For more information on Medicaid benefits, see Chapter 4, Sections 10.3, 30.4 and 210, of the *Medicare Managed Care Manual* at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

Determination of DE# Beneficiaries

Per federal statute, QMBs and qualified Medicare beneficiaries with full Medicaid benefits (QMB Plus) are not liable for Medicare cost sharing; therefore, these individuals are always considered to be DE# beneficiaries, as defined in the "Introduction" section of these Instructions.

The certifying actuary must determine which additional beneficiaries are DE# based on the Medicaid cost-sharing policy for the states or territories in the bid's service area. However, the certifying actuary has the option to approximate the DE# population as described below, if the condition in the second bullet point is satisfied.

- Start with bid-specific enrollment data available in HPMS, under the "Risk Adjustment" link and consider the 2016 membership data posted in HPMS for the contract plan-ID segment(s) listed in Worksheet 1 for the base period.

- If the percentage of total dual-eligible beneficiaries (who comprise all dual-eligible categories and not just the QMB and QMB Plus categories) is less than 10 percent of total beneficiaries, then—
  - The certifying actuary may consider the membership in the QMB and QMB Plus categories to represent the entire DE# population.

Bid Values

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

✓ **Worksheet 1 – Base Period Data**

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

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

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

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

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

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

- Enter projected allowed costs for the non-DE# beneficiaries in column p and projected allowed costs for the DE# beneficiaries in column q.
- If DE# projected member months are between 10 percent and 90 percent inclusive of the total projected member months, then enter distinct DE# and non-DE# projected allowed costs (columns p and q).
- If DE# projected member months are less than 10 percent or greater than 90 percent of the total projected member months, then the user may, at the discretion of the certifying actuary, enter—
  - Non-DE# projected allowed costs (column p) equal to the projected allowed costs for the total population (column o); and
  - DE# projected allowed costs (column q) equal to the projected allowed costs for the total population (column o).
- If the projected member months for the DE# population or for the non-DE# population are equal to zero, then enter projected allowed costs for the non-DE# beneficiaries (column p) and for the DE# beneficiaries (column q) equal to the

projected allowed costs for the total population (column o). Do not enter zero for these costs.
- Complete Worksheet 2, column p on a "per non-DE# member per month" basis, and complete column q on a "per DE# member per month" basis.

✓ **Worksheet 3 – Cost Sharing**

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

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

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

✓ **Worksheet 4 – Projected Required Revenue**

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

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

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

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

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

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

✓ **Worksheet 5 – Benchmark**

The user must enter—

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

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

Considerations for developing projected member months include the following:

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

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

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

Employer/Union Groups

An MAO may offer its individual-market MA plans to employer/union group health plan sponsors and modify benefits for each group, as outlined in Appendix D.

For CY2018, CMS does not require an MA BPT for employer-only or union-only group waiver plans (EGWPs).

End-Stage Renal Disease (ESRD)

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

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status based on CMS eligibility records, with the exception of Worksheet 1, Section VI; Worksheet 4, Section III; and Worksheet 5, Section VIII. Note that all MAOs must enter the projected CY ESRD member months in Worksheet 5.

ESRD Subsidy

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

✓ **Basic Benefits**

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

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

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

✓ **Supplemental Benefits**

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

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

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

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

Enrollment

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

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

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

Gain/Loss Margin

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

By statute the bid must represent the revenue requirement of the expected population; therefore, the margin requirements must be met with the gain/loss margin entered in the BPT. In addition, the combined margin for the MA and Part D components of MA-PD bids cannot be used to satisfy these Instructions. See the "Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2018" for gain/loss margin requirements that are specific to Part D bids.

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

When some benefits offered by the MAO are funded by an outside source (such as a state Medicaid program, the gain/loss margin must be consistent between the Medicare benefits and benefits funded by other sources.

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

Bid-Level Requirements

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

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

✓ **Benefit Value**

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

✓ **Anti-competitive Practices**

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

✓ **Bids with Negative Margin**

If the projected gain/loss margin in the MA BPT is negative, the MAO must develop, submit, and follow an MA bid-specific business plan to achieve profitability within five years as explained below. CMS expects that in subsequent years, MA projected gain/loss margins will meet or exceed the year-by-year MA gain/loss margins contained in the original business plan or in subsequent business plans, if any.

- Product Pairing: If MA products are "paired" and the pricing reflects implicit "subsidies" across benefit or service area offerings as described below, then CMS does not require the MAO to submit a business plan. In this case, the bids in the MA product pairing must—
  - Have identical service areas;
  - All be local coordinated care plans or all be regional PPOs or all be PFFS plans; and
  - Have a positive combined MA gain/loss margin for CY2018.

  Examples include a low-benefit MA plan with a positive margin paired with a rich-benefit MA plan with a negative margin, or an MA-only plan paired with the MA portion of an MA-PD plan.
- Alternate Business Plan: If the projected gain/loss margin in the MA BPT is negative only to comply with the "Aggregate-Level Requirements" or "MA-PD Margin Requirements" sections of these Instructions (and would otherwise be positive), then the MAO may submit an alternate MA bid-specific business plan. An alternate business plan excludes a numeric projection or a numerical comparison to the prior business plan and consists only of a narrative explanation. Note that all other requirements applicable to bids with negative margin, as well as, aggregate level-margin requirements apply; such requirements are not altered by this option.
- Business Plan: If the two situations above do not apply (or the MAO does not choose one of these options), then the MA bid-specific business plan must include both a numeric projection and a narrative explanation.
  - The numeric projection must include, but is not limited to, projected: member months, risk scores, CMS revenue, MA premium,

Medicare-covered and non-covered medical expenses, non-benefit expenses, and gain/loss margin.
    - A suggested negative-margin business plan template can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BidGuidance.html.
- Five-Year Period: An exception to the five-year period to achieve profitability for a unique situation must be disclosed, be fully explained and supported, and ultimately be approved by CMS.

Aggregate-Level Requirements

The aggregate-level gain/loss margin requirements involve comparisons of aggregate MA margins for several groupings of MA bids to: (i) a point estimate of the MAO's corporate margin, and/or (ii) the aggregate MA margins for other groupings of MA bids.

✓ **Definitions**

In the BPT and these Instructions, the term—

- "MA Plan Category" refers to the following groupings of MA bids:
    - General enrollment plans and institutional or chronic care special needs plans (general enrollment plans & I/C SNPs), including MSA and ESRD-SNP plans; and
    - Dual-eligible special needs plans (D-SNPs).

  The aggregate-level requirements are applied separately to each MA plan category.
- "Level of aggregation" refers to the level at which the gain/loss margins entered in the BPTs must comply with the aggregate-level margin requirements. The MAO may choose one of the following three levels: the contract level, organization level (that is, the legal entity that contracts with CMS to provide MA benefits), or parent organization level. The MAO must enter the chosen level of aggregation in the BPT and it must be the same for all general enrollment plans & I/C SNPs and D SNPs. The level of aggregation selected in the MA BPT must match the level selected in the Part D BPT of an MA-PD bid.
- "Aggregate MA margin" refers to the projected enrollment-weighted average BPT PMPM margin for a specified plan category.
- "Corporate margin requirement" refers to the MAO's margin requirement using either the non-Medicare corporate margin basis or the Risk-Capital-Surplus corporate margin basis as explained below.
    - The "Non-Medicare" corporate margin basis applies if the volume of the MAO's non-Medicare business, for which it has discretion in rate setting, is greater than or equal to 10% of the MAO's total non-Medicare business. The term "non-Medicare business" refers to all health insurance business that is not Medicare Advantage or Part D. Non-Medicare business includes, but is not limited to: (i) Medigap (Medicare Supplement); (ii) Medicaid; (iii) MMPs offered through a Financial Alignment Demonstration; (iv) Stop Loss; (v) dental, vision, and commercial lines of business; and (vi) the

non-Part D portion of Section 1876 cost plans, Section 1833 cost plans, and PACE plans. Non-Medicare business excludes administrative services only (ASO) business.

- Under the "Risk-Capital-Surplus" corporate margin basis, the MAO must set the corporate margin requirement by taking into account the degree of risk and capital and surplus requirements of its Medicare business prior to any impact of sequestration. This definition of corporate margin requirement applies if: (i) the volume of the MAO's non-Medicare business, for which it has discretion in rate setting, is less than 10% of the MAO's total non-Medicare business; or (ii) the MAO has no non-Medicare business. The term "Medicare business" is inclusive of all MA and Part D enrollees (including, but not limited to: (i) enrollees in hospice or ESRD status; and (ii) enrollees in SNPs, MSA plans, ESRD-SNPs, and the Part D portion of PACE plans).

✓ **Year-to-Year Consistency**

Although actual margin may vary from year to year, CMS expects certifying actuaries to price bids such that actual MA aggregate returns over the long term are consistent with (that is, follow) the margin assumptions used for pricing. That is, actual aggregate MA margin is to be consistent with the aggregate MA margin used in pricing, as a percentage of revenue; actual corporate margin is to be consistent with the corporate margin requirement used for the MA pricing.

✓ **General Enrollment and I/C SNPs**

For general enrollment plans and I/C SNPs, if the corporate margin basis is—

- "Non-Medicare," then the aggregate MA margin for general enrollment plans and I/C SNPs, as a percentage of revenue, is to be within 1.5 percent of the MAO's corporate margin requirement.
- "Risk-Capital-Surplus," then the aggregate MA margin for general enrollment plans and I/C SNPs, as a percentage of revenue, is to be within 0.5 percent of the MAO's corporate margin requirement.

CMS may grant exceptions to this requirement in limited circumstances. If this requirement is not met, this situation must be disclosed, be fully explained and supported, and ultimately be approved by CMS.

✓ **D-SNPs**

If general enrollment plans and I/C SNPs are offered, then—

- The aggregate MA margin for D-SNPs, as a percentage of revenue, is to be no more than 1 percent higher and no less than 5 percent lower than the aggregate margin for general enrollment plans and I/C SNPs.

If general enrollment plans and I/C SNPs are not offered, and the corporate margin basis is—

- "Non-Medicare," then the aggregate MA margin for D-SNPs, as a percentage of revenue, is to be no more than 1.5 percent higher and no less than 5 percent lower than the MAO's corporate margin requirement.
- "Risk-Capital-Surplus," then the aggregate MA margin for D-SNPs, as a percentage of revenue, is to be within 0.5 percent of the MAO's corporate margin requirement.

CMS may grant exceptions to this requirement in limited circumstances. If this requirement is not met, this situation must be disclosed, be fully explained and supported, and ultimately be approved by CMS.

✓ **Minnesota Senior Health Options Program**

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

MA-PD Margin Requirements

See the "Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2018" for gain/loss margin requirements that affect MA-PD bids.

Exclusions

Non-insurance revenues pertaining to investments, fee-based activities designed to influence state or federal legislation such as the cost of lobbying activities, and the costs of value-added items and services (VAIS) cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009 and Chapter 4 of the *Medicare Managed Care Manual* for more information about VAIS.

Hospice Enrollees

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

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

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

Since hospice enrollees continue to receive mandatory supplemental benefits from the MA plan, the projected allowed cost PMPM may reflect claim costs for these enrollees for mandatory supplemental benefits, at the discretion of the certifying actuary—for example, for a

dental or another additional benefit. If the projected allowed costs for mandatory supplemental benefits include claims costs for hospice enrollees, then the mandatory supplemental medical expenses in Worksheet 1, Section III must include claims for hospice enrollees for the time period that they are in that status.

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

Manual Rating

Manual Rating with FFS Data

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

FFS Costs Used for the Actuarial Equivalent Cost-Sharing Factors

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

Medicare Secondary Payer (MSP) Adjustment

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

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

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

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

- Data described in the following sections of Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) and Appendices, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html:
  - 5.1 Part C Payment Calculation: describes the calculation of MA payments.
  - 5.1.5 Part C Payments When Medicare Secondary Payer (MSP) Status Applies: describes the payment reduction based on MSP status.
  - F.27 "Monthly MSP Information Data File": provides specific information regarding the primary coverage for beneficiaries enrolled in the bid, whose payments were adjusted for MSP that month. It allows MAOs to reconcile beneficiary payments.
- The following data in the Monthly Membership Detail Report (MMR):
  - MSP adjustment factor (field 82).
  - Related fields that provide the payment MSP reduction amount due to MSP for Part A (field 83) and Part B (field 84).
- Rolled-up MSP member counts for the month in the Monthly Membership Summary Data File.
- MSP factors shown in the April Rate Announcement for the applicable payment year.

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

- MSP adjustment = 1 – X/Y, where

  X = Bid portion of payment reflecting reduced payments for MSP beneficiaries, which excludes MA rebates and basic MA premium, if any, as shown in the example below, and

  Y = Bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare. This is determined by (i) grossing up the payments for MSP beneficiaries to the amount that would be paid if they did not have a payer that was primary to Medicare and (ii) adding these payments to the payments for non-MSP beneficiaries. The resulting value of Y explicitly takes into account the distinct risk characteristics of MSP beneficiaries as compared to non-MSP beneficiaries.

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

Example:

The source data to project the CY2018 MSP adjustment for Hxxxx-001-000 is March 2017 MMR data for Hxxxx-001-000. There is no change in the distinct risk

characteristics of MSP beneficiaries as compared to non-MSP beneficiaries from CY2017 to CY2018.

Step 1: Calculate the CY2017 bid portion of payment reflecting reduced payments for MSP beneficiaries (X_{2017}).

$12,000,000 = "Total MA Payment" for the bid from a 2017 MMR file. This field includes all rebates except rebates for reduction of Part B premium and Part D basic premium and excludes part C basic premium, if any.

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

X_{2017} = $12,000,000 – $2,253,975 = $9,746,025.

Step 2: Separate the CY2016 bid portion of payment reflecting reduced payments for MSP beneficiaries (X_{2016}) into payments for non-MSP enrollees and MSP enrollees based on MSP status.

$9,692,896 = CY2017 bid portion of payment for non-MSP enrollees

$53,129 = CY2016 bid portion of payment for MSP enrollees

X_{2017} = $9,746,025 = $9,692,896 + $53,129

Step 3: Calculate the CY2018 bid portion of payment reflecting reduced payments for MSP beneficiaries (X)

$9,692,896 = CY2018 bid portion of payment for non-MSP enrollees

0.173 = CY2017 "MSP factor" for working aged and working disabled

0.173 = CY2018 "MSP factor" for working aged and working disabled

$53,129 = (.173 ÷ .173) × $53,129 = CY2018 bid portion of payment for MSP enrollees

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

Step 4: Calculate the projected CY2018 bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare (Y).

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

Step 5: Calculate the projected CY2018 MSP adjustment to enter into the BPT.

MSP adjustment = 1 – $9,746,025 ÷ $10,000,000 = 0.0254 = 2.54%.

Manually Rated Bids

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

- The basis for both projected allowed costs and projected risk scores is FFS data that are reduced for MSP.

- The projected proportion of MSP members is the same as the proportion of MSP enrollees in the FFS data.

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

- Rate calculation data zip files (for example, "risk_scores 2010-2014 Non-PACE.csv" from the CY2018 MA ratebook).
- Limited Data Sets (or "CMS 5% sample").
- FFS Data zip files (for example "FFS data 20XX").

Non-Benefit Expenses

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

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

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

- Sales & Marketing
  - Examples include, but are not limited to the cost of—
    - Marketing materials;
    - Rewards and incentives allowed under 42 CFR § 422.134;
    - Commissions;
    - Enrollment packages;
    - Identification cards; and
    - Salaries of sales and marketing staff.
- Direct Administration
  - Examples include, but are not limited to—
    - Customer service;
    - Billing and enrollment;
    - Medical management;
    - Claims administration;
    - Part C National Medicare Education Campaign (NMEC) user fees. CMS collects NMEC user fees based on a percentage of revenue; however, the BPT entry is a PMPM equivalent value consistent with the calculation of other BPT values. MAOs may use the CMS estimate, which is $0.25 PMPM on a national basis for CY2017, or develop an alternative estimate that is consistently applied to all bids in the contract—for example, the MAO's historical amount relative to the CMS annual national estimate;
    - Uncollected enrollee premium; and
    - Certain disease management functions. See the "Benefits and Service Categories" pricing consideration for more information about the classification of disease management expenses.
- Indirect Administration
  - Examples include, but are not limited to, functions that may be considered "corporate services," such as—

    - The position of CEO;
    - Accounting operations;
    - Actuarial services;
    - Legal services; and
    - Human resources.
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).
- Insurer fees.
    - This category includes only the Health Insurance Providers Fee imposed by Section 9010 of the Patient Protection and Affordable Care Act, as amended.

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

Costs not pertaining to non-medical costs incurred in the operation of the MA bid must be excluded from non-benefit expenses. Such costs include income taxes, changes in statutory surplus, and investment expenses; and the cost of lobbying activities and value-added items and services. See the "Gain/Loss Margin" pricing consideration for more information.

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

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

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

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

Optional Supplemental Benefits

See the CY2017 Call Letter at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html for the following requirements regarding the total value of all optional supplemental benefits offered to bids under each contract:

- The enrollment-weighted contract-level projected gain/loss margin, as measured by a percent of premium, cannot exceed 15%.

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

Out-of-Area Enrollees

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

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

The user must enter distinct projected member months and projected risk scores for out-of-areas members in Worksheet 5, Section VI, row 38.

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

Part B Premium and Buydown

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

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

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

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

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

Plan Premiums, Rebate Reallocation, and Premium Rounding

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

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

When the bid is initially submitted, the Part D basic premium entered in the MA BPT is an estimated value. The actual premium will be calculated by CMS following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional PPO benchmarks (typically in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2018.

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

For regional PPO plans, the initial bid submission contains an estimated MA premium. The actual MA premium will not be known until August, when the MA regional PPO benchmarks are calculated by CMS. Note that after the regional PPO benchmarks are released by CMS, all regional PPO sponsors are required to resubmit the MA BPTs in order to reflect the actual plan bid component in Worksheet 5, and they may need to reallocate rebates accordingly.

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

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

- A description of the rebate reallocation period.
- A summary of the circumstances under which rebate allocation is required, permitted, or not permitted.
- Specific rules for returning to the target Part D basic premium.
- Limitations on benefit changes that are permitted during the rebate reallocation period.
- Limitations on changes in pricing assumptions that are permitted during the rebate reallocation period, including a small change in gain/loss margin in order to satisfy Total Beneficiary Cost (TBC) requirements.
- Limitations on significant changes to the BPT when rounding premiums.
- Examples of rebate allocation and rounding.

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

Plan Intention for Target Part D Basic Premium

Following CMS' publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional PPO benchmarks, MAOs may reallocate MA rebate dollars in certain MA-PD bids in order to return to the target Part D basic premium. MA-PD sponsors must choose one

of the following two options for the target premium: "Premium amount displayed in line 7d" or "Low Income Premium Subsidy Amount." There is no option to target and reallocate rebates to return to Total Plan Premium.

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

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

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

Point-of-Service (POS)

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

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

Rebate Allocations

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

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

Regional Preferred Provider Organizations (PPOs)

A regional PPO plan must cover only enrollees eligible for both Part A and Part B of Medicare. See Chapter 1 of the MMCM, which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

Intra-Service Area Rate (ISAR) Factors

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

Related-Party Arrangements (Medical and Non-Benefit)

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

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

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

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

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

Comparable rate demonstrations must be based on actual contracts, which must be available for review by CMS upon request. When supporting comparable rates through the related party, the MAO must include with the rate analysis a signed attestation from the related party stating that the actual contracts will be available upon request for review by CMS.

The next two sections describe additional requirements for reflecting in the BPT the cost of administrative and medical services provided under a related-party arrangement for each available option listed above. Note that, if a related-party arrangement includes both administrative services and medical services, the requirements in the "Administrative Related-Party Arrangements" section and the "Medical Related-Party Arrangements" section apply separately to the costs associated with such administrative and medical services, respectively.

Administrative Related-Party Arrangements

✓ **Method 1 Actual Cost for Administrative Services**

An MAO using the actual cost method for administrative services must prepare the BPT in a manner that does not recognize the independence of the related party. Under this method, the BPT is prepared as follows:

- The actual cost of the non-benefit services provided by the related party is entered as the non-benefit expense of the MAO. The gain/loss margin of the related party is excluded from the non-benefit expense of the MAO.
- When entering gain/loss margin in the BPT, the MAO may consider the gain/loss margin of the related party, subject to the gain/loss margin requirements.

Supporting documentation of the development of the actual cost method for administrative services must be provided with the initial bid submission as required in Appendix B.

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

An MAO using the market comparison for administrative services method must—

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

  To meet this requirement, the MAO must demonstrate at the time of bid submission that—

  - The contract with the unrelated party is associated with sufficient costs of services to be considered a valid contract.
  - The fees associated with such arrangements are within 5 percent.
- Prepare the BPT in a manner that recognizes the independence of the related party by entering all costs in the related-party arrangement as non-benefit expenses.

Medical Related-Party Arrangements

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

An MAO using the actual cost method for medical services must prepare the BPT in a manner that does not recognize the independence of the related party. Under this method, the BPT is prepared as follows:

- The actual cost of the medical services provided by the related party is entered as the medical expense of the MAO. The gain/loss margin of the related party is excluded from the medical expense of the MAO.
- When entering gain/loss margin in the bid, the MAO may consider the gain/loss margin of the related party, subject to the gain/loss margin requirements.

Supporting documentation of the development of the actual cost method for medical services must be provided with the initial bid submission as required in Appendix B.

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

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

An MAO using the market comparison method for medical services must—

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

  To meet this requirement, the MAO must demonstrate at the time of bid submission that—

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

✓ **Method 3 Comparable to FFS**

An MAO using the comparable to FFS method must—

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

✓ **Method 4 FFS Proxy**

An MAO using the FFS proxy method must—

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

Risk Score Development for CY2017

The projected CY2017 risk score must—

- Be based on the methodology for calculating CY2017 risk scores, as discussed in the CY2017 Rate Announcement.
  - The CY2017 risk scores will be calculated using the 2017 CMS-HCC risk adjustment model. Risk scores will be a blend of—
    - 25% of the risk score calculated with diagnoses from encounter data and FFS claims; and
    - 75% of the risk score calculated with diagnoses from Risk Adjustment Processing System (RAPS) and FFS claims.
- Reflect the expected risk score trend at the bid level.
- Be appropriate for the expected population.
- Be adjusted for FFS normalization.
- Include the appropriate MA coding adjustment factor.
- For Fully Integrated Dual Eligible (FIDE) SNPs, include a frailty factor, if applicable.

Risk Score Definitions and Information Sources

✓ **Member Weighted Versus Member/Payment Weighted**

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

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

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

CY2017 risk scores will be calculated using the 2017 CMS-HCC risk adjustment model (that is, the "2017 Model").

Additional information on the CMS-HCC model, including the CY2017 HCC model coefficients, normalization factor, and MA coding adjustment factor, is contained in the CY2017 Advance Notice and Rate Announcement.

✓ **Normalization Factors**

At time of payment, the risk score for each enrollee will be adjusted by the appropriate Part C normalization factor for the CMS-HCC model. This adjustment accounts for the underlying FFS trend in risk scores and the effect of that trend on average risk scores between the model denominator year and the payment year (CY2017), and is designed to bring the average risk score back to 1.0. Accordingly, the projected 2017 risk scores must reflect the CY2017 Part C normalization factor of 0.998.

✓ **MA Coding Adjustment Factor**

In addition to normalization, the projected risk scores in the CY2017 bids must reflect the 2017 MA coding adjustment factor. This adjustment accounts for the difference in diagnostic coding pattern differences between MA and FFS. The CY2017 MA coding adjustment is 5.66 percent. Accordingly, the projected CY2017 normalized risk scores must be multiplied by 0.9434 (which is 1-0.0566).

✓ **Risk Adjustment Information Sources**

- The following materials can be found through the "Announcements & Documents" link on the "Medicare Advantage Rates & Statistics" page of the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html:
  - "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" (2017 Rate Announcement).
  - "Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter" (2017 Advance Notice).
- Additional information can be found
  - Under the "Risk Adjustment" and "Ratebooks & Supporting Data" links at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.
  - At http://www.csscoperations.com/.
  - In the February 18, 2015 memorandum released via HPMS titled "Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services."

Risk Score Calculation Approaches

✓ **Preferred Methodology**

The preferred method for projecting the CY2017 risk scores is to start with the CMS-HCC risk scores that are provided by CMS in—

- The bid-level data for the July 2015 enrollee cohort with retroactive enrollment and status adjustments; or
- The beneficiary-level file containing 12 months of 2015 membership with retroactive enrollment and status adjustments.

The bid-level data will be available after the publication of the 2017 Rate Announcement through the "Risk Adjustment" link on the HPMS Home page. The risk score data posted in HPMS are calculated using the 2017 Model used for 2017 payment and are accompanied by technical notes to assist actuaries with understanding the material presented.

Beneficiary-level data will be sent electronically to MAOs around the same time and will provide payment year 2015 risk scores calculated using both the two models used for 2015 payment, as well as the 2017 model, accompanied by technical notes. In addition, the beneficiary-level data will provide a set of 2015 risk scores calculated using the CMS-HCC risk adjustment model recalibrated for 2017 that actuaries may use (along with the 2015 risk scores calculated using the 2017 Model) for calculating final 2015 base period risk scores to enter on Worksheet 1 of the MA BPT.

There are several advantages to using these 2015 CMS-HCC risk scores in the projection of the CY2017 risk score:

- They are consistent with the base-period medical expenses as they include data for out-of-area members.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2014 dates of service submitted through the applicable risk adjustment deadline, which is the final reporting deadline for this period.
- They require no adjustment for risk model changes.
- In both the plan-level data and the beneficiary-level file, they are based on the risk model that will be used for 2017 payment.

  Please note that since the HPMS bid-level risk scores are based on a mid-year cohort using full calendar year data with complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete run-out of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2015 to 2017 with explicit adjustment at the bid level for the following factors:

  - Bid-specific coding trend.
  - Changes in bid population.
  - Other appropriate factors.

MAOs must take into account the effect of future changes in the risk score due to reporting of expected overpayments.

Finally, the projected risk scores must be normalized by dividing by the appropriate CY2017 FFS normalization factors and by applying the CY2017 MA coding adjustment factor.

✓ **Alternate Approaches**

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2016, if there was limited enrollment in 2015, or if there were significant changes in plan or enrollment characteristics between 2015 and 2017.

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

- Conversion to risk model-specific unblended risk scores.
  - If the starting risk score is a blended score, then the certifying actuary must produce an unblended risk score before the conversion to raw scores.
- Conversion to a raw risk score.
  - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized, not adjusted for MA coding) risk score before making other adjustments. (Note that the alternative is to take into account the normalization factor used in calculating the starting risk score when normalizing the projected risk score.)
- Impact of lagged (initial risk score) versus non-lagged (midyear risk score) diagnosis data.
  - If the starting risk score is based on lagged diagnosis data, as it is when the initial risk scores are used, then an adjustment is required to transition the scores from lagged to non-lagged.
  - An example is a starting point of March 2016 MMR data, which contain risk scores based on the July 2014 to June 2015 diagnosis data.
- Run-out of diagnosis data.
  - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is diagnosis data and will be when the starting point is MMR data, then an adjustment factor is required to transition the scores from incomplete (midyear) to complete (final) diagnosis data.
  - Starting risk scores from MMR data do not reflect the final reconciliation.
- Seasonality.
  - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
  - If the starting risk scores are calculated using a risk model (or models) other than those to be used for CY2017 payments, then an adjustment for the risk model change must be made.

- Bid-specific coding trend.
  - Bid-specific coding trends may differ when risk scores are calculated using different models. Therefore, when starting with base year risk scores that are already blended, CMS recommends that plan sponsors assess whether blended scores are to be disaggregated and trended separately, based on expected bid-specific trend experiences under each model.
- Population changes.
  - If the starting risk score is based on a population with different risk characteristics than the expected population, then an adjustment for population changes must be made.
  - Other appropriate factors.

Once projected to CY2017, the scores must be: (i) normalized by dividing by the appropriate CY2017 FFS normalization factors, and (ii) adjusted by the MA coding adjustment factor. Note that, if a raw (not normalized) risk score associated with a different model calibration year is being normalized, the contract year 2017 FFS normalization factors are not appropriate and must be adjusted.

Also note that the risk scores in the files listed below are set to an average of 1.0 using the yearly averages; these files include the average raw risk scores for each year, so that the scores can be unnormalized, if this is desired.

- The rate calculation data zip files (for example, "risk_scores 200x-201x Non-PACE.csv" from the CY201x MA Ratebook).
- FFS Data zip files (for example "FFS data 201x"), such risk scores.

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

Other Considerations

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

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

Sequestration

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

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

- In the case of coinsurance, the effective cost sharing entered in Worksheet 3 may not match the cost-sharing percentage in the PBP. In this case, the MAO must adequately justify such difference. See the "Cost Sharing" pricing consideration for more information about the calculation of the effective coinsurance percentage.

- In the case of the actuarial equivalent cost sharing test (failing "red circle" validations) on Worksheet 4, the MAO must adequately demonstrate the requirement that the plan cost sharing for Medicare-covered benefits entered in the PBP is not greater than FFS cost sharing.

Service Area Changes

Segmented Service Areas

See the uniformity of benefit requirements in Chapter 4 - Benefit and Beneficiary Protections of the *Medicare Managed Care Manual* for information on non-regional PPO bids with segmented service areas at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

Pending Service Area Changes

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

Supporting Documentation

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

III. DATA ENTRY AND FORMULAS

This section includes line-by-line instructions for completing the Medicare Advantage (MA) Bid Pricing Tool (BPT), the Medical Savings Account (MSA) BPT, and the End-Stage Renal Disease-only special needs plans (ESRD-SNP) BPT. It also describes the formulas for calculated cells.

MEDICARE ADVANTAGE

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

The MA BPT 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 bid does not include any optional supplemental benefit packages, then Worksheet 7 may be left blank.

MEDICAL SAVINGS ACCOUNT

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

ESRD-SNP

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

DATA ENTRY

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

Do leave a field blank if—

- The field does not apply, for example, Worksheet 1, Sections II and III, when no base period experience is reported.
- These Instructions state to leave a field blank, for example, the in-network and out-of-network plan deductibles when the annual deductible for a local or regional Preferred Provider Organization (PPO) functions as a combined deductible.

MA WORKSHEET 1 – MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

The purpose of Worksheet 1 is to capture bid-specific experience for the base period, regardless of the level of enrollment and credibility, and to summarize the key assumptions used to project allowed costs to the contract period.

- Section I contains general bid information that will be displayed on all MA BPT worksheets.
- Section II captures base period background information.
- Section III summarizes the base period data for the bid.
- Section IV captures the factors used to project the base period data to the contract period.
- Section V contains a text field that describes other utilization factors and/or additive factors used in Section IV.
- Section VI contains a summary of the base period revenue and expenses.

Section I must be fully completed for all bids. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all bids with experience data for 2016 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

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

Line 1 – Contract Number

Enter the contract number for the bid. The designation begins with a capital letter H (local plan) or R (regional PPO plan) and includes four Arabic numerals (for example, H9999, R9999). Be sure to include all leading zeroes (for example, H0001).

Line 2 – Plan ID

Plan IDs contain three Arabic numerals; however, this field is to be entered as a text input (that is, with a preceding apostrophe). Be sure to include all leading zeroes (for example, '001).

Line 3 – Segment ID

If the bid is in a non-segmented plan, enter zero (0). Otherwise, enter the segment ID. This field is to be entered as a text input (that is, with a preceding apostrophe). Be sure to include all leading zeroes (for example, '000 or '001).

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – Plan Name

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

Line 7 – Plan Type

Enter the type of MA plan. The valid options are listed in the table below. The MA BPT is not completed for Section 1876 and Section 1833 Cost plans; PACE and MSA plans; ESRD-SNPs; and MMPs offered through a Financial Alignment Demonstration. There is a separate MSA BPT and a separate ESRD-SNP BPT.

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

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMOPOS
HMO with a POS Option	HMOPOS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
Regional Coordinated Care Plan:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS

Line 8 – MA-PD

If the bid provides coverage under a Medicare Advantage Prescription Drug Plan (MA-PD), as defined in Chapter 1 of the *Medicare Managed Care Manual*, enter "Y". Otherwise, enter "N".

Line 9 – Enrollee Type

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

If the plan type equals "RPPO," the enrollee type must equal "A/B."

Line 10 – MA Region

If the MA plan is a regional PPO (that is, plan type equals "RPPO"), then input the region number associated with the region that the plan will cover. This field must be entered as a text

input (that is, must include a preceding apostrophe) and must include any leading zeroes (for example, ‘01).

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

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

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

Line 11 – Actuarial Swapping or Actuarial Equivalence Apply

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

Line 12 – SNP

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

Line 13 – Region Name

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

Line 14 – SNP Type

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

Line 15 – VBID

If the PBP includes benefits offered under the Medicare Advantage Value-Based Insurance Design (MA-VBID) model, enter “Y”. Otherwise, enter “N”.

Line 16 – EGWP

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

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

CMS requires base experience data to be based on claims incurred in calendar year 2016 and generally expects at least 30 days of paid claims run-out; 2 - 3 months of paid claim run-out is preferable.

The incurred dates are pre-populated on the first two lines, as 1/1 through 12/31 for the 2 years prior to the contract year. Enter the "paid through" date on the third line. For example, if the data reflect payment information through February 2017, then the "paid through" date is 2/29/2017.

Line 2 – Member Months

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

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

Line 3 – Risk Score

Enter the final risk score for the non-ESRD and non-hospice members of the population represented in the base period data using the CMS-HCC risk models used for payment in CY2016. This risk score must incorporate the appropriate MA coding adjustment factor and normalization factors for payment in CY2016.

Also enter the risk score for the non-DE# subset. The DE# subset will be calculated based on the total and non-DE# amounts entered. The DE# risk score default calculation may be overwritten by the user. See the "Dual-Eligible Beneficiaries" pricing consideration for more information about base period risk scores.

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

Line 4 – Completion Factor

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

For example, assume the following:

Incurred Date	1/1/2016 – 12/31/2016
Paid Through Date (PTD)	2/29/2017
Capitation Payments	$ 100
PTD Claims Requiring Completion	$ 400
Estimate of Unpaid 2016 Claims as of 2/29/2017	$ 30
Total Incurred Claims for 2016	$ 530

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

Line 5 – Bids Included in Base Period Data

The "Contract-Plan ID-Segment ID" columns in line 5 must include the contract number, plan ID, and Segment ID of each bid (including a segment ID of zero (0) for a non-segmented plan), for which: (i) base period data is required to be reported in Worksheet 1 in accord with the "Base Period Experience" pricing consideration, and (ii) such base period data exists.

The required format is "H####-###-###" (with the first character being H, E or R and ending in "000" for a non-segmented plan).

The BPT calculates the "Contract-Plan ID-Segment ID" in cell N14 based on the contract number, plan ID, and Segment ID in Section I. However, the "Contract-Plan ID-Segment ID" in cell N14 may be overwritten by the user, that is, if the base period data excludes the experience of the bid.

In the second column, the user must enter each bid's base period member months. The sum of the member months entered in line 5 is displayed as the total member months in line 2.

If base period data is reported for more than eight bids, then the MAO must include in supporting documentation the base period member months for such bids. Further, the user must: (i) enter in cells N14:N17 and P14:P16, the contract-plan ID of the seven bids with the greatest number of base period member months, and (ii) enter in cell P17, "All Other".

Line 6 – Base Period Description

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

SECTION III – BASE PERIOD DATA (AT PLAN'S RISK FACTOR) FOR 1/1/2016 – 12/31/2016

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

In lines a through q:

- ✓ **Column b – Service Category**

  The benefit service categories are displayed in column b.

- ✓ **Column c – Utilizers**

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

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

- ✓ **Column d – Net PMPM**

  Enter the net medical PMPM for each of the benefit service categories for the base period.

- ✓ **Column e – Cost Sharing**

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

- ✓ **Column f – Utilization type**

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

- ✓ **Column g – Annualized Utilization/1,000**

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

- ✓ **Column h – Average Cost per Unit**

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

- ✓ **Column i – Allowed PMPM**

  Enter the allowed PMPM by service category for the base period.

Line r – COB/Subrogation (outside claims system)

The Coordination of Benefits (COB)/Subrogation service category is intended to include only those amounts that are to be settled outside the claim system. See the "COB/Subrogation" pricing consideration for more information.

- ✓ **Column b – Service Category**

  COB/Subrogation is displayed in lieu of a service category.

- ✓ **Column d – Net PMPM**

  Line r, COB, is set equal to the allowed PMPM in column i by formula.

- ✓ **Column e – Cost Sharing**

  Line r, COB, is set equal to zero.

- ✓ **Column i – Allowed PMPM**

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

Line s – Total Medical Expenses

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

Line t – Subtotal Medicare-Covered Service Categories

Calculated automatically as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS

Section IV contains the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The values in columns j through n are the total adjustment factors from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2016 and that the contract year is 2018. If the utilization trend is 5 percent from 2016 to 2017 and 6 percent for projecting 2017 to 2018, then enter "1.113" in column j (1.05 x 1.06).

In lines a through r:

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

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

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

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

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

  Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the contract period. An example of the use of this factor is to remove the base period experience for certain membership in order for the projected experience rate calculated in Worksheet 2 to be based on actual experience of base period membership continuing in the bid for the contract year. Entering 1.000 would indicate 0 percent change. Do not leave this field blank. Do not enter zero (0).

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

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

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

  Enter the unit cost adjustments by service category for expected changes in provider payments from the base period to the contract period aside from those attributable to

changes in utilization or benefit changes. Examples of this type of change include changes in provider reimbursement due to inflation, sequestration, an indexing provision in provider contracts, or changes in the capitation amount aside from those attributable to changes in utilization or benefit changes. Entering "1.000" would indicate 0 percent trend. Do not leave this field blank. Do not enter zero (0).

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

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

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

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

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

Describe the reason for any additive adjustments in Section V.

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

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

SECTION VI – BASE PERIOD SUMMARY FOR 1/1/2016 – 12/31/2016 (EXCLUDES OPTIONAL SUPPLEMENTAL)

Section VI contains a summary of the actual bid-level base period revenue and expenses. This section must be completed consistently with the "Plans in Base" bid information (reported in Section II line 5) and consistently with the information reported in Section III. See the "Base Period Experience" pricing consideration for more information on reporting base period data.

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

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

Section VI must not include optional supplemental benefits.

This section must not be left blank.

Line 1 – CMS Revenue

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

- Include rebates for the reduction of A/B cost sharing and other A/B mandatory supplemental benefits.
- Include an estimate of the final risk-adjustment reconciliation payment for CY2016, which will be received in mid-2017, such as the final risk-adjustment reconciliation payment for the prior year, if appropriate.
- Do not include rebates applied to Parts B and D premium buydowns.
- Report the CMS revenues gross of user fee reductions and net of sequestration reductions.

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

Line 2 – Premium Revenue

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

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

Line 3 – Total Revenue

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

Line 4 – Net Medical Expenses

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

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

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

Line 5 – Member Months

Enter the base period member months.

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

Line 6 – PMPMs

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

Line 7 – Non-Benefit Expenses

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

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

Line 8 – Gain/Loss Margin

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

Line 9 – Percentage of Revenue

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

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

See the "Dual-Eligible Beneficiaries" pricing consideration for more information about Medicaid data.

The amounts in lines 10a, 10b, 10b1, 10b2, and 10c are in total dollars (not PMPMs).

Line 10b computes the Medicaid cost from Medicaid benefit expenses (line 10b1) and Medicaid non-benefit expenses (line 10b2).

Line 10c computes adjusted gain/loss margin for the bid as gain/loss margin (line 8) plus net Medicaid revenue (line 10a) less Medicaid cost (line 10b).

MA WORKSHEET 2 – MA PROJECTED ALLOWED COSTS PMPM

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

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTED ALLOWED COSTS

Lines 1 and 2 – Projected Member Months and Projected Risk Factor

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

In lines a through q:

- ✓ **Column e – Utilization Type**

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

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

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

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

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

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

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

Column i – Annual Utilization/1,000

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

Column j – Average Cost

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

Column k – Allowed PMPM

Enter PMPM amounts in column k.

✓ **Column l – Credibility Percentage**

Enter the credibility percentage by service category in column l.

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

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

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

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

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

PMPM values in column o must be greater than or equal to zero.

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

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

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

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

See the "Dual-Eligible Beneficiaries" pricing consideration for more information about the reporting requirements of DE# pricing.

PMPM values entered in columns p and q must be greater than or equal to zero.

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

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

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

Line r – COB/Subrogation (outside claim system)

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

- ✓ **Column k – Manual Rate – Allowed PMPM**

  Enter any PMPM any COB/Subrogation offsets to costs.

- ✓ **Column l –Credibility Percentage**

  For a bid with less than fully credible experience or no experience, enter the credibility percentage subject to the conditions described above for lines a through q, column l.

- ✓ **Column o – Blended Rate**

  Calculated automatically based on the projected experience rate, the manual rate, and the credibility percentage.

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

  Enter in columns p and q, the separate allowed PMPM costs for non-DE# (on a "per non-DE# member per month" basis) and DE# (on a "per DE# member per month" basis), respectively, subject to the conditions described above for lines a through q, columns p and q.

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

  Enter the percentage of COB/Subrogation offsets to costs that are expected to be provided out-of-network subject to the conditions described above for lines a through q, column r.

Line s – Total Medical Expenses

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

Line t – Subtotal Medicare-Covered Service Categories

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

Line u – Manual Rate Description

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

MA WORKSHEET 3 – MA PROJECTED COST SHARING PMPM

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

See the "Cost Sharing" and "Dual-Eligible Beneficiaries" pricing considerations for more information on cost sharing, in general, and the cost sharing for DE# beneficiaries.

SECTION I – GENERAL INFORMATION

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

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

Lines 1 through 3 – Plan-Level Out-of-pocket Maximums

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

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

Note that the question in line 3 regarding a combined plan-level maximum enrollee OOP cost applies to a non-network PFFS maximum enrollee out-of-pocket cost amount.

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

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

- For HMO plans and HMO with optional supplemental POS plans enter—
  - "Yes" for the plan-level in-network OOP maximum.
  - "No" for the plan-level out-of-network and combined OOP maximum, even if the PBP includes, in Section C, a POS OOP maximum for a subset of service categories.
- For HMO with mandatory supplemental POS plans enter—
  - "Yes" for the plan-level in-network OOP maximum in Section D.
  - "Yes" or "No" for the plan-level out-of-network OOP maximum in Section D of the PBP, consistent with the PBP.
  - "Yes" or "No" for the plan-level combined OOP maximum, consistent with the PBP.
- For local PPO and regional PPO plans enter—
  - "Yes" for the plan-level in-network OOP maximum.
  - "Yes" or "No" for the plan-level out-of-network OOP maximum, consistent with the PBP.

  - "Yes" for the plan-level combined OOP maximum.
- For full network PFFS and partial network PFFS plans enter—
  - "Yes" or "No" for the plan-level in-network and out-of-network OOP maximums, consistent with the PBP.
  - "Yes" for the plan-level combined OOP maximum.
- For non-network PFFS plans enter—
  - "No" for the plan-level in-network and out-of-network plan-level OOP maximums.
  - "Yes" for the plan-level combined OOP maximum.

✓ **Line 1 – In-Network**

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

✓ **Line 2 – Out-of-Network**

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

✓ **Line 3 – Combined**

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

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

Line 4 – Maximum Cost-Sharing Description

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

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

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

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

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

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

Option A:

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

Option B:

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

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

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

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

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

Line – Description	Column g	Column j	Column k
Line i1 – PCP	5,000	$10.00	$ 4.17
Line i2 – Specialist excl MH	2,900	$20.00	$ 4.83
Line i3 – Mental Health	50	$40.00	$ 0.17
Line i6 – Other	50	$20.00	$ 0.08
Total	8,000	$13.88	$ 9.25

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

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

Line – Description	Col g	Col h (not in finalized BPT)	Col j	Col k
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 – MH	100	$40/visit for indiv MH sessions, $20/visit for group MH	30.00	0.25
Total	8,000		$13.88	$9.25

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

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

In lines a1 through q:

- ✓ **Column c – Service Category**

  This column is pre-populated with line numbers and benefit service categories.

- ✓ **Column d – Service Category Description**

  This column is pre-populated with a description for many of the fixed-line cost-sharing items. For lines with multiple options (for example, "Inpatient Facility"), the description is intended to help you provide detailed information that can easily be checked against the PBP.

- ✓ **Column e – Measurement Unit Code**

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

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

✓ **Column f – In-Network Effective Deductible PMPM**

See the "Cost Sharing" pricing consideration for information about pricing deductibles and entering such pricing in column f or in other columns on Worksheet 3.

✓ **Columns g through k – In-Network Cost Sharing after Deductible**

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

Column g – In-Network Util/1000 or PMPM

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

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

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

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

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

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

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

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

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

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

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

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

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

Column k – In-Network PMPM

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

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

Enter the actual in-network plan-level deductible and the pricing impact of the in-network OOP maximum in line t and line v, respectively.

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

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

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

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

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

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

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

Enter the actual out-of-network plan-level deductible and the pricing impact of the out-of-network OOP maximum in the line t and line v, respectively.

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

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

In blank lines between q and s:

- ✓ **Column c – Service Category**

  This column may be used to provide internal numbering (cells B55:B64) and detailed cost-sharing information. The valid entries for service category (cells C55:C64) are as follows:

  - Inpatient Facility
  - Skilled Nursing Facility
  - Home Health
  - Ambulance
  - DME/Prosthetics/Diabetes
  - Outpatient (OP) Facility – Emergency
  - OP Facility – Surgery
  - OP Facility – Other
  - Professional
  - Part B Rx
  - Other Medicare Part B
  - Transportation (Non-covered)
  - Dental (Non-covered)
  - Vision (Non-covered)
  - Hearing (Non-covered)
  - Suppl. Ben. Chpt 4 (Non-covered)
  - Other Non-covered

  Technical note: The benefit service category entries (cells C55:C64) must match exactly those listed above. 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**

  Enter one of the valid cost-sharing items shown in rows a1 through q.

- ✓ **Columns e through o**

  If a benefit service category is entered in column C (C55:C64), then then the instructions for lines a1 through q, columns e through o apply.

Line s – Total

Calculated automatically as the sum of column f, k, l, or o (or not applicable).

Line t – Plan-Level Deductible Amounts

The cells in columns h, k and n are used to enter plan-level deductible amounts consistent with Section D of the PBP as described below by plan type. When entering such amounts in the BPT, if the PBP indicates that the amount of a deductible is—

- A Medicare-defined deductible (for example, the Medicare-defined Part B deductible) instead of a dollar amount, enter "Medicare FFS" as the amount of such deductible. Do not enter an estimate of the actual Medicare-defined deductible for 2018 or leave the cell blank.
- A dollar amount, enter the amount of such amount, for example, "$500."

If entry in the BPT of a deductible amount is not required, leave the field blank. Do not enter zero (0) as the deductible amount.

✓ **LPPO and RPPO Plan Types**

For a bid with an "LPPO" or a "RPPO" plan type, the deductible always applies to Medicare-covered out-of-network benefits. Therefore, consistent with the PBP, if the deductible—

- Applies to one or more in-network benefits, such deductible is similar to a combined deductible. In this case,—
  - Enter in column h, "Actual combined plan level deductible," the deductible amount or "Medicare FFS".
  - Leave blank column k, "Actual in-network plan-level deductible" and column n, "Actual out-of-network plan-level deductible."
- Does not apply to any in-network benefits, such deductible is similar to an out-of-network deductible. In this case,—
- Leave blank column h, "Actual combined plan-level deductible" and column k, "Actual in-network plan-level deductible."
- Enter in column n, "Actual out-of-network plan level deductible," the deductible amount or "Medicare FFS".

✓ **Plan Types Other Than LPPO and RPPO**

Consistent with the PBP,—

- Enter in column h, combined plan deductible amount or "Medicare FFS".
- Enter in column k, an in-network plan deductible amount or "Medicare FFS".
- Enter in column n, an out-of-network plan deductible amount or "Medicare FFS".

Line u – PMPM Impact of MOOP

Consistent with the PBP,—

- Enter in column k, the PMPM pricing impact of the in-network OOP maximum. Such value must reflect the PMPM difference between the pricing for in-network cost sharing before and after the OOP maximum is applied.
- Enter in column n, the PMPM pricing impact of the out-of-network OOP maximum. Such value must reflect the PMPM difference between the pricing for out-of-network cost sharing before and after the OOP maximum is applied.

The PMPM values must be greater than or equal to zero.

SECTION IV – MAPPING OF PBP SERVICE CATEGORIES TO BPT

Section IV captures the mapping of PBP benefit categories to BPT service categories. The cells for PBP categories 1a through 18b are pre-populated based on the suggested mapping of PBP to BPT categories in Appendix F, but must be overwritten by the user to reflect the actual mapping used in developing PMPM amounts in the BPT.

If the PBP includes benefits offered under the MA-VBID model, the user must enter the mapping for PBP categories 19a and 19b.

MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

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

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

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

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

Section V captures projected Medicaid data.

See the "Dual-Eligible Beneficiaries" pricing considerations for information on completing Worksheet 4 for DE# beneficiaries.

SECTION I – GENERAL INFORMATION

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

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

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

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

In lines a through r:

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

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

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

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

- ✓ **Column g – N/A**

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

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

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

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

The PMPM amounts shown in columns e, f, and h reflect all benefits covered by the MA bid. The user must enter in columns i and j, the expected percentages of benefits that represent Medicare-covered. The percentages may differ for Non-DE# and DE# as explained below.

- For Non-DE# in subsection A,—
  - The BPT uses the percentages in column i, to allocate allowed costs (column e) between Medicare-covered (column m) and A/B mandatory supplemental benefits.
  - The BPT uses the percentages in column j, to allocate the plan's cost sharing (column f) between plan cost sharing for Medicare-covered services (column l) and cost sharing for A/B mandatory supplemental benefits.
- For DE# in subsection B,—
  - The BPT uses the percentages in column i, to allocate provider reimbursement plus actual cost sharing for total benefits (column e) between Medicare-covered (column m) and A/B mandatory supplemental benefits.
  - The BPT uses the percentages in column j, to allocate the plan's cost sharing (column f) between actual cost sharing for Medicare-covered services (column l) and cost sharing for A/B mandatory supplemental benefits.

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

For services that are defined in the PBP as non-covered, the percentage for Medicare-covered services is defaulted to 0.0 percent (for example, line l, "Transportation Non-covered"). For all other services, the MAO must estimate the percentage of covered services. For example, if the MAO's benefit for a service is richer than that under FFS Medicare, or is classified as a mandatory supplemental benefit in the PBP, such as a POS benefit, the user must enter in column i, a percentage less than 100 percent.

Non-DE# Example:

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

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

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

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

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

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

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

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

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

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

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

Column m – Allowed PMPM

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

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

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

Column o – Net PMPM

Calculated as column m minus column n.

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

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

Column p – Net PMPM for Additional Services

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

Column q – Reduction of A/B Cost Sharing

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

Column r – Total A/B Mandatory Supplemental Benefits

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

Line s – Total Medical Expenses

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

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

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

In lines a through r:

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

  Calculated automatically as the sum of columns g and h.

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

  This column contains a formula that may be overwritten by the user. The default formula divides the non-DE# beneficiary cost sharing by the non-DE# allowed, and then multiplies by the DE# allowed from column q of Worksheet 2. See the "Dual-Eligible Beneficiaries" pricing consideration for more information about plan cost sharing.

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

  Calculated automatically as the minimum of columns f and k.

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

  Enter values in accord with the "Dual-Eligible Beneficiaries" pricing consideration.

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

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

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

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

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

  Calculated automatically as column g times column j.

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

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

Column m – Allowed PMPM

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

Column n – Medicaid Cost Sharing

Calculated automatically as column k times column j.

Column o – Net PMPM

Calculated as column m minus column n.

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

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

Column p – Net PMPM for Additional Services

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

Column q – Reduction of A/B Cost Sharing

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

Column r – Total A/B Mandatory Supplemental Benefits

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

Line s – Total Medical Expenses

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

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

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

In lines a through q and t:

- ✓ **Columns e through g – N/A**

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

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

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

- ✓ **Columns i through n – N/A**

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

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

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

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

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

  Column p – Net PMPM for Additional Services

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

  Column q – Reduction of A/B Cost Sharing

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

  Column r – Total A/B Mandatory Supplemental Benefits

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

Line r – ESRD

This line is populated based on Section III.

Line s – Additional Benefits (employer bids only)

N/A for CY2018.

Line u – Total Medical Expenses

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

Line v – Non-Benefit Expenses

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

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

- ✓ **Lines v1 through v5 – Non-Benefit Expenses**

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

  Column h – Non-Benefit Expense PMPM for Total Benefits

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

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

  These values are calculated as column h minus column r.

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

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

- ✓ **Line v6 – Total Non-Benefit Expense**

Column h – Total Non-Benefit Expense PMPM

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

Columns p and q – Non-Benefit Expense PMPM for Additional Services and Reduction of A/B Cost Sharing

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

Columns o and r – Non-Benefit Expense PMPM for Medicare-Covered and A/B Mandatory Supplemental

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

Line w – Gain/Loss Margin

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

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

Line x – Total Revenue Requirement

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

Lines y1 through y3 – Percentage of Revenue

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

Lines z1 through z3 – Overall Gain/(Loss) Margin Level

These fields pertain to the corporate margin requirement and the level at which the overall gain/loss margin requirements are met. See the "Gain/Loss Margin" pricing consideration for more information regarding aggregate-level gain/loss margin requirements.

- ✓ **Line z1 – Corporate Margin Requirement % of Revenue**

  Enter the corporate margin requirement as a percent of revenue.

- ✓ **Line z2 – Corporate Margin Basis**

  This line contains a drop-down menu with two options: "Non-Medicare" or "Risk-Capital-Surplus". The option selected in the MA BPT must match the option selected in the Part D BPT.

  Do not leave this field blank.

- ✓ **Line z3 – Overall Gain/(Loss) Margin Level**

  This line contains a drop-down menu with three options for the gain/loss margin level of aggregation: "Contract," "Organization," and "Parent-Organization." The level selected in the MA BPT must match the level selected in the Part D BPT of an MA-PD.

  Do not leave this field blank.

Lines z4 through z5 – Negative Bid-Level Gain/(Loss) Margin

These fields pertain to an MA bid with a negative projected gain/loss margin in line w. See the "Gain/Loss Margin" pricing consideration for more information regarding bid-level gain/loss margin requirements.

- ✓ **Line z4 – Valid Product Pairing**

  If, in the contract year, the bid satisfies the requirements for the MA product pairing exemption to the bid-specific business plan requirement, enter "Yes" to the question, "Is the bid part of a valid product pairing?" Otherwise, enter "No".

- ✓ **Line z5 – Bids in Product Pairing**

  If the answer in line z4 to the product pairing question is "Yes," enter in line z5, columns j through n, the contract number-Plan ID-Segment ID (including a segment of zero (0) for a non-segmented plan) of each MA bid in the product pairing.

  The required format is "H####-###-###" (with the first character being H, E or R and ending in "000" for a non-segmented plan).

  Leave columns l through n blank to the extent the preceding cells in line z5 identify each bid in the MA product pairing.

  If there are more than five bids in the product pairing, then the MAO must include in supporting documentation the contract number-Plan ID-Segment ID of each bid not identified in line z5.

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

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

CY Member Months (entered by county)

This value is obtained from Worksheet 5.

CY ESRD Member Months

This value is obtained from Worksheet 5.

CY Out-of-Area (OOA) Member Months

This value is obtained from Worksheet 5.

Basic Benefits

See the "End-Stage-Renal Disease (ESRD)" pricing considerations for more information about this section of the BPT.

Supplemental Benefits

See the "End-Stage-Renal Disease (ESRD)" pricing considerations for more information about this section of the BPT.

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

N/A for CY2018.

SECTION V – PROJECTED MEDICAID DATA

This section contains three input cells to capture Medicaid projected revenue and costs. Entries must be reported on a "per Member per Month" (PMPM) basis. Values must be greater than or equal to zero. See the "Dual-Eligible Beneficiaries" pricing consideration for more information about Medicaid data.

MA WORKSHEET 5 – MA BENCHMARK PMPM

This worksheet calculates the A/B benchmark and evaluates whether the bid generates a savings or the need to charge a basic member premium.

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

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

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Member Months (from Section VI)

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

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

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

Line 3 – Medicare Secondary Payer (MSP) Adjustment

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

Line 4 – Weighted Average Risk Factor

This member/payment-weighted average value is obtained from Section VI. You must enter the projected non-DE# value (including non-DE# out-of-area). The DE# value is calculated based on the total and the non-DE# amounts. The DE# risk score default calculation may be overwritten by the user. See the "Projected Risk Score for CY2018" pricing consideration for more information about the DE# risk score default calculation.

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

Line 5 – Conversion Factor

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

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

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

Line 7 – Plan A/B Bid

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

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

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

SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 – Savings

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

Line 2 – Rebate

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

Line 3 – Basic Member Premium

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

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

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

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

Line 1 – Statutory Component for Region

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

Line 2 – Plan Bid Component

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

MAOs may input an estimated average regional PPO bid amount in their initial bid submission.

For bids that are submitted prior to the announcement of the regional PPO bid averages, there are two options for completing this field: (i) leave the cell blank, in which case the plan's submitted standardized bid (Section II, line 8) is used as the plan bid component, or (ii) input a reasonable estimate of the average regional PPO bid for the region. The MA regional PPO announcement includes the weighted-average MA regional PPO bid for each region. MAOs will be instructed at the time of the announcement to submit revised regional PPO MA BPTs with the applicable average regional PPO bid amount entered in line 2. Any changes in rebates due to the actual plan bid component must be reallocated at the same time. Appendix E contains additional guidance regarding the rebate reallocation period.

Line 3 – Standardized A/B Benchmark

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

SECTION V – QUALITY RATING

This section captures quality rating information released by CMS. See the "Affordable Care Act" pricing consideration for more information about QBP star ratings and rebate percentages.

Line 1 – Quality Bonus Rating (per CMS)

Enter the numeric quality bonus rating (that is, QBP "star rating") released by CMS for the contract (that is, a numeric value from "1.0" through "5.0") or leave the cell blank. The value entered in the BPT will be validated upon upload. (That is, if the BPT value does not match the value released by CMS in HPMS, the upload will be rejected.)

Line 2 – New/Low Indicator (per CMS)

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

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

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

Line 3 – Rebate Percentage

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

SECTION VI – COUNTY-LEVEL DETAIL AND SERVICE AREA SUMMARY

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

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

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

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

Line 1 – Use of Plan-Provided ISAR Factors

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

Line 2 – Total or Weighted Average for the Service Area

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

Line 3 – County-Level Detail

✓ **Column b – State-County Code**

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

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

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

✓ **Column c – State**

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

✓ **Column d – County Name**

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

✓ **Column e – Projected Member Months**

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

See the "Pricing Considerations" section of these Instructions for more information about projected member months.

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

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

- ✓ **Column f – Projected Risk Factors**

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

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

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

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

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

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

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

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

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

- ✓ **Column j – ISAR Scale**

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

- ✓ **Column k – ISAR-Adjusted Bid**

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

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

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

SECTION VII – OTHER MEDICARE INFORMATION

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

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

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

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

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

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

Columns t through u – Metropolitan Statistical Area (MSA)

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

SECTION VIII – PROJECTED CY MEMBER MONTHS

This section captures and summarizes the various components of the bid's member months.

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

This value is obtained from Section VI.

Line 2 – ESRD Member Months

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

This amount is used on Worksheet 4 Section III.

Line 3 – Hospice Member Months

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

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

This value is obtained from Section VI.

Line 5 – Total Member Months

Calculated as the sum of line 1 through 4.

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

MA WORKSHEET 6 – MA BID SUMMARY

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

SECTION I – GENERAL INFORMATION

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

SECTION II – OTHER INFORMATION

SUBSECTION A – Part B Information

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

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

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

SUBSECTION B – Rebate Allocation for Part B Premium

Line 1 – PMPM Rebate Allocation for Part B Premium

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

Line 2 – Rounded Part B Rebate Allocation

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

SUBSECTION C – Rebate Allocations

Line 1 – Reduce A/B Cost Sharing

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

Line 2 – Other A/B Mandatory Supplemental Benefits

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

SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the BPT information in three subsections.

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

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

SUBSECTION A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Net Medical Cost

These amounts are obtained from Worksheet 4.

Line 2 – Non-Benefit Expenses

These amounts are obtained from Worksheet 4.

Line 3 – Gain/Loss Margin

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

Line 4 – Total Revenue Requirement

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

Line 5 – Standardized A/B Benchmark

This amount is obtained from Worksheet 5.

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

This amount is obtained from Worksheet 5.

Line 7 – Risk Factor

This amount is obtained from Worksheet 5.

Line 8 – Conversion Factor

This amount is obtained from Worksheet 5.

SUBSECTION B – MA Rebate Allocation

MAOs may choose which of the following category, or categories, in which to allocate rebates:

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

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

Line 1 – MA Rebate

This amount is obtained from Worksheet 5.

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

Lines 2 through 6 – Rebate Allocations by Category

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

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

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

Line 7 – Total Rebate Allocated

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

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

SUBSECTION C – Development of Estimated Plan Premium

Line 1 – A/B Mandatory Supplemental Revenue Requirements

This amount is obtained from Section IIIA.

Line 2 – Less Rebate Allocations

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

Line 3 – A/B Mandatory Supplemental Premium

The sum of lines 1 and 2.

Line 4 – Basic MA Premium

This amount is obtained from Worksheet 5.

Line 5 – Total MA Premium (excluding Optional Supplemental)

The sum of lines 3 and 4.

Line 6 – Rounded MA Premium (excluding Optional Supplemental)

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

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

Line 7 – Part D Basic Premium

- ✓ **Line 7a – Prior to Rebates**

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

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

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

- ✓ **Line 7d – Part D Basic Premium**

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

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

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

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

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

Line 8 – Part D Supplemental Premium

- ✓ **Line 8a – Prior to Rebates**

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

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

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

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

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

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

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

Line 9 – Total Estimated Plan Premium

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

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

Line 10 – Plan Intention for Target Part D Basic Premium

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

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

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

SECTION IV – CONTACT INFORMATION AND DATE PREPARED

MAOs must identify three persons as MA plan bid contact, MA certifying actuary, and MA additional actuarial BPT contact. The MA certifying actuary and MA additional actuarial BPT contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number, and e-mail information for all three contacts; credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

Section IV also contains a field labeled "Date Prepared." This field is populated with a date/time stamp during the BPT finalization.

SECTION V – WORKING MODEL TEXT BOX

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

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

MA WORKSHEET 7 – OPTIONAL SUPPLEMENTAL BENEFITS

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

The PBP packages must be entered in the same order as they are entered in the PBP, and the package name/description must match the PBP.

SECTION I – GENERAL INFORMATION

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

SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

Column b – Package ID

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

Column c – Description

For each package, enter a description of the OSB package. This description must match the description/package name entered in the PBP for each package. Examples: "Enhanced Dental," "Gold Package," etc. The description field must not be left blank when there is an optional supplemental package entered.

Column d – Allowed Medical Expense: PMPM

Enter the projected contract year allowed medical expense PMPM for each package.

Column e – Enrollee Cost Sharing: PMPM

Enter the projected enrollee cost sharing PMPM for each package.

Column f – Net PMPM Value

Column f is calculated automatically as the allowed PMPM (column d) minus the cost sharing PMPM (column e).

Column g – Non-Benefit Expense

Enter the total projected contract year non-benefit expense PMPM for each OSB package offered.

Column h – Gain/Loss Margin

Enter the total projected contract year gain/loss margin PMPM for each OSB package offered.

Column i – Premium

The sum of columns f (medical expenses), g (non-benefit expenses), and h (gain/loss margin). The premiums are automatically rounded to one decimal to comply with premium withhold system requirements. Premium values must be greater than zero if an OSB package is offered and must be equal to zero if an OSB package is not offered.

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

Column j – Projected Member Months

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

SECTION III – COMMENTS

Enter any comments needed to describe the OSB packages.

SECTION IV – BASE PERIOD SUMMARY (ENTERED AT THE CONTRACT LEVEL)

This section contains a summary of the actual contract-level base period revenue and expenses.

Note that Section IV must be completed in total dollars (not PMPMs), and it must include all optional supplemental benefit packages that were provided in the base period.

IV. APPENDICES

APPENDIX A – ACTUARIAL CERTIFICATION

GENERAL

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

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

Certification Module

The certification module contains the following features:

- Standardized required language.
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids.
- Links to additional information regarding the bid package such as the PBP, BPT, and supporting documentation.
- The ability to certify multiple bids/contracts.
- The ability to print and save the submitted certification.

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is, pending CMS approval) via the certification module in August following the CMS publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but they may do so if they wish. Note that in the event that the PBP changes after the "final" bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

Material changes to the certification language (after the initial June certification submission) are not allowed without prior written permission from the CMS Office of the Actuary.

Multiple actuaries may be assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. The instructions contained in this appendix must be followed by all certifying actuaries.

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

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

Required Certification Elements

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

- The certifying actuary's name/user ID and the date, "stamped" when completed.
- Declaration that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy's qualification standards for doing so.
- The specific contract number, plan ID, and segment ID of the bid(s) being certified.
- The contract year of the bid(s) contained in the certification.
- Indication of whether the certification applies to the MA bid(s), the PD (Part D) bid(s), or both.
- Attestation that the bid(s) are in compliance with the applicable laws[1], rules[2], CY2018 bid instructions, and current CMS guidance.
- Attestation that, in accordance with Federal law, the bid(s) are based on the "average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile."
- Attestation that the data and assumptions used in the development of the bid(s) are reasonable for the plan's benefit package (PBP).
- Attestation that the bid(s) were prepared in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries[3].

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

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

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

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

APPENDIX B – SUPPORTING DOCUMENTATION

GENERAL

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

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

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

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.2, "Actuarial Report," the materials provided must be written "with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work."

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

Supporting documentation must—

- Be clearly labeled and easily understood by CMS reviewers.
- Explain the rationale for the assumptions, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Describe bid-specific variations in addition to the overall pricing assumption or methodology.
- Match the values entered in the current BPT and tie to the PBP.
- Include Excel spreadsheets with working formulas, rather than pdf files, and a narrative explanation of the inputs and the calculations and their components.
- Clearly identify it is related to MA, Part D, or both.
- Clearly identify the bid(s) relating to the support. At a minimum, the contract number and organization name must appear on the first page. Specific bid numbers must be included where appropriate, such as on the first page, in a separate chart, or as an attachment.
- Include a hard-coded date.
- Include the contract-plan ID (or organization name) and topic in the beginning of the file name.
- Include the topic in the name of each worksheet in an Excel workbook.
- Be labeled "revised" if any information in the file is revised or appended during bid desk review.

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

- Meeting minutes that include comprehensive documentation of discussions related to bid development.
- A complete description of data sources—for example, a report's official name/title, file name, date obtained, source file, the precise name of any published tables used, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services arrangements.
- A business plan.

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

- Materials accessible only through a secure server link that requires a password.
- A reference to the supporting documentation for another bid, such as "the same as for plan Hxxxx-xxx-xxx," and not the documentation itself. The supporting documentation for a bid must be self-contained.
- Excel spreadsheets with a vague explanation or no explanation of the bid-specific inputs and calculations.
- PDF files with the "Copy" function disabled.
- A statement that the source of a pricing assumption is "professional judgment" with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies, or public information.
- "Living worksheets" that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of bid filings in previous years.

SUBMITTING SUPPORTING DOCUMENTATION

Supporting materials must be in electronic format (for example, Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation.

Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, which compress multiple files into one (.zip file extension). Also note that although one file can be uploaded to multiple bids in HPMS, documentation must not be uploaded to bids to which it does not pertain. Similarly, it is not acceptable to upload to multiple bids materials specific to a Part D plan, MA bid, or certain contract number.

More requirements about the upload of substantiation files are located in HPMS, under HPMS Home > (Plan Bids) Bid Submission > CY2018 > (Upload) Substantiation > Next, for example, the "Notes" section.

Cover Sheet

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

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

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a bid's projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of contract number-plan ID-segment ID (such as "plans 001 – 030" or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact contract number-plan ID-segment IDs to which the documentation applies.

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

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

Timing

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

- The "Initial June Bid Submission" section of Appendix B describes supporting documentation materials that MAOs must upload to HPMS with the initial June bid submission.
- The "Upon Request by CMS Reviewers" section of Appendix B describes materials that MAOs and certifying actuaries must provide within 48 hours of request by CMS reviewers.
- When a BPT is resubmitted, the MAO must upload to HPMS a summary of changes, including the cause and effect of each revision authorized by CMS or CMS reviewers, or proposed by the MAO for rebate reallocation.
    - If a BPT is resubmitted for rebate reallocation, CMS expects the upload of the summary of changes to occur by the end of the rebate reallocation period.
    - If multiple BPTs are resubmitted at the same time, the supporting documentation must include a mapping of specific bid changes to contract number-plan ID-segment IDs.
    - Sample BPTs are not to be uploaded to HPMS.
- Prior to the final actuarial certification,—
    - MAOs and certifying actuaries must revise supporting documentation consistent with the final certified bid.

- MAOs are not to upload to HPMS correspondence from the bid review process, for example, e-mail.
- CMS expects revised supporting documentation to have the same file name as the original substantiation file except for a different date or a word such as "revised."

Initial June Bid Submission

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

1. A cover sheet outlining the documentation files, as described above.
2. A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, changes in service area, type of coverage, contractual arrangements, marketing approach, and any other pertinent information that would help expedite the bid review. For dual-eligible SNPs, include a statement indicating how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management, and margins.
3. A document titled "Related-Party Declaration" that states whether or not the MAO is in a related-party arrangement (Worksheets 1, 2 and 4).
4. Support for sequestration's effect on the bid, including a qualitative and quantitative description of how it is reflected in pricing assumptions.
5. Support for the claims credibility assumptions (Worksheet 2), including—
   - 5.1. A statement of the credibility methodology used—for example, the CMS guideline or the CMS override.
   - 5.2. A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
6. A detailed description of the process used for adjusting cost sharing due to maximum OOP limits, including how the PMPM impact of the maximum OOP was determined. (Worksheet 3).
7. Support for non-benefit expense assumptions (Worksheets 1 and 4). The required elements include—
   - 7.1. A reconciliation of the base period non-benefit expenses reported in Worksheet 1 of the BPT to auditable material such as corporate financials and bid-level operational data.
   - 7.2. A description of the expenses included in each non-benefit expense category in the BPT.
   - 7.3. Detailed support for the development of projected non-benefit expenses. The required elements include—
     - 7.3.1. A description of the methodology used to develop non-benefit expenses.
     - 7.3.2. An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.

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

7.3.4. An explanation for significant differences between actual and expected non-benefit expenses for CY2014, CY2015 and CY2016, including a description of how that knowledge was incorporated into the contract year projection.

8. Justification of the gain/loss margin (Worksheet 4). The required elements include—

8.1. A demonstration of how the corporate margin requirement is set, including an explanation for any change from the prior year.

8.2. Support for overall MA margin levels, including—

8.2.1. The level at which overall margins are determined.

8.2.2. A list of the MA contract numbers offered by the organization, if aggregate gain/loss requirements are met at the organization level.

8.3. A detailed justification for limited situations, in which: (i) the aggregate margin for general enrollment plans & I/C SNPs combined is outside of the stated range of the corporate margin; or (ii) the aggregate margin for D-SNPs is outside of the stated range of the aggregate margin for general enrollment plans & I/C SNPs combined, or the corporate margin, as applicable. This includes—

8.3.1. A description of the limited circumstances supporting an exception.

8.3.2. Evidence of the absence of anti-competitive practices and solvency issues.

8.3.3. Actions taken to bring the margin differential into compliance with these Instructions.

8.4. A demonstration of consistency between the projected aggregate margins for MA and the actual aggregate returns over the long term. If the returns have been inconsistent historically, provide an explanation of how this is addressed in the current bid submission. For example, how pricing assumptions have been made to bring the projected margin closer to the actual returns.

8.5. A detailed justification of the need for flexibility in the gain/loss margin requirements in order to satisfy other CMS requirements such as TBC.

8.6. Support for a bid with a negative margin, including one of the four items outlined below.

8.6.1. A description of the MA product pairing that includes the gain/loss margin for each MA bid and shows that such bids—

a. Have identical service areas;

b. Are all local coordinated care plans, or all regional PPO plans, or all PFFS plans; and

c. Have a positive combined gain/loss margin for CY2018.

8.6.2. An alternate MA bid-specific business plan that includes a demonstration that the MA bid margin is negative only in order to satisfy an aggregate-level margin requirement.

8.6.3. For a new bid, or a bid with a zero or positive projected gain/loss margin for the prior contract year, an MA bid-specific, year-by-year, numeric business plan that demonstrates profitability within five years, including, but not limited to, the elements listed below. A suggested negative-margin business plan template can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BidGuidance.html.

a. For each year, projected: member months, risk scores, CMS revenue, MA premium, Medicare-covered and mandatory supplemental benefit medical expenses, non-benefit expenses, and gain/loss margin.

b. An explanation of steps taken in the contract year and to be taken in each future year to achieve profitability, that is, a year-by-year description of benefit and premium changes, and other actions.

c. The year that profitability will be achieved or the MA bid becomes part of a valid product pairing.

8.6.4. For an MA bid with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the projected gain/loss margin to the MA margin in the original or most recent MA bid-specific numeric business plan. The required elements include—

a. Details and sources of deviation from the original or most recent MA business plan.

b. An explanation and demonstration of how the targeted margin in the original or most recent MA business plan will be met, if the bid is progressing toward a positive margin more slowly than projected in the original or most recent business plan. This includes, but is not limited to,—

i. A revised business plan demonstrating that the MA bid will reach profitability within five years of the original MA business plan. The revised business plan must include the detailed numeric and narrative information required in 8.6.3. (a through c).

ii. Copies of the original and most recent MA business plans uploaded to HPMS in a separate file.

8.7. A detailed justification for a unique situation, in which an MA bid-specific business plan does not achieve profitability within five years, including—

8.7.1. A description of the unique circumstances supporting an exception.

8.7.2. Evidence of the absence of anti-competitive practices and solvency issues.

8.7.3. Actions taken to bring the margin differential into compliance with these Instructions.

9. Detailed support for the development of projected risk scores (Worksheet 5). The required elements include—

    9.1. A detailed description, and corresponding numerical demonstration, of the methodology used to develop projected CY2018 MA risk scores.

    9.2. A description of, and the rationale for choosing, the source data for the development of the projected CY2018 MA risk scores, including—

        9.2.1. Identification of the source of the starting risk score and, if not the CMS-provided risk scores, an explanation of why the alternative source was appropriate.

        9.2.2. For an alternative approach, identification of the years used, the population incorporated, and any data points used as a basis in developing the CY2018 risk score.

    9.3. A description of the methodology used to derive each projection factor, including—

        9.3.1. A summary of the consideration for using or not using the projection factor, a description of and the rationale for choosing the source data, and the data points used in the derivation of the projection factor.

        9.3.2. For the bid-specific coding trend, a statement about the risk score years utilized, the number of years used and whether the scores are normalized or raw.

    9.4. A statement about the consistency between the development of the projected risk scores for the bid population and the development of projected medical expenses.

    9.5. An explanation for significant differences between actual and expected risk scores for CY2014, CY2015 and CY2016, including a description of how that knowledge was incorporated into the CY2018 projection.

    9.6. For an alternate approach, a demonstration that the method used is consistent with the preferred development approach in these Instructions, including an explanation of why such approach is more appropriate than the CMS preferred approach.

    9.7. A statement of the credibility approach used—for example, the CMS guideline or the CMS override.

    9.8. A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.

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

10. Support for the development of the base period data (Worksheet 1).

    10.1. Detailed qualitative and quantitative support for the development of the base period experience. This documentation, which is based on regulatory authority for the review of materials that pertain to any aspect of services provided, is also required in cases in which medical services are provided under a capitated arrangement. The required elements include—

10.1.1. A description of the allocation of allowed costs by service category when the allocation method is not based on bid experience data.

10.1.2. Information regarding the base period member months, if more than eight bids constitute the base period data.

10.1.3. Justification for the lack of encounter data for services provided under capitated arrangements including—

a. An explanation for the deficiency.

b. A detailed description of the steps that the MAO has taken or is taking to obtain encounter data for subsequent year's bid submissions.

c. A description of the data source for utilization per 1,000 and the basis for any adjustments.

10.2. Reconciliation of base period experience to the MAO's audited financial statements and bid-level operational data. The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including claims paid, unloaded claim reserves, non-benefit expenses, and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.

10.3. Cross-walk information regarding data aggregation. See the sample format at the end of Appendix B. The required elements include—

10.3.1. A list of all bids involved in approved cross-walks for CY2017 and proposed cross-walks for CY2018 considered for base period data aggregation.

10.3.2. A statement of the intention to submit a cross-walk exception for CY2018, if applicable.

10.3.3. The rationale for determining the level of significance. A detailed calculation of the proportion of members cross-walked to the contract number-plan ID-segment ID from others bid(s) listed on Worksheet 1, Section II5, Plans in Base, for example, numerical components of the numerator and the denominator.

11. Detailed qualitative and quantitative support for the development of each projection factor (Worksheet 1). The required elements include—

11.1. A description of the source data, including the data's relevance to the MA bid.

11.2. A summary of the MAO's historical trends including—

11.2.1. The percentage trends.

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

11.2.3. The numeric calculations.

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

11.3.1. Industry and/or internal studies.

11.3.2. Benefit design analysis.

11.3.3. A change in the mix of services, including the rationale for the type of projection factor used to reflect such change.

11.3.4. A change in the mix of provider arrangements such as capitated and risk sharing arrangements.

11.4. An explanation for significant differences between actual and expected claims for CY2014, CY2015, and CY2016, including a description of how that knowledge was incorporated into the projection factors.

11.5. Justification for combining data for multiple service categories.

12. Detailed support for the data and methodology used in the development of appropriate manual rates for the expected population (Worksheet 2). The required elements include—

12.1. A description of the source data, including the data's relevance to the MA bid and the exposure (expressed in member months) as used to develop the manual rate.

12.2. Consideration of any adjustments made for annual volatility of the source data.

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

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

12.3.2. Techniques and factors used to reflect differences between the underlying population and that expected of the MA bid.

12.3.3. 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.

12.3.4. Addition of Medicare-covered benefits not reflected in the source data.

12.3.5. Factors to reflect lower claims for expected MSP enrollees in the projected population.

12.3.6. Exclusion of non-covered benefits reflected in the source data.

12.3.7. Methodology and data used to gross up reimbursements to an allowed-cost basis.

12.4. Data and methodology used to project the data from base period to CY2018

12.5. The reasonableness of allowed costs and projection factors for costs based on capitated payments to related parties.

12.6. The allocation of projected allowed costs by service categories.

12.7. All other applicable factors and/or adjustments.

13. Detailed support for related-party medical and administrative service arrangements (Worksheets 1, 2, 3 and 4).

13.1. An MAO in a related-party arrangement must provide the following:

13.1.1. Declaration of every related-party arrangement.

13.1.2. Disclosure of all services provided in every related-party arrangement.

13.1.3. A summary that explains the relationship of the parties involved and common ownership, control and investment.

13.1.4. A summary of the contractual terms of each relationship that includes a description of the services provided and money exchanged.

13.1.5. Disclosure of the method used in preparing the bid for each arrangement. The options are: (i) for administrative service arrangements, Actual Cost for Administrative Services Method or Market Comparison for Administrative Services Method; and (ii) for medical service arrangements, Actual Cost for Medical Services Method, Market Comparison for Medical Services Method, Comparable to FFS, or FFS Proxy Method.

13.2. An MAO that chooses the Actual Cost for Administrative Services Method must provide a qualitative and quantitative summary of the development of the related party's non-benefit expense.

13.3. An MAO that chooses the Market Comparison for Administrative Services Method through the MAO (or through the related party) must—

13.3.1. Demonstrate that the contract with the unrelated party is associated with sufficient costs to be considered a valid contract.

13.3.2. Show that the fees associated with the related-party arrangement are within 5 percent of the fees for similar services in the administrative arrangements between the MAO and the unrelated party (or between the related-party organization and the unrelated party).

13.3.3. For related-party administrative arrangements between the related-party organization and an unrelated party, provide a signed attestation from the related party stating that the actual contract will be available for review upon request by CMS.

13.4. An MAO that chooses the Actual Cost for Medical Services Method must—

13.4.1. Provide a qualitative and quantitative analysis of the development of the related party's medical expense associated with the related-party arrangement.

13.5. An MAO that chooses the Market Comparison for Medical Services Method through the MAO (or through the related party) must—

13.5.1. Demonstrate that the contract with the unrelated MAO (or with the unrelated party) is associated with sufficient costs to be considered a valid contract.

13.5.2. Show that the fees associated with the related-party arrangement are within 5 percent, or $2 PMPM, whichever is greater, of the fees for providing similar services to a Medicare population in medical arrangements between the MAO and the unrelated party in the bid's service area (or between the related-party organization and the unrelated MAO).

13.5.3. For related-party medical arrangements between the related-party organization and an unrelated MAO, provide a signed attestation from the

related party stating that the actual contracts will be available for review upon request by CMS.

13.6. An MAO that chooses the Comparable to FFS Method must—

13.6.1. Provide written evidence of a good-faith, but unsuccessful, effort to obtain the actual costs of the related party to provide medical services to the MAO under the related-party arrangement.

13.6.2. Demonstrate that the fees associated with the related-party arrangement are comparable to 100% FFS for similar services, that is, within 5 percent or $2 PMPM, whichever is greater.

13.7. An MAO that chooses the FFS Proxy Method must—

13.7.1. Provide written evidence of a good-faith, but unsuccessful, effort to obtain the actual costs of the related party to provide medical services to the MAO under the related-party arrangement.

13.7.2. Demonstrate that the fees associated with the related-party arrangement are not comparable to 100% FFS for similar services, that is, within 5 percent or $2 PMPM, whichever is greater.

13.7.3. Provide one of the following elements:

a. A declaration that: (i) the related-party organization does not have an arrangement to provide similar services with an unrelated party, or (ii) the MAO does not have an arrangement to provide similar services with unrelated providers in the bid's service area.

b. Evidence of a good-faith, but unsuccessful, effort to obtain sufficient information about fees for similar services in medical arrangements between: (i) the related-party organization and unrelated parties, or (ii) the MAO and unrelated providers in the bid's service area.

c. A demonstration that fees for similar services are not comparable between: (i) the related-party organization and unrelated parties, or (ii) the MAO and unrelated providers in the bid's service area.

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

15. An explanation of and detailed support for how CY2017 bid audit findings and observations and compliance issues were corrected in the current bid for the same plan. To the extent that an issue applies to other bids in the same contract or parent organization, the documentation for the audited bids must describe how the bids for all plans are treated consistently regarding that issue.

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

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

16.2. Identifies the information relied upon;

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

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

See the sample format at the end of this appendix.

17. Detailed qualitative and quantitative support for the development of the components of pricing assumptions pertaining to the MAO's participation in the Medicare Advantage Value-Based Insurance Design (MA-VBID) model, including an explanation for and a demonstration of the VBID pricing by VBID intervention for each applicable BPT value.

18. Support for the development of DE# and non-DE# bid values. The required elements include—

    18.1. Support for the allocation of enrollment between DE# and non-DE# beneficiaries including the basis for classifying dual-eligible enrollees as DE# (Worksheets 1 and 5).

    18.2. Support for non-DE# projected allowed costs (Worksheet 2).

    18.3. Justification for changes in the DE# plan reimbursement, including the derivation of the revised plan reimbursement PMPMs in Worksheet 4, column h.

    18.4. Support for zero projected DE# member months when there are DE# members in the base period (Worksheet 5).

19. Support for claim costs for hospice enrollees for mandatory supplemental benefits when these costs are included in the projected allowed cost PMPM.

20. The rationale for projecting a zero cost of a benefit in the PBP, including the source data, an explicit statement that the projected cost for the contract year is zero or essentially zero, and a list of each benefit in the bid priced in such manner.

21. Support, at the benefit level, for non-covered services (Worksheet 2, lines l through q, column o), if any, including a breakdown of the PMPM value shown in the BPT. For example, a $4.00 PMPM in column o of row p, "Suppl. Ben. Chpt 4 (Non-Covered)," is to be shown in the supporting documentation as $1.50 PMPM for a smoking and tobacco cessation counseling and $2.50 PMPM for medical nutrition therapy. (Detailed support for the pricing of each additional benefit is available upon request.)

22. Support for the development of projected cost sharing (Worksheet 3). The required elements include—

    22.1. A detailed demonstration of how coinsurance or copayment amounts, for which CMS does not have an established amount (for example, coinsurance for inpatient or copayment for durable medical equipment), satisfies CMS service category requirements. The MAO must upload this demonstration under the "cost sharing justification upload" section in the Bid submission module of HPMS located under HPMS Home > Plan Bids > Bid Submission > CY2018 > Substantiation > Select Applicable Contact Number.

    22.2. The determination of the PMPM impact of deductibles.

23. Support for a global capitation arrangement or risk sharing arrangement. The required elements include—

    23.1. A description of the arrangement.

23.2. A demonstration of the methodology used to allocate the impact of the arrangement to BPT service categories (including the allocation to the MA and Part D BPTs, if the arrangement applies to Part D services)

24. Support for the development of the contract year ESRD subsidy (Worksheet 4). This required documentation includes the following:

24.1. Base period (for example, 2016) revenues and medical expenditures for Medicare-covered benefits provided to enrollees in ESRD status.

24.2. The source for, and the development process of, any manual rates used.

24.3. Relevant base-to-contract year trend factors.

24.4. A statement of the credibility approach used—for example, the CMS guideline or the CMS override.

24.5. A description of the credibility methodology used if varies from the CMS guideline or the CMS override.

25. Detailed support for the MSP adjustment, including justification for a zero amount. (Worksheet 5).

26. Support for the development of plan-provided ISAR factors (Worksheet 5), if used. (This requirement applies to regional PPOs only.) A description of the methodology and data source(s) used to calculate the ISAR factor(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (that is, non-benefit expense and gain/loss margin) that were assumed in the development of the factors.

27. Support for the projected medical expense, projected non-benefit expense, and projected gain/loss margin for specific optional supplemental benefit packages (Worksheet 7).

28. Support for actuarial swapping/equivalence customization for employer/union groups enrolled in individual-market plans (Worksheet 1).

29. – 34. For future use

Upon Request by CMS Reviewers

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

35. Copies of related-party contracts.

36. A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.

37. An explanation of how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.

38. Justification of benefit value in relation to the gain/loss margin. The required elements include—

38.1. An explanation of how the PBP offers benefit value in relation to the margin.

38.2. Support for an MA bid with a high margin, including—

38.2.1. An explanation of a need for a contingency margin that correlates to the "risk" to the MAO, low credibility, and/or significant claims variability from year to year.

38.2.2. A demonstration of incremental benefit and premium changes being made over time to reduce margin while maintaining stability, including a justification that the PBP is providing all possible benefits that the expected population can utilize.

39. Support for the pricing of the non-covered services, including utilization and unit cost (Worksheet 2, lines l through r, column o). (Support at the benefit level is required in the initial June bid submission.)

40. Detailed support for cost-sharing utilization assumptions (Worksheet 3).

41. Support for allocation of allowed costs and cost sharing between Medicare-covered and A/B mandatory supplemental benefits (Worksheet 4).

42. Support for when the formulas provided in the BPT for DE# plan cost sharing (Worksheet 4, Section IIB, column f) are overwritten at the discretion of the certifying actuary.

43. Support for the calculation of the "Medicaid Cost Sharing" (Worksheet 4, Section IIB, column k), including cost sharing required by state or territory Medicaid programs in the bid's service area based on the eligibility rules for subsidized cost sharing for DE# beneficiaries.

44. Support that changes in PMPM bid values as a result of rebate reallocation are consistent with the pricing approach and methodologies used in the initial June bid submission.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

SAMPLE SUPPORTING DOCUMENTATION

MA Checklists for Required Supporting Documentation

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Related-party declaration
Sequestration
Claims credibility assumption
Adjustment to cost sharing for maximum OOP limit
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period data
Projection factors
Manual rates
Related-party arrangements
Input sheets for pricing model
Bid audit results and compliance issues
Reliance information
VBID
DE# and non-DE#
Hospice claims costs for mandatory supplemental
Zero projected benefit cost
Non-covered services benefit-level summary
Cost sharing
Global capitation or risk sharing arrangement
ESRD "subsidy"
MSP adjustment
ISAR factors
Optional supplemental benefit (OSB)
Employer or union groups

Upon Request by CMS Reviewers
Related-party contracts
Reliance letter
OFM audit results
Benefit value/margin
Non-covered services pricing
Cost-sharing utilization
Allocation of allowed costs/cost sharing to Medicare-covered and non-covered
DE# plan cost sharing override
State and territory cost sharing requirements
Rebate reallocation pricing
Other

SAMPLE MA Cover Sheets

MA Cover Sheet #1 - CY2018 Initial Bid Submission

Organization Name: Health One

Contract(s): Hxxxx, Hyyyy, and Szzzz

Date: June 5, 2017

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if Applicable)	MA, PD or Both
Cover sheet	All bids	Cover Sheet HealthOne 6-5-2017.pdf	Page 1	both
Product narrative	All bids	Cover Sheet HealthOne 6-5-2017.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet HealthOne 6-5-2017.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet HealthOne 6-5-2017.pdf	Page 6	both
Non-benefit expenses	All bids	HealthOne AdminProfit 6-5-2017.xls	Sheet 1	both
Gain/loss margins	All bids	HealthOne AdminProfit 6-5-2017.xls	Sheet 2	both
Risk scores	All bids	HealthOne Risk CY2018 6-5-2017.xls	MA-Sheet 1 Part D-Sheet 2	both
Related-Party declaration	All bids	HealthOne Cover Sheet 6-5-2017.pdf	Page 7	both
Sequestration	All bids	Cover Sheet 6-5-2017.pdf	Page 7	both
Manual rates	Hxxxx-003	Manual Hxxxx 6-5-2017.xls	Section II	MA
ESRD subsidy	Hxxxx-001 Hxxxx-004	Manual 6-5-2017.xls	Section I	MA

MA Cover Sheet #2 - CY2018 Subsequent Bid Submission

Organization Name: Health One

Contract(s): Hxxxx, Hyyyy, and Szzzz

Date: July 15, 2017

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if Applicable)	MA, PD or Both
Cover sheet	Hxxxx-001 Hxxxx-003 Hxxxx-004 Hxxxx-801 Hyyyy-001 Szzzz-001	Cover Sheet 7-15-2017.doc	N/A	both
Gain/loss margins	Hxxxx-001 Hxxxx-003 Hxxxx-004 Hyyyy-001	HealthOne AdminProfit Revised 07-15-2017.xls	Sheet 1	both
Manual rates	Hxxxx-003	Manual Rates Revised 6-6-2017.xls	Section I	MA

SAMPLE Reliance on Information Supplied by Others

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

Cross-walk Supporting Documentation

Bid: Hxxxx-001

Significance Level (for all bids): 30%

Determination of the Level of Significance:

[Describe the determination of the level of significance used as a threshold for reporting aggregated period experience.]

CY 2018 WK1 Reporting for: Hxxxx-001

	Member Months (MMs)						
CY2016 Bid	**(c) CY2016 Total MMs**	**(d) # Cross-walked from CY2016 Bid to Reporting Bid**	**(e) # Removed From Reporting Bid**	**(f) # Remaining in Reporting Bid (d-e)**	**(g) % Remaining in Reporting Bid (f/c)**	**Include CY2016 Base Period Data CY2018 Reporting Bid (WK1)**	**Relevant Crosswalk**
Hxxxx-001	3,000	—	2,500	N/A	N/A	Yes	N/A Ongoing bid
Hxxxx-002	500,000	10,000	—	10,000	2.0%	No	Plan 001: CY2017 SAE
Hxxxx-003	200	150	80	70	35.0%	Yes	Plan 001: CY2017 SAE; Intend to file CY2018 SAR Crosswalk Exception Request
Hxxxx-004	6,000	3,000	—	3,000	50.0%	Yes	Plan 001: Intend to file CY2018 SAE Crosswalk Exception Request
Hxxxx-005	6,000	1,000	—	1,000	16.7%	No	Plan 001: Intend to file CY2018 SAE Crosswalk Exception Request

APPENDIX C – PART B-ONLY ENROLLEES

This appendix includes bid requirements for plans that cover only enrollees eligible for Medicare Part B. A regional PPO plan must cover enrollees eligible for both Medicare Part A and Part B.

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

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

CMS encourages MAOs 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 MAO can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if the plan is offering the pre-1999 Part B-only members the same benefits at the same price as those offered to A/B members (that is, members eligible for both Part A and Part B of Medicare), the MAO is not required to submit a separate bid for the Part B-only members.

MAOs are to prepare Part B-only bids in much the same way as those prepared for Part A/B members. For Part B-only plans, MAOs must give special consideration to allocating the portion of services that are considered to be Medicare-covered (Worksheet 4, Section II, columns i and j):

- The Medicare-covered proportion of inpatient services (line a) must equal zero (0) percent.
- While the majority of Medicare expenditures for skilled nursing facilities (SNFs) are covered under Part A (Hospital Insurance), in certain circumstances benefits are covered under Part B (Supplementary Medical Insurance). Guidance on these covered services can be found in Section 70 of Chapter 8 of the Medicare Benefit Policy Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html. We estimate that for calendar year 2015, about 5 percent of Medicare expenditures for SNFs will be covered under Part B.
- Also, as is stated in Section 60.3 of Chapter 7 of the Medicare Benefit Policy Manual, if a beneficiary is enrolled only in Part B and is qualified for the Medicare home health benefit, then all of the home health services are financed under Part B. Thus, for most Part B-only plans, the Medicare-covered proportion of home health services (line c) will be 100 percent.

APPENDIX D – MEDICARE ADVANTAGE PLANS AVAILABLE TO EMPLOYER/UNION GROUPS

INDIVIDUAL-MARKET PLANS ("MIXED ENROLLMENT" PLANS)

An MAO may offer its individual-market MA plans to employer/union group health plan sponsors and modify benefits for specific employer/union groups through two types of allowable customization: "actuarial swapping" or "actuarial equivalence."

Actuarial Swapping

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

Actuarial Equivalence

If an MAO requests the actuarial equivalence category of customization allowable for employer and union groups, the MAO must provide the following information as supporting documentation:

- The proposed change in cost-sharing amounts and the MA plan containing such cost sharing.
- Any modification to the premium charged.
- Any improvement in the benefit related to the changed cost sharing.

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

An MAO must retain in its files, but not upload to HPMS, a package of documents with computations supporting the proposed changes under these two types of allowable customization.

For more information on employer/union group sponsorship of individual MA plans, see Chapter 9 of the *Medicare Managed Care Manual* (MMCM) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

APPENDIX E – REBATE REALLOCATION AND PREMIUM ROUNDING

MAOs may resubmit bids in order to reallocate MA rebate dollars for certain bids and return to the target Part D basic premium after CMS publishes the Part D benchmarks (that is, the Part D national average monthly bid amount, the Part D base beneficiary premium, and the Part D regional low-income premium subsidy amounts), and the MA regional benchmarks. Consequently, rebate reallocation is required for some MA bids, is permitted (but not required) for others, and is not permitted for certain bids, as indicated in this appendix.

Note that in order to satisfy all CMS rebate reallocation requirements, it may not be possible for the MAO to reach the total estimated plan premium prior to rebate reallocation. Rebate reallocation is only an opportunity to get back to the target Part D basic premium and reflect the published MA regional benchmarks in the BPT.

Rebate reallocation may involve minimal benefit changes in order to fully reallocate rebates. In such case, revisions to MA pricing assumptions for the incremental change in benefits and the associated impact on other pricing assumptions, as described in this appendix, are permitted only for the bids involved in rebate reallocation. Note that this step, which may include a minor change in gain/loss margin to satisfy TBC requirements, is separate from, and must be completed prior to, any change in gain/loss margin permitted under the premium rounding rules.

Also note that the Part D bid must be unchanged (aside from a rare exception to address a negative Part D basic premium). However, when resubmitting bids during or after rebate reallocation period, plans must update the national average monthly bid amount and base beneficiary premium in the Part D BPT.

CMS will announce the exact dates of the rebate reallocation period when the Part D and MA benchmarks are released.

I. REBATE REALLOCATION PERMISSIBILITY BY PLAN TYPE

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

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

MA-PD sponsors have two options for the target premium. They can set it equal to—

- The basic Part D premium net of rebates (that is, the amount displayed in line 7d of Worksheet 6, Section IIIC), or
- The low income premium subsidy amount.

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

The target Part D basic premium concept does not apply to MA-only plans, since these plans do not submit a Part D BPT.

All regional PPO plans must resubmit during the rebate reallocation period, to reflect the published MA regional PPO benchmarks within their bids.

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

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

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

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

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

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted	Permitted
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

MA-Only Plans

Type of Plan	Rebate Reallocation	Premium Rounding
Local	Not permitted; these plans are not affected by the Part D and MA regional benchmarks	Not permitted; premiums must reflect desired rounding in the initial June bid submission
RPPO	Required, to reflect the published MA regional benchmarks	Permitted

II. REBATE REALLOCATION RULES AND EXAMPLES

A. Return to the Target Premium

When rebates are reallocated, the Part D basic premium net of rebate must be returned to the target Part D basic premium indicated in the initial June bid submission; there is no option to target and reallocate rebates to return to Total Plan Premium.

CMS will not accept a partial return to the target premium, except in the following situation: the MAO intends to return to the target premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.

B. Negative Part D Basic Premium Net of Rebate after Part D Benchmark Announcement

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

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if the premium resulting from application of the national average monthly bid amount and the base beneficiary premium is negative, then the "excess" rebate allocated to buy down the Part D basic premium must be reallocated to buy down the other premiums (the A/B mandatory supplemental premium, the Part D supplemental premium, and/or the Part B premium).

Example 1

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Resubmission
7a. Part D basic premium prior to rebates (rounded)	$36	$34	$34
7c. MA rebates allocated to Part D basic premium (rounded)	$36	$36	$34
7d. Part D basic premium	$0	−$2	$0
10. Plan intention for target Part D basic premium	Premium amount displayed in line 7d	Not applicable	Not applicable

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

C. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than Target Part D Basic Premium, but Not Less than Zero

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

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

Note: If the MAO elects to allocate the "excess" rebate dollars to the other premiums, then the final Part D basic premium must equal the target premium. In other words, a partial return to the target premium will not be accepted.

Example 2

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

The MAO has one of the following two options for rebate allocation:

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

Note: If the MAO does not want to leave the post-Part D benchmark announcement premium at $15, only a return to $20 is acceptable, not a partial return of, for example, $18.

D. Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than Target Part D Basic Premium

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

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

Example 3

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

The MAO has one of the following two options for rebate allocation:

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

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

E. Increase or Decrease in RPPO Total Rebate Dollars

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

Example 4

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2	Rebate Reallocation Option 3
Total MA rebate (IIIB, line 1)	$55	$53	$53	$53	$53
MA rebates allocated to benefits other than Part D basic premium (IIIB, lines 2-4 and 6)	$40	$40	$38	$43	$38
MA rebates allocated to Part D basic premium (rounded) (IIIB, line 5)	$15	$15	$15	$10	$15
Total rebates allocated (IIIB, line 7)	$55	$55	$53	$53	$53
Unallocated rebates	$0	−$2	$0	$0	$0
A/B Supp premium prior to rebates (IIIC, line 1)	$50	$50	$50	$50	$48

MA BPT Worksheet 6	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option 1	Rebate Reallocation Option 2	Rebate Reallocation Option 3
A/B Supp premium net of rebates (rounded) (IIIC, line 3)	$10	$10	$12	$7	$10
Part D basic premium prior to rebates (rounded) (IIIC, line 7a)	$35	$30	$30	$30	$30
Part D basic premium net of rebates (IIIC, line 7d)	$20	$15	$15	$20	$15
Total MA-PD premium (IIIC, line 9)	$30	$25	$27	$27	$25
Plan intention for target Part D basic premium (IIIC, line 10)	Premium amount displayed in line 7d	Not applicable	Not applicable	Not applicable	Not applicable

The MAO has one of the following three options for rebate allocation:

- Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of $15. Subtract $2 of rebates that were allocated to other premiums such that the total rebates allocated equal the total rebates available.
- Reduce the rebate allocation for the basic Part D premium by $5 in order to return to the target Part D basic premium of $20. Reallocate $3 of rebates to other premiums such that the total rebates allocated equal the total rebates available.
- Make a change to A/B supplemental benefits as discussed in the section III in Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits. Reduce the rebate allocation to benefits other than the Part D basic premium by $2 such that the total rebates allocated equal the total rebates available. Leave the basic Part D premium net of rebate at the post-Part D benchmark announcement premium of $15.

F. Every Plan Bid Must Allocate the Exact Amount of the Plan's Total Rebate

The exact amount of the plan's total rebate must be allocated among the various options described above. MAOs must account for all rebate dollars in a plan's bid. Moreover, the amount of rebate allocated to each benefit (A/B mandatory supplemental, Part B, Part D) must not exceed the value of that benefit. For example, if the Part D supplemental premium is $50, an MAO may not allocate more than $50 to buy down that premium. Rebate allocations to the Part B premium cannot exceed the amount provided by CMS that is pre-populated in the BPT.

G. Examples in which Target Part D Basic Premium Is the Low-Income Premium Subsidy Amount (LIPSA) and the Plan Desires to Reach the LIPSA (Including Di Minimis)

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Less than LIPSA

If the Part D basic premium net of rebate post-benchmark is lower than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the MAO may increase the Part D basic premium in order to reach the LIPSA by either (i) reallocating rebates to reduce other beneficiary premiums (A/B mandatory supplemental, Part B, and/or

Part D supplemental), or (ii) adding A/B mandatory supplemental benefits, in accordance with this appendix, and reallocating rebates to reduce the premium for the newly added benefits.

Example 5a

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	$35	$30	$30
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$12
7d. Part D basic premium	$20	$15	$18
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	$18	$18

The LIPSA is less than expected, and the Part D basic premium net of rebate post-benchmark is less than the LIPSA. To reach the LIPSA, the only option that the MAO has is to reallocate $3 of rebates to other benefits/premiums (adding mandatory supplemental benefits as needed).

Part D Basic Premium Prior to Rebate (line 7a) after Part D Benchmark Announcement Is Less than LIPSA

If the post-benchmark Part D basic premium prior to rebate (line 7a) is lower than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the post-rebate reallocation Part D basic premium net of rebate will necessarily be lower than the LIPSA and the MAO is not allowed to achieve the LIPSA. To be as close to the LIPSA as possible, the MAO may increase the final Part D basic premium by reallocating the entire rebate that was applied to Part D basic premium to other beneficiary premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental).

Example 5b

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation Option
7a. Part D basic premium prior to rebates (rounded)	$33	$32	$32
7c. MA rebates allocated to Part D basic premium (rounded)	$3	$3	$0
7d. Part D basic premium	$30	$29	$32
10. Plan intention for target Part D basic premium	LIPSA	LIPSA	Not applicable
LIPSA	Not applicable	$34	$34

The LIPSA is greater than expected, and the post-benchmark Part D basic premium net of rebate is less than the LIPSA. To try to reach the LIPSA, the only option the MAO has is to reallocate $3 to other premiums.

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA

If the Part D basic premium net of rebate post-benchmark is greater than the LIPSA, and LIPSA is designated as the target Part D basic premium, then the MAO may lower the Part D basic premium to the LIPSA by reallocating the rebate to the Part D basic premium that was applied to buy down other premiums (A/B mandatory supplemental, Part B, and/or Part D supplemental). If the MAO chooses to reallocate additional rebate dollars from other premiums, the final Part D basic premium must equal the LIPSA except in the following situation: the MAO intends to return to the LIPSA premium, and the entire rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the LIPSA.

Example 5c (Similar to Example 3)

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	$35	$40	$40
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$25
7d. Part D basic premium	$20	$25	$15
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	$15	$15

The LIPSA is less than expected, and the Part D basic premium post-benchmark is greater than the LIPSA. To return to the target LIPSA, the only option the MAO has is to reallocate rebates from other benefits/premiums to the Part D basic premium.

Part D Basic Premium Net of Rebate after Part D Benchmark Announcement Is Greater than LIPSA - De Minimis Election

The Part D basic premium post-benchmark is greater than the LIPSA and LIPSA is designated as the target Part D basic premium. If (i) the MAO has no rebates or has allocated all of the MA rebates to the Part D basic premium, and (ii) the difference between the Part D basic premium post-benchmark and the LIPSA is between $0 and the de minimis amount published by CMS, the MAO may volunteer to waive the portion of the Part D basic premium equal to this difference.

Conversely, if the difference between the Part D basic premium post-benchmark and the LIPSA is greater than the de minimis amount published by CMS, the MAO cannot volunteer to waive the de minimis amount.

Example 5d (MA rebates allocated to Part D basic premium equal total MA rebates)

Total MA rebates post-benchmarks are $23.

MA BPT Worksheet 6, Section IIIC, Line—	Initial June Bid Submission	After Release of Benchmark	Rebate Reallocation
7a. Part D basic premium prior to rebates (rounded)	$35	$40	$40
7c. MA rebates allocated to Part D basic premium (rounded)	$15	$15	$23
7d. Part D basic premium	$20	$25	$17
10. Plan intention for target Part D basic premium	LIPSA	Not applicable	Not applicable
LIPSA	Not applicable	$15	$15

The difference between the $17 Part D basic premium post-benchmark and the $15 LIPSA is $2. The MAO may volunteer to waive $2 of the $17 Part D basic premium to reach the target LIPSA only if CMS publishes a de minimis amount greater than or equal to $2. If CMS publishes a de minimis amount less than $2, the MAO may not participate in the de minimis program or waive any portion of the $17 Part D basic premium.

Note that the de minimis amounts in this example are hypothetical and do not reflect CMS' de minimis policy for CY2018. Also note that information regarding CMS' de minimis policy for CY2017 released via an HPMS memorandum dated July 29, 2016 includes the requirement that MA-PDs "allocate all of their MA rebates to buy down the Part D basic premium."

H. First-Time Allocation of Rebate Dollars to Part D Basic Premium during the Rebate Reallocation Period.

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

Example 6

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

III. ADDITIONAL REBATE REALLOCATION GUIDANCE

Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits

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

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

- The net shift in (i) total MA rebate dollars due to an increase or decrease in those dollars after application of the regional benchmark, and (ii) a shift in rebates dollars allocated to Part D basic premium to return to the Part D target premium.
- The shift in total MA rebate dollars due to an increase or decrease in those dollars after application of the MA regional PPO benchmark.

CMS will not allow the MAO to eliminate one benefit and then add another benefit.

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

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

Example 7

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

However, CMS will not allow the MAO to accomplish rebate reallocation by changing the value of benefits by more than $3, for example, by moving $15 out of A/B cost-sharing reductions and moving $18 into an additional benefit. We would consider this to be a substantial redesign of the A/B mandatory supplemental benefit.

When the Part D basic premium net of rebate is greater than the target Part D basic premium after the Part D benchmark announcement, the MAO could—

- Buy down less of the A/B mandatory supplemental premium; or
- Eliminate or reduce an A/B mandatory supplemental benefit (for example, provide an eye exam less frequently), and then buy down the new A/B mandatory supplemental premium to the initial level.

Similarly, to return a regional plan with a decrease in the total amount of rebate to the original premium, the MAO could, for example, eliminate from the A/B mandatory supplemental benefit package the coverage of a non-Medicare covered item or service.

Changes Allowed to the Part B Premium Reduction

One use of rebate dollars allowed under 42 CFR §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars allocated for this purpose may be increased or decreased. However, the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount pre-populated by CMS in the BPT.

Plans Required to Include Prescription Drug Coverage

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

In accordance with 42 CFR §423.104(f), MAOs may not offer an MA coordinated care plan in an area unless that plan (or another MA plan offered by the same MAO in the same service area) includes required prescription drug coverage. In accord with Chapter 5 of the *Prescription Drug Benefit Manual*, for purposes of meeting this requirement, an MA organization is considered to be an MA parent organization.

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

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

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

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

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

During the rebate reallocation period, rebate dollars that are not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. However, no modifications are allowed to the benefit design or pricing of the Part D basic benefit or the supplemental benefit offered under the "enhanced alternative" design. That is, this prohibition includes that no changes are permitted to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits. (Note that in the rare case, in which the basic Part D premium is negative after the release of the national average and base beneficiary premium, limited changes may be allowed to enhance the Part D benefits in order to create a Part D supplemental premium that offsets the Part D basic premium.)

MA Pricing

This section describes changes in MA pricing assumptions allowed or required by CMS as a result of benefit changes made due to rebate reallocation. Such modifications to pricing assumptions are separate from, and exclude, any adjustment to the gain/loss margin pertaining to premium rounding as permitted in Section IV, Rule 3 of this appendix. That is, a change in gain/loss margin under the "50 cents rounding rule" applies after the MA pricing changes described in this section are made.

Incremental Benefit Changes

The BPT must reflect the value of A/B mandatory supplemental benefits added or eliminated as a result of rebate reallocation, including the impact of such changes on other pricing assumptions, consistent with the pricing approach and methodologies utilized in the initial June bid submission. (That is, incremental changes in the cost of benefits and the MA regional PPO benchmark must "flow-through" the original pricing structure supporting the initial June bid submission.) Examples include, but are not limited to changes in—

- Projected allowed costs due to induced utilization related to changes in cost sharing.
- Non-benefit expenses priced as a percentage of revenue or a percentage of premium, such as insurer fees.

The BPT will automatically reflect (that is, calculate by formula) the following small changes to bid values:

- A small change due to the automatic (that is, calculated by formula) proportional allocation of non-benefit expenses and the gain/loss margin in the BPT formulas.
- A small change in the ESRD subsidy due to the automatic impact of changes in mandatory supplemental benefits, non-benefit expenses and gain/loss margin.

Further, CMS expects the provider reimbursement pricing assumption for DE# to be impacted by rebate reallocation due only to changes in additional benefits for services not covered by original Medicare. See the "Dual-Eligible Beneficiaries" pricing consideration for more information.

Total Beneficiary Cost

If the MAO chooses to modify the PBP as a result of rebate reallocation, CMS will allow a minor change in gain/loss margin in order to satisfy CMS TBC requirements as explained below. Such adjustment is based on the CMS published Part D and MA regional benchmarks and the related post-benchmark, pre-rebate reallocation premiums. However, it does not take into account benefit changes resulting from rebate reallocation.

- First recalculate the plan's TBC taking into account the premium changes associated with the CMS published Part D and MA regional benchmarks prior to any changes to benefits.
- Then, calculate the (minimum) amount of premium change needed to satisfy TBC requirements.
- Gain/loss margin may change by the amount necessary to produce such premium change.

Note that the MAO may not further adjust margin in order to account for any change in TBC generated by benefit changes made during rebate reallocation.

Local MA Plan Segments

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

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; it may not vary across segments. Therefore, prior to the allocation of rebates to buy down the premium, the Part D basic and supplemental premium must be the same across segments. However, the amount of rebates allocated to buy down Part D basic and supplemental premiums may differ by segment.

See Chapters 1 and 4 of the *Medicare Managed Care Manual* for requirements for MA plan segments.

IV. RULES FOR ROUNDING PREMIUMS

This section describes system requirements for rounded premiums and the circumstances in which the MAO may round premiums in order to reach plan premium goals.

Rule 1 – System Requirements Regarding Premiums and Rebates

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

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

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

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

Rule 2 – Local MA-Only Plans

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

Rule 3 – Local MA-PD and Regional PPO Plans

Rounding Rule 3 applies to local MA-PD plans and regional PPO plans that are allowed to or are required to participate in the rebate reallocation process. During rebate reallocation, MAOs may round the total plan premium to the nearest dollar (up or down) by slightly increasing or reducing the gain/loss margin in the MA bid, as long as the change in margin results in a total plan premium change of no more than $0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of the combination of the MA basic and mandatory supplemental premiums and the Part D basic and supplemental premiums.)

Further, if the plan has rebate dollars, then the MAO may round total premium by making a small change in the gain/loss margin that results in an increase or decrease in rebate dollars of no more than $0.50. Note that, in order to account for the proportional allocation of the total gain/loss margin to Medicare-covered and A/B mandatory supplemental in the BPT, and also to account for the savings retained by Medicare, the total margin may change by slightly more than $0.50. Specifically, the Medicare-covered margin (Worksheet 4, cell O107) would be limited to:

- At the 70% rebate level: limited to a $0.71 Medicare-covered margin change, to result in a $0.50 change in rebates ($0.71 × 70% = $0.50).
- At the 65% rebate level: limited to a $0.77 Medicare-covered margin change, to result in a $0.50 change in rebates ($0.77 × 65% = $0.50).
- At the 50% rebate level: limited to a $1.00 Medicare-covered margin change, to result in a $0.50 change in rebates ($1.00 × 50% = $0.50).

Note that this rule applies separately from, and after, all other bid adjustments CMS allows during rebate reallocation as explained in the "MA Pricing" and "Total Beneficiary Cost" sections of this appendix.

Examples of Rounding

Example a: An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if (i) the bid equals the benchmark, and no A/B mandatory supplemental benefits are offered, or (ii) the bid is less than the benchmark, and the plan has A/B mandatory supplemental benefits and applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement total plan premium is $30.42, the MAO could round the plan premium to $30.00 by generating $0.42 of additional rebates to allocate to the basic Part D premium by slightly reducing the gain/loss margin for MA benefits. (The gain/loss margin for Part D benefits must not change.)

Example b1: An MA-PD plan has no premium for Medicare-covered or A/B mandatory supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This situation could occur if (i) the bid equals the benchmark, and no A/B supplemental benefits are offered, or (ii) the plan applies rebates to reduce the A/B mandatory supplemental premium to zero.) If the post-Part D benchmark announcement bid results in a total plan premium of $32.42, the MAO could opt to generate $0.42 of additional rebates to allocate to the basic Part D premium by making a slight reduction in the gain/loss margin for MA benefits that would result in a premium of $32.00.

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

Example b2: An MA-PD plan has A/B mandatory supplemental benefits, an initial basic Part D premium (target premium) of $30, and a total plan premium of $70.00. If the post-Part D benchmark announcement bid results in a basic Part D premium of $28.55 and a total plan premium of $68.55, the MAO could opt to make a slight change in the gain/loss margin for MA benefits in order to achieve a $0.45 increase in premium for A/B mandatory supplemental benefits, resulting in a total plan premium of $69.00.

The MAO could not use the rounding rules to adjust the premium to anything higher than $69. For example, the organization could not round to a combined premium of $70 by increasing the gain/loss margin to result in a premium change of $1.45. To return to the target premium of $30, the MAO would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

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

Example d: The target Part D basic premium is the low-income premium subsidy amount. After the Part D national average monthly bid amount is calculated, the Part D

basic premium is $32.00, and the low-income premium subsidy amount is $31.60. The plan has the following three options:

Option 1: The plan can maintain its Part D basic premium of $32.00. The plan's beneficiaries eligible for the full subsidy will pay a Part D basic premium of $0.40.

Option 2: The MA-PD plan can reallocate $.40 of the rebates that were allocated to the A/B mandatory supplemental premium to its Part D basic premium, thus reducing the premium to the low-income premium subsidy amount of $31.60. To account for the reduction in rebates applied to the A/B mandatory supplemental premium, the MA-PD plan may either increase its A/B mandatory supplemental premium by $0.40 or reduce its gain/loss margin appropriately to eliminate the premium increase. Enrollees not eligible for the low-income subsidy would pay a Part D basic premium of $31.60.

Option 3: In order to be able to offer a rounded Part D basic premium to enrollees not eligible for the low-income subsidy, MA-PD plans are permitted in this situation to reallocate A/B mandatory supplemental rebates to reduce their Part D basic premium to the nearest whole-dollar amount below the regional low-income premium subsidy amount. Therefore, the MA-PD plan can reallocate $1.00 of its A/B mandatory supplemental rebates to its Part D basic premium, reducing the Part D basic premium to $31.00, which is the nearest whole-dollar amount below the regional low-income premium subsidy of $31.60. To account for the reduction in A/B mandatory supplemental rebates applied to MA, the MA-PD plan must increase its A/B mandatory supplemental premium by $1.00 and cannot offset the reduction by a change in the gain/loss margin. Please note that in this option, the MA-PD plan forgoes $0.60 in potential low-income premium subsidy dollars per each beneficiary eligible for the full subsidy.

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

Option 1: If the plan were to round the Part D basic premium to $31.70, then it would receive $31.70 as the low-income premium subsidy. The plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since such premium is lower than the LIPSA.

Option 2: If the plan were to round the Part D basic premium to $31.80, then it would receive $31.80 as the low-income premium subsidy as if the LIPSA were $31.80. In this case, the plan's beneficiaries eligible for the full subsidy would not pay a Part D basic premium, since the $0.04 difference between the Part D basic premium and the LIPSA (that is, $31.80 less $31.76) rounds to zero when such premiums are rounded to one decimal.

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

the $37.90 Part D premium, the total plan premium for each segment becomes a whole-dollar amount: $89, $114, and $148.

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

V. SUMMARY OF CONSIDERATIONS FOR REBATE REALLOCATION RESUBMISSIONS

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

- All regional PPO plans must resubmit during the rebate reallocation period, in order to reflect the published regional MA benchmarks.
- If the Part D national average monthly bid amount and base beneficiary premium result in a Part D basic premium that is lower than the rebates allocated to Part D basic, then the bid must be resubmitted.
- When resubmitting bids during the rebate reallocation period, plans must update the national average monthly bid amount and base beneficiary premium in the Part D BPT.
- The Part D bid must be unchanged.
- The Part D basic premium net of rebates must equal the target.
- If the LIPSA is targeted, the resubmitted Part D basic premium net of rebates must be equal to the plan's LIPSA (rounded to the nearest dime or rounded down to the nearest dollar).
- The "plan's intention for the target premium" in the MA BPT must be unchanged.
- Changes to MA pricing assumptions (benefit/non-benefit /gain/loss) must be consistent with these Instructions.
- Re-submitted bids must continue to satisfy CMS requirements, such as service category cost sharing, meaningful difference, and TBC evaluations.

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

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

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

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

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

PBP line #	PBP Category	BPT line #	Corresponding BPT Category: Description/Note (Worksheet 3)
7i	Physical Therapy and Speech Language Pathology Services	i4	Professional: Therapy (PT/OT/ST)
8a	Outpatient Diagnostic Procedures/Tests/Lab Services	h1	OP Facility - Other: Lab
8b	Outpatient Diagnostic/Therapeutic Radiological Services	h2	OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g or h	OP Facility - Surgery; or OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center (ASC) Services	g	OP Facility - Surgery
9c	Outpatient Substance Abuse	h5	OP Facility - Other: Other
9d	Outpatient Blood Services	h5 or k	OP Facility - Other: Other or Other Medicare Part B
10a	Ambulance Services	d	Ambulance
10b	Transportation Services	l	Transportation (Non-Covered)
11a	Durable Medical Equipment (DME)	e1	DME/Prosthetics/Diabetes: DME
11b	Prosthetics/Medical Supplies	e2	DME/Prosthetics/Diabetes: Prosthetics/ Diabetes
11c	Diabetes Supplies and Services	e2	DME/Prosthetics/ Diabetes: Prosthetics/ Diabetes
12	Dialysis Services	h4	OP Facility - Other: Renal Dialysis
13a	Acupuncture and Other Alternative Therapies	q	Other Non-Covered
13b	OTC Items	q	Other Non-Covered
13c	Meal Benefit	q	Other Non-Covered
13d	Other 1	q	Other Non-Covered
13e	Other 2	q	Other Non-Covered
13f	Other 3	q	Other Non-Covered
13g	Dual Eligible SNPs with Highly Integrated Services	q	Other Non-Covered
13h	Medicare-Medicaid Plan	q	Other Non-Covered
14a	Medicare-covered Zero Dollar Preventive Services	k, i1, i2 or i6	Other Medicare Part B; Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14b	Annual Physical Exam	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14c	Eligible Supplemental Benefits as Defined in Chapter 4	p	Health & Education (Non-Covered)
14d	Kidney Disease Education Services	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
14e	Other Medicare-covered Preventive Services	i1, i2 or i6	Professional: PCP; Professional: Specialist excluding MH; or Professional: Other
15	Medicare Part B Rx Drugs (includes Part D home infusion drugs included in bundled services)	j	Part B Rx

PBP line #	PBP Category	BPT line #	Corresponding BPT Category: Description/Note (Worksheet 3)
16a	Preventive Dental	m	Dental (Non-Covered)
16b	Comprehensive Dental	m	Dental (Non-Covered)
17a	Routine Eye Exams/Other	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
19a	Reduced Cost Sharing for VBIDs	[1]	Actuary's discretion
19b	Additional Benefits for VBID	[2]	Actuary's discretion

[1] CMS does not suggest any particular BPT category.

[2] CMS does not suggest any particular BPT category.

APPENDIX G – DE# SUMMARY

MEDICAID ELIGIBILITY DATA

The Medicaid status codes in the beneficiary-level file provided by CMS indicate the Medicaid eligibility status of the beneficiary as reported by the respective state Medicaid agency. These codes are shown in the table below. For descriptions of the dual-eligible Medicaid programs, and of the types of Medicaid benefits to which these beneficiaries are entitled, see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

Medicaid Status Code	Medicaid State-Reported Code (Dual-Eligible Medicaid Program)
01	QMB (Qualified Medicare Beneficiary) only
02	QMB Plus full Medicaid benefits
03	SLMB (Special Low-Income Medicare Beneficiary) only
04	SLMB Plus full Medicaid benefits
05	QDWI (Qualified Disabled and Working Individual)
06	QI (Qualified Individual)
08	Full-benefit dual-eligible beneficiaries who do not have QMB or SLMB status
09	Other dual-eligible beneficiaries without full Medicaid benefits—for example, those in Pharmacy Plus and 1115 drug-only demonstrations
99	Unknown, including Medicaid-eligible beneficiaries reported by plans and territories
Blank	Non-Medicaid

Classifying Dual-Eligible Data

The HPMS plan-level data also include a Medicaid grouping indicator as shown in the table below. This table illustrates how the data for dual-eligible beneficiaries are classified as DE# or non-DE#. The certifying actuary must consider the Medicaid cost-sharing policy for the states or territories in the plan's service area when determining which beneficiaries in Medicaid grouping B are in the DE# population.

Medicaid Grouping	Dual Eligible	Category of Dual Eligible Medicaid Program	Medicaid Status Code	Medicare Cost-Sharing Liability	DE# Status
A	Dual	QMB and QMB Plus	01, 02	None	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Reduced (as determined by the certifying actuary)	DE#
B	Dual	Other Medicaid	03, 04, 05, 06, 08, 09, 99	Full (as determined by the certifying actuary)	Non-DE#
C	Non-Dual	Non-Medicaid	Blank	Full	Non-DE#

The table below outlines the requirements for classifying dual-eligible beneficiaries that are not QMB or QMB Plus (that is, Medicaid Indicator B: Other Medicaid) as DE# or non-DE#. The percentages in the table below represent the number of total dual-eligible beneficiaries relative to total members per the HPMS plan-level data.

Medicaid Grouping/Status Code	Condition	DE# Determination for Base Period Data
A: 01, 02	None	DE#
B: 03, 04, 05, 06, 08, 09, 99	<10% total dual-eligible beneficiaries	May consider as non-DE# or determine actual classification
B: 03, 04, 05, 06, 08, 09, 99	10% to 100% total dual-eligible beneficiaries	Must determine actual classification
C: Blank	None	Non-DE#

BPT Values

The table below outlines the determination of certain BPT values when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2.

BPT Area	Input Item	<10% DE#	>90% DE#	10% to 90% DE#
WS3	Utilization and PMPM values	Enter non-DE# or total values	Enter non-DE# or total values[1]	N/A
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Enter zero or appropriate values[2]	Enter appropriate values[2]	N/A
WS5 II	Non-DE# risk factor	Enter total values	Enter total values	N/A

The next table summarizes the determination of certain BPT values when (i) the value for the DE# projected member months is less than 10 percent, or greater than 90 percent, of the total projected member months and the certifying actuary chooses to separately calculate DE# and non-DE# projected allowed costs; or (ii) the value for the DE# projected member months is between 10 percent and 90 percent inclusive of the total projected member months.

BPT Area	Input Item	Determination of BPT Values
WS3	Utilization and PMPM values	Enter non-DE# values
WS4 IIB	State Medicaid required beneficiary cost sharing (column k)	Determine appropriate values (including zero)[2]
WS5 II	Non-DE# risk factor	Determine distinct non-DE# and DE# values

[1] Enter total values if DE# projected member months equal total projected member months.

[2] Plus plan cost sharing for non-covered, non-Medicaid benefits.

The table below outlines the determination of BPT values in which the requirements are the same for all bids regardless of the percentage of DE# members.

BPT Area	Input Item	Determination of BPT Values
WS3	Cost-sharing values and description	Reflect PBP package
WS4 IIB	Plan cost sharing (column f)	Default to non-DE# ratio of plan cost sharing or override formulas
WS5 II	Non-DE# member months	Determine distinct non-DE# and DE# values

APPENDIX H – RELATED-PARTY ADMINISTRATIVE AND MEDICAL SERVICE ARRANGEMENTS

This appendix outlines some of the requirements for each of the methods used to reflect in the BPT costs associated with related-party administrative services arrangements.

SUMMARY OF MA RELATED-PARTY (RP) REQUIREMENTS – ADMINISTRATIVE SERVICES ARRANGEMENTS

See the "Related-Party Arrangements (Medical and Non-Benefit)" pricing consideration for a complete explanation of the requirements.

Method	Availability	Unrelated Party	Criteria	NBE in BPT
Method 1 Actual Cost	Always available	N/A	• Support method	Actual cost of RP
Method 2 Market Comparison – through MAO	Alternative to Method 1	Provides similar services	• Compare to contracts with sufficient costs of services • Show fees within 5%	Fees paid by MAO
Method 2 Market Comparison – through Related Party				

SUMMARY OF MA RELATED-PARTY REQUIREMENTS – MEDICAL SERVICES ARRANGEMENTS

See the "Related-Party Arrangements (Medical and Non-Benefit) pricing consideration for a complete explanation of the requirements.

Method	Availability	Unrelated Party	Criteria	Net Medical in BPT
Method 1 Actual Cost	Always available	N/A	• Support method	Actual cost of RP
Method 2 Market Comparison – through MAO	Alternative to Method 1	• Similar services • Medicare population • Bid's service area	• Compare to contract with sufficient costs of services • Fees within 5% or $2 PMPM—whichever is greater	Fees paid by MAO
Method 2 Market Comparison – through Related Party	Alternative to Method 1	• MAO • Similar services • Medicare population • Attest to contract availability	• Compare to contract with sufficient costs of services • Fees within 5% or $2 PMPM—whichever is greater	Fees paid by MAO
Method 3 Comparable to FFS	Cannot satisfy Method 1	N/A	• Demonstrate Method 1 not possible • Fees within 5% of 100% FFS or $2 PMPM—whichever is greater	Fees paid by MAO
Method 4 FFS Proxy	Cannot satisfy Method 1, or Method 2, or Method 3	N/A	• Show Method 1, 2, or 3 not possible • Show fees NOT comparable to 100% FFS	100% FFS

APPENDIX I – MEDICAL SAVINGS ACCOUNT BPT

This appendix provides guidance for completing the Medical Savings Account Bid Pricing Tool for Medical Savings Account (MSA) plans offered to Medicare beneficiaries. This appendix highlights only the differences between the MSA BPT and the MA BPT.

The MSA BPT is organized as outlined below:

- Worksheet 1 – MSA Base Period Experience and Projection Assumptions
- Worksheet 2 – MSA Total Projected Allowed Costs PMPM
- Worksheet 3 – MSA Benchmark PMPM
- Worksheet 4 – MSA Enrollee Deposit and Plan Payment PMPM
- Worksheet 5 – MSA Optional Supplemental Benefits

WORKSHEET 1 – MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS (CORRESPONDING TO MA WORKSHEET 1)

SECTION I – GENERAL INFORMATION

Line 7 – Plan Type

MSA is the only valid plan type.

Line 8 – Deductible Amount

Enter the deductible amount that each beneficiary will pay for Medicare-covered benefits. The maximum deductible for CY2017 for MSA plans is $11,650.

Line 9 – Enrollee Type

This cell is pre-populated with "A/B."

SECTIONS II, III, IV, AND V

Base period data in Sections II, III, IV, and V must include only Medicare-covered medical expenses.

WORKSHEET 2 – MSA TOTAL PROJECTED ALLOWED COSTS PMPM (CORRESPONDING TO MA WORKSHEET 2)

SECTION II – PROJECTED ALLOWED COSTS

Data in Section II must include only Medicare-covered medical expenses.

WORKSHEET 3 – MSA BENCHMARK PMPM (CORRESPONDING TO MA WORKSHEET 5)

Follow the instructions for MA Worksheets 5 and 6 for the appropriate inputs.

WORKSHEET 4 – MSA ENROLLEE DEPOSIT AND PLAN PAYMENT (NO CORRESPONDING MA WORKSHEET)

This worksheet calculates the MSA monthly plan revenue requirement and enrollee deposit.

Consistent with other MSA worksheets, information provided on Worksheet 4 must exclude ESRD enrollees.

SECTION II – DEVELOPMENT OF CLAIM INFORMATION INTERVALS (PLAN'S RISK FACTOR AND EXCLUDE SERVICES COVERED WITHIN THE DEDUCTIBLE)

Column c – Annual Projected Claim Interval

The column is pre-populated with annual projected claim intervals.

Column d – Annual Average Claim Amount

Enter the annual average claim amount paid in each claim interval.

Column e – Percentage of Member Months (Use Only the Highest Claim Interval)

Allocate total projected member months to the highest claim interval expected by members and enter the allocation as a percentage.

For example, if projected member months for members expected to incur annual claims of $11,500 represent 20 percent of total projected member months, and projected member months for members expected to incur annual claims of $4,400 represent 10 percent of total projected member months, then enter 20 percent only in the interval containing $11,500 and 10 percent only in the interval containing $4,400. The sum of column e must equal 100 percent.

Column f – Gross Claims (PMPM)

This column calculates total allowed Medicare-covered claims on a PMPM basis for each claim interval. No entry is required. The sum of column f must equal the total Medicare-covered medical expenses shown in column o of Worksheet 2.

Column g – Gross Claims over Deductible (PMPM)

Enter the total allowed Medicare-covered claims on a PMPM basis over the deductible for each claim interval expected to be paid by the MSA plan. Enter zero (0) for claim intervals below the deductible.

SECTION III – DEVELOPMENT OF SUMMARY INFORMATION (PLAN'S RISK FACTOR)

Line a – Medicare-Covered Plan Medical Expenses PMPM

This cell displays the sum of column g of Section II.

Line b – Non-Benefit Expenses

Enter the non-benefit expense information.

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

Line c – Gain/Loss Margin

Input the projected PMPM for the gain/loss margin for Medicare-covered services provided. See the "Gain/Loss Margin" pricing consideration for more information regarding gain/loss margin.

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

Line d – Total Plan Revenue Requirement

This cell is calculated automatically as the sum of projected Medicare-covered medical expense, non-benefit expense, and gain/loss margin.

Line e – Projected Plan Benchmark

This cell displays the value from Section III, column h, line 1 of Worksheet 3—the weighted average for the service area of the risk-adjusted ratebook values.

Line f – Projected Monthly Enrollee Deposit

This cell calculates the monthly enrollee deposit by subtracting the total plan revenue requirement from the projected plan benchmark.

Line g – Percent of Plan Revenue Ratios

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

Line h – Standardized Plan Benchmark

This cell displays the value from Section III, column g, line 1 of Worksheet 3—the weighted average for the service area of the unadjusted ratebook values.

WORKSHEET 5 – MSA OPTIONAL SUPPLEMENTAL BENEFITS (CORRESPONDING TO MA WORKSHEET 7)

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

APPENDIX J – END–STAGE RENAL DISEASE–ONLY SPECIAL NEEDS PLANS BPT

This appendix provides guidance for completing the ESRD-SNP BPT for ESRD-SNP plans offered to Medicare beneficiaries. This appendix highlights only the differences between the ESRD-SNP BPT and the MA BPT.

The ESRD-SNP BPT is organized as outlined below:

- Worksheet 1 – Enrollment and PMPM Revenue Projection
- Worksheet 2 – Projection of benefit cost, non-benefit expenses, and gain/loss margin PMPM
- Worksheet 3 – Program Experience for Calendar Year 2016
- Worksheet 4 – Optional Supplemental Benefits

WORKSHEET 1 – ENROLLMENT AND PMPM REVENUE PROJECTION

SECTION I – GENERAL INFORMATION

Follow the instructions for MA Worksheet 1 for the appropriate inputs.

Line 2 – Contract-Plan-Segment

This field concatenates the contract number, plan ID, and segment ID.

Line 4 – Service Area

Enter a brief description of the service area.

Line 5 – Plan Type

"ESRD SNP" is pre-populated.

SECTION II – SERVICE AREA SUMMARY

Follow the instructions for MA Worksheet 5 for the appropriate inputs.

- ✓ **Column a – State/County Code**

  Similar to MA BPT Worksheet 5, enter the county codes associated with the plan's service area.

  Technical note regarding the ESRD-SNP BPT: the rates populated in column (g) are "state-wide" rates for dialysis and transplant statuses. Therefore, plans may enter one county code (example: entering 05430 for California) and report the dialysis member months and risk scores for the state in that row. Similarly, one county code may be entered for the state-wide transplant information. In other words, the dialysis and transplant member months and risk scores do not need to be reported at the county level. Functioning graft rates are "county-specific," and therefore member months and risk scores must be reported at the county level for functioning graft status.

- ✓ **Column d – ESRD Status (D / T / F)**

  Enter the ESRD status: "D" for dialysis, "T" for transplant, or "F" for functioning graft (that is, post-graft status).

- ✓ **Column f – Projected Risk Score**

  Projected risk scores must—

  - Be based on the CMS-HCC ESRD risk model that will be used for payment year 2017 ("ESRD Model").
  - Reflect appropriate projection factors.
  - Be adjusted for normalization using the 2017 normalization factor shown below for the applicable segment of the ESRD Model.
    - For dialysis and transplant, 0.994.
    - For functioning graft, 1.051.
  - Reflect the MA coding adjustment factor as follows:
    - For post-graft risk scores, apply the 2017 MA coding adjustment factor.
    - For dialysis risk scores and transplant factors, there is no MA coding adjustment.

  See the Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies for more information about the ESRD Model and related normalization factors and MA coding adjustment factor.

- ✓ **Column h – Percentage of MSP Member Months**

  Enter the percentage of Medicare Secondary Payer (MSP) member months applicable for the ESRD status and county/state indicated.

- ✓ **Column i – Projected CMS Monthly Capitation**

  This field is calculated automatically.

SECTION III – ESRD MSP ADJUSTMENT FACTORS FOR CY (FROM APRIL RATE ANNOUNCEMENT)

This section contains the MSP adjustment factors released by CMS in the Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Line 1 contains the MSP factor for functioning graft, and line 2 contains the MSP factor for dialysis/transplant.

SECTION IV – SUMMARY DATA

Line 1 – Part C Mandatory Monthly Enrollee Premium

This amount is obtained from Worksheet 2.

Line 2 – Part C Monthly Plan Revenue

This field is calculated automatically.

Line 3 – Part D Premium (Basic plus Supplemental) Net of Reductions

This information is obtained from Worksheet 2.

Line 4 – Plan Intention for Target Part D Basic Premium

This information is obtained from Worksheet 2.

Line 5 – Quality Bonus Rating (per CMS)

Follow the instructions for MA Worksheet 5.

Line 6 – New/low indicator (per CMS)

Follow the instructions for MA Worksheet 5.

WORKSHEET 2 – PROJECTION OF BENEFIT COST, NON-BENEFIT EXPENSES, AND GAIN/LOSS MARGIN PMPM

SECTION II – PROJECTION OF PLAN COSTS

The medical expense projection is to be consistent with the population reflected in the revenue projections on Worksheet 1. The medical expense projections may be based on a blend of trended plan experience and other data sources.

The allowed costs in rows 16-31 must include only Medicare-covered services. Additional services such as inpatient coverage beyond lifetime reserve days and preventive services not covered by original Medicare must be reflected in additional services on row 37.

The supplemental benefits columns are calculated automatically and reflect cost sharing enhancements to the Medicare-covered benefit package.

For guidance on reporting non-benefit expenses, gain/loss margin and related parties, see the "Pricing Considerations" section and MA Worksheet 4 section of these Instructions.

SECTION III – DEVELOPMENT OF ESTIMATED PLAN PREMIUM AND REDUCTIONS

Follow the instructions for MA Worksheet 6.

In this appendix, the term "excess funds" refers to the difference between the CMS capitation payment and the MAO's cost to provide Medicare-covered benefits. Regarding the rebate reallocation period and the ESRD-SNP BPT, note that—

- After CMS publishes the Part D national average monthly bid amount, the Part D base beneficiary premium, and the Part D regional low-income premium subsidy amounts, the MAO may return to the target Part D basic premium by reallocating "excess funds" allocated in the initial submission to the supplemental benefit items in rows 56 through 60 of Worksheet 2.
- Generally, the rules in effect for other MA-PD plans for changes to the funding of benefits during the rebate reallocation period apply to reallocation of excess funds. For more information about rebate reallocation see Appendix E.

WORKSHEET 3 – PROGRAM EXPERIENCE FOR CALENDAR YEAR 2016

SECTION II – CONTACT INFORMATION

Follow the instructions for MA Worksheet 6.

SECTION III – REVENUES

Enter member months, CMS payments (on a PMPM basis), and enrollee premium (on a PMPM basis) for CY2016. All revenues are to be reported on an earned basis, including retroactive adjustments. Revenues for 2016 are to include an estimate of the final risk adjustment settlement to be received in mid-2017.

SECTION IV – MEDICAL BENEFITS (PMPM)

Enter the paid through date for claims incurred and claims incurred in CY2016. CMS generally expects at least 30 days of paid claims run-out; 2 - 3 months of paid claim run-out is preferable. Medical benefits are to be reported net of enrollee cost sharing.

Enter the paid through date for and claim reserves for 2016. Organizations may allocate claim reserves to appropriate categories in situations where reserves are developed at a consolidated level.

For "Utilizers" column, follow the instructions for MA Worksheet 1.

For guidance on reporting non-benefit expenses and gain/loss margin, see the "Pricing Considerations" section of these Instructions.

WORKSHEET 4 – OPTIONAL SUPPLEMENTAL BENEFITS

Follow the instructions for MA Worksheet 7 for the appropriate inputs.

SUPPORTING DOCUMENTATION FOR ESRD-SNP BPTS

See Appendix B for supporting documentation requirements.

APPENDIX K – TRENDING RISK SCORES

This appendix includes the following considerations for trending Part C and Part D risk scores:

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

APPENDIX L – DATA AGGREGATION EXAMPLES

This appendix includes examples for aggregating base period experience on Worksheet 1 of the MA Bid Pricing Tool (BPT).

Example 1: Formal Cross-walk

An MAO offers non-segmented plans 001, 002 and 003 in CY2016 and CY2017, and non-segmented plans 002 and 003 in CY2018. Plan 001 is consolidated and the membership is formally cross-walked into plan 003 for CY2018 in accord with the limited exceptions described in CMS annual renewal and non-renewal guidance. Base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

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

Example 2: Formal Cross-walk and Enrollment Shift

An MAO offers non-segmented plans 001, 002, and 003 in CY2016 and CY2017, and non-segmented plan 003 and new non-segmented plan 004 in CY2018. Plan 001 is consolidated and the membership is formally cross-walked to plan 003 for CY2018 as submitted in HPMS. Plan 002 is terminated for CY2018 and the certifying actuary expects the membership in plan 002 to enroll evenly between plan 003 and plan 004; however, there is no formal cross-walk or approved cross-walk exception in place. Base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

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

Example 3: PFFS Non-network/Net-work County Reclassification

An MAO offers PFFS non-network plan Hxxxx-001 and PFFS full network plan Hyyyy-001 in both CY2016, CY2017 and CY2018. However for CY2017, county A in Hxxxx-001 is reclassified from non-network to full network and is removed from the service area of Hxxxx-001 to the service area of Hyyyy-001. The proportion of Hxxxx-001 members in county A that are moved to Hyyyy-001 via MARx enrollment transactions under an approved cross-walk exception is greater than the MA level of significance determined by the certifying actuary.

Also for CY2018, county B in Hyyyy-001 is reclassified from full network to non-network and is moved from the service area of Hxxxx-001 to the service area of Hxxxx-001. In this case, the proportion of Hyyyy-001 members in county B that are moved to Hxxxx-001 via MARx enrollment transactions under an approved cross-walk exception is less than the MA level of significance. Base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

- For Hxxxx-001, report base period experience for Hxxxx-001. (Rule 2 and Rule 3) Data aggregation is not allowed.
- For Hyyyy-001, report aggregate base period experience for plans Hxxxx-001 and Hyyyy-001. (Rule 1 and Rule 3)

Example 4: Cross-walks in Successive Years

An MAO offers plan 001 with 100 members and plan 002 in CY2016. In CY2017, 50 members stayed in plan 001 and 50 members were cross-walked to plan 002 via MARx enrollment transactions. For 2018, 25 members stay in plan 001 and 25 members are cross-walked to plan 002 via MARx enrollment transactions. The certifying actuary sets the MA level of significance at 60%.

	CY2016	CY2017	CY2018	Plan 001 Members Remaining in Plan 002
County A	25 in plan 001	25 in plan 001	25 in plan 001	N/A
County B	25 in plan 001	25 in plan 001	25 →plan 002	25
County C	50 in plan 001	50 →plan 002	50 in plan 002	50
Total	100			75

Members in plan 001 are cross-walked as shown in the table below.

The proportion of plan 001 members in the plan 002 bid for CY2018, resulting from both the CY2017 and CY2018 cross-walks is 75/100 or 75%. Since such percentage is above the 60% threshold established by the certifying actuary, base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

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

Example 5: Service Area Reduction

An MAO offers non-segmented plans 001 and 002 in CY2016 and plan 002 in CY2018. Plan 001 is consolidated and the membership is formally cross-walked to plan 002 for CY2017. For CY2018, the service area for plan 002 is reduced to remove most of the counties formerly in plan 001 and an insignificant proportion of the members that were formerly in plan 001 remain. The certifying actuary sets the MA level of significance at 40%.

Members in plan 001 are cross-walked as shown in the table below.

	CY2016	CY2017	CY2018
Counties A…C	200 in plan 001	200 →plan 002	→0 in plan 002
County D	100 in plan 001	100 →plan 002	100 in plan 002
Total	300		100

The proportion of plan 001 members remaining in plan 002 after taking into account the CY2017 cross-walks from plan 001 to plan 002 and the CY2018 service area reduction for plan 002 is 100/300 or 33%. Since such percentage is below the 40% threshold established by the certifying actuary, base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

- For plan 002, report base period experience for plan 002. Data aggregation is not allowed.

Example 6: Service Area Expansion and Service Area Reduction

Plan 001 covers counties A through Y in 2016 and undergoes an exception-based cross-walk in 2017 via MARx enrollment transactions, whereby counties B through Y are cross-walked to plan 002 and county A is not.

Plan 002 undergoes a service area reduction in 2018, whereby counties B through X are terminated. Plan 002 also undergoes a service area expansion for new county Z that does not involve an exception based cross-walk since the plan sponsor does not currently offer a plan in county Z. Therefore, only counties Y and Z are in the service area of plan 002 for 2018.

The certifying actuary sets the significance threshold at 25%.

Members in plan 001 and plan 002 are cross-walked as shown in the table below.

	CY2016	**CY2017**	**CY2018**	**CY2018 Plan 001 Members Remaining in Plan 002**
County A	200 in plan 001	200 in plan 001	200 in plan 001	N/A
Counties B...X	500 in plan 001	500 →plan 002	→0 in plan 002	0
County Y	300 in plan 001	300 →plan 002	300 in plan 002	300
Total	1000			300

The proportion of plan 001 members in the plan 002 bid for CY2017, resulting from both the CY2017 and CY2018 cross-walks and the CY2018 service area reduction for plan 002 is 300/1000 or 30%. Since such percentage is above the 25% threshold established by the certifying actuary, base period experience must be reported on Worksheet 1 of the CY2018 BPTs as follows:

- For plan 001, report base period experience for plan 001. Data aggregation is not allowed. (Rule 3)
- For plan 002, report base period experience for plan 001 and plan 002. (Rule 3 and Rule 4)