User Group Call Date 04/11/2019

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	02/25/2019 11:53	Additional telehealth & opioid treatment services	Did CMS develop utilization and unit cost estimates for additional telehealth and opioid treatment services in their projection of the FFS growth rate? Can you share those estimates?	We estimate that the additional Medicare Part B FFS benefit expenditures during 2020 for both the telehealth expansion and Opioid Treatment Program Services to be negligible (that is, less than $5 million for each benefit). Therefore, we do not have an explicit projection factor for either of these two benefit expansions.
2	Growth Rates	04/02/2019 20:22	FFS Cost Projections	The USPCCs, or per-capita costs, for 2018 and 2019 have been restating higher. What steps has CMS taken to ensure that factors driving restatement of FFS costs in 2018 and 2019 are addressed in the projection of 2020 FFS costs?	The calculation of per-capita cost costs, or USPCC, for 2018 in the 2020 Rate Announcement reflects more complete claim experience than that represented in the 2020 Early Preview and 2020 Advance Notice. For most service types, the 2018 per-capita incurred claims are higher in the 2020 Rate Announcement compared to the earlier announcements. The higher 2018 base experience carries over to the projection for calendar years 2019 and 2020, resulting in an increase in the 2020 ratebook growth rates included the 2020 Rate Announcement.
3	Rebate Reallocation	N/A	N/A	On page 128 of the CY2020 MA Instructions, the statement "Non-benefit expenses priced as a percentage of revenue or a percentage of premium, such as insurer fees" has been removed from the list of examples of updates allowed to ensure the BPT reflects the value of A/B mandatory supplemental benefits added or eliminated as a result of rebate reallocation. Does the removal of the example indicate a change in the treatment during rebate reallocation?	No, the treatment of the health insurer fee during rebate reallocation has not changed.
4	Related Party	03/25/2019 12:09	Question on timing of related party status	When it comes to disclosing related party status and making related party adjustments in the projection period of the BPTs, should we determine related party status based on the legal status of entities as of the date of the initial bid submission, or based on anticipated legal status during the contract year?	The plan sponsor must follow the related party guidance and BPT instructions based on the related party arrangements they anticipate being in place for the contract year.
5	Gain/Loss Margin	N/A	N/A	May plans include a contingency provision for natural disasters?	A contingency margin can be included in the gain/loss margin in the BPT. There is flexibility in setting gain/loss margin at the bid level, including the allowance for contingency margins for events like natural disasters, provided that the final gain/loss margin meets all CMS requirements, anti-competitive practices are not used, and the bid provides benefit value in relation to the margin level.
6	Projection Factors	03/06/2019 7:35	CMS Bid Audit Follow-up	[PARAPHRASED] We have a question about the use of the Additive Adjustments for projecting Non-Covered Service Categories on MA Worksheet 1. The Bid Instructions only describe the use of these adjustments for adding or removing benefits. Our plan capitates these services. We would prefer to project the change in the capitation rate for Non-Covered services using only the Additive Adjustments on MA Worksheet 1. We would calculate the Additive Adjustments as the PMPM change in the capitation rates, inclusive of all reasons for change, between base period and projected period in order to accurately reflect the cost in the projection period. Is our approach a permissible use of the Additive Adjustments?	This response is limited to the projection of Non-Covered Service Categories on MA Worksheet 1: It is permissible to calculate the Additive Adjustments as the PMPM change in the capitation rates, inclusive of all reasons for change, between base period and projected period in order to accurately reflect the cost in the projection period.
7	Telehealth capital and infrastructure costs and investments	N/A	N/A	Final Rule (CMS-4185-F) posted for public inspection on April 5, 2019 excludes capital and infrastructure costs and investments for additional telehealth benefits from the MA bid. (1) May such costs be priced as gain/loss margin? (2) Must these costs be carved out of capitated payments to providers?	(1) No, in accordance with section 1852(m)(2)(A)(ii) of the Act and 42 CFR § 422.254(b)(3)(i) as amended in the final rule scheduled to be published in the Federal Register on April 16, 2019, effective January 1, 2020—the MA BPT must exclude from benefits expenses, non-benefit expenses, and gain/loss margin capital and infrastructure costs and investments directly incurred or paid by the MA plan relating to additional telehealth benefits. (2) Yes, this requirement applies to all types of capitated and non-capitated provider payment arrangements.

User Group Call Date 04/18/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Part B rebates	N/A	N/A	Please clarify the handing in the MA BPT of costs related to Part B prescription drug rebates and retained rebates.	The total amount of rebates for Part B prescription drugs must be reported in the MA BPT as a reduction to allowed cost. When a portion of the total amount of rebates for Part B prescription drugs is retained by a PBM or other entity, this amount must also be reported as an increase to non-benefit expenses.
2	PBP to BPT Comparison Tool	04/16/2019 9:21	PBP to BPT Comparison Tool	During the OACT call held May 24th 2018, it was stated that "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." Does CMS expect the 2020 release to have this limitation too? If not, will users need to select VBID_PBP2020.mdb when comparing plans that feature VBID benefits? Can CMS provide any general guidance about what enhancements MAOs should expect the 2020 release to include?	OACT plans to incorporate benefits for the VBID model, MA Uniformity Flexibility, and Special Supplemental Benefits for the Chronically Ill in the CY2020 MA PBP to BPT Comparison Tool. In order for the tests to incorporate these benefits, users must select VBID_PBP2020.mdb when prompted. If VBID_PBP2020.mdb is not selected, the tests will run based on only the benefits entered in PBP2020.mdb.
3	MA PBP to BPT Mapping	04/16/2019 0:00	Appendix F of the MA BPT Instructions	[Paraphrased] On page 136 of the CY 2020 MA BPT Instructions, there appears to be a reversal of BPT line # for Additional Telehealth and Opioid Treatment Services at the bottom of the Suggested MA PBP to BPT Categories table. The BPT line for "Professional: PCP" should be i1, not i2. Similarly, the BPT line for "Professional: Specialist excl. MH" should be i2, not i1.	This is an error in the MA BPT instructions. The BPT line number in the last two rows of the recommended mapping is incorrect. The correct default PBP to BPT mapping is as follows: - 7j Additional Telehealth maps to BPT Line i1 Professional: PCP - 7k Opioid Treatment Services maps to BPT Line i2 Professional: Specialist excl. MH This error also impacts the default mapping included in Worksheet 3 of the CY 2020 MA BPT. Since the default mapping in the MA BPT is only a recommendation, OACT does not plan to release a new BPT; however, certifying actuaries should be aware of the default mapping and make any necessary changes based on how the PBP benefits are priced in the BPT categories.
4	Compliance Initiative	04/16/2019 10:58	RE: Bid Improvement Initiative	As stated in the April 11, 2019 call, the 2020 Actuarial Bid Training does not include a "Points of Emphasis" presentation and there is no mention of the Bid Improvement Initiative elsewhere in the training. We request clarification about whether or not this Initiative is still in place for CY2020 and if so, we request greater clarity concerning the Initiative's parameters	OACT will continue the initiative to improve the quality of the bid submissions, as we have found this to be an effective means to provide constructive feedback to certifying actuaries. The over-arching goals of OACT's bid improvement initiative are to produce more accurate and transparent bids and to enable more efficient and effective bid reviews. As always, we emphasize that adequate peer review and documentation are critical components of an efficient bid desk review. Therefore, the process places great emphasis on accurate bid submissions and CMS' supporting documentation requirements, and considers factors such as large changes to the bid amount for issues found during bid review, excessive resubmissions, and a large volume of post bid submission supporting documentation uploads to be indicators of the need for a more robust peer review process.
5	Risk Score	N/A	N/A	It appears that the HCCs for some diagnoses from chart review records are missing from recent risk score calculations. Does this issue impact the 2018 risk scores that are being provided for bidding?	CMS has heard from plans that there are some instances where the HCCs for some diagnosis codes reported on the MAO-004 report were excluded from risk scores. In response to these inquiries, CMS researched the issue and we have confirmed that there are instances where diagnoses submitted on accepted linked and unlinked chart review records and reported as allowed ('A') and add ('A') on the MAO-004 report were erroneously excluded from recent risk score calculations. This issue affects the risk scores that were released to support bidding. Research is ongoing to determine the extent to which the issue impacted other years. For determining the impact, we note in this case the MAO-004 is reporting these diagnoses correctly. As such, all diagnoses from chart review records identified as allowed and added should be included in the encounter data-based risk score, as long as these diagnoses have not been replaced or voided. To account for this for bidding, plans impacted by this issue should apply an adjustment for the missing data to the base year encounter data risk scores.

User Group Call Date 04/25/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/18/2019 10:32	RE: Unit cost trends	1) We see that the unit cost trends came out on 4/17. Is there any way you could give us a split out of the unit cost trends for physician administered Part B drugs from 2017 to 2018, 2018 to 2019 and 2019 to 2020? 2) Can you please indicate if the change in UCP/DSH payments were included in the unit cost trends? If not, can you please provide the expected impact of UCP/DSH payment change on the inpatient unit cost trends from 2017 to 2018, 2018 to 2019 and 2019 to 2020? 3) On the overall FFS trends in the final rate notice, can you please provide the impact of baby boomers on the overall trend from 2017 to 2018, 2018 to 2019 and 2019 to 2020? If possible it would be great to get this for Part A and Part B services separately. 4) In 2018, OACT provided information about how MACRA's MIPS Bonus Payment and Quality Payment Program bonuses were impacting the physician unit cost trends for 2019. Can you please confirm whether these MACRA bonus impacts are included in the physician unit costs trends released on 4/17? If not, can you please provide the impact by the bonus payments on the 2018 to 2019, and 2019 to 2020 physician unit cost trends?	1) No, we do not have information on the unit cost trends for Part B physician administered drugs. 2) Expenditures for Uncompensated Care Payments (UCP) and Disproportionate Share Hospital (DSH) payments are not reflected in the inpatient unit cost trends. The combined impact of UCP and DSH on total inpatient fiscal year trend is 0.6% for 2018, 0.9% for 2019, and 0.3% for 2020. The corresponding impact of UCP and DSH on total inpatient calendar year trend is 0.7% for 2018, 0.8% for 2019, and 0.4% for 2020. 3) The estimated impact of demographic changes on annual FFS trends are as follows: Part A: -0.14% 2018, -0.21% 2019, and -0.22% 2020 Part B: 0.12% 2018, -0.05% 2019, and 0.01% 2020 4) The unit cost trend exhibit does not reflect either the bonuses paid under the merit-based incentive payment system (MIPS) or the higher payments for physicians who participate in an advance alternative payment model (APM). The corresponding impact on total physician trend are: MIPS: 0.7% 2018, 0.0% 2019 and 0.0% 2020; APM: 0.3% 2018, 0.3% 2019, and 0.0% 2020 RESPONSE CORRECTED 05-08-2019 4) The unit cost trend exhibit does not reflect either the bonuses paid under the merit-based incentive payment system (MIPS) or the higher payments for physicians who participate in an advance alternative payment model (APM). The corresponding impact on total physician trend are: MIPS: 0.7% 2019, 0.0% 2020 and 0.0% 2021; APM: 0.3% 2019, 0.3% 2020, and 0.0% 2021
2	FFS Trends	04/17/2019 10:32	FW: Questions on the 2020 Rate Announcement and Medicare FFS Trends	1. Based on the recently published Medicare Unit Cost Increases, we see that the 2018, 2019, and 2020 RBRVS unit cost increases are 0.5%, 0.25%, 0.0%, for 2018, 2019, and 2020, respectively. What are the remaining components of the 2018, 2019, and 2020 FFS PMPM trends for the "Physician Fee Schedule" service category, separately for each of the following components? a. Utilization b. Mix c. Payment to MIPS d. Payment to APMs e. Shared savings payments f. Other program changes 2. Based on the recently published Medicare Unit Cost Increases, we see that the 2018 Durable Medical Equipment (DME) unit cost increase is 1.1%. What are the remaining components of the 2018 FFS DME PMPM trend for utilization, mix, and other changes (e.g., competitive bidding program)?	1) We do not have the information in all of the specific the categories asked for, but below is a breakout of the Physician Fee Schedule spending growth that we can provide: a. Utilization and mix: 2.1% 2018, 1.6% 2019, 2.3% 2020 b. Payments to MIPS (bonuses): 0.7% 2018, 0.0% 2019, 0.0% 2020 c. Payments to APMs: 0.3% 2018, 0.3% 2019, 0.0% 2020 d. Other program changes: 0.0% 2018, -0.8% 2019 (expiration of work GPCI floor), 0.0% 2020 2) The unit cost increases published on April 17 do not reflect the impact of the change in DME non-competitive bid areas. Pursuant to CMS-1687-IFC, which was published on May 11, 2018, payments for DME services subject to competitive bidding in rural (non-contiguous) non-competitive bidding areas were increased for June through December of 2018. Furthermore, CMS-1691-F, which was published on November 14, 2018, finalized the continuation of this policy in these rural areas through 2020, as well as the continuation of the 2018 payments in urban non-competitive bidding areas through 2020. The net impact of these regulatory actions is an increase in DME expenditures of roughly 3.4 percent in 2018, and 2.4 percent in 2019.
3	Opioid Treatment Services	04/08/2019 5:00	P 158-159 Opioid Treatment Program Services	Beginning in 2020, coverage for Opioid Treatment Program services is required as a Medicare covered benefit. Does CMS have an average expected rate for the bundled payment(s) for these services, including specifics of what medicines will be covered and the frequency of services, such as counseling, testing, therapy, etc., that are covered within the bundle? Also, will CMS provide an expected utilization rate for this benefit, such as how many Medicare enrollees are expected to be diagnosed with this disorder and will use this benefit?	We have not calculated the average expected rate for the Opioid Treatment Program (OTP) bundled payment. Also, as we previously reported in the 4/11/19 UGC, we estimate that the cost of the OTP expansion to be negligible and do not have a projection of expected OTP utilization.
4	Growth Rates	04/19/2019 10:45	Unit Cost Estimates	In Narrative-2020-Payment-Notice.pdf, section headers indicate trends for 2016-2020 and the narrative also mentions 5-year trend. Would you clarify the time period?	The narrative does reflect trends for five years, 2016 through 2020. This is a change in approach from last year, where we did include the base year in the trend heading (that is, 2014-2019).
5	DSNP Service Areas	04/08/2019 22:08	OACT Question - DSNP plan with service area crossing state lines	Based on a review of CMS Landscape files, it appears that some DSNP plans have service areas that encompass multiple states. 1. Is it permissible for a DSNP plan under a single PBP to submit a single BPT that includes a service area encompassing multiple states, assuming that the plan sponsor has contracts with all applicable state agencies to provide Medicaid benefits? 2. If the answer to question #1 is yes, if the plan sponsor intends to target the LIPSA amount in their bid, what LIPSA amount should the plan use? Is it the projected member-weighted average of LIPSA amounts for the applicable states?	1. Service areas are approved at the contract level and may include counties from multiple states. For example, RPPOs may include multiple states and metropolitan areas may include counties in multiple states. D-SNPs are required to have state contracts for areas included in the plan. 2. Yes, to estimate the LIPSA for a bid spanning multiple Part D regions, it would be appropriate to calculate the member-weighted average of LIPSA amounts.

User Group Call Date 04/25/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
6	Related Party	04/16/2019 16:14	UGC bid question	The Bid instructions for the Market Comparison Approach specify that the fees charged to the Medicare health plan should be within 5% of the fees charged to an unrelated party. Please confirm that differences in excess of the 5% are appropriate as long as they are lower then what the related party charges to third parties.	No, the MA bid instructions require that "The fees associated with such arrangements are within 5 percent." Differences in excess of the 5% requirement are not allowed, regardless of the direction of the comparison. As stated in the bid instructions, "The objective of the requirements for related-party medical or service arrangements is to ensure that financial arrangements between the MAO and related parties . . . (ii) do not provide the opportunity to over- or under- subsidize the bid." Also, as further explained in the actuarial bid training: - For administrative market comparisons, comparable fees means within plus or minus 5 percent - For benefit market comparisons, comparable fees means within plus or minus 5 percent or $2 PMPM—whichever is greater
7	Manual Rates	04/17/2019 15:59	Manual Rates	[Paraphrased] In appendix B of the part D BPT instructions (page 75), 12.2 was added this year: 12.2. An analysis justifying the reasonableness of the manual rate, if the manual rate is based on experience that would not satisfy the CMS guidelines for full credibility, without overriding the CMS formulas for partial credibility. Does the credibility override apply for manuals? In other words, does a manual need justification if the member months are less than 56,000 or if the member months are less than 45,360 [(45,360/56000)^(1/2) = 90%]?	Appendix B, item 12.2, applies if the manual rate is based on less than 56,000 member months of exposure for the Part D BPT and less than 24,000 member months of exposure for the MA BPT.
8	Optional Supplemental	04/17/2019 15:32	BPT Question - Worksheet 7	We have observed that on page 31 of the MA bidding instructions in the "Hospice" section it references that the supplemental benefits continue for members while in a hospice status. It then goes on further to describe that at the discretion of the certifying actuary, the projected allowed costs for the mandatory supplemental benefits may or may not be included. Is it acceptable to treat the optional supplemental benefits similarly and have the inclusion at the discretion of the certifying actuary? Would this apply for both the base period and projected experience on Worksheet 7?	Yes, for beneficiaries in hospice status who have purchased optional supplemental benefits, the certifying actuary has discretion to include or exclude the membership and costs for the base period and the projection period on worksheet 7.

User Group Call Date 05/02/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Health Insurer Fees	04/23/2019 21:13	Health Insurance Providers (HIP) Fee Question	[PARAPHRASED] For CY2019, assume our MAO offered PBPs 001 and 002. For 2020, we intend to offer a new PBP 003, and that we do not expect any enrollment migration from plans 001 and 002 into plan 003. The Index 0999 response in the cumulative UGC Q&A file explicitly indicates that a flat PMPM allocation is not acceptable, and seems to indicate that the new plan 003 should be allocated $0 HIP fee since plan 003 2019 total revenue was $0. The Index 1083 response from the cumulative file states that the HIP fee should be allocated to the plan level using a consistent allocation approach across the Medicare line of business, which I read to be suggestive that a flat PMPM or 2020 projected revenue-based allocation is acceptable. 1. Please confirm whether it is acceptable to allocate a portion of the HIP fee to a PBP first offered in 2020 (plan 003 in our example) even though the PBP did not generate revenue in 2019? 2. Please confirm whether it is acceptable to allocate the total entity-wide HIP fee to the Medicare line of business based on 2019 Medicare line of business premium, but then allocate the Medicare portion down to the plan/PBP level, including new plans, using a method that is consistent with the allocation of other non-benefit expenses. 3. In a hypothetical example in which my MAO discontinues all 2019 plans and offers only new plans in 2020, can you confirm that the Medicare portion of the projected fee (driven by 2019 premium on the discontinued plans) can be allocated to the new plans for 2020?	1. Yes, a portion of the Health Insurance Providers Fee may be allocated to a plan first offered in 2020. A consistent methodology should be used for all new CY2020 Medicare bids for the organization. 2. The preferred method for allocating the Health Insurance Providers Fee is to allocate proportionate to projected revenue for 2020, including both renewal and new business. However, the actuary may use an alternative approach, if the allocations are made using a reasonable and equitable basis. Alternative approaches may include using 2019 revenue-based allocations, as well as, flat PMPM allocations, or a combination thereof. Alternative approaches should consider and address the affect and treatment of renewal, new, and discontinued business. Using a method that is consistent with the allocation of other non-benefit expenses may be acceptable. For example, there may be a reasonable and equitable approach to allocate the total entity-wide fee to the Medicare line of business based on a revenue-based allocation (using estimated 2019 revenue or preferably projected 2020 revenue), but then allocate the Medicare portion down to the plan/PBP level, including new plans, using a flat PMPM allocation. 3. The hypothetical example may be acceptable. The answer will depend upon the circumstances. The actuary should assess whether the resulting allocation to the new plans is based on a reasonable and equitable approach for the projection period. For example, if the projected entity-wide fee is allocated 60% to the Medicare line of business based on 2019 premium, and the new Medicare plans represent only 20% of the entity-wide business for 2020, then these circumstances may be unreasonable and/or not equitable.
2	LIPSA	04/23/2019 16:03	eMTM Bonuses and Low Income Premium Subsidy Calculations	Can you please provide guidance regarding how eMTM bonuses will be considered in the calculation of CY 2020 Low Income Premium Subsidy Amounts?	Given timing and operational considerations, CMS has determined that it will not be possible for the Enhanced MTM model's performance-based payments (that are reflected as premium reductions) to be considered when determining the low-income premium benchmarks.
3	Related Party	03/06/2019 18:06	Actuarial User Group - Question regarding Related Parties	On the 5/18/2017 user group call (UGC), a question was submitted 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 updated their response on 5/30/2017 stating 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." On the 5/17/2018 UGC, CMS confirmed this approach is still applicable for CY2019 bids. Can CMS confirm this approach is still applicable for CY2020 bids?	Yes, this approach is still applicable to CY2020 bids.
4	Risk Sharing	04/25/2019 22:49	Provider Risk-Sharing Program	[PARAPHRASED] An MAO has a risk-sharing arrangement with providers, which includes a single settlement based on actual and target medical loss ratios. The actual and target loss ratios are each determined in aggregate, each of which are based on all medical expenses and revenue under Medicare Parts C and D, as well as, Medicaid. As an example, assume that the settlement is expected to be $0. Part C contributes $75 toward the settlement; Part D contributes $25 toward the settlement; and Medicaid contributes $−100 toward the settlement. How should we reflect the single settlement value ($0) in the BPTs? For this example, consider the following two options: Option 1: Allocate the settlement value ($0) proportionately between the Part C and D BPTs. In this case, the BPTs would reflect a $0 settlement value. Option 2: Have the Part C and D BPTs reflect their respective contributions to the settlement. That is, the MA BPT would reflect the $75 value and the Part D BPT would reflect the $25 value.	The framework for reporting a risk-sharing arrangement is as follows: 1. A risk-sharing arrangement that affects the MA and/or Part D bids is allowed. 2. The risk-sharing arrangement must be documented in a written contract or other agreement that identifies all parties involved and the financial terms of the arrangement for the MA and Part D bids. 3. The contract or other document on the risk-sharing arrangement must be able to support a CMS audit of the bids, including the base period data. 4. The data reported in the MA and Part D bids must be consistent with the terms of the risk-sharing arrangement, as follows: a) The MA and Part D bids must only reflect the financial outcomes for Medicare, and not include the impact (utilization or financial) from non-Medicare payers, such and Medicaid. b) The DIR reported in the "rebate" lines of the Part D bids must be consistent with what is ultimately in the DIR reporting. c) The experience in the base period of the MA and Part D bids must reflect the outcome of any risk-sharing arrangement consistent with the terms of the contract for the arrangement. d) The projections for the MA and Part D bids must include reasonable assumptions on the expected outcomes of any risk-sharing arrangement consistent with the terms of the contract for the arrangement. With this framework in mind, for the example provided, the plan sponsor would use Option 2, in which the MA and Part D BPTs would reflect their respective contributions to the settlement. The MA BPT would reflect the $75 value and the Part D BPT would reflect the $25 value.

User Group Call Date 05/02/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
5	Fee-for-Service (FFS)	04/29/2019 17:09	2020 Rate Announcement - Approximate Calculation of the FFS USPCC Question	[PARAPHRASED] The approximate calculation of the FFS USPCC amounts, as described on page 18 of the 2020 Rate Announcement, produces an annual trend for 2018 to 2019 that is not consistent with the current estimates of the FFS USPCC: Current Estimate of the FFS USPCC = 868.11 (2018), 903.21 (2019), 4.0% (trend) Approximate Calculation of the FFS USPCC = 878.68 (2018), 907.52 (2019), 3.3% (trend) The 2020 Rate Announcement indicates the calculated FFS USPCC will only be approximate because there is an additional adjustment to the FFS data which accounts for cost plan data. Is the difference between the calculated trend of 3.3% and the current estimate trend of 4.0% due solely to the adjustment for cost plan data? Also, is the difference in the trends uniform across provider type or do they vary by provider type? If the difference between the approximate calculation of the FFS USPCC and the current estimate of the FFS USPCC does vary by provider type, what are the amounts of the difference by provider type?	Yes, cost plan adjustment accounts for the difference between the presented tabulation and published FFS USPCCs for CY 2018 and CY 2019. The CY 2018 Part A cost plan adjustment is, in millions, -$2.116 for inpatient, -$464 SNF and -$91 home health for total of -$2,671. The CY 2018 Part B cost plan adjustment is, in millions, -$283 physician, -$1,419 outpatient hospital, -$30 DME, and home health -$122 for total of -$1,854. The CY 2019 Part A cost plan adjustment is, in millions, -$849 for inpatient, -$186 SNF and -$37 home health for total of -$1,072. The CY 2019 Part B cost plan adjustment is, in millions, -$116 physician, -$583 outpatient hospital, -$12 DME, and home health -$50 for total of -$762.
6	Risk Score	N/A	N/A	In prior years CMS instructed actuaries to adjust CMS-provided RAPS and encounter data-based risk scores for the runout in plan-submitted diagnosis data beyond the January 31st cutoff and to adjust the CMS-provided encounter data-based risk scores for expected changes between Phase 3.2 and Phase 3.3 MAO-004 reports. Should a similar adjustment be incorporated for 2020 bids?	No. Adjustments for additional runout in diagnosis data are not necessary. In addition, all encounter data based scores are based on 3.3 MAO-004 logic, therefore adjustments for the application of an updated MAO-004 logic are not necessary.
7	Risk Score	N/A	N/A	In last week's user group call, CMS indicated guidance would be provided to account for diagnoses reported on chart review records that are missing from recent risk score calculations. What adjustments should actuaries preparing 2020 bids make to the risk scores provided in the 2020 Beneficiary-Level Files for this issue?	As stated last week there are some instances where the HCCs for some diagnosis codes reported on the MAO-004 report were excluded from the encounter data based risk scores. Specifically, there are instances where diagnoses submitted on accepted linked and unlinked chart review records and reported as allowed ('A') and add ('A') on the MAO-004 report were erroneously excluded from recent risk score calculations. Despite the exclusion of these diagnoses in the encounter data based risk scores, the MAO-004 is reporting these diagnoses correctly. Therefore, all diagnoses from chart review records identified as allowed and added on the MAO-004 should be included in the encounter data-based risk score assumptions for bidding, as long as these diagnoses were not subsequently deleted, replaced, or voided.
8	Risk Score	N/A	N/A	In last week's user group call CMS also indicated guidance would be forthcoming regarding accounting for missing data for plans receiving beneficiaries previously enrolled in other parent organizations. What adjustments should actuaries preparing 2020 bids make to the risk scores provided in the 2020 Beneficiary-Level Files for this issue?	Similar to annual adjustments that may need to be taken into account for new enrollees in a plan where no data exists to be provided in the 2020 Beneficiary-Level Files, if there are instances where you cannot identify specific diagnoses for a particular member then an actuarial adjustment for missing data can be applied to the base year encounter data risk score for bid development.

User Group Call Date 05/09/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	FFS Trends	04/30/2019 16:34	Questions on FFS Trends and PMPM Projections	On the April 25, 2019 call, OACT provided responses to requests for additional information on trends (e.g. Part B drugs, UCP/DSH, etc.). We have two follow-up questions: 1) Can you please confirm whether the following are included in the FFS USPCC Part A + Part B PMPM projections on page 11 in the April 1, 2019 Rate Announcement? a. UCP/DSH payments b. MACRA MIPS Bonus Payments and Quality Payment Program bonuses c. Impact of DME competitive bidding program 2) Can you please confirm whether the MIPS and APM trends for 2018 are correct? The 2018 trends provided in the posted response from the 4/25/2019 call were 0.7%/0.3% for MIPS/APM, respectively. Our understanding is the MACRA would not have had any impact on 2018 provider payments, which is also consistent with posted responses from the 4/12/2018 and 4/26/2018 user group calls, where MACRA impact applied only to 2019.	1) Yes, these three items are included in the FFS USPCC tabulation. 2) The response to question 1, Part 4 on the 4/25/2019 UGC contained an error. All impacts should be shifted forward a year. The impacts listed are for 2019, 2020, and 2021 rather than 2018, 2019, and 2020. The posted response has been corrected.
2	FFS Trends	05/02/2019 17:49	Unit Cost Estimates	In developing estimated inpatient hospital and outpatient hospital unit cost trends, OACT utilized a hospital market basket estimate of 4.2% which is significantly higher than historical market basket assessments. It is also 1% higher than the 3.2% market basket trend in the proposed IPPS rule that came out about a week later. What was the source of the 4.2% estimate? Is there still reason for OACT to believe, given the hospital market basket trend of 3.2% in the IPPS, that once finalized the IPPS or OPPS market basket could still approach the 4.2% number in initial OACT estimates?	The difference between the 2019-2020 IPPS market basket trend in the 'Medicare Unit Cost Increases' exhibit and that in the FY 2020 IPPS rule is due to the use of different economic assumptions. The market basket trend in the "Medicare Unit Cost Increases" exhibit is consistent with that supporting the CY 2020 USPCCs and ratebook growth rate. Any error in the USPCC forecast will be adjusted for in USPCC updates in future years. In addition, the estimate included in the FY2020 IPPS proposed rule is consistent with the assumption sources and methods that will likely be used in the final rule, so less variation is expected between the proposed and final IPPS rules.
3	Gain Loss Margin	05/03/2019 9:32	Four questions for User Group Call	Based on the definition of "plan-category" on page 15 of the CY2020 Part D bid instructions, the plan-category applicable to a PDP plan also includes PACE, 1876 Cost, and 1833 Cost plans. When meeting aggregate-level margin requirements and demonstrating long-term consistency for Part D plans that do not submit an MA BPT, should PDP bids be combined with other bids such as PACE, 1876 Cost, and 1833 Cost?	Yes, when meeting aggregate-level margin requirements and demonstrating long-term consistency for a Part D plan, the following plan type codes must be aggregated together: PDP, PACE, 1876 Cost, and 1833 Cost.
4	Bid Submission	04/30/2019 15:18	Bid Submission Deadline Flexibility	[Paraphrased] With respect to the uncertainty concerning the Health Insurer Fee moratorium, Pharmacy Price Concessions in the Negotiated Price (in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce OOP Expenses proposed rule), and perhaps other issues, we understand OACT's position that health plans should prepare bids based on best assumptions concerning how these issues will impact plans in CY2020. We are requesting that OACT consider offering flexibility on the bid submission deadlines if new information concerning these high impact issues becomes available shortly before the bid submission deadline. At a minimum, we would request that OACT announce that they would offer deadline flexibility for BPTs and/or substantiation if significant new information becomes available that materially affects a health plan's assumptions about these high impact issues.	The bid submission deadline of the first Monday in June is set by statute and CMS does not have authority to change this date. For a bid submission to be complete, all supporting documentation requirements must also be met by the first Monday in June. We understand that the uncertainty around these assumptions creates a difficult bidding environment and we encourage certifying actuaries to make their best estimate of what will be in place for CY2020 and provide support for all assumptions.
5	Health Insurer Fee	05/02/2019 12:10	Health Insurer Fee	We are allocating the Health Insurer Fee for our company as an equal percentage across all existing Medicare Advantage contracts. However, we have a new contract which is for a joint venture with a separate organization, that we are introducing in 2020.Is it acceptable not to allocate any Health Insurer Fee to the new contract?	The certifying actuary must decide and support the CY2020 assumption based on the bid specific circumstances. There may be acceptable reasons to follow the approach outlined in the question. Some items to consider: a) Are all new plans excluding the fee for 2020, or just the joint-venture? b) Would the joint-venture be charged a fee in renewal years? c) Is this a change from the CY2018 approach for new vs renewal bids, and if yes, then why? d) What impact could there be on TBC in renewal years to add in the fee?
6	Projection Factors	05/06/2019 19:36	Question on New Mail Auto Shipping	I was wondering where I should put the WS2 trend changes due to utilizing the PBM's new mail auto shipping program?	This adjustment should be included in the Other Utilization and Other Cost categories on Worksheet 2 of the Part D BPT.
7	Rebates	05/06/2019 20:10	WS2 Point of Sale Question	I am doing work on shifting manufacturer rebates from POST-POS(point of sale) to POS. I was wondering where the unit cost change should be input on WS2 of the BPT?	This adjustment should be included in the Discount Change category on Worksheet 2 of the Part D BPT.

User Group Call Date 05/09/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	Risk Score	04/30/2019 11:17	Questions for Actuarial User Group Call	Part D risk scores for Platino members in Puerto Rico -- It is our understanding that the risk score calculation for Puerto Rico D-SNP (Platino) members treats them as LIS-eligible. We have observed in 2019 that the MMR-paid risk scores on our Platino plans have dropped considerably from 2018, due to a change in the Part D RA Factor Type that now identifies these members as Non-LIS. 2018 MMR risk scores for these members reflected LIS eligibility. Additionally, the beneficiary-level file risk scores provided by CMS each year treat these members as LIS-eligible. Assuming these 2019 risk scores should reflect the same LIS treatment as the 2018 risk scores, please provide guidance regarding: 1) The timing around when this issue will be resolved so that the Part D RA Factor Type will be corrected in the 2019 MMR. 2) How plans should treat Puerto Rico D-SNP members for purposes of projecting risk scores as part of the 2020 bid submission.	CMS is aware of the changes in LIS-eligible indication for risk scores for Puerto Rico and is currently researching the issue. For the purposes of the 2020 bid submission, plans can treat these beneficiaries with the status they know to be correct for bidding assumptions.

User Group Call Date 05/16/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Provider Incentives	05/08/2019 16:57	CMS Actuarial User Group Call Question	This question is in regards to the projected treatment of provider incentives. Page 10 of the MA BPT Instructions states that worksheet 1, section III must "Include any provider incentive payments". When incentive payments are projected to change in the pricing period, are there additional requirements for reporting the payments on worksheets 2 and beyond? For example, in the 2018 period the MAO contracted with a provider group to enter into a 50:50 risk sharing arrangement, with an 81% MLR target. The MLR without the risk sharing arrangement in 2020 is projected to differ from 2018, but the target margin of 81% is not. Is there a preferred method for projecting the 2018 provider incentive payments on worksheet 1 to worksheet 2 and beyond?	Yes, in this particular situation, CMS expects the change to be reflected in the Unit Cost Adjustment, Provider Payment Change column.
2	Part D Rewards and Incentives	N/A	N/A	We are offering a MAPD that is participating in the new VBID Part D Rewards and Incentive Program. Should payments to members be priced in the MA or Part D BPT?	Part D rewards and incentives provided to members in a plan participating in the VBID model or Part D Payment Modernization model are to be reported as non-benefit expenses in the Part D bid for CY2020.
3	TBC	05/14/2019 10:53	Revised RXCUIs and TBC Impact of Changes in OOPC Model	CMS announced that they will be releasing a revised druglist_rxcui file and OOPC model during the week of May 13, 2019. It is our understanding that the Impact of Changes in OOPC Model component of the TBC technical adjustments released in the Total Beneficiary Cost Plan Data report on April 22, 2019 was derived using the OOPC model released on April 15, 2019. In addition to a revised OOPC model, will CMS also be releasing revised Total Beneficiary Cost Plan Data which include updated Impact of Changes in OOPC Model adjustments or will the currently published adjustments be used for evaluating compliance with TBC limits?	CMS expects to post updated Total Beneficiary Cost (TBC) plan-specific data today. This update will include revised Impact of Changes in OOPC Model adjustments for MA-only plans that will be used for evaluating compliance with TBC. No changes are being made for MA-PD plans.

User Group Call Date 05/23/2019

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Part B Premium Buydown for D-SNPs	N/A	N/A	Are dual eligible Special Needs Plans (D-SNPs) permitted to buydown Part B premium as part of its bid?	D-SNPs may credit some or all of the rebate under 42 CFR 422.266(a) toward reduction of the Medicare Part B premium. The use of rebates toward reduction of the Medicare Part B premium is not limited by a state's Medicare Savings Program.
2	Gain/Loss Margin	05/21/2019 13:23	Product Pairing: non-SNP and D-SNP	Can a general enrollment non-SNP and D-SNP plan be paired together as part of a valid product pairing? We have plans that appear to satisfy the three requirements from the MA BPT instructions (page 29-30): Both plans have identical service areas, both plans are local coordinated care plans (HMOs), and the plans have a combined positive MA gain/loss margin.	Yes, since CY2017 CMS has allowed the pairing of non-SNP and D-SNP plans, as long as all other criteria for a valid product paring are met.
3	Part D Induced Utilization	N/A	N/A	Is there any flexibility around the requirement that the entry for the impact of alternative utilization on standard, cell F73 on Worksheet 5 of the Part D BPT be a positive value for enhanced alternative plans?	Updated Response to Live Question from 5-16-2019 UGC No, the entries for this cell must comply with page 54 of the CY2020 Part D instructions which state "Enter the additional costs for Part D-covered drugs under a DS plan in the first column if the utilization of the EA plan was used to price the DS coverage in the bid. The adjustment applies to the EA plan type only and must be a positive value." We will consider the impacts of this entry further in preparation for the CY2021 bid cycle.

User Group Call Date 05/30/2019

There are no advance questions for posting.