Advance Questions from actuarial-bids@cms.hhs.gov for CY2013 OACT User Group Calls

User Group Call Date 04/12/2012

For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
For Part D policy-related questions: partdbenefits@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Sequestration	N/A	N/A	How should my bid reflect the potential 2% reduction in plan payments due to the budget law sequestration?	The sequestration mechanism in the Budget Control Act creates the possibility that 2013 payments will not be known with certainty at the time of bid submission. CMS will allow this uncertainty to be included as a temporary increase in the plan's risk margin to accommodate the extra risk caused by the potential reduction in plan payments. If included, the level of risk margin included in gain/loss margin must reflect your best estimate of the likelihood of the payment reduction for the Medicare covered or basic bid. Further, your projection of medical expenses must reflect the expected impact of sequestration on provider payments to both contracting and non-contracting providers.
2	CMS Data Releases	04/09/2012 14:17	Timing of Additional CMS Data	1) Will CMS provide MSP files as in prior years? If so, what is the expected date? 2) When can CMS provide the "market basket" trend data? Also, could this information be provided in the Final Announcement/Call Letter and/or the Bid Instructions in future years?	1) MSP information is available on the MMR. Please refer to pages 27-28 of the MA bid instructions for additional details and alternate sources. 2) CMS will post estimated Medicare unit cost increases by service category based on market basket or fee schedule increases on the Medicare Advantage Rates and Statistics web page later this month. We will announce the date of the posting on next week's call.
3	CMS Data Releases	04/07/2012 16:58	2014 PFFS Listing	Page 3 of the 2013 Rate Announcement has a section titled "Location of Network Areas for PFFS Plans in Plan Year **2014**." However, this section states that "The list of network areas for plan year **2013** is available on the CMS website." When and where will the **2014** list be posted?	The 2014 list will be posted to the CMS website by the end of the week.
4	Dual Eligible Coordinated Care Demonstration	04/09/2012 21:13	Question for Thursday's Call	For the states selected to participate in the new Dual Eligible Coordinated Care Demonstration program, does CMS have any guidance at this time on how plans in affected counties should be bidding? Based on the most recent information released, CMS will be likely be responding to the states after the 2013 bid deadline. Specifically, we are interested if the affected dual eligible members currently enrolled with us but eligible for the demonstration program should be included in our bid. Additionally, should we find ourselves in the position of being eligible for additional dual eligible members, do you have any expectations for how these new members should be considered?	Current CMS guidance is that MA/PD bids should reflect your best estimate of what population is expected to enroll in the plan. That expectation should reflect the possibility that some enrollees may be passively enrolled in an approved demonstration plan and your best expectation as to any additional members you may enroll.
5	Risk Score	N/A	N/A	How do I adjust my bid to reflect a potential payment adjustment resulting from a risk adjustment data validation (RADV) audit?	The projected risk score in the bid must reflect your best estimate of the final approved risk score based on valid diagnosis data. If you expect that your final approved risk score will be reduced if your contract has been selected for a RADV audit, this probability should be incorporated into your projected risk score included in the bid. An adjustment for prior losses or recoveries is not allowed.
6	Risk Score	04/10/2012 12:04	Part C & D Beneficiary Files	In the technical notes for the Part C beneficiary files, it mentions the following: "For 2013, CMS will again pay new enrollees in Chronic Condition SNPs with a different set of new enrollee risk scores. Note that CMS did not include these C-SNP-specific new enrollee risk scores in this file; regular new enrollee scores were used." However, the Part C beneficiary file provides a Part C SNP new enrollee risk score for both the 2011 and 2013 model. Are these C-SNP new enrollee risk scores meant to be used, and if so how can we identify when to use the C-SNP new enrollee risk score since the Part C beneficiary status makes no mention of a C-SNP new enrollee category?	The statement in the technical notes was included in error. New enrollee C-SNP scores included in the beneficiary level files are meant to be used.

User Group Call Date 04/12/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
7	Risk Score	04/10/2012 12:04	Frailty Adjustment	I need to know whether or not I should be assuming frailty adjustments in the bid. Does the New York Medicaid Advantage Plus program meet CMS' requirement for a FIDE SNP? Have plans already been contacted with the FIDE determination?	Under the Affordable Care Act (ACA), CMS may pay a frailty adjustment to those plans that meet the legal definition to be categorized as a fully integrated dual eligible special needs plan (FIDE SNP) if the FIDE SNP has similar average level of frailty to the PACE program. At the time bids are due, plans will not know if they will be determined by CMS to be a FIDE SNP in 2013. If, however, a plan believes that in 2013 they will both (a) meet the legal definition of FIDE SNP and (b) have a frailty score above the minimum PACE score as reflected within the 2012 Health Outcome Survey (HOS) performed at the PBP level necessary to receive a frailty adjustment to their risk scores, then it would be appropriate to reflect some probability of the plan being identified as a FIDE SNP in the bid. For additional guidance on this topic, please refer to the 2013 Rate Announcement and final call letter published on April 2, 2012.
8	Risk Score	03/20/2012 11:54	Normalization Factors	I would suggest that the normalization factors and ma-coding adjustments be re-defined to only apply to true diagnosis HCC based risk scores rather than applying them to new enrollee factors and the demographic and status components of the risk score. The normalization factor and ma-coding adjustment accounts for coding trend but demographic and status factors are not subject to coding improvements. The net impact is to diminish the impact of new enrollee factors, as well as the age/sex risk score weights. These factors virtually assure that the risk scores for new enrollees will be too low. Only if plans have equal proportions of new enrollees, and based on status and age/sex will the net impact wash out among plans and be equitable. I do appreciate the simplicity of applying these adjustments to all risk scores, but the penalty on growing plans, who often enroll disproportionate shares of new Medicare enrollees, as well as the impact to plans enrolling disproportionate numbers of Dual Eligibles, cannot be overlooked.	**Normalization:** When we calibrate a risk adjustment model and normalize the risk scores to 1.0, we produce a fixed set of dollar expenditures and coefficients appropriate to the population and data for that calibration year. When the model with fixed coefficients is used to predict expenditures for other years, predictions for prior years are lower and predictions for succeeding years are higher than for the calibration year. Because average predicted expenditures increase after the model calibration year due to coding and population changes, CMS applies a normalization factor to adjust beneficiaries' risk scores so that the average risk score is 1.0 in subsequent years. When we calculate the normalization factor for the payment year, we use the most recent data available for Medicare beneficiaries, so as to reflect recent trends. We create a July cohort of all Medicare beneficiaries in each of the five year, including new enrollees, and calculate risk scores for them for each of the five years. We have decided to calculate an annual trend over five years of risk scores specifically to smooth this trend. No adjustments are made to the data based on expected enrollment or future trends in expenditures. Over time, changes in enrollment patterns, e.g., the influx of baby boomers into Medicare, will be reflected in the trend used to calculate the normalization factors. The normalization factor is intended to be a national factor that takes into account the national trend in risk scores, and is used to keep risk scores at a 1.0 in each payment year. Changes in the proportion of new enrollees in the population are reflected in this trend. **MA Coding:** The MA coding adjustment factor is calculated by taking a difference factor portion, and adjusting it for the number of years that stayers are enrolled in MA plans, and for the number of MA enrollees who are not stayers. The difference factor of the MA coding adjustment is calculated as the average annual difference in MA and FFS stayer disease score growth. "Stayers" are those beneficiaries who remained in MA for at least two years and, therefore, (1) whose risk score in a payment year was calculated using diagnoses submitted by an MA plan in the previous year and (2) whose change in disease score is due entirely to MA diagnosis reporting. When CMS adjusts for the number of enrollees who are not stayers – including those who are new enrollees – the difference factor is adjusted downward. When we apply a coding adjustment factor that has been reduced by the proportion of all MA enrollees who are stayers, we are effectively adjusting for the coding differences of stayers, but in a way that mathematically allows us to operationally apply the factor all enrollees.
9	Minimum Rate Update	04/09/2012 16:00	2013 Minimum Update Rate	Could you provide details of how the 2013 Minimum Update Rate calculation is impacted by "adjustment for new risk score model for non-floor counties"? (This is as referenced in "risk2013.csv" in the 2013 Rate Calculation Data download). For county rates that are not impacted by its respective FFS rates, it appears that their 2013 increase does not equal the MA growth rate.	The minimum update rate equals the prior year's applicable rate increased by the MA growth rate and restandardized for the new risk scores. The restandardization is accomplished by multiplying the trended rate by the prior year's ratebook risk score and then dividing by the current year's ratebook risk score. The ratebook risk score for each year is based on average of the scores for the FFS base period, which is 2006 - 2010 for the 2013 rates

User Group Call Date 04/12/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
10	Benchmarks	04/03/2012 15:53	Blended Benchmarks	Can you explain why some counties (for plans with 2.5 stars, so 0% bonus) would receive a blended benchmark equal to the applicable amount? For example, the blended benchmark for a 2.5 star plan in Umatilla, Oregon is reported to receive a blended benchmark of $753.44 (reflected in the statutorybenchmarkdata2013.csv file column F). This is a 2 year phase in county with the applicable amount equal to $753.44 and the specified amount equal to $760.22. I would have expected the blended benchmark to equal the specified amount of $760.22.	Beginning with the 2012 ratebook, the Affordable Care Act caps the rates at the applicable amount. As announced in the 2012 payment notice, the quality bonus payment (QBP) demonstration waives the cap for rates for 3 or greater stars for CY 2012 through 2014. Thus, in the case of Umatilla, Oregon the 2.5 star rate is capped at the applicable amount, or $753.44
11	Physician SGR	04/09/2012 11:12	Provider Fee Increases and SGR bmark impact	What is the 2013 physician SGR reduction average benchmark PMPM impact?	Under the most current baseline, the estimated impact of a 1 percent SGR update for 2013 is $53 PMPM. We do not have readily available the impact of other SGR update scenarios, such as a 0 percent update.
12	NBE	N/A	N/A	I noticed the bid instructions and bidders training mention the annual fee on health insurance providers required by the ACA. How much should I incorporate in my bid for CY2013 for these fees?	The Internal Revenue Service has not issued final guidance on these fees. However, the fees to be paid in 2014 are to be based on premiums in 2013 and therefore will be incurred in 2013. We are aware of a publicly released study on the projected impact of these fees on health plan premiums. The study can be found at the following links: (1) http://healthreformgps.org/, search for keyword “insurer fees”, select the 10-31-11 article “Oliver Wyman report finds insurer fees will increase premiums”, select the link for “new report”; or (2)http://healthreformgps.org/wp-content/uploads/Oliver-Wyman-Insurer-Fees-report-final.pdf. Supporting documentation for the BPT taxes and fees entry should include details for the projected annual fee included in the bid. PLEASE SEE QUESTION #1 ON THE 4-26-2012 USER GROUP CALL FOR REVISED GUIDANCE.
13	MLR	02/10/2012 10:00	RE: Quality Initiatives in the Bid Form	1) Are quality initiatives in the new bid form consistent with the NAIC’s definition of “expenses to improve healthcare quality” as put forward in the NAIC’s model regulation for uniform definitions and standardized methodologies for calculation of the medical loss ratio? 2) If SNP Model of care management activities also qualify as quality initiatives, should they be reported as medical expenses or quality initiatives? 3) Will Medicare Advantage plans loss ratio regulation closely match that put forward in the Federal Register Vol. 76, No. 235 from December 7, 2011?	1) CMS is not being prescriptive about the Quality Initiative and Taxes and Fees information collected in the BPT this year, which will be used as background information as policy is developed for the Medicare MLR requirement effective for CY2014. You may consider the NAIC definition when completing the CY2013 BPTs. You must list in the text box on the BPT the items included as quality initiatives and provide further detail in supporting documentation as required by Appendix B. 2) For CY2013, continue to report these activities per the bid instructions as medical or non-benefit based on the nature of the activity (see the disease management pricing consideration in the MA bid instructions). If reported as non-benefit expense and you believe the activity qualifies as a quality initiative, also report the expense in the quality initiative line and document as previously described. 3) CMS has not yet issued specific guidance on the Medicare MLR requirement.
14	Gain/Loss	03/04/2012 16:59	bpt instructions	Can I pair a chronic or institutional care SNP with a general enrollment plan for purposes of meeting the negative margin guidance?	To meet the aggregate gain loss margin guidance, chronic and institutional care SNPS may be combined with general enrollment plans. However, to meet the bid-level guidance regarding plans with negative margins, chronic and institutional care SNPS may not be paired with general enrollment plans. The purpose of allowing product pairings within the negative margin guidance is to allow for flexibility in marketing strategies for a high/low pairing that will be marketed to the same population. All beneficiaries enrolled in the general enrollment plan may not be eligible for the SNP plan and therefore this pairing is not allowed within the product pairing rules. In this case for a bid with a negative margin, submit a business plan in accordance with the bid instructions, and this will be reviewed on a case by case basis.
15	Gain/Loss	04/09/2012 18:32	Margin	Page 93 of the MA Instructions state that supporting documentation must be submitted with the June bid to demonstrate consistency between the bid (projected) aggregate margin and “actual aggregate returns over the long term”. We would like more information on what you want to see regarding the “actual aggregate returns”: 1) At what level should this demonstration be performed: contract level, organization level, or parent-organization level? 2)Should it reflect only Medicare Advantage/PDP experience or all lines of business? 3)Should it be on a reported basis (with or without prior year adjustments) or be restated?	1) The demonstration of consistency should be performed at the level you have chosen for meeting the aggregate gain/loss margin requirements. Per the MA bid instructions, the gain/loss margins entered in the BPTs must comply with the aggregate-level margin requirements at one of the following three levels: contract, organization, or parent organization level. The plan sponsor must enter the chosen level of aggregation in the BPT and it must be the same for all general enrollment plans and I/C SNPS and D-SNPS. 2) For this margin comparison, MA projected is compared to MA actual and PD projected is compared to PD actual. 3) Restated.

User Group Call Date 04/12/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
16	MSP	04/10/2012 8:54	MSP Calculation	The MSP Example on Pages 28-29 of the MA bid instructions calculates the MSP adjustment as 1 - ($9,692,899 + $53,436)/[($9,692,899 + ($53,436 / .174)] = 2.537% using the 2012 MSP factor of 0.174. However, that formula does not recognize the change in MSP factor between 2012 and 2013. Shouldn't this change be factored into the numerator of the calculation as follows: 1 - ($9,692,899 + $53,436*0.173/0.174)/[($9,692,899 + ($53,436 / .174)] = 2.540%.	Yes, this revised formula is correct. When working with 2012 payment data, use the 2012 MSP factor of .174 to gross-up MSP payments to the full payment amount, but apply the 2013 factor of .173 to project reduced payments for MSP enrollees.
17	MMR	N/A	N/A	In the MMR files, there are a few cases in which a member is classified into more than one of the following categories: ESRD, Hospice, and Out-of-Area. When this happens, how should we classify the member in the BPT?	In these instances, please enter member months in the BPT using the following hierarchy: • If the member is ESRD, they should be in the ESRD fields of the BPT • Of those who remain, if the person is in hospice, they should be in the hospice fields of the BPT • -Finally, of those who are not ESRD or Hospice, if they are OOA, they should be in the OOA fields of the BPT **Please see the response to Question #14 on the 4-19-12 User Group Call for the most up to date guidance.**
18	ESRD	04/09/2012 9:55	ESRD	Please confirm that if our plans do not have credible ESRD experience, we do not need to fill out Worksheet 4, Section III.	Completing Worksheet 4, Section III is optional, however you must enter ESRD member months on Worksheet 5.
19	User Fees	04/10/2012 10:53	MA-PD Bid NMEC User Fees Question	It is my understanding that there is a MA-PD National Medicare Education Campaign (NMEC) User Fee (0.047% in 2011) and a PDP NMEC User Fee (0.05% in 2011). I see on page 18 of the 4/6/12 Part D BPT instructions that the estimated value of the Part D NMEC fee is $0.06 PMPM for CY2013. I also see on page 30 of the 4/6/12 Part C BPT instructions that the estimated value of the Part C NMEC fee is $0.30 PMPM for 2013. Thus is the estimated MA-PD NMEC fee for CY2013 $0.36 PMPM and the PDP NMEC fee $0.06 PMPM?	Yes, this is correct.
20	PD BPT Error	04/10/2012 17:06	2013 PD BPT WK1 ICL	The ICL in WK1 of 2013 PD BPT is 2830, while the actual 2011 ICL is 2840. Is the BPT erroneous?	Yes, this is an error in the PD BPT. Worksheet 1 should be completed using the correct 2011 ICL of $2,840. We are working on a BPT patch to correct this. More information will be provided when the patch is released.

User Group Call Date 04/19/2012

Introductory note

1) We strongly encourage all plan sponsors to download and use the new BPT2013.xlam file that corrects the following BPT cell labels:
   a) The ICL in PD Worksheet 1
   b) the expiration date in MA Worksheet 1, PD Worksheet 1, and MSA Worksheet 1
   c) the Enrollee Type label for PART B ONLY in the drop down list on MA Worksheet 1
2) MA-PD Spring Conference materials may be found at: http://www.cmsdrughealthplanevents.org/cms/index.php/events/cms-2012-spring-conference/
3) FFS Trends: The Office of the Actuary's current estimate of Medicare unit cost increases by service category for 2011 to 2013 will be posted on the CMS web site in the next few days at: CMS Home > Medicare > (Health Plans) Medicare Advantage - Rates & Statistics > FFS Trends. These trends reflect increases in the applicable market basket or fee schedule and are based on current law and legislated adjustments.

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Sequestration	04/16/2012 23:50	Bid Questions	The first question from the 4/12 OACT User Group call mentioned a 2% reduction to plan payments due to sequestration. Can you confirm the 2% amount? In other words, if my best estimate is to prepare the bid according to the current law, the sequestration mechanism will reduce the payments to MA plans by 2%?	If sequestration is implemented according to current law, Medicare payments may be reduced up to 2%. If sequestration is implemented, rules around this will be developed by the Office of Management and Budget and are not likely to be known to prior to bid submission. This is a government-wide topic that is not specific to MA and PD, or even to Medicare. The Administration is urging Congress to enact balanced deficit reduction legislation that avoids sequestration, as proposed in the FY2013 President's Budget. When considering the impact of sequestration in your bid assumptions, you must reflect the likelihood of the payment reduction.
2	Sequestration	04/16/2012 23:50	Bid Questions	I understand that if I include the impact of sequestration in bid submission, I must include an impact to provider payments. In order for me to estimate the impact on provider payments, I need to understand how CMS would implement sequestration on FFS Medicare. 1) Will all providers be impacted equally, or are some providers/facilities exempt? 2) What is the expected overall reduction to provider payments? Is it also 2%? Does it vary by provider type? 3) Most of our provider contracts are written to pay a certain percentage of the FFS Medicare allowed amount. If sequestration is implemented, will CMS reduce the FFS Medicare allowed amount? Or will the reduction to FFS Medicare expenses occur through another mechanism, such as Fraud, Waste, & Abuse recoveries or payment withholds?	Answers to these questions have not yet been determined and are not likely to be determined prior to bid submission.
3	Sequestration	04/16/2012 13:25	Potential Impact of Sequestration to Part D revenue and bids	I have a few questions related to the 2% revenue cuts which may result from Sequestration: 1) Will the 2% cut apply to Part D revenue in addition to Part C revenue? 2) If yes, how will it apply? Will there be a 2% cut to the Direct Subsidy? Or will there be a 2% cut to the bid revenue? 3) If there is a cut to D revenue will it apply to both PDP plans and MAPD plans? 4) Last week's user group call suggested that plans will be permitted to increase their risk margin in 2013 Part C bids to offset the impact of the 2% cut. In addition it was stated that the certifying actuary must reflect his/her best estimate of the likelihood of the cut taking place and the best estimate of the likelihood of an offsetting cut to Medicare fee schedules to providers. What is the guidance relating to Part D bids if the 2% cuts apply to Part D revenue also. 5) If plans are allowed to reflect but not required to reflect the impact of the 2% cut in Part D bids, how will CMS ensure consistency across all Part D bids? Consistent reflection seems important with regards impact on the national average bid, national average beneficiary premium and low income regional benchmarks.	1) 2) and 3) If sequestration is implemented, specific details on how this will work will not be known until the Office of Management and Budget releases the rules. If sequestration does get implemented, it is likely that the revenue cuts will apply to both MA and Part D (MAPD and PDP). We recognize payments to Part D plan sponsors for reinsurance and low income subsidies, due to their pass-through nature, may be treated differently than the payment for the direct subsidy. 4) The guidance provided on the April 12th User Group Call was intended to apply to both MA and PD. 5) CMS will not be instructing plan sponsors to incorporate specific assumptions in their bids. Therefore, there may be differences in what plan sponsors assume for the likelihood of the sequestration mechanism reducing payments.
4	Sequestration	04/17/2012 10:55	Sequestration	Could you provide more guidance on incorporating sequestration into the bid, in general, including Part D? Please also provide some information on how things may be handled post-bid depending on whether sequestration does not happen, happens partially, or happens fully. For example, will bids be used as is or will there be some adjustments to them?	CMS is unable to provide any further specific guidance regarding sequestration pending further guidance from the Office of Management and Budget. CMS expects to use bids submitted on June 4th for payment purposes in the same way as in the past. There is no expectation that bids will be modified after the June 4th submission. The manner in which payments will be reduced if sequestration is implemented is yet to be determined.

User Group Call Date 04/19/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
5	Sequestra-tion/TBC	04/16/2012 23:50	Bid Questions	The TBC threshold is adjusted to incorporate plan specific changes in revenue. Since sequestration reflects the current law and will result in a change in the plan revenue, will the TBC threshold be adjusted to reflect this change? How can plans adequately adjust risk margin if the TBC threshold is not also adjusted?	CMS does not plan to change the TBC requirement. Regarding risk margin for sequestration and TBC, plans must balance their margin requirements with the need to comply with TBC limits.
6	Compliance	04/17/2012 1:44	Compliance Initiative	In the past, CMS has allowed modifications to bpts and pbps if issues were found during an actuarial certification review, after the bid submission. Will these types of modifications be held against the actuary as part of the compliance initiative?	As with other instructions and guidance, errors discovered during actuarial certification review could result in a compliance action; that is why it is imperative to employ due diligence and peer review before submitting items to CMS.
7	Bid reviews	04/11/2012 12:06	2013 bids - review of PBP vs. BPT	Could you please clarify how the PBP vs. BPT review will be conducted for the 2013 bids, given the elimination of BPT worksheet 3 cost-sharing descriptions?	OACT will still be conducting reviews on the consistency of MOOP and plan level deductibles between the BPT and PBP and ensuring that mandatory supplemental benefits indicated in the PBP are priced in the BPT.
8	Star Ratings	04/13/2012 17:09	Star Rating Question	If a parent company currently offers a HMO product and will be offering a separate PPO product with a new contract number in 2013, what star rating is applied to the new contract PPO contract number?	As stated in the 2013 Advance Notice, for a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization will receive a weighted average of the star ratings earned by the parent organization's existing MA contracts or MA contracts in the previous three years if there are no existing contracts in the current year. A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, and is assigned three stars for quality bonus payment (QBP) purposes for 2013. These contracts are treated as new MA contracts during the demonstration until the contract has enough data to calculate a star rating.
9	Risk Model	N/A	N/A	What is the total impact of the Part C risk model changes?	CMS estimates the aggregate impact of the 2013 CMS-HCC model to be approximately a positive 0.1% on the national average Medicare Advantage risk score. However, the 2013 model will have a differential effect across plans depending upon the make-up of plan-specific populations and, as a result, the impact of the new model on plans' risk scores can vary.
10	Risk Model	04/16/2012 21:44	N/A	I noticed a very large change in the 2013 Part C risk score for HCC1 HIV/AIDs from 2012. The community factor shows a large decrease while the Institutional factor shows a large increase. Can you please explain this?	On the community side, the relative costs of HIV/AIDS is decreasing. The relative factor decreases even more than the dollar coefficients, since the denominator of the relative factor has increased. We think this change in the relative factor reflects improvements in drug regimens (the costs of which are not in this model), and a concomitant reduction in the medical costs of these patients. We note that the coefficient for HIV/AIDS in the RxHCC model has increased over time for most populations. On the institutional side, the marginal cost of an institutionalized HIV/AIDS patient has increased between the model we currently use and the 2013 model (expenditures years 2005 and 2009) over 100%. However, this increase reflects the number of years between calibrations more than it does a change in the increase in the cost of care in an institution for these patients -- we see a similar rate of increase between the CMS-HCC models we used in 2007-2008 and the current model. Because the marginal cost of institutionalized HIV/AIDS patients increases so much more quickly than the overall Medicare mean cost, the relative factor continues to increase. We think we are seeing the coefficient pick up the increased costs of treating this much sicker population -- patients with AIDS rather than just HIV status -- for whom the standard maintenance drugs are not sufficient.
11	Gain/Loss	04/17/2012 9:53	gain/(loss) and Product pairing	We noticed that the bid instructions changed in regards to the rules for product pairings whereby CMS permits positive margin plans to subsidize negative margin plans. In particular the 2012 instructions state the requirement as plans "Be of the same plan type" whereas the 2013 instructions state "All be local coordinated care plans or all be RPPOs or all be PFFS plans". Does this mean that HMO and PPO plans with identical services areas can be "paired" such that the overall margin of the combined HMO and PPO plans is positive? As an example, if all the HMO plans in a given service area have a combined negative margin but all the PPO plans in the identical service area have a combined positive margin, and the overall combined HMO & PPO margin is positive, such that there is implicit benefit design subsidies, is this permitted with the bid instruction change?	Yes to both questions as long as: (i) the plans are of the same SNP type or are all non-SNPs, (ii) the other bid-level margin requirements are met (that is, appropriate bid value and non-anti-competitive practices), and (iii) all aggregate-level margin requirements are met.
12	PBP to BPT Mapping	04/11/2012 9:45	WS3 PBP to BPT mapping	It seems that BPT line item i2 Professional Specialist is not mapped to any PBP category. Could you check and confirm?	The pre-populated BPT line numbers in MA Worksheet 3, Section IV do not include all of the suggested mappings shown in Appendix F for each PBP category. BPT line numbers for items that are often mapped differently by different actuaries may be excluded and you must manually input the actual mapping. This includes i1 Professional, i2 Professional: Specialist excluding mental health, i6 Professional: Other, k Other Medicare Part B, and some of the lines in h Outpatient Facility Other.

User Group Call Date 04/19/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
13	ESRD/ Hospice Hierarchy	04/13/2012 16:17	Question regarding ESRD/Hospice Hierarchy	In previous years, CMS has not been prescriptive about how to handle members who are identified in the MMR files as having ESRD and Hospice status. Guidance from the May 12, 2011 OACT User Group Q&A (Item #12) follows: "If a member is assigned both Hospice and ESRD status, you can put them in either the ESRD or the Hospice category in the BPT and explain the methodology chosen in the supporting documentation. Since the beneficiary is likely in ESRD status before becoming hospice status, it may make more sense to include in the ESRD column, but either approach is acceptable." In response to this guidance and, after confirming that members who have both ESRD and Hospice status are paid the hospice rate in the MMR files, we have programmed our model logic to assign these members to Hospice. On the April 12, 2012 OACT User Group Call, guidance was provided to assign these members as ESRD. Will CMS reconsider the April 12, 2012 guidance and revert back to the non-prescriptive guidance provided in previous years so our model programming does not have to be changed and re-run at this relatively late date?	See next question.
14	ESRD/ Hospice Hierarchy	04/17/2012 9:14	ESRD, Hospice, OOA Hierarchy	In last week's actuarial user group call, OACT indicated that plans should use the following hierarchy for determining enrollee status: ESRD, Hospice then OOA. The revenue that CMS pays to MA plans for Hospice members is equal to the rebate. We confirmed that for members that have both ESRD and Hospice status, the revenue that CMS pays to MA plans is equal to the rebate. To align with the CMS revenue and the health plan's liability, would it be acceptable to put Hospice first in the hierarchy (i.e., Hospice, ESRD then OOA)?	OACT has reconsidered the guidance given on last week's User Group Call and we have revised our guidance to put Hospice first in the hierarchy. Therefore, if a member is assigned to both Hospice and ESRD status, the member should be counted toward Hospice member months in the BPT. Also, ESRD still takes precedent over out-of-area.
15	Preventive Services	04/17/2012 10:07	New Preventive Services	In 2012/2013, CMS introduced the following five new preventive services to be offered at $0 cost sharing. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse; • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral therapy for cardiovascular disease • Intensive behavioral therapy for obesity Is there a safe harbor estimate of 2013 Utilization or PMPM value for these services?	No.
16	MA Hospice Claims Experience	N/A	N/A	The hospice pricing consideration was changed for CY2013 to require hospice claims to be included in medical expenses in Worksheet 1, Section III, if the projected allowed costs include hospice claim costs. Can we still exclude hospice data from worksheet 1?	Yes, but you must report base period claims experience for hospice enrollees consistent with the handling of hospice claims in projected allowed costs. Therefore, if the projected allowed costs exclude hospice claim costs, then you must exclude hospice claims experience in Worksheet 1, section III. However, base period summary data in Section VI must always include hospice data, and base period member months and base period risk scores in Sections II and III must always exclude hospice data.
17	LI Membership Files	N/A	N/A	When will the LI membership files be posted on the CMS website?	These files will be posted in late April or early May.
18	Part D EGWP Plans	04/11/2012 12:13	EGWPs and Part D Copay/Coinsurance limits	On pages 123, 159, and 160 of the Rate Announcement/Call Letter, copay/coinsurance maximums are listed for Part D plans. Do these apply to EGWP Part D plans (either MA-PD or PDP)?	While EGWPs are not part of the benefit package analysis, sponsors should take into consideration these thresholds when designing their tiered benefits to ensure they are not discriminating and discouraging certain beneficiaries from enrolling in the EGWP.

User Group Call Date 04/26/2012

Introductory note

1) We strongly encourage all plan sponsors to download and use the new BPT2013.xlam file (CMS Home > Medicare > (Health Plans) Medicare Advantage - Rates & Statistics > Bid Forms and Instructions) that corrects the following BPT cell labels:
   a) The ICL in PD Worksheet 1
   b) the expiration date in MA Worksheet 1, PD Worksheet 1, and MSA Worksheet 1
   c) the Enrollee Type label for PART B ONLY in the drop down list on MA Worksheet 1
2) FFS Trends: The Office of the Actuary's current estimate of Medicare unit cost increases by service category for 2011 to 2013 has been posted on the CMS web site at: CMS Home > Medicare > (Health Plans) Medicare Advantage - Rates & Statistics > FFS Trends. These trends reflect increases in the applicable market basket or fee schedule and are based on current law and legislated adjustments.
3) Plan-specific adjustment amounts that MA organizations must use to determine their plans' compliance with CMS' TBC requirement have been posted on HPMS and may be accessed by selecting: **Quality and Performance > Part C Performance Metrics > Total Beneficiary Costs.** If you are having access issues, please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	ACA Insurer Fees	04/17/2012 9:15	Insurer Fees	The 2013 Medicare Advantage and Prescription Drug Plans bid instructions require non-benefit expenses to be reported on a GAAP basis. We reviewed the relevant GAAP information on the treatment of insurer fees, which was included in the June 2011 Accounting Standards Update published by FASB and identified the following two sections: **720-50-25-1** The liability related to the annual fee described in paragraphs 720-50-05-1 through 05-4 shall be estimated and recorded in full upon the first qualifying sale for pharmaceutical manufacturers or once the entity provides qualifying health insurance for health insurers in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. **720-50-05-4** For the health insurance industry, the annual fee will be allocated to individual health insurers based on the ratio of the amount of an entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, 2014. The first section indicates that the event that determines when the liability for the annual fee payable in 2014 is to be recorded is when the entity first provides qualifying health insurance in 2014, and the second section indicates that the amount to be recorded by the entity as a payable in 2014 is allocated based on the ratio of the entity's 2013 net premiums written to the 2013 total U.S. market. These sections suggest that a carrier that exits the market at the end of 2013 does not have any insurer fee liability in 2014 on a GAAP basis. The aggregate insurer fee payable in 2014 by all insurers is not a function of 2013 net premiums. Only the allocation of the 2014 aggregate amount to individual carriers is based on the prior year (2013) net premiums. Therefore, we believe the insurer fees payable in 2014 are incurred in 2014 on a GAAP basis and thus should not be included in the non-benefit expense portion of 2013 Medicare Advantage and Prescription Drug plan bids. This is the opposite of the answer given on the 4/12/2012 CMS call to question 12.	We acknowledge that the guidance we provided on question 12 of the 4/12/12 user group call contradicts the requirement that non-benefit expenses be prepared in accordance with GAAP. Since the FASB has determined that the insurer fee should not be expensed until the year it is due, we are rescinding our response to question 12 from the 4/12/12 user group call and are instructing plans to not reflect any insurer fee payable under Section 9010 of the ACA in the 2013 bids.
2	ACA Insurer Fees	04/18/2012 9:07	ACA fee questions	The ACA fee will be allocated to health plans based on 2013 premium. Can you clarify exactly which components of MA revenue will count toward the premium that is used to allocate the ACA fee? For Part C, will it just be the member premium, or will it include the bid payment and rebate. Likewise for Part D, which plan revenue components will be included?	The Department of Treasury has not yet issued specific guidance. Further details will be provided at a later time.
3	Sequestra-tion	04/20/2012 0:09	Sequestration Question	How did OACT incorporate sequestration into the calculation of the "FFS Medicare Actuarial Equivalent cost sharing" amounts in column K of worksheet 4?	The projected Medicare FFS costs on which the cost sharing factors are based do not reflect sequestration.

User Group Call Date 04/26/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
4	Sequestra-tion	04/25/2012 10:11	TBC	1) The sequester cut of 2% is current law and it has been CMS practice on items like SGR to apply current law to bid development even if the administration intends to work with congress to alter current law before the effective date. Given that the 2% cut is current law and that the TBC threshold is adjusted for reductions in plan revenues why has CMS not adjusted the TBC threshold to account for this reduction? 2) If CMS no longer believes that it needs to follow current law in development of projections for the bid will CMS be providing updated benchmarks that account for the likelihood of the SGR cut not occurring?	1) The criteria that could result in sequestration being implemented is included in current law. Whether or not sequestration will actually be implemented, and how it might be implemented, isn't known at this time. 2) While benchmarks must be based on current law, pricing in the bids should always reflect the plans best estimate of required revenue. This includes reasonable and supportable assumptions as to the probability of current law being upheld. For more information regarding the development of the benchmarks please see the CY2013 Rate Announcement.
5	Capitated Financial Alignment Demo	04/18/2012 11:16	Capitated Financial Alignment Demo	I would just like confirmation that the only bid requirement for the Capitated Alignment Demo would be the filing of the plan benefit design and the associated attestations. Other than what is in the application, there is no actuarial certification and/or bid submission process for the demo. Correct?	Neither Bid Pricing Tools nor actuarial certifications are expected to be required. General questions related to this demonstration should be sent to mcocapsmodel@cms.hhs.gov.
6	CPCi Program	04/23/2012 1:57	Questions related to CPCi program	Certain MA plans were awarded to participate in Comprehensive Primary Care incentive (CPCi) program with CMS slated to be effective 1/1/2013. The program is expected to have certain impact to the claims in terms of costs and savings, but the specifics of the program details will not be firmed up until December 2012. The uncertainty surrounding the program is too great that the impact to the claims cost can't be reasonably estimated at the time when the bid is due. Is it acceptable for the MA plans awarded for the program not to include adjustment in the 2013 bids for this initiative?	Plan sponsors participating in this program for CY2013 must make their best estimate of the impact of this program when preparing their bids.
7	TBC	04/23/2012 14:39	Total Beneficiary Costs (TBC) Data for CY 2013 Bid Preparation	We pulled down the TBC files for our contract and note that our two ESRD plans are not included in the data – will these be added at a later ?	We are currently evaluating ESRD-only SNP bids with regards to TBC. Once a determination is made, we will provide further information/guidance to assist plan sponsors with meeting TBC requirements when preparing ESRD-only SNP bids.
8	TBC	04/24/2012 14:45	TBC Spreadsheet in HPMS	We have a question on the spreadsheet for our MA-only PBPS for our contracts . It appears that CMS is calculating the Part D OOP Costs that a member with no Part D coverage would experience. However, since we are not covering Part D on these plans, it does not seem accurate to calculate any increased Part D costs a member might have on the TBC calculation. Did CMS truly mean to include the Part D amount in the MA only plans TBC?	Yes, we intended to include the Part D OOPC amount for MA-only plans. The resulting increase in the Part D OOPC value from 2012 to 2013 is directly offset in the model adjustment amount posted on HPMS.
9	TBC	04/23/2012 10:50	TBC	Similar to last year, the initial TBC HPMS files do not take into account the August NAMBA adjustment to premiums. Will CMS be issuing revised TBCs or will we need to make that adjustment?	We will re-post TBC values next week to reflect the impact of the NAMBA on plan premiums. Note: this affects only a small number of plans that did not resubmit during rebate reallocation
10	FIDE SNPs	04/17/2012 15:19	FIDE SNPs and Frailty	If there is a new FIDE SNP for 2013 that has not yet had a survey to assess frailty levels, would the earliest that the plan could receive frailty adjustments be 2014? Would you accept other sources than the Health Outcome Survey for assessing the frailty level of a new FIDE SNP – for the first year of operation prior to having the HOS data?	CMS calculates frailty scores using data on activities of daily living obtained through the Health Outcome Survey (HOS). We use the ADL data gathered in the survey that is fielded in the year prior to the payment year. So 2014 frailty scores are calculated using ADL data obtained from the 2013 HOS. If a FIDE SNP did not participate in the 2013 HOS, they will not receive a 2014 frailty score. We can use their 2014 HOS results to assess whether they qualify for frailty in 2015. We do not accept other sources of data to calculate frailty scores. For frailty scores to be comparable across plans, the survey methodology must be standardized and we rely on HOS to collect this data.
11	Gain/Loss	04/24/2012 11:43	gain/loss margin	Our organization sets gain/loss margin requirements for the combined block of business for our Medicare products as a whole, not at the product level. Can the gain/loss margin be aggregated across all of the MA and PD bids combined?	Gain/loss margin included in the bid must comply with all of the bid-level requirements, aggregate-level requirements and MA vs. PD requirements (for MA-PD plans) as outlined in the MA and Part D bid instructions.
12	Related Parties	04/23/2012 17:50	actuarial user group call questions	Can you provide specific examples of how to handle related party relationships in the bid forms in the case when the related party a) provides services to unrelated parties and b) the related party does not provide services to unrelated parties, under a capitated arrangement and a non-capitated arrangement?	First, the related-party requirements are the same whether or not the services are provided under a capitated arrangement. As explained in the related-party pricing consideration, unless the criteria for a comparison of fees paid to the related-party organization by unrelated parties of similar size and market position to the Plan sponsor are met, the fee or capitation amount for medical services or administrative services must be allocated to medical expense (if applicable), non-benefit expense, and gain/loss margin.
13	Additive Adjustments	04/17/2012 19:29	Actuarial User Group Question - Additive Adjustments	The Additive Adjustment instructions are not clear on Page 48 of the Part C bid instructions. If we have a new benefit where there is base period experience for other benefits in the same service category, the instructions say to enter the new benefit as a positive number in column p but this column is only util/1000. Where do we input the PMPM?	Enter the PMPM value of the added benefit in column q.
14	MA WS2 OON Utilization	04/19/2012 18:43	OON Utilization - column R of WS 2	For service categories that a Point of Service plan does not cover out of network providers (except for authorized exceptions or emergencies) can it use 0% for Out of Network utilization in column R of worksheet 2 just as an HMO can? These are service categories that the POS plan would always provide at in network benefit levels.	The projected percentage of services provided OON in worksheet 2, column r applies to all claims payments regardless of plan type. If 0% is expected, then enter a zero.

User Group Call Date 04/26/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
15	Bidders Training	04/19/2012 10:30	Regarding the BPT101 training material	I was reading the training material and realized that the BPT101 is last year's. The newly added Sections in each Worksheet were not mentioned in the training material at all. Where can I find the most recent version of this file?	The BPT101 training session was not updated this year. See the CY2013 Points of Emphasis training session for a brief discussion of new BPT worksheet sections.
16	User Fees	04/24/2012 13:19	Margin	Has CMS released the User Fee/Cross-over fees for the bid yet? If so, where can I find the fees? If not, when will the fees be released?	The user fees are published in the MA and Part D bid instructions
17	PD Actuarial Equivalence	04/23/2012 17:31	Actuarial Equivalence Question	If a bid is not able to obtain actuarial equivalence and remain within the copayment thresholds, is there flexibility in the limits to reach equivalence?	No.
18	PD NBE	04/23/2012 17:50	actuarial user group call questions	If the administrative fees in our PBM contract vary by the number of scripts or claims, can we use the same Part D direct administrative cost PMPM for all plans under a specific contract?	Plan sponsors must use a reasonable and well-supported approach when allocating administrative fees among plans. If there are utilization differences among these plans, then different PMPM expenses must be reflected in the bid.

User Group Call Date 05/03/2012

Introductory note

As we did for CY 2012 bids, CMS is imposing a limit on the increase in Total Beneficiary Cost (TBC) from one year to the next. Since payment rates changed from 2012 to 2013, a payment adjustment is needed to equitably enforce TBC requirements for CY 2013 bids.

Illustrative Payment Adjustment Calculations

	2012 Values				2013 Values				
Bid ID	Bid Amount	Benchmark	Rebate Percentage	Rebate	Bid Amount	Benchmark	Rebate Percentage	Rebate	Payment Adjustment
Plan 001	1,000.00	950.00	66.7%	−50.00	1,028.00	975.00	58.3%	−53.00	−3.00
Plan 002	1,000.00	1,050.00	66.7%	33.33	1,028.00	1,100.00	58.3%	41.98	8.65

Notes:

1. Payment Adjustment = ($Rebate_{13} - Rebate_{12}$).
2. Rebate = Benchmark − Bid (if Benchmark < Bid)
   = (Rebate Percentage) × (Benchmark − Bid) (if Benchmark > Bid)
3. Bid Amount 2012 - taken from 2012 BPT.
4. Bid Amount 2013 - is the result of applying the growth rate used to develop the 2013 rate book (2.8%) to the 2012 bid amount.
5. Benchmark 2012 - the weighted average of county-specific payment rates using the 2012 rate book and projected enrollment in the 2012 BPT.
6. Benchmark 2013 - the weighted average of county-specific payment rates using the 2013 rate book and projected enrollment in the 2012 BPT.
7. Rebate Percentage - 2012 and 2013 depend on the plan's QBP rating for each year.

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	MLR	04/30/2012 21:31	Optional Supplemental Benefits	Are Optional Supplement benefits subject to minimum loss ratio requirements?	It has not yet been determined whether or not optional supplemental benefits will be included in the Medicare MLR requirements to be implemented for CY2014. For CY2013, consistent with past years, CMS will evaluate the benefit value provided by optional supplemental benefits following bid submission and contact outlier plans to make adjustments.
2	TBC	04/25/2012 17:12	Questions related to the TBC Changes	1) Can CMS share with plans the exact algorithm/formula used to derive column I "Impact of Benchmark and/or Bonus Payment Changes" from the "Total Beneficiary Costs Plan Data" released as of 4/16/2012? 2) We also noticed that the CY2012 TBC amount in the document is different from the amount we have in record from last year. Could CMS speak to the adjustments made to those numbers?	1) See the introductory note in this week's Q&A posting for details. 2) For the TBC data posting we used the 2012 OOPC values posted on Medicare Plan Finder in November. These are the 2012 OOPC values that will be used in determining the increase in TBC from 2012 to 2013. They differ from the 2012 OOPC values used in the CY2012 analysis due to updates to the Medicare Current Beneficiary Survey data.
3	TBC	04/26/2012 14:24	TBC Model Adjustment	Can we get the "Impact of Changes in OOPC Model Between CY 2012 and CY 2013" split between Part C and Part D?	This was addressed in Monday's TBC data re-posting.
4	TBC	04/27/2012 19:31	Two Questions from [Plan Name Removed]	Can you give us a brief description of how CMS calculated the "impact of benchmark and/or bonus payment changes" in the TBC calculation spreadsheet recently released? Are there any changes in methodology from last year? What USPCC trend did you use to trend the 2012 bids to 2013?	See the response to question #3.
5	TBC	04/30/2012 13:35	FW: Revised Total Beneficiary Costs (TBC) Data for CY 2013 Bid Preparation	Can you please confirm the TBC/OOPC does not apply to 1876 Cost Plans. We confirmed with CMS for the 2012 Bid that this does not apply to Cost Plans and wanted to confirm this had not changed for 2013.	That is correct. Please refer to the chart on page 90 of the Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.

User Group Call Date 05/03/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	Coverage Gap for EA Plans	04/29/2012 18:38	gap coverage requirements for brand for an EA plan	For an EA plan, the bid tool appears to only require actuarial equivalence in the gap for the brand and generic tiers combined. For example, coverage of tier 1 at $0 copay (a generic only tier) and no brand coverage in the gap satisfies the gap actuarial equivalence test in one of the bids we are preparing. This makes sense to me given that the bid tool doesn't require specific cost-sharing on any tier even below the ICL but just actuarial equivalence across all tiers. However, when we enter this benefit into the PBP and print the Summary of Benefits, it generates a report indicating reduced cost-sharing for the brand in the gap equal to the defined standard coverage. Can you clarify if an EA plan must have brand coverage in the gap at least equal to the defined standard coverage of brand in the gap?	Yes
7	Beneficiary Level File Enrollment	N/A	N/A	How much retroactivity was included in the beneficiary level file enrollment?	The 2011 contract-level enrollment was determined on February 7, 2012. Any 2011 enrollment changes after Feb 7th would not be reflected in the beneficiary-level files we sent out
8	Brand only deductible and gap discount program	04/24/2012 11:49	actuarial user group call questions	Can you explain how to implement a Brand Only deductible with regards to the coverage gap discount program? If a member has not reached the brand deductible limit but is in the gap, how do you calculate the 50% manufacturer discount?	CMS has not previously provided guidance with respect to deductibles and the effect, if any, that either the ICL or true out-of-pocket (TrOOP) threshold would have on any deductibles. With the implementation of the CGDP, however, CMS finds it necessary to clarify that for purposes of the CGDP only beginning in 2011, a Part D deductible ceases to apply once a beneficiary's total gross covered drug costs exceed the ICL. This means that for a beneficiary enrolled in a Part D plan with a brand-only deductible, applicable (i.e. brand) drugs that would otherwise be subject to the deductible will be eligible for a coverage gap discount once the beneficiary's total gross covered drug costs have reached or exceeded the ICL even if the beneficiary has not satisfied the deductible.
9	Gap Coverage for EA Plans	04/23/2012 17:50	actuarial user group call questions	Can you provide examples of non-low income brand and generic dispensing fee calculations in the gap for an enhanced alternative plan?	As we state in the Rate Announcement, the beneficiary liability for dispensing fee is commensurate with the coinsurance percentage (if coinsurance) or commensurate with the percentage of total Part D claim cost attributed to the after discount copay (if copay). We do not have examples at this time but would be happy to review examples if a plan wants confirmation of its methodology.
10	Gain/Loss	04/24/2012 14:26	Margin	1. Appendix B of the Part C Instructions requires a demonstration of the consistency between the aggregate margin for general enrollment/I&C SNPs and "other gain/loss margin categories, if applicable". Please explain what is intended by "other" categories. 2. The supporting documentation requested in Appendix B for g/l margin generally seems to require the support relative to the general enrollment/I&C SNPs. Is this correct and the only D-SNP support needed is to be within −5%/+1% of the general enrollment margin?	1)In the context of aggregate margin guidance, the bid instructions refer to 3 categories: one is GE&IC SNP, and the others are D-SNP and EGWP. 2) This accurately describes the aggregate margin requirement that is unique for D-SNPs, *if* GE&IC SNP plans are offered in the same contract/organization/parent organization (depending upon the level of margin aggregation chosen). However, the supporting documentation for the D-SNP must also show that the aggregate margin for GE&IC SNP plans, is within 1.5% of the margin for the Plan sponsor's non-Medicare, health insurance lines of business. If *no* GE&IC SNP plans are offered, the D-SNP aggregate margin must be within 1.5% of the plan sponsor's Non-Medicare, health insurance lines of business. In any event, the D-SNP margin must comply with all bid-level margin requirements.
11	Gain/Loss	04/30/2012 19:01	DE-SNP margin question	The 2012 MA bid instructions stated the following: "CMS expects the margin level for DE-SNPs to be within a small range of the margin level for general enrollment plans and I/C SNPs (that is, up to 1 percent). Exceptions for unique situations must be fully explained and supported." In the 2013 instructions, the range was increased on the downward side, and the exception language was removed. We are aware of several situations in 2012 where exceptions to this rule for valid and supportable reasons were granted. Will such exceptions continue to be accepted for 2013 if the margins fall outside the newly quoted range?	CMS expects compliance with the wider range for the difference between aggregate margins for D-SNPs and general enrollment plans and I/C SNPs without exception. Note that the pricing consideration for dual-eligible beneficiaries now provides that the PMPM equivalent of the Medicaid/Platino gains/losses entered in Worksheet 4, Section V "will be taken into account in satisfying the gain/loss margin requirements". See page 21 of the MA bid instructions.
12	Credibility	05/01/2012 10:59	CY2013 Bid Question	Can the data from a plan with 92% credibility, and assumed to be 100% credible, be used to project the manual rate development of a similar plan that is not fully credible?	The certifying actuary must use his or her judgment as to the best data source for the manual rate development and consider the credibility of the data source.
13	Preventive Services	04/23/2012 13:04	New Preventive Services	Liz Hale addressed a question on the 4/19 call on the New Preventive Services that became effective in late 2011. Because these services were not covered until mid-October and mid-to-late November, we do not have a full calendar year of data in our base period to understand the cost of these services. While CMS will not be providing safe harbor estimates for these services, are there published sources/studies available that would help in estimating the projected costs associated with these new services?	We are not aware of any publically available sources or studies to use as a resource for estimating the projected costs associated with preventive services.

User Group Call Date 05/03/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
14	EGWP	04/30/2012 16:04	Employer Group Question	If we are filing FFS Medicare benefits for the Employer Group, do we need to file a maximum out of pocket? Since FFS Medicare does not have a maximum out of pocket, filing a maximum out of pocket would not technically be filing FFS Medicare benefits.	According to the chart on page 90 of the Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, employer plans are required to have a maximum out-of-pocket limit. For purposes of completing the BPT, if all other cost sharing is set at Medicare FFS levels the bid would be considered to be filed as Medicare FFS.

User Group Call Date 05/10/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	PD	05/01/2012 16:58	Part D Coding Trend	In past years, CMS has provided the Part D coding intensity trend that was used in development of the risk score normalization factor in the final announcement/rate letter. What is the coding intensity trend assumed in development of the 2013 Part D risk score normalization factor?	With the advent of the 2011 RxHCC risk adjustment model, CMS calculates the Part D normalization factor just as we do the CMS-HCC model normalization factor. We first calculate an annual average trend; the normalization factor is the trend compounded by the number of years between the denominator year and the payment year. For 2013, the annual trend is 0.0115, raised to the third power, to adjust for the years between 2010 and 2013. The calculation is 1.0115^3 = 1.034
2	Risk Scores	05/08/2012 8:01	FFS Risk Scores	Are the non-PACE risk scores published for 2006-2010 based on the 2013 CMS HHC model	Yes
3	PD	05/08/2012 8:41	LIS Enrollment	Do you know when the LIS enrollment will be available on the CMS website?	The area within CMS that will be posting this information informs us that it should be posted next week.
4	MA	05/07/2012 19:47	2013 bids-provider incentives	Could you please clarify how shared risk settlements with providers should be reflected in the base period and projection period, i.e., in Health Care Cost, UM/QM, or non-UM/QM, non-benefit expense? These settlements are provided for providers who out-performed certain utilization targets established advance in contracts.	Provider incentives should be included in medical expenses.
5	MA	05/04/2012 16:49	POS benefit	The instructions indicate that benefits provided OON under a POS plan are either mandatory supplemental or optional supplemental. Our plan is choosing them to be mandatory supplemental. For Medicare covered services projected to be received OON under a POS plan (e.g. inpatient stays), we are wondering if those costs need to be reflected in column m (Medicare covered) or column p (mandatory supplemental) of worksheet 4	The benefits and services categories MA pricing consideration states that (i) the allocation between Medicare-covered benefits and A/B mandatory supplemental benefits must be consistent with the benefit type classification in the PBP, and (ii) out-of-network (OON) HMOPOS benefits are always A/B mandatory supplemental benefits for HMOPOS plans. Therefore, the cost of OON HMOPOS benefits such as inpatient stays, must be included in column p (net pmpm for additional servcies) and/or column q (reduction of A/B cost sharing) in worksheet 4.
6	Non-benefit expenses	N/A	Non-Benefit Expense	How should I reflect expenses paid in 2011 for a new plan that was effective in CY2012?	The pricing considerations for non-benefit expenses in the MA and Part D bid instructions define non-benefit expenses as all of the bid-level administrative costs incurred in the operation of the MA or the Part D plan, respectively. Therefore, these expenses should not be ignored as Medicare expenses and the reporting of such expenses must follow generally accepted accounting principles (GAAP) as stated in the bid instructions.
7	Taxes and Fees	05/02/2012 22:29	Bid Instruction Question	The MA bid instructions appear to contain a conflict as follows: Page 9 "Similarly, the cost of taxes and fees (PMPM) is the certifying actuary's best estimate of federal and state taxes and licensing or regulatory fees, which the Plan sponsor believes should be included in this category. Taxes and fees are subtracted from the revenue (denominator) in the calculation of the Adjusted MLR. This cost is a subset of projected non-benefit expenses (line v) and/or gain/loss margin (line w)." "Example: Quality initiatives: care coordination, chronic disease management, hospital discharge program, . . . Taxes and fees: ACA annual fee on health insurance providers, Federal income taxes excluding taxes on investment income and capital gains. . ." Page 30 "Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes,…"	We believe that the bid instructions consistently refer to offsets to revenue such as income taxes. First, the MA bid instructions on page 9 indicate that items in the "Taxes and fees" category may include gain/loss items, i.e., "**Taxes and fees are subtracted from the revenue** (denominator) in the calculation of the Adjusted MLR. This cost **is a subset of** projected non-benefit expenses (line v) **and/or gain/loss margin** (line w)." Second, the non-benefit pricing consideration on page 30 states that "Costs not pertaining to administrative activities must be **excluded from non-benefit expenses.** Such costs include . . . **income taxes**. . .", and finally, the gain/loss pricing consideration on page 26 states that "The **gain/loss margin may reflect revenue offsets not captured in non-benefit expenses (**such as . . . investment expenses, **income taxes** . . ."
8	Taxes and Fees	05/07/2012 9:29	Taxes and Fees	The instructions are not clear about whether taxes and fees are supposed to be on a GAAP (as the rest of the bid is) or a statutory basis. HHS's Supplemental Health Care Exhibit that is the basis for the MLR calculation for individual and group business is on a statutory basis, and the experts at my company assume that the MA and Part D MLR calculations would want to be consistent with that method. Can you please clarify?	The adjusted medical loss ratio pricing consideration in the MA and Part D bid instructions state that "Taxes and fees are . . . a subset of projected non-benefit expenses (line v) and/or gain/loss margin (line w)", therefore, these items should not be adjusted to a different basis, such as from a GAAP basis to a statutory basis. CMS will consider this suggestion in developing formal Medicare MLR requirements for 2014 and we encourage you to expand upon your assumption in the Quality Initiatives and Taxes and Fees text boxes in MA Worksheet 4 and Part D Worksheet 2.

User Group Call Date 05/17/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	OOPC	05/08/2012 16:14	Formulary and OOPC	Since we submitted our formulary in April, we have made decisions to make improvements to the submitted formulary. This will change our OOPC's for our MAPD plans. More importantly, for two of our plans where there were OOPC issues with the old formulary, the OOPC issues will go away with the new formulary. I don't know when the next round of formulary submission will be, but CMS will not be able to validate our OOPC's with the formulary submitted in April. Will our plan fail OOPC during bid review? Can we submit our formulary with our bids so that CMS can validate our results?	As stated in the April, 2, 2012 Call Letter and April 12, 2012 HPMS Memorandum (CY 2013 Medicare Advantage Bid Review and Operations Guidance), plans are expected to satisfy CMS bid review criteria in their initial bid submission. CMS may choose not to allow MAOs to revise their initial bid submissions because MAOs have access to our requirements and the necessary tools to calculate OOPC estimates for each plan prior to bid submission.
2	OOPC/TBC	05/15/2012 14:04	Questions Regarding OOPC and TBC	1. In the 2013 TBC file that CMS released in late April 2012 (*total_beneficiary_costs_3.xls*), how do we calculate column A (*2012 OOPC Value*)? That is: a) Which version of the OOPC Tool was used?, and b) Which formulary file was used? 2. In the 2013 TBC file that CMS released in late April 2012 *total_beneficiary_costs_3.xls*), which formulary file should we use to calculate column K (*Adjusted TBC Change*)? That is: a) The formulary filed in mid-April 2012, or b) If a plan submits improvements to the filed formulary, will those be taken into account when calculating this column?	1a) 2012 v4 1b) The formulary file used in the November update to Medicare Plan Finder OOPC values (presumably the formulary file current as of November 2011) 2) The most recent formulary submitted for CY2013. Generally, that would be the formulary submitted in April 2012. However, if the formulary is resubmitted prior to bid submission as requested by CMS due to issues uncovered during formulary review, then that resubmitted formulary should be used when running the 2013 OOPC model to determine the 2013 OOPC value.
3	MA	05/09/2012 11:51	New Subset Plan	If a new Dual Subset plan is being created out of an existing Dual SNP thru an exceptions process crosswalk rather than a HMPS crosswalk, and the existing Dual SNP will continue – should the new Dual Subset plan show the experience of the existing Dual SNP in Worksheet 1?	No because the existing Dual SNP was not terminated. Correction made 5/24: Exception crosswalks are to be treated the same way as other (i.e., non-exception) crosswalks. Therefore, the new Dual Subset plan should show the full experience of the existing Dual SNP in Worksheet 1 and the plans in the base period section (II line 5) should contain the contract-plan-segment id of the existing Dual SNP.
4	MA	05/09/2012 12:55	Incentive Programs	Do we need to price incentive programs in the BPT's? Is this a medical cost or an administrative cost?	The bid must include all costs of providing coverage which includes provider incentives and preventive services incentives, which are medical expenses. See the May 7, 2012 Actuarial User Group call, the MA Base Period pricing consideration and the MA Preventive Services Incentives pricing consideration.
5	MA	05/15/2012 14:15	Question regarding Provider Incentive Payments to include in Worksheet 1 Base Period Experience	The 2013 MA BPT instructions do not provide detail as to where in Worksheet 1 any base period expenses for provider incentives should be included. Page 11 notes only that the provider incentive payments must be included in Worksheet 1. A previous question to the CMS mailbox from another plan (5/7/12) had a response that only said the provider incentives should be included in medical expenses. Is it acceptable to include the entire provider incentive amount in category i. (professional)? If not, what is the required approach for including these costs on Worksheet 1?	The allocation of medical expense by service category is the certifying actuary's best estimate of a reasonable allocation.
6	MA	05/15/2012 14:15	Question regarding Claims Interest Penalties in the base period	For money paid in the base period for claims interest penalties (for claims paid late), should this be included as base period benefit expense or non-benefit expense? If non-benefit expense, is it to be included under Direct Administration or a different category? If benefit expense, what is the requirement pertaining to which service category(ies) these expenses should be allocated on Worksheet 1?	Claims interest penalties may be reflected as a non-benefit expense using the certifying actuary's best estimate of a reasonable allocation by expense category.
7	MA	05/09/2012 13:05	Safe Harbor for Inpatient Hospital Non-Covered Days	Is the 1.2%-factor applicable to the Allowed Costs or to Cost-Sharing or both?	The 1.2-percent "safe harbor" factor, provided on page 27 of the MA BPT instructions, represents the proportion of inpatient days that are non-covered and can be used directly as the percentage of Medicare-covered inpatient PMPM allowed costs entered in Worksheet 4. However, depending upon the cost sharing structure, the factor may need to be adjusted to estimate the Medicare-covered percentage of cost sharing PMPM.
8	MA	05/09/2012 13:55	CMS-1588-P	On April 24th, 2012, CMS proposed the rule (CMS-1588-P): "We are proposing to update the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and implementing certain statutory changes made by the Affordable Care Act. These proposed changes would be applicable to discharges occurring on or after October 1, 2012" Has this been factored into the trends for 2013? What is the impact of the increase?	Yes. The USPCCs reflect all relevant Medicare ACA provisions; however, the impact analysis of the proposed rule does not separately identify the impact of these particular provisions.

User Group Call Date 05/24/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	OOPC	05/15/2012 19:22	OOPC: Brands Losing Patent	I'm working for a Health Plan that filed a formulary for 2013 that does not cover the brand versions of Lipitor or Plavix (but does cover the generic versions). When we run the OOPC tool, we are seeing a significant increase in member OOPC costs due to not having the brand versions of these drugs covered (vs. 2012 when they were covered). Will CMS take into account OOPC or TBC changes outside the prescribed limits driven by generic launches and allow for those on an exception basis?	The OOPC model uses generic substitutes and associated RxCUIs for Lipitor. Therefore if the MCBS data reflects Lipitor utilization, but Lipitor is not on the plan's formulary, the OOPC model will search the formulary for the generic version of Lipitor. If the generic substitute is there, the OOPC model will consider that drug as being covered at the applicable cost-sharing tier for the generic drug. For Plavix, since a generic product did not exist at the time the formulary reference file was created, the OOPC model does not use a generic substitute. According to an FDA release, the patent for Plavix was extended until May 17, 2012. Which means that at the time of formulary submission, there could not have been a generic product legally on the market. Therefore, no plan will have a generic product on their current formulary. CMS expects submitted bids to comply with all requirements using the current formulary submitted for CY2013.
2	PD	05/18/2012 9:26	Part D Profit Margins	The Gain/Loss Margin Aggregate-Level Requirements section of the 2013 PD BPT Instructions say that aggregate gain/loss for Part D plans must be within 1.5% of the sponsor's margin for non-Medicare health lines of business. The comparable instructions in the 2013 MA BPT Instructions exclude DE-SNP plans from this comparison. Do we include or exclude DE-SNP plans from the Part D Aggregate Level comparison?	1) PDP margin must be within 1.5% of the margin for non-Medicare health insurance lines of business. 2) a) The margin for the PD portion of an MA-PD plan must be set within 1.5% of the corresponding MA margin for the same bid, or b) At the level of aggregation specified in the BPT (contract, organization, or partent organization) the PD margin for General Enrollment and I/C SNPs must be within 1.5% of the MA margin for General Enrollment and I/C SNPs, and the PD margin for D-SNPs must be within 1.5% of the MA margin for D-SNPs.
3	PD	05/17/2012 10:18	Issue 1186: $0 Part D Supplemental Premium Requirement	We understand the requirement that in every county in which we offer MAPD, we must have at least one plan that has a $0 Part D Supplemental premium. We have a plan that has Enhanced Alternative PD benefits and a total MAPD member premium of $0. It has a negative Part D Basic member premium. Since the sum of Part D Basic and Supplemental premiums must be non-negative, we must have a positive Part D Supplemental premium. Since all members would have a $0 premium for this plan, can this plan be used to satisfy this requirement in its service area counties despite having a positive Part D Supplemental premium?	Yes. The intent of the policy is that the beneficiaries are charged/pay no supplemental Part D premium. In this specific example the intermediate supplemental premium is offset by a negative basic premium with the end result being no supplemental Part D premium. Arriving at a $0 supplemental Part D premium in this way is not a violation of our policy regarding required prescription drug coverage.
4	Related Party	05/17/2012 9:51	Individual Part D Substantiation question	My question is in regards to Appendix B in the 2013 Part D BPT instructions. On page 72, there is a new item listed under the substantiation requirements. This item, "Related Party Declaration" is described as a document that states whether or not the Part D sponsor is in a related-party agreement. Can you clarify how this requirement differs from the "Disclosure of Related-Party Agreements" requirement, which appears on page 76 of Appendix B?	The difference is that, starting this year, ALL plans must make a declaration; whereas, previously, only plans WITH agreements with related parties were required to disclose that information. In other words, if you DO NOT have any agreements with related parties, you must include a declaration to that effect with your initial June bid submission. Note that the MA instructions include the same requirement.
5	TBC	05/21/2012 22:38	TBC Issue	I have attempted to replicate the CMS value for the change in TBC model using 2012 formulary and PBP files converted to 2013 format. The value calculated by CMS reduces the TBC threshold for my client by $15, entirely for Part D. It is my understanding that my client has made no changes in formulary or coverage which would approach this level. Is it permissible to submit a bid that reflects my best estimate for this value, with the understanding that this issue will be resolved during review, and if the CMS value is correct, reduce profit?	The data that CMS publishes will be the standard by which TBC will be evaluated.
6	TBC	05/22/2012 13:48	TBC for Consolidating Plans	For plans that consolidate multiple CY 2012 plans into a single CY 2013 plan, CMS will use the enrollment-weighted average of the CY 2012 plan values to calculate the TBC." What membership should be used, 2011 or emerging 2012?	Use projected 2012 member months from the CY2012 bids.
7	MA	05/16/2012 13:43	Question	For members that opt to receive palliative care and have not chosen Medicare hospice status, under which service category on Worksheet 1 should we include the costs for services provided by hospice providers?	The costs should be reported by service category based on the certifying actuary's best judgment taking into consideration the place (inpatient hospital, outpatient hospital, skilled nursing facility, home, physician's office, etc) where the care is provided.
8	MA	05/16/2012 23:24	CPCi Program	For the plans participating in Comprehensive Primary Care (CPC) Initiative program, the CPCi providers will be reimbursed by a fixed upfront fees to support the increased infrastructure to administer CPCi program. Should those fees be reported as benefit expense (professional – category i), or be reported as Direct Administrative expense?	These should be reported as benefit expense.
9	MA	05/22/2012 0:58	FFS Cost Sharing	If Fee For Service Cost Sharing is used and priced using the effective FFS cost sharing factors, does the actuary still have to price the part B Deductible separately in Worksheet 3 Column F?	No. The Medicare FFS Cost Sharing subsection of the Cost Sharing pricing consideration states that if "plan cost sharing is designed to match Medicare FFS cost sharing and the actuary uses the actuarial equivalent cost-sharing factors shown in MA Worksheet 4 to estimate the PMPM amount for plan cost sharing, "the user may enter the entire value of cost sharing in Worksheet 3, columns i for the effective copay/coinsurance before MOOP."

User Group Call Date 05/24/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
10	MA	05/22/2012 8:59	Employer group margins and general enrollment plans	Our general enrollment LHMO plans are priced at a positive margin and our LPPO Plans in the same service area are priced at a negative margin, but the overall combined margin is positive. Our LPPO has a different contract number than our LHMO. The bid instructions state that the employer group bid margins cannot be more than 1% higher than the general enrollment plan average margin at the contract level. However in our situation the LPPO general enrollment average margin is negative and it wouldn't make sense to price the LPPO employer bids negative or with a very slight positive margin in order to be within 1% of the contract level margin. In this case it would make more sense to tie the LPPO employer group margin to the combined LPPO and LHMO general enrollment margin. Would this be acceptable?	No. EGWP margin must be within -5% and +1% of General Enrollment and I/C SNP margin at the contract level.
11	Non-benefit expense	05/18/2012 17:12	Bids: Non-Benefit Expense Question	Is interest on a loan an allowable non-benefit expense?	All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP) or a consistent application of the Plan sponsor's standard accounting practices, if the Plan sponsor is not subject to GAAP or if the specific expense is not address by GAAP.
12	Plan Consolida-tion	05/22/2012 13:36	Clarification of plan consolidation and enrollment shifts rules	Question regarding the interplay of Rule #1 and #3 for Plan Consolidations and Enrollment Shifts in a partial crosswalk: CY2011 Plan is 001. In CY2012, some members of 001 were officially crosswalked by CMS into new plan 002 while the rest of members in 001 remained in 001. Both 001 and 002 continued into CY2013. Is it acceptable to report the entire 001 base period data in the 001 plan worksheet 1 (sections II, III and VI) and leave the 002 worksheet 1 blank (i.e., new plan)?	No. When there is a cross-walk (i.e., the formal cross-walk process in HPMS), Rule #3 requires that base period experience is reported in total at the bid-level. Experience for plan 001 cannot be excluded from Worksheet 1 for plan 002. Further, Section 3, line 5, Plans in Base, must include the bid IDs for plans 001 and 002. Note that under a crosswalk members are moved from one plan to another and do not have the option of enrolling in a new plan of their choosing. This applies to exception crosswalks as well as other (i.e., non-exception) crosswalks; therefore, a correction has been made to the response to a similar question (#3) on the 5/17 UGC.
13	MA	N/A	HMOPOS vs PPO	Please describe the differences between HMO-POS and PPO plans and why the pricing is treated differently in the Bid Pricing Tool (BPT).	An HMO is a type of MA coordinated care plan that is required to furnish access to all plan covered services (i.e. Parts A and B and supplemental benefits) through a network of contracted providers (see 42 CFR section 422.4(a)(1)(iii)(A)). Unlike a PPO an HMO plan is not required to cover any out-of-network services with the exception of emergency, urgently needed and out of area dialysis services. However, an HMO can elect to offer a supplemental POS benefit by which it offers its enrollees the option to receive specified services out-of-network subject to certain conditions (see 42 CFR section 422.105). The out-of-network services offered by an HMO-POS can range from one service to all services and may impose limitations on geographic area and/or providers, as long as the benefit is transparent to beneficiaries. Subject to CMS approval an HMO could impose prior authorization requirements for POS benefits. An HMO can also specify what services it will cover out-of-network under its POS benefit. A PPO is a type of MA coordinated care plan that under the statute and MA regulations (see 42 CFR section 422.4(a)(1)(v)) is required to cover all medically necessary Part A and B services and supplemental benefits both in-network and through out-of-network providers. In addition, the regulations specifically prohibit a PPO from imposing any prior notification or authorization requirements on an enrollee's right to obtain medically necessary care from a non-contract provider. Because the regulation specifies that an HMO can elect to offer a **supplemental** POS benefit, this benefit must be priced in the BPT as a supplemental benefit. Whereas the A/B out-of-network benefits provided by a PPO would be priced as Medicare-covered because the PPO must provide all A/B services out-of-network. The difference in treatment is due to the statutory and regulatory requirements and to the great flexibility given to HMOs in how the POS benefit is structured.

User Group Call Date 05/31/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	PD	05/29/2012 2:47	Part D Premium	I have an MA-PD plan that has a negative Part D basic premium and a positive Part D supplemental premium. The overall premium for the plan is $0. For illustrative purposes assume the following: Part C Premium = $0 Part D Basic Premium = ($5) Part D Supplemental Premium = $20 Part D Supplemental Premium Buydown = ($15) Total Member Premium = $0 After the national average bid gets published, assume that the Part D Basic Premium decreases to ($6). Can we reallocate rebates to change the Part D Supplemental Premium Buydown to ($14) to maintain the overall $0 premium for the product?	Yes.
2	PD	05/29/2012 15:35	Part D EA Plan	Please confirm that the requirement to offer a Basic Part D Plan (DS, AE, BA or EA with no supplemental premium) in each service area is met under the following scenario: A PPO plan is offered in a 4 county service area with an EA Part D plan that has a supplemental premium. An HMOPOS plan is offered in an 8 county service area (covering all 4 counties of the PPO plan) with an enhanced alternative plan that uses MA rebates to buy down the supplemental premium to $0.	This has been confirmed by the PD Benefits area.
3	MA	05/27/2012 15:52	Part C-group bid form worksheet 3 footnote question	We are filing original medicare benefit for Group customers. We are applying original medicare cost sharing % from wk4 to wk3 column I as effective coinsurance before MOOP. Do we need to calculate MOOP impact to get a different set of factors to fill column J (effective coinsurance after MOOP)? If so, in calculating column J, do we need to use our typical plan designs (mostly has copays) or continue using original medicare cost plan which doesn't have copay?	(1) Yes for non-DE#. The OOP max is valued separate from other cost sharing. (2) For estimating the impact of the MOOP, you must assume the cost sharing reflected in the PBP, that is, Medicare FFS cost sharing. However, for DE#, the DE# plan cost sharing in Worksheet 4, Section IIB, column f may be set equal to the effective copay/coinsurance before the MOOP from Worksheet 3 column i (as provided in the Medicare FFS Cost Sharing subsection of the Cost Sharing Pricing consideration). Therefore, the value of the MOOP would not be needed for plan cost sharing in Worksheet 4, Section IIB, column f.
4	Plan Consolida-tion	05/25/2012 12:21	Worksheet 1 Reporting	On the 5/24/12 user group call question 12. CMS provided an answer for WS1 consolidation that seems to contradict the answer given for 2012 bids on the 5/26/11 user group call question 7. (1) Is this a change in CMS policy? The question with the year updated is "We have a 2011 PFFS partial network plan (call it 001) that will continue in 2013. Several of the counties in the 2011 plan will be formally cross-walked under CMS' approved process to a full network plan (call it 002 but under a different contract #), as required to meet 2CCP+ requirements. Here are the relevant comments/questions for this situation. Because plan 001 is continuing in 2013, we know that all the 2011 plan 001 experience must be reported in WS#1 for 2013 plan 001. (2) Due to the formal crosswalk of some of 2011 membership in plan 001 to plan 002 for 2013, should we also report all the 2011 plan 001 experience in WS#1 for the 2013 plan 002?	(1) Yes, this is a change in policy. (2) Yes. Report all the CY2011 data for plan 001 in Worksheet 1 of the CY2013 BPT for plan 002 because CMS approved the crosswalk and passive enrollment of some members in plan 001 to plan 002.
5	MA	05/24/2012 16:58	Margin Requirements and TBC	CMS released BPT guidance regulating that margin requirements be within a certain percentage of commercial gain/loss margins. In addition, CMS limits the premium charged through the TBC. - If the TBC prevents a plan from charging enough premium to achieve an overall margin that meets margin requirements, can the plan submit a margin lower than the margin requirements? - If not, can a plan increase the TBC above the limit?	(1) Yes, only if the initial upload of gain/loss supporting documentation demonstrates that the TBC limit is reached for each bid within the gain/loss margin level of aggregation, that is, for all bids in the same contract, organization or parent organization. (2) No.
6	MA	05/22/2012 14:37	Effect of ACA Provision on Primary Care Rates in Medicaid CMS-2370-P	On May 11, CMS proposed rules to implement the raising of Medicaid's primary care rates to the Medicare rate in 2013 and 2014. What, if any , effect would this increase have on 2013 and/or 2014 bids for duals. Most states currently pay below Medicare and the state's liability is limited to the "Medicaid rate." Does this law and rule even apply to Medicare cost sharing and ,if so , how does this affect the Part C bidding process?	In determining their best estimate of costs for the contract year the certifying actuary must evaluate the impact of the interaction between Medicaid rates, the Plan sponsor's fee schedule, and plan cost sharing.
7	MA and PD	05/29/2012 12:11	Taxes and Fees	For the base period and contract period, do these numbers need to be reported on a total dollar or PMPM basis?	Both the Quality Iniatives and the Taxes and Fees entries on MA and PD Worksheet 1 must be entered in total dollars for the base period. For the contract period these entries on PD Worksheet 2 and MA Worksheet 4 must be entered on a PMPM basis.

User Group Call Date 05/31/2012

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
8	MA	N/A	PBP	Although the enrollees in our D-SNP pay nothing out-of-pocket because the State pays those costs, in the PBP are we still required to enter what the cost sharing would be if the State was not paying, or what the enrollee would pay in cases that the enrollee loses his/her Medicaid eligibility?	Yes. The cost sharing amounts that enrollees would be responsible to pay if the State were not paying cost sharing for them must be entered in the PBP. The fact that the State pays the cost sharing does not mean those amounts were not charged for services provided; or that the services received by the dual-eligible enrollee were fully paid by your plan. In order for your plan to accurately reflect in the PBP and BPT the plan costs of providing services, the PBP and BPT must reflect pricing and cost sharing that are consistent. If a plan enters $0 cost sharing in the PBP because the State will pay the cost sharing amounts for enrollees, it is creating a PBP that may contain benefits not intended to be covered by the MA plan. In that situation, the PBP indicates that the plan is responsible for paying cost sharing. Also, by entering in the PBP $0 cost sharing for services that do, in fact, incur cost sharing charges that are paid for by the State, the plan is entering non-MA plan benefits in its PBP; the payments made by the State to cover enrollees' cost sharing are the benefit that result in $0 cost sharing. The plan may not claim a State benefit, or any benefit not provided by the MA plan, in the PBP. D-SNPs that are All Dual, Full Dual, and Dual Eligible Subset will receive Summary of Benefit sentences that say, "$0 or $XX" for Medicare-covered service categories, where the $XX represents the cost sharing entered by the organization for the given service category.