Advance Questions from actuarial-bids@cms.hhs.gov for CY2014 OACT User Group Calls

User Group Call Date 04/11/2013

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

Introductory Note — 2014 MA RISK SCORE DEVELOPMENT ILLUSTRATION

MA Normalization Factors

Contract Year	Normalization Period	Normalize Factor
2013	2011 to 2013	1.028
2014: 25% 2013 Model	2011 to 2014	1.041
2014: 75% 2014 Model	2012 to 2014	1.026

User Group Call Date 04/11/2013

2014 MA RISK SCORE DEVELOPMENT ILLUSTRATION

		Preferred Method		Alternative Method [1]	
	Risk Score Element [2]	**HPMS Posted Data 2013 Model**	**HPMS Posted Data 2014 Model**	**March 2013 Risk Scores from MMR 2013 Model**	**March 2013 Risk Scores from MMR 2014 Model**
A	**Starting Data** [3]	1.1000	1.0900	1.0376	1.0376
B	**Covert to Raw - remove normalization**	n/a	n/a	1.0280	1.0280
C	**Covert to Raw - remove MA Coding Pattern Adjustment (divide)** [4]	n/a	n/a	0.9659	0.9659
D	**Plan Specific coding Trend** (2.0% annually) [5]	1.0404	1.0404	1.0200	1.0200
E	**Starting Data Adjustments** (i × ii × iii below)	n/a	n/a	1.0160	1.0160
	i) Transition from lagged to non-lagged diagnosis data	n/a	n/a	1.0180	1.0180
	ii) Incomplete reporting of diagnosis data [6]	n/a	n/a	1.0250	1.0250
	iii) Seasonality (needed if not using a July cohort) [7]	n/a	n/a	0.9737	0.9737
F	**Other Plan Specific Data Adjustments** (Population)	1.0000	1.0000	1.0000	1.0000
G	**Risk Model Adjustment** (i × ii / iii below)				
	Note that the Risk Model Adjustment accounts for new model and new denominator year.	n/a	1.0150	n/a	1.0058
	i) Raw 2014 HPMS Posted Data	n/a	n/a	n/a	1.0900
	ii) Missing Diagnosis Adjustment [8]	n/a	1.0150	n/a	1.0150
	iii) Raw 2013 HPMS Posted Data	n/a	n/a	n/a	1.1000
H	**Raw risk scores, projected to 2014** (A × B / C × D x E × F × G)	**1.1444**	**1.1510**	**1.1444**	**1.1510**
I	**MA Coding pattern adjustment** (1 − 0.0491)	0.9509	0.9509	0.9509	0.9509
J	**Normalization Factor (must calibrate to denominator year; divide)** [9]	1.0410	1.0260	1.0410	1.0260
K	**Frailty Factor (additive)**	0.0000	0.0000	0.0000	0.0000
L	**Interim Risk Score** (H × I / J + K)	1.0454	1.0668	1.0454	1.0668
M	**Weight**	25%	75%	25%	75%
N	**Final Weighted Risk Score** (sumproduct of L × M)		**1.0614**		**1.0614**

[1] Note that the Alternative Method uses the same starting point of March 2013 MMR data for both the 2013 model scores and the 2014 model scores. The 2014 Risk Model scores are created at step G, at which point the risk score is adjusted for the new model via a model adjustment factor.

[2] All adjustments are multiplicative unless otherwise noted.

[3] For illustrative purposes enrollment in March 2013 is assumed to be the same as July 2012 enrollment.
HPMS Posted Data for 2013 model is July 2012 cohort with denominator year of 2011.
HPMS Posted Data for 2014 model is July 2012 cohort with denominator year of 2012.

[4] Included in MMR risk score beginning in 2010.

[5] Trend for full calendar years. The seasonality factor adjusts for partial years.

[6] Payment reconciliation using final 2013 risk scores is in August 2014 and uses 2012 diagnosis codes submitted through January 31, 2014.

[7] Using average calendar year cohort is also acceptable (averaging calendar year risk scores is not acceptable).

[8] Plan sponsors must determine which beneficiaries have risk scores that need to be adjusted for missing diagnoses, and the extent to which an adjustment is needed. Plan sponsors should consider:

- Where members were in the data collection period
  - FFS diagnoses data is complete (no adjustment required for beneficiaries who were in FFS all 12 months of the data collection year)
  - Consider own MA plan filtering practice (filtering for C model diagnoses, filter for C and D model diagnoses, don't filter). If the plan sends all diagnosis codes to RAPS, no adjustment is required for the risk scores of members who were in that sponsor's plans in the data collection period.
  - Another sponsor's MA plan
- Can MA sponsor determine its own missing data adjustment, using its own diagnoses?

[9] The normalization for the 2013 model risk scores addesses period from 2011 to 2014. The normalization for the 2014 model risk scores addresses the period from 2012 to 2014.

User Group Call Date 04/11/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Sequestra-tion	04/07/2013 11:54	Questions for Actuarial User Group Call	Please confirm whether the impact of sequestration on 2013 FFS and MA plan payments will be excluded from corrections to prior years' estimates in future calculations of the National MA Per Capita Growth Percentage and FFS USPCC Growth Percentage.	Yes, per section 256(d) of the Budget Control Act, the growth rate will exclude the effects of sequestration.
2	Rate Announce-ment	04/03/2013 10:06	MA rate notice	How accurate are the FY PPS update factor projections in the final Medicare Advantage rate notice and what do those projections include? The market basket? Cuts to the market basket increase enacted into law, including the productivity adjustment? The recoupment from the January fiscal cliff law? Is the estimate just for the operating increase or a combination of operating and capital base payments? Is it just for IPPS or other hospital updates, such as psych, long-term acute-care etc.?	The FY PPS update factor represents the IPPS operating update. It is actual through 2013 and a projection for 2014 and beyond. The factors include an estimate of the market basket, cuts that have been enacted, productivity adjustments and the documentation and coding reductions. This does not include capital or other hospitals such as psych, long-term-care etc.
3	Rate Announce-ment	04/04/2013 19:50	questions re 2014 bids	Please explain the factors that contributed to the 2% reduction in ESRD Dialysis trend from the Advance Notice to the Final Rates.	The reduction in the dialysis trend was primarily due to the actual ratio of ESRD to Non-ESRD coming in lower than projected for 2011.
4	MA Payment Rates	04/07/2013 11:54	Questions for Actuarial User Group Call	Please confirm that in the phase out of Indirect Medical Education from MA plan benchmarks that only Operating IME costs, and not Capital IME costs, are reflected in the IME phase out amount. The reason we are seeking clarification is that it is noted in the CMS document "MA Payment Guide for Out of Network Payments 12/26/2012 Update" (accessed at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/oon-payments.pdf) that "capital IME" does have to be paid by MA plans. It would therefore seem appropriate that only Operating IME and not Capital IME be phased out of the MA payment benchmarks.	That is correct, in the phase out of Indirect Medical Education from MA plan benchmarks, only Operating IME costs, and not Capital IME costs, are reflected in the IME phase out amount.
5	FFS Trends	04/09/2013 10:50	unit cost change for Medicare providers	Please provide OACTs estimate of Medicare FFS unit cost trends from CY2012 to CY2014 by service category. There has been some confusion in the past as to whether previous announcements were for calendar year or fiscal year. Because bids are on a calendar year basis, a calendar year trend number would be ideal.	CMS will post estimated Medicare unit cost increases by service category on the Medicare Advantage Rates and Statistics web page later this month. As in prior years, the time period for the FFS trends will be calendar year for all categories except inpatient hospital and skilled nursing facility. We will announce the date of the posting on next week's call.
6	MLR	02/27/2013 17:33	MA / PDP Loss Ratio Regulations	1) Do the MA and PDP minimum loss ratio regulations apply to 800 series EGWP plans? 2) If so, is all EGWP and individual experience under the same contract (H or S number) combined for testing the loss ratio? The regulations seem to imply the calculations will be based at the contract level, but the entire document is silent regarding the applicability to EGWPs as far as I could tell. It seems like grouping them together under a given contract would allow subsidies between the individual and employer markets, which may not be the desired outcome.	1) The proposed MLR policy is that the MLR requirement applies to 800-series plans. 2) We encourage you to provide your comments through the channels provided in the proposed rule. Note the comment period ends April 16th.
7	Revised MA Payment Rates for Puerto Rico	N/A	N/A	When does CMS expect to publish the revised MA payment rates for Puerto Rico?	The target release date for the revised rates is April 19th.
8	OOPC/TBC	04/08/2013 13:31	SGR and OOPC Model	For the 2014 Bid, will the base year CY 2013 OOPC amounts provided by CMS capture the assumption in the 2014 announcement that Congress will act to prevent the scheduled 25% reduction in Medicare Physician payment rates? Will the inflation factors contained within the CY 2014 benefit OOPC model also capture this assumption? Not having these aligned, or not having this difference captured in the "TBC Change Adjustments" could negatively impact plans by inadvertently reducing the $34 TBC allowance.	The inflation factors for the base year CY2013 OOPC model and the CY2014 OOPC model both assume a physician payment fix; so the models are consistent with each other.
9	Insurer Fees	N/A	N/A	On Worksheets 1 and 4, there are new lines added for Insurer fees. Can CMS please provide guidance in the BPT instruction as to what is included in the insurer fees?	The Internal Revenue Service has issued proposed rules on this health insurance providers fee imposed by section 9010 of the ACA. Please see the Federal Register for more information. There is also a publicly released study on the projected impact of these fees on health plan premiums. The study can be found at the following links: (1) http://healthreformgps.org/, search for keyword "insurer fees", select the 10-31-11 article "Oliver Wyman report finds insurer fees will increase premiums", select the link for "new report"; or (2)http://healthreformgps.org/wp-content/uploads/Oliver-Wyman-Insurer-Fees-report-final.pdf. Supporting documentation for the BPT fields should include details for the projected annual fee included in the bid.

User Group Call Date 04/11/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
10	Gain/Loss and Other CMS Require-ments	N/A	N/A	We are concerned that we will not be able to meet the TBC, MLR and OACT's margin requirements simultaneously. Is there any flexibility allowed or does any one rule take precedence?	If there is a conflict between satisfying gain/loss margin requirements and other CMS requirements, such as Total Beneficiary Cost (TBC) or Medicare Medical Loss Ratio (MLR), flexibility will be given to margin requirements only to the extent necessary to meet other CMS requirements. In this case, the Plan sponsor must provide an adequate explanation of the need for flexibility in the margin in supporting documentation. When other program requirements prevent an organization from meeting the aggregate level requirement to be within 1.5% of the margin for non-Medicare health lines of business for a particular year, this requirement can be met by the plan sponsor demonstrating the margin is within 1.5% of the margin for non-Medicare health lines of business over a longer term (such as three to five years).
11	Gain/Loss	N/A	N/A	1) Can MA and PD general enrollment and institutional/chronic SNP margins be combined to meet the requirement of margin being within 1.5% of the margin for non-Medicare health lines of business? 2) Can MA and PD margins for an MA-PD plan be combined to demonstrate profitability of the plan and not require a business plan to be submitted for the component with negative margin?	The answer to both questions is no. Reviewing the MA and PD margins separately allows us to better assess the margin component of an MA or PD bid to ensure the bid reflects the true total revenue requirement of the plan sponsor for that bid.
12	Gain/Loss	N/A	N/A	What guidelines will CMS use in assessing the appropriateness of the "degree of risk and surplus requirements" for organizations that have less than 10% volume of non-Medicare business?	We will consider support provided, such as risk-based capital needs, illustration of return on investment or equity requirements and other demonstrations of corporate return requirements.
13	Gain/Loss	N/A	N/A	The new language regarding aggregate margin test varies for organizations that have more or less than 10% non-Medicare business, where non-Medicare is stipulated to be business for which the sponsor has "discretion in rate setting". Please confirm that Medicaid business where the State, not the health plan, sets the rate is an example of business where the sponsor does not have this discretion.	That is correct, Medicaid business where the State, not the health plan, sets the rate is an example of "business where the plan sponsor does not have discretion in rate setting."
14	Capitation	02/18/2013 14:57	2014 MA Bid: question about fitness benefit cost classification	Some of our organization's plans offer a fitness benefit for members to utilize gym services. A recent change to our contract with the fitness vendor changed the way in which costs are billed to us; now we are charged a fee based on the number of eligible members (e.g. capitation), and may be charged an additional fee if our organization's total utilization (Medicare Advantage plus other lines of business) exceeds a certain threshold. Our vendor does not provide a split of the administrative component of their services. Is it permissible to classify the entire amount of the cost of this benefit as Benefit Expense?	Assuming the vendor is NOT a related party, then yes it is acceptable to include the capitation rate in allowed costs. If the vendor is a related party, please refer to the related-party requirements in the bid instructions.
15	WS1/Cross-walks	04/09/2013 7:27	2014 Bid Questions	On page 130 of the 2014 Rate Announcement & Call Letter, it says that organizations can change a non-segmented plan to a segmented plan and crosswalk the members. How should WS1 be completed for these plans?	Report the entire base period experience of the non-segmented plan in Worksheet 1 of each new segmented plan for which a significant portion of members are crosswalked (through MARx enrollment transactions) from the non-segmented plan.
16	WS1/Cross-walks	04/09/2013 7:27	2014 Bid Questions	On page 11 of the MA BPT Instructions, there is new guidance regarding how to complete WS1 when there are plan consolidations or enrollment shifts. We expect to have several plans where "an insignificant proportion of members in a plan are crosswalked into existing plans through MARx enrollment transactions." It is our understanding that under Rule 2: WS1 should only include experience from the existing plan – meaning that it should not include the experience from the plan where the insignificant proportion of members were crosswalked from. Is our understanding correct? If this is correct, then what is the preferred method to adjust the base period experience when pricing the new plan with the crosswalked membership? If there is no preferred method, are there any methodologies that are specifically not allowed?	Yes, that is correct. Worksheet 1 must not include the base period experience from the plan where the insignificant proportion of members were crosswalked from. In developing projected allowed costs use the same approach as you would for a plan experiencing enrollment shifts that do not involve formal crosswalks or MARx transactions, that is use the projection factors to show prospective adjustments that reflect anticipated changes between the base period experience for the members enrolled in the plan in the base period and the contract year experience for the projected population, (e.g., population change factor, benefit change factor, utilization per 1,000, etc.). Do not use the other utilization or other unit cost factor as one combined factor reflecting all anticipated changes.
17	Enrollment Hierarchy	04/08/2013 17:43	Enrollment Status Priority	In the Beta MA BPT instructions, the priority was designated as: 1. ESRD 2. Hospice 3. OOA 4. Other In the final instructions, the order for ESRD and Hospice was reversed. We have many processes that would have to be redone to accommodate this late change. Can CMS deem either order to be compliant for the 2014 bids?	Enrollment status classification must follow the final CY2014 MA bid instructions (i.e., 1. Hospice 2. ESRD 3. OOA 4. Other). This is consistent with the guidance given on the April 19, 2012 Actuarial UGC.
18	Risk Score	04/09/2013 7:27	2014 Bid Questions	When will the Beneficiary level files be released? What format will the file be in – i.e. will there be raw risk scores from both versions of the model?	The beneficiary level files were released the evening of Wednesday, April 10th. The HPMS memos with the tech notes and file layouts were released on Thursday, April 11th. The Part C beneficiary-level files include 2012 raw risk scores calculated using both the 2013 and 2014 CMS-HCC models.

User Group Call Date 04/11/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
19	Risk Score	04/04/2013 19:50	questions re 2014 bids	I understand that the change in HCC model was prompted by CMS' observation that certain diagnosis being reported at a much higher frequency by MA plans vs. FFS providers. Could you please confirm that the impact of HCC model is not already accounted for under the MA coding intensity factor? That is, had MA plans been using the 2014 HCC model all along, would the coding intensity difference between MA plans and FFS providers stay at 4.91%?	We do recognize that the risk adjustment model has an impact on the measure of coding differences and we took the model for 2014 payment into account when we determined the appropriate factor for 2014.
20	Risk Score	04/07/2013 11:54	Questions for Actuarial User Group Call	Please clarify how CMS will calculate plan risk scores under the new 2014 CMS-HCC model in the beneficiary file it anticipates releasing to plans in April. In particular, please clarify whether CMS has access to data from all MA plans on diagnosis codes that are new in the 2014 model recalibration. If CMS does not have access to data from all MA plans on the new diagnosis codes, please clarify what data will be used for the new codes in the calculation of scores to be released to plans. Please further describe the effect of any missing data or use of proxy data on the risk scores to be provided.	The Part C risk scores that CMS will provide using the 2014 risk adjustment model will be calculated using all the diagnoses that MAOs submit to RAPs, and complete diagnoses from FFS claims. Because of this, risk scores provided using the 2014 model may not be complete, depending on whether your plan filters for model diagnoses when submitting RAPS data. If your MAO does not filter diagnoses for model diagnoses when you submit RAPS data, then your risk scores calculated using the 2014 CMS-HCC model may be complete. However, if your MAO does filter diagnoses when you submit your RAPS data, then your risk scores are not complete. We provide "missing data" adjustment factors in the technical notes in the Part C HPMS memo to help you develop the 2014 model risk score that will be blended with the 2013 model risk score to calculate your PY 2014 risk score. These "missing data" adjustment factors are derived from FFS data, and are offered to plans only to assist them in determining how to adjust the risk scores under the 2014 model. The actual adjustment will depend on where your 2012 enrollees were enrolled in 2011 (one of your MAO's plans, FFS, or a plan with another MAO).
21	Risk Score	04/09/2013 8:50	CSNP NE Risk Scores in Rate Announcement	Can CMS please provide further explanation to the change in the CSNP New Enrollee (NE) risk scores in the Final Rate Announcement versus those posted in the Advanced Notice? The adjustment on the CSNP NE model appear to be in excess of the expected 2.5% decrease. Was there an update to the relativities between the standard NE model and the CSNP NE model between the Advanced Notice and the Rate announcement. The change in these factors was far more than expected given the changes discussed in the Rate Announcement.	There was a technical revision of the C-SNP NE relative factors.
22	Risk Score	04/09/2013 8:26	2014 RxHCC Risk Model	A new Part C 2014 HCC model was recently posted. Will a 2014 RxHCC model also be posted?	The updated RxHCC model was posted on April 10.
23	PD WS1	N/A	N/A	Should the amount shown in WS1, Section III, column G, line 10 (Part D as secondary) include the Non-LI brand discount?	Yes
24	PD WS1	N/A	N/A	Should the amount shown in WS1, Section V, column m, Non-LI Brand Discount include the Part D as Secondary paid amounts?	Yes

User Group Call Date 04/18/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Sequestration	04/16/2013 14:27	Sequestration	Can you detail how sequestration should be "handled" for bids purposes, both in Part C and Part D?	Similar to 2013 bids, CMS will allow the impact of sequestration to be included as a temporary increase in the plan's risk margin to accommodate the extra risk caused by the potential reduction in plan payments. If included, the level of risk margin included in gain/loss margin must reflect your best estimate of the likelihood of the payment reduction for the Medicare covered or basic bid. Further, your projection of medical and/or pharmacy expenses must reflect the expected impact of sequestration on provider payments to both contracting and non-contracting providers. Your documentation should clearly explain where you have reflected sequestration in your projection assumptions.
2	MLR/ Sequestration	04/13/2013 16:35	MLR and sequestration	Will a loss ratio less than the MLR be accepted due to the potential impact of sequestration. As an example, if an additional 2% is added into the gain loss and the resulting loss ratio is approximately 83% instead of 85%, will that be allowed?	Please note that the BPT MLR is not the formal collection for Medicare MLR reporting. As stated on pages 25-26 of the CY 2014 MA bidding instructions: "While CMS will not automatically disapprove a bid containing an MA MLR that is less than 85%, CMS's expectation is that the gain/loss margin will be set with appropriate consideration for the need to remit funds to CMS if the Plan sponsor's actual claims experience fails to meet the minimum Medicare MLR requirement. Further, if there is a conflict between satisfying gain/loss margin requirements and other CMS requirements, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the other CMS requirements. Such modifications to the gain/loss margin requirements must be fully explained and supported." Thus, if a plan's margin has been adjusted to account for sequestration and the resulting BPT MLR is less than 85%, CMS may question whether the margin is set with appropriate consideration for the need to remit funds should the actual MLR fail to meet the requirement.
3	Insurer Fees	04/15/2013 8:15	Bid Question Regarding Health Insurance Tax	Please confirm that if a company achieved chapter 613 taxable nonprofit corporation status during 2013 and has at least 80% of its revenue from Medicare/Medicaid, then the company should not include the Health Insurer Fee in its 2014 bid development.	The Internal Revenue Service has issued proposed rules on this health insurance providers fee imposed by section 9010 of the ACA. Please see the Federal Register for more information. If you believe your plan meets all of the requirements to be exempt from the health insurer fees in 2014 then you should exclude the fees from your bid.
4	FFS Rates by County	04/11/2013 11:45	Projected FFS Costs by County	Last year you posted a file named "Medicare FFS County 2013 Web.xlsm" in the FFS2010.zip file which was helpful in understanding the FFS rates by county. Will you be providing a similar file for 2014 in the FFS2011.zip file and will the impact of the repricing be included?	We expect to post this file in the next few weeks and the impact of repricing will be included.
5	Dual Eligible Coordinated Care Demonstration	N/A	N/A	For the states selected to participate in the Dual Eligible Coordinated Care Demonstration program, does CMS have any guidance at this time on how plans in affected counties should be bidding? Based on the most recent information, CMS will likely be responding to the states after the 2014 bid deadline. Specifically, we are interested if the affected dual eligible members currently enrolled with us but eligible for the demonstration program should be included in our bid. Additionally, should we find ourselves in the position of being eligible for additional dual eligible members, do you have any expectations for how these new members should be considered?	MA/PD bids should reflect your best estimate of what population is expected to enroll in the plan. That expectation should reflect the possibility that some enrollees may be passively enrolled in an approved demonstration plan and your best expectation as to any additional members you may enroll.
6	Quality Initiatives	04/11/2013 15:57	Questions about Quality Initiative Expenses	CMS requires all MAOs to submit the Healthcare Effectiveness Data Information Set (HEDIS) measures and to participate in the Medicare Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. Could MAOs consider all costs related to those requirements as quality initiative expenses?	The cost of quality initiatives entered in the BPT is the certifying actuary's best estimate of non-benefit expenses for activities that are designed to improve healthcare quality. In determining which expenses to include refer to the definition provided in the Medicare MLR rule.
7	Gain/Loss	04/13/2013 16:29	Gain/Loss Margin	1. Is Medicare Cost (1876) counted as a Medicare or non-Medicare product line for purposes of the gain/loss margin aggregate test? 2. Is Medicare Supplement counted as a non-Medicare product line for purposes of the gain/loss margin aggregate test?	1) For Medicare Cost (1876) plans, if no BPT is submitted, we treat these plans as non-Medicare for purposes of the gain/loss margin requirements. 2) Yes, Medicare supplement insurance is considered non-Medicare.
8	Gain/Loss	04/13/2013 16:26	Adjusted G/L Margin	The adjusted g/l margin amount in cell R127 of MA W/S 4 combines the Medicare and Medicaid margin amounts. How will this information be used by CMS?	As stated in the gain/loss margin section of the MA bid instructions and summarized in the training materials, "if the Plan sponsor has a separate contract with a state or territory for Medicaid services, then the gain/loss margin used to satisfy all gain/loss margin requirements is the adjusted gain/loss margin for the bid calculated in Worksheet 4 Section V." This mean that bid-level gain/loss margin requirements and the aggregate-level gain/loss margin requirements apply to the margin in cell R127 of MA worksheet 4.

User Group Call Date 04/18/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Risk Score	04/16/2013 11:00	Missing Diagnosis Adjustments	The 2014 bid training materials indicate that a missing diagnosis adjustment may be needed for both the Part C and Part D risk scores (2014 model basis) contained in the beneficiary-level files and that the estimate of this impact is contained in the technical notes that were sent out with the files. I was able to find the Part C estimates but unable to find a similar estimate for Part D. Can you clarify that there is a missing diagnosis adjustment that may be needed for the 2014 Part D risk model, and if so, where this information can be located?	A missing diagnosis adjustment is not needed for the 2014 Part D risk model. The Risk score Development Intermediate training session list all adjustment factors that may apply under the preferred risk score calculation approach for any given contract year, including the missing diagnosis (or missing data) adjustment. It refers to the Advanced Payment Notice and the Final Rate Notice for specific factors that apply such as the missing diagnosis adjustment factor. The CY2014 MA and Part D bid instructions describe the specific requirements for CY2014; the Part D instructions do not provide for a Part D missing diagnosis adjustment factor.
10	Risk Score	04/16/2013 9:28	Frailty Factor	One of our PBP is going to be the second year of offering a FIDE. This PBP should have participated in the last HOS survey. How do we figure out whether frailty factor applies to this PBP and what it will be in 2014? Do we need to add a factor frailty factor into our projected risk scores?	Under the Affordable Care Act (ACA), CMS may pay a frailty adjustment to those plans that meet the legal definition to be categorized as a fully integrated dual eligible special needs plan (FIDE SNP) if the FIDE SNP has similar average level of frailty to the PACE program. If a plan believes that in 2014 they will both (a) meet the legal definition of FIDE SNP and (b) have a frailty score above the minimum PACE score as reflected within the 2013 Health Outcome Survey (HOS) performed at the PBP level necessary to receive a frailty adjustment to their risk scores, then it would be appropriate to reflect some probability of the plan being identified as a FIDE SNP in the bid. Use your best estimate based on the 2013 frailty factor to develop your estimate of the factor to include in 2014 projected risk scores.
11	Risk Score	04/16/2013 7:36	BPT Instructions - Risk Factor Development	1. Is the expectation that plans will calculate the impact of 2014 Recalibration solely using the 2014 Beneficiary Files? 2. Why was the 2014 New Enrollee C-SNP risk score not included in the 2014 Beneficiary Files? 3. Should plans expect an unusual amount of Hospice retroactivity in the 2012 Final settlement/2014 Beneficiary Files?	1. We provide this data to help certifying actuaries calculate this impact but alternative approaches are acceptable. You must clearly explain your approach in the supporting documentation. 2. As we mentioned in the HPMS memo accompanying the Part C beneficiary-level files sent April 11, 2013, we will send an updated file that includes the 2014 C-SNP risk scores later in April. We will send this file to C-SNP sponsors and anticipate that this replacement file will be sent the week of April 22nd. 3. The hospice status flag on the beneficiary-level file shows periods during which hospice was in force for some part of the month for their members. The hospice flag on the MMR is turned on when the beneficiary is hospice as of the first of a month, which indicates that the risk payment has not been made. 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. To assess the impact on payment, MAOs should consider the second and later months of hospice status.
12	Risk Score	04/15/2013 19:41	Questions For Weekly OACT Call on 2014 Medicare Bids	1. For Part D new enrollees scores under the 2014 model (fields 38,39 and 40), do we need to adjust them if a member is concurrently ESRD (or are these fields already calculated correctly for members that are ESRD)? 2. For Part D new enrollees scores under the 2012 model (fields 46,47 and 48), do we need to adjust them if a member is concurrently ESRD (or are these fields already calculated correctly for members that are ESRD)?	Because the new enrollee scores are calibrated slightly differently this year, there is no single add on number for each new enrollee segment. As a result, the files were populated differently than before. What is in the files is an ESRD version of each score, if the beneficiary was ESRD at all in the year. Because this is not how we make payments, and plan sponsors with ESRD enrollees need both ESRD and non-ESRD new enrollee scores, we will recreate the files with all six new enrollee scores. The replacement files will provide both the non-ESRD and ESRD version of the Part D new enrollees scores for both the 2012 model and the 2014 model, so there is no need to make an adjustment to any of the new enrollee scores.
13	Formulary Deadline	04/11/2013 11:44	Follow up question on Actuarial User call	Based on a response to a phone question at the last user group call, can you please clarify that if the formulary changes post bid deadline, that the bid would need to be recalculated and resubmitted.	No, similar to past years, we will not allow changes to the BPT due to formulary changes after the initial bid submission deadline in June.
14	National Average	04/11/2013 13:55	actuarial user group call questions	During the actuarial user group call on February 21, 2013, CMS recommended that organizations take care when projecting the national average. A September 2012 Issue Brief issued by the Kaiser Family Foundation indicates the top 10 firms account for 77.5% of 2012 Part D market share with the top 3 firms accounting for 48.6% of 2012 Part D market share. How does CMS suggest smaller health plans develop a reasonable estimate when the top 10 firms are basically determining the national average (with the top 3 firms having a very significant influence)?	Plan sponsors and certifying actuaries must use their best professional judgment when estimating the national average bid amount and should consider information released by CMS and market dynamics and trends.
15	Part D rebates	04/12/2013 9:12	Part D Rebates	As part of our Part D Rx rebates contract, a portion of the rebates are retained by the PBM as payment. Can you confirm that the appropriate way to handle the retained rebates is to include them in the rebates line in Worksheets 1 & 3 and include an offsetting amount in administrative expenses?	This approach is correct. Please see pages 15-16 in the Part D bid instructions for more information about Direct and Indirect Remuneration.

User Group Call Date 04/18/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
16	Part D User Fees	04/12/2013 11:40	Part D User Fees	What amount should be put into direct administration for 2014 Part D user fees?	As stated on page 174 of the Final Call Letter, CMS will not be imposing the Part D COB user fees for CY2014. As stated on page 19 of the Part D bid instructions "CMS collects Part D National Medicare Education Campaign (NMEC) user fees based on a percentage of revenue; however, the BPT entry is a pmpm equivalent value consistent with the calculation of other BPT values. Part D sponsors may use the CMS estimate, which is $0.66 pmpy or $0.05 pmpm on a national basis for CY2014, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Part D sponsor's historical amount relative to the CMS annual national estimate."
17	Part D trends	04/11/2013 13:55	actuarial user group call questions	We consider the impact of brand going generic and the introduction of new drugs as being market place forces as opposed to organizational initiated change. We define trend as the year over year change in spend from market forces and formulary change as being organizational initiated change. Our historic trends include the impact of brands going generic, the introduction of new drugs as well as overall increases in generic fill rates. To separately estimate the future impact of brands going generic and new drugs would imply backing-out this impact from historic utilization when estimating trend. This would not be an easy or efficient exercise. In addition, to separately project the impact of brand going generic would require numerous assumptions, some informed and some conjecture, regarding exclusivity periods and the potential for the FDA to grant additional exclusivity, estimates of additional generic manufacturers entering the market, actual introduction dates of pipeline drugs and the number of brand competitors that mirror those drugs, the impact of clinical trials, the impact of marketing drugs that lose patent expiration in the OTC market, settlement agreements and delayed launchings of new generics, unauthorized generics, etc. Our process considers trend in historic generic use rate and pharmacist assessment of ultimate generic use rate for the contract period. Historic trends, including the impact of brands going generic and new drugs, are examined and compared to industry trends and industry projections for reasonableness, and the resulting generic use rate for the contract period is reviewed for reasonableness. The industry trends used to compare for reasonableness (Express Scripts, MedCo, CVSCareMark) include the impact of brands going generic, patent expirations and new drugs. We view the formulary change factors as factors meant to measure changes in the filed formulary that are not accounted for elsewhere (such as in the trend). 1. Does CMS view this as a reasonable process? OR 2. Does CMS require that the impact of brands going generic and the impact of new drugs be separated from the trend factors and included in the formulary change factor?	1. Yes, this is a reasonable process. 2. No, CMS does not require that plans separate out the impact of brands going generic and the impact of new drugs from the trend factors. We do expect plans, however, to clearly document what is included in each of their projection factors.
18	Health Information Technology	04/10/2013 21:26	Actuarial Questions Related to Rate Announcement	1. How should the Health Information Technology (HIT) be reflected in the Part D bids? Is this applied uniformly across all at-risk revenue components? 2. For a taxable entity, should HIT be grossed-up for income tax?	1. The revenues and costs must be allocated among applicable components using a methodology that reflects the manner in which the revenues are generated and costs are incurred; a detailed description of the methodology must be included in the supporting documentation that is uploaded with the initial bid submission. 2. No, bids are prepared on a pre-tax basis.

User Group Call Date 04/25/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Insurer Fees	04/22/2013 21:39	Insurer Fee treatment	Due to the non-deductibility of the insurer fee and the fact that bid profit is on a pre-tax basis, we have a question regarding the expected bid treatment of the insurer fee. If a plan expected to have a 2014 insurer fee equal to the 2.1% midpoint of the Oliver Wyman range, and further also expected the 35% tax rate assumed in the Oliver Wyman study to produce the 2.1% fee, how would CMS like to see the insurer fee reflected in the bids for 2014: 1) Insurer fee of 1.365% (.65*2.1%) in admin, and .735% in additional gain/loss to fund the tax on the fee itself, or 2) 2.1% in admin, and no change to gain/loss.	The insurer fees should be estimated prior to the consideration of income taxes and reported in non-benefit expenses.
2	ESRD Rates	04/17/2013 9:07	ESRD State Rates	The advanced notice indicated that for the 2014 ESRD Medicare Advantage rates CMS would, essentially, utilize FFS dialysis data by each state from 2007 to 2011 and trend to 2014 as well as remove GME and gradually remove IME. In the final notice, there was no mention of the ESRD state rates at all. Should we assume that the changes proposed in the advanced notice were adopted in their entirety for the final notice?	Yes that is correct, the 2014 ESRD MA rates were calculated as stated in the advanced notice.
3	TBC	04/23/2013 15:46	TBCs	Does TBC requirement apply to I-SNP's?	Yes, TBC applies to I-SNPS.
4	NBE	04/17/2013 15:20	Bid question	On "CY2014 MA BPT Instructions" page 15, it says "'insurer fee' is a subset of 'taxes and fees', which in turn in a subset of projected non-benefit expenses ….". Later, it also states "Worksheet 1 collects the costs of NBE quality initiatives, taxes and fees, and insurer fees... These items are defined in the same manner as for the projection period." So, Tax is part of NBE. Yet, on page 33 on topic of non-benefit expenses, it says "Cost not pertaining to administrative activities must be excluded from non-benefit expenses. Such cost include goodwill amortization, **income taxes,**...". Then, Tax is NOT part of NBE. Please clarify whether income taxes should be included in NBE or not.	Income taxes are not included in non-benefit expenses. The quote from the BPT MLR pricing consideration on page 15 of the MA bid instructions is incomplete. Page 15 states that "Line z3 "Insurer Fees" is a subset of line z2 C5"Taxes and Fees", which in turn, is a subset of projected non-benefit expenses (line v) *and/or gain/loss margin (line w)*" (emphasis added). Including an item in "Taxes and Fees" for the purpose of the BPT MLR calculation does not affect how such item is included in the bid. For example, "Fees" are a subset of NBE and primarily include regulatory authority licenses and fees. "Taxes" primarily include federal and state income/excise/business/other taxes, which are not explicitly reflected in the bid.
5	NBE	04/16/2013 14:48	Non-Benefit Expenses	Can CMS confirm that 'Taxes and Fees' (BPT WS4, line z2), which includes 'Insurer Fees' (BPT WS4 line z3) mandated by the ACA, and 'NBE Quality Initiatives' (BPT WS4 line z1), are to be included 'Direct Administration' (BPT WS4 line v2)? Page 15 of the MA BPT instructions states that 'Insurer Fees' are a subset of non-benefit expenses, and page 32's description of 'Direct Administration' expenses makes it seem logical these items should appear in this category, but the instructions do not explicitly state where which expense group they should be reported in.	"Taxes and Fees" includes items that are entered in the bid as non-benefit expenses or gain/loss margin. For example, income taxes are not included in non-benefit expenses (NBE). "Taxes" primarily include federal and state income/excise/business/other taxes, which are not explicitly reflected in the bid. See question #3 for more information. Non-benefit expenses must be allocated to the NBE categories based on the most appropriate relationship of each quality initiative expense to each NBE category. The Insurer Fees portion of 'Taxes and Fees" should be included in Direct Administration. NBE Quality Initiatives should be included in Direct Administration.
6	NBE	04/23/2013 7:31	Rewards and Incentives	The Bid Review and Operations Guidance stated that Rewards and Incentives are not eligible supplemental benefits. Should we include them as marketing tools, do we need to put them in as administrative expenses?	Non-benefit expenses (NBE) must be allocated to the NBE categories based on the most appropriate relationship of the expense to each NBE category. We expect Rewards and Incentives expenses to be entered as Direct Administration.
7	Risk Score	04/22/2013 11:37	Question on Risk Score Development Illustration	Can you further explain what the adjustment for transition from lagged to non-lagged diagnosis data accounts for? It is Risk Score Element E i) in the Risk Score Development Illustration from the 4/11 user group call.	Payments made from January to June of any year are based on diagnosis data from July 1 to June 30 of the previous year. Thus payments made in March, 2013 are based on diagnosis data from July 1, 2011 to June 30, 2012. These diagnoses are reported to CMS thru September 2012. We call this the "initial payment" and we consider the payment to be based on "lagged" data. It is lagging behind the calendar year. Payments made from July to December of any year are based on diagnosis data from January to December of the previous year. Thus payments made in July, 2013 will be based on diagnosis data from January to December of 2012. These diagnoses are reported to CMS thru March of 2013. Because these are calendar year diagnosis data we consider them to be "non-lagged". If the starting point for the projected risk scores is based on "lagged" data, as is the case when starting with the March, 2013 MMR files, we expect the plan to make an adjustment based on their historical payments to account for the movement of diagnoses from July-June to the calendar year basis since the 2014 projected risk score is projected for a calendar year period.

User Group Call Date 04/25/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Risk Score	04/22/2013 11:00	Part D risk scores in member level file	Are the Part D risk scores for the 2012 model in the member level file normalized? They're virtually identical to the amounts reported on our MMRs for the same population.	The risk scores in the beneficiary-level files and in the HPMS tables are not normalized. Please note that the risk scores in the beneficiary-level files and in the HPMS tables are almost-final 2012 risk scores, with full run out of MA diagnoses. The 2012 MMRs are providing you with mid-year scores.
9	Risk Score	04/19/2013 0:05	Part D Risk Scores	Based on the Part D beneficiary level files, we are seeing a +10% increase in risk scores for low income members and a -10% decrease for non-low income members. Is this result in line with CMS' expectations? If so, could CMS please provide an explanation for the significant risk score swings?	What you are seeing is consistent with our own analyses. While the overall change in risk score was small, the risk scores of low income and non-low income beneficiaries observed this differential change. Our analyses also show that the average contract risk scores vary. We are researching the underlying trends, but this is consistent with recent trends that show low income beneficiaries' costs increasing. By recalibrating the model, these more recent costs trends are incorporated into the model.
10	Risk Score	04/22/2013 11:00	Missing Data adjustment	In the technical notes to the beneficiary level risk score file you note: Missing data adjustment if the score is calculated using diagnoses mapping to the 2013 CMS-HCC model and to the 2013 RxHCC model: 1.015 We noticed that we filter our RAPS data for diagnoses mapped to the 2013 CMS-HCC model and to the 2013 RxHCC model and to the 2013 ESRD risk score model. Does your wording "2013 CMS-HCC model" include the codes that only trigger a 2013 payment for the ESRD membership?	No, when we created the missing data adjustment factor, we used diagnoses that map to the aged/disabled Part C model and the Part D model, but not the additional HCCs in the ESRD model.

User Group Call Date 05/02/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Taxes and Fees	04/30/2013 9:16	Taxes and Fees Entry if Negative Gain/Loss Margin	Our question regards the "Taxes and Fees" entry on the MA Bid Form, WS4 cell M100 and PD Bid Form, WS2, cell J70. In completing our 2013 Bids we calculated this entry as a function of the gain/loss margin for each Bid. In the rare cases where the Bid gain/loss was negative, this meant a negative value for 'Taxes and Fees.' Subsequent communications from CMS Bid Review suggested that this approach may not be acceptable in the 2014 Bid submission. Please clarify how bidders should treat the "Taxes and Fees" entries on the MA & PD Bid forms.	Gain/loss margin is an acceptable allocation basis for the taxes portion of 'Taxes and Fees' and resulting negative taxes are acceptable. The fees portion of 'Taxes and Fees' should never be negative so an alternate allocation method should be used.
2	FFS UC Trends	04/29/2013 14:33	FFS UC Trend	Thank you for publishing the FFS UC trends last week. Could you please confirm if these trends are consistent with the proposed rule published Friday April 26th (Proposed Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals)?	The trends do not reflect the documentation and coding adjustment in the proposed rule. We assumed a 2.0 percent reduction in 2014 for the FFS trends posted last week and what is being proposed is a 0.8 percent reduction. In addition, the hospital market basket used in the FFS trends posted last week was 3.3% along with a productivity estimate of 0.5% and a legislative reduction of 0.3% resulting in an update of 2.5% (3.3-0.5-0.3). However, in the rule that was published last Friday, the market basket was 2.5% along with a productivity estimate of 0.4% and the legislative reduction of 0.3% resulting in an update of 1.8% (2.5-0.4-0.3).
3	MSA BPT MLR	04/30/2013 10:44	MSA MLR Question for 5/2/13 Actuarial User Group Call	Worksheet 4 of the MSA BPT appears to exclude the Monthly Enrollee Deposit from both the numerator and denominator of the BPT MLR calculation. This deposit is similar to the MA rebate in that when the Plan Revenue Requirement is below the Plan Benchmark, this savings is passed along to the member. The MA rebate revenue, along with any associated benefit enhancements, are included in the MA BPT MLR calculation's denominator and numerator, respectively. The Monthly Enrollee Deposit is also similar to Part B premium reductions and Part D reinsurance, since these are both passed through dollar for dollar as revenue and expense. Each of these are included in both the numerator and denominators of the MA and PD BPT MLR calculation. Should a revision to the MSA BPT be made to include the MSA deposit amount in both the numerator and denominator of the MLR calculation? If not, can you provide comment as to why the Monthly Enrollee Deposit should be excluded from the MSA MLR calculation, and how it differs from the other items above?	OACT will forward this question to the appropriate parties within CMS for consideration in the final MLR rule. Bid sponsors should develop their bids based on the final rule. Given that the "adjusted MLR" in the BPT is for bid review purposes only, OACT does not plan to update the BPT forms in the event that the "adjusted MLR" formula is not consistent with the final rule.
4	NBE	04/29/2013 20:52	Bid Question	We understand that all non-benefit expenses must be reported using appropriate, generally accepted accounting principles. In a situation where a carrier is re-entering a market, the company's best estimate of non-benefit expenses, on a PMPM basis, may appear unreasonably high due to start-up costs that are spread over a relatively low enrollment base in the first year of the contract. From a PMPM perspective, is there a threshold at which CMS would deem these non-benefit expenses (including start-up costs that may be incurred in 2012/2013) too high in the first year of the contract? In addition to the requirements as described in the instructions, can CMS provide additional guidance regarding start-up costs to MA plans that exited and will re-enter a particular market? If the plan is targeting a specific loss ratio in the first year of the contract, this will have a significant impact on projected gain/loss assumption as well.	CMS does not set a threshold for the level of projected non-benefit expenses (NBE). The NBE and gain/loss margin requirements are the same for plans that exited and re-entered a particular market as for other plans, that is: (1) the supporting documentation must demonstrate that the projected non-benefits are appropriate for the circumstances of the bid, and (2) the bid-level business plan must demonstrate profitability within 3 to 5 years based on feasible factors such as growth.
5	NBE	04/29/2013 17:34	Non-Benefit Expenses Accounting Principle	The BPT instructions state that "All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP)". Could you please clarify if this prohibits other accounting principles such as the statutory (STAT) basis?	As stated in the bid instructions, the non benefit expenses must be reported using GAAP. Statutory basis is not acceptable.
6	NBE	04/30/2013 10:56	Non-Benefit Expenses	For a given contract, does the MA Worksheet 4 Non-Benefit Expense for General Enrollment & EGWP bids need to be the same pmpm?	No. By MA statute, the bid must represent the revenue requirement of the expected population; therefore, the projected non-benefit expenses must be reasonable and appropriate for the circumstances of the bid.
7	MSP	04/26/2013 18:57	MSP Adjustment	The MSP adjustment calculation in page 31 of the bid instructions looks very similar to the MSP adjustment calculation in the CY2013 bid instruction, which was updated at the 4/12/12 user group call. Is the example in the CY2014 bid instructions the correct example that we should follow? Or should we follow the example from last year's user group call?	The MSP example in the CY2014 MA Bid instructions applies when using 2013 MMR data to project a MSP factor for a CY2014 bid.
8	MSP	04/28/2013 10:27	MSP Factor	Page 30 of the MA bid instructions indicate that the MSP factor will be published in the April Rate Announcement of the particular year. I did not see the MSP factor in the April Rate Announcement. The MSP example on Page 31 of the MA bid instructions use a 0.173 factor. Can you confirm that this is the MSP factor for 2014?	The aged/disabled/postgraft MSP factor for 2014 is .173 (updated in the 2013 Rate Announcement). The ESRD dialysis/transplant MSP factor for 2014 is 0.189 (updated in the 2012 Rate Announcement).

User Group Call Date 05/02/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Gain/Loss Margin	04/25/2013 16:23	Margin adjustments in the event of service area expansion denials	In the event that a some portion of a service area expansion is denied after the bid deadline, will you allow plans to make some margin adjustments to accommodate these changes as long as the margins continue to comply with the margin guidance rule in the bid instructions?	When resubmitting a BPT to remove counties due to the denial of a service area expansion after the bid deadline, plans are permitted to adjust the gain/loss margin of the bid as long as all gain/loss requirements continue to be met. Please note this might require margin changes to other plans in order to comply with all gain loss margin requirements.
10	Gain/Loss Margin	04/26/2013 19:49	Adjusted Gain/Loss margin	Page 19 of the MA BPT instructions says that the adjusted gain/loss margin in WS4 must be taken into account when satisfying the gain/loss requirements. The adjusted gain/loss margin is the MA bid margin PMPM plus the Medicaid margin PMPM. For purposes of reviewing the gain/loss margin as a percent of revenue, is this PMPM divided by MA bid revenue PMPM only or the MA bid revenue PMPM plus the Medicaid revenue PMPM? If it is divided by the MA bid revenue only why is the Medicaid margin being added to the Medicare margin?	When calculating gain/loss margin as a percent of revenue, the adjusted gain/loss margin on WS4, which includes Medicaid margin, would be divided by the sum of the MA bid revenue and the Medicaid revenue. In other words, Medicaid is included in both the numerator and denominator of the ratio.
11	Risk Score	04/23/2013 15:15	Risk Scores 2007-2011 Non-PACE	I would like more information on the risk scores shown in the "Risk Scores 2007-2011 Non-PACE.csv" file. The file was included in "calculationdata2014.zip" posted with the 2014 MA rate announcement. 1) Which version of CMS-HCC was used to develop the risk scores? 2) Has the risk scores been adjusted for FFS normalization and MA coding intensity?	1) We blended FFS population risk scores from the 2013 CMS-HCC model and the 2014 CMS-HCC model, as described in the 2014 Announcement (published April 1, 2013), to calculate the risk scores. 2) We did not apply the FFS normalization factor nor the MA Coding Adjustment. These risk scores have been normalized by setting the average within each year to 1.0.
12	OTC Claims and MLR	04/19/2013 11:05	Part D OTC Claims and MLR Calculation	We currently move Part D OTC claims submitted on PDEs for certain plans to the direct administrative expenses in the BPT per instructions. These are claims, but for the MLR calculation they are now being treated as an administrative expense. Although, the bid MLR is for CMS internal purposes, should we create a quality initiative to maintain the MLR's integrity or ignore the issue or follow some other course?	Since OTC costs are not covered Part D drug costs, they cannot be considered incurred claims per the Federal Register 423.2420(b)(i). The plan sponsor would need to make a determination of the extent to which these costs could be considered a quality improving activity by applying the definition in the Federal Register 423.2430.
13	Specialty Tier	04/22/2013 11:00	Specialty Tier	According to the bid instructions, only Part D-covered drugs with plan-negotiated prices greater than $600 per month supply can be placed in the specialty tier. In some cases, while a plan designates a specialty tier, some drugs with negotiated prices over $600 are placed in other formulary tiers (such as preferred brand or non-preferred brand). Therefore, member cost sharing for these drugs is based on the non-specialty formulary tier in which the drugs are placed. When these high cost drugs are placed in non-specialty tiers under the plan's formulary, please confirm that these drugs are to be reported in their respective non-specialty tiers in Worksheets 2, 6 and 6A of the Part D Bid Pricing Tool.	That is correct, these drugs should be reported in their respective non-specialty tiers in the Part D bid pricing tool.
14	Related Party	04/30/2013 14:34	Related Party Agreements	I was reviewing the related party information in the bid instructions, and noticed a significant change. In last year's instructions, it read (emphasis added): A Part D sponsor in a related-party agreement with an organization that does not have an agreement with **an unrelated party** must prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. This year's instructions read (emphasis added): A Part D sponsor in a related-party agreement with an organization that does not have an agreement with **an unrelated Part D sponsor** must prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. Can you please confirm that a related party must have an agreement with an unrelated Part D sponsor in order to be treated as independent. Under this change, a related party that has an agreement for services with an unrelated party that is not a Part D sponsor is required to be treated the same as a related party with no unrelated business.	For medical or pharmacy benefits the unrelated party must be an MA or PD organization. For administrative services, the unrelated party may be a non-Medicare organization but you must be able to demonstrate that the services and fees are comparable.

User Group Call Date 05/09/2013

Considerations for trending Part C and D risk scores

- Include the most recent available annual consecutive calendar year risk scores
- Risk scores used for trending should be raw -- unnormalized and not adjusted for MA coding patterns.
- Risk scores from each year should reflect the same amount of paid claims run out
- Ideally, use final risk scores from each year, or apply a completion factor to the last set of scores to approximate a final score
- Use the same cohort for each year (e.g., the July cohort)
- Ideally, all payment year scores should be estimated using the same model. If possible, use the risk adjustment model for the upcoming payment year, or apply a conversion factor to each payment year's risk scores to convert to a single risk model.
    - The model conversion factor should be plan-specific. It can be generated from the risk scores that CMS sends to plans to support bidding, but plan sponsors should also consider whether other years in their trend may have a different conversation factor, for example if the population mix differs.
    - The conversion factor can be derived by calculating risk scores from a year under two different models. The factor can be a ratio of the scores under each model.
        - The risk scores should have the same runout and be calculated using the same cohort.
        - Plan sponsors should note that when they convert risk scores from one model to another, they are likely also converting between denominator years. The risk scores in the conversion factor should be raw if the factor will be applied to an old-model raw score, which is then projected to the payment year.
- Divide cohorts into meaningful subgroups, and project enrollment in each subgroup to the payment year.
- Weight subgroup risk scores by enrollment in each subgroup per year to arrive at annual risk scores for trending. If projecting enrollee population growth, create subgroups using the same considerations used to determine allowable costs.
- Compare year over year risk scores to obtain a trend factor. Unless the plan is anticipating changes in coding efforts or population characteristics, more than two years of risk scores will help minimize effect of random changes in coding patterns and enrolled population. If deviations from previous trend are expected in the payment year, documentation supporting such changes is warranted.
- Use this trend factor to project from base year risk scores to payment year (raw) risk scores.

User Group Call Date 05/09/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Jimmo v Sebelius Settlement	05/06/2013 23:28	Home Health Care	What is the CMS/OACT estimate of the impact of the Jimmo v Sebelius settlement on home health care expenses for Medicare beneficiaries? Was this adjustment included in the development of the 2014 Medicare Advantage rate book?	OACT did not estimate an impact of the settlement due to the lack of information available. There was no adjustment in the development of the 2014 ratebook.
2	D-SNP Benefit Guidance	04/26/2013 15:29	MA 2014 BPT Question - Dual Eligibles	We have questions on the pricing for our D-SNPs after reading page 14 of the Bid Review and Operations Guidance Memo released in HPMS on April 17th. Our MCO receives capitation from the State Health Department for Medicaid dual eligibles. Our MCO pays providers on a fee for service basis (based on negotiated payment rates) and the dual eligibles have no cost sharing. The capitation covers the cost of benefits that wrap around Original Medicare, as well as the cost of supplemental benefits, such as preventive dental. 1. In accordance with the 4/17/2013 HPMS memo, we would not report preventive dental as being a covered MA benefit in the PBP because it is being funded through the state Medicaid. program Please confirm the following is the treatment of preventive dental in the BPT: a. WS1 – Exclude dental from Section III. Row m Dental (Non-Covered) b. WS1 – Include dental in Section VI. 11.b1. (Associated administrative expenses would be reported in 11.b.2.) c. WS2 – WS4 – Do not include dental on Row m. d. WS4 – Include dental in Section V. 2.a. (Associated administrative expenses would be reported in 2.b.) 2. The State Medicaid capitation covers the cost of wrapping around Original Medicare (for example, covering up to 365 days of hospitalization per year). In the PBP, we would report Original Medicare for cost sharing on A (and B) services. How would we report supplemental benefits wrapping around Original Medicare using Inpatient Facility as an example?	1a and b) If the plan had a dental benefit in the PBP during the base period, the experience for that benefit must be included on Worksheet 1 in Sections III and VI. Use the projection factors in Section IV to remove the benefit from projected allowed costs since the dental benefit would not be in the PBP for CY2014 1c) Correct 1d) Correct 2) Our understanding of the guidance clarified in the 4/17/2013 HPMS memo is that the state-funded wraparound benefits would not be entered in the PBP as mandatory supplemental benefits.
3	TBC	05/06/2013 16:28	TBC Question	If the result of the TBC test is a negative number, does this pass the TBC test and no further action required, or are there special rules or CMS guidelines that require a plan to make changes to produce at least a $0 TBC value?	The plan-specific Adjusted TBC Change must be no greater than the CMS identified value of $34.00 per member per month (pmpm). A negative Adjusted TBC change would be accepted.
4	TBC	05/03/2013 12:18	TBC Calculation for Consolidated Plans	In the "Contract Year 2014 Medicare Advantage Bid Review and Operations Guidance" Memo, released on 4/17/2013, there is the following clarification as to how to evaluate TBC when consolidating plans: "The following describes how the TBC evaluation will be conducted for plans that consolidate or segment from one year to the next: • Consolidating Multiple Plans into One Plan: The enrollment-weighted average of the CY 2013 plans will be compared to the CY 2014 plan. " Can you please clarify what enrollment is used for the enrollment weighting of CY 2013 plans? Is this enrollment from the 2013 BPTs or for 2013 MMR as of a specific month?	The enrollment used for the weighted average of the CY2013 plans is the projected 2013 enrollment in the final approved 2013 BPTs.
5	Rewards and Incentives	05/07/2013 10:30	Preventive Services Incentives	Per bid review and operations guidance, it is our understanding that preventive services incentives are not allowed benefits for 2013 or 2014. We assume these costs would be included as non-benefit expenses, similar to other value added services. However, page 14 of the 2014 MA BPT instructions state the following: "When an incentive program incurs a cost, then this cost must be priced in the bid. For this purpose, the projected PMPM cost of incentives must be combined with the cost of other non-covered benefits and entered in line q of the MA BPT." Please explain why the bid instructions instruct these costs be entered in line q of the MA BPT if preventive services incentives are not allowed as benefits. If these services were covered in 2012, should the 2012 costs be reported in line q in Worksheet 1, but exclude the 2014 cost in Worksheet 2?	Preventive service incentives should be included in non-benefit expenses in the BPT. This is consistent with the response on the April 25, 2013 UGC. The statement in the MA bid instructions is out of date and will be corrected in future releases. If the plan had these incentives in the PBP as a benefit during the base period, the experience must be included on Worksheet 1 in Sections III and VI. Use the projection factors in Section IV to remove the benefit from projected allowed costs since the incentives are not allowed benefits in the PBP for CY2014.

User Group Call Date 05/09/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	Rewards and Incentives	05/06/2013 13:37	RE: Rewards and Incentives	[PARAPHRASED] 1) There appears to be a conflict between page 14 of the MA BPT instructions and a response, provided in the April 25 OACT User Group call regarding whether rewards and incentives should be included in the bid as non benefit expenses or combined with the cost of other non-covered benefits in the MA BPT. Can you please resolve this apparent conflict? 2) If incentives are NBE, are Incentive Program costs considered to be Quality Initiatives? 3) If the incentive program is provided by a related party, are the costs of the incentives and the costs of administering the program treated differently in the BPT (Other non-covered, Quality Initiatives, or Other Direct NBE)?	1) Please see the response to question # 5 above. 2) The plan sponsor would need to make a determination of the extent to which these costs could be considered a quality improving activity by applying the definition in 422.2430 of the MLR rule. 3) The related party guidance applies to the reporting of the incentive program costs.
7	Medicaid Revenue	05/03/2013 9:24	Medicaid Revenue	On page 18 of the CY2014 MA BPT Instructions it discusses the Medicaid Revenue and Costs, it specifically says to only report these amounts if there is a separate contract with a state or territory for Medicaid services. While we offer Medicaid services, we do not have a separate contract. We do not receive the Medicaid revenue directly either. Are we able to leave this field blank based on the above information?	No. If the Plan sponsor does not have a separate contract with a state or territory for Medicaid services for the bid, then enter $0 for the Medicaid values in section VI of MA Worksheet 1 and section V of MA Worksheet 4.
8	Risk Score	05/06/2013 8:11	Risk Scores	How should out of area (OOA) members be handled when projecting PBP level risk scores? Should they be excluded from the risk factor projection, since on MA BPT WS5, the ultimate risk score used for the bid/rebate calculation is a weighted average of all the county level scores, which excludes OOA members? Also, if these members are excluded from the MA risk score projection, should they also be excluded from the PD risk score projection for the associated PD bid in an MAPD plan (to have consistent populations between the two bids)?	There is flexibility in reflecting the impact of out-of-area members in projected risk scores subject to the conditions listed in the MA Enrollment pricing consideration. OOA members may be excluded from the risk score projection, only if the certifying actuary determines that the difference between the projected risk scores for out-of-area members and other members is not significant. No. Do not exclude the impact of out-of-area members from the Part D risk score projection.
9	Risk Score	05/02/2013 11:50	RE: Missing Data adjustment	[PARAPHRASED] On the 4/25/13 UGC I asked if the 2013 CMS-HCC model includes the codes that only trigger a 2013 payment for the ESRD membership to which you responded "No." I am thinking that probably all plans who filtered their RAPS data, did so where these additional codes would not have been filtered because they trigger payment under the ESRD model. Therefore if CMS's data adjustment assumes these codes were filtered, the missing data adjustment would be overstated for most if not all plans. Can CMS re-run the data assuming these codes were not filtered and publish the resulting missing data adjustment factor?	Some MAOs may include in their filtering algorithm those diagnoses that map to the ESRD model. The ESRD model includes more diagnoses than the 2013 CMS-HCC model. We note that the 2014 CMS-HCC model includes a subset of the diagnoses in the ESRD model. Therefore, if an MAO filters the diagnoses that they submit to CMS using diagnoses that map to all three models for all enrollees – CMS-HCC, RxHCC, and CMS-HCC ESRD models -- then the risk scores CMS sent to plans for bidding may be complete. The missing coding adjustment factor is intended to be used to assist plan sponsors prepare their risk scores for bids when their risk scores are incomplete.
10	Risk Score	05/02/2013 14:45	Part D Risk Scores	CMS released a second version of the Part D beneficiary files on April 24. Is there going to be an update to the plan level risk scores files in HMPS or were the plan level files not impacted?	The plan level risk score files were updated in HPMS on April 25th. The change to the Part D file may affect your ESRD New Enrollees, but none of the other risk scores changed. Given the small number of enrollees' risk scores that this update may have changed, the impact on plan-level risk scores was small. In effect, some plans may not see a change in their aggregate plan-level estimated New Enrollee Part D risk scores posted in HPMS.
11	Risk Score	04/23/2013 16:33	Part D risk score trend	To estimate our actual PDP risk score trend for 2012-2013, we've taken the "un-normalized" 1Q2013 average risk score divided by the "un-normalized" 1Q2012 risk score. The calculations are based off of PDE data paid through 3/2013. Is there any adjustment necessary to account for model changes between 2012 and 2013 that may be imbedded in the PDE data, or is the calculation as outlined sufficient for trend calculation?	Please review the considerations that CMS has provided in the introductory note. Among the considerations to take into account, we will note that it would make sense to get the risk scores on the same model basis, and to make sure that the runout for both scores is the same.
12	PD Plan Type	05/02/2013 19:51	Basic vs. Alternative Plan Classification	If a plan has $0 supplemental premium but provides more coverage in the gap than a defined standard plan, should it be classified as basic or enhanced alternative in the PBP and Bid?	By definition, an alternative plan with no supplemental premium is a basic alternative plan.
13	PD WS1	05/07/2013 11:31	Question for CMS Reporting Base Period Tier in PD BPTs	Part D 2012 claims that were processed and paid in 2013 had the wrong tier reported in the PDEs, even though the claims were adjudicated correctly. Our PBM is working on correcting the issue, but we need to know what to report in the BPTs. For 2012 claims with 2013 paid dates, do we use the tier reported in the PDEs or do we use the tier on which the claims were adjudicated?	Report the base period experience on Worksheets 1 and 2 according to the formulary tier on which the claims were adjudicated. The supporting documentation for the development of the base period experience, uploaded with the initial bid submission, must include qualitative and quantitative substantiation for the adjustment to the PDEs.
14	Projection Factors	05/03/2013 16:36	Dual demonstration question	When adjusting the 2014 bid for members we expect to lose in the dual demonstrations, should we adjust the utilization through the "Risk Change" factor on Worksheet 2 and the unit cost through the "Other Change" factor on Worksheet 2?	Yes, this is a reasonable approach. Refer to Appendix B in the Instructions for Completing the Part D BPT for the supporting documentation requirements for trend projection factors and upload it with the initial bid submission.

User Group Call Date 05/09/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
15	New Tier Structure	05/06/2013 20:08	New Specialty Tier	When a Part D plan goes from two tiers (generic and brand) in 2012 to adding a third tier for specialty drugs in 2014, how should that be represented in worksheet 2, section II, columns e, f, and g of the BPT? Since there is no additive column for the projection period, we are specifically looking for guidance as to what should be in the Retail Specialty row in columns e and f. Should we populate those cells with the base period experience for the drugs that are in the specialty tier in the *2014 formulary*, even though those drugs were in the preferred brand tier in the base period?	Report the base period experience on Worksheet 1 and Section II, columns e, f and g of Worksheet 2 according to the formulary tier on which the claims were adjudicated and without adjustment. Use the Components of Utilization and Cost Change, or projection factors, in Sections II and III of Worksheet 2 to remove the cost and utilization of the drugs that will be on the Specialty tier for CY2014 from the base period experience. Provide a manual rate for the Specialty tier in Section IV of Worksheet 2. Refer to Appendix B in the Instructions for Completing the Part D BPT for the supporting documentation requirements for trend projection factors and manual rate development and upload it with the initial bid submission.

User Group Call Date 05/16/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Catastrophic Claims	N/A	N/A	[PARAPHRASED] There is one member in our MAPD plan in 2012 and 2013 who has a complex condition and incurred about $2.5 million in allowed drug expenses in 2012. We expect this member to continue to incur claims at a similar level in 2014. This claims experience is causing our 2014 PD member premium to increase significantly above the 2013 amount. Are plan sponsors allowed to use large claim pooling techniques to account for experience which includes catastrophic claims? Can you provide any guidance on this issue?	One solution, is to obtain reinsurance from an external reinsurer. Another acceptable solution is self-insurance where the Net Cost of Reinsurance line on the Bid Pricing Tool would reflect the net cost of the self-insurance. The following would be required: • Supporting documentation submitted with the bids must demonstrate that the self-insurance is net revenue neutral across the pool of plans (i.e. pooling charges equal pooling claims). • The pool of plans must be clearly defined and the self-insurance consistently applied to all plans in the pool. The definition must state the attachment point, state the criteria for which plans participate in the pool, and state any other relevant considerations. • The pool should consist only of claims in excess of the attachment point and should only include the incurred plan liability (i.e. not claims already covered by federal reinsurance through Part D) • The pooling charges must be developed and applied to all plans participating in the defined pool and all members included in the plans, regardless of whether or not a plan or member actually had any pooled claims during the base period. Please note this response is applicable to both MA and Part D and is an update to guidance provided on the 5/19/2011 User Group Call.
2	Gain/Loss Margin	05/13/2013 17:43	MA Bid Question - Margin	[REVISED TO ADD CONTEXT] The aggregate-level margin requirements for general enrollment plans and I/C SNPs margins on Page 27 of the MA bid instructions state that "If the volume of the Plan sponsor's non-Medicare health insurance business for which it has discretion in rate setting is greater than or equal to 10% of the Plan sponsor's total non Medicare health insurance business (including Medicaid), then the aggregate margin, as measured by a percentage of revenue, must be within 1.5 percent of the Plan sponsor's margin for all non-Medicare health insurance lines of business. 1. Please discuss the meaning of the phrase "discretion in rate setting". Would rates that are set by the State (like Medicaid in some states) be considered business where no discretion is available to the insurer? What if the insurer is required to bid, but within a narrow range? Or renew within a narrow range, again typical of a Medicaid product. Other states permit bidding, but then establish a contract rate (such as median of all viable bids), which is then the rate that is paid to the insurer - this median is not an amount that an individual insurer has discretion upon. How would such a rate be interpreted for purposes of the MA instructions? 2. When determining that the aggregate margin for general enrollment plans and I/C SNPs margins is within 1.5 percent of the Plan sponsor's margin for all non-Medicare health insurance lines of business, should the non-Medicare lines of business exclude business for which the insurer does not have discretion in rate setting?	1. Rates that are fully set by the State (like Medicaid in some states) are considered rates for which the Plan sponsor does not have discretion for rate setting and such business does not count towards the 10% threshold. On the other hand, the other examples in the question are considered rates for which the Plan sponsor does have discretion for rate setting and such business will count towards the 10% threshold. 2. No. Do not exclude any non-Medicare business from the 1.5 percent comparison to the Plan sponsor's corporate margin as represented by the Plan sponsor's margin for all non-Medicare health insurance lines of business. The consideration of whether or not the Plan sponsor has discretion in rate setting determines which approach to follow to demonstrate consistency with the corporate requirement, but does not affect the lines of business included in the comparison itself.
3	Gain/Loss Margin	05/08/2013 2:09	question for actuarial bids user group call	We have 2 questions regarding the Gain Loss Margin requirement of the D-SNPs. 1) Would CMS consider membership level as exceptions in applying the +1%/-5% gain/loss consistency requirement between D-SNP and GE&I/C plans? When a sponsor has very limited membership in a D-SNP plan, e.g., 1 D-SNP plan with <3% of overall membership, would CMS still compare the D-SNP margin for the <3% membership with the GE&I/C margin for the 97+% membership? 2) The second question is regarding the situation where there is uncertainty in the State's MIPPA contracting for 2014 as of June 3rd. The plan sponsor has received MIPPA contracts from the State in the past for its multiple D-SNPs. When the plan sponsor submits multiple D-SNP bids by June 3rd for 2014, the State may not have issued its MIPPA agreement for 2014. In the event that the State decides after June 3rd not to issue a MIPPA contract for 2014, the plan sponsor has to withdraw some of its D-SNP bids by July 1st. Please clarify whether the gain/loss margin documentation submitted on June 3rd is supposed to be based on the set of plans/bids submitted on June 3rd.	1) CMS will not waive the comparison of the aggregate D-SNP margin to the aggregate margin for GE&I/C plans based on the relative volume of membership. However, if the claims experience of the D-SNP plan(s) at the level of aggregation chosen, as indicated in the BPT, is less than fully credible, CMS would consider a fully supported exception to +1%/-5% gain/loss margin consistency requirement. In this case, the justification for the exception would need to demonstrate that the unduly high or low D-SNP margin is due to credibility rather than plan design, and the aggregate D-SNP margin is expected to be within the required range over a reasonable period of time. 2) All gain/loss margin requirements, including supporting documentation, must be met in the initial bid submission based on the set of plans/bids submitted on June 3rd. If any plans/bids are withdrawn, the supporting documentation and remaining bids must be updated, as necessary, in order for the remaining bids to satisfy all gain/loss margin requirements.
4	Quality Initiatives	05/09/2013 13:06	Quality Initiative	If a plan has some staff positions or cost centers that balance their time between quality functions as defined by CMS and some that would not qualify as quality expenses, but they do not have rigorous time studies supporting the allocations, are they obligated to report quality initiative expenses? Can the amounts be estimated? Can they elect to leave these amounts blank if they are pricing sufficiently above the 85% loss ratio standard so that a refund is unlikely?	Plan sponsors/actuaries are obligated to comply with all bidding requirements, including the reporting of quality initiatives, whether or not they have rigorous time studies for such expenses, and regardless of the level of the projected BPT or Medicare MLR. Plans should provide their best estimate of quality initiatives in the bid with reasonable effort and document the estimate accordingly.

User Group Call Date 05/16/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
5	Projection Factors	05/09/2013 12:22	obligation to make a population change adjustment?	If there is a small subset of a plan's population ~5-6%, that has left or will leave the plan between the base period and contract year, and that population has health characteristics that are not average for the plan, is the actuary required to make a population change adjustment if in the actuary's judgment the impact is immaterial and/or likely to be offset by new members that are entering the plan that have characteristics similar to those departing?	The certifying actuary must use their best judgment in estimating and supporting the impact of a change in population consistent with bid instructions and ASOPs. In this example, a factor of 1.0 may be appropriate and the actuary should document the reasons that the factor is 1.0
6	Rebate Reallocation	05/09/2013 15:16	Rebate Reallocation	Are we allowed to change the MOOP during the rebate reallocation period?	Yes, a change to the MOOP is permitted during rebate reallocation, if this change aligns with the situations described in Appendix E of the bid instructions. Please note that all requirements such as TBC, meaningful difference, and service category cost sharing requirements would still need to be satisfied.

User Group Call Date 05/23/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Quota Share Reinsurance	05/08/2013 18:40	BPT Question - Quota Share Reinsurance	If a plan has entered into a quota share (proportional) reinsurance treaty, some portion of the gross profit would be expected to accrue to the reinsurer. For example, if the reinsurer takes a 50% share, the reinsurer would receive 50% of the revenue, pay 50% of the claims and administration, and expect to earn 50% of the resulting margin. Would that margin paid to the reinsurer be included in Net Cost of Reinsurance, or would it be ignored for purposes of the bid. In other bids, if in this example the plan is priced to earn a 3% gross margin, would the plan put 1.5% into Net Cost of Reinsurance and keep 1.5% in margin, or keep all 3% in margin?	The bid for this proportional reinsurance arrangement should be completed with 1.5% in the Net Cost of Reinsurance and 1.5% in margin.
2	Part D MLR	05/15/2013 17:49	Part D Loss Ratio	1) Can the Part D loss ratio be less than 85% if it is greater than 85% when Federal Reinsurance is added in? 2) Can the Part D loss ratio be less than 85% if the combined MA-PD Part C and D loss ratio is greater than 85%?	1) Yes 2) Yes Note that as stated in the bid instructions CMS will not automatically disapprove a bid containing an MLR that is less than 85%. But, CMS's expectation is that the gain/loss margin will be set with appropriate consideration for the need to remit funds to CMS if the Plan sponsor's actual claims experience fails to meet the minimum Medicare MLR requirement.
3	Optional Supplemen-tal	05/20/2013 4:01	Bid questions - optional supplemental	The MA BPT instructions outline two gain/loss margin and NBE requirements both of which are determined at a "enrollment-weighted contract-level". Please clarify whether the contract-level calculations will include all optional supplemental packages a contract offers, or at a package number level (i.e., all the package #1s, #2s, etc.).	When assessing compliance with the requirements for retention and gain/loss margin for optional supplemental benefits, all packages offered under the contract are included.
4	Gain/Loss	05/18/2013 21:18	MAPD bid question	[PARAPHRASED] The gain loss requirements in the bid instructions state the following: "For both general enrollment plans & I/C SNPs and D-SNPs, the gain/loss margins entered in the BPTs must comply with the aggregate-level margin requirements at one of the following three levels: contract level, organization level (that is, the legal entity that contracts with CMS to provide MA benefits), or parent-organization level." The instructions specifically reference "the gain/loss margins entered in the BPTs" – are the gain/loss margins taken directly from the BPTs the margins that should be used in the MA vs. other lines of business aggregate margin test, without any additional adjustment (e.g. adjustment if sequestration is assumed in the bid). Given the difficulties plans are facing with margin relative to revenue compression in 2014, will CMS grant some flexibility in the interpretation of whether these margin tests are before or after sequestration?	Margin requirements must be met with the gain/loss margin entered in the BPT, including any sequestration impact that has been incorporated into the gain/loss margin.
5	Gain/Loss	05/18/2013 21:20	MAPD bid question	I question whether the aggregate margin requirement for MA vs. non-MA business needs to be revised from its current form. As stated in the bid instructions, the gain/loss margin requirements "are designed to ensure that gain/loss margins are reasonable and that an MA organization's MA business is not used to subsidize its other health insurance lines of business." Given that fact, it would be appropriate for the aggregate margin rule to require that aggregate MA margin be no more than 1.5 percentage points above non-MA margin rather than within 1.5 percentage points on either side. Given the degree of revenue compression in MA related to ACA and HCC risk model changes, plans may choose to operate with lower margins on MA business relative to their non-MA business, and should be allowed to do that without pulling their non-MA business margin down to within 1.5 percentage points of that MA margin. Will CMS allow this?	No, it is not appropriate to modify the 1.5% margin requirement. Not subsidizing non-Medicare health lines of business is one of several gain/loss margin requirements. The MA statute requires the MA bid to represent the revenue requirement for the expected population. Choosing to operate at a lower margin may not comply. The demonstration of being within 1.5% of non-Medicare health lines of business can be done over a longer term period (3 to 5 years).
6	Incentive Programs	05/20/2013 7:43	Incentive Programs	Appendix B of the MA Instructions still requires the provision of supporting documentation of incentive programs for preventive services. Since this needs to be included in administrative expenses and not Worksheets 1 and 2, line q for 2014, is this still required?	Since the costs for these programs must be reflected in the non benefit expense portion of the BPT for 2014 (as stated in responses on the 4-25-2013 and 5-9-2013 UGC), the supporting documentation for NBE must explain the development of these costs.
7	NBE	05/20/2013 12:13	24-hour nursing hotline treatment	We are currently categorizing all of our 24-hour nursing hotline expenses as direct admin, under non-benefit expenses. Is this generally the proper place to account for expenses associated with this type of program, and are there any circumstances under which part of the cost of the program would be properly moved to a benefit expense category?	A nursing hotline is included in PBP category 14c as a Supplemental Education / Health Management Program. It may be priced as a non-covered benefit depending upon the nature of the service provided. Use your best judgment and prepare the required support for the pricing of this benefit including the rationale for including the entire cost as a non-benefit expense, if applicable.
8	MSP	05/14/2013 16:59	MSP recovery improvements	If we anticipate improvements in MSP recoveries in the contract year vs. the base period year, can we treat the improved recoveries thru a WS 2 manual rate adjustment for COB/Subrogation?	No. Use the projection factors in Worksheet 2 to reflect changes in MSP recoveries. Enter the factors by service category in lines a through q or in line r for COB/Subrogation depending upon whether the MSP claims are paid net of the primary party's liability or handled outside the claims system, as explained in the Coordination of Benefits (COB)/Subrogation pricing consideration.

User Group Call Date 05/23/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
9	Rebate Reallocation	05/20/2013 15:19	LIPSA - Rebate Reallocation	If the Target Part D Basic Premium is the LIPSA and our Part D Basic Premium after Part D Benchmark Announcement is less than LIPSA, and we have allocated $0 Part C rebates to buy down our Part D Basic Premium, (1) do we need to return to the targeted LIPSA? (2) if we return to LIPSA, what is the Low Income Premium Subsidy that these members will get? Let's say our Part D Basic Premium is $35 and LIPSA is $38, and we need to add AB Supplemental Benefits of $3 to get back to $38 (so there is a AB Supplemental Premium of $3 and Part D premium of $35). Do LIS members get a Low Income Premium Subsidy of $35 or $38?	1) No, you do not need to return to the targeted LIPSA. 2) The premium target is for the Part D basic premium, not total premium. You would not increase A/B supplemental benefits to increase the total premium to $38. The subsidy in this case would be $35, equal to the Part D basic premium.
10	Part D NBE	05/20/2013 11:24	Part D Admin	For 2012, instead of paying an administrative fee to the PBM, there was a shared savings arrangement. In this shared savings arrangement, the actual discount achieved was compared to a benchmark discount to determine the claims "savings". Half of these claims savings were then paid to the PBM. Can you confirm that the amount paid to the PBM should be included in Part D admin instead of claims?	Yes, the amount paid to the PBM is considered non-benefit expense in the BPT.
11	Related Party Pharmacies	N/A	N/A	If a Part D sponsor contracts with a related-party pharmacy, does the related-party guidance apply to the drug costs? If so, how?	Yes, the related-party guidance applies to the situation where the dispensing pharmacy is a related party to the Part D sponsor. If the related-party pharmacy is unable to demonstrate that comparable rates with unrelated Part D parties are available, the Part D sponsor must complete the bid in a manner that reflects all of the gain or loss of the related-party pharmacy as those of the Part D sponsor, including any gain or loss that the pharmacy experiences from any mark-up over the acquisition cost of the drugs dispensed. In accord with the INSTRUCTIONS FOR COMPLETING THE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2014, a Part D sponsor in a related-party agreement must provide disclosure of every related-party agreement, and a summary that explains the relationship of the parties involved and common ownership, control and investment. For each agreement, the sponsor must provide a summary of the contractual terms of each relationship that includes a description of the services provided and money exchanged, and a description of the approach used to report the gain/loss margin and non-benefit expense of the related-party organization in the bid. A Part D sponsor that chooses to demonstrate that the terms and fees associated with their agreement are comparable to those obtained by unrelated Part D sponsors of similar size and market position must provide a written summary outlining the terms of the actual contracts between the subcontractor and the comparable, unrelated parties for similar services, and demonstrate that the financial arrangements between related parties are not significantly different from those that would have been achieved by the Part D sponsor in the absence of the related-party relationships.
12	Insurer Fees	N/A	N/A	In follow up to the question addressed on the 4/25/2013 user group call regarding the treatment of the insurer fee, what is the appropriate treatment of the fee in the BPT?	The expected fee paid by the plan sponsor to the government should be reported in non-benefit expenses. In the example presented in the question on the 4/25/2013 user group call if 1.365% is the expected fee amount, that is what is entered in non-benefit expenses. Any income tax impact of the fee should be handled in a similar manner to how income taxes are reported in gain/loss margin.

User Group Call Date 05/30/2013

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Seques-tration	05/23/2013 19:00	Sequestration Impact on MA BPTs	We have a question about how to reflect sequestration in the MA BPT. Our plan is able to reduce payments to providers based on their contracted arrangements due to sequestration. This 2% reduction takes place on the net paid amounts after actual plan level member cost sharing. The bid tool does not allow for this to be done appropriately without some inaccuracies in the cost sharing on WS3 and the FFS AE cost sharing calculation and actuarial equivalence tests on WS4. How would you prefer us to show the impact of sequestration in the BPT?	Adjust the unit cost projection factors on worksheet 1 so that the net paid amount reflects the 2% reduction to provider reimbursements. Worksheet 3 should reflect the actual expected PMPM beneficiary cost sharing. Note that for coinsurance cost sharing, plans might have to artificially adjust the coinsurance percentage on worksheet 3 in order to reflect the accurate PMPM value. As for the actuarial equivalence tests on WS4, if the plan were to fail these tests due to the circumstances described in the question, and the plan's approach was detailed in the supporting documentation, CMS would consider these on a case by case basis.
2	Rebate Reallocation	05/28/2013 14:46	LIPSA Target	[PARAPHRASED] Scenario: A plan has an EA benefit and uses MA rebates to buy down the supplemental premium to $0 and the Basic premium to the LIPSA estimate. The Part D basic premium post-benchmark is greater than the LIPSA and the MA organization has allocated all of the MA rebates (after buying the supplemental premium to $0) to the Part D basic premium. Further, the difference between the Part D basic premium post-benchmark and the LIPSA is between $0 and the de minimis amount. Please confirm that in the scenario presented above, the MA rebates originally used to buy down the Supplemental premium to $0 can still be applied to buy down the Supplemental premium and all remaining MA rebates must be used to buy down the Part D basic premium. Then if the difference between the LIPSA and the resulting Basic premium is between $0 and the de minimis amount, the MA organization may volunteer to waive the portion of the Part D basic premium equal to the difference.	If the plan is allocating rebates to anything besides the Part D basic premium, then it is not eligible to elect de minimis. In the case where the total rebate amount available is insufficient to fully buy down the Part D basic premium to the LIPSA and the resulting premium falls within the de minimis amount, the plan would be eligible to elect to waive the de minimis premium. The plan would have a Part D supplemental premium though.