April 4, 2005

NOTE TO: Medicare Advantage Organizations and Other Interested Parties

SUBJECT: Announcement of Calendar Year (CY) 2006 Medicare Advantage Payment Rates

In accordance with section 1853(b)(1) of the Social Security Act (the Act), we are notifying you of the annual Medicare Advantage capitation rate for each Medicare Advantage payment area for 2006, and the risk and other factors to be used in adjusting such rates. Attached is a spreadsheet containing the capitation rate tables for CY 2006, which includes the rescaling factors that will be used with the risk-adjusted portion of payment in 2006. Also included is a spreadsheet which shows the statutory component of the regional benchmarks. The rates are posted on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/healthplans/rates/default.asp.

Enclosure I shows the final estimates of the increase in the National Per Capita Medicare Advantage Growth Percentage for 2006. As discussed in Enclosure I, the final estimate of the increase in the National Per Capita Medicare Advantage Growth Percentage for aged beneficiaries is 4.8 percent. Since these estimates are all larger than 2 percent, these growth rates will be used as the minimum update percentage in calculating the 2006 rates. The CMS has decided not to rebase the county fee-for-service (FFS) rates for 2006. Therefore, all 2006 demographic capitation rates will be the 2005 rate increased by 4.8 percent.

Enclosure II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the National Per Capita Medicare Advantage Growth Percentage.

Section 1853(b)(4) of the Act (added by Section 514 of the BBRA) requires CMS to release county-specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. FFS data for CY 2003 is being posted on the Internet at this time as well.

We received 103 comments from 19 organizations in response to CMS' request for comments on the Advance Notice of Methodological Changes for CY 2006 Medicare Advantage (MA) Payment Rates (Advance Notice), published on February 18, 2005. Enclosure III presents our responses to the issues raised in the comments related to Attachment I of the Advance Notice, entitled Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year (CY) 2006, and Attachment II, which was entitled Changes in the Payment Methodology for Original Medicare Benefits for CY 2006. Enclosure IV contains comments and responses to issues raised regarding Attachment III of the Advance Notice, entitled Overview of Payment for Medicare

Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). Enclosure V contains the Part D CMS-HCC model risk factors for MA-PDs and PDPs.

Questions can be directed to:
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Enclosures

Enclosure I
Final Estimate of the Increase in the National Per Capita Growth Percentages for 2006

The first table below shows the National Per Capita Medicare Advantage Growth Percentages (NPCMAGP) used to determine the minimum update percentage for 2006. Adjustments of -0.3 percent, -0.2 percent, 0.8 percent and -0.2 percent for aged, disabled, ESRD, and combined aged and disabled, respectively, are included in the NPCMAGP to account for corrections to prior years estimates as required by section 1853(c)(6)(C). The combined aged and disabled increase is used in the development of the risk-adjusted ratebook.

The second table below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2005 and 2006. In addition, for 2006, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2006. These data were furnished by the Office of the Actuary.

Increase in the National Per Capita MA Growth Percentages for 2006

	Prior Increases	Current Increases			NPCMAGP for 2006 With Sec.1853(c)(6)(C) adjustment[1]
	2003 to 2005	2003 to 2005	2005 to 2006	2003 to 2006	
Aged	13.30%	13.01%	5.06%	18.73%	4.80%
Disabled	12.49	12.23	4.96	17.80	4.72
ESRD	10.71	11.59	3.95	16.00	4.78
Aged+Disabled	13.08	12.85	5.04	18.53	4.83

[1]Current increases for 2003 to 2006 divided by the prior increases for 2003 to 2005.

Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2005 and 2006

	2005	2006	Change	2006 non-ESRD
Part A Benefits	$30.24	$30.64	1.3%	$29.55
Part B Benefits[2]	89.12	94.31	5.8%	89.26
Total Medicare	119.36	124.95	4.7%	118.81

[2]Includes the amounts for outpatient psychiatric charges.

The maximum deductible for Medical Savings Account (MSA) plans for 2006 is $8,850.

Enclosure II

Key Assumptions and Financial Information

Attached is a table that compares the published United States Per Capita Costs (USPCC) with current estimates for 2000 to 2006. In addition, this table shows the current projections of the USPCCs through 2008. In prior years, information in these tables was presented back to 1997. Since the passage of the MMA, formula changes in the law do not require the use of the USPCCs back to 1997 for the purpose of calculating the 2006 rates (e.g., the area-specific rate is not tabulated for years after 2004 and no adjustments to prior years' estimates are allowed for years before 2004 for calculating the minimum update percentage).

We are also providing an attached set of tables that summarizes many of the key Medicare assumptions used in the calculation of the USPCCs. The USPCCs are the basis for the National Per Capita Medicare Advantage Growth Percentages. Most of the tables include information for the years 2000 through 2008. All of the information provided in this enclosure applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

None of the data presented here pertain to the new Medicare prescription drug benefit.

Comparison of Current Estimates of the USPCC with Published Estimates

PART A:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	$265.10	$286.18	1.080	$217.11	$230.48	1.062	$258.66	$278.61	1.077
2001[1]	$286.28	$288.62	1.008	$235.57	$235.50	1.000	$279.30	$281.25	1.007
2001[2]	$286.28	$298.43	1.042	$235.57	$242.00	1.027	$279.30	$290.59	1.040
2002	$299.41	$294.46	0.983	$249.30	$242.06	0.971	$292.33	$287.10	0.982
2003	$306.56	$290.50	0.948	$258.07	$234.89	0.910	$299.52	$282.50	0.943
2004	$317.20	$326.78	1.030	$265.10	$271.69	1.025	$309.47	$318.43	1.029
2005	$333.76	$348.28	1.044	$278.56	$291.45	1.046	$325.31	$339.49	1.044
2006	$351.38	$351.38	1.000	$295.15	$295.15	1.000	$342.67	$342.67	1.000
2007	$367.00	--	--	$310.88	--	--	$358.25	--	--
2008	$383.64	--	--	$327.36	--	--	$374.83	--	--

PART B:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	$199.93	$218.78	1.094	$194.05	$195.91	1.010	$199.19	$216.03	1.085
2001[1]	$219.99	$217.57	0.989	$214.96	$191.99	0.893	$219.35	$214.32	0.977
2001[2]	$219.99	$223.83	1.017	$214.96	$198.69	0.924	$219.35	$220.63	1.006
2002	$233.57	$244.17	1.045	$236.48	$218.23	0.923	$233.95	$240.76	1.029
2003	$251.54	$232.24	0.923	$261.43	$211.58	0.809	$252.87	$229.47	0.907
2004	$278.89	$263.39	0.944	$286.89	$252.74	0.881	$280.00	$261.89	0.935
2005	$296.97	$281.90	0.949	$304.48	$272.79	0.896	$298.05	$280.58	0.941
2006	$311.28	$311.28	1.000	$316.82	$316.82	1.000	$312.09	$312.09	1.000
2007	$322.54	--	--	$327.93	--	--	$323.33	--	--
2008	$335.29	--	--	$341.16	--	--	$336.15	--	--

PART A & PART B:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	$465.03	$504.96	1.086	$411.16	$426.39	1.037	$457.85	$494.64	1.080
2001[1]	$506.27	$506.19	1.000	$450.53	$427.49	0.949	$498.65	$495.57	0.994
2001[2]	$506.27	$522.26	1.032	$450.53	$440.69	0.978	$498.65	$511.22	1.025
2002	$532.98	$538.63	1.011	$485.78	$460.29	0.948	$526.28	$527.86	1.003
2003	$558.10	$522.74	0.937	$519.50	$446.47	0.859	$552.39	$511.97	0.927
2004	$596.09	$590.17	0.990	$551.99	$524.43	0.950	$589.47	$580.32	0.984
2005	$630.73	$630.18	0.999	$583.04	$564.24	0.968	$623.36	$620.07	0.995
2006	$662.66	$662.66	1.000	$611.97	$611.97	1.000	$654.76	$654.76	1.000
2007	$689.54	--	--	$638.81	--	--	$681.58	--	--
2008	$718.93	--	--	$668.52	--	--	$710.98	--	--

[1]Applies to M+C ratebook for January to February, 2001

[2]Applies to M+C ratebook for March to December, 2001

Comparison of Current Estimates of the USPCC with Published Estimates-continued

PART A:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,320.28	$1,443.13	1.093
2001[1]	$1,432.85	$1,541.76	1.076
2001[2]	$1,432.85	$1,597.34	1.115
2002	$1,531.71	$1,435.62	0.937
2003	$1,619.66	$1,596.58	0.986
2004	$1,638.05	$1,685.25	1.029
2005	$1,717.13	$1,759.90	1.025
2006	$1,717.97	$1,717.97	1.000
2007	$1,708.55	--	--
2008	$1,755.24	--	--

PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,582.16	$2,436.13	1.540
2001[1]	$1,806.81	$1,875.57	1.038
2001[2]	$1,806.81	$1,921.53	1.063
2002	$1,916.48	$2,014.79	1.051
2003	$1,977.62	$1,847.53	0.934
2004	$2,189.97	$2,552.18	1.165
2005	$2,297.24	$2,739.99	1.193
2006	$2,454.98	$2,454.98	1.000
2007	$2,582.64	--	--
2008	$2,680.43	--	--

PART A & PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$2,902.44	$3,879.26	1.337
2001[1]	$3,239.66	$3,417.33	1.055
2001[2]	$3,239.66	$3,518.87	1.086
2002	$3,448.19	$3,450.41	1.001
2003	$3,597.28	$3,444.11	0.957
2004	$3,828.02	$4,237.43	1.107
2005	$4,014.37	$4,499.89	1.121
2006	$4,172.95	$4,172.95	1.000
2007	$4,291.19	--	--
2008	$4,435.67	--	--

[1]Applies to M+C ratebook for January to February, 2001

[2]Applies to M+C ratebook for March to December, 2001

Summary of Key Projections Under Present Law[1]

Part A

Year	Calendar Year CPI Percent Increase	Fiscal Year PPS Update Factor	FY Part A Total Reimbursement (Incurred)
2000	3.5	1.1	-0.9
2001	2.7	3.4	8.6
2002	1.4	2.8	7.8
2003	2.2	3.0	3.8
2004	2.6	3.4	6.4
2005	2.1	3.3	7.0
2006	2.2	3.9	7.1
2007	2.6	4.0	6.4
2008	2.8	4.1	6.6

Part B[2]

Calendar Year	Physician Fee Schedule		Part B Hospital	Total
	Fees	Residual		
2000	5.9	3.6	-0.8	9.8
2001	5.3	4.1	12.5	9.5
2002	-4.2	6.1	-1.4	6.2
2003	1.4	4.9	5.9	7.3
2004	3.8	6.8	11.8	10.3
2005	1.5	4.2	8.2	5.9
2006	-4.6	5.7	8.0	3.5
2007	-5.4	5.4	7.7	2.6
2008	-5.0	5.0	7.7	3.4

[1]Percent change over prior year.
[2]Percent change in charges per Aged Part B enrollee.

Medicare Enrollment Projections Under Present Law (In Millions)

Non-ESRD

Calendar Year	Part A		Part B	
	Aged	Disabled	Aged	Disabled
2000	33.693	5.215	32.419	4.602
2001	33.898	5.406	32.581	4.761
2002	34.074	5.609	32.712	4.931
2003	34.387	5.838	32.904	5.116
2004	34.755	6.057	33.108	5.337
2005	35.102	6.347	33.401	5.573
2006	35.545	6.516	33.750	5.734
2007	36.122	6.676	34.217	5.875
2008	36.802	6.832	34.785	6.013

ESRD Part A

Calendar Year	Part A			
	Aged	Disabled	299I[1]	Total
2000	0.143	0.105	0.101	0.349
2001	0.150	0.110	0.106	0.365
2002	0.158	0.112	0.112	0.382
2003	0.166	0.117	0.117	0.399
2004	0.173	0.124	0.121	0.418
2005	0.179	0.129	0.125	0.433
2006	0.185	0.133	0.129	0.446
2007	0.190	0.136	0.131	0.458
2008	0.196	0.139	0.134	0.468

ESRD Part B

Calendar Year	Part B			
	Aged	Disabled	299I	Total
2000	0.140	0.090	0.083	0.313
2001	0.146	0.094	0.086	0.326
2002	0.153	0.095	0.091	0.338
2003	0.161	0.097	0.094	0.352
2004	0.167	0.100	0.097	0.365
2005	0.173	0.104	0.099	0.376
2006	0.178	0.107	0.102	0.386
2007	0.183	0.109	0.103	0.395
2008	0.188	0.112	0.105	0.404

[1] Individuals who qualify for Medicare based on ESRD only.

Part A Projections Under Present Law [1]

Calendar Year	Inpatient Hospital		SNF		Home Health		Managed Care		Hospice: Total Reimbursement (in Millions)	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
2000	2,241.10	2,373.01	315.41	105.11	91.62	64.01	593.36	270.30	2,831	149
2001	2,431.75	2,581.96	382.26	129.40	120.07	89.98	571.77	256.09	3,541	186
2002	2,606.22	2,767.31	418.21	145.52	126.36	95.26	523.26	228.44	4,614	243
2003	2,682.97	2,877.93	427.49	152.18	133.90	102.49	523.08	222.33	5,908	311
2004	2,732.17	2,927.40	446.36	158.52	150.69	115.20	570.84	241.87	7,200	379
2005	2,858.72	3,063.48	458.64	162.69	164.08	125.47	623.92	264.14	8,460	445
2006	2,861.20	3,155.56	448.89	163.78	169.16	133.24	838.05	358.91	9,546	502
2007	2,851.33	3,241.70	436.15	164.27	172.15	140.11	1,044.67	449.67	10,383	546
2008	2,927.40	3,377.49	434.92	166.87	179.68	148.93	1,164.79	505.18	11,180	588

[1]Average reimbursement per enrollee on an incurred basis, except where noted.

Part B Projections Under Present Law[1]

Calendar Year	Physician Fee Schedule		Part B Hospital		Durable Medical Equipment	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	1,003.19	949.16	238.98	298.42	118.54	183.98
2001	1,131.46	1,061.03	326.91	410.60	137.12	214.59
2002	1,177.30	1,106.00	333.46	434.42	158.98	262.20
2003	1,269.05	1,209.04	379.87	492.55	186.05	313.32
2004	1,412.53	1,336.59	434.96	561.97	190.04	320.34
2005	1,473.55	1,399.64	476.84	606.93	186.09	318.48
2006	1,411.43	1,373.02	513.15	669.15	180.35	316.25
2007	1,337.90	1,336.39	531.78	712.43	178.91	322.06
2008	1,308.43	1,320.27	567.81	768.87	182.90	332.53

Calendar Year	Carrier Lab		Other Carrier		Intermediary Lab	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	58.89	57.87	201.38	194.65	46.25	62.20
2001	64.86	63.52	239.95	231.38	47.73	67.54
2002	70.96	70.94	286.77	287.40	55.32	77.66
2003	76.70	76.89	333.38	365.54	60.33	84.40
2004	82.70	84.57	357.87	428.85	64.71	92.16
2005	88.15	90.65	369.21	448.23	69.47	99.31
2006	87.62	92.15	386.81	475.89	69.32	101.51
2007	86.09	92.84	399.42	498.09	66.62	100.18
2008	86.89	94.58	425.81	531.06	67.51	102.56

Calendar Year	Other Intermediary		Home Health		Managed Care	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	117.89	221.19	139.80	106.45	531.83	220.83
2001	138.53	232.66	130.33	75.13	498.03	189.36
2002	173.55	280.30	140.50	81.49	494.67	204.43
2003	178.45	273.36	143.96	84.99	483.00	202.31
2004	202.31	267.46	162.78	95.06	543.46	219.59
2005	216.85	290.58	177.47	103.90	619.37	258.04
2006	210.90	279.13	183.33	110.10	820.55	345.19
2007	212.45	288.31	187.02	115.78	1,009.60	428.21
2008	219.01	301.67	195.62	123.05	1,116.97	476.84

[1]Average reimbursement per enrollee on an incurred basis.

Claims Processing Costs as a Fraction of Benefits

Calendar Year	Part A	Part B
2000	0.002195	0.014790
2001	0.001862	0.013223
2002	0.001496	0.011708
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001676	0.010542
2006	0.001676	0.010542
2007	0.001676	0.010542
2008	0.001676	0.010542

Approximate Calculation of the USPCC and the National Medicare Advantage Growth Percentage for Aged Beneficiaries

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A:
The Part A USPCC for aged beneficiaries can be approximated by using the assumptions in the tables titled "Part A Projections Under Present Law" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts for the aged over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis. The last step is to multiply by .97503 to get the USPCC for the aged non-ESRD. This final factor is the relationship between the total and non-ESRD per capita reimbursements in 2006. This factor does not necessarily hold in any other year.

Part B:
The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections Under Present Law" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts for the aged over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses and divide by 12 to put this amount on a monthly basis. Then multiply by .95676 to get the USPCC for the aged non-ESRD.

The National Per Capita Medicare Advantage Growth Percentage:
The National Per Capita Medicare Advantage Growth Percentage for 2006 (before adjustment for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2006 dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2005.

Enclosure III. CMS' Responses to Public Comments for Medicare Advantage Plans

Summary
We received 61 comments from 19 organizations on the February 18, 2005 Advance Notice of Methodological Changes for CY 2006 Medicare Advantage (MA) Payment Rates. Our responses to the issues raised by the commenters are organized as follows: Section A: Estimate of the National Per Capita Growth Percentage for Calendar Year 2006; Section B: Overview of Bidding for Non-drug Benefits; Section C: Payment Formulas and Other Non-drug Payment Policies; Section D: Changes to Risk Adjustment Method for MA Organizations; and Section E: Budget Neutral Risk Adjustment in Payments for Local and Regional MA Organizations.

Section A: Estimate of the National Per Capita Growth Percentage for Calendar Year 2006

Comment – Decision not to Rebase: Several commenters asked CMS to reconsider the decision not to rebase the 100 percent FFS rates for 2006 and provide the criteria used to reach this decision. The commenters recommended that CMS rebase annually.

Response: Section 1853(c)(1)(D)(ii) of the MMA states that CMS must rebase the rates not less than once every three years as the Secretary may specify. Thus, the law does not require us to rebase each year. We will consider rebasing the rates each year in context with all other priorities.

The MMA has brought many changes to the Medicare Advantage program that must be effective in 2006. Given the volume of changes required for 2006, CMS chose to exercise its discretion not to rebase for 2006.

Comment: One commenter was concerned that FFS rates for 2006 would not accurately reflect the recent changes in FFS reimbursement in rural areas, since CMS decided not to rebase the FFS rates using updated data. The commenter stated that FFS reimbursements have increased at a faster pace in rural areas than non-rural areas due to the accelerated reimbursement increases such as Health Professional Shortage Area (HPSA) bonuses to providers, hospital wage index reclassification, and critical access hospital designation. The commenter recommended that OACT reconsider rebasing the 2006 FFS cost by forecasting expenditures based on upcoming prospective payment system rules, thus using updated Medicare reimbursement rates that vary by area, rather than using out-dated average geographic adjustment factors (AGAs) to estimate FFS cost by county. If the FFS rates will not be rebased, the commenter recommended that CMS consider applying varying growth rates by rural vs. urban counties that reflect the differences in reimbursement trends between rural and urban counties. If this is not possible, the commenter suggested that the CMS consider designating rural counties as urban counties when determining which floor to use if the majority of hospitals (or hospital) in these rural areas have been reclassified to urban wage indexes.

Response: As discussed above, we will not rebase the FFS rates for 2006. The commenter also made several suggestions about how CMS could update FFS rates in the future. First, the commenter suggested that CMS model historical FFS reimbursement data to reflect the payment system rules and provider classifications that will be in effect for the upcoming payment year, instead of historical reimbursement rules and classifications. In the future, during a rebasing year, we expect to look at the feasibility of reflecting structural changes in FFS payment so that the geographic adjustments will reflect the rules and classifications in place for the upcoming payment year.

Second, the commenter suggested that CMS consider varying growth rates by urban versus rural counties. We do not believe it is feasible to use separate growth rates at this time. CMS data tabulations have not been set up to track trends on this basis. Even if we were to track trends on this basis, it would take several years before reasonable trends between urban and rural counties would be available.

Finally, the commenter suggested that, for those rural counties affected by the provision to temporarily redesignate hospitals to higher wage indices, CMS designates these counties as urban counties to assign them the high floor rate. We believe the commenter is referring to the pre-MMA rate-setting method, under which MA organizations were paid the "highest of three rates" - a floor amount reflecting a minimum specified in statute, a minimum percentage increase of 2 percent, or a blended rate combining local and national data. There were two types of floor rates: a "high" floor rate for counties with population of more than 250,000, and a "low" floor rate for counties with populations of 250,000 or less. Under the MMA, 2004 was the last year when floor rates were part of the "higher of" rate-setting methodology. While the 2004 floors are reflected in future rates, they no longer exist in MA rate-setting. MA rates are minimum percentage increase rates except in rebasing years, when a county rate is the higher of the minimum rate or the FFS rate. Based on these changes, the "low floor" and "high floor" rates are no longer applicable.

Comment – National Per Capita MA Growth Percentage: One commenter asked CMS to discuss the components of the estimate of the National Per Capita MA Growth Percentage, including the costs of national coverage determinations.

Response: The assumptions underlying the components of the National Per Capita MA Growth Percentage can be found in the tables in Enclosure II of this Announcement. These assumptions are based on the 2005 Trustees Report baseline. The assumptions and methodologies used in calculating this baseline are discussed in detail in the 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Trustee's Report), which can be found at http://www.cms.hhs.gov/publications/trusteesreport/. All new NCDs that we are aware of at the time the rates are published are included in the base rates. All new benefits mandated by the MMA have been included in the estimate.

Comment: One commenter recommends that CMS provide greater detail in the Advance Notice with regard to the revisions to rates based on prior years. The commenter felt the

basis for determining the revisions is unclear and further explanation is needed to permit MA organizations to understand CMS' methodology for this important element of the rate calculation.

Response: The United States Per Capita Costs (USPCCs) are the basis for the National Per Capita MA Growth Percentages, and include managed care payments and FFS payments. Each year, Enclosure II of the Rate Announcement provides tables comparing current estimates of the USPCC with prior published estimates. For information on how these current estimates are developed, see the tables in Enclosure II, and for more detailed information, see the 2005 Trustee's Report mentioned above. For information on prior year's estimates, see the assumptions in prior Announcements and prior years Trustees Reports.

Comment: One commenter asked how a Congressional change in physician payment for 2006 would be reflected in payment rates, and when a permanent change to the Sustainable Growth Rate (SGR) would be reflected in the rates if a change was made.

Response: A change to the SGR for a given year would be reflected in the annual capitation rates for the following year, unless the legislation implementing such a change mandates a recalculation of the rates for the year the change is implemented or if the change for the following year is made before the capitation rates are determined for the following year.

OACT does not normally retabulate the annual MA capitation rates to reflect legislative changes to provider payments that are passed after the rates are published, unless the law prescribes it. MA organizations base their bid submissions on these annual rates, and unless the law required it, we would not require MA organizations to re-price benefit packages mid-year.

Comment: One commenter wanted to know the assumption that was used for the physician update to the conversion factor for the National Per Capita MA Growth Percentage for 2005 and 2006.

Response: The physician update to the conversion factor implicit in the National Per Capita MA Growth Percentage for 2005 was 1.5% and for 2006 is estimated to be -4.6%. This is also discussed in the 2005 Trustees Report, mentioned above.

Comment – VA/DoD Costs: The notice does not discuss CMS' plans for implementation of a mechanism for incorporating into the payment methodology costs associated with Medicare covered services provided to beneficiaries in Veterans' Administration (VA) and Department of Defense (DoD) facilities. The Medicare Modernization Act established a requirement for incorporating these costs into the CY 2004 payment methodology (in the "blended" rates and in the 100 percent of FFS rates), but CMS indicated that the Agency was unable to do this at that time due to a lack of reliable data.

Response: Incorporating costs associated with Medicare-covered services provided to beneficiaries in VA and DoD facilities into the payment methodology is a multi-year project that will involve developing methods for matching coverage determinations, pricing of services, etc. CMS will continue to work on obtaining and sorting through the data. Until that project is complete, we expect the adjustment will be zero.

Section B: Overview of Bidding for Non-drug Benefits

The Advance Notice and Rate Announcement are technical notices concerning the MA payment methodology. Pricing policy is discussed in the annual Call Letter and Instructions for Completing the Medicare Advantage Plan Bid Form. We made an exception this year in the February 18, 2005 Advance Notice by also including an overview of the Part C bidding methodology established by the MMA, because of the new links between pricing and payment. We received public comments on the bidding methodology discussed in the Notice, so again we make an exception for this year by responding to these comments in the Rate Announcement.

Comment – Bid Pricing Tool. One commenter wanted to know where to find the Bid Pricing Tool on the CMS website.

Response: The Medicare Advantage bid form and instructions can be found at http://www.cms.hhs.gov/healthplans/. The prescription drug pricing form and instructions can be found at http://www.cms.hhs.gov/pdps/default.asp.

Comment - Actuarially Equivalent Cost Sharing. One commenter noted that while CMS intends to vary the proportions on a geographic basis, it does not appear that CMS intends to vary the proportions for special populations. The commenter recommended that CMS study this further to determine if unique proportions should apply to some of the demonstration plans and to special needs plans.

Response: The data source we use to determine the service-specific proportions of FFS expenditures and beneficiary cost-sharing is the National Claims History, which combines the claims experience of all Medicare FFS beneficiaries without distinguishing types of beneficiaries such as dually-eligible and institutionalized individuals. In addition, we believe that applying proportions that vary by type of service takes into account variation in the types of services used by certain special populations.

Comment: The commenter states that if the bid forms will automatically complete the proportions for each service category line, it will be important for a bidding organization to assign its allowed costs to service category lines on the same basis. The commenter requests that CMS provide detailed information on how to do this such that the costs and proportions are aligned.

Response: We have developed a mapping that crosswalks costs in the Medicare benefit description report to the bid pricing categories. This mapping is available through CMS' Health Plan Management System (HPMS).

Comment – Trending. The commenter asks how CMS applies credibility issues by geographic area/service category.

Response: As we discussed in the Advance Notice, which can be found at www.cms.hhs.gov/healthplans/rates/, the plan A/B bid must reflect cost sharing as required under original Medicare, or an actuarially equivalent (A.E.) amount. Plan-specific actuarially equivalent cost sharing will be determined based on cost sharing proportions in original Medicare that are applied to projected plan allowed costs for Medicare benefits. Our development of the A.E. factors takes into consideration the validity and credibility of the data at the service-specific and county-specific level. Although we call the proportions "county level proportions," there is relatively low credibility in some counties due to small amounts of beneficiaries and claims dollars. As a result, in general (with some exceptions) the proportions have been developed at the level of Metropolitan Statistical Area (MSA) or non-MSA areas in a State using the aggregate claim experience for each of these areas. The same set of proportions will be assigned to all counties in each MSA or non-MSA area.

Comment – Benchmarks. The commenter states that the weights used to compute the statutory component of the regional plan benchmark should exclude not only Part B-Only enrollees (as announced in the Advance Notice), but also Part A-only enrollees.

Response: The MMA specifies that the weights used to determine the statutory component of the regional plan benchmark must be MA eligibles. We agree that Part A-only enrollees should be excluded, in addition to Part B-only enrollees, since in general beneficiaries must be entitled to benefits under Part A and enrolled in Part B to be eligible for enrolling in an MA plan. In fact, we always have excluded Part A-only beneficiaries from the MA eligible count. However, these weights function as a relative scale in the benchmark calculation, so we do not believe the inclusion or exclusion of Part A enrollees would have a significant impact.

Comment – ESRD enrollees. One commenter noted that CMS will allow bids to be adjusted for the "supplemental cost" of ESRD enrollees and asked whether it be possible to apply the MA rebate to this cost.

Response: For 2006, ESRD enrollee costs are excluded from pricing the A/B basic benefit. MA organizations will have the option to adjust a plan's supplemental benefit premium by an ESRD factor, based on an organization's estimate of higher supplemental benefit costs for ESRD enrollees in the plan. Specifically, section V of Worksheet 6 allows MA organizations to estimate a PMPM loss for ESRD enrollees that is added to the price of the A/B supplemental package at Section IIC in Worksheet 6. This is an optional adjustment factor.

The plan's rebate is based on the relationship of the plan A/B bid for original Medicare benefits and the plan's A/B benchmark. The option of applying an ESRD adjustment factor to the price of the A/B supplemental benefit is available after the rebate has been applied to buy down the cost of the A/B supplemental costs. The rebate cannot be applied to this cost. We recognize that choosing to apply the supplemental ESRD factor could preclude a plan from having a zero supplemental premium.

Comment: One commenter noted that PACE organizations and certain demonstrations are transitioning to risk adjustment on a schedule that is lagged one year behind regular MA plans, so their payments for the 2007 contract year will be 25 percent demographic and 75 percent risk adjustment payments, while in 2007 regular MA plans will be paid 100 percent on the risk adjustment model. The commenter asked whether ESRD enrollee costs will continue to be excluded from the benchmark and bid calculations in the 2006 bid forms for the 2007 contract year for PACE and demonstration plans.

Response: The 2005 Rate Announcement addresses questions concerning the 2006 payment year. In February and April 2006 we will address questions concerning 2007 payment policies.

Comment – Administrative Rate: One commenter asked what is the administrative rate on the MA product. The commenter indicated that Fiscal Intermediaries that handle the standard Medicare program are paid less than the HMO organizations.

Response: Each bid must reflect the projected administrative costs of the plan. The average administrative cost per MA plan enrollee as reported by MA plans in their 2005 ACR submissions was approximately 7.5 percent of total revenue.

Comment – Supplemental Benefits and the Employer Group Product: One commenter asked how supplemental benefits can be offered with regard to employer group products. The commenter asked if they can only be offered as packages, so plans would not be able to charge separately for each benefit, and would therefore need to charge one premium for a combination of supplemental benefits. The commenter also asked if an MA plan would need to complete a version of the optional supplemental benefit worksheet for every combination of benefits desired by different employer groups, resulting in multiple submissions of this worksheet. Finally, the commenter asked whether plans can use the "actuarial swapping" method for the 2006 plan bid for employer group organizations.

Response: Plans can offer multiple optional supplemental benefit packages in the form of groups of services. Plans can also offer optional supplemental benefits individually – on a benefit by benefit basis. Finally, plans can offer both a combination of groups of services and individual services. Please see 42 CFR 422.102(d). Members (or employers on their behalf) may pay different premiums for different optional supplemental benefit combinations. However, the cost of a specific group of services or for a specific optional supplemental benefit may not vary within an MA plan. "Actuarial swapping" and "actuarial equivalence" will continue to be available, pursuant to the Call Letter and

Instructions for Completing the Medicare Advantage Plan Bid Form for 2006, which will be released soon. Employer group organizations also should refer to the Employer Group guidance for more information related to these types of plans.

Section C: Payment Formulas and Other Non-drug Payment Policies

Comment – Payment Formulas. One commenter stated they cannot confirm that the diagram on page 11 of the Advance Notice accurately reflects the three payment formulas on Page 9 of the Notice. Please provide this documentation.

Response: For plans with bids less than benchmarks, the statutory formula on p. 9 says the base payment is the standardized A/B bid, adjusted by the county ISAR factor, plus the net rebate. The diagram says the same, because the combined formula in the diagram also says subtract the beneficiary premium, which is always zero for these plans. For plans with bids equal to benchmarks, the statutory formula on p. 9 says the base payment is the standardized A/B benchmark adjusted by the county ISAR factor, while the diagram says the base payment is the standardized A/B bid adjusted by the county ISAR factor. These statements are equivalent for plans with bids equal to benchmarks. For plans with bids greater than benchmarks, the statutory formula on page 9 says the base payment is the standardized A/B benchmark, adjusted by the county ISAR factor. The diagram says the base payment is the standardized A/B bid, adjusted by the county ISAR factor, minus the standardized A/B premium the beneficiary will pay, which results in the same amount (the ISAR-adjusted benchmark). The combined formula in the diagram also says add the rebate, which is always zero for these plans.

Comment – Regional plan risk sharing. One commenter asked what is the rationale for excluding uncollected premiums from the calculation of target amount and allowed costs for regional plan risk sharing.

Response: An organization sets policy for the management of uncollected premiums, and we believe this is an administrative expense. Thus, this amount should be left out of risk sharing. This is consistent with our guidance for pricing of the Part D benefit.

Comment – Regional plan medical expenses for purposes of risk corridor calculation. One commenter asked whether claims data (with IBNR adjustment) be used to calculate allowed medical expenses, or whether CMS could provide some examples of accepted methodologies.

Response: MA organizations offering regional plans should use actual claims data to calculate allowed medical expenses and may include an adjustment for claims incurred during the contract period that remain unpaid as of the reconciliation date, which is 12 months beyond the end of the contract period. MA organizations may build-in a reasonable level of claim reserves when calculating the allowed medical expenses for purposes of regional plan risk corridor payments. Accompanying the reconciliations shall be exhibits and data (that is, “claim triangles”) that support development of the

claim reserves. The reserves, and supporting data, will be reviewed by CMS' Office of the Actuary (OACT). If these amounts are in question, the reconciliation will be considered to be preliminary and a cash settlement will occur with a final settlement to take place 12 months later. The reconciliation exhibit will be audited by an independent Certified Public Accountant, at the expense of the MA organization.

Comment – Out of Area Enrollees. One commenter stated that the ISAR adjustment for "county 99999" (any county outside of filed service area) will be 1.00, which may be inequitable for plans that have a high "snowbird" enrollment. The commenter recommended that CMS consider the allowing a plan to select one of the following options:

- As proposed (exclude from benchmark calculation, include costs in bid, ISAR = 1.000).
- Exclude from benchmark calculation, exclude costs in bid, but set the ISAR for any county outside the service area based on that county's relationship in the MA ratebooks.
- Same as the bullet above, except that plans will also submit an ISAR factor (with supporting documentation if other than 1.000) for all counties combined that fall outside the filed service area.

Response: In the Advance Notice, we stated that for enrollees who are out of the plan's service area, the base payment will be the standardized A/B bid (the "1.0" bid), with individual-level risk adjustment for demographic and health status factors. Here we are clarifying that statement.

An MA plan enrollee must, with limited exceptions, permanently reside in the plan's service area. Beginning in 2006, CMS will make payment based on the counties in a plan's service area, which is the geographic basis for the estimated revenue requirements in the plan's bid. In the event there are plan enrollees with State/county codes outside the plan's service area – which could happen for limited reasons discussed below – we will pay the standardized A/B bid ("1.0" bid). Therefore, we will not allow the MA organization to select an option from those the commenter recommended. The bid should be determined based on the plan's projected enrollment in the plan's service area.

The MA organization is responsible for determining where an enrollee permanently resides. When an organization sees in the CMS monthly payment reports that the standardized A/B bid is the base payment – because the enrollee's State/county code is 99999 (county unknown) or an out-of-service area State/county code, the organization should seek information from the enrollees as to whether they are still permanent residents of the plan's service area, and confirm the correct State/county code. If the beneficiary continues to be a permanent resident in the plan's service area, the MA organization should use the current process for requesting a State/county code change to return the enrollee code to the correct permanent county of residence, to ensure that the appropriate ISAR-adjusted county rate is used to determine payment for the enrollee.

In the MA plan context, a "snowbird" is still a permanent resident of a county in the plan's service area. We recognize that situations may arise where a beneficiary files a change of address with the Social Security Administration to have the benefit check sent to the temporary address outside the plan's service area, or where a change of address is filed with the US Postal Service. In situations where the SSA sends this change of address to our enrollment database, the MA organization should use the CMS' existing process mentioned above for correcting the State/county code back to the code for the enrollee's permanent county of residence in the plan's service area.

Exceptions. There are limited instances in which the regulations permit an MA plan enrollee to permanently reside outside the plan's service area. (For a summary of the circumstances when an MA plan may have out of area enrollees, see Section 20.3 of Chapter 2 of the Managed Care Manual on the CMS website at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp?.) Two of these instances are: (1) Enrollees that fall under the 422.50(a)(3)(ii) rule, which, generally, is for beneficiaries who were enrolled in a commercial plan and converted to MA plan enrollment upon becoming eligible for Medicare; and (2) the 422.50(a)(4) rule for enrollees in an employer group health plans that is part of an MA plan. This latter type of MA plan enrolls a mixture of individual and group enrollees. If a plan has a significant number of "snowbirds" who fall under these 422.250(a) exceptions, the MA organization may choose to include in its 2006 service area the county or counties where these enrollees live if the organization wishes be paid a plan-specific ISAR-adjusted county rate instead of the standardized A/B bid amount. Also, if a plan has significant number of 422.50(a)(4) group health plan enrollees, the organization may choose instead to offer an 800-series employer group health plan (open only to group plan enrollees) with a service area encompassing these enrollees.

Comment – National Coverage Determinations: One commenter asked whether CMS reviews local coverage decisions as well as national coverage decisions to determine whether they have significant costs impact. Another commenter recommended that CMS include an adjustment in the growth rate to account for new therapies that are covered through local coverage decisions similar to what CMS will be doing for National Coverage Determinations (NCDs). The commenter also recommended that CMS establish a process for MA plans to submit claims for FFS reimbursement for local coverage decisions that are introduced mid-year and are determined to be of significant cost. This FFS payment would apply until an adjustment is included in the payment rate, similar to what occurs now for NCDs. The commenter reasoned that it appears that the emerging business model for some significant new therapies is to not seek or receive an NCD due to speed to market considerations (if labeling is quite clear and the likelihood of favorable local coverage determinations is high). A current example of this is "wet macular degeneration." The company developing this technology did not seek or receive an NCD. However, it is covered under some local coverage decisions and as a result will be quite costly to the MA organizations.

Response: Claims costs related to local coverage determinations (LCDs) are reflected in the 100 percent FFS rate and in the National Per Capita Growth Trend, because claims

paid under an LCD in an area are included in both the FFS USPCCs used to determine the FFS capitation rates and in the USPCCs based on all beneficiaries (FFS and MA) that are used to estimate the national MA growth trend. This growth trend is used to tabulate the minimum update rates in years when the trend is greater than 2 percent.

However, in terms of adjusting payments to MA organizations, §422.109 applies only to NCDs and legislative changes in benefits that meet significant cost thresholds set forth in law. When an NCD or legislative change in benefit is determined to be a "significant cost" new benefit in the middle of an MA contract year, CMS must pay providers for MA enrollee claims under the new benefit on a FFS basis on behalf of the MA organization. The statute addresses only NCDs and legislative changes, not LCDs.

Comment – Late Payment for Non-Contracting Providers: One commenter wondered how issues regarding late payment for non-contracting providers, beneficiary dissatisfaction with MA services, and plan refusal to pay for covered services would be handled.

Response: Providers and beneficiaries should let the appropriate CMS regional office or plan manager know about these types of concerns. Plans are required to abide by CMS policies in these areas. CMS will review concerns and investigate and act on any violations of CMS policy.

Section D: Changes to Risk Adjustment Method for MA Organizations

Delay in Implementing Updated CMS-HCC Risk Adjustment Model. CMS has decided to delay the implementation of the updated and recalibrated CMS-HCC risk adjustment model until calendar year 2007. In the Advance Notice, published February 18, 2005, we announced that a refined CMS-HCC model for Part C payment would be effective for 2006. The Notice stated that all segments of the risk adjustment model (community, long-term institutionalized, and ESRD) would be updated for 2006 to reflect newer treatment and coding patterns in fee-for-service Medicare, to use the additional codes being collected for the Part D model, and to accommodate additional codes that complete a Hierarchical Condition Category (HCC).

However, we recognize that implementing an updated risk adjustment model in 2006 at the same time that the new MMA bidding and payment methodology must be implemented introduces additional uncertainty into the MA program. Given the considerable volume of changes that must be in effect for 2006, we have concluded that a delayed implementation of the updated CMS-HCC model is appropriate. The one-year delay will allow MA organizations additional time to gain experience with the bidding and payment changes effective in 2006.

We are committed to working with MA organizations to implement the updated model in 2007. Through open door forums and contacts with expert actuaries, we will develop and present analyses to demonstrate the anticipated impact of the updated model, and we will

have an opportunity to take additional comments into account prior to finalizing the model.

In light of the delayed implementation date, we are not responding to other comments on the recalibrated CMS-HCC model at this time.

Because we intend to implement the updated model in 2007, MA organizations should continue submitting the additional codes for the updated CMS-HCC model. (Instructions and updated codes were posted on 5/17/2004 on the CMS website at cms.hhs.gov/healthplans/riskadj). In addition, we will continue to reflect changes to the ICD-9 codes made by the National ICD-9-CM Coordination and Maintenance Committee twice a year (April and October), so MA organizations should check this website to learn what codes have been added to the model to reflect Committee changes.

The delayed introduction of the refined CMS-HCC model does not affect the treatment of MSP status, including working aged status, as discussed below.

Medicare as a Secondary Payer for Risk Adjustment in 2006

Comment – Medicare as Secondary Payer for Risk Adjustment: In the Advance Notice, CMS proposed to recalibrate the Part C risk adjustment models (CMS-HCC model and ESRD model) for 2006 to include the costs associated with beneficiaries for whom Medicare is a Secondary Payer (MSP). This means that, on average, risk scores would be appropriately adjusted for MSP status and that no further adjustment would be necessary. We received a number of comments on this proposal. Most commenters asked that CMS not include MSP beneficiary costs in the models, and instead retain the current plan-level working aged adjustment for aged beneficiaries. Commenters asserted that calibrating the risk adjustment models on combined MSP and non-MSP costs will result in less accurate plan payments and more burden for MA plans. Several commenters stated that the loss of revenue for plans will be significant under the combined models. Several commenters also concluded that CMS is weakening the ability of the risk adjustment model to accurately forecast the expected costs of any Medicare population that has a significantly different proportion of working aged or MSP than would be assumed in the calibration of the model.

Furthermore, commenters stated that MA organizations have invested significant resources to improve the accuracy of working aged data (the subset of the MSP status that includes beneficiaries age 65 or older with employer group health coverage through their own or spousal employment). Commenters claimed they have achieved considerable success in accurately establishing the appropriate Working Aged (WA) percentage for our enrolled member population. Finally, many commenters suggested that CMS work with the industry to further analyze the proposed introduction of combined models.

Response: Based on the comments, CMS has decided not to proceed at this time with the proposal to recalibrate the Part C risk adjustment models (CMS-HCC and ESRD) for

2006 to include the costs associated with beneficiaries for whom Medicare is a Secondary Payer.

This decision not to proceed with the MSP inclusive model means, however, that payments must be adjusted to reflect MSP status. Changes to the current methodology to address these issues are described below.

Medicare as a Secondary Payer under the CMS-HCC Model. Currently each MA organization surveys a cohort of its aged members and reports to CMS those with coverage primary to Medicare due to working aged (WA) status. The WA status of non-responders to the survey is determined from the Common Working File. Using this information, CMS then calculates a WA payment adjustment factor by comparing prospective capitated blended payments with no WA adjustment to payments with a WA adjustment for those identified as WA. This factor is then applied to the organization's monthly blended capitated payment. We will continue to apply this methodology for the organization's aged enrollees to their demographic payments (rather than to their blended demographic and risk adjusted payments). Specifically, the current adjuster developed for the working aged will apply only to the prospective demographic payments.

This current method of identifying MSP status is not appropriate for risk adjusted payment because the disabled are not included in the development of the plan-level adjustment for WA. Unlike the demographic model for which the current methodology was developed, risk adjusted payments for the disabled must be adjusted for MSP to ensure accurate payment. Therefore, for risk adjustment, we will revise the 2005 methodology to include the disabled. In our estimate of the proportion of beneficiaries with MSP in the plan, we will expand WA status to include MSP status for disabled individuals, as determined by the Common Working File. We will then calculate the appropriate MSP factor and apply it to the prospective risk adjusted payments.

Medicare as a Secondary Payer under the ESRD Risk Adjustment Model. Currently, in the demographic system, there is no adjustment for the MSP status of MA enrollees with ESRD. The MSP and non-MSP populations are averaged. Given that the ESRD model is calibrated as if Medicare were always primary, such an adjustment is necessary. For 2006, we will use CMS' standard system to identify ESRD beneficiaries for whom Medicare is secondary and adjust payments at the individual level.

Based on the extensive comments, we have decided that further study is needed on the impact of our proposal. Therefore, we plan to continue to work through these issues and are committed to working with the industry to determine the payment impact of our combined model proposal, and to determine how to identify the best estimate of the percentage of MSP in these populations. We may propose the combined model again at a future date.

Comment—Definition of New Enrollee Status for Risk Adjustment. One commenter asked whether beneficiaries with Part B-only coverage will be considered new enrollees for purposes of calculating Part D payments. The commenter noted that consistent with

Part D eligibility requirements, PACE organizations have always enrolled beneficiaries with Part A and/or Part B coverage. Further, as a consequence of PACE requirements under §460.92, PACE organizations are required to provide all Medicare and Medicaid covered services to all PACE enrollees regardless of payment source.

Response: This comment regarding which risk adjustment factors apply to payment was submitted as a Part D PACE comment. We have determined that this comment pertains to all risk adjustment payments under Parts C and D for MA plans, demonstrations, and PACE organizations. Therefore, we include this response here and also in Enclosure IV.

Table II-1. Which Risk Adjustment Factors Apply to Payment*

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	**Time Period Beneficiary Has Been Entitled to Benefits under Part A Medicare****	
	0 - 11 months	**≥ 12 months**
0 – 11 months	new enrollee factors	Plan's option: new enrollee or full risk adjustment factors
≥ 12 months	full risk adjustment factors	full risk adjustment factors

* Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled benefits under Part A and enrolled in Part B.
** During data collection period (previous calendar year).

As indicated in Table II-1 above, beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees, as they are now.

Currently beneficiaries with than 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees in this response) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS is creating an option for how the risk adjustment payments for this category of enrollees are determined. Effective for 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision will be applied to all "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.

This option elected by the organization will remain turned "on" until CMS is notified otherwise prior to August 31st of any successive year. CMS will apply this option during reconciliation for a payment year only (that is, it will not be applied prospectively). Plans interested in this option must contact: Angela Porter, at Aporterjames@cms.hhs.gov by 8/31/2005 to elect this option.

Comment – Transition Payment Blends and PACE: A commenter requested confirmation of how payments made by CMS on behalf of PACE enrollees will be calculated for Medicare services covered under Parts A and B.

Response: In 2006, 50 percent of PACE payment will be based on the 2003 PACE payment methodology. The remaining 50 percent of payment will be based on the CMS-HCC risk adjustment methodology, including frailty. Because PACE organizations are excluded from the Part A and B bidding process, the individually risk-adjusted portion of the payment will continue to be equal to the rescaled MA county level rate multiplied by the enrollee's individual risk score. ESRD will be paid 100 percent at the appropriate ESRD rate multiplied by the enrollee's risk score.

Comment – Demographic Factors: One commenter noted that for the new MA Parts A&B bidding, plan bids are expected to be at a CMS-HCC risk score of 1.0 for 75 percent of the bid and at 1.0 demographic factor for 25 percent of the bid. The commenter stated that an additional adjustment to the demographic portion of bid is appropriate only in 2006 because, unlike the CMS-HCC risk adjustment scores, the demographic county benchmarks are not currently normalized to 1.0. The commenter noted that the demographic scores average to be less than 1.0, something on the order of 0.993. For this one year of including the demographic portion in the bidding process, the commenter suggested that plans be able to inflate the demographic portion of their bids by 1/ 0.993 (if 0.993 is the right number) to make the bids on par with the demographic county benchmark.

Response: The 2005 FFS rates do take into account that the demographic factors are no longer normalized to 1.0. We were able to standardize the FFS rates to reflect this shift because these were newly created rates, effective in the revised 2004 ratebook. These FFS rates represent the best estimate of what average FFS costs are per county Specifically, a county FFS rate is determined by dividing the USPCC for FFS by the average demographic factor for the country -- which would reflect the fact that the average is less than 1.0, and then multiplying by a county geographic adjustment. The county rates that were floor, blend, or minimum updates rates in the revised 2004 ratebook do not reflect this shift in the demographic factors. These rates are based on formulas set in law. Floor and minimum update rates were rates established by the Congress as the appropriate amounts to pay, first in the 1997 BBA, and later in the BIPA 2000.

Comment – Changes to Frailty Factors for PACE and Certain Demonstrations. One commenter asked whether frailty factors will be applied outside of the PACE program and certain demonstrations.

Response: Because we are delaying the implementation of the updated CMS-HCC risk adjustment model until 2007, the frailty factors for 2006 will not change. In 2006, frailty factors will only be applied to PACE organizations and certain demonstrations. CMS is continuing to conduct analyses to determine the feasibility of implementing the frailty adjuster for the MA program. We are investigating whether and how the ratebook should

be adjusted. We are also considering refinements to the current model, including re-estimation of the frailty adjuster based on a larger sample. Once the technical issues are resolved, we will calculate impact estimates and address policy issues. If CMS determines that the frailty adjuster is appropriate for application to the MA program, the earliest this application would occur is 2007. CMS will announce payment changes for 2007 through the 2006 Advance Notice of Methodological Changes for CY 2007 MA Payment Rates.

Summary of Comments on Reporting of Medicaid Status for Demographic Payment and Part C Risk Adjusted Payment.

Comment: Several commenters supported CMS' efforts to improve the accuracy and efficiency of the system that captures dual eligible status. Comments were very supportive of the creation of a uniform, standard process to obtain the needed information and look forward with cautious optimism to the implementation of this system. However, a number of major concerns were raised, including the accuracy and reliability of the new Medicare/Medicaid files, the ability of MA organizations to report Medicaid status if the CMS system does not accurately reflect the enrollee's status, and the schedule for implementing the change in the system for Medicaid reporting. Several commenters recommended that CMS provide a process for correcting Medicaid status indicators in situations where the Medicare Advantage plan has information that an enrollee or potential enrollee is Medicaid eligible but the CMS system is not reflecting this Medicaid status. Commenters believed that errors in the data are inevitable and that there should be a process in place to address such errors.

Response: CMS agrees that the completeness and accuracy of the States' monthly submission of Medicare/Medicaid files will be extremely important. The implementation of a number of Part D provisions is crucially dependent on the success of this process. These include: determination of low income subsidy status and auto-enrollment of "deemed" low income beneficiaries in Part D plans; determination of the number of enrollees for the phased-down State contribution payment; and reporting of low income subsidy applications and determinations by the States. However, given the known limitations of the current system for the identification of dually-eligible individuals in MA organizations, CMS is sympathetic to plans' concerns about the reporting of Medicaid status. While we believe that the importance of obtaining the appropriate low-income subsidies under Part D for dually-eligible beneficiaries will provide the incentive for vastly improved reporting, we are also aware that the new system will require monitoring and feedback. Therefore, we will implement a process for Part C payments in 2006 whereby CMS will use the new Medicare/Medicaid Dual eligible file to replace the Third Party Buy-In file as our standard source of the Medicaid status indicator. CMS will continue to provide a process for MA organizations to correct Medicaid Status indicators for Part C payment purposes.

CMS will conduct analyses to assess the reliability and accuracy of the data from the Medicare/Medicaid Dual Eligible enrollment files compared to current sources (i.e. the Third Party Buy-In file and plan-reported Medicaid) and make public, at an aggregate

level, the results of these analyses. We expect to base further decisions on the results of this analysis and consultation with the industry.

Comment: One commenter interpreted the Advance Notice as indicating that the MMA Medicaid file will limit the reporting of Medicaid eligibility to the reporting month plus only one prior month.

Response: There is no intention to limit Medicaid eligibility reporting to the current month plus only one prior month. The phrase "in a prior month" should read "in prior months" and should be interpreted to mean all retrospective monthly changes in Medicaid eligibility. As is the current policy, CMS will impose a limit on the time that retrospective Medicaid status adjustments will be accepted for payment purposes.

Comment: One commenter asked CMS to confirm how enrollees will be assigned Medicaid status in 2006. Specifically, the commenter asked CMS to confirm that Medicaid status in the payment year will no longer be based on a minimum of one month's Medicaid eligibility in the prior year; rather, beginning in 2006, Medicaid status will be assigned on a concurrent basis using data in States' MMA Medicare/Medicaid Dual Eligible monthly submission files.

Response: Only the source of the Medicaid indicator is changing. The rules for assignment of Medicaid status will be the same as in 2005 for both demographic and risk adjusted payment. Briefly, under risk adjustment, Medicaid status for full risk enrollees will be assigned based on Medicaid eligibility during the data collection year and Medicaid status for new enrollees will be on a concurrent basis during the payment year. For non-risk adjusted payment, Medicaid status will be assigned on a concurrent monthly basis. Medicaid status will be reconciled for final payment under risk adjustment after the end of the payment year.

Section E: Budget Neutral Risk Adjustment in Payments to Local and Regional MA Organizations

Comment - Modification of the Budget Neutrality Adjustment for Regional Plan Enrollees: One commenter requested that CMS not adjust the budget neutrality estimate for projected regional plan enrollment. The commenter also asked what is the maximum swing in the budget neutrality factor by county resulting from the technical adjustments to the budget neutrality calculation made because regional plans may exist in 2006.

Response: The Advance Notice announced that the budget neutrality adjustment for 2006 will be calculated as the difference between payments to organizations at 100 percent of the demographic rate and payments at 100 percent of the risk rate. For purposes of the calculation, OACT assumed that payments to local plans will be at the

local benchmarks adjusted for each plan's demographic and risk scores. Current data do not show any enrollment in regional plans, since those plans will not start until next year. OACT assumed an estimate of enrollees in regional plans consistent with the assumptions in the President's FY 2006 Budget baseline and the 2005 Trustees Report (which can be found at http://www.cms.hhs.gov/publications/trusteesreport/). The budget neutrality adjustment is the same percentage for all counties and all regions. The budget neutrality calculation was determined as follows:

1) For enrollees in local plans, the adjustment was calculated as in prior years, i.e. 100 percent of demographic payments to plans minus 100 percent of risk adjustment payments to plans expressed as a percent of risk adjusted payments. This resulted in an adjustment of 14.23 percent.
2) For enrollees in regional plans, the estimated adjustment for local plans was adjusted for the expected difference in risk scores relative to demographic scores for the regional enrollees relative to local enrollees. This resulted in an adjustment of 9.61 percent for expected enrollees in regional plans.
3) An enrollment weighted average of local and regional plan factors was calculated, using the estimated local and regional enrollment as weights. We currently estimate about 74.6 percent of enrollees in 2006 to be in local plans and about 25.4 percent in regional plans. This resulted in a weighted average adjustment of 13.05 percent. This is the budget neutrality factor for 2006.
4) The weighted average budget neutrality factor and the FFS normalization adjustment of 5 percent was applied to all local rates and hence in the statutory components of the regional rates through the weighting of the local rates. Both of the adjustments are reflected in the rescaling factors for the determination of the risk ratebook. As explained in the ratebook file, the rescaling factors are adjusted by 1.0767 (1.1305/1.05).

Comment – Budget Neutrality: One commenter recommended that CMS maintain for the 2006 ratebook the current budget neutrality factor of 8.65 percent utilized for 2005. In addition, the commenter recommended that CMS announce this factor as soon as possible and not wait until the release of rates on April 4, 2005. The rationale for this recommendation is to enhance payment stability and to help plans with their bid preparation by announcing the budget neutrality factor in advance of the Final Rate Announcement on April 4.

Response: The budget neutrality factor is always announced in conjunction with the Medicare Advantage Rates because it is based on the upcoming annual rates. Currently, the budget neutrality (BN) estimate is calculated to ensure that risk adjustment does not reduce the aggregate amount of payments to MA organizations. We must determine each year what the aggregate payments are under the demographic and risk adjustment methods in order to arrive at the correct BN estimate. Budget neutrality is not intended to inflate or deflate risk adjusted rates above or below the level that would produce payments equivalent to demographic payments. Unless the BN adjustment for 2006 is exactly equal to the 2005 adjustment (1.0865), the effect of the commenter's suggestion

would be to either overpay or underpay MA organizations. As indicated above, the BN factor for 2006 is different from the 2005 factor.

Comment: In order to fully understand the implications of phasing-out budget neutrality, it would have been helpful if CMS had provided estimates of the percent reduction in capitation payments that will result from this change in policy. Such information would have provided currently operating and prospective PACE organizations as well as other Medicare managed care programs with the ability to estimate the financial consequences of this policy change on their operations. By waiting until late December 2005 to release such estimates as part of the January 2006 MMRs, programs are prevented from utilizing this information in formulating their responses to the Advance Notice.

Response: Budget neutrality is being implemented at 100 percent in 2006 and therefore there are no payment implications. CMS published the budget neutrality phase-out schedule in the Advance Notice, and we believe organizations will have ample time to estimate the impact of this policy prior to 2007.

Enclosure IV. Response to Part D Public Comments

Summary

The following enclosure provides responses to comments and questions submitted for the Part D Section III portion of the "Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates" published on February 18, 2005. The comment period closed on March 4, 2005.

We received 42 separate sets of comments and questions. The majority of comments and questions were focused on the Part D risk adjustment model, the reconciliation process, and the special payment methodology for PACE. These comments and questions generally can be categorized as requests for clarification and additional information. Some comments only expressed support and do not need to be addressed, including the following:

- one commenter commended CMS for the establishment of an administratively reasonable method to allow Part D plans to receive interim reinsurance and low-income subsidy payments subject to an end of the year reconciliation;
- another commenter expressed support for the efforts CMS has made to establish low-income and institutional multipliers that are designed to ensure that the payment methodology accurately reflects the cost of care for vulnerable populations; and
- another comment fully supported CMS' effort to implement the MMA conference report language and CMS' demonstration authority to make available a demonstration for PDPs, MA-PD plans, and Cost plans that is designed to address a disincentive under the Part D program for plans to provide coverage in the coverage gap.

We also wish to clarify that as was anticipated in the final Part D rule preamble, we will not be conducting a geographic risk adjustment of the national average bid amount in 2006.

Enclosure V is organized as follows:

- Section A-Part D risk adjustment model
- Section B-Reconciliations and risk sharing
- Section C-Special PACE methodology
- Section D-Implementation issues
- Section E-Reinsurance demonstration
- Section F-Private fee-for-service (PFFS)
- Section G-Dual eligibles and institutional status

A-Part D risk adjustment model

Comment—Relative weights for Part D risk adjustment model. The reason for the relative weights for some RXHCCs is unclear. For example, the weight for RXHCC 30 Other Musculoskeletal and Connective Tissue Disorders is greater than for RXHCC 46 Lung, Upper Digestive Tract and Other Severe Cancers. Even though many of the cancer

drugs may be covered under Part B, it is our understanding that there could be a relatively high use of Part D covered drugs for RXHCC 46. We recommend that CMS reexamine RXHCC weights to ensure that they are correct and release information concerning the underlying data and methodology that has result in these weights.

Response: As an integral part of the development of our Part D model, we submitted it to physicians and pharmacists for review. The consultants argued that prospective drug costs for RXHCC 30 (Other Musculoskeletal and Connective Tissue Disorders) can be high because of long term costs. In their original rankings of drug costs using an ordinal scale, they ranked most of the component diagnoses of RXHCC 30 greater than or equal to the component diagnoses of RXHCC 46.

Comment: 70 new ICD-9 codes in the model. It is our understanding that the recently released list of codes includes seventy ICD-9 codes that were not in the list issued in July, 2004, as the basis for expanded collection of diagnoses intended to lay the foundation for the Part D risk adjustment model. While we and our member organizations are still in the process of evaluating the additional diagnoses, at this time, we do not have an objection to their inclusion. If CMS retains these diagnoses in the model, we recommend that CMS explicitly call attention to these new diagnoses to ensure that affected plans are aware of the addition, clarify whether all of these diagnoses are being added for both MA and Part D risk adjustment purposes, and formally announce as quickly as possible the requirement that these diagnoses must be submitted for the period beginning January 1, 2005. We also recommend that CMS provide more detailed information regarding the rationale for their inclusion in the both risk adjustment models.

Response: The omitted codes are included in the Part D model, but not in the MA model, because their inclusion will lead to more accurate Part D risk scores. These additional diagnoses must be submitted for the period beginning January 1, 2005. They were omitted from the earlier list by mistake. All managed care organizations, PDP applicants and PACE organizations have been notified of the codes and submission requirements via the Health Plan Management System (HPMS). In addition, the omitted codes and submission requirements are posted on the CMS website at http://cms.hhs.gov/pdps .

Comment—Risk scores. Two commenters ask that CMS identify the scores that were used and applied to the Federal Employee Health Benefit Program (FEHB) data in developing the risk methodology.

Response: The question implies the use of HCC risk scores in the modeling, however, risk scores were not **assigned** to the observations in the data files. The FEHB data were used to **statistically develop** factors related to the demographic and diagnostic groupings. Diagnoses from the Medicare files were used along with pharmacy expenditures by the FEHB plan for each enrollee from the next year's pharmacy data.

Comment: Disabled Medicaid in risk adjustment model. One commenter asked us to identify to what extent this subgroup of members were included in the modeling construct.

Response: The Medicaid file used in the modeling was a 5% file of dual eligibles including both those under 65 (disabled) and over 65. Some states were omitted because their data were incomplete. All age/sex groups were weighted up to their proportion in the Medicare population.

Comment—Specialized population variation. One commenter asked that the factors that vary for specialized populations such as dual eligibles and institutionalized beneficiaries be identified.

Response: The factors within the model do not vary. However, the resulting total risk factor is augmented by a multiplier that depends on low-income status or institutional status.

Comment—Denominator. Several commenters asked that the denominator used to convert the dollar amounts to factors be released.

Response: The national mean for the Fee-For-Service (FFS) population is used as the denominator and is $993.33.

Comment: Low spenders. Several commenters noted that the Advance Notice stated that the method tends to over-predict for "low spenders". Since Part D is a voluntary program, it is possible that "low spenders" will choose not to enroll in Part D. The commenters asked CMS to identify if the model was calibrated to take into account this potentially skewed spending pattern.

Response: The model is not adjusted to reflect any particular assumptions concerning the enrollment pattern. Over-prediction of low base amounts of spending has a relatively small impact because the expenditures are a small proportion of the total.

Comment: Uniformity. One commenter asked that we confirm that the same risk adjustment factors will be used for all plan designs.

Response: Yes, this approach was adopted in consultation with independent actuaries in an American Academy of Actuaries' workgroup.

Comment: Base Population. Please identify the population base that will be used to establish the standardized risk score.

Response: The base is the entire FFS population present on July 1, 2004 including full risk-adjustable and new enrollee designated beneficiaries.

Comment: Aggregate Weighted Average of 1.0. Please publish the calculations supporting the establishment of this factor by providing the membership distribution and factors used for each individual county.

Response: The factor is 1.0 for the average prediction from the model for the FFS population. The county factors result from the mean predictions for the FFS beneficiaries who reside in each county as indicated in the Medicare Beneficiary Database. The membership distribution and aggregate risk factors for each individual county will be available on the CMS website.

Comment: Cost Sharing Variation. One commenter noted that the spending of all people in the model calibration data was reduced to compensate for the higher cost sharing (reverse of "induced demand effect") and asked that we provided the factor used in this calculation.

Response: The actuarial estimate of the effect of cost sharing in moving from the reference (FEHB) benefit to the standard Medicare benefit is a reduction in spending of 19.8%. The institutionalized were not subject to this adjustment.

Comment: Factor Information. One commenter requested that CMS share further information and supporting documentation to demonstrate that the additional factors identified in the Notice (1.08 and 1.05 for low income and 1.08 and 1.21 for LTC beneficiaries) are appropriate for these populations. This would include documentation to indicate that these factors are sufficient to cover the adjustment made for the spending of all people in the data.

Response: Low income beneficiaries. The additional factors for low income beneficiaries adjust for the "insurance effect" (induction) of the low income subsidies. That is, beneficiaries respond to these subsidies, which reduce out-of-pocket payments for prescription drugs, by increasing their use of prescription drugs. The induction model is based on a regression of drug expenses as a function of out-of-pocket expenses.

The adjustment factors are the ratios of calculated drug plan liabilities using our induction model and drug expense data in the Medicare Current Beneficiary Survey for beneficiaries in the community to the predicted drug plan liabilities using the risk adjustors without induction. Although we calculated factors for each of the low income groups, we found that the difference in the means for the $1/$3 copay group and the $2/$5 copay group was not significant. Hence, we combined these two groups and recalculated their adjustment factor (1.08). The adjustment factor for those who pay a $50 deductible and 15 percent coinsurance is 1.05.

Long term care beneficiaries. The predicted model was developed on the community population only, excluding the institutionalized. The estimate for the additional long-term institutionalized factors was a direct estimate made by comparing predictions using the model to the actual spending by the institutionalized reported in the data. Data for the institutional were not adjusted downward for the induced demand effect in moving from

the reference FEHB benefit to the standard Medicare benefit. Only the scaling of the Medicaid data to FEHB affected the expenditures of institutionalized Medicaid enrollees.. The ratios of reported expenditures to model predicted expenditures for aged and disabled are the additional multiplicative factors.

Comment—Disabled Medicaid Adjustment. Please identify if there is any adjustment provision established for disabled Medicaid status.

Response: The disabled factors derive from the age/sex specific factors for the under 65 and the common set of condition factors. The low-income factor then applies if the disabled person has Medicaid or other low-income status.

Comment—Trend factors. What trend factors, if any, were used to adjust the data? Were different practice, prescribing, or utilization patterns and Rx market changes assumed for 2006 versus 2000?

Response: The Office of the Actuary made spending projections into 2006. The FEHB spending data were from calendar year 2002. This spending was increased by 55.42 percent. The Medicaid data were from calendar year 2000. This spending was increased by 103.98 percent.

Comment—Low income multiplier. Is the low-income multiplier for dual eligible beneficiaries with incomes greater than 100% of the federal poverty level also 1.08?

Response: Yes, as illustrated in the second column of table III-2 on page 47 of the advance notice, low-income beneficiaries up to 135% of the federal poverty level receive the estimated 1.08 multiplier.

B. Reconciliations and risk sharing

Comment—Timing of reconciliations and induced utilization adjustment. When are low-income subsidy and reinsurance reconciliations done? How are the risk corridors adjusted for induced utilization?

Response: The low-income subsidy and reinsurance reconciliations will begin after the coverage year once final data have been submitted, which is no later than six months after the end of the coverage year. As defined by §423.308 of the final Part D rule, allowable risk corridor costs must exclude costs attributable to induced utilization resulting from enhanced alternative coverage. The induced utilization factor used to adjust the costs will be included and negotiated with the bid. For an example see the draft bid pricing tool available online at: http://www.cms.hhs.gov/pdps/.

Comment: Risk sharing in an enhanced alternative plan. One commenter recommended that CMS add an example in this discussion that would identify how risk

corridor calculations are made when the Part D plan includes supplemental benefits under the enhanced alternative benefit design.

Response: As defined in §423.308 of the final Part D rule, allowable risk corridor costs are the subset of actually paid costs for covered Part D drugs not including administrative costs that are attributable to basic drug coverage and adjusted for an induced utilization effect. The example in the Advance Notice still holds except for the adjustments made so the costs are attributable to basic only and for the induced utilization. The adjustment for basic only will be done at the claims submission level and this process is discussed in detail in the forthcoming PDE guidance. The adjustment for induced utilization will be done through a factor provided with the bid. For an example of the induced utilization effect in the bid see the draft bid pricing tool online at http://www.cms.hhs.gov/pdps/.

Comment: Calculation of reinsurance and risk sharing. The calculation and application of the reinsurance and risk sharing need to be logically and algebraically consistent with the bidding process. CMS should carefully review the methodology for calculating the reinsurance and risk sharing to ensure the results are consistent with the application of the reinsurance, induced utilization factor, etc. in the bidding process.

Response: CMS has attempted to make the payment, reconciliation and risk sharing methodologies consistent with the bidding process and with applicable Part D statute and regulations. We also clarify that because dollars resulting from a negative premium described in 42 CFR §423.329 are applied to a supplemental benefit as directed by 42 CFR §423.272(e) these dollars are not included in the target amount, which defined in 42 CFR §423.308 is the total amount of payments to the plan for the risk adjusted standardized bid amount.

Comment: Adequate claims submission. One commenter asked CMS to define "adequate documentation of LICS amounts on PDE records" and identify the "claims submission deadlines" which were not identified in the Notice. Furthermore, the Agency was asked to clarify the statement "CMS may recoup all interim LICS payments" and whether this applies only to the claims of the records for which sufficient data has not been adequately submitted, or whether this applies to all LICS amounts.

Response: Details on the Prescription Drug Event (PDE) records, including submission deadlines, will be provided in separate guidance that will be available online at www.cms.hhs.gov/pdps/. In cases where insufficient data are submitted for LICS, CMS would recoup those interim LICS payments not supported by the PDE records.

Comment—Claims submission deadline. One commenter requested that CMS provide details regarding this process and include in the policy a process that will afford participating organizations extensions for data submission in the event that plans cannot timely obtain necessary records from entities integrally involved in aggregating PDE record data.

Response: As previously stated, details on the Prescription Drug Event (PDE) records and submission process will be provided in separate guidance that will be available online at www.cms.hhs.gov/pdps/. The Part D rule (42 CFR §423.343) states that submission of cost data must be made "within 6 months of the end of the coverage year". Therefore, no additional extension of the data submission deadline is permissible.

C. Special PACE methodology

Comment—New enrollees. One commenter asked whether beneficiaries with Part B only coverage will be considered new enrollees for purposes of calculating Part D payments. Consistent with Part D eligibility requirements, PACE organizations have always enrolled beneficiaries with Part A and/or Part B coverage. As a consequence of PACE requirements under §460.92, PACE organizations are required to provide all Medicare and Medicaid covered services to all PACE enrollees regardless of payment source.

Response: We have determined that this comment pertains not only to PACE Part D payments but to all risk adjustment payments under Parts C and D for MA plans, demonstrations, and PACE organizations. Therefore, we include this response here and also in Enclosure III.

Table II-1. Which Risk Adjustment Factors Apply to Payment*

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	Time Period Beneficiary Has Been Entitled to Benefits under Part A Medicare**	
	0 - 11 months	≥ 12 months
0 – 11 months	new enrollee factors	Plan's option: new enrollee or full risk adjustment factors
≥ 12 months	full risk adjustment factors	full risk adjustment factors

* Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled benefits under Part A and enrolled in Part B.
** During data collection period (previous calendar year).

As indicated in Table II-1 above, beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees, as they are now.

Currently beneficiaries with than 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees in this response) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS is creating an option for how the risk adjustment payments for this category of enrollees are determined. Effective for 2006 payments, organizations may elect to have

CMS determine payments for all “Part A-only” enrollees using either new enrollee factors or full risk adjustment factors. The organization’s decision will be applied to all “Part A-only” enrollees in the plan. Plans may not elect to move some eligible “Part A-only” enrollees into risk adjustment, while retaining others as new enrollees.

This option elected by the organization will remain turned "on" until CMS is notified otherwise prior to August 31st of any successive year. CMS will apply this option during reconciliation for a payment year only (that is, it will not be applied prospectively). Plans interested in this option must contact: Angela Porter, at Aporterjames@cms.hhs.gov by 8/31/2005 to elect this option.

Comment—Risk adjustment and the frail community-based population. Has CMS evaluated the predictive power of the Part D risk adjustment model for a frail community-based population such as that enrolled in PACE? There is a substantial long term care multiplier applied to Part D payments for beneficiaries residing in long term care institutions. PACE programs serve individuals in the community whose acuity levels are consistent with those of individuals residing in long-term care institutions. One commenter argues that many of the same issues that CMS identifies as the basis for the long term care multiplier would also apply to drug costs for long-term care eligible populations in community settings.

Response: There is no evidence that after adjusting for health status that a community-based population such as those enrolled in PACE have higher prescription drug costs. The long-term care multiplier that CMS has developed is reflective of the increased prescription drug spending observed in institutional settings even after health status is held constant.

Comment—Enrollment changes. Referring to p. 57 of the Part D notice related to Part D enrollees who change plans during the coverage year, a commenter requests that CMS take into account any unique circumstances that might result from involvement of PACE enrollees in these transitions, as necessary.

Response: We clarify that the intention of our comment regarding enrollees changing plans on page 57 of the advance notice was to note the issues that will be resolved through the true out-of-pocket (TrOOP) coordination process. The request for proposal for the TrOOP facilitation contract is available online at www.fedbizopps.gov (search on: "CMS2005TrOOP2") and additional guidance regarding TrOOP coordination is forthcoming.

Comment—PDE data and PACE. Referring to CMS’ discussion of prescription drug event (PDE) data reporting requirements for PACE, a commenter requests clarification of the specific PDE data elements that will not be required of PACE organizations. Referring to the draft Prescription Drug Events Paper posted on CMS’ website, these are interpreted to be data elements including patient pay, low-income cost sharing subsidy, and supplemental cost share amounts; as well as those related to the attachment point, i.e. the catastrophic covered flag and gross drug cost below/above catastrophic cap.

Understanding that the PDE data reporting requirements have not yet been finalized, are these generally the types of data elements to which CMS is referring in the Notice?

Response: The commenter is correct in their interpretation of the draft prescription drug event (PDE) paper released December 14, 2004. A revision of the paper based on public comments is forthcoming.

Comment—Medicare-only PACE enrollees and premium methodology. Referring to the sections entitled "CMS payment methodology applicable to Medicare-only PACE enrollees" and "Premium methodology applicable to Medicare-only PACE enrollees", there is no recognition of the possibility that a Medicare-only enrollee may qualify for low-income premium and cost-sharing subsidies under Part D. Rather, CMS explicitly states that "no costs will be attributed to LICS," and the supplemental premium "will apply to all Medicare-only enrollees, regardless of income level." Under what authority would PACE organizations be allowed to deny low-income subsidies to qualified low-income beneficiaries?

Response. To clarify, Medicare-only PACE beneficiaries will be enrolled in an enhanced alternative plan, whereas the dual eligible PACE beneficiaries will be enrolled in a standard plan. Thus the Medicare-only PACE beneficiaries would have a supplemental benefit with a supplemental premium. The low-income subsidy does not apply to supplemental benefits. However, the commenter has recognized that these Medicare only beneficiaries may be eligible for a partial subsidy of the basic portion of the premium. For these beneficiaries, the rules for low-income benchmark premium and appropriate low-income premium subsidies would apply to these PACE plans as they would any other enhanced alternative plan with low-income eligible enrollees.

Comment—Medicare-only PACE enrollees and premium payment. One commenter seeks clarification of CMS' statement that Medicare-only PACE enrollees will be responsible for paying the full base beneficiary premium amount. Isn't it the case that Medicare-only enrollees will generally be liable for the full monthly beneficiary premium, i.e., the base beneficiary premium adjusted for the difference between the PACE organization's standardized bid amount and the national average monthly bid amount?

Response. The commenter is correct. This was a typographical error in the Advance Notice. The statement should be that the Medicare-only enrollees are liable for the monthly beneficiary premium.

Comment—Supplemental premium for Medicare-only PACE enrollees. Referring to CMS' instructions for calculating the supplemental premium for Medicare-only PACE enrollees on p. 60, CMS explains that the supplemental premium must account for the $250 deductible, 25% cost-sharing between $250 and $2250 and full beneficiary responsibility for all costs above $2250. We are not clear on why the 15% plan liability for costs above the out-of-pocket threshold are not included in the plan's basic bid.

Response. Due to the cost sharing prohibitions in sections 1894(b)(1)(A)(i) and 1934(b)(1)(A)(i) of the Act, PACE beneficiaries never reach the out-of-pocket threshold as defined by 1860D-2(b)(4)(B) of Act and therefore there is no reinsurance payments. The 15% plan liability is factored into the basic bid which will be the basis for payment and risk corridor calculations.

Comment—Medicare-only supplemental premiums. One commenter expressed concern that Part D may have unintended consequences for our Medicare-only enrollees. As a consequence of having to build all Medicare enrollees' cost-sharing responsibility into a supplemental premium thereby precluding reinsurance payments that would otherwise have been made on their behalf, we are concerned that the amount of the combined basic Part D and supplemental premiums may, in some situations, be higher than the amount they were previously paying for comprehensive drug coverage through PACE.

Response. As previously stated due to the cost sharing prohibitions, in place before the creation of Part D, PACE beneficiaries never reach the out-of-pocket threshold as defined by 1860D-2(b)(4)(B) of Act. We do not have the authority to make reinsurance payments unless beneficiaries reach the out-of-pocket threshold.

D. Part D Implementation Issues

Comment—Prescription drug claim submission process guidance. Potential Part D sponsors have not received any further guidance or final standards for the prescription drug claim submission process. We urge the Agency to establish the final standards no later than April 1, 2005 and communicate these processes to organizations prior to the CMS training that has been scheduled for April 4th and 5th. Plans will then be better prepared to engage CMS staff regarding issues that may potentially inhibit data submission. We recommend that CMS establish standards that would clearly demarcate timeframes for the submission of data from participants involved in the coordination of LIS benefits. This process should compliment the final prescription drug claim submission requirements that Part D sponsors must ultimately conform.

Response: CMS is making revisions to the draft "Requirements for Submitting Prescription Drug Event Data" based on public comments. The updated version will be released promptly. The CMS training the commenter refers to is specifically focused on the bidding process and will not include a session on requirements for submitting prescription drug event data.

E. Reinsurance demo

Comment—Negotiating the capitated reinsurance payment. One commenter requested that CMS provide additional details for negotiating the capitated reinsurance payment component during the plan bid approval process and asked for clarification on how the estimates for reductions identified in the options will be applied and how the risk corridors will be applied for plans that are approved for participation in option one.

Response: Additional guidance on the reinsurance demonstration will be provided online at www.cms.gov/pdps.

Comment—Different benefit plans. One commenter asked if a demonstration plan could apply for one benefit plan and not another?

Response: Eligible Part D sponsors may provide plans using either of the two options. They are not expected to do both options, but could do so if they were an eligible MA organization and wanted to have two demonstration plans. More details are available in the February 25, 2005 notice in the Federal Register, Vol. 70, No. 37, page 9360 available online at www.gpoaccess.gov/fr/index.html. Additional guidance on the reinsurance demonstration will be provided online at www.cms.gov/pdps.

F. Private fee-for-service (PFFS) plans

Comment—Reinsurance process. One commenter asked if a Private Fee-For-Service (PFFS) plan uses negotiated discounts, can the reinsurance reconciliation process work the same as for a non-PFFS MA-PD plan?

Response: No, the option to provide negotiated prices in section 1860D-21(d)(1) of the Act and the special PFFS reinsurance directive in 1860D-21(d)(4) of the Act are not linked. Irrespective of other special PFFS rules, CMS must make reinsurance payments to PFFS plans taking "into account the average reinsurance payments made under section 1860D-15(b) for populations of similar risk under MA-PD plans".

G. Dual eligibles and institutional status

Comment—Institutional status data. In the Part D final rule preamble, it says "States will be providing information on a full-benefit dual eligible individual's institutional status on a monthly basis to us. We will provide this information to Part D plans. We will address through operational guidance how plans should address situations in which an enrollee's institutional status is different than the information provided to them from us." Will you require PDPs or cost-PDs to do conduct an institutional census to compare against the state data? This is a time consuming and expensive process, especially if you are a regional plan. It would be a substantial effort to waive and track a $1 or $3 copay.

Response: Institutional status for low-income full dual eligibles for the purpose of the Part D cost sharing and premium subsidy will be ascertained from the Medicare/Medicaid dual eligible files submitted by the States. This dataset is discussed extensively above.

Long term institutional status for the purpose of applying the institutional factor for risk adjustment will be determined using CMS' Minimum Data Set (MDS). CMS has been using the MDS for determining LTI status since 2004 and this process has proven reliable.

Enclosure V. Part D risk adjustment model

Introduction

The Part D risk adjustment models are presented below. The plan liability models (for continuing and new enrollees) are the appropriate models for payment purposes. The multipliers for Low-Income Subsidy Eligible and Long Term Care (institutionalized) are also included. These multipliers are used to account for the additional costs of low income and long term care (institutionalized) individuals.

Because of public interest in the spending model which was used to develop Part D risk adjustment we have presented the spending model (full risk and new enrollee) for informational purposes. The spending model presents coefficients in dollars for projected total expenditures on prescription drugs covered by Part D in 2006 not accounting for cost sharing. Again, the spending model is not for payment purposes.

Risk Model for Plan Liability - The Payment Model

The RXHCCs are the condition categories in the model that are assigned incremental payments. They were developed starting with the taxonomy developed for the HCC model used to risk adjust payments for Part A and B services in MA plans. The HCC groupings were built from smaller groups called DXGs. We used both the high level HCCs and lower level DXGs in creating the new groups for drug risk adjustment. A new nomenclature is used because, although some groups are the same as those in the earlier work, there are also a number of splits, additions and deletions. The diagnoses used in the model are those found in Medicare data in the year prior to the drug payment year.

This table associates a risk factor with each RXHCC. The factors are generally additive. An enrollee may be credited with many conditions. In some circumstances a hierarchy is imposed so some conditions are mutually exclusive. The draft model posted in the Advance Notice associated dollar amounts with the conditions and demographics. Using this model a dollar prediction was made for each person in FFS Medicare and the average prediction was computed. The average was divided into the coefficients for the RXHCCs and the other payment factors to compute relative factors.

Below the RXHCCs are three groups labeled DRXHCC. These are add-on factors for people under 65 (disabled) with particular conditions - schizophrenia, other major psychiatric disorders, and cystic fibrosis. These amounts are added to the amount for the main entry of the diagnosis.

Below these categories are demographic categories for age/sex and for an aged person having entered Medicare originally for reasons of disability. Because one cannot predict all diseases with drug consequences by knowing prior year diagnoses, the demographic coefficients are significant in magnitude.

Plan liability takes into account the plan liability for spending after deductibles and other cost sharing in the Standard Part D benefit. These factors were derived for the noninstitutionalized population and without adjustments for the effects of the low income

subsidy. These factors will be discussed separately.

Part D Continuing Enrollee Risk Adjustment Model, Plan Liability Model

RXHCC Groups	RXHCC Labels	Relative Factors
RXHCC1	HIV/AIDS	2.042
RXHCC2	Opportunistic Infections	0.257
RXHCC3	Infectious Diseases	0.073
RXHCC8	Acute Myeloid Leukemia	0.293
RXHCC9	Metastatic Cancer, Acute Leukemia, and Severe Cancers	0.174
RXHCC10	Lung, Upper Digestive Tract, and Other Severe Cancers	0.050
RXHCC17	Diabetes with Complications	0.258
RXHCC18	Diabetes without Complication	0.190
RXHCC19	Disorders of Lipoid Metabolism	0.163
RXHCC20	Other Significant Endocrine and Metabolic Disorders	0.078
RXHCC21	Other Specified Endocrine/Metabolic/Nutritional Disorders	0.049
RXHCC24	Chronic Viral Hepatitis	0.092
RXHCC31	Chronic Pancreatic Disease	0.048
RXHCC33	Inflammatory Bowel Disease	0.182
RXHCC34	Peptic Ulcer and Gastrointestinal Hemorrhage	0.033
RXHCC37	Esophageal Disease	0.176
RXHCC39	Bone/Joint/Muscle Infections/Necrosis	0.023
RXHCC40	Behçet's Syndrome and Other Connective Tissue Disease	0.066
RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.198
RXHCC42	Inflammatory Spondylopathies	0.075
RXHCC43	Polymyalgia Rheumatica	0.043
RXHCC44	Psoriatic Arthropathy	0.150
RXHCC45	Disorders of the Vertebrae and Spinal Discs	0.141
RXHCC47	Osteoporosis and Vertebral Fractures	0.115
RXHCC48	Other Musculoskeletal and Connective Tissue Disorders	0.077
RXHCC51	Severe Hematological Disorders	0.113
RXHCC52	Disorders of Immunity	0.207
RXHCC54	Polycythemia Vera	0.092
RXHCC55	Coagulation Defects and Other Specified Blood Diseases	0.025
RXHCC57	Delirium and Encephalopathy	0.000*
RXHCC59	Dementia with Depression or Behavioral Disturbance	0.221
RXHCC60	Dementia/Cerebral Degeneration	0.142
RXHCC65	Schizophrenia	0.250
RXHCC66	Other Major Psychiatric Disorders	0.158
RXHCC67	Other Psychiatric Symptoms/Syndromes	0.127
RXHCC75	Attention Deficit Disorder	0.254
RXHCC76	Motor Neuron Disease and Spinal Muscular Atrophy	0.152
RXHCC77	Quadriplegia, Other Extensive Paralysis, and Spinal Cord Injuries	0.048
RXHCC78	Muscular Dystrophy	0.083
RXHCC79	Polyneuropathy, except Diabetic	0.077
RXHCC80	Multiple Sclerosis	0.358
RXHCC81	Parkinson's Disease	0.320
RXHCC82	Huntington's Disease	0.055

RXHCC Groups	RXHCC Labels	Relative Factors
RXHCC83	Seizure Disorders and Convulsions	0.127
RXHCC85	Migraine Headaches	0.106
RXHCC86	Mononeuropathy, Other Abnormal Movement Disorders	0.071
RXHCC87	Other Neurological Conditions/Injuries	0.031
RXHCC91	Congestive Heart Failure	0.251
RXHCC92	Acute Myocardial Infarction and Unstable Angina	0.140
RXHCC98	Hypertensive Heart Disease or Hypertension	0.222
RXHCC99	Specified Heart Arrhythmias	0.093
RXHCC102	Cerebral Hemorrhage and Effects of Stroke	0.063
RXHCC105	Pulmonary Embolism and Deep Vein Thrombosis	0.027
RXHCC106	Vascular Disease	0.035
RXHCC108	Cystic Fibrosis	0.163 [a]
RXHCC109	Asthma and COPD	0.163 [a]
RXHCC110	Fibrosis of Lung and Other Chronic Lung Disorders	0.077
RXHCC111	Aspiration and Specified Bacterial Pneumonias	0.043 [b]
RXHCC112	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections	0.043 [b]
RXHCC113	Acute Bronchitis and Congenital Lung/Respiratory Anomaly	0.043 [b]
RXHCC120	Vitreous/Retinal Hemorrhage and Vascular Retinopathy except Diabetic	0.056
RXHCC121	Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies	0.040
RXHCC122	Open-angle Glaucoma	0.161
RXHCC123	Glaucoma and Keratoconus	0.068
RXHCC126	Larynx/Vocal Cord Diseases	0.024
RXHCC129	Other Diseases of Upper Respiratory System	0.083
RXHCC130	Salivary Gland Diseases	0.050
RXHCC132	Kidney Transplant Status	0.215
RXHCC134	Chronic Renal Failure	0.074
RXHCC135	Nephritis	0.051
RXHCC137	Urinary Obstruction and Retention	0.048 [c]
RXHCC138	Fecal Incontinence	0.048 [c]
RXHCC139	Incontinence	0.102
RXHCC140	Impaired Renal Function and Other Urinary Disorders	0.023
RXHCC144	Vaginal and Cervical Diseases	0.033
RXHCC145	Female Stress Incontinence	0.067
RXHCC157	Chronic Ulcer of Skin, Except Decubitus	0.048 [c]
RXHCC158	Psoriasis	0.077
RXHCC159	Cellulitis and Local Skin Infection	0.048 [c]
RXHCC160	Bullous Dermatoses and Other Specified Erythematous Conditions	0.048 [c]
RXHCC165	Vertebral Fractures without Spinal Cord Injury	0.055
RXHCC166	Pelvic Fracture	0.040
RXHCC186	Major Organ Transplant Status	0.079 [d]
RXHCC187	Other Organ Transplant/Replacement	0.079 [d]
DRXHCC65	age < 65 and RXHCC65	0.375
DRXHCC66	age < 65 and RXHCC66	0.165
DRXHCC108	age < 65 and RXHCC108	0.897

RXHCC Groups	RXHCC Labels	Relative Factors
FEMALE 0 - 34		0.421
FEMALE 35 - 44		0.576
FEMALE 45 - 54		0.611
FEMALE 55 - 59		0.583
FEMALE 60 - 64		0.532
FEMALE 65 - 69		0.459
FEMALE 70 - 74		0.447
FEMALE 75 - 79		0.434
FEMALE 80 - 84		0.416
FEMALE 85 - 89		0.395
FEMALE 90 - 94		0.371
FEMALE 95+		0.317
MALE 0 - 34		0.397
MALE 35 - 44		0.519
MALE 45 - 54		0.541
MALE 55 - 59		0.491
MALE 60 - 64		0.433
MALE 65 - 69		0.355
MALE 70 - 74		0.354
MALE 75 - 79		0.348
MALE 80 - 84		0.334
MALE 85 - 89		0.326
MALE 90 - 94		0.301
MALE 95+		0.266
Age ≥ 65, female, originally entitled to Medicare due to disability		0.089
Age ≥ 65, male, originally entitled to Medicare due to disability		0.078

Notes:

1. a, b, c and d coefficients with same letter are restricted to be equal.
2. These relative factors are for community residents without the low income subsidy.
3. *Plan liability coefficient was set to zero because the coefficient was negative under the plan liability model.
4. The long term care or low-income multiplier applies if valid for the payment month
5. The FFS mean expenditures for normalization of the plan liability model is $993.33.

New Enrollee Model – Plan Liability

Enrollees with less than 12 months of Part B enrollment prior to the payment year, potentially do not have a complete diagnostic record in Medicare files. Most of these people are new enrollees in the Medicare program. For such people a model based solely on demographic characteristics is used. This table is not additive. A person is assigned to one cell by age/sex and whether they are aged and entered Medicare due to disability. The Plan Liability model is used for payment.

These factors were derived for the noninstitutionalized population and without adjustments for the effects of the low-income subsidy.

Part D New enrollee factors, Plan Liability Model

	Age-Sex not originally disabled	Age-Sex originally disabled
	Relative Factors	Relative Factors
Female 0 - 34	0.874	--
Female 35 - 44	1.174	--
Female 45 - 54	1.287	--
Female 55 - 59	1.287	--
Female 60 - 64	1.287	--
Female 65	0.903	1.287
Female 66	0.922	1.287
Female 67	0.942	1.287
Female 68	0.949	1.287
Female 69	0.959	1.287
Female 70 - 74	0.995	1.287
Female 75 - 79	1.028	1.204
Female 80 - 84	1.030	1.204
Female 85 - 89	1.005	1.204
Female 90 - 94	0.946	1.057
Female 95+	0.835	0.947
Male 0 - 34	0.845	--
Male 35 - 44	1.109	--
Male 45 - 54	1.109	--
Male 55 - 59	1.109	--
Male 60 - 64	1.109	--
Male 65	0.753	1.109
Male 66	0.767	1.109
Male 67	0.796	1.109
Male 68	0.817	1.109
Male 69	0.835	1.109
Male 70 - 74	0.877	1.109
Male 75 - 79	0.927	1.022
Male 80 - 84	0.941	1.022
Male 85 - 89	0.934	1.022
Male 90 - 94	0.868	0.956
Male 95+	0.804	0.891

Notes:
1. All cells are mutually exclusive. Specifically, an age 65, male who is originally disabled has a relative factor of 1.109; if he is not originally disabled, the relative factor is .753.
2. These relative factors are for community residents without the low income subsidy.
3. The long term care or low income multiplier applies if valid for the payment month.

Disease Hierarchies - Part D Risk Adjustment Model

As in the CMS-HCC model some of the disease groups are clustered in hierarchies. In clinical review it was found that drug regimens may get more intense and more drugs may be added when a disease has a higher severity. In such a case the highest cost

category of the related diseases is triggered and the lower cost categories zeroed out. Such is the case with diabetes, in which diabetes with complications overrides uncomplicated diabetes. In predicting drugs the codes for particular complications picked up the spending that differentiates diabetes with different complications.

If the drugs for diseases differ from one another, even it the diseases are related, the RXHCCs are not placed in the same hierarchy and remain additive.

Disease Hierarchies - Part D Risk Adjustment Model		
If the Disease Group is Listed in this Column….		**… Then Drop the Associated Disease Group(s) Listed in this Column**
Disease Group (RXHCC)	Disease Group Label	
1	HIV/AIDS	3
2	Opportunistic Infections	3, 112, 113
8	Acute Myeloid Leukemia	9, 10
9	Metastatic Cancer, Acute Leukemia, and Severe Cancers	10
17	Diabetes with Complications	18
37	Esophageal Disease	126
45	Disorders of the Vertebrae and Spinal Discs	48
51	Severe Hematological Disorders	54, 55
54	Polycythemia vera	55
59	Dementia with Depression or Behavioral Disturbance	60, 67
65	Schizophrenia	67
66	Other Major Psychiatric Disorders	67
91	Congestive Heart Failure	98
108	Cystic Fibrosis	109, 110, 113
109	Asthma and COPD	110, 113
110	Fibrosis of Lung and Other Chronic Lung Disorders	113
111	Aspiration and Specified Bacterial Pneumonias	113
112	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections	113
120	Vitreous/Retinal Hemorrhage and Vascular Retinopathy except Diabetic	121
122	Open-Angle Glaucoma	123
132	Kidney Transplant Status	134, 135, 140, 187
134	Chronic Renal Failure	135, 140
135	Nephritis	140
138	Fecal Incontinence	137
139	Incontinence	137
157	Chronic Ulcer of Skin, Except Decubitus	138, 160
159	Cellulitis and Local Skin Infection	160
186	Major Organ Transplant Status	187

How Payments are Made with a Disease Hierarchy
EXAMPLE: If a beneficiary triggers RXHCC157 (Chronic Ulcer of the Skin) and RXHCC160 (Bullous Dermatoses and Other Specified Erythematous Conditions) then RXHCC160 will be dropped. In other words, payment will always be associated with the RXHCC in column 1, if an RXHCC in column 3 also occurs during the same collection period. Therefore, the Part D plan sponsor's payment will be based on RXHCC157 rather than RXHCC160.

Long Term Care and Low-Income Multipliers for Part D Risk Adjustment Model (Plan Liability)

Long Term Care and Low Income Multipliers for Part D Risk Adjustment (Plan Liability Model)

Long Term Care Multiplier		Low Income Multiplier	
Disabled < 65 years	Aged ≥ 65 years	Group 1	Group 2
1.21	1.08	1.08	1.05

Notes:

1. The enrollee's base Part D risk score generated by the plan liability model is multiplied by the LI or LTC multiplier if they apply for the payment month.
2. The LI and LTC multipliers are mutually exclusive (i.e. only one multiplier can apply in a payment month) and LTC takes precedence over LI for the purposes of risk adjustment.
3. Long Term Care (Institutional) status is defined as residing in a nursing home for more than 90 days prior to the payment month. This is the same definition as in MA risk adjustment.
4. Group 1 for the LI multiplier includes all full low-income subsidy eligible individuals as defined in regulation at §423.773(b) as having income less than 135% of the Federal Poverty Level (FPL) and resources not exceeding three times the Supplemental Security Income (SSI) resource limit. Group 2 includes all partial low-income-subsidy eligible individuals.

Risk Model for Spending - for reference, not payment

This model is similar to the Plan Liability model in structure. The coefficients are in dollars projected for 2006. This model does not account for cost sharing; it is predictive of total expenditures on prescription drugs covered by Part D. This model is not used for payment but is of potential interest to bidders. The dollar values would have to be scaled to match any particular plan's price structure and deviation from average patterns of utilization. This is not a payment model.

These factors were derived for the noninstitutionalized population and without adjustments for the effects of the low income subsidy. These factors will be discussed separately.

Part D Continuing Enrollee Risk Adjustment Model, Spending Model

RXHCC Groups	RXHCC Labels	Dollar Coefficients
RXHCC1	HIV/AIDS	12314.00
RXHCC2	Opportunistic Infections	1647.65
RXHCC3	Infectious Diseases	345.61
RXHCC8	Acute Myeloid Leukemia	1689.53

RXHCC Groups	RXHCC Labels	Dollar Coefficients
RXHCC9	Metastatic Cancer, Acute Leukemia, and Severe Cancers	729.38
RXHCC10	Lung, Upper Digestive Tract, and Other Severe Cancers	111.55
RXHCC17	Diabetes with Complications	1091.45
RXHCC18	Diabetes without Complication	658.61
RXHCC19	Disorders of Lipoid Metabolism	397.06
RXHCC20	Other Significant Endocrine and Metabolic Disorders	400.91
RXHCC21	Other Specified Endocrine/Metabolic/Nutritional Disorders	158.53
RXHCC24	Chronic Viral Hepatitis	516.44
RXHCC31	Chronic Pancreatic Disease	293.08
RXHCC33	Inflammatory Bowel Disease	753.96
RXHCC34	Peptic Ulcer and Gastrointestinal Hemorrhage	141.62
RXHCC37	Esophageal Disease	644.19
RXHCC39	Bone/Joint/Muscle Infections/Necrosis	202.75
RXHCC40	Behçet's Syndrome and Other Connective Tissue Disease	294.36
RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	931.89
RXHCC42	Inflammatory Spondylopathies	392.74
RXHCC43	Polymyalgia Rheumatica	136.31
RXHCC44	Psoriatic Arthropathy	695.26
RXHCC45	Disorders of the Vertebrae and Spinal Discs	456.69
RXHCC47	Osteoporosis and Vertebral Fractures	292.27
RXHCC48	Other Musculoskeletal and Connective Tissue Disorders	182.63
RXHCC51	Severe Hematological Disorders	624.40
RXHCC52	Disorders of Immunity	1403.95
RXHCC54	Polycythemia Vera	320.79
RXHCC55	Coagulation Defects and Other Specified Blood Diseases	93.35
RXHCC57	Delirium and Encephalopathy	168.96
RXHCC59	Dementia with Depression or Behavioral Disturbance	1103.73
RXHCC60	Dementia/Cerebral Degeneration	558.69
RXHCC65	Schizophrenia	1268.40
RXHCC66	Other Major Psychiatric Disorders	644.59
RXHCC67	Other Psychiatric Symptoms/Syndromes	477.69
RXHCC75	Attention Deficit Disorder	991.13
RXHCC76	Motor Neuron Disease and Spinal Muscular Atrophy	876.70
RXHCC77	Quadriplegia, Other Extensive Paralysis, and Spinal Cord Injuries	261.77
RXHCC78	Muscular Dystrophy	391.39
RXHCC79	Polyneuropathy, except Diabetic	443.15
RXHCC80	Multiple Sclerosis	1926.99
RXHCC81	Parkinson's Disease	1377.19
RXHCC82	Huntington's Disease	269.28
RXHCC83	Seizure Disorders and Convulsions	497.65
RXHCC85	Migraine Headaches	542.02
RXHCC86	Mononeuropathy, Other Abnormal Movement Disorders	323.60
RXHCC87	Other Neurological Conditions/Injuries	147.75
RXHCC91	Congestive Heart Failure	717.49
RXHCC92	Acute Myocardial Infarction and Unstable Angina	436.02
RXHCC98	Hypertensive Heart Disease or Hypertension	469.14
RXHCC99	Specified Heart Arrhythmias	223.95

RXHCC Groups	RXHCC Labels	Dollar Coefficients
RXHCC102	Cerebral Hemorrhage and Effects of Stroke	232.31
RXHCC105	Pulmonary Embolism and Deep Vein Thrombosis	147.95
RXHCC106	Vascular Disease	134.53
RXHCC108	Cystic Fibrosis	637.90 [a]
RXHCC109	Asthma and COPD	637.90 [a]
RXHCC110	Fibrosis of Lung and Other Chronic Lung Disorders	341.15
RXHCC111	Aspiration and Specified Bacterial Pneumonias	158.65
RXHCC112	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections	222.96
RXHCC113	Acute Bronchitis and Congenital Lung/Respiratory Anomaly	115.26
RXHCC120	Vitreous/Retinal Hemorrhage and Vascular Retinopathy except Diabetic	182.63
RXHCC121	Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies	101.03
RXHCC122	Open-angle Glaucoma	446.49
RXHCC123	Glaucoma and Keratoconus	168.39
RXHCC126	Larynx/Vocal Cord Diseases	104.61
RXHCC129	Other Diseases of Upper Respiratory System	243.66
RXHCC130	Salivary Gland Diseases	281.75
RXHCC132	Kidney Transplant Status	882.63
RXHCC134	Chronic Renal Failure	328.48 [b]
RXHCC135	Nephritis	328.48 [b]
RXHCC137	Urinary Obstruction and Retention	156.29 [c]
RXHCC138	Fecal Incontinence	156.29 [c]
RXHCC139	Incontinence	395.50
RXHCC140	Impaired Renal Function and Other Urinary Disorders	72.71
RXHCC144	Vaginal and Cervical Diseases	66.85
RXHCC145	Female Stress Incontinence	228.45
RXHCC157	Chronic Ulcer of Skin, Except Decubitus	156.29 [c]
RXHCC158	Psoriasis	244.58
RXHCC159	Cellulitis and Local Skin Infection	162.37
RXHCC160	Bullous Dermatoses and Other Specified Erythematous Conditions	131.84
RXHCC165	Vertebral Fractures without Spinal Cord Injury	304.88
RXHCC166	Pelvic Fracture	250.06
RXHCC186	Major Organ Transplant Status	433.46
RXHCC187	Other Organ Transplant/Replacement	245.87
DRXHCC65	age < 65 and RXHCC65	1677.91
DRXHCC66	age < 65 and RXHCC66	711.85
DRXHCC108	age < 65 and RXHCC108	5650.38
Female 0 - 34		976.33
Female 35 - 44		1569.12
Female 45 - 54		1659.47
Female 55 - 59		1518.63
Female 60 - 64		1171.04
Female 65 - 69		817.34
Female 70 - 74		736.87

RXHCC Groups	RXHCC Labels	Dollar Coefficients
Female 75 - 79		660.60
Female 80 - 84		576.10
Female 85 - 89		488.31
Female 90 - 94		412.62
Female 95+		263.00
Male 0 - 34		965.44
Male 35 - 44		1485.05
Male 45 - 54		1526.10
Male 55 - 59		1116.51
Male 60 - 64		817.55
Male 65 - 69		561.65
Male 70 - 74		493.61
Male 75 - 79		421.40
Male 80 - 84		336.70
Male 85 - 89		277.13
Male 90 - 94		200.39
Male 95+		97.12
Age ≥ 65, female, originally entitled to Medicare due to disability		473.06
Age ≥ 65, male, originally entitled to Medicare due to disability		361.59

Notes:

1. a, b, and c coefficients with same letter are restricted to be equal.
2. All dollars have been inflated to 2006 and scaled to the Medicare standard Part D benefit.
3. These coefficients are for community residents without the low income subsidy.
4. Neither low-income nor long-term institutionalized multipliers have been computed for the spending model.

New Enrollee Model - Spending

Enrollees with less than 12 months of Part B enrollment prior to the payment year, potentially do not have a complete diagnostic record in Medicare files. Most of these people are new enrollees in the Medicare program. For such people a model based solely on demographic characteristics is used. This table is not additive. A person is assigned to one cell by age/sex and whether they are aged and entered Medicare due to disability.. The Spending model is informational only.

These factors were derived for the noninstitutionalized population and without adjustments for the effects of the low income subsidy.

Part D New enrollee factors, Spending Model

	Age-Sex not originally disabled	Age-Sex originally disabled
	Dollar Coefficients	Dollar Coefficients
Female 0 - 34	2762.77	--
Female 35 - 44	3915.93	--
Female 45 - 54	4159.27	--
Female 55 - 59	4056.48	--
Female 60 - 64	3629.43	--
Female 65	2138.17	3696.27
Female 66	2219.25	3746.65
Female 67	2243.91	3771.31
Female 68	2260.02	3787.42
Female 69	2272.42	3799.82
Female 70 - 74	2367.15	3594.17
Female 75 - 79	2445.51	3181.09
Female 80 - 84	2423.97	3159.55
Female 85 - 89	2333.61	3069.19
Female 90 - 94	2161.52	2897.10
Female 95+	1861.97	2597.55
Male 0 - 34	2852.94	--
Male 35 - 44	4062.05	--
Male 45 - 54	3932.86	--
Male 55 - 59	3354.82	--
Male 60 - 64	2931.37	--
Male 65	1750.51	3091.49
Male 66	1803.73	2974.05
Male 67	1853.76	3024.08
Male 68	1924.60	3094.92
Male 69	1966.66	3136.98
Male 70 - 74	2059.76	2899.48
Male 75 - 79	2173.48	2635.01
Male 80 - 84	2183.40	2644.93
Male 85 - 89	2137.78	2599.31
Male 90 - 94	1950.05	2411.58
Male 95+	1762.15	2223.68

Notes:

1. All dollars have been inflated to 2006 and scaled to the Medicare standard Part D benefit.
2. All cells are mutually exclusive. Specifically, an age 65, male who is originally disabled has spending of $3091.49; if he is not originally disabled, the plan liability is $1750.51.
3. These coefficients are for community residents without the low income subsidy.
4. Neither low-income nor long-term institutionalized multipliers have been computed for the spending model.