# User Group Call Date 02/26/2015

## Introductory note

1) 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

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | RxHCC Model Normalization Factor | Question from CMS-sponsored call on 2/24/2015 discussing the 2016 Advance Notice and Draft Call Letter | N/A | Is the 0.939 preliminary 2016 normalization factor for the Rx Hierarchical Condition Category (RxHCC) model accurate? | Yes – the preliminary 2016 normalization factor for the Rx Hierarchical Condition Category (RxHCC) model is 0.939 as published on February 20, 2015 in the "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 Medicare Advantage (MA) Capitation Rates |
| 2 | Proposed Risk Score Credibility Guidance Starting CY2016 | N/A | N/A | We have a presumption that that risk scores are fully credible even down to a relatively few number of members. Does CMS have any comments? | The CMS analysis was based on a specific methodology and set of assumptions to determine credibility. Our approach did not separately evaluate the effect of process risk. We believe that a more robust approach may result in a lower threshold for full credibility; however, we believe that our results serve as a reasonable credibility guideline under the given assumptions. The certifying actuary has the responsibility to choose and support the level of credibility used in bid pricing. |
| 3 | Proposed Risk Score Credibility Guidance Starting CY2016 | N/A | N/A | Do the risk score credibility guidelines apply for Dual SNP plans or a large influx of new enrollees? | The CMS guideline is based on data from a broad population, including SNP and non-SNP plans; including data from all beneficiaries combined (community, institutional, and new enrollee). The certifying actuary should determine whether or not the CMS guideline is appropriate for a specific type of population. In making this determination, we suggest reviewing the synopsis of how CMS developed the guideline for full credibility. |
| 4 | Proposed Risk Score Credibility Guidance Starting CY2016 | N/A | N/A | Is it appropriate to blend the claims and risk scores at different percentages, given that the guidelines for claims credibility and risk score credibility are different, but are applied to experience from the same membership? | It is not inconsistent to blend risk scores and claim amounts at different credibility percentages because the underlying distributions of these two variables is different. Risk scores and claim amounts are not perfectly correlated. |
| 5 | Proposed Risk Score Credibility Guidance Starting CY2016 | N/A | N/A | Is the risk score guideline appropriate for alternate methods? | The CMS risk score credibility guidelines were developed for projected risk scores based on the CMS preferred methodology. CMS has not developed credibility guidelines for risk scores based on alternate approaches or for CMS-HCC ESRD risk scores. We will revise our guidance. The Beta bid instructions include this specification. |
| 6 | Proposed ESRD Claims Credibility Guidance Starting CY2016 | N/A | N/A | Does the ESRD credibility guidance apply to the entire ESRD population of a plan, i.e., all phases of ESRD population, including dialysis, transplant, and post graft? | The ESRD claims credibility guideline was developed using historic costs for the entire ESRD population as one pool of experience. CMS did not separate the experience into dialysis, transplant, or post graft. The guideline should be applied to the entire ESRD population of a bid. |
| 7 | Proposed ESRD Claims Credibility Guidance Starting CY2016 | N/A | N/A | Is CMS implying a change in completing the ESRD subsidy section on MA Worksheet 4 by introducing the ESRD credibility guideline? | The proposed ESRD credibility guidance will not change the instructions to complete the ESRD subsidy section on MA Worksheet 4. The ESRD credibility guideline is just a resource that may be used if you choose to complete the ESRD subsidy section. Your options are–<br>1) Don't complete the subsidy section, OR<br>2) Complete the subsidy section and use the credibility guideline, OR<br>3) Complete the subsidy section and don't use the CMS credibility guideline (and instead make your own determination for credibility). |

# User Group Call Date 04/16/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | USPCC Trend | 04/12/2015 13:24 | impact on trend of baby boomers | Last year, OACT gave us the following helpful information on the impact of baby boomers on trend on the 2/25/2014 call about the advance notice:<br><br>Q: What is impact of demographic changes (i.e., impact of baby boomers)?<br>A: -0.7 to -0.8% per year for Part A, smaller for Part B -0.2%<br><br>Can we get a similar estimate of the impact on the trend for the period 2014 to 2016? | The estimated annual impact of demographic changes on 2014-2016 FFS USPCC trend is -0.5 percent on Part A and -0.1 percent on Part B. |
| 2 | FFS Rates | 04/10/2015 21:23 | Assumptions for Rebasing FFS Rates | Was the reimbursement for new Chronic Care Management coding considered in the rebasing of FFS claims for the 2016 county rates? The Announcement only mentions DME and DSH funding changes. | The repricing of FFS claims for the 2016 ratebook does not include the Chronic Care Management CPTs. |
| 3 | Sequestration | N/A | N/A | When completing the BPT to reflect sequestration, how should cost sharing and allowed costs be calculated? | If the MAO reduces claim payments by 2 percent because of sequestration, then the affected claim amounts in the BPT should be completed according to the following example: Assume that allowed costs equal $500 PMPM, cost sharing is 20% of allowed costs, and there is a $0 dollar impact of the MOOP. For purposes of completing the BPT, net PMPM equals $500 × (1.00 – 0.20) × (1.00 − 0.02) = $392. The PMPM cost sharing in the BPT is $500 × 0.20 = $100. Allowed costs in the BPT are entered as the sum of the net PMPM and PMPM cost sharing, which is $392 + $100 = $492. |
| 4 | Sequestration | 04/07/2015 19:05 | Sequestration in 2016 | Please confirm that 2% cut of sequestration should be assumed in 2016 contract. If so, the profit margin presented on the BPT will be inflated by 2% as the actual payment from CMS will eventually be cut by 2%. | To account for sequestration during the projection period, net medical expenses must reflect the impact of sequestration on provider payments. Similar modifications must be made to base period data to the extent that sequestration affected actual provider payments.<br><br>As stated in the bid instructions and required by statute, the bid must represent the revenue requirement of the expected population. The law concerning sequestration does not change this fundamental bid requirement, so the margin amount entered into the BPT must be the plan's full revenue requirement. When applied, sequestration reduces plan revenue such that the amount of revenue actually received will be less than a plan's full revenue requirement. The full revenue requirement entered in the BPT, including the margin, is reviewed to ensure compliance with the standards described in the instructions. |
| 5 | DE# plan reimbursement | N/A | N/A | On the MA BPT Worksheet 4, Section B, Column K is labeled "State Medicaid Required Bene. cost sharing". What information should be reflected in this column? | Per page 24 of the MA Bid Instructions, "In column k, the "Medicaid Cost Sharing" reflects the cost sharing that the beneficiary is liable to pay." Thus this column should show the cost-sharing liability of the beneficiary.<br><br>For example, if the State defines DE# beneficiaries as QMB or QMB+ beneficiaries only, because these members are exempt from cost sharing, the "State Medicaid Required Bene. cost sharing" values would be zero. In another example, if the state expands the types of dual-eligible beneficiaries, for which it offers reduced-cost sharing, and the state requires some cost sharing from this expanded group, then Worksheet 4, Section B, Column K must reflect the cost sharing for those beneficiaries on a Per DE# member per month basis. |
| 6 | EGWP Additional Benefits | 03/12/2015 16:08 | bid question for egwp | The CY2016 MA Bid Instructions on page 28 state:<br><br>"When some benefits offered by the MAO are funded by an outside source (such as an employer group), the gain/loss margin must be consistent between the Medicare benefits and benefits funded by other sources. However, for the Platino program, the MAO may request exceptions to the gain/loss margin requirements for unique situations that are fully explained and supported."<br><br>As the terms "benefits" and "consistent" are used in this sentence, I am interested in (1) what counts as a benefit – is it just the addition of a new service or can it also be a change in the benefit design itself, for example, reducing co-payments? And (2) what does it mean to be consistent? For example, if an employer/union's decides to offer richer benefits to its EGWP members, how closely must the gain/loss margin for the basic MA EGWP benefits in the PBP compare with the margin on the benefits added and paid for by the employer/union? | 1) Both the addition of a new service and an enhancement to benefits is considered a benefit. In the terms used on the Bid Pricing Tool (BPT) both "Additional Services" and "Reduction in A/B Cost Sharing" are considered benefits.<br><br>2) When completing the underwriting for any one group, we expect that the underwriter would apply one margin value for the full benefit package. That is we expect the margin to be the same for both the Medicare covered and the supplemental benefit components of the pricing. We also expect that when all groups are aggregated together, the margin in aggregate is consistent with the margin in the bid.<br><br>Further, as stated on page 117 of the CY2016 MA bid instructions, "The pricing in the bid must reflect the expected underwriting assumptions for all groups, in aggregate, that is, . . . Each EGWP bid must reflect the composite characteristics of the individuals expected to enroll in the EGWP for the contract year, across all groups. These characteristics include, but are not limited to . . . gain/loss margins.". |
| 7 | WS1 Reporting for Crosswalks | 04/10/2015 14:21 | Question Regarding Experience Reported in Worksheet 1 | We have members that were crosswalked from 2014 plans to new plans/segments in 2015. In 2016, a new segment is being added and members from a current 2015 segment are being crosswalked to the new segment. However, few members are being crosswalked to the new segment. Even after setting a relatively low significance threshold for membership reported in WS1 due to crosswalking, no experience would be reported in WS1 for this new segment due to the insignificant amount of membership from the original 2014 plan that are being crosswalked. Is leaving WS1 blank acceptable in this case despite the two-year crosswalking? If not, what should be reported? | If the proportion of membership in each 2014 bid that was cross-walked to the new CY2016 segment is insignificant, then the experience data in Sections III and VI are not reported in Worksheet 1 of the new CY2016 segment. |

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| 8 | WS1 Reporting for Crosswalks | 04/14/2015 10:56 | Questions for OACT User Group Call | On slide 7 of the CMS Actuarial Bid Training #6: Base Period Experience, Data Aggregation, and Credibility it is stated that, "the requirements for aggregating base period data may depend on whether or not enrollment changes apply to a 'significant proportion' of members in the bid from which the members are moving." This language is not consistent with the PD approach for data aggregation which states on slide 8 that, "for Part D, any proportion is considered significant." For MA-PD plans with crosswalks that do not meet the MA significance threshold, this implies that the MA and PD BPTs might have a different set of plans in reported base period experience. If plan listings or member month totals do not match between MA and corresponding PD BPTs, will this cause any problems uploading the bids to HPMS? | No, plan listings and member month totals are not critical validations for the HPMS upload of bids. |
| 9 | WS1 Reporting for Crosswalks | 04/14/2015 10:56 | Questions for OACT User Group Call | In the CY 2016 MA BPT Instructions, Data Aggregation: Rule 1, it states that, "If members are cross-walked one year and dis-enrolled the following year, then Rule 4 applies." Do we also apply Rule 4 if there is a bid that has a service area reduction in one year and a formal-crosswalk in the following year or simultaneously in the same year? For instance, bid 001 has 1000 members in CY 2014. Bid 001 has a service area reduction in CY 2015 removing 900 of the members. In CY 2016 bid 001 formally crosswalks into bid 002. Do we need to evaluate for significance to see if bid 001 should be included in WS1 reporting of bid 002? Do we need to evaluate for significance if the service area reduction and crosswalk both occurred during the same year? | A verbal response of "yes to all" was given live on the 4/16 call. However, upon further examination we do not believe there is enough information to give a definitive answer at this time. We will read and post a response to this question on the 4/23 user group call after acquiring more information from the questioner. |
| 10 | WS1 Reporting for Crosswalks | 04/14/2015 10:56 | Questions for OACT User Group Call | In Appendix L, we believe that crosswalk Example 1 is incorrect as stated. Can you confirm that the second bullet should also indicate that Plan 003 should also be included in Plan 003's base period experience. | Yes, in Example 1, report base period experience for both plan 001 and plan 003 in the plan 003 BPT. |
| 11 | Gain/Loss | 04/14/2015 10:56 | Questions for OACT User Group Call | If a plan has an existing negative margin business plan with 2 years remaining until it reaches its original 5 year deadline for achieving positive margin, we would like clarification on how the deadline for achieving positive margin is affected if it is split into multiple segments in 2016, some of which have negative gain margin. What is the deadline for the segments with negative margin to achieve positive margin? | The original deadline applies for each segment. |
| 12 | Rebate Reallocation | N/A | N/A | Appendix E of the MA BPT instructions indicated that changes in MA pricing assumptions as a result of rebate reallocation must be consistent with the pricing approach and methodologies supporting the initial June bid submission. Appendix E lists the pricing examples of induced utilization and insurer fee. We interpret this statement to also include changes in capitation and risk sharing payments consistent with the pricing methodology in the June bids. Can CMS confirm this interpretation? | Yes, examples of acceptable MA pricing changes as a result of rebate reallocation include changes in capitation and risk sharing payments consistent with the pricing methodology in the initial June bid. We have provided clarification on this issue in the online bidders training. |
| 13 | Rebate Reallocation | N/A | N/A | In Appendix E, page 119, we appreciate the new provision, "Changes in MA pricing assumptions as a result of rebate reallocation must be consistent with the pricing approach and methodologies supporting the initial June bid submission." The bottom of page 132 lists some examples of permissible assumption changes.<br><br>Part of our Non-Benefit Expense (NBE) assumption is an uncollected member premium load that is calculated using a step function (e.g. $0.25 PMPM load if member premium is between $0.01 and $10, $0.50 if member premium is between $10.01 and $50, etc.). Assuming we use the same step function during initial submission and rebate reallocation, would we be permitted to change this PMPM load in our NBE during rebate reallocation to reflect any changing member premium? | Yes, examples of acceptable MA pricing changes as a result of rebate reallocation include changes in non-benefit expenses calculated under a step function consistent with the pricing methodology in the initial June bid. |
| 14 | MA Related Party | 03/19/2015 21:12 | Related Party Contracting Question | 1) Are plans allowed to enter into contracts with their related party provider for less than 95% of FFS plus incentive payments that could result in the total payments to 95% of FFS or more (but not more than 105% of FFS) if certain utilization targets are met? For example, could the plan pay the related party provider 90% of FFS as long as the provider has the opportunity to receive additional bonus payments that bring the total payment to at least 95% of FFS (but no more than 105% FFS)?<br><br>2) If so, are there limits to how low the base payment may be as a % of FFS?<br><br>3) Is the answer the same regardless of whether the plan reimburses the related party provider on a FFS, PMPM capitation, or percent of premium capitation basis? | 1) Yes, all forms of compensation and reimbursement, including additional bonus payments, must be included in determining the fees of the related party arrangement. The type of arrangement described would be considered comparable to FFS.<br><br>2) There are no limits on each component of the total related party provider payment expected to be made for the contract year.<br><br>3) Yes, the answer is the same for all types of arrangements |
| 15 | MA Related Party | 04/11/2015 16:48 | Related Party Requirements | Can the Market Comparison Method through the Plan Sponsor be used for a plan that has a physician group as a related party if the plan has materially equal risk sharing contracts for that physician group and other physician groups in the same service area? | Yes, the market comparison method may be used, provided the arrangement meets the requirements outlined in the bid instructions |

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| 16 | Hospice Payments | 03/18/2015 18:10 | hospice payments | Since Medicare payments are based on whole months and hospice elections on any day of the month, how does CMS determine when to start making the hospice payment reductions? My understanding is that it happens the month after the election.<br><br>Also, please confirm that the Medicare Advantage plans obligation to pay primary ends once the hospice election is made, it does not end at the beginning of the next month.<br><br>Similarly, in cases where a member goes off of hospice, does the full payment resume during the next whole month? | CMS determines whether to pay the full A/B rate for a month depending on the hospice status of the beneficiary as of the first of a month. 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 for that month. For the month that hospice is in effect for payment purposes, CMS only pays the rebate amount (if any) and the MAO continues to be liable only for supplemental benefits through the end of the month. Once a beneficiary is not hospice as of the first of a month, the full A/B risk adjustment payment will restart.<br><br>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.<br><br>Note that 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. |
| 17 | Normalization Formula | N/A | N/A | Please explain the formula used to calculate the normalization factors for 2015 and 2016. | The formula used to calculate each normalization factor is comprised of an intercept, plus the Year, plus the Year squared. The Year and the Year squared have coefficients that are created through regression. Specifically, Factor = b0 + b1 x T + b2 x T^2, where T = 1,2,3,4 .<br><br>We used this formula to calculate each normalization factor, and you are able to replicate our results using the data points provided in the Advance Notice by running a regression on those data points to obtain the coefficients, and then calculating the factor – effectively the average risk score – for 2016. |
| 18 | Plan to Plan Payments | 04/13/2015 18:42 | P2P recon | Please comment on how to adjust Base Period experience for Plan-to Plan transactions in Wksht 1 of the Part D BPT. Specifically, can you confirm what we should use is the sum of the NET-GDCA-AMOUNT and NET-GDCB-AMOUNT from our Report 40 minus the sum of the NET-GDCA-AMOUNT and NET-GDCB-AMOUNT from our Report 42. Is there a reason this is not explicitly explained in the BPT instructions? | CMS does not prescribe a specific methodology for adjusting Worksheet 1 for Plan-to-Plan (P2P) transactions. Refer to Appendix B of the Instructions for Completing the Part D BPT for CY2016 for the supporting documentation requirements for the P2P adjustment and upload it with the initial bid submission. |
| 19 | Part D Catastrophic Assignment | 04/13/2015 15:07 | WS3 Part D Catastrophic Assignment | Pages 46-47 of the 2016 Part D Bid instructions for Worksheet 3 Section III states “For CY2016, the “Total Covered Part D Spending at OOP Threshold for Non-Applicable Beneficiaries” of $7,062.50 and “Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries” of $7,515.22 must be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.”<br><br>Our pricing model keeps track of the TROOP by member so we know when each member reaches the catastrophic point exactly. May we use that more exact catastrophic assignment process rather than the approximation methodology in the bid instructions to complete Section III of Worksheet 3? | Yes, this is an acceptable method for completing Worksheet 3. |
| 20 | Medication Therapy Management | 04/09/2015 10:16 | MTM Clinical Services | Our health plan utilizes a vendor who contracts with pharmacies/individual pharmacists to provide Medication Therapy Management (MTM) services and to be reimbursed for clinical services provided. The vendor provides the system by which pharmacists submit MTM documentation and claims, and the vendor pays the claim on behalf of our health plan. All MTM clinical service claims are a pass-through cost to our health plan.<br><br>In the bid, should MTM pharmacist provider payments for clinical services be reported as non-benefit expense or benefit expense and should they be reported in the Part C or D bid? The 2015 Call Letter (pg. 122) indicates MTM program services should be reported as administrative costs but does not specify if this applies to both MTM clinical service claims as well as MTM administrative fees. | MTM pharmacist provider payments for clinical service claims should be reported in the non-benefit expense of the Part D BPT. These claims are not considered a benefit expense for Part D, and are not to be included in the Part C BPT. |

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| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | Worksheet 1 Revenue | 04/02/2015 11:15 | Worksheet 1 Revenue Question | If a health plan anticipates an MLR payment back to CMS for 2014 incurred dates, should the revenue in Section VI of Worksheet 1 be reduced for the accrual of MLR payments? | Do not adjust the base period data applicable to 2014 incurred dates for the accrual of an MLR remittance. In other words, all base period data is completed as if the MLR regulation did not exist. |
| 2 | Risk Score Credibility Guideline | N/A | N/A | [Paraphrased] We do not believe that separately applying credibility to risk scores and claims is appropriate. Applying different weight to risk scores and claims is likely to introduce error. Risk scores are a predictor of claims, and both the claims in the manual rate and the claims in the experience rate are associated with the experience risk score. Separately blending the risk scores and the claims creates a credibility mix error and violates the concept that the risk scores are predictors of claims.<br><br>Consider the following scenario:<br><br>Plan member months = 3,840<br>The MAO offers a comparable plan with 250,000 member months, and uses it as the manual rate<br>Plan Experience Risk Score = 0.80<br>Manual Risk Score = 1.00<br>Plan Experience Claims PMPM = $800<br>Manual Claims PMPM = $1,100<br><br>First approach:<br>Bid at the experience risk score of 0.80.<br>Adjust the manual claim cost to a consistent population as the population being bid. Utilize the risk score difference as the adjustment, i.e. 0.80 / 1.00 * $1,100 = $880.<br>Blend the experience and manual using CMS credibility for claims, i.e. $800*40% + $880*(1-40%) = $848 (at a 0.80 risk).<br><br>Second approach:<br>Blend claim costs at CMS credibility, i.e. $800*40% + $1100*(1-40%) = $980 (at a 0.92 risk = 0.80*40% + 1.00*(1-40%))<br>Blend risk scores at CMS credibility, since they are fully credible the risk score = 0.80.<br><br>The two approaches result in projections that are over 15% different and we believe the second approach is inappropriate. | Separately applying credibility to risk scores and claims does not introduce an error when appropriate manual rates are used. For example, the first approach in the question could be appropriate if the actuary has determined and supported the risk adjustment (0.80/1.00) applied to the manual claims. The second approach could be appropriate if the actuary has determined and supported that allowed costs are not expected to be proportional to the plan's risk score experience. In this approach, the expected claims exhibit a 0.92 risk, even though revenue payments are expected to be based on a 0.80 risk score. Please note that the CMS credibility guidelines do not suggest which approach is appropriate or must be used.<br><br>We would like to clarify that the predictive value of risk scores (i.e. as a predictor of claims) may vary by situation, and the risk score credibility guideline does not assess this predictive value. |
| 3 | MA Risk Score and Claims Credibility Guideline | 04/14/2015 15:46 | OACT UGC Questions | [Paraphrased] Please explain how CMS intends for the integration of the risk score credibility with the claims credibility. Consider a plan sponsor with two plans: plan 001 is fully credible for both allowed costs and risk scores. Plan 002 is partially credible for both. The plan sponsor believes that plan 001 is a good manual rate for both the risk score and allowed costs of plan 002. All actuarial considerations are equal between the plans 001 and 002, except for the risk score. Which of the following methods are appropriate for plan 002:<br><br>Method 1: Project plan 002 allowed costs from experience (developed at the plan 002 risk score) and also from the plan 001 manual rate (developed at plan 001 risk score) and blend these two results per the claims credibility guidelines. Then separately project plan 002 risk scores from the experience risk score and also from the manual risk score of plan 001 and blend according to the risk score credibility guidelines.<br><br>Method 2: First develop the blended risk score as indicated in Method 1 above. Then develop a projected experience rate for allowed costs which includes a population change adjustment that adjusts the experience from the plan 002 risk score to that of the blended risk score. Also develop projected manual rate that adjusts the manual experience from the plan 001 risk score to that of the blended risk score. The final step would then be to blend the projected experience rate and manual rate based on claims credibility guidelines. | CMS believes that Method 1 appropriately reflects the integration of risk score credibility with claims credibility. The key consideration is the development of appropriate manual rates. Method 1 is assumed to include an appropriate manual rate, given the statement: "The plan sponsor believes that plan 001 is a good manual rate for both the risk score and allowed costs of plan 002." Note that this statement would need to be supported. Once the appropriate manual rates for allowed costs and risk scores are determined and supported, the CMS credibility guidelines can be applied to the experience rates, separately for allowed costs and risk scores.<br><br>Method 2 in not acceptable. The scenario presented includes an artificial expectation of a population change to the experience rate, not an actual expected change. |
| 4 | MA Risk Score and Claims Credibility Guideline | 04/14/2015 15:46 | OACT UGC Questions | [Paraphrased] When selecting manual sources for the development of allowed costs and risk scores, does CMS consider it reasonable for a plan sponsor to select one set of plans as a source for the allowed costs and a different set of plans as the source for the risk scores? | Given the numerous considerations in selecting a manual source, CMS will not stipulate such pricing considerations. Please refer to the Actuarial Standards of Practice for further guidance. |

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| 5 | DE# plan reimbursement | 04/20/2015 15:45 | Question Concerning page 24 of MA Bid Instructions | On page 24, about 2/3 of the way down the page, the bid instructions indicate CMS expects the plan reimbursement values in Worksheet 4, Section II. B. col (h) to change only to reflect added or eliminated mandatory supplemental benefits:<br><br>• Additional benefits not covered by original Medicare<br>• Reductions in A/B cost sharing to the extent DE# members are liable for such cost sharing<br><br>These instructions appear to be at odds with an MAO's responsibility regardless of whether the member is responsible to pay the plan cost or not. The Medicare Advantage plan is primary and any benefit package changes impact plan payment to providers for all members including DE# members. If an MAO's cost sharing changes, the net amount (plan reimbursement) they pay providers will change so it appears the plan reimbursement should change. | Plan Reimbursement on Worksheet 4, Section IIB, column h, may change at resubmission if accompanied by justification for changes in the DE# plan reimbursement, including the derivation of the revised plan reimbursement. |
| 6 | DE# plan reimbursement | 03/22/2015 12:46 | Worksheet 4, Section B, column h | The final MA bid instructions on page 24 regarding the DE# section of MA worksheet 4, state that "In column h, plan reimbursement, the user must enter the amount the MAO pays the providers. After the initial bid submission, CMS expects the plan reimbursement PMPM value to change only to reflect the value of added or eliminated mandatory supplemental benefits for—<br>◦ Additional benefits for services not covered by original Medicare.<br>◦ Reductions in A/B cost sharing to the extent DE# members are liable for such cost sharing."<br><br>Also, Appendix B on page 108 states that MAOs must upload "justification for changes in the DE# plan reimbursement, including the derivation of the revised plan reimbursement PMPMs in Worksheet 4, column h."<br><br>My questions:<br>1a) Is it appropriate to use the same formula that was in the bids last year to calculate this column in the initial bid submission?<br><br>1b) When would it not be appropriate to use that formula?<br><br>2) Please confirm the bullets above are in reference to changes in cost-sharing and benefit at rebate reallocation time.<br><br>3) I am unsure the intent of keeping column h the same at rebate reallocation time when Medicare covered cost-sharing is changed. Can you explain the intent? It seems to me that actual costs of the MAO really do change for DE# members when the cost-sharing for the Medicare covered benefits are changed despite the fact that DE# members really don't see a change in benefit. | 1a) Yes. It is acceptable in the initial bid submission to calculate the plan reimbursement in col h using the following formula: DE# allowed (Worksheet 2, column q) minus DE# plan cost sharing (Worksheet 4, column f).<br><br>1b) It may not be acceptable to use this formula for changes to cost sharing after the initial bid submission. The appropriateness is dependent on the details of the provider contracts.<br><br>2) The revised bullets apply to mandatory supplemental benefit changes both as a result of: (i) rebate reallocation, and (ii) as required by CMS after bid submission to comply with bidding requirements such as TBC and meaningful difference.<br><br>3) The intent is to encourage plans to offer benefits that may be better utilized by all members. For DE# members, a change in cost sharing does not directly affect the member since their cost sharing, if any, does not depend on the PBP cost sharing. |
| 7 | File Upload | 04/14/2015 14:54 | Question for 4/16/15 Actuarial User Group Call | Will CMS accept Excel files with .xlsb extension for the June 1st BPT upload process? Previously, only .xlsx extensions have been allowed. We are requesting permission to upload .xlsb extensions as the file size can be compressed up to 50% as compared to .xlsx extension. | Excel files with the extension .xlsb are not supported in HPMS for CY2016. We will look into adding this capability for CY2017. |
| 8 | Worksheet 1 Crosswalk | 04/14/2015 22:56 | Questions for OACT User Group Call | In the CY 2016 MA BPT Instructions, Data Aggregation: Rule 1, it states that, "If members are cross-walked one year and dis-enrolled the following year, then Rule 4 applies."<br><br>1a) Do we also apply Rule 4 if there is a bid that has a service area reduction in one year and a formal-crosswalk in the following year?<br><br>1b) Example: Bid 001 has 1000 members in CY 2014. Bid 001 has a service area reduction in CY 2015 removing 900 of the members. In CY 2016 bid 001 formally crosswalks into bid 002. Do we need to evaluate for significance to see if bid 001 should be included in WS1 reporting of bid 002?<br><br>2) Do we also apply Rule 4 if there is a bid that has a service area reduction in one year and a formal-crosswalk simultaneously in the same year? | **This is a revised response to a question #9 that was read on the 4/16/15 User Group Call**<br><br>1a) No. Rule 4 does not apply if a service area reduction is followed by a formal-crosswalk in the following year because members are not formally cross-walked and dis-enrolled the following year.<br><br>1b) No. A proportion of significance is not considered in the example for question 1 because members are not formally cross-walked and dis-enrolled the following year.<br><br>2) No. Rule 4 does not apply if a service area reduction and a formal-crosswalk apply to a plan simultaneously in the same year because members are not formally cross-walked and dis-enrolled the following year. |
| 9 | MA Related Party | 04/14/2015 16:12 | Related Party Question | In related party method 1 actual cost for medical services, the instructions indicate that the actual cost of medical services provided by the related party is entered as medical expense of the MAO and that the gain/loss margin of the related party should be excluded from the medical expense of the MAO (see page 42 of the CY2016 MA bid instructions). Should the non-benefit expenses of the related party be included in non-benefit expense or medical expense in the bid? Does the answer vary based on the type of medical expense arrangement, for example a global cap medical agreement versus a capitation to cover vision hardware? | For Related Party Method 1, actual cost for medical services *only*, the non-benefit expenses of the related party must be included in medical expense for the bid. This is the case for all related party arrangements for medical services. |

# User Group Call Date 04/23/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 10 | Rebate Reallocation | 04/16/2015 15:11 | Rebate Reallocation - Percent of Premium Capitation | [Paraphrased] The MA Instructions indicate that starting with the 2016 bids, we are to reflect the following during rebate reallocation: "The BPT must reflect the value of A/B mandatory supplemental benefits added or eliminated as a result of rebate reallocation, including the impact of such changes on other pricing assumptions, consistent with the pricing approach and methodologies utilized in the initial June bid submission." Further, the Actuarial Bidders Training state that we are required to adjust pricing assumptions to reflect "pricing assumptions determined as a percent of revenue such as global capitation or risk-sharing arrangements".<br><br>My questions are as follows (assuming that we have a global capitation arrangement):<br><br>1) Suppose that our global capitation arrangement is based on MA and PD revenue, are we permitted to include the entire capitation cost in the MA bid?<br><br>2) Suppose our global capitation arrangement is based on MA revenue, and that we project the Direct Subsidy within $0.50 of actual and are then allowed to change margin to bring us back to the premiums filed. Since the actual medical cost will change as a result of the global capitation arrangement, are we required to align medical costs with the new revenue amount?<br><br>3) Suppose our global capitation arrangement is based on MA revenue, and that we project the Direct Subsidy $4.00 off of actual. We reallocate rebates and change supplemental benefits to bring our PD premium back to target. Do we need to adjust the medical expense to account for the impact to the global capitation expense?<br><br>4) Suppose that some of our non-benefit expenses for the parent organization are allocated based on allowed costs in the bid. If the allowed cost in one bid changes due to rebate reallocation, are we required to resubmit all bids to update the non-benefit expense allocation?<br><br>5) Finally, suppose the related party method used in the initial bid submission yields a comparison falling just within the 5% tolerance. Adjusting pricing assumptions for a change in a global capitation due to the rebate reallocation process could cause the related-party testing to fall just outside the 5% tolerance. Does OACT intend for the bid treatment of the related party cost to change during rebate reallocation? | 1) No, the MA bid is not permitted to contain any global capitation payments related to Part D services. Sponsors must attribute the portion of their global capitation payments related to Part D services to the Part D BPT. See Page 16 of the CY2016 MA BPT instructions for more information.<br><br>2) No, the question refers to premium rounding Rule #3, which applies separately from the MA Pricing requirements as stated on pages 133 and 135 of Appendix E of the MA bid instructions. Therefore, if the decision is to round premiums to the nearest $0.50, then adjust gain /loss margin only as allowed under rounding Rule #3. Do not revise other MA pricing assumptions.<br><br>3) Yes, the pricing change for the incremental A/B mandatory supplemental benefit(s) added or eliminated as a result of rebate reallocation must include the impact of such benefit change on other bid assumptions consistent with the pricing structure in the initial bid submission. To the extent the global capitation expense changes due to the incremental benefit change made as a result of rebate reallocation, the incremental change in the global capitation expense must "flow through" the pricing structure used to set pricing assumptions in the initial bid submission.<br><br>4) No, the pricing must not change if a bid is not eligible for rebate reallocation, or participates in rebate reallocation, but there is no impact to it's A/B mandatory supplemental benefits added or eliminated as a result of rebate reallocation.<br><br>5) Yes, the final submitted bids and supporting documentation must comply with the CY2016 MA and PD Bid Instructions, including the related party requirements. |
| 11 | Plan to Plan Payments | 04/13/2015 18:42 | P2P recon | The bid instructions requires that base period pharmacy experience includes adjustment for Plan-to-Plan (P2P) transactions and that the impact of this consideration must not be included on the completion factor. The P2P Payable amounts are reported to each plan sponsor through reports numbered 42 & 43, where only summary cost information is provided by member.<br><br>The reports do not provide claim level information that can be included with base period PDE data. There is no information on the count of scripts, or what portion of claims are generic, brand or specialty. There is no understanding of what bid or cost-sharing tier any of these expenses are assigned. Based on the P2P data having such limited information, there is only one possible method to include these expenses as required - that is to apply a factor for completion.<br><br>Based on the bid instructions, please confirm that each plan sponsor must apply completion for the P2P payable expenses they incurred in the base period and that this portion of the applied completion must not be reported in the completion factor reported in Worksheet 1, Section II, line 4. In other words, each plan sponsor must develop two completion factors: one that is actually applied to the base period PDE data for use in reporting PDE experience in Worksheet 1 and the second factor used for reporting on Worksheet 1, Section II, line 4. | Plan sponsors must adjust for the impact of Plan-to-Plan (P2P) transactions in the base period experience on Worksheet 1. The Instructions for Completing the Part D BPT for CY2016 state that Worksheet 1 must be completed with data for the plan ID, that these data must include adjustments for Plan-to-Plan transactions and that the impact must be quantifiable and must not be included in the completion factor (Worksheet 1, Section II, line 4). CMS does not prescribe a specific methodology for adjusting Worksheet 1 for P2P transactions. Refer to Appendix B of the Instructions for the supporting documentation requirements for the P2P adjustment and upload it with the initial bid submission. |
| 12 | Drug Launches | 04/15/2015 19:48 | Drug Launches | Please confirm that bids may reflect the impact of both brand and generic drug launches in either (1) Inflation Trend and Utilization Trend or (2) Formulary Change on Worksheet 2 of the 2016 BPTs. We are aware of multiple 2015 bid resubmissions as a result of the CMS clarification that Hepatitis C drug launches were required to be reported in the Formulary Change factor on Worksheet 2. As a result, we seek clarification on the treatment of drug launches in bid development.<br><br>Given the uncertainty of generic and brand launches, we are concerned with the ability to precisely isolate the effect of these launches from the Trend factor to include in the Formulary Change factor. Most prospective trend information does not specifically isolate the effect of drug launches. We believe that this interpretation is consistent with guidance in question #17 in the 4/18/2013 User Group Call Notes | CMS believes that it is highly unlikely that prospective trends developed at an industry level will include the best estimate of the impact of new-to-market drugs at the bid level. Therefore, if the Plan sponsor has added or intends to add new-to-market drugs to its formulary for CY2016, then the formulary change factors must include the impacts of these additions to the plan that are not captured in the inflation and utilizations trends. Refer to Appendix B of the Instructions for Completing the Part D BPT for CY2016 for supporting documentation requirements for trend projection factors. |

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| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 13 | Hep C | 04/14/2015 16:20 | Hep C Drug Impacts | Last year we were required to explicitly document formulary adjustments for Hepatitis C drugs. This year with Hepatitis C drugs already in the base period, is the explicit adjustment still necessary? If so, for documentation purposes, does the explicit adjustment apply to both formulary and trend? | For each Part D bid (contract number and plan ID) submitted for CY2016, Plan sponsors must report the actual CY2014 Hepatitis C allowed amount PMPM and the projected CY2016 Hepatitis C allowed amount PMPM. These PMPM amounts must be clearly labeled in the supporting documentation that is uploaded with the initial bid submission; the location of these amounts must be referenced in the Supporting Documentation Cover Sheet. An explanation of the development of these amounts may be requested during bid desk review and/or bid audit. |
| 14 | Late Enrollment Penalty | 04/17/2015 15:18 | Part D Late Enrollment Penalty | As noted in section 6.2 Late Enrollment Penalty (LEP) of the in the PCUG user guide, "For members assessed an LEP, their premium includes a penalty. If the member elects the withholding option, SSA withholds the penalty amount and CMS retains it. Plans can view the amounts on the Monthly Premium Withhold Report Data File (MPWR). If the member elects the direct billing option, the Plan bills the premium amount that includes the LEP and CMS deducts the LEP from the Plan payment. Plans can view the amounts on the LEP Report. Appendix F contains this file layout."<br><br>As this guidance indicates, the LEP amount is retained by CMS either through the SSA withhold process or through a reduction to the plan payment. Therefore, the revenue from this penalty is never received or held by the plan and ultimately is revenue to CMS. Therefore, shouldn't the member penalty premium always be 0 on WS1 since the plan does not have access to these funds? | Section V of Worksheet 1 of the Part D BPT summarizes the revenue of the Plan sponsor. Plan sponsors must report the components of revenue as they are reported in the Plan sponsor's audited financial statements. |
| 15 | LIS Membership | 04/21/2015 8:34 | LIS Membership | When do you plan to release the LIS membership for 2015? | The files will be posted by early next week. |
| 16 | Part D Product Pairings | 04/21/2015 12:53 | Product Pairings | We observed that there is a difference in the product pairing instructions between MA and PD. In the MA instructions on page 29, first bullet point, sub-bullet point 3 it indicates that product pairings must be of all the same SNP type. However on page 17 of the PD instructions, it does not indicate that plans would need to be of the same SNP type in a product pairing. Can you confirm that the intention is that all PD product pairings must also be of the same SNP type? | Yes, the plans in a Part D product pairing must be of the same SNP type. |

# User Group Call Date 04/30/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | FFS Trends | 04/27/2015 11:44 | Unit Cost Trend Question - for Actuarial User Group Call | In the document that summarizes Medicare Unit Cost Trend Increases for 2014 to 2016 (FFS-Trends-2014-2016.pdf), do the Inpatient Hospital trends for 2016 include the anticipated reductions in DSH and Uncompensated Care? | The Medicare Unit Cost Trend Increases for 2014 to 2016 do not reflect projections for DSH and UCP. The USPCCs, however, do reflect the DSH and UCP projections. |
| 2 | TBC | 04/24/2015 10:10 | Actuarial User Group Call Question | In the Contract Year 2016 Medicare Advantage Bid Review and Operations Guidance released on April 14th, it describes how the TBC evaluation will be conducted for organizations that consolidate or segment plans from one year to the next. It specifically addressing:<br>• Consolidating multiple non-segmented plans into one plan<br>• Segmenting an existing non-segmented plan<br>• Consolidating previously segmented plans<br><br>It does not address moving counties between segments. For example, in CY 2015 Plan 001 has segment 001 with counties X and Y and segment 002 with county Z. How will the TBC be evaluated if in CY 2016 county Y moves from segment 001 to segment 002? Will it be the enrollment-weighted average? If so, what enrollment month is used for the weighting? | Since both segments 001 and 002 exist in 2015, there will be no weighting of adjustments needed and each segment will use its respective TBC adjustments. Weighting for TBC is only done if the 2016 plan did not exist in 2015 and there are plan(s) or portions of plans being crosswalked into the plan. |
| 3 | Data Aggregation | 04/24/2015 17:28 | Worksheet 1 Question | For contract year 2014, an MA sponsor offers two Dual Eligible Subset Medicare Zero Cost Sharing D-SNP Plans with the same service area. Plan 1 enrollment is limited to members from the SLMB+ and FBDE Medicaid eligibility categories, and Plan 2 enrollment is limited to members from the QMB and QMB+ eligibility categories. For 2016, both plans will continue to be offered with no change in service area, but the QMB+ members from Plan 2 will be cross-walked to Plan 1. Should the 2014 base period experience of Plan 2 be reported on Worksheet 1 of the 2016 bids for both Plan 1 and Plan 2? | Since Plan 2 still exists in 2016, Plan 2 base period data would be reported on Worksheet 1 of the Plan 2 BPT.<br><br>If the QMB+ members from Plan 2 are cross-walked into plan 1 via MARx enrollment transactions for CY2016, then Rule 1 applies, assuming there are no cross-walks, service area changes, or other enrollment transactions for CY2015. That is, base period data for plan 1 and plan 2 are reported on Worksheet 1 of the Plan 1 BPT if the proportion of Plan 2 members cross-walked from Plan 2 into Plan 1 is deemed significant by the certifying actuary. |
| 4 | Gain/Loss Margin | N/A | N/A | In the instructions on Gain/Loss Margin on page 30, EGWP bid margins continue to be constrained to no more than 1% higher than the corresponding contract average for GEIC bids. Some of our contracts currently have an average GEIC margin that is less than −1%. For these GEIC bids, we expect to meet the annual targets specified in the negative margin business plans and comply with the maximum 5 year deadline to achieve positive gain margin. In the interim, the low GEIC average profit is the only reason that the corresponding EGWP bids have negative gain margin.<br><br>For EGWP bids in this situation, we would like the option to file a negative margin business plan that omits numeric projections, but simply states that these bids will have positive margin once the corresponding GEIC bids exceed −1% average margin. Any numeric projections for these EGWP bids would not reflect our intention, which is to file positive EGWP margins as soon as OACT rules permit. | An alternate business plan may be submitted, provided that the following requirements are met:<br>• The bid-level margin is only negative in order to comply with the EGWP vs GEIC aggregate margin requirements<br>• The business plan may omit a numeric projection and numeric comparisons to prior business plans.<br>• All other requirements applicable to bids with negative margin are still applied and are not altered by this guidance.<br><br>OACT will extend this guidance to other plan types with negative margin in the same situation. That is, the bid margin is only negative in order to comply with CMS aggregate or MA vs PD gain/loss margin relationship requirements (i.e. D-SNP vs. GEIC aggregate margin requirements, MA vs PD margin requirements) and would otherwise be positive. |
| 5 | Gain/Loss Margin | 04/24/2015 14:24 | Segmented Bid MA to PD G/L Question | While reviewing the 2016 BPT Instructions and Bidder Training, we noticed potential new guidance that we wish to clarify. In the Bidder Training "Non-Benefit Expense, and Gain/Loss Margin" on slide 16 was the statement "For MA segmented plans, **each MA bid must be within 1.5% of the Part D bid**" in reference to the MA to Part D bid comparison. The audio transcript also described that "**the margin for each MA segment must be within 1.5 percent of the margin for the Part D bid**." After further investigation we are unable to find any other references to a policy regarding how segmented plans should be treated in the MA to Part D bid comparison of gain/loss. Is this new guidance for 2016? If so, can you please further clarify your expectations for segmented MAPD plans? | The CY2016 Bidder Training clarifies the instructions, but does not represent a change in the instructions. If a plan uses Option A to set their gain/loss margin as described on page 18 of the CY2016 Part D BPT Instructions, we require that the gain/loss margin of each MA bid be within 1.5% of the Part D bid, even if the MA plan is segmented. |
| 6 | Supporting Documentation | 04/21/2015 11:25 | Supporting Documentation guidance | A new requirement this year is to explain significant differences between actual and expected claims for CY 2012, 2013 and 2014. Could you provide your definition of "significant"? Is this requirement related to total claims, plan liability claims or plan liability claims less plan retained rebates?<br><br>A new requirement this year is to explain significant differences between actual and expected risk scores for CY 2012, 2013 and 2014. Could you provide your definition of "significant"? | The requirement to explain significant differences between actual and expected claims is not new for CY2016. This requirement is related to all claim categories specified in the BPT. OACT does not provide a specified threshold for significance, the certifying actuary must determine the standard for the bids in question.<br><br>Similarly, OACT does not provide a threshold for significant risk score differences, the certifying actuary must make this determination. |

# User Group Call Date 04/30/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 7 | MA Related Party | 04/24/2015 10:03 | Question on Treatment of Administrative Expenses for Medical Related Parties using Actual Cost Method | [PARAPHRASED]<br>Upon hearing the response to the question on the medical related party actual cost method on the 4/23 OACT call we would like to clarify CMS' intention and guidance on this issue. In the 2015 final instructions and the 2016 draft instructions, plans were instructed to EXCLUDE medical related party administrative expense from medical expenses and include them in the MAO administrative expense in the bid when using the actual cost method to recognize non-independence. In the 2016 final instructions, there was no mention of administrative expenses in the medical related party actual cost method. In addition, no such change in guidance was specifically listed as a change from either 2015 or the 2016 draft instructions.<br><br>However, in the response to the 4/23 question, it was stated that the administrative expense needs to be INCLUDED in medical expense when using the actual cost method for medical related parties. This seems to be a significant change in how to handle the administrative expense for medical related parties using the actual cost method. This change may generate a significant amount of re-work.<br><br>Would you allow a similar method to 2015 to be used for 2016 given this change was just clarified on last week's call? | If an MAO used the actual cost method for CY2015 and entered all administrative costs as non-benefit expense in the BPT, then they may continue to use this same approach for CY2016 bids. For the CY2017 bids, CMS requires MAOs to follow the intent as described in the CY2016 bid instructions. |
| 8 | MA Related Party | 04/22/2015 8:40 | Actuarial User Group Call Question | [PARAPHRASED] We have a scenario where the related party is a physician group, which is losing money. The parent company (which owns the physician group, the MAO, and other health insurance companies) makes payments to cover those losses, while also providing a minor profit to the related party. If the parent company then allocates that payment to the MAO and other health insurance companies, how is that payment supposed to be treated in the bid/BPT (medical, administrative, or not at all)?<br><br>For example, assume that the MAO makes regular related-party payments of $32M to the physician group, then the parent company pays an additional $10M to the physician group to cover losses for all lines of business. The parent company allocates $3M of the $10M to the MAO. The MAO assumes that physician group is expected to make a profit of $1M on the related-party arrangement with the MAO. | The BPT must be completed consistent with the actual terms of the related party arrangement and one of the related-party methods described in the bid instructions. For example–<br>• Method 1 (actual cost) would enter the actual cost of the medical services as medical expenses in the BPT. In the example, the actual cost is $34M = $32M + $3M − $1M. The actual cost includes regular payments and any adjustments needed to bring the cost to a $0 margin.<br>• Method 2 (market comparison) and method 3 (comparable to FFS) will depend on the terms of the related-party arrangement. If the additional payment is documented in the terms, then the MAO would enter the full $35M as medical expenses in the BPT. If the additional payment is not documented in the terms, then only the regular payments ($32M) would be entered in the BPT. Please note that the amount entered in the BPT must be consistent with the amount used for either the market comparison or the comparison made to FFS.<br>• Method 4 (FFS proxy) would enter 100 percent FFS costs in the BPT as medical expenses. |

# User Group Call Date 05/07/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | FFS Trends | 04/29/2015 23:03 | Questions Regarding the 2016 Announcement and Medicare FFS Trends | We have the following questions regarding the 2016 Announcement and Medicare FFS Trends:<br><br>1. Are costs for the Chronic Care Management (CCM) program included in the 2015 and 2016 FFS USPCCs? Can CMS provide an estimate of the PMPM cost for each year?<br><br>2. During the OACT call last week, CMS said that the estimated impact of baby boomers on trends is −0.5% for Part A and −0.1% for Part B for 2014, 2015, and 2016. Can CMS provide the estimated impact of the baby boomers for 2012 and 2013, for Part A and Part B services separately?<br><br>3. The overall inpatient update is shown on page 1405 of the Proposed FY2016 IPPS Federal Register to be 0.3% in Table I – "Impact Analysis of Proposed Changes to the IPPS for Operating Costs for FY 2016."<br>a) What changes are included going from the 1.1% in column 2 to the 0.3% in column 9, when the changes shown in columns 3 – 8 add to 0.1%?<br>b) Does the 0.3% include the expected change in DSH/UCP payments that is estimated to be -11.4% (shown on page 1440)?<br><br>4. On page 11 of the 2016 Final Rate Announcement, the 2015 Physician Fee Schedule factor is −1.0% and the 2016 Physician Fee Schedule factor is −0.1%. Can CMS provide the build-up of these fee changes for 2015 and 2016? For example, in 2016, what other factors are included in the development of the −0.1% other than the 0.5% fee increase beginning January 2016? | 1) Yes, spending under the Chronic Care Management (CCM) program is included in the USPCC calculation. Also, CCM codes are to be implemented in a budget neutral fashion. The estimated PMPM impact is $0. Further information on the new CCM HCPCS code, 99490, can be found in the final 2015 physician fee schedule rule, CMS-1612-FC.<br><br>2) First, it is worth pointing out that the impact of the baby boomers is just one component of demographic changes. As stated on the April 16 call, the annual impact of demographic changes on the 2014-2016 FFS USPCC trend is −0.5 percent for Part A and −0.1 percent for Part B. The corresponding annual trends for 2012 and 2013 are −0.7 percent for Part A and −0.2 percent for Part B.<br><br>3a) There are several changes included in the FY 2016 IPPS impacts table which result in the 0.3% overall increase in payments shown in column 9. The first is the proposed update, which is 1.1% or the sum of the proposed market basket (2.7%), proposed multifactor productivity adjustment (−0.6%), statutory adjustment under section 3401 of the Affordable Care Act (−0.2%), and the proposed documentation and coding adjustment (−0.8%). The second is estimated 0.1% increase due to the application of the frontier wage index and out-migration adjustment, as shown in column 8. In addition, we estimate in the proposed rule that estimated payments for FY 2016 will be 0.2% more than estimated payments in FY 2015 due to outlier payment projections as we describe on (80 FR 24655). Finally, we estimate estimated payments for FY 2016 will be approximately 1.0% less than estimated payments in FY 2015 due to a decrease in DSH and uncompensated care payments. (80 FR 24669) When rounding and interactive effects are taken into account, the overall change in projected IPPS payments from FY 2016 compared to FY15 is 0.3%.<br><br>3b) Yes, the 0.3% in column 9 includes the expected reduction in DSH/UCP payments.<br><br>4) The other factors included in the development of the 2016 Physician Fee Schedule factor include legislative impacts such as the expiration of the work GPCI floor, impact of the Medicare-Medicaid demonstration, and the health HIT penalties. |
| 2 | ESRD Payment Rates | 04/30/2015 8:38 | ESRD Payment Rates | Would it be correct to say that the Medicare Advantage ESRD payment rates are based on an estimate of 100% of the Fee For Service equivalent costs of that population? | The Medicare Advantage ESRD ratebook is based on the projection of state-level fee-for-service costs for the dialysis population, standardized by the corresponding risk score. |
| 3 | Sequestration | 05/02/2015 17:32 | Rebate allocation to buy down Part B Premium | Are rebates that are used to buy down the Part B premium subject to sequester? For example, if we use $10 of rebate to buy down the Part B premium, would the beneficiaries' Part B premium be reduced by $10 or by $9.80? | All MA rebates including Part B Premium Reductions are subject to sequestration. However, sequestration cannot impact a beneficiary's plan benefits or liabilities. So in this example, if $10 were used to buy down the Part B Premium, the beneficiary's Part B Premium would still be reduced by $10, but the MAO's payment would also be reduced by $0.20 to account for the 2% sequestration due on the MA rebate. |
| 4 | Risk Score and Claims Credibility | N/A | N/A | 1) Suppose I have an MA plan (plan 001) with fewer than 3600 member months and a manual source (plan 002) with greater than 24,000 member months. Suppose further that the two plans share the same service area, benefit package, network composition, and are otherwise as comparable as possible with the exception of health risk status, and that there are no population changes expected between the base and contract years. Finally, suppose that the CMS HCC risk score model is my only valid source for determining health risk status, that plan 001 has a risk score of 0.7 and projected allowed claims of $700, and plan 002 has a risk score of 0.9 and projected allowed claims of $925. Would adjusting the manual source to reflect the plan 001 risk score to create a manual rate and then blending with plan 001 for risk score and claims be a permissible approach to projecting allowed costs and risk scores?<br><br>2) Given the assumptions from Question 1, is it permissible to first blend the risk scores of plan 001 and plan 002, create a manual rate by adjusting the manual source to the blended risk score, and adjust the plan 001 experience to this blended risk score? | 1) Yes, given all assumptions in the question, this is a permissible approach. The manual claims would be adjusted to reflect the health risk status of the plan population as follows: $925 x (0.7/0.9) = $719.44, and then the $719.44 would be blended with plan 001 projected allowed cost of $700. The manual risk score of 0.9 should be adjusted to reflect the health risk status of the adjusted manual claims as follows: 0.9 x (0.7/0.9) = 0.7, and then this 0.7 would be blended with the plan 001 risk score of 0.7<br><br>Please note that this answer does not suggest that this approach is always appropriate or must be used. The appropriateness will depend on the conditions of the pricing situation.<br><br>2) No, this approach is not permissible. A blended risk score should not be used to determine the appropriate manual rate and should not be used to adjust base period experience. Instead, the manual rate should be developed prior to any blended risk score result. |
| 5 | Non-Benefit Expenses | 04/30/2015 20:45 | ESRD Non Benefit Expenses | Can we use the same part C per member per month non benefit expense allocation for ESRD as is used for the non-ESRD population? | The non-benefit expenses entered into the BPT must be specific to the bid. To the extent that the ESRD population incurs different types of non-benefit expenses or incurs a different proportion of common non-benefit expenses, this difference should be reflected in the BPT. |

# User Group Call Date 05/07/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 6 | Gain/Loss Margin | 04/29/2015 14:37 | MA margin test questions | 1. Does the "Overall Gain/(Loss) Margin Level" (for example, Contract, Organization, or Parent Organization) determine at which level to develop the non-Medicare margin for comparison? For example, if the MA contract is held by Company A, and Company B owns Company A, if we enter "Organization", would we develop the non-Medicare margin just for Company A? If we enter Parent Organization, would the non-Medicare margin be for the combination of Company A and Company B? Please assume there are no other companies owned by Company B.<br><br>2. The instructions say that "non-Medicare business refers to all health insurance business that is not Medicare Advantage . . .". Are dental and vision products to be considered "health insurance" and therefore included? | 1) Yes, the level of aggregation designated in the BPT does determine the level of aggregation of the non-Medicare margin for comparison.<br><br>In this example, Company A is the Organization and Company B is the Parent Organization. If in the BPT, "Organization" is chosen for the level of aggregation, then the margin of all bids submitted with Company A as the organization, including those in other contracts, are compared to the non-Medicare business margin for Company A. If in the BPT, "Parent Organization" is chosen for the level of aggregation, then the margin for all bids with Company B as the Parent Org, including those in other contracts, are compared to the entire non-Medicare business margin for Company B, including Company A non-Medicare business. Further, if in the BPT, "Contract" is chosen for the level of aggregation, then the margin of all bids in the contract should be compared to the non-Medicare business margin for Company A.<br><br>2) Yes, dental and vision products should be included in non-Medicare business margin. |
| 7 | Platino Plans | 05/05/2015 9:54 | Platino Question for OACT User Group Call | 2016 Bidder Training, Session 9, Slide 9 Notes say, "If the plan sponsor has a separate contract with a territory for Medicaid services and is participating in the Platino program, the sponsor may request that the gain/loss margin be determined taking into consideration the premium and mandatory benefits of the program." What steps do we take or who do we contact to request this treatment for the Platino revenue and costs? | If the plan sponsor requests that CMS take into account Platino revenue and costs in satisfying gain/loss margin requirements, then the plan sponsor must upload the required supporting documentation for such exception with the initial June bid submission. |

# User Group Call Date 05/14/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | TBC | 05/11/2015 11:02 | TBC question | We would like to confirm our understanding of the TBC treatment in the following situation. In 2015, we have two non-segmented plans, 001 and 002, in different service areas. We intend to consolidate plan 002 into plan 001 for 2016 (through official crosswalk), and then segment this plan into two segments for 2016, A and B. Our understanding is that the 2015 TBC value for the consolidated plan 001 would be based on the member weighted average 2015 TBC of plans 001 and 002, weighted on the projected 2015 membership in the 2015 BPTs (per 5/3/2013 OACT call answer). Then each segment's 2016 TBC would be compared to this weighted average 2015 amount. Is that correct? | Yes, that is correct. The 2015 TBC values, Payment Adjustments and Technical Adjustments for both of the new segments will be the weighted average of Plans 001 and 002 based on projected 2015 enrollment. |
| 2 | Insurer Fees | 05/12/2015 8:54 | Insurer Fees | Is it acceptable to allocate the insurer fee on a PMPM basis across a product line under one contract, if the premiums are similar? Or, must each individual PBP ID be a separate amount based on that particular PBP IDs premium? | Similar to other non-benefit expenses, the Health Insurer Fee must be appropriately allocated to the Medicare line of business and then further allocated to the plan level using a consistent allocation approach across the Medicare business. |
| 3 | Gain/Loss | 05/06/2015 16:56 | Gain/Loss Margin Requirement | On page 23 of the MA bid instructions for CY2015, when discussing Medicaid revenue and expenses the instructions state "the adjusted gain/loss margin will be taken into account in satisfying the gain/loss margin requirements". This language has been removed from the CY2016 instructions. Please confirm for CY2016 that the gain/loss should not be adjusted for Medicaid revenue and expenses for the purposes of satisfying all CMS gain/loss requirements. | Yes, that is correct. For CY2016, the gain/loss margin entered in cell H107 on WS4 of the MA BPT is the margin that will be used for purposes of ensuring that the gain/loss margin requirements are met. This gain/loss margin is not adjusted for Medicaid revenue and expenses. |
| 4 | Gain/Loss | 05/10/2015 12:26 | Negative Margin Business Plans | The bid instructions state: *"If the projected gain/loss margin in the BPT is negative, the MAO must develop, submit, and follow a bid-specific business plan that is to achieve profitability within five years."* If a bid has a projected has a negative margin for the first time in 2016, does the bid-specific business plan need to achieve profitability in the 2020 bid year or the 2021 bid year? | If the bid has a negative margin for the first time in 2016, the bid must have a positive gain/loss margin by 2021. |
| 5 | Rebates | 05/09/2015 21:51 | CMS User Group Call Questions | On the May 7, 2015 User Group Call, Question #3 on Sequestration, the CMS response says the MAO's payment would be reduced by 2% of any Part B Buydown. Can you please clarify? For example, a plan has $110 of total MA rebate allocated as follows: $10 to Part B Buydown and $100 to A/B cost sharing reduction and additional benefits for services not covered by original Medicare. Would the MAO receive ($110-$10)*98% = $98, or $110*98% - $10 = $97.80? | The MAO would receive ($110*0.98) - $10 = $97.80. |

# User Group Call Date 05/21/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | FFS Trends | 05/13/2015 16:22 | Rebasing Question | Last year, CMS provided the file, *Medicare FFS County 2015 Web.xlsm*, when releasing the FFS 2012 data. This file provides all the pieces used in the calculation of a county's AGA factor. We found this file very useful when considering rebasing. Will CMS be providing a similar file this year? | This file is expected to be released by the end of this week on the CMS website on the Medicare Advantage Rates and Statistics page under FFS Data. |
| 2 | Gain/Loss | 05/14/2015 12:16 | Corporate Margin Box in Part D BPT | How should the cell, "Corporate Margin Requirement % of Rev.", be populated in the CY2016 MA and Part D Bid Pricing Tools? | The cell, "Corporate Margin Requirement % of Rev." must be populated using the following methodology:<br>1) Determine the aggregation level (Contract, Organization, or Parent-Organization) as designated in the BPT. For MA-PD plans, the option selected in the MA BPT must match the option selected in the Part D BPT.<br>2) Determine the basis for the corporate margin (Risk-Capital-Surplus or Non-Medicare) as designated in the BPT. For MA-PD plans, the option selected in the MA BPT must match the option selected in the Part D BPT.<br>3) The "Corporate Margin Requirement % of Rev." is the 'Risk-Capital-Surplus margin percentage' or the 'margin percentage for all Non-Medicare business', based on the level of aggregation selected in step 1 and basis selected in step 2. For MA-PD plans, the percentage entered in the MA BPT must match the percentage entered in the Part D BPT. |

# User Group Call Date 05/28/2015

| # | Topic | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS Response |
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| 1 | Risk Score | 05/26/2015 7:21 | Frailty Factor | Can you confirm that frailty factor is not in the beneficiary level file released by CMS? | We are confirming that frailty is not included in the beneficiary-level file. The scores provided are raw risk scores. |
| 2 | Gain/Loss | 05/19/2015 19:47 | Gain/Loss Compliance Question | The instructions specify to enter "corporate margin %" in Worksheet 4, line z1, but do not define "corporate" as used in this context. It appears that the CMS gain/loss compliance tool released last week compares the amount entered in Worksheet 4, line z1 (corporate margin %) to the aggregate MA GE and I/C SNP margin to test whether it is within 1.5%. The instructions state that the aggregate MA GE and I/C SNP margin should be within 1.5% of the non-Medicare business. This implies that the margin amount entered in line z1 should be non-Medicare business ONLY. We have the following questions/comments:<br>1) Should the margin entered in line z1 include all business, or only non-Medicare business (as defined in the instructions)?<br>2) What should be entered in line z1 if an MAO has NO non-Medicare business?<br>3) Can the margin entered in line z1 vary based on the level of aggregation you have selected for the bid margin? | 1) Based on the CY2016 MA BPT Instructions on page 30: "This requirement depends upon the volume of the MAO's non-Medicare business … If the volume of the MAO's non-Medicare business for which it has discretion in rate setting is greater than or equal to 10% of the MAO's total non-Medicare business, then—" enter only the non-Medicare business' margin in Worksheet 4, line z1. In this case, the corporate margin is defined as the non-Medicare business' margin.<br>2) Based on the CY2016 MA BPT Instructions, on page 30: "If: (i) the volume of the MAO's non-Medicare business for which it has discretion in rate setting is less than 10% of the MAO's total non-Medicare business, or (ii) the MAO has no non-Medicare business; then," enter the MAO's required business margin. In this case, the corporate margin is defined as the margin set by taking into account the degree of risk and capital and surplus requirements of the business. The supporting documentation must specify what is included in this business, and this specification should be consistent from year to year.<br>3) Yes, the margin entered in line z1 may vary depending on the level of aggregation. For example, if the Organization level is chosen, and the Organization basis for the corporate requirement is Risk-Capital-Surplus, then the margin entered in the BPT must be the Organization's corporate requirement for the business, even if the Parent-Organization has Non-Medicare business. |
| 3 | Gain/Loss | 05/19/2015 19:47 | Gain/Loss Compliance Question | PARAPHRASED<br>1) When submitting MA plans that have an aggregate negative margin, accompanied by an appropriate business plan, for an MAO who has positive non-Medicare margin, the CMS gain/loss tool reports non-compliance. Does the inclusion of a business plan serve as an exception for the aggregate margin requirements?<br>2) Please confirm that a business plan serves as documentation of an exception to the margin requirement. This question also pertains to situations where the prior year bid was submitted with a negative margin and this year's meets or exceeds business plan expectations, but is still within the original business plan projection period, so they are not at ultimate margin projections yet. | 1) The business plan for a bid with negative margin does not serve as an exception for non-compliance with the **aggregate** margin requirements. The business plan only serves as exception for bid-specific negative margin requirements.<br>2) A bid that meets or exceeds the prior business plan targets, submits an updated business plan, and complies with the other instructions on bid-specific margin would be in compliance with the CY2016 Bid Pricing Tool Instructions for **bid-specific** negative margin requirements. |
| 4 | Gain/Loss | 05/28/2015 11:28 | Gain/Loss Margin Guidance | Since our plan has no non-Medicare business, we must enter our corporate margin target using the "Risk-Capital-Surplus" justification. We also aggregate margin to the Parent Organization level. Recognizing that in this scenario all of our MA and PD BPTs will have the same corporate margin requirement, should the "Corporate Margin Requirement % of Rev." entered include or exclude the following:<br>• ESRD/Hospice margin<br>• The effect of sequestration on revenue (which is not reflected in the BPT margin calculation)<br>• Part D margin<br>• EGWP margin<br>• DSNP margin | The "Corporate Margin Requirement % of Rev" should reflect the risk and capital and surplus requirements of the Parent Organization prior to any impact of sequestration and be inclusive of all enrollees including those listed in the question (ESRD, Hospice, Part D, EGWP, DSNP). |
| 5 | Part D Completion Factor | 05/23/2015 10:01 | Part D completion factor | We have claims that have been paid, but have not yet been submitted to CMS in a PDE record. These claims are expected to ultimately be submitted to and accepted by CMS. Please confirm that any factor adjustment to the base claims data to incorporate these dollars in worksheet 1 should not be included in the completion factor shown on Worksheet 1.<br>Instructions indicate that PDE rejects and Plan to Plan should not be included in the completion factor, but they do not specifically detail this scenario. | Yes, that is correct. The adjustment should not be included in the completion factor. The completion factor should only represent claims that have been incurred but not yet paid. |