User Group Call Date 02/23/2023

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	Part D	N/A	N/A	Are the vaccines for section IV of Worksheet 6 referring to all vaccines or those under the IRA (member must be >18)?	The vaccine and insulin sections of the BPT must be populated with the drugs that the plan intends to use to satisfy the relevant provisions of the IRA, consistent with all other CMS guidance. Other drugs in these categories that do not need to satisfy the new IRA cost-sharing provisions are not to be reported in the insulin and vaccine sections of the BPT. Please refer to the Health Plan Management System (HPMS) memorandum released on September 26, 2022 titled “Prescription Drug Event Reporting Instructions for the Implementation of the Statutory Cost Sharing Maximums Established by the Inflation Reduction Act for Covered Insulin Products and ACIP-Recommended Vaccines for Contract Year 2023” for detailed examples.
2	Part D	12/07/2022 15:38	Proposed Update Comments	1) Where should the induced utilization impact, due to the cost sharing in the catastrophic phase moving to $0/0%, go in WS2 of the Part D BPT? 2) Where should the impacts of induced utilization, due to the decreased drug prices related to AMP cap, go in WS2 of the Part D BPT? 3) Where should the impacts of induced utilization, due to the decreased drug prices related to POS pharmacy DIR, go in WS2 of the Part D BPT? 4) Where should the induced utilization impact, due to the decreased cost sharing on vaccines and insulins, go in WS2 of the Part D BPT?	The utilization “other change” is the most appropriate column to adjust for induced utilization impact due to the IRA.
3	Part D	12/07/2022 15:38	Proposed Update Comments	Where should the impacts of decreased drug prices related to AMP cap go in WS2 of the Part D BPT?	Column E, Inflation trend, on Worksheet 2 is the most appropriate column to adjust for the impacts of decreased drug prices related to AMP cap.
4	Part D	12/07/2022 15:38	Proposed Update Comments	Where should the impacts of decreased drug prices related to POS pharmacy DIR go in WS2 of the Part D BPT?	The Unit Cost “Other change” column is the most appropriate column to adjust for the impacts of decreased drug prices related to POS pharmacy DIR. (4/13/2023 UPDATED RESPONSE): Based on feedback, we have determined that isolating the pharmacy DIR effects may not always be possible. For consistency, we are rescinding our prior guidance and requiring that plans use the discount change column for pharmacy DIR pricing effects.

User Group Call Date 02/23/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
5	Part D	02/09/2023 13:01	Part D BPT Insulin and vaccine Copay	With insulin costing at most $35 and Vaccines $0. I have the Following procedure questions and BPT questions 1) How will this be treated in the deductible phase? I feel like it is possible to get into the gap phase without ever meeting the deductible. If the member has allowed insulin of $1,000 per 30 days this would have the member jumping into the gap before exiting the deductible phase. How should we handle this? How would you want to show this for WS3, WS6, and WS6A? 2) How do you want us to handle the insulins and Vaccine copays for WS6? Costshare is greyed out for claims subject to deductible. 3) Is the intention to remove all insulin and vaccine from table 1 and 2 and move it to table 3 and 4 in the CY2024 draft PD BPT?	1) Similar to plan designs with non-uniform deductibles, a beneficiary is deemed to enter the gap coverage phase when they have exceeded the initial coverage limit, regardless of whether they have met the deductible at that point. For purposes of worksheets 6 and 6A, the IRA insulins and vaccines are not subject to the deductible, so they should be populated accordingly. For worksheet 3, they should be reported based on their allowed claims cost, inclusive of the spending on insulins and vaccines. 2) IRA insulins and vaccines are not subject to the deductible, so they should not go in the deductible lines of WS6. 3) No, On PD Worksheet 6, Section III and IV are not mutually exclusive from Section II. Section II on worksheet 6 should be filled out the same way as in prior years.
6	Part D	N/A	N/A	For the new cells E56 and E57 on WS6A, should the PMPM be per NLI member months or total member months?	Cells E56 and E57 on WS6A should be per NLI member per month.
7	MA ratebook	02/10/2023 9:29	Medical Education Costs Question	Page 10 of the Advance Notice proposes a technical update to the Medical Education Payments in the calculation of the Non-ESRD USPCC baseline to exclude IME and DGME costs paid on behalf of MA enrollees. Additionally, the 2023 Calculation data file describes the calculation of the FFS rate as follows: FFS Rate excludes phased-out IME and KAC = FFS USPCC x AGA x (1 - GME factor) x (VA-DOD Adjustment Factor) x Credibility Factor - KAC dollar Amount - IME dollar amount. Based on the equation for the FFS rate, we would expect that the IME dollar amount in this formula should also be adjusted to exclude IME associated with MA enrollees. Please confirm that we have the correct understanding and that the appropriate adjustments to the FFS USPCC are being proposed for IME and DGME.	Historically, IME represented in the non-ESRD FFS USPCCs has included IME paid on behalf of MA enrollees. In contrast, IME represented in the ratebook FFS rate calculation is, and always has been, limited to that paid on behalf of FFS admissions. Therefore, no corresponding adjustment is required to the IME in the ratebook FFS rate calculation to remove the costs associated with MA enrollees.
8	MA ratebook	02/15/2023 20:41	Questions for the 2/23 OACT Call	I have the following questions regarding the 2024 Advance a, Can CMS provide additional detailed support for the 2.13% impact to the FFS USPCC growth percent? How should this compare to the magnitude of historical IME costs that are removed after the application of the AGA to the rebased FFS per capita costs? b. CMS indicated that the 2.09% effective growth rate included the technical correction to the per capita cost calculation. How is the IME that is removed from the non-ESRD FFS Growth rate for the technical correction different from the IME that is removed after the AGA? Does this mean both costs will be removed from the calculation of county benchmarks? c. The additional detail on Medicare Fee-for-Service Unit Cost increases notes that the impact of the Consolidated Appropriations Act, 2023 is excluded. Does this confirm that the growth rate also excludes the impact of this legislation?	The responses are a. The net impact of the exclusion of MA medical education from the CY 2024 FFS USPCCs is $9.1 billion. b. The IME carveout from the MA ratebook is calculated directly from FFS claim records. Alternatively, the IME reflected in USPCCs is tabulated from the inpatient cost reports. Previously, the historical IME reflected in USPCC calculation included all IME, including that paid on behalf of MA beneficiaries. The USPCC experience and projections are now limited to IME paid for FFS admissions only. c. Yes, that is correct, the 2024 Advance Notice MA growth rates also exclude the impact of CCA, 2023.
9	FFS unit cost trends	02/03/2023 11:36	Question re: FFS unit cost increases	The published unit cost trends for laboratory fee schedule is showing an increase of 0.0 percent for 2022, 0.0 percent for 2023 and +5.6 percent for 2024. I understand the 0.0 percent for 2022 as section 1834A(b)(3)(B)(ii) limits reductions to CLFS rates based on private payer rates to 0.0 percent for 2022 and there is no update for other clinical laboratory fees schedule (CLFS) services. My confusion begins with 2023. While CAA, 2023 extends the 0.0 percent limit on reductions in CLFS rates for 2023, the paper indicates that unit cost changes do not account for the effect of the CAA, 2023. If that is the case, the table would assume that payment reductions (synonymous with “unit cost” changes in the table) that are occurring under PAMA 2014 would continue in 2023. That brings us to the +5.6 percent updates for 2024. The next PAMA update to the CLFS rates will be based on private payer rates from 2019. Both CBO and CMS appear to be assuming that the next iteration of private payer rates will increase payment for CLFS services. Please confirm that is the case.	Following are key aspects of our projection of the laboratory fee schedule updates represented in the 2024 Advance Notice FFS trends: - Prior to the Consolidated Appropriations Act (CAA), 2023 , the 0.0 percent update went through 2023 with the next update occurring in 2024. This is the basis of the 2024 Advance Notice Growth rate. - CCA 2023 extended the 0.0 percent update through calendar year (CY) 2024, and the next update scheduled to occur in CY 2025. In 2024, labs are to report their 2019 data for use in the 2025 update. - The pre-CCA estimated CY 2024 update of 5.6 percent uses the Consumer Price Index (CPI) as a proxy for the change in lab payment levels from the 2016 data to the 2019 data.

User Group Call Date 02/23/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
10	MA ratebook growth rates	02/14/2023 18:23	Questions for February User Group call	Below are questions we have on the assumptions included in the advance notice. a. What did CMS include for the cost and utilization assumptions for new Alzheimer’s drug treatments such as Aduhelm? b. What did CMS assume for the cost and utilization assumptions for COVID vaccines? c. What adjustments did CMS make to the USPPC for the impact of the cap on the Part B drug price increase, the lower member cost sharing as a result of the cap on the Part B drug price and the $35 copay limit on insulin provided through the Part B benefit? d. What assumptions did CMS make about the potential increased costs in 2024 due to deferred care during the COVID pandemic? e. Page 14 of the Advance Notice indicates that the USPCCs and the growth rates in the Advance Notice did not reflect the provisions of the Consolidated Appropriations Act, 2023, and the impact will be included in the Final Notice. Please provide an estimate of the impact of the provisions of the Consolidated Appropriations Act, 2023.	Following are the responses to the questions: a. There is some historical experience in our base data for the coverage of Aduhelm. We make no explicit additions to our projections for Aduhelm. Also, there are currently no explicit additions to our projections for any drug for the treatment of Alzheimer’s disease. This is because the coverage for the recently FDA-approved drug for treatment of Alzheimer's is made under the existing Medicare coverage decision for this class of drugs, which includes Aduhelm. Under this coverage, there is expected to be minimal impact on Part B fee-for-service (FFS) spending. b. Assumptions for COVID-19 vaccine in CY 2024 are (i) 47 percent of beneficiaries will receive COVID shot with 43 percent represented in Medicare claims; (ii) Average doses per utilizer: 1.3; and (iii) average cost per dose: $105. c. Given the historical price growth for Part B drugs and the current relatively high level of general inflation, we assumed that the Inflation Reduction Act (IRA) rebate provision would have no impact on Part B FFS expenditures in CY2024. We estimate that the reduced cost sharing for Part B insulin associated with DME would reduce FFS beneficiary cost sharing by roughly $20-30 million during CY 2024. d. We are not assuming any increases in costs in 2024 due to deferred care during the pandemic. e. We do not have an estimate of the impact of CAA, 2023 on the 2024 Advance Notice USPCC baseline.

User Group Call Date 04/13/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rate	04/02/2023 8:15	2024 Rate Announcement COVID-19 vaccine question	We see on page 39 of the 2024 Rate Announcement that CMS is assuming the following for 2024 COVID-19 vaccines costs: "Assumptions for COVID-19 vaccine in CY 2024 are (i) 47 percent of beneficiaries will receive a COVID shot with 43 percent represented in Medicare FFS claims; (ii) average doses per utilizer: 1.3; and (iii) average cost per dose: $105". Can you provide similar details for each of the CY 2022 and CY 2023 COVID-19 vaccine costs that are reflected in this year's Rate Announcement FFS USPCCs?	Actual 2022 COVID vaccine expenditures are reflected in the USPCC baseline and are not reflected separately from other program expenditures. Additionally, the impact of projected COVID vaccine costs in the Rate Announcement 2024 USPCC baseline are built in at the service level as: (i) physician fee schedule and outpatient (non-drug): 0.0% for 2023 and −0.1% for 2024, and (ii) physician administered drugs: 0.0% for 2023 and −0.7% for 2024.
2	Growth Rate	04/07/2023 16:58	Question related to CY2024 FFS growth rate	Could CMS provide the impact of the Consolidations Appropriations Act, 2023 to the CY2024 FFS growth rate provided in the CY2024 Rate Announcement (similar to the table on page 33 for the medical education technical update)?	The impact of the Consolidated Appropriations Act, 2023 on the 2024 non-ESRD FFS growth rate is 0.28% for Part A, 0.16% for Part B, and 0.21% combined Part A and Part B.
3	Growth Rate	04/10/2023 15:14	Question related to USPCC	We appreciate the information on COVID-19 vaccine assumptions included in the 2024 Announcement. We have a couple follow up questions on the excess morbidity and COVID-related impacts presented on page 39. 1. Can CMS please provide the estimate of excess morbidity on aggregate per capita Medicare FFS spending by year assumed in the 2024 Advance Notice and the 2023 Announcement? 2. Can CMS please provide an updated view of the COVID-19 cumulative adjustment factors by type of service that supports the 2024 Rate Announcement (similar to the file published with the 2023 Rate Announcement)?	The estimated morbidity impact due to the COVID-19 pandemic on the 2023 Rate Announcement baseline by calendar year is: (i) 2021: −2.90%; (ii) 2022: −3.10%; (iii) 2023: −2.20%, and (iv) 2024: −1.30%. The estimated morbidity impact due to the COVID-19 pandemic in the 2024 Advance Notice baseline: (i) 2021: −2.50%; (ii) 2022: −4.00%; (iii) 2023: −4.40%, and (iv) 2024: −4.40%. The 2024 Rate Announcement USPCC projections use 2022 as a base year for determining the COVID-19 impacts, and as a result, the COVID-19 projection factors do not apply since the pandemic experience is reflected in base experience. In comparison, the 2023 Rate Announcement COVID-19 impacts were developed using 2019 as the base year.
4	Growth Rate	04/10/2023 18:58	User Group Call Question - Alzheimer's drugs	What did OACT include for the cost and utilization assumptions for new Alzheimer's drug treatments such as Aduhelm in the Final Notice? Did OACT make any changes to the assumptions for Alzheimer's drug treatments from the Advance Notice to the Final Notice?	As stated in response to question #10 on the February 23, 2023 actuarial user group call, there is some historical experience in our base data for the coverage of Aduhelm. We make no explicit additions to our projections for Aduhelm or for any drug for the treatment of Alzheimer's disease. This is because the coverage for the recently FDA-approved drug for treatment of Alzheimer's is made under the existing Medicare coverage decision for this class of drugs, which includes Aduhelm. Under this coverage, there is expected to be minimal impact on Part B fee-for-service (FFS) spending. Further, additional quarter of experience, 4th quarter 2022, was added to the 2024 Rate Announcement baseline. The projection factors for 2023 and later were also updated for the 2024 Rate Announcement.
5	Credibility	N/A	MSP	Should the credibility for Medicare as secondary payer (MSP) adjustment factors follow the CMS credibility guidelines for allowed cost or risk score?	CMS has not provided credibility guidelines for MSP. The guidelines for allowed cost and risk scores are inappropriate for MSP.
6	Gain/Loss Margin	N/A	Support for resubmissions	If our initial bid margin is less than 11.5% but upon resubmission the margin is greater than 11.5%, do we need to submit the repricing support required in the MA bid instructions, Appendix B, item 8.6.2?	Yes, if the bid margin is greater than 11.5% in any submission or resubmission of the BPT, then the repricing support must be submitted.
7	Projection Factors	N/A	Additive Adjustments for Provider Risk Sharing	Our plan has global capitation arrangements which include risk sharing. When settlement payments occur we reflect them in the base period medical expenses, but for projection purposes we would like to remove them using the additive adjustment columns. Is this permissible?	No, the additive adjustment columns may not be used to remove risk sharing settlement payments. The projection or removal of these payments must be reported in the unit cost columns on the BPT.
8	Rebate Reallocation	N/A	MOOP Category	Is it permissible to change the maximum out of pocket (MOOP) category (mandatory, intermediate, lower) during rebate reallocation?	OACT considers a change to the MOOP category to be a significant benefit change because changes to the MOOP category require changes to the service-level cost sharing on MA BPT Worksheet 3. This may cause significant benefit restructuring.
9	Projection Factors	N/A	N/A	We make an adjustment that calibrates the projected unit costs for services subject to the percentage of revenue capitation arrangements for plans to equal the contracted capitations. This adjustment is necessary in order to balance the projected net medical expense to an amount consistent with the terms of the provider capitation contracts. In what projection factor on BPT WS1 should this adjustment be reflected?	This adjustment should be reflected in the "Unit Cost Adjustment – Provider Payment Change" column. The MA bid instructions state that "The "Unit Cost Adjustment – Provider Payment Change" factors entered on Worksheet 1 must include the impact of changes in all capitation arrangements aside from those attributable to changes in utilization or benefits." This includes goal seeking and calibration adjustments used to ensure the BPT is consistent with provider capitation contracts and/or provider risk sharing arrangements.
10	Enrollment	02/28/2023	Actuarial Bid Instructions Questions	Page 8 of the CY2024 MA BPT instructions states, "By statute, the bid must represent the revenue requirement of the expected population." In addition, page 48 states that Worksheet 1, Section V, "must be completed consistently with … the information reported in Section III" and the experience data on Worksheet 1 must "reconcile in an auditable manner to the MAO's audited financial statements" and "reflect the current best estimate of incurred claims on an experience basis". Can CMS provide explicit guidance on how to treat medical claims for members associated with a Medicare Advantage plan that would be included in the audited financial statements for the base period, but where there is not a corresponding record in the MMR?	If there are claims associated with the MA plan for members without a corresponding record in the MMR, then one of the two datasets must require reconciliation. The plan sponsor is required to report claims and membership associated with the plan on worksheet 1. Thus Worksheet 1 should either include both the claims and the membership, or should exclude both the claims and the membership. The plan sponsor must show the reconciliation in their support.

User Group Call Date 04/13/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
11	Trend	02/28/2023	Actuarial Bid Instructions Questions	For Worksheet 1, column O, the Unit Cost Adjustment – Other Factor, page 47 of the CY2024 MA BPT instructions includes the following language, "Enter any other factors for unit cost adjustments by service category. An example is a change in unit cost due to intensity of service trend or the impact on unit costs of the covered population's change in risk from the base period to the contract period." For MAOs that do not explicitly carve-out the intensity/mix trend in their historical trend study (i.e., intensity/mix trend would be inherently included in the unit cost and to some extent, the utilization trends), does CMS consider it appropriate to have a 1.0 factor in the Unit Cost Adjustment – Other Factor column?	Yes, this is acceptable.
12	Supporting Documentation	N/A	Feedback to Beta BPT Instructions	We use alternative trend factors on WS1 to develop our bids and do not rely on our own historical trend factors, are we still required to provide qualitative and quantitative support for our historical trends as per Appendix B item 11.2?	Yes, support for the MAO's historical trends is required even when those trends are not applied to the pricing.
13	Part D	02/25/2023 13:41	POS DIR Unit Cost Impact - Part D WS2	We are seeking clarification on the response provided by CMS on the February Actuarial User Group Call to question #4 regarding the WS2 placement of the unit cost impact related to POS pharmacy DIR. The question and CMS response are as follows: Question: Where should the impacts of decreased drug prices related to POS pharmacy DIR go in WS2 of the Part D BPT? CMS response: The Unit Cost "Other change" column is the most appropriate column to adjust for the impacts of decreased drug prices related to POS pharmacy DIR. Pharmacy DIR, and changes to it, is a component of pharmacy network pricing and contracts. Due to the nature of contracting between plan sponsors, pharmacy benefit managers (PBMs), and pharmacies, we do not believe it is feasible to separate the impact of POS pharmacy DIR from other network contracting changes affecting unit cost. Because these components are often interrelated, we do not believe PBM contracts would specify how much unit cost change is due to the removal of pharmacy DIR and how much is driven by other factors considered in the network contracting process. Therefore, we request permission to include any impact to unit cost due to recontracting between pharmacies and PBMs, inclusive of impacts driven by POS pharmacy DIR, in the "Discount Change" column on WS2	Based on feedback, we have determined that isolating the pharmacy DIR effects may not always be possible. For consistency, we are rescinding our prior guidance and requiring that plans use the discount change column for pharmacy DIR pricing effects.
14	Part D	N/A	Feedback to Beta BPT Instructions	Please clarify the treatment of a partial insulin fills (i.e., days supply less than 30) in the bid instructions for WS6 of the Part D BPT. We believe partial fills should be entered as one 30-day script in the new "Insulins" cells F67:F70 and I67:I70 of WS6 because cost sharing for insulin is not pro-rated due to being a liquid.	Yes, partial fills should be entered as one 30-day script in Section III of Worksheet 6. Part D sponsors are not required to prorate the $35 copay if less than a one-month supply is dispensed because insulin is not a solid oral dosage form subject to daily cost-sharing requirements at § 423.153(b)(4). For more information please see the HPMS memo released September 26th, 2022 titled "Contract Year 2023 Program Guidance Related to Inflation Reduction Act Changes to Part D Coverage of Vaccines and Insulin".
15	Part D	N/A	Feedback to Beta BPT Instructions	[Paraphrased] The BPT validation tests for the brand DS cost sharing values in WS6 and the brand DS gap cost sharing values in WS6A will have to change, as now the DS cost sharing will be different than 25% for brands, due to the changes in the insulin and vaccine cost sharing, from the Inflation Reduction Act.	The BPT validation tests for brand DS cost sharing in Worksheet 6 and the brand DS gap cost sharing values in WS6A are not critical errors. The validation checks serve as a reminder of the cost sharing calculation on the pre-IRA basis.
16	Part D	N/A	Feedback to Beta BPT Instructions	Does the suggested formula for WS6A Non-LI Brand Discount Amt PMPM (cell E54) need to be updated as there doesn't seem to be a scenario where the formula is applicable.	The formula for WS6A Non-LI Brand Discount Amt PMPM is unchanged from the CY2023 BPT. It is not correct for all scenarios. If the cell is overridden, then a quantitative description of the development must be provided per Appendix B 6.4.
17	PartD	N/A	Feedback to Beta BPT Instructions	[Paraphrased] Are the total number of scripts for insulin to be entered in "Section II – Projections for Equivalence Tests" on Worksheet 6?	Yes, the total number of scripts for insulin are the to be entered in Section II on Worksheet 6. The number of 30-day equivalent scripts are to be entered in Section III on Worksheet 6.

User Group Call Date 04/13/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
18	Part D	04/10/2023 17:56	2024 Pt D COB Fee - Please Confirm Correct Value	We noticed there is a discrepancy in the COB fee between the Final CY 2024 Part D Bidding Instructions, released on 4/4/2023 and the CY2024 Part d BPT Instructions_2023_04_07, released on 4/7/2023. I have included both documents for ease of reference. The Final Bidding instructions (top of pg 10) states: The 2024 COB user fee will be collected at a monthly rate of $ 0.0833 for the first 9 months of the coverage year for a total user fee of $0.75 per enrollee per year. while the BPT Instructions (bottom of pg 18) states: Medicare Part D user fees, which are $1.05 per-member per-year (PMPY) or $0.087 (PMPM) on a national basis for CY2024. The COB user fee will be collected at a monthly rate of $0.1166 PMPM for the first 9 months of the coverage year. Can you confirm which of these is correct for the 2024 COB fee?	The 2024 COB user fee will be collected at a monthly rate of $0.0833 for the first 9 months of the coverage year for a total user fee of $0.75 per enrollee per year. The COB user fee amounts in the BPT instructions are incorrect.

User Group Call Date 04/20/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	VBID		Questions for the 4/13/2023 OACT User Group Call	Worksheet 1 Section V – Line 4 - Net Medical Expenses, Page 50 of the CY2024 MA BPT instructions released April 7, 2023 “For plans that did participate in the VBID Hospice Benefit Component during the base period, net medical expenses reported for hospice enrollees are to reflect all claims incurred for enrollees in hospice status from the time of hospice election until disenrollment from hospice.” In the instructions for Worksheet 1, Section V, Line 4 – Net Medical Expenses (page 50), we note that the phrase “until the end of the month of hospice disenrollment” has been updated to “until disenrollment from hospice” in the paragraph applicable to plans participating in the Hospice VBID Benefit component during the base period. While we understand the wording was updated, we believe the intended scope of incurred claims reported for hospice enrollees continues to be through the end of the month of hospice disenrollment, rather than to the date of hospice disenrollment. As per the Technical and Operational Guidance for the Model, reporting net medical expenses through the end of the month of hospice disenrollment is consistent with the scope in which the VBID Hospice Benefit is responsible for hospice enrollees’ incurred claims. Can CMS confirm whether our understanding of the intent is accurate?	The MA BPT instructions accurately state that the hospice category in Worksheet 1, section V should include claims from the time of hospice election until disenrollment for plans participating in VBID hospice component during 2022. We are clarifying that the corresponding non-hospice, or unrelated claims, should be included until the end of month of hospice disenrollment.
2	Part B Rx	04/12/2023 20:55	Hemgenix	Has CMS included cost and utilization assumptions regarding the coverage of Hemgenix in the Rate Announcement for CY2024? Does coverage for this drug meet the significant cost threshold for CY2023 given the definition included in 42 CFR § 422.109(a)(1), such that it will be covered under Medicare FFS for 2023?	No explicit adjustments for the coverage of Hemgenix were made to the projection factors used in the development of the USPCCs for the CY2024 Rate Announcement. The significant cost provision in 42 CFR § 422.109 is not triggered by coverage of Hemgenix because there is not a legislative benefit change or a national coverage determination (NCD).
3	Rebate Reallocation	04/11/2023 10:10	Question on Rebate Reallocation	There is much greater uncertainty in projecting the Part D national average bid and low-income premium subsidy amounts compared to prior years as a result of changes in the Inflation Reduction Act. We anticipate this causing larger differences during rebate reallocation when comparing the final Part D amounts to those assumed in the initial bid submission. In an effort to minimize the benefit/premium changes for enrollees, will CMS consider widening the acceptable range of rounding during the rebate reallocation resubmission? Can the allowable change in premium within the rounding rules increase from $0.50 to $2.00 by adjusting the bid margin? Can the allowable change in MA rebate increase from $0.50 to $2.00?	We are not changing the rounding rules for rebate reallocation.
4	Part D	04/18/2023 10:18	Medicare 2024 Bid Question	We have a question about our 2024 Part D bid. We are currently cross walking a plan. The original plan (039) had two segments (001 & 002). We are now only cross walking one segment of the original plan (039-002) to a new plan (045-000). For the base period included in WS1 do we need to include both segments of the original plan (001 & 002) or can we just include the portion of the original plan we are cross walking (002).	Both segments of the original plan (001 and 002) must be included on Worksheet 1 of the PD BPT.
5	Part D	04/18/2023 10:18	Medicare 2024 Bid Question	Two questions regarding WS6 Section III of the CY2024 Part D BPT: 1. For the cost sharing amount in the Gap for the LIS Population: The only thing that needs to be excluded is the gap discount. Therefore, can the low income cost subsidy remain in the cost share column? 2. For the Population Exceeding $5,030 with Std coverage: For the cost share piece, should the gap discount be excluded?	1. Yes, the low income cost sharing subsidy should still be included. 2. Yes, the gap discount should be excluded from cost sharing for all beneficiaries in Section III of Worksheet 6.

User Group Call Date 04/27/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	Live Q&A 4/20 UGC and 04/21/2023 1:34:00 PM	Proposed IPPS trend	[Paraphrased] We reviewed the proposed IPPS trend file and have a question on the update made to the wage index for NY hospitals. We are seeing increases in the wage index in the range of 20–30%, in some areas up to 43% like Albany, Binghamton and Glenn Falls. This has a huge impact on facility unit cost trends. We are seeing trends north of 10% for our markets. Is this magnitude of increase expected? Did this increase affect the 2024 benchmarks for NY counties? Did the grouping of geographies in upstate NY consolidate into 1 vs what appeared to be more than one in the past? For example, we noticed that many hospitals in NY have the same wage index of 1.2183, examples include Rochester general and Albany medical. In past years, the wage index for these hospitals were not the same. Could you please confirm if that is correct?	As discussed in section III.G.1 of the FY 2024 IPPS proposed rule (available at https://public-inspection.federalregister.gov/2023-07389.pdf), CMS has taken the opportunity to revisit the case law, prior public comments, and the relevant statutory language with regard to its policies involving the treatment of hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act, as implemented in the regulations under 42 CFR 412.103. After doing so, CMS now agrees that the best reading of section 1886(d)(8)(E) is that it instructs CMS to treat § 412.103 hospitals the same as geographically rural hospitals. Therefore, we believe it is proper to include these hospitals in all iterations of the rural wage index calculation methodology included in section 1886(d) of the Act, including all hold harmless calculations in that provision. Beginning with FY 2024, we are proposing to include hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations, and to exclude "dual reclass" hospitals (hospitals with simultaneous § 412.103 and Medicare Geographic Classification Review Board (MGCRB) reclassifications) implicated by the hold harmless provision at section 1886(d)(8)(C)(ii) of the Act. Also, the inpatient repricing supporting the 2024 ratebook, or benchmarks, is based on the final FY 2023 IPPS wage index, not the proposed FY 2024 IPPS wage index.
2	FFS Trends	Live Q&A 4/20 UGC	N/A	Could you provide more details on what went into Part B Rx trends? Was 340B drug included? Can we get a split of trend with & without 340B?	The projection factors for Part B drugs are based on historical trends. The trend factors supporting the 2024 Rate Announcement growth rate are 8.8 percent for 2023 and 8.3 percent for 2024. The projections also account for anticipated impacts of the Inflation Reduction Act including the provision lowering cost sharing for insulins furnished under durable medical equipment, and a provision providing a temporary payment increase for biosimilar products. Projected expenditures for Part B drugs are trended off actual experience through December 31, 2022. The base experience reflects actual program expenditures including any reimbursements tied to 340B pricing, and the trend reflects the various price changes to 340B drugs over time. Unfortunately, we are not able to restate historical or projected expenditures excluding the effects of the 340B provisions.
3	FFS Trends	04/21/2023 9:03	Assumptions for In-home intravenous immune globulin services	Per the Consolidated Appropriations Act (CAA), 2023 (H.R. 2617 Sec. 4134), Medicare Part B will cover in-home intravenous immune globulin services (IVIG) beginning January 1, 2024. Please provide information regarding this benefit in the Final Rate Announcement. Specifically, 1. Is this benefit included in the 2024 FFS USPCC? 2. If so, what are the expected cost and utilization split up by services/supplies and drugs for this benefit in 2024?	The IVIG benefit is not explicitly represented in the 2024 FFS USPCC. We do not have the data available to assess the benefit expansion, but expect the impact to be relatively small.
4	TBC	04/25/2023 7:17	Question for the 4/27/2023 OACT User Group Call	1. Can CMS provide more information on how the "Impact of Changes in OOPC Model Between CY 2023 and CY 2024" technical adjustment to TBC is calculated? 2. Our organization's MA-PD plans received much larger Part D OOPC model technical adjustments for 2024 compared to prior years. Our understanding is that this technical adjustment is intended to control for changes in the OOPC model so plan TBC evaluations are not penalized or subsidized by uncontrollable changes in the OOPC model. For plans that received large technical adjustments, should we expect there to be similarly large, offsetting OOPC changes? For example, if a plan has a −$5 Part D OOPC model technical adjustment and does not change any benefits in 2024, should we expect the model to calculate a $5 OOPC reduction that offsets the technical adjustment? 3. Are there other factors that contribute to the calculation of the OOPC model technical adjustment?	1. For MA-PD plans the Part D portion of TBC is calculated by holding a plan's benefit structure and formulary constant from the prior year and updating the OOPC software to reflect changes in policy (IRA impacts, in particular insulin data entry and catastrophic changes for 2024), Part D parameter (deductible amount, ICL, etc.), and a more current Part D beneficiary sample. 2. Yes, assuming changes/updates to the formulary do not significantly impact the estimates. 3. No
5	RPPO	04/21/2023 13:55	RPPO Plan Bid Component question	We are looking to understand how the plan bid component (PBC) is calculated when 2 existing RPPO plans within the same region are cross walked together for the projection year (2024). Is the calculation of the PBC based on the membership of both plans or just the plan that remains for 2024? For example, in plan year 2023 there are two RPPO plans 001 and 002. In 2024 plan 002 is being cross walked into plan 001. Does the membership applied to plan 001 for the 2024 PBC calculation include the June 2023 membership of both plans (001 + 002) or just the membership of plan 001?	The plan-bid component of the standardized RPPO benchmark for each MA region is computed using the weighted average of all of the standardized A/B bids for regional MA PPO plans in the region. The enrollment weights are based on the historical enrollment (less ESRD enrollment) for each region. If a RPPO plan is being cross walked into another plan, the enrollment that is used for the weighting is based on the combined enrollment for that plan (001 + 002 in the example). When a Plan has enrollments cross walked to multiple new Plans in multiple regions, the enrollment counts will be allocated at the county level to the appropriate region.
6	MSP	04/19/2023 12:32	Actuarial UGC Questions	Please confirm the CY2024 "MSP factor" for working aged and working disabled (non-ESRD) is 0.136, as it appears in the example on p30 in the CY2024 MA Bid Instructions.	Yes, the CY2024 "MSP factor" for working aged and working disabled (non-ESRD) is 0.136.

User Group Call Date 04/27/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Rebate Reallocation	04/19/2023 12:32	Actuarial UGC Questions	Appendix E of the CY2024 MA Bid Instructions (p116) notes that as part of Rebate Reallocation, “CMS will allow minor changes to gain/loss margin to comply with CMS’s TBC requirement.” Please provide further guidance on the amount of premium change that would be allowable and considered “minimal” in the event changes are needed to gain/loss to comply with TBC requirements (i.e., where this amount would flow through gain/loss margin in addition to the allowable $0.50 to satisfy TBC)?	As stated in Appendix E, in order to comply with TBC the gain loss change is calculated as follows: “Calculate the (minimum) amount of premium change required to satisfy the TBC requirement. Gain/loss margin may change by the amount necessary to produce such premium change.”
8	Rebate Reallocation	04/19/2023 18:56	Low Income Premium Subsidy Target Plans, Rounding	We expect unusual levels of uncertainty in the 2024 Low Income Premium Subsidy. If a plan believes that there is a good probability that it will be close to or below the Low Income Premium Subsidy (LIPS), but wants to target the LIPS premium as a precaution that it comes in unexpectedly low, can we allocate a minimum of $0.50 PMPM to Part D Basic premium reduction in order to be able to achieve our goal of having an even dollar premium for non-LIS members? If this is not allowed, will you allow us the right to round down our premium to the next even dollar amount, even if that results in a rebate and margin adjustment that is slightly higher than $0.50 PMPM? For example, if 13C was modified for a plan that had no Part D basic premium reductions, could it increase that to $0.80 PMPM by making margin adjustments to hit a $16 member premium?	On page 114 of the MA BPT Instructions, section 1.2 states, “When rebates are reallocated to achieve the LIPSA as the Part D basic premium, the Part D basic premium net of rebate must be equal to (i) the exact published LIPSA, (ii) the LIPSA rounded up or down to the nearest $0.10, when the published LIPSA is not already rounded to $0.10, or (iii) the LIPSA rounded down to the nearest dollar amount.” A plan may round the LIPSA down to the nearest whole dollar amount. If the total plan premium is equal to the LIPSA and there is less than or equal to $0.50 in order to round down to the nearest dollar, then the plan may use the premium rounding rules (that is, they can make a margin adjustment in order to round the premium as long as the total change in rebate dollars is also less than or equal to $0.50). Premium rounding is only permitted for rounding the total plan premium to an even dollar amount. Thus, if a plan is rounding the LIPSA without getting the total plan premium to a whole dollar amount, premium rounding is not permitted and rebate reallocation rules must be followed. Furthermore, if the LIPSA is more than $0.50 away from rounding down to the nearest dollar amount, the plan must use rebate reallocation in order to round down to the nearest dollar. For example, if the LIPSA came in at $31.70, a plan can make the Part D basic premium equal $31 using rebate reallocation. If the Part D Basic Premium is equal to the total plan premium, then the plan has the option to round it up to $32 using premium rounding rules. Keep in mind that if the plan rounds up, each LIS beneficiary must pay $0.30 per month. If the plan chooses to round down, then the plan forgoes the $0.70 per month for each LIS beneficiary in CMS subsidy. For example 13C, the plan is not permitted to use the premium rounding rules to adjust the Part D basic or total plan premium to anything other than $17. The plan is not permitted to round to a total plan premium of $16 by changing the gain/loss margin to result in a premium change of $0.80. To achieve the LIPSA of $16, the plan would have to engage in rebate reallocation. Rebate reallocation can be used regardless of whether or not the initial submission had Part D basic premium reductions.
9	Rebate Reallocation	04/19/2023 18:56	Low Income Premium Subsidy Target Plans, Rounding	Please clarify the situation in example 13C of the new 2024 bid instructions Appendix E for the situation where the After benchmark Basic Premium Post Rebate was $16.40 rather than $16.80. Could the plan increase its Rebate to Basic Part D premiums to achieve a $16 premium target by decreasing its margin?	If a plan’s total plan premium is equal to $16.40 after the benchmark release, the premium rounding rules allow a slight decrease in gain/loss margin in order to achieve a $16 total plan premium as long as the change in total MA rebate dollars is less than or equal to $0.50.
10	Part D	04/19/2023 0:00	actuarial bids questions	In the bid instructions it states “For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 9 must reflect the utilization for the AE, BA or EA plan for members expected to have less than the DS ICL of $5,030 in CY2024. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.” Should this also be the case for sections III and IV for insulin and vaccines. I am concerned for example a member could be low income in the gap in the alternative benefit but in the ICL in the defined standard benefit in which case the vaccine information should be entered in section IV, row 3 which would not allow any LIS cost sharing to be entered in the alternative benefit for these members.	Yes, sections III and IV must adhere to the instructions on reporting intervals for Worksheet 6 of the Part D bid pricing tool. There should be sufficient leeway in the equivalence tests to be able to meet the critical validations even if not all the low-income cost sharing is reported for the vaccines in section IV due to beneficiary phase shifting.

User Group Call Date 04/27/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
11	Part D	04/13/2023 11:25	actuarial bid questions	Under the senior savings model for Plan Selected Model Drugs, supplemental benefits that fall in the Coverage Gap are reported as PLRO. How should these plan costs be reported in WS1? Is it the same answer for plan paid PLRO associated with the VBID program? In the bid instructions page 33 it states, "Enter the total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer. The term "total plan liability" is defined as CPP (Covered Plan Paid Amount) plus NPP (Non-Covered Plan Paid Amount) minus 80 percent of either GDCA (Gross Drug Cost above Out-of-Pocket Threshold) or GDCA minus PLRO (Patient Liability Reduction due to Other Payer Amount) as appropriate. Can you explain the considerations that should be taken into account in on whether it is appropriate to subtract PLRO from that calculation and if those considerations might vary for senior savings model or VBID PLRO?	Both VBID and SSM plans should report the PLRO in member cost sharing on Worksheet 1.

User Group Call Date 05/04/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Growth Rate	04/28/2023 12:59	Question for the 5/4/2023 OACT User Group Call	On the 4/13/2023 Actuarial User Group Call, OACT provided the impact of the Consolidated Appropriations Act, 2023 on the 2024 non-ESRD FFS growth rate. We are hoping to better understand which provisions are driving the Part A impact and why the Part B impact is so low given the +1.25% increase in the physician fee schedule and PAMA delay. Could OACT please provide additional details on their assumptions and which provisions were included when estimating the impact of CAA, 2023 on Part A and Part B?	There are several provisions of the Consolidated Appropriations Act 2023 that directly affect the Medicare Part B fee-for-service (FFS) program. Most of the provisions are expected to have small, or negligible impact on CY 2024 FFS spending. The three CAA provisions with the largest projected impact on Part B FFS UPSCCs are Section 4112 (physician update): +0.28% impact on 2024 Part B FFS non-ESRD USPCC; Section 4103 (add-on payment for ambulance services) +0.08% impact; and Section 4114 (revised phase-in of Medicare clinical laboratory test payment changes): -0.23% impact. For Part A, the two CAA provisions with the largest projected impact on Part A FFS UPCCCs are Section 4101 (Extension of increased payment adjustment for certain low volume hospitals): +0.20% impact on 2024 Part A FFS non-ESRD USPCC; Section 4102 (Extension of Medicare-Dependent Hospital program): +0.08%.
2	FFS Trend	04/27/2023 19:58	USPCC question	On the 04/27/2023 Actuarial User Group Call, it was announced that the end of the 20% add-on payment for IP admits was not included in the announced Unit cost trends. As a follow-up question, can you confirm whether or not the removal of the 20% add-on was included in the USPCC estimates for 2024? More generally, we are curious if the end of the PHE was included in the assumptions when setting the USPCC amounts?	An assumption supporting the 2024 Rate Announcement USPCC baseline is that the 20 percent add-on payment for inpatient stays for individuals with a COVID-19 diagnosis ended during the 2nd quarter of 2023. Accordingly, the 20 percent add-on payment for COVID-19 admissions is not reflected in the 2024 FFS UPSCCs.
3	Fee-for-Service (FFS)	05/01/2023 17:51	FFS Expense Projections	In the projections of 2024 FFS per capita expenditures, was the extra day in 2024 due to it being a leap year taken into consideration?	No adjustments were made to the projection of FFS expenditures to account for the 2024 "leap year day."
4	Question on IRA	Live Q&A 4/27 UGC	N/A	Would CMS be able to share their projected impact on Part B Rx effective coinsurance rate by (A) the $35 monthly cap on Part B insulin and (B) the lower coinsurance on Part B drugs with inflation-related rebates?	The estimated impact of the $35 per month insulin cap is that coinsurance for Part B drugs would be 99.7% of what it would otherwise have been (a decrease of 0.3%). In other words, if coinsurance across all separately payable Part B drugs was 20.00% prior to this legislation, the estimated coinsurance after this legislative change would be 19.94%. Also, we assume that the IRA Part B inflation rebate provision will not have a material impact on CY 2024 Part B expenditures and cost sharing.
5	TBC	05/01/2023 15:28	TBC for ISNP / OOPC question	The current TBC rule treats ISNP plans the same as other plans. However, ISNP plans serve a more frail population which generally has a much higher risk score. With that high risk score, even in the same county, an ISNP plan is more likely to have a significantly higher payment adjustment than a general enrollment plan. This can result in a requirement to add benefits even when revenue trends do not outpace cost trends, since these high risk score plans are still compared against the standard $40 TBC limit. CMS previously made the decision to exclude ESRD CSNPs from TBC, and it seems appropriate for CMS to consider excluding ISNP plans for the same reason.	We will give consideration to this suggestion as policy and guidance is developed for CY 2025. We encourage organizations to provide feedback on annual draft or preliminary guidance.
6	TBC	05/01/2023 15:28	TBC for ISNP / OOPC question	Given the delay of OOPC model release to mid May, it provides very little time for MAOs to validate the high OOPC model change of around $6, and react to TBC limit impact. Can CMS consider increasing the TBC limit given the delay in model release?	As described in the HPMS memorandum titled: "Contract Year 2024 Bid Review Out-of-Pocket Cost (OOPC) Model" issued April 28, 2023, CMS prioritized the release of the Part D model because of the potentially greater impact on results related to the Inflation Reduction Act (IRA) policies. The memo also indicated that the CY 2024 Part C model is not expected to have significant differences in results compared to the CY 2023 Part C baseline model issued in mid-January to help inform bid preparations. As indicated in the HPMS memorandum titled: "Final Contract Year (CY) 2024 Standards for Part C Benefits, Bid Review, and Evaluation" issued April 14, 2023, the TBC change threshold is being maintained at approximately 10% of the CY 2023 baseline TBC amount or $40.00 PMPM for CY 2024.
7	Part D average expected coinsurance	04/28/2023 14:41	Part D Average Expected Coinsurance Question	I have a question regarding the Part D average expected coinsurance, which is required to be entered in the PBPs for non-specialty coinsurance tiers. Should the average expected coinsurance entered for 2024 exclude insulin and vaccine cost sharing?	For the purposes of calculating the average expected coinsurance for a given tier, you should exclude the insulins and vaccines that sit on that tier, as the coinsurance value entered into the PBP does not apply to those drugs.
8	Part D	05/02/2023 11:01	Insulin Cap	I wanted to clarify whether the insulin cost share should be treated as a cap or a regular copay. For example, say the non-insulin cost sharing is a coinsurance of 25%, the insulin copay is $35, and the total cost is $100. Would the member pay $35 or the normal $25 they would pay for a non-insulin drug?	For insulin drugs in CY2024, the member would pay the insulin benefit that is entered in the insulin-specific screens of the PBP. In this example, the member would pay the $35 copay.

User Group Call Date 05/04/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	DIR	N/A	N/A	We have a pharmacy payment arrangement whereby pharmacies, as a condition of participation in the plan's network, must contribute to a pool of money that would then be used to make post-point-of-sale payments to network pharmacies based on pharmacy performance. The pharmacy contribution is not based on the number of prescriptions filled at the pharmacy or otherwise assessed at the claim level. Instead, each pharmacy's contribution to the pool is based on the volume of Part D patients attributed and total payment made to that pharmacy per month. How should the pharmacy's contribution and any potential performance payment to the pharmacy be reported and accounted for in the bid pricing tool?	We wish to remind plans that the pharmacy price concessions provision finalized in the May 9, 2022 final rule (CMS-4192-F) takes effect January 1, 2024 and requires the application of all pharmacy price concessions at the point of sale. If the payment to a Part D pharmacy may be reduced by up to a certain amount, the maximum possible reduction in payment must be treated as a pharmacy price concession and reflected in the negotiated price available at the point of sale and reported to CMS on a PDE record. This is the case regardless of whether the maximum possible reduction in payment is calculated on a per claim basis. As stated on pg. 27851 of the final rule, for pharmacy price concessions that are not assessed at the claim level, Part D sponsors would have to determine a methodology to attribute such concessions to the claim level to remain in compliance with the definition of negotiated price. This guidance is applicable for the kinds of arrangements described in the question. We remind Part D sponsors that the pharmacy's contribution to the plan's pool, even when not assessed on a per claim basis, is considered a price concession that must be applied at the point of sale to reduce the negotiated price. If the pharmacy receives a post-point-of-sale payment from the plan for good performance, then that payment amount must be reported as a negative DIR amount, which would mean a lower total DIR amount reported in the bid pricing tool. OACT will be closely reviewing the DIR and gross cost estimates in 2024 plan bid pricing tools to ensure that the bid reflects the requirements of the final rule.
10	DIR	04/25/2023 17:00	RE: Projection Method, Qualification, Risk-Sharing Arrangement Questions	[Paraphrased] Can all or part of settlement of a risk-sharing arrangement that covers MA and Part D be reported in the Part D bid and to CMS as Part D DIR#10?	A Part D sponsor can only report the settlement amount for the impact of the risk-sharing arrangement on Part D drug cost as Part D DIR in the bid. This data must be reported to CMS as DIR #10 – Risk-Sharing Arrangement Payments and Adjustments. As noted in the March 30, 2022 "Final Medicare Part D DIR Reporting Guidance for 2021", the DIR#10 field should include any gains or losses that are attributable to Part D drug costs that the Part D sponsor may receive or pay resulting from risk-sharing arrangements with entities other than CMS, and should not include any amount not related to Part D drug costs. A settlement for a risk-sharing arrangement that is not calculated based on PDE or Part D allowed costs for the bid sponsor cannot be reported as DIR#10. CMS will review Part D DIR reporting to confirm that the DIR#10 field for risk-sharing arrangements is appropriately reported and supported.
11	DIR	04/06/2023 15:59	Question on retained DIR in CY2024 Bids	[Paraphrased] In 2023 bids, we reported retained DIR under both NBE and DIR as per the 2023 bid instructions. Given the changes related to pharmacy DIR effective 2024, we seek guidance on how the retained DIR should be handled in the 2024 bid.	PBM retained pharmacy price concessions must be reported as NBE in the bid pricing tool. Consistent with the rule finalized in the May 9, 2022 Final Rule (CMS-4192-F), the negotiated price reported on the PDE record must reflect the lowest possible reimbursement for the network pharmacy. The allowed cost in the bid pricing tool must match the PDE reporting. Retained DIR will continue to be a part of NBE in 2024, and it will no longer be reported as DIR in the 2024 bid as it will be a reduction to the gross claim cost in the 2024 bid. Additionally, we want to emphasize that PDE reporting must reflect the lowest possible reimbursement to the pharmacy. If the ultimate reimbursement to the pharmacy is higher than reported on the PDE, that difference must be reported as a negative DIR amount, consistent with DIR reporting guidelines, and must result in a lower 2024 DIR amount reported in the bid pricing tool.

User Group Call Date 05/11/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	05/03/2023 11:32	Question on FFS Trends	Could you please explain why non-ESRD FFS cost projections in the Final Rate Announcement are different from the trends shown in the OACT “Narrative Supporting 2024 Growth Rate”? For example, inpatient costs in the Final Rate announcement imply an annual trend of 4.9% vs. 3.8% (1.160^0.25) over 2020 to 2024 in the 2024 Narrative. Similarly the Final Rate announcement projections imply an annual trend of 6.5% for Physician Fee Schedule vs. 3.6% (1.153^0.25) in the 2024 Narrative.	The impacts in the Narrative Supporting 2024 Growth Rate reflect 5 years of growth from 2019 to 2024. The corresponding ‘24/’19 annual trend in both the narrative and rate announcement is 3.1 percent for inpatient and 2.9 percent for physician. Also, there may be minor differences in the trends in the two sources since the PMPY values in the rate announcement includes FFS expenditures made on behalf of cost plan enrollees whereas the narrative excludes FFS expenditures made on behalf of cost plan enrollees.
2	FFS Trends	Live Q&A 5/4 UGC	N/A	The Advance and Final Notice both indicate that the end of the PHE was included in the USPCC estimates. Can you provide information as to what was and was not included as part of the end of the PHE? For example, what about telehealth extension?	Following is language from page 37 of the 2024 Rate Announcement regarding COVID-19 related Medicare coverage and payment policies in place during the public health emergency. *Several policies and legislative provisions were enacted during the public health emergency that increased spending; notably, the 3-day inpatient stay requirement to receive Skilled Nursing Facility (SNF) services was waived, payments for inpatient admission related to COVID-19 were increased by 20 percent, and the use of telehealth was greatly expanded. The public health emergency is assumed in the actuarial modeling to end in June 2023, when these effects are assumed to be eliminated. The results would not be materially affected if the actuarial modeling had instead assumed the public health emergency to end on the announced date of May 11, 2023, as is currently expected.* Thus, the USPCC baseline reflects expiration of these PHE-related coverage and payment policies starting in the 3rd quarter 2023. It’s also worth noting that stemming from section 4113 of the Consolidated Appropriations Act (CAA) 2023, “the vast majority of current Medicare telehealth flexibilities … will remain in place through December 2024.” This statement is included in the Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap available at this web link: https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html The 2024 Rate Announcement USPCC’s implicitly reflect this telehealth coverage provision of CAA 2023.

User Group Call Date 05/18/2023

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Rebate Reallocation	05/10/2023 13:56	Rebate Reallocation	As has been discussed, there is much greater uncertainty in projecting the Part D National Average Bid Amount due to the Inflation Reduction Act. We anticipate this may result in larger differences during rebate reallocation between the original estimates and the final direct subsidy. Given the potential magnitude of this difference, would CMS consider releasing a range of direct subsidies (+/-$2 PMPM) after the June bid submission to help MAOs better plan for potential benefit changes, which could be significantly more than prior years, during rebate reallocation? This would help MAOs identify better options for members and allow more time to discuss benefit/premium strategies with MAO stakeholders.	CMS will not be releasing any early information on direct subsidies.
2	Part D	N/A	Live Q&A 5/11 UGC	For an EA plan that has insulins at a copay less than $35, what would be considered basic plan liability in the ICL? the cost of the drug less the plan copay or the cost of the drug less a $35 copay?	For an EA plan that has beneficiary copayment of less than $35.00 for covered insulin products, the plan liability during the Initial Coverage phase would be the cost of the drug less the beneficiary copayment to the plan for CY 2024. Please see the HPMS Memorandum entitled “Final Contract Year (CY) 2024 Part D Bidding instructions” to Part D Sponsors on April 4, 2023. As stated in the memo, the standard prescription drug coverage requirement for 2024 includes the value of the Part D plan’s coverage of covered insulin products regardless of whether cost sharing under the plan is equal to the IRA maximum of $35 per month supply or a lower amount. The plan’s coverage of covered insulins will always be reflected in the plan bid as a basic benefit.
3	Part D	N/A	Live Q&A 5/11 UGC	Can you confirm the manufacturer coverage gap discount for part D insulins for non-NLI members in the gap should always be 70% regardless of the effective coinsurance of the $35 copay.	The manufacturer coverage gap discount for Part D insulin for non-low income subsidy (LIS) members in the gap will always be 70% regardless of the effective coinsurance of $35 or less for CY 2024. Again, please see the HPMS Memorandum entitled “Final Contract Year (CY) 2024 Part D Bidding instructions” to Part D Sponsors on April 4, 2023. As stated in the memo, the plan’s coverage of covered insulins will always be reflected as a basic benefit. Therefore, the coverage gap discount will always be calculated based on the negotiated price of the drug that falls within the Coverage Gap Phase. On Tuesday, CMS issued the HPMS Memorandum entitled “Prescription Drug Event Record Reporting Instructions for the Implementation of the Inflation Reduction Act for Contract Year (CY) 2024.” The memo provides PDE examples for CY 2024 for covered insulin products in the Coverage Gap Phase of a Basic Plan and an EA plan.
4	Part D	N/A	Live Q&A 5/11 UGC	In the insulin and vaccines sections of WS6 Script Projection is line 2, the sum of lines 3, 4 and 5? Or should the catastrophic also be included in line 2?	On Worksheet 6 of the Part D BPT in sections III and IV for insulins and vaccines, Line 2 "Population Exceeding $5,030 with Std Coverage" should include all scripts/costs for that population including those above the catastrophic.

User Group Call Date 05/25/2023

There are no advance questions for posting.

User Group Call Date 06/01/2023

There are no advance questions for posting.