April 5, 2010

NOTE TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter

In accordance with section 1853(b)(1) of the Social Security Act (the Act), we are notifying you of the annual Medicare Advantage (MA) capitation rate for each MA payment area for CY 2011, and the risk and other factors to be used in adjusting such rates. The capitation rate tables for 2011 are posted on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.gov/MedicareAdvtgSpecRateStats/ under Ratebooks and Supporting Data. The statutory component of the regional benchmarks is also posted at this website.

As required by Section 1102 of the Health Care and Education Affordability Reconciliation Act of 2010, the capitation rates for 2011 are the same as the capitation rates for 2010. In previous years' Rate Announcements, CMS included final estimates of the National Per Capita Growth Percentages (MA Growth Percentages) as well as tables summarizing the key assumptions that were used to develop the MA Growth Percentages. The final estimates of the MA Growth Percentages were used to trend the previous years' capitation rates to the payment year. Given that the capitation rates for 2011 are the same as the capitation rates for 2010, the MA Growth Percentages have no relevance for the 2011 capitation rates. Therefore, this Rate Announcement does not include final estimates of the MA growth percentages or the associated key assumptions tables.

Section 1853(b)(4) of the Act requires CMS to release county-specific per capita fee-for-service (FFS) expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2008 are being posted on the above website.

Information on deductibles for MSA standard and demonstration plans, and on the maximum out-of-pocket amount for MSA demonstrations plans, is below.

Attachment I presents responses to comments on the Advance Notice of Methodological Changes for CY 2011 MA Capitation Rates and Parts C and Part D Payment Policies (Advance Notice). Attachment IV presents the final Call Letter. We received 78 submissions in response to CMS' request for comments on the Advance Notice/Call Letter, published on February 19, 2010. Eight of the comments were from advocacy groups, 27 were from associations, 1 was from a Congressional agency, 2 were from members of the public, and 40 were from health plans.

Attachment II contains tables with the Part D benefit parameters; Attachment III contains tables with the 2011 Rx-HCC risk adjustment factors.

Key Changes from the Advance Notice/Call Letter:

CMS stated in the 2011 Advance Notice that, if new legislation were enacted after the Advance Notice was released, but before the Rate Announcement was published, we would incorporate changes into the Announcement. The Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act), makes changes to title XVIII of the Act for 2011 that are reflected in this Announcement. The following items have been changed from the Advance Notice to the Announcement, some in response to this new legislation, as noted.

County Rates. Section 1853(j)(1)A) of the Act, as amended by Section 1102 of the Reconciliation Act, requires that CMS maintain the 2011 county rates, which are used for payment for aged and disabled beneficiaries, at the 2010 levels. Therefore, the 2011 capitation rates will not be rebased with updated FFS costs. In addition, because the growth percentage does not affect the 2011 county rates, we have not included the final estimate of the increase in the National Per Capita Growth Percentage for 2011 in the Rate Announcement.

ESRD Payment. In holding the capitation rates constant for 2011, CMS interprets Congress' intent that we minimize changes in the Part C payment methodology for 2011, in order to promote stability and predictability. Therefore, CMS will maintain the 2011 State rates, which are used for payment for End Stage Renal Disease beneficiaries, at the 2010 amounts.

Adjustment to FFS Per Capita Costs for VA-DOD Costs. In the Advance Notice, we concluded that there is sufficient evidence to warrant an adjustment to the FFS rates based on DoD data when the capitation rates are rebased using FFS rates. Given that the capitation rates will not be rebased in 2011 in accordance with Section 1102 of the Reconciliation Act, however, this adjustment will not occur in 2011. CMS will make this adjustment when the capitation rates are FFS rebased in 2012, as required under current law.

Part C Risk Adjustment Model. Based on our interpretation of Congressional intent regarding changes in Part C payment methodology, CMS will not implement the new CMS-HCC and CMS-HCC ESRD dialysis risk adjustment models or the recalibrated frailty factors in 2011. CMS will implement these new models in 2012. To reference the factors in the CMS-HCC risk adjustment model that will be used in 2011, see the 2009 Rate Announcement (published in April 2008). To reference the factors in the CMS-HCC ESRD risk adjustment model that will be used in 2011, see the 2008 Rate Announcement (published in April 2007).

Normalization Factors. Given the continued use of the current CMS-HCC and CMS-HCC ESRD risk adjustment models, the normalization factors for 2011 are calculated using these existing models and are as follows:

CMS-HCC aged-disabled model is 1.058.

CMS-HCC ESRD Functioning graft status is 1.088.

CMS-HCC ESRD dialysis model is 1.060.

MSP Factors. In maintaining current payment methodology, the 2011 MSP factors for aged/disabled or ESRD beneficiaries remain as follows:

Aged/disabled/postgraft: 0.174

ESRD dialysis/transplant: 0.215

Medical Savings Account (MSA) Plans. The maximum deductible for current law MSA plans for 2011 is $10,600. For MSA demonstration plans, the 2011 minimum deductible amount is $2,200, the maximum out-of-pocket amount is $10,600, and the minimum difference between the deductible and deposit is $1,000.

Manufacturer Discount Program. Per Section 3301 of the PPACA, as amended by Section 1101 of the Reconciliation Act, starting contract year 2011 pharmaceutical manufacturers will be required to provide certain beneficiaries access to discount prices for certain brand drugs purchased under Medicare Part D. The manufacturer discount prices will be equal to 50% of the plan's negotiated price defined at §423.100 minus any applicable dispensing fees. These discount prices must be applied prior to any prescription drug coverage or financial assistance provided under other health benefit plans or programs and after any supplemental benefits provided under the Part D plan.

Part D sponsors must make these discount prices available to their Part D enrollees at the point-of-sale. These manufacturer discount prices will be made available to Part D enrollees who have reached or exceeded the initial coverage limit and have incurred costs below the annual out-of-pocket threshold. Medicare beneficiaries will not be eligible to receive these discount prices if they are enrolled in a qualified retiree prescription drug plan or are eligible for the low-income subsidy. The costs paid by manufacturers towards the negotiated prices of drugs covered under this manufacturer discount program shall be considered incurred costs for eligible beneficiaries and applied towards their out-of-pocket threshold.

While this manufacturer discount program will not directly affect the Part D benefit, it may affect drug expenditures in the catastrophic phase of the Part D benefit. Therefore, Part D sponsors may take this into account when estimating plan liability in the catastrophic phase and in developing the reinsurance subsidy estimates for their Part D bids. Additional guidance will be provided at a later date regarding this manufacturer discount program and how Part D sponsors will be reimbursed for the manufacturer discounts made available to their enrollees at the point-of-sale.

Change to Part D Benefit: Reduced Cost sharing for Generic Drugs in the Coverage Gap. Per Section 1101 of the Health Care and Education Reconciliation Act of 2010, the coinsurance under basic prescription drug coverage for certain beneficiaries will be reduced for generic covered Part D drugs purchased during the coverage gap phase of the Part D benefit. The

coinsurance charged to eligible beneficiaries will be equal to 93% or actuarially equivalent to an average expected payment of 93%. To be eligible for this reduced cost sharing, a Part D enrollee must have gross covered drug costs above the initial coverage limit and true out-of-pocket costs (TrOOP) below the out-of-pocket threshold. Medicare beneficiaries will not be eligible for this reduced cost sharing if they are enrolled in a qualified retiree prescription drug plan or are eligible for the low-income subsidy. Part D sponsors must account for this reduced cost sharing when developing their Part D bids for contract year 2011.

LIS Benchmarks. In the Advance Notice, we described how low income beneficiaries in some Part D regions would have a very limited choice of zero-premium prescription drug plans under the statutory methodology for calculating the maximum government premium subsidy. We noted that we would continue to look into solutions to this issue for 2011. In this Rate Announcement, we note that we will calculate the LIS benchmarks using basic part D premiums before the application of Part C rebates, in accordance with Section 3302 of the PPACA and Section 1102 of the Reconciliation Act. Also in accordance with the PPACA, under Section 3303, Part D plans will be allowed to charge subsidy-eligible beneficiaries a monthly beneficiary premium equal to the applicable low-income premium subsidy amount, if the plan's adjusted basic beneficiary premium exceeds the low-income premium subsidy amount by a de minimis amount or less. CMS will issue subsequent guidance specifying the de minimis amount.

New Enrollee Risk Scores for Chronic Condition SNPs. For 2011, CMS developed a methodology that will allow us to adjust new enrollee risk scores for beneficiaries enrolled in chronic condition SNPs to take into account the condition(s) that enrollees in these particular SNPs must have as a condition of enrollment. Although this is a new payment methodology, Congress has required that CMS implement these new risk scores in 2011, per Section 3205 of PPACA . In this Rate Announcement, CMS describes the methodology that we will use to adjust the 'default' risk scores for new enrollees to reflect the predicted costs of full risk enrollees in chronic care SNPs.

Clinical Trials Cost Sharing. In the Advance Notice we stated that, starting in 2011, MA plans will be required to reimburse enrollees for the difference between fee-for-service cost sharing incurred for clinical trial items and services and the MA plan's in-network cost sharing for the same category of service. In addition, starting in 2011, the portion of clinical trial cost sharing that is not otherwise reimbursed by the MA plan must also be included in the out-of-pocket maximum calculation. In their comments, the industry raised concerns about operational challenges associated with identifying which beneficiaries participate in clinical trials and the amount of cost sharing they have incurred. In this Rate Announcement, we note that to receive reimbursement, beneficiaries (or providers acting on their behalf) must notify their plan that they have received clinical trial services and provide documentation of the cost sharing incurred, such as a Medicare Summary Notice (MSN). CMS will explore ways that we can provide this information to plans in the future to alleviate the potential burden on beneficiaries.

Reassignment. Each fall we conduct reassignment of certain low income subsidy (LIS) beneficiaries who were originally assigned to a Prescription Drug Plan (PDP) whose premium is below the LIS benchmark, but will go above the LIS benchmark in the following year. In the past, we have reassigned only individuals who have never chosen a plan on their own and, thus, remain in a plan into which they were auto-enrolled by CMS. For the fall of 2010, we solicited comment on expanding reassignment to these "choosers" based on their 2011 premium liability. We also solicited comment on the feasibility of considering past medication use as part of the reassignment process. In the Call Letter, we state that we will not reassign choosers at this time, but are considering several methods to make beneficiaries more aware of their options. CMS will also continue to evaluate the merits of reassigning beneficiaries based on beneficiary drug utilization.

Calendar. The Call Letter contains a combined calendar listing side-by-side key dates and timelines applicable to MA, MA-PD, Part D and cost-based plans. The calendar contains important operational dates for plans, such as the date that CMS will begin accepting bids, dates for non-renewing plans, and dates for beneficiary mailings. The calendar has changed slightly from the version included in the draft Call Letter based on comments we received. In addition, changes to some calendar items were made to comply with Sections 3203 and 3205 of the PPACA.

Encouragement of Sponsor Practices to Curb Waste of Unused Drugs Dispensed in the Retail Setting. As part of CMS's effort to contain health care costs and reduce waste associated with the Medicare prescription drug benefit, we requested that Part D sponsors consider allowing beneficiaries in the community (versus institutional) setting the option to request a trial supply of no more than 7 to 14 days of a Part D covered medication when first prescribed. We received several comments regarding this proposal, and address some of the concerns raised by the commenters in this final Call Letter.

Release of Payment Data. In the draft Call Letter, we announced that CMS is considering the public release of Part C and Part D payment data. We solicited comment on whether the release of such data would negatively affect the competitive nature of the bidding process. In the Rate Announcement, we announce that we intend to issue a regulation proposing to authorize the release of Part C and Part D payment data.

Proposals Adopted as Issued in the Advance Notice or Draft Call Letter:

As in past years, policies proposed in the Advance Notice that are not modified or retracted in the Rate Announcement become effective in the upcoming payment year, as set forth in the Advance Notice. Clarifications in the Rate Announcement supersede materials in the Advance Notice.

Rate Announcement

Recalibration and Clinical Update of the Rx HCC Risk Adjustment Model. In 2011, CMS will implement an updated version of the RxHCC risk adjustment model, including the coefficients for the community, institutional, and new enrollee segments of the model. The 2011 model will encompass both updates to the data years used to recalibrate the model and a clinical revision of the diagnoses included in each hierarchical condition category (RxHCC). Attachment V contains the updated risk adjustment factors.

Normalization Factors. The normalization factor for 2011 for the RxHCC risk adjustment model is the same as in the Advance Notice and is 1.029.

Frailty Adjustment Transition for PACE organizations. Frailty adjustment will be applied to payment to PACE organizations using the transition schedule for 2011 published in the 2008 Announcement (published April 2, 2007). In 2011 (year 4), we will use 25% of the pre-2008 frailty factors and 75% of the most recent frailty factors (published for payment year 2009).

Frailty Adjustment Transition for Certain Demonstrations. Frailty adjustment will no longer be applied to payment to the following MA plan types, per the phase-out schedule published in the 2008 Announcement (published April 2, 2007): Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans.

Section 3205 of the *PPACA* provides the Secretary the authority to apply frailty payments to certain Special Needs Plans (SNPs), starting in 2011. To be eligible for these frailty adjusted payments, plans must meet the following three criteria:

- Dual SNP,
- Fully integrated with capitated contracts with States for Medicaid benefits, including long term care, and
- Have similar average levels of frailty as the PACE program.

CMS will not implement this provision in 2011, primarily due to the lack of data from the Health Outcome Survey (HOS) to allow us to determine accurately the frailty levels of dual eligible SNPs that have fully integrated contracts with States. CMS expects that larger sample sizes for dual SNPs in the 2011 HOS will allow the calculation and determination of frailty levels for CY 2012.

Adjustment for MA Coding Pattern Differences. For 2011, CMS will apply a 3.41% reduction to each Part C beneficiary's risk score.

EHR Incentives. Incentive payments to qualifying MA organizations may be available as early as calendar year 2011, payable in 2012. CMS has issued a proposed rule that would implement these provisions, CMS-0033-P, which was published on January 13, 2010.

Physician Quality Reporting Initiative (PQRI) and E-Prescribing. MAOs and cost-contracting HMOs are required to pay PQRI bonuses to non-contracted providers, and in the case of PFFS plans meeting access standards through payment of the FFS rate, "deemed contracting" providers.

Location of Network Areas for PFFS Plans in Plan Year 2012. The list of network areas for plan year 2012 can be downloaded from the following website: http://www.cms.gov/PrivateFeeforServicePlans/

Reinsurance Payment Demonstration Plans. In the Advance Notice, we reminded Part D sponsors that no Reinsurance Payment Demonstration plans will be offered in 2011.

Payment Reconciliation. The 2011 risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2010.

Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2011. See Attachment IV for the 2011 Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy.

Call Letter

Special Needs Plans (SNP), State Resource Center. The Resource Center provides States with helpful information as they engage in contract negotiations with MAOs seeking to offer new or expanded dual eligible special needs plans (SNP).

CAHPS and HOS Reporting for Special Needs Plans. For plan year 2011, the Consumer Assessment of Health Plans Survey (CAHPS) and the Medicare Health Outcomes Survey (HOS) will continue to sample, collect, and report data at the contract level. However, oversampling of SNP plan benefit packages will occur within each eligible contract to allow for a more focused analysis of SNP results.

HOS Survey Administration. The current year Healthcare Effectiveness Data Information Set (HEDIS) reporting category that reports the HOS results applies to the following managed care organization types with a minimum of 500 members that had a Medicare contract in effect on or before January 1, 2010: (1) all coordinated care contractors, including health maintenance organizations (HMOs), local preferred provider organizations (PPOs) and regional PPOs; (2) private fee-for-service (PFFS) contracts; (3) medical savings account (MSA) contracts; and (4) continuing 1876 cost contracts with open enrollment. Organizations eligible to report also include MA contracts with exclusively special needs plan benefit packages, regardless of institutional, chronically ill, or dual-eligible enrollment.

All Programs of All Inclusive Care for the Elderly (PACE) with contracts in effect on or before January 1, 2010 should administer the HOS-Modified (HOS-M) survey for current year reporting. Note that, effective 2010, the Minnesota Senior Health Options, Minnesota Disability

Health Options, Wisconsin Partnership Programs, and Massachusetts MassHealth Senior Care Options MA contracts are required to report HOS and no longer participate in HOS-M.

Potential New B versus D Coverage Determination for Beneficiaries with End Stage Renal Disease. CMS will include erythropoiesis stimulating agents, and other drugs and biologicals and their oral equivalents, furnished to individuals for the treatment of ESRD in the new bundled payment as "renal dialysis services." Any such drugs or biologicals that are included as "renal dialysis services" under the new ESRD PPS will not be eligible for coverage under Part D when furnished to individuals for the treatment of ESRD.

Recommended Deadlines for Cost-Based Plan Non-Renewals. Beginning with the application cycle for 2011 contracts, CMS is strongly encouraging all cost-based plans to follow the schedule established for MA plans and MA-PD plans for both submitting service area expansion applications as well as requesting non-renewal/service area reductions.

Coordination of Benefits (COB) User Fees. CMS is authorized to impose user fees on Part D sponsors for the transmittal of information necessary for benefit coordination between sponsors and other entities providing prescription drug coverage. The user fee for 2011 is $1.17 per enrollee per year.

Specialty Tier Threshold. In the Call Letter, we state that we will maintain the $600 threshold for drugs on the specialty tier. Thus, only Part D drugs with negotiated prices that exceed $600 per month may be placed in the specialty tier, and the specialty tiers will be evaluated and approved in accordance with section 30.2.4 of Chapter 6 of the Medicare Prescription Drug Benefit Manual.

Medicare Enrollment Assistance Demonstration. CMS is reevaluating its intended approach to the enrollment demonstration project based on the comments we received in the past, and we do not anticipate implementing the project for plan year 2011.

Risk Adjustment Data Validation (RADV). This notification is to remind contracting MA organizations of their obligations under 42 CFR 422.504(e)(2).

Questions can be directed to:

Attachments I through III:

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Attachments

2011 ANNOUNCEMENT
TABLE OF CONTENTS

Attachment I. Responses to Public Comments

Section A. Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2011

Comment: Many commenters requested more detail and documentation regarding how the growth percentage was calculated for the 2011 Advance Notice, including the basis for CMS' estimate.

Response: Section 1853(j)(1)A) of the Act, as amended by Section 1102 of the Reconciliation Act, requires CMS to maintain 2011 rates at 2010 levels. We will consider these commenters' requests when we develop and announce future growth percentages.

Section B. New Enrollee risk scores for C-SNPs

For 2011, CMS will implement new enrollee risk scores for new enrollees in chronic SNPs. New enrollee risk scores are used for those beneficiaries who do not have 12 months of Part B and, therefore, for whom CMS cannot calculate a full risk score. Because chronic SNP enrollees must, as a condition of enrollment, have specific conditions, the average new enrollee risk score of new enrollees in chronic SNPs is likely to understate these beneficiaries' risk.

New enrollee risk score factors for 2011 for Chronic SNP (C-SNP) enrollees are included in Attachment III, Table 7. The new enrollee factors were developed by first calculating an average risk score for continuing enrollees in chronic SNPs. We then adjusted the current new enrollee risk scores to take into account the incremental risk of continuing enrollees in chronic SNPs. As with the standard new enrollee model, the C-SNP new enrollee factors will include factors that differ depending on age, sex, Medicaid, and original entitlement. The C-SNP new enrollee factors comprise the standard new enrollee factors, plus an incremental amount. The increment to the new enrollee risk scores for C-SNPs is a result of chronic disease; CMS research found that the increment was the same for each category (non-Medicaid, Medicaid, originally disabled) across all age/sex groups, indicating that there no further increments are needed for the costs predicted by Medicaid and original entitlement status.

Comment: A number of commenters offered support for the proposal to implement new enrollee risk score for new enrollees in C-SNPs. One commenter requested that CMS implement these risk scores in such a manner that does not reduce the risk scores of other MA plans. Several commenters requested a comment period prior to Announcement, even if short. Several commenters wanted CMS to also apply separate new enrollee risk scores to dual SNPs -- they stated that dual SNPs enroll beneficiaries with a high level of severity, have high risk scores, and should not be penalized for the targeting of specialized care for high-risk populations. Some commenters wanted CMS to also apply similar new enrollee risk scores to PACE participants -- they argued that PACE new enrollee risk scores are not consistent with the number and

complexity of their medical conditions which contribute to their qualifying for nursing home level of care.

Response: We appreciate the support for developing a set of new enrollee risk scores for new enrollees in C-SNPs. CMS is not considering applying similar new enrollee risk scores to dual SNP and PACE enrollees. We believe that dual SNPs' new enrollee risk scores are adequate to address aggregate risk faced by these plans. The current new enrollee risk score model captures the additional costs due to Medicaid status. As discussed above, in creating the C-SNP model, we found that the new enrollee age/sex factors had a similar increment regardless of Medicaid status. This finding indicates that the predicted costs of Medicaid enrollees are fully accounted for in the current new enrollee model.

Section C. Normalization factors

Comment: Several comments requested that CMS release the underlying data and risk scores so organizations can better understand resulting trend and other factors. One commenter requested the CMS provide (1) historical risk scores for the population for each year (please note if the historical risk scores are normalized and provide the historical normalization factors) and (2) the predicted risk scores for all years included in the calculation of the normalization factor for both the Part C and Part D models. One commenter asked about the changes in the Part C and Part D normalization factors. They noted that the annual normalization factor for Part C has increased since last year, while the factor for Part D has decreased. All else equal, one would expect these trends to generally be in the same direction (since using the same diagnosis data). While the change in HCC models may contribute to this phenomenon, the commenters requested that CMS provide any additional insights as to why the trends are moving in opposite directions. Another commenter stated that Part D normalization factors have been unstable -- 1.085, 1.146, 1.029 – and asked whether it would be feasible to use any smoothing technique to reduce instability of this factor.

Response: The formula for calculating normalization factors used to adjust risk scores takes into account the following factors:

(1) The annual trend, calculated over a rolling set of annual risk scores years and updated each year. Risk scores are calculated without adjustment for trend or for MSP and are rebased to the last year in the trend (i.e., the last year in the trend is set to 1.00 and the previous years' risk scores are divided by the last year's risk score.)
(2) The number of years between the denominator year and the payment year.

In the case of Part D, although the annual trend has not varied much, the normalization factor has varied for two reasons: For 2010, as discussed in the Advance Notice and Rate Announcement for 2010, CMS changed the policy used to calculate the adjustment, from using the risk scores of beneficiaries eligible for Part D to using beneficiaries enrolled in a Part D plan when calculating

the annual trend. This change increased the normalization factor. For 2011, the Part D normalization factor decreases because it is adjusting risk scores trends from 2008 through 2011 (three years), rather than from the denominator of the original model (2004) through each successive payment year.

In the case of both the Part C and Part D, each year's normalization factor may change marginally due to updating the annual trend and, to a larger degree, as a result of any change in the gap between the denominator year and the payment year. The change in the normalization factor to account for coding trends between the denominator year and the payment year should not affect a plan's risk score, as long as the plan's coding trend is consistent with the average trend.

Part C 2011 normalization factor

The final CMS-HCC Part C normalization factor is 1.058.

- The Part C normalization factor is used to normalize the following risk scores: Aged/disabled community, aged/disabled institutional, aged/disabled new enrollee, ESRD postgraft community, ESRD postgraft institutional, and ESRD postgraft new enrollee.
- From 2008-2011, the postgraft factor has been different from the aged/disabled factor. This is because the model denominator years are different. The postgraft model normalization factor is calculated using the trend from the version of the CMS-HCC model with the same denominator as the ESRD postgraft model, which is 2005. The CMS-HCC model with a 2005 denominator was used for payment years 2007 and 2008.
- Population used to calculate annual trend: FFS beneficiaries.

CMS estimates an annual trend using a linear function applied to the following years' risk scores:

2005: 0.972
2006: 0.984
2007: 1.000
2008: 1.009
2009: 1.031

The linear annual trend over these five years (2005-2009) is 0.0141. This annual trend is applied for the years between the denominator year (2007) and the payment year (2011) by taking it to the fourth power. The normalization factor is obtained as follows: $1.0141^4 = 1.058$.

Part D 2011 normalization factor

The final CMS RxHCC Part D normalization factor is 1.029.

- The Part D normalization factor is used to normalize all Part D risk scores.
- Population used to calculate annual trend: PDP and MA enrollees

CMS estimates an annual trend using a linear function using the following years' risk scores:

2006: 0.981
2007: 0.990
2008: 1.000
2009: 1.009 (projected)
2010: 1.019 (projected)
2011: 1.029 (projected)

The linear annual trend is 0.009. This annual trend is applied for the years between the denominator year – 2009 – and the payment year – 2011 by taking it to the third power. The normalization factor is obtained as follows: $1.00949^3 = 1.029$.

Section E. Aged/Disabled MSP Factor

Comment: Several commenters noted that CMS had recently initiated a process to evaluate MA MSP data, and had recently provided updated data files to MA organizations to review and refine the data, and suggested that because this process was ongoing (and MA analysis and action to correct MSP status based upon the latest files had only recently begun), CMS should consider deferring recalculation of the MA MSP factor until 2012, when the reconciliation process will be more stable.

Response: MA plans are refreshing data for beneficiaries in MA plans. We have recently started paying MA plans based on this data. We calibrate the MSP factor based on FFS MSP data, which CMS has used for payment for a number of years. Therefore, the recalibrated MSP factor should be unaffected by the refresh. However, CMS is holding the MSP factor for the age/disabled model the same as in 2010, in keeping with the principle of minimizing changes to the Part C payment methodology.

Section F. Frailty Adjustment Factors

Comment: A few commenters wanted CMS to apply a frailty adjustment to SNPs that enroll a disproportionate number of frail elderly beneficiaries and/or adults with disabilities. One commenter believed that not paying SNPs for frailty was inconsistent with federal law that requires CMS to pay in relation to known costs for comparable populations in FFS and inconsistent with SNP statutory authority that requires targeting of high risk specials needs individuals. Commenters asked why CMS does not apply frailty-adjusted payments to SNPs that seek to specialize in the care of frail beneficiaries and to plans transitioning from demonstration status where they have maintained the same targeted, specialty care approach they used under demonstration status, when CMS assumed a frailty adjustment was necessary and appropriate.

Response: By law, CMS must use the same payment methodology for all MA plans, including Special Needs Plans (SNPs), except as explicitly provided for in statute. For example, Section

3205 of the PPACA permits CMS to make frailty-adjusted payments to certain dual SNPs – those with fully integrated, capitated contracts with States for Medicaid benefits, including long term care, and which have similar average levels of frailty as the PACE program. Thus, CMS cannot make frailty payments to any SNP that does not meet the PPACA criteria without implementing frailty payments program-wide.

Comment: One commenter requested clarification of the relationship between the changes in the HCC model and the reduction in unexplained costs related to frailty, e.g., did CMS assume that the frailty factor accounted for costs related to dementia – a condition excluded from the original HCC model? It would be very helpful to better understand which components of the new HCC model improved payment for frailty- related costs. Another commenter stated that nothing in the current risk adjustment model accounts for limitations in ADLs for those MA enrollees who live in the community, but who qualify for institutional level of care, and that the risk adjustment system must catch up with other efforts to rebalance spending from the nursing home to the community. Another commenter stated that the model still does not explain all costs for functionally impaired.

Response: To calibrate the frailty factors, CMS estimates the unexplained costs (the difference between predicted costs and actual costs) using the newly revised and recalibrated CMS-HCC risk adjustment model (including all the new HCCs in the model). Regression analysis is used to estimate the contribution of ADL factors to these unexplained costs.

Although the commenter who stated that the CMS-HCC model does not explain all costs for frail beneficiaries is correct, we disagree that it does not explain *any* of these costs. The explanatory power of the model can be illustrated by examining the frailty factors for Medicaid eligible beneficiaries. The CMS-HCC model predicts costs for this group particularly well, resulting in a very small residual frailty factors.

Because CMS is not implementing the recalibrated and revised CMS-HCC risk adjustment model, we are also not implementing the recalibrated frailty factors for 2011.

Section G. Coding Pattern Adjustment

Comment: A number of commenters questioned CMS' legal authority to make an adjustment based on differences in coding patterns in 2011, arguing that authority to do so was limited to years specified in the Deficit Reduction Act (DRA) that mandated such an adjustment for the years in question. These commenters cited language added by the DRA to section 1853(a) -- "analyses are incorporated into the risk scores only for 2008, 2009, and 2010" (emphasis added) -- and section 1853(k) – providing for the application of the required coding intensity adjustment to the same benefit years for which payment is affected by the budget neutrality phase out addressed in these provisions. Noting that proposed legislative changes would require the

Secretary to implement coding intensity in 2011 and subsequent years, the commenters argued that CMS does not currently have the authority to apply an MA coding adjustment.

Response: The DRA amendments to Section 1853(a)(1)(C) expressly mandated that CMS make an adjustment to the risk scores in 2008, 2009, and 2010, if a difference in MA and FFS coding patterns was found. Although the DRA used the phrase "only for 2008, 2009 and 2010," this limitation applies only to that mandate for an adjustment. Independent of this DRA language, CMS has broad authority under Section 1853(a)(3) to develop and implement a methodology for risk adjusting MA capitation payments "that accounts for variations in per capita costs based on health status…." Moreover, Section 1102 of the Reconciliation Act requires CMS to make an adjustment to risk scores for years subsequent to 2010 if a difference in MA and FFS coding patterns is found.

As noted above, commenters also cited Section 1853(k)(2)(B)(iv)(III), which requires CMS to "adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under Parts A and B to the extent that the Secretary had identified such differences, as required in subsection (a)(1)(C)," as a time limited provision. However, this provision applies to the calculation of the risk scores used in calculating budget neutrality and therefore, does not apply to risk scores used in payment.

Comment: A number of commenters urged that CMS keep the adjustment the same as in 2010, assuming we were making an adjustment in 2011. These commenters support maintaining the 2010 adjustment level to avoid including yet another change to the payment calculation in a year when other revisions to the risk adjustment model are being implemented. Some commenters expressed concerns about the impact of the MA coding adjustment on their revenues, others thought that it was too large, in combination with normalization, and others expressed concern about the impact on plan benefits and beneficiaries.

Response: We understand the concerns elicited by the many changes anticipated for 2011. In keeping with the principle of limiting Part C payment methodology for 2011, CMS is retaining the proposed MA coding adjustment factor of 3.41% for 2011.

Comment: A number of commenters supported the CMS proposal to apply an MA coding adjustment in 2011. They opined that MA coding patterns result in higher risk scores that do not reflect differences in the health status of the two groups of beneficiaries, but rather differences in coding behavior which artificially suggest that MA enrollees are sicker than they actually are, and undermine the ability of the Medicare risk adjustment system to appropriately lower payments for enrollees who are healthier, on average, than those in FFS Medicare These commenters supported CMS using disease score growth for the four years between 2007 and 2011, instead of limiting the adjustment to a three-year period, as proposed, and adding additional years of data. One commenter urged that CMS update the factor each year just as we update the risk adjustment model's normalization factors each year.

Response: We appreciate the support for continuing to make a coding pattern adjustment. For future years, CMS will consider updating the adjustment using later data and adjusting for coding differences that will have occurred since 2007.

Comment: Several commenters opposed the use of the national average when applying an MA coding adjustment. Some commenters felt that a national average penalizes MAOs operating in geographic areas where local FFS coding increases are greater than the national average or where MA coding trends are below the national average. Commenters also argued that a national average presumes that all MAOs are similar in their coding differences, which is unlikely to be true, particularly when comparing smaller, regional organizations with less sophisticated tools and resources to larger national organizations, and that an adjustment based on all Medicare Advantage enrollees was reflective of larger plans experience. These commenters recommended that CMS derive and apply MA coding adjustments in a more targeted manner.

Response: While the commenter is correct that MA coding trends do differ among MAOs and it is possible that FFS coding trend differ by geographic area, the MA coding adjustment is akin to the normalization factor: industry-wide and not plan-specific in nature, in order to ensure that risk scores in the aggregate are at the correct level, given the coding patterns inherent in the CMS-HCC risk adjustment model and the FFS coding trends reflected in the Part C normalization factor.

Comment: One commenter urged CMS to undertake an analysis of other factors that might influence differences in rates of disease score growth among specific subsets of the Medicare population, e.g., Medicaid eligibles, or subsets of high-cost beneficiaries including beneficiaries with multiple chronic conditions.

Response: CMS' research to date does not support the position that Medicaid eligibility or having high costs has an impact on differential coding between MA and FFS. If other factors are found that CMS believes may affect the coding differential between sectors, we will consider including it in the coding adjustment factor in future years.

Comment: A number of commenters thought that CMS should handle coding intensity as an audit issue for those payers showing the highest probability of coding activity; they felt that it was unfair to reduce payments to all MAOs, when a few might be driving the aggregate coding intensity rate for MAOs generally. Several commenters contended that the MA coding adjustment and RADV audits both were intended to address inaccurate coding and that the 2011 MA coding adjustment is duplicative of any RADV audit-related adjustments. Commenters thought that, to avoid double counting the impact of inaccurate coding, the difference factor should take into account the impact of RADV audits (reduce overall coding intensity adjustment by future expected value of RADV adjustments) or was not necessary. A couple of commenters asked CMS to discuss how the RADV results are removed from the MA coding adjustment, or at least how it will avoid both affecting payments simultaneously.

Response: As we have noted in previous Advance Notices and Rate Announcements, the MA coding adjustment factor is not intended to adjust for inaccurate coding, but for the impact on risk scores of coding patterns that differ from FFS coding, the basis of the CMS-HCC model and the Part C normalization factor. RADV audits have the purpose of validating that diagnosis codes submitted for risk adjustment are documented in the medical record and, therefore, are correctly reported for the beneficiary in question. Moreover, we have not yet conducted RADV audits for the years in which we have applied an MA coding adjustment.

Comment: One commenter complained about the lack of an appeal mechanism, and thought that the adjustment should be nullified if coding is correct.

Response: As structured, the MA coding adjustment is a methodological adjustment to risk scores to ensure payment accuracy given differential coding patterns in MA and FFS. Since the MA coding adjustment is not plan-specific, and is not intended to target plans for their individual coding patterns, an appeal mechanism is not appropriate.

Comment: A couple of commenters believed that the coding adjustment had a disproportionate impact on SNPs, with one noting that this was due to greater numerical adjustment in risk scores for a plan serving high risk special needs individuals. The commenters opined that the adjustment would likely adversely impact SNPs, given the differential between FFS and SNPs, due to the SNP mandate to serve a high risk population with complex medical needs. These commenters urged that CMS devise and implement a plan to enhance the coding practices and accuracy of fee-for-service providers to create a level playing field relative to MA and FFS incentive to code accurately.

Response: As discussed above, CMS is applying an industry-wide adjustment for coding that adjusts risk scores in the aggregate to address coding trends in MA that differ from those in FFS. However, it is important to note the MA coding adjustment reflects *differences* in the year-to-year changes in the disease score portion of the risk score, not the absolute levels of FFS and MA risk scores. Therefore, it is not clear why plans with a higher level of risk scores would experience more or less differential coding than any other plan. Although CMS currently relies on FFS data to calibrate the CMS-HCC model, we anticipate using encounter data to calibrate the model in the future. At that time, a single normalization factor will be adequate to address coding trends and a separate MA coding adjustment factor will not be needed.

Section H. IME Phase Out

Comment: One commenter asked whether, when calculating the Standardized IME cost percentage (expressed as a percentage of FFS costs), the resulting ratio is constant during the phase-out period (i.e., if the IME costs and the FFS costs trend at the same rate), or if the IME cost represents what is left for IME costs yet to be phased-out.

Response: We anticipate recalculating the IME percentage of FFS cost in rebasing years.

Section I. Physician Quality Reporting Initiative (PQRI) and E-Prescribing

Comment: One commenter urged that CMS compensate physicians working under MA contracts for quality performance and e-prescribing commensurate with FFS provisions. This could be done either through a direct payment to physicians or inclusion of such compensation in MA payment, with contractual understanding that the payment amount, in total, would be passed on to participating physicians.

Response: MA payment rates already include an amount attributable to FFS costs for both PQRI and e-prescribing. This is so because when CMS computes 100 percent of FFS costs for purposes of §1853(c)(1)(D) of the Act in rebasing years, or when CMS computes the national per capita MA growth percentage per §1853(c)(6)(A) of the Act, the FFS costs attributable to PQRI and e-prescribing are included in the FFS amount used to establish the MA benchmarks. In effect, MAOs are already being paid for the PQRI and e-prescribing their providers do for MA plan enrollees, in a similar proportion to their efforts for FFS enrollees.

Section J. Clinical Trial Policy

Comment: Advocacy groups, MA organizations, and research associations wrote in support of the proposed clinical trial policy. Commenters generally said they believed the policy would improve coverage for clinical trial costs, as well as improve access and recruitment to clinical trials of MA plan members.

Response: Currently, most MA plan enrollees are responsible for the entire FFS coinsurance for clinical trial items and services, which is 20% of the total allowed amount for Part B services. The cost sharing requirements for similar in-network services are often much lower than they are under FFS for clinical trial items and services. We believe this new policy of limiting an MA enrollee's cost sharing to the plan's in-network cost sharing will increase participating in and access to clinical trial services for MA plan enrollees.

Comment: A few of the commenters misunderstood our policy change. They believed that it was within MAO discretion to choose whether to cover cost sharing for clinical trials at in-network levels. One commenter recommended allowing MAOs to choose which clinical trials would be eligible for cost sharing reduction (to in-network levels) by MAOs.

Response: It was our intent to say that our new policy is that MAOs must reduce cost sharing for clinical trial services to in-network cost sharing levels for items and services of the same category. It is not the case that MAOs can choose the clinical trials or clinical trial items and services to which this new policy applies. Rather, since such items and services are covered by Medicare, MAOs must also cover them. There is no plan discretion.

Comment: Two commenters asked us why we do not "waive" clinical trial cost sharing for MA plan enrollees, similar to the way we "waive" Part A and B deductibles related to clinical trial services reimbursed by FFS for MA plan enrollees.

Response: CMS does not "waive" deductibles related to clinical trial services for MA plan enrollees. Rather, the actuarial value of cost sharing in MA plans, as well as the fact that most MA plans use rebate dollars to buy-down cost sharing (including the actuarially equivalent cost sharing related to Part A/B deductibles), continues to apply. When we say that MA plan enrollees do not need to meet FFS deductibles we are simply acknowledging that enrollment in an MAO and payment of MA plan cost sharing already satisfies these deductible requirements in FFS.

Comment: Many plans expressed concerns with the operational challenges and administrative burdens that are associated with the new policy. Commenters were especially concerned that they do not have a way to identify enrollees who are participating in clinical trials, the services provided, the amount of the provider payment under FFS Medicare, as well as the cost sharing paid to the provider by the enrollee for covered clinical trial services. Many of the commenters pointed out that CMS rules prohibit MAOs from requiring their MA plan members to ask for plan permission, or to give MA plans notice when the member chooses to participate in a Medicare-qualifying clinical trial. One commenter urged CMS to require MA plans to provide reimbursement based on claims data, without requiring beneficiaries to submit receipts showing cost sharing was actually paid. Plans recommended that CMS work with MAOs to establish a process or mechanism for providing this information to MAOs. Commenters suggested two potential models for such a mechanism. One would be the process utilized by CMS to share Part B claims information with Cost Plans under certain circumstances, and the other would be the Medigap crossover claims process. One commenter recommended allowing providers of clinical trials to bill MAOs directly for the cost sharing their MA plan members incur.

Response: We will permit MAOs to ask members to submit MSNs (Medicare Summary Notices) related to clinical trial claims reimbursed by FFS. MSNs contain not only the amount reimbursed by FFS for items and services related to clinical trials, but also the amount of cost sharing owed by the MA plan member. Using this data from the MSN, MAOs should be able to compute the difference between MA plan in-network cost sharing for the same category of service, and thus compute the amount owed by the MAO to the member. We will also permit MAOs to seek MA member FFS cost sharing information directly from clinical trial providers. While we understand MAOs' operational concerns and will work with the industry to obtain the clinical trial data they want in an electronic format, we believe that MA enrollee participation in and access to clinical trial services outweighs the plans' concern for heightened administrative burden. Otherwise, we do not believe the administrative burden in processing these claims will be much greater than the burden MAOs already experience in processing other out-of-network claims.

Comment: Some commenters said it would be difficult to track the amount actually paid in cost sharing by an MA plan enrollee.

Response: MAOs will owe the difference between what the MA enrollee incurred in FFS cost sharing for covered clinical trial items and services and the plan's in-network cost sharing. The member is not required to have actually paid any of the cost sharing. The MAO owes the difference even if the member has not yet paid the clinical trial provider.

Comment: Two commenters suggested allowing MAOs to treat clinical trial services as out-of-network services, and suggested allowing MA plans to impose cost sharing and OOP maximums related to those services, rather than in-network services.

Response: Our policy is that MAOs will need to pay the difference between the FFS cost sharing for covered clinical trial services and the plan's in-network cost sharing for services of the same type, and to require the member's cost sharing liabilities to count towards the in-network OOP limit. Clinical trial services are covered under FFS Medicare and MAOs must cover all Medicare services as in-network services – see section 1852(a)(1)(A) of the Social Security Act. The fact that clinical trial item and services continue to be reimbursed by FFS Medicare provides a more than sufficient rationale for requiring MAOs to cover these services in this manner.

Comment: One MAO commented that the MAO conducts a number of clinical trials itself. This commenter and others went on to say that there is currently no requirement for an OOP maximum. Another commenter recommended requiring MA organizations to automatically add the appropriate cost-sharing for clinical trials toward the calculation of the MA plan's out-of-pocket (OOP) limit.

Response: MA plan members are free to participate in any certified clinical trial that any other (FFS) Medicare beneficiary can participate in. If an MAO conducts its own clinical trial, the MAO can explain the benefits of participating in the MAO-sponsored clinical trial. But, an MAO may not require pre-authorization for a non-plan-sponsored clinical trial, nor may it create impediments to a plan member's use of a non-plan clinical trial, even if the MAO believes it is sponsoring a clinical trial of a similar nature. The final choice in which, if any, clinical trial to participate is the MA plan member's. An MA plan can request, but not require, members to pre-notify the plan when members are participating in clinical trials. In addition, note that in CMS-4069-P CMS proposed requiring that MAOs have OOP maximums for both in-network and out-of-network cost sharing. If the rule in finalized as proposed and released in time, MAOs would be required to provide for OOP maximums for 2011. Finally, since in-network cost sharing will apply to non-plan clinical trial services, the in-network OOP maximum would be the appropriate place to count remaining member cost sharing liabilities for clinical trial services.

Comment: One commenter believed that requiring MAOs to reimburse claims from non-network providers of clinical trial items and services at in-network cost sharing rates would

result in a disparity of benefit administration in MA PPO plans. The commenter said that only individuals participating in clinical trials would be entitled to in-network cost sharing when being treated by non-network providers, while all other MA PPO plan enrollees who are not participating in clinical trials would have out-of-network cost sharing when receiving routine services from non-network providers.

Response: CMS does not believe that the clinical trial cost-sharing policy described in this Announcement creates a disparity in benefit administration.

Comment: Some commenters asked that CMS address the updates that would be necessary for the model Explanation of Coverage (EOC) and Plan Benefits Package (PBP).

Response: No update is necessary to the PBP since the cost sharing an enrollee would pay for clinical trial services would be the amount the plan filed for existing in-network benefits of the same category. For example if the clinical trial included a Part B drug or radiation therapy, the in-network cost sharing that had been entered for Part B drugs and radiation services would be the cost sharing that applied to the clinical trial services. As far as updating the EOC and other marketing materials are concerned, we will require MAOs to mention the new coverage of cost sharing (at in-network levels, and counting towards the in-network cap on OOP expenses) in the 2011 ANOC (Annual Notice of Change) and EOC.

Comment: One commenter requested guidance as to where clinical trial costs should appear in the BPT. One commenter was concerned that this policy change could pave the way to mid-contract year decisions to include new services as required benefits even though coverage of the services had not been part of the bid. Another commenter stated that regardless of whether clinical trial participation is considered an in-network or out-of-network service, plans will need to incorporate in their CY 2011 bids assumptions about the costs related to members' participation. This commenter said that because many MA plans now bear no responsibility for clinical trial costs, plans do not have a basis for making actuarial assumptions about costs for reimbursing enrollee cost sharing or applying clinical trial costs to OOP maximums. The commenter requests that CMS provide plans with data on enrollee participation in clinical trials, affiliated providers, and associated costs for use in bid preparation.

Response: The BPT does not have a separate entry for clinical trials. Plans can include expected cost sharing reductions in their estimate of costs and cost sharing for related in-network services. Preliminary data show that in 2008 a total of $230 million was spent nationally by CMS on clinical trial services (inpatient and outpatient – both FFS and MA enrollees). If more detailed data becomes available, we will provide it.

Section K. Adjustment to FFS Per Capita Costs for VA-DOD Costs

Comment: Section 1853(c)(1)(D)(iii) of the Act directs the Secretary to make an appropriate adjustment to MA payment rates to reflect CMS' "estimate on a per capita basis, of the amount

of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense (DOD) or the Department of Veterans Affairs." OACT has analyzed DoD data and determined that an adjustment is appropriate. One commenter wrote in support of the proposed adjustment. Two additional commenters noted that the statutory authority for the VA-DoD adjustment began with the 2004 rates, yet 2011 will be the first year in which the Office of the Actuary (OACT) has determined that available data support its application. The commenters believed that because the statute allowed implementation to begin with 2004 rates, the adjustment should be calculated by applying it to the 2004 rates and trending it forward to 2011 or extrapolating the counties' 2004 MA rates up to 2011 using the applicable update for each year since 2004, in order to accurately determine its magnitude and the counties to which it should apply. The commenters note that this approach is similar to that used in 2004 to transition from the PIP-DCG risk adjustment model to the HCC model when OACT recalculated the 1998 county rates to reflect the new HCC model then updated the rates for all years from 1998 – 2004 to reflect application of the HCC risk adjustment model.

Response: Section 1853(c)(1)(D)(iii) of the Act directs the Secretary to incorporate the impact of including the costs of VA or DOD Military Facilities in the calculation of Fee-for-Service (FFS) costs. CY 2011 is the first time that data has been available that indicates such an adjustment is warranted in those counties with at least 10 Medicare members in the Uniformed Services Family Health Plan. Although there is some history for retroactively calculating the impact of model change to historic rates, there is no history for incorporating additional data into a historic FFS calculation. In fact, FFS costs are only incorporated into a county rate on a prospective basis in a periodic rebasing year. We plan to incorporate these findings in the county rates the next time we rebase the FFS rates.

Section L. Location of Network Areas for PFFS Plans in Plan Year 2012

"Network area" is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as the area that the Secretary identifies (in the Rate Announcement for the previous plan year) as "having at least 2 network-based plans (as defined in section 1852(d)(5)(C) of the Act) with enrollment as of the first day of the year in which the announcement is made." "Network-based plan" is defined by MIPPA as: (1) an MA plan that is a coordinated care plan as described in section 1851(a)(2)(A)(i) of the Act, excluding non-network regional PPOs; (2) a network-based MSA plan; or (3) a section 1876 cost plan.

As required by MIPPA, for purposes of identifying the location of the network areas for plan year 2012, we determined whether at least two network-based plans with enrollment as of January 1, 2010 exist in each of the counties in the United States, including its 5 territories and the District of Columbia. In some cases, network areas consist of partial counties and are identified by zip codes.

Regional PPOs (RPPOs) meet the definition of a network-based plan only in those areas where the plan is meeting access requirements through written contracts with providers. In a January 19, 2010 HPMS memorandum titled "Transition of Private Fee-for-Service Contractors to Network-Based Access Requirements and Update", we issued an updated list of network areas for plan year 2011. This revision was necessary given that, after reviewing the 2009 Health Service Delivery (HSD) tables for all RPPOs in 601 counties where the presence of a network RPPO was the deciding factor in the county being considered a network area in 2011, we found that none of the RPPOs offered in these counties had contracted providers for all Medicare Part A and Part B services.

In our analysis to identify the network areas for plan year 2012, we used the updated 2009 RPPO provider access data, including the RPPO data we validated. We then reviewed the 2010 Health Service Delivery (HSD) tables for all RPPOs in the counties where the presence of a network RPPO was the deciding factor in the county being considered a network area in 2012 in order to ensure that these RPPOs had contracted providers for all Medicare Part A and Part B services and could be considered network-based plans.

The list of network areas for plan year 2012 can be downloaded from the following website: http://www.cms.gov/PrivateFeeforServicePlans/.

An existing PFFS plan may have some counties (or partial counties) in its current service area that meet the definition of a network area and other counties (or partial counties) that do not. As we stated in the 2010 Advance Notice, CMS will not permit an MA organization offering a PFFS plan to operate a mixed model where some counties (or partial counties) in the plan's service area are considered network areas and other counties (or partial counties) that are non-network areas (where there are no network-based plan options or only one other network-based plan).

Instead, the MA organization must establish a unique plan with a service area consisting of the counties (or partial counties) that are network areas and another plan with a service area consisting of the counties (or partial counties) that are non-network areas. The MA organization must file separate plan benefit packages for the PFFS plan that will operate in network areas and the plan that will operate in non-network areas.

PFFS plans operating in network areas in 2012 must establish networks of contracted providers to furnish services in these areas in accordance with section 1852(d)(4)(B) of the Act in order to meet Medicare access to services requirements. PFFS plans may not use alternate methods to meet access requirements in network areas. If an existing PFFS plan is not able to establish a network of contracted providers that CMS determines to be adequate in a network area, then the plan must exit from that area in plan year 2012. If an MA organization is not able to establish a network of contracted providers that CMS determines to be adequate in a network area, then it may not offer a PFFS plan in that area.

Current PFFS plans whose service areas lie solely in non-network areas can continue to operate as non-network plans, where the plans meet access requirements by establishing payment rates that are not less than the rates that apply under Original Medicare (42 CFR §422.114(a)(2)(i)) and having providers deemed to be contracted as provided under 42 CFR §422.216(f). PFFS plans in non-network areas may choose to operate as full network plans (42 CFR §422.114(a)(2)(ii)) or partial network plans (42 CFR §422.114(a)(2)(iii)).

CMS will not accept Notices of Intent and applications for non-network PFFS products for those counties (or partial counties) determined to be network areas.

Regardless of whether a PFFS plan meets access requirements exclusively through deeming or is subject to the requirement that it establish a network of providers with signed contracts, providers who do not have a contract with the PFFS plan continue to have the option of accepting a PFFS plan's terms & conditions of payment and becoming a deemed provider as described in 42 CFR §422.216(f).

Comment: A commenter asked that CMS reconsider its position that two MA plans count as two network plans for the purposes of the definition of "network area" when the plans are both offered by the same MA organization. The commenter believed that this interpretation was not consistent with the commenter's understanding of the intent of MIPPA, which the commenter believed envisioned two successfully operating and competing organizations. The commenter suggested that CMS's interpretation lends itself to 'gaming,' as a single organization could choose to introduce a second PBP (and not market it) in the interest of pushing out non-network PFFS plans, and then having exclusive access to beneficiaries who were enrolled in those plans. The commenter requested that CMS reconsider its position on this issue for contract year 2012, or, at the very least, put in place a strict monitoring program to assure that organizations operating the only network plan in their service area are not gaming CMS rules to force out non-network PFFS plans in a county without two competing network plans.

Response: MIPPA defines "network area" for a given plan year, as the area that the Secretary identifies (in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year) as "having at least 2 network-based plans with enrollment as of the first day of the year in which the announcement is made." "Network-based plan" is defined in MIPPA as: (1) an MA plan that is a coordinated care plan as described in section 1851(a)(2)(A)(i) of the Act, excluding non-network regional PPOs; (2) a network-based MSA plan; or (3) a section 1876 cost plan. We interpret "having at least 2 network-based plans" to mean that there are at least 2 plans, which meet the definition of a network-based plan, that are offered by the same MAO or by different MAOs. We believe this interpretation is consistent with the statutory requirements for identifying network areas. We do not believe we have the statutory authority to interpret the definition of a "network area" in a different manner.

We do not agree with the commenter's concern about a single MA organization "gaming" the market by introducing a second PBP and not marketing it in order to remove non-network PFFS competition. A network-based plan is required to have at least one beneficiary enrolled in the plan in order to be counted for purposes of identifying the location of network areas. Therefore, if a plan has no enrollees, it would not be counted as a network-based plan.

Section M. Calibration of RxHCC model

Comment: Commenters offered support for decision to include a new RxHCCs for morbid obesity.

Response: We appreciate the support.

Comment: One commenter was concerned that the revised Part D risk adjustment model will result in significant underpayments for ESRD members. Based on their own analysis of the revised Part D scores, they found that the combination of per member per month and reconciliation payments from CMS will not cover their costs. The commenter recommended that CMS consider adding a factor into the model for ESRD status. This factor would help to address this inequity and reduce the negative payment impacts of the revised Part D risk model.

Response: In the RxHCC risk adjustment model, ESRD status is captured by reported diagnosis, except for the new enrollee models, for which we have no diagnoses. In the risk models for continuing enrollees, for whom we have diagnoses, we recognize stages of kidney failure with the 585 ICD-9 codes and dialysis status with V codes reported with the diagnoses. As continuing (full risk) enrollees go through the stages of kidney failure, they will be coded for different RxHCCs. As coding for CKD improves, we expect the coefficients of these RxHCCs to become better differentiated.

Comment: Several commenters suggested that CMS consider including data for beneficiaries enrolled in MA-PD plans as part of the next RxHCC risk adjustment model calibration.

Response: We thank commenters for this suggestion. We will consider this suggestion when we next recalibrate the RxHCC risk adjustment model.

Comment: If new model is found to result in material impact to plans, one commenter urged CMS to phase in the model changes so that the financial impact may be easier to absorb.

Response: CMS analyses have shown that most Part D plans' risk scores change 1% or less, and the vast majority change by 2% or less as a result of the revised and recalibrated RxHCC risk adjustment model. Further, no plans have commented to CMS with concerns about the impact of the RxHCC model in their Part D risk scores.

Comment: A couple of commenters asked that CMS apply the interactions in the institution model to the community model. One commenter wanted CMS to add major depression and

other major chronic conditions such as diabetes, CHF, and COPD, to the coefficients for disease interactions.

Response: Interaction terms can help predict costs when there are higher costs associated with having more than one condition than are captured by the individual demographic and HCC factors. Interaction terms are determined for each model segment (e.g., community and institutional) by assessing the ability of each interaction term to improve that model segment's ability to predict costs. There exist a plethora of possible interaction terms to include in each model segment, and decisions regarding inclusion are identical to those made in deciding which HCCs to include in a model – ability to predict costs for Medicare Part D benefits, as determined by the size of the coefficient and the t-value of the coefficient. When inclusion of an interaction term is not warranted by cost data, CMS does not add the term to the model.

Comment: One commenter stated that, while they expected payments for beneficiaries in long term institutional (LTI) settings to increase (because prices for drugs used by institutionalized beneficiaries in Part D have grown more rapidly than have prices for other Part D enrollees) and while there are legitimate reasons for prescription costs to be higher in long term care settings, ideally prospective Part D payments will continue to give sponsors incentives to manage growth in the drug spending of all enrollees. Similarly, the commenter noted that LIS enrollees experience higher spending and lower use of generic drugs. Inherent in the Part D risk adjustment model, CMS is paying plans more for LIS enrollees based on their higher average costs to plans. The commenter recommended that CMS look for examples of Part D plans that are doing a better job of providing needed medications and still managing the drug spending of their LTI and LIS enrollees, so that we can encourage similar techniques among other plans.

Response: CMS appreciates the comment and will consider these suggestions when further refining the Part D model.

Comment: A few commenters noted that, in numbering the RxHCCs in the revised model, new RxHCCs were assigned to previously-assigned numbers, e.g., Opportunistic Infections was RxHCC2 and is now RxHCC5. They stated that this renumbering may cause confusion with various systems, reporting and provider training and recommended that it would be easier to implement the new model if the numbering system changed to a new set of IDs or if old numbers were not re-used to mean something else.

Response: In addition to adding (RxHCCs) and deleting (RxHCCs) from the current models, the clinical update also modified RxHCCs that were retained in model. Direct comparisons between old and revised RxHCCs need to be made carefully, regardless of the numbering scheme. Due to the full-scale revision of the model, CMS decided to renumber all RxHCCs at this time.

Comment: Some commenters requested that CMS make available the population used to create the relative factors; the actual distribution of members used to create the community and institutional relative factors; and the population shifts from prior years to current model in the

above categories. Several commenters requested the regional impacts of model changes, with some commenters specifically asking for the impact data by the eight categories of the model, along with risk score impact (percent change). Commenters felt that this information would allow plans to understand the impact of the changes for the entire region, and would allow PDPs can to gauge the impact of changes in low income enrollment, thus improving the competitiveness of the bidding process.

Response: To develop the CMS RxHCC model segments, CMS used 100% of the 2007 and 2008 Standard Analytic Files for Part D. Standard Analytic Files comprising PDE data for 5% of the Part D enrollee population are available to the public upon request from the Research Data Assistance Center (ResDAC). Others can use these SAFs to conduct analyses of the impact of the new model on the Part D risk scores of various subsets of the Part D enrollee population.

Comment: One commenter asked that CMS provide PDPs with diagnostic information so they can better predict risk scores.

Response: Recognizing that PDPs do not have the ICD-9 codes submitted and used in risk score creation, CMS sent to all PDPs a set of Part D risk scores under the current and revised models on March 2, 2010.

Section N. LIS Benchmarks

Comment: Many commenters offered support for CMS's efforts to stabilize reassignments through the Medicare Demonstration to Revise the Part D Low-Income Benchmark Calculation, which was approved in August 2009. Commenters also requested the reinstatement of the de minimis policy, where beneficiaries in plans whose premiums were just over the benchmark were not reassigned. One commenter suggested calculating the low income benchmark premiums using only PDP plans that are eligible for reassignment and weighting the basic premiums by LIS enrollment. Commenters requested that CMS make their final policy known well before the deadline for bids, preferably in the 2011 Announcement.

Response: For 2010, CMS implemented the Medicare Demonstration to Revise the Part D Low-Income Benchmark Calculation. This demonstration allowed CMS to calculate the LIS benchmarks using basic Part D premiums before the application of Part C rebates. CMS received broad support for this demonstration from commenters. The demonstration was effective at reducing reassignment and stabilizing benchmarks. The approach focuses directly on the issue of MA rebates, which are the main cause of benchmark destabilization, while upholding the spirit of the statute, which directs us to calculate the benchmarks using premiums from both PDPs and MA-PDs.

In 2011, we will again calculate the LIS benchmarks using basic part D premiums before the application of Part C rebates, as required by Section 1860D-14(b)(2)(B)(iii) of the Act, as amended by Section 3302 of the PPACA and Section 1102 of the Reconciliation Act. Also in

accordance with, Section 1860D-14(a) of the Act, as amended by Section 3303 of the PPACA, Part D plans may be allowed to charge subsidy eligible beneficiaries a monthly beneficiary premium equal to the applicable low-income premium subsidy amount, if the plan's adjusted basic beneficiary premium exceeds the low-income premium subsidy amount by a de minimis amount or less. This approach will eliminate the need to move low-income subsidy beneficiaries to new plans simply because their existing plan's premium exceeded the LIS premiums subsidy amount by a de minimis amount. We will issue subsequent guidance on the de minimis amount and autoassignment.

Section O. Reinsurance Payment Demonstration

Comment: One commenter indicated that the previously released 2011 PD BPT Instructions included language stating that Reinsurance Demonstration plans offered in 2010 may be extended for 2011.

Response: We thank the commenter for bringing this language to our attention. The previously released 2011 BPT instructions were draft and did not reflect proposed policy changes for CY 2011. This language will be updated in the final PD BPT instructions. As proposed in the Advance Notice, Part D sponsors with Reinsurance Demonstration plans will not be allowed to offer such plans in 2011.

Comment: Commenters recommended that we extend the Part D Reinsurance Payment Demonstration. They indicated that this demonstration was successful in encouraging Part D sponsors to offer enhanced alternative plans and provide coverage in the coverage gap. They expressed concern that discontinuing this demonstration would 1) reduce the number of Part D plans offering gap coverage and 2) increase the premiums and cost sharing for beneficiaries currently enrolled in Reinsurance Demonstration plans. One commenter indicated that an increase in premiums resulting from the discontinuation of this demonstration would lead to adverse selection into plans that continue to offer coverage in the coverage gap. A few commenters indicated that ending this demonstration would be inconsistent with current legislative reform efforts to fill the coverage gap because the Part D Reinsurance Payment Demonstration provides the best current option for offering gap coverage.

Response: We implemented the Part D Reinsurance Payment Demonstration in 2006 due to concerns that the reinsurance provisions of the Part D benefit would create a create disincentive for Part D sponsors to offer enhanced alternative plans. Since the start of the Part D program, several sponsors have offered enhanced alternative plans. However, the majority of enhanced alternative plans offered have not been Reinsurance Demonstration plans. In addition, the majority of enhanced alternative plans providing gap coverage are not Reinsurance Demonstration plans. Therefore, we do not believe that this payment demonstration is necessary to provide an incentive for Part D sponsors to offer enhanced alternative plans and provide gap

coverage. For this same reason, we do not believe that ending this demonstration would be inconsistent with current efforts to fill the coverage gap.

We agree that discontinuing this demonstration might increase the premiums and cost sharing for beneficiaries currently enrolled in Reinsurance Demonstration plans. However, these beneficiaries will have the option to enroll in other enhanced alternative plans that may have lower premiums and/or cost sharing. We believe that the number of enhanced alternative plans offering gap coverage should mitigate the possibility of adverse selection.

Comment: Two commenters recommended that CMS reinstate this demonstration for contract year 2012 if the number of plans offering enhanced alternative coverage or the number of plans offering coverage in the coverage gap significantly decreases.

Response: Given the provisions in the PPACA, as amended by Section 1101 of the Reconciliation Act, that close the coverage gap over time, we do not believe that reinstatement of this demonstration will be needed.

Section P. Payment Reconciliation:

Comment: One commenter asked that CMS continue expansion of the risk corridors beyond 2011 if material changes are made to the Part D benefit due to health care reform.

Response: We appreciate the comment and will take this suggestion into consideration.

Section Q. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2011

Comment: A couple of commenters noted that due to the prior year revisions, the annual increase in drug costs is significantly greater than the increases applied to the Part D benefit parameters. One commenter stated that the Part D beneficiaries would receive less value under Part D as a result of the application of prior year revisions in the calculation of the annual percentage increase. The commenter explained that Part D beneficiaries would reach the coverage gap more quickly because the increase in the initial coverage limit is significantly less than the increases in drug price expected for 2011. The commenter recommended that CMS modify the calculation of the annual percentage increase to account for formulary changes and other cost cutting measures employed by Part D sponsors.

One commenter expressed concern that large changes in the Part D benefit parameters followed by no change could affect the stability of the Part D program. The commenter requested information regarding why the Part D benefit parameters were overstated for previous years, resulting in significant prior year revisions. In addition, the commenter asked whether the methodology for calculating the annual percentage increase could be revised to better predict the trend in Part D drug costs.

Response: The annual percentage increase (API) used to determine the Part D benefit parameters is calculated based on the formula described in the statute. That is, the API is equal to the increase in average per capita aggregate expenditures for Part D covered drugs for the 12-month period ending in July of the previous year. As such, there is no provision to directly allow for modification to the update to reflect the cost cutting efforts of the plans. To the extent that these efforts reduced Part D expenditures, they would have an impact on the API and, in turn, the Part D benefit parameters.

Since the law requires the API to be calculated based on data that hasn't been fully submitted at the time of the Announcement, projected data is used to determine the API. In subsequent years, revisions of prior estimates are necessary to reflect the actual increase in average per capita aggregate expenditures. The table shown below provides details for the prior year revisions that were included in the API for 2011.

	Current Estimate	Previous Estimate	Impact
YE July 2006 Increase	6.48%	6.42%	0.06%
YE July 2007 Increase	5.12%	5.34%	-0.21%
YE July 2008 Increase	4.42%	6.12%	-1.60%
YE July 2009 Increase	3.22%	5.79%	-2.43%
Total Prior Year Revision			-4.13%

As shown above, the total prior year revision occurred primarily from the 2008 and 2009 estimated increases. Drug spending in 2008 was lower than expected due to a significant decrease in the lag time in which the claims data was received. For 2009, Part D spending is now projected to be lower than last year based on preliminary 2009 Part D experience.

Comment: One commenter indicated that while the parameters of the defined standard are important, the most significant variables for most beneficiaries are tiering structure, formulary, and utilization management rules. The commenter stated that it is difficult for beneficiaries to access and understand this information when choosing a Part D plan. The commenter asked that CMS simplify the plan options so that beneficiaries can better understand these variables and the impact on their out-of-pocket costs.

Response: We appreciate the concerns raised by the commenter. We are currently addressing the issue of simplifying the prescription drug benefit for consumers by emphasizing that Part D sponsors offer meaningfully different plan benefit packages under the Part D program. Our final regulation (CMS-4085) will provide additional information regarding this requirement.

Comment: A couple of commenters expressed support for our use of Part D program data and prior year revisions to calculate the annual percentage increase. They indicated that Medicare beneficiaries will not see substantial increases in their out-of-pocket costs and the Out-of-pocket threshold as a result of our calculation methodology.

Response: We agree with the commenters that our current methodology is effective in ensuring that the defined standard Part D benefit covers a constant share of Part D drug expenses each year.

Attachment II. Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Annual Percentage Increases

	Annual percentage trend for 2010	Prior year revisions	Annual percentage increase for 2010
Applied to all parameters but (1)	4.63%	-4.13%	.31%
CPI (all items, U.S. city average): Applied to (1)	1.58%	-1.64%	-.08%

Part D Benefit Parameters

	2010	2011
Standard Benefit		
Deductible	$310	$310
Initial Coverage Limit	$2,830	$2,840
Out-of-Pocket Threshold	$4,550	$4,550
Total Covered Part D Spend at Out-of-Pocket Threshold (2)	$6,440.00	$6,447.50
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$2.50	$2.50
Other	$6.30	$6.30
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	$1.10	$1.10
Other (3)	$3.30	$3.30
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.50	$2.50
Other	$6.30	$6.30
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Eligible for QMB/SLMB/QI, SSI or applied and income at or below 135% FPL and resources ≤ $6,600 (individuals) or ≤ $9,910 (couples) (4)		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.50	$2.50
Other	$6.30	$6.30
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $11,010 (individual) or $22,010 (couple)		
Deductible	$63.00	$63.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.50	$2.50
Other	$6.30	$6.30
Retiree Drug Subsidy Amounts		
Cost Threshold	$310	$310
Cost Limit	$6,300	$6,300

(1) CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% FPL.

(2) Amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement. Due to the reduced generic cost sharing discussed in the cover letter, this amount may be higher if a beneficiary purchases generic drugs in the coverage gap

(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2010 values of $62.93, $1.10, and $3.31, respectively.

(4) The actual amount of resources allowable will be updated for contract year 2011.

Attachment III. Final Rx-HCC Risk Adjustment Factors

Tables

Table 1. CMS RxHCC Model Relative Factors for Continuing Enrollees

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

		Continuing Enrollee (CE) RxHCC Model Segments				
Variable	**Disease Group**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
Female	-					
0-34 Years	-	-	0.266	-	0.405	1.555
35-44 Years	-	-	0.472	-	0.599	1.576
45-54 Years	-	-	0.578	-	0.672	1.490
55-59 Years	-	-	0.571	-	0.643	1.411
60-64 Years	-	-	0.577	-	0.617	1.357
65 Years	-	0.418	-	0.449	-	1.447
66 Years	-	0.418	-	0.449	-	1.447
67 Years	-	0.418	-	0.449	-	1.447
68 Years	-	0.418	-	0.449	-	1.447
69 Years	-	0.418	-	0.449	-	1.447
70-74 Years		0.415	-	0.439	-	1.367
75-79 Years		0.421	-	0.436	-	1.309
80-84 Years		0.431	-	0.432	-	1.254
85-89 Years		0.440	-	0.422	-	1.199
90-94 Years		0.438	-	0.399	-	1.127
95 Years or Over		0.414	-	0.328	-	0.981
Male						
0-34 Years		-	0.244	-	0.435	1.582
35-44 Years		-	0.396	-	0.562	1.542
45-54 Years		-	0.521	-	0.604	1.471
55-59 Years		-	0.519	-	0.571	1.377
60-64 Years		-	0.536	-	0.541	1.325
65 Years		0.425	-	0.367	-	1.384
66 Years		0.425	-	0.367	-	1.384
67 Years		0.425	-	0.367	-	1.384
68 Years		0.425	-	0.367	-	1.384
69 Years		0.425	-	0.367	-	1.384
70-74 Years		0.416	-	0.359	-	1.339

		Continuing Enrollee (CE) RxHCC Model Segments				
Variable	**Disease Group**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
75-79 Years		0.407	-	0.354	-	1.295
80-84 Years		0.402	-	0.342	-	1.265
85-89 Years		0.404	-	0.343	-	1.242
90-94 Years		0.429	-	0.364	-	1.197
95 Years or Over		0.433	-	0.357	-	1.094
Originally Disabled Interactions with Sex						
Originally Disabled		-	-	-	-	0.031
Originally Disabled_Female		0.066	-	0.102	-	-
Originally Disabled_Female_Age 65		-	-	-	-	-
Originally Disabled_Female_Age 66-69		-	-	-	-	-
Originally Disabled_Female_Age 70-74		-	-	-	-	-
Originally Disabled_Female_Age 75+		-	-	-	-	-
Originally Disabled_Male		0.018	-	0.091	-	-
Originally Disabled_Male_Age 65		-	-	-	-	-
Originally Disabled_Male_Age 66-69		-	-	-	-	-
Originally Disabled_Male_Age 70-74		-	-	-	-	-
Originally Disabled_Male_Age 75+		-	-	-	-	-

		Continuing Enrollee (CE) RxHCC Model Segments				
Disease Coefficients	**Description Label**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC1	HIV/AIDS	1.625	2.381	2.123	2.545	1.082
RXHCC5	Opportunistic Infections	0.111	0.124	0.083	0.180	0.083
RXHCC8	Chronic Myeloid Leukemia	1.684	2.124	2.099	2.374	1.056
RXHCC9	Multiple Myeloma and Other Neoplastic Disorders	1.116	1.304	1.017	1.215	0.557
RXHCC10	Breast, Lung, and Other Cancers and Tumors	0.207	0.206	0.237	0.254	0.102
RXHCC11	Prostate and Other Cancers and Tumors	0.040	0.051	0.116	0.063	0.081
RXHCC14	Diabetes with Complications	0.246	0.186	0.275	0.271	0.158

		Continuing Enrollee (CE) RxHCC Model Segments				
Disease Coefficients	**Description Label**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC15	Diabetes without Complication	0.173	0.151	0.213	0.222	0.113
RXHCC18	Diabetes Insipidus and Other Endocrine and Metabolic Disorders	0.242	0.564	0.187	0.624	0.126
RXHCC19	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.043	0.060	0.030	0.060	0.060
RXHCC20	Thyroid Disorders	0.037	0.091	0.046	0.104	0.037
RXHCC21	Morbid Obesity	0.038	0.013	0.037	0.049	0.069
RXHCC23	Disorders of Lipoid Metabolism	0.120	0.134	0.142	0.182	0.062
RXHCC25	Chronic Viral Hepatitis	0.078	0.042	0.220	0.111	–
RXHCC30	Chronic Pancreatitis	0.085	0.154	0.046	0.075	0.021
RXHCC31	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.032	0.066	0.034	0.075	0.021
RXHCC32	Inflammatory Bowel Disease	0.264	0.245	0.190	0.315	0.075
RXHCC33	Esophageal Reflux and Other Disorders of Esophagus	0.135	0.111	0.161	0.175	0.075
RXHCC38	Aseptic Necrosis of Bone	0.053	0.153	0.044	0.233	0.068
RXHCC40	Psoriatic Arthropathy	0.321	0.447	0.571	1.011	0.377
RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.169	0.258	0.197	0.390	0.095
RXHCC42	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	0.122	0.236	0.161	0.266	0.084
RXHCC45	Osteoporosis, Vertebral and Pathological Fractures	0.093	0.157	0.125	0.181	0.027
RXHCC47	Sickle Cell Anemia	0.144	0.093	0.133	0.433	0.036
RXHCC48	Myelodysplastic Syndromes, Except High-Grade	0.211	0.370	0.299	0.231	0.426
RXHCC49	Immune Disorders	0.149	0.244	0.130	0.276	0.141
RXHCC50	Aplastic Anemia and Other Significant Blood Disorders	0.044	0.087	0.059	0.073	0.036
RXHCC54	Alzheimer`s Disease	0.468	0.265	0.310	0.184	0.016
RXHCC55	Dementia, Except Alzheimer`s Disease	0.250	0.097	0.143	0.049	–
RXHCC58	Schizophrenia	0.422	0.569	0.645	0.959	0.343

		Continuing Enrollee (CE) RxHCC Model Segments				
Disease Coefficients	**Description Label**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC59	Bipolar Disorders	0.353	0.435	0.427	0.677	0.293
RXHCC60	Major Depression	0.265	0.337	0.308	0.439	0.205
RXHCC61	Specified Anxiety, Personality, and Behavior Disorders	0.159	0.216	0.220	0.439	0.175
RXHCC62	Depression	0.134	0.169	0.146	0.230	0.116
RXHCC63	Anxiety Disorders	0.056	0.122	0.088	0.182	0.116
RXHCC65	Autism	0.171	0.326	0.495	0.661	0.175
RXHCC66	Profound or Severe Mental Retardation/Developmental Disability	0.027	0.326	0.495	0.400	–
RXHCC67	Moderate Mental Retardation/Developmental Disability	0.023	0.178	0.404	0.294	–
RXHCC68	Mild or Unspecified Mental Retardation/Developmental Disability	0.010	0.054	0.239	0.144	–
RXHCC71	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.181	0.303	0.159	0.314	0.057
RXHCC72	Spinal Cord Disorders	0.061	0.156	0.072	0.095	–
RXHCC74	Polyneuropathy	0.085	0.203	0.082	0.182	0.058
RXHCC75	Multiple Sclerosis	0.451	0.811	0.494	1.338	0.123
RXHCC76	Parkinson`s Disease	0.406	0.485	0.295	0.292	0.154
RXHCC78	Intractable Epilepsy	0.355	0.636	0.354	0.915	0.124
RXHCC79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.214	0.267	0.170	0.370	0.079
RXHCC80	Convulsions	0.106	0.125	0.099	0.230	0.041
RXHCC81	Migraine Headaches	0.113	0.216	0.111	0.201	0.146
RXHCC83	Trigeminal and Postherpetic Neuralgia	0.093	0.170	0.107	0.154	0.079
RXHCC86	Pulmonary Hypertension and Other Pulmonary Heart Disease	0.253	0.397	0.292	0.345	0.121
RXHCC87	Congestive Heart Failure	0.175	0.089	0.247	0.108	0.099

		Continuing Enrollee (CE) RxHCC Model Segments				
Disease Coefficients	**Description Label**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC88	Hypertension	0.170	0.078	0.219	0.096	0.064
RXHCC89	Coronary Artery Disease	0.145	0.082	0.133	0.046	0.017
RXHCC93	Atrial Arrhythmias	0.060	0.045	0.023	–	0.011
RXHCC97	Cerebrovascular Disease, Except Hemorrhage or Aneurysm	0.065	–	0.050	–	–
RXHCC98	Spastic Hemiplegia	0.142	0.239	0.056	0.149	0.011
RXHCC100	Venous Thromboembolism	0.013	0.043	–	0.085	–
RXHCC101	Peripheral Vascular Disease	0.056	0.030	0.093	0.064	–
RXHCC103	Cystic Fibrosis	0.198	0.665	0.223	1.346	0.117
RXHCC104	Chronic Obstructive Pulmonary Disease and Asthma	0.198	0.123	0.221	0.204	0.117
RXHCC105	Pulmonary Fibrosis and Other Chronic Lung Disorders	0.113	0.123	0.098	0.202	0.037
RXHCC106	Gram-Negative/Staphylococcus Pneumonia and Other Lung Infections	–	0.070	–	0.042	0.028
RXHCC111	Diabetic Retinopathy	0.094	0.085	0.079	0.039	0.035
RXHCC113	Open-Angle Glaucoma	0.142	0.103	0.154	0.124	0.101
RXHCC120	Kidney Transplant Status	0.266	0.170	0.386	0.407	0.338
RXHCC121	Dialysis Status	0.216	0.303	0.283	0.536	0.217
RXHCC122	Chronic Kidney Disease Stage 5	0.114	0.136	0.130	0.167	0.111
RXHCC123	Chronic Kidney Disease Stage 4	0.114	0.136	0.130	0.167	0.111
RXHCC124	Chronic Kidney Disease Stage 3	0.097	0.136	0.115	0.167	0.081
RXHCC125	Chronic Kidney Disease Stage 1, 2, or Unspecified	0.038	0.056	0.035	0.071	0.042
RXHCC126	Nephritis	0.038	0.036	0.035	0.070	0.013
RXHCC142	Chronic Ulcer of Skin, Except Pressure	0.040	0.055	0.028	0.061	–
RXHCC145	Pemphigus	0.110	0.151	0.123	0.258	–
RXHCC147	Psoriasis, Except with Arthropathy	0.106	0.188	0.206	0.289	0.126
RXHCC156	Narcolepsy and Cataplexy	0.267	0.328	0.164	0.440	0.104
RXHCC166	Lung Transplant Status	0.919	0.905	0.968	1.114	0.688
RXHCC167	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas	0.411	0.372	0.417	0.480	0.338

		Continuing Enrollee (CE) RxHCC Model Segments				
Disease Coefficients	**Description Label**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC168	Pancreas Transplant Status	0.266	0.170	0.386	0.351	0.338
Non-Aged Disease Interactions						
NonAged_RXHCC1	HIV/AIDS	-	-	-	-	1.093
NonAged_RXHCC58	Schizophrenia	-	-	-	-	0.388
NonAged_RXHCC59	Bipolar Disorders	-	-	-	-	0.243
NonAged_RXHCC60	Major Depression	-	-	-	-	0.115
NonAged_RXHCC61	Specified Anxiety, Personality, and Behavior Disorders	-	-	-	-	0.115
NonAged_RXHCC62	Depression	-	-	-	-	0.058
NonAged_RXHCC63	Anxiety Disorders	-	-	-	-	0.032
NonAged_RXHCC65	Autism	-	-	-	-	0.115
NonAged_RXHCC75	Multiple Sclerosis	-	-	-	-	0.477
NonAged_RXHCC78	Intractable Epilepsy	-	-	-	-	0.204
NonAged_RXHCC79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	-	0.040
NonAged_RXHCC80	Convulsions	-	-	-	-	0.034

Notes:

1. The relative risk scores in this table were calculated by dividing the parameter estimates by the Part D national average predicted expenditures (CMS Part D Denominator). The Part D Denominator value used was $1,086.61. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Because Part D drugs post-transplant are less costly for younger Medicare beneficiaries, RxHCC120, which takes precedence over RxHCC121, has a lower coefficient than RxHCC121 for those under age 65.

Source: RTI Analysis of 100% 2008 PDE, 2007 NCH, 2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 2. RxHCC Model Relative Factors for New Enrollees, Non-Low Income

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

Variable	Baseline – Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	0.473	0.908	-	-
35-44 Years	0.789	1.224	-	-
45-54 Years	1.056	1.491	-	-
55-59 Years	1.124	1.559	-	-
60-64 Years	1.173	1.608	-	-
65 Years	0.764	1.199	1.148	1.583
66 Years	0.760	1.195	0.899	1.334
67 Years	0.760	1.195	0.899	1.334
68 Years	0.760	1.195	0.899	1.334
69 Years	0.760	1.195	0.899	1.334
70-74 Years	0.744	1.179	0.744	1.179
75-79 Years	0.681	1.116	0.681	1.116
80-84 Years	0.652	1.087	0.652	1.087
85-89 Years	0.570	1.005	0.570	1.005
90-94 Years	0.570	1.005	0.570	1.005
95 Years or Over	0.570	1.005	0.570	1.005
Male				
0-34 Years	0.323	0.758	-	-
35-44 Years	0.607	1.042	-	-
45-54 Years	0.870	1.304	-	-
55-59 Years	0.927	1.361	-	-
60-64 Years	1.017	1.452	-	-
65 Years	0.781	1.216	1.022	1.457
66 Years	0.765	1.200	0.765	1.200
67 Years	0.765	1.200	0.765	1.200
68 Years	0.765	1.200	0.765	1.200
69 Years	0.765	1.200	0.765	1.200
70-74 Years	0.727	1.162	0.727	1.162
75-79 Years	0.645	1.079	0.645	1.079
80-84 Years	0.544	0.979	0.544	0.979
85-89 Years	0.465	0.900	0.465	0.900
90-94 Years	0.465	0.900	0.465	0.900
95 Years or Over	0.465	0.900	0.465	0.900

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,086.61. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only.
3. Concurrently ESRD is defined as at least one month in 2008 of ESRD status—dialysis, transplant, or post-graft.

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 3. RxHCC Model Relative Factors for New Enrollees, Low Income

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

Variable	Baseline – Not Concurrently ESRD and Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	0.892	1.441	-	-
35-44 Years	1.241	1.790	-	-
45-54 Years	1.278	1.827	-	-
55-59 Years	1.165	1.713	-	-
60-64 Years	1.137	1.686	-	-
65 Years	0.868	1.417	1.061	1.610
66 Years	0.599	1.148	0.756	1.305
67 Years	0.599	1.148	0.756	1.305
68 Years	0.599	1.148	0.756	1.305
69 Years	0.599	1.148	0.756	1.305
70-74 Years	0.610	1.159	0.767	1.316
75-79 Years	0.665	1.214	0.823	1.372
80-84 Years	0.697	1.246	0.855	1.404
85-89 Years	0.696	1.245	0.854	1.402
90-94 Years	0.696	1.245	0.854	1.402
95 Years or Over	0.696	1.245	0.854	1.402
Male				
0-34 Years	0.836	1.385	-	-
35-44 Years	1.115	1.664	-	-
45-54 Years	1.075	1.623	-	-
55-59 Years	0.931	1.480	-	-
60-64 Years	0.882	1.431	-	-
65 Years	0.687	1.236	0.787	1.336
66 Years	0.445	0.994	0.549	1.098
67 Years	0.445	0.994	0.549	1.098
68 Years	0.445	0.994	0.549	1.098
69 Years	0.445	0.994	0.549	1.098
70-74 Years	0.457	1.006	0.561	1.110
75-79 Years	0.487	1.036	0.487	1.036
80-84 Years	0.480	1.029	0.480	1.029
85-89 Years	0.517	1.065	0.517	1.065
90-94 Years	0.517	1.065	0.517	1.065
95 Years or Over	0.517	1.065	0.517	1.065

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,086.61. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only.
3. Concurrently ESRD is defined as at least one month in 2008 of ESRD status—dialysis, transplant, or post-graft.

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 4. RxHCC Model Relative Factors for New Enrollees, Institutional

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

Variable	Baseline – Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	2.136	2.371
35-44 Years	2.136	2.371
45-54 Years	2.050	2.285
55-59 Years	2.013	2.248
60-64 Years	1.952	2.187
65 Years	2.024	2.259
66 Years	1.816	2.051
67 Years	1.816	2.051
68 Years	1.816	2.051
69 Years	1.816	2.051
70-74 Years	1.646	1.881
75-79 Years	1.578	1.813
80-84 Years	1.403	1.638
85-89 Years	1.235	1.470
90-94 Years	1.235	1.470
95 Years or Over	1.235	1.470
Male		
0-34 Years	2.159	2.394
35-44 Years	2.159	2.394
45-54 Years	2.098	2.333
55-59 Years	1.975	2.210
60-64 Years	1.826	2.061
65 Years	1.823	2.058
66 Years	1.715	1.950
67 Years	1.715	1.950
68 Years	1.715	1.950
69 Years	1.715	1.950
70-74 Years	1.603	1.838
75-79 Years	1.567	1.802
80-84 Years	1.533	1.768
85-89 Years	1.317	1.552
90-94 Years	1.317	1.552
95 Years or Over	1.317	1.552

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,086.61. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Concurrently ESRD is defined as at least one month in 2008 of ESRD status—dialysis, transplant, or post-graft.
3. The Part D New Enrollee Institutional sample does not have an Originally Disabled add-on (set to $0 because of regression results).

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 5. List of Disease Hierarchies for the Revised RxHCC Model

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

DISEASE HIERARCHIES

Rx Hierarchical Condition Category (RxHCC)	If the Disease Group is Listed in this column…	…Then drop the RxHCC(s) listed in this column
	Rx Hierarchical Condition Category (RxHCC) LABEL	
8	Chronic Myeloid Leukemia	9,10,11,48,50
9	Multiple Myeloma and Other Neoplastic Disorders	10,11,48,50
10	Breast, Lung, and Other Cancers and Tumors	11
14	Diabetes with Complications	15
18	Diabetes Insipidus and Other Endocrine and Metabolic Disorders	19
30	Chronic Pancreatitis	31
40	Psoriatic Arthropathy	41,42,147
41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	42
47	Sickle Cell Anemia	50
48	Myelodysplastic Syndromes, Except High-Grade	50
54	Alzheimer's Disease	55
58	Schizophrenia	59,60,61,62,63,65,66,67,68
59	Bipolar Disorders	60,61,62,63
60	Major Depression	61,62,63
61	Specified Anxiety, Personality, and Behavior Disorders	62,63
62	Depression	63
65	Autism	61,62,63,66,67,68
66	Profound or Severe Mental Retardation/Developmental Disability	67,68
67	Moderate Mental Retardation/Developmental Disability	68
78	Intractable Epilepsy	79,80
79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	80
86	Pulmonary Hypertension and Other Pulmonary Heart Disease	87,88
87	Congestive Heart Failure	88
103	Cystic Fibrosis	104,105
104	Chronic Obstructive Pulmonary Disease and Asthma	105
120	Kidney Transplant Status	121,122,123,124,125,126,168
121	Dialysis Status	122,123,124,125,126
122	Chronic Kidney Disease Stage 5	123,124,125,126
123	Chronic Kidney Disease Stage 4	124,125,126
124	Chronic Kidney Disease Stage 3	125,126
125	Chronic Kidney Disease Stage 1, 2, or Unspecified	126
166	Lung Transplant Status	167,168
167	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas	168

SOURCE: RTI International.

Table 6. Comparison of Current and Revised RxHCC Risk Adjustment Model RxHCCs

[Note: This table is identical to the table published in the February 19, 2010 Advance Notice.]

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
RXHCC1	HIV/AIDS	Infection	RXHCC1	HIV/AIDS
RXHCC2	Opportunistic Infections		RXHCC5	Opportunistic Infections
RXHCC3	Infectious Diseases			
RXHCC8	Acute Myeloid Leukemia	Neoplasm	RXHCC8	Chronic Myeloid Leukemia
RXHCC9	Metastatic Cancer, Acute Leukemia, and Severe Cancers		RXHCC9	Multiple Myeloma and Other Neoplastic Disorders
RXHCC10	Lung, Upper Digestive Tract, and Other Severe Cancers		RXHCC10	Breast, Lung, and Other Cancers and Tumors
			RXHCC11	Prostate and Other Cancers and Tumors
RXHCC17	Diabetes with Complications	Diabetes	RXHCC14	Diabetes with Complications
RXHCC18	Diabetes without Complication		RXHCC15	Diabetes without Complication
RXHCC19	Disorders of Lipoid Metabolism	Metabolic	RXHCC18	Diabetes Insipidus and Other Endocrine and Metabolic Disorders
RXHCC20	Other Significant Endocrine and Metabolic Disorders		RXHCC19	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders
RXHCC21	Other Specified Endocrine/Metabolic/Nutritional Disorders		RXHCC20	Thyroid Disorders
			RXHCC21	Morbid Obesity
			RXHCC23	Disorders of Lipoid Metabolism
RXHCC24	Chronic Viral Hepatitis	Liver	RXHCC25	Chronic Viral Hepatitis
RXHCC31	Chronic Pancreatic Disease	Gastrointestinal	RXHCC30	Chronic Pancreatitis
			RXHCC31	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis
RXHCC33	Inflammatory Bowel Disease		RXHCC32	Inflammatory Bowel Disease
RXHCC34	Peptic Ulcer and Gastrointestinal Hemorrhage		RXHCC33	Esophageal Reflux and Other Disorders of Esophagus
RXHCC37	Esophageal Disease			
RXHCC39	Bone/Joint/Muscle Infections/Necrosis	Musculoskeletal	RXHCC38	Aseptic Necrosis of Bone
RXHCC40	Behçet's Syndrome and Other Connective Tissue Disease		RXHCC40	Psoriatic Arthropathy
RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy		RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
RXHCC42	Inflammatory Spondylopathies		RXHCC42	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
RXHCC43	Polymyalgia Rheumatica		RXHCC45	Osteoporosis, Vertebral and Pathological Fractures
RXHCC44	Psoriatic Arthropathy			
RXHCC45	Disorders of the Vertebrae and Spinal Discs			
RXHCC47	Osteoporosis and Vertebral Fractures			
RXHCC48	Other Musculoskeletal and Connective Tissue Disorders			
RXHCC51	Severe Hematological Disorders	Blood	RXHCC47	Sickle Cell Anemia
RXHCC52	Disorders of Immunity		RXHCC48	Myelodysplastic Syndromes, Except High-Grade
RXHCC54	Polycythemia Vera		RXHCC49	Immune Disorders
RXHCC55	Coagulation Defects and Other Specified Blood Diseases		RXHCC50	Aplastic Anemia and Other Significant Blood Disorders
RXHCC57	Delirium and Encephalopathy	Cognitive	RXHCC54	Alzheimer's Disease
RXHCC59	Dementia with Depression or Behavioral Disturbance		RXHCC55	Dementia, Except Alzheimer's Disease
RXHCC60	Dementia/Cerebral Degeneration			
RXHCC65	Schizophrenia	Psychiatric	RXHCC58	Schizophrenia
RXHCC66	Other Major Psychiatric Disorders		RXHCC59	Bipolar Disorders
RXHCC67	Other Psychiatric Symptoms/Syndromes		RXHCC60	Major Depression
RXHCC75	Attention Deficit Disorder		RXHCC61	Specified Anxiety, Personality, and Behavior Disorders
			RXHCC62	Depression
			RXHCC63	Anxiety Disorders

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
		Developmental Disability	RXHCC65	Autism
			RXHCC66	Profound or Severe Mental Retardation/Developmental Disability
			RXHCC67	Moderate Mental Retardation/Developmental Disability
			RXHCC68	Mild or Unspecified Mental Retardation/Developmental Disability
RXHCC76	Motor Neuron Disease and Spinal Muscular Atrophy	Neurological	RXHCC71	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
RXHCC77	Quadriplegia, Other Extensive Paralysis, and Spinal Cord Injuries		RXHCC72	Spinal Cord Disorders
RXHCC78	Muscular Dystrophy		RXHCC74	Polyneuropathy
RXHCC79	Polyneuropathy, except Diabetic		RXHCC75	Multiple Sclerosis
RXHCC80	Multiple Sclerosis		RXHCC76	Parkinson`s Disease
RXHCC81	Parkinson's Disease		RXHCC78	Intractable Epilepsy
RXHCC82	Huntington's Disease		RXHCC79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy
RXHCC83	Seizure Disorders and Convulsions		RXHCC80	Convulsions
RXHCC85	Migraine Headaches		RXHCC81	Migraine Headaches
RXHCC86	Mononeuropathy, Other Abnormal Movement Disorders		RXHCC83	Trigeminal and Postherpetic Neuralgia
RXHCC87	Other Neurological Conditions/Injuries			
RXHCC91	Congestive Heart Failure	Heart	RXHCC86	Pulmonary Hypertension and Other Pulmonary Heart Disease
RXHCC92	Acute Myocardial Infarction and Unstable Angina		RXHCC87	Congestive Heart Failure
RXHCC98	Hypertensive Heart Disease or Hypertension		RXHCC88	Hypertension
RXHCC99	Specified Heart Arrhythmias		RXHCC89	Coronary Artery Disease
			RXHCC93	Atrial Arrhythmias

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
RXHCC102	Cerebral Hemorrhage and Effects of Stroke	Cerebrovascular Disease	RXHCC97	Cerebrovascular Disease, Except Hemorrhage or Aneurysm
			RXHCC98	Spastic Hemiplegia
RXHCC105	Pulmonary Embolism and Deep Vein Thrombosis	Vascular	RXHCC100	Venous Thromboembolism
RXHCC106	Vascular Disease		RXHCC101	Peripheral Vascular Disease
RXHCC108	Cystic Fibrosis	Lung	RXHCC103	Cystic Fibrosis
RXHCC109	Asthma and COPD		RXHCC104	Chronic Obstructive Pulmonary Disease and Asthma
RXHCC110	Fibrosis of Lung and Other Chronic Lung Disorders		RXHCC105	Pulmonary Fibrosis and Other Chronic Lung Disorders
RXHCC111	Aspiration and Specified Bacterial Pneumonias		RXHCC106	Gram-Negative/Staphylococcus Pneumonia and Other Lung Infections
RXHCC112	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections			
RXHCC113	Acute Bronchitis and Congenital Lung/Respiratory Anomaly			
RXHCC120	Vitreous/Retinal Hemorrhage and Vascular Retinopathy except Diabetic	Eye	RXHCC111	Diabetic Retinopathy
RXHCC121	Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies		RXHCC113	Open-Angle Glaucoma
RXHCC122	Open-angle Glaucoma			
RXHCC123	Glaucoma and Keratoconus			
RXHCC126	Larynx/Vocal Cord Diseases	Ear, Nose, Throat		
RXHCC129	Other Diseases of Upper Respiratory System			
RXHCC130	Salivary Gland Diseases			
RXHCC132	Kidney Transplant Status	Kidney	RXHCC120	Kidney Transplant Status
RXHCC134	Chronic Renal Failure		RXHCC121	Dialysis Status
			RXHCC122	Chronic Kidney Disease Stage 5
			RXHCC123	Chronic Kidney Disease Stage 4
			RXHCC124	Chronic Kidney Disease Stage 3
			RXHCC125	Chronic Kidney Disease Stage 1, 2, or Unspecified
RXHCC135	Nephritis		RXHCC126	Nephritis

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
RXHCC137	Urinary Obstruction and Retention	Urinary, Genital		
RXHCC138	Fecal Incontinence			
RXHCC139	Incontinence			
RXHCC140	Impaired Renal Function and Other Urinary Disorders			
RXHCC144	Vaginal and Cervical Diseases			
RXHCC145	Female Stress Incontinence			
RXHCC157	Chronic Ulcer of Skin, Except Decubitus	Skin	RXHCC142	Chronic Ulcer of Skin, Except Pressure
RXHCC158	Psoriasis		RXHCC145	Pemphigus
RXHCC159	Cellulitis and Local Skin Infection		RXHCC147	Psoriasis, Except with Arthropathy
RXHCC160	Bullous Dermatoses and Other Specified Erythematous Conditions			
RXHCC165	Vertebral Fractures without Spinal Cord Injury	Injury		*(See Note 2.)*
RXHCC166	Pelvic Fracture			
		Sleep	RXHCC156	Narcolepsy and Cataplexy
RXHCC186	Major Organ Transplant Status	Transplant	RXHCC166	Lung Transplant Status
RXHCC187	Other Organ Transplant/Replacement		RXHCC167	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas
			RXHCC168	Pancreas Transplant Status
		Disabled-Disease Interactions		
DRXHCC65	Age < 65 and RXHCC65 (Schizophrenia)			
DRXHCC66	Age < 65 and RXHCC66 (Other Major Psychiatric Disorders)			
DRXHCC108	Age < 65 and RXHCC108 (Cystic Fibrosis)			
		Interactions That Are in the V03 Institutional RxHCC Model *Only*		
			NonAged_RXHCC1	NonAged * HIV/AIDS
			NonAged_RXHCC58	NonAged * Schizophrenia
			NonAged_RXHCC59	NonAged * Bipolar Disorders
			NonAged_RXHCC60	NonAged * Major Depression
			NonAged_RXHCC61	NonAged * Specified Anxiety, Personality, and Behavior Disorders

Version 01 RxHCCs			Version 03 RxHCCs	
RxHCC	**Description**	**Category Short Name**	**RxHCC**	**Description**
			NonAged_RXHCC62	NonAged * Depression
			NonAged_RXHCC63	NonAged * Anxiety Disorders
			NonAged_RXHCC65	NonAged * Autism
			NonAged_RXHCC75	NonAged * Multiple Sclerosis
			NonAged_RXHCC78	NonAged * Intractable Epilepsy
			NonAged_RXHCC79	NonAged * Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy
			NonAged_RXHCC80	NonAged * Convulsions

NOTES:
1. NonAged is defined as age < 65 as of February 1 of the payment year.

SOURCE: RTI International.

Table 7. CMS-HCC Model for New Enrollees in Chronic Condition Special Needs Plans (C-SNPs)

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.811	1.126	—	—
35-44 Years	1.001	1.316	—	—
45-54 Years	1.180	1.495	—	—
55-59 Years	1.326	1.641	—	—
60-64 Years	1.389	1.704	—	—
65 Years	0.768	1.238	1.369	1.839
66 Years	0.803	1.273	1.404	1.874
67 Years	0.830	1.300	1.431	1.901
68 Years	0.873	1.343	1.474	1.944
69 Years	0.902	1.372	1.503	1.973
70-74 Years	1.020	1.457	1.632	2.069
75-79 Years	1.255	1.629	1.754	2.128
80-84 Years	1.393	1.767	1.892	2.266
85-89 Years	1.502	1.876	2.001	2.375
90-94 Years	1.639	2.013	2.138	2.512
95 Years or Over	1.593	1.967	2.092	2.466
Male				
0-34 Years	0.728	1.071	—	—
35-44 Years	1.008	1.351	—	—
45-54 Years	1.148	1.491	—	—
55-59 Years	1.308	1.651	—	—
60-64 Years	1.415	1.758	—	—
65 Years	0.856	1.330	1.392	1.866
66 Years	0.875	1.349	1.486	1.960
67 Years	0.978	1.452	1.589	2.063
68 Years	0.981	1.455	1.592	2.066
69 Years	0.998	1.472	1.609	2.083
70-74 Years	1.186	1.597	1.684	2.095
75-79 Years	1.422	1.859	1.782	2.219
80-84 Years	1.581	2.018	1.941	2.378
85-89 Years	1.776	2.213	2.136	2.573
90-94 Years	1.890	2.327	2.250	2.687
95 Years or Over	1.996	2.433	2.356	2.793

Notes:

1. For payment purposes, a new enrollee is a beneficiary who did not have 12 month of Part B eligibility in the data collection year. CMS-HCC new enrollee models are not based on diagnoses, but include factors for different age and gender combinations by Medicaid and the original reason for Medicare entitlement.
2. The relative factors in this table were calculated by estimating the incremental amount to the standard new enrollee risk model needed to predict the risk scores of continuing enrollees in C-SNPs.

SOURCE: RTI International analysis of 2008 C-SNP risk scores.

Attachment IV: 2011 Call Letter

How to Use This Call Letter

The 2011 Call Letter contains information on the Part C, cost-based (Quality and Performance Measures section only), and Part D programs. Also, we indicate when certain sections apply to cost-reimbursed HMOs, PACE programs, and employer and union-sponsored group health plans (EGWPs).

This year's letter is structured differently from prior year call letters. Section 1 provides new policy for MA plans, MA-PD plans, PDPs and cost-reimbursed HMOs. Section 2 provides updated information for Parts C and D organizations/sponsors, including the updated calendar for CY 2011.

Over the past year, CMS has committed its resources to improving the quality of plan choices for beneficiaries who elect to enroll in Medicare Advantage and prescription drug plans. As part of this effort, CMS:

- Published a proposed regulation (4085-P) on October 22, 2009 that would make revisions to the Parts C and D regulations to ensure meaningful differences among plan offerings, strengthen beneficiary protections, and improve data for CMS oversight and quality assessment.
- Released new or revised Medicare manual chapters.
- Non-renewed a number of plans for CY 2010 because they had little or no enrollment, thus reducing beneficiaries' confusion when choosing to enroll in a Medicare Advantage or prescription drug plan.
- Conducted listening sessions for industry and advocacy groups before the end of CY 2009, to give them the opportunity to communicate their concerns to CMS regarding any procedural or operational issues they would like CMS to address in the 45-day notice and call letter for CY 2011.

Since we anticipate that this year's final Call Letter will be released the same day as the issuance of the final rule (4085-F), the content is limited to clarification of current policy and operational guidance. We remind sponsoring organizations to continue to remain responsible for familiarizing themselves with new statutory requirements, regulations, and guidance governing the MA and Part D programs, including the Medicare Advantage and Prescription Drug Benefit Manuals. CMS will separately issue technical and procedural clarifications regarding bid and formulary submissions, benefits, HPMS data, CMS marketing models, and other operational issues of interest to sponsoring organizations.

We hope this information helps you implement and comply with CMS policies and procedures as you prepare either to offer a plan for the first time or continue offering plans under the MA and/or Part D programs.

If you have questions concerning this Call Letter, please contact:
Christopher McClintick at Christopher.McClintick@cms.hhs.gov for Part C Call Letter items
Christine Hinds at Christine.Hinds@cms.hhs.gov for Part D Call Letter items

Table of Contents

Section 1 - New Policy

Part C

I. Special Needs Plans (SNP)

State Resource Center

Section 164 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) directed CMS to provide technical assistance to States to promote Medicare-Medicaid benefit integration for dual eligible populations. The Resource Center was CMS' response to equip States with helpful information as they engage in contract negotiations with MAOs seeking to offer new or expanded dual eligible special needs plans (SNP).

The goal of the State Resource Center is to support State Medicaid agencies' efforts to increase coordination with MAOs offering specialized plans for dually eligible individuals (dual eligible SNPs). Additionally, the State Resource Center provides a forum for States to make inquires and share knowledge about the coordination of State and Federal policies pertaining to SNPs. To these ends, since its establishment the resource center has—

- Developed best practices with respect to model contracts with States
- Led training sessions
- Established a website to provide information on coordination issues (http://www.cms.gov/SpecialNeedsPlans/05_StateResourceCenter.asp)

II. Quality and Performance Measures

CAHPS and HOS Reporting for Special Needs Plans

For plan year 2011, the Consumer Assessment of Health Plans Survey (CAHPS) and the Medicare Health Outcomes Survey (HOS) will continue to sample, collect, and report data at the contract level. However, oversampling of SNP plan benefit packages will occur within each eligible contract to allow for a more focused analysis of SNP results. CMS will release information about the expected increase in sample size for applicable organizations in future guidance.

CMS is currently analyzing limited aggregate SNP data available from prior HOS and CAHPS data sets and will publicly share findings in a report that will be released later in 2010.

Note: Continuing 1876 cost contracts should continue to report the same quality and performance measures as they have in the past.

HOS Survey Administration

The current year Healthcare Effectiveness Data Information Set (HEDIS) reporting category that reports the HOS results applies to the following managed care organization types with a minimum of 500 members that had a Medicare contract in effect on or before January 1, 2010: (1) all coordinated care contractors, including health maintenance organizations (HMOs), local preferred provider organizations (PPOs) and regional PPOs; (2) private fee-for-service (PFFS) contracts; (3) medical savings account (MSA) contracts; and (4) continuing 1876 cost contracts with open enrollment. Organizations eligible to report also include MA contracts with exclusively special needs plan benefit packages, regardless of institutional, chronically ill, or dual-eligible enrollment.

All Programs of All Inclusive Care for the Elderly (PACE) with contracts in effect on or before January 1, 2010 should administer the HOS-Modified (HOS-M) survey for current year reporting. A minimum enrollment threshold does not apply to the HOS-M. Note that, effective 2010, the Minnesota Senior Health Options, Minnesota Disability Health Options, Wisconsin Partnership Programs, and Massachusetts MassHealth Senior Care Options MA contracts are required to report HOS and no longer participate in HOS-M.

Part D

I. Part D Benefits

Potential New B versus D Coverage Determination for beneficiaries with End Stage Renal Disease

CMS published a notice of proposed rulemaking (NPRM) in the Federal Register on September 29, 2009 that would implement a case-mix adjusted bundled prospective payment system (PPS) for Medicare outpatient end-stage renal disease (ESRD) dialysis facilities beginning January 1, 2011, in compliance with the statutory requirement of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. (74 FR 49922) The proposed ESRD PPS would replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD services. In accordance with MIPPA, the rule proposes to include erythropoiesis stimulating agents, and other drugs and biologicals and their oral equivalents, furnished to individuals for the treatment of ESRD in the new bundled payment as “renal dialysis services”. Any such drugs or biologicals that would be defined as “renal dialysis services” under the new ESRD PPS would not be eligible for coverage under Part D when furnished to individuals for the treatment of ESRD. Rather, these drugs or biologicals and all other renal dialysis services would be covered under the Medicare Part B benefit. CMS will explore the possibility of providing an indicator on transaction reply reports to identify ESRD beneficiaries in the dialysis stage that could assist Part D sponsors with making associated

Medicare Part B vs. Part D determinations. CMS plans to publish the ESRD PPS final rule in 2010.

Encouragement of Sponsor Practices to Curb Waste of Unused Drugs Dispensed in the Retail Setting

As part of CMS's effort to contain health care costs and reduce waste associated with the Medicare prescription drug benefit, we requested in the draft call letter comments from beneficiary advocate groups and the industry regarding a trial supply program. Specifically, CMS encouraged that Part D sponsors consider allowing beneficiaries in the community (versus institutional) setting the option to request a trial supply of no more than 7 to 14 days of a Part D covered medication when first prescribed. As explained in the draft call letter, Part D sponsors would be expected to prorate cost-share amounts associated with that prescription. We received many comments regarding our request for plan sponsors to consider providing trial supplies of drugs for reduced (prorated) copayments.

While no requirements have been proposed, we want to emphasize that any trial program contemplated by CMS would be strictly voluntary for the beneficiary and, therefore, should not result in additional burden being placed on beneficiaries. In our view, neither the Part D plan sponsors nor the Federal government would determine whether a beneficiary should receive a trial size of a new medication. As envisioned, use of the trial program would be driven exclusively by the beneficiary and his/her prescriber. In practice, the program would begin at the prescriber's office, when the beneficiary received an initial prescription for a new medication and requested a trial supply. If the prescriber thought this appropriate and agreed, the prescriber might write either one prescription for a trial period, or two prescriptions (e.g. one for the initial trial supply and a second prescription for the remainder of a 30 day (or greater) fill which would be filled if the beneficiary and the clinician agreed the therapy should be continued.). Since the prescriber would determine whether the medication being prescribed could be dispensed in a trial or is a medication that should not, or could not be prescribed in trial doses (e.g. antibiotic or prescription ointment), no harm would be expected to come to the beneficiary. Furthermore, since the prescriptions could be written during one office visit, additional visits to the prescriber would not necessarily be required and should not be a burden to the beneficiary. If a beneficiary would have difficulty returning to the pharmacy, presumably he or she would not elect to make use of this option.

We received a number of comments asserting that savings realized by this program would be offset by additional dispensing fees, administrative (programming) costs, or costs of a fill that would otherwise be made available via a free prescription sample. We believe further outreach and discussion with prescribers, pharmacists, and Part D sponsors are warranted to explore these assertions. We would certainly expect plans and pharmacies to negotiate dispensing fees to appropriately reimburse for multiple dispensing events associated with trial fills. However, we also believe that the additional costs of both a trial supply and follow-up supply of some

medications might well be offset by savings associated with reduced dispensing of other medications that become discontinued due to adverse reactions or other reasons. And while it is true that samples received at the prescriber's office are generally available at no cost to the beneficiary or the plan, we believe the use of samples sometimes results in additional costs to the program in the long run and may even increase the risk of adverse medication events as long as plan sponsor drug utilization review (DUR) systems do not reflect the drug therapies initiated through sample use.

We also received a number of positive comments supporting our efforts to curb drug waste. For instance, one commenter indicated that patients should not be asked to shoulder the expense of a 30 or 90 day prescription when it is not clear that the therapy will be an effective course of treatment. However, many commenters qualified their support by indicating their wish to observe the trial program in practice, and suggested technical issues that may develop while implementing the trial program. We understand that the implementation of a voluntary trial program would result in plan programming changes and require clarification of other Part D benefit rules. We were informed that the current "partial fill" standard may not accommodate a voluntary trial fill; therefore, CMS will work with NCPDP to explore whether any changes to adjudication standards are needed to accommodate such transactions. In the meantime, certain practices such as the initial issuances of two prescriptions, mentioned above, might be accommodated without need for changes to the standard. CMS will also contemplate the need for additional guidance around how a trial fill would impact Part D benefit rules, specifically application of the Part D low-income subsidy cost share at the pharmacy and our current transition policy.

CMS would also like to further explore the additional studies, plan programs and drug waste disposal programs cited in the call letter comments. Of particular interest is further discussion with the industry regarding the SMARxT program. While environmental considerations warrant additional thought, we do not agree with one commenter's concerns that the benefits of a trial program may be offset by other additional waste (more plastic bottles and paper inserts, additional trips to pharmacies). We believe the harmful effects on the environment from unused drugs (biological implications) have a much greater impact on the environment than the recyclable surplus noted by the commenter. Furthermore, analysis of the environmental impact of additional trips to the pharmacy would likely find that many beneficiaries time their pharmacy visits during other scheduled outings. Therefore, we suspect the environmental impact of additional pharmacy visits on the environment would be negligible.

We appreciate the extensive comments submitted in response to our request, and we have been persuaded that extensive discussions with prescribers, pharmacies and Part D sponsors are warranted before we would contemplate any requirements in this area. We continue to believe that trial fills of new drug therapies for chronic diseases might be a welcome addition to the Part D program, particularly when the drugs involved have significant probabilities of being discontinued due to side effects or other outcomes as determined between the beneficiary and

his/her prescriber. We commit to exploring this idea further in the coming months. In the meantime, we continue to encourage our Part D sponsors to consider the implications of implementing such a program, as well as any other waste reduction strategies, with their network pharmacy contacts and with CMS.

II. Reassignment

In the draft call letter, we requested comments on two policy issues related to the annual reassignment of certain low-income subsidy (LIS) beneficiaries in stand-alone prescription drug plans (PDPs). Currently, reassignment is limited to LIS beneficiaries who remain in the PDPs to which they were initially assigned by CMS, or in PDPs to which they were subsequently reassigned. All reassignments are done on a random basis to PDPs in a region with premiums below the LIS benchmark in the following year.

First, we requested comments on whether CMS should reassign LIS beneficiaries who chose their PDP on their own if their premium liability would be $10.00 or more the following year ("choosers"). Slightly more than half of commenters supported the proposal to reassign some choosers in principle, although, there was no consensus on the $10.00 threshold. Many of the supporters suggested additional criteria to identify choosers for reassignment, such as whether the plan had a premium over the LIS benchmark when the individual originally selected it, whether one's payment ability or enrollment in a State Pharmaceutical Assistance Program (SPAP). Those who opposed reassigning choosers cited concerns about the need to respect beneficiary choice, the possibility of creating disruptions of drug regimens, and CMS' inability to discern which choosers wanted to stay in their current plan. They also noted that the policy would work against CMS' longstanding goal of minimizing the number of reassignments. There was consensus among both supporters and opponents that additional outreach and education would be helpful.

Given the mixed response to this proposal, the lack of any evidence that this population is failing to pay its premiums, and concerns over the possibility of unintended negative consequences for affected enrollees, we have decided not to expand our reassignment process for 2011 to include this population. However, will continue to explore the merits of this approach for future years and other ways to help beneficiaries enroll in the plans that best meet their needs. We agree that additional education and outreach are warranted, and are considering several methods to make beneficiaries more aware of their options.

CMS also solicited comments on whether reassignments should be based on beneficiary drug utilization (often called "strategic" or "beneficiary-centered" reassignment) rather than our current random methodology among benchmark PDPs. The majority of commenters supported modifying reassignment in this way; however, some commenters expressed concern about whether such reassignments could be conducted effectively. CMS will continue to evaluate the merits of this approach, but we will not pursue implementation for the 2011 contract year. We believe additional analysis is warranted and are committed to continuing to examine the costs

and benefits of strategic assignment both for individual beneficiaries and for the Part D program as a whole.

Section 2 - Updates to Parts C and D Policy/Calendar

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
March 5, 2010	Initial Submission deadline for risk adjustment data with dates of service January 1, 2009 through December 31, 2009.	✓		✓
March 29, 2010	Release Health Plan Management System (HPMS) formulary submissions module.	✓	✓	
Early April 2010	Release guidance regarding potentially duplicative and /or low enrollment plans for 2011 bid submission.	✓	✓	
TBD	Conference call with industry to discuss the 2011 Call Letter.	✓	✓	✓
Early April 2010	Information about renewal options for contract year 2011 (including HPMS crosswalk charts) will be provided to plans.	✓	✓	
Early April 2010	Release guidance regarding benefits review standards for 2011 bid submissions.	✓	✓	
April 5, 2010	2011 Final Call Letter released. Announce CY 2011 MA Capitation Rates and MA and Part D Payment Policies. *(applies to Part C and Part D Sponsors only)*	✓	✓	✓
April 9, 2010	2011 Plan Creation Module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS.	✓	✓	
April 19, 2010	2011 Formulary Submissions due from all sponsors offering Part D (11:59 p.m. EDT). Transition Attestations due to CMS *(Part D sponsors only)*	✓	✓	
April 20-21	Medicare Advantage and Part D Spring Conference	✓	✓	✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
May 2010	Final ANOC/EOC, LIS rider, EOB, formularies, transition notice, provider directory, and pharmacy directory models for 2011 will be available for all organizations. (Models containing significant revisions will be released for public comment prior to this date).	✓	✓	
May 3, 2010	Voluntary Non-Renewal. CMS strongly encourages MA and MA-PD plans to notify us of an intention to non-renew a county or counties for individuals, but continue the county for "800 series" EGWP members, by May 3, 2010.	✓		✓
May 3, 2010	*Voluntary non-renewal*: CMS strongly encourages Part D Sponsors to notify us of any type of service area reduction, or conversion to offering employer-only contracts by May 3, 2010, so that we can make the required changes in HPMS to facilitate sponsors' ability to correctly upload their bids in June.		✓	
May 14, 2010	CMS begins accepting CY 2011 bids via HPMS. *(applies to Part C and Part D Sponsors only)*	✓	✓	✓
May 21, 2010	PBP/BPT upload available		✓	
Mid-May/June 2010	CMS sends contract eligibility determinations to applicants based on review of the 2011 applications for new contracts or service area expansions.	✓	✓	✓
Late Spring/Early Summer 2010	Update of MA/PDP Enrollment, Eligibility, and Disenrollment guidance; update of the Medicare Marketing Guidelines for CY 2011.	✓	✓	✓
Tentative date - June 4, 2010	CMS begins accepting CY 2011 marketing material for review.	✓	✓	✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
June 7, 2010	Deadline for submission of CY 2011 bids for all MA plans, MA-PD plans, PDP, cost-based plans offering a Part D benefit, "800 series" EGWP and direct contract EGWP applicants and renewing organizations; deadline for cost-based plans wishing to appear in the 2010 Medicare Options Compare to submit PBPs (11:59 p.m. PDT). Voluntary Non-Renewal. Deadline for MA plans, MA-PD plans, PDPs and Medicare cost-based contractors and cost-based sponsors to submit a contract non-renewal, service area reduction notice to CMS for CY 2011. Deadline also applies to an MAO that intends to terminate a current MA and/or MA-PD plan benefit package (i.e., Plan 01, Plan 02) for CY 2011.	✓	✓	✓
June 14, 2010	CMS begins accepting Supplemental Formulary files, Free First Fill file, Partial Gap file, Excluded Drug file, Over the Counter (OTC) drug file, and Home Infusion file through HPMS. CMS begins accepting CY 2011 Actuarial Certifications in HPMS.	✓	✓	
June 14, 2010	Requests for SB administrative changes may begin.	✓	✓	✓
June 30, 2010	Final date to submit CY 2010 marketing materials for assured CMS' review and approval. NOTE: This date does not apply to CY 2010 file and use materials since these may be filed with the appropriate CMS regional office five calendar days prior to their use.	✓	✓	✓
Late June 2010	Non-Renewal. CMS to issue an acknowledgement letter to all MA, MA-PD and Medicare cost-based plans that have notified CMS they are non-renewing or reducing their service area.	✓		✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
Late June or early July, 2010	Industry training on revised Medicare Marketing Guidelines and Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) and other marketing models.	✓	✓	✓
Late June or early July, 2010	Submission deadline for agent/broker total compensation amounts due to CMS.	✓	✓	✓
August, 2010	Non-Renewal. CMS to release a special election period (SEP) letter to plans remaining in the service areas of plans that have non-renewed. Additionally, CMS to post the model final non-renewal notification letter, and State-specific final notification letter. Release of the 2011 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the Medicare Advantage regional PPO benchmarks. Rebate reallocation period begins after release of the above amounts.	✓	✓	✓
Early August, 2010	CMS encourages cost-based plans to submit their summary of benefits (SBs) by this date so that materials can be reviewed and approved prior to the publishing of "Medicare Options Compare" and the *Medicare & You* handbook. SBs must be submitted by this date to be assured of being included.			✓
Early August, 2010	Requested for SB changes to benefits information may begin.	✓		✓
August 2, 2010	Deadline for CMS to inform currently contracted organizations of CMS' decision not to authorize a renewal of a contract for 2011.	✓	✓	
August 3, 2010	Plans are expected to submit non-model Low Income Subsidy (LIS) riders to the regional office for review.		✓	

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
August 13, 2010	Dual eligible SNPs that are fully integrated with the State are expected to submit the Annual Notice of Change and Summary of Benefits to the regional office for review.	✓		
Late August, 2010	Non-Renewal: Final date for CMS to approve final beneficiary notification letter of non-renewal.	✓	✓	
Late August/Early September, 2010	CMS completes review and approval of 2011 bid data. Submit attestations, contracts, and final actuarial certifications.	✓	✓	
September 1, 2010	Submission date for contracting MAOs (new and expanding) to provide CMS with a ratified contract with the State in order to operate a Medicaid dual eligible SNP for CY 2011.	✓		
September 1, 2010	Plans are expected to submit model Low Income Subsidy (LIS) riders to the regional office for review.		✓	
September 3, 2010	Initial Submission deadline for risk adjustment data with dates of service from July 1, 2009 through June 30, 2010.	✓		✓
September, 2010	If applicable, plans preview the 2011 *Medicare & You* plan data in HPMS prior to printing of the CMS publication (not applicable to EGWPs). CMS begins accepting plan correction requests upon contract approval.	✓	✓	✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
October 1, 2010	Plans may begin CY 2011 marketing activities. Once an organization begins marketing CY 2011 plans, the organization must cease marketing CY 2010 plans through mass media or direct mail marketing (except for age-in mailings). Organizations may still provide CY 2010 materials upon request, conduct one-on-one sales appointments and process enrollment applications. Plans are required to include information in CY 2010 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2011. Last day for Part D sponsors to request plan benefit package (PBP) plan corrections via HPMS.	✓	✓	✓
October 1, 2010	Deadline for cost-based, MA, and MA-PD organizations to request a plan correction to the plan benefit package (PBP). Deadline for cost-based, MA and MA-PD organizations to request of a SB hard copy change. Dual eligible SNPs that are fully integrated with the State and plan to use a non-standardized, non-combined EOC are expected to submit these for regional office review.	✓		✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
October 2, 2010	Non-Renewal. The final beneficiary non-renewal notification letter must be a personalized letter and received by PDPs, MA plan , MA-PD plans, and cost-based plan enrollees by October 2, 2010. PDPs, MA plans, MA-PD plans, and Medicare cost-based organizations may not market to beneficiaries of non-renewing plans until after October 2, 2010.	✓	✓	✓
October 8, 2010	Tentative date for 2011 plan benefit data to be displayed on Medicare Options Compare and for 2011 plan drug benefit information to be displayed on the Medicare Prescription Drug Plan Finder on Medicare.gov (not applicable to EGWPs).	✓	✓	✓
Mid-October, 2010	Non-Renewal. CMS to issue an acknowledgement letter to all Medicare cost-based plans that are non-renewing or reducing their service areas.			✓
October 15-29, 2010	CMS mails the 2011 *Medicare & You* handbook to Medicare beneficiaries.	✓	✓	✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
October 31, 2010	CY 2011 standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) is due to current members of all MA plans, MA-PD plans, PDPs, and cost-based plans offering Part D. MA and MA-PD plans must ensure current members receive the combined ANOC/EOC by October 31. Organizations are not required to mail the Summary of Benefits (SB) to existing members when using the combined, standardized ANOC/EOC; however the SB must be available upon request. Exception: Dual eligible SNPs that are fully integrated with the State are not required to use the standardized, combined ANOC/EOC. Dual eligible SNPs that are fully integrated with the State must mail an Annual Notice of Change and Summary of Benefits before this date to ensure receipt by members by October 31. All plans offering Part D must mail their LIS riders and abridged or comprehensive formularies before this date to ensure receipt by members by October 31.	✓	✓	

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
November 15, 2010	2011 Annual Coordinated Election Period begins. All organizations must hold open enrollment (for EGWPs, see Chapter 2 of the Medicare Managed Care Manual, Section 30.4.4). Medicare Marketing Guidelines require that all plans mail a CY 2010 EOC to each new member no later than when they notify the new member of acceptance of enrollment. Organizations offering Part D must mail their Low Income Subsidy Rider (LIS) and abridged or comprehensive formularies with the EOC for new members. New members with an effective date of January 1, 2011 or later do not need to (but may) receive the ANOC portion of the standardized/combined ANOC/EOC.	✓	✓	✓
Mid November 2010	Notices of Intent (NOI) for CY 2012 due for MA plans, MA-PD plans, PDPs, "800 series" EGWPs and Direct Contract EGWPs.	✓	✓	✓
Mid November 2010	CMS issues pending HPMS contract numbers for CY 2012 to MA plans, MA-PD plans, cost plans, PDPs, and EGWP NOIs.	✓	✓	✓
November – December, 2010	Non-Renewal. CMS to issue "close out" information and instructions to MA plans, MA-PD plans, PDPs, and cost-based plans that are non-renewing or reducing service areas.	✓	✓	✓
December 1, 2010	Medicare cost-based plans not offering Part D must send the combined ANOC/EOC for receipt by members by December 1, 2010.			✓
December 1, 2010	Non-Renewal. Cost-based plans must publish notice of non-renewal.			✓
December 31, 2010	2011 Annual Coordinated Election Period ends.	✓	✓	

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
December 31, 2010	Dual eligible SNPs that are fully integrated with the State must mail an Evidence of Coverage, LIS riders and abridged or comprehensive formularies before this date to ensure receipt by members by December 31. SNPs that were disproportionate percentage SNPs in 2009 must disenroll all non-special needs members who were enrolled prior to January 1, 2010. Chronic care SNPs must disenroll all members of chronic care SNPs who no longer qualify for the special needs requirement after the redesignation of chronic conditions for 2010 and were enrolled prior to 1/1/2010.	✓		
2011				
January 1, 2011	Plan Benefit Period Begins.	✓	✓	✓
January 1 – February 15, 2011	MA Annual 45 Day Disenrollment Period (ADP).	✓		
Early January, 2011	Automated CY 2012 applications released.	✓	✓	✓
Early January, 2011	Industry training on CY 2012 applications.	✓	✓	✓
January 31, 2011	Final Submission deadline for risk adjustment data with dates of service January 1, 2009 through December 31, 2009	✓		✓
Late February, 2011	Applications due for CY 2012.	✓	✓	✓
March 4, 2011	Initial Submission deadline for risk adjustment data with dates of service January 1, 2010 through December 31, 2010	✓		✓

2011 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**				
2010 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D Sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D Sponsors**	**Cost**
September 2, 2011	Initial Submission deadline for risk adjustment data with dates of service from July 1, 2010 through June 30, 2011	✓		✓

I. Recommended Deadlines for Cost-Based Plan Non-Renewals

Beginning with the application cycle for 2011 contracts, CMS is strongly encouraging all cost-based plans to follow the schedule established for MA, MA-PD for both submitting service area expansion applications as well as requesting non-renewal/service area reductions. Use of concurrent time frames will allow for a more efficient allocation of CMS resources and consistency across managed care programs.

II. Coordination of Benefits (COB) User Fees

CMS is authorized to impose user fees on Part D sponsors for the transmittal of information necessary for benefit coordination between sponsors and other entities providing prescription drug coverage. CMS may review and update this user fee annually to reflect the costs associated with COB activities. For contract year 2010, the Part D COB user fee was decreased to $1.89 per enrollee per year. While we continue to work on the de-linking of the enrollment and payment modules in MARx as well as other projects to improve the quality reliability and timeliness of the COB-related data, a review of the incremental on-going costs of COB activities in 2011 indicates the Part D COB user fee can be decreased further to $1.17 per enrollee per year for contract year 2011. This COB user fee will be collected at a monthly rate of $0.13 for the first 9 months of the coverage year (for an annual rate of $0.10 per enrollee per month) for a total user fee of $1.17 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2011 bids.

III. Specialty Tier Threshold

For contract year 2011, we will maintain the $600 threshold for drugs on the specialty tier. Thus, only Part D drugs with negotiated prices that exceed $600 per month may be placed in the specialty tier, and the specialty tiers will be evaluated and approved in accordance with section 30.2.4 of Chapter 6 of the Medicare Prescription Drug Benefit Manual. In addition to cost calculations, CMS considers claims history in reviewing the placement of drugs on Part D sponsors' specialty tiers. Except for newly approved drugs for which Part D sponsors would have little or no claims data, CMS will approve specialty tiers that only include drugs on specialty tiers when their claims data demonstrates that the majority of fills exceed the specialty tier cost criteria. Part D sponsors should be prepared to provide CMS the applicable claims data during the formulary review process.

IV. Medicare Enrollment Assistance Demonstration

In late 2009, CMS announced that it was considering the implementation of a Medicare Enrollment Assistance Demonstration Project. Under the proposed demonstration, CMS envisioned hiring a contractor to reach out to a targeted group of Medicare beneficiaries with comprehensive information and assistance services to help them in understanding and choosing

among their Medicare coverage options. CMS sought stakeholder input on the development of the project and received input from a diverse group of stakeholders during an Open Door Forum and written comment period.

Stakeholders were generally supportive of enhancing the information available to inform coverage decision-making and exploring efforts to develop more effective outreach to specific beneficiary populations. However, stakeholders did not offer strong support of the Medicare Enrollment Assistance Demonstration Project as a method for developing and testing those strategies. Therefore, CMS is reevaluating its intended approach to the enrollment demonstration project based on the comments we received, and we do not anticipate implementing the project for plan year 2011.

V. Risk Adjustment Data Validation (RADV)

This is to remind contracting MA organizations of their obligations under 42 CFR 422.504(e)(2). MAOs are required to provide CMS access to facilities and records used in the determination of amounts payable under an MA contract. This obligates MAOs to provide CMS access to facilities and records (including medical records) that are to be used for risk-adjustment data validation (RADV) purposes, since such records are used for the determination of amounts payable under the MA contract. We would also like to stress the importance of including specific language in contracts with providers that reminds them of their obligation to cooperate in the provision of such records, in accordance with 42 CFR 422.310(e).

VI. Release of Part C and Part D Payment Data

In the draft Call Letter, we announced that CMS is considering the public release of Part C and Part D payment data after risk adjustment and Part D payment reconciliation has been complete. We solicited comment on whether the release of such data would negatively affect the competitive nature of the bidding process.

In their comments, numerous plans objected to the proposed release of payment data on the grounds that the data are confidential and commercially sensitive and, therefore, protected from public disclosure under FOIA. Commenters stated that CMS's release of the information may violate the Trade Secrets Act in the absence of specific regulatory authority authorizing release. In the near future, we intend to publish a proposed regulation which would propose to authorize the release of Part C and D data.