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INSTRUCTIONS FOR COMPLETING THE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2019

As of April 7, 2017

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I. INTRODUCTION

BACKGROUND

Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each prescription drug plan that they intend to offer Medicare beneficiaries.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format— the Prescription Drug Bid Pricing Tool (BPT). 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.

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 CY2018 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 eight worksheets in the BPT and explains the formulas for calculated cells.
- Section IV, Appendices A through G: contain requirements for Actuarial Certification (Appendix A), Supporting Documentation (Appendix B), Employer/Union-Only Group Waiver Plans (Appendix C), Calculation of the National Average Monthly Bid Amount (Appendix D), Calculation of the Low-Income Benchmark Premium Amounts (Appendix E), Health Care Reform (Appendix F) and Trending Risk Scores (Appendix G).

NEW FOR CONTRACT YEAR 2019 (CY2019)

The key changes between the CY2019 BPT and CY2018 BPT are highlighted below. The changes improve the usability and functionality of the BPT and reflect updated guidance.

BIDDING RESOURCES

The following resources provide information on CY2019 bidding:

- The CY2019 Advance Notice and Announcement at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.
- The CY2019 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/BidTraining2019.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 CY2019 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 > CY2019 > Documentation > BPT Technical Instructions
  - The *Bid Submission User's Manual*, also available in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2019 > Documentation > Bid User's Manual
  - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

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

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the plan level if the plan existed in CY2017, 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

Actuarial Equivalence

Actuarial equivalence must be demonstrated for plan benefit types other than Defined Standard (DS).

When the plan benefit type is Actuarially Equivalent (AE), three tests must be satisfied on Worksheet 4, Section IV, lines 16 through 18 to demonstrate actuarial equivalence:

- The average coinsurance percentage for amounts between the deductible and the initial coverage limit (ICL) must be actuarially equivalent to 25 percent.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

When the plan benefit type is Basic Alternative (BA) or Enhanced Alternative (EA), six tests must be satisfied to demonstrate actuarial equivalence on Worksheet 5, Section VI, lines 1 through 6:

- The value of total coverage is at least actuarially equivalent to DS coverage.
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage.
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL.
- The deductible is not greater than the DS deductible.
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

Base Period Experience

The experience data must be based on a calendar year 2017 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 for the plan ID. Note that these data—

- Must be submitted in Worksheet 1 for all plans with experience data for 2017, regardless of the level of enrollment.
- Must reconcile in an auditable manner to the plan-level Prescription Drug Event (PDE) data submitted to CMS for payment and reconciliation and the Part D sponsor's audited financial statements.
- Must include accepted PDEs, rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan (P2P) transactions and, if appropriate, transfer of over-the-counter (OTC) drug data from the base period experience to the non-benefit expense component. The impacts of each of these considerations must be quantifiable and must not be included in the completion factor.
- Must be reported without adjustment. Adjustments may be made in Worksheet 2, Sections II and III 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 plans only when there are enrollment changes associated with the dissolution of a plan and the retained members are cross-walked into existing plans in the same contract or across contracts. Each contract-plan-segment ID must be identified in Section II, line 5.
- Must be provided for plans acquired by the Part D sponsor.
- May not be used to aggregate data from a number of plans in order to achieve credibility.
- Must be reported in total at the plan level for every contract-plan ID when plans are aggregated; do not include partial plan experience on Worksheet 1.
- May be reported on more than one bid when plans are aggregated, depending upon how enrollment changes are processed.

Data Aggregation

The requirements for reporting base period data for cross-walks and enrollment shifts depend on—

- How enrollment changes are processed.
  - In these Instructions, the term "formal cross-walk" refers to the cross-walk process submitted in HPMS for plan consolidations (that is, consolidated renewals), whereby members are automatically moved from one plan to another (that is, one plan 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 plan to more than one plan, for example, when the service area of one or more plans is redefined.
  - For more information about cross-walks, see the May 18, 2016 memorandum released via HPMS titled "Process for Requesting an HPMS Crosswalk Exception for Contract Year (CY 2017)."

The requirements for reporting base period data for crosswalks and enrollment shifts are described below.

✓ **Rule 1 – Cross-walks**

Base period data for more than one plan must be aggregated and reported on Worksheet 1 of the plan 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.

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

✓ **Rule 2 – Enrollment Shifts**

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

- When an existing member chooses to enroll in different plans.
- When enrollment changes do not involve a cross-walk whether or not a plan is terminated.

✓ **Rule 3 – Partial Experience**

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

✓ **Rule 4 – Two-Year Perspective**

Members may be cross-walked each contract year. For BPT reporting purposes, the actuary must consider the cross-walks from the base period to the contract year (that is, from CY2017 to CY2018 and from CY2018 to CY2019).

Example 1: Formal Cross-walk

A Part D sponsor offers plans 001, 002 and 003 in CY2017 and CY2018 and plans 002 and 003 in CY2019. Plan 001 is consolidated and the membership is formally cross-walked into plan 003 for CY2019 in accord with limited exceptions described in CMS annual renewal and non-renewal guidance. Base period experience must be reported on Worksheet 1 of the CY2019 BPT 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 plans 001 and 003 (Rule 1 and Rule 3).

Example 2: Formal Cross-walk and Enrollment Shift

A Part D sponsor offers plans 001, 002 and 003 in CY2017 and CY2018 and plan 003 and new plan 004 in CY2019. Plan 001 is consolidated and the membership is formally cross-walked into plan 003 for CY2019 as submitted in HPMS. Plan 002 is terminated for CY2019 and the certifying actuary expects the membership in plan 002 to enroll evenly between plans 003 and 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 CY2019 BPT as follows:

- For plan 003, report base period experience for plans 001 and 003 (Rule 1 and Rule 3).
- For plan 004, do not report base period experience (Rule 2). Data aggregation is not allowed.

Example 3: Cross-walks in Successive Years

A Part D sponsor offers plan 001 with 100 beneficiaries and plan 002 in CY2017. In CY2018, 50 beneficiaries stayed in plan 001 and 50 beneficiaries were cross-walked into plan 002 via MARx enrollment transactions. In CY2019, 25 beneficiaries stayed in plan 001 and 25 beneficiaries were cross-walked into plan 002 via MARx enrollment transactions. Base period experience must be reported on Worksheet 1 of the CY2019 BPT as follows:

- For plan 001, report base period experience for plan 001 (Rule 3).
- For plan 002, report base period experience for plans 001 and 002 (Rule 1, Rule 3 and Rule 4).

PDE Mapping

A mapping of PDE fields to required BPT inputs is provided in the following table.

Mapping of Prescription Drug Events to Part D Claims Experience in Worksheet 1, Section III

Column	Field Name	PDE Reference Information
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee) > Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee)
(i)	Average Paid Amount per Member	Σ [Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP) + Low-Income Cost Sharing (LICS)] ÷ Members
(j)	Average Cost Sharing per Member	Σ [Patient Pay Amount + Other TrOOP Amount + Reported Gap Discount + Patient Liability Reduction due to other Payer Amount (PLRO)] / Members
(k)	Supplemental Cost-Share Reduction per Member	Σ [Non-Covered Plan Paid Amount (NPP)] ÷ Members
(l)	Reimbursement for LIS per Member	Σ [Low-Income Cost Share (LICS)] / Members
(m)	Reimbursement for Federal Reinsurance per Member	Σ {[Gross Drug Cost above Out-of-Pocket Threshold (GDCA) with Catastrophic Coverage Codes A or C]× 0.8} ÷ Members

When using PDE data, actuaries must be familiar with the process by which the PDE transactions are developed from claims data and with the timing of the adjustment and deletion processes to ensure that the final transaction is accurately summarized. This process includes, but is not limited to, consideration of rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan transactions and, if appropriate, transfer of over-the-counter drug data from the base period experience to the non-benefit expense component. It is important to note that a PDE maps to one script throughout the BPT regardless of the number of days for which the prescription is dispensed.

Coverage in the Gap

Medicare Coverage Gap Discount Program (CGDP)

The following guidelines apply to all Part D bids:

- Applicable drugs under the Medicare CGDP are defined as those that are on the plan's formulary or are treated as if on formulary through the exceptions process and are approved under a new drug application (NDA) under Section 505(b) of the Federal Food, Drug and Cosmetic Act or, in the case of a biologic, licensed under Section 351 of the Public Health Service Act. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.
- Only those applicable Part D drugs covered by a manufacturer discount agreement are eligible for coverage under the program.
- In CY2018, beneficiary cost sharing for applicable drugs is 35 percent of the negotiated price plus 35 percent of the dispensing and vaccine administration fees, if any; the Part D sponsor's liability is 15 percent of the negotiated price plus 65 percent of the dispensing fee and vaccine administration, if any. Eighty-five (85) percent of the negotiated price of the applicable drug and 35 percent of the dispensing fee and vaccine administration fee, if any, must be reported as beneficiary cost sharing in the bid.
- Coverage gap discounts begin when the beneficiary exceeds the plan-specific ICL.
- The administrative costs associated with administering the program must be included in the non-benefit expense component of the bid.
- The manufacturer discount amounts received under this program are not direct and indirect remuneration because they do not decrease the drug costs incurred by the Part D sponsor. Therefore, the manufacturer discounts must not be reported as rebate amounts in the bid.
- Applicable drugs must be reported as brand drugs in the bid.

Generic Drugs

The following guidelines apply to all Part D bids:

- In the coverage gap, a drug is considered a generic drug, or non-applicable drug, if it is not defined as an applicable drug under the Medicare CGDP. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.
- In CY2018, beneficiary cost sharing is reduced to 44 percent and the Part D sponsor's liability is increased to 56 percent.
- Generic (non-applicable) drug coverage in the gap begins when the beneficiary exceeds the plan-specific ICL.
- Non-applicable drugs must be reported as generic drugs in the bid.

Pricing Considerations

Part D sponsors must model the impact of coverage in the gap on the DS benefit and alternative benefit (AE, BA or EA), if applicable.

- While coverage in the gap does not change the TrOOP threshold, it will affect the point at which the beneficiary reaches the TrOOP threshold for catastrophic coverage.
- The changes to projected average allowed amounts from the base period to the contract year that are expected to occur as a result of reduced beneficiary cost sharing must be reflected in the "Other Change" components of utilization and unit cost trend factors on Worksheet 2.
- The impact on the Federal Reinsurance PMPM must be reflected in line 5, column m of Worksheet 3.

  The following guideline applies when the type of coverage is AE, BA or EA:
  - When an alternative coverage is modeled, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spending may be different because of the impact of the alternative benefits.

  The following guideline applies when the type of coverage is EA:
  - When an EA plan offers coverage in the gap that exceeds the DS coverage:
    - Report the drugs on the "enhanced" tiers based on the plan-specific formulary.
    - Report all other drugs based on the definition of applicable and non-applicable drugs.

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.

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

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Allowed Costs	18,000 member months	$\sqrt{\frac{\text{member months}}{18{,}000}}$

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.

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

Subject Experience	Exposure Required for Full Credibility	CMS Formula for Partial Credibility
Estimated Part D risk scores for development of 2018 bids as posted on HPMS	125 beneficiaries	$\sqrt{\frac{\text{number of beneficiaries}}{125}}$
Beneficiary-level file to support 2018 Part D bids as distributed by CMS	1,500 member months	$\sqrt{\frac{\text{member months}}{1{,}500}}$

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.

Decreased Initial Coverage Limit

Part D sponsors that are decreasing the ICL must modify the pricing of the benefit in the BPT. Specifically:

Worksheet 6, column k, lines 1 through 8 and 19 through 26

Enter the total cost sharing for allowed costs up to the DS ICL of $3,750 by point-of-sale (retail or mail order as defined by the PBP) and type of drug for each line. Total cost sharing is the sum of (i) the amounts calculated based on the cost-sharing structure of the alternative coverage up to the decreased ICL and (ii) 44 percent of the allowed costs of non-applicable (generic) drugs and 85 percent of the negotiated price of applicable (brand) drugs plus 35 percent of dispensing fees and vaccine administration, if any, for applicable (brand) drugs between the decreased ICL and standard ICL.

Direct and Indirect Remuneration (DIR)

Part D sponsors must include all expected amounts that will be reported as DIR under "Rebate" in the BPT. The DIR reported under "Rebate" represents the Part D sponsors' best estimate of all DIR categories and amounts that they expect to report under the Part D payment reconciliation process for the respective contract year. The development of the DIR amounts must be consistent with the development of projected costs.

Definition of Direct and Indirect Remuneration

Per 42 CFR Section 423.308, direct and indirect remuneration (DIR) comprises any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, charge-backs, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits. DIR does not include the manufacturer discount amounts received under the Medicare CGDP.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmacy benefit managers (PBM), even if the price concessions are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the PBM receives from the sponsor for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, Part D sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk around the cost of the drug as reflected on claims data. Any gains or losses that the Part D sponsor may experience as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments, and any adjustments to generic dispensing incentive payments made to pharmacies after the point-of-sale dispensing event, are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point-of-sale are part of the dispensing fee reported on the PDE record and therefore are not included in the DIR Report for Payment Reconciliation.

Enrollment

The projected enrollment for the Part D bid in an MA-PD plan must be consistent with that for the corresponding MA bid and must reflect the same underlying population.

Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirement beyond allowed prescription drug costs and non-benefit expenses.

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.

Do not combine margins for the Medicare Advantage (MA) and Part D components of MA-PD bids to satisfy these Instructions.

Do not combine margin for bids in segmented plans to satisfy these Instructions.

See the "Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2019" for gain/loss margin requirements that are specific to MA 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.

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

The gain/loss margin entered in the BPT is allocated to basic coverage and supplemental coverage based on the distribution of total prescription drug costs between these coverages.

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.

✓ **Anti-competitive Practices**

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

✓ **Bids with Negative Margin**

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

- Product Pairing: If two or more Part D products are "paired" and the pricing reflects implicit "subsidies" across benefit or service area offerings as described below, then CMS does not require the Part D sponsor to submit a business plan

for the bid(s) with negative margin. In this case, the bids in the Part D product pairing must—

- Have identical service areas;
- Have a positive combined Part D gain/loss margin for CY2019.

Examples include a low-benefit plan with a positive margin paired with a rich-benefit plan with a negative margin.

- Alternate Business Plan: If the projected gain/loss margin in the Part D 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 Part D sponsor may submit an alternate Part D 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 Part D sponsor does not choose one of these options), then the Part D bid-specific business plan must include both a numeric projection and a narrative explanation.
  - The numeric (non-pdf) projection must include, but is not limited to, projected: member months, risk scores, CMS revenue, Part D premium, claims 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 Part D margins for Part D bids to a point estimate of the Part D sponsor's corporate margin requirement. For MA-PD plans, the section "MA-PD Margin Requirements" applies to the gain/loss margin in the Part D BPT. For Part D plans without a corresponding Medicare Advantage plan, including but not limited to PDP, PACE, and 1876 Cost plans, then the aggregate gain/loss margin levels in the BPT must comply with the following requirements:

✓ **Definitions**

In the BPT and these Instructions, the term—

- "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 Part D sponsor may choose one of the following three levels: contract level, organization level (that is, the legal entity that contracts with CMS

under one or more contracts to provide Part D benefits), or parent organization level.
    - The Part D sponsor must enter the chosen level of aggregation in the BPT.
    - The level of aggregation selected in the Part D BPT must match the level selected in the MA BPT of an MA-PD bid.
- "Aggregate Part D margin" refers to the projected enrollment-weighted average BPT PMPM margin for a specified plan category.
- "Corporate margin requirement" refers to the Part D sponsor'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 Part D sponsor's non-Medicare business, for which it has discretion in rate setting, is greater than or equal to 10% of the Part D sponsor'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.
    - The "Risk-Capital-Surplus" corporate margin basis applies if: (i) the volume of the Part D sponsor's non-Medicare business, for which it has discretion in rate setting, is less than 10% of the Part D sponsor's total non-Medicare business; or (ii) the Part D sponsor has no non-Medicare business.

✓ **Year-to-Year Consistency**

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

✓ **Requirements for Part D Plans Without Corresponding MA Plans**

For Part D sponsors, if the corporate margin basis is—

- "Non-Medicare," then the aggregate Part D margin as a percentage of revenue is to be within 1.5 percent of the Part D sponsor's non-Medicare business margin requirement.
- "Risk-Capital-Surplus," then the aggregate Part D margin, as a percentage of revenue, must be set by taking into account the degree of risk and capital and surplus requirements of the Part D sponsor's MA and Part D business prior to any impact of sequestration. The term "MA and Part D business" refers to 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, EGWPs, and the Part D portion of PACE plans).

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

The MA-PD margin requirements are separate from the aggregate-level requirements above. There are two options for setting the Part D margin of MA-PD bids:

Option A: Set the margins at the bid level. Specifically, an MA-PD sponsor must—

- Set the Part D margin for a plan as a percentage of revenue within 1.5 percent of the margin for the MA component of the same MA-PD bid, and
- Apply this method consistently for all MA-PD bids submitted by the Medicare Advantage Organization.

Option B: Set the margins at the plan-category level (that is, general enrollment plans & I/C-SNPs or D-SNPs) defined in the "Aggregate-Level Requirements" section of the "Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2019". Specifically,—

- The MA-PD sponsor must set the Part D margins equal for all plans within a plan category as selected in the BPT.
- Within each plan category, the Part D margin as a percentage of revenue must be within 1.5 percent of the aggregate MA margin for all MA-PD bids in such category selected in the BPT.

Exclusions

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

Health Care Reform

See Appendix F for information concerning the provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, known collectively as the Affordable Care Act.

Non-Benefit Expenses

Non-benefit expenses are all of the bid-specific administrative costs incurred in the operation of the Medicare Prescription Drug Plan. Therefore, any allocation of non-benefit expenses to the Part D bid (whether performed at the bid level or a broader level) must take into consideration differences between the Part D bid and other bids, and the impact on non-benefit costs of the Part D bid.

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;
    - 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;
    - Claims administration;
    - True out-of-pocket (TrOOP) administration;
    - Pharmacy benefit management administration, which includes all of the costs for performing call center, claims, formulary management, network development and rebate management functions incurred by the plan or through a subcontractor;
    - Medicare CGDP administration;
    - Medicare Part D user fees, which are $1.05 per-member per-year (pmpy) or $0.087 per-member-per-month (pmpm) on a national basis for CY2018. The COB user fee will be collected at a monthly rate of $0.116 pmpm for the first nine months of the coverage year;
    - Part D 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. Part D sponsor may use the CMS estimate, which is $0.05 pmpm on a national basis for CY2018, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Part D sponsor's historical amount relative to the CMS annual national estimate;
    - Uncollected enrollee premium;
    - Uncollected cost sharing, which includes plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions;
    - Medication therapy management programs;
    - Disease management functions such as patient education and disease monitoring; and
    - Over-the-counter drugs.

- 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 administrative activities must be excluded from non-benefit expenses. Such costs include income taxes, changes in statutory surplus, investment expenses and the cost of lobbying activities. See the Gain/Loss Margin section of Pricing Considerations 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 plans must be allocated proportionately between the Medicare Advantage and Part D BPTs.

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

Non-Uniform Deductible

Part D sponsors that are implementing a deductible that is not applied consistently among all formulary tiers (for example, $0 deductible for Tier 1 – Generics and $405 deductible for all other tiers) must modify the pricing of the benefit in the BPT. Specifically:

- ✓ **Worksheet 5**
  - Enter "$0" in cells D39 and F41.
  - Enter the "Alternative Coverage Deductible Amount" in cell I34.
- ✓ **Worksheet 6**

  Reflect the impact of the non-uniform deductible in addition to the cost sharing required after the deductible is met in the applicable cost-sharing categories by point-of-sale (retail or mail order as defined by the PBP) and type of drug.

PBM Pricing

For CY2019, Part D sponsors must develop their Part D bids using the pass-through price or negotiated amount paid to the dispensing provider at the point-of-sale as the basis for drug costs. For Part D sponsors that are contracted with a PBM, the following provisions apply: (i) when contracted under a lock-in pricing approach, the administrative expense component of the bid must reflect the expected difference between the lock-in price, or amount negotiated with the PBM, and the pass-through price (this difference is referred to as the risk premium or PBM spread); and (ii) when the PBM retains a portion of the rebates, the administrative expense component of the bid must include these costs.

Related-Party Arrangements

The related-party requirements apply to all Part D sponsors that enter into any type of arrangement with or receive services from an entity that is associated with the Part D sponsor by any form of common, privately-held ownership, control or investment. This includes any arrangement where the Part D sponsor does business with a related party through one or more unrelated parties, such as a pharmacy or a pharmacy benefit manager. 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 arrangements is to ensure that financial arrangements between the Part D sponsor and related parties (i) are 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 Part D sponsors to disclose whether or not they are in a business arrangement with a related party. Part D sponsors in a business arrangement with a related party must disclose and support each and every related-party arrangement at the time of the initial bid submission and prepare the bid and documentation in accord with the requirements in this section and Appendix B for each identified related party.

A Part D sponsor in a related-party arrangement must—

- Declare the related-party arrangement(s) to CMS at the time of the initial bid submission.
- Disclose all services that are covered in the arrangement(s). These include, but are not limited to:
  - Claims processing
  - Network (retail and mail order pharmacy) access
  - Clinical services, such as Utilization Management

  - Formulary management
  - Rebate contracting
  - Drugs at related-party retail and/or mail order pharmacies
  - Marketing materials and ID cards
  - Call center operations
- Select one of the following methods for entering costs associated with the related-party arrangement into the BPT.
  - Actual Cost Method for Administrative Services,
  - Actual Cost Method for Benefit Costs,
  - Market Comparison through Part D Sponsor, or
  - Market Comparison through Related Party

Part D sponsors always have the option to use the Actual Cost Method in bid preparation. Part D sponsors only have the option to use the Market Comparison through Part D Sponsor Method when the Part D sponsor has a comparable arrangement with an unrelated party. Part D sponsors only have the option to use the Market Comparison through Related Party Method when the related party has a comparable arrangement with an unrelated party. For comparison purposes, the unrelated party must be a Part D organization for benefit costs arrangements and may be a Part D or non-Medicare organization for administrative services arrangements.

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 Part D sponsor 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. Note that, if a related-party arrangement includes both administrative services and benefit services, the requirements apply separately to the costs associated with such administrative and benefit services.

Actual Cost Method for Administrative Services

A Part D sponsor using the actual cost method for administrative services must prepare the BPT in a manner that does not recognize the independence of the related party. 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 Part D sponsor. The gain/loss margin of the related party is excluded from the non-benefit expense of the Part D sponsor.
- When entering gain/loss margin in the BPT, the Part D sponsor 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.

Actual Cost Method for Benefit Costs

Under the actual cost method for benefit costs, the BPT is prepared as follows:

- All fees paid to the related party for benefit costs are entered as the benefit expense of the Part D sponsor.
- The related-party benefit costs are consistent with the actual and projected PDE experience of the plan.
- The gain or loss of the related party with respect to the Part D benefit costs is provided in the supporting documentation.

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

Market Comparison through Part D Sponsor Method

A Part D sponsor using the market comparison through Part D sponsor method must prepare the BPT in a manner that recognizes the independence of the related party by reporting all costs in the related-party arrangement to non-benefit expense for administrative services arrangements and to benefit expenses for benefit costs arrangements. To demonstrate that the arrangement with the related party is comparable, the Part D sponsor must–

- Provide an analysis that clearly explains how the financial results are not significantly different from what is achieved in the absence of the related-party relationship for the same services.
- Show that results from the same utilization priced through the related and unrelated party contracts are within plus or minus five percent.
- Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

Supporting documentation for the market comparison through Part D sponsor method must be provided with the initial bid submission as required in Appendix B.

Market Comparison through Related Party Method

A Part D sponsor using the market comparison through related party method must prepare the BPT in a manner that recognizes the independence of the related party by reporting all costs in the related-party arrangement to non-benefit expense for administrative services arrangements and to benefit expenses for benefit costs arrangements. To demonstrate that the arrangement with the Part D sponsor is comparable to arrangements with unrelated parties, the related party must–

- Provide an analysis that clearly explains how the financial results are not significantly different from what is achieved in the absence of the related-party relationship for the same services.
- Show that results from the same utilization priced through the related and unrelated party contracts are within plus or minus five percent.
- Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

Supporting documentation for the market comparison through related party method must be provided with the initial bid submission as required in Appendix B.

Risk Score Development for CY2018

The projected CY2018 risk score must—

- Be based on the methodology for calculating CY2018 risk scores, as discussed in the CY2018 Rate Announcement.
- Reflect the expected risk score trend at the bid level.
- Be appropriate for the expected population.
- Be adjusted for Part D normalization.

Risk Score Definitions and Information Sources

✓ **Part D RxHCC Risk Model**

CMS will use an updated RxHCC risk model for CY2018 payment. Diagnosis data from CY2014 were used to predict CY2015 expenditures; the denominator year is CY2015. Additional information, including the CY2018 normalization factor, is contained in the CY2018 Rate Announcement, published April 3, 2017.

✓ **Normalization Factor**

At time of payment, the risk scores for each enrollee will be divided by the Part D normalization factor, which is 1.005 for CY2018. This adjustment accounts for the actual program risk score experience and the expected increase in risk scores between the contract year (2018) and the denominator year (2015). Accordingly, the projected risk scores for CY2018 bids must reflect the normalization factor.

✓ **Risk Adjustment Information Sources**

- The following materials can be found through the "Announcements & Documents" link on the "Medicare Advantage Rates and Statistics" page of the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html:
  - "Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" (2018 Rate Announcement)
  - "Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter" (2018 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," and subsequent overpayment guidance.

Risk Score Calculation Approaches

✓ **Preferred Methodology**

The preferred method for projecting the CY2018 risk scores is to start with the Part D RxHCC risk scores that are provided by CMS in—

- The bid-level data for the July 2016 enrollee cohort with retroactive enrollment and status adjustments; or
- The beneficiary-level file containing 12 months of 2016 membership with retroactive enrollment adjustments and status adjustments.

The bid-level data will be available after the publication of the 2018 Rate Announcement under the "Risk Adjustment" link on the HPMS Home page. The risk score data posted in HPMS are calculated using the model that will be used for 2018 and are accompanied by technical notes to assist actuaries with understanding the material presented. The beneficiary-level data provide the 2016 risk scores calculated using both the risk model used for 2016 payment and the model to be used for 2018. These data are sent electronically to Part D sponsors at about the same time and will provide payment year 2016 risk scores calculated the following four ways, accompanied by technical notes:

- With the model used for 2016 payment, using data from RAPS and FFS claims.
- With the model used for 2016 payment, using data from the encounter data processing system (EDPS) and FFS claims
- With the model used for 2018 payment, using data from RAPS and FFS claims;
- With the model used for the 2018 payment, using data from EDPS and FFS claims.

There are several advantages to using the 2016 Part D RxHCC risk scores in the projection of the CY2018 risk scores:

- They are consistent with the base-period prescription drug expenses.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2015 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 2018 payment.

Please note that the RAPS-based risk scores are based on a mid-year cohort with full calendar year data and complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality.

The encounter data-based risk scores—both those posted to HPMS and those in the beneficiary-level file—are calculated using diagnoses extracted using Phase II filtering logic, and with a data run out cut-off date of January 31, 2017. While these scores will need to be adjusted for run out and the impact of Phase III filtering logic, they do not need to be adjusted for (i) transition from lagged to non-lagged diagnosis data, and (ii) seasonality.

However, the starting risk score is to be projected from 2016 to 2018 with explicit adjustment for the following factors, as appropriate:

- Bid-specific coding trend.
- Changes in plan population.
- Impact of diagnoses in encounter data.
  - MAOs must estimate the impact of diagnoses from additional run out of data from January 31, 2017 through the final cut-off date, as well as the impact of the difference between the Phase II and Phase III logic.
  - If a plan sponsor uses only a RAPS-based risk score as a starting risk score, then the MAO must estimate the impact on the final 2018 risk score of the blend with an encounter data-based risk score
- Other appropriate factors.

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

Finally, the projected risk scores must be normalized by dividing by the 2018 Part D normalization factor.

✓ **Alternate Approaches**

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2017, if there was limited enrollment in 2016, or if there will be significant changes in plan or enrollment characteristics between 2016 and 2018.

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

- Conversion to a raw risk score.
  - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized) risk score before making other adjustments.
- 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 risk scores.
  - An example is a starting point of March 2017 MMR data, which contain risk scores based on the July 2015 to June 2016 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 other than that to be used for CY2018 payments, then an adjustment for the risk model change must be made. The adjustment must include accounting for diagnoses that are not included in the older risk models, but are included in the updated model.
- Bid-specific coding trend.
- 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.
- Impact of diagnoses in encounter data.
  - If the MAO uses only a RAPS-based risk score as a starting risk score, then the MAO must estimate the impact on the final 2018 risk score of the blend with an encounter data-based risk score.
- Other appropriate factors.

Once projected to CY2018, the scores must be normalized by dividing by the 2018 Part D normalization factor. Note that, if a raw (not normalized) risk score associated with a different model calibration year is being normalized, the CY2018 Part D normalization factor is not appropriate.

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 G for more information about trending MA and Part D risk scores.

Sequestration

Pricing assumptions must consistently reflect the effect of sequestration.

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.

Types of Part D-Covered Drugs

Brand Drugs

Brand drugs consist of (i) single-source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA) and (ii) innovator multi-source drugs that were originally marketed under an original NDA and that now have generic equivalents.

Preferred/Non-Preferred Brand Drugs

Brand drugs that are placed in the most favorable position on the formulary in comparison to other similar brand drugs should be allocated to the preferred brand drug category. Brand drugs that are positioned in a less favorable position on the formulary should be allocated to the non-preferred brand category in the BPT.

Generic Drugs

Non-innovator multi-source drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately only when a plan utilizes a designated Specialty tier in the formulary and PBP in accord with CMS guidelines. The CMS guidelines require that (i) only one tier be designated a Specialty tier, (ii) only Part D-covered drugs with plan-negotiated prices greater than $670 per month supply be placed in the tier, and (iii) cost sharing associated with that tier be limited to 25 percent in the initial coverage range when the plan has the standard deductible, which is $405 for CY2018. When the plan has a decreased or no deductible, then an actuarially equivalent coinsurance is permitted.

When a designated Specialty tier is used, all drugs in that tier must be reported by point-of-sale (retail or mail order as defined by the PBP) in Worksheets 2, 6 and 6A of the BPT. The drugs in the Specialty tier must not be sorted by type of drug status and must not be reported as a component of the generic, preferred brand and non-preferred brand drugs in the non-Specialty tiers.

When a designated Specialty drug tier is not used in the formulary and PBP, Specialty drugs must be sorted by generic, preferred brand and non-preferred brand status and must be reported in these categories by point-of-sale (retail or mail order as defined by the PBP). In this situation, the Specialty categories in Worksheet 2, 6 and 6A are not completed.

III. DATA ENTRY AND FORMULAS

This section includes line-by-line instructions for completing the Part D BPT. It also describes the formulas for calculated cells.

PRESCRIPTION DRUG

To complete the Part D bid form, Part D sponsors must provide a series of data entries on the appropriate BPT worksheets. The number of inputs depends on the type of plan being offered and the length of time it has had a contract with CMS, among other factors.

The Part D bid form is organized as outlined below:

- Worksheet 1 – Rx Base Period Experience
- Worksheet 2 – PDP Projection of Allowed/Non-Benefit
- Worksheet 3 – Rx Contract Period Projection for Defined Standard Coverage
- Worksheet 4 – Rx Standard Coverage with Actuarially Equivalent Cost Sharing
- Worksheet 5 – Rx Alternative Coverage
- Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage
- Worksheet 6A – Coverage in the Gap
- Worksheet 7 – Summary of Key Bid Elements

All Part D sponsors must complete Section I of Worksheet 1; completion of subsequent sections of the BPT is based on the plan benefit type being offered. The worksheets and sections that must be completed for each plan benefit type are defined below.

Defined Standard Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2017, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2017, complete Sections II, III, IV Column O, V and VII; for plans with partially credible claims experience in CY2017, complete all sections. For new plans in CY2018 and CY2019, complete Sections IV, V, VI and VII.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete columns f, g, and h of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete columns f, g, and h of Section II for all plans.

- ✓ **Worksheet 7**

  Complete all sections for all plans.

Actuarially Equivalent Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2017, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2017, complete Sections II, III, IV Column O,V and VII; for plans with partially credible claims experience in CY2017, complete all sections. For new plans in CY2018 and CY2019, complete Sections IV, V, VI and VII.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 4**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 7**

  Complete all sections for all plans.

Basic and Enhanced Alternative Coverage

- ✓ **Worksheet 1**

  For all plans, complete Section I; for plans with claims experience in CY2017, complete all sections.

- ✓ **Worksheet 2**

  For plans with fully credible claims experience in CY2017, complete Sections II, III, IV Column O, V and VI; for plans with partially credible claims experience in CY2017, complete all sections. For new plans for CY2018 and CY2019, complete Sections IV, V, VI and VII.

- ✓ **Worksheet 3**

  Complete all sections for all plans.

- ✓ **Worksheet 5**

  Complete all sections for all plans.

- ✓ **Worksheet 6**

  Complete all columns of Section II for all plans.

- ✓ **Worksheet 6A**

  Complete all columns of Section II for all plans

- ✓ **Worksheet 7**

  Complete all sections for all plans.

Data Entry

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

PD WORKSHEET 1 – RX BASE PERIOD EXPERIENCE

Worksheet 1 contains general information about the plan and summarizes the base period Rx experience. Specifically, Section I collects general information about the plan that is displayed on all Part D BPT worksheets. Section II collects base period background information; Section III summarizes the base period Rx experience. Sections IV and V summarize components of the base period non-benefit expense and premium revenue, respectively. Section VI is an Income Statement Summary.

Section I must be fully completed for all plans. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2017 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.

Line 1 – Contract Number

Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional Preferred Provider Organization plan), or S (Prescription Drug Plan) and includes four Arabic numerals (for example, H9999, R9999, S9999). Include all leading zeroes (for example, H0001).

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the PBP being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input and must include any leading zeroes.

Line 3 – Segment ID

If the bid is for a "service area segment" of a local plan, enter the segment ID. This field must be entered as a text input and is to include any leading zeroes.

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – SNP

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

Line 7 – Plan Name

Enter the name of the PBP. This information also appears in HPMS.

Line 8 – Plan Type

Enter the type of Part D plan. The valid options are listed in the table below.

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 HMO POS
HMO with a POS Option	HMO POS
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 Plan (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Prescription Drug Plans:	
Medicare Prescription Drug Plan (PDP)	PDP
Fallback Plan	Fallback
Demonstration Plans:	
National PACE	PACE
Cost Plans:	
1876 Cost	1876 Cost
1833 Cost	1833 Cost

Line 9 – Enrollee Type

If the plan covers enrollees eligible for both Part A and Part B of Medicare, enter "A/B". If the plan covers enrollees eligible for Part B only, enter "Part B Only". When the plan type is "PDP" or "Fallback", then the enrollee type cell is white and locked; no input is required.

Line 10 – VBID

If the plan is participating in the Value-Based Insurance Design Demonstration, enter yes, otherwise enter no.

Line 11 – MTM

If the plan is participating in the Medication Therapy Management Demonstration, enter yes, otherwise enter no.

Line 12 – PD Region

When the plan type is "PDP", enter the region number of the region the plan will cover. This field must be entered as a text input and must include any leading zeroes.

The valid entries are shown in the following table:

Region	Description	Region	Description
01	Maine and New Hampshire	21	Louisiana
02	Connecticut, Massachusetts, Rhode Island and Vermont	22	Texas
03	New York	23	Oklahoma
04	New Jersey	24	Kansas
05	Delaware, District of Columbia and Maryland	25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming
06	Pennsylvania and West Virginia	26	New Mexico
07	Virginia	27	Colorado
08	North Carolina	28	Arizona
09	South Carolina	29	Nevada
10	Georgia	30	Oregon and Washington
11	Florida	31	Idaho and Utah
12	Alabama and Tennessee	32	California
13	Michigan	33	Hawaii
14	Ohio	34	Alaska
15	Indiana and Kentucky	35	American Samoa
16	Wisconsin	36	Guam
17	Illinois	37	Northern Mariana Islands
18	Missouri	38	Puerto Rico
19	Arkansas	39	Virgin Islands
20	Mississippi		

Line 13 – Plan Benefit Type

Enter the plan benefit type that identifies the type of coverage in the PBP. The valid options are "DS" for Defined Standard, "AE" for Actuarially Equivalent, "BA" for Basic Alternative and "EA" for Enhanced Alternative.

Line 14 – SNP Type

If the plan is a SNP as indicated by "Y" on line 6, then enter the type of SNP. The valid options are "Institutional", "Dual-Eligible" and "Chronic or Disabling Condition". The selection must agree with the option identified in the MA BPT.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

Enter the incurred dates of the base period data on the first two lines and the paid through date on the third line. For example, if the data reflect claims paid through February 2018, then the paid through date is 2/28/2018.

Line 2a – Total Member Months

The value is calculated automatically in the BPT from line 6 column e.

Line 2b – LIS Member Months

Enter the number of low-income subsidy (LIS) member months represented in the base period experience based on CMS eligibility records.

Line 3 – Risk Score

Enter the normalized risk score, estimated to three decimal places, for the population represented in the base period data using the Part D RxHCC risk model that was in place for the payment year.

Line 4 – Completion Factor

Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date.

Line 5 – Mapping

Enter the contract-plan-segment ID (in the format H###-###-###) of each plan for which base period data is required by these Instructions to be reported in Section III in the first column. Cell K12 is automatically populated with the contract number, plan, and segment ID in cells D5 and D6; the contract-plan-segment ID in cell K12 can be overwritten if there is no base period data for that plan. When base period data for more than eight plans is entered in Section III, (i) enter the contract-plan-segment IDs of the plans with the greatest number of member months in cells K12:K15 and M12:M14, (ii) enter "all other" in cell M15 and (iii) list the contract-plan-segment IDs and member months of all plans in the "all other" category in the "Base Period Experience Description" textbox in line 6.

Enter the corresponding number of member months in the second column.

Line 6 – Base Period Experience Description

Use the text box to briefly describe the base period data reported in Section III. Note that is it acceptable to enter "See supporting documentation" or leave this field blank.

SECTION III – PART D CLAIMS EXPERIENCE

Lines 1 through 11 include experience relating to Part D-covered drugs only. Lines 12 through 14 include experience for drugs that are covered by the plan but are not Part D-covered drugs at the time they are dispensed.

Lines 1 through 5:

- ✓ **Column d – Number of Members**

  Enter the number of members with total allowed costs in the defined standard allowed costs interval defined for each line. For example, if 7,000 members had total allowed costs between $360 and $3,309, then enter "7,000" in line 3,

column d. The "Total Covered Part D Spending at OOP Threshold for Non-Applicable Beneficiaries" and "Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries" for CY2017 must be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.

- ✓ **Column e – Member Months**

  Enter the number of member months associated with the number of members in column d for each line.

- ✓ **Column f – Total Number of Scripts**

  Enter the number of prescriptions filled for Part D-covered drugs for the members in column d for each line.

- ✓ **Column g – Total Allowed Dollars**

  Enter the total allowed dollars for the prescriptions filled for the members in column d for each line. Total allowed dollars are defined as ingredient cost plus dispensing fee, plus sales tax where applicable, plus the vaccine administration fees, prior to the application of any rebates recovered after the point-of-sale.

- ✓ **Column h – Average Allowed Amount per Member**

  The value is calculated automatically in the BPT as column g divided by column d for each line.

- ✓ **Column i – Average Paid Amount per Member**

  Enter the result of dividing the total dollars paid by the plan for the members in column d by the number of members in column d. Total paid dollars are defined as basic and supplemental payments for Part D-covered drugs and are not net of rebates, low-income subsidy payments or federal reinsurance.

- ✓ **Column j – Average Cost Sharing per Member**

  Enter the average cost sharing per member for Part D-covered drugs for the members in column d for each line.

- ✓ **Column k – Supplemental Cost-Sharing Reduction per Member**

  Enter the average value of supplemental cost sharing per member for Part D-covered drugs for members in column d for each line.

- ✓ **Column l – Reimbursement for Low-Income Cost-Sharing Subsidy per Member**

  Enter the average low-income cost-sharing subsidy amount received and receivable for the members in column d for each line.

- ✓ **Column m – Reimbursement for Federal Reinsurance per Member**

  Enter the average federal reinsurance amount received and receivable for the members in column d for each line.

- ✓ **Column n – Net Plan Responsibility per Member**

  The value is calculated automatically in the BPT as column i minus the sum of columns k through m for each line.

Line 6, columns d through n – Subtotal

The values are calculated automatically in the BPT as the sum of lines 1 through 5 for columns d through g and as the weighted average based on the number of members in column d of lines 1 through 5 for columns h through n.

Line 7 – Percentage OON

- ✓ **Column g**

  Enter the percentage of total allowed dollars in line 6 for prescriptions filled at out-of-network (OON) pharmacies.

- ✓ **Column i**

  Enter the percentage of average paid dollars in line 6 for prescriptions filled at OON pharmacies.

- ✓ **Column j**

  Enter the percentage of average cost sharing per member in line 6 for prescriptions filled at OON pharmacies.

Line 8, column i and columns k through n – PMPM Values

They are calculated automatically by the BPT as the result of the subtotal of the column in line 6 divided by the number of member months in column d.

Line 9 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates received as of the "Paid thru Date" in Section I and expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column m**

  Enter the amount of rebates attributable to the federal reinsurance amount in line 6.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column i minus column m.

Line 10 – Plus Part D as Secondary

- ✓ **Column g**

  Enter the total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer. "Total plan liability" is defined as CPP (Covered Plan Paid Amount) plus NPP (Non-covered Plan Paid Amount) minus 80 percent of either GDCA (Gross Drug Cost above Out-of-Pocket Threshold) or GDCA minus PLRO (Patient Liability Reduction Due to Other Payer Amount) as appropriate.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column i minus the sum of columns k through m.

Line 11, columns i and k through n – Net Average Paid Amount PMPM

The values are calculated automatically in the BPT as line 8 minus line 9 plus line 10.

Line 12 – Non-Covered Supplemental Drugs

- ✓ **Column g**

  Enter the total plan paid amount for prescription drugs that are covered by the plan but are not Part D-covered drugs.

- ✓ **Column i**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

Line 13, column i – Rebates on Supplemental Drugs

Enter the total amount of rebates received as of the "Paid thru Date" in Section I and expected to be received for the claims in line 12. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

Line 14, columns I and n – Net PMPM on Supplemental Drugs

The value in column i is calculated automatically in the BPT as line 40 minus line 41 and is carried to column n.

SECTION IV – PMPM NON-BENEFIT EXPENSES

Section IV summarizes all administrative expenses associated with the operation of the prescription drug plan in the base period, including any expenses that were offset by direct or indirect remuneration.

Lines 1 through 5, column g – Total

Enter the sales and marketing, direct administration, indirect administration, net cost of private reinsurance and insurer fees average pmpm amounts for total coverage on lines 1 through 5, respectively. Include uncollected enrollee premium, uncollected cost sharing and OTC drugs in direct administration.

Line 6, column g – Total Non-Benefit Expenses

The value is calculated automatically in the BPT as the sum of lines 1 through 5.

SECTION V – PMPM PREMIUM REVENUE

Section V summarizes the components of premium revenue of the prescription drug plan for the base period.

Lines 1 through 4, column e – Basic

Enter the CMS Part D direct subsidy payment, low-income premium subsidy, member premium and member penalty premium average pmpm amounts for basic coverage on lines 1 through 4, respectively. The direct subsidy amount must account for the final risk-adjusted reconciliation payment for CY2017 which will be received in mid-2018 and include the impact of sequestration and PACE add-on, if applicable.

Line 3, column f – Supplemental

Enter the member premium average pmpm amount for supplemental coverage on line 3.

Lines 1 through 4, column g and line 5 – Total Premium

The values are calculated automatically in the BPT as the sums of columns e and f.

SECTION VI – PMPM INCOME STATEMENT SUMMARY

Section VI is a summary of the prescription drug plan's income, including the amount of MA rebate allocable to Part D when applicable, for the base period.

Lines 1 through 9, column m

Enter in line 4 the average pmpm amount of the MA rebate dollars, including the impact of sequestration, used to buy down the Part D premium in line 4. The values in lines 1 through 3 and lines 5 through 9 are carried from other sections in Worksheet 1 or are calculated automatically in the BPT as sums or differences in column m.

Total Non-LI Brand Discount Amount

Enter in cell M60 the total non-LI brand discount amount received during or expected to be received for the base period and reported in the "Reported Gap Discount" field on the PDEs.

PD WORKSHEET 2 – RX PDP PROJECTION OF ALLOWED/NON-BENEFIT

Worksheet 2 projects the base period experience to the contract year, blending with a manual rate when the base period experience is not fully credible, by point-of-sale (retail or mail order as defined by the PBP) and type of drug. Specifically, Section I displays general information about the plan. Sections II and III summarize the base period and contract period utilization per 1,000 members and allowed costs per script and the components of utilization and cost trends. Section IV blends the projected allowed costs with a manual rate based on the plan's credibility. Section V summarizes the components of non-benefit expenses in the base and contract periods. Section VI is a text box for entering a description of the development of the manual rate. Section VII calculates the ratios of claims, non-benefit expenses and gain/(loss) to the total basic bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – UTILIZATION FOR COVERED PART D DRUGS

Lines 1 through 8 – Base Period

- ✓ **Column e – Number of Scripts/1000**

  Enter the number of prescriptions that were filled in the base period, expressed as annual prescriptions per 1,000 members, by point-of-sale (retail or mail order as defined by the PBP) and type of drug (generic, preferred brand, non-preferred brand or Specialty) for each line.

- ✓ **Column f – Allowed per Script**

  Enter the average allowed amount per script by type of script filled in the base period for each line. Allowed amount is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable, plus the vaccine administration fee, prior to the application of any rebates recovered after the point-of-sale.

- ✓ **Column g – PMPM**

  The value is calculated automatically in the BPT as column e times column f divided by 12,000 for each line.

Lines 1 through 8 – Components of Utilization Change

- ✓ **Column h – Trend in Scripts/1,000**

  Enter the utilization trend factor by type of script to project scripts/1,000 to the contract period for each line.

- ✓ **Column l – Formulary Change**

  Enter the factor that represents the impact on utilization of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

- ✓ **Column j – Risk Change**

  Enter the factor that represents the impact on utilization of the covered population's change in risk from the base period to the contract period by type of script for each line.

- ✓ **Column k – Induced Utilization**

  Enter the factor that adjusts for the utilization difference between the base period type of benefit plan (DS, AE, BA or EA) and a DS plan by type of script for each line.

- ✓ **Column l – Other Change**

  Enter the factor that represents the impact on utilization of any differences between the base period and contract period not included in the other components of utilization change, columns h through k, by type of script for each line.

- ✓ **Column m – Total Utilization Change**

  The value is calculated automatically in the BPT as the product of columns h through l for each line.

Lines 1 through 8, column n – Projected Scripts/1000

The value is calculated automatically in the BPT as the product of columns e and m for each line.

Lines 1 through 8, column o – Covariance

The value is calculated automatically in the BPT as projected allowed pmpm divided by the product of base period allowed pmpm times total utilization change times total unit cost change for each line.

Lines 9 through 14, columns e through o

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION III – COST FOR COVERED PART D DRUGS

Lines 1 through 8 – Components of Unit Cost Change

- ✓ **Column e – Inflation Trend**

  Enter the factor that represents the impact on cost between the base period and contract period because of changes in drug prices by type of script for each line.

- ✓ **Column f – Discount Change**

  Enter the factor that represents the impact on cost between the base period and contract period because of changes in point-of-sale network pricing, including discounts off of average wholesale price (AWP) and dispensing fees, by type of script for each line.

- ✓ **Column g – Formulary Change**

  Enter the factor that represents the impact on cost because of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

- ✓ **Column h – Other Change**

  Enter the factor that represents the impact on cost of any differences between the base period and contract period not included in the other components of unit cost change, columns e through j, by type of script for each line.

- ✓ **Column i – Total Unit Cost Change**

  The value is calculated automatically in the BPT as the product of columns e through h by type of script for each line.

Lines 1 through 8, column j – Projected Unit Cost

The value is calculated automatically in the BPT as the product of base period allowed per script times total unit cost change for each line.

Lines 1 through 8, column k – Projected Allowed PMPM

The value is calculated automatically in the BPT as scripts/1,000 times projected unit cost divided by 12,000 for each line.

Lines 9 through 14, columns e through k

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION IV – PROJECTED ALLOWED PMPM

Lines 1 through 8

- ✓ **Column l – Manual Utilization/1,000**

  When the base period experience is not fully credible, enter the projected utilization per 1,000 members, based on a manual rate, by type of script for each line.

- ✓ **Column m – Manual Unit Cost**

  When the base period experience is not fully credible, enter the projected unit cost per script, based on a manual rate, by type of script for each line.

- ✓ **Column n – Manual Rate PMPM**

  The value is calculated automatically in the BPT as column l times column m divided by 12,000 by type of script for each line.

- ✓ **Column o – Credibility**

  Enter the credibility percentage by point-of-sale and type of drug that is applied to the projected pmpm allowed amount in Section IV and blended with the pmpm manual rate to calculate the blended pmpm allowed amount for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

- ✓ **Column p – Blended Allowed PMPM**

  The value is calculated automatically in the BPT as the sum of (column o times column k) and [(1 minus column o) times column n] for each line.

Lines 9 through 14, columns l through p

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column. Cell O57, CMS Guideline Credibility is calculated automatically in the BPT as the square root of total member months from Worksheet 1 divided by 18,000, not to exceed 100 percent.

SECTION V – PMPM NON-BENEFIT EXPENSES

Section V summarizes the components of non-benefit expenses in the projection period.

Lines 1 through 5

- ✓ **Column e – Projected Expenses**

  Enter the projected non-benefit expense by component for each line.

Line 6, column e – Total Non-Benefit Expenses

The values are calculated automatically in the BPT using information entered on lines 1 through 5.

SECTION VI – PERCENTAGE OF REVENUE

Section VI summarizes the components of the total basic bid amount and calculates the ratios of claims, non-benefit expenses and gain/(loss) to the total basic bid.

Lines 1 through 3, column j

The values are carried from Worksheets 3 through 5.

Line 4, column j

The value is calculated automatically in the BPT as the sum of lines 1 through 3.

Lines 5a through 5c, column j

The values are calculated automatically in the BPT as percentages of the total basic bid.

SECTION VII – DEVELOPMENT OF MANUAL RATE

Provide a description of the source of the experience data used as the basis for the manual rate, as well as other relevant information including, but not limited to, benefit design, group size, group characteristics, utilization trends, pricing methodology, formulary changes, induction and risk assumptions. Note that is it acceptable to enter "See supporting documentation" or leave this field blank.

PD WORKSHEET 3 – RX CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

Worksheet 3 develops the defined standard bid amount. Specifically, Section I displays general information about the plan. Section II collects contract period information; Section III summarizes the contract period Rx experience. Sections IV and V summarize components of the contract period non-benefit expenses and gain/loss margin and components of the defined standard bid amount, respectively.

Sections II through V must be completed by all plans.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

Line 1 – Projected Member Months

The value is carried from Section III, line 6, column e. For an MA-PD, Part D projected member months are the sum of projected member months for MA, ESRD and hospice members.

Line 2 – Projected Average Risk Score

Enter the estimated average Rx risk score for the population expected to enroll in the contract period. Refer to the topic "Risk Scores" in the "Pricing Considerations" section of the Instructions for information concerning the development of the CY2019 risk score.

Line 3 – Projected Low-Income Subsidy (LIS) Member Months

Enter the estimated number of member months for enrollees who will qualify for and obtain LIS status in the contract period.

Line 4 – Projected non-LIS Member Months

The value is calculated automatically in the BPT as projected member months minus projected low-income subsidy member months.

SECTION III – PART D COVERED DRUG CLAIMS

The projection of contract period Rx experience must reflect the risk score entered in Section II, line 2.

Lines 1 through 5:

- ✓ **Column d – Number of Members**

  Enter the number of members expected to have total allowed claims in the allowed claim interval defined for each line. For CY2018, the "Total Covered Part D Spending at OOP Threshold for Non-Applicable Beneficiaries" of $7508.75

and "Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries" of $8417.60 must be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.

- ✓ **Column e – Member Months**

  Enter the number of member months expected in the contract period associated with the number of members in column d for each line.

- ✓ **Column h – Average Amount Allowed PMPM**

  The value is calculated automatically in the BPT as column g divided by projected member months for each line.

- ✓ **Column n – Plan Liability PMPM**

  The value is calculated automatically in the BPT as column h minus the sum of columns j through m for each line.

Lines 2 through 5

- ✓ **Column f – Number of Scripts**

  Enter the estimated total number of prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line.

- ✓ **Column g – Projected Allowed Amount**

  Enter the estimated total allowed dollars for prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line. Total allowed dollars must reflect the price paid to the dispensing provider at the point-of-sale and must be net of point-of-sale rebates and price concessions.

- ✓ **Column i – Cost Sharing**

  The value is calculated automatically in the BPT as the sum of columns j through l for each line.

- ✓ **Column k – PMPM Deductible**

  Enter the projected pmpm value of the deductible for the members in column d for each line.

- ✓ **Column l – Other Cost Sharing PMPM**

  Enter the projected pmpm value of the 25 percent cost sharing between the deductible and ICL and the catastrophic coinsurance above the catastrophic limit for the members in column d for each line.

- ✓ **Column o – Federal LIS Cost Sharing PMPM**

  Enter the projected amount of low-income cost sharing subsidy that will be received for the members in column d who are LIS-eligible divided by the total projected member months entered in Section II, line 1 for each line.

Lines 4 through 5, column j – GAP PMPM

Enter the projected pmpm value corresponding to amounts between the ICL and catastrophic limit for members in column d for each line. Reflect the impact of gap coverage in this amount.

Line 5, column m – Federal Reinsurance PMPM

Enter the projected amount of federal reinsurance that will be received for the members in column d divided by the total projected member months entered in Section II, line 1 for each line. Reflect the impact of gap coverage in this amount.

Line 6 – Subtotal

The value is calculated automatically in the BPT as the sum of lines 1 through 5 for each column.

Line 7 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Point-of-sale rebates reported in "Column g – Projected Allowed Amount" are not reported here. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates and all other types of DIR must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

- ✓ **Column h**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Columns m and n**

  The value in column h is allocated automatically to columns m and n in the BPT based on the relative amount of federal reinsurance to the total allowed amount.

Line 8 – Minus Other Insurance

- ✓ **Column g**

  Enter, as a positive value, the projected total reduction to the total allowed amount attributable to other Rx insurance.

- ✓ **Column h**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column m**

  Enter, as a positive value, the projected pmpm reduction to federal reinsurance attributable to other Rx insurance.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column h minus column m.

Line 9 – Plus Part D as Secondary

- ✓ **Column g**

  Enter, as a positive value, the projected total plan cost (Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP)) for Part D-covered drugs for which the Part D plan is the secondary payer.

- ✓ **Column h**

  The value is calculated automatically in the BPT as column g divided by line 6, column e.

- ✓ **Column m**

  Enter, as a positive value, the projected pmpm plan liability for Part D-covered drugs attributable to federal reinsurance for which the Part D plan is the secondary payer.

- ✓ **Column n**

  The value is calculated automatically in the BPT as column h minus column m.

Line 10 – Projected Percentage Out-of-Network (OON) Allowed

Enter the percentage of line 6, column g of projected allowed dollars for prescriptions that will be filled OON.

Line 11 – Projected Percentage Out-of-Network (OON) Plan Liability

Enter the percentage of line 6, column n of projected Part D plan liability for prescriptions that will be filled OON.

Line 12, columns g through o – Total

The values are automatically calculated in the BPT as line 6 minus line 7 minus line 8 plus line 9 for each column.

SECTION IV – PMPM NON-BENEFIT EXPENSE AND GAIN/LOSS

Section IV summarizes components of the contract period non-benefit expenses and gain/loss margin.

Lines 1 through 5

The values are carried from other worksheets or are calculated automatically in the BPT.

Line 6 – Total Gain/loss

Enter the estimated pmpm amount of gain or loss projected during the contract period.

Line 7 – Overall Gain/(Loss) Margin Level

Select in cell D46 the level at which the overall gain/(loss) margin requirements are met. The options are "contract", "organization" and "parent-organization". The option selected in the Part D BPT must match the option selected in the MA BPT of an MA-PD.

Line 8 – Corporate Margin Requirement % of Revenue

Enter in cell D47 the corporate margin requirement as a percentage of revenue. The level selected in the Part D BPT must match the level selected in the MA BPT of an MA-PD.

Line 9 – Corporate Margin Basis

Select in cell D48 the basis of the corporate margin percentage. The options are "non-Medicare" and "risk-capital-surplus".

Lines 10 and 11 – Negative Bid-Level Gain/(Loss) Margin

These fields pertain to a PD bid with a negative projected gain/loss margin in line 7. See the "Gain/Loss Margin" pricing consideration for more information regarding bid level gain/loss margin requirements.

Line 10 – Valid Product Pairing

If, in the contract year, the bid satisfies the requirements for the 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 11 – Bids in Product Pairing

If the answer in line 10 to the product pairing question is "Yes", enter in line 11, columns d through h, the contract number-Plan ID-Segment ID (including "000" for a non-segmented plan) of the bids in the product pairing. Leave columns d through h blank to the extent the preceding cells in line 11 identify each bid in the Part D product pairing.

SECTION V – DEFINED STANDARD COVERAGE BID DEVELOPMENT

Section V summarizes the components of the defined standard bid amount.

Lines 1 through 5, columns i and j

The values are carried from other sections in Worksheet 3 or are calculated automatically in the BPT as sums or quotients.

PD WORKSHEET 4 – RX STANDARD COVERAGE WITH ACTUARIALLY EQUIVALENT COST SHARING

Worksheet 4 must be completed when the plan benefit type is actuarially equivalent. The three tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The average coinsurance percentage for amounts between the deductible and the ICL must be actuarially equivalent to 25 percent; and
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

CONSIDERATIONS FOR ACTUARIALLY EQUIVALENT COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for an AE plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, AE plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the AE benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS AND TESTS FOR ACTUARIAL EQUIVALENCE

Lines 1 through 14, columns e, g, i, and l

The values are carried from other worksheets in the BPT.

Line 15 – Rebates

- ✓ **Column l**

  Enter the estimated total amount of rebates expected to be received by the plan.

- ✓ **Column i**

  The value is calculated automatically in the BPT and is prorated for reinsurance.

Lines 16 through 18 – Tests for Actuarial Equivalence

The three actuarial equivalence tests are applied to certain values in Section IV to determine whether the proposed benefit plan qualifies as standard coverage with actuarially equivalent cost sharing.

SECTION V – STANDARD COVERAGE BID DEVELOPMENT WITH ACTUARIALLY EQUIVALENT COST SHARING

Lines 1 through 5

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 6 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

PD WORKSHEET 5 – RX ALTERNATIVE COVERAGE

Worksheet 5 must be completed when the plan benefit type is basic alternative or enhanced alternative. The six tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The value of total coverage is at least actuarially equivalent to DS coverage;
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage;
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL;
- The deductible is not greater than the DS deductible; and
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

CONSIDERATIONS FOR BASIC ALTERNATIVE AND ENHANCED ALTERNATIVE COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for a BA and less than or equal to 25 percent for an EA plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, BA and EA plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the BA or EA benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. The distribution of utilization between generic and brand, and retail and mail, must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

BA and EA plans may reduce the value of the deductible. BA and EA plans may provide additional coverage in the gap. Since the value of coverage up to the ICL must remain the same relative to the DS, a supplemental premium will result unless the cost of the additional coverage is offset by savings in catastrophic coverage.

Additional coverage in the gap can delay the point at which a beneficiary reaches catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, cause induced utilization and increase the risk profile of the group. Members with extremely high spending will not benefit as much as those with moderate amounts of spending.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS

Lines 1 through 3

- ✓ **Columns f, g and m**

  The values are carried from Worksheet 3 in the BPT.

- ✓ **Columns i and o**

  The values are calculated automatically in the BPT as column f plus column g.

Type of Deductible

Select in cell I33 the type of deductible consistent with the description in the PBP for the alternative coverage. The valid options are: "no deductible", "applies to all tiers" or "applies to some tiers".

Alternative Coverage Deductible Amount

Enter in cell I34 the alternative coverage deductible amount consistent with the amount in the PBP.

Type of Gap Coverage

Select in cell M33 the type of gap coverage consistent with the description in the PBP for the alternative coverage. The options are: "DS ICL and cost sharing", "increased ICL and DS cost sharing", "all drugs covered in full", "reduced cost sharing on some drugs".

Alternative Coverage ICL

Enter in cell M34 the ICL consistent with the description in the PBP for the alternative coverage.

Lines 4 through 24

The values in columns d through o include Part D-covered drugs only; the values in column q include non-Part D-covered drugs only. The values are carried from other worksheets or are calculated automatically in the BPT, with the exception of the following, which must be entered:

- ✓ **Line 6, column d – Proposed Deductible**

  Enter the dollar value of the deductible consistent with the description in the PBP Refer to the topic "Non-Uniform Deductible" in the "Pricing Considerations" section of the Instructions for more information.

- ✓ **Line 8, column f – Value of Proposed Deductible**

  Enter the projected pmpm value of the deductible for members with total allowed amount less than the ICL. Refer to the topic "Non-Uniform Deductible" in the "Pricing Considerations" section of the Instructions for more information.

- ✓ **Line 18, column o – Minus Rebates**

  Enter the estimated total rebates pmpm expected to be received for Part D-covered drugs.

- ✓ **Line 18, column q – Minus Rebates**

  Enter the estimated total rebates pmpm expected to be received for non-Part D-covered drugs.

- ✓ **Line 20, columns m, o and q – Minus Other Insurance**

  Enter, as a positive value, the projected reduction to average allowed amount pmpm attributable to other Rx insurance for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

- ✓ **Line 22, columns m, o, and q – Plus Part D as Secondary**

  Enter, as a positive value, the projected plan liability pmpm for which the Part D plan is the secondary payer for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

SECTION V – DEVELOPMENT OF ACTUARIAL EQUIVALENCE TEST

Lines 1 through 8

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 9 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

SECTION VI – TESTS FOR ALTERNATIVE COVERAGE

This section applies the six actuarial equivalence tests to certain values in Sections III through V to determine whether the proposed benefit plan qualifies as alternative coverage.

SECTION VII – DEVELOPMENT OF SUPPLEMENTAL PREMIUM

Lines 1 through 5 and 8

The values are calculated automatically by the BPT from values in Worksheet 5.

Line 6 – Additional Non-Benefit Expenses

The value is carried from Worksheet 3.

Line 7 – Additional Gain/loss

The value is carried from Worksheet 3.

SECTION VIII – DEVELOPMENT OF INDUCED UTILIZATION ADJUSTMENT

This section summarizes the additional costs of DS coverage with respect to the enhanced alternative plan with supplemental benefits and is used to adjust allowable costs for risk corridor payments.

Line 2 – Impact of Alternative Utilization on Standard Benefit

Enter the additional costs for Part D-covered drugs under a DS plan in the first column if the utilization of the EA plan was used to price the DS coverage in the bid. The adjustment applies to the EA plan type only and must be a positive value.

PD WORKSHEET 6 – SCRIPT PROJECTIONS FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6 summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in different distributions of drug spending. In addition, Worksheet 6 illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, non-uniform deductible, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid. Part D sponsors must model the impact of the alternative benefit compared to the DS by making adjustments in utilization and average script pricing in Worksheet 6. The distributions must be based on the intervals defined for DS coverage. For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 9 must reflect the utilization for the AE, BA or EA plan for members expected to have less than the DS ICL of $3,750 in CY2018. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.

Refer to the "Pricing Considerations" section of the Instructions for information on modeling the impact of coverage in the gap, decreased ICL and non-uniform deductible.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTIONS FOR EQUIVALENCE TESTS

Data are collected for four levels of allowed costs on lines 1 through 36. The distribution of the population and Part D covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the deductible, coverage gap and LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 8 – Population Not Exceeding Allowed Costs of $3,750 with Standard Coverage

All utilization for members with projected total allowed costs less than $3,750 must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost-sharing structure of the DS plan by point-of-sale and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 9, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 1 through 8 for each column.

Lines 10 through 17 – Population Exceeding Allowed Costs of $3,750 with Standard Coverage

All utilization for members with projected total allowed costs greater than or equal to $3,750 must be reported on these lines.

- ✓ **Columns f and g – Defined Standard Coverage**

  Enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f and g, respectively, for each line.

- ✓ **Columns i and j – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 18, columns f, g, i and j – Total

The values are calculated automatically in the BPT as the sum of lines 10 through 17 for each column.

Lines 19 through 26 – Population Exceeding $3,750 with Standard Coverage Amounts Allocated up to ICL

All utilization for total allowed costs up to $3,750 for members with projected total allowed costs greater than or equal to $3,750 must be reported on these lines. These amounts are a subset of the amounts reported in lines 10 through 18; amounts in the gap are intentionally excluded.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts allocated up to the ICL of $3,750 in CY2018, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts allocated up to the ICL, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 27, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 19 through 26 for each column.

Lines 28 through 35, columns f through k – Amounts Allocated over Catastrophic Coverage

The amounts in these lines are a subset of the amounts reported in lines 10 through 18.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing

structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 36, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 28 through 35 for each column.

Line 37, columns i through k – Non-Part D-Covered Drugs All Spending

When the plan benefit type is EA and the plan covers non-Part D drugs, enter the projected total number of scripts, total allowed dollars and total cost sharing, for the population identified in Worksheet 3, Section III, using the cost-sharing structure of the EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line.

Network Pricing

Enter the projected average percentage discount off of AWP and the projected average dispensing fees for generic, brand and Specialty drugs dispensed at retail and mail.

The values in this section must be based on the network pricing contracts that will be effective in CY2019 and on the projected weighted utilization by pharmacy of the population identified in Worksheet 3.

PD WORKSHEET 6A – COVERAGE IN THE GAP FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6A summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in the coverage gap. As a continuation of Worksheet 6, Worksheet 6A illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5 and calculates the plan-specific prospective brand discount amount payment. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, non-uniform deductible, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

SECTION I – GENERAL INFORMATION

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

SECTION II – SPENDING IN THE COVERAGE GAP

Data are collected for allowed costs in the coverage gap on lines 1 through 33. The distribution of the population and Part D-covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 11, columns f through k – Amounts Allocated between $3,750 and Catastrophic

The values are calculated automatically in the BPT.

Lines 12 through 21 – Low-Income Population Amounts Allocated between $3,750 and Catastrophic

All utilization for LIS members with projected total allowed costs greater than $3,750 and less than the catastrophic limit must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 22, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 11 through 21 for each column.

Lines 23 through 32 – Non-Low-Income Population Amounts Allocated between $3,750 and Catastrophic

All utilization for non-LIS members with projected total allowed costs greater than $3,750 and less than the catastrophic limit must be reported on these lines.

- ✓ **Columns f through h – Defined Standard Coverage**

  Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

- ✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

  When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 33, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 23 through 32 for each column.

Non-LI Generics in Gap PMPM

The value is calculated automatically in the BPT.

Non-LI Brand Discount Amount PMPM

The value is calculated automatically in the BPT.

PD WORKSHEET 7 – SUMMARY OF KEY BID ELEMENTS

Worksheet 7 summarizes key payment-related components of the bid and the Part D sponsor's estimate of the national average monthly bid amount and calculates premiums.

SECTION I – GENERAL INFORMATION

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

SECTION II – 2019 DEFINED STANDARD BENEFIT PARAMETERS

Line 1 – Deductible

The cell is pre-populated with the deductible for the DS plan benefit type.

Line 2 – Initial Coverage Limit

The cell is pre-populated with the ICL for the DS plan benefit type.

Line 3 – Out-of-Pocket Limit

The cell is pre-populated with the OOP for the DS plan benefit type.

SECTION III – SUMMARY OF KEY BID ELEMENTS

Line 1 – Standardized Part D Bid

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 2 – National Average Monthly Bid Amount (NAMBA)

Enter the Part D sponsor's estimate of the national average monthly bid amount at the time of bid submission. The final national average monthly bid amount for CY2019 will be calculated and published by CMS in early August 2018.

Line 3 – Base Beneficiary Premium (BBP)

Enter the Part D sponsor's estimate of the base beneficiary premium amount. The national average monthly bid amount, basic Part D A/B rebate allocation reported on the MA BPT for MA plans and base beneficiary premium will determine the plan's basic Part D target premium.

Lines 4 and 5 – Basic Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT. Line 4 is calculated as line 1 minus line 2 plus line 3. Line 5 reflects the value of the basic Part D premium from line 4 after the rounding rule selected on line 8 of this section has been applied. If the basic Part D premium is negative and the plan benefit type is DS, AE or BA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP. If the plan benefit type is EA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP or fully offset the negative basic premium with a supplemental Part D premium. The basic Part D premium, before and after the rounding rule is applied, will be updated based on the actual national average monthly bid amount and base beneficiary premium that are calculated and published by CMS in early August.

Lines 6 and 7 – Supplemental Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT when supplemental benefits are offered. Line 6 is carried from Worksheet 5 of the BPT. Line 7 reflects the value of the supplemental Part D premium from line 6 after the rounding rule selected on line 12 of this section has been applied.

Line 8 – Prospective Federal Reinsurance (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 9 – Prospective Low-income Cost-Sharing Subsidy (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 10 – Target Adjustment (Allowed Costs as a Ratio of Bid)

The target adjustment is the allowed costs percentage of the bid and it is used in calculating the target amount for risk corridor payments. The value is calculated as–

[(1.00 – administration cost percentage) X (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount)]

Line 11 – Prospective Brand Discount Amount

The value is carried from Worksheet 6A of the BPT.

Line 12 – Rounding Rule

Select the option from the drop-down box that corresponds to the preferred method for rounding the Part D premium. The valid options are $0.10 and $0.50. MA-PD plans are required to round to the nearest $0.10; Part D plans are permitted to round to either the nearest $0.10 or nearest $0.50.

SECTION IV – PART D BID PRICING TOOL CONTACTS AND DATE PREPARED

Part D sponsors must identify three persons as plan bid contact, Part D certifying actuary and additional Part D actuarial BPT contact, except that the Part D sponsor may designate a centralized mailbox as the Part D plan bid contact Email Address, if the other Part D plan bid contact information is a specific individual's name and phone number. The Part D certifying actuary and additional Part D 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.

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 Part D BPT requires a certification. Likewise, every MA 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] CY2019 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]

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[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, Part D sponsors must provide CMS with supporting documentation for every bid, as described in these Instructions.

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

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

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.2, "Actuarial Report," the materials provided must be written "with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work."

All data submitted as part of the bid process are subject to review and audit by CMS or by any person or organization that CMS designates. Certifying actuaries and additional Part D 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 if it is related to MA, Part D or both.
- Clearly identify the bid(s) relating to the support. At a minimum, the contract number and organization name must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart or as an attachment.
- 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.

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 that are accessible only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as "the same as for plan Hxxxx-xxx," and not the documentation itself. The supporting documentation for a 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 plans in HPMS, documentation must not be uploaded to plans to which it does not pertain. Similarly, it is not acceptable to upload to multiple plans materials specific to a Part D plan, an MA bid or another contract number.

More requirements about the upload of substantiation files are located in HPMS in the "Notes" section, under HPMS Home > (Plan Bids) Bid Submission > CY2019 > (Upload) Substantiation > Next.

Cover Sheet

To expedite the bid review process, Part D sponsors 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 contract number-plan IDs and whether the substantiation is related to MA, Part D or both.

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a bid's projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of contract number-plan IDs (such as "plans 001 – 030" or "all plans under contract Hxxxx"). For these items, the cover sheet must contain the exact contract number-plan IDs (contract/plan) 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 IDs rather than a "range" of contract number-plan 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

Part D sponsors 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 Part D sponsors must upload to HPMS with the initial June bid submission.
- The "Upon Request by CMS Reviewers" section of Appendix B describes materials that Part D sponsors and certifying actuaries must provide within 48 hours of request by CMS reviewers and upload to HPMS prior to the final actuarial certification.
- When a BPT is resubmitted, the Part D sponsor must upload a summary of changes, including the cause and effect of each revision, authorized by CMS or CMS reviewers. If multiple BPTs are resubmitted at the same time, the supporting documentation must include a mapping of specific bid changes and contract number-plan IDs.
    - Sample BPTs are not to be uploaded to HPMS.
- Prior to the final actuarial certification—
    - Part D sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid. This includes additional information or materials provided during bid review to support the bid.

- Part D sponsors 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.
3. A document titled "Related-Party Declaration" that states whether or not the Part D sponsor is in a related-party arrangement (Worksheets 1, 2 and 3).
4. Support for sequestration's effect on the bid, including a detailed 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 quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories used in pricing (Worksheets 2, 6 and 6A). The required elements include–
   6.1. The PBP description of the deductible and copay/coinsurance structure by days supply, point-of-sale and claims interval.
   6.2. Allowed costs, effective cost sharing and script counts by formulary tier within each claims interval based on the cost-sharing structure, including days supply and point-of-sale, specified in the PBP.
   6.3. A quantitative description of the distribution of the allowed costs, effective cost sharing and script counts by formulary tier to each of the categories on Worksheets 6 and 6A.
7. Support for non-benefit expense assumptions (Worksheet 2). 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 plan-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 bid-level actual and expected total non-benefit expenses PMPM for CY2015, CY2016 and CY2017, including an explanation of how that knowledge was incorporated into the current bid submission. "Significant differences" refers to three consecutive years of actual-to-expected ratios that are either (i) all less than or equal to 0.95, or (ii) all greater than or equal to 1.05.

8. Justification of the gain/loss margin (Worksheet 2). The required elements include–

8.1. Support for the corporate margin requirement. This includes—

8.1.1. A demonstration of how corporate margin requirement is set, including an explanation for any changes from the prior year.

8.1.2. A demonstration of consistency between the corporate margin requirement used in pricing and the actual corporate returns over the long term. If the returns have been inconsistent historically, provide an explanation of how that knowledge was incorporated into the current bid submission.

8.2. Support for overall margin levels including—

8.2.1. The level at which overall margins are determined.

8.2.2. A list of the contract numbers offered by the organization, if aggregate gain loss margin requirements are met at the organization level.

8.3. A detailed justification for the limited situations in which the aggregate margin is outside of the stated range of the corporate margin level at which overall margins are determined. This includes—

8.3.1. Disclosure of an aggregate-margin exception request for the contract year.

8.3.2. A description of the limited circumstances supporting an exception.

8.3.3. A description of the historical, current, and future actions taken to bring the margin into compliance with these Instructions.

8.3.4. An aggregate-margin numeric (non-pdf) business plan demonstrating when the applicable aggregate-margin requirements will be satisfied. Include a year-by-year projection of projected member months, risk scores, CMS revenue, Part D premium, claims expenses, non-benefit expenses, and gain/loss margin.

8.4. A demonstration of consistency between the projected aggregate margins for Part D and the actual aggregate returns over the long term. If the returns have been inconsistent historically, provide an explanation of how that knowledge was incorporated into the current bid submission.

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 Part D product pairing that includes the gain/loss margin for each Part D bid and shows that such bids—

a. Have identical service areas;

b. Have a positive combined gain/loss margin for CY2019.

8.6.2. An alternate Part D bid-specific business plan that includes a demonstration that the Part D 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, a Part D bid-specific, year-by-year, numeric (non-pdf) 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, Part D premium, claims 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 Part D bid becomes part of a valid product pairing.

8.6.4. For a Part D bid with a negative projected gain/loss margin for the prior contract year, a numerical (non-pdf) comparison of the projected gain/loss margin to the Part D margin in the original or most recent Part D bid-specific numeric business plan. The required elements include—

a. Details and sources of deviation from the original or most recent Part D business plan.

b. An explanation and demonstration of how the targeted margin in the original or most recent Part D 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 (non-pdf) business plan demonstrating that the Part D bid will reach profitability within five years of the original Part D 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 Part D business plans uploaded to HPMS in a separate file.

8.7. A detailed justification for a unique situation, in which a Part D bid-specific business plan does not achieve profitability within five years, including—

8.7.1. Disclosure of the exception request for the five-year requirement to achieve profitability.

8.7.2. A description of the unique circumstances supporting an exception.

8.7.3. A description of the historical, current, and future actions taken to bring the margin into compliance with these Instructions.

8.8. For MA-PD plans, a description of the approach for setting the Part D margin in relation to the MA margin.

9. Detailed support for the development of projected risk scores (Worksheet 3). The required elements include–
   9.1. A detailed description and corresponding numerical demonstration of the methodology used to develop projected CY2019 Part D risk scores.
   9.2. A description of, and the rationale for choosing, the source data for the development of the projected CY2019 Part D 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 CY2019 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 plan population and the development of projected prescription drug expenses.
   9.5. An explanation for significant differences between bid-level actual and expected risk scores for CY2015, CY2016 and CY2017, including an explanation of how that knowledge was incorporated into the current bid submission. "Significant differences" refers to three consecutive years of actual-to-expected ratios that are either (i) all less than or equal to 0.95, or (ii) all greater than or equal to 1.05.
   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. The required elements include—
      10.1.1. Description of the source data, such as a list of the CMS return files that were used in the compilation of the PDEs

10.1.2. Information regarding the base period member months, if more than eight bids constitute the base period experience

10.1.3. Any applicable adjustments, stated as absolute values or percentages, to the source data, including considerations for—

a. Accepted PDEs.

b. Rejected PDEs expected to be accepted by CMS upon resubmission.

c. P2P transactions.

d. Transfer of OTC drug data from the base period experience to the non-benefit expense component.

10.2. Reconciliation of base period experience to the Part D sponsor's audited financial statements and bid-level operational data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including claims paid, unloaded claim reserves, non-benefit expenses and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.

10.3. Cross-walk information regarding data aggregation (Worksheet 1). The required elements include–

10.3.1. A list of all bids involved in approved cross-walks for CY2018 and proposed cross-walks for CY2019 considered for base period data aggregation.

10.3.2. A statement of the intention to submit a cross-walk exception for CY2019, if applicable.

10.4. Detailed qualitative and quantitative support for the development of the rebates and all other types of direct and indirect remuneration (DIR) (Worksheets 1 and 3).

11. Detailed qualitative and quantitative support of the development of each trend projection factor (Worksheet 2). The required elements include–

11.1. A description of the source data, including the data's relevance to the Part D plan.

11.2. A summary of the Part D sponsor'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. Part D sponsor's experience.

11.3.2. PBM reports and contracts.

11.3.3. Industry and/or internal studies.

11.3.4. Formulary analysis.

11.3.5. Benefit design analysis.

11.3.6. Bid-specific circumstances

11.4. An explanation for significant differences between actual and expected bid-level total allowed PMPM for CY2015, CY2016 and CY2017, including an explanation of how that knowledge was incorporated into the current bid submission. "Significant differences" refers to three consecutive years of actual-to-expected ratios that are either (i) all less than or equal to 0.95, or (ii) all greater than or equal to 1.05.

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 Part D plan 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, formulary differences 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 Part D plan; and

12.3.3. Techniques and factors used to adjust for differences in plan design between the source data and the Part D plan.

12.4. Data and methodology used to project the data from base period to CY2019.

12.5. All other applicable factors and/or adjustments.

13. Detailed support for related-party arrangements (Worksheets 1, 2 and 3).

13.1. A Part D sponsor 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 Actual Cost Method for Administrative Services, Actual Cost for Benefit Costs, Market Comparison through Part D Sponsor Method and Market Comparison through Related Party Method.

13.2. A Part D sponsor that chooses the Actual Cost Method for Administrative Services must provide a qualitative and quantitative summary of the development of the related party's non-benefit expense.

13.3. A Part D sponsor that chooses the Actual Cost Method for Benefit Costs must–

13.3.1. Provide a qualitative and quantitative analysis of the development of the related party's gain/loss margin reflected in the benefit costs, where the related party's gain/loss margin is defined as the allowed amount of the related party entered in the BPT less the cost of purchasing pharmaceuticals and dispensing prescriptions. The gain/loss margin must be reconcilable to the related party's audited financial statements.

13.3.2. Provide the related party's gain/loss margin as i) the allowed amount of the related party entered in the BPT less the cost of purchasing pharmaceuticals and dispensing prescriptions divided by the total member months in the BPT and ii) the allowed amount of the related party entered in the BPT less the cost of pharmaceuticals and dispensing prescriptions divided by the allowed amount of the related party.

13.4. A Part D sponsor that chooses the Market Comparison through Part Sponsor Method must–

13.4.1. Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from what is achieved in the absence of the related-party relationship.

13.4.2. Show that results of pricing at least two quarters of the Part D plan's experience through the related and unrelated party contracts are within plus or minus five percent. All terms of each of the contracts must be included when pricing the plan's experience.

13.4.3. Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

13.5. A Part D sponsor that chooses the Market Comparison through Related Party Method must–

13.5.1. Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from what is achieved in the absence of the related-party relationship.

13.5.2. Show that results of pricing at least two quarters of the Part D plan's experience through the related and unrelated party contracts are within plus or minus five percent. All terms of each of the contracts must be included when pricing the plan's experience.

13.5.3. Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

13.5.4. Provide a signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.

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 CY2018 bid audit findings and observations and compliance issues were corrected in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.

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 plan(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 Part D sponsor's participation in the Medicare Advantage Value-Based Insurance Design (MA-VBID) model or Medication Therapy Management (MTM) model, including an explanation for and a demonstration of elements that affect projected costs.

18. Detailed quantitative support of the development of the induced utilization factor (Worksheet 5).
19. – 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 Part D 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 a Part D 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 Part D sponsor, 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.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

PART D CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Related-party declaration
Sequestration assumptions
Claims credibility assumption
Mapping of allowed costs, script counts and cost sharing in formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and projections
Trend projection factor development
Manual rate development
Related-party arrangements
Input sheet(s) for pricing model
Bid audit results and compliance issues
Reliance information
VBID and/or MTM
Induced utilization factor development
Upon Request by CMS Reviewers
Related-party contracts
Reliance letter
OFM audit results
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD

Supporting Documentation Cover Sheet

CY2019 Bid Submission

Organization Name: Health One

Contract(s): Hxxxx, Hyyyy and Szzzz

Date: June 5, 2018

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, Part D, or Both
Cover sheet	All bids	Cover Sheet 6-5-18.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-5-18.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-5-18.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-5-18.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet2	both
Risk scores	All bids	Risk CY18.xls	MA-Sheet 1 PD-Sheet 2	both
Related-party declaration	All bids	Cover Sheet 6-5-18.pdf	Page 7	both
Sequestration	All bids	Cover Sheet 6-5-18.pdf	Page 7	both
Manual rates	Hxxxx-003-0 Syyyy-001-0	Manual.xls	Section II	PD
ESRD subsidy	Hxxxx-001-0 Hxxxx-004-0	Manual.xls	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD

Supporting Documentation Cover Sheet #2

CY2019 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: July 15, 2018

Documentation Requirement	Specific Bid(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, Part D, or Both
Cover sheet	Hxxxx-001 Hxxxx-003 Hxxxx-004 Hxxxx-801 Hyyyy-001 Hzzzz-001	Cover Sheet 7-15-18.doc	n/a	both

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid	MA or Part D or Both	Source (Name, Position, Company)	Type of Information	Comments
Hxxxx-002-00	MA and Part D	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
Hxxxx-002-00	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.

APPENDIX C – EMPLOYER/UNION-ONLY GROUP (EGWP) REQUIREMENTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives employers and unions a number of options for providing prescription drug coverage to their retirees. Employers and unions can–

- Provide coverage at least as good as Medicare's Part D DS benefit and receive a retiree subsidy of 28 percent of a retiree's drug costs between $405 and $8,350;
- Purchase customized benefits from a PDP or MA-PD pursuant to CMS waivers; or
- Contract directly with CMS to become a PDP and provide customized benefits pursuant to CMS waivers.

Under sections 1860D-22(b) and 1857(i) of the Social Security Act (SSA), CMS may waive or modify Part D requirements that hinder the design of, offering of, or enrollment in an employer or union Part D retiree plan. The waiver authority applies to PDPs and MA-PDs that offer employer/union-only group plans and to employer/union-only groups that contract directly with CMS to become a PDP.

For CY2006, CMS issued guidance that waives or modifies many of the requirements for these entities. All of the standard Part D bidding guidelines apply, with the exception of those specifically waived.

For CY2019, CMS does not require a Part D BPT for employer/union-only group plans.

For additional information on CY2019 EGWP bidding policy, please refer to the CY2019 Call Letter and Advanced Notice.

APPENDIX D – CALCULATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT

For CY2006, the national average monthly bid amount was calculated using equal weighting applied to all PDP sponsors, and MA-PD plans were assigned a weight based upon prior enrollment. New MA-PD plans were assigned a zero weight. This approach was used because no PDP enrollment data existed for 2005.

For CY2007 and CY2008, the national average monthly bid calculation was performed according to the guidelines established by the "Medicare Demonstration to Limit Annual Changes in Part D Premiums due to Beneficiary Choice of Low-Cost Plans." Specifically, 80 percent of the calculation for CY2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average, and 20 percent was based on an enrollment-weighted average. For CY2008, 40 percent of the calculation was based on the uniform-weighting average and 60 percent was based on an enrollment-weighted average. The demonstration was no longer in effect for CY2009 and the benchmarks were based on the 2008 enrollments applied to the 2009 bids. The CY2019 benchmarks will be based on the 2018 enrollments applied to the 2019 bids.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2017 and February 2018. Recall that the 2018 benchmark was calculated as 100 percent of the enrollment-weighted approach.

The same values are presented based on the February 2018 enrollment. Since the 2019 benchmarks will be based on 2018 enrollment, these values may be useful for estimating the 2019 benchmarks. The left section of the table shows the actual 2018 benchmarks, which were calculated based on June 2017 enrollment. The right section, titled "February 2018 Enrollment," indicates how the 2018 benchmarks would have been calculated based on more current enrollment data.

	Enrollment Weighted Approach	
	June 2017 Enrollment	**February 2018 Enrollment**
National average monthly bid amount		
Base beneficiary premium		
Direct subsidy		

This illustrative recalculation of the 2018 benchmarks is provided for the purpose of assisting Part D sponsors in developing the projected 2019 national average monthly bid amount and base beneficiary premium, which will be used in the calculation of the plan's target premium. The final 2019 benchmarks will be based on the 2018 enrollments applied to the 2019 bids.

APPENDIX E – CALCULATION OF LOW-INCOME BENCHMARK PREMIUM AMOUNTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to use a weighted average to calculate the regional low-income benchmark premium amounts used in the determination of the low-income premium subsidy amounts. In determining the 2006 low-income benchmark premium amounts, PDPs were weighted equally, MA-PDs were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PDs were assigned a zero weight. For CY2007, under the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006.

For CY2008, CMS implemented a transition to the statutorily required weighting such that the regional low-income benchmark premiums would experience a smaller decrease. CMS calculated the 2008 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average), as described below:

- The first component, the simple average, was the same as the 2006 weighting methodology for the regional low-income benchmark premium amount. The PDP organization premium amounts for basic prescription drug coverage in each region were weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, were weighted based upon prior enrollment.
- The second component was a weighted average of the premium amounts for each PDP and MA-PD with a weighting based on each plan's prior enrollment as a percentage of all beneficiaries enrolled in those plans.

For CY2008, the regional low-income benchmark amount was based on 50 percent of the first component and 50 percent on the second component, as described above.

For CY2009, the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries" and the de minimis policy were not in effect. The regional low-income benchmark amounts were calculated based on 100 percent of the weighted LIS enrollments.

For CY2010, the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" established that the regional low-income benchmark amounts, based on 100 percent of the weighted LIS enrollments, would be calculated using the Part D premiums for MA-PD plans before they were reduced by any applicable MA A/B rebates.

For CY2011 and subsequent years, in accord with the codification of the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation", the weighted average premium amounts will be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable Part A/B rebates.

The following table illustrates the impact of calculating the regional low-income benchmark amounts based on 100 percent of the weighted LIS enrollments for two enrollment periods, June 2017 and February 2018.

PD Region	State(s)	Enrollment Weighted Approach	
		June 2017 Enrollment	February 2018 Enrollment
01	NH, ME		
02	CT, MA, RI, VT		
03	NY		
04	NJ		
05	DE, DC, MD		
06	PA, WV		
07	VA		
08	NC		
09	SC		
10	GA		
11	FL		
12	AL, TN		
13	MI		
14	OH		
15	IN, KY		
16	WI		
17	IL		
18	MO		
19	AR		
20	MS		
21	LA		
22	TX		
23	OK		
24	KS		
25	IA, MN, MT, ND, NE, SD, WY		
26	NM		
27	CO		
28	AZ		
29	NV		
30	OR, WA		
31	ID, UT		
32	CA		
33	HI		
34	AK		

APPENDIX F – HEALTH CARE REFORM

PROVISIONS

The following provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 apply to Part D bids for CY2019.

Coverage in the Gap

A phase-in approach will be implemented to reduce beneficiary cost sharing in the coverage gap from 100 percent to 25 percent in CY2020. In CY2018, beneficiary cost sharing is reduced from 51 percent to 44 percent for non-applicable (generic) drugs; the Part D sponsor's liability for DS coverage is increased to 56 percent. Beneficiary cost sharing is reduced from 40 percent to 35 percent of the negotiated price for applicable (brand) drugs, defined for purposes of the coverage gap discount program as the gross drug cost minus the dispensing fee and vaccine administration fee, if any, under 1860D-14A(g)(6) of the SSA, and from 40 percent to 35 percent of the dispensing fee and vaccine administration fee, if any. Pharmaceutical manufacturers will provide a 50 percent discount off of the Part D sponsor's negotiated price of the brand-name drug at the point-of-sale. Eighty-five percent of the negotiated price of the drug and 35 percent of the dispensing fee and vaccine administration fee, if any, will count toward the beneficiary's TrOOP; the Part D sponsor's liability is 15 percent plus 65 percent of the dispensing fee and vaccine administration, if any. Applicable drugs are defined in Section 1860D-14A(g)(2) of the statute and are covered Part D drugs that are either approved under a new drug application (NDA) under Section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under Section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351) using a biologics license application (BLA). Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug.

These coverages apply to beneficiaries who, on the date of dispensing a covered Part D drug, are enrolled in an MA-PD or PDP plan, are not enrolled in a qualified retiree prescription drug plan, are not entitled to the low-income subsidy, have reached or exceeded the ICL and have not exceeded the TrOOP threshold.

Low-Income Premium Subsidy Amounts

The approach to determine the low-income premium subsidy amounts that was established in the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" and approved on August 11, 2009 was codified. Therefore, the weighted average premium amounts will be calculated for MA-PD plans using the Part D premiums before they have been reduced by any applicable MA A/B rebates.

Income-Related Part D Premium

Similar to Medicare Part B, an income-related premium is established for Part D beneficiaries with modified gross income greater than specified income thresholds. The income thresholds for CY2012 through CY2019 are $85,000 per individual and $170,000 per couple. The Part D income-related monthly adjustment amounts will be collected by the federal government and will have no impact on the direct subsidy payments received by Part D sponsors.

APPENDIX G – 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 Part D sponsors to support bidding; however, Part D sponsors 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.
        - Part D sponsors should note that when converting risk scores from one model to another, a conversion between denominator years is, more than likely, occurring also. The risk scores in the conversion factor should be raw if the factor will be applied to an old model raw risk score, which is then projected to the payment year.
- Divide cohorts into meaningful subgroups using the same considerations used to determine allowed costs and project enrollment in each subgroup to the payment year.
    - Weight subgroup risk scores by enrollment in each subgroup per year to determine annual risk scores for trending.
- Compare year over year risk scores to obtain a trend factor. Unless the Part D sponsor is anticipating changes in coding efforts or population characteristics, more than two years of risk scores will help minimize the effect of random changes in coding patterns and enrolled population. If deviations from previous trend are expected in the payment year, provide justification for such changes in the supporting documentation.
    - If starting with base year risk scores that are blended, Plan sponsors are to assess whether there are 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.

For encounter data-based scores, note that for bidding, Medicare Advantage Organizations will need to adjust the 2017 (base year) CMS-provided encounter data-based risk scores to account for the run-out in encounters submitted beyond January 31st, 2018, as well as for expected changes between Phase II and Phase III diagnoses. In addition, for projecting risk scores to 2019, organizations may want to consider the following factors that might affect encounter data-based risk scores:

- The volume of diagnoses submitted on encounter data records (encounters or chart review records) for Calendar Year 2018 dates of service relative to the submissions in Calendar Year 2016 (used for payment year 2017 risk scores). Since encounters with 2018 dates of service will be used to determine risk adjustment eligible diagnoses for PY 2019, the impact on risk scores of any improvement in submission rates should be considered.
- To the extent that a plan sponsor is using the MAO-004 reports to determine the risk adjustment eligibility of diagnoses, please consider the impact of the changes made to the MAO-004 report between Phase II and Phase III as identified in the March 2018 EDS & RAPS User Group Call. [4]

[4] http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~User%20Group?open&expand=1&navmenu=Risk^Adjustment^Processing^System||

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