User Group Call Date 04/17/2014

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

2) Summary of Corrections to CY2015 Part D Bid Instructions

Location in CY2015 Part D Instructions	4-11-2014 Release	Corrected Text
Page 13 under "Worksheet 6, column k, lines 1 through 8 and 19 through 26" heading	"Enter the total cost sharing for allowed costs up to the DS ICL of $320…"	"Enter the total cost sharing for allowed costs up to the DS ICL of $2,960…"
Header on Pages 33-37	WS # 2	WS # 1
Appendix B, Page 76	"Evidence of the evidence of anti-competitive…"	"Evidence of the absence of anti-competitive…"

3) FFS Trends: The Office of the Actuary's current estimate of Medicare unit cost increases by service category for 2013 to 2015 has been posted on the CMS web site at: CMS Home > Medicare > (Health Plans) Medicare Advantage - Rates & Statistics > FFS Trends. This same page of the CMS website also contains an exhibit highlighting key components of USPCC trends for 2010-2015.

4) Illustration
Reconciliation of USPCC growth rate for Part C Experience with impacts presented in April 7, 2014 CMS Fact Sheet

Item	Impact
a. 2015 Part C USPCC growth rate	-6.9%
<u>b. 2015 Part C USPCC prior period adjustments</u>	
Final 2014 risk model	-1.5%
2014 coding intensity adjustment change	-1.2%
2014 actual bid and enrollment experience	-1.0%
Subtotal	-3.7%
c. 2015 Part C USPCC growth rate excl. prior period adjustments [(1 + a) / (1 + b) - 1]	-3.3%
<u>d. Change in impact from Advance Notice to Final Announcement 2015 (Fact Sheet)</u>	
Calibration of risk model to account for demographic changes	1.1%
Other risk adjustment updates	2.1%
Subtotal	3.2%
e. Other	0.5%
f. Year-over-year percentage change in payment (c + d + e)	0.4%

<u>Note</u>: USPCC growth rate reflects the increase in projected 2015 payments compared to last year's projected 2014 payments. Fact sheet amounts are calculated based on benchmark impacts.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Sequestration	N/A	N/A	The bid instructions state that "CMS recognizes that under sequestration the gain/loss margin entered in the BPT is not the gain/loss margin that the Plan sponsor will actually achieve; however, margin requirements must be met with the gain/loss margin entered in the BPT." Why is CMS using the BPT margin for testing the gain/loss margin requirements when this margin does not reflect the actual gain/loss that would be achieved after considering the impact of sequestration?	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. This includes the pricing consideration for sequestration which describes how to appropriately report your revenue requirement, if affected by sequestration. * For example, see section 1860D-11(e)(2)(C) of the Social Security Act available at http://www.ssa.gov/OP_Home/ssact/title18/1860D-11.htm.
2	Gain/Loss	N/A	N/A	Do EGWP plans need to submit a business plan for negative margin?	Yes, the business plan requirement for plans with negative gain/loss margin applies to EGWPs.
3	Gain/Loss	N/A	N/A	For the new margin exhibit (page 117 of the MA bid instructions), is it acceptable to group bid IDs, rather than list every one?	No. Each Bid ID must be listed in the aggregate gain/loss supporting documentation exhibit.
4	Global Capitation	04/15/2014 10:45	Actuarial User Group Call Questions - Cap and Risk Share	New guidance with regard to global capitation and risk sharing arrangements was included in the 2015 MA BPT instructions. The instructions indicated that it is not appropriate to provide risk protection for PD through MA or vice-versa. We would like clarification on what this means. 1) If a health plan has a global capitation or risk sharing arrangement with a medical provider in which the Part D revenue and expense is included in the calculation of the medical provider's payment, do we need to allocate a portion of the medical provider's payment to the Part D bid? For example, if there is a risk sharing arrangement with a physician group in which the provider's payment is based on total revenue and expenses (A/B and Part D), do we need to allocate some of the physician's gain or loss to the Part D bid? If so, please explain why it is appropriate to allocate physician expenses to Part D. 2) Further, if we are to allocate a portion of the medical provider's payment or recovery to Part D, do we need to include the additional payment or recovery from the medical provider in DIR reporting? If so, we are assuming the first year this would be reported would be in the reconciliation for 2015 to coincide with the change in the BPT instructions.	1) Yes. By including Part D revenue and expenses in the risk sharing arrangement, the physician group is sharing in risk for Part D and this should be appropriately reflected in the PD BPT. As stated in the bid instructions "In accordance with CMS guidance, Part D sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed fees. Any gains or losses that the Part D sponsor may experience as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative." This is not new DIR guidance. We are merely pointing out the applicability of the DIR guidance on risk-sharing arrangements to how we expect such arrangements to be captured in the BPT. 2) Plan sponsors must assess the need to correct past DIR reporting based on our clarification in the CY2015 bid instructions.
5	Global Capitation/Rebate Reallocation	N/A	N/A	If global capitation amounts are allocated to Part D in the initial bid submission, and then the global capitation amounts change as a result of rebate reallocation, will plans be allowed to change the Part D BPT at reallocation?	We will not allow for resubmission of the Part D BPT to account for such changes. The Part D BPT must reflect the actuary's best assumption at the time of initial bid submission regarding the appropriate allocation of global capitation amounts to Part D.
6	Rebate Reallocation	N/A	N/A	1) What if changes to margin during rebate reallocation push individual margin out of the allowed difference threshold with EGWP margin? Will the EGWP be required to be refiled with modified margin to meet the requirement? 2) What if changes to margin during rebate reallocation push MA margin out of the allowed difference threshold with Part D margin? Will the Part D margin be required to be modified to meet the requirement?	1) Given the limits on margin changes allowed during rebate reallocation, we expect situations like this to be minimal. EGWP bids must be resubmitted to meet the aggregate margin requirement relative to the MA general enrollment and institutional/chronic care SNP margin. 2) We will not allow for resubmission of the Part D BPT to meet this requirement.
7	Related-Party	04/14/2014 11:58	Medical related party question	Pages 43 and 44 of the 2015 MA bid instructions provide guidance on the treatment of medical related-party arrangements. In order to use Methods 3 or 4, one must demonstrate that "it is not possible to comply with Method 1 Actual Costs. . ." Please describe what CMS would consider acceptable reasons for not being able to comply with Method 1.	We would expect the plan sponsor to provide a statement in supporting documentation explaining the reasons they were unable to comply with the Actual Costs Method.
8	Insurer Fees	03/20/2014 15:04	2015 MA BPT - WKST1 - Insurer Fees	Worksheet 1 of the 2015 MA BPT has an "insurer fees" box in section VI, line 7e. What does CMS expect MA organizations to report here? My understanding is that the insurer fee payable in 2014 based on 2013 revenue will not be accrued until 2014 for bid purposes. Let me know if my understanding is incorrect or if CMS has published other information about how to handle insurer fees when reporting base 2013 experience.	Since the first insurer fee payment is not paid until 2014, the base period (CY 2013) insurer fees should be entered as $0.
9	Non-Benefit Expenses	03/20/2014 11:26	MTM Costs	Administrative costs in 2015 are expected to increase with the inclusion of the additional Medication Therapy Management (MTM) requirements in the draft rules. We would like to know if it would be acceptable for an MA/PD plan to allocate a portion of administrative costs for MTM services to the MA bid and a portion to the PD bid. The cost for MTM services are associated with both the identification of members (through Part D claims) as well as the ongoing management of a member, which is partially the responsibility of their PCP. Due to the involvement of a members PCP in the management of their care under an MTM program, it seems reasonable that a portion of the MTM administrative costs could be allocated to the MA bid. Please confirm that this is acceptable.	This allocation is acceptable if sufficiently supported in documentation.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
10	Claims Recoveries	04/15/2014 10:31	Actuarial User Group Call Questions - Claims Recoveries	If a health plan contracts with a vendor for claims recoveries, should the payment to the vendor be included in administrative expenses or medical expenses? Does the answer vary based on the type of contractual arrangement with the vendor? For example, one contracting option may be for the vendor to retain a portion of the recovery as payment. Another contracting option may be for the vendor to be paid a flat PMPM rate.	The payment to the vendor should be included in non-benefit expenses regardless of whether the vendor is paid a flat PMPM rate or a portion of the recovery. If, for example, the vendor retains 10% of a $100,000 recovery, then we would expect the full $100,000 recovery to be reflected in claims and $10,000 to be included in non-benefit expenses.
11	MA Worksheet 1	N/A	N/A	If there is only one plan being reported in the base period and that plan is the plan for which the BPT is being submitted, can I leave Worksheet 1 Section II line 5, called "Plans in Base" on the MA BPT and "Mapping" on the PD BPT blank?	No. This section may not be left blank. It must at least list the bid being submitted for both MA and Part D.
12	Emergency Care and Urgent Care Deductible - MA Worksheet 3	04/12/2014 14:17	ER/UC Deductible	Page 96 in the 2015 Announcement states the following: *"As stated in the draft Call Letter, we are clarifying that enrollees utilizing the Emergency Care or Urgently Needed Care benefits are not subject to a service category or plan level deductible amount; however enrollee cost sharing associated with Emergency Care and Urgently Needed Care visits always apply toward a plan level deductible."* Our question is in regards to the representation of this on Worksheet #3 of the MA BPT. Let’s say that we find that total ER/UC cost sharing is $2.00 PMPM, with $1.00 of this amount incurred prior to deductible fulfillment (and therefore accruing towards the deductible) and $1.00 after the deductible is met. Should we: A) Show $1.00 in column F (Plan Level Ded PMPM) and $1.00 in column K, or B) Show $0.00 in column F since ER/UC services aren’t subject to the plan level deductible and $2.00 in column K.	B is correct. $0 should be entered in column f and $2.00 in column k for Emergency/Urgent Care services.
13	Claims Run-Out	04/14/2014 10:26	Actuarial User Group Question - Claims Run-out	[PARAPHRASED] While we are required to develop MA and Part D bids with the same membership, is it permissible to have different run-out periods for the claims files used for MA and Part D?	Yes, you may use separate run-out periods for MA and Part D bids. However, for enrollment, we expect the same data source to be used for MA and Part D
14	Risk Score	04/09/2014 14:41	Diagnostic "Trend" in bids	As discussed in both the Advance Notice and the Rate Announcement, CMS used negative trend to get its 2015 normalization factors for risk adjustment. Typically, plans in their bids will take the average risk score of their current population and project it forward to the year on which payment will be based (in this case, diagnoses in 2014). Do you expect plans to use negative trend in their risk score projections (unless, of course, they have credible evidence in their risk score history to the contrary)? If so, what factors do you suggest be used? (I assume that the RxHCC projection factor may differ from the CMS-HCC model factors, and there might even be a difference between the factor for the 2013 CMS-HCC model and the factor for the clinically-revised 2014 CMS-HCC model.)	As in past years, it is our expectation that plan sponsors will assess their plan-specific trends for risk score projections, and not assume that the national trends in risk scores underlying the various normalization factors are similar to their own trend in risk scores. In other words, CMS does not expect plans to automatically assume a negative trend in risk scores, as is observed at the national level and, instead, we would expect the trend you use for your risk score projection to accurately reflect the trend in your population whether that trend be negative or positive. It is correct that trends may differ between the various models. Therefore, we suggest analyzing the trends under the models separately. Please note that the normalization factor comprises population trends, as well as coding trends, and other changes in coding that occur between the model denominator year and the payment year so that the risk score is 1.0. Plan risk score trends should reflect all of these factors to best project their 2015 risk score.
15	LIS Enrollment	04/15/2014 10:47	LIS Enrollment	When will the 2014 LIS enrollment be available?	The component within CMS responsible for posting this data has informed OACT that the file will be posted by the end of this week.
16	Part D Projection Factors	04/03/2014 9:32	Hep C Drug Impacts	The new drug available for Hepatitis C is a large impact this year. Is CMS contemplating any special handling of this drug? For the purpose of the Bid Model, is there a specific place you would like to see the impact displayed (i.e., formulary change, or included in trend)?	CMS recognizes that Plan sponsors covering the new-to-market drugs for the treatment of Hepatitis C will experience significant increases in Part D costs. If a Plan sponsor has added, or intends to add these drugs to its formulary for part or all of CY2015, then the Plan sponsor must account for these costs in their CY2015 bids. Specifically, the impact to utilization and cost of drugs that are added to the plan's formulary must be reflected in the formulary change projection factors on Worksheet 2 of the Part D BPT. CMS expects Plan sponsors to consider their recent experience, expected population for CY2015 and industry trends and analysis when developing their assumptions and to thoroughly explain these assumptions in the supporting documentation that is uploaded with the initial bid submission. Refer to Appendix B of the Instructions for Completing the Part D BPT for information on the required elements for documenting the development of the trend projection factors.
17	Part D WS1	04/14/2014 12:58	Part D BPT WS 1	Is the Non LIS Brand Discount only reflected in its own box in the bottom right corner of this worksheet or should the amounts paid for Non LIS Brand Discounts be included in any part of Box III, IV or VI of Worksheet 1 of the Part D BPT?	As stated under PDE Mapping in the Pricing Considerations section of the Instructions for Completing the Part D BPT, the Reported Gap Discount is included in the Average Cost Sharing per Member Amount.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
18	Part D WS6	N/A	N/A	On page 57 of the Part D bid instructions, under Lines 19-26, under the subheading Columns I through k, the first sentence indicates, "When the plan benefit type is AE, BA or EA, enter the projected total number of scripts total allowed dollars and total cost sharing, for amounts allocated up to the ICL, for the population identified in Worksheet 3, Section II, cells D23 plus D24, using the cost-sharing structure of the AE, BA or EA plan by point of sale and type of drug, in columns I,j, and k, respectively, for each line." Please clarify if the ICL being referred to here is the DS ICL or the alternative (AE, EA, BA) ICL.	As stated in the PD Worksheet 6 section of the Instructions for Completing the Part D BPT, "to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan". That is, columns i through k on Worksheet 6 are modelled based on the benefits submitted in the AE, BA or EA PBP. Further, "... members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits."
19	Reporting PD Claims by Claim Interval	N/A	N/A	Consider the following scenario: A beneficiary is enrolled in Plan A from January-June 2013 and in Plan B from July-December 2013. He incurs $2,500 and $2,500 in total allowed drug costs in Plans A and B, respectively. In what claims interval should the beneficiary be reported on Worksheet 1 of the Part D BPT?	The beneficiary should be reported in the "$2,970 - Catastrophic" claims interval.
20	Capitated arrangements and Incentives	N/A	N/A	According to the bid instructions, when a contract pays a PCP an incentive payment to keep overall costs low through a global cap arrangement the costs need to be spread to all lines of the MA BPT. As another example, what if a PCP is incented for generic dispensing rate on the pharmacy side only. Should that incentive payment show up as a pharmacy cost?	Generic dispensing incentive payments are reported as direct and indirect remuneration (DIR) in the Part D BPT.
21	Gap Coverage for a BA plan	04/07/2014 15:06	Part D Design Questions	Page 51 of the 2015 PD BPT Instructions states, "BA and EA plans may reduce the value of the deductible. BA and EA plans may provide additional coverage in the gap. Since the value of coverage up to the ICL must remain the same relative to the DS, a supplemental premium will result unless the cost of the additional coverage is offset by savings in catastrophic coverage." This implies that BA plans can provide gap coverage, however the PBP software currently does not permit this. When can we expect PBP software to be updated to permit variations in gap and catastrophic coverage? If PBP software will not be updated, are there other alternatives for submitting BA plans with gap coverage?	It is important to note that, while it may be permissible from a regulatory perspective to offer gap coverage in a BA plan, it is highly unlikely that a Plan sponsor is able to offer meaningful gap coverage at a cost of less than $0.50 pmpm in supplemental coverage, the threshold for determining a BA versus an EA plan.
22	Manual Rate	04/03/2014 16:08	PD portion of MAPD Bid	When a bid is being submitted for an entity that is new to the Advantage market, the manual rate for both the MA and PD will need to be utilized as there will be no historical experience. Can you confirm that the proposed approaches to development of the manual rate described below are acceptable: 1) For the MA portion, use of the information released via the rate workbooks by CMS in conjunction with the 5% sample data set. Using these data points, a manual base data will be developed which will then feed into the BPT 2) For the PD, there does not seem to be much information available via the rate workbooks. Because of the lack of Medicare Part D data, we propose using Medicaid data for ABD/SSI populations to develop the utilization that will be used in the manual rate. This data will then be adjusted to account for the differences between the chosen formulary and the Medicaid formulary. Are there other data sources available to plans that do not have historical experience with Part D? My question is, will the proposed approaches above (assuming adjustments are made to the base data) meet CMS standards with respect to Manual Rate Methodology?	Plan sponsors and certifying actuaries must use their best professional judgment in selecting the source of the claims experience that will be used in the development of the manual rate and in adjusting the source data to project the expected experience of the expected population in CY2015 under the assigned formulary and PBP. Refer to Appendix B of the Instructions for Completing the Part D BPT for information on the required elements for documenting the development of the manual rate. The methodology sounds reasonable; however, no opinion concerning its acceptability is offered at this time.
23	PBM Change	04/15/2014 12:17	2015 MA/PD Bids--PBM change.	My organization is in the process of changing Pharmacy Benefit Managers (PBM) for 2015. The internal selection process has concluded and the new PBM has been selected. However, the contract with new PBM has not yet been signed and it is unclear whether it will be finalized in time for the 2015 Formulary submission. The only "official" PBM right now is the "old" one currently serving the organization. Based on this information, should the 2015 MA/PD bids be developed based on the 2015 Formulary from the "old" or the "new" PBM?	The CY2015 Part D BPTs must be prepared based on the PBM contract and formulary that are expected to be in-force and approved by CMS, respectively, in CY2015.

User Group Call Date 04/24/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	UGC Recordings	04/21/2014 15:20	Recording Actuarial User Group Calls	Are there recordings available of the Actuarial User Group Calls? Or could our organization record the calls using our own software?	CMS maintains recordings of the calls for internal files but does not post these publicly. CMS has no restrictions on recordings, so yes, listeners may record the call. Please be aware that the live discussions should be considered qualified guidance. The posted User Group Call (UGC) documents reflect official guidance. For an official answer to questions, callers on the live Q&A should follow up with a written question to the actuarial-bids@cms.hhs.gov mailbox.
2	Sequestration	04/17/2014 13:36	RE: Sequestration and Margins	Page 49 of the MA BPT instructions state "To the extent that sequestration is assumed to occur during the projection period, net medical expenses must reflect the expected impact of sequestration on provider payments." Please confirm that we can make an assumption that Medicare sequestration will be repealed, and/or a partial probability that it will be repealed.	Given that sequestration is current law, you must base your assumptions on sequestration using expectations related to the law, including reasonable and supportable assumptions as to the probability of the current law being upheld. Support sequestration as you would any other assumption dependent on current law.
3	Sequestration	03/05/2014 14:22	How to Account for Sequestration in Worksheet 1 of the BPT	I have a question related to how to appropriately account for sequestration in the revenue reported in Worksheet 1 of the BPT. The sequestration payment adjustment is not shown in the Monthly Membership Report, only in the Monthly Plan Payment Report. However, the Monthly Plan Payment Report is on a paid basis, not an earned or accrued basis. Therefore, it would not be appropriate to utilize the sequestration adjustment from the Monthly Plan Payment Report to populate Worksheet 1. So, my question is how should we appropriate reflect sequestration in the revenue reported in Worksheet 1? Specifically, what source should we utilize and what is CMS' calculation/formula for the sequestration payment?	Plan sponsors should do their best to take the sequestration information provided on a paid basis on the Plan Payment Report and adjust it to an incurred basis or take the incurred information from MMR reports and adjust it for the sequestration reductions. For more guidance on the application of sequestration on specified program payments please refer to the May 1, 2013 HPMS memo entitled "Additional Information Regarding Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs."
4	Sequestration	04/18/2014 6:29	Gain/Loss Profit & Sequestration	On the prior CMS User Group Call, the bid instructions were reiterated as they relate to sequestration and gain/loss margin. My question is to clarify how the margin requirement between Medicare Advantage and non-Medicare business should be tested. Let's assume the following: a) Non-Medicare business is projected to have a 2% profit margin in 2015 b) A health plan filing bids expects that sequestration will remain in effect throughout 2015 and projects claims costs 2% lower than otherwise would have been projected because of this. c) The health plan files one general enrollment plan with a $0 member premium which shows a bid profit of 5%. In reality the health plan believes that the payment rates in the BPT are 2% too low due to sequestration. Because of this, the true profit will be closer to 3% after sequestration. The profit test for Medicare vs non-Medicare business (non D-SNPs) is that the profit for Medicare Advantage must be within 1.5% of the plan sponsor's total non-Medicare business. Can you clarify whether or not this plan would pass the profit test? That is, must the health plan profit test be: 1) Non-Medicare = 2% vs Medicare = 5%, or 2) Non-Medicare = 2% vs Medicare = 3%?	As stated in the bid instructions and bidders training, all gain/loss margin requirements must be met with the margin entered into the BPT. In this example, the test would be Non-Medicare = 2% vs Medicare = 5%, and the plan would not pass the aggregate margin requirements.
5	Sequestration	04/22/2014 11:09	Sequestration	Are sequestration reductions based on incurred or paid month? So, in the August 2014 payment, will payments for Jan-Mar 2013 be reduced 2%?	Payments for January - March 2013 are not subject to sequestration reductions. Any payment adjustments made in August 2014 for these months would not be reduced by 2%.
6	Credibility	04/15/2014 16:56	Question on 2015 Medicare Advantage Bid Instructions: Credibility	The 2014 Medicare Advantage Bid Instructions stated in the Claims Credibility section (page 16) that actuaries may use a credibility methodology other than the CMS credibility guideline and that it must be deemed acceptable by CMS. The 2015 Bid Instructions simply state that actuaries may use a different credibility methodology, but do not include a statement requiring CMS approval (page 21). Does this mean that CMS pre-approval of an alternate credibility methodology is no longer required?	CMS will continue to review and evaluate all credibility approaches after bid submission, but will not require pre-approval prior to bid submission. The CMS credibility guideline is provided as a service to all certifying actuaries, but is not a requirement. Any method used must be consistently applied among all bids in the contract. Include appropriate support for your credibility methodology and assumptions, consistent with the supporting documentation requirements listed in the bid instructions.
7	Gain/Loss	04/15/2014 20:24	Aggregate-Level Requirements (Overall Margin) Bid Instruction Clarification Request	Page 31 of the MA bid instructions states: "Non-Medicare business includes, but is not limited to, the following lines of business: Medicare-Medicaid, Medicare-supplemental, Medicaid, and commercial." Please clarify what is meant by "Medicare-Medicaid."	Medicare-Medicaid refers to the Managed FFS and Capitated Medicare-Medicaid Plans under the Financial Alignment Demonstration.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Gain/Loss	04/18/2014 15:06	Margins	Will CMS provide a definition of high margin plans that could be denied or asked to reduce their margins?	CMS has not established a specific definition of high margin. Plans sponsors must be prepared to demonstrate benefit value in relation to margin for all plans.
9	Gain/Loss	04/18/2014 14:59	Margins on MA Only plans	Will CMS accept a high margin on a MA-only plan if its benefits are set equal to another plan with drug benefits in order to avoid incenting members to drop their drug coverage?	This alone would be insufficient justification for a plan with high margin. Under the bid-level gain/loss margin requirements, the initial bid submission must provide "Justification for bids with relatively large projected gain/loss margin, including an explanation of how the PBP offers benefit value in relation to the margin level." If the plans in question are a valid product pairing, CMS will consider the reasonableness of benefit relativities in order to assure that the excess margin for the high margin bid is commensurate with the difference in benefits. Please keep in mind though that pairing a high margin bid with another positive margin bid is not valid and cannot be used for high margin justification.
10	AE Cost Sharing MA Worksheet 4	04/16/2014 11:12	Failing Actuarially Equivalent Cost Sharing Test on WS4	The 2015 MA bid instructions include an example for documenting why a benefit might fail the actuarially equivalent cost sharing test on WS4 due to effective coinsurance caused by sequestration. Specifically, the instructions at the bottom of page 49 of the instructions state the following: "In the case of the actuarial equivalent cost sharing test (failing "red circle" validations) on Worksheet 4, the Plan sponsor must adequately demonstrate the requirement that the plan cost sharing for Medicare-covered benefits entered in the PBP is not greater than FFS cost sharing." Can we use this same approach to document failing the actuarially equivalent cost sharing test on WS4 for other reasons besides sequestration? We are pricing a plan with benefits that are as good as or better than original Medicare, but we are failing the actuarially equivalent cost sharing test on WS4. The benefits are consistent with the Part B FFS benefits ($147 deductible and 20% coinsurance). However, when we price these benefits in our model, more of the deductible costs are being allocated to Part B Rx services, causing us to fail the actuarially equivalent cost sharing test on WS4 for this benefit. The reason is because the FFS Equivalent Cost Sharing on WS4 for Part B services averages the impact of the deductible across all Part B services (increasing the 20% coinsurance to 21.5% for all Part B services, for example), while our model incorporates the deductible impact based on the distribution of individual services (not an average). In this situation, is it permissible keep the benefit as is as long as we can demonstrate that the plan cost sharing for Medicare-covered benefits entered in the PBP is not greater than FFS cost sharing even though we fail the actuarially equivalent cost sharing test on WS4?	This approach may be used in any instance where the actuarial equivalent cost sharing test is not met.
11	Related-Party	04/21/2014 15:42	Related Parties and Bids - Question to BIDS SME	[PARAPHRASED] Our organization has a joint venture company as well as additional subsidiary companies. However, these subsidiary companies do not provide any services for the organization generally, nor for our Medicare advantage plans specifically. Therefore, it is our understanding that we would not be required to disclose these related parties during our bid process. Is that correct?	Yes, that is correct. You would not be required to disclose these particular related parties. It is not our intent to capture related parties that are not providing services for the plan.
12	Non-Benefit Expense Allocation Between MA and PD	04/18/2014 16:40	Question for 2015 Bids	We are using revenue to allocate our admin costs between MA and PD bid components. Would risk corridor payments be included as a portion of revenue for this purpose?	Non-benefit expenses must be allocated proportionately between the MA and PD components of an MA-PD bid using reasonable and supportable methods. Given the timing of the risk corridor payments with respect to the contract year for which they are paid, it may or may not be appropriate or possible to include them in the allocation.
13	Catastrophic Claims Interval	04/18/2014 16:40	Question for 2015 Bids	In the PD BPT WS1 no allowed claim level is specified for determining catastrophic members. I have not yet been able to find the appropriate methodology for determining this amount in the bid instructions. Can you please point me to the correct page in the bid instructions and/or give additional guidance as to how we should determine catastrophic members for reporting on the BPT?	Page 34 of the Part D BPT Instructions specifies that Worksheet1, section III, column d values are based on the defined standard claim intervals. Catastrophic coverage in the defined standard benefit for CY2013 was reached when the member incurred $4,750 in true out-of-pocket costs (TrOOP). Part D sponsors' CY2013 PDE data contains sufficient information to determine which members reached catastrophic coverage.

User Group Call Date 05/01/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Related-Party	04/23/2014 13:56	Actuarial Bid Question on Related Parties	Can you please confirm that for purposes of applying the requirements for related party agreements, plans can continue to rely on the guidance provided for the May 1, 2008 User Group Call in identifying related parties, i.e., the relevant ownership interest is more than 10 percent?	There is no minimum percentage ownership requirement as conveyed in subsequent user group calls, bidder's training presentations, and bid instructions.
2	Related-Party	N/A	N/A	The bid instructions say to "demonstrate that the contracts with the unrelated parties are associated with sufficient costs of services to be considered valid contracts" when following the comparable rates approach. What does this mean and how should this be demonstrated?	As an example, if the plan sponsor can show that at least as much utilization is flowing through the contract with the unrelated party as with the contract with the related party, this would demonstrate that the contract with the unrelated party is a valid contract with sufficient volume for comparison.
3	Gain/Loss	04/24/2014 11:40	product pairings	Can we form product triplets, with two plans with positive margin subsidizing a third plan with a negative margin?	Yes, product pairings apply to two or more bid IDs that meet the specifications listed in the bid instructions.
4	MA Worksheet 4 - Home Health	04/25/2014 15:30	home health plan cost share in MA BPT WS4	On page 92 of the Call Letter 2015, Table 4 lists the cost sharing limits for different service categories. For voluntary MOOP plans, 20% or $35 cost share is allowed for Home Health. Yet in BPT Worksheet 4, cell L22, since FFS Medicare home health cost share is zero, it shows an error if there are any cost share for home health. (Plan cost sharing for Medicare Covered services appears to be in excess of Medicare FFS AE cost sharing). Can this error be ignored?	Yes, this red-circle validation can be ignored for voluntary MOOP plans that are entering the cost sharing amounts allowed in the 2015 Call Letter.
5	Specialty Drugs in Defined Standard Bid	04/23/2014 18:27	RE: Specialty Drugs Inclusion in the Part D Defined Standard Benefit Set	Per the instructions regarding the formulary for a Defined Benefit plan, only one tier is to be included on the formulary file. The Part D BPT instructions state that "When a Specialty drug tier is not used in the formulary and PBP, Specialty drugs must be sorted by generic, preferred brand, and non-preferred brand …" Since our plan is a SNP and will be submitting a bid with the Defined Standard benefits for Part D, and thus submitting a one tier formulary, we will not report Specialty drugs separately on Worksheets 2, 6, and 6a. Is this correct?	Yes, this is correct.
6	PDP G/L Margin	04/23/2014 14:05	CMS	Current regulations require that margin for Part D be consistent with other lines of business offered by the insurer. In practice the margin can vary based on the degree of risk inherent in the product (e.g., ASO business has less margin than fully insured business). Since CMS is introducing more risk to PDP sponsors by a) changing regulations after bids have been submitted and b) proposing rule changes and potentially not finalizing rules prior to bid submissions, there is a much greater degree of risk in Part D business than other insurance lines. As a result, is it now reasonable to allow margin requirements to increase for PDP sponsors?	No. The gain/loss margin requirements, as stated in the Instructions for Completing the Medicare Prescription Drug Plan BPT, apply to all Part D plans submitting a bid for CY2015.

User Group Call Date 05/08/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Non-Benefit Expenses	05/04/2014 15:11	Question on ACA Insurer fee	[PARAPHRASED] We have an HMO contract in one company and a PPO contract in another company, both under the same Parent Organization. We expect significant membership shifts from one of these contracts to the other in 2015. We would like to calculate and apply the ACA Insurer fee (based on 2014 premium volume, and 2015 membership) as a flat PMPM across both contracts. Is this acceptable?	No. The method used to allocate the ACA Insurer fee (which is based on 2014 plan revenue) to the plan sponsor's CY2015 MA and Part D bids must be consistent with the manner in which such expense was incurred. The gain/loss margin requirements allow sufficient flexibility to achieve pricing targets at the bid level. If the resulting gain/loss margin is negative, then the business plan may explain the impact of the insurer fee on projected gain/loss margin.
2	Gain/Loss	05/06/2014 8:38	Gain/Loss question	When determining the appropriate Medicare profit margin, the instructions state we should compare non-Medicare gains to Medicare gains. In this comparison, should a Medicare 1876 Cost product be included in the non-Medicare category?	[REVISED 5/15/2014]: For CY2015, when a BPT is not submitted, cost plans may be included or excluded from the non-Medicare category at the plan sponsor's discretion for aggregate gain/loss margin comparisons. The chosen approach must be applied consistently for all applicable comparisons. We expect to implement a more narrow requirement in the CY2016 bid instructions. Cost plans that submit a Part D BPT must follow the gain/loss margin requirements in the bid instructions.
3	Service Area Reduction / Manual Rating	05/05/2014 12:15	Question for this week's Actuarial User's call	[PARAPHRASED] Our plan currently has a single PBP, Plan 001, that serves both a metro area and a surrounding rural area. 1) If we reduce the service area for Plan 001 to just the metro area and introduce another plan, Plan 002, for the rural area, can we use the experience for current Plan 001 as the experience portion of the pricing for both plans? Or must new Plan 002 be priced entirely off a manual rate? 2) If we can use the Plan 001 experience to calculate a projected experience rate for new Plan 002, is it appropriate to narrow it to just the counties included in the 2015 service area?	1) Plan 001 is ongoing; therefore, report the entire base period experience in the Plan 001 BPT Worksheet 1, which becomes the basis for the projected experience rate. If a significant portion of Plan 001 members (as determined by the certifying actuary) are crosswalked through MARx enrollment transactions into Plan 002, then report the entire Plan 001 base period experience in the Plan 002 BPT Worksheet 1. Otherwise, leave Worksheet 1 blank and plan 002 is 100% manually rated. 2) No. The MA and Part D bid instructions state explicitly to report base period experience in total at the bid level for every bid ID and not to include partial plan experience on Worksheet 1.
4	Part D Insurer Fees	05/02/2014 11:05	Part D insurer fees	In worksheet 2, section V of the 2015 PD BPT, insurer fees are trended forward from the base period. Since we have no base period insurer fees to trend forward, should the expected 2015 insurer fees be entered in the manual rate expense cell?	Yes.
5	Worksheet 1 PDEs	05/02/2014 20:08	Bid Question - Incorrect PDEs	Recently, errors in how the PBM completed the CPP and NPP fields within PDEs was discovered. In the event the PBM cannot correct the PDEs in time for bid submission, should Worksheet 1 of the Part D bid be populated based on the actual PDEs without adjustment, or should Worksheet 1 reflect estimates of how the PDEs should have been processed?	Worksheet 1 must reflect the Part D sponsor's best estimate of how the final PDEs will be processed. The supporting documentation for the development of the base period experience, uploaded with the initial bid submission, must include qualitative and quantitative substantiation for the adjustment to the PDEs.
6	Hep C Drugs	N/A	N/A	On a prior user group call CMS described how to treat the impact of new Hepatitis-C drugs in bid pricing, and stated that supporting documentation should justify the assumption. Can you provide an example of what you would like to see in the documentation for Hepatitis C?	On the April 17, 2014 UGC, we stated that the impact to utilization and cost of the Hepatitis C drugs must be reflected in the formulary change projection factors on Worksheet 2. As stated in Appendix B of the Instructions for Completing the Part D BPT, the required elements of the quantitative and qualitative support for the development of each trend projection factor include a description of the source data, a summary of the Part D sponsor's historical trends and any applicable adjustments to the source data, such as considerations for the Part D sponsor's experience, PBM reports and contracts, industry and/or internal studies, formulary analysis and benefit design analysis. The adjustment made to the bid through the formulary change factors for Hepatitis C drugs must be quantified as the per member per month (pmpm) impact to the total average allowed amount pmpm.

User Group Call Date 05/15/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Star Ratings	05/12/2014 20:42	Multiple MA questions	Page 10 of the Part C BPT instructions state that "For a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization received a weighted average of the QBP star ratings earned by the parent organization's existing MA contracts (weighted by enrollment)." 1) Can you tell me what time period enrollment will be used to perform the weighting? 2) The resulting score is rounded to the nearest ½ star, correct? 3) Is it the final star ratings that are weighted, or the component scores of the stars? 4) When contracts are novated from one company to another, does the contract retain its existing star rating?	1-3) The QBP rating is based on the highest numeric rating possible for the MA contracts included in the parent organization. So, for an MAPD contract it is the overall rating and for an MA-Only contract it is the Part C Summary Rating. The enrollment used is the enrollment the contract is paid for in the month of November of the year the Star Ratings are released. The 2015 QBP Rating used the 2014 Star Ratings which were released in October 2013, so the November 2013 contract enrollment posted at this path was used: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html The full explanation of how the QBP ratings are calculated is contained in the annual QBP memo which can be found on HPMS. The results of the QBP calculations for all contracts are posted in HPMS at the path: Quality and Performance | Part C performance Metrics | Quality Bonus Payment Rating. 4) Yes, the rating stays with the contract.
2	Gain/Loss	05/13/2014 10:27	ESRD SNP and Aggregate Level Margin Requirements	For purposes of the Aggregate Level Margin Requirements described on pages 31-33 of the MA BPT Instructions, we would like to verify that ESRD SNPs are to be treated the same as Chronic SNPs that cover other chronic conditions.	Yes. ESRD-SNPs are treated the same as Chronic-Care SNPS.
3	Risk Score Credibility	05/13/2014 10:57	Part D - Risk Score Credibility	[PARAPHRASED] The bid instructions state (under Risk Score credibility) "This section pertains to the application of credibility in developing projected risk scores. The use of the CMS claims credibility guideline above is not permitted for risk scores. The certifying actuary must use actuarial judgment in developing a credibility guideline for risk scores. CMS has not developed a separate credibility guideline for risk scores." What level of documentation and type of methodology is acceptable for submission? Is this mainly to ensure an appropriate manual plan was selected? Is it to handle the differences between long-term and short-term risk score expectations for new plans versus mature plans? Understanding the reason for the statement makes it easier to build a solution that meets CMS's requirements.	If you are blending a plan's risk scores with another source **for the purpose of credibility**, provide information to sufficiently justify your credibility approach. This documentation does not serve to justify that an appropriate manual rate was selected or to handle differences between long-term and short term expectations for new versus mature plans. The documentation serves to justify how risk score credibility (if any) is derived and applied in the bid. For example, describe any data sources, a description of the theory or methodology used to determine full and partial credibility, and an analysis of any results.
4	Risk Score	N/A	N/A	Our plan has discovered that it has submitted diagnoses in error for 2012 dates of service and recently submitted delete RAPs for the erroneous diagnoses. Therefore, our risk scores in the beneficiary level files are overstated. If we are using the beneficiary-level files, should we adjust the beneficiary risk scores down to what we believe are the appropriate scores?	You should reflect in Worksheet 1 the sponsor's best estimate of the risk score that will result when all deletes are processed and risk scores are rerun. The supporting documentation for the development of the base period experience, uploaded with the initial bid submission, must include qualitative and quantitative substantiation for the adjustment to the risk scores. This adjusted base period risk score should be the basis for the projected risk score.
5	Global Capitation	05/08/2014 11:59	Global capitation and risk-sharing payment -- Part D portion	We have risk-sharing arrangements with our PCP groups with incentive capitation payments. In the past, we allocated these payments solely to MA bid's different service categories accordingly. This year, on page 19 of CY2015 MA BPT Instruction 041114.pdf, under "Global Capitation and Risk-Sharing Arrangements" section, it states that the MA BPT must not include the portion of global capitation payment attributable to Part D – the Part D BPT must include such amount. Our questions are: 1) Where do we report the Part D portion of capitation payment on PD BPT? 2) Can we report the payment as a negative rebate amount? (PD BPT Worksheet 3 cell G27, and Worksheet 5 cell O56?) 3) Does global capitation split between MA and PD need to be reported in the base year as well? (even though in practice we didn't split), and where do we report PD portion of capitation payment in WS 1?	As stated in the Instructions for Completing the Part D BPT, "In accordance with CMS guidance, Part D sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed fees. Any gains or losses that the Part D sponsor may experience as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative." The Part D Instructions also state on page 13 that "Part D sponsors must include all expected amounts that will be reported as DIR under "Rebate" in the BPT." This applies to both the base and projection periods.
6	LIPSA	05/12/2014 18:21	Actuarial User Group Questions - LIPSA	Page 40 of the MA BPT instructions includes the following statement: "*CMS expects a consistent estimate of the LISPA among bids in the same region*". A health plan has two plans within the same region and the health plan's estimate of the LIPSA is $20. If the Part D basic premium before buydown is $22 in Plan 001 and $18 in Plan 002, the Part D basic premium after buydown would be $20 in Plan 001 and $18 in Plan 002. In this situation, our estimate of the LIPSA is the same even though the Part D basic premium after buydown is different. Is this the correct interpretation of the instructions?	Yes, the interpretation is correct. We do not expect that two plans within the same region will have the same premium before or after buydown, but we do expect two plans within the same region to have consistent assumptions on LIPSA.

User Group Call Date 05/15/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	PDE Exclusion Report	05/13/2014 10:24	Part D Wks 1 data	This question is regarding the new PDE Exclusion Report. These are paid claims that currently have an accepted PDE on file with CMS but most have had a retro eligibility change after the PDE was accepted. We have reviewed this report and our best estimate is that most errors, like retro LICS changes, we expect to be corrected while a small number of other items may not have a solution and would ultimately be excluded from settlement. How does CMS expect us to handle these items for the purpose of the bid and base period experience?	Worksheet 1 must reflect the Part D sponsor's best estimate of how the final PDEs will be processed. This includes determining which PDEs will ultimately be accepted as well as adjusting paid claims to an incurred basis. The supporting documentation for the development of the base period experience, uploaded with the initial bid submission, must include qualitative and quantitative substantiation for the adjustment to the PDEs.

User Group Call Date 05/22/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Provider Risk Sharing	05/14/2014 15:19	Question Regarding Provider Risk Sharing	An MA Plan Sponsor has a provider risk-sharing program in which a bonus is paid to participating physicians contingent upon the physicians achieving a specified medical loss ratio target for the members under their care. The bonus payment itself can be dependent on the MLR calculation in two ways: a) For Limited Risk providers, the bonus payment is limited to a fixed amount and cannot be negative (the provider cannot owe the plan sponsor at the time of settlement). b) For Full Risk providers, the bonus payment is a portion of the difference between the actual medical expense for their members and the expense that would have been incurred at the target MLR. In these cases, if the actual MLR exceeds the target, the contract may allow the provider to owe the plan sponsor at the time of settlement. Since this bonus is paid to providers for the effective performance of their duties as PCPs in managing members' medical care, we believe that this cost should be included in the MA Bids as a professional cost. However, the instructions relating to Global Capitation and Risk Sharing Arrangements on page 19 of the MA bid instructions could be interpreted to cover this type of arrangement. Our questions are: 1) For each of the two types of risk-sharing arrangements listed above, do the instructions regarding Global Capitation and Risk Sharing Arrangements apply? AND 2) If these arrangements are covered by the Global Capitation instructions, and the MLR calculation to determine the amount of bonus paid includes all Part C services (both Medicare covered and non-covered), should the bonus payment then be allocated to all Part C service categories?	1) Yes the instructions apply. 2) Allocate bonus payments to all MA service categories that are included in the calculation of the bonus. If the risk sharing arrangement includes Part D claims costs, then any gain or loss for this portion of the risk sharing constitutes DIR and must be reported to CMS as such.
2	Gain/Loss	05/20/2014 10:06	Aggregate Gain/Loss	On Page 31 of the "Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2015" regarding Aggregate-Level Requirements for Gain/Loss it is defined that: "Non-Medicare business" refers to all health insurance business that is not Medicare Advantage or Part D. Non-Medicare business, includes, but is not limited to, the following lines of business: Medicare-Medicaid, Medicare supplement, Medicaid, and commercial. Based on this definition, it is understood that self-insured business is to be excluded from the definition of "non-Medicare business" because there is no insurance risk on this business. Please confirm this interpretation.	It is our expectation that self-insured business, similar to ASO products, would be excluded from the definition of non-Medicare business because there is no insurance risk. Given the late date of this clarification, if a plan sponsor has consistently included this business in the Non-Medicare category in previous years, they may do so again for CY2015. We expect to clarify this in the CY2016 bid instructions.
3	Gain/Loss	05/18/2014 18:44	Negative margin question	I have a question regarding a new plan that we were going to "attempt" to file for 2015. Currently, we are projecting this new plan to have a negative margin of approximately 11%. Could you please let us know if this is too great a negative margin for us to attempt to file (i.e. would the plan likely be rejected with that kind of projected margin)?	CMS has not established a specific loss threshold that would be considered "too negative". Plans sponsors must be prepared to support the large negative gain/loss margin. In addition, the Plan sponsor must develop, submit, and follow a bid-specific business plan that is to achieve profitability within 5 years. Exceptions to the 5-year period for unique situations must be fully explained and supported.
4	Gain/Loss	05/16/2014 11:55	Margin Guidance	[PARAPHRASED] CMS has stated that gain margins must be consistent from year to year. Is this a precaution against significant changes in margins, or is there some room for year to year adjustments to match circumstances?	CMS cannot provide a complete answer because margin consistency from year to year has numerous considerations. There can be year-to-year fluctuations in the projected gain/loss margin for plan specific circumstances within the guidance outlined in the bid instructions. Documentation must fully support the gain/loss margin entered in the BPT.
5	Additive Fields	05/15/2014 11:45	Additive Fields	Would changes in the Model of Care expenses be considered a legitimate use of the additive field in WS 1, column q? Or do we need to support the change thru the other unit cost change adjustment?	Use the other unit cost adjustment factor to project the changes in the benefit since Model of Care services are being provided in the base period.
6	MA Segments	05/13/2014 12:21	Segmented Question	We are changing from non-segmented PBP's to segmented PBP's for CY2015 and have the following questions: 1) Can administrative costs vary between 2 MA segments within a PBP? 2) Can cost share on supplemental benefits differ between the 2 MA segments within a PBP?	1) Yes. All pricing assumptions must be bid specific. As stated in the bid instructions and on prior UGCs "By Part C statute the bid must represent the required revenue of the expected population." 2) Yes. The bid instructions contain several references to Chapter 4 "Benefit and Beneficiary Protections" of the Medicare Managed Care Manual (MMCM) for benefit information. MMCM Chapter 4, Part I 10.5.1 - Uniformity states that "the MA plan may vary premiums and cost sharing by segment."

User Group Call Date 05/22/2014

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
7	WS1 Validation	05/19/2014 12:04	Validation issue	I have a bid with non zero ESRD member months but zero hospice member months and I realize the following validation issue: IF WS1 cell E61 (hospice MM) = zero, then round(F65,2) MUST EQUAL round(D45,2) However, to do this I would need to make the ESRD member months = 0 as well.	If hospice member months equal zero, then the net medical PMPM for “All Other” in section VI must equal the Total Medical PMPM in section III because both values exclude ESRD (per bid instructions) and Hospice (no Hospice members). This validation does not require ESRD member months to be set to zero.
8	Regional Benchmarks	05/14/2014 10:26	Dual Demonstration Programs and Regional Benchmarks	Could you explain how the Medicare-Medicaid plans will be included or excluded from the PDP benchmark calculations.	Since the Medicare-Medicaid plans do not submit Part D bids, they will not be included in the calculations of the Part D national average monthly bid amount, base beneficiary premium and regional low-income premium subsidy amounts.

User Group Call Date 05/29/2014

Introductory note:

1) Please remember that when filling out the “Plans in the Base/Mapping” line on the BPTs (WS1 Section II Line 5) that you must include all plans represented in the base period experience, including the bid ID of the submitted bid if that plan is continuing.

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	New Add-in File	N/A	N/A	I noticed a v2 of the BPT add-in file on HPMS. Why is there a new file and are we supposed to be updating our BPTs?	A “version 2” add-in file for the CY2015 BPTs was released via HPMS last Friday. This BPT add-in is designed for all contracts that have been designated as a **“new contract under new parent org” or as “low enrollment”** in the Part C Quality Bonus Payment Rating functionality. You can view this rating using the following navigation path: HPMS > Quality and Performance > Part C Performance Metrics > Quality Bonus Payment Rating > 2015. All impacted contracts have been notified via an HPMS email and must update their add-in file to the version 2 file. Plans can use the batch tool to update the add-in file for several bids at once. After applying the version 2 add-in, the contract MUST leave the Quality Bonus Rating cell blank in the BPT (MA WS5 Cell L24, MSA WS3 Cell I12, ESRD-SNP WS1 Cell I10), even though a red circle validation indicates the cell cannot be blank. This new BPT add-in allows your organization to validate and upload your BPT with this field left blank. All other plans will be permitted to upload using either the original add-in file or the new v2 file.
2	Gain/Loss	05/23/2014 10:52	Gain Loss	Is there any guidance regarding setting G/L margins if your non-Medicare lines of business are flat or slightly negative? It is my understanding that we must be within 1.5% of non-Medicare lines of business, and that it must be gross of sequestration. This could potentially cause a net-negative margin situation or at best to be priced break even. Is there a de minimis rule regarding gain loss margins?	There is no de minimis rule regarding gain/loss margin. The gain/loss margin requirements outlined in the bid instructions still apply. If these circumstances cause margin for particular bids to become negative, the Plan sponsor must develop, submit, and follow bid-specific business plans that achieve profitability within 5 years.
3	Gain/Loss	05/26/2014 0:04	Start up business plan	We have a client that is a new start-up in a county without any other MA plans. Because of this they were unsure of what the take-up rates would look like. They submitted a business plan to return to profitability as part of their start-up MA bid last year, but they are unlikely to reach profitability in that timeframe. Now that they have real membership numbers and their operations are all up and running, they intend to submit a five-year plan from this point. We will document this in the submission, but would like to know if this is acceptable?	Plan sponsors must attempt to achieve profitability within the same timeframe as the original business plan. First, as stated in the bid instructions, supporting documentation “For a bid ID with a negative projected gain/loss margin for the prior contract year, (must include) a numerical comparison of the gain/loss margin to the MA margin in the original business plan. The required elements include— • Details and sources of deviation from the original business plan. • An explanation and demonstration as to how the targeted margin in the original business plan will be met, if the bid ID is progressing towards a positive margin less rapidly than projected in the original business plan, including— ◦ A revised business plan demonstrating that the bid will reach profitability within 5 years of the original business plan. ◦ A description of benefits reductions or premium increases for CY2015. • The year the bid reaches profitability or becomes part of a valid product pairing. • A copy of the original business plan uploaded to HPMS in a separate file. Then, if the documentation clearly demonstrates that despite taking significant steps in each of the next four years to return to the original business plan, the bid is unlikely to become profitable in the original 5-year time frame, the plan sponsor may request to adjust the original 5-year time period. Detailed justification for such exception must include— • “A description of extenuating circumstances supporting an exception. • Evidence of the absence of anti-competitive practices and solvency issues. • Actions taken to bring the margin differential into compliance with these Instructions.”
4	LIPSA	05/26/2014 14:37	de Minimis	Page 130 of the MA bid instructions indicates that a plan with no MA rebates must still target the LIPSA as the Part D basic premium in order to be eligible to participate in the De Minimis program. Page 40 The bid instructions state that CMS expects a consistent estimate of the LIPSA among bids in the same region. If a plan has no MA rebates, then the Part D basic premium cannot be adjusted to achieve a certain LIPSA estimate. Therefore, it is not possible for the estimate of LIPSA among plans (one with MA rebates and one without) to be the same in a region. Please confirm that in this circumstance, it is acceptable for a plan to target the LIPSA as the Part D basic premium for two plans in a given region (one with MA rebates and one without) with a different premium amount reported in line 7D of worksheet 6.	A plan is required to target the Low Income Premium subsidy as the plan intention for the Part D basic premium to be eligible to waive the de minimis amount. Plans with and without rebates can be eligible. It would be acceptable for two plans in a given region (one with MA rebates and one without) to have a different premium amount on line 7d of Worksheet 6. Our expectation is that a plan sponsor is applying a consistent LIPSA estimate across bids in the same region when completing Worksheet 6 Section III C. We understand there are circumstances where this will result in different premium amounts on line 7d.