User Group Call Date 02/25/2021

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: partdpolicy@cms.hhs.gov
For Part D benefit-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
For questions related to risk score models and released data: riskadjustmentpolicy@cms.hhs.gov
For questions related to the Encounter Data Processing System: riskadjustmentoperations@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	Growth Rates	N/A	N/A	How many years of historical experience are used to calculate the FFS USPCCs?	The historical experience in the baselines supporting the USPCCs are based on tabulation by incurred year of paid claims and reserves for outstanding claims. The projection models include historical experience back to calendar year 1966.
2	Growth Rates	N/A	N/A	What adjustments are made to historical experience (e.g., repricing) when calculating the USPCCs?	The tabulation of the non-ESRD FFS USPCCs reflects the following adjustments to historical experience: (i) Remove expenditures for hospice care (per statute), (ii) Remove expenditures for health information technology (HIT) bonus payments (per statute), (iii) Reverse sequestration offset to claims, (iv) Remove National Claims History (NCH) claims paid on behalf of cost plan enrollees, and (v) Make adjustment to FFS trend for 2014-2020 to account for net migration of enrollment from FFS to Medicare Medicaid Plans (MMP).
3	Growth Rates	N/A	N/A	Will OACT please specify which payments from Medicare cost reports are included in the "outside the system" claims? Are they payments in addition to pass-through costs and bad debt payments?	These amounts reflect the cost report settlements in excess of the pass through estimates represented in the NCH claims. The settlements include direct graduate medical education (DGME), organ acquisition costs, bad debt, certain capital costs for new hospitals, nursing and allied health education costs, disproportionate share hospital payments, uncompensated care payments, and settlement with non-PPS providers.
4	Growth Rates	N/A	N/A	How does OACT exclude HMO and Cost Plan enrollees from the non-ESRD FFS USPCC? Are these members excluded based on their status at a point in time or the member month level?	Medicare Advantage and cost plan enrollees are excluded from the baseline projections supporting the USPCCs based on the beneficiary's monthly enrollment status, not as of a point in time.
5	Ratebook	N/A	N/A	The claims experience supporting non-ESRD ratebooks represent claims with Medicare status codes '10' and '20'. For enrollment how does OACT exclude ESRD beneficiaries from the non-ESRD FFS USPCC. Are these members excluded based on their status at a point in time or the member month level?	The ESRD beneficiaries reflected in the baseline projections and USPCC are tabulated monthly based on their dialysis and transplant status in Medicare Common Environment (CME). Our testing has revealed a close match of identification of ESRD beneficiaries based on MSC codes and the CME tables.
6	Ratebook	N/A	N/A	When developing risk scores used in the standardization of the ratebook FFS rate, are risk scores for beneficiaries with Part A only or Part B only included in the calculation?	No, Part A only and Part B only beneficiaries are excluded from the risk scores used in standardization of the CY2022 ratebook.
7	COVID-19	N/A	N/A	Can you provide the projected COVID-19 vaccination rates over the next several years?	The CY 2023 and CY 2024 USPCCs included in the 2022 Rate Announcement reflect annual COVID-19 vaccination rates that are fairly consistent with our estimate for CY 2022 (52 percent).
8	Enrollment	N/A	N/A	Can CMS provide the actual ESRD enrollment migration experienced during the 2021 annual election period (AEP) and how that impacts projections for 2022 and beyond?	Based on enrollment through February 2021, we estimate that about 40,000 beneficiaries in ESRD status migrated from Medicare FFS to Medicare Advantage during the 2021 AEP. We have not revised our baseline projection of MA ESRD enrollment to reflect actual 2021 experience.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Fee For Service	02/19/2021 11:55	Home Health Trends	The 2022 Announcement ("Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies") shows per capita spend on Home Health decreasing from 2019 to 2022 (page 20 and page 22). Since this is to 2022, I would not expect a negative impact due to the Covid-19. At the same time, FFS unit cost trends were estimated to increase by about +2% per year for Home Health. See the attached sheet that was released with the actuarial bid calls. Can you help me understand the cause in the drop in Home Health per capita in the Announcement?	The per-capita spending figures on pages 20-22 of the 2022 Rate Announcement are on a non-ESRD, per-beneficiary basis, including enrollment in both Medicare fee-for-service (FFS) and Medicare Advantage. The home health values can be tabulated per-FFS beneficiary by multiplying the per-capita values on page 20 or 22 by the total Aged + Disabled enrollment on page 18 and dividing by the FFS Aged + Disabled enrollment on page 18. Expressed on a per-FFS beneficiary basis, the Part A home health per-capita spending is estimated to be $173.59 in 2019 and $187.15 in 2022 yielding a '22/'19 trend of 7.8 percent. The corresponding '22/'19 trend for Part B home health is 6.5 percent per FFS beneficiary.
10	Fee For Service	02/19/2021 11:30	CY2022 Bid Questions	Could you please provide the expected impact of DSH/UCP payment change on the inpatient unit cost trends from 2020 to 2021?	The approximate impact of the DSH/UCP payment change is a 0.3 percent increase.
11	Fee For Service	02/19/2021 11:30	CY2022 Bid Questions	Could you please provide the impact of baby boomers on the overall trend from 2021 to 2022 for Part A and Part B services separately?	The estimated impact of demographic shifts on the '22/'21 fee-for-service trend is −0.5 percent for Part A services and −0.1 percent for Part B services.
12	Fee For Service	02/19/2021 11:30	CY2022 Bid Questions	Has CMS observed any change in the average age of Medicare beneficiaries as a result of COVID?	We have not studied the impact of COVID-19 on the average age of Medicare beneficiaries.
13	Fee For Service	02/19/2021 11:30	CY2022 Bid Questions	With respect to projected physician costs, could you please provide the impact of the following for CY2019, CY2020, and CY2021? (a) Payment to MIPS and (b) Payment to APMs	(a) MIPS payments are set to be budget neutral with the exception of $500 million in additional payments each year. (b) Payments to qualified participants in advanced APMs are to be 5% of their Medicare payments. It is estimated that these 5% bonus payments are $274 million in CY2019, $403 million in CY2020, and $324 million in CY2021.
14	Fee For Service	02/19/2021 11:30	CY2022 Bid Questions	Can you please provide the estimated impact of the DME competitive bidding program on DME costs for 2019, 2020, and 2021?	In CY 2019, DME prices increases in non-competitive bidding areas are estimated to have increased DME spending by 2.4%. In CY2021, moving knee and back braces to competitive bidding is estimated to reduce DME spending by 2.0%.

User Group Call Date 04/15/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	LIPSA	03/05/2021 16:40	Feb 2020 Actuarial User Group Call Questions and Feedback	Page 4 of the February 25, 2021 Actuarial User Group Call agenda details how to calculate the LIPSA for plans that span multiple Part D regions. We appreciate this clarification of the requirements for submitting bids where LIPSA is the Plan Intention for Target PD Basic Premium. We would appreciate additional clarification as to whether the LIS membership to use in the weighting is base period, projected period, or as of some other date.	The CMS calculation of the LIPSA uses actual June enrollment of the prior year for the plan, and accounts for enrollment moved into or out of the plan in the HPMS crosswalk from the prior year to the bid contract year. It does not take into account base period enrollment, as that is two years prior and it does not take into account projected enrollment in the BPT. The enrollment in the HPMS crosswalk from the prior year to the contract year is the only thing that should be used to determine the weighting of multiple LIPSA's for a plan that spans multiple Part D regions.
2	Credibility	03/17/2021 13:44	MA Bid Questions	1. With respect to assigning credibility to base period experience, please consider the following scenario for CY2022: - Plan 001 has 2019 and 2020 MA experience, with 40% and 60% credibility, respectively implied by its membership and the CMS credibility formula. - The 2020 experience is clearly affected by COVID, and the actuary believes it is not appropriate to use as a basis for projecting 2022. - The actuary elects to use 2019 claims as alternate bid-specific experience, and makes adjustments in Worksheet 1 using the "Other Factor" column. What credibility should be used in this example? Should the actuary use 60%, based on the BPT, or override it to be 40% since 2019 experience is being used?	The projected experience rate on MA Worksheet 2 should be assigned credibility consistent with the experience that was used to make the projection. Based on the scenario for CY2022, the credibility would be calculated from the 2019 experience, and would be 40%, because the 2019 experience was used as the basis to project the 2022 experience rate.
3	Part B	03/17/2021 13:44	MA Bid Questions	On last year's UGC, CMS provided estimated Part B drug spending trends. Could you please provide updated per-capita spending trends for Part B drugs and biologics in 2021 and 2022?	Our latest estimate of the trend in per capita spending for Part B drugs and biologics is 6.9% for CY 2020, 14.9% for CY 2021, and 10.3% for CY 2022.
4	NCH	N/A	N/A	Can you provide us with your latest completion factor for experience in the National Claims History (NCH) file?	Table 1 below represents the completion factors for National Claims History experience supporting the FFS USPCCs in the 2021 Rate Announcement
5	Ratebook	03/22/2021 10:42	Vaccine Administration Fee Rates	On 3/15/21 CMS announced an increase in the payment rate for administering the Covid-19 vaccinations. Will the 2022 Ratebook be updated to include this increased administrative cost for vaccinations?	No, we finalized the 2022 ratebooks in January. Once finalized, we do not reopen the rates.
6	EGWP	04/02/2021 22:04	EGWP MSA Payment Question	The 2022 Advance Notice Part II states that the monthly prospective EGWP MSA payment rates are: the 2022 MA Monthly Capitation County Rate x beneficiary risk score – 1/12 of the Annual Deposit Amount. Does the MA Monthly Capitation County Rate refer to the published county benchmark rates for MA plans? As an example, if an MAO had a 5-Star rating for their MSA contract and had an EGWP MSA group only in Autauga, AL, the MAO would receive $1,126.52 x (risk score) – 1/12 of Annual Deposit for each member?	Yes, this is the correct understanding of monthly prospective EGWP MSA payments in 2022 for a plan eligible for a 5 percent QBP rate in Autauga, AL . Please refer to the following guidance on page 38 of the 2022 Advance Notice, Part II. "MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2022, but the 2022 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2022 MA Monthly Capitation County Rate x beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2022 Annual MSA Deposit Amount must be submitted in the appropriate Plan Benefit Package field. Consistent with individual market MSA plans, MA EGWP MSA plans will not be able to use a portion of the Part C payment to buy down the Part B premium."
7	FFS Trends	04/05/2021 23:47	Actuarial UGC Question	[Paraphrased] Page 27 of the Final Announcement states, "As deferred care is now estimated to continue to return in 2022, 2022 FFS spending is estimated to be about two percent higher than estimates for both Part A and Part B supporting the CY 2021 Rate Announcement – this is also partially the reason for the difference between the 2022 FFS spending estimates in the CY 2022 Advance Notice Part II and this Rate Announcement." Are you able to provide the 2022 FFS USPCC estimate (currently $1,028.38) that excludes the impact of deferred care or confirm this value would be approximately 2% lower ($1,028.38 * 0.98) without the impact of CMS' assumed deferred care? Also, can you confirm if the deferred care assumption includes or excludes the projected cost of the COVID-19 vaccine? Finally, what is CMS' expectation around health plans including consideration for deferred care in the 2022 bids?	The 2022 non-ESRD FFS USPCC excluding deferred COVID care is approximately 2 percent lower than the published USPCC of $1,028.38. Also, the deferred care assumption of 2 percent does not include the estimated cost of the COVID-19 vaccine. Finally, certifying actuaries must make their best estimate of the cost of deferred care to include in their bids and provide support for that assumption.

User Group Call Date 04/15/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Ratebook	04/10/2021 15:39	COVID Vaccine/Booster Assumptions	The 2022 Rate Announcement includes the following note on page 2 that states: "The 2022 Rate Announcement does not catalog CMS' actions related to the 2019 Coronavirus Disease (COVID-19) public health emergency (PHE), but it does incorporate aspects of the impact of COVID-19 on health care costs in its estimates of prior and future Medicare spending." What assumptions were built in for Vaccinations/Boosters and administration for 2022 benchmark rates? • Based on a prior CY2022 Actuarial User Group question that was asked, we believe that CMS assumed 52% utilization. • Based on https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment: Current Administration Fee = $28.39 for single shot series and $16.94 / $28.39 for Shot 1/ Shot 2 in a two shot series. • Based on https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies: Current Pfizer / Moderna / J&J Cost = $40 per Unit	The following text is from page 29 of the 2022 Rate Announcement: "…The COVID-19 vaccine assumptions supporting the 2021 FFS USPCCs are: 60 percent of FFS beneficiaries will receive a COVID-19 vaccine during CY2021, there will be an average of 2.2 doses per utilizer, and the average Medicare program cost per dose will be $28. The per-dose cost is based on estimated administration cost of $25 and vaccine cost of $3. The vaccine cost was developed under the assumption that most of the approved vaccines would be funded through Operation Warp Speed. Additionally, the COVID-19 vaccine assumption supporting the 2022 FFS USPCCs are: 52 percent of FFS beneficiaries will receive a COVID-19 vaccine during 2022, there will be an average of 2.0 doses per utilizer, and the average Medicare program cost per dose will be $88. The per-dose cost is based on estimated administration cost of $28 and vaccine cost of $60. …"

Table 1

Trust Fund	Service Category	Cohort	Completion Factor by Quarter							
			Qtr-0	Qtr - 1	Qtr - 2	Qtr -3	Qtr - 4	Qtr - 5	Qtr - 6	Qtr - 7
A	Inpatient hospital	Aged	72.28%	99.19%	99.40%	99.79%	99.97%	100.01%	100.03%	100.02%
A	SNF	Aged	61.63%	97.76%	99.50%	99.85%	99.99%	100.01%	100.01%	100.01%
A & B	HHA	Aged	78.45%	95.78%	99.21%	99.92%	100.19%	100.06%	100.02%	100.02%
B	Physician Fee Schedule	Aged non-ESRD	76.30%	97.73%	99.15%	99.74%	100.00%	100.00%	100.00%	100.00%
B	DME	Aged non-ESRD	76.51%	97.05%	98.93%	99.69%	100.00%	100.00%	100.00%	100.00%
B	Carrier Lab	Aged non-ESRD	70.93%	96.57%	98.76%	99.56%	99.96%	99.99%	100.00%	100.00%
B	Physician Admin Rx + Other Carrier	Aged non-ESRD	79.23%	98.41%	99.48%	99.85%	100.00%	100.00%	100.00%	100.00%
B	Outpatient PPS	Aged non-ESRD	72.92%	98.17%	99.40%	99.81%	99.98%	99.99%	100.00%	100.00%
B	Intermediary Lab	Aged non-ESRD	75.72%	98.08%	99.34%	99.80%	99.99%	100.00%	100.00%	100.00%
B	Dialysis	Aged ESRD	62.51%	97.88%	99.23%	99.56%	99.91%	99.97%	99.99%	100.00%
B	Therapy	Aged non-ESRD	59.14%	96.32%	98.67%	99.58%	100.00%	100.00%	100.00%	100.00%
B	Non-dialysis non-therapy other	Aged non-ESRD	71.80%	97.03%	98.89%	99.66%	99.99%	100.00%	100.00%	100.00%

User Group Call Date 04/22/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Credibility	Live Question from 4/15 UGC	N/A	If the actuary determines 2020 experience to be an unreliable rating basis for CY 2022 bids and decides to use alterative bid-specific experience from 2019 instead can the actuary fully manually rate a plan that was new in 2020? For example, if "Plan A" had zero member months in 2019 and 100,000 member months in 2020 would it be appropriate to assign 0% credibility on the BPT and manually rate "Plan A" if the certifying actuary decided it is most appropriate to use 2019 data (more precisely a manual rate based on 2019 data) as the rating basis for all plans?"	The certifying actuary is responsible for choosing and applying the data, pricing assumptions, and methods for this issue, along with fully supporting their pricing decisions. See Table 2 below for how to complete the BPT under different cases. This question would apply to Case 3 in Table 2. The actuary has determined and supports why the base period data is an unreliable basis for CY 2022. There is no alternate bid-specific experience from 2019. The actuary would assign 0% credibility on the BPT and enter a manual rate.
2	Credibility	04/15/2021 13:34	2022 MA Bid: COVID adjustment for plans first filed in 2020	If 2019 is used as the basis for rating due to COVID considerations, and the PBP is new in 2020, with less than 100% claim credibility in the 2020 experience period, can the plan be fully manually rated in 2022? A similar question was asked (live, see the preceding topic) on the OACT call (April 15) but the caller stated that the 2020 enrollment was 100% claim credible. Does the ability to fully manual rate change with the enrollment claim credibility in 2020?	The certifying actuary is responsible for choosing and applying the data, pricing assumptions, and methods for this issue, along with fully supporting their pricing decisions. See Table 2 below for how to complete the BPT under different cases. This question would apply to Case 3 in Table 2, similar to the preceding response. The ability to fully manual rate depends on the actuary providing appropriate support for not using the available bid-specific experience.
3	Credibility	04/15/2021 12:46	Credibility	As a follow-up to question #2 from the 4/15/21 AUG call, we are intending to calibrate the 2020 experience to 2019 only for plans that are fully credible in both years. For plans that are not fully credible in either 2019 or 2020, we plan to apply a 'COVID-19 Adjustment' factor to the (partially credible) 2020 experience to adjust for the impact of COVID-19, where the factor is based on market-level or corporate-level averages from the fully credible plans. Because we are not explicitly using plan-specific 2019 experience to project to 2022 for the plans that are not fully credible, we had intended to use the 2020 credibility on WS2. Please confirm this is an acceptable method.	Applying a 'COVID-19 Adjustment' to the (partially credible) 2020 experience, as stated in this question, could be an acceptable method. The credibility would be based on the 2020 experience. See Table 2 below for how to complete the BPT under different cases. This question would apply to Case 1 in Table 2. Topic #2 from the User Group Call on 4/15/2021 would apply to Case 2 in Table 2.
4	Credibility	04/15/2021 17:14	Questions	OACT has indicated that the projected experience rate on MA Worksheet 2 should be assigned credibility consistent with the experience that was used to make the projection. If a certifying actuary elects to use 2019 claims as alternate bid-specific experience, and uses a credibility percentage based on 2019 membership and the CMS credibility formula, would this be considered as following CMS guidelines for purposes of supporting documentation (see item 5, page 103 of the CY2022 MA BPT Instructions)?	Applying the CMS credibility guidelines to 2019 data would be considered as following the CMS guidelines for the purposes of supporting documentation. Please note that the CMS guidelines may change over time, and the actuary would apply the guidelines applicable to the data being used.
5	Cost Sharing	04/15/2021 17:14	Questions	On page 23 of the April 9, 2021 MA BPT Instructions, the following language was added in the Pricing Considerations section under "Cost Sharing", and was not present in the April 10, 2020 MA BPT Instructions. "Worksheet 3 is not meant to reflect the limited cost sharing for the DE# beneficiaries except when the DE# enrollees make up less than 10% or greater than 90% of the total bid enrollees. Completion of Worksheet 3 must be consistent with how the non-DE# and DE# Allowed PMPM columns on Worksheet 2 are completed and follow the guidance specified in Appendix G". In 2020, OACT indicated that "Worksheet 3 should be completed in this case as though the beneficiary were paying the FFS cost sharing" in response to the following question related to new language in the April 10, 2020 MA BPT Instructions: Consider the following situation in light of the new language: if a plan projects 100% DE# members and offers Medicare FFS benefits, then should the PMPM impact of in-network OOP max (cell K68) be valued assuming FFS cost sharing counts toward the OOP max (i.e. which would be the case for non-DE members)? Does the additional language in the April 9, 2021 MA BPT Instructions change OACT's response to the above question posed in 2020?	The changes are an effort to clarify the instructions. Per Appendix G when the certifying actuary chooses to set the projected DE#, non-DE#, and total allowed costs all equal on Worksheet 2, then on Worksheet 3 utilization and PMPM values may reflect non-DE# or total values when the DE# enrollment is <10% or >90% of the total enrollment. However, when the certifying actuary chooses to separately calculate DE# and non-DE# projected allowed costs on Worksheet 2, then on Worksheet 3 utilization and PMPM values must reflect the non-DE# values regardless of DE# membership.
6	Base Period Experience	04/16/2021 17:26	CY 2022 Bid Questions - Part C Member Premiums	A portion of Part C member premiums were waived in CY 2020 in accordance with COVID-19 permissive actions. Should this waived amount be included in the WS1 Section V premium revenue calculation?	CORRECTED RESPONSE (Note this response corrects/clarifies the live response read on 4/22 call): Per page 34 of the MA bid instructions, uncollected premiums should be reported as a direct administrative expense. These uncollected premiums should also be included as premium revenue so that the net result is $0 cost included in the base period experience.

User Group Call Date 04/22/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Related Party	04/19/2021 16:52	Feedback to OACT regarding related parties	In Appendix H, page 141, the Availability for Method 3 states that this method is only available if Method 1 cannot be satisfied. However, this requirement has been removed from Pricing Considerations (page 41) and Appendix B (page 104). Should the Availability for Method 3 be revised to read "Alternative to Method 1"? Similarly, should the first Criteria bullet reading "Demonstrate Method 1 not possible" be removed?	The table in the MA Instructions, Appendix H "Summary of MA Related-Party Requirements – Medical Services Arrangements" should have been updated to state that Method 3 is an alternative to Method 1 and does not require a demonstration that it is not possible to use Method 1.
8	FFS Trends	Live Question from 4/15 UGC	N/A	Can you provide the PMPM estimate of opioid treatment included in the 2022 FFS USPCCs?	Actual CY 2020 Medicare fee-for-service spending for opioid treatment programs (OTP) was $175.1 million, or $0.45 PMPM. A corresponding estimate of OTP spending in CY 2022 is not available.
9	Growth Rates	04/16/2021 17:26	CY 2022 Bid Questions - Part C Member Premiums	A final national coverage determination was released December 2020 updating the coverage policies for artificial hearts and ventricular assist devices for Medicare beneficiaries. What assumptions did CMS include in the growth rate for these updates? Please provide any utilization and cost information that CMS may have.	This national coverage decision was not explicitly built into the baseline supporting the 2022 Rate Announcement USPCCs.

Table 2

This table is written in terms of the CY2022 MA BPT, but may be applied similarly to other BPTs.

Case	2019 bid-specific experience (alternate data)	2020 bid-specific experience (base period data)	How to Complete the BPT
Case 1	This data does not exist or it is not used in pricing the BPT.	This data exists, is reported on Worksheet 1, and is used in pricing the BPT.	Project the base period data on Worksheet 1 to 2022, using the projection assumptions on Worksheet 1. Enter the credibility of the base period data on Worksheet 2. Enter a manual rate on Worksheet 2, if necessary.
Case 2	This data exists and is used in pricing the BPT.	This data exists, is reported on Worksheet 1, but is not used in pricing the BPT.	Project the alternate data to 2022 outside of the BPT, to be used as the projected experience rate on Worksheet 2. Use the projection assumptions on Worksheet 1 to equate the base period data on Worksheet 1 to the projected experience rate on Worksheet 2. Enter the credibility of the alternate data on Worksheet 2. Enter a manual rate on Worksheet 2, if necessary. Support why the alternate data was used, instead of the base period data, to develop the projected experience rate.
Case 3	This data does not exist or it is not used in pricing the BPT.	This data does not exist, or the data is reported on Worksheet 1 but not used in pricing the BPT.	Enter 0% in the credibility on Worksheet 2. Enter a manual rate on Worksheet 2. Support why the base period data, if it exists, was not used to develop the projected experience rate. Support why the alternate data was not used to develop the projected experience rate, if the alternate data exists and the base period data was not used.

User Group Call Date 04/29/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Sequestration	03/30/2021 16:08	Sequestration	The American Rescue Plan Act implies that sequestration will be 4% in CY2022, barring any legislation to alter it. Should plans assume 4% sequestration for purposes of projecting CY2022 Medicare covered claim expenses?	The impact on plan sponsor payments to providers will depend on the specific terms of the contracts between the Medicare Advantage Organization (MAO) and its in-network providers. Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in the payment arrangements between MAOs and contract providers. The statute specifies that CMS "may not require any MA organization to…require a particular price structure for payment under such a contract…." Thus, whether and how sequestration might affect an MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider. Based on current publicly reported estimates from the CBO, the American Rescue Plan Act of 2021 may trigger provisions of the Statutory Pay-As-You-Go Act of 2010 that would result in an additional 4% sequestration of Medicare payments in 2022, if Congress does not take action to prevent it. If ordered, this additional 4% sequestration of Medicare payments would be ordered within 14 days after the close of the Congressional session, would take effect at the beginning of the following month, and would continue for 12 months. Certifying actuaries should consider the likelihood of this additional sequestration being implemented, and the extent to which it could affect their medical costs, when projecting CY2022 medical costs for Medicare-covered services. In doing so, certifying actuaries should consider previous Congressional action to reduce or eliminate reductions, when significant cuts to payments for Medicare providers were looming. Additionally, the gain/loss margin bid instructions are not affected by the potential impacts of sequestration.
2	Sequestration	04/21/2021 14:20	Bid Question	We have a question pertaining to establishing an adequate target bid margin in light of the significantly increased 4% sequestration that could be in place in 2022 (our understanding of what current law calls for absent legislative action). On page 29 of the Part C bid instructions, we see that if the corporate gain/loss margin basis is "Risk-Capital-Surplus," "the aggregate MA gain/loss margin as a percentage of revenue must be set by taking into account the degree of risk and capital and surplus requirements of the MAO's MA and Part D business prior to any impact of sequestration." Please consider the following hypothetical situation: • An MAO is using the risk-capital-surplus approach to determine the corporate gain/loss margin basis • The MAO determines it would need a 3% margin to meet its risk-capital-surplus requirements if sequestration were 0% Please confirm that the MAO would be able to set its target bid margins such that once 4% sequestration is applied to the MAO revenue, a 3% margin would be achieved. If the MAO instead submitted a bid based on a 3% margin, then that would mean the plan would estimate a negative margin net of sequestration, which would not be adequate to meet the MAO's risk-capital-surplus requirement.	The bid margin is on a pre-sequestration basis. Accordingly, the corporate margin requirement is on a pre-sequestration basis.
3	Related Party	04/21/2021 13:53	Related Party	I have a question regarding Related Party testing in the experience period. We are using the Market Comparison approach to compare a Related Party to a non-Related Party. In the past, the contract has passed given that utilization of services has remained relatively stable over the years and most features are identical to the non-Related Party. However, during CY2020, two things occurred: 1.A feature was added to the Related Party that pays additionally for mandated services during the pandemic (i.e., an extra payment if the patient has COVID and special accommodations are needed). 2. A feature of the Related Party that generally had very low utilization (again, skilled care that was triggered by a person being exposed to, in this case, COVID) was unexpectedly highly utilized. Would it be allowable to exclude pandemic based costs and services from the comparison for the base period?	No, pandemic based costs and services should not be excluded from the comparison for the base period. In this situation it would be acceptable to complete BPT Worksheet 1 following the same Related Party Method as was used for the original projection for CY2020, and disclose in supporting documentation if this Method does not comply with the related party guidance, the reason it does not comply, and how that information was taken into consideration for the projection period.
4	CAR T-cell Therapy	04/24/2021 11:47	CAR T-cell therapy	In the 2021 Rate Announcement (page 26), it seems the CMS considered CAR T-cell therapy spending part of Part B drugs and biologics. In FY 2021 IPPS final rule, CMS added a MS-DRG 018 for CAR T-cell therapy. So Medicare reimbursement for it is under IPPS. For 2022 bids, which bid category on MA BPT Worksheet2 should we put the projected CAR T-cell therapy costs and utilization?	The Medicare fee-for-service (FFS) CAR T-cell benefit will continue to be provided in both inpatient and outpatient settings in CY 2022. There will be a separate FFS payment for Part B drugs for CAR T-cell services provided in an outpatient setting. It is up to the certifying actuary to determine the allocation of CAR T-cell expenditures and utilization reported in the inpatient facility, outpatient, and Part B Rx categories of the MA BPT.

User Group Call Date 05/06/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Crosswalks	04/28/2021 9:18	part d cross-walks	We just noticed that the language in the Part D instructions regarding cross-walks and what to include in worksheet 1 is not the same as the MA instructions. Specifically, there is no reference to a significance threshold in the Part D instructions. I understand that Part D doesn't have segments, but it seems that you need the same significance threshold language for circumstances of partial cross walks between non-segmented PBPs. Can you please clarify that the same significance threshold logic should apply to the PD portion of an MA-PD plan? A good example of this is Example 4 of Appendix L in the MA bid instructions. If in Example 4 the PBP was an MAPD, can you please confirm that Plans 001 and 002 should also be included in the Plan 002 bid worksheet 1 of the PD bid?	Yes, in Example 4 of Appendix L in the MA Instructions, the Part D BPT should include Plans 001 and 002. This answer though is not tied to the MA significance level used in the example (60%). The concept of significance level is not applicable to the completion of the Part D BPT, so in this example, the Part D BPT would include Plans 001 and 002 independent of the what significance level is chosen for the MA BPT.
2	ESRD	03/25/2021 17:55	Follow-Up Questions About ESRD Migration	Thank you for your response that approximately 40,000 ESRD beneficiaries migrated from FFS Medicare to MA during 2021 AEP. We have a few follow-up questions: a. Can CMS provide data about the total number of ESRD beneficiaries currently enrolled in MA plans (split by Individual/Group), regardless of whether they migrated during 2021 AEP? b. Could CMS provide additional detail about these migrated members broken down by plan type and ESRD status (Individual/Group; Dialysis/Transplant/Post-graft)? c. Does CMS have an estimate for full-year ESRD migration from FFS to MA for 2021 that includes enrollment outside of the AEP?	The responses to the questions are as follows: a. The average monthly ESRD enrollment in MA for Q1 2021 is 169,000. b. The Q1 2021 ESRD enrollment is 24,000 in EGWP plans and 145,000 in non-EGWP plans. We do not have a breakdown of the ESRD enrollment by dialysis/transplant/post-graft. c. No, we do not have an estimate of the 2021 full-year ESRD migration from FFS to MA.

User Group Call Date 05/13/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	NCH Completion Factors	05/05/2021 10:56	Question for UGC	Thank you for the response on the completion factors on 4/15/2021. In the Table 1 you provided, we noticed the factors are for the Aged cohort. Since the Disabled cohort is around 14% of beneficiaries, do you create separate completion factors for the Disabled cohort? If so, can you please provide us with your latest Disabled cohort completion factors for experience in the National Claims History (NCH) file? Will you please confirm if the completion factors are developed based on dollars or claim counts? Are the completion factors applied by taking the claim amount times the reciprocal of the published completion factors? If not, can you please provide how the completion factors are applied? Can you please provide the COVID-19 impact by service type to the completion factors and the magnitude of the impact?	Yes, separate completion factors are developed for and applied to the disabled FFS population. Attached table 3 includes the corresponding factors for disabled population supporting the 2021 Rate Announcement. The factors are based on dollars and are essentially applied by multiplying the claim amount by the reciprocal of the completion factor. Given the complexity of the associated modeling, we are not able to provide the impact of the COVID-19 pandemic on the completion factors. Please note that these completion factors define a claim as received when posted to the weekly National Claims History (NCH) and subsequently loaded to our internal claims database, the Integrated Data Repository (IDR). Claims are incurred on a mid-point of claim from and through dates for Inpatient, SNF, HHA, and Hospice services and the claim line through date for all other services and tabulated by netting credit and debit claims. Loading timelines may be different for data accessed from public use files (PUFs). Claims loading patterns for PUFs may vary from those presented significantly due to a variety of factors such as geography, holiday placement, legislation, judicial decisions, service mix, and general claims processing errors. The mapping of claims to service categories is based on OACT's unique business requirements and non-OACT users will likely have different mappings. Therefore, we do not believe that these factors are appropriate for direct use in other pricing or reserving exercises and that each data user should develop their own completion factors based on the PUF source data and user-specific mappings of benefits.
2	COVID-19	05/10/2021 19:18	[CMS 2022 MA Bid Question] COVID 19 Vaccination Categorization	Prior guidance from CMS notes that the COVID-19 vaccine assumption in the 2022 FFS USPCC is that the per-dose cost will be $88, with administrative cost of $28 and a vaccine cost of $60. Does CMS have guidance for how plans should be projecting the $60 vaccine cost split between the professional and Part B Rx categories for doses provided in 2022?	The assumptions supporting the 2022 Rate Announcement are that 44 percent of total cost the CY 2022 COVID-19 vaccine paid by FFS Medicare will be covered under the physician fee schedule and the balance will be covered as a Part B drug. The certifying actuary must make their best estimate of the allocation of the vaccine cost and provide support for their estimate in supporting documentation.
3	Risk Score	N/A	N/A	What normalization factor should we be using for reporting the base period risk score on Worksheet 1 for Part D bids? Similarly, what normalization factor should be used for our projected risk score on Worksheet 3? We are a non-PACE organization.	For reporting the base period risk score on worksheet 1, the plan should use the 2020 RxHCC model normalization factor of 1.043 that is applicable to payment year 2020. When normalizing projected 2022 risk scores for non-PACE bids, the plan should use the 2022 RxHCC normalization factor of 1.043 that is applicable to the payment year 2022.
4	Related Party	05/10/2021 2:53	related party pmpm cells	2 pairs of newly added cells in BPTs (related party pmpm) – What denominator should be used? Whole plan's member months, or just related parties' member months?	The denominator for the related party cells should be the total plan member months.

User Group Call Date 05/13/2021

Table 3

NCH Completion Factors for Disabled Beneficiaries

Trust Fund	Service Category	Cohort	Completion Factor by Quarter							
			Qtr-0	Qtr - 1	Qtr - 2	Qtr -3	Qtr - 4	Qtr - 5	Qtr - 6	Qtr - 7
A	Inpatient hospital	Disabled	71.78%	97.33%	98.51%	99.38%	99.80%	99.91%	99.98%	100.01%
A	SNF	Disabled	65.41%	99.38%	99.50%	99.85%	99.99%	100.01%	100.01%	100.01%
A & B	HHA	Disabled	72.83%	93.61%	98.72%	100.09%	100.29%	100.32%	100.31%	100.32%
B	Physician Fee Schedule	Disabled non-ESRD	73.41%	96.84%	98.79%	99.64%	100.00%	100.00%	100.00%	100.00%
B	DME	Disabled non-ESRD	73.51%	96.63%	98.86%	99.66%	100.00%	100.00%	100.00%	100.00%
B	Carrier Lab	Disabled non-ESRD	67.74%	95.72%	98.37%	99.43%	99.98%	99.99%	99.99%	100.00%
B	Physician Admin Rx + Other Carrier	Disabled non-ESRD	72.36%	96.27%	98.63%	99.55%	99.95%	100.00%	100.00%	100.00%
B	Outpatient PPS	Disabled non-ESRD	70.93%	97.21%	98.94%	99.64%	99.94%	99.98%	99.99%	99.99%
B	Intermediary Lab	Disabled non-ESRD	73.43%	97.02%	98.85%	99.61%	99.95%	99.98%	99.99%	99.99%
B	Dialysis	Disabled ESRD	61.73%	97.03%	98.60%	99.08%	99.51%	99.62%	99.69%	99.74%
B	Therapy	Disabled non-ESRD	57.30%	95.26%	98.11%	99.35%	99.94%	99.96%	99.97%	99.99%
B	Non-dialysis non-therapy other	Disabled non-ESRD	70.67%	95.90%	98.35%	99.47%	99.98%	99.99%	99.99%	99.99%

User Group Call Date 05/20/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Credibility	05/05/2021 11:38	Worksheet 2 Adjustment	We are pricing a partially credible plan with a single high cost claimant (pharmacy claims in excess of $3 million) that has a material impact on the Part D pricing. We expect these claims have a high probability of continuing through 2022, and we need to apply a greater weight to this member's claims than the standard credibility to ensure the plan is sufficiently priced. We are seeking guidance on how to appropriately reflect this adjustment on Worksheet 2 of the Part D BPT. We intend to perform an experience and manual projection excluding this member, then add the member's claims back in (with an assumed probability weight) to compute the projected allowed cost. We are considering two ways of reflecting this adjustment on Worksheet 2: • Add the member to both the experience and manual (at the assumed probability), and assume the standard credibility applies to both the experience and manual. • Add the member to the manual rate and adjust the tier-specific credibility on Worksheet 2 to solve for the blended allowed cost including this member. Please provide feedback on which approach OACT prefers and if you have any concerns with either approach.	In this case, the partially credible experience excluding the member is projected (E), along with a corresponding manual rate (M). A separate, fully credible experience rate is projected for the high cost claimant (H). The preferred method to complete the BPT is to set the projected experience rate equal to the union of E and H, then set the manual rate equal to the union of M and H. The credibility in the BPT would equal the credibility of E. The second option listed in the question is not preferred because it may significantly distort the credibility value. Likewise, the characteristics of the manual rate will be different from the projected experience rate, even though the blended rate may be appropriate.
2	COVID-19	05/10/2021 11:29	Monoclonal antibody COVID-19 infusion	Can you provide clarity on whether monoclonal antibody COVID-19 infusion will be the responsibility of the MAOs in 2022? We understand that it is currently covered by CMS under the PHE, but are unable to find specific guidance from CMS around whether health plans will be responsible to cover in 2022+. Please advise on expectations for handling this treatment for 2022 bid development purposes.	We confirmed that Medicare FFS does cover monoclonal antibody COVID-19 infusion, and it is paid for under the COVID-19 vaccine benefit. So this is being treated the same as the COVID vaccine. It is carved out for FFS to pay in 2020 and 2021 for MA enrollees. In 2022 and later MA plans sponsors will pay be responsible for paying for this benefit for their enrollees. Additional information is available at the following links: https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies
3	COVID-19	05/12/2021 17:02	Question for the Upcoming Actuarial User Group Call	Is it accurate to assume $0 cost for the COVID-19 booster shots (including the administration cost) in 2022 bids given Biden health official comments that the COVID-19 vaccine booster shots will be free in 2022?	The actuary must make their best estimate of the costs based on the likelihood of the cost of the booster shots being free. The estimated cost of the COVID-19 vaccines administered during CY2022 is reflected in the 2022 capitation rates and benchmarks, and MA organizations must cover such costs beginning January 1, 2022. Note that even if the cost of the vaccine itself is covered by the government, the cost to administer the vaccine is the responsibility of the plan sponsor.
4	COVID-19	Live Question from 5-13 UGC	N/A	Should projected costs for the COVID-19 vaccine be introduced into the CY2022 projections using the projection factors or through the additive adjustments?	Any COVID-19 benefit costs that will be covered by the plan sponsor in CY 2022 that were not paid for by the plan sponsor in CY2020 may be reflected in either the projection factors or additive adjustments.

User Group Call Date 05/27/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	05/20/2021 12:38	questions on USPCC amounts and unit cost trends	The Unit Cost Trends File contains a brief description of the calculations as follows: "These unit cost increases reflect increases (or decreases) in the applicable market basket or fee schedule, as implemented on the specified effective date; they do not include assumptions for utilization, case-mix, enrollment, or other payment changes." Please confirm that these unit costs do not reflect: a) sequestration changes between fiscal years or b) changes in reimbursement related to COVID 20% add-on payment or c) or additional amounts related to New COVID Treatment Add-On Payments (NCTAP). If the unit cost trends reflect any of the adjustments related to a), b), or c), please quantify the amounts included for these changes.	The unit costs included in the 2020-2022 exhibit do not reflect sequestration changes between fiscal years, changes in reimbursement related to the COVID-19 20 percent add-on payment, or additional amounts related to New COVID-19 Treatment Add-On Payments (NCTAP).
2	USPCC	05/20/2021 12:38	questions on USPCC amounts and unit cost trends	In 2021, kidney acquisition costs (KAC) were no longer the responsibility of the MAOs and benchmarks were adjusted to remove the impact of KAC. a. Please confirm that the 2021 and 2022 FFS USPCCs include the KAC for both the MA and FFS members. If not, please explain why they are not included. b. Please identify the total amount of KAC costs in the 2021 and 2022 FFS USPCCs for the MA and FFS members separately. Total dollars for the MA and FFS would be preferable. c. Please confirm the KAC costs are included in the Inpatient hospital bucket of the FFS USCPCCs (i.e. column 2 of the table at the top of page 20 in the Final Announcement).	Yes, the 2021 and 2022 FFS USPCCs reflect projected expenditures for kidney acquisition costs paid on behalf of both FFS and MA beneficiaries. The expenditures are included in the inpatient hospital category. The total projected KAC expenditures on an incurred basis are $1.4 billion in CY 2021 and $1.5 billion in CY 2022. We do not have a breakdown of the projected KAC expenditures separate for FFS and MA beneficiaries.
3	USPCC	05/20/2021 12:38	questions on USPCC amounts and unit cost trends	Similar to how you provided the opioid treatment costs in 2020 in response to a previous question, can you also provide the PMPM costs of the newly covered acupuncture benefit in 2020? If possible, please include the amount of acupuncture costs included in the 2021 and 2022 FFS USPCC amounts.	As reported on the May 7, 2020 and May 21, 2020 actuarial user group calls, we estimated the cost of the national coverage decision (NCD) to cover acupuncture treatment for lower back pain to be $0.47 PMPM in CY 2020. Based on actual claim experience, the fee-for-service cost of this benefit in 2020 is estimated to be $0.01 PMPM. We have not prepared a subsequent estimate of the impact of the acupuncture NCD for CY 2021 or CY 2022.
4	Related Party	05/21/2021 19:40	Related Party Question	The MAO pays a global capitation to a related management company (X), which in turn contracts with related provider (Y) at a fee that is not comparable using the Market Comparison Method. A key fact is that the MAO does not hold the contract directly with the related provider (Y). Related management company (X) has a similar global capitation arrangement with an unrelated MAO in another service area. Is it appropriate to report costs in the BPT at the global capitation contract with related management company (X), relying on the market comparison to X's global capitation arrangement with the unrelated MAO?	Yes, in this case the plan sponsor may use the comparison method to compare the global capitation payment they make to management company (X) with the payment that the management company (X) receives in another global capitation arrangement with an unrelated MAO. The specifications of this type of arrangement are found on page 40 of the MA Bid Instructions. Recall that the expected outcome of any risk sharing arrangement must also be taken into consideration in the comparison.

User Group Call Date 06/03/2021

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	05/28/2021 15:43	RE: questions on USPCC amounts and unit cost trends	One last set of follow-up question on KAC in the 2020 FFS USPC: 1) What was the total amount of KAC in the 2020 FFS USPCC? (interested in how it compares to the $1.5B in 2021 and 2022) 2) Did the KAC in the 2020 FFS USPCC reflect both the MA and FFS members? Or did it reflect just the FFS members? Same questions for 2019: 3) What was the total amount of KAC in the 2019 FFS USPCC? 4) Did the KAC in the 2019 FFS USPCC reflect both the MA and FFS members? Or did it reflect just the FFS members?	The estimated kidney acquisition costs (KAC) reflected in the 2022 Rate Announcement USPCCs is $1.4 billion in CY 2019 and $1.3 billion in CY 2020. These amounts reflect KAC spending for FFS beneficiaries only.