User Group Call Date 04/12/2018

Introductory note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@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
For questions related to risk score models and released data: riskadjustment@cms.hhs.gov
For questions related to the Encounter Data Processing System: encounterdata@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rates	02/05/2018 19:51	Advanced Notice questions	Can CMS provide additional quantitative detail regarding how the impact of MACRA's QPP was included in the calculation of the FFS costs and the growth percentages?	We have assumed that 13.5 percent of CY 2019 physician payments would include the 5 percent MACRA Quality Payment Program bonus. These bonuses are expected to add roughly 0.7 percent to the 2019/2018 physician cost trend.
2	Growth Rates	04/09/2018 18:17	Actuarial User Group Call	How much of the 2019 growth rate is explained by the expected payments for MIPS bonuses?	Similarly, we expect that the calendar year 2019 incurred MIPS bonus payments to add 0.7 percent to the physician trend. Collectively, the MACRA and MIPS added about 0.25 percent to the 2019 FFS growth rate
3	Growth Rates	02/19/2018 13:00	Question for Feb 22, 2018 OACT Call	The FFS USPCC (non-ESRD) table from the Final Call Letter shows trends at 2.6%, 2.9% and 4.0% respectively for 2017, 2018, and 2019. a) What can you share about the drivers impacting the bigger increase for 2019? b) Can you say which is the main driver for the increase in 2019, unit cost or utilization? c) Are there any specific cost categories impacting the 2019 trends?	The increase in the FFS trend rate for 2019 compared to 2017 and 2018 is broad based with a positive impact across most payment systems. The category with the largest positive differential inpatient hospital where the trend is up 1.5 percent due to the expectation of higher Uncompensated Care Payments stemming from anticipated increase in the US uninsured population. Other service categories with higher trends in 2019 vs average of 2017 and 2018 are: (i) Physician spending, due largely to the MACRA QPP and MIPS bonus payments, (ii) Skilled nursing stemming from higher trends in utilization and case mix, (iii) Home health resulting from increased utilization, and (iv) DME due to expectation of new competitive bidding parameters for 2019
4	Growth Rates	02/02/2018 16:44	2019 Advance Notice (Part 2) Question	In the 2016 FFS data that was published on Feb 2, risk scores were not included. Risk scores are necessary to adjust the data to gauge the impact of 2016 data on final 2019 FFS rates. Is it possible to receive the average risk score by county that aligns with the data provided?	We discontinued the practice of publishing the risk scores with the FFS data since the risk score is tied to a specific model, and the model is typically updated every one to four years. Rather, we recommend that the FFS costs be normalized for risk through use of the county level risk scores applicable for the contract year. The contract year non-ESRD 2019 risk scores are contained in this link https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html, file 2019 Rate Calculation data.zip, spreadsheet risk scores 2012-2016 non-PACE.csv
5	Growth Rates	04/09/2018 18:20	Actuarial User Group Call	Can CMS provide information about how much the change in FFS USPCC trends from year to year is driven by change in the FFS population demographics? Could CMS provide a distribution of the age/gender for each year from 2012 to 2019 (e.g., under 65, 65, 66, 67, 68, 69, 70-74, 75-79, 80-84, 85+)?	For the 5 year period, 2014-2019, the estimated impact of shifting demographics on Part A fee-for-service trend is -1.5 percent. There is no corresponding impact on Part B per capita spending. These impacts are included in the 5 year growth rate narrative, which was posted on the web today. Unfortunately, at this time we are not able to provide a distribution of demographic impacts for years 2012 to 2019 by the requested age ranges.
6	Star Ratings	04/09/2018 18:59	Stars impact of consolidation	I would like additional clarity on how the payments under the new consolidations rules will work. My reading of final notice is that any plan which is approved for consolidation will be paid based on the stars for the surviving contract for the next two years. For example: Plan A and Plan B are consolidated into Plan B, approved in April of 2018 for a Jan 2019 eff date. Plan A's experience would have resulted in 3.5 stars for the 2019 payment year and 3.0 stars in 2020. Plan B's experience (based on original Plan B only) would have resulted in 4.0 stars in 2019 and 4.5 stars in 2020. The consolidated plan has 4.0 stars in 2019 and 4.5 stars in 2020. There is no blending for this plan in 2020. In 2021, the stars payment is based on the 2019 consolidated experience. Can you please confirm?	The new policy only applies to consolidations approved on January 1, 2019 or after, therefore the current policy is in place for this example. For consolidations approved on or after 1/1/2019, the new policy will not impact payments until 2020. The QBPs are determined at the contract level, not the plan level. If contract A is the consumed contract and contract B is the surviving contract, the 2020 QBPs would be the enrollment weighted 2020 QBP rating of contract A and contract B. The 2020 QBP ratings of contract A and contract B are their 2019 Star Ratings. The 2020 and 2021 Star Ratings for contract B would combine data from both contract A and contract B so for future years the QBPs would be based on contract B's Star Rating.

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7	Related Party	02/22/2018 18:19	Beta Testing Comment 1741: Issue common to both MA and PD Instructions	[Paraphrased] We are an organization (XYZ Plan) trying to use the Market Comparison through Related Party Method. The related party is unwilling to share details of comparable arrangements with unrelated organizations. Due to the proprietary nature of our contract with the related party, we believe it would be inappropriate for the related party to release information or analysis demonstrating how their contracts with XYZ Plan are comparable to those with an unrelated organization. Furthermore, supplying such information to XYZ Plan could violate anti-trust. Our questions are: 1. In order to protect the proprietary nature of the agreements between a related party and an unrelated organization, will CMS allow an attestation stating that actual contracts between the related-party entity and unrelated organizations, as well as documentation demonstrating that those contracts are comparable to contracts with the XYZ Plan are available to CMS upon request? 2. If so, will CMS contact the related party directly?	1. The initial upload to HPMS by XYZ Plan must include all of the required supporting documentation, including a demonstration of comparable market rates and an analysis of the terms of the corresponding contracts in this case. Note that it would be acceptable for the related-party supporting documentation for the Market Comparison through Related Party Method to de-identify names of the unrelated organizations and the exact volume of business. Market Comparison through Related-Party Example Assumptions: - XYZ Plan and Client B contract with XYZ Plan's related-party provider to provide similar services. - Client B is unrelated to both XYZ Plan and XYZ Plan's related-party provider - "Large" means > 100,000 lives Client Name / Client Size / PMPM XYZ Plan / Large / $100 Client B / Large / $97 within 5% Services Covered: Clinical services, marketing, payment, and billing 2. CMS auditors and reviewers will contact the plan sponsor about receiving additional, detailed information directly from the related party, as necessary.
8	Base Period Experience	04/09/2018 17:37	Two Questions	Page 10 of the CY 2019 MA BPT Instructions discusses base period experience cross-walk and data aggregation requirements and states that "MA data excludes data for Section 1876 cost plans". Please confirm this guidance applies to cases where an 1876 Cost contract is terminating and members may be eligible to deem into an MAPD conversion plan. Specifically, since deeming will not be final until after bids are submitted, and is dependent on a TBC comparison using the finalized bids, we assume the deemable experience would not be included in Worksheet 1 of the bids, but that we would take the experience into consideration when setting the manual rates and projections for the 2019 bids.	Base period data reported on MA Worksheet 1 must exclude Section 1876 cost plan data in all cases, as noted on page 10 of the CY2019 MA bid instructions both for data aggregation and base period experience, in general. It would be acceptable for the certifying actuary to take Section 1876 cost plan experience into consideration when setting the manual rates and projections for the 2019 MA bids with sufficient supporting documentation as outlined in Appendix B, item 12 of the MA bid instructions.
9	Gain/Loss Margin	02/26/2018 16:00	Gain/Loss Testing Rules	The aggregate gain/loss instructions state that "the 'Non-Medicare' corporate margin basis applies if the volume of the [bid sponsor's] non-Medicare business, for which it has discretion in rate setting, is greater than or equal to 10% of the [bid sponsor's] total non-Medicare business." We have 2 questions related to this: 1. Does the 10% threshold apply to membership or revenue? 2. Is the calculation based on base period, current year, or projected year membership and/or revenue?	1. and 2. The threshold for the bid sponsor's non-Medicare business, for which it has discretion in rate setting, is based on projected revenue for the contract year.
10	Gain/Loss Margin	03/02/2018 14:32	Beta Testing Comment 1770: MA Instructions	In the instructions for bids with negative margin, the first sub-bullet under "Five-Year Period" says, "The five-year period to achieve profitability excludes contract years in which the bid is projected to be in a product pairing." How do we count the fourth year in the following example: • The BPT has a projected negative profit margin for three consecutive years and files a negative-margin business plan (NMBP) for the first two years. • In the third year, the BPT is part of a valid product pairing. • In the fourth year, the BPT again has a projected negative profit margin, but must file a NMBP because there is no longer a valid product pairing. Is that fourth year considered the third year of the five-year period, or does it reset to be the first year of a new five-year period?	In the example, the fourth consecutive year with a projected negative margin is considered the third year of the five-year period. Years with a projected negative margin that are part of a valid product pairing do not count toward the five-year limit, but also do not reset the five-year period.
11	Gain/Loss Margin	03/02/2018 14:32	Beta Testing Comment 1771: MA Instructions	In the instructions for bids with negative margin, the second sub-bullet under "Five-Year Period" says, "If the contract number-plan ID-segment ID changes for a certain contract year, then the five-year period to achieve profitability begins with such contract year." If we had a change in the contract, plan and/or segment number in CY2018 or a prior year, but did not restart the five-year period in our negative-margin business plan (NMBP) at that time, may we now revise our CY2019 NMBP, so that the year of the "ID" change be considered year one of the five-year period?	Yes, if the contract-, plan- and/or segment-number changed for CY2018 or earlier, you may update the CY2019 negative-margin business plan for this bid to treat the year of the "contract-plan-segment" combination change as year one of the five-year period to achieve profitability.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
12	Credibility	3/2/2018 14:15 and 3/1/2018 18:59	Beta Testing Comment 1767: PD Instructions and Plan Specific Credibility for Part D bids.	[Paraphrased] We request OACT explicitly and clearly address their willingness to accept an alternate claims credibility approach. For example, we would like to use separate approaches for Part D non-specialty and specialty drugs, or a separate approach for unique populations (SNP). We also request the safe harbors (less than 20% or more than 90%) described in the instructions extend to the alternate credibility approach.	CMS does accept alternate claims credibility approaches. The following guidelines apply: First, Appendix B (item 5.2) of the bid instructions requires "an actuarial report of the credibility procedure used if it varies from the CMS guideline or the CMS override." The actuary should provide an actuarial report that satisfies Actuarial Standard of Practice (ASOP) No. 23 (Data Quality), ASOP No. 25 (Credibility Procedures), ASOP No. 41 (Actuarial Communications), and any other applicable ASOPs. For example, the actuarial report is described further in ASOP No. 41, section 3.2 Second, the alternate credibility approach must be consistent with the inputs permitted in the bid pricing tool (BPT). For example, the Part D BPT does permit inputs separated by non-specialty and specialty drugs, where these drug categories are defined by CMS. As a contrary example, the MA BPT does not permit separate credibility inputs by dual-eligible and non-dual-eligible members, so you could not apply separate credibility factors within the same bid for these two populations. Third, the CMS overrides (less than 20% or more than 90%) are not prohibited for use in an alternate credibility approach. CMS cannot comment on whether or not these overrides would be appropriate to any particular alternate approach. The actuary must make this determination as part of the development of the credibility procedure.
13	Manual Rating	03/08/2018 17:36 and 03/28/2018 9:17	Bid Question: Part D Manual Rate Credibility and Part D credibility question	[Paraphrased] We are developing a manual rate based on plan experience that is less than 100% credible under CMS's guideline. The manual rate data is selected based on identifying similar membership characteristics as the population expected to enroll (e.g. provider prescribing patterns, product design attributes, expected cost profiles, geography, etc.). We believe that our manual rate is more representative of the expected experience than a larger population with less similar membership characteristics, requiring greater adjustment. Does CMS require any substantiation of the credibility of underlying manual rate data, or is it sufficient to document the other reasons why this data was selected?	CMS does not require substantiation of the credibility of underlying manual rate data. Instead, sufficient substantiation should adequately support the reasonableness and appropriateness of the manual rate itself, including the reasons why the source data was selected. CMS has the following specific comments related to the substantiation of the manual rate: 1) The actuary must provide the information required in the bid instructions, Appendix B, item 12 (manual rate support). Items 12.1 and 12.2 apply to this issue as follows: ▪ "12.1. A description of the source data, including, but not limited to, the data's relevance to the [MA, Part D] bid, incurred dates, and the exposure (expressed in member months) as used to develop the manual rate." 2) In response to this issue, the actuary should state why the source data is considered reasonable and appropriate for the pricing, with consideration given to the limited exposure. ▪ "12.2. Consideration of any adjustments made for annual volatility of the source data." 3) In response to this issue, the actuary should consider the impact that the limited exposure may contribute to uncertainty or risk in any results. The actuary may provide support for considerations made in assessing the volatility and/or reducing the volatility of the source data, e.g., using two years of data, instead of a single year of data. 4) The actuary should consider the pricing of the manual rate with limited exposure by referring to the Actuarial Standards of Practice (ASOPs). Emphasis is placed on, but not limited to, the following (ASOPs): ▪ ASOP No. 23, Data Quality ▪ ASOP No. 25, Credibility Procedures ▪ ASOP No. 41, Actuarial Communications.
14	Part D	2/22/2018 12:41 and 03/06/2018 11:53	Beta Testing Comment 1721: PD Instructions and Sensipar	[Paraphrased] Please review and clarify which beneficiaries are, and are not, eligible for Sensipar as a Part D drug beginning in 2018, then answer the following two questions about completing the Part D bid regarding Sensipar: 1. Should the cost and utilization of Sensipar be included in base year experience (2017) in Part D BPT worksheet1? 2. When adjusting the projections of the CY2019 PD bids for this change, which Worksheet 2 projection factor accounts for it, formulary change factor or other change factor?	If Sensipar is received at a renal dialysis center for the purposes of dialysis, then it is covered under the Part B ESRD bundle. If Sensipar is received outside the dialysis setting, it is coverable under Part D. Sensipar must be included in the base period experience. Please use the "other change" factors on worksheet 2 of the Part D BPT to account for the coverage change in the projection period.
15	Part D	03/02/2018 11:10	Beta Testing Comment 1765: PD Instructions and late enrollment penalty	With the removal of the member penalty premium line on Worksheet 1 of the CY2019 Part D BPT, how should we account for the Late Enrollment Penalty in the other revenue lines?	Part D plan sponsors must report the Late Enrollment Penalty in the manner that is most consistent with their financial statements. For example, if the plan sponsor receives $100 in directly billed late enrollment penalty, and the Part D payment from CMS is $900 = $1000 original payment less $100 LEP withholding, and both are reported as revenue in the sponsor's financial statement, then the plan should enter $1,000 for the CMS Part D Payment in Worksheet 1, Section V, line 1.

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16	Part D	03/29/2018 10:09	Part D EGWP Actuarial Equivalency Tests	[Paraphrased] We want to get confirmation on which, if any, of the following six Enhanced Alternative actuarial equivalency tests apply for Part D EGWP pricing: 1. Equivalent Value of Total Coverage must be greater than or equal to the standard benefit 2. Equivalent Unsubsidized Value must be greater than or equal to the standard benefit 3. Maximum Required Deductible must be less than or equal to the standard benefit 4. Catastrophic Coverage must be greater than or equal to the standard benefit 5. Payment for Costs at Initial Coverage Limit must be greater than or equal to the standard benefit 6. Payment for Costs in the Gap must be greater than or equal to the standard benefit Can you confirm exactly which of these tests apply to Part D EGWP pricing? Is there specific guidance that CMS has published that explains which tests apply? If so, could you provide or point us to this guidance for future reference?	The tests that apply to Part D EGWPs are as follows: 1. 42 CFR 423.104(e)(1) the annual deductible does not exceed the annual deductible specified in defined standard coverage; 2. 42 CFR 423.104(e)(2) cost-sharing no greater than the cost sharing in defined standard coverage once the annual out-of-pocket amount is met; 3. 42 CFR 423.104(e)(3) the total or gross value of the coverage be at least equal to the total or gross value of defined standard coverage;

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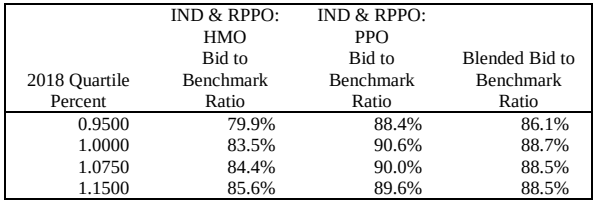
#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Growth Rates	04/09/2018 18:17	Actuarial User Group Call	[Paraphrased and Emails Combined] In 2019, coverage for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) items and services should be included in Medicare Advantage plan benefits and bids for basic Medicare benefits. What is the expected net cost impact in 2018 and in 2019, separately, for coverage of supervised exercise therapy (SET)? Were the SET and PAD costs included in the 2019 benchmarks and if so can you quantify the magnitude of the cost and impact they had on the 2019 FFS USPCC growth rate?	**READ ON 4/19/18 CALL:** As stated in an August 12, 2017 HPMS memo, "CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans. Plans should account for these items and services in their contract year 2019 bids." Supporting this national coverage decision was a projection prepared by the Office of the Actuary that the estimated cost of SET for 2018, which is the first full year of coverage, was about 0.1 percent of 2018 FFS spending excluding hospice care. We did not prepare an estimate of the SET spending for CY 2019. Also, given that there was limited SET experience in our base data for 2017, the SET coverage expansion had little direct effect on the 2019 FFS USPCC growth rate. **CORRECTED RESPONSE (4/25/18):** As stated in an August 12, 2017 HPMS memo, "CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans. Plans should account for these items and services in their contract year 2019 bids." Supporting this national coverage decision was a projection prepared by the Office of the Actuary that the estimated FFS cost of SET in 2018, would exceed 0.1 percent of 2018 FFS spending excluding hospice care. The estimated CY2019 cost of SET reflected in the FFS USPCC supporting the 2019 rate announcement is $900 million. There was no corresponding SET spending assumed in the 2018 rate announcement since the SET national coverage decision was published after the 2018 rate announcement. Thus, the entire CY 2019 SET estimate of $900 million is reflected as an increase in the USPCC baseline, resulting in an impact on the 2019 FFS ratebook growth rate of about 0.2 percent Finally, based on our analysis of actual claim data and other factors, our current expectation is that actual FFS SET spending for CY 2019 will be about 0.1 percent of FFS expenditures.
2	Growth Rates	04/06/2018 15:47	Medicare Trends	We have been looking through the 2019 rate announcement trends and have a few questions. 1) The 2016 Skilled Nursing Facility FFS PMPM trend is −3.8%. This trend is lower than other most recent historical years' trends which are between 1% and 2%. What is driving the negative trend? 2) The 2018 and 2019 projected Home Health FFS PMPM trends are 3.3% and 5.1%, which are much higher than all historical years' trends which are between −4% and 2%. What are the components of the 2018 and 2019 trends (i.e., utilization, mix, price trends)?	1) In 2016, the SNF utilization (days per 1000) decreased by 5.7 percent, compared to an average decrease of 1.4 percent for the prior four years. Case mix was also lower in 2016 (0.5 percent) compared to the average for the prior four years (1.4 percent). There was also an adjustment to the market basket update for forecast error that lowered the 2016 update by 0.6 percent. 2) The HHA utilization assumptions for 2018 and 2019 have been updated to be based on longer term trends as opposed to the most recent years. The utilization trends for 2018 and 2019 are 1.5 percent and 1.2 percent respectively. For case mix, the increases are 1.5 percent each in the two years. The price the increases are 0.1 percent in 2018 (due to legislated update of 1 percent and a reduction for case mix of 0.9 percent) and 2.5 percent in 2019. It is also important to note that the rebasing reductions have been completed which had lowered the updates in the recent past
3	EGWP Rates	04/12/2018 14:25	Question for Next Call: Individual PPO B2B	Will you be posting the Individual PPO Bid-to-Benchmark ratios by quartile that were used to develop the 2019 Local EGWP rates?	

2018 Quartile Percent	IND & RPPO: HMO Bid to Benchmark Ratio	IND & RPPO: PPO Bid to Benchmark Ratio	Blended Bid to Benchmark Ratio
0.9500	79.9%	88.4%	86.1%
1.0000	83.5%	90.6%	88.7%
1.0750	84.4%	90.0%	88.5%
1.1500	85.6%	89.6%	88.5%

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	Plan Payment Data	04/16/2018 14:47	Plan Payment Data	In calculating estimates of risk scores for MA members versus FFS data in any particular service area, we generally look at the plan payment files posted at https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html as one source of information. These files are typically available in February of each year; however, the 2016 data still hasn't been added to the site. Could you please let us know when CMS is planning to post these files?	As indicated in the February 20th 2018 HPMS memo titled "Updated Announcement Regarding Encounter Data Deadlines for Payment Years 2016 and 2017 Final Reconciliation", CMS intends to conduct a second interim reconciliation run of the PY2016 risk scores, as well as a final risk adjustment reconciliation run for PY2016, later this year.
5	Crosswalks	04/16/2018 19:47	Crosswalk Question	We are filing a new FIDE DSNP plan in 2019 for which we are requesting a crosswalk exception to crosswalk members from an existing DSNP plan in the same service area. The crosswalk exception is dependent on both CMS approval and State approval of the MIPPA contracts. We do not expect to have either of these approvals prior to the bid submission. How should we reflect this in the 2019 bids? Should we assume the crosswalk exception and MIPPA contract will both be approved and reflect the crosswalk exception in the bid? Or should we not reflect the crosswalk since it has not yet been approved and base the bid projections entirely on a manual rate?	The bid pricing tool should be completed assuming that the requested crosswalk exception will be approved.
6	Base Period Experience	04/16/2018 11:13	Question Regarding MA-PD Enrollment Consistency	The BPT instructions now state: "Enrollment data for the Part D bid in an MA-PD plan must reflect the same underlying population as that for the corresponding MA bid." Will you please clarify whether this implies that the base period enrollment on Worksheet 1 of the MA and corresponding PD BPTs must match exactly? We use the same data source and same underlying population for both MA and PD BPTs. However we use different data processing approaches which result in minor differences in the values summarized on Worksheet 1 of the MA and PD BPTs. In the past, our auditors have been comfortable with the differences. Will this continue to be acceptable or does the BPT instruction change require us to modify our approach?	We expect the base period enrollment on both the MA and PD bid pricing tools to match, with the exception of any differences between the MA and Part D instructions, such as data aggregation rules or the treatment of segmented bids. We expect the certifying actuaries of the MA and PD bids to coordinate and establish a process for determining the base period population for both bids.
7	Part D	04/13/2018 16:27	Treatment of Sensipar on WS2 of the PD BPT	On the 4/12/2018 Actuarial Bid User Group Call, it was asked if the removal of Sensipar should be reflected in the "Other Change" column on Worksheet 2 of the BPT, which was then confirmed to be CMS' preference. Our Part D model is structured to treat any drug removals (as is the case with Sensipar), reclassifications, or substitutions as "Formulary Change" since these types of changes are typically a result of changes in the formulary or drug coverage status. Our models are not currently set up to carve out a portion of these types of changes as anything other than "Formulary Change". Would it be acceptable to classify the removal of Sensipar as "Formulary Change" or is it required to be reflected in the "Other Change" column?	No, because Sensipar will still be covered under Part D in some circumstances, the change in coverage does not necessitate a change in formulary position. Accordingly, this change must be reflected in the "Other Change" columns of the BPT.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/20/2018 19:22	FFS Trends Review	[Paraphrased] While developing the trends, we ran into a couple of instances where we were unclear of what had been accounted for in the FFS trends posted. 1) In the Actuarial Bid Questions posted by OACT for the 4/12/2018 call, questions 1 and 2 indicate that MACRA and, separately, MIPS add roughly 0.7% to physician trends for 2019. Our interpretation is that these elements add 0.7% each, and together should add about 1.4% to the physician trends. Is this correct, or is the combined impact of MACRA and MIPS 0.7%? 2) Is the impact of MACRA and MIPS accounted for in the +0.25% 1/1/2019 physician unit cost trend posted in 'FFS-Trends-2017-2019.pdf'? Based on the wording of the response, we are currently assuming that they have not been included in the OACT unit cost trends, but have been included in the Final Rate Notice PMPM trends. Is this correct? 3) Similarly, in the Actuarial Bid Questions posted by OACT for the 4/12/2018 call, question 3 indicates that IP trend is up 1.5% due to an expected increase in uncompensated care payments. Based on the wording of the response, we are currently assuming that this impact has already been accounted for in the posted IP trends effective 10/1/2018. Is this correct?	1) The combined impact of MACRA QPP and MIPS bonuses on the 2019 physician FFS growth rate is about 1.4 percent. 2) Yes, the impact of 2019 MACRA and MIPS bonuses are excluded from the 1/1/2019 unit cost trend. 3) The projected impact of UCP is not reflected in the 10/1/2018 unit cost trend exhibit. Similarly, projected decreases in inpatient utilization are not reflected in the 10/1/2018 unit cost trend.
2	FFS Trends	04/06/2018 15:47	Medicare Trends	The 2018 projected physician fee schedule PMPM trend is 3.8%, which is higher than all historical years' trends which are between -1% and 3%. What are the components of the 2018 trend (i.e., utilization, mix, price trends)?	For 2018 physician fee schedule, the per capita growth is 2.6% excluding the impact of shared savings payments under innovation models. This trend is composed of 0.5% price and 2.1% non-price (volume and intensity). This is similar to recent historical trends. Further the Part B impact of 2018 shared savings payments under innovation models is fully included in the physician category, which added 1.1 percent to the 2018 physician trend.
3	TBC	04/20/2018 10:34	TBC Question	An existing contract will be consolidated into another contract for CY2019, and the continuing contract has a higher quality rating. The TBC file provided by CMS does not take into account the increase in Star rating for plans in the non-continuing contract in the adjustments to TBC. Will the final TBC test applied by CMS in August take into account the increase in Star rating for these plans, and if so, can a revised TBC file be provided that would allow the plan sponsor to ensure plans are meeting the TBC requirement including the impact of the higher Star rating?	The TBC file released by CMS assumes that all plans are continuing and the payment adjustment factors take into account only the CY2019 Star Rating for that contract. The adjustment factors are applied consistently from bid submission to bid approval as described in the HPMS Memo issued on Friday, April 13, 2018 (memo is dated April 12) and titled: "Contract Year 2019 Medicare Advantage Bid Review and Operations Guidance" (see page 5). Below is language from the memo describing the process: CMS will maintain the TBC evaluation used during CY 2018 for consolidating or crosswalking plans. Each individual plan being consolidated/crosswalked into another plan must meet the TBC requirement on its own merit. Therefore, the TBC adjustment factors for each plan being consolidated/crosswalked will be part of the calculation as if the plan were continuing. For example, Plan A is being consolidated/crosswalked into Plan B. Plan A's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan A's consolidation into Plan B. Plan B's TBC adjustment factors (technical and payment) would be used in the TBC evaluation for Plan B. The following describes how the TBC evaluation will be conducted for organizations that consolidate/crosswalk or segment plans from one year to the next: • Consolidating/crosswalking multiple non-segmented plans into one plan: TBC for each CY 2018 plan will be compared independently to the CY 2019 plan. • Segmenting an existing plan: TBC for each CY 2019 segmented plan will be compared independently to the CY 2018 non-segmented plan. • Consolidating/crosswalking previously segmented plans: TBC of each existing CY 2018 segmented plan will be compared independently to the non-segmented CY 2019 plan. • Consolidating/crosswalking segmented plans into other segmented plans: TBC of the existing CY 2018 segmented plan will be compared independently to the segmented CY 2019 plan.

User Group Call Date 04/26/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
4	TBC	04/23/2018 18:23	Plan-Specific TBC Calculation question	We received the plan-specific TBC adjustment amounts that were released on Monday, April 13 and had a question regarding the "Gross Payment Adjustment" – item H. Could you please confirm whether the "Gross Payment Adjustment" includes or excludes the 5.11% FFS growth percentage released CY2019 Final Rate Announcement on Monday, April 2.	The Gross Payment Adjustment uses the Total USPCC rate of 5.93%. The Gross Payment Adjustment is the estimated difference between CY2018 Rebate and the CY2019 Rebate and is calculated using the following steps: 1. To estimate the bid amount for CY2019, we grow the CY2018 bid by 5.93%, the Total USPCC. 2. To estimate the benchmark we use the projected enrollment in the CY2018 bid and the CY2019 benchmarks, taking into account the CY2019 Star Ratings, including the rebate percentage associated with the Star Rating. 3. The Gross Payment Adjustment is then the estimated CY2019 Rebate less the CY2018 Rebate.
5	Gain/Loss Margin	04/19/2018 9:45	CY2019 MA bid question	[Paraphrased] We're seeking clarification on the guidance for bids with negative margin. Consider the following scenario for non-segmented bids X and Y: bid X was first negative in CY2016 and negative in CY2017 under the same PBP number. Bid X consolidated into renewal bid Y for CY2018. Does the 5-year period to reach profitability for consolidated bid Y reset due to the bid consolidation? That is, should we demonstrate profitability of bid Y within 5 years of bid X first being negative?	Since bid Y is the continuing bid after consolidation, the gain/loss history of bid X has no bearing on the negative margin requirements of bid Y. For example, if bid Y is in its second year of negative margin in CY2019, the bid sponsor would need to demonstrate profitability for bid Y by CY2023.

User Group Call Date 05/03/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/24/2018 21:33	FFS Medicare unit cost trends	Thank you for releasing the two documents on FFS Medicare trends – Narrative of 2014-2019 USPCC Trends and FFS Unit Cost Trends for 2017-2019. I have two questions: 1) The first question is on IP Hospitalization. In the Narrative of 2014-2019 USPCC trends, it was mentioned that beginning with FY2019, the uncompensated care payments (UCPs) are projected to increase due to an expected rise in the uninsured population. Offsetting these increases are lower SNF utilization and case mix, resulting in an increase in the calendar 2018 USPCC trend of 1.14% in the 2019 Payment Announcement. Please confirm the year during which UCP is projected to increase – FY2019 or FY2018. Furthermore, for the FFS Unit Cost Trends 2017-2019 document, please confirm whether the projected IP Unit Cost Increase of 2.1% effective 10/1/2017 and 2.6% effective 10/1/2018 included the effect of the UCP changes. Please let us know which line item embedded this change – market basket, documentation & coding, legislated adjustments or per CMS regulations. 2) The second question is on DME. In the Narrative of 2014-2019 USPCC trends, it was mentioned that growth in 2019 of 8.7% reflects anticipated changes in the bidding program starting 1/1/2019. In the FFS Unit Cost Trends 2017-2019 document, a 1.8% trend is shown effective 1/1/2019. Could you please help us understand the large difference between these two trend figures?	1) The increased trend in the Uncompensated Care Payments (UCP) is projected to take effect in FY 2019. The repeal of the individual mandate which has caused the increase in the projected number of uninsured occurred after the FY 2018 UCP projection was developed. Also, UCP is not reflected in the recently posted unit cost exhibit labeled "Medicare Unit Cost Increases Reported as of April 2018." This exhibit shows the update to the inpatient hospital PPS rates for each year. Since UCP payments are made outside the inpatient prospective payment system (PPS) (they are an add-on to those payments) they are not included in the unit cost exhibit. 2) Section 16008 of the 21st Century Cures Act requires changes to 2019 fee schedule for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for non-competitive bid areas. That is, CMS must take into account the highest amount bid by a winning supplier in a competitive bidding area and other factors that collectively will likely lead to higher program expenditures in 2019 and later. Our estimate is that these changes will result in a 5 percent increase in the aggregate DMEPOS expenditures for CY 2019. This increased trend is reflected in the USPCC growth rates, but not the unit cost exhibit.

User Group Call Date 05/10/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	UCP Payments	05/03/2018 11:20	Uncompensated Care Payments for Non Network Hospitals	The OON payment guide for Medicare Advantage plans (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf) states: a new "uncompensated care payment" (UCP) is paid to DSH hospitals starting in FY 2014. The CMS policy for the methodology of plan payments for UCP to non-network hospitals is being determined and should be available soon. Was this guidance issued in the Federal Register?	In the FY 2014 Hospital Inpatient Prospective Payment System Final Rule (78 FR 50496, 50644-46), CMS discussed MA organizations' obligation to pay uncompensated care amounts to non-contract hospitals. As explained in the final rule, MAOs should include the estimated uncompensated care per claim (or "per discharge") amount in their payments to non-contract hospitals. Each eligible hospital's estimated per claim uncompensated care payment (UCP) is published with the annual IPPS final rule. UCP eligibility and payment information is included in the DSH data files for each payment year, which are available on the CMS website's Disproportionate Share Hospital (DSH) page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html). In addition, the CMS Medicare Inpatient PPS PC PRICER software tool (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html) displays the uncompensated care per claim amount in the pricing information it calculates.
2	FFS Trends	05/04/2018 11:58	Question on Trends	In Narrative-2019-Payment-Notice.pdf, it mentioned that the 8.7% growth in 2019 reflects anticipated changes in the bidding program starting January 1, 2019 for DME. What are the components (utilization, unit cost, etc.) of the 2018-2019 growth rate for DME?	The 2019 DME growth rate of 8.7 percent is composed of a unit cost trend of 1.8 percent, legislated change in non-competitive bidding of 5.0 percent, and residual impact of 1.7 percent.
3	FFS Trends	05/07/2018 20:08	FFS Trends Review	1) Is it possible for you to tell us where Part B Drug costs are bucketed within the PMPM trends provided in the Final Rate Notice? 2) Additionally, will you please provide these Part B Drug trends separately so that we can be more accurate in projecting costs for this particular service category	Part B drugs are included in several categories of services including other carrier, outpatient hospital, DME, and other intermediary. For the non-ESRD population, the two largest categories are other carrier and outpatient. Included in other carrier are physician administered drugs with per-capita FFS trends of 9.5 percent on average for 2013-2016, 9.0 percent for 2017, 8.0 percent for 2018, and 7.4 percent for 2019. We do not have a break out of the Part B drug trends included in the other benefit categories.
4	FFS Trends	05/07/2018 11:22	2019 Bid Development questions - margin test, SET for PAD costs	CMS has stated that Supervised Exercise Therapy is expected to be 0.1% of FFS expenditures. Does CMS have an average expected claim cost for these services or an average visit amount or an average cost per patient episode that can be shared to help MA plans estimate costs?	Based on fee for service claims paid during the first quarter of 2018, the average allowed cost for Supervised Exercise Therapy is about $20 for services provided in a physician's office and about $58 for services provided in an outpatient setting.
5	Gain/Loss Margin	05/07/2018 11:22	2019 Bid Development questions - margin test, SET for PAD costs	In light of the health insurer fee holiday, would CMS consider increasing the margin test threshold? This is to assist MA plans in maintaining benefit stability and to not be forced to increase benefits one year (just to pass the margin test) and then be compelled to remove them the next year when the fee gets reinstated.	No, the gain/loss margin requirements will not be adjusted because of the suspension of the Health Insurance Providers Fee.
6	Gain/Loss Margin	05/03/2018 16:07	Margin Documentation	Regarding the margin substantiation uploaded with bid documentation, how should acquisitions be treated in the historical lookback analysis? For example, if an MA plan acquired another organization with MA business, with the deal closing late 2017, should all historical margins in the year to year consistency demonstration include all plans currently under the parent organization, or should they only include plans that were part of the parent organization in that particular calendar year? If the latter is true, are separate exhibits required for each historical parent organization?	The purpose of the demonstration of consistency between historical actual and projected margins is to assist us with assessing the reasonableness of the projected margins for the Contract Year. Our goal is to review how well the projections have been tracking with the actual outcomes and how the projection for the contract year has taken the historical information into account. The certifying actuary may choose whether or not to combine the historical information of the merged organizations as the basis for supporting the projected margins. Whether the historical consistency is demonstrated on a combined basis or separately for each of the merged organizations will depend on availability of the information and the circumstances of the merger.

User Group Call Date 05/10/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Gain/Loss Margin	05/04/2018 19:49	Flexibility of Margin Requirements due to TBC	We would like additional clarity around the sort of flexibility we could be afforded if we are limited in our benefit changes due to TBC. 1. If we have a negative margin plan in the second year of a 5 year plan to profitability, and we are unable to meet the second year profit target due to the TBC limit, would we be allowed an additional year to get to profitability? 2. If our DSNP plans have profit more than 1% higher than General Enrollment plans, are we given the flexibility to file the DSNP profit at that level, if we can demonstrate that the GE plan profit was limited due to TBC? 3. The instructions say "exceptions to the gain/loss margin requirements must be disclosed, be fully explained and supported, and ultimately be approved by CMS." Do we submit our exceptions for approval prior to bid submission? If not, and the exception is not approved, what happens?	All plans must meet the TBC requirement. If there is a conflict between satisfying gain/loss margin requirements and the TBC requirement, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the TBC requirement. Please keep in mind that when OACT reviews negative margin business plans, plan sponsors will need to demonstrate that they are making meaningful changes in each of the 5 years to reach profitability, knowing that TBC requirements will limit a major benefit and/or premium change in any one year of the business plan. 1. In this scenario, the plan would need to have premium and/or benefit changes up to the TBC limit to get as close as possible to the original business plan. The plan sponsor may then need to adjust their original business plan for years 3-5 in order to ensure profitability within the 5 year requirement. The TBC limit in year 2 does not automatically allow for an additional year to reach profitability. 2. In this situation the aggregate D-SNP gain/loss margin requirement still applies. The plan sponsor has the option to submit a margin exception request to CMS and the specific plan circumstances will be reviewed. 3. CMS does not pre-approve gain/loss margin exception requests. Plan Sponsors may submit exception requests (Appendix B, 8.7) with their initial bid submission. If the exception request is not approved by CMS, the Plan Sponsor will be asked to resubmit the bids to comply with the gain/loss margin requirements or will be asked to modify the actions (Appendix B, 8.7.3) contained in the exception request.
8	Part D BPT	05/01/2018 12:05	CY 2019 BPT - Worksheet 3 cell H33	In the CY 2019 Part D BPT, on Worksheet 3, we note the formula for cell H33 subtracts the value for Part D as Secondary in H29. In the CY 2018 Part D BPT, the same cell of Worksheet 3 added the value for Part D as Secondary in H29. Is CMS planning to release a revised BPT to change this formula to add, rather than subtract, the value for Part D as Secondary in H33 of Worksheet 3?	You are correct that there is an error on Worksheet 3 cell H33 of the Part D BPT. The formula should be adding the value for Part D as Secondary rather than subtracting it. Since the value in cell H33 does not get used elsewhere in the BPT and does not impact the bid value or payment calculations, we have decided not to release a new Part D BPT for CY2019 but instead will fix this issue with the release of the CY2020 Part D BPT.
9	Part D BPT	05/03/2018 13:01	Non-Uniform Deductible Question	In the 2018 PD BPT instructions, there was a section starting on page 20 that described how Worksheet 5 and Worksheet 6 need to be populated for non-uniform deductibles. In the 2019 PD BPT instructions, this section has been removed, such that there is currently no distinction between deductibles that apply to all tiers and deductibles that do not. We're looking further guidance for how to populate the BPT for non-uniform deductibles. Specifically: - On Worksheet 5, in the Value of Proposed Deductible section (cells F40 and G40), should any amounts associated with the non-uniform deductible be populated in these cells, or should these cells be $0 for non-uniform deductibles? - For Worksheet 6, the 2019 BPT instructions say on page 60 that that we should "Calculate the cost sharing as if there were no deductible." We also note that the footnote on WK6 states that "The cost sharing for the section labeled "Amounts Up to ICL" should include non-uniform deductibles." Can you confirm for the 2019 bids whether or not cost sharing for plans with a non-uniform deductible should also be calculated as if there were no non-uniform deductible?	The value of proposed deductible (cells F40 and G40 on Worksheet 5 of the PD BPT) must be populated for all deductible types. This is a change from prior years when non-uniform deductibles were instructed to enter 0. Please disregard the reference to non-uniform deductibles in the footnote on Worksheet 6 of the PD BPT. Worksheet 6 must be populated the same way for all deductible types for CY2019, with cost sharing calculated as if there were no deductible. This footnote will be removed for the CY2020 BPT release.
10	Part D BPT	05/07/2018 13:33	Question for MA/PD actuarial user group call	The February 22 actuarial user group call agenda states the following about Sensipar benefit changes: "Beginning 1/1/2018, the costs for Sensipar utilization by beneficiaries with End-Stage Renal Disease are covered under Part B payments and are no longer covered under Part D. Plan sponsors must adjust their projections for the CY2019 bids to account for this change from the experience prior to 1/1/2018." We have reviewed a plan's 2017 Sensipar experience among ESRD beneficiaries and found that the impact on costs is less than $0.01 PMPM. Is it acceptable to consider this immaterial and make no adjustment for Sensipar in our CY2019 MA/PD bids?	The decision on materiality must be made by the certifying actuary, considering both base period and projected period expense. Supporting documentation must clearly show the estimated impact and explain why it was determined to be immaterial to the bid.

User Group Call Date 05/17/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Base Period Revenue	05/14/2018 15:28	User Group Call Question re: Medical Loss Ratio Remittances	[PARAPHRASED] If MLR remittances are anticipated for CY2017, how does CMS anticipate these amounts to be presented in the CY2019 BPTs? Do we: A) Reduce revenue on Worksheet 1 by the MLR remittances; or B) Include these remittance amounts in our reconciliation to audited financial statements required in supporting documentation? While this question focuses on the MA BPT, the same issue also applies to the Part D BPT and Instructions, and we'd ask that the guidance CMS provides be applicable to both MA and Part D BPTs.	Plan sponsors should follow Option B. Do not adjust the base period data on Worksheet 1 for anticipated MLR remittances. In other words, all base period data is completed as if the MLR regulation does not exist.
2	RPPOs	05/13/2018 13:49	Individual RPPO bid component calculation methodology	Please confirm how the 2019 bid component will be calculated for RPPOs. The 2019 MA bid instructions indicate that it is "the weighted-average MA regional PPO bid" for that region. Will it be weighted based on projected 2019 membership or current 2018 enrollment?	The weighted-average MA regional PPO bid uses June reference month enrollment of the current year including any applicable crosswalks. For the 2019 bid component, the June 2018 reference month enrollment would be used.
3	Data Aggregation	05/09/2018 8:43	Please confirm-WS data aggregation	A PBP had two segments in the base period, but will have one segment in the contract period. The sponsor is not planning on cross-walking the PBP to a non-segmented PBP in order to keep the option to modify and add segments in the future. Surviving segment 1 will contain some of the counties and experience in base period Segment 1 and none of the Segment 2 membership will be crosswalked into Segment 1 or any other PBP. Please confirm that for MA Worksheet 1 (WS1), the plan should report only the Segment 1 experience. Segment 2 will not be reported on WS 1 in any 2019 Part MA BPT. For Part D, WS1 will report the full combined experience for both segments.	Yes, for MA it is correct to report the base period experience of Segment 1 on the contract year MA BPT for surviving Segment 1 and not report base period experience for Segment 2 on any MA BPT. For Part D, it is correct to report the full combined experience for both segments on the contract year Part D BPT for this PBP.
4	Related Party	05/04/2018 14:41	Related Party Testing Question	For purposes of testing related parties, do all types of services need to be based on the same related party testing method? For example, Hospital ABC is related to Plan XYZ and provides inpatient and outpatient services to its members. Hospital ABC is able to supply a market comparison showing that payments from Plan XYZ and another unrelated plan are within 5% for inpatient services. Actual costs are available for outpatient services, however. Can the related party requirements be met by providing a market comparison (Method 2) on inpatient services and the actual cost method (Method 1) for outpatient services for the same related party (Hospital ABC)?	Yes, this is acceptable. We expect non-arbitrary, broad categories to be selected. For example, a split between inpatient and outpatient would not be considered arbitrary.
5	Related Party	05/10/2018 11:10	Question on Related Parties	On a 5/18/2017 UGC question regarding a relationship between an MAO and health center (where the two entities have joint board members but no other relationship other than provider network relationships), CMS responded (updated on 5/30/2017) that "… for CY2018 CMS will give the MAO the option to treat the health centers as either related parties or non-related parties, at the MAO's discretion." Does this documentation option exist for CY2019, assuming all of the context that CMS described in the response still holds?	Yes, this approach is still applicable for CY2019 bids.
6	Credibility	05/10/2018 8:21	Credibility %s in Worksheet 2 for Fully Credible benefits that are being eliminated	[Paraphrased] Per page 61 of the MA bid instructions, we are to use a 100% credibility percentage for any category of service on Worksheet 2 where we are not using a manual rate. 1) What credibility percentage should we use on MA worksheet 2 for non-Medicare benefits that are fully credible in the base period, but are eliminated in the contract period? 2) What credibility percentage should we use on Worksheet 2 for a non-Medicare BPT service category, if no benefits were offered in the base period or the contract period?	For scenario 1 enter 100% credibility on worksheet 2 and use the additive adjustment columns on worksheet 1 columns P and Q to remove benefits. Please refer to page 57 of the MA bid instructions for more details. For scenario 2, where a mandatory supplemental benefit was not offered in the base period and will not be offered in the contract period, plan sponsors may either leave the credibility percentage blank or enter 100%.

User Group Call Date 05/17/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	Risk Score	05/11/2018 14:06	CY2019 Phase 3.3 EDS MAO-04 release date	When will the Phase 3.3 EDS MAO-04 reports will be released?	As of 4/30/2018, all Phase III version 3 MAO-004 reports for encounter data records submitted between 1/1/2014 and 12/31/2016 have been released. We anticipate that all Phase III version 3 MAO-004 reports for encounter data records submitted between 1/1/2017 and 12/31/2017 will be released by 5/19/2018. The remaining MAO-004 reports for records submitted in 2018 are expected to be released by the end of May. Phase III version 3 MAO-004 reports will be released for terminated contracts once all reports for active contracts have been released. There are several differences between the Phase III version 2 and Phase III version 3 MAO-004 report. Please refer to the December 20th, 2017 HPMS memo "Phase III Version 3 MAO-004 Report Release Date and Announcement Regarding Final Encounter Data Deadlines for Payment Years 2016 and 2017" and the September 2017 User Group slides for more information on the changes to the report between Phase III version 2 and Phase III version 3 For bid projections, organizations can take into account the information that has been provided (e.g. the differences in the diagnoses on the reports you have received, the changes identified between the versions in the HPMS memo, etc.) to estimate any necessary adjustment.
8	Risk Score	N/A	N/A	If I find a conflict in the dual status between the MMR and individual beneficiary risk score file, which should I rely on for dual status?"	What you are observing is likely due to the timing and data used for Medicaid status. For example, in the risk score for bidding file the data was pulled more recently. The Medicaid status in the beneficiary level risk score file is based on Medicaid status in the payment year (i.e. 2017), with status updates through January 2018. The Medicaid status that is populated on the MMR for community members is determined on a rolling month basis, where the status for each payment month is based on the status 3 months prior Organizations can evaluate and determine the most appropriate source of data and accurate status when completing bid projections.
9	Part D	05/11/2018 16:57	American Patients First Blueprint	Can you make it clear on next week's call what portions of the American Patients First Blueprint that impacts Part D will take effect in 2019 thru executive orders vs. what things are proposals or require legislation? What is the time period for implementing a portion of the rebates at point of sale? What is the portion for 2019?	The CY2019 bids must be in accord with requirements and guidance provided in the Call Letter and the final C&D regulation. If we were to announce changes for CY2019, they would go through the normal methods.

User Group Call Date 05/24/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Related Party	05/15/2018 15:03	Related Party Capitation	For a related party that is performing medical services under a capitation arrangement using the actual cost method is it permissible to allocate all of the actual cost expenses to medical services or must a portion that represents the administration of the services be allocated to non-benefit expense?	If the related party is performing only medical services for the insurer, and not administrative services (such as claims adjudication or provider credentialing), then the entire actual cost is to be allocated to medical cost. Please see page 42 of the MA Bid Instructions for more details.
2	PBP to BPT Comparison Tool	05/21/2018 9:48	PBP to BPT testing	When running the CMS tool comparing the PBP database to the finalized BPTs, does it check for VBID benefits or Flexible benefits? We are offering a VBID supplemental benefit and /or a supplemental benefit under uniform flexibility. However, the PBP to BPT test results in an error because these benefits are listed as "No" in the PBP column. How should we handle this?	No, the PBP to BPT Comparison tool checks the PBP2019 database which excludes benefits offered under the VBID model or MA Uniformity Flexibility. Due to this limitation, the test result in this case would be misclassified as an error on the Summary Report from the tool. You should consider this as a warning and check the sufficiency of VBID supporting documentation required in Appendix B, #17.
3	ESRD-SNP BPT	05/21/2018 17:25	ESRD BPT Question	Should the 'Experience' tab of the ESRD BPT only include membership, revenue and claims of members with ESRD status in CY2017? Or should it also include data for non-ESRD members with enrollment in the ESRD CSNP? This includes non-ESRD and non-hospice members, and ESRD members who also have hospice status. According to earlier CMS guidance, members with both ESRD and hospice status should be bucketed as hospice in the non-ESRD BPT development. Does this same logic extend to the ESRD BPTs?	The Experience tab of the ESRD BPT should include data for the non-hospice enrollees in the ESRD CSNP plan in CY2017 regardless of ESRD status.

User Group Call Date 05/31/2018

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Consolidation	05/26/2018 0:00	Question on Contract Consolidation	Scenario: • Contract HXXXX was acquired by contract HYYYY effective 1/1/2019. Since HYYYY is the surviving contract, 2019 bids will be filed under the new HYYYY contract and CMS will provide new plan IDs for the surviving contract. Old New HXXXX-001 HYYYY-011 Questions: 1. Is it appropriate to show HXXXX-001 2017 base data in Worksheet 1 for HYYYY-011? Note, HYYYY-011 did not exist in 2017. This is the new contract #/plan id as a result of contract consolidation. 2. Is HYYYY-011 still held to the original five year return to profitability for HXXXX-001? Or is the original business plan for HXXXX-001 void since that contract has been acquired?	1. Yes. If HXXXX-001 is part of an official HPMS crosswalk where members are being moved from plan to plan, then the terminating plan (HXXXX-001) CY2017 data should be represented as the base period data for the new plan (HYYYY-011). 2. HYYYY-011 would not be held to the original five-year timeframe to return to profitability.