User Group Call Date 02/20/2025

Introductory Note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
For COVID-19 policy and benefit related questions: https://ma-covid19-policybenefits.lmi.org/covid19mailbox
For Part C policy-related payment questions: PartCpaymentpolicy@cms.hhs.gov
For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
For Part D policy-related payment questions: PartDpaymentpolicy@cms.hhs.gov
For Part D policy-related questions: partdpolicy@cms.hhs.gov
For Part D benefit-related questions (including OOPC/PDP Meaningful Difference policy): partdbenefits@cms.hhs.gov
For Part D formulary related questions: partdformularies@cms.hhs.gov
For questions related to risk score models and released data: riskadjustmentpolicy@cms.hhs.gov
For questions related to the Encounter Data Processing System: riskadjustmentoperations@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov
For questions related to Dual Eligible Special Needs Plans (D-SNPs): MMCO_DSNPOperations@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	ESRD	N/A	N/A	Can you expand on the change to the ESRD definition for CY2026, to Chronic Kidney Disease (CKD) with two categories—(i) CKD requiring dialysis/ESRD; and (ii) CKD not requiring dialysis? Is this a broader change to the current three ESRD categories of dialysis/transplant/post-graft that would affect plan payments, or is this limited to ESRD-SNPs	The Final Rule, effective June 3, 2024 codified the list of 22 chronic conditions to be used by CMS to approve C-SNPs. One of the changes includes renaming the "End Stage Renal Disease (ESRD) requiring dialysis" condition category to "Chronic kidney disease (CKD)" with the following conditions: CKD requiring dialysis/ESRD, and CKD not requiring dialysis. This rule change does not change the plan payments for ESRD beneficiaries.
2	Risk Sharing	N/A	N/A	Our capitation arrangements often have non-contingent, fixed PMPM care coordination fees associated with them. We typically report these amounts as a medical expense. Should these care coordination fees be included in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4?	No, these amounts should not be reported in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4. Only amounts payable contingent on achieving a certain outcome specified in a risk-sharing arrangement contract should be reported in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4. Fixed amounts, such as salaries, FFS payments, capitations, or returned withholds, should not be included in these cells.
3	Risk Sharing	N/A	N/A	Should monthly capitation payments, as defined in ASOP 5, be included in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4, or should only payment adjustments be included in these cells?	No, these payments should not be reported in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4. Fixed amounts, such as salaries, FFS payments, capitations, or returned withholds, should not be included in these cells. Only amounts payable contingent on achieving a certain outcome specified in a risk-sharing arrangement contract should be reported in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4. As an example, assume that a plan sponsor contracts with a MA provider to provide MA services. The contract specifies that the provider will be paid FFS, and that the provider will share in 100% of the upside and downside risk when an 85% target medical loss ratio is not achieved (100% is used as an example, but this percentage could be any number). Assume the following: MA Revenue = $1000 MA Claims = $900 Target MLR Claims = $850 MA claims fall above the target by $50 ($850 – $900), for a total settlement payment from the provider to the insurer of $50 (100%* $50). If the arrangement is between a provider and a single bid, negative $50 is what should be reported in the Risk-Sharing Arrangement Payment Adjustment cells on MA Worksheets 1 and 4. If the arrangement is between a provider and multiple bids, this amount would be allocated among all participating bids. If you are uncertain about whether an item should be reported in these cells, please contact the actuarial-bids mailbox.

User Group Call Date 02/20/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	Gain/Loss Margin	N/A	N/A	OACT has proposed that plans with gain/loss margins as a percentage of revenue less than −10 percent that have existed since CY2022 be added to those requiring additional documentation under Appendix B Section 8.6. Can OACT please confirm (a) if the plan(s) to be included are those that are less than −10 percent only in the bid year, regardless of the gain/loss margins since CY2022 (that is, the plan could have had a positive gain/loss margin at any point since and including CY2022) and (b) if the plan(s) to be included are only those that have a continuing Contract-Plan ID-Segment ID since CY2022.	(a) The plans to be included are only those that are less than −10 percent in the bid year, regardless of what the plan's margin was in prior years. (b) The plans to be included are only those that have had a unique Contract-Plan ID-Segment ID since CY2022
5	Inflation Reduction Act (IRA)	01/28/2025 10:38	Questions about Reporting Estimated Remuneration at POS Amount (ERPOSA) in CY2026 PD BPT WS1	The PDE data of CY2024 which will be reported to CY2026 PD BPT WS1 has the field of "Estimated Remuneration at POS Amount (ERPOSA)" which for 2024 includes the full cost of the Part D Plan-Facilitated USG PAP. We have two questions about how to report this field in WS1. 1. Will this field be included in the claim allowed in lines 1 to 6? 2. Will this field be included in the total rebates in line 7 if it is not included in the total allowed?	The ERPOSA must be reflected in the allowed cost in lines 1–6 on Worksheet 1 of the CY2026 Part D BPT.
6	Base Period Experience	N/A	N/A	For reporting members, scripts, and costs by ending phase on WS1, will CMS provide more explicit guidance about how to estimate when the 2026 TrOOP threshold is met for NLI and LI members?	- Worksheet 1 Section III – Part D Claims Experience: - When completing the CY2024 base period experience in the CY2026 BPT, plan sponsors must enter the number of members with total CY2024 allowed costs equal to $0, between $1 and $544, between $545 and catastrophic, and above catastrophic. - For the purposes of completing Worksheet 1 of the CY2026 BPT, all members with TrOOP costs less Gap Discount amounts greater than $2,100 are considered to have reached the catastrophic phase. - This is a temporary transition for one more year until the base period benefit phases align with the IRA. - Plan sponsors should not enter Gap Discount amounts into column J, Average Cost Sharing per Member on WS1. Gap Discount amounts will need to be a component of base period reconciliation to financials. - For Plan-to-Plan transaction reporting on worksheet 1, plans will need to estimate the gap discount using whatever method they believe produces the most reasonable result and provide support for that methodology
7	Selected Drug Subsidy	N/A	N/A	We are aware the Selected Drug Subsidy will be paid to plans for MFP drugs in 2026 below the catastrophic threshold. Will the Selected Drug Subsidy be reduced in the event that there are manufacturer rebates associated with MFP drug claims, similar to how rebates are distributed between plans and the federal government based on the plan's gross reinsurance?	The Selected Drug Subsidy will be reconciled dollar for dollar with what is reported on the PDE and what the plan receives in prospective payments (meaning, in totality, the plan will be paid the amount that is reported on the PDE). We will not be removing the reported DIR from the actual payment amount, which is what we do in the reinsurance reconciliation.

User Group Call Date 04/17/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	03/25/2025 11:51	FFS Trend Questions for OACT	What specific elements are captured in the non-negligible 'other' line items in the PMPM trend buildup within the CMS file titled 'Trends Supporting 2026 Growth Rates'? Specifically, the 'other' trend components in the Part A − PMPM Trend (2026 Rate Announcement) section (bottom of page 1 – page 2) and the Part B − PMPM Trend (2026 Rate Announcement) section (page 4 – page 5).	Items that are reflected in the "other" trend line include beneficiary population changes, medical education, pass through payments, cost report settlements, and bad debt.
2	FFS Trends	03/25/2025 11:51	FFS Trend Questions for OACT	Does the CY 2025 2.93% reduction in average payment rates under the PFS capture the impact of new policies in the calendar year 2025 Medicare Physician Fee Schedule including the temporary additional payments for certain non-opioid treatments and the new G codes for SPI (G0560), FCI (G0544), DMHT (G0552, G0553, G0554), and Interprofessional Consultations (G0546-G0551)? If so, what has CMS valued as the impact of these items?	The 2025 physician update is not calculated based on any particular HCPCS codes. Also, please note that the -2.93 percent conversion factor update in the 2025 physician fee schedule regulation, CMS-1807-F, is different than the -2.5 percent value in the Medicare unit cost exhibit posted on the "FFS Trends" tab of the MA ratebook web page. The -2.5 percent unit cost trend accounts for the increase over the composite 2024 update of 1.25 percent January 1, 2024 through March 8, 2024 and 2.93 percent from March 9, 2024 through December 31, 2024.
3	FFS Trends	03/25/2025 11:51	FFS Trend Questions for OACT	Can CMS provide detail and quantification regarding the expected impact of tariffs on the FFS trend? Does CMS have an expectation for the impact on medical supply and drug costs? Will potential future tariffs be considered when projecting FFS trends in the Final Rate Notice?	The anticipated effects of tariffs are not reflected in the baselines supporting the 2026 Advance Notice, 2026 Rate Announcement, and 2026 ratebook growth rates.
4	FFS Trends	04/07/2025 6:02	Pre-exposure prophylaxis (PrEP)	Was there consideration for the impact of Pre-exposure prophylaxis (PrEP) on the 2025 and 2026 Medicare FFS trends? If so, please provide the PMPM trend impacts of including PrEP or the estimated PMPMs for PrEP.	CY 2025 and CY 2026 spending for pre-exposure prophylaxis (PrEP) was not explicitly projected in the 2026 ratebook USPCCs and growth rates.
5	Base Period Experience	04/09/2025 9:56	Part C Wk 1 Question	My client inadvertently paid for some non-emergency transportation claims in 2024 for a plan that did not have the benefit in the PBP. Should this experience be excluded from Worksheet 1 of the Part C BPT (so it would be included as a line item in the financial reconciliation)? Or include as a claims expense or NBE?	The claims should be excluded from worksheet 1 since the benefits were not included in the CY2024 PBP. We would expect to see these claims as a line item in the base period reconciliation to audited financial statements within the supporting documentation.
6	Base Period Experience	03/05/2025 12:06	BPT Paid Through Date	Some of our CY2026 bids will have base period plans whose FFS claims are paid on different claim systems. One system will only have runout available through 1/31/25 for the bids, while the other can be updated through 2/28/25. Is it allowable to use different runout periods for each base plan? If so, should we put the latest paid through date in WS1 cell E16 of the MA BPT (in this case, 2/28/25)?	It is allowable to use different run out periods in order to include the most up to date information. The plan sponsor should enter the earliest paid through date on Worksheet 1 of the BPT (In this example, the paid through date of 1/31/25). Please include additional details in supporting documentation explaining the different claims systems and runouts periods.
7	Risk Sharing Arrangements	N/A	N/A	Last year for CY2025, there were five CMS responses under the topic, "Risk Sharing Arrangements." The responses include the following from the cumulative UGC Q&A file: 1547, 1548, 1555, 1562, and 1565. Does CMS have updated responses, or can we continue to follow the same responses for CY2026?	The same CMS responses, as for CY2025 under the topic of Risk Sharing Arrangements, are applicable to CY2026. OACT will continue to study this issue for CY2027 and expects to provide more information in the fall of 2025.
8	MMP	N/A	N/A	Our organization has a Medicare-Medicaid Plan (MMP) that will terminate at the end of 2025. We are using the CMS plan crosswalk functionality in HPMS to transition members to a D-SNP. Our MMP had membership in 2024. If we perform the crosswalk, would we be expected to report 2024 base period experience in the 2026 MA and Part D BPTs? If so, what MMP benefits should be reflected on Worksheet 1? In addition, how should expectations for recoveries of quality withholds be reflected on Worksheet 1?	Yes, if a crosswalk is performed as described in the memo, the CY2024 MMP experience must be included in the base period of the CY2026 MA and PD BPTs (in accordance with the Data Aggregation section of the Base Period Experience pricing consideration in the MA and PD Instructions). The benefit costs entered on Worksheet 1 should be consistent with the MMP's CY2024 PBP design (if the benefit appeared in the CY2024 PBP, the cost should be reported on Worksheet 1). Expectations for quality withhold payments should be reflected in the revenue reported on Worksheet 1. Note that experience reported on Worksheet 1 must be reconcilable to audited financial statements.
9	Supporting Documentation	03/14/2025 11:24	Risk Share Documentation	We have a question on the new capitation and risk share supporting documentation in #23 of the MA bid instructions. Item 23.1 says it applies to Worksheets 1 and 4. Does Item 23.2 apply to projection period only or both the base period and projection period?	Item 23.2 applies to both the base and projection periods.

User Group Call Date 04/17/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
10	Selected Drugs	Beta Feedback	N/A	Consistently in the Final Calendar Year 2026 Part D Redesign Program Instructions, instructions are outlined separately for applicable, non-applicable, and selected drugs. However, the BPT instructions do not specify if selected drugs should be included in generic (non-applicable) or brand (applicable) rows on Worksheet 6 of the Part D BPT. As these drugs are currently applicable in 2025 but will become non-applicable for the purposes of determining reinsurance payments, could CMS clarify how projected utilization and costs associated with these drugs should be grouped on Worksheet 6?	Selected drugs must be placed in the category they would normally be placed in regardless of how they are treated for reinsurance. Hence, in most cases selected drugs would be placed in the brand rows on WS6.
11	Base Period Experience	Beta Feedback	N/A	Page 10 of the Final Part D BPT instructions defines allowed as the sum of ingredient cost, dispensing fee, sales tax, and vaccine administration fee. The response to question 5 of the 2/20/2025 user group call specifies the estimated remuneration at POS amount (ERPOSA) should also be included in the allowed cost. Can CMS clarify how ERPOSA should be reported on Worksheet 1?	Report the allowed costs in Section 3, lines 1-6 of Worksheet 1 according to the Part D BPT instructions, The PDE fields specified for allowed costs will automatically represent the plan's cost after accounting for the PAP program and other ERPOSA amounts. Plan sponsors do not need to make separate adjustments for ERPOSA outside of the specified fields for allowed.
12	Selected Drug Subsidy	Beta Feedback	N/A	Will the selected drug subsidy be sequestered?	Yes, the selected drug subsidy is subject to sequestration.
13	Insulins/Vaccines	N/A	N/A	Should insulins/vaccines be included in the value of the deductible/claims subject to the deductible on WS3/WS6? Should insulins/vaccines be included when determining whether a member has progressed from the deductible phase to the initial coverage phase on WS3/WS6.	Insulins and vaccines are not subject to the deductible. As such, insulin and vaccine costs (for example, insulin cost sharing) must not be included in the Deductible PMPM column on Worksheet 3 and must not be included in the Claims Subject to Deductible rows on Worksheet 6. However, in so far as insulin or vaccine costs accumulate to the TrOOP (for example, insulin cost sharing), these costs must be included when determining whether a member has moved from the deductible phase to the initial coverage phase and from the initial coverage phase to the catastrophic phase when filling out both Worksheet 3 and Worksheet 6.
14	Risk Score	03/19/2025 14:30	PY2026 Bid Part D Risk Scores Projection Question	We project Part D risk scores based on low-income and non-low-income conditions per CMS guidelines. However, there are many of our plans that are either with predominantly low-income members or with non-low-income members. Are there any safe harbor rule that if low-income or non-low-income member percentage is higher than a certain threshold within a given plan, then we can project the whole plan based on that category?	There is no safe harbor rule for this situation. Certifying actuaries must provide their best estimate of the projected risk scores for the anticipated plan population, ensuring they adhere to all relevant actuarial standards of practice. Additionally, supporting documentation must thoroughly explain and justify any simplifying assumptions made in the projection.
15	Maximum Fair Price Drugs	04/07/2025 18:55	MFP Drugs and Formulary Review	If a PD plan submits their initial bids with an MFP drug disadvantaged vs a competing product and CMS does not accept the justification for the non-preferred tier placement, could CMS confirm that the change will occur during the formulary stage review and therefore BPT pricing changes will not be permitted?	BPT changes will not be permitted for minor formulary revisions during the bid review process. Significant changes to formularies that may require BPT changes will be reviewed on a case-by-case basis.
16	Projection Factors	04/09/2025 15:06	Question about CY2026 Part D Cost due to Tariffs	[Paraphrased] The government's announcement of potential tariffs on pharmaceutical medications could have a material effect on the CY2026 bids. 1. Does OACT have any guidance on how health plans should adjust their pricing strategies to account for potential tariff changes? 2. Is it appropriate to bucket this impact into trend change column or other change column in the BPT WS2 unit cost section?	1. The certifying actuary must make their best estimate of the likelihood of pharmaceutical tariffs going into effect and the expected impact on pricing. Actuaries should follow all applicable actuarial standards of practice and provide numerical supporting documentation for these assumptions. 2. The impact of tariffs on unit cost trend, if any is assumed, should be included in the inflation trend component of unit cost trend on Worksheet 2 of the Part D BPT.
17	Low-Income Benchmarks	04/14/2025 21:12	Restated LIB Questions	1. Last year, the 2024 restated LIBs were calculated using the 2024 restated direct subsidy. This was a change from prior years, where the restated LIBs were calculated with the actual direct subsidy. Can you confirm that the 2025 restated LIBs were calculated using the 2025 restated direct subsidy? 2. We are looking for the 2025 low income membership file to support our projections of the 2026 LIBs. Do you know when that file will be released?	1. Yes, the 2025 restated LIBs were calculated using the 2025 restated direct subsidy. 2. The CMS component responsible for creating this file expects to post the information soon.

User Group Call Date 04/17/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
18	Part D Benefits	N/A	N/A	According to regulation 1860D-2(b)(9)(D)(ii), insulin cost share for plan years 2026 and beyond should be "the lesser of $35 or 25% of either (1) the maximum fair price (if HHS has negotiated a price) or (2) the Part D plan negotiated price." Can CMS please expand upon the "lesser of" logic, with examples, for beneficiary cost sharing pertaining to insulin products?	Beginning in CY2026, a member taking an insulin that is not a "selected drug" under the Medicare Drug Price Negotiation Program (non-selected insulin) will pay no more than the lesser of: (1) $35 (or the PBP submitted copay, if lower) or (2) 25% of the negotiated price (or the PBP submitted coinsurance, if lower). Using an example of an insulin tier copay of $30 and a negotiated price of $100 for a non-selected insulin, the beneficiary would pay no more than $25. [$30 copay vs $25 (0.25 x $100 negotiated price)]. If the member is taking an insulin that is a "selected drug" under the Medicare Drug Price Negotiation Program (selected insulin) in CY 2026, they will pay no more than the lesser of: (1) $35 (or the PBP submitted copay, if lower); (2) an amount equal to 25 percent of the maximum fair price (MFP) established for the covered insulin product in accordance with part E of Title XI of the Social Security Act; or (3) an amount equal to 25 percent of the negotiated price (or the PBP submitted coinsurance, if lower). Using an example of an insulin tier copay of $30, an established maximum fair price of $80, and a negotiated price for a selected insulin of $84, the beneficiary would pay no more than $20. [$30 copay vs $20 (0.25*$80 MFP) vs $21 (0.25*$84 negotiated price)].
19	Part D Benefits	N/A	N/A	Can CMS please clarify how you will calculate the potential premium changes for PDP consolidated renewal crosswalk exception requests that are submitted in June 2025 for the CY 2026 plan year? Will CMS use the terminating PBP's CY 2025 premium (i.e., the PBP from which enrollees will be crosswalked into another plan) that includes reductions in the premium amount that occurred as a result of the Premium Stabilization demonstration as baseline? Will CMS apply a discount to the estimated CY 2026 premium for the receiving PBP (i.e., the PBP into which that the PDP sponsor proposes to crosswalk enrollees) in anticipation of a CY 2026 Premium Stabilization demonstration?	Additional guidance for PDP sponsors pertaining to this and similar questions will be issued in the upcoming weeks.
20	Part D Benefits	04/15/2025 22:38	Tier Placement for Negotiated Drugs	Does CMS have any requirements around formulary tiering for the Negotiated Price drugs? For example, if Eliquis is currently covered on a Preferred Brand tier in 2025, would a plan be able to uptier this drug to a Non-Preferred Tier in 2026?	We refer sponsors to the IPAY 2026 Revised Guidance Section 110 (starting on page 175) (https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf) and the recently released memorandum "CY 2026 Part D Formulary Submission Information" from April 16, 2025, which provides details on the formulary review process related to selected drugs.

User Group Call Date 04/24/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	USPCCs	04/21/2025 10:16	Question on Medicare Secondary Payer (MSP) Claims	On page 43 of the 2026 Rate Announcement, CMS states “Medicare secondary payer claims are included in the tabulation of non-ESRD USPCCs and AGAs.” Does CMS apply an adjustment to Medicare secondary payer claims when developing the USPCC and/or the AGA factor calculation? If yes, please explain how the adjustments are calculated and applied to the MSP claims for the USPCC and/or AGA factor development.	No adjustments are applied to claims in MSP status in the development of non-ESRD USPCCs and AGAs.
2	ESRD	04/16/2025 18:04	Question regarding ESRD subsidy	While CKD CSNPs are required to fill section III (ESRD subsidy box) in WS4, is it required to select "Y" in cell J131 to reflect the subsidy, or do we have the freedom to choose "N" for CKD/ESRD plans?	CKD CSNPs are permitted to choose "N" in cell J131 on MA Worksheet 4.
3	Supporting Documentation	04/21/2025 17:53	2026 Cost Sharing Support	We would like clarification regarding what support is required as a result of changes to item 22.1 of Appendix B in the MA BPT instructions (in particular the new text under 22.1.c) and the Final Contract Year 2026 Part C Bid Review memo released on 4/16/25. For PBP data entry fields that do not appear in Table 4 of the Bid Review memo, are plans required to demonstrate compliance with the 50% coinsurance cap on original Medicare benefits under 42 CFR 422.100(f)(6)(i) (as shown in https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.100#p-422.100(f)(6)(i))? For example, there is no established copay or coinsurance limit for ambulance benefits in this table (PBP line 10a). Will all plans be required to document that their cost sharing for this benefit does not exceed 50% coinsurance on an actuarially equivalent basis, and will they be required to upload that support into HPMS via the ‘Cost-Sharing Justification’ module? Can CMS also confirm that this applies to all Medicare-covered PBP lines that do not appear in Table 4?	Plans are required to demonstrate compliance with the 50% coinsurance cap on original Medicare benefits under 42 CFR 422.100(f)(6)(i). All plans are required to document that their cost sharing for these benefits do not exceed 50% coinsurance on an actuarially equivalent basis. This applies to all Medicare-covered PBP lines that do not appear in Table 4. This documentation must be included with item 22 of Appendix B of the MA BPT instructions and must be included with the Appendix B substantiations upload. This documentation must also be uploaded to the Cost-Sharing Justification module.
4	Script Projection	04/15/2025 14:31	Question on CY 2026 Part D Bid Instructions	We have a question on the Part D BPT guidance provided on April 11, 2025. The instructions for assigning members to phases in Section III of Worksheet 3 was updated relative to the 2025 bid year instructions. On page 40 of the BPT instructions, we are directed to report information for members with $0 in total allowed on line 1 of Section III. We would like to clarify if this guidance also applies if the member is projected to have a non-zero count of scripts in the plan year (i.e., the member filled at least one script and all scripts were for $0 in allowed). On the April 28, 2022 user group call, OACT instructed us to include members in this situation in line 2 of Section III on Worksheet 1 and 3. Does the guidance from the user group call still apply, or should these members be reported in line 1 going forward? If the latter, where should we report scripts for these members and does this change also impact Worksheet 1? The script entries on Worksheet 1 and 3 for line 1 are not editable.	The April 28, 2022 UGC still applies. These members should be reported in Section III, Line 2.
5	Low-Income Benchmarks	04/16/2025 16:01	Restated LIB Questions	I have one additional question on the 2025 restated Low-Income Benchmarks (LIBs). Can you confirm if the Part D bids used in the calculation of the restated LIBs was based on the bids before rebate reallocation, or the bids after rebate reallocation.	The restated LIBs were based on the bids after rebate reallocation.
6	DIR#10	04/17/2025 22:56	Question on Projection Period DIR #10	A health plan’s Pharmacy Benefit Manager (PBM) has informed them (the health plan) that the PBM already knows they will not be able to manage the pharmacy discounts throughout 2026 to meet the discount guarantees in their PBM contract. Therefore, the PBM is forecasting a true-up payment to be made to the health plan at 2026 yearend. The PBM is paying this cost themselves and will not be going back to the pharmacies to recoup this money. We believe that this true-up payment amount should be reflected as DIR in the DIR #10 box in Section VIII on Worksheet 2 of the 2026 Part D BPT. Do you agree that it is correct to reflect this anticipated 2026 true-up payment in Section VIII of Worksheet 2 of the 2026 Part D BPT?	DIR #11 is the most appropriate category to report the PBM’s “true-up” payment described in the question. Therefore, the plan must NOT include this amount in Section VIII on Worksheet 2 of the Part D BPT as it is not DIR#10. This amount must be reflected in the rebate line of the bid pricing tool.

User Group Call Date 05/01/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Rebate Reallocation	N/A	N/A	In some cases, CMS's announced Part D direct subsidy exceeds the MAO's estimated subsidy in the BPT, leading to a negative total Part D premium—even after reducing rebates allocated to Part D supplemental benefits. Appendix E of the MA bid instructions notes that in rare cases where (1) the total Part D premium remains negative after rebate reallocation and (2) cannot be made positive by reducing supplemental rebates, limited benefit enhancements may be allowed. We've encountered two scenarios where we believe benefit enhancements are insufficient to resolve the negative premium: 1) Enhanced Plans: Total Part D premium remains negative even after cost sharing is reduced to $0, with potential anti-selection concerns due to overly rich benefits. 2) Basic Plans: The plan is the only basic option in the region, and CMS requires at least one plan that meets basic benefit requirements. Given these constraints, what adjustments to other BPT components (beyond rebate reallocation) would CMS consider acceptable to ensure a non-negative total Part D premium?	CMS recognizes the challenges, including anti-selection and requirements for basic plan offerings, that some plan sponsors may face in addressing negative Part D basic premiums. Plan sponsors are expected to review and apply the existing rebate reallocation guidance and make all reasonable efforts to resolve negative Part D basic premium issues before reaching out to OACT. If assistance is needed, please contact OACT at the beginning of the rebate reallocation period to allow sufficient time for a collaborative and timely resolution. CMS will work with each MAO as needed to achieve a non-negative total Part D premium, but sponsors should be prepared to share updated BPTs promptly to avoid delays in resubmissions during the rebate reallocation period.

User Group Call Date 05/08/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	ESRD	04/30/2025 16:36	MSP factors for ESRD population	Last year, MSP adjustment factors for ESRD (Functioning Graft = 0.136 and Dialysis/Transplant = 0.135) were given in ESRD BPT WS1. What are the adjustment factors for CY2026, now that there is no ESRD BPT?	The 2026 MSP adjustment factors for ESRD are the same as last year (Functioning Graft = 0.136 and Dialysis/Transplant = 0.135). Any changes to these factors from a prior contract year will be announced in the Advance Notice/Final Rate Announcement.
2	Part B Buydown	N/A	N/A	Will including a Part B buydown impact a member's low-income status, and thus affect their Medicaid eligibility? Since these members do not pay the Part B premium, we would like to understand how the Part B premium buydown works, and whether this could be considered income. It seems that certain types of supplemental benefit allowances have been determined to impact income eligibility, even though it is not a direct cash payment.	For non-Modified Adjusted Gross Income (non-MAGI) Medicaid beneficiaries—those who qualify for Medicaid under SSI methodologies—the SSA POM's (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815050) provides that while payments by a third party of an individual's medical insurance premiums are not considered a medical service, these payments are not considered countable income per SI 00815.400 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815400). Therefore, the Part B premium buydown does not affect the Medicaid eligibility of these low-income beneficiaries. For Medicaid eligibility determinations using MAGI-based methodologies, payments by a third party of an individual's Part B premiums are generally not considered taxable income and are therefore not countable income for MAGI. See, for example, IRS Publication 525 (page 20). As a result, the Part B premium buydown does not affect Medicaid eligibility status of these low-income beneficiaries.
3	PACE	04/23/2025 13:27	PACE Cost Sharing Add-on calculation	[Paraphrased] We are noticing a difference between what we would calculate the PACE Cost Sharing add-on to be and what the value in the MMR files are. In addition, the differences we are observing vary both above and below what we calculate. Published information regarding the PACE Cost Sharing Add-on indicates the value should be about 2% of allowed costs below the out-of-pocket threshold. However, calculating the amount as 2% of costs below the catastrophic threshold using values from Worksheet 6 results in values that differ from the MMR files both above and below depending on the specific organization. Can you please help explain this difference?	Changes were made to the PACE cost sharing add-on calculation for 2025. The *PACE cost sharing add-on* is calculated as: 2% * [(PD WS3, Cell H25) – *PACE cost sharing adjustment*] The *PACE cost sharing adjustment* for CY2025 is calculated as: (PD WS3, Cell H24) * 0.7051 The value, 0.7051, was calculated using the 2025 Defined Standard PACE bids' projected level of catastrophic costs relative to total allowed costs for beneficiaries reaching the catastrophic phase.

User Group Call Date 05/15/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Risk Sharing Arrangements	05/06/2025 16:55	Risk-Sharing Arrangement Clarification re: quality incentives	As a variant on #2 from the 2/20/2025 UGC, does OACT consider quality incentives an item to report in the Risk-Sharing Arrangement Payment Adjustment cells? These quality incentives are often structured as an additional PMPM payment to a provider if they achieve performance measure thresholds - often related to Star measures thresholds - and therefore contingent on achieving a certain outcome, and are often written in as part of a broader risk-sharing adjustment contract. However, often these quality incentive payments are separate from, and not included in, the separate contractual terms which are contingent on achieving a target MLR, as question #3 from the 2/20/2025 UGC provides an example for.	Yes, these amounts must also be included in the Risk-Sharing Arrangement Payment Adjustment cells. These incentive payments are contingent on achieving a certain outcome specified in a risk-sharing arrangement contract. Please be sure to detail in supporting documentation how much of the Risk-Sharing Adjustment is from these quality incentive payments.
2	Crosswalk	05/08/2025 8:42	2026 Bid: Actuarial User Group Calls, Question	Assume an MAO offered segmented plans during the base period (e.g., HXXXX-001-001/002/003) and is now redefining the service areas for all segments. As a result of the realignment, the enrollment crosswalk from each base period segment for Segment 2 falls below the actuary's level of significance (40%). Specifically— • 10% of Segment 1 enrollment transitions to Segment 2, • 20% of Segment 2 remains in Segment 2, and • 30% of Segment 3 transitions to Segment 2. Notably, the 20% of Segment 2 that remains represents 90% of the total base period enrollment for Segment 2's MA BPT. Given that each segment's crosswalked enrollment is below the significance threshold, is it appropriate for the MAO to report no experience on Worksheet 1 of the MA BPT and instead use the experience from Segment 2 to develop the manual rate for projecting bid year experience?	Segment 002's data must be reported on MA Worksheet 1 of Segment 002's BPT. Since Segment 002 is the ongoing bid, the level of significance rule does not apply. Level of significance is only used to determine whether a crosswalking bid's data should be reported on MA Worksheet 1 of the bid it is being crosswalked into, not to determine whether the ongoing bid's data should be reported on MA Worksheet 1 of that same ongoing bid. The experience of Segments 001 and 003 can be excluded as it is below the actuary's level of significance. See page 109 of the MA Instructions for a demonstration of this.
3	Base Period Experience	05/09/2025 8:22	MMP to DSNP BPT WS1 Question	We have an MMP plan offered in 2025 that is being crosswalked into an existing DSNP plan for 2026. We have a question regarding the MMP experience that should be reflected in WS1. The MMP receives separate revenue amounts to fund claims costs for (a) Medicare services net of original Medicare cost sharing and (b) the Medicaid crossover claims that fill in a portion of the Medicare cost sharing. Unlike the MMP, the DSNP does not receive revenue from Medicaid, so when combining the DSNP and MMP experience for WS1, we are proposing to exclude the Medicaid portion of both revenue and claims from the MMP experience reflected in WS1. This would put it on a consistent basis with the DSNP experience reflected in WS1. The MMP claims are adjudicated in a manner that allows this allocation and as mentioned above there are distinct revenue amounts. Is this an acceptable approach?	Only non-Medicaid revenues and benefit costs should be entered on Worksheet 1, Section III and Worksheet 1, Section V, lines 1-9. In general, Worksheet 1, Section III and Worksheet 1, Section V, lines 1-9 should be consistent with how the benefit would have appeared in the CY2024 PBP in the absence of the Medicaid crossover claim.
4	Rebates	Various	Question Clarification on Reporting ERPOSA in CY2026 Part D BPT Worksheet 1 Part D Worksheet 1 Reporting Questions - ERPOSA	[Paraphrased and Combined] We understand from the 4-17-2025 UGC that "allowed costs in Section 3, lines 1-6 of Worksheet 1 should be reported according to the Part D BPT instructions, The PDE fields specified for allowed costs will automatically represent the plan's cost after accounting for the PAP program and other ERPOSA amounts" and that "plan sponsors do not need to make separate adjustments for ERPOSA outside of the specified fields for allowed." 1. Can CMS confirm it is appropriate to include ERPOSA values as DIR (cell G36) on Worksheet 1 of the Part D BPT such that the DIR reported on Worksheet 1 aligns with the DIR report? 2. Furthermore, what is the correct amount to report as DIR in cell G36 of WS1 in the Part D BPT? Is it the ERPOSA reflected in the PDE, the payment made from the manufacturer to the plan sponsor, or the net difference between the two, the last of which would effectively be the net DIR amount reflected in the plan sponsor's DIR reporting for 2024? 3. If we include ERPOSA DIR in cell G36, N36 will be incorrect. To mitigate this, can we include the ERPOSA DIR in M36 to get to the accurate net plan paid?	1. We confirm it is appropriate to include ERPOSA values in the rebates cell (WS1 G36) of the Part D BPT. 2. The rebate entry in WS1 cell G36 needs to match the anticipated DIR reporting for CY2024 in total. That is, if there is a negative DIR entry for a particular DIR field offset by a positive DIR entry for a different field, the total estimated net DIR goes in G36. 3. Yes, this is the correct approach
5	Part D Benefits	05/12/2025 17:41	Executive Order | Most Favored Nation	[Paraphrased] On 5/12/2025, President Trump signed an Executive Order setting a 30-day deadline for drugmakers to lower the cost of prescription drugs in the US or face new limits over what the government will pay. We are seeking clarification and guidance from CMS on how Plan Sponsors should price for the material risk introduced.	The certifying actuary must make their best estimate of the expected impact on pricing resulting from this Executive Order. Actuaries should follow all applicable actuarial standards of practice and provide numerical supporting documentation for these assumptions.

User Group Call Date 05/15/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	D-SNP	N/A	N/A	On August 19, 2024, CMS released the HPMS memorandum titled, "CY 2024 Prescription Drug Event (PDE) Reporting Guidance for MMPs" which included guidance specific to PDEs with dates of service (DOS) in CY 2024 that are submitted by MMPs that reduce the cost-sharing for Low-Income Subsidy (LIS) category 1 and 2 beneficiaries to $0.00. Will CMS be releasing similar CY 2024 PDE guidance specific to D-SNPs that receive capitations from state Medicaid programs to reduce the LIS 1 and 2 cost-sharing in a similar manner?	Thank you for your inquiry. No, CMS will not be releasing similar guidance as unlike plans participating in the Value-Based Insurance Design (VBID) Model and Medicare-Medicaid plans (MMPs), other dual-eligible special needs plans (D-SNPs) do not operate under waiver authority that would permit CMS to alter the calculation of prescription drug event (PDE) records for claims that would straddle the out-of-pocket (OOP) threshold absent the buy-down of the nominal low-income (LI) copayment. Rather, D-SNPs with state-funded wrap coverage that buys down the nominal LI copayment are structured like Employer Group Waiver Plans (EGWPs) where EGWP supplemental coverage wraps around the Part D benefit. In the case of EGWPs, prior to the amendments to the definition of incurred costs made by the Inflation Reduction Act (IRA), a claim that would have straddled the OOP threshold could fall completely in the penultimate phase of the benefit because of the application of EGWP supplemental coverage. Please refer to the Prescription Drug Event (PDE) reporting examples for benefit year 2014, example #18 for an example of an EGWP claim that would have straddled the OOP threshold absent the application of EGWP supplemental benefits. Like EGWP supplemental coverage prior to the IRA, the state-funded buy-down of the nominal LI copayment is not true out-of-pocket cost (TrOOP)-eligible and is applied after the total low-income cost sharing subsidy (LICS) on a claim is calculated. As such, beneficiaries do not accumulate sufficient TrOOP to satisfy the annual out-of-pocket (OOP) threshold. The buy-down of the nominal LI copayment effectively prevents beneficiaries that owe nominal copayments from entering the catastrophic phase of the benefit. For D-SNPs not participating in the VBID Model, like EGWPs, this result is a consequence of the statutory and regulatory structure of the Part D benefit. As such, CMS cannot alter the calculation of PDE records to avoid this result when state-only wrap coverage buys down the nominal LI copayment. As MA organizations prepare D-SNP bids for CY 2026, they should keep in mind that, because CMS's reinsurance payments are based on Part D drug costs incurred when a beneficiary is in the catastrophic phase, this means that D-SNPs that contract with states to buy down the nominal LI copayment using state-funded wrap coverage will consequently forgo any federal reinsurance subsidies for any portion of the gross covered prescription drug costs actually paid by the MA organization on behalf of its LI enrollees that owe nominal LI copayments during the plan year. We would also like to take this opportunity to reiterate current regulatory and statutory rules regarding D-SNPs with state-funded wrap coverage. Under section 1935(d) of the Social Security Act, in the case of a Part D eligible individual, Medicaid funds may not be used to pay for Part D covered drugs or any cost sharing with respect to Part D covered drugs. As such, MA organizations may not offer wrap coverage funded by Medicaid to provide any coverage for Part D covered drugs, including coverage that buys down the nominal LI copayment. States may use state-only funds to buy down the nominal LI copayment, but such expenditures are not covered under Medicaid and may not be claimed for federal Medicaid matching funds. In this scenario, an MA organization offering a D-SNP would include the nominal LI copayment amounts in the plan bid submitted to CMS and then enter into a contract with the state to provide wrap coverage that buys down the nominal LI copayment outside of the Part D benefit. Under this arrangement, the MA organization is reimbursed for the nominal LI copayment amounts by the state and for the remainder of the actuarial equivalent cost sharing by CMS through LICS. CMS reminds MA organizations that for this arrangement to be consistent with applicable statutory and regulatory provisions, the source of the nominal LI copayment buy-down must be state-only funds and not Medicaid funds. CMS expects MA organizations to be able to demonstrate that wrap coverage that buys down the nominal LI copayment is exclusively state funded.

User Group Call Date 05/15/2025

Negative Part D Basic Premium Guidance Announcement

We have received several inquiries regarding how to address negative Part D basic premiums in specific scenarios related to the CY2026 initial and rebate reallocation submissions. Additionally, there have been questions about whether OACT will allow PBP-level variation in the NAMBA estimate in initial submissions.

- OACT continues to believe that the direct subsidy estimates should be consistent across bids within the same organization. Given the ongoing phase-in of the IRA for CY2026 bids, OACT will allow varying assumptions for the direct subsidy for CY2026, as was allowed for CY2025—provided the certifying actuary can justify the estimate. OACT expects reasonable estimates and may challenge assumptions if significant discrepancies are observed.
- MA and Part D margin requirements specified in the bid instructions must be followed for the initial submission.
- Plan sponsors may submit a total negative Part D premium in the initial submission.
    i. While a red circle validation will flag total Part D premiums below $0, CMS will accept these for initial submissions. However, negative total Part D premiums will not be permitted in the final submission.
    ii. The critical validation for the estimated total plan premium in the MA BPT will remain in place.
    iii. Plan sponsors should enhance Part D benefits to the greatest extent feasible to offset the negative premium.
    iv. In accordance with CY2025 UGC #1573 guidance, consider the availability of a Part B premium buydown to reallocate during rebate reallocation if the goal is to maintain a $0 total plan premium. The CY2026 rebate-reallocation tool has been updated to accurately reflect Part B premium buydown adjustments, and this guidance includes scenarios where a plan's premium changes from negative to less negative.
- If an MA-PD plan has a negative total Part D premium at initial submission, the plan sponsor must provide supporting documentation. The supporting documentation must—
    i. Be provided in an Excel file;
    ii. Be titled using the format **[PlanID]_NegativePDPrem_[YYYYMMDD]_[v##]**;
    iii. Explain the reason for the negative Part D basic premium; and
    iv. Describe how the plan intends to resolve the situation if it still has a total negative Part D premium at the time of rebate reallocation.

User Group Call Date 05/22/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Rebate Reallocation	05/19/2025 13:28	Rebate Reallocation Negative Part D Basic Premium Considerations for Low Income Members	[Paraphrased] In CY2025 UGC #1557, it was stated that—"In the situation that a plan (i) has a population with a significant number of low-income enrollees; (ii) targets LIPSA as the target plan intention for the Part D basic premium; (iii) has the Part D basic premium equal to the total estimated plan premium in the pre-rebate reallocation BPT; and (iv) has a significant value of insufficient rebate dollars allocated to the Part D basic premium after the published benchmarks for NAMBA and base beneficiary premium, CMS recognizes that the plan may be required to have low-income beneficiaries pay a non-zero MA premium in order to maintain the limits of Appendix E guideline #10.3 during rebate reallocation. In this unique scenario, [OACT] request[s] that the plan sponsors and/or certifying actuaries contact OACT directly during the rebate reallocation period to determine a solution to best serve their low-income beneficiaries." Does this guidance apply when a plan sponsor targets LIPSA and allocates $0 in rebates to the Part D basic premium due to a negative value? Will plan sponsors have the flexibility to change MSBs in the Part C BPTs during rebate reallocation in these situations to prevent low-income beneficiaries from being charged a non-zero premium? Additionally, does this flexibility extend to both D-SNPs and general enrollment (GE) plans targeting LIPSA, given their substantial low-income populations?	UGC #1557 addressed plans targeting the LIPSA that also have a significant value of insufficient rebate dollars allocated to the Part D basic premium after applying the published benchmarks. In the scenario where there are $0 in rebates allocated to buydown the Part D basic premium due to it having a negative value, the plan sponsor is eligible to participate in rebate reallocation, but is not permitted to modify the MSB revenue requirement. If the intent is to maintain a $0 total premium for low-income beneficiaries, allocating rebates to the Part B premium buydown in the initial submission must be considered. We continue to encourage plan sponsors and/or certifying actuaries to contact OACT directly during the rebate reallocation period to explore appropriate solutions that best support low-income beneficiaries—both for D-SNPs and GE plans targeting LIPSA.
2	Rebate Reallocation	05/20/2025 10:23	Negative Part D Basic Rebate Allocation	[Paraphrased] Will CMS allow flexibility in the initial submission to allocate a non-zero rebate amount to the Part D basic premium when the Part D basic premium is negative? If the Part D basic premium increases but remains negative after the release of NAMBA, this would provide greater flexibility during rebate reallocation for the plan to not increase the total premium.	The MA BPT has a critical validation that will not allow rebates to be applied to a negative Part D basic premium. If there is a negative Part D basic premium that increases but remains negative after the published benchmarks, the plan sponsor is eligible to participate in rebate reallocation, but is not permitted to modify the MSB revenue requirement. Therefore, in this situation, allocating rebates to the Part B premium buydown in the initial submission must be considered.
3	D-SNP	N/A	N/A	[Paraphrased] 1) We would like to resolve whether state payment of co-pays will impact cost sharing subsidies that the D-SNPs receive from CMS through the LIS Subsidy program. One interpretation is that the guidance reinforces that D-SNPs offering $0 Part D copays (through state-funding of the LI copays or otherwise) in CY 2026 and beyond will impact the cost sharing subsidies the D-SNPS receive from CMS and, thus, may be prohibitively expensive for the D-SNPs. 2) Are D-SNPs required to include state payment of Part D co-pays in the PBP? 3) If a state chose to pay the Part D co-pays, can the state only pay for D-SNP enrollees or must the state pay the Part D co-pays for enrollees who opt out of D-SNP? 4) What are potential repercussions of prohibiting enrollees from entering into the catastrophic phase?	1) Under an arrangement where state-funded wrap coverage buys down the nominal LI copayment, the MA organization is reimbursed for the nominal LI copayment amounts by the state and for the remainder of the actuarial equivalent cost sharing by CMS through LICS. Because the state-funded wrap coverage is outside of the Part D benefit, it does not reduce the LICS paid by CMS for a low-income beneficiary. 2) There is currently no mechanism for D-SNPs to include state payment of Part D co-pays in the PBP. In a scenario where state-funded wrap coverage buys down the nominal LI copayment, the MA organization offering a D-SNP would include the nominal LI copayment amounts in the plan bid submitted to CMS and then enter into a contract with the state to provide wrap coverage that buys down the nominal LI copayment outside of the Part D benefit. The state-funded wrap coverage would not be reflected in the PBP for CY 2026. We will consider future PBP enhancements to collect this information. 3) The State is permitted to enter into a contract with an MA organization offering a D-SNP to provide wrap coverage that buys down the nominal LI copayment outside of the Part D benefit. In this scenario, the State would not be required to pay the Part D copayments for beneficiaries who are not enrolled in the D-SNP with which the State has contracted to provide wrap coverage. 4) Should an MA organization offer a D-SNP where state-funded wrap coverage buys down the entire nominal LI copayment, LI beneficiaries who owe nominal LI copayments will not enter the catastrophic phase of the benefit at any point during the plan year. Because CMS's reinsurance payments are based on Part D drug costs incurred when a beneficiary is in the catastrophic phase, this means that D-SNPs that contract with states to buy down the nominal LI copayment using state-funded wrap coverage will consequently forgo any federal reinsurance subsidies for any portion of the gross prescription drug costs actually paid by the MA organization on behalf of its LI enrollees that owe nominal LI copayments during the plan year.

User Group Call Date 05/22/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	D-SNP	05/17/2025 1:25	Part D low income copay buydown	[Paraphrased] Following the OACT User Group Call on May 15, CMS posted responses to all five questions discussed during the call, as well as a sixth question and response related to Part D copay buydowns for low-income beneficiaries that was not discussed during the call. We have several follow-up questions regarding the response provided to this additional question. 1) We ask CMS to clarify whether this guidance applies to specific types of fully integrated D-SNPs only, as non-integrated D-SNPs would not have the contract in place with the state necessary to provide such state-funded wrap coverage. 2) CMS's response refers to the SSA to clarify "Medicaid funds may not be used to pay for Part D covered drugs or any cost sharing with respect to Part D covered drugs" and later says, "States may use state-only funds to buy down the nominal LI copayment." Our interpretation of this language is federal Medicaid dollars may not be used to pay for Part D covered drugs and cost sharing, but state Medicaid dollars may be used to do so. Is this interpretation correct? 3) CMS's response states "state-funded buy-down of the nominal LI copayment is not true out-of-pocket (TrOOP)-eligible and is applied after the total low-income cost sharing subsidy (LICS) on a claim is calculated." Can CMS clarify how it is defining "state-funded" in this context. For example, does this statement specifically refer to state Medicaid dollar-funded buy-downs and not include state funds sourced from outside of Medicaid? 4) We interpret CMS's statement that, "D-SNPs that contract with states to buy down the nominal LI copayment using state-funded wrap coverage will consequently forgo any federal reinsurance" to mean members whose LI copayments are paid by state-funded wrap coverage will get "stuck" in the initial coverage phase and never advance to the catastrophic phase in 2024, as well as in 2025 and 2026. As plans are completing preparation of 2026 bids, please confirm this is CMS's intended interpretation of this guidance. 5) We note CMS's response to this question does not mention payments made by qualified State Pharmaceutical Assistance Programs (SPAPs), which are expressly TrOOP-eligible, per the SSA and other recent guidance regarding TrOOP accumulation. a) Because payments from qualified SPAPs are TrOOP-eligible, members whose LI copayments are paid by a qualified SPAP would be able to reach the catastrophic phase and therefore would be subject to federal reinsurance payments. b) Please confirm the May 15 CMS response does not apply when LI cost sharing is bought down through qualified SPAPs and that our understanding of TrOOP accumulation for such members described above is accurate.	1) This guidance is not limited to specific types of fully integrated D-SNPs and applies to any D-SNP that contracts with a state to provide state-funded wrap coverage. 2) Under the Medicaid program, every Medicaid expenditure is paid by the state and then claimed for federal matching funds and effectively consists of both federal and non-federal funds. As stated in CMS's response, states may use state-only funds to buy down the nominal LI copayment, but such expenditures are not covered under Medicaid and may not be claimed for federal Medicaid matching funds. 3) In this context, 'state-funded' means any state funds that meet the definition of a "government funded health program" at 42 CFR 423.100, which comprises "any program established, maintained, or funded, in whole or in part … by the government of any State … which uses public funds, in whole or in part, to provide to, or pay on behalf of, an individual the cost of Part D drugs." This definition includes state programs that use public funds to pay for the cost sharing that an individual would otherwise be required to pay for Part D drugs. Note that cost-sharing assistance provided by a qualified State Pharmaceutical Assistance Program (as defined in § 423.464); by the Indian Health Service, an Indian tribe or tribal organization, or urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) or under an AIDS Drug Assistance Program (as defined in part B of title XXVI of the Public Health Service Act) are included in the definition of incurred costs and do accumulate toward TrOOP. 4) This interpretation is correct. 5) The May 15 response would not apply to scenarios where nominal LI copayments are bought down through qualified SPAPs. As stated in the CY 2025 Part D Redesign Program Instructions, cost-sharing assistance provided by an SPAP continues to be TrOOP-eligible. As such beneficiaries whose LI copayments are paid by a qualified SPAP would be able to reach the catastrophic phase and MA organizations would receive federal reinsurance payments for such beneficiaries.
5	D-SNP	05/21/2025 11:08	Follow-up to Q6 of the 5/15 Written Q&A	[Paraphrased] Consider a claim where catastrophic would have been reached on the prior claim but the wrap paid the nominal copay and so catastrophic was not reached. For the next claim, which is a straddle claim, we interpret the statement that the D-SNP will "forgo any federal reinsurance subsidies for any portion of the gross covered prescription drug costs actually paid by the MA organization on behalf of its LI enrollees that owe nominal LI copayments" to apply to the portion of the straddle claim that occurs before catastrophic (that is, the nominal copay amount). In this case the D-SNP would forgo reinsurance on the nominal copay portion of the claim but receive reinsurance on the rest of the claim. The next claim would then also be processed as though catastrophic had not been reached and the subsequent claims would also straddle catastrophic (in ping-pong fashion). Can CMS confirm this is correct?	This interpretation is not correct. Because the buy-down of the nominal LI copayment is not TrOOP-eligible and is applied after the total LICS on a claim is calculated, LI beneficiaries that owe a nominal LI copayment will never accumulate sufficient TrOOP to satisfy the OOP threshold for claims that would otherwise straddle the initial coverage and catastrophic coverage phases of the benefit if no buy-down had occurred. The buy-down of the nominal LI copayment effectively prevents such beneficiaries from entering the catastrophic phase of the benefit. After the first claim that would have straddled the OOP threshold absent the buy-down of the nominal LI copayment, there are no costs that accrue towards TrOOP for any subsequent claim sufficient to satisfy the OOP threshold and no part of any subsequent claim will straddle into the catastrophic phase of the benefit.

User Group Call Date 05/29/2025

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Rebate Reallocation	Various	Rebate Reallocation Final C/D Margin Testing and Resubmission	[Paraphrased and Combined] We have the following questions related to permitted adjustments during rebate reallocation for TBC compliance. 1. Scenario 1: If a bid ID has already reached the TBC limit prior to rebate reallocation and the direct subsidy is lower than expected, what changes are the plan sponsor permitted to make? 2. Scenario 2: Following the release of the published benchmarks, if the direct subsidy is $7 lower than expected and the bid ID exceeds the TBC limit by $5, what modifications are permissible under the applicable guidelines? 3. Can the MA gain/loss margin be further adjusted under premium rounding rules after the necessary changes have been made to achieve TBC compliance? 4. If the bid ID is found to be noncompliant with the MA-PD gain/loss requirement due to updates for TBC compliance at rebate reallocation, will the plan sponsor be required to revise and resubmit the margin assumption for all impacted Part D bids—including those not eligible for rebate reallocation?	In accordance with Appendix E guidelines— 1. Scenario 1: a) If participation in rebate reallocation is either not permitted or permitted but the plan sponsor chooses not to participate, the plan sponsor must adjust the gain/loss margin to bring the plan into TBC compliance. b) If participation is required or permitted and the plan sponsor elects to participate, then after applying the maximum allowable premium change via gain/loss margin adjustments to achieve TBC compliance, any further adjustment to A/B mandatory supplemental benefits to meet the target Part D basic premium must not cause the plan to fall out of TBC compliance. 2. Scenario 2: a) If participation is either not permitted or permitted but the plan sponsor opts not to participate, the plan sponsor must adjust the gain/loss margin to reduce the premium by $5. b) If participation is required or permitted and the plan sponsor chooses to participate, the gain/loss margin may be adjusted only enough to reduce the premium by up to $5. The additional $2 in Part C rebate dollars needed to reach the target Part D basic premium may be created by reducing A/B mandatory supplemental benefits. However, any such benefit reductions must not cause the bid ID's OOPC (including the premium change) to fall out of TBC compliance. Appendix E guidelines permit an additional adjustment of up to $1 to the MA gain/loss margin when changes are made to A/B mandatory supplemental benefits. 3. After applying the maximum allowable premium change through gain/loss margin adjustments to achieve TBC compliance, the plan sponsor may further adjust the MA gain/loss margin in accordance with premium rounding rules, allowing for an additional premium change of up to $0.50. 4. If, following changes to the MA gain/loss for TBC compliance during rebate reallocation, the MA-PD gain/loss requirement is no longer met, OACT will not require further changes to bids to correct the margin assumption.
2	Supporting Documentation	05/22/2025 11:36	Question on 8.2.2 on Part C BPT Instructions	Could OACT clarify the scope of 8.2.2 in the MA BPT Instructions? In this business plan, would we be required to only show the MA portion of an MAPD plan, or would we need to show the combined MAPD projections?	The business plan referred to in 8.2.2 of the MA Instructions is for the MA portion of the MA-PD plan.
3	DSNP	N/A	N/A	Can CMS clarify whether Medicaid managed care organization (MCO) plan-funded buy-down of nominal LI copays through a Medicaid value-added benefit would be true-out of pocket (TrOOP)-eligible? If so, would the TrOOP-eligibility be dependent upon whether this MCO is affiliated with an applicable integrated plan (AIP), fully-integrated special needs plan (FIDE), or highly-integrated special needs plan (HIDE) in the state?	For a dual-eligible special needs plan where a Medicaid value-added service is used to eliminate low-income (LI) beneficiaries' statutory cost-sharing for Part D drugs in accordance with 42 CFR 438.3(e)(1), the LI cost-sharing amounts paid by the value-added service will be regarded as incurred costs for Part D drugs that are "reimbursed through insurance" when that value-added service is funded exclusively by plan profits or otherwise through the sponsor's own funds and is not funded by any Medicare, Medicaid, or state-only funds. For 2026, incurred costs that are reimbursed through insurance count towards the accumulation of TrOOP. TrOOP-eligibility is not dependent on whether the MCO is affiliated with an AIP, FIDE, or HIDE plan.