Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 04/14/2011

Introductory note

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

<table>
<tr><th>#</th><th>Topic</th><th>Date E-Mail Sent</th><th>E-mail Subject</th><th>E-Mail Body Text</th><th>CMS response</th></tr>
<tr><td>1</td><td>Star Ratings</td><td>04/11/2011 19:54</td><td>star rating, low enrollment and new plans</td><td>The bid instructions indicate:
Both the star rating and new/low indicator will be validated during upload, to check that the BPT entries match the information released by CMS.

Can you please provide more information about how/when the information from CMS will be released on these items?</td><td>The bid instructions, and bidders training, provide the following path to view the star rating and new/low indicator released by CMS:
HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating ></td></tr>
<tr><td>2</td><td>Star Ratings</td><td>04/11/2011 13:43</td><td>QBP Star Rating Questions for 2012 Bids</td><td>We have questions regarding how new plans will get QBP STAR ratings when using the parent organizations STAR rating.
1) For a MAO parent that has three existing contracts with CMS (HXXXA, HXXXB, and HXXXC) when will rounding apply in the calculation of the QBP STAR rating for a new H Number for the parent organization (HXXXD)? a) Will the exact STAR rating of the three contracts be used in the calculation for the new contract or the rounded rating? b) Also will the final QBP rating for the HXXXD be rounded and if so how? Will it be rounded nearest, up, or down?

Below are two examples which show the two different methodologies pertaining to the a) part of the question leading to different outcomes in the QBP STAR rating for HXXXD. We are assuming in the two examples that rounding nearest applies – as in the b) part of the question.
<table>
<tr><th></th><th>Dec. Membership</th><th>Method 1 (rounded)</th><th>Method 2 (no rounding)</th></tr>
<tr><td>HXXXA</td><td>17,000</td><td>3.00</td><td>2.79</td></tr>
<tr><td>HXXXB</td><td>1,000</td><td>2.50</td><td>2.61</td></tr>
<tr><td>HXXXC</td><td>22,000</td><td>2.50</td><td>2.74</td></tr>
<tr><td>Weighted Avg for New Contracts</td><td></td><td>2.71</td><td>2.76</td></tr>
<tr><td>New Contract H# (if rounding nearest)</td><td></td><td>2.50</td><td>3.00</td></tr>
</table>
2) A MAO parent organization has several contracts that receive the low enrollment QBP STAR rating. If that organization expands into a new state, is the new contract's QBP STAR rating going to be the weighted average of the STAR ratings of all of the MAO's existing contracts? Specifically, are the low enrollment contracts included in this calculation at a 3.0 STAR rating, at some other value, or excluded for purposes of calculating the QBP STAR rating for new contract?</td><td>1a) The Quality Bonus star rating for a new contract under an existing parent org would be calculated using the rounded ratings of the existing contracts (Method 1 in this example).

1b) Calculated scores are rounded to the nearest half-star (new contract would receive 2.50 stars in this example).

2) Low enrollment contracts are not included in the calculation for a New contract in an existing Parent Organization. Only contracts that have a QBP rating based off of their numeric Plan Rating are used to determine the rating for the "New" contract.</td></tr>
<tr><td>3</td><td>Base period experience</td><td>03/15/2011 13:43</td><td>Segmentation</td><td>If a PBP that was not previously segmented in 2010 or 2011, becomes segmented in 2012, can and should the actuary preparing the bid use the entire PBP's experience as the base period? Or should the actuary carve the base period experience into the segmented service areas?

Can the Plan D bid for each segment use the consolidated claims experience of the PBP, or does the Plan D bid base period need to also be carved according to each segment's service area?</td><td>Use the entire PBP's experience as the base period for both segments.
Do not carve the base period experience into the segmented service areas.
This applies to MA and PD.</td></tr>
</table>

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
4	Out-of-area members	04/07/2011 16:14	Out Of Area Members	Part C bids exclude ESRD and Hospice members from the base year experience (in Worksheet 1) and projected risk score (in Worksheet 5). According to the MA BPT Instructions, OOA county members are excluded from Worksheet 5. Should OOA member experience be also excluded from Worksheet 1 as we do not see specific instruction for doing so ?	The MA bid instructions indicate to exclude out-of-area (OOA) member months from the county-level enrollment projections on Worksheet 5. In the benchmark calculation, the county codes entered are based on the plan's service area (i.e., "in-area" member months only). For payment purposes, since plans are paid the average for OOA members, the exclusion of OOA member months does not impact the benchmark calculation. Worksheet 1 (base data entered in Sections II, III and VI) must include OOA members, and the projected bid (Worksheet 4) must also include OOA members.
5	Projection factors	N/A	N/A	Our organization provides most medical services through capitation agreements. We base the projected allowed costs on an aggregate projection of the current capitated amounts and expected changes in the terms of the agreements, which are not necessarily modified to reflect each benefit change. We use encounter data and FFS data to enter projection factors for utilization and unit cost trends. All other changes are implicitly reflected in the utilization– other factor, which, in effect, balances projected allowed costs with base period allowed costs and is consistent with the pricing approach. Is this acceptable?	No. The instructions for entering projections factors are the same regardless of the pricing arrangement or pricing model. The actuary must estimate the impact of changes in the population and benefits, and enter separate utilization population change and benefit change projections factors on Worksheet 1. Further, it is inappropriate to set the projection factors to 1.000 if there have been changes in benefits or the population between the base period and the projection period.
6	Credibility	04/12/2011 10:22	Base Period Manual Rates	Page 15 of the MA BPT Instructions and page 13 of the PD BPT instructions contain the following: If the proposed manual rate lacks sufficient independence from the base period experience, then an alternative manual rate must be developed (by removing the base period experience from the manual rate development and/or by increasing the use of other, non-base period experience in the manual rate development). As an equivalent alternative to removing the base period experience from the manual rate development, CMS will allow the credibility percentage in the BPT to be adjusted such that the experience for the plan is assigned the appropriate credibility (based on the CMS standard formula), taking into consideration the proportion of the manual experience that is from the subject base plan. Do you have a guideline as to the % that a partially credible plan's experience contributes to the manual rate that would require adjusting the manual rate or the credibility?	CMS does not have a guideline that dictates when adjustment is necessary. For a partially credible plan, the actuary must use a manual rate that is appropriate. If base period experience is included in the manual rate, then the actuary must evaluate the extra weight given to the base period experience through its inclusion in the manual rate. The extra weight is in addition to the weight already assigned by the CMS credibility formula. The actuary must consider the question, "Does the extra weight place too much dependence on the base period experience?" The actuary must justify their answer to this question and include it in the supporting documentation for credibility.
7	MA Worksheet 3 Cost Sharing	03/24/2011 20:07	Worksheet 3 Cost Sharing	New in the instructions this year (page 55 of the instructions for MA) column G on Worksheet 3 should represent only the utilization for the time period of the cost sharing. Please clarify. I am interpreting this to mean, for example, for IP acute, if my cost sharing is $100 / day for days 1-5, rather than using a copayment of $64 (assuming days 1-5 make up 64% of my IP days), I am to use $100 in column i and 64% of my total IP utilization in column G. Is that correct? Is it now wrong to use the effective copayment or will still be allowed to use that methodology?	The example cited in this question is the preferred method for data entry. An alternative method would be to enter the unadjusted utilization for all inpatient days (in column g) and the reduced effective copayment (in column i). However, it is inappropriate for the actuary to not reduce both the utilization (column g) and the effective copayment before OOP max (column i), even if the correct effective in-network effective co-pay after OOP max is entered (in column j). This would incorrectly state the impact of the OOP maximum, as it would incorrectly include the effect of $0 cost sharing for days 6 and later.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
8	Physician fix/ Projection Factors/ Physician Quality Incentive Payments/ Margin/ Non-benefit expenses	04/11/2011 23:25	re: 2012 bids	1) If a two year mitigation of the physician reimbursement cut is passed as part of the 2011 budget, will CMS revise the projected Fee For Service Trends and benchmark rates accordingly?	1) This would be evaluated at such time.
				2) Please provide examples of what constitutes a provider reimbursement change vs. unit cost inflation. If the provider reimbursement contracts have not changed but the terms are indexed to charge-masters or Medicare allowed, is the increase in reimbursement attributed to inflation or a provider reimbursement change? Where would we assign intensity of service trend as opposed to a fixed market basket approach to trend.	2) Increases in provider reimbursements due to indexing must be reflected as "Provider Payment Change" (column n). Increases in provider reimbursements due to inflation must also be reflected as "Provider Payment Change" (column n). It would be appropriate to use the unit cost adjustment "Other Factor" (column o) to reflect changes in unit cost due to intensity of service trend.
				3) In allocating physician quality incentive payments that are not based on utilization, would it be acceptable to allocate based on the amount of favorable experience in each plan, linking the quality incentive payments to more favorable financial results?	3) This would be acceptable.
				4) a) Please confirm that bids with negative margins can be exempted from the supporting business plan documentation requirement if they are paired with other bids, such that, in aggregate profitability is achieved.	4) a) Plans with negative margin can be exempt from providing a business plan when paired with other plans if all of the following requirements are met - the plans have identical service areas, the plans are the same plan type, and the combined margin is positive.
				b) If the bid is priced at a negative margin to avoid being a total beneficiary cost outlier, will it be exempted from the business plan requirement?	b) No.
				c) Can a product pairing be used if the two plans have significant overlapping service areas but they are not literally the same? If the subsidization removes the impact of the non overlapping service area?	c) No.
				d) Can the business plan include the assumption that the impact of the physician sustainable growth rate will ultimately be removed from the Medicare Advantage payment formula?	d) No.
				5) a) When considering the allocation of non direct benefit expenses for an organization offering an MA PD but using a PBM, would it be reasonable to consider the indirect and sales & marketing expenses as expenses common to both and allocate the sponsoring organizations indirect and sales and marketing proportionally to Part C and D, but to treat the direct expenses of the Parent Organization as related to Part C, and the expenses of the PBM specific to Part D?	5) a) That would be appropriate if the direct expenses of the organization are all for Part C with none for Part D. Also, if any of the sales&marketing expenses are directly related to Part C or to Part D those expenses must be attributed accordingly.
				b) Would it also be acceptable to simply pool all direct expenses, and allocate them proportionally regardless if their source is the PBM or Sponsoring Organization's?	b) No. Expenses directly related to Part C must be attributed to Part C and expenses directly related to Part D must be attributed to Part D.
				c) If a reinsurance contract does not rule out but makes highly improbable a Part D reinsurance recovery from a private reinsurer, would it be acceptable to allocate the reinsurances premiums solely to Part C?	c) If the reinsurance contract covers Part C and Part D and it has a combined premium, the premium must be allocated to Part C and Part D.
9	Non-benefit expense allocation	N/A	N/A	The MA and Part D bid instructions state that "Non-benefit expenses that are common to the MA and Part D components of MA-PD plans must be allocated proportionately between the Medicare Advantage and Part D BPTs." Our organization administers and accounts for most non-benefit expenses for its MA-PD plans at a integrated level. Must we separate out all expenses attributable solely to MA or Part D before allocating the remaining expenses to the MA bids or the Part D bids proportionately based on revenue or benefit for all MA-PD bids?	The MA and Part D bid instructions require that "Non-benefit expenses are all of the administrative costs incurred in the operation of the MA plan" or "of the Medicare Prescription Drug Plan", respectively. Therefore, any expense attributable solely to MA may not be allocated to the Part D bid and vice versa. Note that the bid instructions do not specify the basis for the proportion used to allocate expenses in common to MA and Part D. The certifying actuary may use a different proportion for different types of expense based on the nature of the expense as long as the proportion reasonably reflect the best estimate of actual costs of administering the MA and Part D products (for example, allocation by member months, number of calls, revenue, etc.).
10	Disease Management	N/A	N/A	Due to recently released MLR regulation, would it be acceptable to CMS to use the definition of Quality Improvement (QI) expenses (as defined by the Federal Register/Vol. 75 No. 230) to define DM expenses as medical? Can all of the items defined as QI be defined as medical expenses in the bid?	The Federal Register citation in this question is not applicable to Medicare bidding. For CY2012, we refer you to the bid instructions.
11	Margin	N/A	N/A	The MA instructions indicate: The margin for EGWPs must be positive and within a reasonable range of the margin for general enrollment plans not to exceed minus 5 percent or plus 1 percent of the margin. If the average general enrollment margin for a contract is less than -1% what margin should be used for the EGWPs in the contract? In this situation a plan would not be able to meet both the requirement of being positive and being within minus 5% and plus 1%.	In the limited instances where the contract-level average margin for general enrollment and IC/SNP is less than -1%, the EGWP margin must be zero (0%).

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
12	A.E. c.s. factors	04/12/2011 11:38	Part B Equivalent Coinsurance % Excluding Deductible	[PARAPHRASED] In the ratebook section of the MA BPT, the FFS coinsurance %, including the impact of the Part B deductible, has been reduced from 23.3% to 22.4%. The presumption is this is to recognize that Preventative Benefits are not subject to either the Part D deductible or coinsurance. What would be the corresponding reduction to Part B coinsurance to exclude the deductible impact?	OACT intends to provide this information on the next user group call (4/21/11 UGC). Response provided on the 4/21/11 UGC: The removal of cost sharing for preventative benefits, per the ACA, is expected to reduce the 2012 Part B cost sharing requirement by 0.1 percent. Also, the 2012 Part B coinsurance percentage, which excludes the impact of the deductible, is projected to be 19.5 percent. Finally, the primary factors driving the reduction in the cost sharing percentage from 2010 to 2012 is (i) the scheduled phase-out of the excess mental health coinsurance, and (ii) continued decreases in outpatient hospital cost sharing for specific procedures in specific markets.
13	FFS costs	04/12/2011 13:15	Development of 2012 FFS Rate	Could you provide more detail on how to calculate the 2012 FFS rate-specifically, how to get the 2005-2009 FFS costs by county on a 2012 basis? It seems like you use the USPCC estimates at least in part to get there, but I have been unable to find definitive confirmation on how it works.	Using data in the risk2012.csv file, which is posted on CMS' site with the ratebook materials, the field FFS including all IME (col O) can be replicated. This calculation requires four pieces of information for each county: 1. the 2012 AGA (col N), 2. GME factor (col L) 3. DoD adjustment (col M), and 4. 2012 FFS USPCC of $743.54. The calculation of the FFS cost for each county is the AGA * (1 - GME factor) * DoD factor * $743.54. Additional steps are required to derive the FFS cost excluding phased out IME (col S), and this is a straightforward calculation using data in in risk2012.csv file.
14	AGA	04/07/2011 17:32	AGAs	a) Would it be possible for you to send us the 5 year AGA file used to develop the 2012 AGA factor? Also, would it be possible to have the previous 5 year file (used to estimate the AGAs for the 2010 projected FFS cost by county)? b) [PARAPHRASED] Since the quartile ranking is based on 2009 FFS data, certain counties are receiving a 107.5% FFS adjustment rather than a 115% FFS adjustment. This inconsistency in the data used to determine the ranking (and the resulting FFS cost adjustment percentages) and the 2012 FFS cost to which the adjustment is applied has a negative impact on this county and likely others. Will CMS reconsider this interpretation in the year used to determine the quartile ranking? This interpretation seems to have unanticipated consequences. If 2013 quartiles and the resulting FFS cost adjustment percentages are based on revised projected FFS cost by county, this could contribute to future volatility in the benchmarks.	a) We are in the process of developing an excel workbook that will illustrate the development of the FFS cost for each county. We hope to have this information released in early May. b) As stated on page 8 of the 2012 Advance Notice, "To determine the CY 2012 applicable percentages for counties in the 50 States and District of Columbia, CMS will rank counties from highest to lowest based on their 2009 FFS costs, because 2009 is the most recent FFS rate rebasing year prior to 2012." For 2013 and future years, we will continue to base the quartile rankings on the most recent published FFS rates. Also note that, in future years, if the quartile for a county changes then the applicable percentage will be a blend of that year's applicable percentage and the previous year's percentage, per Section 1853(n)(2)(D).
15	Medicare Unit Cost increases	04/05/2011 9:38	unit cost trends	Can you please provide the summary unit cost trends for Medicare Allowable rates from CY 2010 to CY2012 by service category as you have done for in previous years?	OACT intends to provide this information on the next user group call (4/21/11 UGC) as an introductory note.
16	Medicare Unit Cost increases	04/11/2011 23:26	RE: 2012 bids	Will CMS release its national fee for service unit costs and utilization trends, as it has in the past?	See above response.
17	LIS Enrollment Data	04/04/2011 16:10	2011 LIS Enrollment by Plan	Could you tell me when the file detailing LIS Enrollment by Plan for 2011 will be available? The following is a link to the 2010 LIS Enrollment by Plan file, in case it's not clear what file I am referring to: https://www.cms.gov/MCRAdvPartDEnrolData/LISC/itemdetail.asp?itemID=CMS1237477	This data should be posted within the next week.
18	LIS Enrollment Data	04/12/2011 10:20	LIS Enrollment	When will the 2/2011 LIS enrollment that was used for calculating the restated low-income benchmarks in the 2012 instructions be posted at: http://www.cms.gov/MCRAdvPartDEnrolData/LISP/list.asp#TopOfPage (LIS enrollment by Plan) http://www.cms.gov/MCRAdvPartDEnrolData/LISC/list.asp#TopOfPage (Lis Enrollment by County)	See above response.
19	5 star PDPs	04/07/2011 19:24	Special Election Period for Enrollment in 5-Star PDPs	In reading the final call letter, I noticed that the Special Election Period for Enrollment in 5-Star Plans was expanded to include PDPs along with the MA plans that was outlined in the draft call-letter (see page 120 of the final call letter). With the benefit structured with a gap, this could cause financial harm to the company that a member leaves and a financial windfall to the company that receives the member. This is caused by the fact that most of the expense is in the early part of the year while the premium received is on an level basis. This concern will be mitigated as the gap is closed, however, it could cause severe harm in the mean time. What guidance will the Office of the Actuary put out on how this item should be addressed in the bids (a possible increased expense for less than 5-star plans, and a possible windfall for 5-star plans)?	The certifying actuary must take this possibility into consideration for pricing purposes, and reflect his/her best estimate of costs in the bid.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
20	DE# data	04/12/2011 9:33	DE# Categories	Recently we received a file for each of our contracts showing the split of DE's between QMB/QMB+ and other. However, with the new contracting requirements with state Medicaid agencies for Medicaid Subset DE SNP's, several states are also covering SLMB+ and FBDE categories. Can/will CMS provide a more detailed (for example, member level) DE file that breaks out all the categories of DE for 2010, so that we can assure that our bids properly reflect state DE# members? If not, can you recommend a source for this data for 2010, which plans could access?	In addition to the plan-level data posted in HPMS, CMS has pushed out beneficiary-level files to plans (see April 7th memos for more details). The file includes monthly "Medicaid status" fields (fields 38-49, in file positions 145-168). These fields have codes for FBDE, SLMB, etc. FYI - The MMR now contains Medicaid status information.
21	Payment	03/27/2011 12:58	Question regarding payment for I-SNPs	[PARAPHRASED] What is the value of the institutional flag in the MMR file for members who are living in the community but require an institutional level of care based on State assessment?	The institutional flag on the MMR is a payment-related field, and is not necessary aligned with the residence of the beneficiary in that month. At final reconciliation, CMS applies either a community or an institutional risk score for a beneficiary for each monthly payment, depending on the residence of the beneficiary in that month. A beneficiary is considered long term institutional if CMS has received a 90-day assessment from a nursing home and the beneficiary has not been discharged. If a beneficiary has not been in a nursing home for at least 90 days, even if they have been determined to require an institutional level of care, the month's payment will use a community risk score. The MMR fields related to institutional status (one for MA payments, one for Part D payments) indicate which risk score was used in payment for that month.

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Introductory note

1) MA-PD Spring Conference materials may be found at: http://www.cmsdrughealthplanevents.org/cms/events/baltimore-april-2011/

2) The Medicare FFS unit cost increase information, requested during the 4/14/11 UGC, is not yet available. OACT intends to provide this information on next week's UGC (4/28/11 UGC) as an introductory note.

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Bid reviews	04/18/2011 13:25	Responses to Information Requests of Bid Reviews - 48 Hours	On page 4 of the CY2012 Part D BPT Instructions, with regard to requests for additional documentation or supporting information in the BPT it states "Organizations must be prepared to provide this information in a timely manner – that is, within 48 hours." Does this imply that requests for additional information received on a Friday afternoon at 5:00 PM require a complete response by Sunday afternoon at 5:00, or is this to be interpreted as 48 "business hours" – in other words a request received on a Friday afternoon at 5:00 PM requires a response by Tuesday at 5:00 PM. Requests received early Saturday morning pose a similar issue if requests for information are received in the early morning hours and require a response by early Monday morning – in this case, the entire 48 hour window could fall outside of "standard operating hours."	The 48 hours requirement applies to business days (that is, the business workweek of Monday through Friday). A request at 3:00PM ET Friday would require a response by 3:00PM ET Tuesday. If reviewers send an email on Saturday or Sunday, it would require a response by COB Tuesday (that is, the organization would have Monday and Tuesday, 2 business days, to develop and send a response). OACT continues to emphasize the importance of having knowledgeable "back-ups" that can respond to inquiries in the case of your absence. There are several caveats to this response: 1) The 48-hour requirement is specific to the bid reviews/requests conducted by the CMS Office of the Actuary (OACT) and our contracted reviewers. We cannot address bid review timelines for other CMS components and their bid reviews. 2) At certain times during bid review, organizations may be asked by OACT to provide responses in a shorter timespan than the 48-hour timeline. OACT strives to reduce and eliminate such urgent situations, but cannot guarantee that they will not occur. 3) Requests for upload (resubmission/gate opening) by OACT are often for less than 2 business days.
2	MA Worksheet 1 Section VI	04/15/2011 10:45	EGWP premiums on worksheet 1	From the bid instructions for [MA BPT] Worksheet 1, Section VI. premium line instructions from the bid are [copied] below. Please clarify if the EGWP premiums are to be included (unsure as to whether EGWP premiums are considered optional supplemental benefits or not.) Line 2 – Premium Revenue Enter the revenue from earned MA premiums for the base period in total dollars. Include premiums associated with Medicare-covered and all A/B mandatory supplemental benefits. Do not include premiums for optional supplemental benefits. Do not include Part D premiums. In the first column, enter the amount applicable for ESRD enrollees. In the second column, enter the amount applicable for hospice enrollees. In the third column, enter the amount applicable to all other enrollees. The sum total is displayed in the fourth column.	Do not classify all EGWP plan premiums as optional supplemental. Customized benefit plan packages for entire employer groups under an EGWP plan are not optional supplemental. The instructions for MA BPT Worksheet 1 Section VI do not make a distinction between EGWP plans and non-EGWP plans. That is, in Worksheet 1 Section VI, optional supplemental premiums must always be excluded; basic and mandatory supplemental premiums are included on Worksheet 1. Basic and mandatory supplemental premiums are employer and employee premiums that are charged for all enrollees of an employer group for Medicare-covered and non-Medicare-covered benefits. Optional supplemental premiums are charged to a subset of enrollees that have elected to add an optional supplemental benefit (OSB) package. As an example, EGWP plan 805 includes two employer groups. In group A, members are changed $X to enroll in the plan, but can add an OSB package at a premium of $Y. In group B, members are charged $Z to enroll in the plan, and there are no OSB packages available. Worksheet 1 Section VI would include $X and $Z; Worksheet 1 would exclude $Y. Even though the two employer groups have different customized benefits and premium ($X vs $Z), this is not classified as optional supplemental.
3	Base period data, manual rates, and credibility	04/13/2011 12:29	Reflection of discontinued PFFS plans in bids	We shut down our PFFS EGWP plans at the end of 2010. However, some of our larger PFFS clients renewed in 2011 under our PPO EGWP. I am assuming that the experience of these PFFS clients should be reflected in our PPO EGWP bids for 2012 based on the last sentence of page 8 of the bid instructions, which reads: "Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year." If we use the PFFS EGWP experience as a manual rate in our bids, would it be acceptable to use the credibility percent in worksheet 2 to blend together the projected worksheet 1 experience with the manual rate. In other words the credibility percentage would be used to weight together the existing PPO EGWP experience with the new PFFS client experience reflected in the manual rate. I ask this because I did not see anything in the credibility section within pricing considerations of the bid instructions that addresses this scenario.	Worksheet 1 must include the experience of the PPO plan. If the PFFS plans were terminated and not crosswalked into the PPO plan, then Worksheet 1 must not include the experience of the PFFS plans. If Worksheet 1 contains fully credible data, then the actuary must use the "population change" factor and other projection factors to adjust the data to the population and benefit package projected in the contract year. If Worksheet 1 data is not fully credible, then an appropriate manual rate and a reasonable credibility assumption also must be used. Based on the limited information provided in this specific circumstance, it sounds like this approach would be inappropriate. However, the PFFS experience may be used in the development of a manual rate that best represents costs for the projected population.

User Group Call Date 04/21/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
4	MA Worksheet 3	04/15/2011 14:32	worksheet 3 reporting - please reconsider	This was [what we heard] in the Q&A [last week]: Q: What is the preferred way to show utilization in WS3. For example, IP-Acute cost sharing is $50/day for days 1-5 and $0 thereafter. Should the plan show $50 and reduced utilization or full utilization and a copay less than $50. A: Show $50 and reduced utilization [as the preferred method]. Is it still ok to show the entire utilization in worksheet 3? Doing what you indicate requires a rewrite of our models, which I hesitate to do at this point in the game. Just want to make sure that we won't get dinged in an audit or desk review for not using the "preferred" approach.	During last week's (4/14) Q&A, we indicated that an alternative method would be to enter reduced copay and full (that is, unadjusted) utilization. We also indicated that it would be inappropriate to not reduce both the utilization and the copay and only adjusting the copay after OOP max (in col j). Using either the preferred method or the "alternative method" described by CMS above are acceptable methods of preparing the BPT for CY2012.
5	Margin	04/19/2011 12:04	gain/loss margin	When preparing the 2009 bid filings, our contract had a negative gain/loss margin at the contract level. We filed a 3-year business plan to return to profitability, with the commitment to have a positive gain/loss in 2012. We are still planning to file a positive gain/loss for 2012 at the contract level. However, with the recent changes in reimbursement from the Affordable Care Act, we are concerned about the impacts on our members if we have to file a positive gain/loss margin in every PBP. Is it possible for us to file a negative gain/loss in one PBP for 2012, while filing a positive gain/loss at the contract level? We would file a business plan to return to profitability for the applicable PBP. Please note that the different PBPs we file under this contract are for separate service areas; we do not have multiple plan designs in a service area.	The bid instructions provide flexibility for negative margin at the PBP-level while the contract-level is positive, even for plans that are not "paired", as long as the margin requirements in the instructions are met. Also see Appendix B for documentation requirements for plans with negative margin that were also negative in prior contract years.
6	Non-benefit expenses	N/A	N/A	Under the Medicare FFS bidding option for EGWPs, should bid values be determined as if the plan actually provides FFS benefits? For example, is it acceptable for the total non-benefit expense PMPM in the BPT to include non-benefit expenses associated with non-covered benefits that will be provided outside of the PBP?	Under the FFS bidding option for EGWPs, non-benefit expenses associated with non-Medicare-covered benefits may only be included in the BPT for the benefits that are accounted for in the BPT. For example, if the value of "unspecified" additional benefits are entered (in MA Worksheet 4 cell R116) to offset MA rebates, then associated non-benefit expenses may be included. However, it is not acceptable to include non-benefit expenses associated with non-Medicare-covered benefits that are provided outside the BPT. That is, if an EGWP plan customizes a benefit package for an employer group, and the customized benefits exceed the amount entered in the BPT, it would be inappropriate to include the non-benefit expenses associated with benefits above the BPT level.
7	MSP	04/15/2011 13:36	MSP question	Can you please provide the appropriate source for the X and Y included in your MSP example in the instructions on pages 26 and 27?	X is the bid portion of payment reflecting reduced payments for MSP beneficiaries in the plan, which can be developed from the MMR file using the components listed in the numerical example in the bid instructions. Y is the bid portion of payment that would be paid if no beneficiaries had a payer that was primary to Medicare. It can be calculated from a portion of X, by applying a factor of (1/.174) to the payments for MSP beneficiaries.
8	A.E. c.s. factors	04/15/2011 12:18	FFS Cost sharing factors	P 26 of the MA BPT instructions indicates there are further details about the development of the cost-sharing factors, in the Ratebooks & Supporting Data page on the cms website. Was just there and couldn't find it. Can you please provide the link?	OACT intends to publish this information next week, at the link provided in the bid instructions.
9	QBP	04/17/2011 18:33	Star Bonus Adv Notice to Notice Change	In the Advanced Notice, it says on page 9 that "Under the demonstration for 5 star plans, CMS will apply the QBP percentage to the entire 2012 blended county rate". However, in the final rate announcement, the QBP % is no longer getting applied to the entire blended county rate. The final rate announcement formula is: 2012 (benchmark) Rate = [(2012 Pre-ACA Rate) x (1 + bonus %) x (Pre-ACA transition blend %)] + [(2012 FFS rate excluding phase-out IME) x (quartile % + bonus %) x (FFS transition blend %)]. To apply the QBP % to the entire blended benchmark, the formula would be: 2012 (benchmark) Rate = [[(2012 Pre-ACA Rate) x (Pre-ACA transition blend %)] + [(2012 FFS rate excluding phase-out IME) x (quartile %) x (FFS transition blend %)]] * (1 + bonus %)? Why did this change in the final notice?	Under the Affordable Care Act (ACA), the quality bonus percentage is added to the applicable percentage of the fee-for-service rate in that county. In order to be consistent with the statute, the quality bonus percentage should be applied to both portions of the benchmark, and should not be calculated as a multiplication of the entire benchmark. That is, the quality bonus percentage is an additive, and not a multiplicative, add-on to the rates. Furthermore, because the pre-ACA amount is being phased out over time, applying the quality bonus percentage to each portion of the blended benchmark will mean that once the pre-ACA amount is phased out, the rate will be consistent with the ACA calculation methodology.

User Group Call Date 04/21/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
10	PD BPT validations	04/18/2011 14:44	Part D BPT Validation Error Questions	I am running the Validation Report on draft Part D bids. We are pretty sure the two items below are not errors, but want to be absolutely sure. Do you have guidance on the following two types of Validation Report errors? 1) Cells: 'Drug Plan Base Financials'!K13:K15, 'Drug Plan Base Financials'!M12:M15 ◦ Cell value: [left blank] ◦ Input Message: The Contract-Plan ID must be 9 characters in length with the first character being a capital E, F, H, R, or S and the last 8 characters in the following format: H#####-### ◦ Description: The 'Drug Plan Base Financials' tab has space for up to 8 base experience plans. Our plans use only one or two base period plans. 2) Cells: 'Script Projection'!H49:52 ◦ Cell value: $0.00 ◦ Input Message: The Mail Order Generic Cost Sharing Dollars should be greater than zero if the associated Population/Member Months cell is greater than zero and should be greater than or equal to 5% of the Allowed Mail Order Generic Dollars. ◦ Description: For Wksh 6 Amounts Allocated over Catastrophic Coverage mail order drugs, we sometimes have zero scripts, and therefore zero cost sharing.	1) Regarding the validations on PD WS1 cells K12:K15 and M12:M15: Leaving these cells blank does not trigger a validation error. Please double-check that you do not have any "spaces" or zeroes or other extraneous characters in the cell that could be triggering the error. 2) If the number of scripts in column f are zero and the allowed $ in column g are zero, then the cost sharing in column h can be zero.
11	Base period data - PDEs	04/14/2011 12:31	WS1 Financial Reconciliation for Part D	a) The Part D BPT instructions state that it is now required to upload documentation of the reconciliation of the base period experience to company financial data with the initial bid submission. Given that WS1 is populated with PDE data, not financial data, what should be submitted? b) Is the expectation that we adjust the PDE data to tie to the financials?	a) The required supporting documentation for the base period experience in Worksheet 1 includes: • A description of the source data, such as the CMS PDE return files • All adjustments made to the source data including, but not limited to, amounts attributable to: ◦ Accepted PDEs ◦ PDEs rejected at time of bid preparation but expected to be accepted by CMS upon resubmission ◦ Plan-to-Plan transactions ◦ Transfer of OTC experience to non-benefit expenses ◦ Removal of ESRD drugs covered under Part D in base period but not in CY2012 (if removed) ◦ Incurred but not yet paid claims (represented by the completion factor) • An explanation and numeric quantification of any differences between the data in Worksheet 1 and audited company financial data. An example of an explanation would be: Worksheet 1 data is reported on an incurred basis while the financial statements are reported using GAAP. b) No.
12	PD Worksheet 6A	04/18/2011 8:50	Worksheet 6A Instruction Clarification	[PARAPHRASED] Please confirm that Worksheet 6A applies to all members with drug spend above the ICL, but only the amounts between the ICL & Catastrophic (i.e. the gap) should be reported?	Yes, that is true.

User Group Call Date 04/21/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
13	PD	04/19/2011 9:26	Part D Questions for 2012 Bids	1) Page 12 of the PD BPT instructions states that EA plans that offer gap coverage in excess of the defined standard coverage should "Report the drugs on the 'enhanced' tiers based on the plan-specific formulary.". Please clarify if drugs covered in the gap should be classified on Worksheet 6A (Coverage in the Gap) according to the formulary tier label or according to their status as applicable or non-applicable. For example, if a drug that is on a tier labeled "Generic" is an applicable (brand) drug and is covered in the gap, should this be reported on the generic line or the preferred brand line on Worksheet 6A? If it should be reported on the generic line in Worksheet 6A, then should it also be reported on the generic line in Worksheet 6 (Script Projections), as well? Or should it be reported on the Preferred Brand line in Worksheet 6? 2) This question concerns PD Worksheet 3, column j – GAP PMPM (lines 4 and 5). The instructions state to, "Enter the projected pmpm value corresponding to the amounts between the ICL and catastrophic limit for members in column d for each line. Reflect the impact of gap coverage in this amount." My question concerns the effect of LIS membership on this amount. Should we account for the LIS status of the members when entering this amount? That is, for LIS members, should we enter 100% of the allowed GAP PMPM, regardless of the applicability status of their drugs? Then, for non-LIS members, should we enter 86% of the allowed GAP PMPM for non-applicable drugs and 100% of the allowed GAP PMPM for applicable drugs to reflect Defined Standard Gap Coverage? Consistently with this, the Federal LIS Cost Sharing Subsidy would be calculated to include 100% of the allowed GAP PMPM, less any copayments for LIS members in the GAP.	1) Clarification of reporting of drugs in the coverage gap: In the coverage gap, when the type of coverage is DS, AE, BA or EA with defined standard gap coverage, drugs must be reported based on their status as applicable and non-applicable drugs as defined under the Medicare Coverage Gap Discount Program. When an EA plan offers coverage in the gap that exceeds defined standard, report drugs on the enhanced tiers based on the plan-specific formulary. For example, the Part D sponsor offers a $0 copay for all drugs on tier 1 of the formulary. The PBP labels tier 1 as GENERIC and includes generic and brand drugs. If a non-applicable drug under the Medicare CGDP is labeled as a brand on the plan-specific formulary and, in this scenario resides on tier 1, such as the branded Percocet, then report those drugs as brands on the right-hand side of Worksheet 6A. In general, it is expected that there will be few, if any, drugs that are reported in this way. 2) Yes. The status of the LIS members should be accounted for. The Federal LICS subsidy includes 100% of the allowed gap pmpm for LI beneficiaries less any copayments paid by LI beneficiaries in the gap.
14	Risk Score data	04/14/2011 13:03	Risk Score files released on HPMS	This question is related to the CMS Beneficiary files that were released to plans on 4/7/11 for the CY 2012 bid purposes. Was the risk score data in that file gross or net of MSP?	MSP is an adjustment to payment, generally not applied directly to risk scores. The beneficiary-level files are not adjusted for either MSP or MA coding (or normalization).
15	Risk Score data	04/13/2011 22:05	Part C Beneficiary-Level file risk scores	Have the risk scores in the Part C beneficiary-level files already been adjusted downward for the -3.41% MA coding pattern difference? For example, to enter the base period risk score in worksheet 1, would we need to apply an adjustment of (1-3.41%) to the risk scores provided in the beneficiary-level file, as well as applying the FFS normalization adjustment?	As stated in the above response, the beneficiary-level files are not adjusted for MA coding. The base period risk score entered in Worksheet 1 is the final risk score; therefore, apply the applicable MA coding pattern differences adjustment factor (which is 1-3.41% for CY2010) to the risk scores provided in the beneficiary-level file, as well as applying the FFS normalization adjustment.
16	Risk Score data	04/15/2011 13:37	Bene Files - Hospice status	Is the Hospice status flag in the bene files follow the MMR basis or the date of election basis? For example, assume a member elects hospice status on March 28th and remains on hospice thru July 10th. Would the hospice flag be "0" for March and "1" for June and July? Or, would March also be "1"?	The hospice flag in the beneficiary-level file that we sent out is created slightly differently than the hospice flag on the MMR. The MMR flag is purely a payment flag. The hospice flag on the beneficiary-level file is a benefit flag. Payment: in the month of hospice election we pay the full MA capitation to the plan. In any additional month in which hospice was in force for the full month we pay only the hospice rate. Finally, in the month that hospice terminates, we still pay the hospice rate. Because the hospice flag on the MMR is as of the first of the month, when the flag indicates that the beneficiary was in hospice status as of the first of the month, it indicates that that month's payment is the hospice rate. Benefit: As of the date of hospice election, the MAO is only responsible for supplemental benefits – FFS pays for all non-hospice related A/B services as well as the hospice benefit. Finally, in the month that hospice terminates -- when we still pay the hospice rate -- the MAO continues to be liable only for supplemental benefits through the end of the month. Beneficiary-level file: On the beneficiary-level file, the hospice status flag shows periods during which hospice was in force for some part of the month. To assess the impact on payment, MAOs should consider the second and later months of hospice status. For this example, is a member elects hospice on March 28th, the beneficiary-level file would indicate hospice status in March to show that the beneficiary elected hospice status during the month. The MMR would not reflect hospice status in March, since the beneficiary was not in hospice status as of the first of the month, but would reflect hospice in April.
17	Risk Score data	04/15/2011 13:45	Frailty	Page 40 of the Announcement indicates that FIDE-SNPs with frailty above the "minimum PACE score" will receive the frailty add-on to their risk scores. Where do we find the "minimum PACE score"? Will our frailty scores to be used in the 2012 bids be posted on HPMS?	2012 frailty scores will be calculated in the fall 2011, using results from 2011 Health Outcomes Survey; therefore, frailty scores are not available for bidding. Because many of the 2012 FIDE SNPs have not previously had frailty scores calculated, we are taking the position that FIDE SNP bids should not include frailty in their 2012 bids.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 04/28/2011

Introductory note

Medicare Unit Cost Increases 2010-2012

Service Category	Unit cost increases 2010	2011	2012	Comments
Inpatient hospital	1.9%	-0.6%	1.4%	Updated on October 1st
Market basket	2.1%	2.6%	2.7%	
Documentation & coding	0.0%	-2.9%	0.0%	
Legislated adjustments	-0.25%	-0.25%	-1.3%	
Skilled nursing facility	-1.1%	1.7%	1.4%	Updated on October 1st
Market basket	2.2%	2.3%	2.6%	
Per CMS regulations	-3.27%	-0.6%	0.0%	
Legislated adjustments	0.0%	0.0%	-1.2%	
Home health agency	-0.8%	-5.2%	-2.4%	Updated on January 1st
Market basket	2.0%	2.1%	2.4%	
Case mix adjustment	-2.75%	-3.79%	-3.79%	
Outlier adjustment	0.0%	-2.6%	0.0%	
Legislated adjustments	0.0%	-1.0%	-1.0%	
Outpatient hospital	1.9%	2.4%	1.2%	Updated on January 1st
Market basket	2.1%	2.6%	2.7%	
Legislated adjustments	-0.25%	-0.25%	-1.50%	
Physician	1.3%	0.9%	-28.3%	Updated on January 1st
Carrier - lab	-1.9%	-1.8%	-1.5%	Updated on January 1st
Consumer price index (CPI)	-1.4%	1.1%	1.7%	
Legislated adjustments	-0.5%	-2.85%	-3.15%	

Source: 2012 President's Budget assumptions.

The physician increases represent the average annual increase, since updates changes occurred multiple times during 2010.

Legislated adjustments include multifactor productivity and other adjustments required by the ACA.

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Medicare unit cost increases	04/21/2011 14:41	OACT User Group Question: Medicare Unit Cost Increases	In each of the prior two years, OACT provided a table of projected unit cost increases for the FFS program (see introductory notes for 4/23/2009 UGC Q&A and 4/22/2010 UGC Q&A). Could a table for CY2010-2012 time period be provided this year?	See introductory note to 4/28/2011 UGC Q&A.
2	Medicare unit cost increases	04/21/2011 15:59	Medicare Unit Cost Increases	In the April 22, 2010 edition of Actuarial Bid Questions on the CMS website, OACT presented projections of Medicare Unit Cost Increases for CY 2009-2011. Could you present the same information this year for CY 2010-2012?	See introductory note to 4/28/2011 UGC Q&A.

User Group Call Date 04/28/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
3	QBP ratings	04/20/2011 17:56	MA/PD Star Rating Question	In the following example, for purposes of developing 2012 bids, what star rating should we use for the MA-only plan? A company has only two plans, both of which are under the same contract number. One plan is an MA/PD and one is an MA-only plan. The company has a 3.0 star rating for Part C and a 3.5 star rating for Part D, which gives a rounded average star rating of 3.5. The MA/PD would use 3.5 stars in their bid. Should the MA-only plan also use 3.5 stars, or would it use 3.0 since it does not have Part D benefits? In the same example, if the MA-only plan is under a different contract number within the same organization and is too new to have its own star rating, for purposes of developing the 2012 bid, would the MA-only plan's star rating be 3.0 or 3.5?	For purposes of developing 2012 bids, the Quality Bonus Payment (QBP) ratings released by CMS must be used in the bids, not the Plan Ratings. The QBP rating can be found from the HPMS Home page by selecting Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating. QBP Ratings are applied at the contract-level; all plans under a contract receive the same rating (whether the plan is MA-only or MA-PD). The Part C summary and Part D summary Plan Ratings used in this example do not apply to the calculation of the QBP rating. The QBP rating is based on the overall plan rating which is calculated using all the measures used in the plan ratings, not the average of the two summary ratings. New contracts under an existing parent org receive the weighted average QBP rating of all rated MA contracts under the parent org. CMS has released the contract-level QBP rating to be used in the 2012 bids, see HPMS reference above to view these ratings.
4	EGWP bidding	04/22/2011 17:15	Question for EGWP Bids Related to WS 1 Section IV Column k	We are developing EGWP bids using the Medicare FFS cost sharing approach and base period data that reflects actual experience for groups enrolled in a variety of benefit plans. Please clarify how we should interpret for these bids what to include in the utilization adjustment for benefit plan changes (WS 1, section IV, column k). a) For these bids, is it intended that these adjustments represent expected utilization differences between the aggregate benefits in the experience versus FFS cost sharing utilization levels? b) Should we instead interpret these adjustments as the expected impact of the change in aggregate actual benefits? c) Should we make no adjustment (use a 1.0 factor) since we are filing FFS cost sharing? d) Or, is there another way we should interpret this section?	Enter base period data (including utilization) without adjustment. Use the additive factors to remove additional mandatory supplemental benefits to project the costs of Medicare-covered benefits. Even though beneficiaries will not be charged FFS cost sharing, do not adjust utilization for the difference between actual and FFS cost sharing. The Benefit Change utilization factor (column k) can be used for minor adjustments in the utilization of Medicare-covered benefits due to changes in FFS benefits over the two years between the base period and the contract period, if any.
5	Worksheet 1 Risk Score	04/22/2011 20:12	Risk score in worksheet 1	The instructions say the following for the risk score to be entered in worksheet 1: Line 3 – Risk Score Enter the normalized risk score for the non-ESRD and non-hospice members of the population represented in the base period data using the CMS- HCC risk model for payment in CY2010. Also enter the risk score for the non-DE# subset. The DE# subset will be calculated based on the total and non-DE# amounts entered. If DE# members equals zero, then the non-DE# risk score must equal the total risk score. Can you please confirm that we should take the bene file risk score and divide by both the FFS normalization (1.041) and multiply by the coding intensity factor (1 - ~~0.341~~ 3.41%).	Yes, for Worksheet 1 risk score reporting, adjust the raw risk scores for both the 2010 normalization factor (which is 1.041) and the 2010 coding intensity factor (which is 1 - 0.0341).
6	LIS enrollment data	04/25/2011 19:46	RE: LIS Enrollment	1) You indicated on the 4/14/2011 call that the LIS information was going to be posted the following week (presumably by 4/22/2011). a) The enrollment by county was posted late on Monday 4/25/2011 but the information by plan was not posted. b) The information by county is missing the PDP information for Mississippi, Missouri, and Montana. When will this missing information plus the plan level file be posted? 2) In addition, does the county level enrollment file exclude any of the following types: • MA private fee-for-service plans, • PACE programs under section 1894 • plans established through reasonable cost reimbursement contracts under section 1876(h) of the Act. • • EGWP plans	1) The information by plan will be posted in the next few days. The missing information for Mississippi, Missouri, and Montana will also be posted soon. 2) No (none are excluded).
7	LIS enrollment data	04/26/2011 15:08	LIS Information By County	In addition to missing Missouri, Mississippi, and Montana, this file has approximately 20% fewer LIES members than what was reported last year. This change does not seem reasonable, and the enrollment reported does not match to what our client's own enrollment files indicate. Is there an explanation for the change and difference?	CMS is reviewing the data that was posted, and will post correction(s) next week if necessary.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 05/05/2011

Introductory note

As we did for CY 2011 bids, CMS is imposing a limit on the increase in Total Beneficiary Cost (TBC) from one year to the next. Because payment rates were frozen from 2010 to 2011, no payment adjustment was needed to enforce TBC requirements for CY 2011 bids. Since payment rates changed from 2011 to 2012, a payment adjustment is needed to equitably enforce TBC requirements for CY 2012 bids.

Illustrative Payment Adjustment Calculations

	2011 Values				2012 Values					
Bid ID	Bid Amount	Benchmark	Rebate Percentage	Rebate	Bid Amount	Benchmark	Rebate Percentage	Rebate	Payment Adjustment	Member Months
Plan 001	1,000.00	950.00	75.0%	−50.00	998.40	925.00	66.7%	−73.40	−23.40	15,000
Plan 002	1,000.00	1,050.00	75.0%	37.50	998.40	1,025.00	66.7%	17.73	−19.77	45,000

Notes:

1. Payment Adjustment = $(\text{Rebate}_{12} - \text{Rebate}_{11})$.
2. Rebate = Benchmark – Bid (if Benchmark > Bid).
   = (Rebate Percentage)×(Benchmark − Bid) (if Benchmark < Bid).
3. Bid Amount 2011 - taken from 2011 BPT.
4. Bid Amount 2012 - is the result of applying the growth rate used to develop the 2012 rate book (-0.16%) to the 2011 bid amount.
5. Benchmark 2011 - the enrollment weighted average of county-specific payment rates using the 2011 rate book and enrollment in the 2011 BPT.
6. Benchmark 2012 - the enrollment weighted average of county-specific payment rates using the 2012 rate book and enrollment in the 2011 BPT.
7. Rebate Percentage - is 75% for 2011; for 2012 it depends on the plan's QBP rating.
8. Member Months - are projected CY 2011 member months taken from the 2011 BPT.

Illustrative Payment Adjustment for Cross-walked Plans

	Payment Adjustment
Payment Adjustment when Plan 002 is cross-walked into Plan 001	−20.67

Notes:

1. −20.67 = [(−23.40)×15,000 + (−19.77)×45,000] / (15,000 + 45,000)
2. Member Months – are projected CY 2011 member months taken from the 2011 BPT; similar (weighted average) calculations should be used to determine other 2011 TBC-related values (e.g., Premium, OOPC) for cross-walked plans.

User Group Call Date 05/05/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	QBP ratings	04/27/2011 17:22	New plan QBP Star Rating questions	I understand that new plans for a MAO with existing contracts will receive a star rating equal to the average of the existing contracts' ratings, where the average is weighted on December 2010 enrollment and rounded as described in CMS's answer to another question submitted via email. I have three follow-up questions: 1) Are the star ratings of Medicare Cost plans of the MAO included in the weighted average for determining the ratings for new plans? 2) Is December 2010 employer group enrollment included when determining the weighted average star rating? 3) Is there any way to validate the star rating we are calculating prior to bid submission, to make sure we are consistent with CMS's calculation?	1) 1876 Cost contracts are not Medicare Advantage contracts, so their plan ratings results are not included in calculating the Quality Bonus Payment (QBP) rating for new contracts under existing Parent Organizations. 2) CMS pays the contract for their entire enrollment and the Quality Bonus Payment will be applied to the entire enrollment, so the entire enrollment of the contract from December 2010 was used. 3) Certifying actuaries do not need to calculate the QBP star rating to be used in CY2012 bids. CMS has released the QBP rating for all CY2012 contracts in HPMS, under HPMS Home > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating.
2	TBC data posted	04/28/2011 8:32	TBC Adjustment Factor	On page 128 of the Announcement (4th paragraph), an adjustment factor for TBC is discussed. It states that CMS will provide the adjustment factor to each plan shortly after the release of the final call letter. Has this been released and where can we find it?	An HPMS mass email was released on April 29, 2011 to announce that TBC data was posted at: HPMS Home > Quality and Performance > Part C Performance Metrics > Total Beneficiary Costs. A memo was also released via HPMS on April 19th with additional information regarding TBC data.
3	TBC data posted	05/02/2011 10:45	Total Beneficiary Costs (TBC) Data for CY 2012 Bid Preparation	The TBC Data is not available in HPMS for our plan, Hxxxx. Our plan is a Dual Eligible Special Needs Plan. Is that data not available for Dual SNPs?	As indicated in the April 19th memo (page 5): "For CY 2012, CMS is evaluating TBC for non-employer plans (excluding D-SNPs) …"
4	TBC data posted	04/27/2011 18:36	Total Beneficiary Cost Test and Dual Special Needs Plans	The call letter states that D-SNPs will be exempted from the "second approach" of the total beneficiary cost test, but it does not specify whether or not the TBC change test will apply to Dual SNPs. Please verify (for my peace of mind) that D SNPs are exempted from the TBC change test. I recognize that often Duals don't pay cost sharing for Medicare covered services, but there are other benefits such as dental or vision that could change from year to year.	See response above.
5	TBC data posted	05/01/2011 12:22	Total Beneficiary Costs (TBC) Data for CY 2012 Bid Preparation	We cannot find the Total Beneficiary Costs (TBC) Data for CY 2012 Bid Preparation on the HPMS for the following contracts: Hxxxx [these contracts are not D-SNPs]	The HPMS staff is in the process of revising access restrictions, such that the certifying actuary assigned to each contract is able to access the TBC page in HPMS (and the QBP page and the risk adjustment page). If you are not the certifying actuary (assigned to the actuarial certification module), it's possible that your HPMS user ID may not have access to these pages. Another HPMS user at the plan sponsor organization would have to access the information and provide it to you.
6	TBC data posted	05/02/2011 12:44	Questions	What level of Part B Premium for 2012 should we assume when considering the Total Beneficiary cost?	As indicated in the April 19th memo (page 5): The TBC calculations assume the Part B premium level that CMS pre-populated in the CY2012 MA BPT Worksheet 6 cell E14 (namely, $96.40). This is the maximum amount that plans may "buy-down" the Part B premium using MA rebates.
7	TBC data posted	05/02/2011 19:27	Question Regarding Column H TBC Adjuster for Bonus and Benchmark Amounts	Would CMS be willing to discuss and describe its methodology for the column H adjustment that vary significantly by plan for the bonus and benchmark amounts? We have 3 plans all with the same star rating, all with the same service area so with exactly the same double bonus counties but all 3 have very different TBC adjustments in column H. In fact, the high option's adjuster is double the low option plan's TBC column H adjustment. Can you explain how this situation could occur? Can you give us a write-up of the general methodology used to develop these adjustment amounts in column H by plan, including how much variation there is between plans with less than a 3 star rating up to a 5 star rating; how much variation there is for double bonus counties versus single bonus counties, and explain the impact of rebasing had on these TBC adjustment amounts, if any. In addition, is this amount in column H determined by a percentage adjuster to 2011's OOPC amount or is it an absolute amount unrelated to 2011's OOPC amount?	See introductory note to 5/5/2011 UGC Q&A.
8	TBC data posted	05/02/2011 9:39	TBC Calculation When Plans Are Being Consolidated	Would it be possible for CMS to release a hypothetical but numerical example of the calculations that should be done and the specific comparisons that should be made to ensure that newly consolidating plans for 2012 meet the TBC requirements when compared to the base period data for the constituent plans in 2011? For example, say plan B is being crosswalked into Plan A, given the 2011 Plan A and B TBC values, and the 2011-2012 adjustments for benchmark/bonus payment change and OOPC model change, what are the specific calculations that should be to ensure that the new consolidated Plan A meets the TBC requirements for 2012?	See introductory note to 5/5/2011 UGC Q&A.

User Group Call Date 05/05/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
9	EGWP bidding	05/02/2011 18:56	Question Regarding EGWP Bid Margins Being Positive vs Margin Corridor Rule of -5% and 1%?	On page 24 of the bid instructions, the instructions require EGWP bid margins to be positive and also have bid margins within -5% and +1% of the general enrollment plan bid margins. Suppose at the contract level, an organization has its general enrollment plans with more than a -1% overall margin (with negative margin business plans) so even with a positive 1% difference, the EGWP bid margins will be negative. Which rule takes precedence? Should EGWP bids always have positive margins even if the EGWP bid margin corridor rule with general enrollment plans is not adhered to or should EGWP bids always obey the margin corridor rule even if the EGWP bid margins will be negative?	As indicated in the 4/14/2011 UGC Q&A #11: In the limited instances where the contract-level average margin for general enrollment and IC/SNP is less than -1%, the EGWP margin must be zero (0%).
10	Classification of medical vs. non-benefit	04/27/2011 18:14	Related Party Expenses	The plan would like to know if certain IT expenses (such as electronic medical records, QI, etc.) similar to those described in the MLR instructions for annual filings required under the PPACA for insurance companies could be considered medical expenses.	As indicated in the 4/14/2011 UGC Q&A #10: The MLR regulation is not applicable to Medicare bidding. For CY2012, we refer you to the bid instructions. The classification of expenses depends upon the nature of the expense.
11	PD BPT WS1: hospice	04/29/2011 12:56	Part D Hospice claims	On page 113 of the call letter, it states "The only drugs covered by the hospice program are those used primarily for relief of pain and symptom control related to the individual's terminal illness. However, because hospice care is a Medicare Part A benefit, the drugs provided by the hospice and covered under the Medicare per-diem payment to the hospice program are not covered under Part D." In 2010, some of these drugs were [paid] under Part D, but will not be [paid] in 2012. Since we are still waiting for CMS to release guidance regarding how to identify hospice drugs, is it appropriate to create an estimated list of drugs "used primarily for the relief of pain and symptom control", and exclude those drugs for hospice members in the base data set on Wk1 of the PDP BPT?	If the base period experience includes drugs covered under the Part A Hospice benefit that were inadvertently paid under Part D, then an adjustment must be made using the "Other Change" factors on Worksheet 2. The adjustment and methodology used to calculate them must be documented in the supporting documentation that is required with the initial bid submission.
12	PD BPT WS1: settlement amounts	05/02/2011 12:31	Bid Question for Actuarial User Group Call	Concerning the PD BPT, Worksheet 1, Section VI: Are the amounts reported there to include the PD settlement amounts? LICSAA Low Income Cost-Sharing Subsidy Adjustment Amount RSAA Reinsurance Subsidy Adjustment Amount RA Risk Sharing Adjustment BNAA Budget Neutrality Amount	No.
13	Low income identifier	05/03/2011 10:54	Low income identifier used for LIRB determination	What data source and fields are used to identify low income status for the purpose of developing the low income regional benchmarks? Is this changing between 2010 and 2011? If so, how?	The low income regional benchmarks are based on the low income status in the MMR data. This has not changed between 2010 and 2011.
14	Risk Score data	05/02/2011 16:44	Clarification of Submitted Through Date on Part C risk score data	In the technical notes for the Estimated Part C Risk Scores provided to us, it mentions that 2009 plan diagnosis data was used that was submitted through January 31, 2011. The final sweep date for 2009 data happened on Feb. 11, 2011. Does the data used in the Estimate Part C Risk Scores really go through Feb. 11? The reason why I ask is that we had several submissions that happened after Jan. 31 but before Feb. 11. I just want to make sure whether they are in the data provided to us or not.	Yes.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
15	Risk Score data	04/25/2011 14:01	FIDE-SNP Frailty Factors	1) As a follow-up to the 4/21/2011 CMS actuarial user group call, please confirm that all FIDE SNPs should exclude frailty factor estimates in their 2012 bids, regardless if the plan had prior ADL survey information available. 2) We understand that OACT does not have the actual minimum PACE frailty factor that would be used to determine whether a FIDE-SNP will receive a frailty payment in contract year 2012. However, we would like to know what this minimum was in the last two years so that we have some sense of whether we might qualify for the additional frailty factor. Also, since PACE plans have had a change in the frailty factors being phased in, we would need to know the basis of the calculation for the amount you provide (eg, old factors, new factors, or the blend applicable to the year for which it is calculated). 3) If our FIDE-SNP plan meets the minimum threshold (ie, the min PACE value) for frailty in 2012, will CMS ask for revised bids at that time? If so, are their restrictions on how the additional revenue must be used with regard to benefits, admin expense and gain/loss margins?	1) MAOs planning to sponsor a FIDE SNP in 2012 should not include their anticipated frailty score in their bid. The payment of frailty to FIDE SNPs is new: many of these plans have not previously had frailty scores calculated for their enrolled populations and there is no experience among these plans in estimating a frailty score. If these plan bids included a projected frailty score and then the plan was ineligible for the frailty payment, their plan payment would be too low. CMS is not going to provide an opportunity to resubmit bids after frailty scores have been calculated and plans know their scores and how their scores compare to PACE levels of frailty. For 2012, FIDE SNP bids should not include frailty scores. 2) In the 2012 Announcement, we state that we will apply a frailty adjustment to the payments of FIDE SNPs whose frailty scores are equal to or greater than the lowest PACE frailty score. We will consider the frailty scores of PACE organizations with 100 or more respondents to the HOS-M. To make this comparison for 2012, we will calculate PACE scores using the same factors to be used to calculate the scores with which we will pay FIDE SNPs. [Note: this is not the methodology to be used to calculate PACE frailty scores for purposes of paying PACE organizations.] Using the frailty factors that will be used to pay FIDE SNPs in 2012, the minimum PACE frailty scores for the past two years are as follows: Using 2009 ADLs (used for calculating 2010 frailty scores) – 0.068 Using 2010 ADLs (used for calculating 2011 frailty scores) – 0.067 The 2012 frailty scores – using 2011 ADLs -- will be available in the late fall of 2011. 3) CMS will not be reopening FIDE SNP bids after the frailty scores are announced.
16	Risk Score data	04/20/2011 10:11	FIDE SNP Frailty Scores	What is your expected timeline for establishing a PACE organization range of frailty, and then submitting to applicable FIDE-SNPs a frailty add-on to 2012 risk scores (as described on Page 40 of the April 4, 2011 Payment Letter)?	See response to 4/21/2011 UGC Q&A #17.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 05/12/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	TBC	05/04/2011 11:12	RE: Total Beneficiary Cost Test and Dual Special Needs Plans	When the benchmark rates were higher, a plan included some counties that were higher than average cost (relative to their benchmark) because they could afford to do so and still offer competitive benefits. Now that the benchmarks are decreasing relative to trend, the plan would like to pull the higher cost counties out of the service, dis-enrolling those members. The preferred approach would have been segmentation, but this is no longer allowed. The plan would like to offer a replacement product in the higher cost service area, for a higher premium. Given the fact that the members in those areas were dis-enrolled, and not automatically enrolled in the new plan, please confirm that the new plan be exempted from the change in Total Beneficiary cost rule in its first year.	Since TBC measures changes from one year to the next, new plans are not subject to TBC in their first year. If plans had been crosswalked (i.e., members automatically enrolled in another plan), then TBC would apply.
2	TBC	05/04/2011 12:29	Change in Part D OOPC for MA-only plans	The April 29, 2011 HPMS email on TBC data indicates that MA-only plans should use $270.82 PMPM as the Part D OOPC amount for CY2012 in their TBC calculations. Please confirm that the Unadjusted TBC change for an MA-only plan would be $12.62 (assuming identical Part C OOPC and premium values in 2011 and 2012) due to the change in the Part D OOPC amount ($270.82 in 2012 vs. $258.20 in 2011).	Assuming the OOPC values for 2011 and 2012 are equal, and assuming that the premium (net of rebates) for 2011 and 2012 are equal, then the Unadjusted TBC change would be the $12.62 amount cited in this question.
3	Therapy cap	05/07/2011 23:22	2012 therapy cap	Is there an estimate for the 2012 physical therapy/speech therapy and occupational therapy cap amounts for calculating the additional benefit for paying over the caps? I see the 2011 therapy caps were $1870. I'm just looking for the 2012 estimate to use to calculate the additional benefit of not applying the therapy caps, since the 2012 amount isn't available yet.	The estimate for the 2012 therapy caps (physical therapy/speech and occupational) is $1,870. The mechanism for updating the caps is the MEI (Medicare Economic Index), which is assumed to be 0.2% in the Presidents' Budget 2012, then caps are rounded to the nearest $10. This would result in a 2012 therapy cap estimate of $1,870 (i.e., no change for 2012. The 2012 caps are estimated to be the same as the 2011 caps). Please see the following link for more information: http://www.cms.gov/TherapyServices/ .
4	Medicare unit cost increases	05/08/2011 15:15	FFS Trend Assumptions	Why is the FFS inpatient hospital trend for FY 2012 in the 4/28/2011 call notes different from what is shown in the 4/19/2011 press release, 4/19/2011 fact sheet, and in the federal register notice regarding the proposed FY2012 inpatient update? Inpatient — 4/28/2011 Call — 4/19/2011 Press Release Market Basket — 2.70% — 2.80% Documentation and Coding — 0.00% — -3.15% Cape Code Lawsuit — 0.00% — 1.10% Legislated Updates — -1.30% — -1.30% Total — 1.40% — -0.55% The SNF estimates were similar (but not exactly the same) as the first option in the proposed FY2012 SNF update in the 4/28/2011 press release and federal register notice. SNF — 4/28/2011 Call — 4/19/2011 Press Release Market Basket — 2.60% — 2.70% Documentation and Coding — 0.00% — 0.00% Legislated Updates — -1.20% — -1.20% Total — 1.40% — 1.50% I assume the second option for SNF which includes a reduction of 11.3% and a revamping of the RUG weights was deemed extreme and not likely to be implemented.	The two set of trend assumptions are based on two different CMS announcements. The figures presented during the April 28 call are from our 2012 Presidents' Budget and are based on the final inpatient and SNF updates for FY 2011. The figures reflected in the April 19 press release are from the proposed inpatient and SNF updates for FY 2012.
5	MA BPT WS 4: DE#	05/05/2011 8:37	DE# Determination	When determining DE# population and associated Medicaid copayment for Wkst 4, Section B, column K, is the actuary to consider the provider fee hierarchy provisions existing in most states?	DE# beneficiaries are defined as those who are exempt from full Medicare cost sharing due to their Medicaid eligibility status. The fee schedules are not determinants of DE# membership. See pages 16-17 of the MA BPT instructions.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	MA BPT WS 4: DE# Section V	05/10/2011 13:05	MA BPT - Medicaid Section (Worksheet 4)	All enrollees in our bid are dual-eligible beneficiaries who receive benefits in the form of eliminated Medicare cost sharing. The Medicare cost sharing liability is covered through Medicaid capitation payments from the State to the MCO. Our BPT benefits mirror original Medicare FFS cost sharing. For this specific type of bid (100% dual-SNP with benefits mirroring Medicare FFS and no member liability), please clarify/confirm how CMS expects us to complete Section V of Worksheet 4 in our MA BPT (Projected Medicaid Data for DE#). Below are our specific questions: Line 2 – Medicaid Projected Cost: The BPT instructions indicate that this amount should include both benefit expenses and non-benefit expenses, and should only include costs "not in bid". Please clarify what is meant by "not in bid". In particular: a) For the type of bid in question (100% dual-SNP with benefits mirroring Medicare FFS and no member liability), is CMS expecting this amount to exclude or include the projected "cost sharing" that is shown in Worksheet 3 of the MA BPT? b) If the State provides these enrollees with Medicaid benefits that are outside the scope of the benefits shown in the MA BPT, is CMS expecting the projected costs for those Medicaid benefits to be excluded or included in this amount (Worksheet 4, Section V, Line 2) since those benefits are completely unrelated to the Medicare benefit set? Line 1 – Medicaid Projected Revenue: We have similar questions on the revenue side of things. a) For the type of bid in question (100% dual-SNP with benefits mirroring Medicare FFS and no member liability), is CMS expecting this amount to exclude or include the projected Medicaid capitation payments associated with the Medicare cost sharing portion of the benefit set? b) If the State provides these enrollees with Medicaid benefits that are outside the scope of the benefits shown in the MA BPT, is CMS is expecting the projected Medicaid capitation payments for those benefits to be excluded or included in this amount (Worksheet 4, Section V, Line 1) since those benefits are completely unrelated to the Medicare benefit set?	For all four parts of this question, the answer is: include.
7	MA BPT WS 3: OOP max	05/04/2011 16:29	Combined MOOP	For a PPO plan, there is an In-Network, Out of Network, and a Combined MOOP in Worksheet III (MA Cost Sh), section II. However, in section III there is only a PMPM Impact for In-Network and Out of Network MOOP. We are currently adjusting the In-Network cost sharing to account for the In-Network MOOP and adjusting the Out of Network cost sharing to account for the Combined MOOP. We have no Out of Network Max. Is this acceptable?	Yes. Another option is to allocate a portion of the cost of the Combined MOOP to the PMPM Impact for the In-Network MOOP.
8	MA BPT WS 4: ESRD Section III	05/05/2011 16:41	MA BPT - ESRD Section (Worksheet 4)	Can you confirm that for the ESRD Subsidy section on Worksheet 4, plans that do not have credible ESRD experience are only required to fill in the Projected [ESRD] Member Months.	Yes.
9	MA BPT WS 4: ESRD Section III	05/10/2011 13:58	ESRD	Please confirm that if our plans do not have credible ESRD experience, we do not need to fill out Worksheet 4, Section III.	The line "ESRD CY member months", near the top of Section III, must be completed for all plans.
10	Net investment income	05/11/2011 8:42	Medicare Advantage & Prescription Drug Plan Sponsors and Certifying Actuaries (Question)	This question is in regard to the allocation of net investment income in bid development. Should net investment income be accounted as negative margin or negative admin? Current BPT instructions seem to indicate the former while past user group Q&A seems to indicate the latter.	From page 15 of the Part D bid instructions, and page 25 of the MA bid instructions: "The gain/loss margin may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income."
11	Margin	05/03/2011 16:50	Question for Actuarial User Group Call	The "slide narrative" for Slide 21-Support for Negative Margins" states that it must be demonstrated "how the targeted margin in the original Business Plan will be met". 1) As conditions evolve over time (CMS reimbursements, competitive environment, provider contracting, internal goals, sales results, etc.), business plans often change as well. Or is that not permitted? 2) The business plans submitted last year were aggregated across larger service areas, and are not directly comparable to the more limited product pairings, which are now part of the guidance. What guidance is there if there is not a comparable prior year business plan?	1) It is acceptable to make adjustments to the original business plan as conditions evolve. However, CMS expects plan sponsors to modify premiums and benefits so that projected margins follow a similar trend as in the original business plan and, over the time period specified in the bid instructions, the plan reaches profitability. The supporting documentation should include what actions are being taken to progress to profitability. 2) As indicated in the bid instructions, business plans must be provided at the bid-level. If previous business plans were provided at a more aggregated level than at the bid level, then the actuary would need to "restate" (disaggregate) the original business plan at the bid level, and upload it as supporting documentation.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
12	MA BPT Section VI, PD BPT	05/03/2011 16:13	Bid Questions	1) If a member is both on Hospice and ESRD according to the MMR, where should we put the claims dollars in ESRD or Membership? 2) What is the maximum coinsurance percentage allowed on Part D drugs for Tier 4 (Specialty)? In the past CMS has allowed 33% with no deductible (Basic Alternative). Is this still in effect or has this changed with ACA?	1) For MA BPT Worksheet 1 Section VI, you can put them in either the ESRD column or the hospice column and explain the methodology chosen in the supporting documentation. Since the beneficiary is likely in ESRD status before becoming hospice status, it may make more sense to include in the ESRD column, but either approach is acceptable. 2) This is still in effect.
13	PD BPT WS1: ESRD	05/04/2011 10:15	OACT User Group Question: ESRD Drugs in PD BPT	According to a CMS response to #11 of the 4/21/2011 user group call: The required supporting documentation for the base period experience in Worksheet 1 includes: • Removal of ESRD drugs covered under Part D in base period but not in CY2012 (if removed) Does this response mean that ESRD drugs should be excluded from Worksheet 1 of the PD BPT?	You may exclude ESRD drugs from WS1 of the PD BPT if you can identify them. Otherwise, adjust WS1 data using the projection factors on WS2. In either case, document and quantify the adjustment in the supporting documentation.
14	PD BPT WS6A	05/09/2011 9:35	Worksheet 6A-Part D	Please clarify that this worksheet is intended for Rx costs between $2,930 and Catastrophic for Enhanced Alternative plans, even when the EA plan has lowered the plan ICL below that of the defined standard.	Yes.
15	Low income enrollment data	05/03/2011 19:24	LIS By Plan File	Thank you for providing this new file with LIS enrollment by plan. The enrollment on it looks much more reasonable than the LIS by county information when compared to prior year information. 1) The LIS by plan file states it is as of 4/1/2011. Does this mean the file reflects 4/1/2011 LIS enrollment or restated February 2011 enrollment as of 4/1/2011? 2) The LIS file by Plan includes members in plans for which the February 2011-April 2011 monthly enrollment by plan files (http://www.cms.gov/MCRAdvPartDEnrolData/EP/list.asp#TopOfPage) do not. This difference represents 17,094 low-income beneficiaries as the attached spreadsheet details. Is there any explanation for this discrepancy? I believe some of the plans in the file were terminated or cross-walked prior to 1/1/2011.	We forwarded these questions to the CMS component that develops and publishes the LIS enrollment data. The responses we recieved are copied below. FYI - OACT was informed this week by the CMS component that publishes the LIS data that a discrepancy has been discovered between April enrollment data and the published LIS data on the website. The CMS component is investigating why some contract/plan combinations had a higher LIS enrollment than what was showing for plan enrollment. Responses from CMS component regarding these specific questions: 1) The LIS by plan files reflect enrollment as of 4/1/2011. 2) The data in PEAR (Provider Enrollment, Eligibility, Economic Attribute Reporting) are not static, and are used for the LIS by plan files. Retroactive enrollments/disenrollments are captured for up to 3 months.
16	Low income identifiers	05/03/2011 10:50	Low income	How do the low income values of 1 through 6 in the TRR's [transaction reply report] relate to the Y/N low income flag on the MMRs [monthly membership report]? Is there a direct mapping that is used?	The values for field 50 (Low-Income Co-Pay Category) on the TRR are: 0 = none, not low-income 1 = (high) (note: $2/$5) 2 = (low) (note: $1/$3) 3 = (0) 4 = 15% 5 = Unknown Space = not applicable Field 68 of the MMR is the "Part D Low Income Indicator": From 2006 through 2010, an indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2), or blank. Beginning in 2011, value "Y" indicates the beneficiary is Low Income, value "N" indicates that beneficiary is not Low Income for the payment/adjustment being made. For risk scores in payment years 2006 – 2010: • 1 and 2 on the TRR would have mapped to "1" in field 68 of the MMR ("Part D Low-Income Indicator") • 3 on the TRR indicates a beneficiary is institutional, and would receive an institutional risk score (and not a low income risk score) • 4 on the TRR would have mapped to "2" on the MMR. For 2011 and onward, 1, 2, and 4 on the TRR would map to "Y" on the MMR, indicating that the beneficiary would receive a low income risk score. 3 on the TRR continues to indicate that the beneficiary would receive an institutional risk score. More details can be found in the Plan Communications User Guide.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
17	Risk scores	05/04/2011 11:42	FW: 2012 Part D Risk Scores - Coding Intensity Trends	In past years, CMS has provided the Part D coding intensity trend that was used in development of the risk score normalization factor in the final announcement/rate letter. I was unable to find the Part D coding intensity trend in this year's document. What is the coding intensity trend assumed in development of the 2012 Part D risk score normalization factor?	The 2012 normalization factor for the RxHCC model is 1.031. To calculate the normalization factor for the RxHCC risk adjustment model, CMS used the risk adjustment model to be implemented in 2012 and calculated four years of risk scores for the population of Medicare beneficiaries enrolled in Part D plans. We used only four years of data for the trend (instead of the standard five years) because we only had Part D enrollees' risk scores for 2006 through 2009. We calculated an annual trend over these four years of 0.01033, and then compounded the annual trend for three years, to adjust for three years of Part D risk score growth, i.e., from the denominator year of 2009 to the payment year of 2012. The calculation is 1.01033^3 = 1.031.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 05/19/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	TBC	05/16/2011 22:24	TBC questions	1) The 2011 to 2012 TBC comparison includes a premium comparison between 2011 and 2012 which includes the Part B premium of $96.40. Please confirm that the Part B premium to be included in the total 2012 premium should be $96.40 (consistent with the 2010 Part B premium). 2) Also, if a plan is consolidating two PBPs in 2012, how should the adjusted TBC change be calculated for the new consolidated plan? Will it be a weighted average of the TBC changes for each plan and if so, what membership should be used to calculate the weighted average?	1) As indicated in the 5/5/2011 UGC Q&A # 6: $96.40 is the Part B premium included in the CY2012 TBC, as it represents the maximum amount of rebates that can be applied to Part B for CY2012. 2) As indicated in the introductory note to the 5/5/2011 UGC Q&A: When two plans are consolidated into one and a crosswalk is in place, the consolidated plan's 2011 TBC is based on the weighted average of the two plans. The projected CY2011 membership (from the CY2011 BPT) is used to weight the two plans.
2	TBC	05/16/2011 8:05	TBC Question	Upon reviewing the April 19, 2011 memo re TBC there is no mention of the situation where a plan's increase in premium is primarily due to a significant growth in its membership from 2009 to 2010. In a clients situation, a plan being priced went from 30% credibility to 100% credibility in one year. The result is a significant increase in claim cost that could not have been anticipated (> $100 pmpm difference in the claim experience at 30% credibility vs 100%). In this situation we will not meet TBC requirements due to going from 30% credibility to 100% credibility. Also, there is not enough margin to offset this large an increase. From an actuarial prospective, this TBC is primarily due to a change in credibility status and the fact that claims unexpectedly increased between years. There seems as though there should be an exception or special rules for TBC in those situations where a plan is converting from partial experience to fully credible experience. This situation could also happen for a fully manual rated plan transitioning to a fully credible plan in one year. In reading the memo there does not appear to be any special consideration for this situation. Please let me know if CMS would consider a special adjustment relating to this situation. If not then I will need clarification to the following question. 1) If TBC applies regardless of partial vs fully credible experience then it appears a plan has two choices. A plan could not decrease benefits to reduce premium because that would only add to the TBC. a) Eliminate the plan because it cannot be priced at its "now" fully credible experience and would create a loss the plan cannot sustain. b) Offer the plan but assume a negative margin as a direct result of the TBC rules, that will have to be made up over several years Please provide guidance or clarification regarding the TBC in this situation and whether there are more options that I have identified above.	As indicated in the Call Letter, CMS's TBC requirement enables the Secretary (of HHS) to deny bids that pose a significant increase in cost or decrease in benefits from one year to the next. This effectively requires plans to consider a multi-year horizon when pricing their plans—especially new plans. Bids that are not compliant with TBC requirement (described in the Call Letter) are considered to have significant increases in cost (or decreases in benefits) and may be disapproved by the Secretary. The policy does not consider changes in credibility of plan experience in evaluating TBC compliance.
3	Ratebook in MA BPT	05/14/2011 17:38	Broomfield County Colorado	Broomfield Colorado seems to have been left out of the rate tables in the bid form. The PBP data entry will include Broomfield. What will happen if we submit a bid with the Broomfield enrollment placed in Boulder county? They have the same rate.	Broomfield CO was not left out of the rates table in the MA bid form: In CY2011, Broomfield was county code 06064 and in CY2012, Broomfield is county code 06630. As a reminder: the counties entered in the MA BPT for the plan's service area MUST match the service area defined in HPMS. If the service areas do not match, the bid upload will receive an error message.
4	Margin	05/11/2011 11:54	Gain/Loss	The instructions specify that MA products which are paired can have implicit subsidies across benefit or service area offerings, but they need to have identical service areas. If two PBP's have significant overlapping service areas, same plan type, and the second plan was only introduced as a subset of the first plan's service area due to other business concerns but was intended to be a benefit pairing of the first plan for the overlapping service area, can these plans have implicit subsidies in their gain/loss margin?	No.
5	Margin	05/17/2011 13:18	Margin Guidance	According to the BPT instructions, paired plans must have identical service areas, be the same plan type, and have positive combined gain/loss margin. Can you confirm that MA-only and MAPD plans count as being the same plan type? The example given pairs a MA-only and a MA-PD plan with the same MA benefits. Is it required that the paired plans have the same MA benefits?	For MA-only and MA-PD plan pairings, by "same plan type" we mean they must both be HMO plan type, or both be LPPO plan type, etc. The benefits offered by the MA-only plan and the MA-PD plan need not be identical.
6	MSP	05/10/2011 17:47	MSP Question	We are looking for clarification on whether ESRD and Hospice members must be excluded from the data used for the MSP adjustment calculation. The bid instructions don't explicitly address this detail.	Since the MSP factor reported in the MA BPT is developed based on plan payments, exclude ESRD and hospice.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
7	MSP	05/12/2011 13:48	MSP data	On page 26 of the MA Bid instructions, it says that MSP data provided by CMS serves as the basis for projecting the MSP adjustment. Can this data be modified to reflect the Plan's own review and research into the true MSP status of its members, for that MSP projection?	The MA bid instructions indicate that plan payments are the basis for projecting the MSP adjustment (not the percentage of members with MSP status). If a plan's review of the MSP status of its members results in potential MSP corrections, these corrections should be communicated to the CMS COB (coordination of benefits) contractor as requested changes. If necessary, such a review could be factored into the MSP calculation for the BPT. If such changes are factored into the MSP calculation, the plan must include the following in the uploaded substantiation: 1) quantify any adjustments made, 2) explain and justify any modifications made to the CMS MSP status, and 3) provide the plan's communication to CMS COB contractor regarding the requested MSP corrections.
8	Large claims	05/16/2011 16:49	MA Question	[PARAPHRASED] Are plan sponsors allowed to use large claim pooling (also known as specific stop-loss) techniques to account for experience which includes catastrophic claims? We have a plan with low enrollment that experienced a large claim during the base period. One member incurred claims of $750,000. If we include the full value of the $750,000 in the development of the projected 2012 rates, we believe the calculated rates will be overstated. Can you provide any guidance on this issue?	Large claim pooling techniques are permissible with the following minimum considerations: 1. Pooling must be applied to allowed charges. 2. The actuary must demonstrate that the pooling charges are priced equal to the projected pooled claims. 3. The pool must be clearly defined and consistently applied to all applicable bids. The definition must state the attachment point, state the criteria for which bids participate in the pool, and state any other relevant considerations. 4. The pooling charges must be developed and applied to all bids participating in the defined pool and all members included in the bids, regardless of whether or not a bid or member actually had any pooled claims during the base period. 5. The attachment point must be set such that the expected claims in excess of the attachment point are a very low percentage of total claims, such as 3%. 6. The base period data on Worksheet 1, sections II, III, and VI, must not be adjusted. 7. Use the additive adjustments in the projection assumptions on Worksheet 1, section IV to reflect the pooling charges and 8. The credibility formula must not be adjusted due to the use of the large claim pooling. 9. All supporting documentation must be uploaded to HPMS at the time of the initial June bid submission.
9	Part D plan offerings	05/17/2011 9:06	BA Drug Plans	I have one question regarding section 42 CFR § 423.104(f) of the Part D regulations: Our organization has one and only one PBP in a specific county, for which we charge a member premium. Is it possible for us to offer an enhanced alternative drug plan here, assuming that we completely buy down the Part D supplemental premium and Part D basic premium, but not the Part C supplemental premium (ie, we pay for all the drug benefits with the MA rebate, but use the member premium to cover the supplemental benefits)?	Yes.
10	Part D low income benchmarks	05/16/2011 14:59	How to interpret the re-stated low income benchmarks found in the Part D BPT Instructions	When calculating the restated low income benchmarks found on page 80 of the bid instructions, did you use the actual 2011 plan member premiums weighted by the revised membership? Or, did you calculate new member premium amounts based on the restated Nationwide averages shown on page 78, and then re-weight?	We used actual 2011 premiums.
11	Frailty	05/10/2011 15:31	Frailty factor questions	I have some questions around the calculation of a frailty factor, but I'm not exactly sure of the right place to submit these questions. CSSC Operations didn't quite seem like the correct place, so here they are. Please let me know if I should contact someone else. 1) Please verify that I understand the high level process correctly. a. Members are surveyed one year (e.g. 2011) and an ADL difficulty distribution is calculated. b. That distribution is used with the factors to calculate an overall frailty factor for the plan in the following year (e.g. 2012). c. In that following year (2012), all members who are eligible will have the same frailty factor added to their risk score, regardless of their specific ADL difficulties or whether or not they were enrolled in the plan previously. 2) Are institutional members included in the calculation of the frailty factor? That is, are they surveyed and their ADL difficulties included in calculating the frailty factor above, even though they are not eligible to receive the frailty factor? Or are they just not surveyed? 3) Is there a minimum number of members required before the survey will be conducted and/or the results used to calculate the frailty factor?	1) a. Yes b. Yes c. Yes 2) They are surveyed but they do not receive a frailty score, and their ADL distributions are not included in calculating the frailty factor. 3) The sample size for the survey (HOS) that is being conducted at the plan benefit package level is 30, in general the minimum sample size for the survey (HOS) sampled at the contract level is 500.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 05/26/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	TBC	N/A	N/A	If a plan has rich benefits (for ex: significant additional benefits, zero copays, large amount of rebate dollars available to buy-down premiums, etc.): what flexibility is there regarding the margin and TBC requirements?	All plans must meet all TBC and margin requirements. The plan must exhaust all possibilities regarding benefit design. For example, if the plan has not already done so, apply rebate dollars to buy-down the Part B premium. Ideas for additional benefits may be found in Chapter 4 Benefits and Beneficiary Protections of the Managed Care Manual: http://www.cms.gov/manuals/downloads/mc86c04.pdf.
2	TBC	05/17/2011 15:51	TBC & Crosswalking	If a plan crosswalks part of its service area into a new plan for 2012, is the new plan subject to TBC?	Generally speaking, if there's a crosswalk then TBC will be applied.
3	TBC	05/23/2011 23:15	OOPC Test for Consolidating Plans	[In] the Introductory Note from the 5/5/11 User Group Call, there is an Illustrative Payment Adjustment for Cross-walked Plans. Are plans supposed to calculate a Payment Adjustment, or should we just use the values that CMS provided in HPMS? When consolidating two or more plans from CY2011 to CY2012, should we: 1. Perform multiple TBC tests, one for each CY2011 plan against the consolidated CY2012 plan, OR 2. First consolidate the values provided by CMS (OOPC, Premium, Impact of Benchmark/Bonus Changes, Impact of OOPC Model) for the CY2011 plans using the projected member months from the CY2011 BPTs, and then compare the weighted average values against the consolidated CY2012 plan, OR 3. If neither of those methods is correct, could you please explain how CMS will perform the test.	When consolidating plans, first consolidate the CY2011 values provided by CMS and then compare the weighted average against the CY2012 plan (i.e., # 2 on the list provided in this question). Please note that the values posted in HPMS (OOPC dated as of 5/17/2011 and TBC dated as 5/18/2011) do not reflect the CY2012 crosswalk, as this information is not available until bids are submitted on June 6th. After bid submission, CMS will re-calculate OOPC/TBC based on the bid submissions and the crosswalk.
4	MLR	05/17/2011 16:57	Medical Loss Ratio Guidance	According to the Affordable Care Act, beginning in contract year 2014 if a Medicare Advantage insurer is below the 85% medical loss ratio standard for three years, they will no longer be allowed to accept new enrollees. Could you clarify that for contract year 2014, does this mean that if the plan has been below the standard for contract years 2011-2013 they would not be able to accept new enrollees or would this provision initially apply to contract years 2014-2016?	CMS has not yet announced this policy.
5	SNF	05/18/2011 16:07	SNF % for covered services	Does a safe harbor percentage exist for the SNF % for covered services on Worksheet 4 of the MA bids?	CMS does not have the data to provide a safe harbor percentage of SNF (Skilled Nursing Facility) services that are Covered under Parts A and B. Regarding waiving SNF coverage where there was not a preceding hospital stay of at least 3 days, please note that under Medicare FFS this is Non-Covered. From page 36 of the MA bid instructions: "Users may price the waiver of prior hospitalization requirement as a Medicare-covered benefit."
6	Service Areas	N/A	N/A	I received an upload error stating that Alaska counties 02105 and 02195 are in my MA BPT but are not in my HPMS defined service area. These two counties appear to not be available in HPMS. Please advise.	Thank you for bringing this to our attention. For CY2012, HPMS service areas will not include counties 02105 and 02195 and therefore users should not use these codes in their CY2012 MA BPT Worksheet 5 service area. [The BPT service area must match the HPMS service area.] Members for county 02105 should be included in 02230, and members for county 02195 should be included in 02275 (as shown below): <u>2012 BPT/Ratebook</u> — <u>2012 HPMS/Bid Submission/Set up Plans</u> 02105 AK Hoonah-Angoon — Not available - Include in 02230 02230 AK Skagway — 02230 AK Skagway-Hoonah-Angoon 02195 AK Petersburg — Not available - Include in 02275 02275 AK Wrangell — 02275 AK Wrangell-Petersburg Please note that these are the only two county codes that are not available in HPMS. Also note that the ratebook values for county 02105 = county 02230 and the ratebook values for county 02195 = county 02275.

User Group Call Date 05/26/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
7	Base period experience	05/24/2011 12:45	Crosswalk Guidance	We have a 2010 PFFS partial network plan (call it 001) that will continue in 2012. Several of the counties in the 2010 plan will be formally cross-walked under CMS' approved process to a full network plan (call it 002, but under a different contract #), as required to meet 2CCP+ requirements. Here are the relevant comments/questions for this situation. Because plan 001 is continuing in 2012, we know that all the 2010 plan 001 experience must be reported in WS#1 for 2012 plan 001. Due to the formal crosswalk of some of 2010 membership in plan 001 to plan 002 for 2012, should we also report all the 2010 plan 001 experience in WS#1 for the 2012 plan 002? Or, should we report none of the experience from 2010 plan 001 in WS#1 for 2012 plan 002.	Since plan 001 is continuing, do not report the experience for plan 001 in WS1 for plan 002. Only report plan 001 experience in WS1 for plan 001.
8	Margin	05/19/2011 11:11	negative margin question	On page 89 of the MA BPT instructions (appendix B), one of the options for a bid with a negative margin is to provide – A description of the product pairing, which includes the gain/loss margin for each plan and shows that the plans have— • Identical service areas, • The same plan type, and • A positive combined gain/loss margin. Our question is whether three plans (of the same plan type) can be shown to have a combined positive gain/loss where two of the plans have the exact same combined service area as the third plan?	No. All plans in a product pairing must have the exact same service area. Three plans could be paired together if all three plans had the exact same service area.
9	Margin	05/17/2011 16:36	Profit	We see the following in the bid instructions: Support for bids with negative margins, including one of the following items: A description of the product pairing, which includes the gain/loss margin for each plan and shows that the plans have— • Identical service areas, • The same plan type, and • A positive combined gain/loss margin. Our scenario is as follows (simplified): (1) Service Area = Counties 1, 2 and 3 (2) Plans Available = High Option HMO Service Area 1+2+3, Low Option HMO Service Area 1, Low Option HMO Service Area 2+3 (3) Aggregate combined profit for all 3 plans is positive. Here, the High Option plan is a premium plan and covers all three service areas. The Low Option plans are both $0 plans, in aggregate they cover the entire three county service area, and the service areas do not overlap. However, to get to a $0 premium, the two low option plans have different benefit plans and profit margins, one being negative. Is this scenario covered under this option for support of a negative margin?	See above response.
10	Non-Benefit Expenses	05/18/2011 18:44	Supporting Documentation for Non-Benefit Expenses	In Appendix B, the BPT instructions list a new required piece of supporting documentation for non-benefit expenses: "A reconciliation of the base period non-benefit expenses reported in Worksheet 1 of the BPT to audited material such as corporate financial statements and plan-level operational data." 1) If an organization does not yet have audited financial statements completed for the base period, could you provide examples of other material you would consider acceptable as a reconciliation source? 2) Our contract number covers a multi-state joint enterprise of four organizations that cooperatively offer PDP plans throughout our region. The joint enterprise does not have a consolidated audited financial statement. Would it then be necessary for each organization to independently reconcile their share of base period expenses to audited materials, and then supply a reconciliation of how each state's experience was aggregated as inputs for the BPT?	1) The supporting documentation requirement in appendix B is to provide a reconciliation of reported base period non-benefit expenses to "auditable" material. It is acceptable to reconcile Worksheet 1 experience to internal financial statements that are prepared in a manner to withstand an audit. 2) Yes.

User Group Call Date 05/26/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
11	Non-Benefit Expenses	05/16/2011 20:32	Questions Contract # Hxxxx-xxx	[Regarding] Non Benefit expenses and Development costs. We have some development costs incurred in 2010 which relate to start-up expenses for expansions into new counties in 2011. These are included in our 2010 GAAP Financial statements. My question is since they did not pertain to our 2010 counties and plans, should these be included or excluded from work sheet 1 for the 2012 bids. My assumption is that we would exclude these expenses and explain the difference between the aggregate non benefit expense in our bids and our GAAP financial statements as part of our reconciliation documentation, but I am looking for any guidance available from OACT.	Include the expenses for expansion counties in worksheet 1 if the plan existed in 2010 albeit with a different service area, or if the plan includes members that were cross-walked from another plan that existed in 2010. Otherwise, do not report start-up expenses incurred in 2010. Start-up expenses that are incurred in 2010, but are not reported in any of the bids can be explained in the reconciliation to auditable financial statements.
12	Case management	05/22/2011 15:37	Bid Question - Case Management Medicare Covered or Non-Covered	Are case management costs that are determined to be medical costs according to CMS instructions (provided by a medical provider) considered Medicare covered medical costs or non-Medicare covered medical costs? Which service category on the BPTs should case management costs be assigned to?	Use your best judgment to allocate in a reasonable manner, and document the methodology.
13	MSP	05/26/2011 10:10	MSP Factor	To what extent may a plan sponsor use survey information conducted via telephone interviews to adjust the MSP information included in the monthly file provided by CMS for purposes of calculating the MSP adjustment factor on Worksheet 5 of the BPT. For example, if a plan calls members listed as having other coverage primary to Medicare (those for which they are currently receiving a reduced payment from CMS), records the call, and submits the recorded calls to the CMS COB coordinator with a request to have the MSP status reversed for those individuals who state they have no other coverage, may these individuals be treated as non-MSP for purposes of developing the bids? Many of these individuals are new enrollees effective January 1st of this year to whom surveys have been mailed but written responses have not yet been returned. If so, would a listing of the individuals called that indicated no other coverage be sufficient documentation for the bids. The recorded calls information would be available upon request.	As indicated in the 5/19/2011 UGC Q&A # 7: The MA bid instructions indicate that plan payments are the basis for projecting the MSP adjustment (not the percentage of members with MSP status). If a plan's review of the MSP status of its members results in potential MSP corrections, these corrections should be communicated to the CMS COB (coordination of benefits) contractor as requested changes. If necessary, such a review could be factored into the MSP calculation for the BPT. If such changes are factored into the MSP calculation, the plan must include the following in the uploaded substantiation: 1) quantify any adjustments made, 2) explain and justify any modifications made to the CMS MSP status, and 3) provide the plan's communication to CMS COB contractor regarding the requested MSP corrections. Additional response for this specific question: If the plan has communicated to CMS proposed MSP corrections based on specific knowledge regarding individual beneficiaries, these individual's MSP status can be adjusted for pricing purposes. For new enrollees, the plan can either (for pricing purposes): 1) assume an individual beneficiary is not MSP until they hear otherwise, or 2) can apply a reasonable assumption regarding the MSP status of a group of new enrollees (based on the entire plan's population, if the new enrollee group is expected to be similar).
14	Projected member months	05/20/2011 13:31	Part D projected member months	Does Part D projected member months on PD BPT ws3 have to match projected member months on MA BPT ws5? Or projected mm on PD BPT ws3 =projected mm in MA BPT ws5 + esrd/hospice mm?	The projected CY member months reported in PD BPT Workskeet 3 (cell E25) must match the sum total of the following four groups: 1) projected member months in MA BPT Worksheet 5 (cell E36) + 2) projected ESRD member months (in MA Worksheet 4 cell F117) + 3) projected hospice member months (not reported in the MA BPT) + 4) projected out-of-area member months (not reported in the MA BPT). The only exception to this is for segmented plans: when the same PD BPT is submitted for each segment (ex: H1234-001-01 equals H1234-001-02) and the MA BPT is completed distinctly for each segment.
15	PD BPT WS6A	05/23/2011 15:54	PD Worksheet 6A	Please clarify how LIS members should be treated on Worksheet 6A regarding their coverage gap cost sharing. The instructions state for columns f – k to "Calculate the cost sharing as if there were no deductible and LIS subsidy". Does this mean that the cost sharing shown on worksheet 6A for LIS members should reflect the 86% member cost-sharing for generics? Or, should the cost sharing shown on worksheet 6A be at 100% for LIS members?	The 14% coverage for generic drugs in the gap does not apply to LIS beneficiaries.
16	PD BPT WS6A	05/24/2011 17:49	Part D worksheet 6A	In the first 2 paragraphs on page 59 of the Part D BPT instructions (regarding worksheet 6A), should the reference to "cell D23" be changed to "cells D23 plus D24" as it is in the worksheet 6 instructions (near the bottom of page 52)? There are two more references to "cell D23" lower down on page 59. My question below applies to these references as well.	Yes.

Advance Questions from actuarial-bids@cms.hhs.gov for CY2012 OACT User Group Calls

User Group Call Date 06/02/2011

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Supporting documentation deadline	05/27/2011 18:27	Supporting Documentation Question	Given the increase in the amount of supporting documentation needed for the 2012 bids, would CMS be willing to extend the deadline for supporting documentation another 24 or 48 hours after the Monday, June 6th deadline? Thank you for your consideration of this request.	We cannot extend the deadline for the submission of supporting documentation. Supporting documentation is due by the same deadline was the bid submission (Monday June 6, 2011 by 11:59pm PT).
2	Bid Desk Review	05/28/2011 10:44	Measuring 48 hour response time during desk review	You have provide[d] guidance regarding expectations for 48 hour response for desk review questions received during a weekend. What about desk review questions that are sent out at 9pm or 2am in the morning (yes we have received desk review questions at those hours). In the interest of assuring that the desk review process goes as smoothly as possible, what is your expectation for a response for questions received outside what may be viewed as normal work hours of 8am - 6pm?	As stated in the 4/21/2011 UGC Q&A # 1: The 48 hours requirement applies to business days (that is, the business workweek of Monday through Friday). Additional response for this inquiry: For requests sent outside the normal work hours on Monday through Friday, the actuary would have 48 hours to respond. For example, for a request sent at 3AM ET on Tuesday, the actuary would have until 3AM ET on Thursday to respond.
3	AGA	05/31/2011 9:35	Development of 5 Year AGA	In the 4/14 Actuarial User Group call [Q&A # 14], you had mentioned that you hoped to create an excel workbook that would develop 2012 FFS costs for each county. Do you project that you will still be able to provide that information?	This information is currently being peer-reviewed. We intend to release this information sometime in June.
4	EGWP Service Areas	05/24/2011 10:46	EGWP Service Areas	If I file an EGWP in 1 county, does that cover retirees from employers who are based in that county regardless of where the beneficiary retires or only the retired beneficiaries who live in those counties?	Below is the response from the Medicare Drug and Health Plan Contract Administration Group: Applying for EGWP in 1 county does not mean that the EGWP can cover employers in that county when beneficiaries reside in other counties. The question is related to the definition of service area. If the plan files as an EGWP in a county, the expectation is that the member resides in that service area and the plan maintains network availability in that county. The explicit definition of service area is provided in Medicare Managed Care Manual Chapter 1, Section 20 – Definitions, and is also listed as applicable to EGWPs in Chapter 9, Section. 20.1.1.
5	EGWP PBP data extry	05/31/2011 9:18	800-series Bids and the PBP	I have a client who is offering an EGWP using Medicare FFS benefits for the first time and not sure how to fill out the PBP. The PBP says they can't include any other benefits other than Medicare FFS when selecting the built-in buttons for FFS Medicare. Does that pertain to after bids are submitted and the health plan is negotiating with employers on reduced cost sharing and additional benefits? Surely this does not limit them to only FFS benefits during the negotiation process, does it?	Below is the response from the Medicare Drug and Health Plan Contract Administration Group: When the plan is entering benefit information in the PBP for EGWP, they are entering shell information. It is acceptable for the plan to select the built in buttons for FFS Medicare and then negotiate additional benefits with the employer. In other words, it does not limit their negotiation process with employers after bids are submitted.
6	Margin	05/27/2011 0:56	Margin Guidance	The PBP-Level Guidance for Gain/Loss Margin on pages 22 and 23 of the bid instructions state that a plan must offer benefit value in relation to the margin level. 1) Do the plan pairing rules also apply here? 2) If so, would the following plan pairings scenarios satisfy the benefit value to margin level requirement" Scenario 1: a low-benefit plan with high margin is paired with a rich-benefit plan with low or negative margin, such that the combined margin is positive? Scenario 2: a low-benefit MA-only plan with high margin is paired with the same low-benefit MAPD plan with low or negative margin, such that the combined margin is positive?	Plan pairings (and their combined margin) may be considered when evaluating benefit value in relation to margin.
7	Margin	05/31/2011 9:20	Gain/Loss Margin	The bid instructions allow exceptions to the business plan requirement in cases in which MA products are paired and the pricing reflects implicit subsidies across benefit or service area offerings. Is it permissible to apply the "pairing" across more than two plans? An example would be pairing a PFFS MA Only Plan, a PFFS MA-PD Plan, a PPO MA Only Plan, and a PPO MA-PD Plan with identical service areas.	It is possible for a product "pairing" to include more than two plans, if all of the criteria stated in the MA bid instructions are satisfied (i.e., identical service areas, the same plan type and a positive combined margin). However, the example given does not describe a valid product pairing because it includes plans of different plan types. In this case, the two PFFS plans form one product pairing and the two PPO plans form a separate product pairing. As discussed on the call last week, the requirement for "the same plan type" is applied as "like product types" or "the same delivery system," which allows an HMO plan to be paired with an HMO-POS plan, but not with a PPO plan. Similarly, a PFFS plan cannot be combined with a PPO plan.
8	Part D BPT WS2 Section VI	05/26/2011 18:16	Part D & Worksheet 2	When we finalize our bids, Section VI in Worksheet #2 ["Development of Manual Rate"], reduces to one cell. Initially we had problems inputting data as the text field was a series of cells instead of being one entry cell.	Thank you for bringing this to our attention. The description of the PD manual rate should be entered in cell L62 (which is the upper-most cell on the left side of this Section). This will be corrected next year (in the CY2013 PD BPT) to have one merged cell in Section VI (as it was last year for CY2011).