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**To: Clients and Friends**  
**From: John Gorman and Jean LeMasurier**  
**Date: February 23, 2010**  
**Re: 45 Day Advance Notice and Draft Call Letter for 2011**

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#### **45 Day Advance Notice and Draft Call Letter for 2011**

On February 19, 2010, CMS issued the Advance Notice of Methodological Changes for CY 2011 for Medicare Advantage (MA) capitation rates and Part C and Part D Payment Policies. Under the Advance Notice, MA rates are estimated to increase **2.26 percent** in 2011 due to the combined effect of the national growth rate and normalization factor. In addition, Indirect Medical Education (IME) Costs will continue to be phased out, however the impact will vary by county. The preliminary rates reflect current law which includes a 21 percent physician fee cut scheduled to take effect March 2010, and an additional cut projected for 2011. Final rates will be announced on April 5, 2010 and will include the effects of any legislation enacted by that time.

CMS included the draft 2011 Call Letter with the 45 day Advance Notice. The Draft Call letter did not include any substantive policy or operational changes for 2011 since CMS plans to include these in a final regulation 4085 that will be issued around the time of the final rate announcement for 2011.

#### **45 Day Advance Notice**

Since CMS is rebasing the value of county FFS costs in 2011, MA capitation rates in each county will be the greater of the county's FFS costs or the prior year MA rate updated by the national MA growth rate. This impact will vary by county.

Highlights include:

- **MA National Growth Rate** – The preliminary estimate of the National Per Capita MA growth rate is a 1.38 percent increase over 2010 county rates. This reflects a 1.75 percent change in the underlying trend for aged and disabled and a net reduction of 0.38 percent for adjustments for prior years. This compares to the final 2010 national growth factor of 0.81 percent.
- **Coding Adjustment** – CMS is proposing a 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. CMS is requesting comments on

the methodology e.g. the use of more recent cohorts which could result in a higher coding pattern adjustment.

- **Risk Adjustment Normalization Factor** – The preliminary Part C normalization factor for the aged and disabled is 1.031. This is a smaller adjustment than the 2010 factor of 1.041, resulting in a 0.98 percentage increase in the 2011 rate relative to what the rate would have been if the factor had remained unchanged from 2010. For 2011, the Part D normalization factor is 1.029 which is smaller than the 2010 factor of 1.146.
- **Budget Neutrality** – There will be no budget neutrality factor applied to the risk portion of the final rates announced in April for 2011. The budget neutrality factor was phased out beginning in 2007 and was completed in 2010. The final elimination of the budget neutrality factor has the effect of reducing the trend applied to MA rates 0.1 percentage point.
- **ESRD Rates** – For 2011, ESRD payment will be 100 percent of the revised 2008 rate book which uses updated state information on payment for enrollees who are in dialysis or transplant status. For 2011, the ESRD risk adjustment model is recalibrated and the MSP factor is revised.
- **Recalibration and Clinical Update of Hierarchical Condition Category (HCC) Risk Adjustment Model** – In 2011, CMS will implement an updated version of the CMS HCC risk adjustment model that will update data years. CMS also has revised clinical diagnoses included in the HCC model based on a review of the assignment of all ICD-9 codes to diagnosis groupings.

CMS has made a number of modifications to the HCC methodology that could have far-reaching impact for plans. Overall, the number of HCCs has been increased to 87 HCCs from 70, reflecting CMS' ongoing efforts to refine the model. Most significantly, for the first time, two HCCs for dementia, one for morbid obesity, and one for uncomplicated angina have been added. With such high prevalence of all of these—especially dementia—in the senior population, these inclusions will potentially have a dramatic effect on RAF scores. Also new to the methodology: other endocrine and metabolic abnormalities and exudative macular degeneration are now represented; likewise atherosclerosis of extremities with ulceration has been given its own HCC. The decision was made to allot the same risk factor value to all degrees of pressure sore (from pre-ulcer to frank decubitus) and all degrees of chronic kidney disease (CKD). The CKD decision means that renal disease can be coded as unspecified in cases where the Glomerular Filtration Rate (GFR) is not known with no change in RAF value.

Equally significant is what was “taken away:” the Diabetes classifications have been changed from five HCCs to just three: diabetes with acute complications, diabetes with chronic complications, and uncomplicated diabetes. The net intended result of the change is to decrease the reimbursement for multiple diabetic codes. We expect the net effect to be a decrease in RAF scores attributable to diabetes that will be offset by the addition of dementia, obesity, and angina codes to the extent that those are documented and captured. This effect can be more accurately assessed when a crosswalk from the new HCCs to actual ICD-9 codes is available.

- **SNP Risk Scores** - For 2011 CMS is proposing a different new-enrollee risk adjustor for enrollees in chronic care SNPs. Currently chronic care SNPs are paid the average new-enrollee rate, without taking into consideration the enrollment bias that means their enrollees are higher risk than average.
- **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.
- **Medicare Secondary Payer (MSP) Adjustment** – CMS has revised the MSP factor for 2011 resulting in a lower adjustment of 0.163 (compared to 0.174 in 2010).
- **IME Adjustment** – For 2011, IME costs will be phased out under the MIPPA formula based on the amount of IME included in the FFS rate, up to a maximum of 1.2 percent for the FFS rate in a given county. The final announcement will identify the amount of IME for each county rate and will reflect county rates with and without the IME reduction.
- **Bonus and Incentive Payments** – MA plans must pay qualifying non-contracted physicians PQRI and E-prescribing bonuses respectively of 2 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 plans’ in-network cost sharing and to include the cost sharing for clinical trials in the out of pocket maximum calculation.
- **DOD Adjustment** – For 2011, CMS will adjust 138 county rates with at least 10 beneficiaries who are eligible for the Uniformed Services Family Health Plan (USFHP) by approximately \$1.85 (ranging from a decrease or \$0.10 to an increase of \$5.00).
- **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 will be included in the final 2011 Rate announcement.
- **Part D Benefit Parameters** – The Advance 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.

<b>Part D Benefit Parameters</b>	<b>2010</b>	<b>2011</b>
<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
<b>Retiree Drug Subsidy</b>		
Cost Threshold	\$310	\$310
Cost Limit	\$6,300	\$6,300

### Draft Call Letter for 2011

- **SNP plans** - For 2011, CMS will oversample SNP enrollees for CAHPs and HOS reporting. CMS plans to release future guidance regarding the expanded sampling.

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.

Existing 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.

- **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 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 choosing this option will complete a new field in the PBP for 2011.
- **LIS Reassignment Demonstration** – CMS has requested comments on whether they should reassign beneficiaries who have chosen a plan on their own as part of the reassignment demonstration if the LIS premium is above the LIS benchmark by a specified threshold, e.g. \$10 or greater. CMS is also requesting comments on other LIS reassignment criteria it should consider in addition to premium liability and medication use.

- **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. While this contract language may not yet be in place with participating providers, the first data submission is due from Part C and Cost-Based Plans at the beginning of next month. Key dates are as follows:
  - March 5, 2010: initial submission deadline for risk adjustment data with service dates January 1, 2009 through December 31, 2009
  - September 3, 2010: initial submission deadline for risk adjustment data with service dates July 1, 2009 through June 30, 2010.
  - March 4, 2011: initial submission deadline for risk adjustment data with service dates January 1, 2010 through December 31, 2010
  - September 2, 2011: initial submission deadline for risk adjustment data with service dates July 1, 2010 through June 30, 2011
- **Release of Part C and Part D Payment Data** – CMS is requesting comments on a proposal to release the following Part C and D payment data annually to the public in the year following the actual payment year. Though CMS does not believe that the availability of this information would pose any competitive or proprietary threat to a Plan, comments should be provided to CMS regarding any negative impact that this release would have, specifically if it would affect the competitive nature of the bidding process, or if the release of this data would reveal information that is of a proprietary nature.
  - Part C payment data at the plan benefit package level including per member per month payments, average rebate payments, average risk score and aggregated payment data by county.
  - For Part D, CMS would release payment data at the plan benefit level including per member per month direct subsidy payments, low income cost sharing subsidy and the federal reinsurance subsidy and average risk score.