Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

April 16, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Risk Score: data provided by CMS	4/16/2009	4/13/2009 4:01 PM	CMS User Group Call - Questions [PART 1]	The risk scores posted on HPMS use the same membership counts for the MA and PD risk scores. The MA technical notes state that ESRD and Hospice members were excluded from the calculations. The PD technical notes do not indicate that ESRD and Hospice members were excluded. If we are to use the posted risk scores in HPMS on which to do our risk score projections, will CMS post revised risk scores for the entire PD population in each plan? If not, can you confirm that these members were excluded? And, can you confirm that they were also excluded from the PDP populations?	The Part C risk scores posted in HPMS exclude ESRD and hospice beneficiaries. The Part D risk scores originally posted in HPMS exclude ESRD and hospice beneficiaries. However, since the Part D model is used for payment for ESRD and hospice beneficiaries, risk scores for these beneficiaries should be posted. Revised Part D risk scores have been posted on HPMS as of 4/16/09.
2	Risk Score: data provided by CMS	4/16/2009	4/13/2009 9:31 AM	Beneficiary Level File	I have a question about the beneficiary level file. We understand this file to be based on each plan's July 2008 members. Can you confirm that ESRD and Hospice members are excluded from this file? When using this file to identify DE# members in the 2008 base period data, we are potentially under-identifying the DE# population as there were DE# members who termed prior to July 2008 and those who became effective after July 2008. Is there a suggested method for dealing with this issue? Ideally, we would like the beneficiary level file to contain one record per member per month of eligibility in all of 2008. Therefore, a member could have up to 12 records. This would allow us to identify all DE# members and their associated claims in the base period.	ESRD and hospice beneficiaries are excluded from the beneficiary level file. CMS is providing beneficiary level information for the first time to assist plan sponsors in their 2010 bid submissions. For the 2011 bids, CMS will consider incorporating monthly eligibility into the beneficiary level file, but for the 2010 bid submissions plan sponsors are recommended to use the current beneficiary level file that has been posted on HPMS.
3	Risk Score: data provided by CMS	4/16/2009	4/9/2009 8:28 AM	Beneficiary level File	Can you confirm the accuracy of the plan level beneficiary level file provided on April 7 and that this is the file plans should rely on for bid preparation? There are about 10% of our plan's members with a "changed" risk scores from the non-lagged risk scores for 2008 after accounting for all accepted RAPS reporting through the end of January 2009. Some of the changes for members are negative, and do not seem to be demographic-related. Is this possible? Also, within the same file, the dual statistics seem to be quite a bit off from the dual eligibility we can derive from the Part D copay levels. Which one is the more reliable source?	CMS believes that the risk scores included in the plan level file posted in HPMS are accurate and plans may rely on this file for bid preparation. Additionally, a plan may make adjustments provided the adjustments are actuarially sound. Yes, the risk scores included in the plan level file may differ from plan's risk scores. The differences are attributable to submission or deletion of diagnosis for beneficiaries who were enrolled in a different plan for some portion of the data collection period or who were enrolled in fee-for-service for some portion of the data colllection period. The plan may be unaware of these diagnosis. The effect of this could either be positive or negative for a given beneficiary. Part D Low Income Subsidy beneficiaries consist of Medicaid eligible and non-medicaid beneficiaries.
4	Risk Score: data provided by CMS and MSP	4/16/2009	4/13/2009 10:41 AM	MSP	Please confirm that we need to use the MSP percentages as provided on HPMS. Please provide supporting documentation of the calculation as provided by CMS since this is significantly different than actual MSP experience and / or adjustments in our plans' experience. Please also clarify if this plans should apply the percentage at the contract level or plan level, since all historical MSP adjustments were applied at the contract level.	The MSP percentages provided on HPMS should be used. Plans should apply the percentage at the plan level. The new method will make MSP adjustments at an individual level.
5	Risk Score: MSP	4/16/2009	4/10/2009 12:07 PM	2010 Bid - Medicare Secondary Payer Adjustment	I am trying to determine how to calculate the MSP adjustment factor in Worksheet 5 of the 2010 bid, using the member level file provided to us earlier this week with our July 2008 membership. Is the following formula correct? Adjustment = (% Working Aged/Disabled) x (1 - 0.174) • "% Working Aged / Disabled" = (Members with MSP flag of '2' or '3' in the July 2008 File) / (Total Membership in the July 2008 File) • 0.174 - The relativity between Medicare Secondary costs to Medicare primary (from the 2009 Announcement) Can you confrim that this calculation is correct? Or publish an official version of the detailed calculation?	This calculation is not correct. Because the risk score of members with MSP tends to be lower than average, the proportion of enrollees who have MSP is not the same as the proportion of dollars that are affected.

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6	Risk Score: normalization	4/16/2009	4/13/2009 1:47 PM	Risk Score Normalization	Historically, the Fee-For-Service Risk Score normalization factor has been applied in bids and in payment as a reciprocal, e.g., multiply by 1/(1.041). Now that CMS has announced an Adjustment for MA Coding Pattern Differences, it appears that you would like us to apply that adjustment multiplicatively rather than by dividing: multiply by (1-0.0341). Do you want us to change the FFS normalization factor to (1-0.041) as well? Should we combine these two factors in any way (multiplying or dividing), or should they be kept separate?	Apply the normalization factor as we have in the past, ie., multiply by 1/1.041. For the coding intensity adjustment multiply by (1-.0341), We require that they be applied as we have instructed.
7	Risk Score: normalization	4/16/2009	4/10/2009 10:30 AM	Part D Normalization Factor Question	The Part D normalization factor changed from 1.085 in 2009 to 1.146 in 2010, in part due to a change in the methodology for calculating the factor. Can you provide an estimate of the impact of the change in methodology, as opposed to the change in coding or other factors?	The change in methodology in calculating the Part D normalization factor will decrease the contribution to revenue from the direct subsidy and increase the beneficiary premium; overall revenue will remain the same. CMS estimates that this change in methodology will increase beneficiary premiums by approximately $1.50.
8	Medicare FFS trends	4/16/2009	3/10/2009 5:00 PM	Medicare FFS Trends to 2010	Do you plan to provide Medicare FFS trends for 2010 (vs 2009) on a service category basis such as trends for the following: RBRVS, DRG, Home Health, DME, APC, etc.?	We will provide this information on a future user group call.
9	Medicare FFS trends	4/16/2009	4/14/2009 10:51 AM	trend	Please provide the cost and utilization trend assumptions in the payment rates by major service category (e.g. - inpatient, SNF, HHC, outpatient, professional, DME)	We will provide this information on a future user group call.
10	Credibility/ supporting documentation	4/16/2009	2/27/2009 9:00 AM	n/a	Page 82 of the [BETA] MA instructions stated that MCOs must submit alternative crediblity approach before May 1 for CMS approval. Does over-riding credibility to 0 for plans with low credibility (e.g. <25% or 30%) or over-riding crediblity to 100% for plans with high credibility (e.g. 95%) require this type of approval? Same question related to PD instructions.	For credibility approaches different than the CMS guideline (24,000 member months MA and 12,000 member months PD), we encourage plans to submit their proposed methodology to CMS for evaluation. If a proposed methodology is submitted before May 1st, OACT will review and respond within a week or two. CMS Office of the Actuary is applying the following "safe harbor" when over-riding the recommended credibility formula to 0% or 100%. Plans may over-ride the credibility to 0% when the CMS credibility formula would result in a credibility of 20% or less. That is, if a plan has 960 or less MA member months, or 480 or less PD member months, then the credibility may be over-ridden to 0%. Similarly, plans may over-ride the credibility to 100% when the CMS credibility formula would result in a credibility of 90% or more. Therefore, if a plan has 19,440 or more MA member months, or 9,720 or more PD member months, then the credibility may be over-ridden to 100%. The safe harbor rule is applicable only to the CMS credibility formula, not any alternative credibility formula. Plans are not required to apply the rule, but if a plan sponsor uses the safe harbor credibility rule, then it must be applied consistently among bids. The credibility over-ride cannot be applied selectively among bids. Over-riding credibility that is not within the safe harbor would require the same level of documentation and justification as any alternative credibility approach, including the option to submit the alternative credibility approach to CMS in advance of the bid submission.

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11	Credibility/ WS1 reporting	4/16/2009	4/14/2009 2:52 PM	Questions for technical user group calls	1. If the company is using a credibility standard consistent with the CMS guidance, but which has a minimum number of member months required for any credibility (ex. if fewer than 50 member months in the base period, then the plan is assigned 0 credibility), do they need to have that explicitly approved by OACT? If explicit approval is not required, what is the "safe harbor" minimum number of member months? 2. The bid instructions do not allow for aggregation of plan experience except in the case of terminated plans. Is plan experience allowed to be aggregated when rating areas are changed? In a number of cases we are considering moving counties from one PBP to another PBP. We feel it would be more appropriate to aggregate the experience based on the way counties will be filed in 2010, not how they existed in the base period. The instructions, citing the plan termination only exception would appear to not allow this. Please provide guidance.	1. See above response. 2. The following answer is provided in the context of the MA BPT, but applies similarly to the PD BPT. Base period data (section III of MA WS1) must be reported without aggregation, except in cases of terminated plans where the members are retained by the Plan sponsor . There are no other exceptions. In the case cited in the question, the Plan sponsor could use the population change factor on WS1, section IV, to adjust for changes in the covered population. This implies that the population change factor may be calculated using the aggregated data relative to the non-aggregated data reported in WS1, section III. Note that aggregation at any point in the claim development process (base period thru projected) is not allowed in order to achieve consistent pricing among various bids, which instead may be addressed through the gain/loss margin.
12	Related Party	4/16/2009	4/14/2009 11:07 AM	related party agreement question	In the base period, suppose a health plan has a global cap agreement (say at 85% of Revenue) with a related party and the related party does not have any other contracts with unrelated parties. In addition, the health plan has a global cap agreement with a non-related party with the same terms (@ 85% of Revenue). I am wondering if I really need to reprice the related party encounters @ FFS costs.	Absent reliable data, FFS data may be used. Specific experience may also be used as the basis.
13	Related Party	4/16/2009	4/1/2009 1:29 PM	Pricing Considerations	1) Our organization has performance-based surplus distribution for some of our at-risk hospital providers. Should this surplus (at the level implied based on our base year performance) be reflected on Worksheet 1 of the BPT. Similarly, does the section on “Capitated Arranagement for Medical Services” also apply for global capitation provider arrangements as well as performance-based risk-sharing targets, i.e. we need to do our projections based on a “reasonable” fee schedule. Please clarify. 2) Please also clarify the term “related party”. Are contracted providers a “related party”, or does the term only apply to owners-subsidiary relationship.	1) If the arrangement is part of the experience, it should be reported on WS1. And the projection should reflect what is expected to be paid in the contract year. 2) Contracted providers are not a related party. Related parties refer to common parent/ownership.
14	Related Party	4/16/2009	3/27/2009 2:46 PM	Question re: Related Party Requirements	1) We are looking at setting up some type of provider incentive type program. This could involve paying some physicians an extra PMPM or a percentage over fee-for-service, with also some possible additional risk sharing. Our goals would be to improve efficiency, quality and patient experiences. We may start this initiative with our related provider only or possibly also with some non-related provider. We’re assuming that extra fees paid to providers and any appropriate claim saving estimates would go to the claim costs categories. We could then allocate any resulting gain as appropriate. Please confirm that this is correct. 2) If we set up a program only for our related provider, would it be correct that extra payments would not have to go to margin, if the extra fees paid are reasonable costs? If we set up a program with both related and non-related providers, do the programs have to be the same? Are we allowed to set up different financial arrangements? 3) Page 11 of the bid instructions addresses extra capitation going to gain. Does this also apply to fee-for-service and risk sharing reimbursement also? 4) If a related provider in the program had significant savings in year one, are we allowed to pay them extra amounts compared to other providers in year two and future years based on those savings that would flow to claim costs without having to put the additional amounts in the gain margin? 5) We are also thinking about employing case managers at our related party providers and possibly also at some non-related party providers. This seems to be okay under the administrative related party requirements, as long as they’re paid reasonable amounts similar to what non-related parties would be paid.	1) Correct. 2) The programs do not need to be the same. 3) No. This section of the instructions was intended solely to provide guidance for completing the BPT for capitation arrangements. 4) Yes. 5) Correct.

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15	Risk Sharing Arrangements	4/16/2009	4/13/2009 10:51 AM	Risk-sharing arrangements	Please clarify if any risk-sharing arrangements based on plans' performance should be factored in the projected experience on Worksheet 2. Please also clarify that any risk-sharing settlements based on plans' performance for incurred 2008 are NOT to be factored into Worksheet 1.	If the arrangement is part of the experience, it should be reported on WS1. And the projection should reflect what is expected to be paid in the contract year.
16	Margin	4/16/2009	4/10/2009 1:15 PM	Quick question	1. There is guidance in the MA BPT bid instructions that states that investment income can be used in the development of margins. We interpret this to mean that we could show a negative margin in the bid on Worksheet 4, but our documentation will show how investment income offsets the negative margin so that there is not a real loss. Is that a correct interpretation? 2. If our interpretation in question number 1. is correct, could we also use our surplus to offset negative bid margins? That is, could we project surplus reductions (or use investment principal) throughout the year to offset negative bid margins? This assumes, of course, that the health plan never comes close to going below any regulatory equity or surplus requirement. It is my understanding that CMS' allows negative margins if the MA organization can justify the purpose for it and the MA organization is fiscally sound. For that reason, I think the answers to the question would be that these would be permissible? Am I right?	1. No, the margin entered on the Bid Pricing Tool should incorporate investment income. 2. No, surplus reductions cannot be used to support negative margin. However, note that plan level negative margins are allowable.
17	DE#: definition	4/16/2009	4/13/2009 4:48 PM	DE# Definition	The final instructions released last Friday appear to define DE# differently than the draft instructions released in February. The draft instructions define DE# as: the term "DE#" (d • e • pound) refers to dual eligible beneficiaries without Medicare cost sharing liability. Note that this is a subset of the dual eligible beneficiaries. Similarly, the term "non-DE#" refers to non-dual eligible beneficiaries and dual eligible beneficiaries with Medicare cost sharing liability. The final instructions define DE# as: Medicare beneficiaries who are dually eligible for Medicare and Medicaid benefits without full Medicare cost-sharing liability. These beneficiaries are referred to in the BPT and in these instructions as the "DE#" (d • e • pound) population. The first definition clearly indicates that DE# is to include those beneficiaries who have no cost sharing requirement. The second would appear to expand the the definition of DE# to include beneficiaries who may have partial, but not full, cost sharing. What is the intent? Or is there no in-between? That is, either DE beneficiaries have full cost sharing or no cost sharing?	DE# includes dual eligible beneficiaries with partial cost sharing, and dual eligible beneficiaries with no cost sharing.
18	DE#: identifying members	4/16/2009	3/18/2009 4:52 PM	Identifying DE# Members	We have learned that the MMR may not be a reliable source for identifying DE# members using the various Medicaid flags. We understand that we need to identify dual eligible members who have $0 Medicare Cost sharing. We are confirming, but believe that all Medicaid beneficiaries in the state [in which we operate] pay $0 cost sharing. Therefore, if we are able to identify Medicaid beneficiaries, these will represent the DE# members. Is there a reliable method using the MMR? If the MMR is not a reliable method for identifying dual eligibles (DE#s), please provide direction regarding a suggested method for identifying these members. Is there a procedure using the Batch Eligibility Query (BEQ) process that could be used to identify these members for a plan?	DE# includes dual eligible beneficiaries with partial cost sharing, and dual eligible beneficiaries with no cost sharing. See the MA bid instructions and Bidders Training for guidance on identifying DE#. Also, CMS has released beneficiary-level data files. These files include a Medicaid Status indicator (01, 02, etc.) and a Medicaid Group indicator (A/B/C). Group A are QMB and QMB+, and are always DE#. We expect that where you have additional information regarding the Medicaid program in the state/territory of your plan, the DE# identification would include other Medicaid groups

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19	DE#: pricing questions	4/16/2009	4/3/2009 12:26 PM	[STATE] Dual Eligible Bid Issues	In regard to the 12/16/2008 memo from Paul Spitalnic about the dual eligible bid changes, I've been researching the issues internally regarding our only service state [XXX]. On page 1 of the 12/16/208 memo, the last sentence of the second bullet states that "All State funding that is "assed through" to providers must be netted from plan reimbursements". Our internal claims department has told me that our Medicare Advantage product is always the prime payer when any type of Medicaid program is involved. Claims are paid the same for members no matter if they also have coverage with a Medicaid program or not." As a result, I don't think that I need to net anything from plan reimbursements. Are there any issues that I'm missing here that I may need to check? For the page 8 Worksheet 4 Section V section stating that "Revenues should reflect capitation, or other payments, received by the MA plan sponsor from the state for benefits provided for dual eligible beneficiaries". We receive capitation for HMO members, but I'm told by our Government Relations department that those members are not allowed to be on Medicare Advantage plans. So our only dual eligible members would be fee-for-service members and other Medicaid program members that I'm told we have no capitation or payment contracts with. As a result, would both items (1) & (2) of Worksheet 4 Section V be zero? Again I'd like to check that I'm not missing any issues.	Worksheet 4 Section V is to be completed for members of the MA plan. That is, if the plan has an arrangement with the State for non-MA-plan members, these members should not be included on WS4 Section V.
20	Part D: plan offerings	4/16/2009	3/30/2009 12:02 PM	Hxxxx: Urgent Pricing Question	We have a question about pricing our MA-PD plans that we urgently need an answer to before we can continue modeling our 2010 bid. After running the payment information contained in the advance notice through our models, we are looking at the possibility that our low-cost plan with basic alternative Part D coverage may be left with some supplemental Part C member premium. In past years, we have always bought down the medical member premium with rebate allocation. We are unclear about the regulations that govern our requirement to offer a basic Part D option in our service area, and if that regulation allows for medical member premium on your basic Part D option. Specifically, we are looking at the definitions section of the CFR (2008 CFR Title 42, Sec. 423.100, "Definitions") and reading the definition of "required prescription drug coverage": "Required prescription drug coverage means coverage of Part D drugs under an MA-PD plan that consists of either— (1) Basic prescription drug coverage; or (2) Enhanced alternative coverage, provided there is no MA monthly supplemental beneficiary premium (as defined under section 1854(b)(2)(C) of the Act) applied under the plan due to the application of a credit against the premium of a rebate under Sec. 422.266(b) of this chapter." We are understanding that to mean that any plan with MA supplemental member premium must have basic prescription drug coverage to meet the requirement to offer required prescription drug coverage in our service area. Can you confirm that this is the case? This is an important component of our bid pricing and planning, so a timely response would be greatly appreciated.	Required prescription drug coverage under an MA-PD plan consists of either: (1) basic prescription drug coverage, that is, Defined Standard, Actuarially Equivalent or Basic Alternative coverage, or (2) Enhanced Alternative coverage, provided there is no MA monthly supplemental beneficiary premium for the drug coverage applied under the plan. Such Enhanced Alternative coverage could be provided without a Part D monthly supplemental beneficiary premium only if a plan applied a credit of rebate dollars available under the plan's Part C bid against the otherwise applicable supplemental premium. This ensures that MA organizations offer at least one option for Part D coverage for a premium at the cost of basic prescription drug coverage.

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21	Part D: basic premium	4/16/2009	3/9/2009 8:20 PM	Negative Part D Basic Premium in MAPD June Bid Submissions	In certain situations, low cost MAPD plans may have negative basic Part D premiums. I have two questions regarding negative basic Part D premiums: 1) If an MAPD plan files a Basic Alternative, Defined Standard, or Actuarial Equivalent plan design that has a negative basic premium, should the plan lower its estimate of the national average monthly bid amount to prevent a negative basic premium? 2) If an MAPD plan files an Enhanced Alternative plan design that has a negative basic premium, does the plan have the option of either lowering its estimate of the national average monthly bid amount to prevent a negative basic premium or offsetting the negative basic premium with a supplemental part D premium, so that the overall Part D premium (basic plus supplemental) is greater than or equal to zero?	An MA-PD plan with a negative Part D basic premium in the June bid submission has the following options. When the type of coverage is Defined Standard, Actuarially Equivalent or Basic Alternative, the Plan sponsor is permitted to lower its estimate of the national average monthly bid amount (NAMBA) and base beneficiary premium (BBP). When the type of coverage is Enhanced Alternative, the Plan sponsor is permitted to lower its estimate of the NAMBA and BBP or fully offset the negative basic premium with a supplemental Part D premium. Recall from the 2009 bidding guidance, that for PDP plans, we expect that an organization's estimate of the national average monthly bid amount and base beneficiary premium will be the same for all plans submitted by the organization. However, in limited circumstances, a PDP may have a lower estimate of the national average monthly bid amount to prevent a negative premium expectation for a basic plan. When the benchmarks are calculated and released in August, PDP sponsors will have the opportunity to add supplemental benefits to their basic plans to offset any negative basic premiums. However, they will not have an opportunity to reduce supplemental Part D coverage to offset any misestimate of the national average monthly bid amount.
22	Part D: payment demo	4/16/2009	3/12/2009 2:33 PM	Beta instructions feedback - Part D payment demonstration	I just reviewed the section of the beta instructions where new Part D payment demonstrations for 2010 are not going to be allowed. If a MA organization used the reinsurance demo in 2009 for plan A, can the MA organization use the reinsurance payment demo in 2010 for Plan A and B? Does it matter if Plan B is a new plan or not?	For CY2010, CMS will not accept any new or expanded applications for reinsurance demonstration plans. Therefore, in this example, Plan A is permitted to remain under the payment demonstration but Plan B is not permitted to be offered under the demonstration.
23	Part D: Low Income Benchmarks	4/16/2009	4/13/2009 4:01 PM	CMS User Group Call - Questions [PART 2]	The LIBs provided in Appendix E of the Part D Instructions do not indicate, as they did last year, the NABA and National Average Member Premium ("NAMP") used to calculate the values. So, were these values calculated using the June 2008 weighted NABA & NAMP, or the February 2009 weighted NABA and NAMP?	The Low-Income Benchmark Premium Amounts in Appendix E of the Part D Bid Instructions were calculated using the 2009 National Average Monthly Bid Amount and Base Beneficiary Premium that were released in August 2008.

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Introductory Note to the 4/23/2009 UGC Q&A:
Medicare Unit Cost Increases
CY 2008-2010

Service Category	CY 2008	CY 2009	CY 2010	Comments
Inpatient hospital	3.4%	3.4%	3.1%	Based on FY market basket updates
Skilled nursing facility	3.3%	3.3%	3.0%	Based on FY market basket updates
Home health agency	3.0%	2.9%	2.9%	
Outpatient hospital	3.3%	3.6%	2.9%	
Physician	0.5%	1.1%	-21.5%	
Carrier - lab	2.3%	5.0%	-0.2%	

Answers to Bid Questions

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1	Risk Scores	4/23/2009	4/21/2009 1:31 AM	Risk Scoring Question - Related to 2010 Bids	We asked this question verbally on the [4/16/09] technical user call, but apparently did not explain our concerns sufficiently as they relate to MAO risk score projections for the 2010 bids, and the actuarial certifications that accompany the bids. In accordance with the April 6, 2009 rate notice, we wish to confirm our understanding that it is not necessary to adjust projected risk scores for ordinary errors in diagnoses submitted by providers to the extent that the coding is similar to Medicare FFS. This is based on our interpretation of the rate notice that, for payment purposes, the risk adjustment methodology is valid and MAOs are coding accurately when the coding is done in a manner similar to FFS coding.	MA coding is an industry-wide adjustment to risk scores for differences in coding patterns between MA and FFS, akin to the FFS normalization factor in that it adjusts for industry-wide coding patterns. We expect plans to take into account adjustments to risk scores (normalization and MA coding adjustment) in their projections. Also, we expect plans to take into account their own experience and knowledge of the plan (trends, etc.). Projections should be based on the actuary's best estimate of final CY 2010 risk scores. This projection must reflect that risk scores will be based on plan provided diagnoses in a manner consistent with risk adjustment reporting requirements. We are not aware of any current requirement that plan diagnoses error rates be comparable to those in FFS.
2	Risk Scores	4/23/2009	4/21/2009 11:50 AM	Question on Risk Scores Published in "risk_scores 2002-2007.csv" File	Our understanding is the county-specific risk scores published in the "risk_scores 2002-2007.csv" file at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/calculationdata2010.zip are reflective of risk scores for the traditional, fee-for-service Medicare population. Do you agree that if we are using these risk scores for 2010 manual rate development, we should adjust them to reflect estimated coding pattern differences between our plan and traditional Medicare, including (but not limited to) how long the plan has been in operation and what proportion of 2010 membership is likely to be enrolled in the plan in 2009?	This is correct. If plans use this 2007 risk score data (for any purpose), they would apply a trend to project to 2010 that include both the FFS growth and plan-specific growth above and beyond FFS.
3	Risk Scores	4/23/2009	4/20/2009 5:19 PM	Final Reconciliation Risk Scores and specific dual status	[PARAPHRASED] Can CMS add information about specific dual status to the MMR?	We will take this into consideration for future years. Please note that the status is provided for informational purposes (i.e., the status is not used for payment purposes).
4	Risk Scores and MSP	4/23/2009	4/15/2009 1:57 PM	Questions for the 4/16/09 Actuarial User Call	1. Risk Score Projection: Please provide clarification of the methodology (formulas) for projection the 2010 risk score is a plan starts with the 2009 payment scores. a. Please provide the exact formula including all applicable adjustments for the 2009 and 2010 normalization factors b. Please provide for both Part C and Part D 2. Coding Intensity Adjustment: Please confirm that the correct application of the coding intensity adjustment factors to calculate risk scores for payment is to multiply by (1 – coding intensity factor) or (1- 0.0341) 3. Medicare as Secondary Payer: Please confirm how the MSP Factor on worksheet 5 of the MA bid form shoud be calculated from the MSP information published on HPMS. Please provide the formula.	1. As indicated on page 27 of the MA bid instructions, it is CMS' preference that plans use the risk score data posted in HPMS. If an alternate method is used, then the instructions indicate the adjustments that are needed. Documentation is required to illustrate that the two methods are comparable. 2. Yes. 3. On MA Worksheet 5, plans can enter (1 - MSP Factor from HPMS).

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5	MSP	4/23/2009	4/21/2009 4:59 PM	Questions Regarding MSP Data from CMS	Regarding the plan-level and beneficiary-level MSP data CMS recently provided: If we find that any of the beneficiary-level COB information in the July 2008 cohort is no longer valid (e.g. a working aged member retired from his/her job in February 2009), how do we include an adjustment to the CMS data in our bids? What kind of documentation will be needed to support such an adjustment?	To the extent that the mix of MSP and non-MSP enrollees in the plan's population is expected to change from the base period to the contract year, the MSP adjustment factor posted on HPMS should be modified to reflect the resulting change in payments. Documentation should be provided showing how the modification was developed. Additionally, the resulting changes expected to medical expenses due to this change in population should be reflected in the population change factor on WK1.
6	MSP	4/23/2009	4/17/2009 3:57 PM	Question for Actuarial Calls	For a plan using the MSP factor as provided on HPMS, is 1 – MSP factor the correct input for cell E14 on worksheet 5?	See response to Question # 4 part 3.
7	MSP	4/23/2009	4/20/2009 12:57 PM	MSP Adjustment to Projected Claims in Part C Bid	Of the X individuals in our beneficiary file whom CMS flagged as MSP as of July 2008, only Y were currently labeled as such in our system, with information about the primary carrier, etc. My questions are as follows: Where should we reflect the expected reduction to our claims that will occur as we receive correct COB information for our 2010 enrollees (starting, as you said, this November)? Is the increase in COB savings from (X - Y) additional MSP members best reflected in the Population Change, the Other Factor, or the Additive Adjustments PMPM column of worksheet 1? And can the reduction be applied across all benefit categories, or must we use the COB/subrogation row only (line r), even though we do not use that row for our Base Period Data? If a bidder does use that row for their Base Period Data, do your answers to the above questions change?	If the plan sponsor will pay claims differently (i.e. as secondary rather than primary) in the contract year than in the base period for the newly identified MSP enrollees, the corresponding adjustment for each service category's medical expenses should be reflected in the Other Factor projection assumption on WK1. As indicated in the bid instructions, the COB/subrogation row is intended for amounts settled outside the claims system.
8	MSP	4/23/2009	4/20/2009 7:45 PM	MSP Factor	The OACT MSP factor determined from the CMS COB file indicates that there are almost twice as many members on this year's files than on any previous files released from CMS. After the Health Plans completed the surveys and reported results there are over 8 times more MSP members than we have considered in previous years. Question: Due to the instructions we will turn on the MSP flag for all members identified by CMS and adjust the benchmark accordingly. This imply these same members are truly MSP and as such we will process these members claims as a secondary payor. The additional expected MSP COB saving is not in our history. Is it appropriate to estimate the additional COB saving using the members identified in the OACT file and report this COB as an negative additive pmpm on worksheet 1, section III, line r, col p with 100% credibility and then let it flow through the rest of the bid worksheets? If no, what is the process OACT would recommend?	See response to Question #7.
9	MSP	4/23/2009	4/16/2009 12:32 PM	MSP credibility	In [the 4/16/09] user group call, it was indicated that we should be applying MSP adjustments at the PBP level based on the data most recently available on HPMS. If an MA PBP had less than 24,000 member months in 2008, for example, only 1200 member months, would it still be appropriate to base our 2010 MSP estimate for that PBP without any sort of manual MSP blending with other PBPs under that contract number?	Both the projection of base period experience and the manual rate should reflect the allowed costs for the expected mix of MSP and non-MSP enrollees. The MSP adjustment entered on WK5 should be consistent with the development of allowed costs.
10	ESRD bid forms and instructions	4/23/2009	4/17/2009 10:48 AM	ESRD Bid Forms and Instructions	When will the bid forms and instructions for ESRD only C-SNP plans going to be released? Where will the bid forms and instructions for these plans be published?	The forms and instructions were sent through HPMS the morning of 4/16/2009 to ESRD-only SNP sponsors.
11	Physician Fees	4/23/2009	4/15/2009 12:50 PM	2010 MA Bid Questions	Our physician contracts are tied directly to the RBRVS conversion factor, thus under current law we would expect physician fees to be reduced by 21.3% from 2009 to 2010. Since CMS has assumed a 21.3% physician cut in its calculation of the benchmarks and thus is assuming that the rate cut will go into effect, would it be acceptable for us to assume that our physician reimbursement trend for 2009 to 2010 will be negative 21.3%?	Projections should be based on the actuary's best estimate of CY 2010 plan expenses. Of course, the estimate should take into account the possibility that Congress will ultimately modify the -21 percent physician update for CY 2010.
12	Physician Fees	4/23/2009	4/21/2009 3:31 PM	physician payment rates	The 21% cut to Medicare physician payment rates required under the Sustainable Growth Rate formula called for in current law is significant and requires organizations to anticipate whether there will be legislative intervention and if so, to what extent. Will organizations have an opportunity to resubmit bids to reflect any legislative intervention? If not, does CMS have any suggestions?	As with the response to the prior questions, the projection of physician spending is to reflect the actuaries' best estimate of plan expenditures for CY 2010. Absent explicit statutory authority, there will be no opportunity to change your pricing assumption after June 1, 2009.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
13	MA regional benchmarks	4/23/2009	4/17/2009 9:28 PM	Disaggregating RPPO C-SNP Into Separate Disease Specific Plans - Impact on Competitive Bid Component	1. Will plans be able to map enrollment of their enrolled chronic care SNP beneficiaries to new disaggregated CY 2010 plans? 2. Given the issues around mapping current chronic SNP RPPOs, how will the weights for the CY 2010 RPPO benchmarks be determined.	3. Yes, subject to CMS approval, plan sponsors will be able to determine how their chronic care SNP enrollees are redistributed into new disaggregated CY 2010 plans. Preliminary guidance on this topic can be found on page 38 of the CY 2010 Call Letter. 1. Since the mapping of enrollees is subject to CMS approval, it is too early to say if this process will be completed prior the release of the RPPO benchmarks. We will use the plan mappings to weight the 2010 RPPO benchmarks if they have been approved by CMS in sufficient time to be included in the calculations.
14	MA regional benchmarks	4/23/2009	4/17/2009 9:29 PM	RPPO ESRD Bid Amounts in Competitive Bid Component	Are RPPO C-SNP ESRD only plans factored in to the determination of the competitive bid component calculation?	No.
15	MA Rates	4/23/2009	4/20/2009 7:45 PM	Key Assumptions in the Announcement of the CY 2010 MA Capitation Rates	I am interested in getting a better understanding the assumptions in the 2010 rate announcement. I am hoping that an understanding of these assumptions will be useful in setting trends for a PFFS plan which pays based on a 100% of Medicare level. In particular, can you explain each of the columns on the Key assumptions table of page 8 of the Announcement? <u>Part A</u> 1. Calendar Year CPI Percent Increase 2. Fiscal Year PPS Update Factor (is this the average expected cost increase for FFS part A?) 3. FY Part A Total Reimbursement (Incurred) (What is this? How does it tie in to the Part A per capita cost increases shown? Does it include Managed Care payments?) <u>Part B</u> 4. Physician Fee Schedule 5. Part B Hospital 6. Total (How does it tie in to the Part B per capita cost increases shown? Does it include Managed Care payments?) Any other suggestions for resources useful in projecting cost and utilization levels for PFFS Medicare would be appreciated.	1. Percent increase in the Consumer Price Index consistent with the latest benefit projection baseline. 2. Increase in the hospital market plus any adjustments allowed or required by law. This factor is used to update the inpatient hospital DRGs. For 2010, it represents the increase in the hospital market basket plus adjustments for the excess coding measured in the new MS-DRG system. More details for FY 2010 will be discussed in the upcoming proposed regulation for the 2010 inpatient hospital payments. 3. Increase in total Part A reimbursement measured on a fiscal year incurred basis. This is total reimbursement, not per capita. It includes all benefits including hospice care. The per capita cost increases shown are on a calendar year incurred basis and assumes all enrollees (FFS and managed care) in the denominator. 4. Reflects the update in physician fees as required in the SGR system under current law for physicians. For 2009 and earlier, it reflects the actual updates for the physician fee schedule. It does not assume that Congress will override the cut for 2010. Current law requires the -21.5% cut in fees. 5. Reflects the increase in charges per aged Part B enrollee for outpatient hospital services. 6. The total column is the increase in charges per aged enrollee for all Part B services including managed care. It is consistent with the Part B per capita increases shown, which are the increases in reimbursement per capita instead of charges.
16	FFS trends	4/23/2009	4/20/2009 7:22 PM	Request for FFS Cost Trends	In previous years you were kind enough to provide the latest estimates of the Medicare fee-for-service unit cost increases for by major service category. Can you do so again this year, for 2008, 2009 and 2010?	See introductory notes to 4/23/2009 user group call.
17	EGWP bids	4/23/2009	4/15/2009 1:14 PM	800-series Medicare Advantage non-calendar year bids	We are seeking confirmation that the calendar year vs. non-calendar year distinction for 800-series Medicare Advantage bids applies only to Part D coverage. In particular, we are confirming that only one distinct 800-series plan benefit ID under a contract number is required to offer Medicare Advantage coverage, without Part D, to all employer groups, irrespective of the time period of accumulation (calendar year vs. other period) for medical deductibles and out-of-pocket maximums applicable to an employer group coverage under that contract.	Yes, there is no requirement that sponsors submit separate calendar year and non-calendar-year bids for MA-only 800-series "EGWP" plans.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
18	EGWP bids	4/23/2009	4/16/2009 11:17 AM	2010 Bid Questions	I have the following two questions related to employer group medical bids: 1. In a situation where an employer product is brand new to the market, a company's best estimate of administrative expenses on a pmpm basis may be relatively high due to start-up costs and due to fixed costs that are likely to be spread over relatively low enrollment in the first year or two. In this situation, should a company reflect its best estimate of actual administrative costs for the projection period in the bid or should a company reflect its best estimate of administrative cost levels that can actually be sold in the marketplace (i.e. what the market is likely to bear) in the bid? 2. Because employer group rates are often calculated anywhere from 3 to 9 months after the employer bids are submitted, should companies develop actual employer premium rates based on the best estimate administrative expense that was available at the time of the bid or should a company use a more recent and likely more accurate estimate that is available at the time of the quote?	The bid must reflect the certifying actuary's best estimate of actual PMPM administrative costs for the projection period. For an EGWP bid, this is the expected, actual administrative cost, in aggregate, for all groups. Regarding 'start-up costs' and 'fixed costs', the CY2010 MA BPT instructions address the reporting of acquisition expenses and capital expenditures on pages 21-22.
19	DE#	4/23/2009	4/20/2009 9:27 PM	Two Questions From [ORG]	The MA bidding instructions permit actuaries to project allowed medical expense for Non-DE# beneficiaries equal to the projected allowed costs for the total population, in the event that an the plan's projected DE# member months are less than 10% or more than 90% of total member months. A) If the plan's projected DE# member months are less than 10% or more than 90% of total member months, are plans permitted to project the same risk score for Non-DE# members as the total population? B) If the plan's projected DE# member months are less than 10% of total member months, may plans use $0 PMPM as a safe harbor for the state Medicaid required bene. cost sharing? [WS4 Section IIB column k]	A) Yes, as risk scores should be consistent with projected allowed costs. B) Yes, in this specific instance (where the Non-DE# Allowed equals the Total Allowed and DE# member months are less than 10% of total member months).
20	DE#	4/23/2009	4/19/2009 4:34 PM	Medicaid Beneficiary Cost Sharing	If a plan has less than 10% of the total membership projected as DE#, and they choose to apply the Safe Harbor provision where the Non-DE# and DE# costs will not be required to be projected separately, can you assume that the State Medicaid Required Beneficiary Cost Sharing in Section B on Worksheet 4 be $0 for Medicare Covered Services for all DE# members?	See response to Question 19 Part B.
21	DE#	4/23/2009	4/17/2009 1:47 PM	New DE# Definition	The full-duals (non-QMB, non-SLMB) in our state are not liable for paying Medicare cost-sharing expenses. Does that mean that our plan should include the full duals (Category 8) according to the new DE# definition?	Yes.
22	Risk Scores and DE#	4/23/2009	4/16/2009 8:04 AM	2010 Part C Bid	Beneficiary-level Files to support 2010 Part C Bids has two fields: Risk Score 2008 Model and Risk Score 2009 Model. Please explain what these fields are for and how they should be used in the Bid.	CMS provided these fields to illustrate the impact of the risk score model change. If the preferred approach to projecting risk scores is used, then this impact is not needed.
23	Risk Scores and MA bid instructions	4/23/2009	4/14/2009 7:11 PM	Question on Base Period Risk Score for CY2010 MA BPT	[PARAPHRASED] What risk scores should be entered on WS1 and WS5?	The risk scores entered on WS1 should be based on the risk score model used for 2008 payments and the 2008 normalization factor. The risk scores entered on WS5 should be based on the risk score model used for 2010 payments, the 2010 normalization factor, and also adjusted for the MA coding intensity.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
24	Risk Scores and FFS trends	4/23/2009	4/16/2009 1:43 PM	Questions and credibility confirmation	Medicare fee schedule trends Last year you released estimated unit cost trends based on actual and planned Medicare fee schedule changes between the base year and the contract year. Would you consider releasing those again, and including trends with and without the impact of the sustainable growth rate formula? (assume 0% in lieu of the rate cut produced by the sustainable growth rate formula) Would you also consider publishing your estimates of the volume/intensity/complexity trends that impact unit cost above and beyond the unit cost trends using a constant mix of procedures year over year? Would you consider breaking out your trends to include the standard fee schedule vs. other special medicare payments such as quality incentive payments? Risk Score projections In the training webcast you mentioned that your preferred risk score projection approach was to use either the July 2008 cohort or to use RAPs data submitted by the plan. Would it be acceptable to use the MMR data to calculate an adjustment for the difference between the July 2008 risk score and the average for the entire year? Can we also consider the possibility for changes in the risk score based on growth such as that which would be experienced by a PDP that qualifies for Low Income Auto Assignees?	1) See response to Question # 16. 2) See response to Question # 4.
25	ESRD Subsidy	4/23/2009	4/21/2009 3:44 PM	Credibility assumption for ESRD Subsidy	What considerations does CMS require to be taken into account in determining 100% credibility for ESRD claims experience, when projecting the ESRD subsidy on Worksheet 4, Section III of the MA Bid Pricing Tool worksheet?	CMS has not released credibility guidelines for ESRD.
26	Part D : Low Income Benchmarks	4/23/2009	4/15/2009 9:58 AM	Regional Benchmark Information in Bid Instructions	In August of 2008, CMS published the Regional Benchmarks. Region 29 was published at $20.20, but included the following note: *Note: The low-income benchmark premium amount calculated for region 29 is $19.68. The low-income premium subsidy amount of $20.20 is the lowest monthly beneficiary premium for a PDP that offers basic coverage in region 29. Section 1860D-14(b)(3) of the Social Security Act states that the low-income premium subsidy amount is the greater of the lowest monthly beneficiary premium for a PDP that offers basic coverage and the low-income benchmark premium amount. Last week, CMS republished the Regional benchmarks in the bid instructions for 2010 and included updated numbers which took the weighted enrollment as of February 2009 for plans into consideration. The benchmark published for Region 29 continues to be reported at $20.20, but no longer includes the asterisk or the explanatory note. The benchmark information is on page 67. In order to utilize this benchmark information correctly during our bid development, we would appreciate having the underlying calculated premium for Region 29 updated for the weighted enrollment as provided for the other Regions. Is it possible to receive that calculation?	Based on the weighted LIS enrollment as of February 2009, the low-income benchmark premium amount calculated for Region 29 is $18.23. The low-income premium subsidy amount of $20.20 is the lowest monthly beneficiary premium for a PDP that offers basic coverage in Region 29.
27	Part D : BPT	4/23/2009	4/20/2009 12:30 PM	Part D question	If for a certain plan there is no expected Mail Order Non-Preferred Brand utilization, thus no cost sharing for that tier, a red circle is generated in the bid tool on the Script Projection tab for cell H51. Will CMS allow the bid to be accepted?	Yes, this red circle is not indicative of a critical error that would prevent the bid from being finalized/uploaded.
28	Part D : BPT	4/23/2009	4/21/2009 1:41 PM	Script Reporting	Which of the following ways (if any) is the correct way to report scripts on the Part D bids: 1) each PDE entry is one script 2) calculating the number of scripts from the Days Supply - where 0-30 days is 1 script, 31-60 is 2 scripts, etc.	Number 1 is correct. As stated in the Part D bid instructions, a PDE maps to one script throughout the BPT regardless of the number of days supply dispensed of the prescription.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
29	Part D : BPT	4/23/2009	4/21/2009 3:41 PM	Rx Rebate at Point-of-Sale	Should the estimated rebates field from the PDE records be included as an allowed cost for worksheet 1 of the PDE BPT? It seems that if the allowed is intended to be the amount paid to the pharmacy, the estimated rebate should be included (i.e. Total Allowed Dollars = Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine fee + Rebate). However if that is the case, the Net Plan Responsibility per Member would be overstated. Regardless of the answer to the first question, if the PD plan eliminates rebates at POS for the contract period, it certainly seems like the rebates in the 'estimated rebates' field from the base period PDEs should be included in the allowed amount on worksheets 3 – 6. Then the expected contract period rebates would be removed on the 'rebates' like of the BPT. Please confirm.	1. No, the "Estimated Rebates" field of the PDE records should not be included in the base period allowed costs on Worksheet 1, Section III. 2. If a plan applied rebates at point-of-sale in CY2008 but will not in CY2010, the projected allowed costs in Worksheet 3, Section III should reflect the impact of the base period "Estimated Rebates". Further, Line 7 "Rebate" should include the total projected rebates for the contract year in addition to any other components of DIR that are applicable to the plan. For additional information, refer to the guidance titled "Reporting Rebates Applied to the Point-of-Sale Price" released in HPMS and the Base Period Experience portion of the Pricing Considerations section of the Part D bid instructions.
30	Part D : BPT	4/23/2009	4/20/2009 12:58 PM	PD Lock-In vs. Pass-Through Adjustment	We understand that PD plans with 2008 PDE data priced under the lock-in approach must develop the 2010 bid using the pass-through approach. It appears that data in Worksheets 1 & 2 would be entered using the lock-in-based 2008 PDEs; correct? Would it then be permissible to make a global adjustment in the "Other Change" column of Worksheet II, Section III, Column (h) to account for the difference between the lock-in vs. pass-through pricing? For example the PBM indicates that the pass-through method would result in 2008 claims that were 3% lower than the claims reported in the 2008 PDE – so "Other Change" would be set equal to 0.970 for all tiers. Is this an acceptable methodology for bid development? Other than a written statement from the PBM, would any additional documentation be considered necessary by CMS?	1. Worksheets 1 and 2 should be completed using the actual CY2008 PDEs which reflect the lock-in pricing approach. 2. Yes, it is appropriate to use the "Other Change" column of Worksheet 2, Section III, column h to adjust for the expected difference between the lock-in and pass-through pricing. 3. A written statement from the PBM is considered sufficient documentation; it should be uploaded with the supporting documentation at the time of the initial bid submission.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	coding intensity/ payment	4/30/2009	4/23/2009 1:53 PM	ESRD and coding intensity adjustment	Please confirm how the coding intensity adjustment will apply to ESRD payments in 2010.	Coding intensity is applied to ESRD payments for postgraft, but not for dialysis and graft.
2	MSP and ESRD-only SNPs	4/30/2009	4/22/2009 11:09 PM	MSP Adjustment and ESRD	1. MSP Will the MSP adjustment be applied to all of the revenue, including the rebate, received for a member? 2. ESRD Please provide guidance regarding how to complete an MA bpt for an ESRD Chronic SNP. The MA bid instructions do not mention this scenario.	1) The MSP adjustment will be applied to the bid portion of payment, not the rebate portion. 2) As announced on the 4/23/2009 user group call, the ESRD SNP bid forms and instructions were sent through HPMS on the morning of 4/16/2009 to ESRD-only SNP plan sponsors.
3	MSP	4/30/2009	4/27/2009 2:34 PM	MSP follow-up questions	The following questions relate specifically to the Medicare as Secondary Payer adjustment factor that is to be included on worksheet 5 of the 2010 BPT by bid. Our questions are: 1. Can CMS provide additional support for specifically relying on the July '08 cohort in estimating the MSP adjustment percentage? If so, when would this be available? 2. Can CMS provide additional support in estimating the 0.174 factor as described in the "Estimated MSP Adjustment" technical note? If so, when would this be available? 3. Since this methodology effectively results in a sampling methodology, if a plan could demonstrate that its experience for calendar year 2008 was significantly different than the amount calculated by CMS, would this support the use of the plan-calculated number? 4. Would such an alternative approach be approved before initial bid submission on June 1, 2009, or would this be an item that would be approved during desk review?	#1 and #3. We use the July cohort because average MA plan risk scores change during the year (mainly due to death of sicker beneficiaries and enrollment of younger healthier beneficiaries) and July represents the average month in terms of risk score profile. While we do not provide the information for each month in the year, we have provided the factor based on all enrollees in the plan in July and do not regard this as a sampling methodology. If a plan's experience is such that the July cohort does not represent the average risk profile for the plan, then appropriate adjustments may be made based on documentation. #2. The MSP factor (0.174) is calculated as the ratio of actual costs of MSP beneficiaries for A/B services divided by the predicted cost of MSP beneficiaries. The predicted cost is estimated using dollar coefficients from the risk adjustment model calibrated on beneficiaries without MSP. #4. This will be reviewed during desk review.
4	MSP	4/30/2009	4/28/2009 8:28 AM	Question on claims adjustment related to MSP	In the [4-23-2009] OACT Technical User Group call, CMS provided guidance regarding how to adjust claim experience for the impact of additional recoveries due to MSP reporting. CMS instructed plans to adjust for recoveries using the "Other Factor" in Worksheet 1. There would seem to be two potential problems with this approach. 1) One is that the "Other Factor" adjusts utilization, and therefore use of this factor to lower expected claims would also have an impact on cost sharing. The factor for reducing claims due to expected recoveries would have to be grossed up by the corresponding reduction in cost sharing in order for the net claims impact to be accurate. This is an inefficient and non-transparent approach. 2) The other potential problem is that manual rate tables would also need to be modified to reflect the claims impact for plans that are not fully credible. It may be difficult to implement such modifications at this point in the process, in particular for organizations with many manual rate tables. A simpler and more transparent approach would be to use the "Additive Adjustments" PMPM in Worksheet 1 for COB and/or the Manual Rate Allowed PMPM for COB in Worksheet 2. These numbers would be inclusive of trend and would not impact cost sharing. Will CMS allow plans to use the approach described above as an alternative to or in place of the previously issued guidance?	In addition to reflecting any utilization impact in the "Other Factor" on WK1, changes in unit costs should be reflected in the unit cost projection assumption on WK1. Cost sharing utilization on WK3 should also be adjusted appropriately. As indicated in the bid instructions, the COB/subrogation row is intended for amounts settled outside the claims system.
5	Part D: Admin	4/30/2009	4/21/2009 5:25 PM	Part D Reinsurance Demonstration - $10.77 offset	Page 21 of the Advance Notice (issued 2/20/2009) stated that $10.77 per member per year is to be offset in the direct administrative expense line item of the PD BPT. The cover memo to the Announcement (issued 4/6/2009) included this topic as a "Proposal Adopted as Issued" in the Advance Notice. I just want to confirm, do I need to add or subtract the $10.77 pmpy from the direct administrative expense line item?	The $10.77 pmpy amount should be added to the direct administrative component of the non-benefit expenses.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	Hospice	4/30/2009	4/21/2009 7:57 PM	Hospice Question	For members that elect hospice, I understand that any claims related to the hospice benefit itself is paid fee for service. My client's claim system has edits to deny claim payments for these types of claims, however, they believe that they would still be responsible for Covered A/B services not related to the hospice service itself. In looking at their data, they find significant non-hospice dollars coming through for hospice members while they are officially on hospice status. The Bid Instructions indicate that Hospice claims are to be excluded from the BPT. This does not seem to be correct since they would effectively not receive payment for covering these claims. Is it ok to include non-hospice claims for hospice members in the bid development?	The liability for hospice claims depends on hospice status and whether or not the claims are Medicare-covered. When a Medicare Advantage enrollee goes into hospice status, original Medicare assumes responsibility for Part A and Part B services; therefore, claims for Medicare-covered services are excluded from the BPT. However, since hospice enrollees continue to receive mandatory supplemental benefits from the MA plan, the BPT may reflect claim costs for Non-covered benefits, at the discretion of the certifying actuary.
7	Related Parties	4/30/2009	4/24/2009 3:12 PM	Related Party Reimbursement	This is in regard to question # 14 sub-question 3 in the Actuarial Bid User call # 1 on 4-16-2009. The answer was that page 11 of the bid instructions only addressed extra capitation going to gain. Are we allowed to pay our related party on a fee-for-service (i.e. non-capitated) basis at a higher % of original Medicare fee-for-service reimbursement (e.g. at 110%) versus most other providers at 100% without having to put reimbursement over original Medicare in the gain (i.e. it stays in the claim costs). Also, if we had risk sharing in future years with our related provider based on results, do those risk sharing amounts go to the claims expense? Non-related party risk sharing would go to claims expense also?	The principles are the same for reporting and projecting the cost of administrative and medical services provided by related parties under all types of arrangements including capitation, risk sharing, etc. The Plan sponsor must use the cost-based approach outlined in the bid instructions if the related party charges the Plan sponsor more than it would charge a non-related party for the same services. In this case, the handling of the 110% of FFS payment to the related-party depends upon whether the related party charges other health plans less than 110% for the same services. Claims costs for services provided by non-related parties are treated as claims costs.
8	ESRD section of BPT	4/30/2009	4/27/2009 5:34 PM	ESRD Section III of Worksheet 4	Please confirm that the only the projected ESRD Member months is required in Section III of Worksheet 4 and that the ESRD Subsidy is optional.	Yes. Projected ESRD member months are required. Data entries to calculate the ESRD subsidy are optional, but preferred in certain circumstances as explained in the bid instructions.
9	WS1	4/30/2009	4/23/2009 1:06 AM	Actuarial Technical User Group Calls	I have a question on the data input in Worksheet 1. There is one 2009 PBP that we want split it into two PBPs in 2010. My question is that if we should leave the Worksheet 1 blank for both of the new PBPs. Theoretically, I do have experience for the two new PBPs.	No. Report the entire 2008 experience for the 2009 PBP on WS 1 of one or both of the 2010 PBPs depending upon the shift in enrollment.
10	WS1	4/30/2009	4/28/2009 2:30 PM	Adjusting for plan segments and service area reductions	Regarding adjusting for plan segments and service area reductions: I wanted to confirm that for Worksheet 1- Section III, the base period data should reflect the entire experience from the 2008 plan, and that adjustments for 2010 plan segmentation and service area reductions should be done using the "other factor" in column M.	Yes. Base period data must be reported without adjustment. Adjustments for plan segmentation and service area reductions must be done using the "other factor" in column M for utilization, the unit cost intensity trend factor and other projection factors, as appropriate.
11	Credibility and DE#	4/30/2009	4/27/2009 7:00 PM	Two Additional Questions from [ORG]	1) If a plan has 20% credibility based on the OACT credibility rules and the actuary seeks to use the "safe harbor" rule suggested by CMS on [the 4/16/2009] user group call that allows the actuary to assume 0% credibility for this plan, can the plan file a bid with worksheet 1 blank since there is no credibility assumed for the experience? 2) For Section V of Worksheet 4, Line 2, Medicaid Projected Benefits (not in the bid): Are these Medicaid benefits provided by the State AND, at the same time, provided by the MA plan or is this supposed to represent Medicaid benefits provided by the State Medicaid Program, but not necessarily provided by the MA plan?	1) No, Worksheet 1 must be completed even if the credibility percentage assigned to the base period experience is zero (0%), with no exceptions. Note that the projection factors in Section IV may be entered as “1.000” when the assigned credibility percentage is zero (0%). 2) W4 Section V line 2 is to be completed for benefits that the MA plan sponsor has contracted with the state Medicaid program to provide and the plan provides these benefits to enrollees, but these benefits are not reflected elsewhere in the BPT.
12	DE#	4/30/2009	4/24/2009 10:26 AM	Identifying DE# members	On the 4/16/2009 call, as well as the BPT Training Podcast, CMS stated that Group A Medicaid members are always DE#. In the state [in which our plan operates], Medicaid states that it will not cover any cost-sharing for Medicaid members who choose to enroll in Part C plans. Must we categorize our Group A Medicaid members as DE# on the BPT?	Although the state is not funding the cost sharing, per the Social Security Act beneficiaries who are identified as QMB and QMB+ are not responsible to pay the cost sharing. Thus they are to be identified on the BPT as DE# members.

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April 30, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
13	DE#	4/30/2009	4/29/2009 3:32 PM	Non-benefit expense...question	My understanding is that we are to report in MA Worksheet 4, section V, the revenues and benefits associated with Medicaid capitations from the State. Where do we reflect the non-benefit expenses associated with the administration of the Medicaid benefits?	The benefit cost in Wk4 section V should include the full cost of non-Medicare benefits (for example, LTC benefits) that are provided in the contract with the state and are not otherwise reflected in the bid, which includes non-benefit expenses and gain /loss margin. As stated in page 22 of the MA bid instructions, when Medicare benefits are funded by an outside source, the non-benefit expenses must be allocated proportionally between the Medicare Advantage bid and the other funding sources. The proportion of expenses related to the outside sources must be excluded from the bid. This guidance applies to funding received from states for Medicaid benefits, and for EGWP plans - the contributions from employers and their members in excess of the filed premium. Similar guidance for the gain/loss margin is found on page 17 of the MA bid instructions.
14	EGWP experience in 2YRLB	4/30/2009	4/23/2009 3:38 PM	2-year lookback form - reporting of EGWP experience	For a health plan with EGWP experience in the base period, please clarify what would constitute the following items cited in the instructions for completing the 2-year lookback form, assuming the health plan had completed the bid associated with the experience period using a plan design equal to a Medicare FFS benefit level. We are requesting clarification of what goes into columns j and k (for the experience period) as opposed to columns f and g (associated with the original bid.) • Optional Supplemental Benefits (from Page 70) • Line 1b: member premium for basic A/B benefits and mandatory supplemental benefits • Footnote 2, Line a: Covered Benefits (excluding risk share) • Footnote 2, Line b: A/B Mandatory Supplemental Benefits	Data reflected in the Two-Year Lookback Form is to exclude experience for optional supplemental benefits. All non-optional supplemental revenues and benefits are to be reported in the form, including those related to employer customization.
15	EGWP bids	4/30/2009	4/28/2009 12:13 PM	MA-Only Employer Group Plans	I would like to clarify a comment from the 4/23/2009 User Group Call. If a plan files just a calendar year employer group 800 series MA-Only bid (and do not file a non-calendar year version), can the plan enroll a group into that PBP if their plan year is not January 1 to January 1?	Yes, that is correct for MA-Only EGWP bids.
16	ESRD-only SNP forms and instructions	4/30/2009	4/28/2009 12:21 PM	3 Questions Related to ESRD only bids	1. In the bid forms for ESRD only plans, Schedule A-1 cells B25 includes a factor of .95 for demo plans. Cells C25 - K25 include the .95 factor for all plans (both demo and non-demo plans). Should this .95 factor only apply to demo plans in cells C25 - K25? 2. What file identifies (how does one identify) members in Transplant status vs non-Transplant status? - this is needed for the split in the ESRD bid forms. 3. For RPPO ESRD only plans, does the competitive bid component impact the county payment rate used as a basis for payment for functioning graft members?	1. Yes, the 0.95 factor only applies to demo plans. Thus, the formula in cell B25 should be copied into cells C25 through K25. We will send new forms through HPMS or you can manually make the change yourself. 2. The MMR field RA Factor Type Code G1 and G2 represent transplant beneficiaries. G1 is for the first month of transplant payment; and G2 is for the second and third. In addition to the MMR, this information can be accessed through the MARx user interface (UI) 3. No
17	Commissions	4/30/2009	4/24/2009 2:57 PM	Proj 2010 Commissions	Please give some direction on how to handle projected 2010 commissions in the bid. We switched from lifetime commissions (i.e. paying every year a member has the policy forever) in 2008 to the lifecycle commission required in 2009. When doing that, our 2009 commissions ended up being significantly lower than our 2008 commissions and significantly lower than our competition. Are we going to have a chance in 2010 to make our commissions more similar to our competitors? We want to make sure that our 2010 bid reflects as close to possible what our 2010 commissions will end up being.	Your commission policy for CY 2010 is to be consistent with CMS guidance. Of course, your bid is to reflect your best estimate of the 2010 commission payments.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 7, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Risk Scores	5/7/2009	4/28/2009 6:31 PM	Risk Scores	I have a question regarding the published Rate Calculation Data (www.cms.hhs.gov > Medicare > Medicare Advantage - Rates and Statistics > Ratebooks and Supporting Data > 2010 > calculationdata2010.zip). Do the 2006 and 2007 risk scores (risk_scores 2002-2007.csv) reflect the necessary Fee for Service (FFS) normalization factor of 1.041 and the MA 2009 Coding Intensity of 3.41%, or do both of these need to be applied to the listed risk scores?	The risk score data referenced in this inquiry is standardized at 1.0000 for each year, for the purpose of the ratebook calculations. The MA Coding Intensity factor does not apply to FFS.
2	Risk Scores	5/7/2009	5/3/2009 4:57 PM	Baby boomers impact on FFS normalization factor	As the baby boomers become Medicare eligible in 2010 and beyond, they will eventually bring down the average age and morbidity of the Medicare eligible population. Please consider the impact that this will have on the FFS normalization factor. The FFS and MA coding trend may reverse or be reduced for some time due to this. New medicare eligibles will be given new beneficiary risk scores and so will not have data that is subject to coding trend for on average, 18 months.	This comment is more appropriate for the Advance Notice comment period, not for these user group calls. The normalization factor includes changes in diagnoses and demographics. The normalization factor is based on actual experience, consistent with the ratebook development. Therefore, changes are reflected as the experience is realized, not as it's anticipated.
3	Risk Scores	5/7/2009	4/29/2009 2:17 PM	Risk Score Questions for Part D	1) The 2010 risk score normalization factor includes a component that accounts for the change in population (i.e., using only enrolled beneficiaries instead of eligible beneficiaries). The risk score normalization factors of 1.065 for 2008 and 1.085 for 2009 would imply that the 2010 risk score normalization factor might have been 1.105 had the population change not been included. Does this indicate that PDP sponsor should expect 3.7% less revenue for a 1.0 risk score population in 2010 because of the population change (1.146/1.105 = 1.037)?	The amount of plan revenue remains the same. (The risk score change impacts the standardized bid; the direct subsidy and beneficiary share are impacted. The total to the plan does not change.)
4	MSP data	5/7/2009	5/5/2009 9:33 AM	MSP Flag in Beneficiary-level File to Support 2010 Part C Bids	I have a question regarding the MSP Flag field in the Beneficiary-level File to Support 2010 Part C Bids. The ["Definitions of Table Fields" in the Technical Notes] state: 5. MSP Flag - This flag indicates whether the beneficiary had a payer that was primary to Medicare July 2008 and the reason for the entitlement. 1=ESRD; 2=Disabled; 3=Working Aged; However, on "Exhibit 1: Beneficiary-level file layout" states that # 2 = Working Aged. Field 7 "MSP Flag" 1=ESRD 2=Working Aged 3=Disabled Blank: Not MSP We would like to get clarification on which indicator we should use as ESRD, Working Aged, Disabled, Not MSP. We are trying to identify if CMS provided information is consistent with our Health Plan information.	"Exhibit 1: Beneficiary-level file layout" is correct. Please note that both groups (Working Aged and Disabled) are MSP.
5	MSP data	5/7/2009	5/5/2009 9:20 AM	Question on MSP vs. Part D COB	In [the 4/30/2009] user group meeting, a user mentioned a "Part D COB?" dataset available from CMS. The user mentioned that she compared the MSP member counts based on the Beneficiaries Level Report from CMS and the member counts based on the "Part D COB?" report and saw some discrepancies. Could you tell us what the report name is and where we can find that report?	For more information on the Part D COB report, please refer to Chapter 14 of the Medicare Prescription Drug Manual, "Coordination of Benefits"; see discussion on page 18 regarding "Data from CMS to sponsors." http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/R4PDBChapt14v2.pdf For the file layout, see the Plan Communication Users Guide, page E-23, for the Coordination of Benefits Data File layout. http://www.cms.hhs.gov/mmahelp/downloads/PCUG_v4_0_122308_Appendices_Final_with_Cover.pdf

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May 7, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	MSP	5/7/2009	4/30/2009 8:12 AM	MSP	I have a couple of MSP related questions: 1) Please provide a detailed buildup of how the Numerator and Denominator used in the MSP Factor are calculated? (i.e. the Dates, HCC Model year if applicable, etc.) 2) I thought in previous weeks calls, the statement was made to "Not use the factor" provided on the HPMS file for MSP. Can you please clarify in what circumstances are appropriate to use the factor (bid-worksheet 5?), versus we should NOT use the factor to do what? Second part of this, is when the individual said to not use the factor, I believe they said use the $ amount difference, can you please expand your explanation of this? 3) Can you provide guidance on a plan who has actively coordinated COB for MSP individuals, thus the lowered medical expense will be in the experience base for the bid, and if the # of MSP members identified by CMS now has increased by very large (and unexpected) amounts, it seems like if the factor provided by CMS if used on an unadjusted basis the plan will be overly negatively affected by the reduction in benchmark, because we wouldn't think that a base experience medical expense adjustment is warranted.	1) The MSP factor (0.174) is calculated as the ratio of actual costs of MSP beneficiaries for A/B services divided by the predicted cost of MSP beneficiaries. The predicted cost is estimated using dollar coefficients from the risk adjustment model calibrated on beneficiaries without MSP. For details on the calculation of the plan-specific MSP factors, please see the technical notes posted in HPMS. 2) We recommend, and expect, that plans will use the MSP factor posted in HPMS. We have previously stated that plans should not use the beneficiary file's proportion of MSP beneficiaries as the MSP factor. The MSP percentages are not based on the proportion of enrollees who have MSP, they are based on the proportion of dollars that are affected. Because the risk score of members with MSP tends to be lower than average, the proportion of enrollees who have MSP is not the same as the proportion of dollars that are affected. 3) Projected allowed costs should be consistent with the MSP factor entered on Worksheet 5.
7	Part D: BPT	5/7/2009	4/28/2009 10:39 PM	WS 1 for Flex Cap Pmt demo plans	Can I substitute the actual federal reinsurance capitation instead of using 80% above the catastrophic out of pocket limit? This is for box III.m.5. (Section III; cell M32) If I use 80% of the amounts above the catastrophic TROOP limit, this understates the actual amount of reinsurance that was given to the plan under the payment demo plan.	Yes, you should enter the (actual) federal reinsurance capitation.
8	Part D: BPT	5/7/2009	5/4/2009 3:25 PM	2010 PDP Bidding Question	I have a question about 2010 PDP bidding. Our organization failed 2009 Low income benchmark in some regions which resulted in significant population change in 2009 enrollment. For example, the LI member % was 90% in year 1 and dropped to 30% in year 2. Should we use the trend factor to adjust the projected claims for year 3 or does CMS have specific guidance for this situation?	Yes, it is appropriate to use the trend projection factors on Worksheet 2 to adjust for the expected reduction in LIS members in CY2010.
9	Part D: benchmarks	5/7/2009	5/5/2009 10:15 AM	Benchmark calculations	In the calculation of the National Average Benchmark and the LIS benchmark, please describe how the enrollment weights are determined under the following situations: 1) In 2009, an organization has three separate plans(A,B,and C). In 2010, the organization crosswalks Plan A into Plan B and develops a new plan D. Plans A, B and C have membership for February 2009. In the enrollment weighted calculation of the 2010 NAB, is the membership from plan A included in plan B or is it ignored in the calculation since plan A no longer exists? 2) Is the calculation of the LIS benchmark impacted by a change in benefit design type? For example, if a basic plan with significant LIS enrollment changes to an enhanced plan (Plan A) and a new basic plan (Plan B) is introduced, what weight would be attached to Plan A and Plan B in the 2010 LIS benchmark calculation?	1) If the Organization indicated in the plan crosswalk table that Plan A is being consolidated into Plan B, and the service areas overlap (otherwise the beneficiaries are service area reductions), then the enrollment in Plan A is used in the weighted calculations as part of Plan B in the calculation. 2) No, the LIS benchmark calculation is not impacted by a change in the type of coverage. In this example, Plan A is weighted according to its enrollment in the reference month (likely June 2009) and Plan B is assigned a weight of zero. Please note that any plan benefit type changes are reviewed by CPC.
10	Part D: User fees	5/7/2009	5/5/2009 9:22 AM	Question- Part D User Fees	On page 11 of the Part D bid instructions, it talks about the 2010 Part D user fee being $0.90 per member per year. On page 80 of the Call Letter it talks about the Part D COB user fee of $1.89 per enrollee per year. I just wanted to confirm that both of these user fees should be accounted for in the non-benefit expense section of the bid. Note, I was unable to find a reference to the COB user fee in the bid instructions.	Yes, both the Part D user fee and COB fee should be included in the non-benefit expenses.

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May 7, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
11	DE#	5/7/2009	5/4/2009 5:56 PM	DE#: w/s 4, Section II.B, Column k	We have a dual-eligible SNP plan projected to have 100% DE# members in 2010. The PBP is completed showing traditional Medicare benefits and cost sharing, plus the limitation of the ER copay to not exceed $50 (per the BBA requirement). We would like confirmation of how to complete Worksheet 4, Section II.B. We have overridden the cost sharing formulas in column f to be equal to the cost sharing computed for Worksheet 3. In our state, the types of DE# members in this SNP plan do not have any cost sharing under the Medicaid program. In this case, the Instructions appear to indicate that we should enter zeros in column k of W/S 4, Section II.B. When we do this, the calculation for Total Members in Section II.C shows the Basic Bid claims (column o) to be equal to the Total Benefits claims amount (column h), and Mandatory Supp benefits equal to $0. The BPTs in prior years would have shown a Mandatory Supp benefit equal to the value of the reduced cost sharing on ER services (since the $50 max copay is estimated to be less than the cost sharing under traditional Medicare) and a correspondingly lower Basic Bid. Please confirm that we do not need to reflect the reduced ER cost sharing as a Mandatory Supp benefit.	One way to accomplish reflection of the cost sharing on Worksheet 4 Section II is to overwrite the Plan cost sharing formula in column f (as you've noted). The preferred approach is to set the non-DE# allowed costs equal to the total allowed cost on Worksheet 2. This will set the Allowed costs equal for total, non-DE#, and DE# members (wk2 Cols O, P and Q) and will flow thru the rest of the worksheet. Since the state does not require the beneficiary to pay any cost sharing you are correct in setting the State Medicaid Level of Beneficiary Cost Sharing on wk4 Col k equal to zero. We confirm that you do not need to reflect the reduced ER cost sharing as a Mandatory Supplemental benefit. The key here is to consider the cost sharing that the beneficiary would pay under both traditional Medicare and the MA plan. In both cases, the beneficiary is not liable to pay any cost sharing. Thus the MAO has not added a benefit from the standpoint of the beneficiary.
12	DE#	5/7/2009	5/5/2009 12:27 PM	DE# Definition	Based on the definition of DE# members, QMB and QMB+ beneficiaries are always considered DE#. SLMB+ and FBDE are only responsible for cost sharing to the extent Medicaid fee schedules are greater than the MA plan liability under a given benefit design. In this case, then the member is responsible for the difference between the Medicaid fee schedule and the MA liability (not the difference between the Medicare fee schedule and the MA plan liability). If the Medicaid fee schedule is less than the MA liability, then the member does not pay any cost sharing. Given the DE# definition includes partial cost sharing reductions, are SLMB+ and FBDE also considered to be DE# in all states?	The fee schedules are not relevant in defining DE# members. The DE# distinction is based on whether the dual-eligible beneficiary is not liable for full Medicare cost sharing.
13	Related Party	5/7/2009	4/28/2009 4:02 PM	Actuarial Bid Question - Related party, benefit expense	Regarding related party agreements for benefit expense and bid instructions: "If the related party does not have an agreement with a non-related party on which to base the average cost, FFS data may be used to estimate this amount." Can a similar agreement the health plan has with a non-related party be used to demonstrate that the related party's agreement is reasonable? For example, if a health plan pays a related party IPA x% of revenue to accept risk for a certain list of services, and the health plan has same or comparative agreement with non-related IPA, does this demonstrate that the related party is not charging the health plan excessive amounts?	Yes, this example is acceptable.
14	Capitated arrangements	5/7/2009	5/5/2009 9:10 AM	Questions on cost and utilization data reporting for Capitation services	We have some MA HMO business in one state under heavy capitation. Although we have been trying hard to get encounter data from the institutional providers there, the data we get so for are very limited or not available for us to calculate the util/1000. Our question is for Worksheet 1 utilization data, should we leave these cells blank or fill in some estimated utilizations based on experience from similar product that are not under capitation?	Do not leave utilization data on Worksheet 1 blank. Enter your best estimate of utilizations rates for these costs.
15	MA BPT	5/7/2009	5/4/2009 6:37 PM	Pt C Wkst 2 Sect II Col r OON%	Is the Part C Worksheet 2 Section II Column r "% of services provided out-of-network" for benefits provided at an out-of-network payment level only? Or does it also include out-of-network emergency room, urgent care, or out-of-network referrals?	The last column in MA Worksheet 2, for the percentage of projected allowed costs for services provided out-of-network, is based on benefits provided out-of-network and not on the basis of payment.

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May 7, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
16	GainLoss	5/7/2009	4/29/2009 12:47 PM	Bid Question	In light of the fact that revenue increases for plans will be close to 0% for 2010, will CMS give more leniency to business plans that result in an overall loss in 2010?	No, the guidance is the same as in previous years. Plans are permitted some flexibility in gain/loss margin; however, actual organization returns are expected to achieve the organization's requirement over a longer term period (for example, 3 to 5 years). Below is an excerpt from pages 17-18 of the bid instructions: "Overall Medicare margin levels for general enrollment and institutional/chronic care SNP plans are to be consistent with the Plan sponsor's corporate requirement. Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level. The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range, not to exceed plus or minus 1.5 percent of other lines of business. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE), the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business must take into account the degree of risk or surplus requirements of the business. The overall margin level expectations are to be consistent on a year-by-year basis. Actual organization returns are expected to vary year to year, in practice, but to achieve the organization's requirement over a longer term period (for example, 3 to 5 years). There is flexibility in setting gain/loss margin at the plan level, including the allowance for negative margin, provided that the overall margin meets CMS requirements, anti-competitive practices are not used, and the plan offers benefit value in relation to the margin level. For plans with negative margins, the Plan sponsor must develop and follow a business plan to achieve profitability."
17	SNF	5/7/2009	5/5/2009 12:26 PM	SNF Safe Harbor	In CMS' response to an advance question for a CY2009 OACT user group call, CMS indicated that the safe harbor proportion of unlimited inpatient allowed costs that are non-covered, or supplemental, is 1.2%. Can CMS please also provide the safe harbor proportion of unlimited SNF allowed costs that are non-covered, or supplemental? To clarify, can CMS please provide the value of waiving SNF coverage where there was not a preceding hospital stay of at least 3 days?	CMS has not calculated a safe harbor limit for the supplemental allowed cost of unlimited SNF coverage. Regarding waiving SNF coverage where there was not a preceding hospital stay of at least 3 days, please note that under Medicare FFS this is Non-Covered, while under an MA plan it may be treated as Covered or Non-Covered.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 7, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
18	FFS trends	5/7/2009	5/4/2009 8:12 PM	2010 Inpatient cost trends	Can you help me reconcile several sources for 2010 Medicare IP cost trend? 1. From the April 23rd "Actuarial Bid Questions" sheet (page 7), 2010 IP cost trend is 3.1% 2. From a May 1st CMS Press Release: "In the announcement issued today, CMS is proposing to update acute care hospital rates by 2.1 percent for inflation less an adjustment of 1.9 percentage points to remove the effect of increases in aggregate payments due to changes in hospital coding practices that do not reflect increases in patient's severity of illness." 3. From the "Key Assumptions in the Announcement of the CY 2010 MA Capitation Rates" (page 8) the Fiscal Year PPS Update Factor for 2010 = -0.9% 4) Lastly, if there is an adjustment in 2010 to remove the effect of changing coding practices, might we expect higher than average costs for 2009, before the adjustment is added?	Per #1, the IP cost trend represents the calendar year increase in the unit cost only, or the market basket. The CMS Press Release (#2) refers to the fiscal year increase in the market basket (rates) less an adjustment for documentation and coding practices resulting from the implementation of the MS-DRG inpatient PPS. The market basket increase and documentation and coding practice adjustments for FY2010 assumed in the 2010 Payment Announcement was -0.9 percent. At the time the announcement, CMS had not settled on the final policy regarding the inpatient hospital update for 2010. OACT used their best estimate of the hospital market basket and their best understanding of what the law provided for in terms of the documentation and coding practices adjustment for 2010. Subsequent to the release of the MA payment rates, CMS settled on the proposed update for FY 2010 as announced in the Federal Register Notice on May 1, 2009. The proposed market basket and adjustments differ somewhat from that assumed in the baseline used for the MA payment rates. As just mentioned, the CY 2010 Announcement (#3) assumptions reflect the best estimates of the FY 2010 market basket and the adjustment for documentation and coding practices made at the time the MA rates were announced. (#4) The 2009 average costs already reflect our current best estimate of the anticipated excess coding stemming from the implementation of the MS-DRG inpatient PPS. The current assumption is about half a percent higher than what was assumed when the 2009 MA rates were announced last year.
19	5% sample data	5/7/2009	4/29/2009 5:42 PM	Medicare FFS 5% sample data location	Please provide a link to the Medicare fee-for-service 5% data sample and any information describing it.	The below site contains information on data contents, ordering procedures, and a searchable Q&A database. http://www.cms.hhs.gov/FilesForOrderGenInfo/
20	Two Year Lookback Form	5/7/2009	5/5/2009 9:43 AM	Two Year Lookback	Please confirm that we do not need to file the 2 Yr Lookback form if we are not renewing our contract for 2010.	If a contract is being moved/merged into another contract, where membership is being retained ("crosswalked"), then the 2YRLB should still be completed and uploaded as bid substantiation for the continuing contract.
21	EGWP	5/7/2009	5/5/2009 11:13 AM	EGWP Service Area	If a plan intends to take advantage of the local CCP service area waiver for EGWPs to enroll group members outside its standard service area, should the 800-series bids be submitted as national with all 3200 or so counties in the service area? I assume the answer is yes.	An EGWP 800-series bid is permitted to use a national service area, but is not required to do so. All of the plan's service area counties must be included in the bid form for payment and enrollment systems. Note that projected enrollment for a specific county may be zero (or a fraction) in the BPT. For specific questions regarding service areas, please contact CPC.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 14, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Coding Intensity Adjustment	5/14/2009	5/6/2009 3:38 PM	Coding Intensity Adjustment	Last Year CMS provided the following estimates for coding intensity: • Part C – 1.015 • Part D – 1.017 Has CMS updated these estimates for projecting 2008 risk scores to 2010? If so, where can I find them? If not, does CMS plan to do so?	The numbers referenced in this question are annualized trends inherent in the 2009 Part C and Part D normalization factors (Note: the Part D trend was actually 1.016). For the 2009 Part C normalization factor, the annual trend was applied for the two years between the denominator year and the payment year – 2007 to 2009 – and was calculated as follows: 1.01492 = 1.030. For Part D, the 2009 normalization factor was 1.085. As discussed, the Part D normalization factor comprises two components – the base risk score from two years prior to the payment year and the FFS trend, which is used to project from the base risk score year to the payment year. The effective annual trend is backed out by taking the normalization factor and taking the root for the number of years between the denominator year and the payment year. For 2009, this was five years (2004-2009), and the effective annualized amount is 1.016. For 2010, the numbers are as follows: For Part C, the annual trend used to calculate the 2010 normalization factor is 1.0136. Applied for the three years from 2007 to 2010, we calculate the 2010 Part C normalization factor as 1.01363 = 1.041. For Part D, we would calculate an effective annual trend over the six years from 2004 to 2010 as follows: 1.146 to the 1/6 = 1.023.
2	Risk Scores	5/14/2009	5/7/2009 5:34 PM	Base Period Risk Score Normalization	The estimated part C risk scores for development of 2010 bids (which was released on HPMS) has raw risk scores without normalization. It mentioned in the technical notes that 2007 was the denominator year. I understand that to project risk scores to 2010 requires three years of normalization (the 1.041 factor). To appropriately normalize the risk scores entered in Worksheet 1 for the 2008 base period experience, would I apply one year of normalization trend (1.041^(1/3)=1.0135). For example, if my raw risk score was .95. For the 2008 base period would I enter a risk score of .95/1.0135 =.937?	The risk scores entered on WS1 should be based on the risk score model used for 2008 payments and the 2008 normalization factor (1.040). The beneficiary-level file provided by CMS has two 2008 risk scores (calculated with 2007 diagnoses) – one with the risk model used in the 2007/2008 payment years and one with the model used in 2009/2010. Both scores in the file are not normalized.
3	MSP	5/14/2009	5/8/2009 8:51 AM	MSP percentage for EGWP plans	The MSP percentages that we've seen from HPMS are actually lower for our EGWP plans than for our individual plans. Should we expect the EGWP percentages to be higher, as these members are by definition retired? I recognize that there may be working spouses involved to complicate the question.	Not all enrollees in an EGWP plan are retired. That is, members are not, by definition, retired by being in an EGWP plan. There are some active workers in EGWP plans.
4	MSP	5/14/2009	5/10/2009 8:36 PM	MSP Question	I have reviewed the MSP amount provided by CMS and have analyzed how the beneficiaries in the beneficiary-level file identified as MSP (codes 2 and 3) correspond to the Part D COB notifications. For my particular client, the beneficiary-level file shows X members with MSP. Of those, only 6% beneficiaries appeared in any Part D COB notification between March 2008 and March 2009. 1) It was my understanding that the beneficiary-level file and the Part D COB notifications are generated from the same source. How can the two have such very different information? 2) It was stated in the [5/7/09] user group call that the Part D COB notifications can be used to adjust the MSP factor supplied by CMS if we can find detailed information on the Part D COB notifications that would provide reasons to believe that the beneficiary-level file information would be changed in the future. Because, per my example, most of the people marked as MSP on the beneficiary-level file simply do not exist on the Part D COB notifications, may we adjust the MSP factor supplied by CMS based on the assumption that the people not found in the Part D COB notifications were truly not MSP? In other words, assuming that all of the 6% beneficiaries found in the Part D COB notifications did have other primary coverage during July 2008, could we adjust the MSP factor by a factor of 6% (0.06)? 3) The situation also exists that there are several beneficiaries in the Part D COB notifications who do not have MSP per the beneficiary-level file. Should we assume that these beneficiaries truly are MSP for the purpose of submitting an MSP factor in the bids? Which source of MSP is more reliable (beneficiary-level file or the Part D COB notifications)?	1) The 6% "match rate" sounds low. We would recommend that the plan verify that the data is being distinguished correctly. The Part D COB information contains two types of records - primary records and supplemental records. 2-3) No, this is not appropriate. The 6% sounds very low. CMS released a beneficiary-level MSP file with carrier information on 5/14/2009. We recommend that the plan do more investigation into reconciling the MSP information. Rather than matching on the Part D file, plans should use the beneficiary-level file released by CMS on 5/14/2009 for further analysis.

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May 14, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
5	MSP	5/14/2009	5/8/2009 1:43 PM	MSP Adjustment - Comparison of Bene Lvl file to Part D COB file	We have tried to match the beneficiaries listed as "MSP" on the file supplied to us for the 2010 Part C bids, with the Part D COB file (H9999.Marxcob.dyymmdd.txxxxxxx.x). We used all of the Part D COB files we have received since the files began being supplied to us in late 2007. We were only able to match [approx. 100] members out of the [approx. 1,000] shown on the Part C Bene file. 1. Is this a reasonable result? We believe these two files should have been similar . 2. Can we use this result to estimate our 2010 Part C MSP adjustment? That is, we assume that we can correct the CMS records, and the final results will be closer to our Part D experience.	See above responses regarding matching the Part C and Part D information, and using this "match rate" as the adjustment. To reiterate, do not use the "match rate" as the adjustment to the Part C MSP factor. However, if the plan experienced an X% correction rate for Part D, then this should be taken into account for adjusting the Part C MSP factor.
6	MSP	5/14/2009	5/7/2009 2:14 PM	MSP Data	I would like to clarify a few questions from the actuarial technical user group call on 5/7/09. 1) Is it acceptable for a plan to contact the COB contractor to correct MSP data after acceptable challenge information is provided, such as beneficiary reported as an employer group health retiree? 2) After the COB contractor has accepted the information and corrected the beneficiary's MSP data and the HPMS file is still not reflecting the correct change, does the plan contact CMS?	Yes, plans may notify CMS regarding MSP corrections. However, please note that such corrections would be effective for 2010 payment purposes. CMS will release guidance regarding the MSP correction process. For bidding purposes, plans should use the MSP information provided by CMS as a starting point and make appropriate adjustments, based on substantiated and reasonable sources. Examples of acceptable and unacceptable sources were discussed on the 5/14/09 user group call (example: survey data is not acceptable). For bidding purposes, it is important that the allowed costs are consistent with the MSP factor.
7	MSP	5/14/2009	5/6/2009 8:59 AM	[None]	In order to make the best use of the MSP data provided by CMS in our bids, we need to know more about the contents of the Common Working File. Can we get a the name of a contact person at CMS who can answer such questions as: 1) What COB data does this file contain about MA members? 2) What are the most frequent sources for MSP information in the file (e.g. Commercial Medical carriers, medical claim submissions)? 3) How often is the file updated for MA members?	See the Common Working File manual on http://www.cms.hhs.gov Data sharing agreements. The file is updated daily, whenever information is submitted.
8	DE#	5/14/2009	5/5/2009 1:38 PM	DE# BPT Question	Can you confirm or clarify the following: The term "Allowed" costs in the BPT for DE# in WS2 (section II, col (q)) is different than the way "Allowed" is used in WS4, Section IIB, Col. (i) and (m). In WS4, the % of cov svc's for "Allowed" in col. (i) should really be the % of cov svcs of the "Reimb + Actual Cost Sharing" in col (e). Is this correct?	Yes.
9	DE#	5/14/2009	5/12/2009 10:58 AM	State Medicaid Required Beneficiary Cost-sharing	In column k of section B of Worksheet 4, we are to enter the Medicaid level of beneficiary cost-sharing for each service category for the DE# beneficiaries. For benefits not covered by Medicare FFS or Medicaid, should the corresponding cost-sharing in column K be $0, or should it be the actual amount of cost-sharing paid by the beneficiary?	Enter the cost sharing paid by the beneficiary in column K.
10	DE#	5/14/2009	5/7/2009 2:05 PM	worksheet 4 and DE# - consistency between policy and BPT	[PARAPHRASED] If the beneficiary does not pay cost sharing, how do I reflect that the plan sponsor is paying the cost sharing? Please clarify how to complete Worksheet 4.	When the beneficiary is not responsible for paying cost sharing, this does not mean that the plan sponsor is paying the cost sharing for the beneficiary. Column F of the DE# section of Worksheet 4 must reflect the PMPM value of the plan cost sharing entered in the PBP even though the enrollee may not be liable for the full amount of this cost sharing. The PMPM value of cost sharing the beneficiary is liable to pay is entered in Column K. The amount the plan sponsor pays the provider is captured in Column H.
11	MA Benefits	5/14/2009	5/11/2009 4:52 PM	ER Co-pays	If traditional Medicare part B cost sharing is 20% after a deductible, why is the ER co-pay limited to $50 if the average cost per visit is well over $250?	The maximum ER copay is specified in regulation with no provision for an inflation adjustment. See 42 CFR 422.113(b)(2)(v) – "[The MAO is responsible for emergency/urgent services] with a limit on charges to enrollees for emergency department services of $50 or what it would charge the enrollee if he or she obtained the services through the MAO, whichever is less."

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 14, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
12	MA Benefits	5/14/2009	5/8/2009 11:52 AM	2010 therapy cap amounts	Have the 2010 physical therapy/speech therapy and occupational therapy cap amounts been released yet? I have that they were both $1840 for 2009. I need to calculate the additional benefit for us paying over the therapy cap and am wondering if I should use $1840 or some other amount?	The therapy caps are updated by the MEI (Medicare Economic Index), then rounded to the nearest $10. For 2009, the therapy caps are $1840. The 2010 MEI has not yet been determined, and will be finalized for the November 1, 2009 final physician rule. The 2009 Trustees' Report assumed the 2010 MEI was 0.8%. This would result in a 2010 therapy cap estimate of $1,850.
13	Network Development Administrative Costs	5/14/2009	5/6/2009 10:52 AM	Network Development Administrative Costs	We are trying to decide what is the best way to account for network development costs in the 2010 bids. How should we handle each of the following scenarios. 1) Network development costs incurred in 2009 for 2010 expansion counties? 2) Network development costs incurred in 2010 for counties we will sell in for 2010? 3) Network development costs incurred in 2010 for counties we will expand into for 2011?	These costs should be treated according to the relevant GAAP standards (to the extent that is consistent with the organization's standard accounting practices, if not subject to GAAP).
14	medical expenses vs non-benefit expense	5/14/2009	5/6/2009 9:28 PM	medical expenses vs non-benefit expense	Please clarify whether we should include the following expenses as medical expenses or non-benefit expense. None of the providers below are related parties. 1. Administrative fees component of the capitation paid to a capitated medical vendor 2. Administrative fees paid to a vendor that administers fee-for-service claims 3. Administrative fees paid to a contracting consortium.	1) It depends on the capitated arrangement. If it's included in the capitation, then it should be included as allowed. 2&3) Non-benefit expenses.
15	COB fees	5/14/2009	5/5/2009 2:24 PM	Part C coordination of benefit user fees	I was looking through the 2010 Call Letter for the Part C coordination of benefit user fees but I can't find it. I have located that the Part D coordination of benefit user fees is $1.89 annually but am unable to find the Part C fees. Can you tell me where I can locate these?	COB fees are not applicable to Part C.
16	COB fees	5/14/2009	5/6/2009 1:19 AM	Part D COB User Fee for 2010 Bids	Could you please provide guidance on the value of the Part D COB User fee for the 2010 bid development?	As stated on page 80 of the 2010 Call Letter: the Part D COB user fee is $1.89 per enrollee per year.
17	COB fees	5/14/2009	5/8/2009 8:48 AM	Part D COB amount for 2010	Could you please share the Part D COB amount we should use for 2010?	See above response.
18	Part D BPT	5/14/2009	5/11/2009 11:37 AM	Part D Question	In 2008, the health plan used a PBM with a lock-in contract. Given that the PBM will use a pass-through approach, there will be a reduction factor in drug cost which will be reflected in the other changes column on WS 2. However correspondingly there ought to be a projected increase in overhead cost (the admin payment that the health plan will make to PBM on per script basis given the pass through). Should this additional charge be reflected in increase trend in number on WS 2 cell F62? If that is the case, the projected loss ratio might not correspond with the rest of the book of business of the health plan, which can raise an issue at the time of certification. How would you intend to address this issue?	Yes, it is acceptable to use the trend projection factor for the direct administration component of non-benefit expenses to reflect the increase. Further, the change in the PBM pricing approach may impact the projected loss ratio of the plan which would be appropriate and should be documented with substantiation uploaded with your bid.
19	LIS/ benchmarks	5/14/2009	5/11/2009 5:22 PM	Low Income Benchmark Calculations	How are the Part D Low Income Regional Benchmarks determined when an MA-PD or an MA-PFFS plan exits the market that has Low Income Subsidy members in a plan that will no longer be offered?	As mentioned on the 5/7/09 user group call, if an Organization indicated in the Plan Crosswalk Table that Plan A is being consolidated into Plan B, and the service areas overlap (otherwise the beneficiaries are service area reductions), then the enrollment in Plan A is used in the weighted calculations as part of Plan B in the calculation. If a plan that exists in CY2009 will not be offered in CY2010 and the enrollment is not mapped into another plan through the Plan Crosswalk Table, then the 2009 enrollment is not included in the calculation.
20	LIS/ benchmarks	5/14/2009	5/7/2009 11:30 AM	Low Income Enrollment Data	Is it possible for CMS to release the number of low income beneficiaries by plan for both 2008 and 2009 for purposes of projecting the regional Low Income Benchmarks?	See "Downloads" under: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/ This page can also be accessed by the following path: http://www.cms.hhs.gov > Research, Statistics, Data and Systems > Medicare Advantage/Part D Contract and Enrollment Data > Overview
21	2010 FFS cost sharing	5/14/2009	5/4/2009 11:14 AM	Part A Hospital Stay Deductible and other Cost Sharing for 2010	Does anybody know what the expected Hospital Deductible per stay will be for 2010?	$1,112 per the 2009 Trustees' Report.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 14, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
22	2YRLB	5/14/2009	5/11/2009 2:53 PM	2Yr Look-Back form for withdrawn contract	Please confirm that the 2 year look back form has to be uploaded to the HPMS for the plan (contract) that existed in 2008 but will be withdrawn for the CY2010 bid.	As mentioned on the 5/7/09 user group call, if a contract is being moved/merged into another contract, where membership is being retained ("crosswalked"), then the 2YRLB should still be completed and uploaded as bid substantiation for the continuing contract. If a contract is terminated and enrollment is not crosswalked into another plan then the 2YRLB need not be submitted.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 21, 2009

Introductory Note to the 5/21/2009 UGC Q&A:

To clarify previous user group call discussions regarding Part D trends in the normalization factor, OACT is releasing the following introductory note:

Generally speaking, there are two components to the Part D normalization factor: risk score and trend. For CY2010, these components are:

- 1.1159 = Average 2008 risk score for enrollees in a Part D plan
- 1.0135 = Annual trend factor (which is based on FFS enrollees, and represents a rolling average trend (2004-2008)). To state this as a percentage: 1.35% trend.

CY2010 Normalization Factor = 1.1159 × (1.0135)^2 = 1.146

Regarding the impact of the change in DR (diagnostic radiology): the risk score component is approximately 0.7% lower without DR (that is, 0.007). The risk score data in the trend component excludes DR and therefore is not affected by DR change.

On a previous call, the CY2010 normalization factor was deconstructed into an annual amount as follows: (1.146)^(1/6) = 1.023. The 1/6 factor is based on the six years from 2004-2010. This is not a real "trend", and is likely not meaningful for bidding purposes.

Answers to Bid Questions

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Normalization Factors	5/21/2009	5/16/2009 9:34 AM	Annual FFS Normalization Trend	During [the 5/14/09] call, CMS clarified the annual trends in Part C and D FFS normalization factors. If I heard correctly, the underlying annual trends were: Part C: 1.0136 (from 2007-2010) Part D: 1.023 (from 2004-2010) Can you clarify the annual trend in Part D FFS normalization factors in the absence of the reporting change (removing OP radiology) and the methodology change.	See introductory note to 5/21 UGC Q&A.
2	Normalization Factors	5/21/2009	5/16/2009 10:26 AM	Part D risk score trends	There was a [question during a previous user group call's Live Q&A session] around what Part D risk score trends were being used in setting the 2010 Part D normalization factor. I thought that the answer to what trend rate from 2007 to 2009 was 1.035% per year. But on [the 5/14/09] call this was restated and indicated that the annual FACTOR was 1.035 meaning 3.5% per year. Can you please clarify which it is? To restate: What was the assumption of annual FFS coding intensity change prospectively on the Part D side?	See introductory note to 5/21 UGC Q&A.
3	MSP	5/21/2009	5/12/2009 5:37 PM	MSP Documentation	1. With regard to the MSP adjustment percentage factors that sponsors are instructed to use in the development of 2010 bids, is the calculation of the factor applied to the payments of individuals who have MSP status (.174) the same for individuals who are working-aged versus individuals who are MSP qualified for other insurance (workmen's comp, auto, etc…)? 2. In the guidance, CMS indicates that "to the extent that the mix of MSP adjustment factor of MSP and non-MSP enrollees is the plan's population is expected to change from the base period to the contract year, the MSP adjustment factor posted on HPMS should be modified to reflect the resulting change in payments. Documentation should be provided showing how the modification was developed." What documentation does CMS consider acceptable (i.e. is documentation of reconciliation required to be at a member-level)?	1) The 0.174 factor is not applied to "other" (workmen's comp, etc). Only working aged, working disabled, ESRD working aged, and ESRD working disabled are flagged as MSP in the MSP data provided by CMS. 2) The documentation need not be at the beneficiary level. If the adjustment is developed based on the beneficiary-level data, then the information should be rolled up to the plan level for documentation purposes. If the adjustment is developed based on broader information (for example, at the contract level), the documentation should be prepared at that same level. Of course, the documentation should be in accordance with the ASOPs and the guidance in the bid instructions.
4	MSP	5/21/2009	5/19/2009 9:05 AM	CMS Bidder Calls - MSP Question	This question is related to MSP and a reasonable adjustments to the claim costs. Is it appropriate to adjust the claims side by a % that is less than the % adjusted on the revenue side? For example, the revenue adjustment provided by CMS is 2%, would an 1.5% (or 75%) adjustment on the claims side be appropriate? If not, will CMS provide a safe harbor for plans to use on CY2010 MA bids?	CMS will not provide a safe harbor. Revenues and claims should be in sync. In order to bring them in sync, a different adjustment may be needed for claims than for revenue. The example described here may be acceptable depending on the particular circumstances.
5	MSP	5/21/2009	5/19/2009 10:27 AM	MSP calculation question	I would like to confirm that we are supposed to use 1-MSP adjustment percentage provided by CMS in the appropriate cell on the MA Benchmark tab (Worksheet 5).	Answer provided in 4/23/09 UCG Q&A (question #4): Yes.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 21, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	MSP	5/21/2009	5/14/2009 8:14 AM	MSP Adjustment Based on Plan Data	Is it acceptable for plans to use their own adjustment factor instead of the factor provided by CMS via HPMS as long as that factor is consistent with revenue and other projections? If a plan is confident in their data, can they use their own factor as long as it is consistent with other segments in the bid as to revenues?	As discussed on previous user group calls, plan sponsors should use the MSP information provided by CMS as a starting point and make appropriate adjustments, based on substantiated and reasonable sources. Examples of acceptable and unacceptable sources were discussed on previous user group calls (example: survey data is not acceptable). For bidding purposes, it is important that the allowed costs are consistent with the MSP factor.
7	DE#	5/21/2009	5/14/2009 12:14 PM	RE: worksheet 4 and DE# - consistency between policy and BPT	For a benefit plan where the filed benefit cost-sharing is greater than $0 (suppose Medicare FFS benefits): My interpretation is that the BPT and instructions assume that the cost-sharing for the QMBs do not need to be picked up by the plan. In particular, please confirm the required revenue does not include any provision of costs for covering this cost-sharing.	Yes.
8	DE#	5/21/2009	5/18/2009 10:01 AM	DE# Risk Scores	If our projected DE# members within a plan is less than 10% or greater than 90%, and we are setting columns (o), (p) and (q) on worksheet 2 to be the same, can we assume that our projected risk scores for DE# and non-DE# members to be the same?	Answer provided in 4/23/09 UCG Q&A (question #19): Yes, as risk scores should be consistent with projected allowed costs.
9	Gain/Loss Margin	5/21/2009	5/12/2009 5:01 PM	Gain/Loss Margin Guidance	The Part C instructions (under Pricing Considerations, Gain/Loss Margin on page 17) state that "Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level." During desk review last year, setting the margin level at a more aggregated level than contract level was not allowed. Will this now be allowed for 2010 bids?	The contract level determination is described in the bid instructions under the margin guidance for EGWP plans (pages 18-19).
10	Gain/Loss Margin	5/21/2009	5/15/2009 11:47 AM	gain/loss for EGWP vs. general enrollment plans	The bid instructions state that: The difference in the margin level between EGWP and general enrollment plans must not exceed 1 percent, calculated at the contract level. Would CMS consider an exception to this rule in the event that in aggregating gain/loss percentages under one contract for either 1) all EGWP plans or 2) all general enrollment plans if the weighted average gain/loss for one of these segments is expected to be negative for 2010 (due to, e.g., poor expected claim experience in a general enrollment plan with significant membership).	CMS will not consider an exception for this situation.
11	Gain/Loss Margin	5/21/2009	5/15/2009 12:12 PM	MA-PD Margin	Can the margin vary between the C and D portions of an MA-PD bid, if the variation is being done to maintain a proper premium relativity between plan options?	See MA instructions pages 17-19. Excerpt from page 18: "The overall margin levels included in the MA and Part D (PD) components of MA-PD bids must be within a reasonable range of each other, not to exceed plus or minus 1.5 percent, with any variation reflecting the different levels of financial risk for the two components. The individual Part D margin of an MA-PD bid can either be the same for all plans or may vary by plan in relation to the MA margin."
12	Gain/Loss Margin	5/21/2009	5/18/2009 4:20 PM	Gain/Loss Margin Differential	The bid instruction seems to state that if a contract has both SNP and non-SNP plans, the composite gain/loss differential between SNP and non-SNP plans cannot be greater than 1%. I thought that I heard from last week's call that 1.5% was mentioned to be that differential. Can you confirm which one is the correct differential?	See MA instructions pages 17-19. Excerpt from page 19 regarding dual eligible (DE) SNPs: "...There may be a small difference (that is, up to 1 percent) in the margin level between DE-SNPs and general enrollment plans. "If corresponding general enrollment plans are not offered, then ...Overall DE-SNP margin levels are to be within a reasonable range, not to exceed plus or minus 1.5 percent, of the margin for other similar lines of business."
13	Projecting Base Period Data	5/21/2009	5/13/2009 8:37 AM	Question for Thursday Calls	If a plan is removing an mandatory supplemental benefit such as coverage for hearing aids, is the appropriate methodology to include the base period experience and then apply a benefit change factor of 0, or should we just remove those dollars from the base experience data? Inputting a benefit change factor equal to zero currently produces a red circle error in the spreadsheet.	Do not enter a benefit change factor of zero and do not remove the claims from the base experience data. Enter the base period data on Worksheet 1, and then enter a negative additive adjustment on Worksheet 1 (columns O and P) to adjust for the removed benefit.
14	Reporting Base Period Data	5/21/2009	5/12/2009 2:27 PM	Deleted Plan	If we get rid of a plan such as the SNP, and there is no other plan to map them to, do you expect us to provide you with the deleted plan's experience? If we must report the experience, how do we do so?	If the enrollment is not mapped into another plan, then the deleted plan's experience need not be reported.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 21, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
15	Supporting Data	5/21/2009	5/15/2009 11:31 AM	Question regarding Substantiation	I see in appendix B regarding "Input Sheet for Pricing Model". Could someone elaborate further about what you are looking for regarding the "Input Sheet for Pricing Model"?	Answer provided during last year's (CY2009) user group call. See 5/15/08 UCG Q&A (question #8): The input sheet for a pricing model is a list of the assumptions that were used in the modeling and pricing of the bid. For example: For Plan sponsors that rely on an actuarial consulting firm to complete the bid, this refers to the document provided by the consulting firm that lists all of the inputs to the pricing model that were used in the bid. "Inputs" will include assumptions such as projection factors, pharmacy network discounts, benefit design, etc. Plan sponsors should be prepared to provide substantiation of the input items, either at the time of bid submission if required by the Instructions or upon request by a CMS reviewer.
16	Supporting Data	5/21/2009	5/19/2009 3:48 PM	Supporting Documentation Clarification	We have noticed that the MA BPT instructions, in Appendix B, indicate as supporting documentation "the input sheet(s) for the pricing model used in the development of the bid". This is listed in the section for documentation needed only if a bid contains certain specified assumptions In 2009, this was only referenced in the Part D BPT instructions. We have 2 related questions: 1) Under what conditions in the bid should a MAO submit these input sheets? 2) What type of information would CMS expect on these sheets? We would expect a comprehensive listing of bid inputs to be extremely extensive.	1) It is required when a pricing model is used in the development of the bid. 2) This requirement refers to a list of all inputs (assumptions) used by the pricing model, not a list of all BPT inputs. See above response for more information on the input sheet of a pricing model.
17	Non-Benefit Expenses	5/21/2009	5/12/2009 7:16 PM	2010 Bid Non-Benefit Expense Question	Are advertising and direct mail costs associated with the acquisition of new members allowed [that is, permitted] non-benefit sales & marketing costs in the 2010 bids.	Yes.
18	Non-Benefit Expenses	5/21/2009	5/18/2009 4:42 PM	Case managers at providers--admin or clms expense?	If we pay the salaries of case managers employed with providers to improve quality, efficiency, and patient satisfaction, should that be an administrative expense in the bid or a claims expense. If it's a claims expense, would it be a Medicare Covered or Additional Benefit claims expense?	The instructions cite salaries as an administrative (non-benefit) cost (see pages 21-22 of the MA bid instructions). Also refer to the Disease Management section of the MA bid instructions (pages 13-14) for more information on this topic.
19	SAE	5/21/2009	5/13/2009 1:37 PM	pending counties/service area expansions	In the past, if a plan had a pending SAE and the counties were part of a bid that contained established counties, CMS stated that if the SAE was rejected, then the entire bid is rejected. Is this still the case?	Yes. Service area expansion (SAE) questions should be directed to CPC.
20	VAIS	5/21/2009	5/14/2009 12:47 PM	VAIS	On [the 5/14/09] user group call, a comment was made by CMS stating that value-added services may be included in the indirect admin portion of the bid. According to page 22 of the call letter, "Value-added items and services should not be included within the bid (PBP or BPT)." Please confirm that value-added services may be incorporated in the indirect admin portion of the bid.	OACT correction to the question: CMS stated "DIRECT" admin, not "INDIRECT" admin. In response to this question: There may have been a misstatement during the Live Q&A portion of last week's (5/14/09) call. The Call Letter is correct. These would not be included as medical nor admin; they are implicitly an offset to profit. Plans may incur a cost, but it cannot be included in the bid. One exception: if it is a pass-through/discount program. Also see Chapter 10 of the Medicare Marketing Guidelines: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf
21	VAIS	5/21/2009	5/14/2009 12:48 PM	VAIS	The response to the last caller [on the 5/14/09 UGC] indicated that the cost of VAIS can be included in the administrative cost in the bid. I believe this is incorrect. Managed care manual says that no Medicare program dollars can fund VAIS benefits. It goes on to say that VAIS costs are strictly administrative (which I view as different than being in the administrative component of the bid). Please reconcile your response with the Managed Care Manual: Link: http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf	See above response.
22	FFS trends	5/21/2009	5/16/2009 10:09 AM	Unit Cost Trends	Can you please provide us with the updates to the following Medicare FFS unit cost trends consistent with the assumptions in the May 12, 2009 Medicare Trustees report. These were the numbers previously provided during the [4/23/09]actuarial user group call (prior to the release of the Medicare Trustees Report): 2009 2010 IP 3.4% 3.1% SNF 3.3% 3.0% HH 2.9% 2.9% OP 3.6% 2.9% Phys 1.1% -21.5% Carrier lab 5.0% -0.2%	These are consistent with the assumptions in the 2009 Trustees' Report.

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May 21, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
23	FFS	5/21/2009	5/19/2009 12:37 PM	PQRI	Do the FFS claims CMS released with this year's MA rate update include the physician incentive payment amounts (PQRI, and e-prescribing)? Do the trend increases provided on the actuarial bid calls for 2008 and 2009 include estimates for changes in these payment amounts?	Yes. Yes.
24	Part D	5/21/2009	5/12/2009 5:03 PM	Question Regarding Qualifying Part D Plan	We were hoping that you could help us with a Part D question or refer us to the right person. We have a Part D MA-PD plan that provides coverage of certain non-Part D drugs (e.g., benzos). When we run the plan through the bid form, it produces a $0 supplemental premium. That is, the cost sharing is equivalent to standard and the cost of the non-Part D drugs is low enough that the cost falls within the tolerance that the bid form allows to support a $0 supplemental premium. Since this plan has a $0 supplemental premium, can you confirm that the plan would satisfy the requirement that an MA plan offer either a basic plan or an enhanced plan which has the supplemental premium bought down to $0.	The scenario described below does not satisfy the requirements for an Enhanced Alternative plan. That is, coverage that exceeds the actuarial value of defined standard coverage through additional benefits that reduce beneficiary cost-sharing and/or provide coverage for non-covered Part D drugs. The value of the additional benefits results in a supplemental premium in the Part D BPT. The $0.50 pmpm threshold value for supplemental coverage in the BPT ensures that meaningful supplemental benefits are provided by the EA plan. Therefore, in this scenario, if an Enhanced Alternative plan is desired, benefits that increase the value of the supplemental coverage to a minimum of $0.50 pmpm must be added. If a Basic Alternative plan is desired, the coverage of non-Part D drugs must be removed. Once an EA or BA plan is established, then the requirements for an MA-PD plan to offer basic Part D coverage can be satisfied.
25	Part D	5/21/2009	5/19/2009 10:54 AM	Question Actuarial Technical User Group Call	According to the 2009 call letter (page 58), all Part D bids for Platino plans in Puerto Rico must reflect only “basic benefits.” Please define “basic benefits” for this context. In particular, does “basic benefits” refer to standard 2010 Part D benefits (e.g. $310 deductible, 25% coinsurance up to the initial coverage limit of $2,830, and catastrophic coverage after $6,440 in drug cost)? If so, why are dual SNPs in Puerto Rico being required to bid standard Part D benefits when stateside plans are free to bid any plan design they wish to?	“Basic Benefits” refers to the three types of Basic Part D benefit types – Defined Standard, Actuarially Equivalent and Basic Alternative. Comments regarding policy in the Call Letter should be directed to CPC; they are outside the scope of this call.
26	Rebate Reallocation	5/21/2009	5/18/2009 4:25 PM	Rebate Reallocation	If a plan chose “LIPSA” as the target premium and allocated $28 as the Part D basic premium in the June submission, but the Low income benchmark turns out to be $30. Can the plan increase the $28 to $30 for line 7d (worksheet 6 IIIC) in August? Or the plan can only decrease this amount?	If the question is referring to a Basic Part D premium NET OF REBATES (that is, after the application of rebates) equal to $28, then the plan may be able to re-allocate rebates to result in a $30 Basic Part D premium. If the Basic Part D premium equals $28 and zero rebates are applied to Basic Part D, then the plan CANNOT increase the premium to $30.
27	Rebate Reallocation	5/21/2009	5/19/2009 12:01 PM	Part D Question from [ORG] Regarding National Benchmark Release	For the upcoming release of the national Part D benchmarks that usually occurs in the middle of August; this year, would you be willing to give the Industry at least a week's notice prior to when you will release the final benchmarks? This will help the Industry better prepare for the resubmission process after the benchmarks are released.	Unfortunately, OACT cannot commit to the prior notice requested in this inquiry. We can share this comment with CMS leadership. Ultimately, OACT does not determine the release date of the benchmarks.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

May 28, 2009

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Risk Scores	5/28/2009	5/19/2009 8:56 PM	Part D Risk Score	[PARAPHRASED] Is it appropriate to apply the trend factor (1.0135) used in the normalization factor to my plan's risk scores?	We would expect the plan to use its own experience to develop a trend.
2	MSP	5/28/2009	5/21/2009 7:17 AM	MSP question	Many of the other carriers listed on the recent MSP files are other Medicare Advantage organizations. CMS does not allow simultaneous enrollment in two Medicare Advantage products. So, for bid purposes, can these records be considered errors by just matching the other carrier name to a Part C product offering from the other organization?	Not necessarily. The MSP data does not reflect enrollment status; the data indicates who is primary/secondary. The MSP data contains the name of the carrier who has been identified as being primary to Medicare. You should not assume that the beneficiary is enrolled in that carrier's MA plan. For example, an employer group may have contracted with that carrier for working aged. Do not assume this is an error; the plan needs to investigate the beneficiary MSP data further to determine if any records are in error.
3	Substantiation deadline	5/28/2009	5/22/2009 1:22 PM	Question Asking For Extension of Deadline for Submitting SupportingDocumentation for Bids	Given that June 1st is the earliest possible due date for bids and supporting documentation, would you be willing, as you did last year, to extend the deadline for the submission of the supporting documentation past the midnight Pacific June 1st deadline? Thank you for consideration of this issue.	It is our expectation that all substantiation be prepared and uploaded by the June 1st bid deadline. However, having said that, if you are in the process of finalizing the substantiation (that is, double-checking that the substantiation is thorough, complete, accurate, reviewed, and in accordance with the bid instructions), you may upload the substantiation by COB Wednesday 6/3/2009. OACT will then download all the substantiation information at that time and distribute the information to our reviewers.
4	Reinsurance	5/28/2009	5/20/2009 3:58 PM	CMS development of reinsurance estimate for 2010 Part D	For 2010, will CMS be developing the reinsurance estimate that goes into the development of the member premium from its own estimates or based upon a compilation of bid estimates?	The following response was given on a CY2009 user group call (see Q&A from 5/22/2008 #12): It is based on the plans' estimates in the bids, not normalized for risk.
5	Benchmarks	5/28/2009	5/21/2009 12:53 PM	estimation of national benchmark	When you prepare the national average benchmark amount, you must calculate an aggregated federal reinsurance amount in order to estimate the base beneficiary premium. Two questions on the federal reinsurance aggregate number used to calculate the BBP: 1) Is the federal reinsurance amount normalized to a 1.0 beneficiary before being used to calculate the BBP? 2) If so, what risk factor is used (total plan cost risk scores or plan liability risk scores or something else?)	See above response.
6	Substantiation	5/28/2009	5/20/2009 9:24 AM	Drug Tier mapping to Formulary	Regarding Drug Tier mapping to Formulary: Can you provide either examples or more detailed instruction as to what you are looking for this mapping requirement in the documentation?	The primary purpose of the mapping is to assist bid reviewers in evaluating the development of the effective cost-sharing by type of drug and place acquired (retail/mail). With the exception of the Specialty tier, in general, there is not a one-to-one correspondence between the tiers designated in the plan's formulary and PBP and the BPT. Therefore, this document or spreadsheet must "crosswalk" the formulary/PBP to the BPT: 1. For each formulary tier, show the breakout of total allowed costs, total number of scripts and total cost-sharing amounts by type of drug (generic, preferred brand, non-preferred brand) and retail/mail. 2. Sum the breakout amounts by type of drug and retail/mail. Please recall that when a Specialty tier is designated in the formulary and PBP, the associated costs and scripts are always reported separately in Worksheets 2 and 6 of the BPT and should reported separately in this spreadsheet also.
7	Credibility	5/28/2009	5/22/2009 11:22 PM	Override of Credibility assumption	In the April 16th Actuarial User group call, it states that plans may over-ride the crediblity to 100% when the CMS credibility formula would results in a credibility of 90% or more. On worksheet 2, when I enter the 100% credibility, I get a red circle around the cell showing the CMS credibility (L39). Can you verify that this will not result in a problem when loading the bid?	This will not be an issue when uploading the bid. The BPT technical instructions contain a list of the BPT critical validations that affect finalization and upload. The supporting documentation should cite the use of the CMS safe harbor.
8	Margin	5/28/2009	5/20/2009 7:42 AM	Margin Question	May plans aggregate MA or PD margin across service areas to demonstrate consistency with corporate objectives? For example, Plan 001 in service area A projects a margin of 5% and Plan 002 in service area B projects a margin of -3%. The two average to 2%, which is consistent with the corporate objective. Service areas A & B are separate sets of counties. The company does not offer any other plans. Please comment.	MA gain/loss margins may be determined at the contract level or at a more aggregated level. The same holds for Part D bids. However, as explained in the bid instructions, "the overall margin levels included in the MA and Part D (PD) components of MA-PD bids must be within a reasonable range of each other, not to exceed plus or minus 1.5 percent, with any variation reflecting the different levels of financial risk for the two components." Further, a business plan that demonstrates profitability within a few years is required for bids with negative margins. (If any of the plans are an EGWP or a DE-SNP, then the gain/loss requirements for those plan types must be met.)

Advance Questions from actuarial-bids@cms.hhs.gov for CY2010 OACT User Group Calls

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9	Optional Supplemental Benefits	5/28/2009	5/19/2009 6:12 PM	Optional Supplemental benefits	How would you fill it as Allowed Medical Expenses vs. Enrollee Cost-Share on the Optional Supplemental benefits if the optional supplemental benefits pay for the member cost-sharing required under the PBP. For example, the PBP requires a 20% coinsurance for outpatient hospital and the optional supplemental benefit pays for the 20%. What goes under Allowed Medical Expenses and Enrollee Cost-Share?	It is our understanding of CMS' policy that reductions of Medicare-covered cost sharing are not permissible optional supplemental benefits. The regulatory basis is CFR 422.102(a)(4). For additional information, please contact CPC.
10	DE SNP	5/28/2009	5/22/2009 1:41 PM	Bid Question	We are pricing a Dual Eligible, age 60+ Special Needs Plan that will coordinate with the State to provide a long term care benefit. However, given the current information from the state we do not expect the State capitation amount to fully cover the cost of this additional benefit. How should the shortfall be reflected in the bid pricing tool? Increase Allowed Amounts, Gain Loss etc? If the answer to the above is Gain/Loss then is this a valid reason to vary the Gain/Loss requirement from the company ROE requirement (which is the usual basis that we use to determine our Gain/Loss)? That is, are we justified in adding this amount on top of the actual gain/loss expected for this product? Would the PDP gain loss need to match the amount including the additional benefit or is it o.k. to have the PDP match the actual expected revenue for the plan?	First, the expected revenue and expenditures for non-covered Medicaid benefits (that is not Medicare–covered or mandatory supplemental benefits) are to be reported in MA BPT Worksheet 4, Section V. Also, in limited cases where MA plans are required by a state (statute) to offer non-covered Medicaid benefits at a loss, the BPT margin may take into account total plan revenue and expenses for the MA plan and the additional Medicaid benefit. Thus, in the situation described, the margin filed in the MA BPT may represent both the requirements for the Medicare Advantage -covered bid and an offset to the revenue shortfall of the Medicaid supplemental package. Finally, the PD gain/loss margin would be based on expected plan revenue and expenses and be compared against the MA margin after the Medicaid offset.
11	SAE	5/28/2009	5/27/2009 9:06 AM	Question for Thursday's call	We do not have official CMS approval of our service area expansion. The counties show pending in HPMS. Should we assume approval and include the counties in our bids? If not, how can we confirm approval?	Per CMS policy, initial bids are to be filed with pending counties. Also, service area expansion questions should be directed to CPC.