User Group Call Date 12/01/2016

Introductory note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@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
For questions regarding risk score models and released data: RiskAdjustment@cms.hhs.gov
For questions related to the Encounter Data Processing System: encounterdata@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov
For questions related to Crosswalk Exceptions: https://dmao.lmi.org/dmaomailbox/

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Reinsurance	06/02/2016 2:33	Question re use of reinsurance of Part C and D	[PARAPHRASED] I have a question regarding conducting Medicare Parts C and D business through a quota share reinsurance agreement. I note that the language of 42 U.S.C. 1395w-25 could potentially be read to permit the reinsurance of MA business only under certain structures. As quota share reinsurance does not appear to be specifically included in this provision, I would like to know if this omission precludes the reinsurance of MA and Part D business under a conventional indemnity quota share reinsurance agreement.	All MAOs must comply with our statutory requirements, including section 1855 of the Act (42 U.S.C. 1395w-25). Section 1855(b) provides four categories of permissible reinsurance arrangements and the types of risk for which an MAO may seek reinsurance. CMS has not thus far provided additional regulatory guidance interpreting or applying this provision to specific arrangements and does not provide legal advice to outside parties, including MAOs. Depending on the specifics of the arrangement, quota share may or may not comply with the terms of the statute. Please note, that CMS may provide further clarifying guidance at a later time for future years, to which MAOs would be held accountable.
2	User Group Calls (UGC)	N/A	Recording Actuarial User Group Calls	Does CMS still record the user group calls, as previously stated on the 4/24/2014 user group call?	Beginning today, December 1, 2016, CMS is discontinuing its practice of recording the user group calls. Today's call is not being recorded by CMS. Notice will be provided if CMS decides to reinstate recordings in the future.

User Group Call Date 02/23/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Reinsurance	N/A	N/A	We noticed the CY 2018 Draft Call Letter language regarding reinsurance on pages 131-132 and that CMS requested comments on establishing the aggregate threshold for the first category in Section 1855 of the Act (42 U.S.C. 1395w-25). Will CMS also accept comments on the permissibility of specific types of reinsurance, including quota share reinsurance?	CMS welcomes comments on all portions of the CY 2018 Draft Call Letter, including whether and how different types of reinsurance align with the four categories of reinsurance permitted by the statute.
2	TBC	N/A	N/A	We did not notice the thresholds for the Total Beneficiary Cost (TBC) evaluation or an explanation of the meaningful difference evaluation process in the CY 2018 Draft Call Letter. Is there any information that you can provide to us?	As indicated in the CY 2018 Draft Call letter on pages 114 and 115 respectively, the meaningful difference evaluation process will be the same as indicated in the final CY 2017 Call Letter, and CMS will maintain the TBC requirements and change thresholds communicated in the final CY 2017 Call Letter. CMS will provide a detailed explanation of the TBC and meaningful difference evaluation process in mid-April 2017 via an HPMS Memorandum titled “CY 2018 MA Bid Review and Operations Guidance.” Please make sure to review the meaningful difference and TBC sections in the draft Call Letter for policy clarifications.

User Group Call Date 04/13/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Ratebook	N/A	N/A	It is stated on page 3 of the announcement that "The Secretary has directed the Office of the Actuary to adjust the fee-for-service experience for beneficiaries enrolled in Puerto Rico to reflect the 2018 GPCIs included in the 2017 Medicare Physician Fee Schedule Rule." However the documentation supporting the GPCI physician repricing indicates that the Puerto Rico repricing is based on the 2017 GPCIs. Please clarify the basis for the repricing of Puerto Rico physician claims.	The basis for the repricing of Puerto Rico physician claims is, in fact, based on the 2018 GPCIs included in the 2017 Medicare Physician Fee Schedule Rule. The initial documentation supporting the repricing was not updated to reflect the 2018 GPCI basis. We have since updated the following supporting materials posted on the ratebook page under the tab "FFS Data 2015": Geographic indices 2011-2018 – Physician.xlsx and FFS repricing specifications CY2018 ratebook.pdf.
2	Sequestration	N/A	N/A	Please confirm whether the actuarial equivalent (AE) cost-sharing values on Worksheet 4 already include sequestration. If the Worksheet 4 AE cost-sharing values do not include sequestration, please provide clarification for how MAOs should account for sequestration when pricing cost sharing designed to match Medicare FFS cost sharing, as allowed under the Medicare FFS cost-sharing pricing option.	The claims supporting the development of the actuarial equivalent cost-sharing factors on MA BPT Worksheet 4 have been grossed up for sequestration. Further, there is no sequestration cut for beneficiary cost sharing. Thus, the actuarial equivalent factors are developed on a pre-sequestration basis and should not be adjusted.
3	Related Party	03/08/2017 13:53	Question Regarding Related Party Guidance for Medicare Bids	[PARAPHRASED] We are looking for clarification on whether or not the following entities are considered Related Parties: 1) ABC Health Plan is a not-for-profit Medicare Advantage plan. 2) No other entity has an ownership or investment interest in ABC Health Plan, nor do we have an ownership or investment interest in any other entity. 3) We do have provider network relationships with separate health centers. 4) Some employee representatives of the separate health centers sit on the Board of Directors for ABC Health Plan. Are the health centers considered Related Parties to ABC Health Plan?	RESPONSE GIVEN ON 4/13/17 CALL: The relationship described in this situation is considered a related party. The designated employee representatives of the health centers who sit on the Board of Directors for ABC Health Plan are the basis for determining that a related-party relationship does exist. Board membership falls under a form of control, and a related party is defined in the CY2018 MA Bid instructions as "an entity that is associated with the Medicare Advantage Organization (MAO) by any form of common, privately held ownership, control, or investment." This definition of related party does not have a level of materiality for the degree of control. Please note that this related-party definition is intended for use only in completing the Bid Pricing Tools (BPTs). UPDATED 5/30/17 For situations like the one described in this question, for CY2018 CMS will give the MAO the option to treat the health centers as either related parties or non-related parties, at the MOA's discretion. If the MAO treats the health centers as non-related parties, then the MAO must do both: a) disclose that the representatives of the health centers are on the MAO's board, and b) disclose that the MAO has opted to treat the health centers as non-related parties for purposes of completing the BPT. If the health centers are treated as related parties, then follow all of the related-party guidance in the bid instructions.
4	Reinsurance	N/A	N/A	Item 7.2 in Appendix B of the bid instructions requires "a description of the expenses included in each non-benefit expense category in the BPT." What level of detail should be provided for the category: Net Cost of Private Reinsurance?	For the Net Cost of Private Reinsurance, include the type of reinsurance and applicable benefits, attachment points, and maximums. Include any other descriptions that are pertinent to the reinsurance coverage. For example, "The net cost of private reinsurance applies to specific stop-loss coverage for hospital inpatient costs exceeding $X per member, after which the reinsurer pays Y% of costs up to a maximum member cost of $Z. This coverage does not apply to one member who has a preexisting condition."
5	POS Benefit	04/04/2017 10:40	Actuarial Bid Question on POS plan offering	[PARAPHRASED] We have two questions about including the cost of POS benefits in the MA BPT. 1) Where do we report out of network (OON) services? Do we report them mixed with the in network benefits in the respective service categories and then adjust the percentage of Medicare Covered Services on w/s 4? Or, do we report them separately in line p (Eligible Supplemental Benefits as Defined in Chapter 4 of the Medicare Managed Care Manual)? 2) Secondly, do we report the OON Cost Sharing under columns m & n on w/s 3 in the respective service categories or again roll them up in line p?	1) Enter on Worksheets 1 and 2, the allowed cost and projected manual rate for a specific POS benefit based on the PBP category for such POS benefit and the PBP to BPT category mapping entered on Worksheet 3 of the MA BPT. For the applicable service category, enter on Worksheet 2, column r, the OON percentage for projected allowed costs, and in Worksheet 4, column i, use the percentage of Medicare-Covered Services to allocate the POS benefit to Non-Medicare-covered. 2) In a similar manner, enter the projected OON cost sharing on Worksheet 3, columns m and n, and use the percentage of Medicare-Covered Services in Worksheet 4, column j, to allocate the POS cost sharing to Non-Medicare-covered. See the POS pricing consideration.
6	Duals Demo	03/03/2017 11:37	Credible Experience Data for New Bid	I am working with a health plan that has been participating in the state's Financial Alignment Dual Demonstration the past few years, which has not required the need to complete a BPT. The program is going away so they are submitting a bid for 2018. They have fully credible experience, as well as consistent bid ID. Should the BPT include the 2016 experience in Worksheet 1, or should we use the experience to develop a manual rate (for Worksheet 2) since there was technically no BPT in the prior years?	Since the plan has the same bid ID (HXXXX-XXX-XX), they must report the 2016 experience on worksheet 1 of the CY 2018 MA and PD BPTs.
7	FFS Cost Sharing	04/06/2017 15:28	Original Medicare Cost Sharing (SNF)	For one of our plans with original Medicare benefits, we use the FFS cost-sharing pricing option described on page 17 of the 2016 BPT Instructions. The SNF effective member coinsurance in the 2016 BPT was 12.4%. We wish to confirm that SNF days 101+ are excluded from the calculation of the 12.4%, i.e., that the numerator of the calculation is the value of the per day copay for days 21-100 and the denominator of the calculation is the expected allowed cost for days 1-100.	That is correct, SNF days 101+ are excluded from the calculation.

User Group Call Date 04/13/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Rewards and Incentives	04/11/2017 9:21	Bid submission - RI programs	We have piloted various member incentive programs and are currently analyzing them for effectiveness in different markets. At the time of bid submission, complete and finalized data is not available to make the most informed decisions on which of our markets or populations may benefit the most from a rewards and incentives (RI) program. Given the significant difference in points of time between a) the bid submission for the upcoming year and b) the finalized data and analysis of the RI programs within the current year, is there is flexibility in what we submit in the bid at the contract/PBP level and PMPMs post-bid submission? (i.e. Are we required to offer incentives in the markets and at the PMPM amounts we posted in the bid? Additionally, can we offer incentives in markets that were not included in the bid?	At the time of bid submission, the plan sponsor must make its best estimate of the cost of the RI program it anticipates being in place for CY2018. The cost of these programs must be included in the bid as a non-benefit expense, but must not be entered in the Plan Benefit Package, as stated in Chapter 4 of the Medicare Managed Care Manual. Incentives in markets that are not included in the bid are prohibited. All RI programs must be included in the bid as a non-benefit expense in order to be compliant with CMS regulations and policy.
9	Hepatitis C	N/A	N/A	Do Part D sponsors still need to include a separate estimate of Hepatitis-C drug cost in their supporting documentation for CY2018?	No, while Hepatitis-C costs continue to be significant, we do not require the value for projected Hepatitis C costs be shown separately in the supporting documentation for CY2018.

User Group Call Date 04/20/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rate	04/19/2017 9:59	FFS Growth Rate and Trends	The FFS growth rate was listed for 2018 as 2.73%. What was the impact of demographic change (baby boomers) on that estimate?	The impact of demographic changes on the 2018 growth rate is -0.1 percent for Part A and +0.1 percent for Part B.
2	Risk Score	N/A	N/A	Can you please provide the location of the risk adjustment for EDS and RAPS user group call slides that provide more information on Phase II filtering?	You can find the user group call slides from the last several months at CSSCOperations.com under "Risk Adjustment Processing System," and then under "User Group."
3	Risk Score	04/12/2017 9:41	Question on Risk Scores in Worksheet 1	What is acceptable to report for Part C and D risk scores in Worksheet 1 given that some EDPS data submissions and Phase III filtering logic are not reflected in the beneficiary file? For example, is it acceptable to add completion to the base period risk scores available in the beneficiary-level files if completion is supported by the certifying actuary?	Yes, this example would be acceptable. Supporting documentation should clearly explain any adjustments made to the starting risk scores from the beneficiary-level files.
4	MSP Factor	04/13/2017 0:18	MSP Factor	It appears that many of the dates in the MSP section on page 33 and 34 of the 2018 bid instructions were not updated from the 2017 instructions. Can you verify that the 2018 MSP Factor will remain the same as the 2017 factor of 0.173?	The MSP factor remains at 0.173 for CY2018. This was missing from the instructions, but all MSP examples in this section are still applicable.
5	Gain/Loss Margin	04/11/2017 17:48	Actuarial User Group Call - Question Submission	The CY 2018 MA BPT Instructions require the MAO to "develop, submit, and follow an MA bid-specific business plan to achieve profitability within five years." Please provide clarification on the following illustrative scenarios: 1) A bid was submitted with a negative margin and supporting business plan in CY 2017. For CY 2018, the plan is being segmented and one or both of the resulting segmented plans has a negative margin. Page 26 of the CY 2018 bid instructions notes, "Do not combine margin for bids in segmented plans to satisfy these Instructions." We interpret this to mean the 5-year projection period resets for each, separate segment. As such, the supporting documentation requirements under 8.6.3 of Appendix B (page 105) would apply and 8.6.4 of Appendix B (pages 105-106) would not be applicable. Please confirm our understanding or provide further clarification. 2) A plan was submitted with a negative margin and supporting business plan in CY 2015. The plan then had a positive projected margin in the CY 2016 and CY 2017 bids, but is expected to have a negative margin in CY 2018. Actual 2016 experience shows the plan had a positive margin. Does the 5-year projection period reset in CY 2018 or are the requirements under 8.6.4 of Appendix B (page 105-106) still applicable?	1. Since the bid ID (contract number-plan ID-segment ID) for the plan submitted in CY2018 did not exist in CY2017, requirement 8.6.4 (comparison to prior year business plan) does not apply. For the newly segmented bids with negative margin in CY2018, follow the remaining applicable requirements under 8.6 of Appendix B. 2. The 5-year projection period would reset in CY2018 and 8.6.4 of Appendix B would not apply.
6	Rebate Reallocation	04/13/2017 16:55	BPT Instruction Clarification Question	We have a question about the 2018 MA BPT Instructions, Appendix E, page 123. Section C describes permissible actions when PD Basic Premium Net of Rebate after Benchmark is less than Target PD Basic, but not less than zero. It states that a partial return to target premium will not be accepted, and provides Example 2 to illustrate. Example 2 has $15 rebate allocated to PD Basic of $35 in the June submission, and then a $5 decrease in PD basic in line 7a after the benchmark announcement. We would like additional clarification for a slightly modified scenario. Suppose that in the June submission, only $3 of rebate were allocated to PD Basic resulting in $32 in line 7d. Then assume the same Benchmark announcement as in Example 2, which causes line 7a to reduce by $5 and becomes $30 and PD basic net of rebate "After Release of Benchmark" in line 7d is $27. Since we only have $3 rebates in line 7c, if we allocate all of the rebate away from PD Basic, line 7d will be $30, and not the $32 target in our June submission. In the case where line 7a after benchmarks (before rebate) is less than Target Part D Basic Premium, is a partial return to the target permissible when all rebates are removed from line 7c?	Since it is not possible in this situation to return to the $32 premium net of rebates indicated on line 7d in the initial bid submission, it would not be considered a partial return to the target for the plan to either: 1) keep the post-benchmark announcement value in line 7d of $27 ($30 - $3) or, 2) remove the rebate entirely to have $30 in line 7d. It would not be acceptable to apply a rebate of anything other than $3 or $0.
7	Part D	04/11/2017 10:35	MSP in Part D BPT	Page 38 of the Part D BPT instructions includes the following guidance for reporting base period Medicare as secondary claims in Worksheet 1: Enter the total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer. "Total plan liability" is defined as CPP (Covered Plan Paid Amount) plus NPP (Non-covered Plan Paid Amount) minus 80 percent of either GDCA (Gross Drug Cost above Out-of-Pocket Threshold) or GDCA minus PLRO (Patient Liability Reduction Due to Other Payer Amount) as appropriate. The last part of that guidance ("or GDCA minus PLRO … as appropriate") is new for CY2018 bids. It gives two options for calculating Medicare as secondary plan liability. When is it appropriate to use the second formula, which subtracts PLRO from GDCA? Could you provide an example of a situation in which the second portion of the formula is necessary?	For typical Medicare as secondary Part D claims, the appropriate formula is CPP plus NPP minus 80% of adjusted GDCA, where adjusted GDCA is GDCA less PLRO. Since the gross drug cost includes amounts paid by the primary source, federal reinsurance will ultimately reconcile to 80% of GDCA less PLRO. See the 4/23/2013 HPMS memo on Medicare Secondary Payer for more information. In limited circumstances, it is possible that consistency with the population of other fields on worksheet 1 of the PD BPT requires the use of the formula excluding PLRO. The certifying actuary must use their judgment to determine which method is appropriate so that worksheet 1 is consistent and accurate.

User Group Call Date 04/20/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Part D	04/18/2017 3:07	LIS Eligibility in US Territories	We are seeking guidance on how to handle identification of Part D LIS-eligible members for plans offered in the US Territories of American Samoa, Guam, Northern Mariana, and Puerto Rico. In particular, we seek clarification on the following: 1. For PD BPT WS1 cell I12, should we rely on the LIS indicator of the MMR/Beneficiary file or guidance in Chapter 13, section 90 of the Prescription Drug Benefit manual indicating “Part D eligible individuals who are not residents of the 50 States or the District of Columbia are not eligible for the low-income subsidy program”? These two items appear to be in conflict for residents of some territories. 2. For purposes of determining eligibility for the coverage gap discount program, how should we treat members that are tagged as LIS-eligible in the MMR but are residents of the territories mentioned above?	US Territories of American Samoa, Guam, Northern Mariana, and Puerto Rico are not eligible for low-income subsidies. They should not be counted as LIS members and are eligible for the coverage gap discount program.

User Group Call Date 04/27/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Medicare FFS Cost Sharing	04/19/2017 11:36	Medicare FFS Cost Sharing Question	Our MAO is filing a special needs plan in CY2018 using Medicare FFS cost sharing pricing option and projecting DE# membership in excess of 95%. Since the DE# membership exceeds 90%, the projected allowed costs for the total population will be entered on Worksheet 2 of the MA BPT for both Non-DE# and DE#. The MA BPT instructions for this pricing option state the following regarding the application of FFS cost sharing on Worksheet 3; "Note that, if Worksheet 3 is completed for the total population and such population includes non-DE# members, then the effective copay/coinsurance after MOOP (column j) may be less* than the effective copay/coinsurance before MOOP (column i)." Due to the low percentage of Non-DE# membership in the projected population, is the actuary required to include a PMPM impact of in-network MOOP greater than zero in cell K68 on Worksheet 3 of the MA BPT? * *Note from CMS:* CY2018 MA bid instructions should read "less than" rather than "greater than."	No, the actuary is not required to enter a non-zero PMPM impact of in-network MOOP in cell K68 on Worksheet 3 of the MA BPT. The actuary is required to enter a projected in-network MOOP impact greater than or equal to zero consistent with the projected effective in-network cost-sharing after the plan-level deductible and including the impact of the MOOP entered in column j.
2	DIR	04/21/2017 11:36	DIR Question	[Paraphrased] A portion of the total direct and indirect remuneration (DIR) that we receive is retained by our PBM. The instructions indicate that we should include the retained amount in the rebates line of worksheet 1 and an offsetting amount in non-benefit expense. Is this also true for the contract year, and, if so, should we account for the portion of the retained amount that is used in federal reinsurance reconciliation?	Both the base and contract year rebates must account for the total DIR amount, even if a portion is retained by the PBM. The offsetting amount in non-benefit expense must account for the total rebate retained by the PBM, regardless of any portion used for federal reinsurance reconciliation. For example, if the contract year retained rebate is $10, and the portion allocated to federal reinsurance is $3, then $10 must be included in the total rebates and an offsetting amount of $10 must be included in non-benefit expenses. Note, this response is changed from the verbal response issued on the call.
3	LI Benchmark Premium Amounts	04/24/2017 20:44	Restated LIBs	Are the restated Low-Income benchmark (LIB) premium amounts on page 84 of the 2018 PD Bid Instructions calculated as either (1) the restated LIB benchmarks less the actual direct subsidy of $25.45 or (2) the restated LIB benchmarks less the restated direct subsidy of $24.94?	The low-income benchmarks on page 84 of the instructions are calculated using the actual direct subsidy of $25.45, as described in (1).

User Group Call Date 05/04/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Gain/Loss Margin	04/19/2017 16:22	Clarification of Aggregate-Level Gain/Loss Requirements	[PARAPHRASED] Assume an MAO has non-Medicare business for which they typically target a small positive gain/loss margin. However, emerging results on a couple of very large groups that represent a significant portion of the plan's non-Medicare business are causing the expected gain/loss margin for the MAO's entire non-Medicare business for 2018 to be negative. Given the aggregate-level requirements in the bid instructions, this case may cause the Medicare Advantage bids to have an expected loss for 2018, which the MAO would prefer to avoid. 1) In this case, is there an exception to meeting the aggregate-level margin requirements? 2) Does the non-Medicare margin have to reflect the expected results solely during 2018, or can it reflect a long-term expectation?	1) The gain/loss margin requirements of the instructions apply, even if the corporate margin requirement is low or negative. 2) The corporate margin requirement can reflect a short-term or long-term expectation. In your example, a short-term expectation may be "for 2018 to be negative." Alternatively, a long-term expectation may result in setting the non-Medicare margin to "target a small positive gain/loss margin" for some period longer than 2018. In any case, the bid instructions require that the "actual corporate margin is to be consistent with the corporate margin requirement used for the MA pricing" over the long term.
2	Risk Score	05/02/2017 9:41	EDS Adjustment Factors	The following questions pertain to the required runout and Phase II to III EDS adjustment factors: 1) Do you require that the EDS adjustment factor for additional runout be applied to the base year beneficiary level file risk score and included on Worksheet 1 of the BPT? Or alternatively, do you only require that this adjustment be reflected in the 2018 projected risk score? 2) Do you require that the EDS adjustment factor for Phase II to Phase III be applied to the base year beneficiary level file risk score and included on Worksheet 1 of the BPT? Or alternatively, do you only require that this adjustment be reflected in the 2018 projected risk score? 3) For standalone PDPs, we observe minor differences between the RAPS and FFS beneficiary level file risk score (in the RAPS field) and the EDS and FFS beneficiary level file risk score (in the Encounter Data field). We have the following questions regarding PDP risk scores: a) Do you require the RAPS and FFS projection model risk score be blended with the EDS and FFS projection model risk score according to the 85%/15% weights, respectively, when developing the 2018 projected risk score for PDPs? b) Do you require the RAPS and FFS base year model risk score be blended with the EDS and FFS base year model risk score according to the 90%/10% weights, respectively, for PDP Worksheet 1 risk scores? c) Do you require the runout and Phase II to III EDS adjustments be applied to the EDS and FFS risk scores for PDP? If so, do you require these adjustments be reflected in the Worksheet 1 risk score for PDPs? Or alternatively, do you only require that these adjustments be reflected in the 2018 projected risk score for PDPs?	1) and 2) Yes, the EDS adjustment factor should be applied to the base year scores as the CY2016 risk scores entered on MA BPT Worksheet 1 are final risk scores. 3a) and 3b) Yes, the RAPS and EDS risk scores must be blended. 3c) Yes, the EDS adjustment factor should be applied to the base year scores as the CY2016 risk scores entered on PD BPT Worksheet 1 are final risk scores.
3	Service Area Expansion	04/28/2017 13:42	Service Area Expansion	We have applied for a service area expansion to add one county to our current service area. The MAO is currently contemplating whether to include this in their existing PBP IDs or create separate PBP IDs – with a preference to add to the existing PBPs. If the SAE is included in the current PBP ids and is ultimately not approved, would the plan be required to adjust the bids to remove the county from the BPTs even if the denial happens after the bid submission deadline?	Yes, the plan would need to resubmit the bid to remove the counties that were not approved. Note that only changes related to the county removal would be allowed and that no other assumptions may be changed at this point.
4	Rewards and Incentives	05/01/2017 20:04	Reward and Incentives Program	Our Health Plan intends to roll out an R&I program. We understand from prior guidance that the cost of these programs is to be reported as NBE in the bids. In our case, the Health Plan already capitates provider networks to provide the Plan's MA benefits, and would like to further delegate the administration of the R&I program to the capitated provider networks. The Health Plan will continue to adhere to CMS' data collection requirement. The Health Plan and the provider networks are not Related Parties. In the bids, are we supposed to allocate a portion of the provider capitation cost associated with the R&I program to NBE, leaving the remainder of the provider capitation cost associated with MA benefits as Healthcare Cost?	Yes, the portion of the provider capitation cost associated with the Rewards and Incentive program must be included in the bid as a non-benefit expense, as stated in Chapter 4 of the Medicare Managed Care Manual.

User Group Call Date 05/11/2017

Introductory note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
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For questions related to Crosswalk Exceptions: https://dmao.lmi.org/dmaomailbox/

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	BPT Critical Validations	05/05/2017 11:28	MA BPT WS1 N14 critical error	When creating a 2018 MA BPT for a plan with WS1 base period experience not populated, I get a critical error that WS1 cell N14 is not populated correctly. I can finalize the BPT if I enter the plan number in WS1 cell N14. Is this an acceptable solution? Do you intend to release a revised BPT to fix it?	This is an error in the BPT validation process. If the plan did not exist in the base year, and therefore there is no base period experience in Section III of Worksheet 1, then it is appropriate for cell N14 to be blank. The validation process should have allowed this BPT to finalize. To address this critical validation error for CY2018, please put the Bid ID in cell N14 even if there is no base period experience for the plan. We do not plan to release a BPT patch to fix this issue. For CY2019, this validation issue will be corrected to allow for a blank in cell N14 when WS1 section III is not populated.
2	Insurer Fee	05/06/2017 18:59	Health insurer fee and other legislative changes near bid due date	Can CMS establish and communicate a date after which legislative changes near the bid due date would not be required to be reflected? For example, the proposed AHCA would repeal the health insurer fee. If this legislative change becomes law days before the bid is due, it may be too late for health plans to incorporate into 2018 bids. Can you please provide guidance?	The bid submission deadline is the cut off date. Our expectation is that bid assumptions are based on the statutory provisions that will be in effect for the contract year. It is acceptable to consider the likelihood of current law continuing given that the bid must reflect the best estimate at the time of bid submission of required revenue for the contract year. Supporting documentation must provide reasonable justification for bid assumptions that vary from statutory provisions. There is not an opportunity to modify bid assumptions for legislative changes that occur after the bid submission deadline.
3	Risk Score	04/28/2017 14:06	Risk Score trends	Page 45 of the 2018 MA Bid Instructions states that the risk scores are to be projected from 2016 to 2018 with an adjustment factor for "Bid-specific coding trend". Page 42 states that the projected risk score must "reflect the expected risk score trend at the bid level" and Appendix K provides additional guidance on "trending risk scores". Are the "bid-specific coding trends" that are mentioned on page 45 intended to be synonymous with the "risk score trends" discussed in Appendix K and if not, could you please provide further explanation as to the differences of these two?	These terms all mean that plans should be including the impact of risk score trends, including coding patterns, on the projected payment year risk score. Plans should assess the impact of risk scores trends, including coding, on the risk scores of each specific bid. Appendix K was added a few years ago to assist MAOs in determining an approach to assessing their plan-specific risk score trend. One reason we sometimes place an emphasis on applying the plan-specific coding trend is to ensure that MAOs take this into account, especially since other risk score trend factors, particularly population trend factors, may capture some of the other drivers of risk score changes.
4	Gain/Loss Margin	05/05/2017 23:43	Question for Actuarial User Group call	An MA contract includes several provider-specific plans (PSPs) and other general enrollment MAPDs with identical service areas. For 2018, they no longer need to pass meaningful difference testing via OOPC difference, based on the 2018 Call Letter. Are we still permitted to pair PSPs with non-PSP plans in their service area in order to achieve a positive gain/loss margin? The MA BPT instructions do not mention PSPs at the top of page 28 where product pairing requirements are discussed.	As long as the plan is following the bid instructions for a valid product pairing as outlined on page 28 of the CY2018 MA bid instructions, then it is acceptable to pair PSPs with non-PSPs. This means the plans must: -Have identical service areas; -All be local coordinated care plans or all be regional PPOs or all be PFFS plans; and -Have a positive combined MA gain/loss margin for CY2018.

User Group Call Date 05/11/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
5	Gain/Loss Margin	05/05/2017 9:02	Reflecting a potential sale in 2018 bids	This question is related to question #6 from the "User Group Call Date 04/14/2016", regarding mergers. Background: An MAO is in the process of reviewing purchase offers, and plans to: 1) Have a letter of intent executed after the bid deadline, but before 1/1/2018. 2) Complete the transaction before the end of the bid year (2018) – at which point, the MAO would be operated by the buyer. Based on the response to question #6 from the 4/14/2016 call, it is clear CMS will accept a bid that does not reflect the sale of the MAO in this situation. In this case, the sale is very likely to occur and will result in material changes to administrative costs during the bid year. Will CMS accept a bid that reflects the expected changes during the bid year, specifically changes to the administrative costs of the plan? Please note the MAO being purchased (~30k members) is much smaller than the potential regional / national buyer. If these changes due to the potential (and likely) sale are included in the bid, does this have an impact on gain/(loss) margin testing? The MAO expects to perform margin tests at the contract level, and does not currently have any other lines of business – so intends to use the "risk-capital-surplus" test.	CMS' response on the 4/14/2016 UGC regarding mergers recognizes the difficulty plan sponsors may have obtaining the information required to reasonably and appropriately submit bids reflecting a change in ownership when a change in ownership happens shortly before the bid submission deadline. Gathering the required information to support bids that reflect a change in ownership is likely even more difficult for changes in ownership that are finalized after the bid submission deadline. In the rare instance where a change in ownership is to be finalized after the bid submission deadline and the certifying actuary has enough detailed information about the new organization, CMS will allow the certifying actuary flexibility in setting assumptions that reflect the certifying actuary's best estimate of what is most likely to occur during the contract year. The certifying actuary will be required to demonstrate that the change in ownership is highly likely and also demonstrate that there will be an impact on pricing assumptions for the contract year. For the specific situation outlined in this question, without a letter of intent at the time of bid submission, CMS would find it difficult to justify adjusting these assumptions for the 2018 bids.
6	Platino Program	N/A	N/A	[Paraphrased] Our plan fully participates in the Puerto Rico ASES Platino program. As a participant in the ASES program, we fund significant costs outside Medicare benefits. 1) As in past years, we are requesting an exception to the gain/loss margin requirements to recognize the additional costs. These costs will be fully included in WS 4 of the CY2018 MA-BPTs. 2) In addition, we are requesting permission to assume that all members in the Platino plans are DE# members, regardless of the Medicaid codes used in the MMR files or Beneficiary Level Files. This is consistent with our understanding of how the ASES Platino program works.	1) Please include this margin exception request in the supporting documentation uploaded with the initial bid submission. 2) Please make your best determination as to which members in the Platino plans are DE# members and upload documentation to support that assumption within your supporting documentation.
7	Care Management Services	05/04/2017 16:07	Bid Question - SNP care management expenses	The 2018 MA BPT instructions state the following on page 13: *"For care management services provided under a SNP model of care—for example, services provided by an interdisciplinary care team as mandated by Medicare Improvements for Patients and Providers Act (MIPPA) and addressed in a HPMS memorandum dated September 15, 2008—costs are treated as medical expenses. Should the team provide additional services, any added costs may be classified by the certifying actuary as medical expenses or non-benefit expenses."* In what bid service category does CMS expect these SNP care management services to appear?	CMS does not specify a default mapping by service category of care management services provided under a SNP model of care that are classified as medical expense. For such medical expenses, CMS expects— 1) The certifying actuary to include the cost of such expenses in the same kinds of service categories used for care management services that would be classified as medical, if incurred outside of the SNP model of care. 2) Supporting documentation to include an explanation of the allocation by service category of such medical expenses that would otherwise be classified as non-medical expense, if not required to be provided by the interdisciplinary care team. See the example in the Disease Management section of the Benefits and Services Categories pricing consideration for more information.

User Group Call Date 05/11/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	AE FFS Cost Sharing	05/09/2017 10:52	Part B RX Cost Sharing - AE Cost Share Test	One of the cost sharing requirements is that the Part B RX cost sharing needs to be less than the FFS actuarial equivalent value of 21.8%. How should an MAO handle this test in a situation where the health plan receives rebates on the Part B drugs? Similar to Part D, Part B RX cost sharing is applied to the allowed cost at the point of sale and the health plan later receives a rebate. For example, if an MAO has cost sharing of 20%, the cost at the point of sale is $100 and the rebate is $10 then the cost sharing on worksheet 4 would be 22.2% = ($100 * 20%) / ($100 - $10). This would fail the actuarial equivalent test because it is greater than 21.8%. However, 20% cost sharing is less than FFS Medicare levels. In this situation, would it be acceptable to file the cost sharing at 20% and provide supporting documentation showing that the cost sharing passes the test when based on the allowed cost at the point of sale? Similarly, for a plan with OON benefits if the cost sharing based on the allowed cost at the point of sale is less than 21.8% and the cost sharing when including the rebate dollars is greater than 21.8%, would it be acceptable to file the benefits and provide documentation showing that the benefit passes the test if applied to the allowed cost at the point of sale.	In this situation it would be acceptable to file the cost sharing at 20% in the PBP and provide supporting documentation showing that the cost sharing passes the actuarial equivalent test when based on the allowed cost at the point of sale. The AE testing is done on total cost sharing (In and Out of network), so the plan can provide a similar statement in supporting documentation for both In and Out of network benefits.
9	AE FFS Cost Sharing	04/29/2017 15:28	Part B Deductible	We are working with an HMO that is submitting a Dual-Eligible SNP with the Medicare-defined Part B deductible where they want to enhance the Part B Rx benefit to 0% coinsurance. 1) Please confirm our understanding that since they are enhancing this benefit, we cannot use the actuarial equivalent cost sharing percentages that are displayed on Worksheet #4, which includes the estimated impact of the Medicare Part B deductible. 2) Since the Medicare Part B deductible will not be released until November, do plans typically enter an estimate of the Part B deductible for 2018 in the PBP and BPT? If so, does CMS have a recommended approach?	1) That is correct, HMO Plan Sponsors may not use the actuarial equivalent cost sharing percentages for Part B services unless all cost sharing in the PBP for Medicare Part B services aligns with Medicare FFS cost sharing. 2) In order for the PBP to include the published Medicare Part B deductible, Plan Sponsors must indicate this intent in the PBP, but not enter an estimate of such deductible in the PBP or BPT. However, any assumed value for the Part B deductible used in pricing must be fully documented in the initial bid submission. See pages 17-18, 72-73 and 112 of the MA bid instructions or contact the CMS mailbox: https://mabenefitsmailbox.lmi.org/.

User Group Call Date 05/18/2017

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Related Party	05/12/2017 17:15	Related-Party Declaration	Regarding the "Related-Party Declaration" referenced in the list of documentation needed for the June bid submission on page 103 of the Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2018, what exactly is CMS looking for? Is a short sentence stating that the plan advises CMS that the plan has entered into a related-party arrangement with ABC Company enough? Or, is more needed? I assume the "Related-Party Declaration" is different from #13 on page 109. Also, who must it be signed by? May it be legal counsel? Or, must it be the actuary or plan?	Yes, #3 within the documentation requirements on page 103 of the CY2018 MA Bid Instructions is simply a statement indicating whether or not the MAO is in a related-party arrangement and who the parties are in that arrangement. Documentation item #13 on page 109 includes the detailed support for any such related-party arrangement declared within #3 above. Please be sure to include all applicable required documentation items listed within the sub bullets of #13. There is no requirement that the documentation be signed by legal counsel. By completing the actuarial certification module, the actuary is certifying that to the best of their knowledge and judgment, the bids are in compliance with applicable laws, rules, Contract Year bid instructions and current CMS guidance and were prepared in compliance with the Actuarial Standards of Practice.
2	POS Benefit	05/15/2017 15:10	Point-of-Service (POS) Benefit Removal	A plan offered a POS benefit in the base period and will be removing that benefit completely in the projection period. It is our assumption that a portion of the claims that were POS claims in the base period will move in-network and continue to be covered there in the projection period. Should the additive adjustment shown in columns (p) and (q) of worksheet 1 reflect the net impact of removing the POS benefit? For example, if there were $20 PMPM of POS claims in the base period and it's expected that $4 PMPM of that will move in-network and be covered in the projection period. Would it be appropriate to show −$16 PMPM in the additive adjustment column (q) on WS1 for that service category?	It is appropriate to use the additive projection factors to reflect the net impact of removing the POS benefits for the contract year. Since the additive projection factors are applied after the multiplicative projection factors, in this example, project the $20 PMPM of POS claims in the base period to the contract year. Then use the additive factors in Worksheet 1, column q for the applicable service categories to reflect the projected allowed costs corresponding to the net −$16 PMPM base period impact of removing the POS coverage. See page 57 of the CY2018 MA BPT Instructions.

User Group Call Date 05/25/2017

There are no advance questions for posting.

User Group Call Date 06/01/2017

There are no advance questions for posting.