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CHCS Primer

Medicare Advantage Rate Setting and Risk Adjustment:

A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefits

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The Center for Health Care Strategies (CHCS) is a national non-profit organization devoted to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. CHCS advances its mission by working directly with state and federal agencies, health plans, and providers to design and implement cost-effective strategies to improve health care quality.

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Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173) allows Medicare Advantage (MA) managed care plans to specialize in serving Medicare beneficiaries who are dually enrolled in state Medicaid programs, are residents of nursing facilities or similar institutions,[1] or who have severe or disabling chronic conditions (Section 231).[2] The Centers for Medicare & Medicaid Services (CMS) approved 276 Special Needs Plans (SNPs) for 2006, including 226 dual eligible plans, 37 institutional plans, and 13 chronic condition plans.[3]

State Contracting with SNPs

In 2006, most SNPs are contracting only with Medicare, but several states have taken advantage of Medicare's SNP option to negotiate contracts with SNPs to include Medicaid benefits for dually eligible individuals enrolled in such plans. At least 42 SNPs in 13 states were providing Medicaid managed care to dual eligible enrollees in 2005, and were allowed by CMS to "passively enroll" their dual eligible enrollees into their Medicare SNP for 2006.[4] The opportunity in these and other states to integrate Medicare and Medicaid acute and long-term care services through SNPs prompted the Center for Health Care Strategies (CHCS) to institute its Integrated Care Program (ICP). With resources from the Robert Wood Johnson Foundation (RWJF), CHCS has made ICP grants to five states—Florida, Minnesota, New Mexico, New York, and Washington—to develop and/or expand models of care that integrate the financing, delivery, and administration of primary, acute, behavioral health, and long-term care services and supports for beneficiaries with chronic conditions who are dually eligible or covered solely by Medicaid. CHCS is using RWJF funding as well as supplemental grants from Evercare and Schaller Anderson, Incorporated to create a comprehensive technical assistance strategy that promotes the integration of care for dual eligibles. In addition to the ICP grantees, CHCS is working with or planning to work with other states that have integrated care programs in place (such as Arizona, Massachusetts, Texas, and Wisconsin) or are developing plans to move in that direction (Arkansas, Maryland, Michigan, Rhode Island, and Virginia).

This primer on Medicare managed care rate setting and risk adjustment is aimed at helping state Medicaid agencies better understand how the Medicare rate-setting system works so that states can work more effectively with SNPs and other MA plans to integrate Medicaid and Medicare services. It does not provide the level of detail on Medicare rate setting that would be needed to

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[1] Eligible long-term-care institutions include skilled nursing facilities, intermediate care facilities, and inpatient psychiatric facilities. Institutional SNPs can also enroll those living in the community but requiring a level of care equivalent to those residing in a long-term-care facility.

[2] SNPs may serve these categories of special needs beneficiaries exclusively or may enroll a "disproportionate percentage" of the target population, that is, a higher percentage than the national average. In 2006, few plans used the disproportionate percentage option, but more plans have reportedly applied to do so in 2007.

[3] Under the MMA, MA organizations may offer SNPs through coordinated care plans (CCPs), which can be health maintenance organizations (HMOs) or preferred provider organizations (PPOs). HMOs are local plans that can be offered in one or more counties. PPOs can be either local or regional. Regional PPOs can be offered in one or more of the 26 MA regions, each of which includes one or more states. A single MA contract may include more than one plan, including more than one SNP. There are 164 MA contracts in 2006 offering 276 SNPs in 42 states and Puerto Rico, and these contracts represent 91 distinct corporate entities. SNPs normally define their service area by county, but a single plan may serve multiple counties in a state.

[4] Medicare Payment Advisory Commission, "Increasing the Value of Medicare," Report to the Congress, June 2006, p. 216.

fully assess the adequacy of MA rates or to understand all the intricacies of the MA rate payment and risk adjustment system. It focuses instead on issues that Medicaid agencies need to understand when Medicaid and Medicare services and funding intersect in SNPs.

Overlaps between Medicare and Medicaid and Opportunities for Better Coordination

Looking at the services and funding streams from both programs together, rather than in their separate silos, can help identify opportunities for better integration of care. Integrating care for dual eligible beneficiaries can significantly improve beneficiary care and can also be a major asset for public purchasers like Medicaid and Medicare and for SNPs. Integration can be achieved by focusing on acute care benefits that both Medicare and Medicaid support, or more comprehensively by also including Medicaid's long-term-care benefits. With a comprehensive integrated benefit package, purchasers and plans can focus on more effective ways to integrate care and on designing service delivery systems that help beneficiaries get the right care in the right setting, rather than worrying about who pays how much for which piece of care.

States interested in contracting with SNPs and other MA plans to cover Medicaid benefits for dual eligibles need to understand how Medicare managed care payment rates are determined in order to assess how state capitated payments to plans for Medicaid services fit into the federal payments that plans receive for Medicare services. This is particularly important for services where Medicaid and Medicare responsibility overlaps (home health, skilled nursing facility care), and also where MA plans may provide supplemental benefits not covered under fee-for-service Medicare that Medicaid also provides (dental, vision, hearing, transportation, care coordination) or where Medicaid pays premiums and cost sharing for dual eligible MA enrollees, since there can be significant opportunities to better integrate care in these areas.

Understanding the overlap between Medicaid and Medicare payments to SNPs can also help states ensure that the payments to plans from both sources combined are appropriate, do not result in double payment for services, and minimize incentives for cost shifting from one payer to another.

Medicare Advantage Rate-Setting Basics[5]

By law, SNPs are paid under the same rules as other MA plans. As described further below, MA capitation rates are adjusted for risk based on beneficiary health conditions, and demographic characteristics such as dual eligible status, disability eligibility status, and institutional status, so CMS's per-enrollee MA payments to SNPs are generally higher than those for other MA plans in the same area. That, however, is a function of the fact that SNPs are allowed to specialize in serving beneficiaries who have predictably higher-than-average costs, not of SNP status itself.

All SNPs must offer coverage of original Medicare benefits and the Part D prescription drug benefit, that is, they must be MA-PD plans.[6] Payments to MA-PD plans have two basic components. The first includes services provided under Medicare Part A (inpatient hospital care, skilled nursing facility services, hospice, and some home health) and Part B (physician services, outpatient care, lab and x-ray, durable medical equipment, physical and occupational therapy,

[5] For a recent glossary of Medicare Advantage terms, see National Health Policy Forum, "Medicare Advantage Program: Acronyms and Glossary," May 20, 2005. Available on the Web at: http://nhpf.org/pdfs_other/acronym.glossary.pdf.

[6] Some MA plans do not offer Part D prescription drug benefits.

and some home health care).[7] The second component is for Part D prescription drug services and is calculated separately.

MA Bidding, Benchmarks, and Supplemental Benefits

Beginning with the 2006 contract year, MA plans participate in a bidding process in which plans submit bids in three parts, representing the estimated per-person, per-month revenue needed to offer: 1) Medicare Part A and B benefits; 2) Medicare Part D benefits (for plans offering Part D); and 3) supplemental benefits that add benefits[8] or reduce Medicare's cost sharing. The standardized bid reflects the expected monthly cost of a plan enrollee who has nationally average demographic and health status as defined under the CMS risk adjustment model (a "risk score" of 1.0).

CMS then compares the first part of this bid (for Medicare's Part A and B benefits) with a benchmark. CMS sets the benchmark for local plans, based on county-level MA capitation rates in the plan's service area. For 2006, the county benchmarks are the 2005 MA county payment rates, updated by the projected national growth in per capita Medicare spending.[9] For regional PPOs, CMS uses a more complicated formula required by law that incorporates the plan bids and administratively set capitation rates. A region's benchmark is a weighted average of the average of county rates in the service area and the average plan bid.[10] These benchmarks are the maximum amount CMS will pay an MA plan and serve as targets in the bidding process.

Plans that bid above the benchmark receive the benchmark payment from CMS and have to collect the difference from beneficiaries in the form of premiums. If a plan bids below the benchmark, CMS splits the "savings" with the plan. The Medicare program retains 25 percent of the savings, and the plan is required to use the remaining 75 percent (called a "rebate") to expand benefits or pay various enrollee costs.

In a preliminary analysis of plan bids for 2006, MedPAC found that local HMO plan bids came in below the benchmark 98 percent of the time, and when they did the average rebate was about $80 per month.[11] Over time, this spread between plan bids and the benchmark is likely to narrow as plan bids increase in response to higher costs or other factors, and/or if benchmarks go up more slowly than expected in response to Part A and B cost trends or legislative changes.[12]

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[7] Technically, Medicare Advantage services are provided under Part C of Medicare (Social Security Act, Sections 1851-1859).

[8] The added benefits can be either a non-Medicare medical item or service or a Part D "enhanced" benefit.

[9] National Medicare per capita growth is defined as "the projected per capita rate of growth in expenditures ... for an individual entitled to benefits under Part A and enrolled under Part B…" [Social Security Act, Section 1853(C)(6)(A)].

[10] For more detail on the 2006 MA bidding process for local and regional plans, see Medicare Payment Advisory Commission. "Issues in a Modernized Medicare Program." Report to the Congress, June 2005, pp. 74-76, available on the Web at: http://www.medpac.gov/publications/congressional_reports/June05_Table_of_Contents.pdf. For more detail on MA payment in general, see MedPAC. "Medicare Payment Basics: Medicare Advantage Program Payment System." December 9, 2005, available on the Web at: http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_MA.pdf

[11] MedPAC, "Increasing the Value of Medicare," June 2006, pp. 208-209. The MedPAC analysis did not look separately at SNP bids, but most SNPs are local HMOs. Some SNPs may also be local or regional PPOs, which were somewhat less likely to bid below the benchmark than local HMOs and had lower average rebates in 2006, according to the MedPAC analysis. While the MedPAC analysis did not report the range in rebates around the national average, the local and regional variation is likely to be substantial.

[12] For analysis for some of the reasons for the current wide differences between MA benchmarks and Medicare fee-for-service spending, see MedPAC. "Medicare Advantage Benchmarks And Payments Compared With Average Medicare

For 2006, rebate dollars available to plans were used in all the ways permitted by CMS: 65 percent were allocated to reducing Part A and B cost sharing, 14 percent to adding benefits Medicare does not cover (vision, dental, hearing, transportation), 11 percent to reducing the Part D premium, five percent to enhancing Part D benefits, and four percent to reducing the Part B premium.[13]

The supplemental benefits funded with rebate dollars must be directly health-related and not covered by Medicare.[14] Typically these are benefits such as vision, dental, and hearing, but they can also include caregiver resource services that provide information and assistance to relatives or friends of enrollees who spend significant time as caregivers, or electronic monitoring of beneficiaries.[15] MA plans are also required to undertake various activities to "ensure continuity of care and integration of services," including "coordination of plan services with community and social services,"[16] but MA plans normally fund these activities out of the administrative portion of their rate rather than with rebate dollars. While Medicare funding for this kind of care coordination and care management activity is limited, it can be supplemented by Medicaid funding for care coordination if MA plans contract with states to cover these services under Medicaid.

MA plans normally use supplemental benefits to attract additional enrollees, but that approach may be less effective for SNPs enrolling significant numbers of dual eligibles, because Medicaid already covers many of the typical supplemental benefits (vision, dental, reduced cost sharing) for dual eligibles. For these SNPs, additional care coordination may be an especially attractive benefit for purposes of marketing to duals.

Geographic Variation

MA capitated payments to plans vary by county and by region. Only MA PPOs are eligible to bid for entire regions, not other MA plan types such as HMOs. For 2006, only three out of 276 SNPs are regional plans (United HealthCare plans in Florida, Hawaii, and New York).[17]

The starting point for the local MA rates is Medicare fee-for-service (FFS) payments in the county. Over the years, these amounts have been adjusted by policy changes that have created minimum payment levels and have sought to limit the wide county-by-county variation in MA rates that results from the differences in per-capita spending in traditional Medicare. Substantial geographic variation in rates remains, however, since Medicare FFS costs continue to be a factor in setting MA rates.

Fee-For-Service Spending." June 9, 2006, available on the Web at: http://www.medpac.gov/publications/other_reports/MedPAC_briefs_MA_relative_payment.pdf .

[13] MedPAC, "Increasing the Value of Medicare," June 2006, p. 208.

[14] Technically, these supplemental benefits may be either mandatory (available to all enrollees in a plan) or optional (available only with payment of an additional premium). Optional supplemental benefits cannot be funded with rebate dollars. Since SNPs are not likely to offer supplemental benefits for which an additional premium must be paid, this primer discusses only mandatory supplemental benefits.

[15] CMS, "Medicare Advantage, Medicare Advantage-Prescription Drug Plans CY 2007 Instructions," Call Letter April 4, 2006, pp. 31-33. Available on the Web at: https://www.cms.hhs.gov/BenePriceBidFormPlanPackage/Downloads/2007CallLetter.pdf.

[16] See 42 CFR sec. 422.112(b) for more detail on these continuity of care and integration of services requirements.

[17] CMS, "January 2006 Special Needs Plans Report," Available on the Web at: http://www.cms.hhs.gov/specialneedsplans/01_overview.asp?

To illustrate the variation, the monthly county benchmark rate for aged beneficiaries in Miami, Florida, (Dade County) in 2006 was $1,033 (Parts A and B combined), compared with $686 in Minneapolis, Minnesota, (Hennepin County). The regional MA Part A and B rates, which are being used for the first time in 2006, have less geographic variation than the local rates, because the regional rates are based on weighted averages of the local rates, as well as on plan bids.[18]

Risk Adjustment

Before 2000, Medicare's payments to private plans for Part A and B benefits included adjustments for risk that were based entirely on demographic factors: age, sex, working status, Medicaid coverage, disability eligibility status, and institutional status. Beginning that year, CMS gradually began implementing a risk adjustment system that adjusted payments based not only on demographic factors but also on beneficiaries' predicted health status, determined by diagnoses that appear in Medicare claims in the prior year. CMS phased in the new health-based risk adjustment system over a seven-year period, and it will be fully in effect for calendar year 2007 MA payments.[19] The risk adjustment system—called the CMS Hierarchical Condition Category (CMS-HCC) system—retains adjustments for age, sex, Medicaid, disability, and institutional statuses, but these factors have less weight in the new health-based system. For new enrollees who did not have 12 months of Part B eligibility in the preceding calendar year, rates are based on age, sex, Medicaid status, and original reason for Medicare entitlement (disability or age), not on diagnoses.[20]

CMS-HCC scores vary around the "average beneficiary" score of 1.0. The individual risk scores for each beneficiary, which are used to adjust the plan's base payment rate, are based on the beneficiary's health status and other characteristics. For Medicaid eligibility status, for example, the CMS-HCC model adds the following amounts to the risk score for Medicare beneficiaries in the community (separate factors apply for institutionalized beneficiaries):

Female		
	Disabled	0.137
	Aged	0.177
Male		
	Disabled	0.090
	Aged	0.202

The risk adjustment system for Part D payments (called Rx-HCC) is separate from that for Parts A and B, but follows the same health-based risk adjustment approach, with additional adjusters in 2006 and 2007 for Medicaid, low-income, and institutional status. These adjusters and the Part D risk adjustment system are discussed in more detail below.

[18] For 2006, for example, the risk portion of the weighted averages of the local rates ranges from $699.04 in Region 19 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming) to $853.24 in Region 17 (Texas).

[19] The full phase-in of risk adjustment for certain special demonstration plans and for Program of All-Inclusive Care for the Elderly (PACE) organizations will not be complete until 2008.

[20] For details on these adjustments, see CMS, "Announcement of Calendar Year 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies," April 3, 2006, Enclosure IV. Available on the Web at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf.

Frailty Adjuster

Program of All-Inclusive Care for the Elderly (PACE)[21] programs, CMS dual eligible demonstration programs in Massachusetts, Minnesota, and Wisconsin, and Social HMO (S/HMO)[22] demonstration plans have an additional feature in their MA payment systems that results in higher per-enrollee payments for enrollees in the community with significant limitations on activities of daily living (ADLs). The demonstrations are scheduled to end in 2008, and CMS will then no longer have the authority to apply the frailty adjuster to their payments. PACE plans will continue to receive the frailty adjuster. CMS is considering applying a frailty adjustment broadly across all MA plans, but the earliest that could take effect would be 2008.

For 2007, the following amounts are added to (or subtracted from) an individual enrollee's risk score for ADL difficulties:

0 ADLs	–0.141
1-2	+0.171
3-4	+0.344
5-6	+1.088

Part D Rates

The CMS payments for Part D prescription drug coverage are calculated in essentially the same way for SNPs and other MA plans and for stand-alone prescription drug plans (PDPs). CMS pays plans a subsidy that is approximately 74.5 percent of the average bid amount for basic Part D coverage for the average Part D beneficiary. The actual CMS payments to plans are then adjusted based on the actual health status of the plans' enrollees, as determined by the CMS Rx-HCC risk adjustment model.[23]

For 2006 and 2007,[24] CMS increases certain enrollees' risk scores when making Part D direct subsidy payments to plans by the amounts shown below:

Long-term institutionalized, aged	8%
Long-term institutionalized, disabled	21%
Dual eligibles and others with very low income and assets	8%
Others eligible for the Part D low-income subsidy	5%

In addition to this direct subsidy, CMS pays Part D plans through three other payment streams:

- ***Individual reinsurance***, under which CMS covers 80 percent of an enrollee's drug spending above a catastrophic threshold. Individual reinsurance also acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

[21] PACE is a program operating in several parts of the country that provides integrated Medicare and Medicaid services in community facilities to beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility.
[22] S/HMOs offer the full range of Medicare benefits offered by standard HMOs, plus chronic and extended care services. There are currently four S/HMO sites, in California, Nevada, New York, and Oregon.
[23] For more information on the CMS risk adjustment model for Part D, see the CMS Web page at: https://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp#TopOfPage
[24] The amounts may change in future years based on CMS analysis of prescription drug and other data.

- ***Risk corridors***, under which CMS pays a portion of a plan's higher-than-expected overall costs or recoups excessive profits. These symmetrical corridors are scheduled to widen in 2008-2011, and the CMS share will fall, so plans will bear a higher share of the overall insurance risk in those years.

- ***Low-income subsidies***, under which CMS makes payments to plans that cover most premiums and cost sharing for low-income beneficiaries.

Part D plans receive additional payments from beneficiaries in the form of premiums, deductibles, and coinsurance. Since information on the structure of the Part D benefit and the amounts paid by beneficiaries and through CMS low-income subsidies is readily available from other sources, it is not included here.[25]

Drugs Excluded by the MMA from Part D Coverage

The MMA excludes from Part D coverage several types of drugs that Medicaid has been allowed since 1990 to exclude from coverage, including benzodiazepines, barbiturates, and non-prescription (over-the-counter) drugs.[26] States have chosen to cover many of these drugs, however, and CMS requires states that cover the drugs for any Medicaid beneficiaries to continue to cover them for dual eligibles.[27]

Part D plans may also choose to cover some of these drugs as enhanced benefits, and over-the counter drugs can be paid for as an administrative cost if part of a step therapy regimen. MA plans may be more likely to provide this additional coverage than PDPs, since MA rebate dollars could be used to cover the extra costs of the enhanced benefits. PDP plans would have to cover the cost solely out of the payments they receive under Part D, which may or may not turn out to be sufficient to cover these additional costs.

As discussed further below, states interested in contracting with SNPs to cover Medicaid benefits likely will want to discuss with plans the potential for SNP coverage of these drugs, with an appropriate capitated payment from Medicaid, because doing so could result in administrative efficiencies for both Medicaid agencies and SNPs and improved access to these drugs for dual eligible beneficiaries.

MA and Part D Bidding Schedule

Each year, CMS must publish the capitation rates (county benchmarks) in effect for the upcoming calendar year no later than the first Monday in April. No later than 45 days before the annual April Rate Announcement, CMS must publish a notice of proposed changes to the MA and Part D payment methodologies in the Advance Notice of Methodological Changes for

[25] For additional detail on the structure of the Part D benefit and the Part D payment system, see MedPAC, "Medicare Payment Basic: Part D Payment System," December 9, 2005, available on the Web at: http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_PartD.pdf. For additional detail on Part D low-income subsidies, see Kaiser Family Foundation, "Low-Income Assistance under the Medicare Drug Benefit," May 2006. Available on the Web at: http://www.kff.org/medicare/upload/7327.pdf.

[26] For the full list, see Section 1927(d)(2) of the Social Security Act.

[27] CMS, Dennis G. Smith, State Medicaid Director Letter #05-002, June 30, 2005. For information on which states cover some of these excludable drugs, see National Pharmaceutical Council, "Pharmaceutical Benefits under State Medicaid Programs, 2004," pp. 4-24 and 4-29 to 4-30.

Medicare Advantage (MA) Payment Rates and Part D Payment. The annual Advance Notice and Rate Announcement for the 2007 contract year can be found on the CMS Web site at: https://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage.

Plan bids are due the first Monday in June. This year, CMS plans to sign contracts for 2007 with successful applicants in early September in order to be ready for the annual coordinated election period for beneficiary enrollment that begins on November 15. More detail on key dates in the MA and Part D bidding schedule is available on the CMS Web site at: https://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CY2007timeline.pdf.

Opportunities for States to Better Integrate Medicare and Medicaid Funding and Coverage

States that want to contract with SNPs to cover Medicaid services have a number of options. A threshold question is whether there are SNPs in the state that are interested in contracting with Medicaid and qualified to provide the services for which Medicaid would like to contract. SNPs that cover exclusively dual eligibles are most likely to be interested, while institutional and chronic condition SNPs, which also cover non-duals, may be less interested because of the potential extra complexity involved in having different benefit packages for dual and non-dual enrollees. Dual eligible SNPs that cover only a "disproportionate percentage" of dual eligibles (more than the national average) may be less interested in contracting with states for the same reason. However, the overwhelming majority of currently approved SNPs are exclusively for dual eligibles.

Assuming there are interested plans, states can contract with SNPs and other MA plans to cover a variety of Medicaid services. The options below are listed in approximately the order of the contracting complexity likely to be involved, with the least complex and comprehensive Medicaid coverage listed first.

- Medicare premiums and beneficiary cost sharing that Medicaid is required or chooses to pay for dual eligibles and others enrolled in Medicare Savings Programs (MSPs);
- Prescription drugs excluded by the MMA from Part D, but covered by Medicaid;
- Acute care services not covered or only partially covered by Medicare (vision, dental, hearing, durable medical equipment, transportation, care coordination);
- Behavioral health services not covered or partially covered by Medicare;
- Comprehensive case management and personal care services; and
- Medicaid long-term care services not covered by Medicare (nursing facility, home health, and home- and community-based services).

Apart from the issue of which services to include, there are a host of issues relating to the different types of joint Medicare and Medicaid contracting that are feasible and the Medicare and Medicaid rules that apply. These issues are discussed in detail in the March 2006 CMS "State Guide to Integrated Medicare & Medicaid Models" and so are not discussed further here.[28]

[28] Available on the Web at: http://www.cms.hhs.gov/DualEligible/Downloads/StateGuide.pdf.

CMS July 27, 2006 Integrated Care Fact Sheet

CMS released a Fact Sheet on July 27 titled "Improving Access to Integrated Care for Beneficiaries Who Are Dually Eligible for Medicare and Medicaid."[29] Under the heading of "Opportunities to Improve Coordination and Enhance State Savings through Medicare and Medicaid Contractual Arrangements with SNPs," CMS highlighted a number of potential benefits for states from better integration. Excerpts from the fact sheet are in the text box below.

Excerpts from CMS July 27, 2006 Integrated Care Fact Sheet

The SNP Medicare contracting process provides an opportunity for States to benefit from better coordinated and more effective services for dual eligible beneficiaries, making State Medicaid programs more sustainable and effective. On an annual basis, SNPs submit bids to CMS to provide beneficiaries with Medicare-covered services, and sometimes supplemental services. Plans that bid below a benchmark amount receive a rebate equal to 75% of the savings relative to the benchmark. Plans are required to use the rebate money to provide extra benefits to enrollees. Possible extra benefits include the reduction of cost sharing for Medicare-covered services, added benefits such as vision and dental care not covered by Medicare, . . . or the Part D premium, or the Part B premium.

For duals, these extra benefits could either directly replace financial obligations of the State (e.g. when the SNP rather than the State pays Medicare cost sharing on behalf of a dual eligible), or provide services that would otherwise have to be covered by Medicaid. Consequently, SNP plans have the potential to save States money, particularly if the State is making capitated payments to a Medicare Advantage plan that is providing both Medicare and Medicaid Services.

Because SNPs may consider their bidding information to be proprietary, CMS does not release such information unless required by law. However, plans may share this information with States, and States can get publicly available information on the covered services and additional benefits offered by the plan before entering into a contract for Medicaid services. Further, states may require that bidding information be shared with the State as a condition of contracting for Medicaid services.

Capitalizing on Information on Cost and Utilization that MA Plans Submit to CMS

As states consider contracting with SNPs and other MA plans to cover Medicaid services, it will be important for states to know how much Medicare is paying the MA plan for these services. MA plans are required to spell out in the Plan Benefit Package portion of their bid submission the cost-sharing rules for members ($20 co-pay for a physician visit, $50 for an emergency room visit, etc.). In the Bid Pricing Tool (BPT) portion of the bid submission, MA plans spell out the per-person per-month average cost of the Part A and Part B cost sharing they will require, by service category (inpatient facility, skilled nursing facility, professional, etc.). In the BPT, the plans are also required to spell out how they propose to allocate any rebate dollars they receive because the bid for coverage of A/B services is below the benchmark (reduction in Part A/B cost sharing, reduction in Part B or D premiums, and so on). If they propose to offer any supplemental benefits, they are required to specify their utilization and cost assumptions for those benefits,

[29] Available on the Web at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912.

including annual utilization per 1,000 members, annual cost, and per-member, per-month (PMPM) cost by type of service. Worksheets 1-7 of the BPT can be found in Appendix A[30]

CMS is restricted in its ability to share this information with others, but states could find it very useful to get all or an extract of this information from SNPs either voluntarily or as a condition for contracting with the state. The Medicare information would allow states to develop detailed data on Medicare and Medicaid services available to dual eligibles by combining the SNP bid data and the states' own Medicaid data. New York State has developed a template for doing this. Some illustrative excerpts are reprinted in Appendix B. The text box on the next page contains more information on the New York Medicaid Advantage Integrated Care Program in which this approach is being used.

In line with the New York approach, such a combined analysis could include:

- Projected enrollment of dual eligibles under age 65 and age 65 and over by county and by number of member months.[31]
- Estimates of medical service costs showing, by service, estimates of utilization per member per year (PMPY), unit cost, and cost PMPM for both Medicare and Medicaid services:
  - Separate estimates for dual eligibles under age 65, age 65 and over, and a weighted average of both age groups, since states may want to serve these different categories of dual eligibles in different ways.[32]
- Summary Medicaid capitation rate calculation sheets showing estimated Medicaid cost sharing for specified Medicare services, including estimated utilization of services PMPY, estimated unit cost, and cost PMPM:
  - Separate estimates for dual eligibles under age 65, age 65 and over, and a weighted average of both combined if needed by the state.
- Projected administrative expenses for Medicare and Medicaid combined, by Medicare expense category (marketing and sales, direct administration, indirect administration, and net cost of private reinsurance), for direct and contracted expenses, including salary and non-salary expenses, number of full-time equivalent (FTE) employees, and PMPM estimates for each expense category.[33]

[30] More information on the MA Bid Pricing Tool is on the CMS Web site at: http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/03_2007Bid.asp.
[31] CMS requires only member months, not counts of members, in the BPT.
[32] The BPT does not require such age breakouts, so states would have to specifically require it.
[33] The BPT does not require this level of detail for non-medical expenses; only overall PMPM expense estimates are required for each category of expenses.

New York State Medicaid Advantage Integrated Care Program Medicaid Premium Proposal Requirements[34]

New York's Medicaid Advantage Integrated Care Program is a voluntary managed care program for dual eligibles 18 years of age or older who are eligible for a nursing home-level of care. It provides Medicaid long-term-care services that supplement and wrap around Medicare services, including broader coverage of nursing facility and some health services, personal care services, dental services, transportation, private duty nursing, nutrition, medical social services, social and environmental supports, home delivered and congregate meals, adult day health care, social day care, and personal emergency response services. It also covers most Medicare cost sharing for Part A and B services, although some copayments for emergency room and specialist services are retained.

As part of the bidding process for this program, New York requires plans to submit information from their Medicare Advantage bids on cost sharing and Medicare services (including supplemental services), essentially following the format of the MA Bid Pricing Tool (BPT). New York requires more detail than the BPT in some areas, including breakouts of the data by enrollee age (over and under age 65), and additional detail on administrative expenses. Appendix B includes excerpts from the forms New York uses to obtain this information.

The program is being implemented in New York City, Long Island, and several upstate counties. Two plans (Evercare and WellCare) have submitted bids to participate in the program.

Potential Uses of Combined Medicare MA Bid Data and Medicaid Data

Integrating data that MA plans submit to CMS in their bids with the state's own information can help ensure that there is no inappropriate duplication and overlap of services and funding and can identify opportunities for better integration of the Medicaid and Medicare benefit packages and funding streams. If, for example, the MA plan assumes a certain level of inpatient hospital, emergency room, or skilled nursing facility utilization by dual eligible beneficiaries, joint analysis of the Medicare and Medicaid data might reveal opportunities to reduce the use of these high-cost Medicare services through better use of Medicaid-covered behavioral health and home-and-community-based services, and through more comprehensive case management. This could help to better align incentives for plans and providers and result in more appropriate care for beneficiaries. States currently have no incentive to provide additional Medicaid services if the savings all accrue to Medicare, so some method of sharing some of the Medicare savings with the state would have to be devised.

Specific Payment Rate and Contracting Issues States Could Discuss with SNPs

As states enter into more detailed discussions with SNPs regarding potential contracting for Medicaid services, several specific payment rate and contracting issues that relate to areas of overlap between Medicare and Medicaid may be relevant to discuss:

- **Medicare cost sharing.** Medicaid is not required to make Medicare cost-sharing payments directly to plans, and the cost-sharing payments Medicaid makes either to plans or provid-

[34] This information was obtained through documents provided by and interviews with New York State Department of Health, Bureau of Managed Care Financing.

ers may be limited by the amounts Medicaid would pay for the service, even if Medicare payments are higher.[35] In many states, therefore, states may be able to offer significant benefits to SNPs by agreeing to pay these cost-sharing amounts directly to the plan in the form of up-front capitated payments, which could result in administrative efficiencies for states, plans, and providers. Most states would, of course, want something in exchange for such benefits, so discussions around these cost sharing issues could open the door to discussions of a wider range of Medicare and Medicaid integration issues.

- **Drugs excluded by statute from Part D coverage.** The excluded drugs that Medicaid programs continue to cover are not costly (most are generics), and they are most valuable to beneficiaries when they are part of a broader care package. Medicaid programs could achieve administrative efficiencies and improve care for beneficiaries if they contracted with SNPs to cover these drugs as an additional no-cost benefit, or with an appropriate up-front capitated payment to cover their additional cost, if any. The capitated payment could be approximately equivalent to what the Medicaid agency would otherwise have to pay for such drugs, with perhaps some adjustments to reflect the administrative efficiencies that both parties could achieve. Again, this could be part of a broader discussion of other Medicaid services that could be included in the SNP benefit package.

- **Sharing data on prescription drug utilization.** States have an interest in obtaining information on prescription drug utilization by dual eligibles for care coordination and quality monitoring purposes, especially in settings where Medicaid remains responsible for most of the cost of care for dual eligibles, such as home- and community-based services and long-term nursing facility care.[36] SNPs have an interest in obtaining information on prior drug utilization by new dual eligible enrollees, which states are likely to have for under-65 disabled Medicaid beneficiaries who are emerging from the two-year waiting period for Medicare coverage or Medicaid beneficiaries approaching age 65. Arrangements for sharing this kind of data could be another topic for discussion in contracting discussions between states and SNPs.

- **Acute care services not covered by Medicare.** Medicaid covers some acute care services that Medicare does not cover or covers less extensively (vision, dental, hearing, durable medical equipment, transportation, care coordination). These Medicaid benefits are generally not very costly, and probably could be handled more efficiently for duals if Medicaid contracted with Medicare SNPs for these services. These services could be funded either as an additional no-cost benefit offered by the SNP, if there are savings under the Medicare Advantage capitation payment, or through additional capitation payments provided by Medicaid.[37] Including these services in the SNP benefit package would also facilitate coordination of care for beneficiaries.

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[35] See Social Security Act, Section 1902(n)(2). For a summary of the CMS rules for Medicaid payment of Medicare premiums and cost sharing for different categories of dual eligibles, see: http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#TopOfPage.

[36] SNPs and other MA-PD plans are required to submit detailed Part D prescription drug data to CMS on a monthly basis, but CMS has said it does not have authority to share these data with states.

[37] While Medicaid agencies may have to incur additional costs for actuarial services to calculate these capitation payments, states that include non-dual disabled beneficiaries in capitated Medicaid managed care programs will likely have reliable actuarial information on the use of these services by a population similar to the most costly dual eligible population, those who are under age 65 and disabled.

- **Mental health services.** Medicaid coverage of mental health services is considerably broader than Medicare's.[38] About half of under-age-65 disabled dual eligibles have significant mental health problems and are heavy users of costly antipsychotic and antidepressant medications. They are also likely to be heavy users of Medicare-funded inpatient hospital and emergency room services. Including Medicaid mental health services in the SNP benefit package would provide a more integrated and comprehensive benefit. This broader benefit could help to reduce overall costs for dual eligibles with mental health problems by providing a broader range of less costly services (targeted case management, rehabilitation services, community mental health center services) that could reduce the use of costly inpatient hospital and emergency room services and improve care for beneficiaries over the longer term. Again, since most of the financial savings would accrue to Medicare, some way of sharing these savings with the state would have to be devised.

- **Comprehensive case management, personal care services, care coordination, and MA supplemental benefits.** Medicaid coverage of care management and personal care services is substantially broader than Medicare's, so including all or some of these Medicaid benefits in the SNP benefit package would make more resources available to improve care coordination between Medicare and Medicaid. As noted above, SNPs can use savings from their MA bid for Part A and B services to fund some forms of care coordination as a supplemental benefit, and some Medicare care coordination activities may be covered by SNPs as an administrative expense. SNPs are likely to find that the ability to offer care coordination and "one-stop shopping" can be a major advantage for them in marketing to dual eligibles, over 90 percent of whom are currently in stand-alone PDPs where they do not have this kind of care coordination benefit.

- **Prescription drug use in nursing facilities.** Many SNPs (along with other MA plans and PDPs) have little experience in managing prescription drug use in nursing facilities.[39] These SNPs could benefit by partnering with Medicaid to help manage the Part D benefit in nursing facilities, especially since Medicaid is responsible for non-drug nursing facility services for dual eligibles after the short-term Medicare skilled nursing facility benefit ends. It could be useful, for example, for SNPs to have historical (pre-2006) data from the state on use of Medicaid-funded prescription drugs by dual eligibles in nursing facilities, as well as post-2006 data for Medicaid-covered nursing facility residents who become eligible for Medicare. The data could help with overall care planning and decision-making on SNP formularies. It could also be valuable for SNPs to have past Medicaid data on drug use in specific facilities or in facilities served by specific institutional pharmacies, to help the SNP determine which facilities and pharmacies to contract with and how to manage the contractual relationships that emerge. This kind of data sharing and partnership between Medicaid and SNPs could help lay the groundwork for inclusion of Medicaid-funded nursing facility services in the SNP benefit package.

- **Medicaid nursing facility, home health, and home- and community-based services.** The broadest integration of Medicare and Medicaid benefits within SNPs would be to include

[38] Medicare requires 50 percent coinsurance for most mental health services (as opposed to 20 percent for other services), limits lifetime inpatient psychiatric hospital coverage to 190 days, and generally does not cover services unless they are medically necessary, thus excluding some services that may be more social and educational than medical, but that are nonetheless valuable for beneficiaries with mental health problems.

[39] In the short-term Medicare Part A skilled nursing facility benefit, drugs are included in the nursing facility per diem rather than being paid for separately and managed as a separate benefit.

Medicaid nursing facility, home health, and home- and community-based services in the SNP benefit package. If these services were added to those described above, the ultimate goal of fully integrating Medicare and Medicaid acute and long-term-care services in a single managed care benefit package could be achieved.[40] Medicare coverage of long-term-care benefits is limited, so adding Medicaid benefits would be a major enhancement. Medicare covers only 100 days of skilled nursing facility care in a benefit period, and it must be preceded by a three-day hospital stay (although MA plans may waive this latter requirement).[41] Medicare requires that those receiving home health care have a need for skilled care and be "homebound," and the care is time-limited (part-time or intermittent).[42] Medicare does not cover any non-medical community services beyond the limited home health benefit. Including Medicaid nursing facility, home health, and home- and community-based services in the SNP benefit package could open up more opportunities for less costly community placements that could reduce Medicare nursing facility and inpatient hospital costs, and provide greater satisfaction for plan enrollees. Again, some way of sharing these Medicare savings with states would be needed. Effective use of home-and community-based services could also result in reductions in nursing facility costs for Medicaid. In this case, the potential Medicaid savings could be reflected in Medicaid capitated payments to SNPs by, for example, paying plans more if they are successful in reducing utilization of Medicaid-funded nursing facility services.

- **Use of Medicare savings resulting from inclusion of Medicaid services in the SNP benefit package.** As noted at a number of points above, there are likely to be savings to Medicare if Medicaid services are included in the SNP benefit package, especially from the reduction of inpatient hospital, emergency room, and skilled nursing facility utilization, and from more appropriate use of prescription drugs. These potential savings and their uses should be an explicit topic of discussion between states and SNPs.[43] Some of the savings could be used to further enhance care coordination and other high-value services for dual eligibles, and some could be used to reduce the capitated payments that Medicaid agencies might otherwise pay to SNPs for coverage of Medicaid services. There may be more flexibility in Medicaid than in Medicare in terms of uses of savings, since, as noted above, Medicare MA supplemental services must be "directly health-related." Section 1915(b)(3) of the Social Security Act allows Medicaid "to share (through the provision of additional services) with recipients under the State plan cost savings resulting from the use by the recipient of more cost-effective medical care." The statute does not define these "additional services," and Medicaid covers a number of services that may not be viewed as directly health related, especially in home- and community-based services programs. However, Medicaid managed care "actuarial soundness" requirements may constrain this flexibility to some extent, since CMS requires evidence that these "(b)(3)" services have actually been provided by the Medicaid managed care organization in the past before they can be incorporated into future capitated rates.

[40] For a further discussion of these issues, see CHCS, "Integrated Care Program Design, Rate Setting, and Risk Adjustment: A Checklist for States," June 2006, available on the Web at: http://www.chcs.org/usr_doc/ICP_TA_Tool.pdf.
[41] See 42 CFR sec. 422.101(c) for this authority to waive the hospital stay requirement in MA plans.
[42] MA plans may have more flexibility in providing home health benefits than is permitted in the Medicare fee-for-service program, but the extent of that flexibility is not fully clear.
[43] States and SNPs should also consult CMS guidelines on what kinds of services may and may not be paid for by Medicare. Section 20 in Chapter 4 of the Medicare Managed Care Manual has a good summary: http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf.

Conclusion

States are at varying places in their discussions with SNPs and other MA plans about covering Medicaid services. Some states, such as Arizona, already contract with SNPs for a wide range of Medicaid services throughout large portions of the state. Others contract for some Medicaid services, but not all. Some states are in early program design and contract discussion stages, and some are not yet in a position to give these options serious consideration.

This primer is intended to be helpful to states (and SNPs) at any of these points. The intricacies of Medicare Advantage rate setting and risk adjustment are not at all familiar to most states. SNP sponsors that have operated primarily in the Medicaid market in the past may also face a steep learning curve in dealing with the Medicare rate-setting system. It is not possible in a document of this length to do more than sketch out the basics of Medicare rate-setting, with references to other sources that can provide more detail. Nonetheless, state Medicaid agencies do not have to become experts in Medicare in order to have productive discussions with SNPs about joint contracting opportunities. There are broad similarities between the rate-setting and risk adjustment systems that Medicare uses and that states use in their own Medicaid managed care programs, so states with Medicaid managed care experience are not starting from scratch when they deal with Medicare managed care issues.

States thus need not be daunted or deterred by the complexities of Medicare rate setting and risk adjustment. They can start now to explore the potential for better integration of Medicare and Medicaid services, with the expectation that better care for beneficiaries likely will result, and that cost savings for both Medicaid and Medicare may result as well.

Appendix A

Excerpts from 2007 CMS Medicare Advantage Bid Pricing Tool
(Worksheets 1-7)

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

MA-2007.2
OMB Approved # 0938-0944

I. General Information

1. Contract Number:		5. Organization Name		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2007	8. MA-PD:		12. SNP:		14. % of CY Enrollees that are Dually-Eligible:	

II. Base Period Background Information

1. Time Period Definition		2. Member Months (excl ESRD)		5. Plans In Base	Contract-Plan ID	% of MMs
Incurred from:		3. Non-ESRD Risk Score		a.		
Incurred to:		4. Completion Factor		b.		
Paid through:				c.		
6. Describe the source of the base period experience data (1000 character limit)				d.		

III. Base Period Data (at Plan's non-ESRD Risk Factor) / **IV. Projection Assumptions**

	(c)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
			Total Benefits			Util. Adjustments to Contract Period					Additive Adjustments	
	Service Category	Util Type	Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Unit Cost/ Intensity Trend	Util/1000	PMPM
a.	Inpatient Facility			$ -								
b.	Skilled Nursing Facility			-								
c.	Home Health			-								
d.	Ambulance			-								
e.	DME/Prosthetics/Supplies			-								
f.	OP Facility - Emergency			-								
g.	OP Facility - Surgery			-								
h.	OP Facility - Other			-								
i.	Professional			-								
j.	Part B Rx			-								
k.	Other Medicare Part B			-								
l.	Transportation (Non-Covered)			-								
m.	Dental (Non-Covered)			-								
n.	Vision (Non-Covered)			-								
o.	Hearing (Non-Covered)			-								
p.	POS			-								
q.	Health & Education (Non-Covered)			-								
r.	Other Non-Covered			-								
s.	COB/Subrg. (outside claim system)											
t.	**Total Medical Expenses**				$ -							
u.	Subtotal Medicare-covered services				$ -							

V. Description of Other Utilization Factor and Additive Values (1000 character limit)

CMS - 10142 (03/31/2009)

WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name: N/A
2. Plan ID:	6. Plan Name:	10. MA Region: N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply	
4. Contract Year: 2007	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible: 0.0%

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
		Projected Experience Rate			Manual Rate			Exper.	Contract Year Rate			% of svcs
Service Category	Util Type	Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM	Cred. %	Annual Util/1000	Avg Cost	Allowed PMPM	provided OON
a. Inpatient Facility		-	$ -	$ -		$ -			-	$ -	$ -	
b. Skilled Nursing Facility		-	-	-		-			-	-	-	
c. Home Health		-	-	-		-			-	-	-	
d. Ambulance		-	-	-		-			-	-	-	
e. DME/Prosthetics/Supplies		-	-	-		-			-	-	-	
f. OP Facility - Emergency		-	-	-		-			-	-	-	
g. OP Facility - Surgery		-	-	-		-			-	-	-	
h. OP Facility - Other		-	-	-		-			-	-	-	
i. Professional		-	-	-		-			-	-	-	
j. Part B Rx		-	-	-		-			-	-	-	
k. Other Medicare Part B		-	-	-		-			-	-	-	
l. Transportation (Non-Covered)		-	-	-		-			-	-	-	
m. Dental (Non-Covered)		-	-	-		-			-	-	-	
n. Vision (Non-Covered)		-	-	-		-			-	-	-	
o. Hearing (Non-Covered)		-	-	-		-			-	-	-	
p. POS		-	-	-		-			-	-	-	
q. Health & Education (Non-Covered)		-	-	-		-			-	-	-	
r. Other Non-Covered		-	-	-		-			-	-	-	
s. COB/Subrg. (outside claim system)				-							-	
t. Total Medical Expenses				$ -			$ -				$ -	
u. Subtotal Medicare-covered services				$ -			$ -				$ -	

v. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable (1000 character limit)

WORKSHEET 3 - MA PROJECTED COST SHARING PMPM

I. General Information

1. Contract Number:		5. Organization N	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:		6. Plan Name:	10. MA Region: N/A		
3. Segment ID:		7. Plan Type:	11. Act. Swap/Equiv Apply:		
4. Contract Year:	2007	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:	0.0%

II. Maximum Cost Sharing Per Member Per Year

1. In Network | 2. Out of Network | 3. Combined

4. Briefly explain the methodology for reflecting the impact of maximum cost sharing in Section III (1000 character limit):

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

	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)
					In-Network Cost Sharing After Deductible is Satisfied (incl. OOP max**)							
	Service Category	Description/ Note	Measurement Unit Code	Effective In-Network Plan-Level Deductible PMPM*	In-Network Util/1000 or PMPM	In-Network Cost Sharing Description	In-Network Effective Copay/ Coinsurance	In-Network PMPM	Total In-Network Cost Sharing PMPM	Out-of-Network Cost Sharing Description	Out-of-Network Cost Sharing PMPM*** (formerly 3B col N)	Grand Total Cost Sharing PMPM (INN+OON)
a.1.	Inpatient Facility	Acute						$ -	$ -			$ -
a.2.	Inpatient Facility	Mental Health						-	-			-
b.	Skilled Nursing Facility							-	-			-
c.	Home Health							-	-			-
d.	Ambulance							-	-			-
e.1.	DME/Prosthetics/Supplies	DME						-	-			-
e.2.	DME/Prosthetics/Supplies	Prosthetics/Supplies						-	-			-
f.	OP Facility - Emergency							-	-			-
g.	OP Facility - Surgery							-	-			-
h.1.	OP Facility - Other	Lab						-	-			-
h.2.	OP Facility - Other	Radiology						-	-			-
h.3.	OP Facility - Other	Observation						-	-			-
h.4.	OP Facility - Other	Renal Dialysis						-	-			-
h.5.	OP Facility - Other	Other						-	-			-
i.1.	Professional	PCP						-	-			-
i.2.	Professional	Specialist excl. MH						-	-			-
i.3.	Professional	Mental Health (MH)						-	-			-
i.4.	Professional	Therapy (PT/OT/ST)						-	-			-
i.5.	Professional	Radiology						-	-			-
i.6.	Professional	Other						-	-			-
j.	Part B Rx							-	-			-
k.	Other Medicare Part B							-	-			-
l.	Transportation (Non-Covered)							-	-			-
m.	Dental (Non-Covered)							-	-			-
n.1.	Vision (Non-Covered)	Professional						-	-			-
n.2.	Vision (Non-Covered)	Hardware						-	-			-
o.1.	Hearing (Non-Covered)	Professional						-	-			-
o.2.	Hearing (Non-Covered)	Hardware						-	-			-
p.	POS							-	-			-
q.	Health & Education (Non-Covered)							-	-			-
r.	Other Non-Covered							-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
								-	-			-
	Total			$ -				$ -	$ -		$ -	$ -

*The actual in-network plan level deductible is:
** PMPM impact of in-network OOP max is:
***Actual OON plan level deductible is:
***PMPM impact of OON OOP max is:

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2007	8. MA-PD:		12. SNP:		14. % of CY Enrollees that are Dually-Eligible:	0.0%

II. Development of Projected Revenue Requirement

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor:

III. Comparison of cost sharing for covered services with FFS Medicare

1. Standardized FFS cost sharing Medicare-covered services	$0.00
2. Standardized plan cost sharing for covered services	$0.00
3. Is covered cost share within FFS Medicare limit?	**Yes**

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
	Total Benefits			**% for Cov. Svcs**		FFS Medicare	Plan cost shr	**Medicare Covered (w/AE cost shr)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Allowed PMPM	Cost Sharing	Net PMPM	Allowed	Cost Sharing	Actl. Equiv. cost sharing	for Medicare-covered svcs.	Allowed PMPM	FFS AE Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total
a. Inpatient Facility	$ -	$ -	$ -			0.0%	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Skilled Nursing Facility	-	-	-			0.0%	-	-	-	-	-	-	-
c. Home Health	-	-	-			0.0%	-	-	-	-	-	-	-
d. Ambulance	-	-	-			0.0%	-	-	-	-	-	-	-
e. DME/Prosthetics/Supplies	-	-	-			0.0%	-	-	-	-	-	-	-
f. OP Facility - Emergency	-	-	-			0.0%	-	-	-	-	-	-	-
g. OP Facility - Surgery	-	-	-			0.0%	-	-	-	-	-	-	-
h. OP Facility - Other	-	-	-			0.0%	-	-	-	-	-	-	-
i. Professional	-	-	-			0.0%	-	-	-	-	-	-	-
j. Part B Rx	-	-	-			0.0%	-	-	-	-	-	-	-
k. Other Medicare Part B	-	-	-			0.0%	-	-	-	-	-	-	-
l. Transportation (Non-Covered)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
m. Dental (Non-Covered)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
n. Vision (Non-Covered)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
o. Hearing (Non-Covered)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
p. POS	-	-	-			0.0%	-	-	-	-	-	-	-
q. Health & Education (Non-Covered)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
r. Other Non-Covered	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
s. ESRD (Section IV)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
t. Additional Benefits (employer bids only)	-	-	-	0.0%	0.0%	0.0%	-	-	-	-	-	-	-
u. COB/Subrg. (outside claim system)	-	-	-			0.0%	-	-	-	-	-	-	-
v. Total Medical Expenses	$ -	$ -	$ -			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
w. Non-Medical Expense:													
1. Marketing & Sales										$ -			$ -
2. Direct Administration										-			-
3. Indirect Administration										-			-
4. Net Cost of Private Reinsurance										-			-
5. Total Non-Medical Expense			$ -							$ -	-	-	$ -
x. Gain/(Loss) Margin										$ -	-	-	$ -
y. Total Revenue Requirement			$ -							$ -	-	-	$ -
z. Percent of Revenue (excluding ESRD)													
1. Net Medical Expense			0.0%							0.0%			0.0%
2. Non-Medical			0.0%							0.0%			0.0%
3. Gain/(Loss) Margin			0.0%							0.0%			0.0%

IV. Development of Projected Contract Year ESRD "subsidy"

Non-ESRD CY member months	-		
ESRD CY member months			
Basic benefits (user entries should be reported as "per ESRD member per month")		Supplemental Benefits	
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	$ -
		Non-ESRD CY additional benefits	$ -
CY Medical Expenses for Basic Services			
CY Non-Medical Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Margin Requirement for Basic Services	$ -	ESRD CY additional benefits	
CY Gain/(Loss) Margin for Basic Services	$ -		
		Incremental CY cost of cost sharing reductions	$ -
Cost for CY basic benefits allocated to all plan members	$ -	Incremental CY cost of additional benefits	$ -

Total CY ESRD "subsidy" = $ -

V. For Employer Bid Use Only ("800-series")

1. PMPM for additional/ unspecified MS benefits (see instructions for additional information)	

WORKSHEET 5 - MA BENCHMARK PMPM

I. General Information

1. Contract Number:		5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:		6. Plan Name:	10. MA Region: N/A		
3. Segment ID:		7. Plan Type:	11. Act. Swap/Equiv Appl		
4. Contract Year:	2007	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:	0.0%

II. Benchmark and Bid Development

1. Standardized A/B Benchmark (@ 1.000)	**$**	-
2. Medicare Secondary Payer Adjustment		
3. Weighted Avg Factor (excl ESRD)		-
4. Conversion Factor		-
5. Plan A/B Benchmark	**$**	-
6. Plan A/B Bid	**$**	-
7. Standardized A/B Bid (@ 1.000)	**$**	-

III. Savings/Basic Member Premium Development

1. Savings	$	-
2. Rebate	$	-
3. Basic Member Premium	$	-

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	85.9%	
2. Plan Bid Component (from CMS)*	14.1%	
3. Standardized A/B Benchmark (before bonuses)	100%	
4. Stabilization Fund Adjustment (with prior approval from CMS OACT)		
5. Standardized A/B Benchmark		

** See instructions - if Line 2 is not filled in, then Line 7 of Section II will be used.*

6. Stabilization Funding (PMPM)	

V: County Level Detail and Service Area Summary (excl ESRD)

1. Use of plan-provided ISAR factors? (see instructions - Regional Plans only - enter Yes or No)

(b) State/County Code	(c) State	(d) County Name	(e) Projected Member Months	(f) Projected Risk Factors	(g) Plan Provided ISAR factors for risk rates	(h) MA Risk Ratebook Unadjusted	(i) MA Risk Ratebook Risk-Adjusted	(j) ISAR scale	(k) ISAR-Adjusted Bid	(l) Risk Payment Rate A only	(m) Risk Payment Rate B only
2. Total or Weighted Average for Service Area:			-	-	-	$0.00	$0.00	-	$0.00	51.910%	48.090%
3. County Level Detail:											

WORKSHEET 6 - MA BID SUMMARY

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2007	8. MA-PD:		12. SNP:		14. % of CY Enrollees that are Dually-Eligible	0.0%

II. Other Information

A. Part B Information

1. CMS Estimate of CY Part B Premium	$94.90
2. Part B % of USPCC (aged)	47.42%

3. Maximum for Part A Package on 'Part B Only' Members

a. Required Revenue for Part A Services	n/a	
b. Average benchmark rate for Part A	n/a	
c. CMS Part A Charge	n/a	Maximum
d. Mandatory Suppl. Prem for Part A Package		$ -

B. Rebate Allocation for Contract Year Part B Premium

1. PMPM rebate allocation for Part B premium (max value=$94.90)		
2. Part B Rebate Allocation - rounded (see instructions)	$	-
3. Does plan intend to reduce the entire standard Part B premium using rebates? Enter Yes/No. (See instructions for further info).		No reduction

III. Plan A/B Bid Summary

A. Overview

	Medicare-covered	A/B Mandatory Supplemental
1. Allowed medical cost	$ -	n/a
2. Less cost sharing	0.00	n/a
3. Net medical cost	$ -	$ -
4. Non-medical expense	$ -	$ -
5. Gain / loss margin	-	-
6. Total revenue requirement	$ -	$ -

B. MA Rebate Allocation

	Rebate PMPM Allocation				Maximum
	Medical	Admin	Gain / (Loss)	Total	Value
1. MA Rebate	n/a	n/a	n/a	$ -	
2. Reduce A/B Cost Sharing	$0.00	$0.00	$0.00		$ -
3. Other A/B Mand Suppl Benefits	-	-	-		-
4. Pt B Premium Buydown	-	n/a	n/a	-	94.90
5. Pt D Premium Buydown Basic	-	n/a	n/a	-	-
6. Pt D Premium Buydown Suppl	-	n/a	n/a	-	-
7. Total	$ -	$ -	$ -	$ -	
			Unallocated rebate	$ -	

C. Development of Estimated Plan Premium

1. A/B Mandatory Supplemental revenue requirements	$0.00
2. Less rebate allocations:	
2a. Reduce A/B Cost Sharing	-
2b. Other A/B Mand Supplemental Benefits	-
3. A/B Mandatory Supplemental premium	-
4. Basic MA premium	-
5. Total MA Enrollee Premium (excl. Opt. Suppl.)	-
6. Rounded MA Premium (excl. Opt. Suppl.)	**$0.00**
7. Part D Basic Premium	
7a. Prior to rebates (rounded value from Rx BPT)	
7b. A/B rebates allocated to Part D Basic Premium	
7c. A/B rebates for Part D Basic Premium (rounded)	$0.00
7d. Part D Basic Premium*	**$0.00**
8. Part D Supplemental Premium	
8a. Prior to rebates (rounded value from Rx BPT)	
8b. A/B rebates allocated to Part D Suppl Premium	
8c. A/B rebates for Part D Suppl Premium (rounded)	$0.00
8d. Part D Supplemental Premium	**$0.00**
9. Total estimated plan premium*	**$0.00**
10. Plan Intention for Part D target premium	Premium amount displayed in line 7d

* The premium shown here is an estimate. The actual plan premium will be calculated by CMS when the Part D national average is determined by CMS. The premium shown here may not be

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

IV. Contact Information

Plan Contact Person:	
Name, Position	
Phone Number	
Email Address	
Certifying Actuary:	
Name, Credentials	
Phone Number	
Email Address	
Date Prepared	

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

I. General Information

1. Contract Number:		5. Organization Nam		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2007	8. MA-PD:		12. SNP:		14. % of CY Enrollees that are Dually-Eligible:	0.0%

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				Enrollee cost sharing				Net PMPM value	Non-Medical expense	Gain/ (Loss) Margin	Premium	Projected Member Months
Package ID	Service category	Benefit category or pricing component	Util. type	Annual Util / 1000	Average cost	PMPM	Measurment unit code	Util/1000 or PMPM	Average cost shr	PMPM					
						$ -				$ -	$ -	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0	**Package Total**					$ -				$ -	$ -			$ -	
						$ -				$ -	$ -	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0						-				-	-	n/a	n/a	n/a	n/a
0	**Package Total**					$ -				$ -	$ -			$ -	

Appendix B

Excerpts from New York State Template for Obtaining Selected Medicare Advantage Bid Data

Schedule C1
Capitation Rate Calculation Sheet
Premium Group: 18-64 M&F

			Medicare[1]			Medicaid		
#	Category of Service	Amount of Copay	Utilization PMPY	Unit Cost	PMPM Cost	Utilization PMPY	Unit Cost	PMPM Cost
			a	b	c	d	e	f
1	Inpatient Hospital - Acute				$ -			
2	Inpatient Mental Health				$ -			
3	Inpatient Mental Health Days in Excess of 190 Day Lifetime Limit							$ -
4	Skilled Nursing Facility				$ -			
5	Skilled Nursing Facility Days in Excess of 100 Per Benefit Period							$ -
6	Home Health (Excluding Home Health Aides)				$ -			$ -
7	Home Health Aides				$ -			$ -
8	Personal Care							$ -
9	Primary Care Physician				$ -			
10	Chiropractic Services				$ -			
11	Outpatient Surgery				$ -			
12	Ambulance				$ -			
13	Durable Medical Equipment, Prosthetics & Supplies				$ -			
14	Diagnostic Testing				$ -			
15	Hearing Services				$ -			
16	Dialysis				$ -			
17	Vision Care				$ -			
18	Part B Drugs				$ -			
19	Other Part B				$ -			
20	Health & Education				$ -			
21	Emergency Room	$50			$ -			$ -
22	Outpatient Mental Health	$20			$ -			$ -
23	Outpatient Rehabilitation/Therapy	$10			$ -			$ -
24	Outpatient Substance Abuse	$20			$ -			$ -
25	Podiatry	$10			$ -			$ -
26	Specialty Care (Including Urgent Care)	$10			$ -			$ -
27	Dental							$ -
28	Private Duty Nursing							$ -
29	Transportation - Non Emergency							$ -
30	Nutrition							$ -
31	Medical Social Services							$ -
32	Personal Emergency Response Services							$ -
33	Adult Day Health Care							$ -
34	Social and Environmental Support							$ -
35	Social Day Care							$ -
36	Home Delivered and Congregate Meals							$ -
37	Proposed Medical Capitation (Copay Adjusted)				$ -			$ -
38	Administration (from Schedule G)				$ -			$ -
39	Surplus/Reserves[2]							$ -
40	Proposed Capitation/Revenue Requirement				$ -			$ -
41	Enrollee Premium To Be Paid By Medicaid (if applicable)[3]							
42	**Total Capitation**				$ -			$ -
43	Combined Medicare & Medicaid Capitation							$ -

[1] Medicare Utilization and Unit Costs - Derive from Worksheet 2, Part II, columns (m) - (o) and Worksheet 3, col g, of the Plan's CMS Bid. Note proposed Medicare Medical Capitation (line 37, col c) has been reduced by the cost sharing amounts in lines 21..26, col f.

[2] Medicare Surplus - Extract from Worksheet 4, line x, column g, of the Plan's CMS Bid. Medicaid Surplus/Reserves - 2% of Proposed Capitation, line 40, col f.

[3] Enrollee Premium To Be Paid By Medicaid - Derive from Worksheet 6, Section III, Part C, line 6 of the Plan's CMS Bid.

1

Schedule C2
Capitation Rate Calculation Sheet
Premium Group: 65+

			Medicare[1]			Medicaid		
#	Category of Service	Amount of Copay	Utilization PMPY	Unit Cost	PMPM Cost	Utilization PMPY	Unit Cost	PMPM Cost
			a	b	c	d	e	f
1	Inpatient Hospital - Acute				$ -			
2	Inpatient Mental Health				$ -			
3	Inpatient Mental Health Days in Excess of 190 Day Lifetime Limit							$ -
4	Skilled Nursing Facility				$ -			
5	Skilled Nursing Facility Days in Excess of 100 Per Benefit Period							$ -
6	Home Health (Excluding Home Health Aides)				$ -			$ -
7	Home Health Aides				$ -			$ -
8	Personal Care							$ -
9	Primary Care Physician				$ -			
10	Chiropractic Services				$ -			
11	Outpatient Surgery				$ -			
12	Ambulance				$ -			
13	Durable Medical Equipment, Prosthetics & Supplies				$ -			
14	Diagnostic Testing				$ -			
15	Hearing Services				$ -			
16	Dialysis				$ -			
17	Vision Care				$ -			
18	Part B Drugs				$ -			
19	Other Part B				$ -			
20	Health & Education				$ -			
21	Emergency Room	$50			$ -			$ -
22	Outpatient Mental Health	$20			$ -			$ -
23	Outpatient Rehabilitation/Therapy	$10			$ -			$ -
24	Outpatient Substance Abuse	$20			$ -			$ -
25	Podiatry	$10			$ -			$ -
26	Specialty Care (Including Urgent Care)	$10			$ -			$ -
27	Dental							$ -
28	Private Duty Nursing							$ -
29	Transportation - Non Emergency							$ -
30	Nutrition							$ -
31	Medical Social Services							$ -
32	Personal Emergency Response Services							$ -
33	Adult Day Health Care							$ -
34	Social and Environmental Support							$ -
35	Social Day Care							$ -
36	Home Delivered and Congregate Meals							$ -
37	Proposed Medical Capitation (Copay Adjusted)				$ -			$ -
38	Administration (from Schedule G)				$ -			$ -
39	Surplus/Reserves[2]							$ -
40	Proposed Capitation/Revenue Requirement				$ -			$ -
41	Enrollee Premium To Be Paid By Medicaid (if applicable)[3]							
42	**Total Capitation**				$ -			$ -
43	Combined Medicare & Medicaid Capitation							$ -

[1] Medicare Utilization and Unit Costs - Derive from Worksheet 2, Part II, columns (m) - (o) and Worksheet 3, col g, of the Plan's CMS Bid. Note proposed Medicare Medical Capitation (line 37, col c) has been reduced by the cost sharing amounts in lines 21..26, col f.

[2] Medicare Surplus - Extract from Worksheet 4, line x, column g, of the Plan's CMS Bid.
Medicaid Surplus/Reserves - 2% of Proposed Capitation, line 40, col f.

[3] Enrollee Premium To Be Paid By Medicaid - Derive from CMS Worksheet 6, Section III, Part C, line 6.

1

Member Months = 0

Schedule C3
Capitation Rate Calculation Sheet
Weighted Average Rates

#	Category of Service	Amount of Copay	Medicare[1] Utilization PMPY	Medicare[1] Unit Cost	Medicare[1] PMPM Cost	Medicaid Utilization PMPY	Medicaid Unit Cost	Medicaid PMPM Cost
			a	b	c	d	e	f
1	Inpatient Hospital - Acute							
2	Inpatient Mental Health							
3	Inpatient Mental Health Days in Excess of 190 Day Lifetime Limit							
4	Skilled Nursing Facility							
5	Skilled Nursing Facility Days in Excess of 100 Per Benefit Period							
6	Home Health (Excluding Home Health Aides)							
7	Home Health Aides							
8	Personal Care							
9	Primary Care Physician							
10	Chiropractic Services							
11	Outpatient Surgery							
12	Ambulance							
13	Durable Medical Equipment, Prosthetics & Supplies							
14	Diagnostic Testing							
15	Hearing Services							
16	Dialysis							
17	Vision Care							
18	Part B Drugs							
19	Other Part B							
20	Health & Education							
21	Emergency Room	$50						
22	Outpatient Mental Health	$20						
23	Outpatient Rehabilitation/Therapy	$10						
24	Outpatient Substance Abuse	$20						
25	Podiatry	$10						
26	Specialty Care (Including Urgent Care)	$10						
27	Dental							
28	Private Duty Nursing							
29	Transportation - Non Emergency							
30	Nutrition							
31	Medical Social Services							
32	Personal Emergency Response Services							
33	Adult Day Health Care							
34	Social and Environmental Support							
35	Social Day Care							
36	Home Delivered and Congregate Meals							
37	Proposed Medical Capitation[2]				$ -			$ -
38	Administration (from Schedule G)				$ -			$ -
39	Surplus/Reserves[3]							
40	Proposed Capitation/Revenue Requirement				$ -			$ -
41	Enrollee Premium To Be Paid By Medicaid (if applicable)[4]							
42	**Total Capitation**							
43	Combined Medicare & Medicaid Capitation							

[1] Medicare Utilization and Unit Costs - Weighted averages derived from schedules C1 and C2 should be consistent with data from Worksheet 2, Part II, columns (m) - (o) and Worksheet 3, col g, of the Plan's CMS Bid.

[2] Medicare Medical Capitation (line 37, col c) - The sum of lines 1..26, col c, less sum of lines 21..26, col f, and should equal CMS Worksheet 4, line v, column g.

[3] Medicare Surplus/Reserves - should equal CMS Worksheet 4, line x, column g.
Medicaid Surplus/Reserves - 2% of Proposed Capitation, line 40, col f.

[4] Enrollee Premium To Be Paid By Medicaid - should equal Worksheet 6, Section III, Part C, line 6 of the Plan's CMS Bid.

1

Schedule C4
Summary Medicaid Capitation Rate Calculation Sheet
Rate Period: January 1, 2007 to December 31, 2007

			Premium Group: 18-64			Premium Group: 65+			Weighted average		
		Member Months	0			0			0		
#	Category of Service	Medicaid Capitation	Estimated Utilization PMPY	Estimated Unit Cost	PMPM Cost	Estimated Utilization PMPY	Estimated Unit Cost	PMPM Cost	Estimated Utilization PMPY	Estimated Unit Cost	PMPM Cost
	Cost Sharing of Medicare Benefits										
1	Emergency Room	$50 Copay	-		$ -	-		$ -			
2	Outpatient Mental Health	$20 Copay	-		$ -	-		$ -			
3	Outpatient Rehabilitation/Therapy	$10 Copay	-		$ -	-		$ -			
4	Outpatient Substance Abuse	$20 Copay	-		$ -	-		$ -			
5	Podiatry	$10 Copay	-		$ -	-		$ -			
6	Specialty Care (Including Urgent Care)	$10 Copay	-		$ -	-		$ -			
7	**Total Cost Sharing * (Sum lines 1..6)**				$ -			$ -			$ -
8	**Medicaid Only Benefits**										
9	Inpatient MH/SA	Days in excess of 190 day lifetime limit	-	$ -	$ -	-	$ -	$ -			
10	Skilled Nursing Facility	Days in excess of 100 per benefit period	-	$ -	$ -	-	$ -	$ -			
11	Non-Medicare Home Health (Excluding Home Health Aides)	Non-Medicare Visits	-	$ -	$ -	-	$ -	$ -			
12	Home Health Aides	Non-Medicare Visits	-	$ -	$ -	-	$ -	$ -			
13	Personal Care	All services	-	$ -	$ -	-	$ -	$ -			
14	Dental	All services	-	$ -	$ -	-	$ -	$ -			
15	Private Duty Nursing	All services	-	$ -	$ -	-	$ -	$ -			
16	Transportation - Non Emergency	All services	-	$ -	$ -	-	$ -	$ -			
17	Nutrition	All services	-	$ -	$ -	-	$ -	$ -			
18	Medical Social Services	All services	-	$ -	$ -	-	$ -	$ -			
19	Personal Emergency Response Services	All services	-	$ -	$ -	-	$ -	$ -			
20	Adult Day Health Care	All services	-	$ -	$ -	-	$ -	$ -			
21	Social and Environmental Support	All services			$ -			$ -			
22	Social Day Care	All services	-	$ -	$ -	-	$ -	$ -			
23	Home Delivered and Congregate Meals	All services	-	$ -	$ -	-	$ -	$ -			
24	**Medicaid Only Capitation (Sum lines 9..22)**				$ -			$ -			$ -
25	Proposed Medical Capitation - (Sum lines 7+24)				$ -			$ -			$ -
26	Administration (see Schedule G)				$ -			$ -			$ -
27	2% Medicaid Surplus/Reserves				$ -			$ -			
28	Subtotal - Proposed Medicaid Capitation (Sum lines 24..27)				$ -			$ -			
29	Enrollee Premium To Be Paid By Medicaid (if applicable)*				$ -			$ -			
30	**Total Proposed Medicaid Capitation (Sum Lines 28+29)**				$ -			$ -			

* Total Cost Sharing must agree with the Total Cost Share in Worksheet 4, Section II, column (f), line v of the Plan's A/B Bid, while Enrollee Premium To Be Paid By Medicaid must agree with Total Enrollee Premium in Worksheet 6, Section III, Part C, line 6 of the A/B Bid.

1