INSTRUCTIONS FOR THE SUBMISSION OF CY 2012 ESRD-ONLY PLAN ACTUARIAL PRICING DATA

For contract year (CY) 2012, ESRD enrollee costs will not be represented in either the Medicare Advantage (MA) benchmarks or the plan A/B bid. Therefore, ESRD-only special needs plans (SNPs) will not complete the standard MA bid pricing tool, but will instead complete ESRD-specific actuarial pricing forms (which is also referred to as the ESRD bid). The submission should correspond to the MA plan benefit package (PBP) and Part D bid (if applicable). **The submission due date for these materials is June 6, 2011.**

The information represented in the actuarial exhibits will satisfy the statutory actuarial pricing requirements.[1] Exhibits must be completed for each PBP included in the CMS Health Plan Management System (HPMS).

Each ESRD-only plan will provide CMS with data regarding their projection of 2012 program revenues and medical expenses and actual plan experience for CY 2009 and 2010. Further, most plan forecasts will be supported by relatively low enrollment and, as a result, the 2012 medical expense projections reported in Attachment A-2 may be based on a blend of trended plan experience and other data sources.

Below are instructions for completing the exhibits.

<u>Attachment A-1: Enrollment and PMPM Revenue Projection</u>

1. In Section I, “General Information”, enter the Contract-Plan-Segment ID, Organization Name, and Service Area.
2. In Section II, “Service Area Summary”, enter data in columns a through h, as described below. Data is to be reported by state for dialysis and transplant status, and by county for functioning graft status.
   a. In column a, enter the county code (for functioning graft status only).
   b. In column b, enter the name of the state (for all statuses).
   c. In column c, enter the county name corresponding to the county code entered in column a (for functioning graft status only).
   d. In column d, enter the ESRD status from the following:
      i. For Dialysis status, enter D.
      ii. For Transplant status, enter T.
      iii. For Functioning Graft status, enter F.
   e. In column e, enter the projected member months incurred for CY 2012 for the ESRD status indicated.
   f. In column f, enter the projected risk scores which must:
      i. Be based on the CMS-HCC ESRD Model.
      ii. Reflect appropriate projection factors.
      iii. Be adjusted for FFS normalization.

[1] Social Security Act, Section 1854

iv. Reflect the MA coding pattern differences adjustment factor as follows: postgraft risk scores must reflect the MA coding adjustment factor in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Dialysis risk scores and transplant factors should not incorporate the MA coding adjustment.

g. In column g, enter the applicable 2012 state or county rate for the ESRD status indicated.
(Note: The applicable rate is also dependent on the plan's quality bonus rating, or "star rating", for CY2012)

h. In column h, enter the percentage of Medicare Secondary Payer (MSP) member months applicable for the ESRD status and county/state indicated.

i. In column i, the Projected CMS Monthly Capitation is calculated automatically.

3. Section III, "ESRD MSP Adjustment Factors for CY": Contains the adjustment factors released by CMS in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies.
Line 1 contains the MSP factor for Functioning Graft, and line 2 contains the MSP factor for dialysis/transplant.

4. Section IV, "Summary Data": In Line 4, enter the plan intention for Part D target premium. This should reflect either the PMPM targeted amount of Part D basic premium after reduction (i.e., the rounded Part D basic premium from the Part D BPT Worksheet 7 cell F21 minus the Part D basic premium reduction from Attachment A-2 cell D35) or indicate "Low income premium subsidy amount". After CMS' release of the Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, and the Part D Regional Low-Income Premium Subsidy Amounts, CMS will allow plans to return to their target Part D basic premium by reallocating "excess funds" allocated in the initial submission to the supplemental benefit items in rows 56 through 60 of Attachment A-2. Here, the term "excess funds" refers to the difference between the CMS capitation payment and the plan's cost to provide Medicare-covered benefits. Generally, the rules in effect for other MA-PD plans for changes to the funding of benefits during the rebate reallocation period will apply to reallocation of excess funds. For further information on rebate reallocation, see Appendix E, Rebate Reallocation and Premium Rounding, in the *Instructions for Completing the Medicare Advantage Bid Pricing Tool and Medical Savings Account Bid Pricing Tool for Contract Year 2012* (i.e., the CY2012 MA BPT Instructions).
In Line 5, enter the plan's CY2012 Quality Bonus Rating (i.e., "star rating") released by CMS. In line 6, enter the new/low indicator released by CMS for CY2012. The plan's star rating and new/low indicator can be found at: HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating.

Attachment A-2: Projection of benefit cost, non-benefit expenses, and gain / loss margin PMPM

1. The medical expense projection is to be consistent with the population reflected in the revenue projections on Attachment A-1.
2. The medical expense projections may be based on a blend of trended plan experience and other data sources.
3. The allowed costs in Rows 16-31 should include only Medicare covered services. Additional services such as inpatient coverage beyond lifetime reserve days and preventive services not covered by original Medicare should be reflected in Additional Services on row 37.
4. The Supplemental Benefits section is calculated automatically and reflects cost sharing enhancements to the Medicare-covered benefit package.
5. The Part B and Part D (basic & supplemental) premium reductions should be entered as positive amounts and must both be rounded to the nearest dime.
6. The Part C mandatory enrollee premium in cell D53 should match the Part C mandatory enrollee premium shown on Attachment A-1.
7. 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 (marketing and sales) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

   Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes, changes in statutory surplus, investment expenses, and the cost of lobbying activities. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009.

   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.

8. Costs that are common to the Medicare Advantage and a Prescription Drug components of an MA-PD plan must be allocated proportionately between Medicare Advantage and Part D.

9. Plans must be prepared to report on the contractual terms of administrative services, and to identify when the service is performed by the plan sponsor, by a related party, or by an unrelated party. Administrative service agreements with related parties must reflect a competitive cost for the contracted services, and you must be prepared to support this upon request. For further information regarding reporting for related parties, please see Section II "Pricing Considerations" in the CY 2012 MA BPT Instructions.
10. Gain/loss margin levels are to be consistent with the plan sponsor's corporate requirement. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE) bases, the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business should take into account the degree of risk or reserve levels of the business. Plans with negative margins must develop and follow a business plan to get to profitability.

Attachment A-3: Program Experience

1. Revenues: Enter member months, aggregate CMS payments, and aggregate enrollee premium. All revenues are to be reported on an earned basis, including retroactive adjustments. Revenues for 2010 are to include estimate of final risk adjustment settlement to be received in mid-2011.
2. Medical benefits: enter claims incurred in each of the specified periods and paid through March 31, 2011. Likewise, March 31, 2011 claim reserves are to be reported separately for 2009 and 2010.
3. Organizations may allocate claim reserves to appropriate categories in situations where reserves are developed at a consolidated level.

Actuarial Certification

The requirements for the development and submission of the actuarial certification are contained in Appendix A of the *Instructions for Completing the Medicare Advantage Bid Pricing Tool and Medical Savings Account Bid Pricing Tool for Contract Year 2012* (i.e., the CY2012 MA BPT Instructions).

Supporting Documentation

Supporting documentation requirements are discussed in Appendix B of this document.

Appendix B - Supporting Documentation

General

In addition to the ESRD bid and actuarial certification, plan sponsors must provide CMS with supporting documentation for every bid, as described in these instructions.

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

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the plan sponsor, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, those individuals are subject to the same documentation requirements. The actuary must be prepared to produce all substantiation pertaining to the bid, even if it was prepared by others or is based on a 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 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 assumption, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Describe plan-specific variations in addition to the overall pricing assumption or methodology.
- Tie to the values entered in the current ESRD bid and the PBP.
- Include Excel spreadsheets with working formulas, rather than pdf files.
- 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 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.

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

- Meeting minutes from discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources—for example, a report's official name/title, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- Materials that are accessed only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as "the same as for plan Hxxxx-xxx," and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is "professional judgment" with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies or public information.
- "Living worksheets" that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid, independent of prior bid filings.

Submitting Supporting Documentation

Supporting materials must be in electronic format (Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, which compress multiple files into one (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload to multiple plans materials specific to a Part D plan, MA plan or certain contract ID.

Cover Sheet

To expedite the bid review process, plan sponsors must upload a cover sheet that lists all of the supporting documentation that is uploaded or provided on the bid form. The filename must include the phrase "cover sheet." A cover sheet is required for each upload of substantiation.

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

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

For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (that is, the cover sheet must not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact bid IDs rather than a "range" of bid IDs.

Timing

Plan sponsors and certifying actuaries must prepare all supporting documentation and upload required documentation into HPMS at the time of the initial June bid submission. When additional substantiation is requested by CMS reviewers, it must be provided within 48 hours and uploaded into HPMS prior to bid approval. Plan sponsors must also upload additional substantiation provided in e-mail correspondence and supporting documentation consistent with the final certified bid.

Initial June Bid Submission

The following documentation requirements apply to all bids (as all bids contain these assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, service area changes, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.

- Support for the development of the projected allowed medical expenses for Medicare-covered benefits. The required elements for this documentation include:
    - A description of the source data, including its relevance to the plan and the precise name of any published tables used.
    - Credibility standards applied to the data and corresponding adjustments, if applicable.
    - Consideration of any adjustments made for annual volatility of the source data.
    - Any applicable adjustments to source data, such as:
        - Approach and factors applied to account for incomplete claim run-out and/or expenditures that are not reflected in the source data;
        - Addition of Medicare-covered benefits not reflected in the source data;
        - Exclusion of non-covered benefits reflected in the source data;
        - Techniques and factors used to reflect differences between the underlying population and that expected of the plan;
        - Techniques and factors used to adjust for differences in health care delivery system and plan design of the source data as compared to the plan;
        - Methodology and data used to gross-up reimbursements to an allowed-cost basis.
    - Data and methodology used to project the data from base period to contract year (CY). The trends for utilization and unit cost should be demonstrated separately.
    - All other applicable factors and/or adjustments
- Support for non-benefit expense assumptions. The required elements include—
    - A description of the non-benefit expenses included in each non-benefit expense category in the ESRD bid.
    - Detailed support for the development of projected non-benefit expenses. The required elements include—
        - A description of the methodology used to develop projected non-benefit expenses.
        - A description of the data source.
        - A demonstration of the development of each line item using relevant data, assumptions, contracts, financial information, business plans, and other projections.
    - A reconciliation of the non-benefit expense line items reported in the ESRD bid and auditable material such as corporate financials and plan-level operational data.
- Justification of the gain/loss margin. The required elements include—
    - Support for overall margin levels, including a description of the methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.

- A demonstration of year-by-year consistency between the expected overall margin level and the plan sponsor's corporate margin requirement over time (for example 3 to 5 years) including any change in the plan sponsor's corporate margin requirement in the prior 2 years.
- Support for bids with negative margins–that is, a year-by-year numeric business plan that illustrates profitability within a few years.
- For a plan with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the gain/loss margin to the original business plan The required elements include—
  - Details and sources of deviation from the original business plan.
  - An explanation and demonstration as to how the targeted margin in the original business plan will be met, if the plan is progressing towards a positive margin less rapidly than projected in the original business plan.
  - A copy of the original business plan uploaded to HPMS in a separate file.

  Justification of the margin for bids with relatively large projected overall gains/losses including an explanation of how the PBP offers benefit value in relation to the margin level.

- Detailed support for the development of projected risk scores. The required elements include—
  - A detailed description, and corresponding numerical demonstration, of the methodology used to develop projected CY2012 MA risk scores.
  - A description of the source data for the development of the projected CY2012 MA risk scores.
  - A description of all projection factors and the basis for the factors. A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected medical expenses, if the plan pricing is based on manual rates

Upon Request by CMS Reviewers

The following items are not required to be provided with the initial submission, but must be prepared around that time in order to be readily available to provide to CMS reviewers upon request. If these materials are requested by CMS reviewers, the requested substantiation is expected to be provided within 48 hours.

- Support for the development of claim reserves.
- If applicable, a list of materials that were relied on and an accompanying reliance letter.
- Support for the development of revenue assumptions including enrollment distribution.
- Additional information (not specified in this list) may be requested by CMS reviewers, as needed.