User Group Call Date 02/22/2024

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 questions: partdpolicy@cms.hhs.gov
For Part D benefit-related questions (including OOPC/TBC policy): partdbenefits@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

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Part D	N/A	N/A	Should members that join the plan mid-year rely on reported CGDP from the PDEs or an estimated CGDP number when determining if they have reached the catastrophic phase? We will not have access to reported CGDP from PDEs from the plan the member came from. Is the CGDP approximation [(minimum(gross total drug cost, 11,206.28) − 4,660) x (92.13% x (94.969% − 25%))] intended to calculate the member's full CGDP amount, or is it intended to be used to calculate some amount of CGDP for only the Plan-to-Plan transaction (and, depending on the answer to #1, the member's prior spend), which would be added to reported CGDP?	The CGDP approximation referenced in the question was presented on the November 2023 User Group call as a suggestion for how to estimate the CGDP. Plan sponsors should use whatever method they believe produces the most reasonable result and provide support for that methodology.
2	Part D	N/A	N/A	Should the approximated CGDP amount be reported anywhere on WS1 or is it purely to be used for determining if a member has reached the catastrophic phase and all reported amounts should be based on actuals from the PDEs	The base period CGDP amount should only be entered in cell M60 on worksheet 1. 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.
3	Part D	N/A	N/A	For WS1, the November UGC agenda said "For Plan-to-Plan transaction reporting on worksheet 1, please estimate the gap discount according to the values provided in the 2023 Rate Announcement". The formulas provided only works for Non-LIS members. However, there is no gap discount for LIS members and the LICS in ICL and GAP intervals also count towards the TrOOP in the base year data. How should plans allocate the OOP cost for LIS members to ICL from Catastrophic phase?	Plan sponsors may allocate the OOP using the estimated allowed cost at catastrophic for low income beneficiaries published in the contract year 2023 Rate Announcement. We recognize that this will create significant differences between the base and projection year distributions. Similar to the response above, plan sponsors should use a method that produces a reasonable result and provide support for that methodology.
4	Part D	N/A	N/A	With respect to the new IRA Part D Drug Experience section on WS1, should these amounts include or exclude PDEs with Part D as secondary?	New Section VI on Worksheet 1 for IRA Part D Drug Experience should include Part D as secondary.
5	Part D	N/A	N/A	Where should we put the subsidy amount for CY2023 for insulins and vaccines?	2023 IRA subsidy amount (IRASA) for insulins and vaccines should be included in member cost sharing.
6	Part D	N/A	N/A	How should utilization and costs be reported on Worksheet 6 for a member with utilization and costs that exceed the catastrophic under the alternative benefit, but do not exceed the catastrophic under the DS benefit?	The utilization and costs for this member should be split between lines 1–10 and line 39 on Worksheet 6. The utilization and costs for this member that do not exceed the catastrophic should be reported in line 1–10, while the utilization and costs for this member that exceed the catastrophic should be reported in line 39.
7	USPCC	N/A	N/A	[Paraphrased] What is the CMS 2024 and 2025 PMPM estimate for Leqembi?	In the 2025 Advance Notice non-ESRD FFS USPCC tabulations, the estimated Leqembi spending is $1.67 PMPM for CY 2024 and $4.67 PMPM for CY 2025.

User Group Call Date 02/22/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	USPCC	02/01/2024 21:01	Advance Notice Question	We are working on our comments on the Advance Notice and it would be helpful if we could understand the impact of the restatements in the FFS USPCCs in Table I-5. Specifically, can you provide the restatements by year separately for each of the following: 1) Impact of the Year 2 Phase-in Removing MA-related IME/DGME 2) Remedy for the 340B-Acquired Drug Payment Policy for Years 2018–2022 3) Other (If there are items within this category that are large enough to identify separately, please do so)	As reflected in table 1, there are three significant adjustments in the 2025 Advance Notice non-ESRD FFS USPCCs compared to the 2024 Rate Announcement: a. Removal of 33 percent MA medical education phase-in for years prior to CY 2024. The pre-2024 reduction in the contract year 2024 Rate Announcement USPCCs was incorrect but had no impact on the 2024 ratebook growth rates. b. Impact of 340B acquired drug remedy for CY 2018–CY 2021. No adjustment was required for 2022 since the CY 2022 340B claims were reprocessed during calendar years 2022 and 2023. c. Impact of increase of MA medical education FFS phase-in from 33 percent in CY 2024 to 67 percent in CY 2025. Please note that the first two of these items, MA medical education correction and historical 340B remedy, have no impact on the 2025 Advance Notice growth rates.
9	USPCC	N/A	N/A	Please provide the impact of the remedy for the 340B-Acquired Drug Payment Policy for Years 2018–2022 and 2026.	The impact of the 340B-Acquired Drug remedy on the non-ESRD Part B FFS USPCCs is 2018: 1.07%; 2019: 1.16%, 2020: 1.30%, 2021: 1.23%. The CY 2022 remedy was addressed through reprocessing of the claims and the estimated impact is about 1.20%–1.30% on the Part B non-ESRD FFS USPCC. Consistent with CMS' regulation, CMS-1793-F, to budget neutralize the remedy there will be a 0.5-percent reduction in payments for non-drug outpatient hospital services beginning in 2026. This reduction is expected to reduce the non-ESRD Part B USPCC by about 0.11% in 2026.
10	USPCC	N/A	N/A	It is difficult to understand the baseline Part A USPCC trends given the tables in the 2025 Advance Notice include the effects of the MA medical education phase-in. Can you provide additional information on the Part A FFS trends excluding the impacts of MA medical education?	Please refer to table 2 which illustrates the 2025 Advance Notice FFS USPCCs as published and excluding the phase-in of the MA medical education. The annual impacts of the MA medical education adjustment on the non-ESRD FFS USPCCs are 2024: 33% phase-in of MA medical education and −$9.41 impact; 2025: 67% phase-in of MA medical education and −$20.90 impact; and 2026: 100% phase-in of MA medical education and −$33.80 impact. Also, the illustration excluding the impact of the MA medical education phase in shows that the Part A annual trends for 2022–2026 are relatively consistent with a low of 3.96% in 2025 and a high of 4.86% in 2024.
11	USPCC	N/A	N/A	Based on the published USPCCs, the implied trends for 2024 decreased from 4.5% to 3.3% and 2025 implied trends decreased from 4.1% to 3.8%. What is driving the reduction in forward looking trends from the 2024 Final Notice to the 2025 Advance Notice? We are surprised to see this reduction in forward looking costs especially given public statements from MAOs regarding continued elevated utilization during Q3/Q4 2023.	Please refer to table 3, which has three presentations of USPCCs: (i) Published in 2024 Rate Announcement (RA), (ii) 2024 Rate Announcement with corrected MA medical education phase out for years 2021-2023, and (iii) 2025 Advance Notice (AN). The table shows that the 2024 and 2025 Parts A + B trends for the restated CY 2024 RA values are within 40 basis points for both years. Following are some of the factors contributing to the changes in the trend rates from restated CY 2024 RA to the CY 2025 AN. The 2023 Part A trend decreased from 7.93% in the restated CY 2024 RA to 4.00% in the CY 2025 AN baseline. The main driver of this difference is lower actual 2023 spending for inpatient and home health than was projected in the CY 2024 RA. The 2024 trend for Part A is 1.75 percent higher in the CY 2025 AN versus CY 2024 restated RA baseline. This increase for CY 2025 AN is largely due to assumptions for projected utilization more that is more consistent with pre-pandemic levels. For inpatient there is an additional 2024 trend of 1.9% in 2024. And for home health, we expect an increase in spending due return to normal from the current labor shortage. This additional home health trend is 2.4% per year for 2024–2026. The 2023 Part B trend decreased by 0.24% from the CY 2024 RA to CY 2025 AN baseline. This change is due to a combination of lower actual outpatient spending for 2023 than was projected in the CY 2024 AN and higher spending for DME and Part B drugs. The 2024 Part B trend is down 1.86% in the CY 2025 AN primarily due to a new assumption that outpatient utilization will not return to pre-pandemic levels, reduction in DME spending, and reduction in other carrier services due to elimination of spending for COVID-19 tests once the Public Health Emergency ended on May 11, 2023.
12	USPCC	N/A	N/A	What did OACT assume for the cost and utilization assumptions for COVID-19 vaccines in each of the 2024 and 2025 projection years?	FFS spending for COVID-19 vaccines was $1.85 PMPM in 2022 and $3.85 in 2023. The CY 2025 Advance Notice USPCC baseline includes 2023 COVID-19 vaccine experience through the third quarter, which is then trended forward with category-level assumptions for price, utilization, and residual.

User Group Call Date 02/22/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
13	USPCC	N/A	N/A	Can CMS please provide the estimates of excess morbidity on aggregate per capita spending used to support the 2025 Advance Notice?	The excess morbidity factors supporting the CY 2025 Advance Notice baseline are the same as that used in the development of the CY 2024 Rate Announcement baseline, and the CY 2023 Medicare Trustees' Report baseline. These factors are reported on page 39 of the CY 2024 Rate Announcement.
14	USPCC	N/A	N/A	Can CMS please explain how the excess morbidity estimates were applied in the development of the FFS USPCCs?	The annual change in morbidity factors is included as an additional trend factor in the Medicare fee-for-service baseline. For example, the aggregate morbidity factor is −4.4 percent for 2023 and −3.9 percent for 2025. Given that 2023 is the base period, the change in morbidity assumptions from 2023 to 2025 resulted in approximately +0.5 percent increase in FFS trend in the CY 2025 Advance Notice baseline.
15	USPCC	N/A	N/A	Please provide information on what is driving the restatements in ESRD USPCCs shown in the CY 2025 Advance Notice Table I-6 for 2022 to 2026?	The lower ESRD USPCCs in the CY 2025 Advance Notice are due primarily to lower actual experience for 2023 than reflected in the CY 2024 Rate Announcement, and the removal of the assumption that dialysis utilization will return to pre-2020 levels.

Table 1: Impact of 2025 AN adjustments on A+B non-ESRD FFS USPCCs

Item	2018	2019	2020	2021	2022	2023	2024	2025
a. Remove 33% MA med. ed. pre-2024	0.40%	0.44%	0.54%	0.60%	0.67%	0.77%	0.00%	0.00%
b. 340B acquired drug remedy	0.60%	0.66%	0.73%	0.72%	0.72%	0.00%	0.00%	0.00%
c. Transition from 33% to 67% med. ed.	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	−0.93%

Table 2: Non-ESRD FFS USPCCs

	USPCCs AN 2025			USPCC w/o MA med ed phase-in		
	Part A	Part B	A + B	Part A	Part B	A + B
PMPM						
2021	$390.91	$557.21	$948.12	$390.91	$557.21	$948.12
2022	$407.54	$578.89	$986.43	$407.54	$578.89	$986.43
2023	$423.83	$633.29	$1,057.12	$423.83	$633.29	$1,057.12
2024	$435.00	$657.21	$1,092.21	$444.41	$657.21	$1,101.62
2025	$441.10	$692.35	$1,133.45	$462.00	$692.35	$1,154.35
2026	$450.27	$735.17	$1,185.44	$484.07	$735.17	$1,219.24
Annual trend						
'22/'21	4.25%	3.89%	4.04%	4.25%	3.89%	4.04%
'23/'22	4.00%	9.40%	7.17%	4.00%	9.40%	7.17%
'24/'23	2.64%	3.78%	3.32%	4.86%	3.78%	4.21%
'25/'24	1.40%	5.35%	3.78%	3.96%	5.35%	4.79%
'26/'25	2.08%	6.18%	4.59%	4.78%	6.18%	5.62%

User Group Call Date 02/22/2024

Table 3: Non-ESRD FFS USPCCs

	RA 2024 (published)			RA 2024 (corrected MA med ed 2021–2023)			AN 2025		
	Part A	Part B	A + B	Part A	Part B	A + B	Part A	Part B	A + B
PMPM									
2021	$384.05	$550.73	$934.78	$389.69	$550.73	$940.42	$390.91	$557.21	$948.12
2022	$398.10	$573.64	$971.74	$404.72	$573.64	$978.36	$407.54	$578.89	$986.43
2023	$428.63	$629.07	$1,057.70	$436.83	$629.07	$1,065.90	$423.83	$633.29	$1,057.12
2024	$440.70	$664.40	$1,105.10	$440.70	$664.40	$1,105.10	$435.00	$657.21	$1,092.21
2025	$451.09	$698.89	$1,149.98	$451.09	$698.89	$1,149.98	$441.10	$692.35	$1,133.45
2026	$459.88	$739.42	$1,199.30	$459.88	$739.42	$1,199.30	$450.27	$735.17	$1,185.44
Annual trend									
’22/’21	3.66%	4.16%	3.95%	3.86%	4.16%	4.03%	4.25%	3.89%	4.04%
’23/’22	7.67%	9.66%	8.85%	7.93%	9.66%	8.95%	4.00%	9.40%	7.17%
’24/’23	2.82%	5.62%	4.48%	0.89%	5.62%	3.68%	2.64%	3.78%	3.32%
’25/’24	2.36%	5.19%	4.06%	2.36%	5.19%	4.06%	1.40%	5.35%	3.78%
’26/’25	1.95%	5.80%	4.29%	1.95%	5.80%	4.29%	2.08%	6.18%	4.59%

User Group Call Date 04/11/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	OOPC/TBC	04/09/2024 9:13	OOPC/TBC Questions for the 4/11/2024 User Group Call	[Paraphrased] Can CMS share the anticipated release dates for the OOPC models and final TBC threshold?	The OOPC models are expected to be released mid-April and the TBC guidance and posting are expected to follow.
2	USPCCs	03/18/2024 10:00	USPCC Follow Up	On page 20 of the Advance Notice, the ESRD Dialysis-Only FFS USPCC shows a current 2025 estimate of $9,842.94, which is 10.3% higher than the current 2024 estimate of $8,921.01. 10.3% is notably higher than prior year trends, which are in the low- to mid-single digits. Is this higher trend anticipating the add-on payment for phosphate binders moving from Part D to Part B (to later become part of the PPS bundled rate)? Are there other factors?	Yes, the primary driver of the relatively high 2025 dialysis trend in both the 2025 Advance Notice and 2025 Rate Announcement is due to the inclusion of Part B phosphate binders beginning in 2025.
3	USPCCs	04/05/2024 18:51	Questions on the 2025 Rate Announcement FFS USPCCs	On page 27 of the Rate Announcement, the 2023 and 2024 PMPMs for "Other Carrier" are equal to $36.47 and $29.25, respectively. What services are included in the "Other Carrier" category? What is driving the 20% decrease in the PMPM?	Included in the other carrier category are payments for services provided in ambulatory surgical centers (ASCs), ambulance, and certain medical supplies. The large reduction in PMPM costs for 2024 is due to the end of the coverage of certain COVID tests, which concluded with the end of the public health emergency.
4	USPCCs	04/05/2024 18:51	Questions on the 2025 Rate Announcement FFS USPCCs	What are the 2024 and 2025 RBRVS conversion factor changes assumed in the 2025 Rate Announcement USPCCs (e.g., 2024 RBRVS conversion factor is 1.25% lower than the 2023 conversion factor)?	The 2024 conversion factor is $33.8872. The projected 2025 conversion factor included in the 2025 Rate Announcement baseline is $32.7442.
5	USPCCs	04/05/2024 18:51	Questions on the 2025 Rate Announcement FFS USPCCs	Was there consideration for the impact of Leqembi on the 2024 and 2025 Medicare FFS trends? If so, please provide the PMPM trend impacts of including Leqembi or the estimated PMPMs for Leqembi.	Yes, Leqembi is represented in the physician administered drug category beginning in 2023. The projected non-ESRD fee-for-service cost for Leqembi included in the 2024 Rate Announcement USPCCs is $1.62 PMPM in 2024 and $4.56 PMPM in 2025.
6	Leqembi	03/12/2024 12:55	Leqembi PMPM Clarification	Can you please clarify are the PMPM estimates for Leqembi in the February, 2024 user group notes of $1.67 PMPM for CY2024 and $4.67 PMPM for CY2025 the cost of the drug plus administration only? Or are they the cost of the drug plus administration plus additional costs related to the treatment (e.g. additional imaging)? The former option being approximately 86% of the latter according to the November CMS user group estimates.	The PMPM estimates include the cost of the drugs themselves, the cost for administration of the drug, and the costs of associated diagnostic testing and office visits.
7	Rebate Reallocation	N/A	N/A	During the rebate reallocation period, suppose the change in Worksheet 4, cell R108, must be between $0.00 and $4.00, according to item 10.3.1 in MA Appendix E. The plan increases R108 by $4.00 through adding A/B mandatory supplemental benefits and increasing the gain/loss margin PMPM in Worksheet 4, cell H107, by $1.00. These changes result in a total plan premium of $30.60. May the plan make additional increases to the gain/loss margin, which will further increase R108, in order to round the total plan premium to $31.00?	Yes, item 10.3 (and subparts) in MA Appendix E describe limitations to changes in A/B mandatory supplemental benefits (and gain/loss margin) that are separate from premium rounding rules. Additionally, the limitations per item 10.3 in MA Appendix E are separate from any changes to comply with CMS' TBC requirement per item 11.
8	Rebate Reallocation	N/A	N/A	Our understanding is that TBC and Premium Rounding are the only two reasons that GLM would be permitted to change after the benchmarks are announced. Could OACT provide some examples of permissible GLM changes that would be subject to the $1 limit?	Per item 10.3.2 in MA Appendix E, the gain/loss margin may change by up to $1.00 when making changes to the A/B mandatory benefits and at the discretion of the certifying actuary. Premium rounding is the final step of the rebate reallocation process. Premium rounding rules are separate from and in addition to item 10.3.2. When a plan sponsor encounters a TBC compliance issue during rebate reallocation, item 11 in Appendix E addresses how gain/loss margin changes may be used to comply with TBC.
9	Rebate Reallocation	N/A	N/A	Please allow more variance than the current $0.50 change in MA rebate dollars. This would permit plans to maintain benefits that are more stable for the member by allowing the flexibility to avoid material unintended plan design changes.	The 50 cent change in MA rebate dollars described in Appendix E guidelines for premium rounding is only applicable to the premium rounding step after rebate reallocation. That is, the change in MA rebate dollars is measured by comparing (i) the amount of MA rebate dollars after rebate reallocation for updates to the RPPO benchmark and achieving the Part D basic premium and (ii) the amount of MA rebate dollars after rounding the total plan premium to the nearest whole dollar value. While there are no limitations described in Appendix E for the changes in MA rebate dollars for rebate reallocation prior to premium rounding, CMS expects this change to be minimal and will review all BPTs to ensure that all changes to the MA rebate dollars are reasonable and appropriate.
10	Part D	N/A	N/A	We identified an issue with one of the actuarial equivalence tests on Worksheet 5 of the Part D BPT. The specific test in question – "3. Average Cost at Catastrophic >= Std (G >=F)" appears more restrictive in light of other 2025 changes, including supplemental benefits accumulating to TrOOP. Are there any plans to change this test?	The test in the CY2025 Part D BPT is as set forth in statute.

User Group Call Date 04/11/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
11	Part D	N/A	N/A	On the CMS user call on 02/22/2024, there was a question : "How should utilization and costs be reported on Worksheet 6 for a member with utilization and costs that exceed the catastrophic under the alternative benefit, but do not exceed the catastrophic under the DS benefit?", and CMS responded as ""The utilization and costs for this member should be split between lines 1–10 and line 39 on Worksheet 6. The utilization and costs for this member that do not exceed the catastrophic should be reported in line 1–10, while the utilization and costs for this member that exceed the catastrophic should be reported in line 39". This response was inconsistent with the BPT instruction and the Actuarial User Group Call on 11/9/2023, which said "Consistent with the CY2024 BPT instructions, when an alternative coverage is modeled, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spending may be different because of the impact of the alternative benefits". Based on CY2025 and historic BPT instructions, we think that the utilization and costs for this member should be reported in lines 1-10 and not split.	In order for the catastrophic costs to be allocated to the correct cells on WS 4 and WS5 for actuarial equivalence testing, the utilization and costs for this member that exceed the catastrophic threshold must be reported in line 39. Also please note that, consistent with past guidance, for the purposes of modeling the alternative coverage, members must still be reported in the claims interval in which they were reported under DS coverage. It is only utilization and costs that exceed the catastrophic that must be reported in line 39.
12	Part D	N/A	N/A	On Worksheet 1, should the 2023 Coverage Gap Discount Amount be included in column I or column J in Section III?	No, the CGDP amount should not be included in Section III.
13	Part D	N/A	N/A	PD Bid Instructions states WS1 section VI IRA Part D Drug Experience: Enter all base period experience for insulins and vaccines that are associated with IRA drug experience. Include low-income cost sharing subsidy (LICS) and exclude the coverage gap discount amounts. Would you confirm that Total Cost Sharing in this section = Σ [Patient Pay Amount + Other TrOOP Amount + Patient Liability Reduction due to other Payer Amount (PLRO)] + LICS? The sum of the first three terms is consistent with the reporting requirements for section III Average Cost Sharing per Member, while the last term, LICS, is specifically required for section VI IRA Part D Drug Experience. If this is the correct interpretation, since Other TrOOP Amount includes IRASA, should the Total Cost Sharing for Vaccines (BPT cell G69) be greater than zero (the cell is blocked out currently)?	This is the correct interpretation, however, the IRASA amount does not need to be included for the IRA vaccine cost sharing in Worksheet 1 Section VI.
14	Part D	03/20/2024 21:30	Medicare Prescription Payment Plan NBE Question	[Paraphrased] Under the Medicare Prescription Payment Plan, Part D plans will be required to pay for ("float") cost sharing at the point of sale on behalf of members, after which the plan will receive monthly payments from these members to offset that initial float amount. Plans are explicitly prohibited from charging interest or fees on these payments. Ignoring impacts due to uncollected cost sharing, this is not a plan liability concern, because the member is still ultimately responsible for the same total cost sharing, whether or not the member elects to participate in the Medicare Prescription Payment Plan. This is, however, a cash flow concern, and Part D plans may experience lost interest or investment earnings on the float amount they pay on behalf of the member at the point of sale ("float costs"). To the extent a Part D plan expects to experience float costs as a direct result of requirements under the Medicare Prescription Payment Plan, where is the appropriate spot in the Part D BPT for the plan to reflect those costs? Should plans include or exclude these anticipated costs from projected NBE?	Lost interest, lost investment earnings, or "float costs" incurred while administering the Medicare Prescription Payment Plan must not be included in the Part D BPT.

User Group Call Date 04/18/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/10/2024 0:42	Question for User Group Call- Fee-for-Service Costs (New Drug Treatment)	The FDA recently approved a new drug treatment for metastatic melanoma, Amtagvi (lifileucel). Were associated costs included in the Final Notice? Does OACT have an estimate of anticipated cost for these therapies?	We have not explicitly modeled Amtagvi. In past years, there have been new drugs introduced that have affected Part B spending. The average historical change in spending from new drug introductions is included in our modeling, and would implicitly capture the estimated impacts of Amtagvi and other new drugs on projected Part B spending.
2	USPCCs	04/12/2024 2:45	RE: USPCC Follow Up	Can you provide a table with the impact on the 2025 Rate Announcement USPCCs of the medical education adjustments and 340b adjustments, similar to what was provided on the 02-22-2024 user group call?	Attached is a revised table 1, which is based on the 2025 Rate Announcement USPCCs.
3	Supporting Documentation	04/09/2024 14:11	MA Documentation 2.1	In the CY2025 MA BPT instructions, Appendix B has added this line: “2.1. When a decision by CMS on a service area change remains outstanding as of July 15th , a sample BPT omitting the pending change must be provided to the OACT. The sample BPT is not to be uploaded to HPMS.” Could you please clarify what is expected to happen as of the June 3 bid submission? Sample BPT’s clearly wouldn’t be uploaded to HPMS on June 3. Should the sample BPTs be held ready until requested, presumably no earlier than July 15, similar to substantiation items 34 and beyond?	A sample BPT, as described in item 2.1, is not required with the initial June bid submission. Documentation item 2.1 will be treated similar to items “Upon Request by CMS Reviewers”. If a decision by CMS on a service area change remains outstanding as of July 15th, then CMS will request a sample BPT omitting the pending change.
4	Part D	04/11/2024 17:42	PD Bid Questions	For WS1 Section 6 & WS6: Should the insulin and vaccine scripts always be based on 30 day script count? For example, if we have one 90 day script do we need to record it as three 30 day scripts?	Scripts should not be normalized to a 30-day supply, even for insulins.
5	Part D	04/11/2024 20:37	Part D BPT Worksheet 1 Allowed / Paid / Cost Sharing	The current definitions of allowed, paid, and cost sharing on page 12 of the Part D BPT instructions will result in allowed not being equal to paid + cost sharing in Worksheet 1, Section III of the Part D BPT because CGDP is implicitly included in the allowed amount but explicitly excluded from both paid and cost sharing. Please confirm that this is CMS’s expectation and intent.	That is correct. As mentioned on the November 2023 UGC, 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.

Table 1: Impact of 2025 Rate Announcement adjustments on A+B non-ESRD FFS USPCCs

Item	2018	2019	2020	2021	2022	2023	2024	2025
a. Remove 33% MA med. ed. pre-2024	0.40%	0.44%	0.54%	0.60%	0.67%	0.78%	0.00%	0.00%
b. 340B acquired drug remedy	0.60%	0.66%	0.73%	0.72%	0.72%	0.00%	0.00%	0.00%
c. Transition from 33% to 52% med ed	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	−0.52%

User Group Call Date 04/25/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	USPCCs	04/17/2024 9:54	Part B trend question	In final announcement page 24 (table II-8a), "Other carrier" column, projections for future years drop significantly from 2023's $205.78 to 2024's $156.09 and 2025's $154.98. Can you explain the reason behind this?	This pattern is largely due to the large increase in spending on certain COVID tests in 2023 as the public health emergency (PHE) ended and stopping coverage of those COVID tests when the PHE ended.
2	USPCCs	04/22/2024 9:17	Table 1 From 4/18 UGC	Can you provide a table with the Part A and Part B non-ESRD FFS USPCC trends, both with and without the MA medical education for Rate Announcement 2025?	Yes, please see the attached table, which contains comparable information as table 2 posted with the February 22, 2024 actuarial user group call.
3	USPCCs	04/17/2024 18:40	Questions related to USPCCs and Rebate Reallocation	On page 3 of the 2025 Announcement, CMS noted that "… the enrollment base used to calculate 2023 per capita costs was updated for the Rate Announcement and resulted in greater Part A enrollment." i. What drove the higher Part A aged enrollment in 2023? Are these enrollees part of a certain subset of the population (e.g. Part A only, located in a specific state, etc.)? ii. We noticed there was no information provided about the claim costs associated with the 403,000 newly added Part A enrollees. Did OACT assume these enrollees had no claims or lower than average claim costs in 2023? If the latter, what was the assumed average FFS Part A per capita cost for these enrollees relative to the rest of the population?	The Part A fee-for-service enrollment increase from 2025 Advance Notice to 2025 Rate Announcement is due to an update in the population basis from Social Security data. Also, the 2023 expenditures were tabulated separately from enrollment and the revision to the Part A enrollment had no impact on estimated 2023 Part A expenditures.
4	USPCCs	04/17/2024 18:40	Questions related to USPCCs and Rebate Reallocation	In Table II-2 (FFS USPCC – non ESRD) of the 2025 Announcement, what percent of the medical education technical adjustment is applied to the 2026 and 2027 Part A FFS USPCC?	The non-ESRD FFS USPCCs included in the 2025 Rate Announcement are based on assumption of 100% phase-out of MA medical education for CY 2026 and CY 2027.
5	USPCCs	04/17/2024 6:40:00 PM and 04/23/2024 1:10:00 PM	Questions related to USPCCs and Rebate Reallocation and 2025 Bid Pricing Question	On the April 27, 2023 Bid Actuarial User Group call, CMS commented that the projection factors for Part B drugs are based on historical trends. Can CMS please provide more details about their methodology, including at what level of detail projections are calculated (e.g., by drug class), which historical trends are used to project costs, and whether more weight is put on recent utilization and cost trend? Also, can CMS please explain how new to market drugs are accounted for in the projections and what criteria they use to determine whether a new to market drug or class of drugs will have an impact on Part B FFS spending? On December 8th, 2023 the FDA approved the first cell-based gene therapies for treatment of sickle cell disease. The two drugs are Casgevy and Lyfgenia and are expected to cost $2.2M and $3.1M respectively per treatment. We have a few questions regarding pricing for these new drugs: Was there consideration for the impact of Casgevy and Lyfgenia on the 2024 and 2025 Medicare FFS trends? If so, please provide the PMPM trend impacts of including these two drugs. And if so, are the assumptions different for duals vs non-duals? Also, were there considerations for the impact of other genetically engineered drugs on the 2024 and 2025 Medicare FFS trends? If so, what are the drugs and the PMPM trend impacts?	Spending for Part B physician-administered drugs is estimated using 100% Medicare claims data and analyzing the relevant historical trends. New drugs have been introduced in many past years that have affected Part B spending. The average historical change in spending from new drug introductions is included in our modeling, and in general, would implicitly capture the estimated impacts of new drugs on projected Part B spending. Also, spending for Casgevy, Lyfgenia, and other genetically-engineered drugs was not projected separately.
6	Rebate Reallocation	04/16/2024 11:39	Rebate Reallocation Clarifying Question Part C Risk Share Situation	[PARAPHRASED] Assume a plan has a provider arrangement such that net medical expenses are a function of plan premium. If plan premium changes during rebate reallocation, but there is no change in A/B mandatory supplemental benefits, how should Appendix E guideline #10 be applied to this situation?	In this scenario, the A/B mandatory supplemental benefits have not changed; therefore, the flexibilities described in 10.3 are not permitted. Item 10.3 applies only "in conjunction with changing A/B mandatory supplemental benefits during the rebate reallocation period." In this scenario,– • Cell R108, per 10.3.1, is not permitted to change. • Cell H107, per 10.3.2, is not permitted to change. • Flow-through pricing, per 10.3.4, is not permitted.
7	Supporting Documentation	04/19/2024 16:03	MA BPT Instructions - Appendix B Item 2	In the MA BPT Instructions, Appendix B Item 2 was expanded this year to include "significant benefit changes". Is the intended time period for changes between the base and projection period, aligned with item 11.3.3, or year over year? Is the threshold for "significant" at the discretion of the Certifying Actuary?	The intended time period for benefit changes is from the base period to the projection period. The threshold for significance is to be determined by the certifying actuary who is expected to make the determination based on the affect of the changes on the projection factors.
8	Risk Sharing	04/10/2024 0:42	Questions for User Group Call- Risk Sharing Arrangements	An MAO contract with a provider group includes provisions to incentivize performance on quality of care metrics (such as STARS & HEDIS), data sharing, and engagement in the medical management process. Per the MA BPT instructions, any payments earned for achievement of these measures would be considered provider incentive payments and therefore should be included as medical expenses in the MA BPT. We believe it is not appropriate to allocate any portion of these expenses to the Part D BPT or DIR#10, because they do not have any impact on Part D drug cost and are typically paid to physician groups. Please confirm that this approach is appropriate.	Yes, it is appropriate to allocate the entire amount to the MA BPT.

User Group Call Date 04/25/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Risk Sharing	04/16/2024 10:28	DIR #10 question	[PARAPHRASED] An MAO has a risk-sharing arrangement with medical providers which includes a single settlement based on a target medical loss ratio. The settlement is determined in aggregate, based on all benefit expenses and revenue under Medicare Parts C and D for beneficiaries that use the provider. As an example, assume that the target medical loss ratio is 85%, the combined revenue is $1200 ($1150 from MA and $50 from PD) and the combined benefit expense is $960 ($920 from MA and $40 from PD), so the combined settlement paid to the provider is 85% × $1200 − $960 = $60. Is it appropriate to allocate the entire amount in the MA BPT since the payment is going to medical providers, not pharmacies?	Yes, it is appropriate to allocate the entire amount to the MA BPT.

Table 2: Non-ESRD FFS USPCCs

	USPCCs RA 2025			USPCC excl. MA med ed phase-in		
	Part A	Part B	A + B	Part A	Part B	A + B
PMPM						
2021	$390.92	$557.20	$948.12	$390.92	$557.20	$948.12
2022	$407.73	$578.70	$986.43	$407.73	$578.70	$986.43
2023	$419.82	$628.51	$1,048.33	$419.82	$628.51	$1,048.33
2024	$431.23	$654.25	$1,085.48	$440.52	$654.25	$1,094.77
2025	$441.68	$689.17	$1,130.85	$457.71	$689.17	$1,146.88
2026	$446.80	$731.88	$1,178.68	$480.33	$731.88	$1,212.21
Annual trend						
’22/’21	4.30%	3.86%	4.04%	4.30%	3.86%	4.04%
’23/’22	2.97%	8.61%	6.28%	2.97%	8.61%	6.28%
’24/’23	2.72%	4.10%	3.54%	4.93%	4.10%	4.43%
’25/’24	2.42%	5.34%	4.18%	3.90%	5.34%	4.76%
’26/’25	1.16%	6.20%	4.23%	4.94%	6.20%	5.70%

User Group Call Date 05/02/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	USPCCs	N/A	Live Q&A from 4/25 UGC	On the 4/11 UGC, CMS published an explicit projection for Leqembi. Given that CMS thinks that the sickle cell drugs and other new drugs' impact will be in line with the historical impact of new drugs, can it be said that the impact of Leqembi is expected to be above and beyond the historical impact of new drugs since it was separately valued?	The best available information indicated that the spending for Leqembi and similar drugs would likely be an outlier, and therefore we separately estimated the spending in the 2025 Advance Notice and 2025 Rate Announcement baselines.
2	USPCCs	N/A	Live Q&A from 4/25 UGC	Please clarify what the figures represent in table 1 posted with the 04-18-2024 Q&A file.	Attached is a revised table, 1b. The heading clarifies that the impacts are for the 2025 Rate Announcement relative to the 2024 Rate Announcement (RA). Also, row c has been updated to reflect the impact of 52% phase-out of MA medical education for CY 2025 in the 2025 RA versus the 67% phase-out represented in the 2024 RA.
3	USPCCs	04/25/2024 11:28	DME fraud	Is DME fraud included in the CMS FFS trend projection?	When fraud is known in any Medicare FFS spending, including DME spending, the spending projections include the expected CMS responses to such known Medicare spending fraud.
4	USPCCs	04/17/2024 18:40	Questions related to USPCCs and Rebate Reallocation	Attachment I, Section A of the 2025 Advance Notice summarizes the data and assumptions supporting the USPCCs. We noticed that there is no mention of FFS risk scores in this section. Is it correct to assume that the average FFS risk score supporting the FFS USPCC is 1.00? If not, can OACT please explain why	The average non-ESRD FFS risk score for CY 2025 is projected to be 1.0
5	USPCCs	04/29/2024 13:01	Questions for the 5/2/2024 User Group Call	We noticed that the 2018-2021 total risk score enrollments in the “Medicare FFS County 2025 Web.xlsm” file (columns BE:BH on the ffs_worksheet tab) are approximately 60,000-65,000 higher than the same values in last year’s file (“Medicare FFS County 2024 Web.xlsm”). This does not appear to be consistent with prior year versions where the risk score enrollment for a given year is fixed and unchanged as new data is added to the workbook. Can OACT please explain what drove the change in the 2018-2021 risk score enrollments? Given the impact varies by county, can OACT please provide additional details on how the county level risk scores were impacted by this update?	Yes, the non-ESRD ratebook risk score enrollment increased for years 2018-2021 from 2024 to 2025 due to inclusion of post graft beneficiaries with successful kidney transplant for 37 months or more. County-level impacts of the change is minimal given that this update resulted in an average 0.2 percent increase in risk score enrollment and the county-level scores are standardized to 1.0 national score. We do not have the impact of this update isolated from the overall change in risk scores from 2024 ratebook to the 2025 ratebook.
6	USPCCs	04/29/2024 13:01	Questions for the 5/2/2024 User Group Call	We appreciate the level of detail provided in the Trends Supporting 2025 ratebook growth rates file. Can OACT please provide additional details on what assumptions are driving the -1.3% “Other” trend component in the 2025 Inpatient trend?	Most of the “other” inpatient trend is attributed to pass through payments, medical education, and cost report settlements.
7	Risk Sharing	N/A	Live Q&A from 4/25 UGC	Page 15 of the MA bid instructions states "it is not appropriate to provide risk protection for Part D through MA or vice versa.” This section seems to suggest that some portion of costs should be allocated to Part D; the response to #9 on the 4/25/2024 UGC suggests that is not the case. Could you clarify what would be considered inappropriate risk protection between Part D and MA?	The original question is regarding a risk-sharing arrangement between a Medicare Advantage Organization and medical providers. CMS’s response is that allocating the entire amount to the MA BPT is an appropriate allocation. There may be other appropriate allocation methods. In making allocation determinations, plan sponsors should consider the services covered in the risk-sharing arrangement, the providers who provide those services, and the population that receive the services. The original question used combined revenue ($1200) and combined benefit expense ($960) as factors to calculate the settlement for a medical provider. These factors determine the amount of the settlement ($60) but do not necessarily determine the allocation of that settlement.
8	Rebate Reallocation	04/26/2024 15:10 and 04/25/2024 14:32 and 04/26/2024 20:38	Rebate Reallocation	[Paraphrased] On the 4/18 UGC CMS noted that all flexibilities for rebate reallocation are documented in the bid instructions, however we would like to confirm our understanding and CMS’ intention with the new limitations for MA BPT WS 4 cells H107 (MA gain/loss margin) and R108 (MSB revenue requirement). There is a likelihood that plans could be forced to add premiums to keep worksheet 4, cells R108 and H107 in compliance at the same time with Appendix E guideline #10.3. We are concerned that adding a premium in certain scenarios may be harmful to beneficiaries or may cause significant disruption to both the member and the overall market. Can you confirm that there will be no flexibilities for cells R108 and H107 in these scenarios? The following are a two examples of these scenarios: (1) A plan with initial assumptions for MA gain/loss margin as a percentage of revenue, such that adding A/B mandatory supplemental benefits within the limits for R108 compliance of Appendix E #10.3 would increase the plan's premium and result in an increase in the MA margin by more than $1.00. (2) A plan that has risk sharing arrangements with initial assumptions targeting an 85% MLR and zero-dollar total plan premium.	In accordance with the 2005 final rule, CMS does not expect, and will not allow, MA organizations to substantially redesign Part C supplemental benefits during the rebate reallocation period. Therefore, we do not intend to provide any further flexibility for these requirements and require all plan sponsors to be able to meet both requirements simultaneously. Furthermore, this request would expand the purpose of rebate reallocation to achieve a desired total plan premium. Rebate reallocation is only an opportunity to (i) achieve the target plan intention for the Part D basic premium, and (ii) reflect the published MA regional benchmarks in RPPO bids. It may not be possible for plan sponsors to return to the total estimated plan premium. Actuaries may refer to ASOP #8 for preparing their BPTs and in their supporting documentation during rebate reallocation.

User Group Call Date 05/02/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Rebate Reallocation	Live Q&A from 4/25 UGC and 04/30/2024 10:36	Rebate Reallocation	[Paraphrased] Due to the limitations of Appendix E guideline #10.3 of the MA BPT instructions, there is a likelihood that changes in the direct subsidy at rebate reallocation could lead to adding a premium for a D-SNP plan that targets the low income premium subsidy amount (LIPSA) and enrolls members with cost sharing support from state Medicaid agencies. While we understand there is no regulation that indicates that rebate reallocation is an opportunity to return to the overall target premium, we are particularly concerned that requiring low-income members to pay out of pocket is contrary to current CMS policy goals. Does CMS have the authority to allow for greater flexibility during rebate reallocation in this scenario?	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, we request that the MAOs and/or certifying actuaries contact OACT directly during the rebate reallocation period to determine a solution to best serve their low-income beneficiaries.
10	M3P	04/29/2024 10:19	bid questions	For the Medicare Prescription Payment Plan, does CMS have an estimate of national average utilization in this program and an estimate of national bad debt?	CMS does not currently have an estimate for the expected utilization or bad debt as a result of the Medicare Prescription Payment Plan. CMS expects that plan sponsors' estimates of the utilization and bad debt are reasonably and fully supported in documentation.
11	M3P	04/29/2024 16:49	Medicare Prescription Payment Plan	We appreciate CMS response to question 14 of the April 11 user group call. We are concerned that plans are unlikely to have cash on hand to fund this float and may need to access a credit/debt instrument in which the plan would then be liable for interest expense to the credit provider. Is this interest expense allowable in the Part D Bid? Should it be included in projected NBE?	This expense should not be included in non-benefit expenses.

Table 1b: Impact of 2025 Rate Announcement adjustments on A+B non-ESRD FFS USPCCs relative to 2024 Rate Announcement

Item	2018	2019	2020	2021	2022	2023	2024	2025
a. Remove 33% MA med. ed. pre-2024	0.40%	0.44%	0.54%	0.60%	0.67%	0.78%	0.00%	0.00%
b. 340B acquired drug remedy	0.60%	0.66%	0.73%	0.72%	0.72%	0.00%	0.00%	0.00%
c. Update from 67% to 52% med ed phase-out for 2025	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.41%

User Group Call Date 05/09/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	USPCC	04/29/2024 13:01	Questions for the 5/2/2024 User Group Call	On March 6, CMS posted the Final National Coverage Determination (NCD) for Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for Myelodysplastic Syndromes (MDS). Has OACT been asked to project the impact of this NCD? Can OACT share more information on the typical timeline once an NCD is approved and the determination of whether the significant cost threshold will be met?	Medicare has been providing coverage for this benefit for 10 years -- Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for Myelodysplastic Syndromes (MDS) – with restrictions that the patient must be enrolled in a clinical study. The updated national coverage decision (NCD) allows the benefit to be covered outside of clinical studies and the NCD liberalizes coverage which allows more people to qualify for the benefit. CMS' program area did not ask OACT to perform a significant cost assessment of this NCD given that the patient population is very small and the associated costs are not likely to exceed the NCD significant cost thresholds.
2	USPCC	04/29/2024 13:01	Questions for the 5/2/2024 User Group Call	In the reconciliation of the 2025 non-ESRD FFS USPCC file: 1) Can OACT please explain why there is a non-zero Part B adjustment for 2022 for "MA IME included in FFS USPCC?" Our understanding was the MA IME payments were included in Part A only. 2) The 2022 "Bulk payments for 340B-acquired drug remedy" Part B adjustment is $0. Is it correct to assume that all claims were reprocessed and there were no lump sum payments made for 2022 claims? 3) Can OACT please explain why the "Out of country / invalid counties" Part B claims adjustments are negative?	1) The amount reported in the 2022 Part B MA IME should have been reflected in the Part B balance line. The reconciliation exhibit posted on cms.gov has been revised accordingly. 2) The vast majority of relevant 2022 340B-acquired drug claims were reprocessed, and baseline modeling reflects no lump sum payments made for the 2022 340B-acquired drug claims. 3) Ratebook FFS claims are tabulated from the National Claims History using a "debit/credit" approach. The vast majority of the negative Part B expenditures for invalid counties are "credits" for Part B home health expenditures with unknown state/county code of "99999." Similarly, the bulk of the positive Part A expenditures for invalid counties are the corresponding "debit" for home health expenditures with unknown state/county code of "99999."
3	Risk Sharing	04/10/2024 0:42	Questions for User Group Call- Risk Sharing Arrangements	[Paraphrased] Page 15 of the MA bid instructions pertaining to risk-sharing arrangements states, "the BPT must reflect the benefit costs in the service categories included in global capitation and risk-sharing contracts." Please clarify the scope of the service categories included in the risk-sharing contract, using the following example: For a single BPT, assume a risk-sharing contract with provider group A pays a year end incentive payment to provider group A. Provider group A provides all services in categories A K of the MA BPT. Provider group A has also agreed to coordinate and manage all services in categories A-K and L-Q. A second group, provider group B, provides all services in categories L Q under a separate contract, and does not share in the incentive payment to provider group A. All benefit expenses are paid to both groups throughout the year, as incurred. The calculation of the incentive payment to provider group A is as follows: • Revenue = $1000 (MA) • Benefit expense during the year = $800 (MA service categories A-K) + $20 (MA service categories L-Q) • Incentive payment = (85% × $1000) – ($800 + $20) = $30. The $30 incentive payment should be allocated to which service categories in this BPT?	The most recent UGC response from contract year 2015 (cumulative index 1012) stated, "Allocate bonus payments to all MA service categories that are included in the calculation of the bonus." This response would result in allocating the $30 incentive payment to all service categories, A-Q. For CY2025, given OACT's developing understanding of these arrangements, the actuary may (i) use the method above, or (ii) determine that the allocation for your circumstance is more appropriately attributed (and then allocated) to a subset of the service categories, A-Q. Reasonable support is required for making the determination to use option (ii). When using option (ii), the actuary should understand that OACT has observed the following concern: If the resulting net medical costs in a service category (after allocation of the incentive payment) is negative, then the allocation may be inappropriate. OACT will continue to study this issue for CY2026.
4	Rebate Reallocation	04/30/2024 20:24	Rebate Reallocation Questions	[Paraphrased] As noted on the April 25th user group call, the rebate reallocation requirements in Appendix E #10.3.1 and #10.3.2 may result in requiring a plan sponsor to add a small total member premium when there are insufficient rebates during rebate reallocation. The addition of a small member premium may (i) change the initial assumptions for projected membership and/or (ii) add administrative cost for premium mailing and bad debt. We recognize Appendix E #10.3.4 identifies flow-through pricing may be limited. If changes to membership and/or administrative cost is not permissible, we believe this will require a change to initial pricing assumptions and that such a change contradicts CMS' goals of rebate reallocation. Are changes to initial pricing assumptions allowed during rebate reallocation?	One of CMS' goals of rebate reallocation and premium rounding is to not change initial pricing assumptions. When there is a change in A/B mandatory supplemental benefits for rebate reallocation, a plan sponsor may update non-benefit expenses as long as the resubmission complies with Appendix E guideline #10.3. During rebate reallocation, plan sponsors must not change the projected membership. If the certifying actuary is concerned that a change to mandatory supplemental benefits and/or premium warrants an assumption change (for example, no change to projected membership with an increase in premium), then they may disclose this concern in accordance with the ASOPs.
5	Rebate Reallocation	05/04/2024 13:51	Rebate Reallocation Questions	[Paraphrased] We are encountering a scenario where it appears that it is not possible to satisfy the rebate reallocation constraints in Appendix E, Section II, item 10. Please consider the scenario where a plan sponsor has (i) significantly overestimated the allocation of rebate dollars, (ii) allocated the maximum allowed amount to the Part B premium, MA premium and Part D premiums after adding A/B mandatory supplemental benefits such that worksheet 4, cell R108 did not change by more than the amount of unallocated rebate dollars and worksheet 4, cell H107 did not change by more than $1, and (iii) has a small amount of unallocated rebate dollars greater than $0 that cannot be allocated while complying with Appendix E, Section II, item 10. What options does the plan have in this situation?	In the unique scenario that a plan has (i) significantly overestimated the allocation of rebate dollars, (ii) allocated the maximum allowed amount to the Part B premium, MA premium and Part D premiums after adding A/B mandatory supplemental benefits such that worksheet 4, cell R108 did not change by more than the amount of unallocated rebate dollars and worksheet 4, cell H107 did not change by more than $1, and (iii) has a small amount of unallocated rebate dollars greater than $0 that cannot be allocated while complying with Appendix E, Section II, item 10, we request that the MAOs and/or certifying actuaries contact OACT directly during the rebate reallocation period to determine a solution.

User Group Call Date 05/16/2024

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Risk Sharing	05/08/2024 12:13	Risk Sharing Question	[Paraphrased] As a follow up to questions 8 and 9 from the 4/25/2024 user group call and question 7 from the 5/2/2024 call regarding the allocation of provider risk sharing payments, please clarify whether such guidance applies to the base period experience for 2023 on worksheet 1, or the projections for 2025, or both. Additionally, how does such guidance relate to the Part D DIR reporting guidance for 2023?	
2	Gain/Loss Margin	05/07/2024 23:51	MA-PD Gain/Loss Margin Requirements	The “MA-PD Gain/Loss Margin Requirements” on page 16 of the CY2025 Part D BPT instructions state that there are two options for setting the Part D gain/loss margin and only one option may be used per parent organization. When selecting Option B, “set the Part D gain/loss margins at the aggregate level”, is the aggregate margin required to be set at the parent organization level or are plan sponsors permitted to set this aggregate gain/loss at the organization level?	
3	Rebate Reallocation	05/14/2024 17:59	Direct Subsidy Estimate Variation	OACT indicated that for a particular certifying actuary and a particular organization, the expectation is that the direct subsidy assumption would be the same and that they weren’t “seeing a reason” for varying the assumption. We believe there are many valid reasons to vary the assumption. Given the significant impact of the Inflation Reduction Act on CY2025 bids, certifying actuaries are estimating a wide range of potential direct subsidies. However, the bid submission requires a point estimate. Given the much wider range of plausible national direct subsidy results in 2025 and the constraints in Appendix E, Section II, item 10.3, we believe that varying the direct subsidy assumption by PBP will substantially increase the likelihood that plans will be able to achieve the benefit levels, member premiums, and gain/loss margins intended in the June submission as well as to avoid exception requests related to TBC and margin compliance. We request that OACT revise its expectations to allow actuaries to vary the direct subsidy estimate by PBP within a given organization or contract, thereby allowing this risk to be mitigated and creating more stability in the MA market from the initial submission.	