# Advance Questions from actuarial-bids@cms.hhs.gov for CY2011 OACT User Group Calls

April 15, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | PD coverage in the gap | 04/15/2010 | 4/12/2010 3:28 PM | Worksheet 3 entries for generic in the gap | Should the amounts entered in lines 4 and 5 of column j be inclusive of the amount to be entered in the "Generics in the Gap PMPM" in column j? | Yes. Also, please note that the "Generics in the Gap PMPM" (PD BPT WS3 cell J26) only includes generics for non-LIS beneficiaries. |
| 2 | PD coverage in the gap | 04/15/2010 | 4/12/2010 2:45 PM | Part D generic gap coverage | In Appendix F, the instructions indicate that the impact of coverage in the gap must be modeled and explicitly lists one of the impacts to be considered as being the impact on LIS cost sharing PMPM. I would not expect there to be an impact on LIS cost sharing PMPM unless CMS is interpreting the statute to mean that the 7% generic coverage in the gap is a plan benefit for both non-LIS and LIS beneficiaries.<br><br>If a full dual LIS beneficiary is in the gap and incurs $30 in allowed expense for a generic drug under a plan with no supplemental gap coverage, what would be the plan benefit, if any, and what would be the LICS subsidy payment? | There is no change to the LICS calculation. |
| 3 | PD coverage in the gap | 04/15/2010 | 4/12/2010 1:48 PM | LICS Partial Subsidy in the Gap | For LIS members with a partial subsidy, does the 15% coinsurance in the coverage gap apply to 50% or 100% of the plan's negotiated rate? | The manufacturer discount program does not apply to LIS members. |
| 4 | PD coverage in the gap | 04/15/2010 | 4/10/2010 6:26 PM | actuarial equivalence | For part D, it doesn't appear that you need coverage in the gap to pass the actuarial equivalence tests. Is that correct? | The actuarial equivalence tests in the PD BPT are unchanged since last year. However, OACT will be reviewing this particular actuarial equivalence test as part of summer bid reviews. Plans must also continue to satisfy the current equivalence tests contained in the PD BPT. |
| 5 | PD coverage in the gap | 04/15/2010 | 4/13/2010 9:52 AM | Question For OACT Conference Call | Regarding how brand rebates in donut hole interact with the bid:<br>Beginning in contract year 2011, members reaching the donut hole will now only have a 50% coinsurance for brand drugs and the brand drug manufacturers will be providing a 50% discount on certain Part D covered brand drugs for these drugs in the donut hole.<br>How will this discount be accounted for in the BPT for 2011?<br>Should it be added to the rebates (DIR) on worksheets 3-5?<br>How will the member's 50% coinsurance for brand drugs be accounted for in the BPT for 2011? | The manufacturer discount program is not a rebate. It is not considered DIR.<br>The discount program does not affect how costs are reported (i.e., still 100% beneficiary cost share even if 50% is discounted). |
| 6 | PD Specialty Tier | 04/15/2010 | 4/13/2010 8:43 AM | Specialty Tier | Can I assume that if a plan does not have a deductible, a 33% coinsurance in the specialty tier is still the "default" maximum to be considered as Actuarially Equivalent to a plan with deductible and 25% coinsurance in the specialty tier? | OACT is not aware of any changes to these parameters. |
| 7 | PD LIS membership data | 04/15/2010 | 4/13/2010 10:04 AM | LIS Membership | When will the 2/2010 LIS membership by contract be posted?<br><br>I only see 2009 and prior posted at http://www.cms.gov/MCRAdvPartDEnrolData/ | This information is expected to be posted by CMS soon. |
| 8 | Medicare Unit Cost increases | 04/15/2010 | 4/8/2010 11:37 PM | Medicare Unit Cost Increases | [PARAPHRASED]<br>Last year, OACT provided a table of the CY2008-2010 projected Unit Cost Increases for the FFS program (see introductory note for the 4/23/2009 UGC Q&A).<br>Could such a table for 2009-2011 be provided this year? | OACT will provide this information on an upcoming user group call. Please note that the information to be provided will not reflect the impact of the recently enacted legislation (PPACA and HCERA). |
| 9 | MA Benefits | 04/15/2010 | 4/9/2010 12:03 AM | Max OOP and Zero Cost Share Dual SNPs | Since zero cost share Dual SNPs are exempted from out of pocket for Medicare Covered Services, will they similarly exempted from the Max OOP rules? Or put another way, since their Max OOP for Medicare Covered Services is automatically zero, do they automatically meet this requirement without having to change the way they pay claims for this Zero Cost Share Dual SNP? | Dual-eligible individuals are entitled to have their cost sharing paid by the State and an enrollee in a SNP may experience midyear changes in their Medicaid eligibility. In those cases, these individuals may be required to directly pay the plan cost sharing that otherwise would be the obligation of the State. In addition, the State would not be expected to pay above the MOOP amount if the State is responsible for paying the cost sharing. Accordingly, we will not exempt SNPs from the requirement that they implement a MOOP amount as established annually by CMS. |
| 10 | MA Benefits | 04/15/2010 | 4/12/2010 7:03 AM | OOP options | Question is around valuing the maximum OOP for a benefit plan that mimics FFS benefits for a dual SNP plans which is offered to $0 cost-sharing members. Because these members don't pay cost-sharing, can the value of the OOP maximum be $0? Or must we value the maximum OOP at the benefits in the PBP regardless of what the member actually pays? | As indicated in response to the previous question, dual-eligible SNPs are not exempt from the Maximum OOP rules. The impact of the OOP Maximum must be valued in the BPT. |
| 11 | MA pricing | 04/15/2010 | N/A | N/A | For a high cost population, actual cost sharing for Medicare-covered services is a much lower percentage of allowed costs than the actuarial equivalent cost–sharing factors used in the bid form. Consequently, the bid for Medicare-covered services significantly understates the cost of providing Medicare–covered benefits and overstates the cost of providing mandatory supplemental benefits, more so than for other unhealthy populations. Further, the risk model tends to understate scores for the sickest individuals and overstate them for the healthiest.<br>If a plan targets a very high cost population, such as a chronic care SNP, may the allowed costs and cost sharing be adjusted to produce a more realistic allocation of net medical costs between Medicare-covered and non-Covered? | No. Although the average county FFS actuarial equivalent cost sharing factors may not be reflective of specific populations such as those enrolled in a chronic care SNP, we cannot allow any modifications to other bid amounts, to "back into" a different enhanced cost-sharing amount due to a population being different than the average. Note that for plan cost sharing designed to match Medicare fee-for-service cost sharing, the bid instructions allow the actuary to use the actuarial equivalent cost sharing factors in the BPT to price plan cost sharing, which prevents the BPT from generating a mandatory supplemental benefit for reduction of A/B cost sharing. |

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| 12 | MA Optional Suppl. Benefits | 04/15/2010 | 4/13/2010 2:02 PM | OSB's | [PARAPHRASED]<br>Based on the Medicare Managed Care Manual Chapter 4: An MA plan may not offer as an optional supplemental benefit (OSB) reduced cost sharing for Original Medicare benefits.<br><br>Then, why are the Medicare covered service categories, shown for WS#7 on Page 75 of the MA instructions, included as postential OSB's? Why is this list not just limited to non-covered services? | Plans can offer additional benefits, that are not a reduction in cost sharing, even for benefit service categories classified as Covered. |
| 13 | MA BPT | 04/15/2010 | 4/13/2010 8:41 AM | Medicaid Projected Benefit (Worksheet 4) | Please confirm that the Medicaid Projected Benefit cell on Worksheet 4 is intended for projected DE# medical expenses only. | In Section V of MA BPT WS4, the Medicaid data includes DE# members of the MA plan. It includes benefit expenses, non-benefit expenses, and gain/loss margin (as indicated on page 17 of the MA bid instructions). |
| 14 | MA BPT | 04/15/2010 | 4/13/2010 8:34 AM | ESRD Section (Worksheet 4) | Can you confirm that for the ESRD Subsidy section on Worksheet 4, plans that do not have credible ESRD experience are only required to fill in the Projected Member Months. | Yes. |
| 15 | MA BPT | 04/15/2010 | 4/12/2010 12:50 PM | Hospice Member Months | Instruction for Worksheet 1 Section II Line 2 states that the cell should be populated with non-ESRD member months. Should an actuary decide to use non-ESRD and non-Hospice members for bids projections (per Pricing Considerations), should this cell reflect non-ESRD and non-Hospice member months instead? | Base period member months exclude ESRD and hospice member months for ALL plans. (See page 21 of the MA bid instructions.) |
| 16 | MA BPT | 04/15/2010 | 4/12/2010 12:47 PM | Worksheet 1 - Cost Inflation Factor | Please clarify what adjustments Section III column (n) is intended for. If there are provider contractual changes, is that part of an inflation adjustment? | In MA BPT WS1 Section IV, column (n) "Unit Cost Inflation Trend" includes provider contractual changes. |
| 17 | WS1 base period experience data | 04/15/2010 | 4/12/2010 2:47 PM | PFFS EGWP base period experience | We currently have significant enrollment in our PFFS EGWP plans. We will not offer PFFS EGWP plans in 2011. We hope that most of this PFFS EGWP enrollment will move to our PPO EGWP plans, but we aren't sure if that will happen or not. We would appreciate CMS guidance on what, if anything, we should do with the PFFS EGWP base period experience, in other words should it be reflected in any way in the PPO EGWP bids where the enrollment may or may not move. And will CMS be giving guidance on how to handle PFFS plan experience, as I assume many plans will be terminating them in 2011? | Guidance will be released by CPC shortly regarding plan crosswalk policy.<br><br>For all plans, Worksheet 1 is reported based on the plan crosswalk. Plans that are not crosswalked (including if a terminated plan is not crosswalked) would not be reported on WS1. |
| 18 | WS1 base period experience data | 04/15/2010 | 4/12/2010 5:56 PM | Interest Payments on late Claims | According to my plan's contract, they owe interest on claims paid late, i.e. after a certain number of days. Do these interest payments go in Section III, Worksheet 1 in the appropriate care category or would they be considered non-benefit expenses? | CMS currently does not have guidance on this issue. Therefore, until further guidance is released by CMS, either reporting approach is acceptable (as benefit expenses or non-benefit expenses), but should be consistent with the plan sponsor's system processing and financial reporting. |
| 19 | Admin | 04/15/2010 | 4/9/2010 12:03 PM | Administrative Services Only Contracts and the Allocation of Overhead to Medicare Lines of Business | In allocating its overhead and other indirect charges to the Medicare line of business, could an organization start with its indirect and overhead costs and deduct the proportion associated with the revenues received for admin only contracts before allocating to its lines of business where it takes risk? | We have been fairly flexible, to date, regarding the allocation of expenses. It must be a reasonable method of allocation.<br>More guidance will likely be released by CMS for CY2012+ related to the MLR requirements. |
| 20 | MSP | 04/15/2010 | 4/12/2010 8:14 AM | 2011 Aged/Disabled MSP Factor | [PARAPHRASED]<br>Per the Call Letter, "CMS is holding the MSP factor for the age/disabled model the same as in 2010."<br>Can you please elaborate on the MSP factor that should be entered in the BPT? For example, should plans be projecting MSP factors based on updated information? | The MSP factor applied to payment is not changing for CY2011 (0.174).<br>Plans must project MSP factors using updated MSP status and plan payment information. |
| 21 | Actuarial Certification Module | 04/15/2010 | 4/12/2010 10:54 AM | Actuarial Certification within HPMS | Based on CMS direction, I took the steps necessary in order for me to perform the actuarial certification of our bids. Is there a way in HPMS that I can determine whether or not I have in fact been granted the functionality to certify the bids? | Please see the user access report in HPMS (HPMS Home > User Resources > User Access Report). The users who are set-up as a certifying actuary will have the profile include "Actuarial Certification Consultant User" (they may also have other profiles associated). Please contact Sara Silver for more information (410-786-3330). |

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April 22, 2010

Introductory Note

Medicare Unit Cost Increases
CY 2009-2011

| Service Category | CY 2009 | CY 2010 | CY 2011 | Comments |
|---|---|---|---|---|
| Inpatient hospital | 3.2% | 2.3% | 3.3% | Based on FY market basket updates |
| SNF | 3.1% | 2.3% | 3.0% | Based on FY market basket updates |
| Home health agency | 2.9% | 2.0% | 2.9% | |
| Outpatient hospital | 3.6% | 2.1% | 2.9% | |
| Physician | 1.1% | -17.7% | -10.2% | |
| Carrier - lab | 5.0% | -1.4% | 1.9% | |

Source: 2011 President's Budget assumptions. CMS Office of the Actuary projections as of April 22, 2010.
Note: This information does not reflect the impact of health care reform legislation (PPACA, HCERA).
Note: This information reflects a physician update as follows: 0% for January and February of 2010, and -21.3% for the remainder of the year.

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| 1 | ESRD drug bundling | 04/22/2010 | 4/20/2010 9:12 AM | ESRD drug bundling | When will the proposed rule on bundling of drugs for ESRD beneficiaries be finalized? (Will plans know the outcome in time for consideration in pricing of 2011 bids?) | We do not know when this rule will be finalized. |
| 2 | Part D coverage in the gap | 04/22/2010 | 4/19/2010 9:33 PM | Copays vs. Coinsurance for Generics in the Gap | My question is about the generic coverage in the gap. I read the memo released 04/16/2010 named "2011 Part D Plan Benefit Package (PBP) Submission and Review Instructions" and had a question regarding the statement on Page 2:<br>"While the statute includes reference to actuarially equivalent amounts, we will not be accepting such amounts for 2011 given the high degree of risk associated with defining an appropriate actuarially equivalent benefit structure. Instead, Part D sponsors must submit basic bids reflecting 93% coinsurance in the coverage gap for generic drugs on their formulary."<br><br>Does this mean that plans must offer exactly 93% coinsurance for these drugs or can the benefit be richer than that for an EA plan? For example, could a plan offer a $7 copay for these generics instead? This would significantly reduce the copay for the member (vs. the 93% coinsurance) and be actuarially much richer for them. | A basic plan - Defined Standard, Actuarially Equivalent or Basic Alternative - must have a 93% coinsurance for generic drugs in the coverage gap. An Enhanced Alternative plan may offer a richer benefit, such as reduced beneficiary cost sharing on generic drugs in the coverage gap. |
| 3 | Part D coverage in the gap | 04/22/2010 | 4/20/2010 8:25 AM | Standard Part D Plan | Can you provide more specific instructions in the treatment of LICS and Reinsurance for LICS and non-LICS members once they are above ICL? Do the 7% coinsurance for generics in the gap apply only for non-LICS members, and hence the standard benefit is different for LICS and non-LICS members? Would the difference between the 93% cost-share for generics in gap and the LICS copayment be considered as part of the LICS pre-payment calculation (or would it be the difference between 100% and LICS copayment still)?<br><br>As for Fed Reins, should LICS and non-LICS members have different standard Part D benefit, they would reach the TrOOP differently – LICS members still can reach TrOOP using a benefit level of 6447.50, but non-LICS members would vary based on generics vs brand utilization. Is this true? | The 7% coverage for generic drugs in the gap does not apply to LIS beneficiaries; therefore, there are no changes in the LICS calculations. LIS and non-LIS beneficiaries reach catastrophic coverage differently. |
| 4 | Part D coverage in the gap | 04/22/2010 | 4/18/2010 2:56 PM | LIS impacts to Part D bids | In cell J26 in worksheet 3, (Generics in the Gap PMPM): should this be the generics in the gap PMPM for all members in the projection, or only the projected non-LIS members? | As stated in the 4/15/2010 UGC Q&A:<br>The "Generics in the Gap PMPM" (PD BPT WS3 cell J26) only includes generics for non-LIS beneficiaries. |
| 5 | Part D admin | 04/22/2010 | 4/15/2010 4:36 PM | Part D User Fees | [PARAPHRASED]<br>What are the Part D COB, crossover and user fees for CY2011? | As stated in the bid instructions, the CY2011 Part D fee is $1.17 PMPY. It supports the transmittal of information on secondary payers and payments on Part D claims among payers, pharmacies and Plan sponsors through the COB and TrOOP facilitation coordinators. |
| 6 | Part D admin | 04/22/2010 | 4/19/2010 10:43 AM | Part D User Fees | [PARAPHRASED]<br>What are the Part D COB, crossover and user fees for CY2011? | See above response. |

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| 7 | Part D admin | 04/22/2010 | 4/13/2010 1:26 PM | Question For OACT Conference Call | [PARAPHRASED]<br>What are the Part D COB, crossover and user fees for CY2011? | See above response. |
| 8 | Part D risk score projection | 04/22/2010 | 4/20/2010 9:03 AM | 2009 Part D Normalization Factor | Do the 2009 new model Part D risk scores need to be adjusted by a 2009 normalization factor? If so, what is the normalization factor? | The risk scores released through HPMS for the July 2009 cohort are not normalized. The risk scores reported on Worksheet 1 of the Part D BPT must be normalized by the CY2009 normalization factor of 1.085 and be based on the "old model".<br>See the Instructions for a description of the adjustments that are needed to project the Part D risk score data, the CY2011 Bidders Training for a numerical example of projecting the Part D risk score and the Technical Notes released with the risk scores for general information. |
| 9 | MA BPT rebates | 04/22/2010 | 4/19/2010 9:49 AM | Question on MA Rebates within MA BPT | According to the Health Care Reform, it's stated that the quality adjusted MA rebate formula would be phased in starting in the CY2011 bids (i.e. the 75% would be reduced to 70% or 50% based on the quality rating assigned to the health plans).<br><br>The current CY2011 BPT does not seem to reflect this formula change. Will there be any updates in the BPT to include this prior to the CY2011 bid submission? | Under health care reform, the change to the rebate formula is phased in. For CY2011, the rebate percentage remains at 75% for all plans, as reflected in the MA BPT. The quality bonus ratings do not affect payments in CY2011. |
| 10 | MA Benefits | 04/22/2010 | 4/16/2010 10:05 AM | Maximum Out of Pocket | I know that you have answered a similar question, but the answer has not yet made the issue clear to me.<br><br>Can the maximum out of pocket (MOOP) be based on the actual member cost share for Zero Cost Share Duals? In a Zero Cost Share Dual SNP, could the plan continue to pay claims in such a way that providers could continue to collect residual cost sharing from the state Medicaid payer while guaranteeing the member a zero cost share for Medicare Covered Services? Would the accumulated out of pocket costs for Medicare Covered Services in this case be zero since the Zero Cost Share Duals are guaranteed not to have to pay cost sharing for Medicare Covered Services? | Per page 4 of the 4/16/2010 Benefits Policy and Operations guidance, dual-eligible-SNPs are required to establish maximum out of pocket limits. Also, per page 18, the PBP must show the plan cost sharing, even if Medicaid will pay the cost sharing. |
| 11 | MA BPT WS1 Section VI | 04/22/2010 | 4/16/2010 10:05 AM | Part C Worksheet 1, Section VI _ Question For OACT Call | The Part C bid instructions require us to exclude revenue and expenses for Part D benefits when developing the margins shown on Worksheet 1, Section VI. For the EGWP Part C bids, do we therefore exclude all revenue and expenses related to employer groups purchasing an outpatient pharmacy benefit? | Yes, exclude these amounts from Worksheet 1, Section VI of the MA BPT. Part D information for EGWP plans must be available upon request. |
| 12 | WS1 Mapping | 04/22/2010 | 4/15/2010 4:44 PM | WS1 Mapping Question | This question regards WS1 Mapping. Below is a type of scenario we are facing and would like to know how we should report WS1 experience.<br><br>Members are in PBP 001, 002, 003.<br><br>In 2011 most members will be cross-walked based on the county they live in into different PBP. Some members will be dropped as we don't have a NPFFS plan to serve them.<br><br>001->001<br>001->005<br>001->006<br><br>002->002<br>002->005<br>002->006<br><br>003->001<br>003->005<br>003->006<br><br>When we report base period experience for 2011 should we report all of it on 001, 005 and 006 or split the experience based on where the counties are mapping? For 003 since it will be completely dropped or moved into new PBP do we need to do anything different there? | The Pricing Considerations section of the bid instructions describe the reporting of plan terminations.<br><br>Assuming plan 003 is terminated and officially crosswalked, then report plan 003 experience on Worksheet 1 (WS1) of plans 001, 005, and 006. Report whole experience, not partial exper., in all three WS1s.<br><br>Since plans 001 and 002 are not terminated, their WS1 must contain:<br>001 experience in plan 001 WS1, and<br>002 experience in plan 002 WS1.<br><br>In other words:<br>001 WS1 contains 001 and 003 exper.<br>002 WS1 contains 002 exper.<br>005 WS1 contains 003 exper.<br>006 WS1 contains 003 exper. |

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| 13 | Disease Mgmt | 04/22/2010 | 4/19/2010 7:10 PM | Case Management | I have a question related to Page 13 of the MA bid instructions regarding Disease Management. There is a sentence that reads, "Care management services provided under a SNP model of care – for example, services provided by an interdisciplinary team – are treated as medical expenses."<br><br>Can you confirm whether care management services provided by an interdisciplinary team must be treated as medical expenses or if they can be treated as medical expenses, non-benefit expenses or both? Please confirm that your response applies to both special needs plans and non special needs plan. If not, please specify the requirements for SNPs vs. non SNPs. | For all plans (that is, SNPs and non-SNPs), disease management expenses are classified as medical expenses, non-benefit expenses or both based on the nature of the expense. The example in the bid instructions refers to mandated care management services provided by an interdisciplinary team as mandated by MIPPA and addressed in a HPMS memo dated September 15, 2008. Should the team provide additional services, they may be classified by the certifying actuary as non-benefit expenses depending upon their nature. |
| 14 | FFS trend | 04/22/2010 | 4/20/2010 10:59 AM | Question for Actuarial User Call | FFS Trend Information: On the [4/15/2010] user call, OACT indicated that FFS unit cost trends would be released. Will you be able to provide trends for both utilization and unit cost, split by service category? | See the introductory note to the 4/22/2010 UGC regarding the FFS unit cost increases. OACT will not be able to provide similar information for utilization. |
| 15 | Clinical Trials | 04/22/2010 | 4/17/2010 11:36 AM | Clinical Trials | I suspect that the impact of the new clinical trial cost sharing policy is very little but could you provide even a rough estimate of how much Medicare fee for service is projected to spend in total for clinical trials on a per member per month basis? Is this predominately Part B Services? | The estimated FFS Medicare spending for clinical trials was $0.66 PMPM in CY 2008. About 63% was for Part A services and 37% for Part B. |

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| 1 | Part D coverage in the gap | 04/29/2010 | 4/22/2010 11:46 AM | Puerto Rico Dual Eligibles and Gap Generic Coverage | The bid guidance for 2011 indicates that the mandated 7% generic coverage in the gap does not apply to low income subsidy members. In Puerto Rico, dually eligible members, the vast majority of whom are in Platino dual eligible SNP plans, are not subsidized by low income subsidies. Does the 7% generic coverage in the gap apply to these dual eligibles in Puerto Rico because they are not low income subsidized, or should it apply because they would be subsidized if they resided in the 50 states? | Dual eligible beneficiaries in Puerto Rico are not eligible for LIS. Since the 7% applies to non-LIS members, the 7% applies to duals in PR. |
| 2 | Part D DIR | 04/29/2010 | 4/21/2010 1:56 PM | Part D DIR | Page 11 of the Part D bid instructions states that the Part D rebates retained by a health plan's subcontracted PBM are to be included as DIR for bid purposes. For example, if total gross rebates were $100, and $65 was provided to the health plan and the remaining $35 was retained by the PBM, the total amount of $100 should be reported in the BPT as DIR. Can the amount of rebates retained by the PBM (e.g., $35) be considered direct administration in the bid? | Yes. |
| 3 | Part D user fee | 04/29/2010 | 4/26/2010 11:15 AM | PD education user fee | Does the $0.08 PMPM education user fee still apply to PDP plans in 2011? | The $0.08 PMPM National Medicare Education User Fee applies for Part D in CY2011. This amount is unchanged from last year. As discussed on last week's UGC (4/22/2010), there is a second Part D fee of $1.17 PMPY. This supports the transmittal of information through the COB and TrOOP facilitation coordinators. |
| 4 | Part D user fee | 04/29/2010 | 4/22/2010 4:25 PM | National Medicare Education Campaign User Fee and Part D COB User Fees | It is my understanding that there are two types of fees that CMS collects from MAPD and PDP plans:<br>1) National Medicare Education Campaign (NMEC) User Fee which is collected nine months of the year via plan payment report<br>For MAPD Plans = MA Factor * (Total MA Payment field from MMRs + Total PD Payment from MMRs ) for non-adjustment records<br>For PDP Plans = PD Factor * (Total PD Payment from MMRs) for non-adjustment records<br><br>2) Part D COB User Fee which is collected nine months of the year, as flat PMPM charged to both MAPD and PDP plans.<br><br>The following table summaries the values from 2006-2011 that have already been announced [ATTACHED TABLE HAS BEEN REMOVED]. The NMEC-MA and NMEC-PDP percentages are never known until December but the bid instructions normally show PMPM estimates. I found the MA value for 2011 of $0.33 PMPM on page 23 of the MA bid instructions. QUESTION: I saw no mention of a comparable fee in the Part D instructions.<br><br>The COB-PD fee for 2011 of $1.17 PMPY was shown on page 8 of the call letter; in the bid instructions it is shown on page 13 as the Part D user fees but doesn't mention the word COB. In the 2010 Part instructions, the user fee that was listed was $0.08 PMPM which ties to the NMEC amount and the COB was an additional amount that was found in the call letter. QUESTION: Has the NMEC-PD fee been discontinued for 2011? | See above response. |
| 5 | PD risk scores in base period | 04/29/2010 | N/A | N/A | How is the CY2009 risk score information [provided by CMS] for CY2011 bid development used to calculate the base period risk score reported on Worksheet 1 of the Part D BPT? | The beneficiary-level file includes risk scores under both the "old" model (i.e., the risk model in effect for CY2009 payment) as well as for the new Part D risk model. After calculating the average CY2009 risk score under the "old" model, divide by the Part D CY2009 normalization factor of 1.085. That amount is then reported on PD BPT WS1. |

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| 6 | Part D coverage in the gap | 04/29/2010 | 4/26/2010 9:47 PM | Bid Question - PD coverage in the GAP | We understand that CMS is going to use specific definition for generic and brand drugs to be covered through gap.<br>Is there a plan to post Proxy NDC list with Brand and Generic assignment for each NDC to be used? Or the assumption is that each plan will have to compile the list and CMS will check if it is correct? How do you plan to handle inconsistencies in this case? As we all know, there are multiple ways to define drug as Brand vs Generic (MediSpan, FDB, etc.) | As stated in the memo released on 4/16/2010: " the regulation at 42 CFR 423.4 defines generic drugs as those drug products for which there is an approved application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)). The type of application on file with the Food and Drug Administration (FDA) determines whether or not the drug product is considered to be a generic drug. A drug is considered a generic drug if its approval is based upon an abbreviated new drug application (ANDA). This definition applies to the coverage gap regardless of whether the sponsor's formulary includes the same drug on its generic cost-sharing tier or on a higher tier, or how a particular drug product is identified by the major drug listing services. Thus, regardless of tier placement on a plan's formulary, generic drugs (as defined above) that are covered below the plan's ICL, must be available at 93% cost sharing in the coverage gap."<br>CMS does not plan to release a Proxy NDC list. |
| 7 | Part D coverage in the gap | 04/29/2010 | 4/22/2010 11:41 AM | Questions | I think it would be worthwhile to mention that even generic specialty drugs in the gap would be covered at 93% coinsurance. This may [clarify the issue].<br><br>Have you made a determination on multi source brand drugs in the gap? If those are placed in a generic or preferred brand tier will they have to be covered at 93% coinsurance in the gap? | See above response. |
| 8 | Part D coverage in the gap | 04/29/2010 | 4/22/2010 12:37 PM | PD Enhanced Alternative Plans and the 93% Coinsurance | Do PD Enhanced Alternative plans have to have the 93% coinsurance for Generic drugs in the gap? | As stated on the 4/22/2010 UGC:<br>A basic plan - Defined Standard, Actuarially Equivalent or Basic Alternative - must have a 93% coinsurance for generic drugs in the coverage gap.<br>An Enhanced Alternative plan may offer a richer benefit, such as reduced beneficiary cost sharing on generic drugs in the coverage gap. |
| 9 | Part D risk scores | 04/29/2010 | 4/23/2010 2:18 PM | Part D Risk Scores | For plans new in 2010, is there any guidance on the value of the adjustment to convert 2010 risk score to the new 2011 basis - e.g. impact of lagged versus non lagged diagnosis data? Would using the change in risk scores based on the files CMS provided appropriate?<br><br>Any guidance on the expected range or value risk score coding trend? Historical trends may not be valid due to changes in the RxHCC risk model. | For new plans that are using 2010 risk scores to develop their 2011 bids, organizations should use the experience of comparable, existing enrollee populations to establish base risk scores and to develop 2011 risk scores. CMS does not have any experience with lagged to non-lagged data or with runout under the new RxHCC model. While plans should use their own calculations of model impact on comparable enrollee populations, CMS will provide additional data on industry-level Part D model impacts (ratios of old model:new model) for plans without such populations. |
| 10 | Part D risk scores | 04/29/2010 | 4/26/2010 3:16 PM | Part D risk score | On April 22, 2010 CMS actuarial users' call, CMS mentioned that there was no Part D normalization factor in the Part D beneficiary level risk score files released on April 13, 2010. However, for the risk scores released on March 1, 2010, CMS corrected that the risk score under the 2011 model should be normalized by one year trend of Part D enrollees' risk scores, which is 1.009. We want to check if we need to normalize the risk scores by 1.009 again for the April 13, 2010 risk score files. | Both the March and the April files with Part D risk scores provided risk scores that were not normalized. The risk scores in the April file are to be used to develop 2011 risk scores, as per OACT bidding instructions. Once un-normalized 2011 risk scores have been projected, the 2011 normalization factor, which accounts for three years of trend (2008-2011), should be applied to the risk score. |
| 11 | Part C risk scores | 04/29/2010 | 4/20/2010 3:34 PM | FW: Part C Beneficiary Files vs. Part C Summary file | We have a question regarding the Part C Beneficiary level risk scores and the corresponding summary level risk scores for the July cohort. When we try to compare the July cohort of the beneficiary level file we get the same total membership, the same total risk score by plan ID but the distribution of members by Medicaid Status indicator is significantly different than what is shown in the summary file. Can you please verify whether or not these two files should have the same Medicaid status distribution (i.e. they should both be based on the most recent status through January) or if one is based on the status at that point in time and the other is restated based on the most recent Medicaid status? | The beneficiary-level file provides information on each beneficiary's monthly Medicaid status in 2009. The HPMS contract-plan level table also provides risk scores by Medicaid status, but unlike in the beneficiary-level file, the HPMS table uses Medicaid status only if it is included in the 2009 risk score. Because full risk enrollees' risk scores reflect their 2008 Medicaid status -- while the beneficiary-level file only considers 2009 Medicaid status -- the counts in the HPMS tables may not match the counts in the beneficiary-level file. |
| 12 | Beneficiary Level files | 04/22/2010 | 4/16/2010 3:49 PM | Status changes in bene files | We have noticed that CMS processed a lot of bene status changes (both Inst and Comm) in the month of the 2008 final sweep (ie, Aug 2009) and the 2009 mid-year sweep (ie, July 2009). The effect of status changes had a very large impact in the value of the sweeps (ie, final average risk score for the Plan ID). Is it correct to assume that the bene files received the week of April 12th do NOT reflect the status changes that CMS would likely process in August 2010 (ie, just before the 2009 final sweep)? If so, what additional information could CMS provide to correct for this issue? Please also indicate if there might also still be significant changes in the Medicaid status indicators for 2009. | There may be additional status changes reflected in the final 2009 risk score, compared to the scores provided in April. |

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| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 13 | Risk Score data | 04/22/2010 | 4/20/2010 6:02 AM | risk scores released by CMS | What changes, if any, might still affect the 2009 risk scores released by CMS for use in developing 2011 bidding? As an example, will there be changes in Medicaid or institutional status coming through that would change a plan's 2009 risk score from that which was released? | See above response. |
| 14 | Risk scores for ESRD-ony SNPs | 04/22/2010 | 4/19/2010 1:40 PM | HPMS-Posted Risk Scores for ESRD SNPs | The [Part C] risk scores released on HPMS last week did not include risk scores for ESRD enrollees. In the past, we have received separate files for the ESRD SNPs/demonstration plans showing information for ESRD enrollees in those plans. Will those files be made available again this year? | The ESRD-only plans' risk score data are now posted in HPMS. |
| 15 | Allocation of expenses between MA and PD | 04/29/2010 | 4/24/2010 12:51 PM | Allocation of expenses shared between MA and Part D | Would it be acceptable to allocate the expenses shared between Part C and Part D according to benchmark revenue for part c adjusted for risk scores and Medicare Secondary Payer adjustments (the maximum that CMS would pay) and based on the expected direct subsidy on Part D?<br>Must the allocation include the member premium revenue and must it be adjusted for the managed care savings and rebates?<br>Allocating based on benchmarks and expected direct subsidy has the advantage of eliminating the circularity involved in allocating shared expenses (admin allocations impact expenses, managed care savings, benefits and revenue which in turn impacts admin allocations which again impacts expenses, managed care savings, benefits and revenue , repeated until the circular calculation converges.) | To date, we have not been prescriptive on the allocation. The allocation must be on a reasonable basis and documented. The approach described here sounds like an appropriate allocation. |
| 16 | MA risk score projection | 04/29/2010 | 4/20/2010 3:32 PM | Credibility for Risk Score Projections | The MA bid instructions (page 13) state that something less than the 24,000 MM may be considered when determining a 100% credibility assumption in our risk score development. Does CMS have a MM value that they would consider fully credible for risk scores? | CMS does not intend to release guidance on the member month value considered fully credible for projecting risk scores. |
| 17 | MA BPT WS1 | 04/29/2010 | 4/23/2010 10:29 AM | Worksheet 1 section VI | My question is related to section VI of the MA WS1.<br>How does line 1(CMS Revenue) differ from line 2 (Premium Revenue)?<br>The way that I am interpreting it is that line 1 (CMS Revenue) is the revenue received from CMS based on the MA bid while line 2 is what plans charge in premiums from members and groups. | As indicated in the MA bid instructions:<br>Line 1 captures the bid-based MA payments from CMS and Line 2 captures revenue from earned premiums. |
| 18 | MA base period risk scores | 04/29/2010 | 4/21/2010 6:40 PM | Questions for User Group Call | Questions relating to Worksheet 1, Section 2, Line 3 (Non-ESRD Risk Score):<br>1) Is DE# equivalent to non-blank values in the Medicaid Status fields on the Part C Risk Score files?<br>2) Preparatory to calculating risk scores for this line in the BPT, do we need to assign a risk score for each month a beneficiary was active in a contract, using the risk score appropriate to the Beneficiary Status for that month?<br>3) Assuming the answer to Q2 is "Yes", what risk score is used when the member is in a Hospice status? | 1) DE# is not equivalent to the non-blank values. See Appendix G of the MA bid instructions for information regarding the Medicaid Status codes.<br>2) This approach sounds appropriate.<br>3) As indicated on page 21 of the MA bid instructions, base period risk scores and member months must exclude enrollees for the time period they are in hospice status. |
| 19 | MSP | 04/29/2010 | 4/21/2010 1:23 PM | MSP Indicators | I have reviewed an MMR file and did not detect anybody that would have an MSP indicator. Is there other data source that would have that information? | The interim MSP files provided by CMS have the MSP status at the beneficiary level. See the memo released via HPMS on January 25, 2010 for more information. |
| 20 | FFS unit cost increases | 04/29/2010 | 4/22/2010 1:26 PM | FFS Costs Trend | Would you please provide the latest estimates of the Medicare FFS units cost increases for 2009, 2010, and 2011 by major service category? | This information was provided with the 4/22/2010 UGC Q&A. |
| 21 | FFS unit cost increases | 04/29/2010 | 4/24/2010 6:27 PM | Market Basket Trends for Outpatient Hospital | During the 4/22/2010 call, you quoted the unit cost increase for outpatient hospital to be 3.0%. I think the number should be 3.6% for the market basket for that year. 3.0% was the initial assumption used in the proposed rule but 3.6% was what was used in the final rule issued in November.<br><br>See page 68564 of the Federal Register Vol. 73, No.. 223 from Tuesday, November 18, 2008. (http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf)<br><br>....provides that, for CY 2009, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act. The final hospital market basket increase for FY 2009 published in the IPPS final rule on August 19, 2008 is 3.6 percent (73 FR 48759). To set the OPPS conversion factor for CY 2009, we increased the CY 2008 conversion factor of $63.694, as specified in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66677), by 3.6 percent.<br><br>Table 51 on page 68799 of this same document shows how they start with the 3.6% and the adjust for mix/intensity to get to 3.9%. | The CY2009 outpatient hospital increase should have been 3.6% (not 3.0% as stated verbally on the 4/22/2010 user group call.) The table included with the 4/22/2010 UGC Q&A posting includes this correction. |

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|---|---|---|---|---|---|---|
| 22 | Pricing of benefit guidance | 04/29/2010 | 4/27/2010 3:21 PM | Request for Benefit Clarification | In the April 16, 2010 memo from CMS providing benefit guidance, pages 10 and 11 address the fact that Traditional Medicare will be required to cover preventive services with a grade "A" or " B" by the U.S. Preventive Services Task Force beginning in 2011. The memo also encourages MA plans to cover these services with no cost sharing in 2011.<br><br>1. Can you clarify whether or not this change in cost sharing under Traditional Medicare was reflected in the "Original Medicare Cost Sharing" percentages that are populated in Worksheet 5 of the MA bids. If not, are there adjustments that need to be made elsewhere in the bid? If so what are those adjustments?<br><br>2. The list on page 11 only references the Welcome to Medicare Physical Exam and does not mention additional annual wellness visits that will be required to be covered by Traditional Medicare in 2011 (with no cost sharing) as found in PPACA §4103. The additional wellness visits are typically covered by MA plans as mandatory supplemental benefits and rebate dollars are used to cover the cost. Do you agree that in developing the 2011 pricing we should now consider these services as Medicare covered and no longer need to use rebate dollars to pay for the cost? | 1) The actuarial equivalent cost sharing factors on MA Worksheet 5 have been unchanged since last year. Therefore, no benefit changes have been incorporated in the factors.<br>No adjustments should be made to the factors.<br><br>2) Any benefits that are required to be covered under Traditional Medicare in 2011 should be classified as Covered for bid pricing. |
| 23 | Pricing of benefit guidance | 04/29/2010 | 4/26/2010 7:40 PM | Worksheet 4 Treatment of Mandated MOOP | MAO's are required to offer Medicare A/B services as a minimum and at their option may add Supplemental benefits. Since Medicare does not have a Max Out of Pocket "MOOP" I would assume that a voluntary MOOP would be considered a Supplemental Benefit and reflected on worksheet 4 as such. Since the MOOP is being mandated by CMS shouldn't this be considered part of the minimum allowable Medicare benefits and therefore a Medicare A/B covered services on worksheet 4? | The MOOP is a Supplemental Benefit. |
| 24 | Pricing of benefit guidance | 04/29/2010 | 4/23/2010 4:05 PM | Plans with FFS Costs Share | If we have a plan that mimics Original Medicare cost sharing (ie an integrated D-SNP), CMS allows us to compute worksheet 3 cost sharing using the FFS AE factors on W/S 4. The 4/16/2010 guidance for cost sharing standards indicates that these factors are understated for Pt B services on IP, SNF and HH service categories. Can we then increase our W/S 3 calculations by using the adjustment factors in combination with the W/S 4 percents? | Do not adjust the actuarial equivalent cost sharing factors.<br>The actuarial equivalent cost sharing factors on MA Worksheet 4 and 5 may be used to compute the pricing of cost sharing "before the OOP max". |
| 25 | Pricing of benefit guidance | 04/29/2010 | 4/28/2010 12:19 PM | Max OOP and Zero Cost Share Dual SNPs - Follow Up Questions | Per the responses to #9-10 posted by CMS from the 4/15/2010 User Group Call, CMS will not exempt SNPs from the requirement that they implement a MOOP amount as established annually by CMS and the impact of the OOP Maximum must be valued in the BPT for dual-eligible SNPs. We have a couple of follow-up questions:<br><br>1) Will the 2011 mandatory MOOP amount be implemented for Medicare FFS enrollees, or does the MOOP only apply to Medicare Advantage plans?<br><br>2) According to page 12 of the 2011 MA BPT Instructions, "The actuary may also use the actuarial equivalent cost-sharing factors shown in Worksheet 4 to estimate the PMPM amount for plan cost sharing that is designed to match Medicare FFS cost sharing. In this case, the user may enter the entire value of cost sharing in columns i and j and adjust the projected allowed costs in order to reflect this PMPM value of the cost-sharing amount. This approach does not apply for other levels of cost sharing".<br>For dual-eligible SNP plans that mimic Original Medicare FFS benefits and are offered to $0 cost-sharing members, is CMS expecting us to reduce the FFS Medicare AE Cost Sharing Factors (provided in column k of Worksheet 4) by an estimated impact of the MOOP even though the plan's benefits are identical to Medicare FFS benefits? | 1) The MOOP applies to MA plans, not Medicare FFS.<br><br>2) You may use the actuarial equivalent cost sharing factors to price the cost sharing "before the OOP max". You must then reflect the impact of the OOP max in column j of Worksheet 3. |
| 26 | Pricing of benefit guidance | 04/29/2010 | 4/26/2010 9:31 PM | Duplicative Plan Offering Questions | 1) The April 16th CMS "Duplicative Plan" memo indicates CMS will be sending out letters "in the next few weeks" that will provide MAOs with CY 2010 OOPC estimates for each of their current plans so that organizations can use the information in developing CY2011 plan bids.<br>Can you tell us when these letters will be sent out by CMS and to whom will they be sent?<br><br>2) Secondly, it's clear that the out of pocket cost sharing algorithm under personal plan finder is a complicated calculation. Is there any actuarial guidance you can give us to make sure plans change copays by the pmpm value needed to ensure plans will meet this $20 pmpm differential? In other words, is there any "rule of thumb" for us to estimate the impact of a copay change on personal plan finder? | 1) The information will be provided soon.<br><br>2) Plans can use their own models to measure, and compare against CMS' calculations. |

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| 27 | Pricing of benefit guidance | 04/29/2010 | 4/20/2010 7:08 PM | Duplicative Plan Offerings Question | Regarding OOPC estimates to identify meaningful differences among similar type plans, how will mandatory supplemental benefits be recognized in the OOPC calculation for a Plan with or without the mandatory supplemental benefit? | As stated on page 3 of the 4/16/2010 memo, OOPC calculation includes mandatory supplemental benefits. |

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| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | Part D coverage in the gap | 05/06/2010 | 4/28/2010 1:42 PM | Generic Coverage in Gap for DS Plans | During the OACT call from April 22, it was clarified that all generics, independent of tier, would need to be covered at the 93% member coinsurance in the coverage gap. For instance, generic/non-generic drugs may coexist in a injectable/specialty tier and the generic portion would need to be covered at 93%. Is it correct to assume that, because drugs within a tier are not allowed to have different cost sharing amounts, this would require the non-generic drugs within the tier to be covered at 93% as well? | No, the assumption is not correct. In a basic plan - DS, AE or BA - the tier placement of a drug on a plan's formulary does not apply in the coverage gap. As stated in the memo released on 4/16/2010, a drug is considered a generic drug if its approval is based upon an abbreviated new drug application (ANDA). This definition applies to the coverage gap regardless of whether the sponsor's formulary includes the same drug on its generic cost-sharing tier or on a higher tier or how a particular drug product is identified by the major drug listing services. |
| 2 | Part D BPT | 05/06/2010 | 5/4/2010 10:12 AM | Type Of Rx Mapping | If Tier 3 on a formulary contains both non-preferred brand and generics Rx, can you illustrate how this should be mapped on worksheet 2 and worksheet 6? Should the category "non-preferred Brand" contain all Tier 3 Rx, or should the non-preferred generics Rx go under "Generics" on worksheet 2? | As in prior years, drugs are reported on Worksheets 2 and 6 of the BPT by type of drug and place of service, not by formulary tier. The only exception is the reporting of Specialty drugs when they are on a designated Specialty tier on the formulary. In the scenario presented in the question, non-preferred generics are reported in the generics - retail and/or mail - categories. Refer to the Instructions for more information. |
| 3 | Part D BPT | 05/06/2010 | 4/27/2010 7:46 AM | Late Enrollment Penalties | I believe that the revenue reductions associated with Late Enrollment penalties (LEP) in the plan payment reports are based on the expectation that plans are collecting the late payment penalties; is this correct?<br><br>So on WS 1, I believe that we should show a positive amount in the Member Penalty Premium box (although this appears as negative in the plan payment report) but we should deduct this amount from the CMS part d payment; is this consistent with your understanding? | Response from CMS payment group:<br>If the beneficiary has elected direct billing of his premiums (including LEP), the LEP is presumed to have been collected by the plan and [CMS] offsets that amount from the plan payment.<br><br>Additional response from OACT:<br>In Section V of Worksheet 1, report the Member Penalty Premium (LEP) on line 4 and subtract that amount from the CMS Part D Payment reported on line 1. |
| 4 | Part D coverage in the gap | 05/06/2010 | 5/4/2010 12:06 PM (part 1 of 2) | Part D Bid Questions (part 1 of 2) | 7% Generic Gap Coverage – LIS Exclusion<br>As instructed, the Generics in Gap PMPM (cell J26) on worksheet 3 will not include projected LIS members. Is this amount the Generics in the Gap Per Non-LIS Member per Month? Regardless, this input directly impacts premium as both LIS and non-LIS members have the same premium. Thus, it appears that the projected proportion of LIS members impacts member premium. To the extent that this projection is accurate, member premium will be accurate. What happens if actual LIS membership greatly differs from expected? If we understand this correctly: less LIS members than expected results in inadequate premium and more LIS members than expected results in higher than needed premium. The latter has an impact on sales, which could negatively impact market share. This appears to be a double edge sword; do you have any suggestions on how to mitigate this perceived plan risk? | As previously stated, the "Generics in the Gap PMPM (WS3 cell J26) only includes generics for non-LIS beneficiaries.<br>CMS has not provided specific guidance regarding mitigating risk in bid development. We recognize that there is uncertainty associated with bid assumptions, which is why we require that qualified actuaries prepare and certify the bids. |
| 5 | Part D coverage in the gap | 05/06/2010 | 5/4/2010 12:06 PM (part 2 of 2) | Part D Bid Questions (part 2 of 2) | Prospective 50% Brand Gap Discount Amount<br>The guidance explains that this will be calculated from the bid. The bid only displays total GAP pmpm and Non-LIS Gap pmpm; will the prospective payment amount assume that LIS and Non-LIS members have the same brand GAP pmpm? | Yes. These payments will be subject to the reconciliation process at the end of the year. |

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| 6 | Part D risk scores | 05/06/2010 | N/A | N/A | Regarding Part D new enrollees that are ESRD status:<br>There is only one version of each type of Part D new enrollee score, but some of our enrollees were ESRD for only part of the year. How do I know if the ESRD add-on is in the score or not? | For 2011, there is an ESRD add-on in the new enrollee risk scores. The add-on is included in the new enrollee score starting in the month when the beneficiary enters ESRD status; the beneficiary does not leave ESRD status – they remain in either dialysis, transplant, or post-graft – so the add-on will remain in the score once it is added. In the April file, we included the ESRD add-on in the new enrollee score if the enrollee was ESRD in any month of 2009. However, for those months that the enrollee was not ESRD, the ESRD add-on should be subtracted out of the new enrollee risk score. The add-on factors (that you would need to subtract from non-ESRD months), by new enrollee risk score type, are:<br>New enrollee, non-LI – 0.435<br>New enrollee, LI – 0.549<br>New enrollee, LTI – 0.235<br><br>(Note: these may not exactly match what you would back out of the published new enrollee tables, due to rounding)<br><br>If plans wish to, the 3 new enrollee risk score tables in the Rate Announcement provide all the scores for age/sex combinations with and without ESRD, so you can verify the scores. |
| 7 | Part C risk scores | 05/06/2010 | 5/3/2010 2:52 PM | Actuarial Bid Question | With respect to the Demonstration plans phasing out the frailty factors in 2011, how are frailty factors reflected in the beneficiary-level risk score file sent out from CMS on April 13 to support the Part C bids? | Frailty factors are not included in the risk scores provided by CMS. |
| 8 | Part C risk scores for ESRD-only plans | 05/06/2010 | 5/2/2010 3:43 PM | ESRD HCC Risk Scores | The technical notes released on HPMS along with the ESRD-HCC risk scores indicated that the risk scores were based upon diagnosis data for 2008 submitted through January 31, 2009. I assume that this was a typo and that the diagnosis capture is actually through January 31, 2010 (and therefore that no further late diagnosis adjustment is needed. Can you confirm that? | The technical notes should have stated "submitted through January 31, 2010" (not 2009). |
| 9 | FFS unit cost increases | 05/06/2010 | 5/1/2010 5:41 PM | clarification of unit cost trends | In the most recent Q&A posting of 4/22/2010 questions, there is a table containing CY2009, CY2010 and CY2011 trends. Can you please explain how to interpret these trends?<br><br>Specifically, under the column CY2009, is the trend listed the increase seen in CY2009 over CY2008? Or is the increase listed the trend from Jan 1, 2009 to Dec 31, 2009? Or something else? | These rates represent the increase in price for the specified service over the prior year. |
| 10 | Credibility | 05/06/2010 | 4/28/2010 3:29 PM | Credibility for small plans | We have both MA and MAPD plans that have suffered large membership decreases from 2009 to 2010. We are redesigning the plans for 2011, and anticipate a lasting resurgence in the membership starting with 2011. At the same time, we do not expect the 2011 and beyond membership to be comparable to the 2009 membership. For worksheet 1 of the MA bid, we must reflect our 2009 experience for the plan. Must we project that experience forward to 2011, using the CMS credibility formula based on the 2009 membership, or can we base the credibility on the 2010 membership. 2009 MA membership is 19,150 member months, 2010 is projected to be 4,500 member months. | Worksheet 1 must reflect the 2009 experience for the plan.<br>For projection purposes, you may enter population change factors on Worksheet 1 to make adjustments. The bid instructions provide the credibility guideline, and directions on using alternative credibility methods and manual rates. |
| 11 | MA BPT WS1 Section VI | 05/06/2010 | 4/28/2010 1:44 PM | WS1 Section VI - CMS Revenue - include plan level adjustments? | The BPT instructions state the CMS revenue entered in WS1 Section VI should be gross of user fees, however should the CMS revenue entered include other "plan level adjustments" from the Plan Payment Report, such as the working aged/disabled adjustment? | The reported revenue must reflect all adjustments. |
| 12 | MA BPT WS1 Section VI | 05/06/2010 | 5/4/2010 11:50 AM | Question Re WS1 Section 6 | At the bottom of worksheet 1, in section 6, we are required to report "earned" member premium for 2009. Would it suffice to report filed 2009 premium, multiplied by the number of actual 2009 member months? | Uncollected premiums must be reported under Line 5b Direct Administration. Therefore, you should not multiply the filed premium by the actual member months. |
| 13 | Optional Supplemental Benefits | 05/06/2010 | N/A | N/A | Are there specific margin requirements for Optional Supplemental Benefits (OSB)? | CMS has not provided specific margin guidance for Optional Supplemental Benefits. However, we will be reviewing margin levels for Optional Supplemental Benefits with the the expectation that the premiums charged are reasonable in relation to the benefits provided. More flexibility in margin will be given to OSB than for the margin associated with the Medicare Covered and Mandatory Supplemental benefits. |

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| 14 | Admin expenses | 05/06/2010 | 5/3/2010 6:57 PM | Question on FAS123 Compensation Expenses | What is CMS's guidance on whether to include or exclude SFAS123 Stock Compensation expenses as part of the SG&A development? Per GAAP, these expenses are recorded as part of Compensation expense, however it is a non-cash expense recorded on an Income Statement. | If GAAP indicates that an expense be recorded as compensation, then it should be reported as a non-benefit expense. |
| 15 | Admin expenses | 05/06/2010 | 5/1/2010 1:19 PM | Direct Admin Expense Related to Performance Measures and Improvements | During the Bid User Group call this week [4/29/2010], I think one of the commentators indicated that CMS will be looking for health plans to call out direct admin expense related to improving performance measures. Can you clarify this comment? I was not able to catch the full discussion during the call. | CMS will review the costs associated with offering and managing administrative programs and services for CY2011 to ensure that they are adequate and reasonable relative to the performance of the programs in CY2009.<br><br>On the 4/29/2010 call, the CPC Part D benefit team discussed performance issues of particular plans that will be reviewed by CMS. |
| 16 | Related Party | 05/06/2010 | 5/4/2010 9:29 AM | Related Party Question | [PARAPHRASED]<br>If there is a common ownership within a joint venture, is this considered a related party? | Yes. Requirements for related-party agreements apply to a sponsor that enters into any type of service agreement involving a parent company and subsidiary or between subsidiaries of a common parent. |
| 17 | Related Party | 05/06/2010 | 4/29/2010 11:09 AM | FW: Draft CMS Actuarial user Group Call Questions | Related third-party agreements: Page 28 of the MA Bid instructions states:<br>"For purposes of completing the BPT, consider the gain/loss and non-benefit expense of the related party to be those of the sponsor. For example, the plan sponsor cannot allocate all administrative costs in the related-party agreement to non-benefit expense."<br><br>Can you clarify what is meant in the second sentence? | The second sentence is intended to clarify that, in a related party agreement, ALL costs should not be allocated as non-benefit expenses. |
| 18 | Pricing of benefit guidance | 05/06/2010 | 4/29/2010 4:52 PM | BPT Question (64) | For a Point of Service plan, will the Worksheet 4 PMPM Actuarially Equivalent Cost Sharing Maximums be based on a combined in and out of network cost share? | The Worksheet 4 Actuarially Equivalent Cost Sharing Maximums are based on total cost sharing PMPM (including in-network and out-of-network). |
| 19 | Pricing of benefit guidance | 05/06/2010 | 4/29/2010 8:20 PM | MOOP for EGWP Plans | We understand from the 4/16/2010 memo that the MOOP requirement applies to EGWP plans unless they receive a waiver. However, if we use the BPT/PBP approach of filing FFS benefits for EGWP plans, do we need to include the MOOP in the BPT and PBP? That is, we would include it in the actual benefits sold to a group, but do we need to include it in the BPT/PBP if we use the FFS filing option? | If the PBP must include the MOOP, then the MOOP must be priced in the BPT. |
| 20 | OOPC | 05/06/2010 | 5/3/2010 5:08 PM | OOPC Calculation | This question is regarding evaluation of benefit changes in order to meet the $20 PMPM OOPC plan variance requirement. When valuing benefit for this purpose, is it appropriate to account for anticipated changes in utilization that would occur with a different level of benefits. | Anticipated changes in utilization will not affect the OOPC calculation. OOPC is calculated based on a standardized utilization distribution. See the technical notes released with the OOPC data. |
| 21 | OOPC | 05/06/2010 | 5/4/2010 8:41 AM | OOPC Determination | We received the OOPC information provided through HPMS and have the following questions: We have 2 MAPD plans that are $9 PMPM apart in the OOPC calculation, but we wanted to keep both going forward. If we were to "fix" the OOPC's for these plans and make them farther apart, is it acceptable to make our own determination of the additional $11 PMPM that needs to be added to set these 2 plans apart? | Plan sponsors may choose how to modify benefits to provide at least a $20 difference between plans. If you run the standard utilization through the plans, you can approximate the OOPC calculation. |

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| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | Part D coverage in the gap | 05/13/2010 | 4/10/2010 6:25 PM | manufacturer discount | In 2011, does manufacturer discount always begins at $2840, or does it begin at the revised ICL if ICL>$2840? | The discount begins at the plan's designated ICL. |
| 2 | Part D coverage in the gap | 05/13/2010 | 4/26/2010 4:43 PM | Part D Issues | (1) If an enhanced Rx plan has an ICL that is greater than the statutory ICL, when does the manufacturer's 50% brand discount start? If, when the plan ICL has been met, does it continue until the member's TrOOP is met under the enhanced Rx plan?<br><br>(2) If an enhanced Rx plan has an ICL that is less than the statutory ICL, when does the manufacturer's 50% brand discount start? If when the statutory ICL has been met, how is that determined? Does the amount between the plan ICL and the statutory ICL count toward the member's TrOOP?<br><br>(3) New Section 1860D-14A(b)(1) indicates that it is the responsibility of the manufacturer to reimburse the pharmacy or mail order organization. However, we have heard that plans will be expected to reimburse the pharmacy, with a year-end settlement between plans and manufacturers. Can you confirm what the process will be?<br><br>(4) When will guidance be released identifying the brand drugs that will be covered by the manufacturer's discount? | 1) and 2) See above response.<br><br>3) and 4) See memos released April 30th. |
| 3 | Part D coverage in the gap - 7% generics | 05/13/2010 | 4/12/2010 6:31 PM | Part D | 1. For a decreased ICL benefit structure, does the 7% generic plan liability start to apply at the plan's alternative decreased ICL or at the CMS ICL? Page 10 indicates that for a decreased ICL, WS6 should assume 100% member cost sharing between the CMS and decreased plan ICL (instead of 93%). Will plans be allowed to charge 100% cost sharing (for generics) starting at the decreased ICL?<br><br>2. Is it possible to have an alternative (BA/EA) design that enhances the benefit under the ICL to a level such that the generic gap coverage can be set to 100% member liability (e.g. provide no coverage in the gap, since the benefit below the gap is actuarially equivalent per test)? | 1) See response above.<br><br>2) No. |
| 4 | Part D coverage in the gap | 05/13/2010 | 4/13/2010 9:52 AM | Question For OACT Conference Call | Can plans convert the 50% [brand discount] coinsurance into an actuarially equivalent copay for their 2011 Part D benefit design? | No. |
| 5 | Part D plan terminations | 05/13/2010 | 4/20/2010 6:15 AM | effect of terminated plans on autoassign status | Based upon the benefit guidance recently released, we would expect more plan terminations in 2011 than have historically occurred. With respect to plan terminations which occur without crosswalk of beneficiaries to other plans,<br>1) will beneficiaries from those plans be excluded from the determination of the national average Part D bid for 2011, and<br>2) will the voluntary low income population from those plans be expected to choose new plans, or will they revert to autoassign status and be distributed among plans that bid below the benchmarks? | 1) The calculation of the national average is based on enrollment as of a reference month and the CY bid. If there is no CY bid (i.e., plan termination), then it is not included in the calculation. [Clarification added on 5/20/2010: This was a response to a question regarding plan terminations that occur without crosswalk of beneficiaries to other plans.]<br><br>2) Response from CMS enrollment staff:<br>Beneficiaries eligible for LIS would be reassigned from a terminating plan via the annual reassignment process, which mirrors the daily auto assignment and enrollment process.<br>[CMS] reassigns all LIS (whether they chose the plan or were assigned; whether they have full or partial subsidy) in terminating plans. |
| 6 | Part D coverage in the gap | 05/13/2010 | 5/11/2010 7:55 AM | LICS Subsidy | For a Defined Standard plan, the low income members that are in the coverage gap do not have the benefit of the 93% generic in the gap. The low income cost sharing subsidy would be the difference of 100% of the cost and the $1.10 that the member would pay point-of-sale.<br><br>If an Enhanced Alternative plan offers generic coverage in the gap (i.e. $7 copay in the gap) would the low income cost sharing subsidy be the difference of:<br>A) 100% of the cost and the $1.10 copay or<br>B) $7 copay and $1.10<br>This assumes the cost of the generic gap drug would be more than $7 and also that the low income member falls into the FPL that they would pay the $1.10 for generics. | The answer to this example is B. This is unchanged from previous years' methodology. |

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| 7 | Part D coverage in the gap | 05/13/2010 | 5/8/2010 7:42 PM | Type of Coverage in the Gap | 1) Please confirm that if a plan is simply providing the mandated non-LIS generic gap benefit, that they should indicate "no gap coverage" on WS 5 of the BPT and in the PBP.<br><br>2) On WS 5, the Defined Standard Coverage defaults to a gap OOP % that is less than 100% (based on inputs on WS 3 for the mandated generic gap benefit). If pricing an alternative benefit plan, should we similarly enter an effective out of pocket of less than 100% even if we are only offering the mandated generics in the gap benefit?<br><br>3) If we enter "no gap coverage", Basic (not Enhanced) Alternative coverage, and yet show an effective out of pocket of less than 100% in IV.12.k on WS 5 (cell K47) is this going to cause upload/red circle error headaches? | 1) Correct. Page 7 of the April 16th Part D PBP memo states: "For 2011, we clarify that sponsors will no longer indicate their level of gap coverage in the PBP. Instead, CMS will quantify each plan's gap coverage based upon the percentage of formulary drugs (brand or generic above the 7% standard coverage) covered through the gap and then will assign appropriate descriptions. "<br><br>2)Yes.<br><br>3) This will not prevent BPT finalization and upload. |
| 8 | Part D LIB | 05/13/2010 | 5/5/2010 11:30 AM | Part D Instructions Appendix E | Last year, the LIB for region 29, Nevada defaulted to the lowest premium in the region of $20.20. This number again appears in the current Part D bid instructions, Appendix E in the February 2010 Enrollment column. Will you confirm this number ($20.20)? | The $20.20 Low Income Benchmark Premium Amount for region 29 (Nevada) in Appendix E of the bid instructions was a typo (it was the amount in this table in last year's bid instructions).<br><br>Instead of $20.20, the amount (based on February 2010 enrollment) should be $25.27. |
| 9 | Part D LIB | 05/13/2010 | 5/5/2010 6:07 PM | Question on Nevada benchmark in Appendix E of the Part D bid instructions | [PARAPHRASED]<br>Please confirm the $20.20 amount indicated in Appendix E of the Part D bid instructions for region 29 (Nevada). | See above response. |
| 10 | Part D admin | 05/13/2010 | 5/10/2010 11:21 AM | Direct Admin Expenses | Is the plan responsible for knowing the staffing, pay rates and skill level of its vendors? For example, the delegated vendor PBM's contract included prior authorization and step therapy services as part of its per script admin charge to the insurer. Is the insurer or sponsoring contract responsible for knowing whether the PBM has sufficient staff to cover the prior authorization and step therapy volume? | Yes. |
| 11 | Part D admin | 05/13/2010 | 5/10/2010 2:11 PM | Part D COB and User Fees | Questions 5-7 of the 4/22 call inquired about these fees, and the response was the fee is $1.17 PMPY. For 2010, the Part D COB fee was $1.89 PMPY, while the 2010 BPT instructions (page 11) provided the separate $0.08 PMPM Part D User Fee. As stated in the 4/5/2010 Final Rate Notice, the 2011 Part D COB user fee is $1.17 PMPY. Can you please specify the amount of the separate Part D user fee, or are you stating that both fees will be $1.17 PMPY in 2011? | Per the 4/29 UGC Q&A (#3):<br>For CY2011, there are two Part D fees to include as non-benefit expenses:<br>1) $0.08 PMPM National Medicare Education User Fee (unchanged from last year), and<br>2) $1.17 PMPY which supports the transmittal of information through the COB and TrOOP facilitation coordinators. |
| 12 | Part D risk scores | 05/13/2010 | 5/10/2010 8:54 PM | Benefit designs and Risk score questions (2 of 2) | For the purpose of reporting the risk score on worksheet 1, we will use the 2009 risk scores from the beneficiary level file under the current model. Please advise us of the correct normalization factor. | From 4/22/2010 UGC Q&A (#8):<br>The risk scores reported on Worksheet 1 of the Part D BPT must be normalized by the CY2009 normalization factor of 1.085 and be based on the "old model".<br><br>And from 4/29/2010 UGC Q&A (#5):<br>The beneficiary-level file includes risk scores under both the "old" model (i.e., the risk model in effect for CY2009 payment) as well as for the new Part D risk model. After calculating the average CY2009 risk score under the "old" model, divide by the Part D CY2009 normalization factor of 1.085. That amount is then reported on PD BPT WS1. |
| 13 | Part D risk scores | 05/13/2010 | 5/11/2010 10:31 AM | Part D Risk Scores | We noted a significant increase in Part D risk scores under the new model for dual SNP members while this increase was not noted in the non dual SNP population.<br><br>Per the bid instructions, we applied to the following adjustments to the 2009 risk scores under the new model scores provided in the beneficiary level file:<br>1. Anticipated increase for coding improvement from 2009 to 2011<br>2. Divide risk scores by 1.029 normalization factor<br>3. Adjustment for missing diagnosis codes (if applicable)<br>4. Adjustment for population changes (if applicable)<br><br>Please confirm that no further adjustments are required for these risk scores for the dual SNP population or the non dual SNP population. | Generally speaking, this approach seems appropriate. |

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|---|---|---|---|---|---|---|
| 14 | Part D risk scores | 05/13/2010 | 5/10/2010 8:26 PM | CMS User Group Call - Question | Can you please let us know why the Part D coding trend to project Part D risk scores is projected to be 0.9% per year whereas in the past it was around 2% per year? Is this due to the RxHCC model change? | The 0.009 annual trend underlying the 2011 Part D normalization factor was calculated by first calculating risk scores under the new model for 2006, 2007, and 2008, and then estimating a linear regression on the average risk scores of MAPD and PDP enrollees across these years. Previous year's Part D normalization factors comprised two parts: a base risk score (the average enrollee Part D risk score) and trend (based on the FFS population and applied from the year of the average risk score to the payment year). The trend part of the normalization factor has decreased slightly from year to year. |
| 15 | MSP | 05/13/2010 | 5/7/2010 8:06 AM | MSP | Was there a change made in the MSPCOB files in April (vs. January thru March)? I saw a significant increase in the number of MSP members that were identified. | The monthly files that started in April contain the history of all beneficiaries enrolled in a plan, including all MSP types. The interim files contained records only of those beneficiaries enrolled in the plan who had an open MSP period of one of the following types: A (working aged), B (ESRD), and G (disabled); only A/B/G records were included on the interim files.<br>Further, the interim files had multiple records per line. If the first record in a line was not valid, the second could have been. So if a plan skipped a line based on the validity of the first record, their counts may be off. |
| 16 | Part C beneficiary file | 05/13/2010 | 5/7/2010 10:22 AM | Hospice status in Pt C bene file | The Part C bene file provided by CMS had significantly more hospice member months than we expected based on our MMRs including retro adjustments through April 2010. We have researched this difference and it appears that the difference is explained by the bene file flagging hospice in the month that the member entered hospice status, rather than the 1st of the month after elected hospice status. For example, if a member elected hospice status on July 20, 2009 and terminated hospice status in Sept 2009, the bene file shows a hospice flag for July, Aug, and Sep. However, we would have rec'd a "regular" payment for the month of July based on the member's risk score (community or institutional). Only the payments for Aug and Sep would have been reduced due to hospice status. Please confirm that this is the way the hospice flag was set for the bene file and indicate if this approach should have been revised to reflect the way the MMR payments work. Also, will you be sending out a corrected bene file? | The hospice status flag on the file does not affect MA payment, so much as it shows periods during which hospice was in force for some part of the month. As of the date of hospice election, the MAO is only responsible for supplemental benefits; FFS pays for all non-hospice related A/B services as well as the hospice benefit. To assess the impact on payment, MAOs should consider the second and later months of hospice status. Because the file does not provide payments, we will not be resending the file. |
| 17 | Gain/Loss margin | 05/13/2010 | 5/6/2010 3:52 PM | Profit Margin Variance | How much can the profit margin vary between two plans?<br>One scenario is there are two MA-PD plans how much can the profit vary between plan 00A and 00B for instance.<br>Another scenario is individual MA-PD verses EGWP MA-PD what is the maximum profit variance between 00A and 80A?<br>I did not see any information regarding inter-plan profit variance only variance between Medicare Advantage and other lines of business which is 1.5%. | Page 20 of the MA bid instructions state:<br>"There is flexibility in setting gain/loss margin at the plan level provided that the overall margin meets CMS requirements, anti-competitive practices are not used, the plan offers benefit value in relation to the margin level, and negative margin satisfies the guidance in this subsection."<br>"If corresponding general enrollment plans are offered, the assumptions used for general enrollment plans must be the basis for the margin requirements for EGWPs. The difference in the margin level between EGWP and general enrollment plans must not exceed 1 percent, calculated at the contract level."<br><br>There is no further guidance on margin variance beyond what is stated in the bid instructions. |
| 18 | Related Party | 05/13/2010 | 5/11/2010 10:30 AM | Related Party Caps | During last week's [5/6/2010] actuarial call there was discussion regarding splitting capitation for related-parties. I see the reference on page 28 of the MA instructions "Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all medical expenses and administrative costs in the related-party agreement to medical expenses and non-benefit expense, respectively."<br><br>This splitting seems to be inequitable treatment relative to non-related capitated parties. Their expenses can be included solely as medical. Please confirm this inequity is what CMS requires.<br><br>If we are required to split the capitation for related parties between medical and non-benefit expenses, is it OK to allocate gain/loss proportionately to the two items? | As indicated on page 10 of the MA bid instructions, amounts paid for medical services under capitated arrangements with related parties and non-related parties may be treated differently. Capitation payment to non-related parties is treated as medical costs similar to the handling of other negotiated medical expenses. Capitation payments to related parties may be treated the same, only if the plan sponsor demonstrates that the capitation is comparable to the amount paid to a non-related party of similar size and market position. Otherwise, the excess (or deficiency) over the average cost of providing the medical services is treated as gain/loss margin. (Note that references to non-benefit expenses on page 28 of the MA bid instructions apply to administrative service agreements and not to arrangements for providing medical services.) |

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| 19 | MA risk score projection | 05/13/2010 | 5/10/2010 2:06 PM | Issue 127: credibility method for development of risk scores | The bid instructions state that "the credibility assumption for projected allowed costs may vary...from the credibility method used in the development of risk scores, as risk scores tend to reach full credibility at lower levels of membership." Is there a recommended credibility formula for risk scores? | From 4/29/2010 UGC Q&A (#16):<br>CMS does not intend to release guidance on the member month value considered fully credible for projecting risk scores. |
| 20 | EGWP | 05/13/2010 | 5/6/2010 11:53 PM | EGWP Bids - Actuarial Equivalences & Swaps | We would like to file our group bids with the "average" benefit package that 99% of our group members are enrolled in. However, we would still like to accommodate those groups that do ask for high cost outlier copays or cost sharing that this filed benefit package would not accommodate. Can we continue to file actuarial swaps and actuarial equivalences for employer group bids where the group bid that is filed represents the average cost sharing for 99% of its group members? The bid instructions seem to imply that actuarial swaps and equivalences can now only be filed in "Individual-Market Plans". | Appendix D of the MA bid instructions describes two options for offering an MA plan to employer groups: individual-market plans and EGWPs.<br>Actuarial swaps / equivalence are necessary for individual-market bids if the benefits are changed from what was filed. There are no actuarial equiv / swaps for EGWP plans because EGWP bids are filed with the expectation that the benefits will be customized for specific groups. |
| 21 | MA BPT WS1 Section VI | 05/13/2010 | 5/11/2010 9:00 AM | WS1 Revenue | During the 5/6/2010 actuarial call, a comment was made while discussing how to complete Worksheet 1, new section 6, that MAOs should both subtract uncollected premium from revenue as well as put uncollected premiums in direct expenses. If you make both of those adjustments, you are double-counting the impact of a member not paying premium.<br><br>We believe that including uncollected premiums as part of direct expenses makes the most sense while showing revenue based on what the MMRs say you should have collected. Please confirm our interpretation is correct. | Your interpretation is correct.<br>To clarify the instructions for MA BPT WS1 Section VI:<br>For Line 2, Premium Revenue, enter the earned premiums which would include any uncollected premiums.<br>In Line 5b, Direct Administration expenses, include any uncollected premiums. |
| 22 | AE c.s. factors | 05/13/2010 | 5/8/2010 10:59 AM | Part B Issue | Do the Part B Actuarial Equivalent percentages developed in WS#5 (MA Bnchmrk) assume that preventative services will generally be provided with $0 copay, even though that will not be mandatory until 2012? | From the 4/29/2010 UGC Q&A (#22):<br>The actuarial equivalent cost sharing factors on MA Worksheet 5 have been unchanged since last year. Therefore, no benefit changes have been incorporated in the factors. |
| 23 | Pricing of benefit memo | 05/13/2010 | 5/5/2010 1:40 PM | Issue 120: April 16th Memo Questions | Re: Actuarial Equivalent Cost Sharing Maximums<br>For IP Facility and SNF, is the Original Medicare actuarially equivalent cost sharing pmpm already adjusted in the BPT to reflect Part B cost sharing? Or does that test require an out-of-model adjustment factor? If so, when will those adjustment factors be released? | The test does not require an out-of-model adjustment factor. The table on page 8 of the April 16th memo contains the factors, and these factors are already incorporated into the MA BPT (see table on Worksheet 4 cells AD18:AJ24). |
| 24 | MOOP | 05/13/2010 | 5/11/2010 9:46 AM | MOOP Questions | Question 1: For HMO, HMOPOS, and LPPO plans, is it necessary to enter a combined MOOP if the intent is to use the mandatory maximum in worksheet 3 of the BPT?<br><br>Question 2: For HMOPOS, is a combined MOOP applicable since there is no mandatory OON MOOP. | 1) For HMO and HMOPOS, the mandatory MOOP amount of $6700 would be entered in the in-network plan level maximum enrollee out-of-pocket cost on the PBP and in the in-network box on Worksheet 3 of the BPT. For LPPO, the mandatory MOOP amount of $6700 would be entered in the in-network plan level maximum enrollee out-of-pocket cost and $10000 would be entered in the combined plan level maximum enrollee out-of-pocket cost in the PBP. Also, $6700 would be entered in the in-network box and $10000 in the combined box on Worksheet 3 of the BPT.<br><br>2) No. |
| 25 | MOOP DE | 05/13/2010 | 5/11/2010 10:26 AM | MOOP DE# | Please clarify if the MOOP guidance provided on May 10th applies to DE# eligibles in Dual eligible SNPs only or all DE# eligibles regardless of plan type. | The guidance applies to dual eligible enrollees regardless of the plan type in which they are enrolled (i.e., applies to SNP and non-SNP). |

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| 26 | MOOP DE | 05/13/2010 | 5/11/2010 8:33 AM | MOOP Determination | Since MOOP is calculated on Worksheet 3, should this adjustment be for Non-DE# members only? Where would the MOOP for DE# members be reflected?<br><br>If all DE# beneficiaries in the State are not responsible for any cost-sharing since the State picks up what the MA plan does not pay, should there be no MOOP adjustment for DE# beneficiaries for all MA plans (SNP and non-SNP)? | As a reminder, from page 15 of the MA bid instructions:<br>If (i) DE# projected member months are < 10 % or > 90 % (but not 100 %) of total projected member months, and (ii) the projected allowed costs in Worksheet 2 for the total, DE#, and non-DE# populations are all equal, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, may, at the discretion of the certifying actuary, apply to either the non-DE# population or the total population.<br>If DE# projected member months are 100 percent of total projected member months, then the utilization rates entered in Worksheet 3, and hence the PMPM value of cost sharing, must apply to the total population.<br>In all other cases, the utilization and PMPM value of cost sharing apply to the non-DE# population.<br><br>Regarding these specific questions:<br>DE# plan cost sharing is entered on WS4 Section IIB column (f).<br><br>For DE# members who are not responsible for paying cost sharing, the MOOP adjustment would likely be zero. However, for non-DE# members (in both SNPs and non-SNPs), the MOOP adjustment would not necessarily be zero for the plan. |
| 27 | MOOP DE | 05/13/2010 | 5/11/2010 7:51 PM | RE: Type of Coverage in the Gap | I would like to confirm that the following statement from the May 10th memo, Supplemental 2011 Benefits Policy and Operations Guidance on Application of the Mandatory Maximum Out-of-Pocket for Dual Eligible SNPs, and Cost Sharing for Preventive Services, seems to overturn earlier guidance:<br>"We are clarifying, however, that for purposes of tracking out-of-pocket spending relative to its MOOP limit, a plan must count only the actual out-of-pocket expenditures for which each enrollee is responsible. Thus, for any DE enrollee, MA plans must count toward the MOOP limit only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost-sharing and not the cost sharing amounts for services the plan has established in its plan benefit package. Effectively, this means that for those DE enrollees who are not responsible for paying the Medicare Parts A and B cost sharing, the MOOP limit will rarely be reached. However, plans must still track out-of-pocket spending for these enrollees."<br><br>Specifically, the application of this rule on the state Medicaid payer based on earlier guidance given in the April 16th memo and the actuarial bid Q&A that stated<br>"the State would not be expected to pay above the MOOP amount if the State is responsible for paying the cost sharing"<br>and<br>"the State Medicaid program would not be expected to pay more than the MOOP amount when it is responsible for the enrollee's cost sharing." | The May 10th memo does not overturn earlier guidance, but it mitigates the effect of the policy on dual eligibles.<br><br>If a DE# member is not responsible for paying cost sharing, the MOOP would likely not be reached.<br>State payments for cost sharing, on behalf of a DE# member, do not count towards the MOOP.<br><br>In the unlikely event that a DE# member's cost sharing reaches the MOOP, then the State is limited by the MOOP plan provision. That is, once the MOOP is reached, the State would no longer be responsible for the beneficiary's cost sharing buydown because of the plan's out-of-pocket provisions. |
| 28 | MOOP | 05/13/2010 | 5/10/2010 12:24 PM | CY2011 Cost Sharing Requirements - DME and Home Health | 1) I have a question about the CY2011 cost sharing requirement for DME and Home Health. For the $6700 MOOP, the 4/16 guidance document describes that cost sharing can be no greater than original Medicare. I think you stated on the actuarial user group call last week [5/6/2010] these cost sharing requirements are for combined in-network and out-of-network.<br><br>2) For example, if we have a $6700 MOOP and our in-network benefit is the same as original Medicare for DME (20%), does this mean the out-of-network benefit cannot exceed 20%? What if we do not have a Part B deductible - can we account for that difference or not?<br><br>Another example, if we have a $6700 MOOP and our in-network benefit is $0 for Home Health, does this mean the out-of-network benefit also has to be $0? | 1) From 5/6/2010 UGC (#18)<br>The Worksheet 4 Actuarially Equivalent Cost Sharing Maximums are based on total cost sharing PMPM (including in-network and out-of-network).<br><br>2) The cost sharing standards (chart on pages 9 and 10 of the April 16 memo) are applied to in-network cost sharing only. |

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May 20, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | Part D policy | 05/20/2010 | 5/12/2010 11:04 AM | Part D Bid Question | The current Part D bids require plans to provide a composite bid for two different products. The recent Health Reform changed Part D to provide coverage for generics and in the future brand drugs in the gap. This coverage is provided for Non Low Income beneficiaries, while Low Income beneficiaries have a less rich benefit that does not provide this coverage. As the amount of the coverage in the gap increases, the discrepancy between the two products will increase. This will create an increasing level of cross subsidization that is dependent on the mix of enrollees in the product. Eventually, this will destabilize the market and could cause significant disruption and large changes in premium amounts each year depending on enrollment shifts. Further, a large influx of Non Low Income individuals into plans with high Low Income enrollment will necessitate large premium increases, and cause significant disruption in Low Income premiums and options for Low Income plans below the benchmark. Will CMS address this issue? | CMS is aware of this issue; it is a long-term policy issue. OACT has shared these concerns with CMS policymakers for their consideration in future contract years. |
| 2 | Part D policy | 05/20/2010 | 5/10/2010 12:31 PM | Part D Question | As stated in the call last week [5/6/2010], CMS recognized a risk in the adequacy of premium related to the accuracy of the LIS membership projection due to the different generic gap benefit for LIS and non-LIS members. CMS said it is the responsibility of the credentialed actuary to manage this risk in the projection assumptions. As a credentialed actuary, my opinion is that plan designs with separate benefits are not rated together to avoid selection risk. Because CMS has chosen to implement the LIS and non-LIS benefit differential as a blended premium, I am not able, as a credentialed actuary, to properly manage this risk through benefit specific premiums. Was it the intent of CMS to increase the premium adequacy risk of plans resulting from the operational decision to create a blended premium for LIS and non-LIS members? Please note this risk increases each year as the amount of gap coverage increases for non-LIS members. How does CMS plan to correct the outcome of the decision to rate two different plan designs as one blended premium? | See above response. |
| 3 | LIS enrollment data | 05/20/2010 | 5/17/2010 6:35 PM | LIS information | The link on the CMS website to 2010 Part D Low Income Subsidy Contract Enrollment by County [ZIP, 608KB] produces the zip file 2010_PartD_LIS_Contract_Enrollment_by_County.zip<br><br>This zip file is missing the PDP information for most states that begin with the Letter N (e.g., New York, Nevada, New Mexico, etc). | CMS is in the process of correcting the data and it will be re-posted soon. |
| 4 | MLR policy | 05/20/2010 | 5/12/2010 10:25 AM | Part D Questions: MLR, OOP test & Manufacturer's Rebates | Do the 85% MLR requirements apply to PDPs? | There is no MLR requirement for CY2011. MLR policy will be announced at a later date for future contract years. |
| 5 | MOOP | 05/20/2010 | 5/14/2010 3:47 PM | Group Bids and MOOP Impact | If our organization has requested a waiver of the MOOP and Cost Sharing limits for its employer group plans, will we still need to include the estimated impact of the MOOP in our bid calculation for our 800-series bids for which we file a Medicare FFS level benefit? | Until a waiver has been granted, bids must be submitted to include the MOOP and must be priced accordingly. |
| 6 | MOOP | 05/20/2010 | 5/18/2010 8:22 AM | MOOP Adjustment | Since 99.9% of the time MOOP was applied to members with either an inpatient stay of a SNF stay, can the total MOOP adjustment be spread only to lines a and b (Inpatient and SNF) on Worksheet 3 of the BPT? | MOOP must be priced in all service categories that it applies to. |
| 7 | Part D risk scores | 05/20/2010 | 5/12/2010 11:18 AM | User Group Questions | Risk Score Model Changes - For Part D, the RxHCC model was updated for payment year 2011. We would like to calculate the impact of the model change for Part D risk scores. Is CMS releasing the 7/2009 cohort Part D risk scores using the 2009 RxHCC model? If yes, can you please inform us when and where we are able to locate this information? | See HPMS memo dated April 13, 2010 entitled: "Incoming File from CMS: beneficiary-level file to support 2011 Part D bids". |

# Advance Questions from actuarial-bids@cms.hhs.gov for CY2011 OACT User Group Calls

May 20, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 8 | Part D risk scores | 05/20/2010 | 5/13/2010 9:21 PM | RxHCC New Enrollee Factors and plan specific trend development | 1. Are the RXHCC new enrollee factors developed to reflect the specific costs associated with enrollees new to Medicare, or are these factors just averages based on all members? That is, are the new enrollee factors inappropriate to use in estimating the average risk score for a non-new enrollee population?<br><br>2. New enrollee scores for non-low income populations drop as they age above 65. We were surprised by this result, which is different than the previous model.<br>If risk scores are expected to drop with age, and we notice a year over year "same member" increase in our risk scores of (for example) 2.5%, is it appropriate to assume that the coding trend is a number higher than 2.5%, to counteract the expected decrease?<br><br>3. Is it appropriate to use the trend we see in risk scores based on the old RxHCC model, to develop a plan specific coding trend? Since the new enrollee factors for the prior model increased with age, and the new model decrease with age, it would seem that the trends would be very different. However, if we don't use the old RxHCC model results, what else can we use? We do not have the diagnosis data, nor do we have the indicators that tie to the new RxHCCs. | Each of the three RxHCC new enrollee model segments was calibrated using separate samples of new enrollees only. These factors differ somewhat from a similar demographic model estimated on the full or continuing population. "New enrollees" are those who do not have 12 months of Part B in the data collection year, which will include both those beneficiaries new to Medicare and those continuing enrollees who have been entitled to Part A and enrolled in a Part D plan, but have not enrolled in Part B. Because the new enrollee factors under the new RxHCC model are based on a unique population, it is inappropriate to use these new enrollee factors to estimate the average risk score for a non-new enrollee population.<br><br>The new enrollee model coefficients are not affected by coding trends, as diagnoses are not part of the model. Further, the beneficiaries who are classified as "new enrollees" are being captured at a point in time and reflect the impact of the demographic characteristics of the population on the expect costs of each age-sex group at that time. Therefore, the new enrollee factors are not able to suggest a trend across age groups. While some beneficiaries may be classified as "new enrollees" for consecutive years, the average for an age bracket may not equal the costs of these particular people. The coefficient for a bracket depends on the whole population falling into the age bracket.<br><br>Regarding trends, plans should be developing risk score trends for use in projecting their enrollee risk scores to the payment year based on their own enrolled populations. If plans don't have all the diagnoses, either because they are a PDP or because the beneficiary was in another MA plan or in FFS in the previous year, and want to develop a trend that specifically incorporate coding trends for their full risk enrollees, they can use the RxHCC information in the Model Output Report (MOR) that is sent out each time the risk scores are updated.<br><br>If plans really want to use a demographic model that reflects the total Part D population, the new enrollee segment of the current model will suffice as it was estimated on a sample including continuing and new enrollees. We don't recommend this because the model is built using older data that was not actual program data.<br><br>The annual trend that CMS calculates when it establishes a normalization factor for use in payment is based on the trend of all enrollees in the July cohort in each of a number of years – because it is an industry-level trend, it is not necessarily the same trend seen for a given subgroup group of enrollees or a given plan type. In past years, the annual trend itself was based on FFS beneficiaries (and the base risk score was an average of all Part D enrollees). For 2011, the normalization factor is based on Part D enrollees. |
| 9 | Coding Intensity Trends | 05/20/2010 | 5/17/2010 2:41 PM | FFS Coding Intensity Trends | In prior years, CMS provided estimates for FFS coding intensity trends (based on the effective annual trends underlying the normalization factors):<br>• For 2009 Bid Development: Part C = 1.015; Part D = 1.017<br>• For 2010 Bid Development: Part C = 1.0136; Part D = 1.0135 (2010 Normalization Factor = 1.1159 × (1.0135)^2 = 1.146)<br><br>Could CMS provide updated estimates for projecting 2009 risk scores to 2011 and/or confirm the estimates below?<br><br>Based on the 2011 normalization factors, we are assuming the FFS coding intensity trends are:<br>• Part C = 1.0141 or 1.41% (Page 14 of Final Call Letter)<br>• Part D = 1.00949 or 0.949% (Page 15 of Final Call Letter) | These annual trends -- which are published in the 2011 Announcement -- are the most recent trends that CMS has calculated. Please note that the Part D trend is not FFS, but is based on Part D enrollees (in MAPDs and PDPs). |

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| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 10 | Non-Benefit expenses | 05/20/2010 | 5/14/2010 1:30 PM | Charitable Contributions | Can charitable contributions be included in non-benefit expenses on the bid? | No. Page 24 of the MA bid instructions:<br>"Costs not pertaining to administrative activities must be excluded from non-benefit expenses." |
| 11 | Related Parties | 05/20/2010 | 5/14/2010 1:29 PM | Related Parties | Please provide further insight into what constitutes related parties.<br>In particular, how much ownership is required to have the entity fall into the category requiring the additional documentation? | There is no minimum ownership requirement. Page 28 of the MA bid instructions:<br>"These requirements for related-party agreements apply to a plan sponsor that enters into any type of medical or service agreement involving a parent company and subsidiary or between subsidiaries of a common parent." |
| 12 | GainLoss Margin | 05/20/2010 | 5/17/2010 3:47 PM | Negative Margins | Would CMS accept negative margins at the contract level? If so, would the same rules apply for gain/loss margin between SNP/non-SNP, Part A/B and Part D plans? | The bid instructions describe that the overall Medicare margin levels may be determined either at the contract level or at a more aggregated level. If it is determined at the more aggregated level, then it is possible that contract-level negative margins may meet the requirements (depending on the margin levels of the other contracts).<br><br>All gain/loss margin rules apply as stated in the bid instructions. These rules include that overall margin must be within a certain range of other lines of business and must be consistent with the plan sponsor's corporate requirement. There is flexibility in setting gain/loss margin at the plan-level provided that the overall margin meets CMS requirements, anti-competitive practices are not used, the plan offers benefit value in relation to the margin level, and negative margin satisfies the bid instructions. As a reminder for plans with negative margins, the plan sponsor must develop and follow a business plan to achieve profitability. |

# Advance Questions from actuarial-bids@cms.hhs.gov for CY2011 OACT User Group Calls

May 27, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | Cost Sharing tests in MA BPT | 05/27/2010 | 5/21/2010 10:51 AM | MOOP Testing and the BPT | My SNF benefit passes the OOPC tests. However, on Worksheet 4 of the BPT, my cost sharing appears to be more than FFS cost sharing for SNF benefit because the reduction in A/B cost sharing amount is negative. I don't think this SNF benefit is actually worse than FFS, it's just the experience of my plan causing the effective coinsurance of FFS to be higher than it would be for this specific population.<br><br>Do I need to change cost sharing so I show no negatives on Worksheet 4, column Q of the BPT? | Plans must pass both the cost sharing standards and the actuarial equivalent (A.E.) cost sharing tests.<br><br>If plan cost sharing is different than FFS cost sharing (as indicated in the PBP), then generally speaking, it is not meeting the A.E. tests for the example presented in this question.<br><br>An exception to the AE tests is: If plan cost sharing is determined to be equal to FFS cost sharing, then this example may be found acceptable. The plan must demonstrate that their pricing is appropriate. |
| 2 | Supporting Documentation | 05/27/2010 | 5/24/2010 9:14 PM | Question about Supporting Documentation Deadline for Upload | 1) We know the bidding instructions this year clearly state that the supporting documentation must be uploaded prior to the same time as to when the bids are due, Monday, June 7th, midnight Pacific. In the past few years when the bids were due earlier in June, you allowed plans an additional 48 hours for the supporting documentation to be uploaded. Would you consider allowing an additional 24 to 48 hours for the supporting documentation to be uploaded this year?<br><br>2) Also, do you want to see how the plan is estimating the $20 pmpm cost sharing differential between plans as part of the supporting documentation we submit or hold on to it in case asked by desk reviewer or others at CMS? | 1) Supporting documentation is due by the bid submission deadline (Monday June 7, 2010 11:59pm PDT).<br><br>2) The OOPC information is not part of the supporting documentation requirements for the BPT. |
| 3 | Part D coverage in the gap | 05/27/2010 | 5/24/2010 8:31 PM | Part D EA generics | For an EA plan with a $7 generic copay in the gap, if a generic drug costs $7.25 in the gap, should the member be charged 93% * $7.25 = $6.74 or $7? Is either method acceptable? | From the May 25th memo released by CMS:<br><br>Q5. To comply with the new legislation, when constructing 2011 bids do enhanced alternative plans need to use lesser of logic when offering additional gap coverage of generics?<br>A5. No. However, when constructing the 2011 bids, any enhanced benefit for additional gap coverage of generics should be meaningfully different from the new 7% standard coverage of generics in order to reflect a common understanding of supplemental coverage by the beneficiary. An enhanced alternative plan may establish a copayment amount in the gap for pre-ICL covered generics at the tier level without applying lesser of logic at the claim level so long as the enhanced benefit across the gap for generics is actuarially equivalent to significantly more than the required standard coverage. In addition, consistent with our existing regulations, the cost sharing at the point of sale for a generic drug cannot be more than the plan negotiated cost of the drug. For example, a copayment of $5 for generics in tier 1, which represented an actuarially equivalent benefit to 50% of the generic drug costs for generics in that tier, would clearly demonstrate a more meaningful benefit than the new standard cost share of 93%. In this same example, if at the point of sale the plan negotiated cost of a tier 1 generic was only $4, the beneficiary must be charged the lower amount (i.e., $4 instead of the tier 1 gap copayment of $5). Thus, the beneficiary pays the lesser of the copay or the cost of the generic drugs in tiers subject to an enhanced supplemental gap coverage benefit and pays 93% of the cost of generics in all other "non-enhanced" tiers. Similarly, an enhanced alternative plan may establish a coinsurance amount in the gap for pre-ICL covered generics provided that the beneficiary cost share for the additional gap coverage of generics is significantly less than 93%. For example, CMS would not consider supplemental coverage of 10% of generic drug costs in the gap meaningfully different from the new standard of 7%.<br><br>Any further questions should be directed to PartDBenefits@cms.hhs.gov |

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| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
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| 4 | Part D coverage in the gap | 05/27/2010 | 5/25/2010 10:32 AM | Bid Question | CMS has scheduled a conference on June 1 to discuss the 'Coverage Gap Discount Program'. Will any additional information be released at this conference that will need to be incorporated into the 2011 bids? Or to put it more simply, would the Office of the Actuary recommend that an actuary attend specifically for the purpose of 2011 bid development? | OACT is not aware of the conference agenda specifics at this time, so we cannot advise whether it's worthwhile to attend.<br><br>Information about the conference can be found at: http://www.cms-cpcevents.org/cms/events/baltimore-june-2010/ |
| 5 | PD BPT | 05/27/2010 | 5/25/2010 10:03 AM | Part D Wkst 1 | In 2009, we offered an enhanced alternative plan where we bought the supplemental premium down to zero using MA rebate dollars.<br>1) Can you confirm that we would put a zero in Section V, Line 3, column f (the supplemental member premium cell) since no member premium was collected?<br>2) In this case, under Section IV, would we still be required split the non-benefit expenses between basic and supplemental? | 1) Yes.<br><br>2) Yes. |
| 6 | MSP | 05/27/2010 | 5/20/2010 10:11 AM | RE: Question on MSP in WS5 | On Page 23 of the MA Bid Instructions, the MSP adjustment is defined as 1-A/B, where B is defined as "Total plan payments that would be paid if no beneficiaries had a payer that was primary to Medicare".<br><br>Could you please clarify what is meant by "Total plan payments"?<br>Are Part D payments such as direct subsidy, LICS and LIPS included?<br>Does this mean the MA risk payment only, or does it include the MA Rebate? | As stated on Page 23 of the MA bid instructions, "the BPT uses the MSP adjustment to reduce the standardized A/B benchmark" and "The total plan payment used to calculate the MSP adjustment exclude MA rebates."<br>Thus, total plan payments used to calculate the MSP factor exclude Part D payments and exclude MA rebates. |
| 7 | Related Parties | 05/27/2010 | 5/21/2010 10:04 AM | RE: Related Parties | We have a related party that performs administrative functions on our behalf. This related party does not wish to disclose how much of the fee it charges us is profit. Instead, they wish to share that information with CMS, per page 29 of the BPT instructions.<br>"To satisfy proprietary concerns, CMS can initiate separate contact with the plan sponsor and subcontracted related party when addressing related-party issues in the bid. Plan sponsors interested in this level of discussion must request it and identify a point of contact at the related party at the time of bid submission."<br><br>In the BPT, would we put the entire fee in admin, as the related party has not shared which portion is profit, and disclose the issue and a point of contact at the related party in the substantiation uploaded with the bid, so that CMS can contact the related party directly? | This approach sounds appropriate. |
| 8 | Non-benefit expenses | 05/27/2010 | 5/25/2010 12:35 PM | Non Benefit Expense Questions | In previous calls you mentioned that we have some freedom, in adjusting our corporate overhead charges within the organization – could an organization elect to make a full or partial reduction in the overhead charges that it puts into the bid?<br><br>Please confirm that employees and services dedicated to Medicare should be fully expensed in the bids not allocated. | The certifying actuary must use a reasonable allocation of non-benefit expenses to Medicare, and to the bid, consistent with the allocation used for other lines of business. It is not reasonable to allocate the costs of employees and services dedicated to Medicare to other lines of business. |
| 9 | Non-benefit expenses | 05/27/2010 | 5/25/2010 2:08 PM | Staffing Ratios, expertise and pay rates | Can CMS provide benchmark staffing ratios, expertise and rates of pay for specific functions that are used to build the admin expenses, in particular the direct admin functions? | CMS will not be providing this information. |
| 10 | Disease Mgmt Services | 05/27/2010 | 5/19/2010 10:15 PM | Disease Mgmnt Services | If the SNP Model of Care Services are applied to general enrollment plans or Dual SNPs that exist under grandfathering provisions without state contracts, should those expenses be included as medical or non benefit expenses? | See #13 in the 4/22/2010 UGC Q&A posting which reads, "For all plans (that is, SNPs and non-SNPs), disease management expenses are classified as medical expenses, non-benefit expenses or both based on the nature of the expense. The example in the bid instructions refers to mandated care management services provided by an interdisciplinary team as mandated by MIPPA and addressed in a HPMS memo dated September 15, 2008. Should the team provide additional services, they may be classified by the certifying actuary as non-benefit expenses depending upon their nature." |
| 11 | Disease Mgmt Services | 05/27/2010 | 5/24/2010 2:56 PM | Question regarding SNP Model of Care Expenses | Are SNP Model of Care expenses to be considered Medicare-covered or non-Medicare covered services in the 2011 bids? | SNP Model of Care expenses that are medical in nature must be allocated to Non-covered to the extent that non-covered benefits are provided. |
| 12 | Case Mgmt Fees | 05/27/2010 | 5/19/2010 10:07 PM | Case Management Fees Paid to Related Parties | If a physician group that has representation on the board of directors is paid a capitation not for direct medical services but case management services in addition to their fee schedule reimbursement, is that case management fee subject to related party rules? Would completely carving out the case management fee from the claims experience satisfy the related party bid rules? | Participation on a board of directors does not constitute common ownership, and therefore the related party guidance does not apply. Case management expenses are to be allocated appropriately in the bid. |

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May 27, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 13 | Rebate reallocation | 05/27/2010 | 5/20/2010 3:59 PM | Rebate Reallocation Guidance | Would a plan be allowed to buy-down (or return if necessary) the Part B deductible during the rebate reallocation period? Specifically as this relates to DE# members, if the Part B deductible is bought down the bid tool as it currently works would change the allowed and net medical expense amounts for the DE# members resulting in a change in the overall bid and the amount of rebates available to spend. Please confirm if this would be acceptable during the rebate reallocation period. | Generally speaking, this sounds appropriate. However, as a reminder, CMS has issued guidance regarding the benefit changes permitted during rebate reallocation. See Appendix E of the MA bid instructions. Also, from the CY2010 Call Letter:<br>"MAOs should make re-allocations that reflect the following priorities...<br>1. Reduce or remove non-Medicare covered benefits;<br>2. Increase cost sharing for widely-used services such as primary care visits; and<br>3. As a last resort, increase cost sharing for more limited-use services such as inpatient, skilled nursing facility (SNF), and home health care." |

# Advance Questions from actuarial-bids@cms.hhs.gov for CY2011 OACT User Group Calls

June 3, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 1 | MSP | 06/03/2010 | 5/20/2010 7:53 PM | MSP Adj | Please verify that only those members with MSP status of Working Aged (A), ESRD (B) or Disabled (G) will receive the MSP payment reduction. Are you also restricting the adjustment to only those members that have medical coverage? Are you going to be using the MSP reduction for individuals that have only drug or hospital coverage without medical? | CMS makes an MSP adjustment to payment only for those beneficiaries who have an MSP status of A (Working Aged), B (ESRD), or G (Disabled). The MSP adjustment is applied to Part C payments for all beneficiaries with MSP status of Working Aged (A), ESRD (B) or Disabled (G), including those with "A and B", "A-only", and "B-only" coverage.<br><br>Benefit policies that are mapped to these three MSP categories are not necessarily comprehensive policies, i.e., they may only cover a subset (e.g., hospital only coverage). In the case of a drug-only policy, Part D sponsors would coordinate benefits with other drug coverage and CMS conducts reconciliation using PDE data which reflect payments from other payers. |
| 2 | MSP | 06/03/2010 | 6/1/2010 12:04 AM | MSP Adjustment | To calculate the MSP Adjustment to be entered into Line 3, Worksheet 5 of the BPT, is it correct to multiply the 2011 MSP adjustment factor (0.174) by the ratio of valid MSP members (non-ESRD members with a "MSP Termination" date >= 12/31/2009 or blank) from the 1/29/2010 interim file relative to the January, 2010 MMR, non-ESRD membership?<br><br>If this is not correct, what is the correct calculation? What, if any, plan payment information should be taken into account? | This is not correct; the MSP adjustment entered in the BPT is based on plan payment information (not enrollment information). From pages 22-23 of the MA bid instructions:<br><br>"MSP data provided by CMS serve as the basis for projecting the MSP adjustment. See the ―Announcement of April 2010 Software Release‖ memo dated January 12, 2010 released via HPMS, and the ―Medicare Secondary Payer Information for Plan Payment Adjustment 2010‖ memo dated January 25, 2010 released via HPMS, for an interim source of data .<br><br>The BPT uses the MSP adjustment to reduce the standardized A/B benchmark; the method to calculate the MSP adjustment is described below.<br>MSP adjustment = 1 – A/B, where<br>A = Actual total plan payments reflecting reduced payments for MSP beneficiaries, and<br>B = Total plan payments that would be paid if no beneficiaries had a payer that was primary to Medicare.<br>The total plan payments used to calculate the MSP adjustment exclude MA rebates." |
| 3 | Related Parties | 06/03/2010 | 6/1/2010 12:39 PM | Related Party | Our PBM does not want to share any supporting documentation with us. Per the Bid Instructions we can request that CMS would work directly with the PBM. But, do we need "pre-approval" to do this? If so, how do we do that? | The plan does not need "pre-approval" from CMS for this circumstance.<br><br>Please disclose this issue, and include a point of contact at the related party, in the substantiation uploaded with the bid, so that CMS can contact the related party directly |
| 4 | Related Parties | 06/03/2010 | 6/1/2010 2:53 PM | FW: Related Parties | We have a related party that performs administrative functions on our behalf which has now agreed to disclose how much of the fee it charges is profit and how much is its actual cost. In 2009, the PMPM they charged us was not sufficient, and they suffered a financial loss. Should we increase the amount of non-benefit expenses reported in worksheet 1, section VI, by the amount of the loss that the related party suffered? | The MA bid instructions describe reporting requirements under various related-party scenarios (for ex: organizations that do (or do not) have an agreement with an unrelated party).<br><br>If, in this case, the scenario on page 28 of the MA bid instructions applies, for which the plan sponsor must "consider the gain/loss and non-benefit expense of the related party to be those of the sponsor", then the adjustment that you described would be appropriate. Also note that, to the extent possible, related party costs must be treated consistently between Worksheet 1 (base period actual experience) and Worksheet 4 (projected). |

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June 3, 2010

| # | Topic | UGC date | Date E-Mail Sent | E-mail Subject | E-Mail Body Text | CMS response |
|---|---|---|---|---|---|---|
| 5 | A.E. cost sharing maximums in the MA BPT | 06/03/2010 | 6/2/2010 12:17 PM | Issue 285: Actuarial Equivalent Cost Sharing Maximums | On page 8 of the April 16th memo, the table shows a Part B adjustment factor of 1.366 for the inpatient AE test. Can you confirm that this factor can be part of the actuarial equivalence test? In other words, is my pmpm plan cost sharing for inpatient required to be less than my BPT's Original Medicare cost sharing multiplied by 1.366? | Yes. As indicated on the table on page 8 of the April 16th memo: Original Medicare A.E. cost sharing (WS4 cell N20, for inpatient) is multiplied by the 1.366 factor, and the result equals X. The plan's cost sharing (cell L20 for inpatient) must be less than X to satisfy this test.<br><br>In the MA BPT, the logic is contained in Worksheet 4 cells AD18:AJ24. |
| 6 | Plan premiums | 06/03/2010 | 6/1/2010 10:28 AM | member premium mode discounts? | Is there any way for us to give members a discount on their premium if they paid annually or semi-annually instead of monthly? | Response from CMS policy division:<br>No. From Chapter 4 of the Medicare Managed Care Manual, Section 10.10 entitled Uniformity:<br>"The following rules apply to any MA plan...<br>• An MAO offering an MA plan must offer it at a uniform premium...to all Medicare beneficiaries with Parts A and B of Medicare;...<br>• The uniform premium requirement prohibits plans from offering nominal discounts to those enrollees electing to pay premiums electronically."<br><br>Also, per 42 CFR 422.264(c)(1) and (d), MA organizations "may not provide for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose." A discount on monthly premiums for pre-payment would constitute a prohibited rebate.<br><br>Lastly, such a discount would discriminate against lower income enrollees who are unable to pay up front.<br><br>Premium uniformity applies to both MA and Part D. Additional references: see 42 CFR 423.286(a), and from § 423.265 "Each potential Part D sponsor must submit a bid and supplemental information in a format to be specified by CMS for each Part D plan it offers. Each bid must reflect a uniform benefit package, including premium (except as provided for the late enrollment penalty described in §423.286(d)(3)) and all applicable cost sharing, for all individuals enrolled in the plan." |
| 7 | Timing of Bid Review and Benchmark release | 06/03/2010 | 5/28/2010 8:22 PM | Questions about Timing of Desk Review and Benchmark Release | 1) Can you give us a likely date that plans will start seeing Part C and D bid questions from the desk reviewer this year? Is it likely to be a week later than last year given the bids are being submitted almost a week later than last year's bids?<br><br>2) Could you give us the date in August the Part D benchmarks are to be released? If you cannot give us the date today, could you give us a week's heads-up prior to the release of the Part D benchmarks in August? | 1) Questions from CMS desk reviewers could begin immediately after the bids are submitted.<br><br>2) Unfortunately, OACT cannot commit to the prior notice requested in this inquiry. We can share this comment with CMS leadership. Ultimately, OACT alone does not determine the release date of the benchmarks. |