

Medicare Advantage: Strategies to increase plan revenue

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Profitability is critical for long-term sustainability in the Medicare Advantage (MA) market and a major consideration for new and established MA organizations (MAOs). While there are many paths to increase profitability, increasing revenue is often a first consideration for MAOs. This paper explores the various components of MA revenue, avenues MAOs may explore to increase their Part C and Part D revenue, and key considerations for each approach.

Background

MAOs receive funding from the Centers for Medicare and Medicaid Services (CMS) and, in some cases, from their enrolled beneficiaries. Total revenue is often considered separately for Part C and Part D.

PART C REVENUE

As shown in Figure 1, Part C revenue from CMS depends on the county benchmark rate, which CMS sets as the maximum funding it will provide to cover traditional fee-for-service (FFS) Medicare benefits (Medicare Part A and Part B services) for an average beneficiary. Each year, an MAO estimates a bid amount (i.e., the cost to provide FFS benefits inclusive of administration and margin to the MAO's beneficiaries) for each of its plan offerings. In cases where the bid is below the benchmark, CMS shares a portion of this savings (i.e., the excess of the benchmark beyond the bid) with the MAO to fund supplemental Part C benefits, buy down Part B premium, and/or buy down Part D premium. This amount retained by the MAO to offer these additional benefits is the Part C "rebate" and the percentage of retained savings varies by MAO's contract star rating. If the MAO is not able to submit a bid at or below the benchmark rate, the MAO must collect a basic Part C premium from its beneficiaries to fund the cost of these services above the benchmark rate.

MA plans may offer supplemental benefits for services not covered by FFS Medicare, funding these benefits through the Part C rebates and/or supplemental Part C member premium.

PART D REVENUE

As shown in Figure 2, CMS funds a portion of Part D coverage through the direct subsidy, calculated as the difference between the national average bid amount (NABA) and the national average member premium (NAMP). MAOs may charge a Part D basic member premium to cover any costs beyond the direct subsidy for standard Part D benefits. If an MAO's standardized bid amount (i.e., the cost to provide standard Part D benefits inclusive of administration and margin to an average beneficiary) is lower than the NABA, the MAO's Part D basic member premium will also be lower than the NAMP, and vice versa. MAOs can choose to use rebates generated on the Part C side to reduce the MAO's basic Part D premium.

Additionally, MAOs may offer enhanced coverage beyond standard Part D coverage, which the MAO must fund through rebates generated on the Part C side and/or supplemental Part D premium.

FIGURE 1: PART C REVENUE

Part C



Revenue from CMS

- Lesser of benchmark rate and bid
- Rebates allocated to Part C

Revenue from Member

- Basic Part C premium
- Supplemental Part C premium

FIGURE 2: PART D REVENUE

Part D



Revenue from CMS

- Direct subsidy (NABA - NAMP)
- Rebates allocated to Part D

Revenue from Member

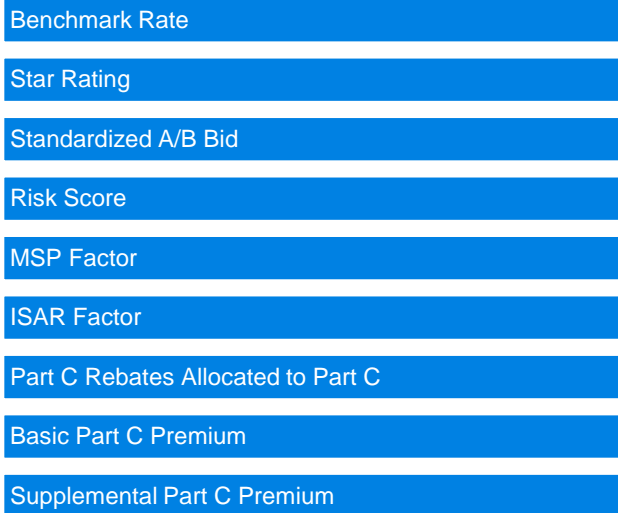
- Basic Part D premium
- Supplemental Part D premium

Revenue components

Total MAO revenue is determined by a number of components. Below we describe each of the components separately for Part C and Part D. Please see Appendix A and Appendix B for additional details regarding the calculation of actual and projected Part C and Part D revenue, respectively.

PART C

FIGURE 3: PART C REVENUE COMPONENTS



PART C REVENUE FORMULA(S)

If the bid is less than the benchmark rate:

Part C Revenue =
 (Standardized Bid x Risk Score x MSP Factor x ISAR Factor)
 + Rebate Allocated to Part C
 + Supplemental Part C Premium

If the bid is greater than the benchmark rate:

Part C Revenue =
 (Standardized Benchmark Rate
 x Risk Score x MSP Factor x ISAR Factor)
 + Basic Part C Premium
 + Supplemental Part C Premium

Benchmark rate

The benchmark rate represents the maximum revenue the government offers MAOs to provide FFS Medicare coverage in each county. CMS updated its methodology for calculating benchmark rates with the implementation of the Patient Protection and Affordable Care Act (ACA). This new methodology aligns county benchmark rates to each county’s respective FFS Medicare projected costs. The new methodology also incorporates each MAO contract’s star rating (discussed below), allowing MAOs with higher star ratings (4.0 and above) to realize quality bonus payments, increasing their benchmark rates. CMS caps an MAO’s post-ACA benchmark rate at the corresponding pre-ACA benchmark rate in each county, trended to the current year. An MAO’s overall benchmark rate reflects the member-weighted average of the county-level benchmark rates. The standardized benchmark rate is the benchmark rate adjusted from the plan’s conversion factor—risk score times the Medicare Secondary Payer (MSP) factor—to a 1.00 conversion factor.

Star rating

The ACA introduced star ratings as a means to align MA payments with measures of quality and performance. MAO contracts earn an overall star rating annually based on a number of underlying star measures, each of which falls into one of five broad categories: outcomes, intermediate outcomes, patient experience, access, and process. A contract's aggregate star rating can increase the MAO's benchmark rate and/or rebates, as shown in Figure 4.

FIGURE 4: IMPACT OF STAR RATING ON BENCHMARK RATE AND REBATES

Star Rating	Benchmark Rate Bonus*	Rebates %** (% of Savings)
3.0 or lower	0%	50%
3.5	0%	65%
4.0	5%	65%
4.5 or higher	5%	70%
New/Low Enrollment	3.5%	65%

*The bonus is double the percentage shown in this table for qualifying counties.

**The rebate percentage is the portion of the difference between the benchmark rate and bid retained by the MAO.

Standardized A/B bid amount

MAOs project their revenue requirements to provide FFS Medicare benefits to their members, including medical, administrative, and margin components in their plan-specific bid forms. This revenue requirement represents the plan's bid. The standardized A/B bid is the plan's bid adjusted from the plan's conversion factor (risk score times the MSP factor) to a 1.00 conversion factor.

Risk score

The risk score represents the estimated morbidity for a given member, relative to the average morbidity of Medicare FFS members. CMS uses standardized risk score models to generate a member's risk score using the member's demographic information and prior year medical diagnoses. If the bid is less than the benchmark rate, the risk score applies to the standardized bid when calculating revenue. If the bid is greater than the benchmark rate, the risk score applies to the standardized benchmark rate when calculating revenue.

MSP factor

In certain cases, Medicare beneficiaries may have additional healthcare coverage beyond Medicare. The Medicare Secondary Payer (MSP) factor reduces the MAO's revenue payment, accounting for the MAO having reduced claim responsibility for a member with other coverage. If the bid is less than the benchmark rate, the MSP factor applies to the standardized bid when calculating revenue. If the bid is greater than the benchmark rate, the MSP factor applies to the standardized benchmark rate when calculating revenue.

ISAR factor

The intra-service area rate (ISAR) adjustment for a given county is the ratio of that county's benchmark rate to the composite benchmark rate for the plan's whole service area. This adjustment factor is applied to the plan A/B bid amount to determine the amount the MAO receives for members enrolled in a given county. That is, the ISAR factor adjusts the final composite payment received by the plan to account for variations in actual to expected membership mix by county.

Part C rebates allocated to Part C

CMS and the MAO share the excess of the benchmark rate beyond the bid (i.e., the "savings"). The Part C rebate is the portion the MAO retains and ranges from 50% to 70% of savings, as shown in Figure 4 above. MAOs must use Part C rebates to offer Part C supplemental benefits, reduce the member's Part B premium, or reduce the member's Part D premium. Part C rebates allocated to Part B and Part D premiums are generally not considered Part C revenue.

Basic Part C premium

If the standardized bid is greater than the standardized benchmark rate, the MAO must charge its members a basic Part C premium to cover the shortfall in CMS revenue relative to the estimated cost of offering traditional FFS benefits.

Supplemental Part C premium

A supplemental revenue requirement results from an MAO offering supplemental coverage via reduced member cost sharing or additional benefits not covered by Medicare (e.g., vision hardware). An MAO can choose to buy down a portion or the entire supplemental revenue requirement with Part C rebates, if available. However, if the supplemental revenue requirement is greater than the available Part C rebates, the MAO must require a supplemental Part C member premium.

PART D

FIGURE 5: PART D REVENUE COMPONENTS

Standardized Bid Amount
National Average Bid Amount
National Average Member Premium
Direct Subsidy
Risk Score
Basic Part D Premium
Supplemental Part D Premium
Part C Rebates Allocated to Part D

PART D REVENUE FORMULA(S)

Total Part D Revenue:

Part D Revenue =
 Risk-Adjusted Direct Subsidy
 + Basic Part D Premium
 + Supplemental Part D Premium

Where:

Basic Part D Premium =
 Standardized Bid Amount – NABA + NAMP

Risk-Adjusted Direct Subsidy =
 (Standardized Bid Amount x Risk Score)
 – Basic Part D Premium

Standardized bid amount

MAOs project their revenue requirements to provide standard Part D benefits to their members, including pharmacy, administrative, and margin components in their plan-specific bid forms. This revenue requirement represents the plan's bid amount. The standardized bid amount is the plan's bid amount adjusted from the plan's estimated risk score to a 1.00 risk score.

Risk score

The risk score represents the estimated morbidity for a given member, relative to the average morbidity across all Part D members. CMS uses standardized risk score models to generate a member's risk score using the member's demographic information and prior year medical diagnoses. The risk score adjusts the NABA when calculating an MAO's revenue. Note that CMS develops the Part D risk score separately from the Part C risk score.

NABA

CMS calculates the national average bid amount (NABA) as the member-weighted average of the standardized bid across all Part D plans. This amount is the same for all Part D plans.

NAMP

CMS calculates the national average member premium (NAMP) as 25.5% of the sum of the member-weighted average reinsurance payment amount and the NABA across all Part D plans. This amount is the same for all Part D plans.

Direct subsidy

CMS pays a direct subsidy to MAOs to subsidize the cost of standard Part D benefits. The standardized direct subsidy refers to the direct subsidy amount at a 1.00 risk score (i.e., the NABA minus the NAMP) and determines the plan's basic Part D premium (see below). The actual direct subsidy a plan receives reflects the risk score of the enrolled members by determining the total funding needed as the excess of the standardized bid multiplied by the actual risk score relative to the calculated basic Part D premium. As such, it reflects the morbidity of each MAO's enrolled population.

Basic Part D premium

As is often the case, when the CMS direct subsidy amount is less than a plan’s actual cost of providing standard Part D benefits, the MAO must charge its members a basic Part D member premium. However, MAOs may allocate Part C rebates to reduce, or eliminate, the basic Part D premium.

Supplemental Part D premium

MAOs can choose to offer additional benefits beyond standard Medicare Part D coverage. However, CMS does not provide additional revenue to offset the cost for these additional benefits. Therefore, MAOs must collect a Part D supplemental premium to cover the cost of these additional benefits. (The MAO may allocate Part C rebates to reduce this supplemental Part D premium.)

Part C rebates

As discussed above in the Part C section, MAOs may use Part C rebates to reduce the members’ Part D premium. In this case, the MAO should treat the portion of Part C rebates used to buy down Part D premium as Part D revenue.

Ways to increase revenue

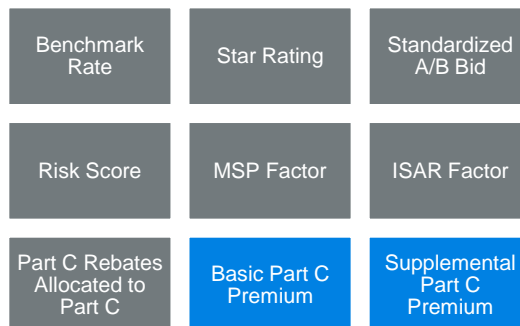
In this section, we explore a number of ways an MAO could increase its Part C or Part D revenue. We describe each method below and identify considerations that should be deliberated prior to implementation. MAOs should evaluate these methodologies given their specific situations, as there is not a one-size-fits all strategy.

PART C

Increase member premium

MAOs receive a portion of any bid savings (i.e., the rebate) to help cover the cost of supplemental benefits. However, for each \$1.00 of savings MAOs generate, they only receive \$0.50 to \$0.70, as rebates depend on their star ratings. Charging a higher member premium will increase revenue, on a dollar-for-dollar basis, and reduce the need for rebates.

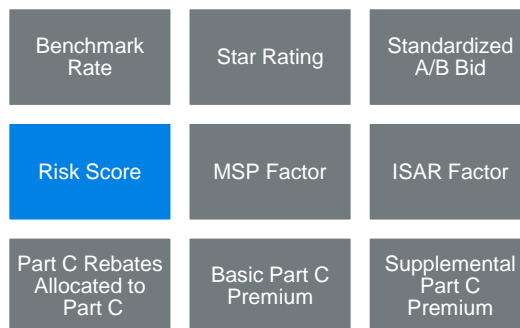
Considerations: This approach may reduce the plan’s competitive position within its service area and could result in lower membership. MAOs should consider the sensitivity of their target markets to premium changes. Members located in competitive or saturated markets are more likely to react adversely to premium increases because they have a wider variety of plan options from which to select. Plans with a zero-dollar premium should be particularly aware of the implications of increasing the premium.¹



Increase morbidity of population

Targeting members with higher morbidities will likely result in higher risk scores and CMS risk-adjusted revenue payments.

Considerations: Members with higher morbidity will have higher claim costs, which may offset increases in revenue received due to higher risk scores or result in reduced profitability. MAOs should also consider the opportunity for care management activities in populations with higher risk scores.



¹ Piper, B.J. & Gabe, M.L. (April 2019). Hang on Tight! Why Maintaining a Zero-Dollar Plan Is Worth the Effort. Milliman White Paper. Retrieved November 20, 2019, from <http://assets.milliman.com/ektron/zero-dollar-ma-pd-premium-plan.pdf>.

Increase accuracy and completeness of risk scores

Increasing the accuracy and completeness of risk scores, via comprehensive risk score coding efforts and proper documentation and submission of risk adjustment data, may result in higher risk scores and CMS risk-adjusted revenue payments for the subsequent year. Improvements in the accuracy and completeness of risk scores and corresponding revenue payments do not increase claim costs. Successful coding programs often incorporate medical record reviews, health risk assessments, and analyses to identify inaccurate or incomplete diagnoses from one diagnosis period to the next.

Considerations: The initiatives necessary to improve the accuracy and completeness of risk scores will require an increase in administrative costs and engagement from many areas across the organization. Additionally, MAOs may consider modifying their provider contractual payments to ensure the interest of all parties are appropriately aligned. Risk score coding efforts may yield diminishing returns in risk scores and additional revenue for MAOs with established initiatives already in place. As with all risk score coding practices, the MAO should ensure sufficient documentation to support all submitted diagnoses and the final risk scores.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Decrease MSP penalty: Fix errors in MSP member identification file

Reviewing and correcting any errors in an MAO's MSP member identification file (which CMS releases monthly) will result in increased revenue for any members who are incorrectly reported as MSP and corrected to be non-MSP. MAOs allocating resources to review these files may find members they feel CMS incorrectly flagged as MSP. If an incorrectly flagged member is reported appropriately, the MAO should expect to see an increase in revenue due to the removal of the member's MSP penalty factor.

Considerations: Reviewing and correcting monthly MSP member identification files requires resources and may result in an increase in administrative expenses. Additionally, the review should consider all types of errors, including correcting members currently listed as non-MSP to MSP, if appropriate, potentially resulting in a revenue reduction.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Reduce supplemental benefits

Reducing supplemental benefits will result in a direct increase to CMS revenue when keeping member premium constant. The MAO receives the bid plus only a portion of the savings between the bid and the benchmark. MAOs can maximize their CMS revenue by increasing bids to hit the benchmark rate. Because rebates fund supplemental benefits, an MAO can increase the bid by reducing or eliminating supplemental benefits. In this situation, bid form mechanics force the retention rate (allowance for administrative expenses and margin) to increase.

Considerations: Reducing supplemental benefits will likely decrease the market positioning and competitiveness of a plan. Additionally, any margin increases must still meet CMS requirements per the bid instructions.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Increase star rating

Increasing a contract’s star rating from less than 4.0 stars or new or low enrollment status to at least 4.0 stars will directly increase CMS revenue in most cases. Contracts with 4.0 star ratings and above receive quality bonus adjustments increasing the benchmark rates by 5% (or 10% in a qualifying county). Plans also receive an additional 15% and 5% of savings (plan benchmark less plan bid) when their star ratings increase from 3.0 to 3.5 and from 4.0 to 4.5, respectively.

Considerations: Initiatives to improve star ratings are often resource-intensive and result in increases in administrative expenses. Additionally, the revenue impact of star rating improvements may be dampened or even nonexistent for counties where the benchmark is already at the pre-ACA rate cap. However, the benefit of an increased star rating generally outweighs these considerations.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Target qualifying counties (double bonus counties)

Attracting members in qualifying counties will directly increase CMS revenue in many cases relative to the underlying population cost. CMS offers higher star rating incentives to qualifying counties—those counties with lower than average costs, high MA penetration rates, and designated as urban floors. The star rating bonus in qualifying counties is double the bonus in all other non-qualifying counties (i.e., 10% bonus for 4.0+ star plans).

Considerations: The revenue impact of qualifying counties may be dampened or even nonexistent for counties where the benchmark is already at the pre-ACA rate cap. Further, there will be no benchmark rate increase for contracts with less than 4.0 stars, as there is no bonus amount. Careful consideration should be given when entering into any new county to consider factors such as network adequacy, provider contracting terms, medical management capabilities, relativity of costs to the benchmark, and competition.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Target counties below the pre-ACA cap

Attracting membership from counties with benchmark rates below the pre-ACA cap maximizes potential revenue increases from star ratings and qualifying counties.

Considerations: Careful consideration should be given when entering into any new county, as discussed in the prior item.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Increase ESRD member identification

Appropriately identifying existing members as end-stage renal disease (ESRD) directly increases the CMS revenue. MAOs receive a significantly higher benchmark rate for ESRD-identified members compared to the benchmark rate for non-ESRD beneficiaries.

Considerations: Reviewing existing membership to determine ESRD status requires resources and may result in an increase in administrative expenses. Given these members are already covered by the MAO, this approach will not increase the MAOs underlying medical costs.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Maximize premium levels during rebate reallocation

MAOs have the ability to modify their prescription drug (MA-PD) plan premiums and supplemental benefits during the rebate reallocation process if the actual direct subsidy amount deviates from their initial June submission estimates. If their direct subsidy estimates are lower than the actual amount, MAOs should add Part C supplemental benefits to their plans to prevent reductions in their premium levels. Alternatively, if their direct subsidy estimates are higher than the actual amount, MAOs should increase their Part C premiums, rather than reducing their Part C supplemental benefits, to ensure they are maximizing their revenue amounts.

Considerations: While there is some opportunity to be revenue-efficient during the rebate reallocation process, the overall impact is generally small. MAOs should primarily aim to bid using their best estimates of the direct subsidy. Additionally, MAOs should consider the effects this will have on their competitive positions in the market. Increasing premiums in saturated service areas, even by a nominal amount, could adversely affect the MAO's membership.

Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

Reduce or eliminate bad debt premium

Members are obligated to pay a premium to the MAO if they sign up for coverage in one of their plans. However, if the member does not pay the premium, it is recorded as bad debt and added to the plan administrative expenses. MAOs should follow up with members who are not paying their premiums to help reduce their bad debt expenses.

Considerations: The MAO should consider the size of the plan and expected net premium collection levels that will result from a bad debt collection program.

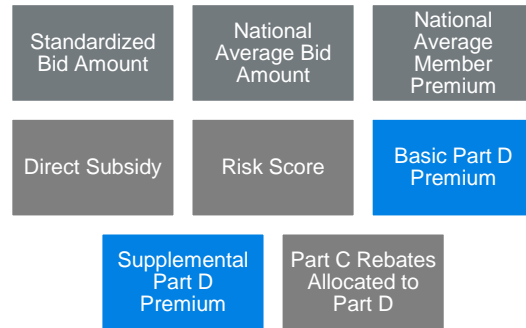
Benchmark Rate	Star Rating	Standardized A/B Bid
Risk Score	MSP Factor	ISAR Factor
Part C Rebates Allocated to Part C	Basic Part C Premium	Supplemental Part C Premium

PART D

Increase member premium

Charging a higher member premium will directly increase revenue.

Considerations: This approach may reduce the plan’s competitive position within its service area and could result in lower membership (i.e., less non-low-income membership if the basic Part D premium is below the LIB, and less total membership if the basic Part D premium is above the LIB). MAOs should consider the sensitivity of their target markets to premium changes. Members located in competitive or saturated markets are more likely to react adversely to premium increases because they have a wider variety of plan options from which to select. However, for plans with a high concentration of low-income members, increasing the basic Part D premium to the LIB will maximize the CMS subsidy, while having no impact on most members.



Increase morbidity of population

Targeting members with higher morbidities will likely result in higher risk scores and CMS risk-adjusted direct subsidy revenue payments.

Considerations: Members with higher morbidity will have higher claim costs, which may offset increases in revenue received due to higher risk scores or result in reduced profitability. MAOs should also consider the opportunity for care management activities in populations with higher risk scores.



Increase accuracy and completeness of risk scores

Increasing the accuracy and completeness of risk scores, via comprehensive risk score coding efforts and proper documentation and submission of risk adjustment data, may result in higher risk scores and CMS risk-adjusted revenue payments for the subsequent year. Improvements in the accuracy and completeness of risk scores and corresponding revenue payments do not increase claim costs. Successful coding programs often incorporate medical record reviews, health risk assessments, and analyses to identify inaccurate or incomplete diagnoses from one diagnosis period to the next.

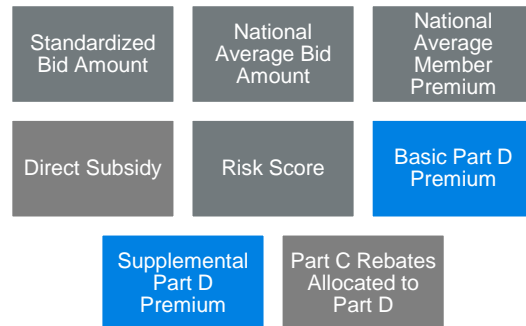
Considerations: The initiatives necessary to improve the accuracy and completeness of risk scores will likely require an increase in administrative costs and will require buy-in and engagement from many areas across the organization, as well as providers. Additionally, MAOs may consider modifying their provider contractual payments to ensure the interests of all parties are appropriately aligned. Risk score coding efforts may yield diminishing returns in risk scores and additional revenue for MAOs with established initiatives already in place. Additionally, Part D coding improvement efforts may not be as lucrative as Part C coding improvement efforts, because Part D revenue is typically much smaller than Part C and Part D risk scores are based on medical diagnoses, with potentially less of a direct correlation to Part D risk scores than Part C risk scores.



Reduce or eliminate bad debt premium

Members are obligated to pay a premium to the MAO if they sign up for coverage in one of their plans. However, if the member does not pay the premium, this is recorded as bad debt and added to the plan administrative expenses. MAOs should follow up with members who are not paying their premiums to help reduce their bad debt expenses.

Considerations: The MAO should consider the size of the plan and expected net premium collection levels that will result from a bad debt collection program.



Final takeaways and conclusions

MAOs face the same challenge as many businesses: increase revenue while decreasing expenses to maximize profitability, while at the same time growing membership. As we have shown, there are many components and approaches to increasing revenue in the MA market. As with any decision an MAO makes, it is important to consider the implementation costs, ongoing efforts, and expected revenue gain for each initiative. Successful MAOs efficiently balance many of these revenue components, while also leveraging their resources to control expenses and grow membership. The complexity of the MA bidding process and revenue formula highlights the need for expertise in bid development, revenue management, and reporting processes. MAOs must ensure that the chosen pathways to increase revenue do not ultimately increase expenses or further reduce revenue in other aspects of their business.

Qualifications and caveats

Please note the opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

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This information is intended to provide a discussion of strategies MAOs could employ to increase their revenue and key advantages and disadvantages of each. The list of methodologies discussed in this article, as well as the advantages and disadvantages, are not exhaustive and careful consideration should be given to unintended impacts of each methodology. This information may not be appropriate, and should not be used, for other purposes. Milliman does not intend to benefit and assumes no duty of liability to parties who receive this information. Any recipient of this information should engage qualified professionals for advice appropriate to its own specific needs.



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Appendix A: Calculation of Medicare Part C Revenue

Projected (Bid) Part C Revenue

TOTAL PART C REVENUE

= Part C Revenue from CMS¹ + Part C Revenue from Beneficiary

Part C Revenue from CMS¹

= Plan A/B Bid Amount - Basic Member Premium + Part C Rebates Allocated to Reduce A/B Cost Sharing + Part C Rebates Allocated to Other A/B Mandatory Supplemental Benefits

Part C Revenue from Beneficiary

= Rounded MA Premium (excl. Opt. Suppl.)

- **Plan A/B Bid Amount:**
MA Worksheet 5, Section II, Item 7
- **Basic Member Premium:**
MA Worksheet 5, Section III, Item 3
- **Part C Rebate Allocated to Reduce A/B Cost Sharing:**
MA Worksheet 6, Section III B, Item 2
- **Part C Rebate Allocated to Other A/B Mandatory Supplemental Benefits:**
MA Worksheet 6, Section III B, Item 3
- **Rounded MA Premium (excl. Opt. Suppl.):**
MA Worksheet 6, Section III C, Item 6

Actual (MMR² and Bid) Part C Revenue

TOTAL PART C REVENUE

= Part C Revenue from CMS¹ + Part C Revenue from Beneficiary

Part C Revenue from CMS¹

= Monthly Payment/Adjustment Amount Part A/B - Part C Basic Premium Part A/B

Part C Revenue from Beneficiary

= Rounded MA Premium (excl. Opt. Suppl.)

- **Monthly Payment/Adjustment Amount Part A:**
MMR Files Position 126-134
- **Monthly Payment/Adjustment Amount Part B:**
MMR Files Position 135-143
- **Part C Basic Premium Part A:**
MMR Files Position 199-206
- **Part C Basic Premium Part B:**
MMR Files Position 207-214
- **Rounded MA Premium (excl. Opt. Suppl.):**
MA Worksheet 6, Section III C, Item 6

¹ Values should be reduced by 2% if calculating post-sequestered revenue amounts.

² Positions in Monthly Membership Detail Data File (MMR) are based on the layout provided in the Plan Communications User Guide for Medicare Advantage Prescription Drug plans, version 13.0, released February 28, 2019.

Appendix B: Calculation of Medicare Part D Revenue

Projected (Bid) Part D Revenue

TOTAL PART D REVENUE

= Part D Revenue from CMS¹ + Part D Revenue from Beneficiary

Part D Revenue from CMS¹

= (Standardized Part D Bid x Projected Average Risk Score) – Basic Part D Premium + Part C Rebate Allocated to Part D Premium Buydown Basic + Part C Rebate Allocated to Part D Premium Buydown Supplemental

Part D Revenue from Beneficiary

= Basic Part D Premium + Supplemental Part D Premium – Part C Rebates Allocated to Part D

- **Standardized Plan D Bid:**
PD Worksheet 7, Section III, Item 1
- **Projected Average Risk Score:**
PD Worksheet 3, Section II, Item 2
- **Basic MA Premium:**
PD Worksheet 7, Section III, Item 6
- **Supplemental MA Premium:**
PD Worksheet 7, Section III, Item 8
- **Part C Rebate Allocated to Part D Premium Buydown Basic:**
MA Worksheet 6, Section III B, Item 5
- **Part C Rebate Allocated to Part D Premium Buydown Supplemental:**
MA Worksheet 6, Section III B, Item 6

Actual (MMR³ and Bid) Part D Revenue

TOTAL PART D REVENUE

= Part D Revenue from CMS¹ + Part D Revenue from Beneficiary

Part D Revenue from CMS¹

= Total Part D Payment – Reinsurance Subsidy Amount⁴ – Low Income Cost Sharing Amount² – Low Income Premium Subsidy Amount^{2,5} – Part D Coverage Gap Discount Amount²

Part D Revenue from Beneficiary

= Basic Part D Premium + Supplemental Part D Premium – Part C Rebate Allocated to Part D Premium Buydown Basic – Part C Rebate Allocated to Part D Premium Buydown Supplemental

- **Total Part D Payment:**
MMR Files Position 379-389
- **Reinsurance Subsidy Amount**
MMR Files Position 359-368
- **LIS Cost Sharing Amount**
MMR Files Position 369-378
- **LIS Cost Sharing Amount**
MMR Files Position 114-151
- **Part D Coverage Gap Discount Amount**
MMR Files Position 448-455
- **Basic MA Premium:**
PD Worksheet 7, Section III, Item 6
- **Supplemental MA Premium:**
PD Worksheet 7, Section III, Item 8
- **Part C Rebate Allocated to Part D Premium Buydown Basic:**
MA Worksheet 6, Section III B, Item 5
- **Part C Rebate Allocated to Part D Premium Buydown Supplemental:**
MA Worksheet 6, Section III B, Item 6

³ Positions in Monthly Membership Detail Data File (MMR) are based on the layout provided in the Plan Communications User Guide for Medicare Advantage Prescription Drug plans, version 13.0, released February 28, 2019.

⁴ Values represent pass-through payments. Plan sponsors receive prospective payments for certain future expected costs. A reconciliation payment is made at the end of the benefit period to align revenues with actual costs.

⁵ Low-income premium subsidy amounts are paid by CMS on the member's behalf and are reported as Part D revenue in the MMR file.