User Group Call Date 04/14/2016

Introductory note

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

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	EGWP	04/11/2016 12:06	Actuarial User Group Call question	For EGWP plans, could it be clarified how the payments would work for B only members?	The Part B only plans will receive the A/B payment amount multiplied by the Part B percentage of the rate.
2	EGWP	04/08/2016 15:34	EGWP Certification?	Please confirm that EGWPs will no longer require actuarial certification.	That is correct. Since no BPTs will be uploaded, there will be no actuarial certification required.
3	EGWP	04/06/2016 9:13	MSA EGWP 2017 Bids	Our client will provide medical savings account (MSA) employer group waiver plans (EGWPs) for the 2017 bid year. Per the 2017 announcement, released April 4, 2016, CMS will not require MAOs to submit BPTs for EGWPs. Does this change also apply to MSA EGWPs?	Yes, this change also applies to MSA EGWPS. These plans will no longer be submitting BPTS.
4	Gain/Loss Margin	N/A	N/A	[PARAPHRASED] It appears that the margin rules have changed by citing requirements for exceptions. What margin rules should I follow if I have MA BPTs with negative margins which cause my aggregate margin for CY2017 to be less than 1.5% of my corporate margin requirement based on non-Medicare business?	CMS has separate bid-level and aggregate-level margin requirements. The bid-level requirement requires a business plan showing that a plan with negative margin becomes profitable within 5 years. The aggregate-level margin requirement requires the organization's aggregate MA margin to be within 1.5% of non-Medicare margin. These requirements are not changing. What is changing is that CMS is adding a formal process for exceptions to be requested for each of these requirements. In the past, plan sponsors presumed that if they submitted a business plan for negative margin they were automatically granted an exception for meeting the aggregate-level margin requirement. CMS expects to grant an exception to the aggregate-level margin requirement in situations where an organization has plans with negative margin (as long as the business plan shows reasonable progression towards meeting the aggregate-level margin requirement). However, the process will be more formal, where the plan sponsor will specifically request an exception to the aggregate-level margin requirement, explain and document the reason for the exception, and then CMS will formally approve the exception or have further discussion with the plan sponsor.
5	Gain/Loss Margin	N/A	N/A	The wording regarding the year over year consistency in gain/loss margins changed slightly from 2016 to 2017 BETA instructions. The wording changes are subtle and it is unclear whether this language constitutes a change and what the intent of the change is. Please clarify what CMS is expecting health plans to do differently in 2017.	CMS is clarifying that the actual aggregate MA or Part D margin must be consistent with the aggregate MA or Part D margin used in pricing. In addition, the actual corporate margin must be consistent with the corporate margin used for the MA or Part D pricing. In other words, this means that actual aggregate benefit expenses plus non-benefit expenses must be consistent with the projections used for pricing over the long term. We have removed the requirement that the aggregate projected MA or Part D margins must be consistent from year to year. For example, the aggregate projected margin for CY2017 is not required to be consistent with the aggregate projected margin for CY2016.
6	Mergers	02/25/2016 15:46	Question for 2017 bids	[PARAPHRASED] We have a question regarding the impact of the planned merger of two Medicare Advantage organizations on bid preparation. The merger is not complete yet, but is likely to be completed during the first half of CY 2016. We are requesting CMS' guidance regarding the point in time (relative to the completion of the merger) at which the two companies should be considered a single parent organization for the purposes of bid preparation.	IF A MERGER IS FINALIZED: - After the June bid submission deadline, CMS would accept bids where the merger is not reflected. Each organization may bid independently. - **After the first Monday in April** through the June bid submission deadline, then the merged entity should document whether or not it can reasonably and appropriately submit bids on a merged basis, and then submit bids accordingly on a merged or unmerged basis. - Prior to the dates listed above, then CMS expects that the bids will be submitted for the single, merged entity for the purposes of meeting the bid instructions. Please note that for related party purposes, plans must still disclose all anticipated related party arrangements for CY2017 even if data/timing limitations prevent them from being able to price bids reflecting the related party arrangements resulting from the merger.

User Group Call Date 04/14/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Rebate Reallocation	N/A	N/A	A reference to CY2010 Call Letter language that mandated a specific priority for benefit cuts during rebate reallocation was deleted from the CY 2017 MA BPT Instructions-Appendix E. What guidance are plans expected to follow for CY 2017 with regard to this situation?	In past years, CMS directed MA organizations to follow guidance from the CY 2010 Call Letter when the Part D basic premium (net of rebate) was greater than the target Part D basic premium and MA-PD plans were allowed to reallocate Part C rebate dollars in order to return to the target Part D basic premium. [This guidance also applied when there was a reduction in the total regional PPO premium (net of rebates).] When engaged in rebate reallocation for CY2017, MA organizations have the flexibility to reallocate Part C rebate dollars toward payment for a variety of benefits, as described under 42 CFR §422.266(b) Form of rebate.
8	Cost Sharing	04/11/2016 14:59	Medicare FFS Cost Sharing Question	The CY2017 MA BPT instructions clarified when plans can use the actuarial equivalent cost sharing factors on Worksheet 4 to price plan cost sharing (pg 17-18). In the PBP for Emergency Room (4a) and Urgent Care (4b) , there is not an option to enter Medicare FFS and the copay maximums for these categories are $75 for Emergency Room and $65 for Urgent Care. 1) If an HMO plan files a $75 copay for Emergency Room, a $65 copay for Urgent Care and Medicare FFS cost sharing for the remaining Part B benefits, would the plan be allowed to use the FFS actuarial equivalent factors for Part B benefits? 2) Similarly, if a PPO plan files a $75 copay for Emergency Room, a $65 copay for Urgent Care and Medicare FFS cost sharing for the remaining benefits, would the plan be allowed to use the FFS actuarial equivalent factors? 3) If the cost sharing in the PBP is the Medicare-Defined cost share amount for inpatient (IP) Acute services, but not for IP Psych services, may the certifying actuary use the FFS actuarial equivalent cost-sharing on Worksheet 4 to price IP Acute services and reflect the actual cost sharing for IP Psych services. Or does CMS require the cost sharing pricing methodology in the bid to be the same for both IP Acute and Psych at the PBP level?	1) Although the PBP does not ask if the cost sharing for Emergency Room (4a) and Urgent Care (4b) is designed to match Medicare FFS cost sharing per se, for CY2017 the user may enter a copayment or coinsurance with a maximum dollar amount. CMS will consider 20% coinsurance and dollar limits of $75 and $65 for Emergency Room and Urgent Care, respectively, as matching Medicare FFS cost sharing. If the PBP contains such cost sharing for Emergency Room and Urgent Care, Medicare FFS cost sharing for the remaining Part B services, and the Medicare-defined deductible specified in the "cost sharing" pricing consideration (p 17), then an HMO may use the FFS actuarial equivalent factors on Worksheet 4 of the MA BPT to price all Part B services. 2) For PPOs, the only Medicare FFS pricing option applies to all Part A and all Part B services. Therefore, an MAO may use the use the FFS actuarial equivalent factors for pricing Part B services only if: the cost sharing in the PBP for all Part A and all Part B services matches FFS Medicare cost sharing; and the deductible is the Medicare-defined Part A and Part B combined deductible specified in the "cost sharing" pricing consideration. 3) The certifying actuary may use the FFS actuarial equivalent cost-sharing on Worksheet 4 for pricing IP Facility services, only if the cost sharing at the PBP level is the Medicare-Defined cost share for all inpatient facility services, that is, both IP Acute and IP Psych services.
9	Supporting Documentation	04/11/2016 15:07	Supporting Documentation - Product Narrative	One of the items to be included in the product narrative supporting documentation is type of coverage. Please clarify what CMS expects MAOs to include for type of coverage. Does type of coverage refer to Plan Type (e.g., HMO, LPPO)?	The description of the type of coverage in the product narrative is intended to be broader than BPT plan type and could include Part B only, MA only and MA-PD in addition to plan type.
10	Technical	N/A	MA and Part D BPT Text Boxes	There are several text boxes in the MA and Part D BPTs that must be populated to describe required topics in BPT substantiation. This includes MA and Part D Base Period Experience Data (MA WS1, Section II, Line 6; PD WS1, Section II, Line 6) and Manual Rates (MA WS2, Line u; PD WS2, Section VII); MA Additive Adjustments to Projection Factors (MA WS 1, Section V); and MA maximum out-of-pocket (MOOP) methodology (MA WS3, Section II, Line 4). We believe that substantiation is a more effective method for describing these topics since substantiation is much less constrained in how much can be written and it can include tables or charts as needed. Are MA Organizations permitted to populate the BPT text boxes with words such as, "Please refer to page xx of substantiation file zzzz.docx"?	Yes, it is acceptable for BPT text boxes to include a specific reference to the corresponding documentation for the bid. However, for the MOOP methodology on MA worksheet 3, CMS prefers the text box to contain the description of how a zero impact of the MOOP was determined, if applicable.

User Group Call Date 04/21/2016

Introductory note

1) Bid-to-Benchmark Ratios for EGWPs Separated by Individual and Group

Quartile	Ratio	INDIVIDUAL	GROUP
0.950	88.7%	83.1%	94.3%
1.000	92.2%	87.4%	96.9%
1.075	93.3%	89.2%	97.3%
1.150	93.6%	89.7%	97.5%

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Star Ratings	04/12/2016 21:36	Effective date of CAI analytical adjustment for star ratings	Will the Categorical Adjustment Index for star ratings impact the star ratings used for the 2017 bids? Or is the impact first seen in the star ratings used in the 2018 bids?	The adjustment will be part of the 2017 Star Ratings which would impact 2018 bids.
2	Star Ratings	04/19/2016 13:02	QBP Star Ratings	Have the QBP Star Ratings used for CY2017 payment been posted in HPMS? If so, can you tell me where they are located?	The QBP Ratings can be found on HPMS using the following path: Quality and Performance > Performance Metrics > Costs > MA QBP Rating > 2017
3	EGWP	04/11/2016 12:26	OACT User Group Call Questions	In regards to the 2017 MA Ratebook on the tab called "Local EGWP Rate 2017", with the data in cells A2:B6, we have the following questions: 1) The bid to benchmark quartiles are blended group and individual. Could CMS provide the group and individual splits separately? 2) Are quartiles ultimate when calculating the bid to benchmark ratios?	1) Please see the introductory note for this week's UGC Q&A posting. 2) The bid-to-benchmark calculations are based on the 2016 bids and 2016 quartiles and then applied to 2017 quartiles. The bid-to-benchmark calculations are based on the unblended quartiles.
4	EGWP	04/11/2016 15:12	Employer Group	Please provide a numeric example of the calculation of the RPPO employer group benchmark rate.	The RPPO Employer group rate will be calculated as shown below. Note that we cannot compute a concrete example since the bid component of the 2017 Regional Rate is not available at this time. **RPPO EGWP Payment Formula:** (Base County Payment Rate + Regional Rebate) x beneficiary level risk score. a) Base County Payment Rate = 2016 Bid to Benchmark Ratio x 2017 MA Monthly Capitation Rate b) Regional Rebate = (1 - 2016 Bid to Benchmark Ratio) x 2017 Regional Rate x Rebate percentage c) The 2017 Regional rate is based on a blend of the statutory and bid component. d) If there is no bid component of the 2017 Regional rate (i.e. no individual bids in a region), then the rate will be based solely on the statutory component.
5	Gain/Loss Margin	04/18/2016 15:16	Questions regarding product pairing	[PARAPHRASED] 1) Are product pairings against two or more plans that meet the product pairing requirements still allowed? For example, could a negative margin plan H9999-001-000 be mapped to positive margin plans H9999-002-000 and H9999-003-000, provided all plans meet the requirements? 2) On page 27 of the 2017 MA BPT instructions, one of the requirements is that all plans in the product pairing "All be local coordinated care plans or all be regional PPOs or all be PFFS plans" Would a mix of HMO and HMO-POS plans fulfill this requirement under "local coordinated care plans?"	1) Yes, it is acceptable to have a product pairing with more than two plans as long as the plans meet the requirements for a valid product pairing as outlined in the bid instructions. 2) Yes, a mix of HMO and HMO-POS plans is acceptable since they are both local coordinated care plans. Please see page 50 of the MA bid instructions for a summary chart of plan types that fall under the Local Coordinated Care Plan category.

User Group Call Date 04/21/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	Credibility	04/13/2016 13:30	bid question on credibility of plan segments	Let's say we have a plan serving counties A and B in 2016. We intend to divide it into 2 segments in 2017 (Same PBP number, but 2 different segment IDs). In the base year, together they were fully credible, but if segmented, none of them would be fully credible. How do we calculate the credibility of each segment? Based on the base year enrollment in each county? In MA BPT WS1, I assume we still need to report both counties together as whole. Then what about cell L39 in WS2, the "CMS Guideline Credibility" cell, will this be 100%?	CMS' response to this question is based on the assumption that the proportion of members crosswalked into each segment is greater than the MA level of significance determined by the certifying actuary. Therefore, base period experience for the non-segmented plan must be reported in total on both the county A and county B BPT (crosswalk rules #2 and #3). The preferred approach for entering projection factors and assigning credibility is to report both counties as whole in the base period, then use the projection assumptions to adjust all of the experience relative to the characteristics of the segment being priced. Under this approach, the credibility is calculated using the base period membership of both counties as whole. For example, if you are pricing for county A, then you would use the experience of both counties in Worksheet 1. All of the experience would be adjusted and projected relative to county A's characteristics (risk, geographic, provider network, etc.) through the projection assumptions. Finally, the credibility would be calculated using the base period membership of both counties. As a more general answer, the credibility that the actuary enters into the BPT should be based on the exposure applicable to the base period data (MA BPT Worksheet 1, Cell I13), plus any change in exposure from using projection assumptions. Changes in exposure will only occur in certain circumstances. For example, a change in exposure occurs when using the population change factor to remove the base period experience for certain membership in order for the projected experience rate calculated in Worksheet 2 to be based on actual experience of base period membership continuing in the bid for the contract year. Please note that the preferred approach above does not have the effect of removing or adding experience; and therefore, does not include a change in exposure from using projection assumptions.
7	Part D	04/12/2016 12:04	Segmentation and MA PD plans	[PARAPHRASED] Please confirm that the Part D portion of a segmented bid must be uniform across all segments and use claims experience that is consolidated across all segments.	Per CFR § 423.265, Part D benefits are not permitted to vary by segment. The Part D bid pricing tool for a segmented plan must be completed using the consolidated experience for the entire PBP and be uniform across segments, with the exception of the information in Worksheet 1, Section I.
8	Risk Score	04/15/2016 18:55	2017 Risk Scores for Beneficiaries in Medicare FFS in 2016	We have several questions regarding 2017 risk scores and the RAPS/EDS blending: 1) Page 61 of the 2017 Rate Announcement states that "We will sum 75% of the RAPS/FFS-based risk score with 25% of the encounter data/FFS-based risk score." a) For beneficiaries in Medicare FFS for at least part of the diagnosis collection year (i.e. 2016 for 2017 payment), will CMS use a single set of diagnosis filtering logic to calculate both portions of the "FFS-based risk score" or different logic for each component? b) If a single set, will the single set of filtering logic be consistent with the filtering logic used in prior years (i.e. payment years 2015)? c) If not a single set, can you share and publish both sets of filtering logic so MA plans can review the differences between the two sets of filtering logic, e.g. is the filtering logic for the 75% FFS-based risk score consistent with the filtering logic used for 2015 and 2016 payment years and is the filtering logic for 25% FFS-based risk score consistent with the filtering logic used under EDS? 2) For beneficiaries in Medicare FFS in the base year (2016) is the diagnosis filtering logic for 2017 Part D risk scores for MAPD plans consistent with how the filtering methodology will be applied for Part C? If not, please explain the differences. 3) For beneficiaries in Medicare FFS in the base year (2016) is the diagnosis filtering logic for 2017 Part D risk scores for PDP plans consistent with how the filtering methodology will be applied for Part C? If not, please explain the differences. 4) Will the initial 2017 risk scores for January 2017 payments (based on lagged diagnosis data) reflect the 75%/25% blending? If not, at what point will the blending be applied in the actual risk scores used for 2017 payment.	1-3) CMS is not changing how we filter FFS claims, and continue to produce a single set of FFS diagnoses that we use when calculating all risk scores. This is the same filtering method that plans are to use for submitting RAPS diagnoses. This filtering method uses specialty codes to identify risk adjustment eligible diagnoses on professional claims and has been used in prior years. CMS uses any FFS diagnoses for a beneficiary, along with any MA-submitted diagnoses for that beneficiary, to calculate beneficiary-level risk scores. These risk scores include Part C, Part D, and ESRD risk scores used to pay all plans (MA, MAPD, PDP). 4) The initial 2017 risk scores (used starting with January 2017 payments) will not reflect the 75% RAPS/FFS and 25% EDS/FFS blend. The blend will be applied at the 2017 Mid-Year Payment Run.

User Group Call Date 04/21/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Risk Score	04/18/2016 13:36	Question about "Risk_Scores 2010-2014 Non-PACE.csv"	What method of risk score data filtering and processing do the risk scores published in the "Risk_Scores 2010-2014 Non-PACE.csv" file reflect? In particular, do the risk scores reflect: 1) A weighted average with: - a. 75% weight on risk scores developed by using FFS data subject to a filtering process which implements logic consistent with RAPS filtering rules and then processing through the 2017 risk score model and - b. 25% weight on risk scores developed by filtering FFS data through the EDS filters and then processing through the 2017 risk score model. This blended approach would be similar to how MA risk scores will be calculated in 2017. 2) Risk scores built using the 2017 risk score model based on FFS data subject to a filtering process which implements logic consistent with RAPS filtering rules and supplemented with FFS data filtered through EDS filters. This approach would be consistent with 2015 payment year risk score calculation. 3) Risk scores built using the 2017 risk score model based on FFS data subject to a filtering process which implements logic consistent with RAPS filtering rules only, or 4) Another approach (if so, please explain)	1) The risk scores in the rate-book file are for FFS beneficiaries, using only FFS diagnoses. There are no MA diagnoses associated with these scores, and as a result the blend does not apply here. 2-4) The FFS risk scores are calculated using diagnoses that were identified using filtering logic that is consistent with RAPS filtering rules.

User Group Call Date 04/28/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	EGWP	04/25/2016 10:53	Actuarial User Group Call question	As part of the new EGWP payment methodology, CMS will be setting 2018 EGWP payments based on bid to benchmark ratios resulting from 2017 bids. When does CMS plan to publish these 2017 bid to benchmark results?	CMS expects to publish the updated bid to benchmark ratios coinciding with the release of the 2018 Advance Notice.
2	FFS Trends	04/23/2016 8:27	trend questions	1) We are reviewing the FFS unit cost trends posted on the website. Last year, you OACT indicated that the posted IP trend did not reflect the DSH/UCP changes. Can you please indicate if the trends posted this year for IP similarly do not include the DSH/UCP changes? 2) The FFS growth rate was listed for 2017 as 3.12%. What was the impact of demographic change (baby boomers) on that estimate?	1) That is correct, changes in DSH/UCP payments are not reflected in the Inpatient unit cost increases. 2) As reflected in the recently published narrative, **Key Components of USPCC Trends: 2012-2017**, the five-year impact of changing demographics on FFS trends is −2.2 percent for Part A and −0.6 percent for Part B. The one year impact, '17 / '16, is -0.2 percent for Part A and -0.0 percent for Part B.
3	Gain/Loss Margin	04/19/2016 18:15	Gain Loss question	In Q4 from the User Group notes from 04/14/2016, the CMS response states: "However, the process will be more formal, where the plan sponsor will specifically request an exception to the aggregate-level margin requirement, explain and document the reason for the exception, and then CMS will formally approve the exception or have further discussion with the plan sponsor." Can you please provide an explanation or time line for the process for requesting an exception. Is it only included in the bid or is work or approval obtained before the bids are submitted?	If the plan sponsor cannot meet one of the margin requirements and has an extenuating circumstance which causes this situation, it may request an exception for the current contract year. During bid review, CMS will approve requests for one year at a time. The exception request must be included in the supporting documentation at the time of bid submission. The supporting documentation requirements for margin exceptions are listed in Appendix B of the bid pricing tool instructions, items 8.3, 8.5, and 8.7. CMS does not approve margin exceptions prior to the bid submission deadline but is open to discussions with plan sponsors about potential issues.
4	Non-Benefit Expenses	04/21/2016 10:43	Allocation of PBM admin between Parts C and D	A health plan's PBM administers both Part B and D drug claims for multiple PBPs; however, it's admin expenses are not always charged in a manner than facilitates ready allocation between Parts C and D and between plans. Would CMS consider it reasonable to aggregate the PBM's fees and then allocate the expenses by PBP and Parts C vs. D based on script counts?	Non-benefit expenses must be allocated between the MA and Part D bids using the plan's best estimate of how the costs relate to each component and how they are incurred. If, for example, a PBM charges a per claim admin fee, then using prescription counts to determine the allocation between the MA and Part D bids is a reasonable method. Non-benefit expenses must also be bid specific, so any allocation of aggregate expenses by bid must consider differences in the particular bid and its costs.
5	Part D	04/19/2016 18:04	Part D BPT Instructions - Induced Utilization	We are seeking clarification on Worksheet 2, Section II – Utilization for Covered Part D Drugs of the PD BPT Instructions. Column k – Induced Utilization states the following: Column k – Induced Utilization Enter the factor that adjusts for the utilization difference between the base period type of benefit plan (DS, AE, BA or EA) and a DS plan by type of script for each line. Will CMS please clarify if the reference to "DS plan" refers to the base period DS plan or the contract period DS plan?	The reference to "DS plan" refers to the contract period Defined Standard plan design. The "Blended Allowed PMPM" on Worksheet 2, Section III, line 14, column p must correspond to the projected allowed amount under the contract period defined standard plan on Worksheet 3, Section III, line 6, column h.

User Group Call Date 05/05/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	TBC	05/02/2016 15:22	Segmentation questions	If 2017 is the first year of segments for a plan, will the TBC requirements be conducted as a comparison of the total plan's benefits in 2016 versus the segment-specific benefits in 2017?	TBC for each CY 2017 segmented plan will be compared independently to the CY 2016 non-segmented plan.
2	EGWP	05/02/2016 11:45	Question regarding calculating EGWP county level benchmark	Our understanding is that the 2017 EGWP benchmark rates reflect a 50/50 blend between the individual MA benchmarks and the proposed EGWP benchmark methodology. Therefore, we believe that the correct calculation is to blend 50/50 the county benchmarks from the CountyRate2017 tab and the Local EGWP Rate 2017 tab of the 2017 MA Rate Book file. We are looking for confirmation that this is the correct methodology to use for 2017.	The description outlined in the question is not the correct EGWP benchmark methodology. The CY2017 payment rates for non-RPPO EGWPs are in the Local EGWP Rate 2017 tab in the 2017 MA Rate Book file. These rates reflect the 50/50 blend of Individual and EGWP bid-to-benchmark ratios and no further calculations are needed.
3	DE#	04/29/2016 14:26	Question on DE# Provider Payments after Rebate Reallocation	We have a question about the effect of rebate reallocation on the DE# Worksheet 4 values: Page 23 of the 2017 MA Bid Instructions states that the DE# plan reimbursement on Worksheet 4 should not change on bid re-submission except for a change of benefits not covered by Medicare or in the case that DE# members are required to pay a portion of a changed cost sharing amount. Our question is whether changes to projected Global Capitation and Risk Sharing payments resulting from benefit changes are an exception to this requirement. For example, suppose a plan has a portion of its membership covered by a percent of premium global capitation arrangement and chooses to eliminate a supplemental dental benefit during rebate re-allocation. The change in the plan's overall revenue due to the benefit change would also cause a change in the expected capitation payment. Because the bid instructions require the global capitation payment to be allocated to all service categories covered under the agreement, provider payments for Medicare covered services, including those for DE# members, would be required to change as well. We would like CMS to verify that this change to DE# plan cost would be permitted.	When the payment made for a global capitation is reduced, a change to DE# plan cost would be permitted.
4	Gain/Loss Margin	05/02/2016 15:22	Segmentation questions	1) Can all segments within a plan ID be combined to apply the gain/loss margin rules? 2a). For purposes of determining if a business plan must be submitted: If one segment has a negative margin and other segments have positive margins, and in aggregate, the total plan ID has a positive margin, must the health plan submit a business plan for the segment with a negative margin? 2b) The question focuses on the allowances for product pairings and in particular, the service area differences. Segments within a plan ID have mutually exclusive service areas, but can segments within a plan ID be combined for purposes of product pairings? 3) A health plan would like to increase the premium within one segment to be in line with competitor premiums for that area. This would create quite different margins between segments, but would allow the overall margin of the plan to be within margin thresholds set forth by CMS. Is this allowed?	1) No, the gain/loss margins for bids in segmented plans may not be aggregated to satisfy gain/loss margin requirements. Gain loss margin requirements do not vary for bids in segmented plans as compared to bids in non-segmented plans. 2a) Yes, a business plan for the segment with a negative margin must be submitted. The bid instructions defines the term "bid" as "the Medicare Advantage (MA) Bid Pricing Tool (BPT) and/or the MA Plan Benefit Package (PBP) required for a contract number-plan ID-segment ID. Therefore, the bid instructions do not vary for bids in segmented plans as compared to bids in non-segmented plans and the aggregate margin for all segments in a plan ID is not a factor in determining compliance with any of the gain/loss margin requirements. 2b) No, segments of a plan ID, having mutually exclusive service areas, may not be combined in a product pairing. 3) Although premiums and margin may vary by segment, the overall margin of a segmented plan ID is not a factor in determining compliance with gain/loss margin requirements. The margin for each segment must satisfy each bid-level gain/loss margin requirement.
5	ESRD-SNP	04/29/2016 14:26	ESRD-SNP BPT WK1	Can you clarify how to complete WK1: Enrollment and PMPM Revenue Projection on the ESRD BPT? Since County Name only appears when the ESRD Status is "F" (Func Graft), do you expect Status "D" and "T" to be combined for the plan despite each row starting with a single State/County Code? (i.e. If we have multiple counties within a plan, should we pick a single State/County Code for column (a) but list the combined enrollment information in the subsequent columns for those with "D" (Dialysis) or "T" (Transplant) ESRD Status?)	ESRD statuses "D" and "T" should not be combined into a single row. Use one county code to enter statewide Dialysis member months and risk scores, and use one county code in another row to enter statewide Transplant member months and risk scores. Please see the technical notes on page 147 of the MA bid instructions for more information.
6	Part D	04/21/2016 1:41	Target premium for segments	Instructions are clear that segmented plans can have differing member premiums. In Worksheet 6 of the MA bid, where the plan intention for target PD basic premium is listed as a drop-down option, can segments differ in terms of what they enter? As in, could one segment select "LOW INCOME PREMIUM SUBSIDY AMOUNT," and another segment select "TARGET PREMIUM DISPLAYED IN LINE 7D?"	It is permissible to vary the plan intention for the Part D basic premium by segment. However, if there are two segments in the same Part D region, our expectation is that a plan sponsor is applying a consistent LIPSA estimate across these segments when completing MA Worksheet 6 Section III C.

User Group Call Date 05/05/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Part D	05/02/2016 14:19	Hep C Drug Impacts	Appendix B of the Part D bid instructions does not mention a requirement to show an explicit supporting documentation exhibit that summarizes actual 2015 PMPM and projected 2017 PMPM for Hepatitis C costs in the bids. Last year, per direction from the 4/23/2015 call, OACT had requested this exhibit in addition to the requirements in Appendix B. As the Hepatitis C drug experience should be fully incorporated into the base period given the release dates of many of the medications, is OACT still requiring this item for the substantiation package?	For each Part D bid (contract number and plan ID) submitted for CY2017, Plan sponsors must report the actual CY2015 Hepatitis C allowed amount PMPM and the projected CY2017 Hepatitis C allowed amount PMPM. These PMPM amounts must be clearly labeled in the supporting documentation that is uploaded with the initial bid submission; the location of these amounts must be referenced in the Supporting Documentation Cover Sheet. An explanation of the development of these amounts may be requested during bid desk review and/or bid audit.
8	Risk Score	04/25/2016 10:25	Beneficiary level risk scores	Can you please confirm how the encounter and RAPS data were used to calculate the beneficiary level risk scores, it seems like it may have been the union of the RAPS and encounter data was used as the source to calculate the risk scores rather than a 75%/25% blend, is this correct? If this is the case why was this done as the 2017 payment risk scores will not be based on this methodology? We are seeing the beneficiary level risk scores are significantly higher than our 2015 MMR risk scores (adjusted for the final payment) and think this is the reason.	The Payment Year 2015 risk scores that we provided in the beneficiary-level files were calculated using the PY2015 methodology: using encounter data as a supplement to RAPS and FFS data, and using two risk models to create blended scores (we provided scores using both the 2013 model and the 2014 model). For comparison sake, we also ran the PY2015 risk scores using the 2017 CMS-HCC model.
9	Risk Score	04/21/2016 12:11	2016 RAPS/EDS Blend	On the User Group call two weeks ago, it was noted that the 2017 blend of RAPS and EDS risk score would not be seen during the Initial time period, but would be enacted for the 2017 mid-year adjustment. Is this also true of 2016?	This is correct -- for PY 2017, CMS will apply the applicable blend in the mid-year risk scores. We will sum 75% of the RAPS/FFS-based risk score with 25% of the encounter data/FFS-based risk score. For PY 2016, the blend of RAPS/FFS-based and encounter data/FFS-based risk scores will be applied in the final risk score. The initial and MY PY2016 risk scores will include only RAPS and FFS diagnoses. Specifically, for the final PY 2016 payment run, CMS will calculate a risk score using diagnoses submitted to RAPS and FFS diagnoses, and another risk score using diagnoses filtered from encounter data and FFS diagnoses. We will sum 90% of the RAPS/FFS-based risk score with 10% of the encounter data/FFS-based risk score. For more information about payment runs and risk adjustment deadlines, please reference the HPMS memo entitled 'Deadline for Submitting Risk Adjustment Data for Use in Risk Score Calculation Runs for Payment Years 2016, 2017, and 2018 HPMS memo.
10	Risk Score	04/25/2016 17:31	Beneficiary File question	Page 2 Item #3 of the Part C beneficiary file layout states has two statements that we are trying to reconcile: 1) "The 2015 risk scores provided are calculated consistent with the risk score calculations" 2) "CMS used diagnoses from the Encounter Data Processing System (EDPS) as an additional source of data in addition to diagnoses submitted to the Risk Adjustment Processing system (RAPS) and from FFS claims" Based on statement #2, it is our understanding that diagnoses submitted under both RAPS and EDPS are included in the calculation of the 2013, 2014, and 2017 model scores provided. In other words, rather than ignoring EDPS-submitted data for determining the actual 2015 risk score (as one would expect from statement #1) or weighting the separate risk scores produced based on diagnoses from each data source for 2017, the beneficiary file includes all diagnoses and develops a single risk score. Can you confirm this? If that is correct, there seem to be a few issues: 1) Statement #1 seems inconsistent with statement #2 since diagnoses submitted through EDPS will not be included for 2015 risk scores. Hence, using the beneficiary file for reporting of revenue and risk scores for CY2015 would not produce a score consistent with how CMS will ultimately reimburse the plan. 2) We are concerned this could lead to overstating 2017 risk scores since diagnoses submitted through EDPS and RAPS are not always the same. Calculating separate risk scores and weighting them together produces a materially different result than including all diagnoses regardless of submission source, so we believe adjustments are needed to scores before they can be used for projection.	1) As stated in the Announcement for PY 2015, when calculating base year 2015 risk scores for payment, CMS used risk adjustment eligible diagnoses from encounter data, FFS claims, and RAPS. All diagnoses were used in equal measure to calculate risk scores, one source was not weighted differently than the other. 2) As we mentioned during the actuarial user group call today, we are considering what additional information to provide, in time for bid submission, to allow plans to better evaluate the impact of encounter data on their risk scores

User Group Call Date 05/12/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	TBC	05/10/2016 10:15	TBC Change Scenario for Contract Novations	We have a H contract that will have a decrease in STAR rating for 2017 bids over 2016, and these bids are currently labeled with plan situation 2 in the total_beneficiary_costs file from HPMS. However, we have been approved to novate bids from that H contract to another H contract, resulting in an *increase* in STAR rating for those bids in 2017. Do we need to adjust the situation in the TBC file from 2 to either 4 or 1 for these bids?	As has been stated in TBC guidance, for consolidating multiple non-segmented plans into one plan, TBC for each CY2016 plan will be compared independently to the CY2017 plan. In this calculation, the payment adjustment and model adjustment will be those of the plan being crosswalked. The same methodology applies to bids undergoing a novation. The payment adjustment and plan situation will remain unchanged even though a crosswalk or novation may occur.
2	Optional Supplemental	04/27/2016 12:54	Negative Margin on Optional Supplemental Benefit	We note that page 35 of the 2017 MA BPT instructions list the following requirements for optional supplemental benefits: • The enrollment-weighted contract-level projected gain/loss margin, as measured by a percent of premium, cannot exceed 15%. • The sum of the enrollment-weighted contract-level projected gain/loss margin and non-benefit expenses, as measured by a percent of premium, cannot exceed 30% of revenue. Are there any restrictions on a minimum gain/loss margin for an optional supplemental benefit, if the plan wishes to price the premium below the actual net medical cost? To clarify, the plan would project actual allowed medical expense, enrollee cost sharing, and non-benefit expense for the optional supplemental benefit as required in the BPT instructions, with a negative projected gain/loss to reduce the premium below the net medical cost. We do not see any restrictions in the guidance that would prohibit the plan from pricing an optional supplemental benefit with negative gain/loss margin, but would appreciate confirmation that this is allowed.	A plan sponsor may price an optional supplemental benefit package with a negative gain/loss margin, as long as, a positive premium is maintained and anti-competitive practices are not used.
3	Rebate Reallocation	05/09/2016 15:55	Rebate Reallocation Question – Part B Premium Reduction	The MA BPT Instructions on page 129 state that, "during rebate reallocation, rebate dollars allocated for this purpose [Part B Premium reduction] may be increased or decreased." Can CMS confirm that a plan may reduce rebates allocated to Part B premium reduction in conjunction with adding new supplemental benefits to return to the target Part D premium?	The MAO may not both reduce rebates allocated to buy down Part B premium and increase benefits as CMS expects only marginal adjustments to reallocate rebates. The value of the added benefit is required to match the amount of rebate that must be shifted. For example, the MAO may not reduce the Part B premium allocation by $2 and re-allocate $5 rebates to enhanced A/B supplemental benefits. See the section in Appendix E of the MA bid instructions for "Changes Allowed to Funding of the A/B Mandatory Supplemental Benefits" (pages 128-129) and Example 5a (pages 124-125).
4	Rebate Reallocation	N/A	N/A	I am looking for guidance regarding the benefits that can be adjusted depending on the results of the Part D National Average Bid Amount for 2017. We know that MAPD plans can make updates to mandatory supplemental benefits; are plans able to make updates to or no longer offer optional supplemental benefits during when the NABA is released?	CMS does not expect, and will not allow, MA organizations to substantially redesign Part C supplemental benefits during the rebate reallocation period. Accordingly, any elimination of mandatory supplemental benefits must be consistent with this principle. If an organization adds or removes a mandatory supplemental benefit during the rebate reallocation period, and the change is consistent with the rebate reallocation guidance, then they will be permitted to eliminate or offer that exact benefit as an optional supplemental benefit.

User Group Call Date 05/12/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
5	Risk Score	N/A	N/A	On the Actuarial User Group call CMS said they will not publish separate risk scores using RAPS and encounter data. We would like CMS to provide the 2015 risk scores calculated with the data that will be used in 2017, with separate scores using RAPS-only and an EDS-only. We have had data issues on the reconciliation of MAO-004 file to our encounters and we'd at least like to see the risk scores. Is CMS going to address these issues?	Last week, we announced that, in response to questions about the MAO-004 reports and requests for risk scores based on encounter data and FFS only, CMS would work to develop additional resources to assist plans in projecting 2017 risk scores for their bids. After careful consideration, CMS has decided not to calculate separate encounter data- and RAPS-based 2015 risk scores. While we appreciate plans' requests for additional information, we do not think 2015 encounter data-based risk scores would represent what encounter data-based risk scores will look like in the future. The completeness of plans' encounter data submissions are generally improving each year and the 2016 encounter data (used in the 2017 risk scores) are likely to be more complete than encounter data reported for 2014 (used in the 2015 risk scores). Given the additional time that would be needed for CMS to re-run risk scores to provide separate encounter data and RAPS-based risk scores, we do not think that risk scores that we would provide would be either timely or convey helpful information prior to the bid submission deadline. CMS expect plans to use the data on their MAO-004 reports, in combination with their own application of the filtering logic to the encounters that they have submitted to CMS and their projections of the completeness of their encounter data, to project their 2017 risk scores. CMS has researched plan inquiries regarding the encounter data diagnosis information reported as risk adjustment eligible on the MAO-004 reports. CMS has determined that, in some circumstances, diagnoses on encounter records reported as accepted on the MAO-002 report are not able to be identified for risk adjustment on the MAO-004 report. To assist plans in evaluating the information provided on the MAO-004 reports and to make adjustments, as necessary, to project risk scores for 2017, we provide the following information: 1) Currently, the MAO-004 report does not distinguish between an original encounter, a replacement, or a void. Further, it does not indicate when diagnoses are coming from a chart review – either to add or delete diagnoses. We are developing an updated layout of the MAO-004 report that will specify what type of record the diagnoses are coming from, which will allow plans to see when we have received a record that alters previously submitted diagnoses, either by adding or deleting the diagnoses from a prior record. This is a reporting issue only; the data as submitted will be incorporated into the risk scores appropriately. 2) There are a few issues that lead to the exclusion of diagnosis that should have been identified as risk adjustment eligible. a. Certain diagnoses in the header – for example, Admitting and Patient reason for visit diagnosis codes – are excluded. b. Due to a sort issue associated with allowable HCPCS list, in some cases HCPCS in the 99000 series are excluded. c. When a linked chart review record was submitted, the MAO-004 includes diagnoses from the chart review, but not the encounter record. This affects both adds and deletes – the chart review was read as adding diagnoses and the encounter itself was not recognized. CMS is currently working to address and resolve the considerations noted above, after which we will send out updated MAO-004 reports. We are targeting early fall for release of updated MAO-004 reports.

User Group Call Date 05/19/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Related Party	05/02/2016 19:32	Related Party	[Paraphrased] Our plan has global capitation arrangements that cover medical services as well as administrative services (for network development and claims adjudication) in the same contract. The cost for each piece is not specified in the contract. We have these contracts with physician groups. Some physician groups are related parties and some are not related parties. The contracts are identical for related and unrelated parties. For the unrelated parties, we have no way of knowing the portion of the cost to cover medical services and the portion to cover the administrative services. How should these arrangements be reported on the BPT and can these contracts be compared to meet the related party guidance?	For reporting on the CY2017 BPTs, for unrelated parties, the full capitation amount is reported as a medical expense, unless the contract specifies which portion is for medical services and which is for administrative services. To meet the objectives of the related party requirements, we require separate handling of related party arrangements for administrative services and for medical services. Under the related party requirements, medical services are reported as medical expense and administrative services are reported as non-benefit expense in the BPT. Under the market comparison approach for related party, the arrangement with the related party for medical services would be separately compared to an arrangement with an unrelated party for similar medical services and the arrangement with the related party for administrative services would be separately compared to an arrangement with an unrelated party for similar administrative services. Items that would be considered provider group administrative expenses (e.g., the cost of the receptionist at the medical office) would be included in the medical expense comparison. If there aren't separate arrangements with unrelated parties for the medical services and administrative services contained in the arrangement with the related party, then the market comparison approach would not be available. Under the actual cost method for related party, the MAO would report the actual cost to provide the medical services in medical and the actual cost to provide the administrative services in non-benefit expenses. Any gain/loss margin would be removed from the medical and non-benefit expenses reported in the bid.
2	ESRD	05/10/2016 21:45	bid questions re ESRD payment rates	Could CMS please clarify the application of CMS User Fees to ESRD dialysis population? The ESRD dialysis payment rates in the BPT are shown after the deduction of user fee of $5.25 PMPM. In the plan payments, we see another CMS User Fee (0.041% for 2016) being applied to the payments. In other words, it appears that both deductions apply to dialysis members. Are these two fees for the same purpose? We would like to confirm that both fees are to be applied.	The $5.25 PMPM is for Network Administration costs and applies to the statewide rates for ESRD beneficiaries in Dialysis and Transplant statuses. The 0.041% is for the National Medicare Education Campaign (NMEC) and is collected based upon the plan's prospective payments. These fees are not for the same purpose and they both apply to dialysis and transplant beneficiaries.
3	Medicare FFS Pricing	05/17/2016 11:00	FFS Pricing in BPT	If a PBP is a Medicare FFS look alike plan, with the exception of the PCP copay, may we use the effective cost-sharing on worksheet 4 to price Part B services other than Professional PCP?	No, the FFS actuarial equivalent cost sharing factors on MA BPT Worksheet 4 are based on FFS cost sharing for all Part B services. The Medicare FFS pricing option does not apply to a subset of Part B services.
4	NBE	05/12/2016 17:29	Non-Benefit Expense Question	I have a question about non-benefit expense reporting for the 2017 bids. a) On page 35 of the Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2017, the non-benefit expense exclusion list appears to have changed. More specifically, goodwill amortization was removed from the prior year's instructions. During our 1/3 financial audit, we were observed to have included amortization of intangible asset acquisition costs in the non-benefit expenses. Should we include or exclude amortization of intangible asset acquisition costs or goodwill amortization from the non-benefit expenses in the 2017 bids? b) Please also give examples of value-added items and services.	a) We removed the reference to goodwill amortization in the bid instructions because FASB 142 no longer permits amortization of goodwill. The intention of the bid instructions is to exclude from non-benefit expenses any costs not pertaining to administrative activities to operate the MA plan. Both goodwill and amortization of intangible assets that were acquired during purchase must be excluded from non-benefit expense in the bid. b) Chapter 4, section 80 of the Medicare Managed Care Manual includes a definition and examples of value-added items and services.
5	TBC	05/12/2016 17:29	Segments and TBC	In 2016 we have Counties A and B in segment 001 and Counties C, D, and E in segment 002. For 2017, we are moving County B from segment 001 to segment 002. How do we perform the TBC test for segment 002 given the change in counties within each segment from 2016 to 2017?	For these two segments, there will be three tests that need to pass. 1. 2017 segment 001 (comprised of just County A) will be compared to 2016 segment 001 (comprised of County A and B). The payment and model adjustments will be that of segment 001 released in April. This test is to determine the TBC increase for enrollees in County A. 2. 2017 segment 002 (comprised of County B, C, D and E) will be compared to 2016 segment 001 (comprised of County A and B). The payment and model adjustments will be that of segment 001 released in April. This test is to determine the TBC increase for enrollees in County B. 3. 2017 segment 002 (comprised of County B, C, D and E) will be compared to 2016 segment 002 (comprised of County C, D and E). The payment and model adjustments will be that of segment 002 released in April. This test is to determine the TBC increase for enrollees in Counties C, D and E.

User Group Call Date 05/26/2016

Introductory note

Question

Please provide guidance on how the beneficiary-level risk score file or plan-level risk score data posted on HPMS may be used under the preferred approach for developing risk scores for payment year 2017 (PY2017).

Response

Background: Payment Year 2017 risk scores will be a blend of: (1) 75% of the risk scores calculated using diagnoses from RAPS and FFS, and (2) 25% of the risk scores calculated using diagnoses from encounter data and FFS.

Determining impact: In order to determine whether or not there is an impact of using diagnoses from encounter data on risk scores, plan sponsors may be using the diagnoses identified on the MAO-004 reports and/or developing a parallel filtering approach to their encounter data records. You may want to consider the following factors that might affect encounter data-based risk scores:

- Will the volume of encounters submitted for Calendar Year 2016 dates of service be greater than in the prior years? Since encounters with 2016 dates of service will be used to determine risk adjustment eligible diagnoses for PY2017, the impact on risk score of any improvement in submission rates should be considered
- Will the volume of chart review encounter data records increase for dates of service 2016? The impact on risk score of any increase in the submission of diagnoses from chart review should be considered.
- How closely aligned is the approach that a particular plan sponsor is taking to filter diagnoses for submission to RAPS with the filtering approach for encounter data?
- To the extent that a plan sponsor is using the MAO-004 reports, please consider the following:
    - The MAO-004 report does not distinguish between an original encounter, a replacement, or a delete. Further, it does not indicate when diagnoses are coming from a chart review – either to add or delete diagnoses. Deletes submitted via voids or replacements of encounter data records are captured correctly in the risk scores (this is a reporting issue only). Delete chart reviews are not reflected in the risk scores.
    - There are a few issues that lead to the exclusion of diagnoses on both the MAO-004 and in the risk scores that should have been determined to be risk adjustment eligible.
        - Certain diagnoses in the header – for example, Admitting and Patient reason for visit diagnosis codes – are excluded.
        - Due to a sort issue associated with allowable HCPCS list, in some cases HCPCS in the 99000 series are excluded.
        - When a linked chart review record was submitted, the MAO-004 includes diagnoses from the chart review as an add, but excludes the diagnoses on the encounter record. This affects chart reviews submitted to add and delete diagnoses – the chart review was read as adding diagnoses and the encounter itself was not recognized.

User Group Call Date 05/26/2016

Application in the bids:

1. If a plan sponsor determines that their PY2017 encounter data-based risk scores will not be different than their PY2017 RAPS-based risk scores, the development of the PY2017 risk scores in their bids can use an initial RAPS-based risk score to project to the payment year (2017) and can use the same approach as in years when there was no blended risk score –in other words, they can project a single risk score from the starting point (either the base year under the preferred method or the March MMR under the alternative method) to the payment year.
    a. If using the beneficiary-level file (or the HPMS data), it is allowed to use these scores as proxies for RAPS-based scores, although plan sponsors are allowed to make their own assessments and substitute adjusted scores.
2. If a plan sponsor determines that their PY2017 encounter data-based risk score will be different from their PY2017 RAPS-based risk score, plan sponsors may want to use one of the following approaches to take into account encounter data-based risk scores as part of developing their projected 2017 risk scores. The following approaches are compatible with either the preferred method (starting with base year risk scores distributed in the beneficiary-level file or in the plan-level HPMS data) or alternative method (e.g., starting with March 2016 MMR risk scores).
    a. Use the starting risk score to project the 2017 risk score as a single risk score, and apply an adjustment factor for the expected impact of encounter data risk scores.
        i. Plan sponsors should document the development of their adjustment factor.
        ii. If using the beneficiary-level file (or the HPMS data), it is allowed to use these scores as proxies for RAPS-based scores, although plan sponsors are allowed to make their own assessments and substitute adjusted scores.
        iii. If using an independently calculated RAPS-based risk score, please include in the supporting documentation how this score was developed (e.g., independently calculated, or an adjustment factor was applied).
    b. Separately project encounter data-based and RAPS-based risk scores.
        i. If using the beneficiary-level file (or the HPMS data), it is allowed to use these scores as proxies for RAPS-based scores, although plan sponsors are allowed to make their own assessments and substitute adjusted scores. Plan sponsors should document the development of their adjustment factor.
        ii. If using an independently calculated RAPS-based risk score, please include in the supporting documentation how this score was developed (e.g., independently calculated, or an adjustment factor was applied).
        iii. In the supporting documentation, describe how the encounter data-based scores are developed.

User Group Call Date 05/26/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Risk Score	05/19/2016 11:28	CMS call	There was a live Q&A on the OACT call last week, that I believe was answered incorrectly. We asked if the bene file on the Part D side reflected a blend of EDS and RAPS risk scores, and the answer was "yes." I believe the answer should have been "No," that the part D bene file reflects the risk score based on the ***combination*** of EDS and RAPS risk scores, not a blend.	To clarify, the Part D scores that were provided were calculated the same way that the Part C scores were calculated – with diagnoses from encounter data, RAPS, and FFS being used jointly to calculate a single score. The risk scores were not calculated separately using different data sources and then blended together.
2	Gain/Loss Margin	05/24/2016 13:42	FW: Gain/Loss Margin Guidance	[PARAPHRASHED] Last year we submitted a question that read as follows "Since our plan has no non-Medicare business, we must enter our corporate margin target using the "Risk-Capital-Surplus" justification. We also aggregate margin to the Parent Organization level. Recognizing that in this scenario all of our MA and PD BPTs will have the same corporate margin requirement, should the "Corporate Margin Requirement % of Rev." entered include or exclude the following: (ESRD/Hospice Margin, Part D margin, EGWP margin, DSNP margin, the effect of sequestration on revenue (which is not reflected in the BPT margin calculation))? The response last year was "The "Corporate Margin Requirement % of Rev" should reflect the risk and capital and surplus requirements of the Parent Organization prior to any impact of sequestration and be inclusive of all enrollees including those listed in the question (ESRD, Hospice, Part D, EGWP, DSNP)." Now that CMS has waived the requirement to submit EGWP bids, should the Corporate Margin still be calculated inclusive of EGWPs?	Yes, the response remains the same as last year. The "Corporate Margin Requirement % of Rev" should reflect the risk and capital and surplus requirements of the Parent Organization prior to any impact of sequestration and be inclusive of all enrollees including those listed in the question (ESRD, Hospice, Part D, EGWP, DSNP)."
3	Part D	05/23/2016 20:33	Non-Preferred Drug tier	The new "Non-Preferred Drug" tier definition allows for a mix of generics and brands to be offered at one cost-sharing level. On Worksheet 6 and 6A of the BPT, can all the experience from this tier be allocated to the "Non-Preferred Brand" category since all drugs in this tier will follow the same cost sharing? Or, does the generic experience need to be removed from the "Non-Preferred Brand" category and added to the generic data (where the cost-sharing is different)?	Worksheets 2, 6, and 6A of the BPT must be populated by type of drug and place of service, not by formulary tier. The only exception is the reporting of Specialty drugs when they are on a designated Specialty tier on the formulary. Please use the formulary mapping described in initial bid submission item 6 on page 70 of the Part D BPT instructions to document how the formulary tiers are reflected in the BPT.

User Group Call Date 06/02/2016

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Non-Benefit Expenses	05/27/2016 10:54	MA Bid Question	Part 1: A tax may be introduced in the plan sponsor's state, which would tax the plan sponsor at a percent of their revenues, including on CMS revenue and beneficiary premium. Since this is not an income tax, our understanding is that such a tax is legitimately counted as a non-benefit expense. Can you confirm? Part 2: If taxes applicable to the bid year are introduced after the initial bid submission date, are plan sponsors permitted to resubmit bids if such taxes would be legitimately considered non-benefit expenses in the BPTs? If the new taxes become law during the desk review process, may they be incorporated into the bids?	Part 1: We cannot opine on whether or not this tax is a legitimate non-benefit expense without seeing additional clarifying language about the nature of the tax. Part 2: The plan sponsor should make their best estimate of the fees that will be paid during the contract year, including the likelihood that the fee will be introduced at all. The plan may not alter the bid to incorporate this fee after the bid submission deadline, consistent with the development of all other pricing assumptions.