#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Base Period Data/ HIPAA	4/17/2008	4/2/2008 3:08 AM	BPT Preparation Question	I noticed that the draft instructions do not include a minimum threshold for including experience in Worksheet 1 of the MA or PD BPTs. Have you considered the case of a plan that has only one member enrolled? In this case, it seems it may be a HIPAA violation to report the actual experience. Is there a minimum threshold for including experience in Worksheet 1?	We assume that you are referring to the HIPAA privacy rules. If so, we do not believe that that the situation you presented is in conflict with HIPAA given that the base period data will not be provided to the general public absent an approved Freedom of Information Act (FOIA) request.
2	Base Period Data and Projections	4/17/2008	3/31/2008 12:09 PM	Acceptable approach to bids question	We would like to use a particular actuarial process to price Medicare Advantage bids that are collectively fully-credible over a given service area. Specifically, we would like to develop a credibility-adjusted projected allowed amount for each bid. This would be achieved by calculating the "other factor" in Worksheet 1 as the ratio of projected allowed experience to this credibility-adjusted allowed amount. Is this an approach that is acceptable to CMS?	The approach that has been outlined is not consistent with the CY2009 MA bid instructions. Specifically, it is not appropriate to use "other factor" fields as the means to effectively adjust credible experience to a blended pricing approach. Alternative approaches that are consistent with the BPT instructions include the use of the manual rating approach and direct projection of the base data with corresponding gain/loss margin variation consistent with our guidance. Of course, appropriate corresponding substantiation would have to be provided in support of either approach.
3	Gain/Loss Margin	4/17/2008	4/16/2008 12:11 PM	Question on Gain/Loss	Can our plan vary our gain/loss margin by PBP within each region (we have 3 MAPD's within each region) since two of the plans in the region are not performing as well as the main plan. We do not want to significantly increase member premiums on the other two plans or significantly decrease benefits, either of which may create an experience spiral.	Variations in margin by PBP are acceptable when executed in accordance with the CY2009 bid instructions.
4	Bad Debt/ Admin Expenses	4/17/2008	4/10/2008 10:45 AM	Technical User Group Question - Bad Debt	A plan has high premiums associated with some of their MA plans. Historically, they have accumulated a material amount of bad debt due to uncollected premiums. Can the plan include a line item for bad debt in the development of their administrative costs to be used in their 2009 bids? If not, how can bad debt be incorporated in the development of the 2009 bids?	As indicated in the bid instructions, uncollected enrollee premiums may be reported as "Direct Administration" expenses. Also, if a particular plan has experienced relatively high levels of uncollected premiums, the sponsor should make sure that their collection procedures are consistent with CMS requirements.
5	MA Disease Management Expenses	4/17/2008	4//2008 4: 14 PM to Rich Coyle	Disease Management Costs	In completing the MA bid pricing tools, are disease management expenses to be treated as medical, non-benefit, or both?	The short answer is both, in many cases. That is, DM services provided in a clinical setting by approved providers may be treated as medical expenses. Also, the cost of durable medical equipment associated with DM activities is typically classified as supplemental medical expenses. Absent other CMS guidance, other disease management (DM) and care coordination efforts are to be classified in the bid as non-benefit, or administrative, expenses. For instance, costs incurred during recruiting, enrollment, and general program communications are to be classified as non-benefit expenses. In all cases, the classification of DM expenses in the bid must be appropriately documented consistent with the BPT instructions.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
6	Risk Model and LIS Benchmark Calculation	4/17/2008	4/16/2008 11:50 AM	2009 HCC Model Change and Low Income Benchmark Calculation	HCC Change: The 2009 rate notice (page 16) indicates that at the aggregate level the HC model calibration has a neutral impact on the MA risk scores. What population was measured to determine that the impact would be neutral. We have seen preliminary results that show a consistent downward bias in risk scores. This includes modeling of risk scores using the published 5% sample data. Low Income Benchmark Calculation: CMS communication around the change to the LIB calculation indicates that lower member disruption is expected from the change in the LIB calculation (850,000 members). What is the lower disruption measured against? For example, are saying that disruption is expected to be less under the final rule than the proposed rule, but that there will still be a lot of disruption? What is your estimate of the total number of beneficiaries that would have been disrupted in 2008 if the new calculation had been in place for the 2008 plan year?	CMS reviewed the data in aggregate. CMS also looked at several major organizations and found the results to be consistent. Note that individual plan experience may vary, based on their covered populations. Please review the plans' risk score data posted in HPMS, and review the bid instructions for the proper use of this information. The rule includes the relevant comparison points. Please note that a technical correction to the final rule was released by CMS. See Federal Register published April 17, 2008 under: http://edocket.access.gpo.gov/2008/pdf/08-1136.pdf If the benchmarks were calculated using the prior regulation basis (without consideration of the demonstration), we would have reassigned 2.18 million beneficiaries in 2008. With the new rule, the correction indicates that 1.60 million beneficiaries would have been reassigned, or 580,000 less than the prior rule.
7	LIS Benchmark/ PD Instructions	4/17/2008	4/15/2008 7:56 PM	Updated LIS Weighted Benchmarks	In the final rule regarding the "Modification to the Weighting Methodology Used to Calculate the Low-income Benchmark Amount", it states, "We estimated that, in 2008, if the low-income benchmarks had been calculated based on LIS enrollment weighting (rather than based on total Part D enrollment weighting), the benchmarks would have been higher in 27 of the 34 PDP regions." Based on the data released in the Part D bid instructions (Appendix E), the LIS enrollment weighted benchmark is higher than the total enrollment weighted benchmark in only 21 of the PDP regions. Can you explain the difference?	A technical correction to the final rule was released by CMS. See Federal Register published April 17, 2008 under: http://edocket.access.gpo.gov/2008/pdf/08-1136.pdf
8	Benefit Question	4/17/2008	4/14/2008 1:51 PM	SNP Benefit Question	A SNP wants to offer Visa gift cards of $10 and $50 to plan participants who get their shots or follow through on certain procedures recommended for diabetics, for example. Can the SNP do this? If not, what changes or restrictions should be added so that they can? If the SNP can offer this service, how would it be priced in the bid? It's neither a "benefit" or "VAIS" as defined in Chapter 4 of the MMCM, is that correct? Could this service be mentioned in the marketing materials?	Benefit questions should be directed to: MA_Benefits@cms.hhs.gov. The described situation sounds like a “reward and incentive.” As correctly pointed out, it is neither a benefit nor a VAIS. Following is an excerpt from page 13 of the CY2009 Call Letter: "Incentives and Rewards CMS recognizes the potential value of a skillfully selected rewards and incentive program which can greatly facilitate participation in prevention activities. For this reason, CMS expects to develop guidance for rewards and incentives for the contract year 2010. Consequently, CMS will not be accepting new reward and incentive programs for contract year 2009."

INFORMATION PROVIDED ON 4/24/08 USER GROUP CALL

Introductory notes for discussion of MA Supplemental Pricing and Support
Actuarial User Group 04/24/2008

- As you know, the MA bid substantiation requirements have been revised for 2009.
  - For 2008 and prior, support was only required if the value of a particular non-covered MA benefit was projected to be $5.00 PMPM or greater.
  - For 2009, supporting documentation is required for all MA supplemental benefits.
- Also, for some non-covered supplemental benefits, such as dental and vision, there are explicit BPT lines to reflect the pricing. For enhancements to Medicare-covered benefits, such as inpatient, SNF, and professional, the supplemental benefits are priced through the "% for non-covered" fields in MA worksheet 4. These are columns h and I of the spreadsheet.
- Also, coinciding with the new documentation requirements is an increased emphasis from CMS on consistency between the PBP and BPT. For example, if the PBP you are offering contains extra inpatient days or world wide coverage, the MA BPT must reflect the pricing for these benefits and there must be corresponding documentation.
- In the course of reviewing the 2009 bids, CMS will be performing a comprehensive PBP-to-BPT consistency review of all supplemental benefits. PBP-to-BPT inconsistencies that are identified through this process will trigger a resubmission.

Following is an overview of some of the common enhancements to Medicare-covered services (Please refer to Medicare coverage manuals for comprehensive list):

- Most of you are probably familiar with the limits on Original Medicare coverage for inpatient stays: max of 90 per benefit period; 60 lifetime reserve days, and no coverage beyond 150 days of a benefit period.
  Clearly, coverage of these extra days is a common supplemental benefit, and you must use care in estimating the cost of extra coverage if available.
- Also, you are probably aware of Medicare's requirement that a skilled nursing stay must be proceeded by a 3-day or longer hospital stay for a related condition, and that coverage is provided for 100 days.
  Again, you must appropriately price and document SNF coverage that is more generous than FFS Medicare.
- Several categories of professional services are not covered in complete by Medicare:
  - Routine physical exams with the exception of the "welcome to Medicare examination."
  - Routine foot care
  - Most chiropractic care
  - Acupuncture
  - Most dental and routine eye care
  - Most chiropractic care
- With limited exception, Medicare does not provide coverage outside the US. Many plans provide benefits for the "worldwide coverage."

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Risk Scores	4/24/2008	4/21/2008 6:25 PM	coding intensity factor and FFS normalization factors	I wanted to confirm the "Recalibrated Part C Scores for Development of 2009 Bids" that was published on HPMS does not need any further adjustment for FFS normalization.	The Technical Notes in the HPMS Part C risk score posting state that "the 2009 FFS normalization factor , 1.03, was not applied" and refer plan sponsors to the bid instructions. Per the bid instructions, the posted risk scores must be projected for FFS and plan-specific trend, then be divided by the CY2009 FFS normalization factor of 1.03 (for Part C).
2	Part D Risk Scores	4/24/2008	4/22/2008 9:03 AM	Technical Notes for Part D Risk Scores Posted on HPMS	The Part D technical notes state that the risk scores have not been normalized, stating "the Part D normalization factor is not applied to the risk scores on the table". Can you clarify the intent of this statement, as there was no normalization factor in place for 2007 risk scores?	The statement was meant to point out that there was no Part D normalization factor for 2007. (And that there is a normalization factor for 2009.) See the bid instructions for guidance on the proper use of the risk score data posted in HPMS.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
3	Risk Scores	4/24/2008	4/22/2008 1:55 PM	User Group Call Question regarding risk scores of the 2009 bids	We recently downloaded the risk scores for the development of the 2009 bids from HPMS, and I did a comparison with July 2007 restated risk scores that we received from CMS MMR. The HPMS risk scores appeared to be lower than July MMR risk score for over 100 bids. This is different from what we expected. We were expecting that HPMS risk scores to be higher since the technical notes from HPMS indicated that July MMR risk scores reflect less complete run out data. This is also opposite to what we observed for 2006 bids last year. Would you please explain why the HPMS risk scores are lower than July MMR risk scores? (Note: This question is referring to Part D risk scores of specific PBP IDs, with differences between 0.5% to 1.0%.)	CMS has removed certain data sources that were previously classified as acceptable sources for risk adjustment submissions. This change is not yet reflected in the MMR data. The change is reflected in the HPMS risk score data, and will be reflected in the final plan risk scores.
4	Risk Scores and Trend	4/24/2008	4/21/2008 5:46 PM	Questions for Actuarial User Group Calls	1) With respect to risk score, is there any guidelines for completion factors and seasonality adjustment? In the past seasonality was approximately a downward adjustment of .0057 per month and completion factor was 2.5% on average for the year. 2) In the 2009 announcement, you provided the total trend by service category. Is this broken down by unit cost and utilization?	1) CMS has not released updated guidelines (as of 4/24/08 user group call). However, it is important to note that CMS expects that plans will be projecting their CY2009 risk scores based on the CY2007 risk score data posted in HPMS, making appropriate adjustments in accordance with the bid instructions. Only in limited circumstances should plans be projecting using their 2008 MMR risk score data. 2) Given that the USPCC reported in the ratebook announcement is a mixture of FFS Medicare and Medicare Advantage spending and enrollment, we cannot provide a breakdown of unit cost and utilization.
5	FFS trends by service category	4/24/2008	4/17/2008 12:30 PM	Medicare FFS price Trends	Please provide the latest estimates of the Medicare fee-for-service unit cost increases for 2007, 2008 and 2009 by major service category.	See table at the bottom of this Q&A. (Table is below the last Q&A on the 4/24/08 list.)
6	Using FFS data	4/24/2008	4/22/2008 1:59 PM	Using 2006 FFS experience to develop projected costs for a PFFS plan	Do you have an estimate of the amount of adjustment I should use (for IBNR and missing claims) when using 2006 FFS claims to project PFFS costs? I know that I should remove IME and GME from the FFS experience when developing comparable costs, since a Medicare Advantage plan does not need to pay these amounts to a hospital under a 100% of Medicare Allowed agreement. Would it also be appropriate to remove DSH from an expected cost for a PFFS contract (assuming the plan pays 100% Medicare Allowable?). Do PFFS plans pay DSH under that sort of arrangement?	We estimate that about 2 percent claims are missing / incomplete from Medicare FFS data tabulations with 6 months of claim run-out. Also, Medicare makes direct payments for medical education on behalf of MA enrollees. Further, DSH payments do need to be made to hospitals. Finally, we suggest that you use the out-of-network payment guide posted on CMS' website as a reference when using FFS Medicare as a pricing basis. See: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/
7	Impact of future legislation on plan payments	4/24/2008	4/16/2008 1:39 PM	Risk Score adjustment	[PARAPHRASED] We've heard rumors that Congress is considering legislation that may affect Medicare Advantage payments in 2009. If a proposal was passed and signed into law after June 2, will plans have the opportunity to change their bids to account for such changes?	Congress is aware of the bidding requirements and we'd anticipate that any legislative change in payments will preserve the integrity of the bidding process and attempt to minimize any disruption to bid cycle. It is possible, however, that an adjustment for 2009 could be signed into law. If this is the case, we will evaluate the law and determine what, if any, 2009 bid changes would be permitted.
8	EGWP plans base period data	4/24/2008	4/16/2008 1:27 PM	Worksheet 1	The instruction specifies that plans now need to use PBP-specific experience to complete Worksheet 1. Does this apply to 800-series plans? Each PBP in the 800-series may correspond to multiple employers who have different plan designs, would you expect plans to just use manual rates for employer plans?	PBP-specific experience must be entered into Worksheet 1 - this applies to EGWP plans as well.
9	MA Base Period Risk Scores	4/24/2008	4/22/2008 10:09 AM	Part C BPT - W/S 1 risk score	How should the risk scores provided in CMS be used for the W/S 1 risk score (Part C BPT)? Should we use the quoted "re-calibrated" amounts without further adjustment (except for frailty, if applicable)?	As indicated on page 12 of the MA bid instructions, the risk score should be based on the "recalibrated" model.
10	MA Worksheet 3	4/24/2008	4/16/2008 5:59 PM	MA WS 3 Question	In 2009, MA WS 3 Section III, there are columns Effective Copay/Coins Before OOP Max and Effective Copay/Coins After OOP Max. Is my understanding correct that if a SNP plan is offering only Medicare FFS Cost Sharing the second column should be left blank and all of the cost sharing will be in the column Before OOP Max?	As stated in the MA bid instructions, you must enter Effective Copay/Coins After OOP Maximum in the "second" column, i.e., column j. This column is used to calculate total in-network and out-of-network cost sharing PMPM values in columns k, l and o that are carried forward to Worksheet 4. If there is no OOP maximum, then enter the same values for Effective Copay/Coins Before OOP Max and Effective Copay/Coins After OOP Max.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
11	EGWP plans administrative expenses	4/24/2008	4/22/2008 10:00 AM	Non-Benefit expense for EGWP	The instructions seem to imply that administrative expenses for EGWP members is easily distinguished from non-EGWP. Please confirm that the health plan would in reality be applying some sort of allocation algorithm and that this is acceptable.	While some costs may be clearly identifiable as EGWP, other non-benefit costs may need to be allocated appropriately. It is acceptable to use a reasonable method for allocating such administrative expenses to EGWP and non-EGWP plans. Of couse, the projection approach must be documented in accordance with the BPT instructions.
12	Administrative Expenses and Credibility	4/24/2008	4/22/2008 9:58 AM	Part D Admin	The instructions state that we should use actual experience and trend it, and are able to adjust using a manual rate if less than full credibility. How does CMS envision applying the concept of "credibility" to administrative expenses? Why is there a difference in the treatment of administrative expenses between Part C and Part D BPTs? Also, for an MA-PD plan, historical expenses would need to be first split between Pt C and Pt D -- does this affect the credibility issue?	We have not provided guidance on the use of credibility to estimate non-benefit expenses. Also, while there are differences in the instructions for the support of Part C and Part D non-medical expenses, the development and support of Part C and Part D expenses should be comparable for given organization.
13	Medicare user fee	4/24/2008	4/22/2008 9:55 AM	National User Fee Estimates	The bid instructions provide an estimated amount for Part C of $.36pmpm nationally. Can we use this amount as a "safe harbor", or should it be modified for each bid? Also, is there a similar estimate for Part D?	The estimated PMPM beneficiary education user fees for 2009 are $0.36 for Part C and $0.07 for Part D. These values may be used as a safe harbor.
14	Part D Medicare user fee	4/24/2008	4/17/2008 7:11 PM	Part D Medicare user fees	I have been unable to locate the 2009 Part D Medicare user fee, which was $.08 PMPM in 2008. Has this been posted somewhere?	See previous response.
15	Medicare user fee	4/24/2008	4/22/2008 12:39 PM	question on Part D WS1	On WS1, for Part D or a MA-PD plan, how would a plan go about in estimating Medicare User Fees (part of Direct Administrative Expenses)? Please describe separately for PD and MA-PD. I know there is a Part D COB User Fee of $2.52 PMPY, does that apply to MA-PD as well?	As described in the earlier response, the MA user fee is estimated to be $0.36 PMPM for 2009 and the Part D user fee is projected to be $0.07 PMPM. For an MA-PD plan, both of these values are to be included in the development of the respective non-benefit expenses. Also, as you correctly stated, the Part D COB is estimated to be $2.52 per year, or $0.21 PMPM. The COB applies to both PDPs, and the Part D portion of an MA-PD.
16	Part D bid instructions	4/24/2008	4/21/2008 10:44 AM	Specialty Drugs	Page 34 of the Part D bid instructions indicated that cost sharing associated with specialty drugs tier need to be limited to 25% in the initial coverage range. Last year, there was a clarification in the Q&A that this 25% can be extended to 33% if the plan does not have a deductible. Does this rule stay for 2009?	Yes. As in previous years, for CY2009, the cost-sharing for the Specialty tier is limited to 25% up to the initial coverage limit when the plan has the standard deductible, which is $295. When the plan has a decreased or no deductible, then an actuarially equivalent coinsurance is allowed.
17	Base Period Data	4/24/2008	4/22/2008 12:03 PM	WKS 1 Base Data	In 2008 we opened a new Part D plan offering generic only in the gap and had members that had been in our full gap coverage plan enroll in it. In filling out worksheet 1 it seems appropriate to move these members to the generic only plan. However since we didn't close the other plan it appears that moving these members between plans would not be in accordance with the bid instructions. Please confirm.	Base period data should be reported in Worksheet 1 without adjustment. Members should not be moved.
18	Base Period Data	4/24/2008	4/22/2008 7:54 AM	Pricing for Part C and Part D	There is a new requirement that we were to report PBP-specific experience on Worksheet 1 for both Part C and Part D bids. It was stated that "data from a number of plans cannot be used to aggregate data to achieve credibility:" Our plan have a number of smaller plans, with only one PBP with fully credible experience. it is essential that we pool experience for each region for pricing purposes to achieve more credibility. Does this contradict the new requirement stated above?	Entering plan-level data in WS 1 does not preclude combining the data for multiple plans for pricing, as explained in the bidders training. However, supporting documentation is required when the experience credibility percentage differs from the percentage calculated based on CMS guidelines, including when entering 0% credibility for MA service categories with credible data.
19	Partially Credible Plans	4/24/2008	4/21/2008 1:42 PM	PD Worksheet 3 and 6 for Partially Credible PBPs	For partially credible PBPs how to complete worksheets 3 and 6?	See Part D bid instructions and bidders training.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
20	Pass Through and Lock In	4/24/2008	4/17/2008 11:43 AM	Lock In vs. Pass through	Could you provide specific definitions and examples of Lock in and Pass Through contracting for Part D?	Pass-through: A method of contracting by which the Plan Sponsor pays a PBM for prescription drug costs using the same negotiated price that the PBM negotiates with the pharmacy. In other words, the prescription drug costs of the Plan Sponsor are identical to the amounts paid by the PBM to the pharmacy. Lock-in: A contract method by which the Plan Sponsor agrees to pay the PBM a set rate for a particular drug and the PBM negotiates with the pharmacy to achieve the best possible price. This method is also sometimes called the "price risk" method because the PBM bears the risk associated with negotiating pricing with the pharmacy, while the plan pays a set rate. In lock-in, the rate the Plan Sponsor negotiated to pay the PBM may be higher or lower than the price the PBM negotiated with the pharmacy.
21	Rejected PDE records	4/24/2008	4/21/2008 6:16 PM	User Group Call Question	We asked the OACT team this question earlier: **Many submitted PDE records are often rejected despite a health plan actually paying for the claims. This can be for various reasons; however, the health plan still paid the claims. Therefore, this risk of rejected PDE records must be factored into pricing as a cost of doing business. We are wondering how to price in the cost of rejected PDE records.** I believe placing the cost in the Admin section of the Bid Form would be most appropriate since it is not flowing through the risk corridor. Here is the response from the OACT team: Part D sponsors can include the costs of rejected PDEs that represent legitimate Part D covered drug costs in the non-expense component of the bid, when these costs are not incurred as a result of Plan sponsor errors. However, here is the pending question we still have: Will you be able to provide a more precise definition of the PDE rejects that can be included? As we know there is a reject code associated with each rejected PDE record. I am thinking that it will be very helpful if a list of reject codes for the legitimate Part D covered drug costs is available.	QUESTION is bolded. RESPONSE: Part D sponsors can include the costs of rejected PDEs that represent legitimate Part D covered drug costs in the non-benefit expense component of the bid, when these costs are not incurred as a result of Plan sponsor errors. (CMS will not be providing a list of PDE reject codes for this purpose.) Please include documentation of the costs of rejected PDEs included in the non-benefit expense component of the bid as part of the supporting documentation uploaded into HPMS with the initial bid submission.
22	Part D BPT validations	4/24/2008	4/21/2008 6:27 PM	Errors in 2009 PD BPT	While trying to populate a 2009 PD BPT that was downloaded from HMPS on April 11, 2008, I noted the following data validation error: Script Projection Tab, Cells H45-H52 (i.e.,Worksheet 6) -- The data validation for catastrophic is using 25% instead of 5% as the test. The comment box in that section also says 25% instead of 5% and I get red-circles around my entries.	The validation formulae and comment boxes were inadvertently changed following industry beta-testing. The validation comments and formulae should be 5%, consistent with the cost-sharing in the catastrophic portion of the benefit, not 25%. Please ignore the red circles. (OACT has tested the BPT and believes that this problem does not impact the validation and finalization of the bid.)
23	Part D BPT	4/24/2008	4/21/2008 4:04 PM	PD BPT 2009	When I enter the data into the BPT, it shows an error across all of the fields in the Cost Sharing Amount column under the Catastrophic/Defined Standard section of Worksheet 5. Also, the error tells me that the number should be 25% of the allowed amount; however, the instructions reference the cost-sharing structure associated with each allowed interval, and it looks as though my number (5% of allowed) should be correct.	See previous response.
24	Part D data	4/24/2008	4/21/2008 12:48 PM	2006 Claim Cost Data	It would be extremely helpful to have access to average Part D claim cost data by region.	CMS cannot provide this information.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
25	Part D EGWP Benefit Question	4/24/2008	4/18/2008 11:59 AM	EGWP Benefit Question	This is a series of questions related to maximum cost sharing for an EGWP. It can be assumed that the benefit design was rated through the PD BPT and successfully passed the tests within the BPT. The benefit design also can be assumed to be credible coverage. The benefit design has no deductible and has coverage beyond the ICL. Drugs are adjudicated on a four tier basis. Are there further constraints for the cost sharing by tier that a benefit design must meet? Specific questions follow. For the specialty tier, is there a limit of 33%? 50%? For the specialty tier, is there a limit for a copay at the preferred network? For the non-formulary tier, is there any limit for the coinsurance? For the non-formulary tier, is there a limit for a copay at the preferred network? For the brand formulary tier, is there a limit for a copay at the preferred network? For the generic formulary tier, is there a limit for a copay at the preferred network?	As indicated in the 4/17/2008 memo released via HPMS, EGWP policy questions should be directed to: USREE.BANDYOPADHYAY@CMS.HHS.GOV Response from Usree: The cost sharing limits have not been waived for the employer group plans. Therefore, the EGWP plans have the same cost sharing limits as the individual market plans.

TABLE REFERENCED IN RESPONSE TO 4/24/08 UGC QUESTION # 5

Medicare Unit Cost Increases
CY 2007-2009

Service Category	Unit cost increases			Comments
	CY 2007	CY 2008	CY 2009	
Inpatient hospital	3.4%	3.4%	3.7%	Based on FY market basket updates
Skilled nursing facility	3.2%	3.4%	3.7%	Based on FY market basket updates
Home health agency	3.3%	3.0%	3.7%	
Outpatient hospital	3.4%	3.3%	3.7%	
Physician	0.0%	-4.8%	-10.4%	'07 update excludes bonuses for quality data
Carrier - lab	2.0%	1.2%	1.1%	

INFORMATION PROVIDED ON 5/1/08 USER GROUP CALL

MA Comments on SNF, inpatient, and hospice

Pricing of skilled nursing facility (SNF) supplemental benefits

- Received some responses last week about the long-standing policy on waiving the SNF 3-day inpatient requirement for Original Medicare.
  - Commentors were correct, in that Medicare Advantage plans can treat such stays as covered.
  - The regulation is found at 42 CFR 422.101(c), which reads in part: "MA organizations may elect to furnish, as part of their Medicare covered benefits, coverage of post hospital SNF care …in the absence of prior qualifying hospital stay that would otherwise be required for coverage of this care."
- Also, as you probably realize, the PBP needs to be completed to reflect the waiver of prior hospitalization requirement, if such benefit is offered.
- Thus, you do not need to reflect the cost of this "additional benefit" as supplemental benefit in the bid pricing tool.
- Finally, through reliance on this guidance, certifying actuaries do not need to qualify their actuarial opinions to reflect the PBP-to-BPT differences in coverage of SNF stays that do not preceed a 3-day minimum hospital stay.

Pricing of inpatient hospital non-covered days

- It's our understanding that some actuaries do not have access to reliable data on the proportion of inpatient days that are considered to be non-covered for use in pricing unlimited hospital days.
- Using Medicare FFS data. We are in the process of developing a factor that can be used as a "safe harbor" for determining the proportion of inpatient days that are non-covered.
  - Will announce this safe harbor assumption during next week's call.
- Of course, if you're non-covered hospital pricing is based on an assumption other than the safe harbor; you must be prepared to provide support for the data and methodology used in its development.

Hospice benefits

- Last week we responded to a live question on whether or not hospice benefits are required to be included in the bid, or can be treated similar to ESRD enrollees & excluded.
  - As you know, our instructions specifically state that hospice benefits should be included in the bid.
- We've had some discussions about what, in practice, it means to include hospice coverage in the MA bids. For example, when a plan enrollee goes into hospice status:
  - Original Medicare assumes responsibility for A/B services, and the plan continues to cover supplemental benefits.
  - CMS continues to pay MA rebates to the plan; but CMS not pay the capitation for A/B benefits.
  - The member continues to pay premiums, if any.
  - Part D coverage continues without change.
- Thus, when we say must include hospice enrollees, it is clear what this means for MA supplemental benefits, but not for Medicare-covered where the plan has no liability.
  - That is, for supplemental benefits, plans receive full revenues from rebates and premium and must provide full coverage;
  - For Medicare-covered benefits, plans receive no revenues and are not responsible for coverage of benefits.
- Thus, by means of this guidance, we are modifying our guidance to say that it is appropriate to exclude hospice enrollees from MA pricing
  - Specifically, you can exclude hospice enrollees when developing risk scores, projection of member months, and calculation of supplemental benefits.
  - Of course, must document adjustments to data to exclude and be prepared to support the adjustments – either during bid review or audit.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Risk Score Data	5/1/2008	4/28/2008 8:33 PM	RE: User Group Call Question regarding risk scores of the 2009 bids	Follow-up to a Q&A from last week's user group call: Has the radiology diagnosis been currently purged when calculating the interim 2008 premium pmpm in CMS MMR. I.e., should health plans expect a reduction in the 2008 interim rates as a result of radiology adjustment?	The radiology diagnosis has been purged in the "interim" 2008. Therefore, the health plan should not expect a further adjustment in the interim 2008.
2	Risk Score Data	5/1/2008	4/29/2008 10:45 AM	Impact of Radiology data exclusion on Part D risk score normalization	The elimination of the radiology data from the determination of risk scoring appears to have a material impact on Part D risk scores. How was this data elimination considered and factored into the development of the 2009 normalization factor for Part D?	Yes, the elimination of the radiology data from the determination of risk scoring has been accounted for in the development of the 2009 normalization factor for Part D.
3	Risk Score Data	5/1/2008	4/29/2008 11:36 AM	Actuarial Bid Question	1 The HPMS posted risk scores for each organization include Current Model, FFS Normalized risk scores. For the July 2007 membership that the risk scores are based on, what MMR adjustments are included (through January 2008 like submitted diagnoses, February 2008, etc.)? 2 Historically, we have been able to reconcile risk scores on MMRs to those calculated from RAPs data and to those reported in other CMS reports / correspondence. However, the risk scores calculated from MMRs for July 2007 are materially lower than those being reported in the Current Model risk scores in the HPMS report. A similar question was asked on the last call. Can you elaborate further, especially with respect to any additional information we can obtain to assist in reconciliation (can we obtain RAFs by HICN for current model, FFS Normalized records)? If we aren't able to reconcile, which source or combination of sources do you recommend we use?	1. Refer to the risk score technical notes. 2. The risk score data posted in HPMS is "nearly complete". That is, they are an estimate of the "final" 2007 risk scores. CMS expects that plans will use the risk score data posted in HPMS when developing their CY2009 risk scores.
4	Risk Score Data	5/1/2008	4/25/2008 11:41 AM	Hospice Risk Score of 0 in HPMS 2007 Risk Scores?	Do the 2007 Part C risk scores by plan id in HPMS reflect a risk score of 0 for hospice members?	The risk scores posted in HPMS (as of 5/1/08) contain the "full" risk scores for hospice members (that is, the hospice risk scores are not zeroed out).
5	Supplemental MA Benefits - SNF	5/1/2008	4/29/2008 8:13 AM	SNF covered vs non-covered stays	On the 4/24/08 user group call, I heard Rich state that SNF stays are to be characterized as non-covered if not proceeded by a minimum 3-day IP admission. This is contrary to CMS guidance issued in the Federal Register dated 8/22/03 (see p. 50847, column 3, item B). Can you confirm that the guidance is being overturned?	See introductory notes for 5/1/08 UGC regarding SNF.
6	Supplemental MA Benefits - SNF	5/1/2008	4/24/2008 11:36 AM	Extended SNF Coverage Question	In discussing supplemental benefits on the 4/24/08 Actuarial Bid Call, Rich Coyle noted that Medicare covers SNF stays from days 1 to 100 following a hospital stay of at least 3 days. I recall a policy decision that said that MA organizations may waive the 3-day hospital stay requirement without triggering a benefit enhancement. Can you confirm this policy still holds? Does it hold for all MA plans or just Coordinated Care plans?	See introductory notes for 5/1/08 UGC regarding SNF.
7	Supplemental MA Benefits - SNF	5/1/2008	4/25/2008 3:36 PM	SNF waiver of 3 day hospital stay	On the technical user group call on 4/24, it was indicated that additional benefits for Medicare covered services will be targeted in desk review of the 2009 bids. One of the named benefits that would be reviewed is the Skilled Nursing Facility (SNF) additional costs. Since the 2003 ACRs, based on responses from OACT, I have been including costs for both Medicare covered Skilled nursing facility (SNF) and non-Medicare waiver of three day stay for SNF under Medicare Covered services. My understanding of the rationale of this exception was that this non-Medicare benefit saves Medicare covered costs by eliminating acute bed days and replacing them with SNF bed days. Therefore, there is no "cost" of adding the 3-day waiver. It is actually a savings. Instead of reporting the mandatory supplemental cost as a negative amount, the rule of thumb was to just report all SNF days as Medicare covered. Please let me know if we can again report 100% of all SNF costs as Medicare covered. If that is not permissible, can you please indicate if a negative additional cost will be acceptable pricing for the non-Medicare covered waiver of 3 day hospital stay for the SNF benefit?	See introductory notes for 5/1/08 UGC regarding SNF.
8	Hospice	5/1/2008	N/A	N/A	Could you please clarify the bid reporting requirements for hospice enrollees?	See introductory notes for 5/1/08 UGC regarding hospice.

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9	Hospice	5/1/2008	4/23/2008 9:29 AM	Hospice Members	In past years' bids, MA plans were instructed to exclude claims and enrollment for members in hospice. This was consistent with the subsequent payment which we currently receive for hospice members: no risk-adjusted capitation for parts A & B; just the rebates applied to Mandatory Supplemental benefits for all members. The 2009 BPT instructions very clearly state that plans should include hospice members in all data and calculations. Consequently, are we to understand that in 2009 MA plans will be paid a full capitation for hospice members, despite their admittedly low costs? Otherwise, it would not seem appropriate to "water-down" the capitation we receive for non-hospice members by averaging in these lower costs in the bid. If plans are paid a capitation for hospice members in 2009, will it be lowered by applying a reduction to their risk adjustment factor, in the same way that Institutional members currently receive an increased risk score and payment? Finally, since we are including hospice members' claims and enrollment in our bid data, shouldn't their risk score be incorporated in the data supplied to plans on HPMS?	See introductory notes for 5/1/08 UGC regarding hospice.
10	Worksheet 1 and Hospice questions	5/1/2008	4/22/2008 3:51 PM	Questions--Plan IDs & Hospice Issues	1) We have 2 Plan IDs that have the exact same medical benefits except that one has Part D & the other one doesn't. The risk score for the 2 plans are similar, with the plan without drugs having a higher risk score than the one with drugs. This is contrary to what would be normally expected, except for the fact that the only state we are in offers a Part D credible coverage program through the State government. The risk scores between the 2 Plan IDs are about 5% apart. Are we able to combine the experience together since the benefits & risk scores are similar. We have another 2 Plan IDs that have a similar issue of just differing with Part D coverage that are also less than 5% apart. Are we able to combine the experiences for each pair of Plan IDs together on Worksheet 1 since the experience is so similar & we desire the same medical member premium for both? If we can't, are we allowed to adjust them together through either Wkst 1 Section IV or Wkst 2? Similarly, we have 2 Plan IDs that have the same Part D benefits, but just different medical benefits. Are we able to combine the experience together for these? If not & if it makes sense, could we adjust them together through either Wkst 2 Sections 2 & 3 or Wkst 2 Section 4? 2) Why is Hospice included in the Part C bid this year, when it was excluded last year?	See introductory notes for 5/1/08 UGC regarding hospice.
11	Dual Eligible Special Needs Plans	5/1/2008	4/22/2008 5:36 PM	Technical User Group Call	I have a Dual Eligible Special Needs plan that I will be submitting this year for which the plan will be covering Medicaid benefits and receiving a capitation from the State to pay for those benefits. How should we file this?	CMS' Center for Beneficiary Choices (CBC) is working out a number of issues regarding integrated plans and bid submissions. You may want to contact CBC at MA_Benefits@cms.hhs.gov
12	MA Worksheet 1	5/1/2008	4/24/2008 3:21 PM	Credibility for MA for Plans with less Than 1,500 Member Months	For 2008, although no specific guidance appeared in the MA Instructions, it was understood that if a plan had less than 1,500 member months in the base period then no experience was required to be shown in Worksheet #1, and credibility was considered to be 0%. For 2009, there is a requirement to include any experience for a plan in WS#1, regardless of the number of member months. Does the 1,500 member months guideline still apply for purposes of determining credibility? I.e., if there is less than 1,500 member months in the base period, is credibility to continue to be treated as 0%, or is to be calculated using the traditional formula, even if there are only a few member months?	The 1,500 threshold was a reporting requirement, not a credibility guideline, in CY2008. The 1,500 reporting requirement is no longer applicable. As you noted, Worksheet 1 must be completed for all plans (and for both MA and PD BPTs) regardless of the level of member months. Plans have flexibility in the credibility guideline utilized, but it must be in accordance with the bid instructions (see credibility guidelines and supporting documentation sections of the bid instructions).
13	Related Party - Medical	5/1/2008	N/A	N/A	If medical services are provided under a capitated arrangement, what information must be entered into Worksheet 1 MA Base Period Experience?	The utilization entered in Worksheet 1 must be based on claims or encounter data for the plan whether or not a related party is involved. In the case where medical services are provided under a capitated arrangement with a non-related party, the allowed cost is the capitation plus any related cost-sharing. For a capitated agreement with a related party, the allowed cost (and cost sharing) may need to be adjusted similar to the guidance in the bid instructions for related party administrative agreements.
14	Part D Base Period Data	5/1/2008	4/28/2008 11:29 AM	Part D Base Period Question	For Part D base period experience, should P2P receivable and/or payable values be included? If so, and the P2P payable values are in line 10, should LICS and REIN values be removed?	The answer to both questions is Yes.
15	Part D Cross-Over Fee	5/1/2008	4/23/2008 4:13 PM	2009 Cross Over Fee For Part D	Do we have the 2009 cross-over fee for Part D?	The Part D crossover or COB user fee is estimated to be $2.52 per year for CY2009.

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16	Related Parties	5/1/2008	4/22/2008 10:11 AM	Related Parties	Please provide further insight into what constitutes related parties. In particular, how much ownership is required to have the entity fall into the category requiring the additional documentation?	The requirements for related-party agreements apply to a Plan sponsor that enters into an administrative service agreement involving a parent company and subsidiary, or between subsidiaries of a common parent. In accord with Financial Accounting Standards Board (FASB) Statement No. 57, this applies to parties when the principal owners are owners of record or known beneficial owners of more than 10 percent of the voting interests of the enterprise.
17	Administrative Expenses and Supporting Documentation	5/1/2008	4/22/2008 10:08 AM	Non-Benefit Expenses - Part D	The Part D instructions (page 30) state that supporting documentation at the June submission must include a list of all non-benefit items plus a full description of each line item and the relationship to auditable materials. Such documentation seems that it could be quite exhaustive. Or, is CMS only looking for a fairly high-level document? Please provide more information on this requirement. Also, please confirm that similar information is not being requested for the Part C BPT.	CMS expects plans to provide the same level of documentation for both MA and Part D bids. Plans must provide a description of the relationship between the non-benefit expense line items reported in the BPT and auditable material such as corporate financials and plan-level operational data.
18	MA Pricing	5/1/2008	4/22/2008 6:17 PM	MA Bid Question	We are working with a plan that offers two MA plans with consistent MA benefit designs, but one includes Part D and the other does not. The client wants the MA premiums to be consistent between the two plans. The experience and risk scores for these two plans is different. The instructions allow for combined experience of the two plans. In order to achieve same premiums, we would need to assume the same risk scores in each plan. In order to achieve the same MA premium for each plan, would it be allowable to bid the combined risk scores for each plan (despite different health status existing in the two plans)? This would allow for more rational marketplace pricing.	Experience cannot be combined for reporting purposes. If it is appropriate to combine experience for pricing purposes, plans have the option to do so in accordance with the bid instructions. If each plan is credible on its own, each plan should be projected separately. See the bid instructions for guidance on permissible variations in gain/loss margin.
19	LIB Calculation	5/1/2008	4/23/2008 4:03 PM	LIB Calculation	Is it correct that there are approximately 1.45M LIS beneficiaries enrolled in MAPD plans that will be counted in the LIB calculations? Is there, or will there be, any data released by CMS showing the MAPD LIS enrollment by region to assist plans in projecting the benchmarks?	CBC has released some enrollment data on CMS' website, see: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/ See Appendix E of the Part D bid instructions regarding implication of the regulation on the LIB calculation by region.
20	Base Period Data	5/1/2008	4/23/2008 9:15 PM	BPT Preparation: Question on merging two plans	How would you like us to handle the base period data when merging two plans. Should we combine the base period data for worksheet 1 and project off the combined in worksheet 2?	As discussed on the 4/24 user group call, as well as the bid instructions and bidders training, base period data should be entered on Worksheet 1 for the plan ID without adjustment (for both MA and Part D). Under rare circumstances, such as one plan is completely terminated and combined with another plan, then the experience would be combined on worksheet 1. Worksheet 1 would then contain the entire experience of both plans (not partial experience), and the plan IDs should be entered on Worksheet 1 Section II.
21	Part D BPT	5/1/2008	4/23/2008 10:39 AM	Question regarding the CY2009 PD BPT	I have a question on Part D worksheet 6. Cells H45 to H43 denote the cost sharing for Amounts Allocated over the Catastrophic Coverage and the comment says that it should be 25% of the Allowed Amount. But the Part D regulations on cost sharing says that it should have a cost sharing which is 5% coinsurance or have a generic and brand co-pay of $2.40 and $6.00 respectively whichever is greater. So % cost sharing ought to be 5% of allowed amount or a little more than that (which was true in the CY2008 PD BPT from last year) but this year it gives us validation errors if we have anything other than 25% of allowed amount on allowed amounts beyond the catastrophic limit. Is this a flaw in the BPT or are we missing something?	See Q&As from 4/24/08 UGC.
22	Part D User Fees	5/1/2008	4/23/2008 3:22 PM	Medicare User Fee	I am trying to find out what the "Medicare User Fee" amounts are for the direct administration portion of the 2009 MA-PD bids. I found $.36 PMPM in the MA BPT instructions, but the PD BPT instructions do not specify an amount. Is there any guidance that has the figures to use?	See Q&As from 4/24/08 UGC.

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1	Risk Scores	5/8/2008	4/29/2008 3:09 PM	Elimination of Diagnostic Radiology Data from the Physician Specialty Type	1) Can you provide an estimate of the average impact of the elimination of diagnostic radiology data from the Physician Specialty Type on the 2007 Part D risk scores? 2) Can you confirm that the current 2008 risk scores are being derived after the elimination?	1) The estimate is 0.007 2) Yes
2	Risk Scores	5/8/2008	5/5/2008 8:29 PM	coding intensity	On page 46 of 111 in the MA BPT instructions and on page 8 of 88 on the Part D BPT instructions, CMS indicates the risk score projection from 2007 to 2009 should reflect coding intensity trends. What would be considered an appropriate range for this trend. I believe in prior years, CMS had indicated 1.45% for health and 2.0% for Part D.	As plans project their experience, they should be able to develop their own trend. CMS uses FFS data in their estimates, while each plan's experience is different. The trend used should be plan-specific. That said, the CMS estimates for FFS are: Part C 1.015, and Part D 1.017
3	MSP	5/8/2008	4/30/2008 1:47 PM	MSP Question	Page 42 of the MA BPT instructions discuss calculation of the Medicare Secondary Payer (MSP) adjustment. The numerator of the calculation is defined as the Working Aged Adjustment dollars from the MMR file. After review of the MMR we cannot find any field that appears to correspond to a "Working Aged Adjustment". Please provide additional guidance regarding the calculation of the MSP adjustment and preferred data sources.	Refer to the Monthly Membership Summary Report (MMSR). The bid instructions refer to Appendix I.12 of the Medicare Advantage and Prescription Drug Plan Communications User Guide, which describes the Plan Payment Report (APPS Payment Letter). The MSP/working aged factor is applied at the contract level and is one of the monthly payment adjustments listed in this report. The current version of this guide is version 3.1 and can be found at http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp#TopOfPage. The path from CMS's home page is: http://www.cms.hhs.gov > Research, Statistics, Data and Systems > MMA Systems Help > Medicare Advantage and Prescription Drug Plans Communications User Guide
4	prescription drugs not covered by Part D	5/8/2008	5/2/2008 3:46 PM	Covering Non-Part D Prescription Drugs on Medicare Part A/B Bid	Can an MA/PD plan cover Viagra or other prescription drugs that are not covered by Part D (or Part A/B) in their Part A/B bid as a supplemental benefit?	Benefits questions should be directed to CMS Center for Beneficiary Choices (CBC). As indicated in the CY2009 Bid Conference, Part D benefit questions should be directed to: denise.mcdonnell@cms.hhs.gov
5	Dual Eligible SNPs and documentation	5/8/2008	5/1/2008 4:41 PM	Bid Documentation	The MA Bid instructions (Appendix B – page 75 of 111) state that the bid documentation should "for Dual Eligible SNPs, include a statement of how the plan conforms to state and territorial Medicaid regulations for benefits, cost sharing, care management and margins." Can you please provide further information/clarification related to what you are looking for on this statement? I don't believe our plan will be paying cross-over claims or Medicaid claims for these members; therefore, we are not sure what type of statement you are looking for.	This is parallel guidance to the 2009 call letter requirements, which specifies that special needs plans are to have eight key elements in their model of care. We suggest that you become familiar with the call letter requirements and incorporate relevant information into the narrative supporting the bid pricing tool.
6	Dual Eligible SNP	5/8/2008	4/30/2008 2:09 PM	Inpatient Hospital/SNF and Professional Services - Cost Sharing	Given that #9 on page 15 of the Call Letter states the following: "Cost sharing for inpatient services should be expressed in the PBP as a single amount for the enrollee. MAOs should not separately bill for a physician service(s) that was part of an inpatient hospitalization, skilled nursing visit, or for lab or radiology services received as part of an inpatient stay. The total cost sharing amount for these services must be identified within the standard variables of the PBP. Notes in the PBP reflecting separate physician cost sharing for these services will not be permitted." [PARAPHRASED] This guidance appears to be contradictory to the approach we use to price dual eligible SNP products that have Medicare FFS cost sharing requirements. For instance, in the past, we have used the percentages provided by OACT in Worksheets 4 (column j) and 5 (columns n-p) of the BPT (FFS Medicare Actuarial Equivalent Cost Sharing), which include FFS cost sharing for Inpatient professional services as well as the Inpatient facility cost sharing. We are hoping that we can continue with this methodology since the members are not responsible for the physician cost sharing specified in the Call Letter.	The FFS Actuarially Equivalent Cost Sharing factors provided in the MA BPT may be used for this purpose (DE-SNPs with Medicare FFS cost sharing).

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7	Dual Eligible SNP ques and Part D benefit ques	5/8/2008	5/5/2008 2:32 PM	Bid Questions	1) For a Dual Eligible Special Needs Plan which will pay hospitals/providers for bad debt, how should the bad debt be classified on the bid pricing tool? Should the cost sharing be reduced or the allowed amount increased? 2) Would you release some guidance regarding copay maximums and ratios. What is the 2nd and 3rd tier maximum copays? Are they limited by a ratio? How does the percentage for the Specialty tier become affected with Brand Only deductibles? I do not believe there is any official guidance but I believe you might have "safe harbor" numbers that would not immediately generate an audit.	1) As with all plans types, the bad debt payments should be treated as plan reimbursement, thus increasing the projected allowed cost. 2) As indicated in the CY2009 Bid Conference, Part D benefit questions should be directed to: Denise McDonnell at (410) 786-0157 or denise.mcdonnell@cms.hhs.gov
8	Part D BPT	5/8/2008	4/29/2008 3:54 PM	Type of Gap Coverage WS5 - question	For the "Type of Gap Coverage" input in WS5, I understand the options available to be: no coverage, full coverage, partial - increased ICL, partial - generics only, partial - other. Can you please provide the definitions behind each of these selections?	The selection from the drop-down box on WS5 should correspond to the type of gap coverage that the Plan sponsor enters in the PBP. "No coverage" means that the beneficiary cost-sharing between the ICL and TrOOP is 100%. "Full coverage" means that all drugs are covered between the ICL and TrOOP at some level of beneficiary cost-sharing which is, more than likely, the same as the pre-ICL level. "Partial - increased ICL" means that the point at which beneficiary cost-sharing between the ICL and TrOOP is 100% is delayed. "Partial - generics only" means that there is coverage for generic drugs between the ICL and TrOOP at some level of beneficiary cost-sharing, more than likely, the pre-ICL cost-sharing. "Partial - other" may mean there is coverage for brand drugs between the ICL and TrOOP at some level of beneficiary cost-sharing or it may mean that there is a fixed dollar coverage in the gap.
9	Part D BPT	5/8/2008	4/29/2008 8:31 PM	Question for 5/1/2008 Actuarial User group calls	1) In the event that our PDE data differs slightly from our financials for Part D, should our projections in Bid WS #2 (i.e. Other Factor) be adjusted accordingly to reflect a reconciliation to our financials? Or is such an adjustment not required? 2) Are we required to fill out part D bids for the employer group (800 series)?	1) The "Other Factor" may be used for this purpose. 2) See the 4/17/2008 memo released via HPMS regarding employer bidding. Employer group bid pricing tools are not required for Part D, but there are other requirements for these plans.
10	Part D BPT	5/8/2008	4/30/2008 9:50 AM	Handling Additional Tier in Worksheet 2 of Part D BPT	A fully credible plan was on a formulary that had no non-preferred brand drug tier in the base year; It is to be moved to a formulary that does have non-preferred brand tier in the contract year. Worksheet 2, Projection of Allowed-Admin, is structured along tier-by-tier change assumptions, but no change number can get you from 0 to some finite projection. We want to handle this problem in Worksheet 2 by allocating the base-year brand utilization experience between preferred and non-preferred and apply normal change numbers. Is this acceptable?	As stated on previous calls, experience data should be reported without adjustment. For a new category that is not in the base period data, use manual rates to price the new category (and make any necessary adjustments to the other categories on Worksheet 2).
11	Part D BPT	5/8/2008	5/2/2008 1:32 PM	Part D Wks 6 for Flexible Payment Demo	Would you please clarify how to fill out Part D worksheet 6, rows 28 – 36, columns i – k, for the flexible cap option? Is the catastrophic level defined as TrOOP > 4,350 or Total Claims > 6154?	The catastrophic coverage begins when the out-of-pocket threshold is met or $4,350 for CY2009.
12	Non-benefit expenses	5/8/2008	4/30/2008 11:34 AM	PBM Admin	Our situation is that both the insurance company and the PBM are wholly owned subsidiaries of the same parent company. There is a contract in place that stipulates a specific pmpm admin fee be paid by the insurance company to the PBM. Is it appropriate to use that contracted fee in the bid?	Please refer to the Related Party Agreements section in the Instructions for Completing the BPT for the details concerning the requirements for reporting admin based on the relationship of the contracting entities.

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13	Part D premiums	5/8/2008	5/6/2008 12:42 PM	Negative Basic Premiums	For PD plans with low costs, there are situations where the basic premium is negative. For an MAPD plan, can the negative basic PD premium be used to offset a supplemental PD premium? For a PDP plan, how would negative Basic PD premiums be handled?	For MA-PD plans, the negative basic Part D premium can be used to offset a supplemental Part D premium. (Note: a negative Basic premium must be fully offset.) For PDP plans, we expect that an organization's estimate of the national average monthly bid amount and base beneficiary premium will be the same for all plans submitted by the organization. In limited circumstances, a PDP may have a lower estimate of the national average monthly bid amount to prevent a negative premium expectation for a basic plan. When the benchmarks are calculated and released in August, PDP sponsors will have the opportunity to add supplemental benefits to their basic plans to offset any negative basic premiums. However, plan sponsors will not have any opportunity to reduce supplemental Part D coverage to offset any misestimate of the national average monthly bid amount.
14	LIB calculation	5/8/2008	5/6/2008 1:57 PM	LIB Weighting Question	If two 2008 plans will be consolidated in 2009, how will CMS count the LIS enrollment when calculating the Low Income Benchmark? For instance, suppose Plan A has 5,000 LIS members in 2008 and Plan B has 10,000. If Plan A will be merged into Plan B in 2009, will Plan B's weight be calculated using 10,000 LIS members, or 15,000?	If two plans are consolidated (i.e, one plan is terminated, and merged into the second plan), AND the plans have successfully completed all HPMS requirements for plan crosswalks, then the combined 15,000 membership would be used in the calculation.
15	Part D premiums	5/8/2008	5/6/2008 11:58 AM	Supplemental Drug Premium	If an MA-PD PFFS plan has a drug benefit that requires a supplemental premium, is there a requirement that the supplemental premium must be "bought down" to $0 with MA rebates?	Each plan offering must have at least one MA-PD plan with no supplemental premium.
16	Non-benefit expenses	5/8/2008	5/5/2008 7:20 PM	User Group Call Question	The question is regarding non-benefit expense. In the 2009 BPT Instructions one of the bullet points under direct administration reads "Uncollected Cost Sharing (for example, plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions)". Would you elaborate some more? We are not sure what should or shouldn't be included. For example, can we include uncollected member underpayment in cost sharing caused by PDE restatements?	Part D sponsors can include uncollected member underpayment in cost sharing caused by PDE restatements when these are not incurred as a result of Plan sponsor errors. Supporting documentation must be uploaded into HPMS with the initial bid submission.
17	Gain/Loss Margin	5/8/2008	5/6/2008 1:55 AM	Margin Cross Subsidy	I have a question about the cross subsidy of margins that is permissible between PBP's offered by a plan. We are working with a plan that offered MA and MA/PD plans in multiple counties in 2008. The experience in one of the counties has been significantly higher than the other counties. The plan is considering submitting bids by segment in order to differentiate rates by county. Can the bid for this higher cost county include a negative margin while the bids for the other counties include a positive margin whereby the plan achieves their overall margin requirement? In other words, can margins be cross subsidized across counties within the whole plan's overall service area? The bid instructions state: " For plans with negative margins the plan sponsor must develop and follow a business plan to achieve profitability. Exceptions to the business plan requirement are cases in which multiple MA products are offered in a given service area and the pricing reflects implicit "subsidies" to mitigate premium spirals. " Do these instructions mean that a plan can cross subsidize margins across different counties within a service area, including the allowance for a negative margin in one county and positive margin in other counties?	The gain/loss margin guidance included in the BPT instructions and elsewhere does not preclude having margin subsidies across multiple plans.

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18	EGWP service area	5/8/2008	5/1/2008 7:48 AM	EGWP - Service Area in BPT	The EGWP's have their individual plan service area and then a request can be made for an expanded service area. If our plan has requested to cover an expanded service area for 2009 for an EGWP so that we can provide coverage to enrollees who may live in contiguous counties/states to our service area but do not plan on the expanded service area being our principal place of business, would we still list all counties from the basic service area as well as the expanded service area in the BPT Worksheet 5? If not, would we list those anywhere? Would they all (basic and expanded service areas) have to be listed in HPMS?	Generally speaking, all counties of a plan's service area must be included in the MA BPT, as well as in the HPMS defined service area. This rule applies to all plans - individual market and EGWPs. The HPMS upload process will reject any plans where the BPT service area does not match the HPMS defined service area. This requirement has not changed since previous years. Specifically regarding this question: EGWP questions should be directed to: USREE.BANDYOPADHYAY@CMS.HHS.GOV. HPMS service area questions should be directed to: Sara.Walters@cms.hhs.gov Here's the response OACT received from Sara Walters: The complete service area for the EGWP should be indicated during plan creation, and this would follow through to the PBP (i.e., HPMS). The EGWP service area in the PBP/BPT must match. The BPT service area therefore indicate all of the counties covered under the given plan (both the "basic" (individual) and employer group only service areas).
19	UGC Q&A	5/8/2008	5/1/2008 11:35 AM	ActuarialBidQuestions: Pre-Posting of Questions	Would you be able to post the actuarial bid questions on the CMS website prior to the user group call? I understand that the answers may not be posted until after the user group call; however, it would be very helpful to be able to review the questions as the answers are spoken since catching everything verbally can be difficult.	CMS cannot post the questions prior to the weekly calls, due to time and resource constraints.

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	MA BPT	5/15/2008	5/6/2008 9:05 PM	Actuarial Bid Question - % dually eligible	We have a question regarding the % dually eligible field required in MA Bid Worksheet #1. It is our understanding that the Medicaid flag in the MMR file (MTHMDC) is no longer updated. If so, is there another source where we may obtain this information?	CBC: It is true that that field has changed in meaning so now it only represents the members that are Medicaid at the time MARx computes a default factor. (These are situations when MARx must compute a default factor because one is not available; these are mostly beneficiaries new to Medicare.) There are plans to add a new field to the MMR to reinstate the current Medicaid status reporting; but that will not be until later this year. Plans can estimate the percentage of dual members by adding the positive values in fields 19 and 21 on the MMR.
2	Credibility and Supporting Data	5/15/2008	N/A	N/A	The bid instructions require support for the credibility assumption, in particular, for 0% credibility for a service category with credible data. Is it sufficient to explain that the data of a high / low benefit plan combination marketed in the same area was combined for pricing?	No. The supporting data must demonstrate that the projection for a plan/segment reflects the credibility of that plan/segment. Since our approval is at the bid level, the projections must reflect the revenue requirements for a particular bid. The flexibility in our margin guidance allows plans to achieve their pricing objectives for benefits and premiums. Further, we expect that if either of the plans has credible data, the credible plan(s) will be priced separately based on its own data. Similarly, the non-credible plan(s) must project the costs associated with the members expected to enroll in the respective plan.
3	2YRLB	5/15/2008	5/13/2008 10:54 AM	2-Yr LB Revenue	For reporting the 2007 Actual Incurred CMS revenue in columns J and K, should the plan try to estimate the impact of the final sweep that we won't receive until the summer, or should we report only what we've received to date?	The 2-year lookback should reflect your best estimate of plan revenues and expenses, including the impact of subsequent CMS payment adjustments.
4	MSP	5/15/2008	5/7/2008 11:12 AM	MSP Adjustment Factor	On page 12 of the 4/7/08 rate announcement, there's a statement that the Medicare as Secondary Payer Adjustment Factor for Aged & Disabled Enrollees will be .174 in 2009. Can you please tell us how we are to use this factor in the BPTs?	Per response to question # 3 from last week's call, the bid MSP factor should be calculated from the Monthly Membership Summary Report. Further, it is important to recognize that the 2007 and 2008 MSP factor was .215, and has be adjusted to .174 for 2009. Thus, your projection of the bid MSP factor should account for the change in the MSP adjustment from .215 to .174.
5	FFS trends by service category	5/15/2008	5/6/2008 2:59 PM	Cost Trends	OACT published the costs trends by service categories with the 4/24/08 User Group Q&As. Do those cost trends include coding intensity as well as pure "fee schedule" changes?	The published cost trends reflect only fee schedule or market basket updates. The factors do not include coding intensity trends.
6	DE-SNP	5/15/2008	5/13/2008 12:19 PM	New [STATE] Legislation affecting SNP Pricing	Attached is the 2008 BPT for a dual eligible SNP plan that operates in a certain state. In the past, we have priced the Part C portion of the product assuming FFS Medicare cost sharing. Thus the value of the "Reduce A/B cost sharing" is $0. Also, there was no Part C premium. This state has issued this new rule that we believe should change the pricing. The State is now paying $25 PMPM to plans to cover cost sharing and the adjudication rules are described in the attached document. It appears that providers will take a hit on what they are reimbursed in certain situations. What benefit plan should we use (still FFS Medicare Cost sharing?). Also, how do we reflect the $25 from the State?	Yes, you should still reflect the BPT cost sharing as that filed in the PBP, which is Medicare FFS in this example. Also, as with all plan types, the bid allowed cost for dual eligible SNPs equals the projected plan payment plus the estimated cost of enrollee cost sharing as represented in the PBP. With respect to dual eligible enrollees, the allowed cost does not include payments to providers for waived cost sharing. Similarly, the cost sharing component of allowed cost must not be reduced to reflect waived cost sharing. Therefore, the capitated amount paid to the plan sponsor for enrollee cost sharing will not be reflected in the bid. In a like manner, funding received from the States for other Medicaid benefits, such as dental or transportation, must not be represented in the bid.

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7	P2P	5/15/2008	5/12/2008 4:11 PM	PDP: P2P Question	I have a follow-up question to a question that was answered on 5/1/2008. The original question was: Q: For Part D base period experience, should P2P receivable and/or payable values be included? If so, and the P2P payable values are in line 10, should LICS and REIN values be removed? A: The answer to both questions is Yes. My follow-up question is: Are we required to put the P2P payable values in Worksheet 1 - Section III - Line 10? Our original intention was to embed the values into the lines 1-6 by scaling the total allowed with a completion factor. This assumes that the distribution for the P2P claims is the same as the distribution for the accepted PDE claims. This is what we did last year for our bids. Worksheet 1 Line 10 refers to Part D as secondary and it is not clear to me that this would include P2P payables. If CMS requires us to put P2P payables in Line 10, that is fine; but we just need to know if it MUST be placed there.	No, there is not a requirement to put P2P values in line 10 of Worksheet 1.
8	Part D supporting documentation	5/15/2008	5/12/2008 3:22 PM	Part D Supporting Documentation	In appendix B of the "Instructions for Completing the Medicare PDP BPT", one of the items on the checklist of required supporting documentation is "Input sheets for pricing models." Can you please clarify what needs to be supplied? Also, in the worksheet 3 section of the instructions, it states "plans are required to provide a written description of their average discount and rebate assumptions for their utilization in WS 3 and 6." These items are not mentioned in the Part D checklist for required documentation. Should plans include a written description of rebates and discounts in their supporting documentation?	(1) The input sheet for a pricing model is a list of the assumptions that were used in the modeling and pricing of the bid. For example: For Plan sponsors that rely on an actuarial consulting firm to complete the bid, this refers to the document provided by the consulting firm that lists all of the inputs to the pricing model that were used in the bid. "Inputs" will include assumptions such as projection factors, pharmacy network discounts, benefit design, etc. Plan sponsors should be prepared to provide substantiation of the input items, either at the time of bid submission if required by the Instructions or upon request by a CMS reviewer. (2) Yes, as stated on page 39 of the Instructions for Completing the BPT, Plan sponsors are required to provide, as part of the supporting documentation uploaded at the time of bid submission, a written description of the average discount and rebate assumptions in Worksheets 3 and 6.
9	Base Period Experience	5/15/2008	5/7/2008 3:57 PM	Question - Please answer at tomorrow's call	In the BPT Instructions, Section III (Base Period Data) states (third bullet) states: Can be presented in aggregate for a number of plans only when enrollment changes that are associated with the dissolution of a plan, and retention of the members are mapped into existing plans. We are consolidating two segments into one for our PPO plans. Does this constitute the dissolution of a plan, hence, do we need to submit the bid for the two segments separately for the base period data? We'd like to consolidate the two segments into one, and provide base data (worksheet 1) in aggregate since this is the way we will be reporting information in the 2009 bid. We aren't dissolving a plan, we're just consolidating two segments of a plan into one.	If two segments are fully consolidated (where one segment is terminated and merged into the second segment), then the experience should be combined for reporting on Worksheet 1.
10	Inpatient Factor Announced on the UGC	5/15/2008	N/A	N/A	During the May 8th user group call, it was mentioned that the default cost of unlimited hospital stays is between 1 and 2 percent. What is the exact factor?	The "safe harbor" proportion of unlimited inpatient allowed costs that are non-covered, or supplemental, is 1.2 percent.

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1	Base Period Data	5/22/2008	5/19/2008 9:49 AM	Worksheet 1 - Service area split	In the base period, multiple counties were filed as one service area. In the projection period, the counties will be filed individually. Do we report the experience for all of the counties on worksheet 1, or just the individual county's experience? If we are to report the combined experience, do we use (a) column j on worksheet 1 to trend the individual county's utilization experience and (b) column m on worksheet 1 to show utilization changes from the combined counties to the individual county, and (c) column n to show cost changes of the individual county versus the combined counties?	Report base period experience for all counties on Worksheet 1. Do not report partial plan experience. Report base period data intact. Do not split the data. Note that, in this example, the plan's experience would be entered in each of the CY2009 BPTs. (Using columns j, m, and n is an appropriate section to adjust the base period data).
2	MA Supporting Documentation	5/22/2008	5/16/2008 5:00 PM	Cost Sharing Category Mapping (WS 3)	Per appendix B supporting documentation needs to be supplied regarding Cost Sharing Category Mapping. I have reviewed the bid pricing tool instruction regarding that issue. I am unclear of what your expectations are. From page 25 on the instructions give examples how to fill out the cost sharing in the BPT. Would you please provide an example?	This applies to plans whose pricing is based on actuarial models where the pricing categories are grouped differently than the BPT categories. We would expect to see a "mapping" of the pricing categories to the BPT categories.
3	Risk Score Supporting Documentation	5/22/2008	5/18/2008 10:15 AM	Actuarial Bid Question	We are beginning to work with a vendor to help us find improvements to our coding and claims submission, as the plans' risk scores are below the industry average. The vendor has identified several errors in our claims submission process, along with other improvement opportunities (finding members with risk conditions in prior years that have not yet been seen in the current year, etc.). They have also put estimated revenue increase estimates upon successful implementation of these programs based on their experience in the field (e.g. 2% of revenue for initiative A, 2.5% for initiative B, etc..). We would like to factor a portion (one third, one half, etc.) of these projected improvements into the bid pricing, but will not realize actual measured results until July 2008 at the earliest. What type of backup to our projected risk score change is acceptable to CMS?	The support should include the estimates the actuary relied upon, and how it was used in the bid. The actuary should include support that demonstrates the development of the estimate. Also, the support needs to demonstrate how the estimate relates to each particular plan and its risk characteristics. That is, it may not be appropriate to use one factor across multiple plans. As with all reliances, the actuary is expected to review the estimates/information for accuracy and reasonableness for the plan population being priced.
4	Part D Risk Score Projection	5/22/2008	5/19/2008 4:30 PM	Further Clarification on Part D Risk Score Projection	In the PD BPT instructions, gives the following guidance on when to forecast CY2009 risk scores based on 2008 MMR data instead of 2007 HPMS risks scores: "An alternate approach to forecasting the CY 2009 Part D risk scores for experience-rated plans is to use the scores from a 2008 Monthly Membership Report (MMR) file as the base scores. This approach may be appropriate if the plan was first offered in 2008, there was limited enrollment in 2007, or if there were significant changes in plan or enrollment characteristics between 2007 and 2008." We want to clarify what would be considered significant enrollment changes in enrollment characteristics: - Would a 15% change in membership (net growth or net lapse) be considered a significant change? At what level would it need to change to be significant: 50%, 75%? - Would a 15% change in membership along with a significant change (10%?) in the mix of Low Income vs non-Low Income membership be considered a significant change? In general our 2007 HPMS scores are generally in line with our 2008 MMR scores; however, for some of the regions where there are significant net membership growth/lapse, or for regions where the LI benchmark was failed/passed and membership declined/increased significantly, we have a greater variation in the 2007 HPMS score vs the 2008 MMR score. Since we notice that the values for 2007 HPMS and 2008 MMR seem generally in line, we want to ensure that our 2009 projected risk scores appropriately capture major changes in the underlying membership risk.	Regarding what is to be considered a significant change, we would expect you to use your own professional judgment. The actuary is expected to quantify the change in enrollment characteristics.
5	2YRLB form, EGWP bids	5/22/2008	5/19/2008 4:06 PM	Bid Questions	1) Two Year Lookback Form: We are having trouble breaking out plan benefit expense into Line 2a (Covered Benefits) vs. Line 2b (A/B mandatory supplemental benefits). Would CMS prefer that we allocate based on the original projection in columns (f) and (g), or just put the entire expense in 2a? 2) Employer Group Bids: Please confirm that the new Base Period experience guidance applies to employer group bids as well. We would like to file the same bid and assumptions across our entire service area for - Calendar Year (with Part D) - Non Calendar Year (With Part D) - MA only And want to know if we can show the combined experience for all three bids.	1) Neither. We expect that you put forth your best effort to allocate the expenses, based on your most recent data. 2) The new base period experience guidance applies to all plans, including EGWP plans. Experience cannot be combined.
6	MA Admin	5/22/2008	5/16/2008 10:47 AM	2009 Medicare Cross Over Fee For Part C	Is there a Cross Over Fee for Part C in 2009?	There are no cross over fees for Part C.

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7	MA IP factor	5/22/2008	5/16/2008 5:37 PM	Value of Unlimited Days in Hospital	Please clarify that the 1.2% estimate of the cost of unlimited days in a Hospital excludes inpatient mental health care. Also, is the 1.2% a % of Acute IP excluding Mental Health, or is it 1.2% of all Inpatient Facility (Acute and MH)?	The 1.2% factor applies to all inpatient costs (acute + mental health). Note this factor is a "safe harbor" amount; plans are free to use other estimates, as appropriate.
8	Part D supporting documentation and benefits question	5/22/2008	5/21/2008 10:57 AM	Questions For OACT Weekly Call	1) Can you kindly elaborate on the "Input sheet for pricing models" on the Part D check list for required supporting documentation in the part D bid instructions? No additional detail is given in the instructions. 2) Can we do actuarial equivalence on A/B benefits along with D benefits. For example, can we substitute a higher copay on a A/B benefit than filed in our A/B bids, with a richer than standard Part D coverage for the employer group's pharmacy benefit?	1) See responses to 5/15/08 UGC Q&As. 2) As indicated in the 4/17/2008 memo released via HPMS, EGWP policy questions should be directed to: USREE.BANDYOPADHYAY@CMS.HHS.GOV
9	Margin	5/22/2008	5/20/2008 6:05 PM	Question on margin	We are experiencing negative profit margins, in 2008, on our Enhanced Plans. We intend on following the 2009 Bid Pricing Tool Instruction for Contract Year 2009 on page 14, which states "Plans with negative margins must develop and follow a business plan to achieve profitability". Please advise what specific information you require in our bid documentation regarding this business plan.	The bid instructions allow for variations in profit margins accross plans, including negative margins under certain circumstances. In all cases of negative margins, a business plan must be included. For example, if the plan is partnered with other products in the region and collectively the margins are projected to be positive, then the business plan should represent that the overall margin for the region is consistent with our guidance, including a comparison with commercial requirements. If the overall projected margin for the region is negative, then we would expect to see either (i) a year-by-year projection of the margins, with anticipated profitability within a 2 - 3 year period; or (ii) demonstration that projected margins over a broader area are consistent with the bid instructions. Of course, in all cases, the negative margin must not be reflective of anti-competitive business practices.
10	Part D BPT	5/22/2008	5/14/2008 4:53 PM	CY 2009 PD BPT - Worksheet 1 Section 5 Premium Revenue PMPM	Just wanted to get some further clarification regarding Section V of Worksheet 1. For line item 1, "CMS Part D Payment" – should we be summarizing the Part D Direct Subsidy payment that the plan received from CMS in 2007?	Yes, the 2007 Part D direct subsidy payment must be entered on Worksheet 1 - Section V ("CMS Part D Payment").
11	National Average Calculation	5/22/2008	5/16/2008 2:42 PM	Low Income Benchmark Calculation	In the January 28, 2005 Federal Register, it states that the calculation of the National Average Monthly Bid Amount is to exclude MA PFFS, specialized MA plans for special needs individuals, PACE programs, and reasonable cost reimbursement contracts. I assume these exclusions also apply to the calculation of the regional Low Income Benchmarks. Do these exclusions still apply under the new LIS weighting methodology for the LIB calculation? Specifically, are Special Needs Plans still excluded from the calculation even though they have high LIS enrollment?	The assumptions in this question are incorrect. The exclusions for the National Average calculation are NOT the same exclusions as the Low Income Benchmark calculation. Per 423.780(b)(2), the following are excluded from the LIB calculation: PACE, PFFS and 1876 Cost. The change in the weighting methodology has no impact on the exclusions for the LIB calculation.
12	Base Beneficiary Calculation	5/22/2008	5/20/2008 11:45 AM	Reinsurance questions	Can you describe at some level of detail how CMS develops the estimate of reinsurance that goes into the determination of the base beneficiary premium so that we have a better means of estimating? Is it a weighted average of the reinsurance amounts in the bids or a CMS estimate independent of the bids? Is it adjusted by the risk score and the normalization factor?	It is based on the plan's estimates in the bids, not normailzed for risk.
13	Additional Contact Information in the MA and PD BPTs	5/22/2008	5/16/2008 4:41 PM	Additional BPT Contact	The bids will have the Additional BPT Contact information. This person is believed to be the best choice as an additional contact. However, there may be plans such as ours where their knowledge of exactly went into the bids is limited. My suggestion is to have a means to either let CMS or the desk reviewer know of the Primary Contact's availability of planned absence. I believe that this will allow the reviewers plan for any Primary Contact's absence.	The additional contact person is expected to be familiar with the bids, and act as a "back up" when the primary contact is unavailable. To support the 48-hour-turnaround, all three contacts will be cc:ed on bid review communication from OACT reviewers. The "backup" contact is expected to be able to provide information on the bids, in circumstances when the primary contact is not available. We encourage you to communicate any planned absences with your OACT reviewer during the course of bid reviews this summer.

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14	Reliance	5/22/2008	5/20/2008 3:37 PM	Reliance	Can you more explicitly explain under what circumstances do we need to list reliance information? For example, if senior management has approved our medical trend assumptions, budget, etc. who are we listing in the reliance section?	We generally expect you to refer to the Actuarial Standards of Practice, and use your own professional judgment when relying upon others for information. With regard to one of the examples listed in this question, medical trend assumptions and other actuarial assumptions should be developed/prepared by the qualified actuary (even if it is approved by another area).
15	Part D BPT	5/22/2008	5/16/2008 10:40 AM	Part D Worksheet 6	I have a client who is providing the standard coverage. On worksheet 6, Column H, Lines 28-35, I believe it has to be 5% of allowed (column g). However when enter the 5% of column g, it gives me a red circle and the comment box says that it has to be 25%. Could you explain the logic behind entering 25%?	See responses to 4/24/08 UGC Q&As.

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1	Part D BPT	5/29/2008	5/27/2008 3:47 PM	Base Period Experience for PDP	Should an estimate for the risk corridor be included on WS1? If so, where should the adjustment be made?	No.
2	Late Enrollment Penalty	5/29/2008	5/27/2008 1:58 PM	Late Enrollment Penalty Population	Do you have any specific guidance relating to the population of the Late Enrollment Penalty?	No.
3	Part D BPT	5/29/2008	5/28/2008 9:19 PM	W6 6 errors	I'm still receiving errors on WS 6 of the bid BPT saying that the defined standard catastrophic co-pays should be 25% (cells H45:H52). Are you going to release corrected versions of the bid worksheets soon?	CMS will not be re-releasing the BPTs for this issue. From 4/24/08 UGC Q&A: The validation comments and formulae should be 5%, consistent with the cost-sharing in the catastrophic portion of the benefit, not 25%. Please ignore the red circles.
4	Risk Scores	5/29/2008	5/23/2008 3:44 PM	Actuarial Technical User Group Calls - Question	In response to a question during the 5/22 call, it was stated that FFS estimates of the coding intensity trend could be used when a plan has insufficient experience to project the trend using its own experience. From the response, I am assuming that it would be reasonable for a plan lacking credible experience to adjust the FFS coding intensity trend estimate (1.015 [Part C] from May 8 Q/A) based upon plan specific information. Is this approach reasonable?	This approach may be appropriate. However, we do question the use of "plan specific information" when this data is deemed to be non-credible. Of course, you must appropriately document the data and assumptions used in the development of the risk score.
5	Supporting Documentation	5/29/2008	5/25/2008 6:58 PM	Supplemental Benefit Documentation	The initial submission supporting documentation requires PMPM level support for all non-covered services. Is it reasonable to assume that it would be appropriate to note that certain preventive benefits, such as additional screenings (pap, pelvis, prostate) covered under PBP section 14, are negligible and included in the cost estimate for preventive exams and are not priced separately? Similarly, is it sufficient to state that the cost for waiving the 3 pint deductible for outpatient blood is negligible?	A reasonable assumption would be that for services that, when rounded, account for less than one tenth of one percent of costs for the service category (i.e., 0.1%), they would not need to be priced separately. Stated differently, if the resulting factor in worksheet 4, column h would display as 99.90% or greater, then there is no need to separately report the supplemental benefits.
6	Actuarial Certification Module	5/29/2008	5/28/2008 10:51 AM	CY2009 Certification Wording	Is the new wording available yet? Have there been any changes from 2008? It appears from the instructions that supporting documentation for the reliance on information provided by others is now to be uploaded with the bids. We were thinking that this might result in a change in the standard certification wording.	As indicated in Appendix A of the bid instructions, the CY2009 certification language will contain a statement that supporting documentation for the reliance on information provided by others has been uploaded with the bid.
7	2YRLB	5/29/2008	5/28/2008 9:42 PM	RPPO Risk Share on 2 Year Look Back	RPPO risk share on the 2 year look back form asks for "Paid (Rec'd)" risk share amounts while the general instructions discuss incurred costs. The note on the cells for risk share also indicate the amount must be positive (implying paid). Given these instructions (which are not clear in my mind), what do you intend an organization that anticipates a risk share payment to be received from CMS to enter? Will a negative amount be accepted contrary to the cell notes?	RPPO risk share is entered in footnote 2 of the 2YRLB. The first section is for "incurred and paid" and the second section is for "claim reserves". If an organization anticipates receiving a risk share payment from CMS, then enter a negative amount (and ignore the resulting "red-circle" error).