Response to Public Comments

OMB # 0938 - 0944
CMS-10142
Bid Pricing Tool (BPT) for Medicare Advantage and Prescription Drug Plans

Health Net, December 21, 2007 letter

BPT Tool

1. Optional Supplemental Worksheet 7: please add a place to describe each benefit, cost sharing and any maximums.

   Response: Optional Supplemental Worksheet 7 provides 1000 characters to describe each benefit category. If more space is need, a detailed description may be uploaded in supporting documentation. We believe that this is more efficient than expanding the size of the 100 benefit categories (20 for each of the five optional supplemental packages) or adding 100 or more fields for additional information that would be used by a relatively small number of plans.

2. Part D only BPT cost sharing, please add a place to describe the cost sharing by tier and any maximums, etc.

   Response: This information is contained in the PBP submitted with the BPT.

AHIP, December 21, 2007 letter

MA

- **Cost Sharing Categories – Worksheets 1, 2, and 3.** Aggregated cost sharing categories appear in Worksheet 1—MA Base Period Experience and Projection Assumptions, and Worksheet 2—MA Projected Allowed Costs PMPM, and it is not clear how the disaggregated list in Worksheet 3—MA Projected Cost Sharing PMPM tracks to the categories in Worksheets 1 and2. For clarity and for ease and consistency of entry of cost sharing information, AHIP recommends that the disaggregated list in Worksheet 3 also be used in Worksheets 1 and 2.

Response: Worksheet 3 contains subcategories for most service categories in order to provide flexibility in classifying cost sharing. For example, cost sharing for the professional component of a vision benefit may be reflected in the professional category or in the vision category. Subcategories are also used for variation in types of cost sharing within a service category such as coinsurance and co pays. Further, plans may define additional subcategories need for their plan design. However, this level of detail would result in a relatively small pmpm cost in many cases that is not necessary or significant for pricing purposes. It would increase the size of Worksheets 1, 2 and 4 and the work needed for plan sponsors to map costs from the various classifications in their internal pricing systems to the service categories in the BPT. Therefore, we decided not to expand the service categories on Worksheets 1 and 2. Plan sponsors may upload supporting documentation to clarify their classification of cost sharing and the relationship to the service categories on Worksheets 1 and 2.

PD

- **Use of Prescription Drug Event (PDE) Data to Complete Part D Bids.** The instructions for completing the Part D BPT indicated that plan sponsors with experience providing Part D benefits in CY 2007 were required to use PDE transactions as base period experience for CY 2009, unless the PDEs did not appropriately capture the plan's expected experience. However, plan sponsors have noted additional circumstances in which claims data may be a more appropriate basis for the PBT. For example, we understand that PDEs do not contain some of the data that is required for completion of the BPT. This is illustrated by the need for a breakout of generic and brand drug utilization which is not found in PDE data but is available in plan sponsor pharmacy claims data. AHIP recommends that CMS revise the BPT instructions to permit plan sponsors greater discretion to use either PDE or claims data.

Response: The source of the data for completion of base period experience in Worksheet 1 needs to be the PDE, because this is the source of the data used in the reconciliation. To split out items like generic use on Worksheet 2 it is appropriate to rely upon additional sources of data. This data however, must tie to the PDE data unless the PDEs do not appropriately capture the plan's expected experience.

- **Summary of Part D Benefit Structure.** The MA bid submission includes a summary of the benefit structure, but no similar summary is included in the bid submission for the Part D prescription drug benefit. To facilitate coordination of the Part D PBP and BPT, we recommend that a summary of the Part D benefit be added.

Response: This information is contained in the PBP submitted with the BPT.

- **Establishment of Credibility Guidelines for Medicare Part D.** Under the "Special Considerations" section (page 4) of the draft CY 2009 Part D BPT instructions in the second paragraph under the heading "Base Experience", the instructions discuss the guideline for credibility for Medicare Advantage plans and indicate that credibility guidelines for the Part D benefit have not been established. AHIP recommends that CMS provide credibility guidelines for the Part D benefit for CY 2009.

Response: Credibility guidelines for Part D are being considered for the BPT instructions for CY 2009.

Ovations, December 21, 2007 letter

Medicare Advantage Bid Pricing Tool Instructions

1. Part D Reallocation

For CY 2009 we would like to see more flexibility in changing gain/loss margin with regard to reallocation on MAPD bids. The current parameters do not allow for much flexibility. Also, we feel using a percentage of revenue is more appropriate than a flat pmpm amount. Specifically, we recommend that plans be allowed to change gain/loss margin by up to plus or minus 0.25% (1/4%) to .50% (1/2%) of revenue during the rebate reallocation process.

This is particularly important for $0.00 premium plans, since an adjustment to member premium is not an option when reallocating rebates on a $0.00 premium product and, therefore, the only real option is adjusting member benefits. The limited flexibility to change gain/loss margin at reallocation time causes increased disruption to member benefits, which is not in the best interest of Medicare beneficiaries. At a minimum, plans should be allowed more flexibility to decrease gain/loss margin at reallocation time since that would put the members' interests first by giving plans the option to take more of any Part D reallocation shortfall out of the plan's gain/loss margin as opposed to out of the member's benefits.

Response: CMS' policy regarding the gain/loss changes permitted during rebate reallocation has not changed since the first year of the bidding process. Plans have the ability to change member premiums and/or benefits during rebate reallocation. As an additional option, they can make minor changes to the gain/loss margin assumption. Generally, changes to the actuarial bid assumptions are not permitted, but plans are afforded the opportunity to slightly revise the gain/loss margin assumption.

2. Allocation of SG&A and Gain/Loss Margin

The SG&A and Gain/Loss Margins are allocated proportionally between Medicare Covered and A/B Mandatory Supplemental benefits, which is a generally reasonable approach. However, when we need to round the A/B member premium to the nearest dollar, say by $0.25 pmpm, because only the A/B Mandatory Supplement gain/loss impacts member premium, the total gain/loss would change by more than $1.00 pmpm. This is particularly problematic when we are reallocating A/B rebates in August given the tight guideline CMS established with regard to changes in gain/loss margin from the original bid submission (change in gain/loss margin was limited to just .67 cents pmpm). We suggest that CMS build in some flexibility on how to allocate SG&A and Gain/Loss Margin between Medicare Covered and A/B Mandatory Supplemental benefits to help mitigate these issues.

Response: The allocation of SG&A and gain/loss margin proportionately between Medicare Covered and A/B Mandatory Supplemental Benefits applies to rebate allocation as well as the initial bid development.

3. Earlier Release of National Averages

We recommend CMS complete desk reviews earlier and release National Averages sooner so materials production deadlines, as required by CMS, can be met. In addition, it would be extremely helpful to have advance notice of at least a week of the expected release date of the Part D National Average. This will allow plans to arrange and organize staffing to be available to handle the rebate reallocation process.

Response: This comment does not affect the CY2009 Bid Pricing Tools or instructions but will be considered this summer prior to the release of the Part D National Average and Regional PPO benchmarks in early August.

4. Earlier Release of Tools

CMS released beta test versions of the 2008 Bid Pricing Tools in February 2007 that were very helpful in preparing for the large volume of bids submitted by our organization. We encourage CMS to continue this practice with every annual bid cycle.

Response: We expect to release a beta test version of the CY2009 Bid Pricing Tools in early 2008.

5. Release of Bid Pricing Tools (BPT) Instructions

The CY 2009 draft instructions are very similar to the CY 2008 final instructions, with the dates changed. It would be helpful for planning and preparation purposes to get a substantive draft of CY 2009 bid instructions released in January of 2008. We understand it would be a draft and still subject to change, but we expect CMS to know about the significant changes at the time of release of the draft instructions. We also request that there be no changes after May 1st in instructions, rules, guidance, BPT templates, etc. due to volume and complexity of bidwork.

Response: The draft CY2009 bid instructions were revised to list major changes from CY2008. Our goal is to release all bid related guidance no later than in early April, if at all possible.

Medicare Advantage Bid Pricing Tool

Worksheet 1

If a plan has more than one PBP category included in a bid line of the tool, the tool uses the average cost per service for the bid line rather than the average cost per service for the particular PBP category. We request that the additive utilization adjustment from Worksheet 1 not automatically calculate the PMPM allowed cost on Worksheet 2. This would make it easier to confirm that the correct utilization and cost per service flow through to Worksheet 2.

Response: Worksheet 2 is a summary of projected allowed costs. Detailed information about the calculations can be uploaded as supporting documentation, which does not require a revision to the BPT.

HPMS Bid Submission Module (as it relates to the MA BPT)

1. Bid Validation

Bid validation for 2008 did not check to see if we had correct versions of BPT files and PBP software. Since the Bid validation doesn't check if current versions of the BPT files and the PBP software are being uploaded, we have to wait for the HPMS e-mail with the reject notice, and then we have to re-upload. If a version check was contained in the Bid validation process (like in past years), then we would not submit bids with invalid versions. This would lower the amount of re-uploads and the time spent on filing.

We also recommend CMS enhance and expand the validation tool in the software. Specifically, validation of the manually entered data against the bid file would increase plan data accuracy and would significantly reduce the number of plan corrections prior to the rebate reallocation process.

CMS is exploring ways in which to improve validation that the correct versions of the BPT and PBP are being submitted. This comment does not impact the BPTs or the bid instructions.

2. Simplifying the Upload Selection Process for Revisions

We recommend that CMS add to the tool the ability to upload a PBP and/or MA BPT and/or Part D BPT independent of one another. We had many instances where changes were required after the initial bid submissions that only impacted one of the three components, but we were required to submit all three components each time. When two of three components are not changing this seems like unnecessary work. This problem is compounded by the version issues identified in #3 below.

Response: A bid submission generally includes a PBP, and a MA and/or Part D BPT. It is not possible to upload an incomplete bid submission or make edits to a previously submitted bid. If a resubmission is required, both the PBP and required BPTs need to be submitted.

3. Previous BPT Versions

Current software does not allow previous versions of the BPT to be accepted. Having the ability to accept earlier BPT versions would save large amounts of time. For example, if we are only updating the PBP, we shouldn't have to re-run a Part D BPT in the latest version (since Part D numbers are not changing). Similarly, if we are only updating an MA BPT, we should not have to re-run a Part D BPT.

Response: Technical improvements in the forms have minimized the need for additional versions of the BPT.

4. Upload Deadlines

This year, the 800 series gates closed before the stated deadline. Please ensure that the gates for all plans stay open until the deadline for bid submission and develop and communicate an appropriate escalation process within CMS to resolve such issues when they occur.

Response: Technical issues related to the bid submission should be provided to the HPMS Help Desk.

Prescription Drug Plan (PDP) Bid Pricing Tool

Worksheet II

1. Total Unit Cost (Section 3, column J). The total uses the Base Period Scripts as the "weights." We recommend the weighting be done using the projected scripts. Since the Total Unit Cost is an average of the projected unit costs, the "average" calculation should consider the projected utilization, not the beginning utilization. Otherwise, it isn't really an "average projected number."

Response: The interaction between utilization and price changes may be accounted for as "other" changes for purposes of completing Worksheet 2.

2. Credibility (Section 4, column P). The calculation of Blended Allowed is done using the Allowed Dollars. We recommend the Unit Cost and Utilization components be blended separately (and the Allowed Dollars based as the product of these components). The BPT also projects both utilization and unit costs (the components to Allowed Dollars). If the components are blended, and have the Allowed Dollars to be the product of the blended components, the pieces will tie out to the total. With the current approach, they may not tie out.

Response: The credibility factors are applied to the total cost. The credibility factors may be adjusted slightly to tie out to the exact projected cost.