User Group Call Date 12/05/2019

Introductory note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
For COVID-19 policy and benefit related questions: https://protect2.fireeye.com/url?k=8e079ecc-d25387b0-8e07aff3-0cc47adc5fa2-730480acf6095ec9&u=https://ma-covid19-policybenefits.lmi.org/
For Part C policy-related payment questions: PartCpaymentpolicy@cms.hhs.gov
For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
For Part D policy-related questions: partdbenefits@cms.hhs.gov
For questions related to risk score models and released data: RiskAdjustment@cms.hhs.gov
For questions related to the Encounter Data Processing System: encounterdata@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	N/A	N/A	On the CMS Actuarial User Group Call cumulative Q&A File in cell J184 (index 0182) of the "Historic Actuarial UGC Guidance" tab, there is a reference to claims paid outside the system. Specifically, it says about the FFS data file as of 2005 – "This file is about 99 percent complete, and does not include claims paid outside the system which account for an additional 1-to-2 percent of the ultimate incurred claims". a) Is it still the case, since the comment above pertains to the 2005 data file, that the FFS data file excludes claims paid outside the system? The files in question are located at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. b) If the answer to a. is yes, can OACT please provide the amount of claims paid outside the system, split by Parts A/B and year? c) Is there a published data source for this information?	Below are the Part A and Part B "outside the system" FFS claims for CY 2013 through CY 2017, in billions. CY Part A Part B 2013 $5.3 $1.1 2014 $5.4 $1.2 2015 $6.0 $1.6 2016 $7.7 $2.5 2017 $7.9 $2.7 The Office of the Actuary calculates these payments for use in our projections through the Medicare cost reports. The cost reports are publically available, but we are not aware of published summaries of the "outside the system" adjustments to provider reimbursements.
2	FFS Trends	N/A	N/A	The Medicare Trustees report for 2019 lists Medicare administrative expenses of around $9 billion for 2018 (Part A on p44, Part B on p76). The 2020 rate notice lists claims processing percentages corresponding to costs of around $500 million for this same year (p17 of the 2020 rate announcement). Can OACT please clarify which administrative expenses are included in the FFS USPCC calculation? Specifically – does it include only the claims processing costs listed in the rate announcement, or are other administrative expenses as shown in the Medicare Trustees report also included? What is the rationale for what is included in the USPCC?	Only the claims processing costs listed in the rate announcement are included in the FFS USPCC. Other administrative expenses as shown in the Medicare Trustees report are not included. The underlying rationale for including the claims processing costs in the USPCC is found in Section 1876(a)(4) of the Social Security Act. This provision requires that the tabulation of the cost must include "...administrative costs incurred by organizations in sections 1816 and 1842." Sections 1816 and 1842 organizations are the Medicare Administrative Contractors, or MACs. Thus the claims processing costs CMS pays to the MACs are included in the MA rates as required by law.
3	FFS Trends	N/A	N/A	[Paraphrased] For the risk scores used in the standardization of the ratebook FFS rates, can OACT please clarify whether a member's risk score is excluded for the entire year (if he/she was in hospice status at any point during the year) or only for the months in which the member was in hospice status?	The risk scores used in the standardization of the ratebook FFS rate are based on the July cohort for each applicable year. Thus, the ratebook tabulations exclude risk score for beneficiaries in hospice status as of July 1 of each year.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	FFS Trends	N/A	N/A	When developing the FFS Normalization Factor that is applied to MA risk scores, CMS applies the current CMS-HCC risk score model to the five most recent years of data to determine a trend. As it pertains to applying the CMS-HCC model to the Original Medicare population for the development of this normalization factor, how is the overall average risk score calculated? Are those with Part A only or Part B only weighted differently than those with both Parts A and B? Is the overall average risk score member-month weighted or just member-weighted? That is, would a FFS beneficiary with 12 months of coverage be weighted more heavily in the average risk score calculation than a FFS beneficiary with only one month of coverage?	The average FFS risk score for the trend is based on the population of Medicare beneficiaries with Part A and Part B who are not in ESRD or hospice status. The national average risk score is member weighted. Beneficiaries with less than 12 months of Part B coverage are considered new enrollees and receive a new enrollee risk score.
5	Gain/Loss Margin	N/A	N/A	Why are GEIC and D-SNP bids separated for purposes of the aggregate margin test?	The main reason that historically gain/loss margin for D-SNP bids has been reviewed separately from GEIC gain/loss margin is that D-SNPs focus on a particular population and margin for that population may not get the appropriate level of attention if it were combined with the GEIC margin.
6	Gain/Loss Margin	N/A	N/A	Why are Group Medicare and ESRD/Hospice excluded from the calculation of Medicare margins?	Our aggregate margin tests focus on what is in the bid. We no longer have bid data available for group plans, and members with ESRD or in hospice status have, to date, been excluded from the bid development. Ultimately, we concentrate on the population represented in the bid.
7	Gain/Loss Margin	N/A	N/A	With respect to inclusions/exclusions from non-Medicare business, why are other sources of non-Medicare revenue specifically excluded from non-Medicare margin? For example: ASO, Investment Income, Life, Disability Income, etc.	Our goal is to get as close as we can to a similar comparison of insured health business. With regard to investment income, since the bids do not take this into consideration we do not want it in the comparison.
8	Gain/Loss Margin	N/A	N/A	Why is the comparison between Medicare and non-Medicare margin not normalized to account for the fact that Medicare margins are impacted by sequestration while non-Medicare lines of business primarily are not?	Sequestration is applied on the back end to the payment, while the bid shows the total required revenue prior to sequestration necessary to provide the plan's benefits. It is more appropriate to directly compare the pricing in the bid to pricing for other health insurance lines of business. The bid cannot be developed based on a post sequestration amount.
9	Gain/Loss Margin	N/A	N/A	Why use a threshold of as low as 10% of business subject to discretion in rate setting when determining the basis for the non-Medicare comparison in the margin test?	The comparison to non-Medicare is more robust than the comparison to RCS. Thus, OACT designed the instructions to limit the number of bids that use the RCS basis.
10	Gain/Loss Margin	N/A	N/A	What other approaches have been considered in the past to applying an aggregate margin test and what were the issues with those approaches?	In the first few years of bidding, there was no aggregate requirement. Instead, each bid was required to be within a tight range of the RCS requirement. This method offered very little flexibility, so we developed the aggregate tests to offer more flexibility. Alternate approaches we've considered for the aggregate margin are to move away from the Medicare vs Non-Medicare approach in favor of a RCS measurement, or setting a maximum margin level.
11	Gain/Loss Margin	N/A	N/A	When approving rates for other lines of business – Small Group Community Rated business as an example – state regulators are not required to take into account CMS "non-Medicare" aggregate margin requirement. Thus regulators may not approve the rates that a particular MAO would need comply with the CMS aggregate margin requirement. Along the same line of thinking as it relates to the "risk-capital-surplus" basis for the margin test, in using the MAO's risk and capital and surplus requirement prior to the impact of sequestration, the resulting post-sequestration Medicare margin may not be adequate to meet 1) state regulatory capital requirements and/or 2) bond rating agency requirements. How has CMS taken into account these other requirements in designing the aggregate margin test?	If a company were to encounter difficulties in the form of insufficient funds to meet state regulatory capital requirements or bond rating agency requirements, OACT would consider that situation as part of a margin exception request.
12	AE Cost Sharing Factors	N/A	N/A	In the development of Worksheet 3 cost sharing, can projected allowed costs be grossed up to remove the impact of sequestration prior to applying the AE Cost Sharing Factors from Worksheet 4?	When using the unadjusted Worksheet 4 Actuarial Equivalent Cost Sharing Factors on Worksheet 3 under the Medicare FFS pricing option, CMS does not preclude the use of pre-sequestration allowed PMPMs in Worksheet 3 column G.

User Group Call Date 02/20/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	End-Stage Renal Disease (ESRD)	N/A	N/A	Table 25 of the CMS proposed regulation, CMS-4190-P, shows that CMS is expecting an additional 41,500 ESRD enrollees during 2021 in MA plans due to the removal of the prohibition of ESRD enrollment into MA plans. We are concerned about the financial effect that this enrollment expansion will have on our Medicare Advantage plans. Has CMS studied the impact of the ESRD enrollment expansion on MA organizations?	Yes, the Office of the Actuary has studied possible impacts of the ESRD enrollment expansion, including an analysis of the illustrative impact on the 2020 MA bids. The 2020 bid analysis was based on the ESRD base period experience for 2018 reported on MA Worksheet 1, section V. The key data and assumptions used in the projection of the MA ESRD experience MA bid analysis are: • Calendar year 2018 ESRD experience, as reflected in 2020 MA BPT Worksheet 1, Section V was consolidated at the contract level on a per-member per-month (PMPM) basis. To avoid duplication of experience, plans were excluded that had identical bids in the base as represented by the "Bids in the Base" section of Worksheet 1, cells N14 – Q17. Contracts with less than 500 ESRD member months were pooled together. Experience for several contracts were excluded due to known problems with the reported data. The aggregate 2018 experience on a PMPM basis was used for contracts that existed in 2020, but not 2018. • The contract level PMPM values were trended from 2018 to 2020 as follows: o CMS Revenue PMPM were trended using the 2019 and 2020 dialysis ESRD ratebook growth rates of 9.81 percent and -0.48 percent, respectively, resulting in a two-year revenue trend, 2018-2020, of 9.28 percent. o Net Medical Expenses PMPM were trended using the current estimate of ESRD dialysis USPCCs in the 2020 rate announcement resulting in a 2018-2020 medical trend of 5.52 percent. o The 2018-2020 trend for Premium Revenue was set at 0 percent. • The non-benefit expense (NBE) excluding insurer fee for the ESRD population was set conservatively at $400 PMPM for each plan. • The 2020 insurer fee for the ESRD population for each plan was developed from the projected insurer fee in the 2020 MA bid multiplied by the ratio of (ESRD net medical expense plus NBE, excluding insurer fee) to (MA BPT net medical expense plus NBE, excluding insurer fee). More specifically, the ESRD insurer fee equals the MA BPT insurer fee for total benefits (MA BPT Wks 4, cell H104) / Total Medical Expenses and NBE, excluding insurer fee, for the total BPT population (sum of fields in MA BPT Wks 4, cells H98, H100, H101, H102, and H103) * (2020 ESRD net medical expenses + ESRD NBE, excluding insurer fee ($400)). • As reflected in Table 25 of the proposed reg, CMS-4190-P, we estimated the ESRD enrollment in MA plans to increase by average 41,500 members in 2021, based on an OACT analysis that was informed by outside studies and articles. Further, based on the current distribution of MA ESRD enrollment by status, we assumed that 79 percent, or 32,785 average enrollees, of the expanded enrollment would be in non-EGWP plans. The expanded dialysis enrollment of 32,785 average members or 393,420 member months, was apportioned to MA plans in proportion to projected ESRD member months on MA BPT worksheet 5, cell U15. • Contract level 2020 Margin PMPM for the ESRD population = Projected ESRD (CMS Revenue + Premium Revenue – Net Medical Expenses – NBE excluding insurer fee ($400) – insurer fee.) • The aggregate projected 2020 ESRD values, PMPM, are Revenue: $7,344.54; Net Medical: $6,919.63, NBE including insurer fee: $520.43, and a resulting gain / (loss_ margin: -$95.52 The projected 2020 ESRD experience was combined (based on member month projections) with the 2020 MA bid projections to assess the impact of the ESRD expansion for plan. On average, the inclusion of the ESRD experience is projected to impact the plan margin by -$0.23 PMPM or about -0.02 percent of the aggregate plan Total Revenue Requirement, as reported on MA BPT Wks 4, cell H108. This analysis was limited to the effect of expanded ESRD enrollment on 2020 MA bids. The study did not account for other program changes that may be implemented in 2021 such as the carveout of kidney acquisition costs from the ratebooks, updates to mandatory and voluntary out-of-pocket limits, and statutory elimination of the health insurer fee.
2	Medicare Covered	N/A	N/A	The CY 2020 Physicians Fee Schedule file rule, CMS-1715-F, included guidance on the new opioid treatment programs (OTP). Do you have a estimated cost of the OTP coverage expansion?	The estimated Medicare cost of the OTP expansion on the fee-for-service population is $63 million in CY 2020 and $140 million in CY 2021. The corresponding monthly per-capita costs are estimated be about $0.16 in 2020 and $0.35 in 2021. This estimate is based on an assumption of 5,300 average beneficiaries receiving OTP services each week in 2020 and 11,500 average utilizers in 2021. The average weekly benefit cost was assumed to be $229 in 2020 and $234 in 2021.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
3	Fee-for-Service (FFS)	N/A	N/A	As was stated on the February 7 Advance Notice call, the 2021 non-ESRD ratebook FFS growth rate of 2.57 percent is comprised of a prior period adjustment of 1.87 percent and a current 2020-2021 trend of 4.53 percent. It was mentioned on the call that the period adjustment was affected by restatements to enrollment and claims. Can you provide more detail on the impacts of the prior period adjustment?	The prior period adjustment to the 2021 non-ESRD fee-for-service (FFS) ratebook growth rate is primarily due to updates to historical enrollment and claims. The 2021 Advance Notice growth rate is based on revised enrollment for 2017 and 2018 which resulted in a -0.8 percent impact on the 2021 FFS growth rate. There were also some restatements of pre-2017 incurred claims due to re-allocation of Part A home health spending from non-ESRD to ESRD, revisions to tabulation of incurred bad debt expenditures, improvements in modeling of incurred claims for Part A buy in beneficiaries, and re-mapping of some Part B services to new benefit categories resulting in updated historical cash-to-incurred relationships. Collectively, these adjustments to claims experience affected the 2021 FFS non-ESRD growth rate by about -0.7 percent. The remainder of the prior period adjustment is due to emerging claim experience for 2018 and 2019 and revisions to 2020 projection factors. It is also worth noting that the non-ESRD growth rate in the 2021 Early Preview announcement of 4.46 percent reflected a -0.58 percent prior period adjustment.
4	Credibility	01/10/2020 17:17	Feedback on December 2019 Actuarial User Group Call Agenda Topics	[Paraphrased] The instructions for the bid pricing tools state, "CMS does not permit adjustments to the credibility percentages on Worksheet 2 for the purpose of modifying the manual rate. For example, do not adjust the credibility percentages in the BPT as an equivalent alternative to removing the base period experience from the manual rate development." These instructions seem to imply that the BPT must not include the WS1 experience in the manual rate for that bid. Please provide specific guidance as to the credibility to use in WS2. An example would be extremely helpful. For example, assume WS1 experience would normally be 30% credible, and that same WS1 experience comprises 10% of the WS2 manual rate. If the BPT used 30% credibility in WS2, the WS1 experience would effectively receive a weighting of 30% + 10% x (100% - 30%) = 37% in the WS2 Blended Rate.	The manual rate may include Worksheet 1 (base period) experience as a subset. The use of the Worksheet 1 experience in the manual rate must be determined and supported by the actuary. The actuary should refer to ASOP 25 (Credibility Procedures), Section 3.3 (Selection of Relevant Experience): "The actuary should consider the extent to which [Worksheet 1] experience is included in [the manual rate]. If [Worksheet 1] experience is a material part of [the manual rate], the actuary should use professional judgment in deciding whether and how to use that [manual rate]." In the example, if the actuary determines and supports that the Worksheet 1 experience is 30% credible and comprises 10% of the manual rate, then the BPT should use the 30% credibility assumption. The BPT would also use the manual rate, comprised of 10% of the Worksheet 1 experience and 90% of other experience. In the example, if the actuary determines that the Worksheet 1 experience is 30% credible and comprises 10% of the manual rate, but the actuary does not support the extra weight given to the Worksheet 1 experience through its inclusion in the manual rate, then the actuary could modify the manual rate accordingly. In this case, the actuary is not permitted to modify the credibility percentage that is entered in the BPT, as an alternative to modifying the manual rate.
5	Gain/Loss Margin	08/23/2019 16:28	CY2020 Actuarial Lessons Learned	We would like to see more well-defined guidance in the BPT Instructions concerning high gain margins so that our initial submissions would be compliant.	CMS cannot provide specific requirements for compliance because benefit value in relation to the margin level depends on bid-specific circumstances; however, the following approaches are best practices for achieving compliance: 1) For renewing plans, reductions to benefits and/or increases to member premiums from the preceding year may be inappropriate to support a high margin. 2) For renewing plans, incremental benefit and premium changes that improve benefit value in relation to the margin level may be appropriate to support a high margin. 3) For new plans, providing all possible benefits that the expected population can utilize may be appropriate to support a high margin. This practice can be used to minimize or eliminate the high margin for new plans. 4) For new plans, the use of member premiums may be inappropriate to support a high margin. 5) Supporting documentation should provide a useful analysis of premium and benefit changes from the preceding year. 6) Document circumstances that restrict the ability to reduce the margin, for example certain provider reimbursement structures such as global capitation arrangements.
6	Related Party	N/A	N/A	When the sponsor has partial ownership of a related party, can the sponsor remove only the related party gain/loss margin associated with the ownership percentage when reporting the actual cost of the related party in the bid?	The bid instructions are deliberate in not including an option to account for degree of ownership pertaining to related parties. The instructions treat all related parties equally, regardless of the degree of ownership (0% through 100% ownership). The instructions apply to "any form of common, privately held ownership, control, or investment."

User Group Call Date 04/16/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	COVID-19	04/02/2020 16:00	Medicare Advantage Concerns During COVID-19 Pandemic	[Paraphrased and Combined] In light of the unfolding COVID-19 public health emergency, we would like to get guidance from CMS on the following topics as we prepare 2021 bids. 1. What expectations does OACT have for plans as far as reflecting anticipated changes to costs for 2021 for COVID-19, both for MA and PD? 2. What guidance can OACT provide to assist in forecasting potential changes in medical costs in 2021? 3. Is it okay to file service area expansion bid while the state approval is still pending? We are seeing increased delays in getting approvals from the state. 4. Whether the impact of COVID-19 will be taken into account in the exceptions process for 5-year negative margin business plans? Will there be a relaxation of rule around meeting the margin requirement as per the original business plan. 5. Given that most employees are working from home causing difficulty in coordination, would there be some relaxation on the turnaround times during bid desk review from the 48hrs rule?	1. We understand that the uncertainty around assumptions creates a difficult bidding environment. We expect certifying actuaries to make their best estimate assumptions of what costs may be for CY2021 and provide detailed support for all assumptions. 2. The certifying actuary must determine and support the CY2021 assumptions based on the bid specific circumstances. We are unable to provide more specific guidance since the potential impact to medical costs for CY2021 will vary based on geography and other factors. 3. The bid should be submitted based on the counties expected to be in the plan's service area for CY2021 (consistent with the counties submitted for approval). If the service area ultimately is not approved, the plan would need to resubmit the bid to remove the counties that were not approved. Note that only changes related to the county removal would be allowed and that no other assumptions may be changed at this point. 4. The gain/loss margin requirements will not be changed from those detailed in the final bid instructions. Plan sponsors always have the option of submitting a margin exception request, and the impact of COVID-19 on costs will be taken into consideration along with all other details outlined in the exception request. 5. The 48 hour rule for responses during bid desk review will remain, but there is always flexibility when working with our contracted reviewers. Please work directly with your reviewer if you need more time to respond to questions, but keep in mind that the reviewers have more flexibility to extend deadlines during June and less flexibility in July.
2	COVID-19	04/06/2020 12:47	COVID-19 guidance for 2021 bids	What, if any, assumptions should be made surrounding risk score projections given that beneficiaries are not going to their doctors' offices for routine visits. We expect a downward impact to risk score from the cancelled doctors' visits and cancelled non-emergency services.	The certifying actuary must make their best estimate of the projected risk score, taking into consideration how they expect encounter experience to impact risk score data submissions.
3	COVID-19	04/06/2020 16:38	COVID-19 and USPCC	Can you please provide detail regarding the assumptions for COVID-19 costs built into the 2021 FFS USPCC estimates?	The FFS USPCCs do not include any assumption for the effect of COVID-19 on CY 2021 FFS projections.
4	COVID-19	N/A	N/A	Plans are thinking about 2021 bids and seeking information on potential costs for a vaccine for COVID-19. Is this something that plan sponsors should be incorporating into their bids and does OACT have any cost information available?	The CARES act stipulates that any COVID vaccine is covered under the Part B drug benefit. As with other changes anticipated in the contract year, plans are required to include their best estimate of COVID-19 related costs in their CY2021 bid submissions. Plan sponsors should also include support for these projected costs in their supporting documentation for their MA bids.
5	SSM	03/18/2020 7:57	Part D Senior Savings Model - PDE Guidance and BPT Submission	[PARAPHRASED] We are wondering how to fill out the Part D Bid Pricing Tool (BPT) when a plan elects to participate in the Senior Savings Model, particularly as it relates to the additional plan liability in the coverage gap resulting from the difference between defined standard cost sharing and the $35 or less copay. We expect the additional plan liability (reported as PLRO in the PDE) must be reported somewhere in the Part D BPT and reduce the plan's profit margin or increase premiums by increasing administrative cost or supplemental benefit cost. Can you please advise?	The Part D BPT must be completed as though the additional coverage for the model is an enhanced benefit. We recognize that the additional coverage will not be reflected in this way in the PDE. Also, cell E54 on WS6A will become an input cell for plans that are participating in the SSM model and have selected "Y" on WS1 cell P6.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	FFS Trends	04/09/2020 8:23	Questions on the 2021 Rate Announcement Medicare FFS Trends	1. Was there consideration for the impact of COVID-19 on the 2020 and 2021 Medicare FFS trends? If so, please provide the trend impacts on utilization/mix and unit cost, separately for 2020 and 2021, and separately for Inpatient hospital, Skilled Nursing Facility, Home Health, Outpatient hospital, Physician fee schedule, and other Part B services. 2. What is driving the higher Skilled Nursing Facility (SNF) trends in 2020 and 2021 compared to historical trends? Do these trends reflect the impact of the Patient Driven Payment Model (PDPM) and the waiver of the 3-day hospital stay during the COVID emergency period? If so, please provide the trend impact of each of these changes, and any other program impacts, on the 2020 and 2021 SNF trends. 3. What is driving the higher Home Health (HH) trends in 2019, 2020, and 2021, particularly 2020, compared to historical trends? What are the utilization/mix and price trend components of the 2019, 2020, and 2021 trends for the HH service category? Please provide the impact of the Patient Driven Groupings Model (PDGM), and any other program impacts, on the 2020 and 2021 HH trends 4. What are the utilization/mix and price trend components of the 2018 trend for the Durable Medical Equipment (DME) service category? What is the impact of changes in the DME competitive bidding program on the 2018 price trend? 5. For 2019 and 2020 separately, what is the impact of the changes in the DME competitive bidding on the price trends? Does the 2020 trend reflect the impact of changes in fees specified in Section 4410 of the CARES Act for "REVISING PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM THROUGH DURATION OF EMERGENCY"? 6.What is driving the higher Physician Fee Schedule trends for 2019 and 2020, compared to historical trends? What are the components of the 2019, 2020, and 2021 trends for the Physician Fee Schedule service category, separately for each of the following: utilization/mix, RBRVS fee update, payments to MIPS, payments to APMs, and any other program changes impacting the trends?	1. There was no impact of COVID-19 assumed in these projections. The projections were completed before any COVID-19 impact could be determined. 2. The higher SNF trends in the projection are due to a return to the longer trend results in both utilization and case mix. The assumption was made that the recent past has shown large decreases which will not continue into the future. Instead, a return to the longer trend averages was used for the projections (0% growth in utilization and 1.5% growth in case mix). We assumed that the PDPM requirements have no impact on trend and we did not reflect any estimated impact(s) of COVID-19. 3. The trends before 2019 included adjustments to the price component for rebasing and case mix adjustments. Those did not occur in 2019 or later. This caused larger increases in these years than the previous few years. In addition, a 30-day episode payment began in 2020 as opposed to the old 60-day payment. At first, it was believed that this would be implemented in a budget neutral manner. However, when the system was finally implemented, the payment determination was not done in a budget neutral way, but instead resulted in an estimated 4% increase in payments in 2020. This 4% increase was due to both the change to a 30 day episode and the implementation of PDGM. This amount will be recovered in a few years once data comes in and we are able to determine the actual amount of the overpayment (we are assuming this will occur in 2022). This, and a return to the longer term trends for utilization (1%) and case mix increases (1.5%), were used in the projection (for home health the recent experience is closer to the longer term trends than for SNF). 4. Prices for non-competitively-bid areas were increased 5.8% starting in June 2018. Other price updates were 0.8% for 2018. Volume and intensity growth was 13.3% in 2018. Volume for certain braces greatly increased in 2018, which has resulted in criminal charges being filed against some DME suppliers. 5. There was no impact of COVID-19 or the responding legislation assumed in these projections. The projections were done before any impact could be determined. Prices for non-competitively-bid areas were increased 5.8% starting in June 2018, and this has an impact of 5.8% for the first 5 months of 2019. 2020 has no assumed changes due to competitive bidding. 6. The trends for 2019 are based on actual claims experience. The 2020 assumptions are based on historical trends. The price update for 2019 was 0.25%, and for 2020 and 2021 is 0%. Volume and intensity growth was 2.3% in 2019, and is assumed to be 2.1% in 2020 and 2.1% in 2021. MIPS payments start in 2019. The MIPS payment adjustment is budget neutral, and the MIPS additional payment adjustment is a total Medicare cost of $500 million each year. The 5% bonuses for qualified participants in advanced APMs are estimated to change Medicare spending by 0.3% in 2019, 0.3% in 2020, and -0.1% in 2021.
7	Growth Rates	03/04/2020 16:01	CAR T-cell Therapy	MA plans will be responsible for CAR T-cell therapy and services for certain types of cancer starting CY 2021. To help MA plans estimate costs, what utilization and unit cost information does CMS have? 1) How did CMS include the CAR T-cell therapy into the growth rate? 2) What assumptions did CMS make for including CAR T-cell therapy into the growth rate	The USPCCs include the cost impacts of CAR T-cell therapy services provided through both outpatient and inpatient settings. We have six quarters of experience with the CAR T-cell therapy benefit provided through hospital outpatient departments (2nd Quarter 2018 through 3rd Quarter 2019). In 2018, 14 patients received CAR T-cell therapy at an average cost of $464,000 per patient. In 2019, 24 patients received CAR T-cell therapy at an average cost of $427,000 per patient. Averaged across all Medicare FFS beneficiaries, the hospital outpatient per-member per-month cost of CAR T-therapy coverage in FFS is $0.02 in 2018 and $0.03 in 2019. We anticipate that a summary of recent hospital inpatient experience for CAR T-cell services will be included in the fiscal year 2021 hospital inpatient prospective payment system (IPPS) proposed rule.

User Group Call Date 04/16/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Growth Rates	02/25/2020 0:00	Questions regarding Growth Rate in CY 2021 Advance Notice	We note that there is a significant difference between the FFS USPCC Growth Rate of 2.57 percent and the National Per Capita MA Growth Percentage of 4.52 percent. CMS explained in a User Group call on February 20, 2020 that the revised 2017 and 2018 historical FFS enrollment resulted in a negative 80 basis point impact on the 2021 FFS growth rate1. Will OACT please clarify whether Total enrollment also increased or there was a movement of members between MA and FFS? If total enrollment increased, please provide the years impacted as well as the impact of revised historical total enrollment on the 2021 Total USPCC growth rate. We also request that CMS provide additional details about the 2017 and 2018 populations that was previously not captured in the USPCC development to help us understand why 2017 and 2018 FFS enrollment is increasing. Additionally, based on our calculations using the data from the 2020 Final Notice, the 2018 FFS enrollment restated to be approximately 250,000-300,000 higher than previously reported. However, a comparison of the total FFS enrollment from the 2018 FFS cost data by county2 used in the development of the 2021 ratebook to the published 2017 FFS cost data by county3 used in development of the 2020 ratebook indicates FFS Part A and Part B enrollment is decreasing by 42,500 and 219,700, respectively. Will OACT please explain why the change in enrollment from the FFS cost worksheets does not support the statement about higher FFS enrollment restatements?	The enrollment change affected both the non-ESRD FFS and total USPCC baselines. The impact on the CY 2021 USPCC is about -0.45 percent. The increase in the 2017 and 2018 enrollment was due to a revision in the baseline and corresponding update in the tabulation of total and FFS enrollment. These are two distinct issues. That is, the first item pertains to tabulation of 2017 enrollment and 2018 enrollment under two separate baselines. The second issue is the change in enrollment reflected in the county-level ratebook data from 2017 to 2018.
9	Growth Rates	04/02/2020 16:02	Growth Rate and Benchmark Questions	Could you please quantify the impact of including acupuncture as a Medicare benefit?	On January 21, 2020 CMS issued a National Coverage Decision "to cover acupuncture for Medicare patients with chronic lower back pain." We are in the process of estimating the cost of this NCD.
10	Growth Rates	04/02/2020 16:02	Growth Rate and Benchmark Questions	Were kidney acquisition costs for MA enrollees included in the 2021 growth rate? If so, could you please quantify it?	No, the baseline supporting the 2021 ratebook growth rates does not reflect an assumption for the change in MA kidney acquisition cost payment beginning in 2021.
11	Growth Rates	04/02/2020 16:02	Growth Rate and Benchmark Questions	We would like to better understand the kidney acquisition cost (KAC) removal from Part C benchmarks. In the CMS file "Preliminary Kidney Acquisition Cost Carve-out Factors.xlsx", total KAC amounts for non-ESRD/nonPACE beneficiaries are about 12.6 times higher than for Dialysis/NonPACE. When we analyze 2018 Limited Data Set claims, we find a much higher rate of kidney transplants for Dialysis beneficiaries than for non-ESRD. Can you please explain why the KAC amounts are so high for NonESRD/NonPACE?	Pages 36-42 of the "Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" available at https://www.cms.gov/files/document/2021-announcement.pdf emphasizes that kidney acquisition costs are included in pass-through costs and that these pass-through costs are allocated over all discharges (regardless of transplant or ESRD status). Since section 17006(b) of the 21st Century Cures Act excludes the costs for kidney acquisitions from MA capitation rates and benchmarks beginning with 2021 (including the non-ESRD county rates), we must carve-out these costs in a consistent manner. Because most Medicare beneficiaries do not have ESRD, it is not surprising that their share of kidney acquisition costs would be very high. The rate of transplants for ESRD vs. non-ESRD has no bearing on these calculations.
12	Cost Sharing	01/08/2020 15:55	Fee For Service Equivalent Benefit Design and VBID	Please consider a Dual SNP that files a Fee For Service Equivalent benefit package that wants to use a VBID for diabetics who participate in their diabetes disease management program. The benefit would be eliminating the cost sharing on diabetic monitoring supplies. Would the Dual SNP be able to use Fee For Service Cost sharing factors in categories other than diabetic monitoring supplies? Or would the VBID exception violate the condition that a plan must match Fee For Service cost sharing for all Medicare covered benefit categories?	Participating in VBID programs is considered an exception to the condition that plans must match Fee For Service cost sharing for all Medicare-covered benefit categories. In this example, the D-SNP is permitted to use the fee for service cost sharing factors for all categories other than diabetic monitoring supplies.
13	Related Party	N/A	N/A	If we have a related party that has a global capitation arrangement, may we compare it to an unrelated party with a global capitation arrangement that is very similar but not exactly the same arrangement?	This comparison is permitted in certain circumstances. It must be shown that the two global capitation arrangements are sufficiently similar, for example that they are the same except for the ancillary services covered.
14	Related Party	N/A	N/A	We would like to use the market comparison method (Method 2) to meet the related party guidance. Must the comparison be in the same service area?	The service areas need not be identical as long as the MAO supports that they are comparable. An example of a comparable situation would be when an MAO contracts with a national provider for a particular service such as dental or vision benefits with comparable national fees.
15	Related Party	N/A	N/A	For purposes of testing a related party contract, do all services need to use the same testing method.	No, but the use of more than one method must be supported and not be arbitrary. For example, excluding a set of services because they cause the test to fail, is not acceptable. However, if a related party contract covers 10 services and the unrelated party contract covers 9 of these services, then the MAO may use market comparison for the 9 services in common and another method for the tenth service. Further, if there is a market comparison for a related-party arrangement in one bid's service area, but not in another bid's service area, then different methods may be used for the different bids. This response is related to the response from the 5/17/2018 UGC.

User Group Call Date 04/16/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
16	Related Party	03/25/2020 14:32	Related Party - Method 3	We are using Method 3 (Comparable to Medicare FFS) to demonstrate that our contract with a related party is within 5% of Medicare FFS. Note that in addition to fees paid to the related party, our contract with the related party includes provider incentives that assess overall performance (not service category specific performance) when determining provider incentives payments associated with the related-party contract. According to section 13.2.5 of Appendix B of the 2021 draft bid instructions, Medicare advantage sponsors may demonstrate that one or more services are comparable when the utilization of the related party is priced through the unrelated-party arrangement and the financial results are within 5 percent or $2 PMPM, whichever is greater. Please confirm the above provision in the bid instructions means it is acceptable for us to demonstrate that the results of pricing the utilization of all services provided through Medicare FFS are within 5 percent or $2 PMPM, whichever is greater.	Yes, OACT will accept the pricing of the related party arrangement's utilization through Medicare FFS as a valid method for a related party comparison. This opens Method 3, Comparable to FFS, to the utilization test. Please note that all provider incentives must be included in the related party cost when making the comparison.
17	Related Party	04/13/2020 17:12	BPT Instructions Question	In the Final CY2021 MA BPT Instructions Appendix B Section 13.2 has undergone significant revisions relative to the Draft CY2021 Instructions. Can OACT provide clarification as to why corresponding revisions were not made to Appendix B Section 13.2 in the Final CY2021 Part D BPT Instructions?	Edits were not made to the Part D Instructions because they were determined to be unnecessary. Although examples were presented supporting the use of more than one comparison method for MA, only one comparison method may be used for Part D. The other changes to the MA instructions were to clarify statements that plan sponsors found to be confusing. These statements were deemed to be sufficiently clear in the Part D instructions.
18	Rebate Reallocation	N/A	N/A	With respect to the guidance that CMS will not allow the MAO to eliminate or significantly reduce one benefit and then add or significantly enhance another benefit, if an MAO's Part D basic premium net of rebates shifts from $0 to -$3 is the MAO permitted to add $3.90 value of dental benefits (assuming the MAO only has limited negotiated dental benefit packages priced at $1.00, $2.00, $3.90, and $5.00), and then remove a vision benefit or reduce an OTC benefit worth $0.90? Is this offset in benefit changes to match the $3.00 rebate shift to return to the Part D target premium acceptable?	Yes with support that the dental benefit cost is $3.90 rather than $3, this example would be acceptable. However, an addition of $15 in dental benefits offset by a reduction of $12 for other mandatory supplemental benefits would not be permitted.
19	Gain/Loss Margin	N/A	N/A	If the plan sponsor can show that a particular plan, which is not in a product pairing, is not anti-competitive and that the financial outcome for the plan does not jeopardize the financial solvency of the MAO, may the plan sponsor request an exception to have a negative margin for more than five years?	Yes, plan sponsors in this situation should refer to Appendix B of the MA Bid Instructions, Item 8.6.4 which states the requirements for bids that have negative margins for more than five consecutive years.
20	Gain/Loss Margin	N/A	N/A	Regarding anti-competitive support, would a comparison of a plan's current year benefits and premium against those offered by competitors and a demonstration that the plan's benefits and premium are not substantially changing in the bid year (e.g. as measured by total beneficiary cost) be acceptable?	Yes, this would be an acceptable demonstration.
21	Gain/Loss Margin	03/11/2020 17:13	Non-Medicare margin from BPT instructions	We have a question regarding MA BPT instructions. On page 27, it states "The non-Medicare business must be calculated consistently with what is reported as net underwriting gain (loss) or net income (loss) in the financial statements without adjustment". This is new language added this year. We are concerned that the financial statement margin and the Bid Pricing Tool (BPT) margin are not reported on the same basis. Financial statements follow GAAP accounting rules, while the BPT margin requires adjustments and/or exclusions to revenue and expenses. As an example, CMS requires that sequestration be excluded in the BPT, but it is included in the financial statement as a reduction of revenue. This discrepancy results in lower reported margins in the financial statements vs. the BPT. Another example is that the BPT is adjusted for related party arrangements whereas the financial statement is not. Can you clarify this new language from bid instructions? We recommend that CMS allow for adjustments that would reconcile margins on the same basis.	Our goal in adding this statement to the bid instructions was to give more guidance on our expectation of the non-Medicare margin reference point. Thus we have pointed to the line items in the financial statements on which we expect the corporate target to be based. This measure should not be adjusted from what is reported in the financial statements. We recognize that there is a difference between what is reported in the bid and what is reported in the financial statements. In the event that following this guidance leads to difficulty in meeting the margin guidance, include well documented support of these differences for our consideration in any margin exception request you submit.

User Group Call Date 04/16/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
22	Projection Factors	03/30/2020 14:37	Projection Factor Adjustment	We are seeking guidance on whether a projection factor adjustment for the following situation is permissible. An MAO's worksheet 1, section III data is in compliance with the paid claims run-out required by the following Medicare Advantage BPT Instructions: "The experience data must be based on calendar year 2019 data with at least 30 days of paid claim run-out; 2-3 months paid claim run-out is preferable". Before initial bid submission in June, the MAO gains an additional month or two of paid claim run-out for incurred year 2019 but does not have sufficient time to restate all the data appearing on worksheet 1, section III. Would the MAO be permitted to make a projection factor adjustment to account for the impact the extra months' paid run-out would have on the projected claims shown on worksheet 2? If this is permitted, should the date reported as the "Paid through" date on worksheet 1 be consistent with the data in section III, or should it reflect the additional months incorporated into the projection factor adjustment?	Do not adjust the projection factors. Instead, prorate the change in incurred claims across all benefit service categories in the Net PMPM and Allowed PMPM columns of Section III on MA worksheet 1. You do not need to update the utilization information on Section III. Do not change the paid through date. The paid through data must correspond to the date that the detailed paid claims were determined. The completion factor should change to reflect the new difference between the paid claims and the incurred claims.

User Group Call Date 04/23/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Ratebook	N/A	N/A	We have attempted to reconcile the published non-ESRD fee-for-service (FFS) USPCC values for 2017 and 2018 with the county-level FFS ratebook support and are not able tie out the figures. The FFS USPCC values published in the 2021 Rate Announcement are $821.89 for CY 2017 and $848.61 for CY 2018. Can you explain how we can reconcile the two items?	Yes, we can explain how to reconcile the two sources. First, it is worth noting that the published USPCC values are presented on a pre-sequester basis and include a loading for claims processing costs. This compares to the ratebook FFS values that are post-sequester and do not include claims processing costs. Applying the sequestration adjustment and removing the claims processing costs, reduces the published CY 2017 value from $821.99 to $804.22 and the CY 2018 value from $848.61 to $830.32. The tabulation of PMPM values from the unadjusted 2017 county level FFS data yields a PMPM value of $779.53, which is 3.1 percent lower than the corresponding USPCC value of $804.22. Once the adjustments for the 2017 innovation model payments and HPSA bonuses are added, the resulting ratebook value is $784.59 PMPM, which is 2.4 percent lower than the USPCC value. The 2.4 percent difference between the ratebook and USPCC value is attributed to experience reflected in the USPCCs but not the ratebook including, but not limited to, provider settlements, bad debt payments, and experience for A-only and B-only Puerto Rico beneficiaries. Comparable tabulations for 2018 yield unadjusted ratebook PMPM values of $805.45 based on the county-level FFS data, and $811.96 including adjustments for innovation model payments and HPSA bonuses, which are respectively 3.0 percent and 2.2 percent lower than the USPCC values. The 2.2 percent difference between the ratebook and USPCC value is attributed to experience reflected in the USPCCs but not the ratebook including, but not limited to, provider settlements, bad debt payments, and experience for A-only and B-only Puerto Rico beneficiaries.
2	COVID-19	04/14/2020 10:49	Actuarial User Group Call Question - COVID Impacts	[PARAPHRASED] 1) We would like to know if the following COVID-related items are represented in the USPCC projections supporting the 2021 MA ratebook growth rate: • Calendar year 2021 expenditures for COVID admissions, vaccines, and antibody tests • An adjustment to account for potential pent-up demand from 2020 health care being pushed into 2021 given safety and capacity concerns and delays in elective treatments • An adjustment to DSH and uncompensated care for expected increases in the number of insured for FY 2021 IPPS 2) The CARES Act included a 20% add-on payment for admissions with COVID ICD10. While that additional payment is not permanent is CMS anticipating any additional changes for the IPPS update in October 2020 or OPPS in January of 2021?	1) No, the baseline supporting the 2021 ratebook USPCC projections does not reflect these, or any other, COVID-related assumptions. 2) The proposed FY 2021 Inpatient PPS (IPPS) and Outpatient PPS (OPPS) regulations have not been published. Therefore, we are not in a positon to comment on the corresponding regulatory provisions.
3	Part D	04/10/2020 12:23	Clarification on Conflicting Guidance on Non-Uniform Part D Deductibles	[Paraphrased] We would like to get clarification on some conflicting guidance that has recently been released by CMMI. An excerpt from page 2 of the 3/23 CMMI memo suggests that costs for drugs not subject to the Part D deductible should still accrue towards the deductible. Then, CMMI reiterated this guidance in the FAQ memo released on April 9th 2020, which can be found in the following link: https://innovation.cms.gov/media/document/partd-senior-savings-model-cy21-faqs However, the longstanding guidance from CMS has been that costs for drugs not subject to the Part D deductible do not accrue towards the deductible Please confirm that there is no change in the application of non-uniform deductibles, and that the guidance in the 9/20/2011 Chapter 5 of the Medicare Prescription Drug Benefit Manual and the 5/3/2012 CMS response cited above are still valid and not superseded by the 3/23/2020 CMMI memo. Furthermore, please confirm that applicable insulin in the Part D Senior Savings Model will also follow the current treatment of non-uniform deductibles such that costs for insulin that is not subject to the deductible should not accrue towards the deductible.	Additional guidance is forthcoming on this issue. There is no need to change existing processes at this time.

User Group Call Date 04/23/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	Rebate Reallocation	04/16/2020 15:42	BPT Instructions Change	Below is a change in the rebate reallocation section (on page 131) of the 2021 Bid Instructions. The BPT must reflect the value of A/B mandatory supplemental benefits added or eliminated as a result of rebate reallocation and may include the impact of such changes on other pricing assumptions, consistent with the pricing approach and methodologies utilized in the initial June bid submission. (That is, incremental changes in the cost of benefits and the MA regional PPO benchmark must "flow-through" the original pricing structure supporting the initial June bid submission.) Examples include, but are not limited to changes in— • Projected allowed costs due to induced utilization related to changes in cost sharing... We are unclear what the wording is trying to indicate. Does the wording above indicate the induced utilization factor must remain fixed, even if you modify cost sharing during the rebate reallocation period? Or is the intent to say the opposite? For Additional clarity, I have created the example below: Submission / Copay / IU Factor / IU Factor – Used in Pricing June Submission / $5 / 1.00 / 1.00 Rebate Reallocation - Option #1 / $10 / 0.90 / 0.90 Rebate Reallocation - Option #2 / $10 / 0.90 / 1.00	The pricing model is not to be altered during rebate reallocation. Thus if the model at the time of the June bid submission was to associate 1.0 induced utilization with a $5 copay and 0.9 induced utilization with a $10 copay, then if the copay is changed from $5 to $10 the induced utilization should be changed from 1.0 to 0.9. The instruction is meant to make clear that the model may not be changed or updated between the initial bid submission and the rebate reallocation. In this example Option #1 is correct.
5	Cost Sharing	04/21/2020 10:25	Medicare FFS cost sharing	According to the guidance in the Medicare Advantage bid instructions, there are requirements for electing the option to use the Medicare FFS Equivalent cost sharing amounts in creating the bid for a PPO plan. These requirements are as follows from the bid instructions (on Page 17) For a local PPO or a regional PPO bid, the Medicare FFS cost sharing pricing option is available only for all Medicare Part A and Part B services. • The deductible in the PBP must be— - "Medicare-Defined Part A and B Deductible amount combined as a single deductible." - "Differentially applied to Part A and Part B Medicare services, reflecting Original Medicare payment structure." Please confirm or correct the following about the two requirements listed for the deductible in the PBP: 1. The first bullet refers to how the deductible is entered into the PBP; it does not refer to how the deductible will be applied. 2. The second bullet describes how the two deductibles will be applied during the contract year. 3. The "Medicare Defined Part A and Part B deductible" constrains the plan to only use the actual Medicare FFS Part A and Part B deductible that are applicable for the contract year. A plan wanting to use Medicare FFS cost sharing in a 2021 bid for a PPO plan would have had to: a. use acceptable estimates of these deductibles for these parameters when submitting the PBP by the first Monday in June 2020. b. set these deductibles precisely to those levels of these 2021 deductibles when they became known later in 2020. (I.e. the plan could not use values for these deductibles that deviated from these 2021 Medicare FFS deductible levels.)	Yes, this is the correct interpretation of the bid instructions.
6	Deadlines	N/A	N/A	Will CMS consider changing the supporting documentation requirements for bid-level negative margin business plans to be available upon request, as this information does not directly affect the bid inputs?	CMS agrees with this change; therefore, CMS is changing the timing of the following supporting documentation requirements (as listed in Appendix B of the CY2021 MA and Part D bid instructions) from "Initial June Bid Submission" to "Upon Request by CMS Reviewers:" - 8.6.2. (bid-specific business plan for a new bid with a negative gain/loss margin) - 8.6.3. (bid-specific business plan for a renewing bid with a negative gain/loss margin) - 8.7. (justification for a bid-specific business plan that does not achieve profitability within five years).

User Group Call Date 04/30/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	COVID-19	N/A	N/A	Will MAO's be responsible for the cost of a COVID-19 vaccine?	• 1852(a)(5) and § 422.109 provide CMS authority to pay for certain new Medicare benefits with significant costs through FFS Medicare until the costs for the new benefits are factored into the Medicare Advantage payment benchmarks. • OACT performs that significant cost assessment, based on thresholds defined in regulation, once the benefit becomes available in FFS, and a FFS price is determined for the service. • The significant cost criteria include an estimated impact of a particular legislative change representing at least 0.1 percent of the national average per capita costs. • The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) specifies coverage for a COVID-19 vaccine by Medicare Part B without cost sharing. • This legislative change would trigger a significant cost assessment for a COVID-19 vaccine. • A significant cost assessment can't be performed until more details are known about the actual indications and pricing of a potential COVID-19 vaccine. • Based on the criteria, a potential vaccine will either be determined to meet the significant cost assessment threshold or be expected to have smaller than a 0.1 percent effect on overall Medicare spending. • Either way, it is expected that MAOs will not be responsible for significant costs associated with a potential COVID-19 vaccine in CY2021.
2	DE#	04/21/2020 11:28	Cost Sharing with DE# Safe harbor	[Paraphrased and combined] We have plans where the DE# projected member months are less than 10 percent or greater than 90 percent of the total projected membership, and the certifying actuary chooses to set the WS2 Non-DE# and DE# projected allowed costs equal to the projected allowed cost for the total population. WS3 is based on the benefits outlined in the PBP which will be paid by the non-DE# beneficiaries and does not reflect the limited cost sharing for the DE# beneficiaries, as required by the Instructions. In Appendix G of the CY2021 MA BPT Instructions, the table on page 141 outlines the determination of certain BPT values when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2 and indicates that plans with <10% or >90% projected DE# should enter only non-DE# information into Worksheet 3 for the Utilization and PMPM values. In prior years, plans were allowed to enter non-DE# or total values. On Worksheet3, is it acceptable to use the same total population utilization that is used for Worksheet 2 column p, or does Appendix G require us to use the non-DE# utilization and PMPMs? If this is not acceptable, we are concerned that the Worksheet 2 column p Allowed and Worksheet 3 Cost Sharing both flow into the calculation of projected net cost on Worksheet 4 for non-DE# beneficiaries and the two pieces would be based on different utilization assumptions. Furthermore, we are concerned that, in the situation where a plan's DE# projected member months are greater than 90%, the utilization used to develop projected cost sharing may not be credible and may drive unreasonable cost share estimates on Worksheet 3. Lastly, for Platino plans there is no Non-DE# membership; and, without using the utilization of the total population we are unable to populate Worksheet 3 column g.	The goal is to have Worksheet 3 represent the cost sharing for members who will be paying the cost sharing, but we recognize that when the DE# population is in the safe harbor, that is less than 10 percent or greater than 90 percent of the total population, then using only non-DE# values to populate worksheet 3 will make the cost sharing either inconsistent with worksheet 4 or not credible. Thus we are returning to the guidance in the beta release of Appendix G which stated that when the DE# population is less than 10 percent or greater than 90 percent of the total population and the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2 then the utilization and PMPMs on Worksheet 3 may be completed using either non-DE# or total values.
3	PBP to BPT Mapping	04/21/2020 16:58	Medicare-covered Acupuncture	Guidance from the Contract Year 2021 Medicare Advantage Bid Review and Operational Instructions memo released on Apr 20, 2020 states "For CY 2021, cost sharing and other parameters for Medicare-covered acupuncture services should be incorporated into the appropriate PBP service categories in B-7." From a BPT-to-PBP mapping and pricing perspective for Medicare-covered Acupuncture, should the "appropriate PBP service category" be 7D Specialist or 7G Other Health Care Professional?	For CY 2021, cost sharing and other parameters for Medicare-covered acupuncture services should be incorporated into the appropriate PBP service categories in B-7. Supplemental acupuncture benefits will continue to be entered in PBP service category B-13a. Reasonable and supported mappings may be used at the certifying actuary's discretion. Please reference appendix F of the MA Bid instructions for the suggested PBP to BPT Mapping.
4	Part D	N/A	4/23 UGC Chat Q&A	Regarding the Part D Senior Savings program, will the additional cost-sharing reduction in the gap (between the defined standard and the $35 cost-share threshold) be considered Non-covered Plan Paid and therefore be excluded from the Risk Share calculations?	The additional cost-sharing will be considered PLRO for purposes of PDE reporting and therefore not included in the risk share calculations.
5	Risk Score	N/A	4/23 UGC Chat Q&A	Can you provide more guidance on the additional required filtering logic adjustment to risk scores? When is the adjustment required and what is an appropriate way to calculate it?	Adjustments for "filtering logic application updates" is language that we added in for prior years when the filtering programming was being revised, and left it here in case plans think they need to use such an adjustment. Plans using the beneficiary or plan-level data files provided by CMS to project risk scores do not have to consider this adjustment, because the provided risk scores are based on the most current filtering logic. For specific questions, email the risk adjustment mailbox at riskadjustment@cms.hhs.gov.

User Group Call Date 04/30/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	Risk Score	N/A	4/23 UGC Chat Q&A	When we loaded the beneficiary files, they seem to have additional decimal places. Where can we find the layout for the beneficiary files?	The layout for the 2021 beneficiary files can be found in the April 16, 2020 HPMS memos titled, "Incoming File from CMS: Beneficiary-level file to support 2021 Part D bids" and "Incoming Files from CMS: Beneficiary-level file to support 2021 Part C bids & ESRD Risk Scores". If you have specific questions, please email the risk adjustment mailbox at riskadjustment@cms.hhs.gov.

User Group Call Date 05/07/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rates	05/04/2020 12:08	Two Questions for the 5/7/2020 User Group Call	Question #9 during the 4/16/2020 User Group Call included the following question and response: Question: Could you please quantify the impact of including acupuncture as a Medicare benefit? Response: On January 21, 2020 CMS issued a National Coverage Decision "to cover acupuncture for Medicare patients with chronic lower back pain." We are in the process of estimating the cost of this NCD. Could CMS provide an update on when the estimated cost of this NCD will be communicated?	CORRECTED 5-21-2020 The estimated cost in 2020 of the acupuncture benefit for chronic lower back pain is $0.47 PMPM. We have determined that this estimated cost does not exceed the 2020 NCD significant cost threshold and therefore the acupuncture benefit will be covered by Medicare Advantage plans in 2020. We have not completed the NCD cost assessment for CY 2021, but fully expect that the cost will be less than the 2021 significant cost threshold. Additional information on the acupuncture benefit can be found in the April 20, 2020 HPMS Memo titled "Contract Year 2021 Medicare Advantage Bid Review and Operational Instructions."
2	Growth Rates	05/04/2020 15:50	Questions on the 2021 Rate Announcement Medicare FFS USPCCs	In the 2/20/2020 Actuarial Bid Questions regarding the opioid treatment program (OTP), CMS states: "The estimated Medicare cost of the OTP expansion on the fee-for-service population is $63 million in CY 2020 and $140 million in CY 2021. The corresponding monthly per-capita costs are estimated be about $0.16 in 2020 and $0.35 in 2021." Are the $0.16 and $0.35 projected PMPM amounts included in the FFS USPCCs published in the 2021 Rate Announcement? If different estimates of the OTP expansion are included in the FFS UCPCCs, please provide those 2020 and 2021 PMPM amounts.	Yes, reflected in the FFS USPCCs in the 2021 Rate Announcement are estimated OTP costs of $63 million in CY 2020 and $140 million in CY 2021.
3	Growth Rates	05/04/2020 15:50	Questions on the 2021 Rate Announcement Medicare FFS USPCCs	What are CMS' 2020 and 2021 PMPM cost estimates for the Medicare coverage expansion of telehealth that began in 2020? Are these amounts included in the FFS USPCCs published in the 2021 Rate Announcement?	As reflected in the final CY 2020 physician fee schedule rule (PFS), CMS-1715-F, three services used in the treatment of opioid use disorder (OUD) have been added to the "telehealth list." The corresponding HCPCS codes are G2086, G2087, and G2088. Also, it is stated in in section VII of the regulation, Regulatory Impact Analysis, that "we estimate there will only be a negligible impact on PFS expenditures from these additions." Accordingly, OACT did not prepare a cost estimate for the CY 2020 telehealth expansion and did not add an explicit adjustment for the telehealth expansion to the FFS USPCCs included in the 2021 Rate Announcement.
4	FFS Trends	04/28/2020 3:18	Trend questions	1. Could you please confirm if the change in DSH/UCP payments were included in the unit cost trends? If not, could you please provide the expected impact of DSH/UCP payment change on the inpatient unit cost trends from 2020 to 2021? 2. Could you please provide the impact of baby boomers on the overall trend from 2020 to 2021 for Part A and Part B services separately?	1. Spending for Medicare disproportionate care hospital (DSH) payments and Uncompensated Care Payments (UCP) is not reflected in the 2019-2021 unit cost trend exhibit. The estimated combined spending for DSH and UCP is $12.21 billion in CY 2020 and $12.63 billion in CY 2021 resulting in a '21/'20 trend of 3.4 percent. 2. The estimated impact of changing demographics on 2021 FFS trends is -0.5 percent for Part A and -0.1 percent for Part B.
5	FFS Trends	04/28/2020 14:52	Home Infusion Benefit	Please provide information regarding expected costs for the new Home Infusion benefit documented by the following website and effective 1/1/2021. https://www.cms.gov/files/document/se19029.pdf Specifically, can you indicate: 1) Is this benefit included in the FFS USPCC trend? And 2) What is the expected PMPM costs of this benefits in 2021?	The home infusion benefit is represented in the 2021 FFS ratebook growth rate and USPCCs and the projected impact on CY 2021 FFS spending is about $0.01 PMPM.
6	Part D Related Party	04/30/2020 11:20	Related Party Documentation Question e-secure	Background 1) Medicare Advantage Organization (MAO) has an over-the-counter (OTC) benefit which pays an allowance up to a monthly limit. 2) MAO has a related party which plans to newly offer OTC services. 3) Related Party will have a single set of OTC prices that will apply to Medicare beneficiaries independent of insurance. The MAO would like to use the "method 2 market comparison - through the related party" approach to document the services received from the related party. However, there is no contract for the non-Medicare covered benefit expense. Rather, all customers effectively pay 100% of charge. Would CMS allow this related party method to be used for this type of arrangement, specifically noting that there are no "actual contracts" available for review by CMS?	Use of the market comparison through the related party for an arrangement where "all customers effectively pay 100% of charge" must include a written contract that includes a fee schedule between the two parties so there is information to reprice claims when comparing the utilization, or to demonstrate that the contracts are "identical."
7	Part D	05/04/2020 17:11	PD Negative Standard Bid	Is it permissible for a Part D bid to have a negative standardized bid amount as long as the supplemental benefit more than offsets it?	Yes, the BPT permits negative standard bid amounts but does not permit negative total premium.

User Group Call Date 05/14/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Non-Benefit Expense	05/05/2020 12:34	Question Regarding Commission Allocation for 2021 Medicare Bid	We have a question regarding allocating commission between Part C and Part D. We pay the same commissions for MA Only plans and MAPD plans. Is this sufficient justification for applying 100% of commission to MA NBE?	No, a commission paid for an MA-PD plan must be split proportionately between the MA and PD BPTs.
2	Non-Benefit Expense	05/11/2020 17:16	Question on administrative costs for interoperability final rule	The Interoperability final rule indicates that plans may pass on the implementation costs into the administration section of their bids. The rule now has a July 1, 2021 enforcement date for key provisions (instead of January 1), but the rule itself isn't effective until June 30 (60 days after publication), which is after the bid submission date. This wasn't addressed in any of the 2021 bid instructions. Are plans permitted to include these costs in 2021 bids?	Final rules expected to be in effect for the Contract Year should be reflected in bid submissions.
3	Cost Sharing	05/05/2020 15:02	Sequestration Adjustment when using Medicare FFS Cost Sharing Pricing Option	For a plan using the Medicare FFS cost sharing pricing option to develop Worksheet 3, what is the appropriate adjustment (if any) to the Medicare FFS actuarial equivalent cost sharing percentages in Worksheet 4 to account for sequestration?	There is no adjustment for sequestration permitted in this case. While no adjustment for sequestration is permitted to the actuarially equivalent cost sharing percentages, CMS does not preclude the use of pre-sequestration allowed PMPMs in Worksheet 3 column G for the development of Worksheet 3 cost sharing.
4	VBID	05/06/2020 20:57	Clarification on BPT Worksheet 1 Change	We would like to get clarification on a Worksheet 1 BPT change. The change is summarized on page 6 of the CY2021 Bid Instructions: "Renamed MA BPT Worksheet 1, Section I, Item 15 to be VBID-C to reflect additional benefits for VBID/Uniformity/Special Supplemental Benefits for Chronically Ill (SSBCI)." However, page 48 of the CY2021 Bid Instructions states: "Line 15 – VBID-C If the PBP includes benefits offered under the Medicare Advantage Value-Based Insurance Design (MA-VBID-C) model, enter "Y". In all other cases, including PBP variations consistent with CMS MA uniformity flexibility or Special Supplemental Benefits for the Chronically Ill (SSBCI) criteria outside of the MA-VBID-C model, enter "N"." Please confirm the guidance provided on page 48 of the Bid Instructions; VBID-C should denote "Y" if the PBP includes benefits under VBID and "N" under Uniformity Flexibility or SSBCI.	Yes, we can confirm that only plans participating in the VBID program should answer yes on worksheet 1, Section I, Item 15, VBID-C. This indicates participation in the MA VBID program to offer Value-Based Design Flexibilities by Condition or Socioeconomic Status and/or MA Rewards and Incentives. Plan sponsors may offer some benefit flexibilities such as uniform flexibility or special supplemental benefits for the chronically ill without taking part in the VBID program. If this is the case, then the VBID-C indicator should be completed with "N".
5	Part B Rx	05/11/2020 17:54	bid questions regarding Part B Rx rebates	In the MA BPT instruction, page 13 states that the "Part B Rx" service category includes prescription drug rebates that serve to decrease the MAO's cost of providing Part B Rx benefits. Page 34 states that retained rebates or other items defined as DIR had such items been attributable to a Part D prescription drug be included in non-benefit expenses. Consider the following scenarios: Scenario: PBM retains some manufacturers' rebates per contract with the MAO. Part B Rx net cost prior to rebate is $10. Manufactures provided $8 of rebates, of which, $1 is retained by PBM and $7 is received by the MAO. Should we report – A. $2 as net cost in Benefit Expense ($10 - $8) and $1 as NBE, or, B. $3 as net cost in Benefit Expense ($10 - $7)?	For this scenario, the plan should use option A.
6	Manual Rate	05/11/2020 20:47	Question about adjustments to Part C manual data	We have a very small D-SNP where experience Part C costs have consistently been significantly higher than the manual data projected. For the past several years, we have selected a subpopulation of the FFS 5% sample that very closely reflects the demographics of this plan's population as our manual data and adjusted for morbidity. However, this plan is uniquely high-cost beyond what risk scores reflect. In our analysis of Part C actual-to-projected claims, we have found that our actual experience has been 9%-46% greater than manual projections. Is it acceptable to use this historical data to make an additional adjustment to the manual projected allowed?	In general, OACT has found this type of adjustment to be unsupported. Similar adjustments have been identified as a Finding during bid pricing audits. The actuary should have a sound justification for requiring the adjustment. For example, a sound justification may include identifying the factors that are contributing to the differential, then basing the adjustment on these factors. It may not be appropriate to make an adjustment simply to achieve an intended result (e.g., to bring the manual rate closer to actual plan experience) without understanding the cause.
7	MTM	05/11/2020 16:29	eMTM Bonus Revenue in Base Period	Please advise where the revenue from receiving a bonus payment from eMTM program participation in the base period should be placed in Worksheet 1. Section V, item 1(e): CMS Part D Payment or Section V, item 3(e): Member Basic premium	The revenue from the MTM program should be included in Worksheet 1. Section V, item 1(e): CMS Part D Payment.

User Group Call Date 05/21/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Supporting Documentation	05/19/2020 11:38	HPMS - Allowable File Types for Supporting Doc	Is there any chance HPMS will allow the upload of .xlsb files as part of the substantiation upload this year? It appears CMS is sending files in that format now, so we were wondering if we could upload those files to HPMS. xlsb is not currently listed as an allowable file type	No, the .xlsb file type is not allowed for substantiation upload. We would recommend for the user to save the upload as a zip file and upload the zipped version instead.
2	Growth Rates	05/13/2020 22:40	more ffs uspcc/trend questions	Thank you for providing PMPM estimates for the additional Opioid Treatment Program and Acupuncture services covered by Medicare in 2021. Can you provide a quick answer as to whether these benefits were included in setting the USPCC amounts?	As reflected in the response to question #2 on the May 7, 2020 user group call, the estimated CY 2021 Opioid Treatment Program cost of $0.35 PMPM is included in the fee-for-service USPCCs supporting the 2021 MA ratebook. The estimated CY 2021 cost of acupuncture treatment for chronic lower back pain is not included the 2021 ratebook USPCCs.
3	Growth Rates	05/14/2020 11:09	Acupuncture and OTP Utilization/Unit Cost	Can you provide either utilization or unit cost estimates for the opioid treatment program benefits in 2021 for FFS, on average?	The projected cost of $0.35 PMPM is based on estimated weekly utilization of 0.035 percent of Medicare beneficiaries and an average weekly per-service cost of $233.89.
4	Growth Rates	05/14/2020 11:09	Acupuncture and OTP Utilization/Unit Cost	Can you provide either utilization or unit cost estimates for the Medicare acupuncture benefits in 2021 for FFS, on average?	In response to question #1 on the May 7, 2020 user group call is "The estimated cost in 2021 of the acupuncture benefit for chronic lower back pain is $0.47 PMPM." This cost estimate actually applies to CY 2020 expenditures and not CY 2021. The corresponding nationwide per-service cost for the acupuncture benefit is estimated to be $70.00 We do not have a corresponding estimate of the per-service cost for CY 2021. However, it's worth noting that the '21/'20 per-capita trend in FFS spending under the physician fee schedule is estimated to be 1.6 percent.
5	Growth Rates	05/12/2020 21:53	IPPS Increase in Proposed Rule vs USPCC	Can you please comment on how IPPS trend estimates assumed for the CY 2021 USPCC growth estimate compare to IPPS increases for FY 2021 proposed in "Fiscal Year (FY) 2021 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule (CMS-1735-P)"?	The increases in the FY 2021 proposed IPPS rule match that in the unit cost trend exhibit: (i) 3.0 percent market basket update, (ii) -0.4 percent multifactor productivity adjustment, and (iii) 0.5 percent update for documentation and coding.
6	Non-Benefit Expenses	05/13/2020 20:57	Question on non-benefit expense	[Paraphrased] Where should network access fees go in the BPT? Are they considered a benefit expense or a non-benefit expense? For example, we pay a mental health organization a network access fee for which they provide the patient network and we pay the claims on a fee for service basis. In this case, were should we put the network access fee? Is this different from the case in which we pay a mental health organization a capitation and the mental health organization is responsible for the claims as well as creating the network? In the latter case are we expected to estimate what portion of the capitation is for non-benefit expenses (the remaining being benefit), while in the former case the network access fee is considered to be a non-benefit expense?	Network access fees are a non-benefit expense and should be reported in the BPT as NBE. If a capitation fee includes network access fees and the fees are known, then they should be reported as NBE in the BPT. If it is not possible to determine what part of the capitation amount is for network access fees and what part is for medical expenses, then the full capitation may be reported as medical.
7	Validations	05/12/2020 17:08	Question on BPT Validation error	We are getting the following BPT validation error when projecting 100% DE#: "if DE# member months (WS5 cell G12) = total member months (WS5 cell E12) then Worksheet 3 cost sharing (WS3 cell O65) must equal to DE# cost sharing (WS4 cell F67)." Our understanding is that Worksheet 3 cost sharing should be completed assuming members pay the cost sharing, so if FFS benefits were offered, the impact of the in network MOOP in WS3 (cell K68) would be greater than $0.00. In Worksheet 4, DE# cost sharing could be priced assuming cost sharing does not count toward MOOP for DE# members, assuming this is consistent with MAO operational practices, and therefore, the total cost sharing in WS4 cell F67 would be different than WS3, cell O65. Please clarify if our understanding is correct, and if we can ignore this validation error.	Yes, you may ignore this validation error. This situation will be corrected for the CY2022 BPTs.

User Group Call Date 05/21/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	SSM	N/A	Question on Basic Alternative Deductibles	In light of the guidance released to support the Part D Senior Savings Model, could you clarify how non-uniform deductibles for Basic Alternative plans are administered?	Please see the additional information below on basic alternative deductibles: • BA plans are not required to map their alternative benefits to the defined standard when reporting CPP on the PDE record like EA plans are required to do. That is, BA plans must report CPP based on the alternative benefit design, which essentially means that whatever the EA plan would report in the NPP field in a no deductible scenario is instead reported in the CPP field for a BA plan. • As is the case for EA plans, when adjudicating the benefit and determining beneficiary liability, the BA plan must account for its actual alternative benefit design. That is, the beneficiary moves through the deductible phase based solely on the gross drug costs for the drugs that are subject to the deductible under the plan's benefit design, and the benefit phase indicators, the Patient Pay field, and the True Out-of-Pocket Cost (TrOOP) Accumulator on PDEs must be reported according to the plan's own benefit design and cost-sharing structure. • Like is the case for EA plans, it must be noted that, as stated in the September 10, 2010 HPMS memorandum, Additional Guidance Concerning Closing the Coverage Gap in 2011, a Part D deductible ceases to apply once a beneficiary's TGCDC amount exceeds the initial coverage limit, irrespective of the alternative benefit design, even if the beneficiary has not satisfied the deductible under the plan.
9	COVID-19	05/20/2020 22:12	COVID Benefits in BPTs	Please confirm bidders may set their own assumptions for how long they expect the public health emergency to apply and/or how likely it is to still be in effect in 2021.	Yes, this is correct. Certifying actuaries must make their best estimate and support all assumptions.
10	COVID-19	05/20/2020 22:12	COVID Benefits in BPTs	Please confirm or correct our understanding that the Medicare Covered FFS percentages in the BPT do not include an adjustment for any COVID related services being offered in FFS Medicare without cost sharing.	That is correct, the Medicare Covered FFS percentages in the BPT have not been adjusted for any COVID related services.
11	COVID-19	05/20/2020 22:12	COVID Benefits in BPTs	COVID-19 testing and specified testing-related services must be covered without cost-sharing to the end of the public health emergency. Are the cost-sharing reductions from standard MA plan cost-sharing for COVID testing and testing-related services considered Medicare covered benefits or supplemental benefits?	These cost sharing reductions are considered Medicare covered, but only for the period of the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act (PHSA), including any renewals of such declaration pursuant to section 319 of the PHSA. Please see the HPMS memo titled, "Contract Year 2021 Part C Bidding and Benefits Instructions Related to COVID-19" issued May 19, 2020 for additional information on COVID-19 testing and specified testing-related services.

User Group Call Date 05/28/2020

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	COVID-19	N/A	N/A	The HPMS memo Titled "Contract Year 2021 Part C Bidding and Benefits Instructions Related to COVID-19" issued May 19, 2020 summarizes how MA organizations may prepare their CY 2021 Part C Bid Pricing Tools (BPT) and Plan Benefit Packages (PBP). Does this guidance preclude a plan sponsor from offering benefits in CY 2021 during a continued or renewed public health emergency, if those benefits are not included in the CY2021 PBP?	The May 19th memo gives plan sponsors the opportunity to account for benefits in the PBP and BPT pricing that they wish to offer in CY 2021 for the period of the specific public health emergency. CMS issued an HPMS Memorandum titled "Information Related to Coronavirus Disease 2019 - COVID-19" on April 21, 2020 (revised from March 10, 2020) that informed MA organizations and Part D sponsors of the obligations and permissible flexibilities related to the declarations of disaster and public health emergency resulting from the COVID-19 pandemic. Offering and covering supplemental benefits that are not included in the MA bid is generally prohibited and CMS is exercising its enforcement discretion to permit those mid-year benefit enhancements in 2020 for limited purposes and in response to the unique circumstances resulting from the outbreak of COVID-19. We cannot confirm at this time that this enforcement discretion will be continued or renewed in 2021.
2	DE#	05/23/2020 9:41	Gain/Loss testing and Puerto Rico DE# Membership	We are requesting clarification on how to distinguish DE# and Non-DE# members for worksheet 1 membership and risk scores. We interpret the MA BPT instructions to instruct Puerto Rico plans to identify DE# membership for Puerto Rico to be defined as members enrolled in a Platino plan regardless of MMR Medicaid status. Page 5: "In the BPT and these Instructions,— • The term "DE#" (d-e-pound) refers to dual-eligible beneficiaries without full Medicare cost-sharing liability. Included are dual-eligible beneficiaries who receive benefits in the form of reduced, as well as eliminated, Medicare cost sharing. • The term "Non-DE#" refers to dual-eligible beneficiaries with full Medicare cost-sharing liability and beneficiaries who are not eligible for Medicaid (that is, non-dual eligible). • The terms "Total population" and "total beneficiaries" refer to the combined non-DE# and DE# population and beneficiaries, respectively, including out-of-area members." Page 21: "Per federal statute, QMBs and QMBs with full Medicaid benefits (QMB Plus) are not liable for Medicare cost sharing; therefore, these individuals are always considered to be DE# beneficiaries, as defined in the "Introduction" section of these Instructions. The certifying actuary must determine which additional beneficiaries are DE# based on the Medicaid cost-sharing policy for the states or territories in the bid's service area. However, the certifying actuary has the option to approximate the DE# population as described below, if the condition in the second bullet point is satisfied." Our confusion is that the instructions also suggest that plans should use Medicaid status in Appendix G. Our interpretation of the instructions and understanding of Puerto Rico Platino program is that all members enrolled in Platino plans qualify as DE# per the definitions on pages 5 and 21 as shown above. Please confirm that our judgment is appropriate and we can override the Medicaid mapping in Appendix G given all Platino members are DE# by definition.	So long as the Platino program continues to offer a reduction to the Medicare cost sharing liability, the beneficiaries who are participating in the Platino program should be categorized as DE# for bidding purposes.
3	Substantiation	N/A	5/21 UGC Live Chat	[Paraphrased] For the first question on substantiation from the 5/21/2020 UGC, are you saying an uploaded ZIP file can contain an XLSB file, but XLSB files cannot be uploaded individually?	The system will prevent the user from uploading an .xlsb file even if it is in a zipped folder. Given this, the user will need to convert their file to one of the following types in order to successfully upload substantiation: .txt, .doc, .docx, .xlsx, .pdf, .zip, .gif, and .jpg.