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To: Clients and Friends

From: John Gorman and Jean LeMasurier

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**Re: 2011 Payment Policies and Call Letter for Medicare Advantage (MA)
and Prescription Drug Plans (PDPs)**

On April 5, 2010 CMS issued the Final Notice of Payment Policies and the Final Call Letter for Medicare Advantage and Prescription Drug Plans for CY 2011. The documents also include provisions from the Patient Protection and Affordable Care Act (PPACA) that go into effect in 2011 or that impact plan bids for 2011.

Final Rate Announcement

As required by health care reform, the MA capitation rates for 2011 are the same as the capitation rates for 2010. CMS will not rebase the value of county FFS costs in 2011.

- **Coding Adjustment** – CMS is keeping the 3.41 percent coding pattern adjustment, which is the same as the 2010 adjustment. The coding adjustment accounts for MA disease scores that are higher than Fee for Service disease scores over a three year period.
- **ESRD Rates** – For 2011, CMS will maintain the 2010 State rates and will not make the modifications that were proposed in the advance notice.
- **Recalibration and Clinical Update of Hierarchical Condition Category (HCC) Risk Adjustment Model** - CMS will defer the new CMS-HCC and CMS-HCC ESRD risk adjustment models to 2012.
- **Risk Adjustment Normalization Factor** – The Part C normalization factor for the aged and disabled is 1.058. The ESRD factor is 1.088 for the functioning graft status and 1.060 for dialysis status. For 2011, the Part D normalization factor is 1.029 which is smaller than the 2010 factor of 1.146.
- **SNP Risk Scores** - For 2011 CMS is implementing a different new-enrollee risk adjustor for new-to-Medicare enrollees in chronic care SNPs. The new method takes into consideration the full risk of the chronic condition of new-to-Medicare enrollees who lack prior year claim-based risk adjustment data. CMS will not extend the new enrollee risk score to Dual Eligible SNPs since CMS determined that the predicted costs of Medicaid enrollees are fully accounted for by the Medicaid risk score adjustment.

- **Recalibration and Clinical Update of the RxHCC Risk Adjustment Model** – For 2011, CMS will update the Part D risk adjustment model by using PDE (Prescription Drug Event) program data and using more recent data from 2007. In addition, CMS clinically revised the pharmacy diagnoses in the hierarchical condition categories (RxHCC).

The 2011 model has 78 RxHCCs (compared with 84 in prior years), due to the addition of new codes (e.g. developmental disability), splitting of codes (e.g. Alzheimer's) and removal of codes. CMS is eliminating multipliers for low income and long term care institutional status and instead will use 5 sets of coefficients: long term institutional, aged low income, aged non-low income, disabled low income, and disabled non-low income. Based on comments, CMS renumbered all RxHCCs.

- **Medicare Secondary Payer (MSP) Adjustment** – CMS will retain the 2010 MSP factors for 2011 - 0.174 for aged/disabled/post-graft and 0.215 for ESRD dialysis/transplant.
- **IME Adjustment** – For 2011, CMS will keep the 2010 IME adjustment of .6 percent of the FFS rate in a given county.
- **Bonus and Incentive Payments** – MA plans must pay qualifying non-contracted physicians PQRI and e-prescribing bonuses, respectively, of two percent of Medicare allowed charges under FFS. PFFS plans pay these bonuses to deemed providers.
- **Clinical Trials** – Beginning in 2011, as a condition of Medicare paying fee for service for clinical trial items and services provided to MA enrollees, MA plans will be required to reimburse beneficiaries for cost sharing that exceeds the MA plan's in-network cost sharing and to include the cost sharing for clinical trials in the out of pocket maximum calculation. To facilitate implementation, beneficiaries or providers must provide documentation to their plans for cost sharing incurred such as the Medicare Summary Notice.
- **DOD Adjustment** – For 2011, CMS will defer the adjustment discussed in the Advance Notice to 2012 when the capitation rates are rebased using FFS rates and DOD data.
- **SNP Frailty Adjustor** – In 2011, CMS will not apply frailty payments to certain dual eligible SNPs as authorized by PPACA.
- **PFFS Network Areas** – In 2011, non-employer PFFS plans that are offered in counties that have two or more network plans open to enrollment must have networks that meet CMS access standards. The counties are listed at: <http://www.cms.hhs.gov/PrivateFeeForServicePlans/>. The list of network areas for 2012 is included in the final 2011 Rate announcement.
- **MSAs** – The maximum deductible for 2011 is \$10,600. For demonstration plans, the 2011 minimum deductible is \$2,200, the maximum out of pocket deductible is \$10,600 and the minimum difference between the deductible and deposit is \$1,000.
- **Part D Benefit Parameters** – The Final Notice includes the updated Part D and RDS benefit parameters which will be increased by 0.31 percent for 2011 (4.63 annual percentage trend for 2010 adjusted by -4.13 percent for prior year revisions). Most of the benefit parameters remain unchanged with the exception of the Initial Coverage Limit which increases from \$2,830 to \$2,840 for 2011. Maximum copayments for duals will not increase for 2011.

Part D Benefit Parameters	2010	2011
<u>Defined Standard Benefit</u>		
Deductible	\$310	\$310
Initial Coverage Limit	\$2,830	\$2,840
Out-of-Pocket Threshold	\$4,550	\$4,550
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	\$2.50	\$2.50
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	\$6.30	\$6.30
Retiree Drug Subsidy		
Cost Threshold	\$310	\$310
Cost Limit	\$6,300	\$6,300

- **LIS Benchmarks** – The LIS benchmark will be calculated using basic Part D premiums before the application of Part C rebates. If a plan’s adjusted basic beneficiary premium exceeds the low income premium subsidy by a “de minimis” amount or less, a plan may waive the excess and set the LIS beneficiary premium equal to the low income premium subsidy amount. CMS has not yet published the dollar value of “de minimis”.
- **Manufacturer Discount Program** – Drug manufacturers must discount brand name drugs at the point of sale, charging only 50 percent of the price negotiated with a Part D plan sponsor to enrollees who have reached or exceeded the initial coverage limit and have incurred costs below the annual out-of-pocket threshold. LIS beneficiaries and beneficiaries in qualified retiree prescription drug plans (RDS plans) are not eligible for these discounts. Since the discounts may increase drug utilization in the coverage gap and accelerate beneficiary movement through the coverage gap into catastrophic coverage, plans should take these discounts into account when estimating plan liability in the catastrophic phase and in developing reinsurance subsidy estimates for the 2011 Part D bids. Discounts do not extend to dispensing fees.
- **Reduced Cost Sharing for Generic Drugs in the Coverage Gap** – For 2011, cost sharing for generic drugs is 93 percent, or actuarially equivalent coverage. LIS beneficiaries and beneficiaries in qualified retiree prescription drug plans are not eligible.

Final Call Letter for 2011

- **State Resource Center** – CMS has created a State Resource Center to support state Medicaid efforts to increase coordination for dual SNPs.
- **SNP Plans** - For 2011, CMS will oversample SNP enrollees for CAHPs and HOS reporting.

SNPs that were disproportionate SNPs in 2009 must disenroll all non-special needs members who were enrolled prior to 1/1/2010. Chronic care SNPs must disenroll all members who were enrolled prior to 1/1/2010 and who no longer qualify for the special needs requirements after the redesignation of chronic conditions for 2010.

New and expanding Dual Eligible SNP plans must provide CMS with evidence that they have contracted with the State by September 1, 2010 in order to operate a dual eligible SNP for CY 2011.

- **HOS Survey Administration** – The following plans with 500 members that have a Medicare contract in effect on or before January 1, 2010 must report HOS results: all coordinated care contractors; PFFS plans; MSA plans; 1876 cost contractors; all SNP plans.
- **ESRD Drugs** – CMS is developing a revised bundled payment methodology in FFS that will include drugs as part of “renal dialysis services” that would not be eligible for coverage under Part D. Final regulations implementing this revision will be issued in 2010. CMS will explore the use of an indicator on the transaction reply reports that will assist Part D plan sponsors in identifying beneficiaries undergoing dialysis treatment so the proper Part B vs. Part D determination can be made.
- **Partial Fills of Part D Drugs** – Part D plan sponsors are requested to voluntarily provide a trial supply of newly prescribed drugs for beneficiaries in the community of 7-14 days with a pro-rated copayment to reduce unnecessary waste of unused drugs. Plans that choose to implement this program should consider issues such as negotiating different dispensing fees; the option of having a physician fill two prescriptions to avoid additional visit costs; system changes and the impact on LIS cost share at the pharmacy. CMS will continue discussions with stakeholders on this issue before any program is required and will work with NCPDP to explore whether changes are needed to adjudication standards.
- **LIS Reassignment Demonstration** – For 2011, CMS will not reassign beneficiaries who have chosen a plan on their own as part of the reassignment demonstration. Comments to the proposal to reassign “choosers” were mixed and included lack of evidence that “choosers” are failing to pay premiums and concern about unintended negative consequences for affected enrollees. CMS will not reassign beneficiaries based on drug utilization in 2011 (beneficiary –centered reassignment). CMS will continue to consider these options for the future.
- **COB User Fee** – The Part D COB user fee will be reduced to \$1.17 per enrollee per year for 2011.
- **Specialty Tier Threshold** – For 2011, the Part D specialty tier threshold will remain at \$600.

- **Enrollment Assistance Demonstration** – CMS does not intend to implement a demonstration to assist beneficiaries with enrollment decisions in 2011.
- **Risk Adjustment Data Validation (RADV) Audits** - CMS encourages MA plans to include language in provider contracts regarding obligations to provide data and records for risk adjustment validation audits.
- **Release of Part C and Part D Payment Data** – CMS plans to issue a proposed regulation on the release of Part C and D payment data to the public in the year following the actual payment year (after risk adjustment and Part D payment reconciliation is complete).

If you have specific questions, contact Gorman Health Group at 202-364-8283 or at ghg@gormanhealthgroup.com.

Access the CMS Announcement of [Calendar Year \(CY\) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter](#) dated April 5, 2010.