User Group Call Date 04/14/2022

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://ma-covid19-policybenefits.lmi.org/covid19mailbox
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	USPCC	N/A	N/A	We appreciate the additional information on COVID assumptions included in the 2023 USPCC that was provided on the February 24 Actuarial User Group Call. We have a follow up question on the inclusion of some small negative impacts for delayed services. Is CMS estimating that more care will be deferred from 2023 to 2024 due to COVID than is deferred from 2022 to 2023 resulting in a net -0.4% impact for Part A and -0.1% impact for Part B, or are the quoted figures only for care deferred from 2023 to 2024 and there is a separate estimate for services deferred from 2022 to 2023?	The underlying COVID-19 modeling is conducted at the quarterly level. Each quarterly estimated impact on utilization may reflect an increase in expenditures due to services provided that were deferred from an earlier period and services that would otherwise have been provided that are forgone or deferred to a later period. Unfortunately, we are not able to provide a breakdown of the net annual impact by source of utilization change.
2	Related Party	N/A	N/A	If most or all Part D allowed costs reported for a plan are processed through a related party PBM, should data entered into the Part D bid, Worksheet 3, Section IV, Line 7 – Related-Party Benefit Expense PMPM, report all PDE from related and unrelated pharmacy providers processed through a related party PBM, or only data for PDE from related-party pharmacies?	Data entered into Line 7 – Related-Party Allowed Cost PMPM in the Part D bid should only reflect PDE from related-party pharmacy providers. If the PBM only provides administrative services and is not a pharmacy provider, data for related party PBM costs should be entered Line 8 – Related-Party Non-Benefit Expense PMPM.
3	Related Party	N/A	N/A	1. If an MAO contracts for medical services with a related party via a single PMPM capitation amount, may the certifying actuary split the contracted PMPM rate between medical services, non-benefit expenses, and gain-loss margin as appropriate based on the expenses of the related party? 2.Suppose instead that the MAO contracts for medical services with a related party and there are two separate PMPM capitation amounts specified in the contract – one for medical services and a second fee for administrative expenses. Does the actuary have the option to determine the portion of the total payment that should be allocated to medical or non-benefit expense based on the expenses of the related party?	1. The bid should be reported consistently with the contractual arrangement and financial statements. If there is an inconsistency between the contractual arrangement and financial statement, explain the inconsistency in supporting documentation. 2.The bid should be based on the contractual terms and the financials of the bid sponsor. If these are inconsistent, please explain in supporting documentation
4	Related Party	N/A	N/A	1. If an MAO contracts with a related party management company for administrative services and pays a management fee based on plan revenue, can the certifying actuary split the management fee between Direct, Indirect, and Sales and Marketing costs based on the services provided by the related party? Would including the entire management fee in only the Indirect Expense category also be an acceptable approach? 2. If an MAO contracts with a related party management company for administrative services and pays a management fee based on plan revenue, can the certifying actuary split the management fee between MA and Part D expenses as appropriate based on the services provided by the related party?	1a. Yes, the plan sponsor may distribute the capitation amount paid for NBE between Direct, Indirect, and Sales & Marketing based on the nature of the services provided and consistent with the financial statements of the plan sponsor. 1b. If the services in the contract cover Direct, Indirect, and Sales & Marketing, then the capitation amount should be split into these categories. It may only be fully reported in the indirect category if that is consistent with the financial statements. 2. Yes, if services are provided for both MA and Part D and the revenue on which the management fee is based represents revenue for both MA and Part D, then the fee must be split between the MA and Part D BPTs.
5	Crosswalk	03/17/2022 16:48	Crosswalk MMP to DSNP	For an existing MMP that intends to crosswalk the MMP's membership into an existing DSNP, should the 2021 MMP experience be aggregated with the 2021 DSNP experience in worksheet 1 of the BPT? Or should worksheet 1 only reflect the 2021 experience of the existing DSNP?	The reporting of the experience of the MMP should be handled according to the Base Period Data Aggregation bid instructions. Therefore, whether or not the data is included will depend on if there is a formal crosswalk, and the actuary's determination of the level of significance etc.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	CMC Initiative	03/15/2022 15:21	CY2023 Bid Questions	We have two questions on behalf of a health plan that we assist with the bid development. These two questions are related to the Cal MediConnect initiative in California. As of 1/1/2023 the CMC plan will change to Medicare plan for impacted members. 1.Are we required to report the CMC 2021 experience on Worksheet 1? If not, is it acceptable to just adjust risk scores, claims, and membership as appropriate to reflect the anticipated 2023 population which would include the CMC members? 2. This health plan has a PBP with over 80% dual membership and we are working towards crosswalking the impacted members into other MAPDs. It is our understanding that CMS historically has not allowed plans to formally crosswalk dual members into D-SNP in a county where the CMC operates. Since the CMC is transitioning to D-SNPs for Medicare benefits in 2023, do plans have the ability to formally crosswalk duals into D-SNPs in the impacted CCI counties for 2023?	1. Please refer to response to question #5 above. 2. With the CMC transition, for 2023 plans can formally crosswalk enrollees from MMPs to D-SNPs in the CCI counties when those D-SNPs meet criteria that promote integration and continuity, as established by CMS and the California Department of Health Care Services (DHCS). Further guidance on that criteria is forthcoming.
7	Supporting Documentation	N/A	Beta Feedback	In the agenda for the February User Group Call, OACT indicated that the support for mandatory supplemental benefits (#38 in MA instructions) should not include any adjustments, including induced utilization. We tested the impact of allowing pricing adjustments to change and in most cases, the differences were minimal. For internal purposes, we already price the 2022 benefits at 2023 pricing levels allowing the pricing factors to change. Pricing the 2022 benefits at 2023 pricing levels without allowing any of the pricing factors to change would significantly increase the amount of work. In addition, if we don't allow the pricing factors to change, we cannot complete this until the 2023 bids are final because we need all the final pricing factors. If we allow the pricing factors to change, we are able to run the 2022 benefits prior to the 2023 bids being finalized. We request that OACT allow flexibility in how this calculation is done (either hold factors constant or allow for minor differences) in order to reduce burden for MAOs.	The intent of supporting documentation item #38 is for OACT to assess the change in benefit value from CY2022 to CY2023. OACT will accept alternative methodologies that achieve this intent. However, the comparison must be completed using the final CY2023 pricing assumptions except in situations where the benefit is no longer provided in CY2023 in which case we will accept the CY2022 pricing estimates.
8	Supporting Documentation	N/A	Beta Feedback	[PARAPHRASED] Our dental pricing is based on "package" selections. We frequently adjust our Dental "packages". The options within that package may have no direct 1:1 mapping of a prior year package to a contract year package. How should we complete supporting documentation item #38?	In this specific situation, it is acceptable to show the change in costs from prior year's package to current year's package. For example, if the prior year's dental package cost the plan $5 pmpm and the current year's package cost the plan $8 pmpm, please report the prior year's cost, the current year's costs, and the difference between the two.
9	Additive Adjustments	N/A	Beta Feedback	[PARAPHRASED] We have a question about the use of the Additive Adjustments for projecting Non-Covered Service Categories on MA Worksheet 1. The Bid Instructions only describe the use of these adjustments for adding or removing benefits. Our plan capitates these services. We would prefer to project the change in the capitation rate for Non-Covered services using only the Additive Adjustments on MA Worksheet 1. We would calculate the Additive Adjustments as the PMPM change in the capitation rates, inclusive of all reasons for change, between base period and projected period in order to accurately reflect the cost in the projection period. Is our approach a permissible use of the Additive Adjustments?	Originally, the additive columns were available to price new or removed benefits only. If a service category had experience and a new benefit was being added to that service category, the additive columns could not be used. Effective with the CY2020 bid guidance, the additive columns could be used to price changes in capitated rates for non-covered services only. Please see the UGC Q&A guidance from April 2019. Effective with the CY2023 bid guidance, the additive columns may be used for new or removed benefits when other benefits are offered in the same service category.
10	Cost Sharing Methodology	N/A	Beta Feedback	We note that the phrase, "after the plan-level deductible has been satisfied" has been deleted from the 2023 instructions. We also note that the label in Worksheet 3, cell G20 is unchanged and continues to read, "In-Network Cost Sharing After Deductible". It is not clear if the Instruction language now requires MAOs to change historical methodologies for completing Worksheet 3 for CY2023. We recommend that OACT clarify that methodologies need not change since the final values in Worksheet 3 must ultimately reflect any impacts of all deductibles.	All utilization is to be reported on Worksheet 3 including the utilization for which the cost sharing is zero.
11	Aggregate Margin	N/A	Beta Feedback	[PARAPHRASED] We request additional information on what metrics will be used during the bid review when the aggregate margin is outside the 0% - 5.5% or the bid-level margin is high.	For both aggregate margin and bid-level margin reviews, CMS will be looking at the change in premium and benefits (or initial premium and benefit levels for new bid IDs), and the persistency of the margin level. All reviews will focus on issues at the bid level. For example, bids that have higher positive margins may be reviewed for increases in premium, decrease in benefits, and the number of consecutive years with a higher margin. Benefits will be assessed using the data submitted in supporting documentation item #38. For additional information on best practices for achieving compliance, refer to Index #1296 in the UGC Cumulative Q&A file.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
12	Supporting Documentation	N/A	Beta Feedback	Appendix B - Supporting documentation item 22.1 is unclear. The examples appear to imply the documentation should only be submitted if the Plan has a benefit structure for the services that CMS identifies which is counter to the identified limits (coinsurance for inpatient or copays for DME). Does this item only need to be submitted if that is the case?	Appendix B - Supporting documentation item 22.1 must be submitted to justify cost sharing for services without a CMS defined threshold in order to comply with Chapter 10 of the Bid Submission User Manual.
13	Credibility	04/02/2022 16:06	Manual rate credibility question	As per CMS BPT instructions, certifying actuary is allowed to override the CMS credibility formula for plans that are more than 90% credible for experience rating. Is this guidance also applicable to the manual rate? We have a plan that is 99% credible that we would like to use as a manual rate for another plan. This plan is the best manual since it has the same service area and similar benefit design. Would CMS be okay if we used this 99% credible plan as a manual rate?	The CMS credibility guidelines and pricing considerations are a reference only. These references are not a requirement and do not supplant the actuary's responsibility for choosing and applying credibility. The certifying actuary is responsible for choosing, applying, and supporting credibility in the bid pricing. Please refer to Actuarial Standard of Practice No. 25.
14	Crosswalk	04/11/2022 13:36	Level of Significance Test for MA-PD	Can CMS confirm that it is acceptable to apply the same level of significance test as outlined in Appendix L and documentation item 10.3.3 in the MA Bid Instructions for determining whether to include base period data on the Part D bid for an MA-PD plan? Our intention is to align the plans included in WS1 base data reporting between the MA and Part D BPTs, but the Part D Bid Instructions do not directly reference this topic.	The concept of significance level is not applicable to the completion of the Part D BPT. The MA and Part D Worksheet 1 base data are not required to align.
15	PDP Meaningful Difference	N/A	N/A	Can CMS please provide more guidance as to what PDP meaningful difference "outlier tests" will be conducted and / or what defines an outlier? What model will be used in determining outliers and when will that review be conducted?	As noted in the HPMS memorandum "Enhanced Out-of-Pocket Cost Model Update" issued November 19, 2021, CMS will be using the enhanced versions (both Part D and Part C) of the OOPC model for purposes of CY 2023 bid review. The enhancement to the Part D model is a change to the cohort that historically was established using MCBS data to a cohort of a 0.1% sample of Part D enrollees and their associated prescription drug events (PDE). This enhancement provides for a larger, more representative cohort, along with more timely and accurate drug cost estimates. The CY 2022 Baseline Part D model (reissued on January 21, 2022) and the CY 2023 Bid Review Part D Model released April 2022 both utilize a 2021 Part D cohort and their associated PDE data. The PDP meaningful difference requirement ensures that PDP sponsor bid submissions reflect substantial differences relative to other bids submitted by that sponsor in the same service area, with respect to beneficiary out-of-pocket costs or formulary structures. CMS has historically established a minimum dollar threshold for the OOPC differential required between a basic plan and enhanced plan(s) offered by a parent organization within a PDP region. This threshold had been established by analyzing the resulting distribution based on the previous year bid data. The threshold was annually proposed and finalized in the Call Letter. In recent years, CMS has maintained the $22 differential, last established for CY 2019, and notified sponsors through either the annual Call Letter or, more recently, Part D Bidding Instructions. CMS stated in the HPMS memorandum "2023 Part D Bidding Instructions" issued February 3, 2022, that we would be using the updated models, inclusive of the enhancement to the Part D cohort noted above, for purposes of CY 2023 Bid Review. The CY 2023 Part D Bid Review OOPC model will be released in early April 2022. Given the change to the model methodology resulting in varied OOPC values, we noted in the Part D Bidding Instructions that we would not be using the $22 minimum OOPC threshold as we had done in years past, and that we would not establish a new dollar threshold required for CY 2023 bid approval for this initial year of implementation of the enhanced model. However, we expect the OOPC value of the basic plan offering to be higher than that of the OOPC value(s) of the enhanced plan offering(s). CMS intends to conduct our analysis of PDP meaningful difference shortly following the CY 2023 bid deadline. We will use the plan-level benefits entered into the CY 2023 Plan Benefit Package (PBP) and associated formulary data submitted via the Health Plan Management System (HPMS) to estimate the plan-level OOPC values run through the CY 2023 Part D Bid Review OOPC model released in April 2022. We will determine the OOPC differentials between the basic plan and enhanced plan(s) offered by a parent organization within a PDP region. CMS intends to then conduct a comparative analysis of the OOPC differentials of all PDP parent organizations to identify outliers based on the distribution of that data. We will conduct outreach to those parent organizations that have been identified as outliers relative to other CY 2023 bid submissions. If identified as an outlier, we expect sponsors to be prepared to provide written justification upon request, to demonstrate that the plan offerings identified as outliers are substantially different from one another in terms of key benefit or plan characteristics such as cost-sharing, formulary structure or benefits offered. We note that as part of our negotiation authority under 42 C.F.R. § 423.272(a), sponsors may be asked to make modifications to their Part D benefit structure or formulary, if the submitted justification is not accepted.

User Group Call Date 04/21/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Part B Rx	04/13/2022 16:15	Part B Drug Trends	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 2022 and 2023, if not already provided?	Our latest estimate of the trend in per capita spending for Part B drugs and biologics is 17.5% for CY 2022, and 8.2% for CY 2023.
2	Related Party	N/A	N/A	For related party, if an MAO does not have a contract with the related party (claims are adjudicated OON), do we still have to provide the analysis required in section 13 of the supporting documentation and include any experience in z1 of WS4?	The instructions do not differentiate between INN and OON related parties. The related party disclosure and z1 inputs are required. The comparison in section 13 for this related party is required only if it is one of the five largest.

User Group Call Date 04/28/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/22/2022 17:17	Inpatient Unit Cost Trends	In the Final Announcement, it was stated that "The 20-percent payment bump for COVID-19 hospitalizations occurs only during the public health emergency. For purposes of our COVID-19 modeling, the public health emergency (PHE) was projected to run through the first half of CY 2022". Can you please confirm that the impact of the assumption of the PHE ending in the first half of CY2022 and therefore the 20-percent payment bump not applying for any of CY2023 was included in the development of the 3.2-percent inpatient unit cost trends first published here https://www.cms.gov/files/document/ffs-trends-2021-2023-april-2022.pdf and later confirmed in the IPPS proposed rule?	The 20 percent add-on for COVID-19 discharges is not reflected in the FY 2023 inpatient prospective payment system (IPPS) unit cost trend of 3.2 percent.
2	Part D	04/08/2022 19:07	$0 Script Entry	In the final 2023 Part D bid instructions, page 10 was changed to require scripts ">= Zero" to be reported in column F on Worksheet 1 in Section III. However, the Part D BPT does not allow for scripts to be entered for members that have no total allowed. This can happen when a member only takes scripts that cost $0. This is true for the base period (cell F28 on Worksheet 1) and the projection period (cell F20 on Worksheet 3). This also causes multiple validation errors since the total scripts on Worksheet 3 do not match the total scripts on Worksheet 2 or Worksheet 6. Is it possible to release a revised BPT that allows for script inputs for members with no total allowed?	Plans should input the scripts and members for these $0 scripts into the deductible phase on WS1 and WS3.
3	Gain/Loss Margin	04/25/2022 22:01	Proposed MOOP Rule Question	[Paraphrased]. For plans with gain/loss margin greater than 11.5%, does OACT have any guidance on MOOP levels in addition to that in the April 7, 2022 Final Rule CMS-4190-FC4 and cited in the April 20, 2022 Final Contract Year 2023 Part C Benefits Review and Evaluation?	OACT views the changes in MOOP levels to be a lever in benefit value. Increasing the MOOP would decrease benefit value. No change in the MOOP equates to no change in benefit value.
4	Related Party	04/22/2022 11:40	related party	Suppose that an MAO contracts with a related party to give them effectively 100% of revenue and 100% risk for all medical costs and non-benefit expenses for certain PBPs. The instructions state that the expenses "must be reported in the BPT in a manner consistent with the contractual arrangement". The certifying actuary's interpretation is that the contractual arrangement makes the related party the de-facto risk-taking entity and therefore the bids should be filled out showing the related party's medical costs, non-benefit expenses, and gain/loss margin. We believe this would meet CMS' objective that related parties do not lead to over- or under-subsidized bids. Given the circumstances, would OACT be opposed to this interpretation?	This appears to be a quota share reinsurance arrangement, and as such the plan should ensure that the arrangement complies with Section 1855(b) of the Social Security Act and regulation section 422.3. To the extent that this arrangement does comply, the plan should report the NBE and allowed cost the same as would be reported if there was no risk or related party arrangement, and report the gain/loss margin for the quota share arrangement in the NBE as net cost of reinsurance. The related party does not change how data is reported in the bid. Also note that the related party must be appropriately disclosed and supported as required in Appendix B.
5	Related Party	04/25/2022 16:57	User Group Call Question - Related Party Documentation	Item 13.5.1 of the MA Supporting Documentation is "The PMPM cost of services or benefits consistent with the contractual arrangement and the number of beneficiaries affected by each contract". We do not typically track beneficiaries through the MA bid projections. Please confirm that it is acceptable to include member months instead of beneficiaries.	Yes, it is acceptable to use member months instead of beneficiaries who are eligible for each contract.

User Group Call Date 05/05/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/25/2022 13:17	2023 Rate Announcement FFS USPCC Trend Question	We have the following question regarding the 2023 Rate Announcement FFS USPCC Trends: With regards to the additional information on COVID assumptions in the "COVID-19 adjustment factors" file posted on the CMS website, besides the impact of these "COVID-19 adjustment factors", what are the major drivers of the 4% difference between the 2022 and 2023 FFS USPCC trends of 9.4% and 5.4%, respectively.	The non-ESRD fee-for-service USPCC trends excluding the impact of published annual COVID-19 adjustment factors are about 6.4 percent for 2022 and 4.8 percent for 2023. Key drivers of the 2022 versus 2023 difference in this "pre-COVID" trend include service types physician fee schedule, physician administered drugs, and inpatient hospital. The current law physician fee schedule update is –0.7 percent for 2022 and –2.9 percent for 2023. Also, trends excluding the annual COVID adjustment factor for physician administered drugs are 15.0 percent for 2022 and 8.2 percent for 2023. The 2022 trend is relatively high due to it being the first year in which Medicare is assumed to pay for COVID-19 vaccines. Finally, the projected trends in inpatient pass through payments and demographic factors are higher in 2022 versus 2023.
2	VBID	04/25/2022 22:01	DS VBID Cost Sharing	Defined standard plans participating in the VBID model with waived LI cost sharing include the cost of this benefit in the non-benefit expenses for the projection period. How should the experience be reported for this benefit on worksheet 1 of the Part D BPT?	Report the waived cost sharing amounts for low income beneficiaries as member cost sharing in Worksheet 1. Do not include this expense in the non-benefit expenses on Worksheet 1. OACT will advise our reviewers and auditors of the difference between experience and projection reporting for these plans.
3	Related Party	N/A	N/A	Should rebate dollars associated with related parties be reported anywhere on section IV of WS3 of the Part D BPT?	The Part D bid instructions, Line 7 – Related-Party Allowed Cost PMPM, state "Enter the best estimate of the plan sponsor's total allowed PMPM cost for the sum of the following: 1) All related-party pharmacy services in the bid, and 2) Services that are provided by entities with the same tax identification number and that are reported in the bid. This entry must reflect the expected allowed costs consistent with actual contracts, capitation and risk arrangements, and financial reporting. Part D sponsors must include all expected DIR amounts under "Rebate" in the BPT. Rebates are not reported as allowed cost in the Part D bid, and therefore should not be reported in Line 7 – Related-Party Allowed Cost PMPM. The Part D bid instructions, Line 8 – Related-Party Non-Benefit Expense PMPM, state "Enter the best estimate of the plan sponsor's total PMPM cost for all related-party non-benefit expenses reported in the bid. This entry must reflect the expected non-benefit expenses for all related parties, consistent with actual contracts and financial reporting." If DIR was paid to, or retained by a related party in exchange for a service reported in NBE, this transaction must be reported in the NBE for the Part D bid as well as DIR, and if the entity is a related party, this transaction should be reported in Related-Party Non-Benefit Expense PMPM.

User Group Call Date 05/12/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Related Party	05/04/2022 13:55	Related Party Question	In Appendix B, Section 13.5 of the MA BPT instructions, it states that "If the ratio of the related-party expenses (Worksheet 4 cell M104 plus Worksheet 4 cell M105) to the total allowed cost plus total non-benefit expenses (Worksheet 2 cell O38 plus Worksheet 4 cell H106) is greater than 10 percent, provide items 13.5.1 and 13.5.2 for the five largest related parties declared in the projection period." For the up to five related parties in the projection period subject to 13.5, can you confirm that 13.5.1 and 13.5.2 only need to be provided for projection period costs and not for base period costs?	Yes, this is correct. Items 13.5.1 and 13.5.2 only need to be provided for the projection period.
2	Base Period Experience	N/A	User Group Call Questions	1. We are considering not renewing one segment of a multiple segment MAPD in 2023. If we do not renew the segment, should we include that segment's 2021 base data in WS1 of the MA BPT's and the Part D BPT for the continuing segments? 2. If we should include the experience of the dropped segment in the WS1 of the BPT's, how should we account for the dropped segment in pricing?	1. If a segment is not renewed in CY2023, unless there are counties from the dropped segment undergoing an official crosswalk to other segments in the plan, the MA BPTs for the remaining segments should not include CY2021 experience from the terminating segment. However, for Part D, segments must all have the same BPT and even if the one segment is terminated, the experience for that segment should be included in the Part D BPT that is submitted for all segments that do exist in 2023. 2. For the Part D BPT, pricing adjustments for the removal of the terminating segment should be accounted for in the "Other Change" columns for Utilization and Unit Cost on WS2. Note that service area expansions or service area reductions should be handled in a similar way on the MA BPT, in the "Other Factor" columns for Utilization and Unit Cost on WS1.
3	MA FFS actuarial equivalent cost sharing	N/A	Asked live on 5/5/22 UGC	The recently released final 2023 MA BPT shows a FFS Actuarially Equivalent cost sharing level of 19.95% for Part B services. Our understanding is that the Original Medicare benefit is the Part B deductible plus 20% coinsurance, which should be more than 20% effective coinsurance. Can CMS explain why the entry in the BPT is below 20%? This is especially important because it can cause the BPT to show 20% coinsurance on DME to fail the cost sharing test, even when there is no deductible, which would actually be a richer benefit than Original Medicare.	The main driver of the 2023 Part B cost sharing below 20 percent is outpatient hospital which has estimated 2023 sharing equal to 15.8 percent of allowed costs. The cost sharing for outpatient hospital is capped at the inpatient hospital deductible level. Therefore, the effective outpatient cost sharing will be below 20 percent for services with high allowed costs. Support for the outpatient cost sharing policy is included on this webpage: https://www.medicare.gov/coverage/outpatient-hospital-services

User Group Call Date 05/19/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Supporting Documentation	05/10/2022 16:36	Bid Support Documentation #38	For the bid support documentation #38, can you please clarify if it is sufficient to include just continuing PBP plans given it is a comparison to prior year's benefits?	Supporting documentation item 38 is only required for continuing Bid IDs.
2	Medicaid Revenue	05/09/2022 18:48	DSNP Medicaid Questions	[Paraphrased] Our bid client offers a south Florida DSNP which collects Medicaid revenue. They do not believe any non-benefit expenses would be considered Medicaid only or be in addition to their Medicare Advantage non-benefit expenses. Can we input $0 PMPM Non-Benefit Expenses in the Projected Medicaid Data section of Worksheet 4 – MA Projected Revenue Requirement PMPM? The plan was able to identify a very small portion of Medicaid claims. Would it be acceptable to allocate NBEs based on the proportion of paid Medicaid claims?	It would be inappropriate to project $0 NBEs when there is a non-zero Medicaid Projected Revenue. Please see the CY2023 MA BPT Instructions, pages 31-32 which states "Non-benefit expenses consist of all the bid-specific administrative and other non-benefit costs incurred in the operation of the MA bid… When Medicare benefits are funded by an outside source such as a state Medicaid program, the non-benefit expenses must be allocated proportionately between Medicare and the other revenue source." Therefore, use an appropriate methodology to separate out the expenses that belong to the Medicaid line of business. CMS does not have a specific methodology that plan sponsors must follow. The plan sponsor must include appropriate documentation to support the chosen allocation methodology.
3	Base Period Experience	Asked Live on 5-12 UGC	N/A	[Paraphrased] On last week's UGC a question was asked regarding how to account for a dropped segment in pricing if the plan is required to include the base period experience of the dropped segment on the WS1 of the BPT. The answer stated that pricing adjustments for the removal of the terminating segment should be accounted for in the "Other Change." We agree that the adjustments should be put into "Other Change" columns for Unit Cost on PD WS2 or MA WS1 because there are no "Risk Change" factors or "Population Change" factors for Unit Cost on PD WS2 or MA WS1.We think it is more appropriate to put the adjustments into the "Risk Change" columns on PD WS2 and the "Population Change" columns on MA WS1 for Utilization because this is a population change. Would you please confirm that this adjustment should be put into "Risk Change" columns on PD WS2 and "Population Change" columns on MA WS1 for Utilization?	The certifying actuary should determine if the adjustment would be more appropriate in the "Other Change" or "Risk/Population Change" column for Utilization and support their choice in supporting documentation.

User Group Call Date 05/26/2022

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Service Area	05/18/2022 10:50	MN DSNP Question	We are planning on filing a DSNP plan in the State of MN. In order to file a DSNP in MN, MAOs need to have a Medicaid contract in each of the counties in the DSNP. MN has not yet announced which health plans will be awarded the MN MSHO & SNBC contract for each of the counties, and the State has stated that the award will not be announced until the last week in May or first week in June. Our draft BPT contains all of the counties in the State of MN. How are MAOs supposed to file the DSNP bids if the State awards the MN MSHO & SNBC contract after June 6th, or prior to June 6th but not with enough time for MAOs to modify the bid filings? Will there be an opportunity to revise the bids to reflect the correct service area?	Plan sponsors should submit the bids with their best estimate of the counties that will be in the service area for the Contract Year. If a decision is made after the bid submission deadline that impacts the counties, the plan will be given the opportunity to remove counties not in the service area from the BPT. With this removal, the plan may only adjust assumptions that are directly related to the county removal.
2	COVID-19	05/18/2022 15:31	2023 COVID-related Expenses	The rate announcement specified that OACT projected an average per dose vaccine cost of $64 and vaccine administration cost of $40 for CY2023. How did OACT arrive at a $64 average per dose vaccine cost?	The estimated CY 2023 per dose ingredient cost for the COVID-19 vaccine was estimated based on our assessment of statements from pharmaceutical companies, historical vaccine price patterns, potential market dynamics, and statements from market analysts.

User Group Call Date 06/02/2022

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1	Crosswalks	05/25/2022 20:22	Exceptions Plan Crosswalk instructions	Today, the Process for Requesting an HPMS Crosswalk Exception for Contract Year 2023 was released. The email says “Please refer to Chapter 11 of the Bid Submission User Manual for a full explanation to complete the various steps to submit a crosswalk exception. The Bid Submission User Manual can be found at the following HPMS path: HPMS>Plan Bids>Bid Submission>CY 2023> View Documentation”. However, there is no Chapter 11. Where can we find 2023 instructions?	Chapter 11 of the Bid Submission User Manual is expected to be released on June 7th.
2	Part B Premium	05/28/2022 14:50	Overestimating Part B Premium Buydown Question	The 2022 Medicare Part B Premium amount is $170.10. For CY2023 we are planning to buy-down the entire $170.10 using MA rebates as allowed within the BPTs. What happens in the possible situation later this year after bid finalization when the 2023 Part B premium is announced and it is possibly lower than $170.10?	CMS would retain any excess rebate dollars greater than the standard Part B Premium for an enrollee who has the standard Part B Premium. Additionally, our interpretation of the regulations is that the Part B buydown cannot be applied to other amounts besides the standard Part B premium, such as a late-enrollment penalty amount or an income-related premium adjustment amount.