April 6, 2009

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

SUBJECT: Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies

In accordance with section 1853(b)(1) of the Social Security Act (the Act), we are notifying you of the annual Medicare Advantage (MA) capitation rate for each MA payment area for 2010, and the risk and other factors to be used in adjusting such rates. The capitation rate tables for CY 2010 are posted on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/ under Ratebooks and Supporting Data. The spreadsheet that shows the statutory component of the regional benchmarks is also posted at this website.

Attachment I shows the final estimates of the increases in the National Per Capita MA Growth Percentages for 2010. These growth rates will be used to update the 2010 rates, except for the ESRD State rates, which are subject to a 2 percent minimum increase under Section 1853(a)(1)(H). As discussed in Attachment I, the final estimate of the increase in the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 0.81 percent. Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the National Per Capita MA Growth Percentages.

Section 1853(b)(4) of the Act requires CMS to release county-specific per capita fee-for-service (FFS) expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2007 are being posted on the above website.

Attachment III presents responses to comments on the Advance Notice of Methodological Changes for CY 2010 MA Capitation Rates and Parts C and Part D Payment Policies (Advance Notice). We received 66 submissions in response to CMS' request for comments on the Advance Notice, published on February 20, 2009. Three of the comments were from advocacy groups, three were from Congress (members or agencies of Congress), seven were from associations, nine were from consultants, and forty-four were from health plans.

Attachment IV contains tables with the Part D benefit parameters.

Key Changes from the Advance Notice

Attachment I provides the final estimates of the National MA Growth Percentages (growth trends) and information on deductibles for MSA standard and demonstration plans, and on the maximum out-of-pocket amount for MSA demonstrations plans.

Attachment III, Section E announces the policy decision on the MA coding pattern differences adjustment for 2010. After consideration of comments, CMS has modified the methodology proposed in the Advance Notice. Section D includes the Budget Neutrality factor for 2010. Attachment IV announces the final version of the update to the Part D Benefit Parameters.

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

Proposals Adopted as Issued in the Advance Notice:

Frailty Adjustment Transition for PACE organizations. Frailty adjustment scores will be applied to payment to PACE organizations using the transition schedule published in the 2008 Announcement (published April 2, 2007). PACE frailty scores for payment year 2010 will be calculated using a blend of 50% of the frailty factors in use prior to 2008 and 50% of the recalibrated frailty factors implemented in 2009.

Frailty Adjustment Transition for Certain Demonstrations. Frailty adjustment scores will be applied to payment to the following MA plan types using the phase-out schedule published in the 2008 Announcement (published April 2, 2007): Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans. The phase out schedule for 2010 is 25% of the pre-2008 frailty factors. 2010 will be the final year in the phase out for these MA plan types.

Normalization Factors. Normalization factors for 2010 are as follows:

- The final 2010 normalization factor for the aged-disabled model is 1.041.
- The final 2010 normalization factor for the ESRD dialysis model is 1.039.
- The final 2010 normalization factor to be applied to the risk scores of enrollees in functioning graft status is 1.072.
- The final 2010 normalization factor for the RxHCC model is 1.146.

ESRD Payment. For payment year 2010, CMS' payments for ESRD dialysis and transplant enrollees will be based on State rates calculated using a blend of 25% of the old State ratebook (in use through 2007) and 75% of the revised State ratebook (implemented in 2008).

IME Phase Out. For 2010, CMS will begin phasing out indirect medical education (IME) amounts from MA capitation rates (including ESRD).

Location of Network Areas for PFFS Plans in Plan Year 2011. The list of network areas for plan year 2011 can be downloaded from the following website: http://www.cms.hhs.gov/PrivateFeeforServicePlans/ The list has not changed since the publication of the Advance Notice.

Continuation of Clinical Trial Policy. In 2010, we will continue the policy of paying on a fee-for-service basis for clinical trial items and services provided to MA plan members that are covered under the relevant National Coverage Determinations on clinical trials.

Adjustment to FFS Per Capita Costs for VA-DOD Costs. For payment year 2010, OACT concludes that there is insufficient evidence to incorporate any VA adjustment into the rate making process.

Calculation and Source Data of MSP Factor. For payment year 2010, CMS no longer requires that MA organizations conduct, nor will we use the results of, plan surveys conducted in 2009. Rather, CMS will adjust for MSP status using Coordination of Benefits (COB) data.

Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM). In accordance with the January 12, 2009 Final Rule with Comment, "Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions", Part D sponsors must use the amount paid to the pharmacy (or other dispensing provider) when calculating beneficiary cost sharing, developing their Part D bids, and reporting drug costs to CMS. For Part D sponsors that contract with a PBM, amounts paid to the PBM for Part D drugs that exceed the amounts paid to the pharmacy (or other dispensing provider) must be included in the administrative expense component of the bid. Starting in 2010, Part D sponsors will not be required to submit an Attestation of Pricing Approach.

Reinsurance Payment Demonstration Plans. 2010 is the last scheduled year for the Part D Reinsurance Payment Demonstration. CMS will not accept any new or expanded applications for reinsurance demonstration plans to be offered in 2010. Reinsurance demonstration plans which were offered in 2009 may continue through 2010. The budget neutrality offsets applied to the capitated reinsurance payments for these plans will be $10.77 per member per year for contract year 2010.

Payment Reconciliation. The 2010 risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2009. The risk percentages for the first and second thresholds remain at 5% and 10% respectively of the target amount for 2010. The payment adjustments for the first and second corridors are 50% and 80% respectively.

Questions can be directed to:

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Attachments

Attachment I. Final Estimate of the Increase in the National Per Capita MA Growth Percentages for 2010

The first table below shows the National Per Capita MA Growth Percentages (NPCMAGP) used to determine the minimum update percentages for 2010. Adjustments of 1.99 percent, 0.64 percent, 1.23 percent and 1.76 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 ratebook.

The second table below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2009 and 2010. In addition, for 2010, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2010. These data were furnished by the Office of the Actuary.

Increase in the National Per Capita MA Growth Percentages for 2010

	Prior Increases	Current Increases			NPCMAGP for 2010 With §1853(c)(6)(C) adjustment[1]
	2003 to 2009	2003 to 2009	2009 to 2010	2003 to 2010	
Aged	38.97%	41.74%	−0.97%	40.36%	1.00%
Disabled	46.87%	47.81%	−0.67%	46.82%	−0.04%
ESRD[2]	15.44%	16.86%	−0.95%	15.76%	0.28%[3]
Aged+Disabled	39.94%	42.40%	−0.93%	41.07%	0.81%

[1]Current increases for 2003 to 2010 divided by the prior increases for 2003 to 2009.
[2]Starting in 2008, increases for ESRD reflect an estimate of the increase for dialysis-only beneficiaries.
[3]The NPCMAGP for ESRD for 2010 will be the minimum 2 percent increase.

Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2009 and 2010

	2009	2010	Change	2010 non-ESRD
Part A Benefits	$37.94	$40.31	6.2%	$38.34
Part B Benefits[4]	$97.97	$100.01	2.1%	$93.98
Total Medicare	$135.91	$140.32	3.2%	$132.32

[4]Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for current law MSA plans for 2010 is $10,600. For MSA demonstration plans, the 2010 minimum deductible amount is $2,200, the maximum out-of-pocket amount is $10,600, and the minimum difference between the deductible and deposit is $1,000.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentages. Attached is a table that compares the published United States Per Capita Costs (USPCC) with current estimates for 2003 to 2010. In addition, this table shows the current projections of the USPCCs through 2012. We are also providing an attached set of tables that summarizes many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2012.

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 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
2003	$301.42	$290.50	0.964	$250.04	$234.89	0.939	$293.87	$282.50	0.961
2004	$321.21	$326.78	1.017	$268.86	$271.69	1.011	$313.24	$318.43	1.017
2005	$343.27	$348.28	1.015	$286.31	$291.45	1.018	$334.31	$339.49	1.015
2006	$352.70	$351.38	0.996	$309.67	$295.15	0.953	$345.97	$342.67	0.990
2007	$363.56	$370.34	1.019	$317.49	$318.17	1.002	$356.07	$362.06	1.017
2008	$388.02	$385.61	0.994	$342.42	$344.31	1.006	$380.69	$379.02	0.996
2009	$410.78	$414.22	1.008	$362.11	$378.40	1.045	$402.88	$408.50	1.014
2010	$415.28	$415.28	1.000	$366.83	$366.83	1.000	$407.38	$407.38	1.000
2011	$429.04			$380.50			$421.12		
2012	$446.59			$400.33			$439.13		

PART B:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2003	$250.81	$232.24	0.926	$246.76	$211.58	0.857	$250.26	$229.47	0.917
2004	$276.49	$263.39	0.953	$274.57	$252.74	0.920	$276.22	$261.89	0.948
2005	$296.64	$281.90	0.950	$293.34	$272.79	0.930	$296.16	$280.58	0.947
2006	$319.09	$311.28	0.976	$311.80	$316.82	1.016	$318.00	$312.09	0.981
2007	$336.19	$334.02	0.994	$331.91	$343.76	1.036	$335.54	$335.47	1.000
2008	$354.57	$354.44	1.000	$352.88	$343.26	0.973	$354.31	$352.75	0.996
2009	$371.93	$358.03	0.963	$372.21	$357.10	0.959	$371.97	$357.89	0.962
2010	$359.82	$359.82	1.000	$362.57	$362.57	1.000	$360.25	$360.25	1.000
2011	$365.13			$369.74			$365.85		
2012	$375.68			$381.49			$376.58		

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
2003	$552.23	$522.74	0.947	$496.80	$446.47	0.899	$544.13	$511.97	0.941
2004	$597.70	$590.17	0.987	$543.43	$524.43	0.965	$589.46	$580.32	0.984
2005	$639.91	$630.18	0.985	$579.65	$564.24	0.973	$630.47	$620.07	0.984
2006	$671.79	$662.66	0.986	$621.47	$611.97	0.985	$663.97	$654.76	0.986
2007	$699.75	$704.36	1.007	$649.40	$661.93	1.019	$691.61	$697.53	1.009
2008	$742.59	$740.05	0.997	$695.30	$687.57	0.989	$735.00	$731.77	0.996
2009	$782.71	$772.25	0.987	$734.32	$735.50	1.002	$774.85	$766.39	0.989
2010	$775.10	$775.10	1.000	$729.40	$729.40	1.000	$767.63	$767.63	1.000
2011	$794.17			$750.24			$786.97		
2012	$822.27			$781.82			$815.71		

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

PART A:

	All ESRD				Basis for Growth Percentage	
Calendar Year	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only*	Adjusted Current Cumulative Trend
2003	1,854.38	1,596.58	0.861			
2004	1,690.26	1,685.25	0.997	0.9115		0.9115
2005	1,735.53	1,759.90	1.014	0.9359		0.9359
2006	1,807.19	1,717.97	0.951	0.9746		0.9746
2007	1,891.18	1,874.54	0.991	1.0198		1.0198
2008	2,015.22	1,843.42	0.915	1.0867	1.0067	1.0940
2009	2,112.67	1,885.71	0.893	1.1393	1.0134	1.1546
2010	2,133.76	2,133.76	1.000	1.1507	1.0202	1.1739
2011	2,200.43			1.1866	1.0271	1.2187
2012	2,299.34			1.2400	1.0340	1.2820

PART B:

	All ESRD				Basis for Growth Percentage	
Calendar Year	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only*	Adjusted Current Cumulative Trend
2003	2,021.41	1,847.53	0.914			
2004	2,161.14	2,552.18	1.181	1.0691		1.0691
2005	2,297.12	2,739.99	1.193	1.1364		1.1364
2006	2,297.76	2,454.98	1.068	1.1367		1.1367
2007	2,356.60	2,470.81	1.048	1.1658		1.1658
2008	2,446.23	2,887.38	1.180	1.2102	0.9709	1.1749
2009	2,533.58	2,371.73	0.936	1.2534	0.9426	1.1815
2010	2,523.56	2,523.56	1.000	1.2484	0.9152	1.1426
2011	2,581.94			1.2773	0.8886	1.1350
2012	2,608.15			1.2903	0.8627	1.1131

PART A & PART B:

	All ESRD				Basis for Growth Percentage	
Calendar Year	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only*	Adjusted Current Cumulative Trend
2003	3,875.79	3,444.11	0.889			
2004	3,851.40	4,237.43	1.100	0.9937		0.9937
2005	4,032.65	4,499.89	1.116	1.0405		1.0405
2006	4,104.95	4,172.95	1.017	1.0591		1.0591
2007	4,247.78	4,345.35	1.023	1.0960		1.0960
2008	4,461.45	4,730.80	1.060	1.1511	0.9871	1.1362
2009	4,646.25	4,257.44	0.916	1.1988	0.9748	1.1686
2010	4,657.32	4,657.32	1.000	1.2016	0.9633	1.1576
2011	4,782.37			1.2339	0.9523	1.1751
2012	4,907.49			1.2662	0.9430	1.1940

* Starting in 2008, increases for ESRD reflect an estimate of the increase for dialysis-only beneficiaries

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)
2003	2.2	3.0	3.6
2004	2.6	3.4	8.8
2005	3.5	3.3	8.9
2006	3.2	3.7	6.2
2007	2.9	3.4	5.6
2008	4.3	3.3	8.2
2009	−1.0	2.7	9.1
2010	1.7	−0.9	3.1
2011	2.3	2.6	5.3
2012	2.7	4.9	7.4

Part B[2]

Calendar Year	Physician Fee Schedule		Part B Hospital	Total
	Fees	Residual[3]		
2003	1.7	4.5%	5.4%	6.9%
2004	1.5	5.9%	10.0%	9.7%
2005	1.5	3.2%	9.8%	6.9%
2006	0.2	4.6%	4.1%	5.9%
2007	0.0	3.5%	8.4%	4.3%
2008	0.5	3.6%	3.8%	4.4%
2009	1.1	2.6%	6.1%	4.4%
2010	−21.5	8.1%	5.8%	−3.8%
2011	−5.6	2.8%	6.1%	1.7%
2012	−5.3	2.9%	6.3%	2.4%

[1]Percent change over prior year.
[2]Percent change in charges per Aged Part B enrollee.
[3]Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

Medicare Enrollment Projections Under Present Law (In Millions)

Non-ESRD

Calendar Year	Part A		Part B	
	Aged	Disabled	Aged	Disabled
2003	34.428	5.929	33.027	5.187
2004	34.835	6.249	33.282	5.458
2005	35.241	6.576	33.609	5.747
2006	35.892	6.657	33.962	5.987
2007	36.432	7.068	34.445	6.187
2008	37.264	7.133	34.979	6.335
2009	37.768	7.318	35.503	6.485
2010	38.473	7.500	36.065	6.645
2011	39.371	7.679	36.752	6.798
2012	40.657	7.813	37.806	6.922

ESRD Part A

Calendar Year	Part A			
	Aged	Disabled	299I[1]	Total
2003	0.160	0.126	0.096	0.383
2004	0.167	0.132	0.100	0.399
2005	0.174	0.137	0.104	0.415
2006	0.182	0.141	0.107	0.430
2007	0.190	0.143	0.110	0.443
2008	0.198	0.144	0.113	0.455
2009	0.206	0.146	0.116	0.467
2010	0.212	0.149	0.118	0.478
2011	0.218	0.151	0.120	0.489
2012	0.226	0.154	0.121	0.501

ESRD Part B

Calendar Year	Part B			
	Aged	Disabled	299I	Total
2003	0.161	0.120	0.088	0.370
2004	0.168	0.125	0.089	0.382
2005	0.175	0.130	0.092	0.396
2006	0.183	0.133	0.095	0.411
2007	0.190	0.135	0.098	0.423
2008	0.198	0.135	0.100	0.433
2009	0.205	0.137	0.102	0.444
2010	0.211	0.140	0.103	0.454
2011	0.217	0.142	0.105	0.464
2012	0.225	0.144	0.106	0.475

[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
2003	2,657.65	2,861.53	419.92	150.13	132.41	71.96	522.55	218.64	5,446	287
2004	2,775.49	3,005.59	469.88	173.01	143.46	78.03	569.16	236.85	6,506	342
2005	2,885.13	3,139.82	513.88	193.18	151.60	82.67	675.68	299.94	7,618	401
2006	2,830.27	3,212.38	541.17	211.94	151.48	85.64	823.25	516.26	8,866	467
2007	2,776.45	3,147.05	574.84	227.61	154.16	87.70	981.74	659.27	9,991	526
2008	2,861.37	3,285.05	608.19	245.18	160.79	93.02	1,160.89	812.33	11,094	584
2009	2,930.10	3,400.83	638.32	261.85	164.90	96.90	1,340.39	922.44	12,032	633
2010	2,904.68	3,413.61	658.25	275.22	165.52	98.95	1,402.32	950.92	12,667	667
2011	3,017.84	3,557.11	678.55	287.01	166.81	100.58	1,437.67	965.70	13,515	711
2012	3,154.87	3,743.18	693.61	298.78	171.29	104.73	1,498.52	1,014.58	14,480	762

[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
2003	1,263.11	1,190.84	378.19	470.64	182.20	302.52
2004	1,393.34	1,311.08	429.21	545.45	180.99	301.09
2005	1,451.27	1,354.77	482.59	602.99	181.31	303.92
2006	1,456.82	1,327.97	498.14	614.52	181.80	307.02
2007	1,428.28	1,313.39	527.81	655.89	178.26	305.51
2008	1,430.09	1,329.54	536.91	678.15	184.97	323.44
2009	1,459.42	1,364.59	561.03	716.66	188.65	336.77
2010	1,200.72	1,134.42	589.34	759.93	190.54	344.55
2011	1,158.11	1,095.03	632.20	815.49	200.34	364.09
2012	1,123.10	1,048.67	677.78	874.11	212.59	387.26

Calendar Year	Carrier Lab		Other Carrier		Intermediary Lab	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2003	76.42	79.72	337.18	349.92	60.27	80.00
2004	82.36	86.53	362.39	394.84	65.27	88.18
2005	86.70	91.41	370.65	416.71	67.44	91.99
2006	89.75	94.92	375.76	379.88	67.62	92.56
2007	94.76	104.06	378.16	389.56	67.22	95.21
2008	97.95	113.14	374.00	405.60	66.12	96.53
2009	106.24	124.29	389.94	436.29	69.37	102.38
2010	109.81	129.63	399.97	448.65	67.96	101.27
2011	110.54	130.59	425.25	476.82	67.19	100.23
2012	117.25	138.33	452.30	505.73	70.51	105.07

Calendar Year	Other Intermediary		Home Health		Managed Care	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2003	179.80	138.02	139.32	117.11	481.20	199.56
2004	205.81	165.80	159.56	133.66	537.12	233.86
2005	227.10	178.95	183.00	154.37	624.09	291.73
2006	232.17	193.37	206.78	175.63	835.76	529.27
2007	241.88	213.35	236.25	205.17	1,006.33	676.72
2008	245.10	220.65	252.04	217.40	1,197.45	823.14
2009	259.41	240.62	258.15	226.98	1,308.34	889.44
2010	246.99	240.31	259.86	231.77	1,392.73	932.58
2011	263.00	259.80	263.03	235.76	1,406.65	930.81
2012	278.68	278.67	271.14	245.27	1,451.31	965.53

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

Claims Processing Costs as a Fraction of Benefits

Calendar Year	Part A	Part B
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001515	0.009540
2006	0.001245	0.007126
2007	0.000968	0.006067
2008	0.000944	0.006414
2009	0.000944	0.006414
2010	0.000944	0.006414
2011	0.000944	0.006414
2012	0.000944	0.006414

Approximate Calculation of the USPCC and the National MA 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 .97035 to get the USPCC for the aged non-ESRD. This final factor of .97035 is the relationship between the total and non-ESRD per capita reimbursements in 2010. 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 .96240 to get the USPCC for the aged non-ESRD.

The National Per Capita MA Growth Percentage:
The National Per Capita MA Growth Percentage for 2010 (before adjustment for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2010 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2009.

Attachment III. Responses to Public Comments

Section A. Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2010

As mentioned in Attachment I, the final estimate of the 2010 MA growth trend for combined aged and disabled beneficiaries is 0.81 percent, which is 0.3 higher than the preliminary estimate of 0.5 percent announced February 20, 2009 in the Advance Notice. The President's Budget current-law baseline was used for the preliminary estimate, and a more recent baseline was used for the final estimate. The primary reason for the higher final estimate is that the more recent baseline is based on a different set of economic assumptions. In addition, some additional program data and assumption modifications had nearly offsetting impacts.

Comment: Many commenters contend that, if rates are reduced, MA organizations will have trouble maintaining their provider networks, because they will have to pay providers less, and will have to raise premiums, increase copays and deductibles, especially in rural areas, Puerto Rico, in the case of Special Needs Plans (SNPs), PACE plans, and plans that are in direct competition with cost plans.

Response: Plans prepare bids that reflect their revenue requirements. If plan costs grow at a faster rate than increases in benchmarks, plans may choose to reduce their margins or benefits or increase premiums and copays from prior levels. Our intent here is not to hurt providers, beneficiaries or plans, but to update the rates in a way that is consistent with longstanding practice and current law.

Comment: Many commenters felt that the growth trend was underestimated, especially compared to other recent estimates. Some commenters argued that, based on the USPCCs published in the 2009 Payment Rate Announcement and the trend restatements published in the 2010 Advance Notice, trends have been running approximately 5% for the past 4 years. The −1.1% trend for 2010, they say, is materially lower than these trends.

Other commenters contended that the estimate of the Medicare growth in the Advance Notice does not track with other estimates of healthcare cost increases. On average, over the last decade, they say, Medicare spending has increased 5.8 percent annually. CMS' estimate of negative growth in the Advance Notice is significantly lower than other estimates, including other CMS estimates, such as the April 2008 announcement of MA rates (3.8%), the 2008 Medicare Trustees Report (4.6%), and a 2/24/09 *Health Affairs* Article (2.5%) written by CMS actuaries among others.

Therefore, commenters asked for more information on the calculation of the growth trend, especially in terms of projected trends in other Medicare expenditures (hospital inpatient and imaging, for instance), as well as utilization projections that may be relevant to explaining the low growth percentage.

Response: While the estimate for the national growth percentage has been succeeded by the final national growth percentage as announced in this notice, we provide the following rough derivation of the estimate announced in the Advance Notice.

In last year's rate announcement, we provided an estimate of the 2010 per capita growth rate of 3.8 percent. At that time, the relative reduction in physician fees for 2010 was expected to be 5 percent. Subsequent legislation amended the law to provide for roughly a 20 percent cut in physician fees beginning in January 2010. The difference between the originally expected cut of 5 percent and the cut of approximately 21 percent provided for under current law accounts for roughly a 3 percentage point reduction in the USPCC growth rate.

In addition, OACT has updated their databases since last year's estimates to account for new utilization and intensity trends. The updating of historical databases accounts for roughly another 1 percent change in the USPCC growth rate. The remainder of the difference between last year's estimate of 3.8 percent and the estimate of −1.1 percent is due to different economic assumptions which lead to lower provider market baskets, CPI, and other price indices used for updating payments to Medicare providers.

Some commenters pointed out what they suggested were inconsistencies in various published CMS growth rates for 2010. The 3.8 percent per capita growth rate in last year's announcement was based on the 2008 Trustees Report. The 4.6 percent cited in some comments was also from the 2008 Trustees Report. However, the 4.6 percent includes Part D expenditures whereas the 3.8 percent includes just Parts A and B. The 2.5 percent cited from the 2/24/09 Health Affairs article is also based on the 2008 Trustees Report. The 2.5 percent is growth in total expenditures, not per capita. In addition, the 2.5 percent was adjusted to account for the legislation that modified the physician fee increase for 2010, but it does not include any of the changes made from the updating of the historical data bases.

Some commenters have asked for more information on the growth trend. As has always been the practice, CMS provides detailed information on assumptions and trends in the final announcement of the payment rate update. See attachment II of this Notice.

Comment: Several commenters asked that OACT revisit several assumptions used in the growth trend. Commenters asked CMS to review economic assumptions that are utilized in the preliminary estimates in light of continuing increases in health care spending as well as the projected economic impact of the stimulus package. Other commenters wanted to better understand the analytic support behind the suggested lagged effect of a slowing economy on medical trends, specifically in the Medicare environment. Commenters said they did not believe that the slowing economy would result in reduced utilization of medical services by the Medicare population. Two commenters indicated that their MA plans have not experienced a drop in utilization of Part B drugs. One questioned whether the change in the trend is driven by a real decrease in part B drug utilization across Medicare or if it is an artifact of enrollment shifts from traditional FFS into MAPD plans, where hospital cost sharing is limited. Another has found that while unit costs are falling, utilization has continued to grow at a high rate. As a result, this commenter says, cost trends overall appear to have moderated in the past several years, but there have been no significant decreases in per member Part B drug costs.

Response: When OACT stated that new economic assumptions are one reason for a lower estimated per capita growth rate for 2010, they were specifically referencing the effect of the economic assumptions on projected unit costs. The lower economic growth rates affect various price indices such as the CPI, the hospital market basket, etc., which in turn affect projected unit costs. Utilization and intensity trends are developed from historical trends using the latest Medicare claims data available. For the latest budget baseline projections, OACT had fairly complete data for 2007 and about one-half year's data for 2008. For one service in particular, Part B physician administered drugs, the latest data showed much lower utilization compared to prior estimates. Our current data shows residual growth rates of about 7 percent per capita compared to prior estimates of about 16 percent per capita. We used this later data in developing the historical base and in developing the lower projected trend rates. Prior projections graded the trend down to about 7 percent. We now project a flat 7 percent residual factor. These trends are measured on a per capita basis, so they are not an artifact of enrollment shifts from traditional FFS into managed care plans as one commenter suggested.

Comment: Several commenters thought that CMS should follow what the commenters believed to be the assumptions in the President's Budget, and in the *Health Affairs* online article published 2/24/09, and assume in its estimate of the Medicare growth percentage that the 21% reduction in the physician fee schedule will not be implemented as provided for under current law. The assumptions in the President's Budget and the *Health Affairs* article would, in the opinion of these commenters, be a more reasonable predictor of the actual growth in Medicare expenditures considering Congress's historical actions on the issue of physician rates. Commenters suggested that CMS take historical patterns into account in making its estimate for the current year. Alternatively, commenters asked that CMS provide a citation to any provision of law that would prevent CMS from reflecting assumptions other than the reduction in the SGR provided for under current law in the development of the trend. One commenter recommends that OACT adjust utilization and coding factors in their model so that total physician reimbursement per beneficiary would be the same as if the physician schedule were increased as the commenter believes will happen, even while incorporating the reduction in the SGR provided for under current law. Other commenters suggested a transition to ensure a smooth transition to the new rates.

Response: The President's Budget and the *Health Affairs* online article both show current law projections that assume roughly a 21 percent cut in physician fees. While it is true that each shows an additional illustration of an adjustment to current law if physician fees were held constant, this is not the current law scenario. CMS's consistent interpretation and longstanding practice has been to base the projected growth percentage on the law as it exists on the date of the announcement of the payment rate update. The statute requires that the growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title." We believe that the best read of this statutory language is that the growth percentage should be based on the provisions of "this title" (Title XVIII) as of the date that the rates are announced. As a result, every ratebook to date has been based on a USPCC increase estimated under the then current law. Changes to the Medicare statute are a fairly common occurrence. There have been a number of years where Medicare expenditures were expected to be reduced by pending legislative action. In those years, if we had anticipated the legislative changes in the projections, payments to Medicare Advantage plans would have been reduced. By following current law as the basis for the projection, any judgment regarding the likelihood or implications

of unknown possible law changes is removed. Plans have sometimes benefited from this practice and other times been disadvantaged by it. In each case, the advantage or disadvantage has been temporary, affecting only the first contract year following the change in law.

Comment: One commenter asked how the 2010 rates will be adjusted if Congress acts to stop the 21% physician pay cut. Commenters asked that we make efforts to incorporate the approach at another time before the 2010 contract year, such as through the bidding process. Forecasting a decrease in the current year and allowing for a correction in the future will cause unnecessary benefit cuts or premium increases.

Response: We are required by law to release the CY2010 ratebook on April 6, 2009. We expect that this will be the ratebook that will be used in the CY2010 bid preparation and plan payment. If Congress acts to override the physician pay cut, CMS will work with Congress to explore viable options for incorporating any changes in physician pay into the MA payments for CY 2010.

Comment: Several commenters asked for our legal basis for not giving MA organizations a 2% minimum increase.

Response: Section 5301 of the Deficit Reduction Act of 2005 (DRA) added §1853(k) of the Act to create a single rate book for calculating Medicare Advantage (MA) payments and applicable adjustments. The DRA also modified the methodology for updating the MA payment rates by adding §1853(k)(1)(B) of the Act. Beginning in 2007, the statute requires that the previous year's benchmarks be updated annually using the national per capita MA growth percentage as described in §1853(c)(6) of the Act. Since the statute, as revised by the DRA, no longer provides for the 2 percent minimum update, CMS cannot apply it to the 2010 MA rates. The 2 percent minimum update still applies to the end stage renal disease MA update because the statute at §1853(a)(1)(H) provides that ESRD rates are to be calculated in a manner consistent with the way those rates were calculated "under the provisions of [section 1853] as in effect before the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003." The pre-2003 version of section 1853 of the Act included the 2 percent minimum update.

Comment: One commenter suggested that PACE needs its own rate book because it cannot charge premiums or deductibles and therefore cannot respond to a decrease in the rate book.

Response: PACE rates are determined in accordance with §1894(d) of the Act. PACE plans already have their own rate book in the sense that, unlike all other MA plan payment rates, IME payments are not carved out of PACE rates. Under current law, CMS does not have authority to apply a different growth percentage to the rates for PACE plans.

Comment: One commenter asked that we publish an explanation of how each kind of payment amount is determined. The commenter would especially like an explanation of which fields on the MMR are used to establish payment for an ESRD case, which fields in the bid tool are the drivers for the fields in the MMR, etc.

Response: CMS is in the process of drafting a Medicare Manual Chapter with this information. We will seek comment on the revision in the near future.

Comment: We received two comments on the Bid Pricing Tool and one regarding payments to physicians.

Response: The subject of the Advance Notice is payment to Medicare Advantage organizations. These comments are not relevant to the subject of the Advance Notice. We will respond to these comments in the appropriate forums. We will respond to comments on the Bid Pricing Tool during our Actuarial Bidding Calls this Spring.

Section B. Frailty Adjustment

Comment: One commenter believed that the current risk adjustment system does not adequately account for limitations of daily living for those MA enrollees who live in the community despite being at an institutional level of care. The commenter encouraged CMS to make changes to address payment adequacy for this population. One commenter was concerned that the revised frailty adjustment model in combination with the CMS-HCC risk adjustment model does not fully account for Medicare costs for beneficiaries comparable to those enrolled in PACE. The commenter encouraged CMS to accelerate efforts to assure that the risk adjustment model and frailty adjustment accurately reflect costs incurred by a PACE-eligible population.

Response: CMS is continuing to study ways to predict the expenditures of high cost beneficiaries enrolled in MA and PACE plans. By statute, CMS must adjust payment to PACE organizations for frailty, and has historically made a separate adjustment to PACE rates under this authority. By law, CMS must pay all MA plans, including SNPs, using the same risk adjustment methodology.

Comment: One commenter asked if the reference to the 2008 HOS-M was a typographical error and if we instead meant the 2009 HOS-M.

Response: The commenter is correct; CMS will use the 2009 HOS-M as the source of ADL distribution for the 2010 frailty scores.

Section C. Normalization Factors for the Rx Hierarchical Condition Category (RxHCC) Model

Comment: Several commenters expressed concerns that normalizing the Part D risk scores based on Part D enrollees instead of Part D eligible beneficiaries would increase premiums and be disruptive to Part D beneficiaries. Two commenters variously estimated that the proposed 2010 Part D normalization factor of 1.146 would increase monthly beneficiary premiums by amounts ranging from $2 to $9. One commenter indicated that the proposed Part D normalization factor will result in a significant reduction to the 2010 Part D risk scores that will exceed the risk score trends compared to the 2008 base year. The commenter stated that this reduction in 2010 Part D risk scores will shift costs from the federal government to Medicare beneficiaries in a way that will cause Part D premiums to increase faster than prescription drug costs.

Response: We expect that the methodology change will increase beneficiary Part D premiums, but by a relatively modest amount ($1-$2). This change is necessary to help ensure that the beneficiary premium is equal to 25.5 percent of aggregate plan payments as specified in statute.

Comment: We received a couple of comments suggesting that CMS maintain the current methodology and develop the Part D normalization factor based on Part D eligible beneficiaries. The commenters expressed concerns that the proposed methodology would result in the decreased enrollment of healthy beneficiaries. One commenter indicated that normalizing the Part D risk scores based on Medicare Part D enrollees would increase the possibility of an upward spiral in premiums and a downward spiral in enrollment as healthy beneficiaries drop out or choose not to enroll in the Medicare Part D program in the first place.

Response: We disagree with the commenters. Using the risk scores of Part D enrollees to develop the Part D normalization factor will help to ensure that the beneficiary premium remains at the appropriate proportion of aggregate plan payment: approximately 25.5 percent from beneficiary plan premiums and 74.5 percent from the government as intended by Congress. We do not expect that the increase in Part D beneficiary premiums will be large enough to create a significant disincentive for the enrollment of healthy beneficiaries, nor that it will create an upward spiral in beneficiary premiums.

Comment: Several commenters recommended that CMS phase in the proposed change in methodology to create a smooth transition from the current methodology to the proposed methodology. Commenters recommended phasing-in this proposed change over 2, 3, or 4 years to provide Part D sponsors with sufficient time to adapt to this change and reduce disruption to Part D beneficiaries. One commenter stated that implementing a transition period for this change in methodology would be consistent with the phasing in of other significant changes such as the changes to the frailty factors and the low-income subsidy (LIS) benchmarks.

Response: We do not believe that an additional transition period is needed to phase-in the new methodology for determining the Part D normalization factor. The change in our methodology for computing the Part D normalization factor is intended to ensure that the beneficiary premium remains at the appropriate proportion of aggregate plan payment. We also note that to the extent that the Part D normalization factors for contract years 2008 and 2009 were developed based on the risk scores for Part D eligible beneficiaries the normalization factors were lower than they would have been if the normalization factor had been based upon Part D enrollees. As a result, these years were, in effect, a transition period before the implementation of a Part D normalization factor based upon Part D enrollees.

Comment: One commenter recommended that CMS synchronize the proposed change to the methodology for normalizing the Part D risk scores with the development of a new RxHCC model based on historical medical and prescription drug data. The commenter indicated that both changes would significantly affect beneficiaries and therefore, should be implemented during the same contract year to minimize disruption to beneficiaries.

Response: While we appreciate the concerns expressed by the commenter, we believe that the transition to normalizing based on Part D enrollees should not be delayed an additional year.

Comment: One commenter stated that the proposed methodology does not consider the risk scores of newly enrolled or newly eligible beneficiaries and recommended that CMS adjust the Part D normalization factor to account for these enrollees. Another commenter indicated that the composition of the Medicare Part D enrollee population could change under current financial conditions due to Medicare Part D eligible beneficiaries losing their employer group benefits. The commenter asserted that the proposed 2010 Part D normalization factor could be lower if there is an increase in the number of younger (and healthier) beneficiaries who seek to enroll in Medicare Part D due to loss of employer coverage.

Response: The risk scores for newly enrolled individuals were included when determining the 2010 Part D normalization factor. We believe that it would be inappropriate to make an adjustment to the 2010 Part D normalization factor based on current financial conditions since CMS cannot accurately determine how Part D enrollment will be affected. For example, while there may be an increase in the number of healthy beneficiaries who enroll due to the loss of employer benefits, there could just as likely be a significant increase in the number of LIS-eligible beneficiaries who enroll in Medicare Part D for the same reason.

Comment: We received a couple of comments suggesting that CMS include individuals receiving drug coverage under the Retiree Drug Subsidy program in the base of Part D enrollees used to normalize the Part D risk scores. The commenters asserted that these individuals are participants in the Medicare drug program under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and therefore, should be included as Part D enrollees. One commenter also recommended including Part D eligible individuals enrolled in employer plans when determining the Part D normalization factor.

Response: Part D beneficiaries enrolled in employer group/union-only waiver plans (EGWPs) were included when determining the Part D normalization factor. We disagree with the commenters' recommendation that CMS include individuals receiving drug coverage under the Retiree Drug Subsidy program when determining the Part D normalization factor. These individuals are not affected by Part D risk adjustment and are explicitly excluded from the Part D payment calculations including the national average monthly bid amount and the regional LIS benchmarks. Thus, we believe it would also be inappropriate to consider these individuals when determining the Part D normalization factor.

Section D. Budget Neutrality

The Deficit Reduction Act (DRA) of 2005 specifies the components that CMS must include in the estimate of budget neutral (BN) risk adjustment factor, and codifies the phase-out of the BN factor. As in prior years, the BN factor was estimated as the difference between aggregate payments to plans using 100 percent demographic payments and aggregate payments to plans using 100 percent risk adjustment payments, expressed as a percent of risk adjusted payments. For purposes of the calculation, CMS assumes that risk payments to plans will be at the local benchmarks, adjusted for each plan's risk score. CMS calculates a single BN factor for all MA plan enrollees.

The BN factor estimate for 2010 is 0.10%. This factor was calculated based on a full BN factor of 2.0%, multiplied by the BN phase-out percentage of 5 percent. 2010 is the fourth and final year of the phase-out required by the DRA, and 5 percent of the full BN factor is applied to the rates, as the same percentage for all counties.

Section E. Adjustment for MA Coding Pattern Differences

In the Advance Notice, we proposed a coding difference adjustment of 3.74%. This adjustment was based on adjusting for three years of differential coding between MA and FFS, i.e., from 2007 to 2010. This adjustment factor was calculated based on beneficiaries who were enrolled for seven months or more in any given year, using data for three cohorts (2004-2005, 2005-2006, and 2006-2007). In the Notice, we stated our intention to update the adjustment factor with data for an additional cohort (2007-2008) for the Rate Announcement.

Our analysis of the 2007-2008 cohort showed that coding pattern differences have accelerated and this finding has strengthened our conclusion that coding pattern differences between MA and FFS are having a notable impact on payment. Because this is the first year that CMS is implementing this MA coding adjustment under the provisions of the DRA, however, CMS is taking a conservative approach and implementing an adjustment factor using a coding difference factor based on the earliest three cohorts (2004-2005, 2005-2006, and 2006-2007). CMS will consider the 2007-2008 data and later cohort data for future MA coding pattern difference factors.

CMS received a number of comments suggesting that the stayer percentage and enrollment duration factor used to calculate the MA coding pattern difference adjustment factor should be based only on beneficiaries who are enrolled in MA for a full 12 months in any given year, rather than seven months or more. CMS concurs with these comments; in finalizing the 2010 MA coding pattern difference adjustment factor, CMS is basing the stayer percentage and enrollment duration factor on 12 months of continuous MA enrollment.

Based on these changes in methodology, the final 2010 MA coding intensity adjustment will be 3.41%. Table 1 summarizes the calculation of the adjustment.

Table 1: Calculation of Difference Factor

Calculation of difference factor for 2010 Cohorts between 2004 and 2007 EDF = 2.38 Stayer percentage = 81.8%	
Weighted average of Year 2 MA risk scores	0.9806
Weighted average differences in disease score growth	0.0171
Difference factor as a percent of risk score	1.75%
Apply EDF to obtain adjustment factor (2.38)	4.16%
Adjust for percent of stayers to allow application of adjustment factor to all enrollees' risk scores (81.8%)	3.41%

Comment: A number of commenters offered CMS strong support for our determination in the Advance Notice that we were required to apply a coding pattern difference adjustment in 2010. Several commenters cited several reasons why the adjustment was appropriate. They agreed with CMS that the adjustment will improve payment accuracy, reduce unnecessary Medicare expenditures, and better assure financial neutrality between FFS and MA. Some commenters opined that the adjustment was long overdue. Commenters noted that MA organizations had an incentive to identify and code diseases, whether the diseases were treated or not, and that as a result unadjusted risk scores show MA enrollees to be sicker than they actually are. Several commenters noted that the increased MA payments resulting from coding pattern differences are in addition to the 14% payment differential resulting from MA benchmarks being set above Medicare FFS levels. One commenter noted that because physicians in FFS do not have a financial incentive to code as intensely, MA plan risk scores can increase at a greater rate than FFS risk scores, making MA enrollees look less healthy and more costly without any change in their actual health status.

Response: We concur with these comments.

Comment: Several commenters argued that the coding pattern difference adjustment was being made on the assumption that coding observed in the FFS program is accurate, and argued that CMS should not penalize MA organizations for differing from FFS coding patterns if, in fact, these FFS patterns were somehow inaccurate or inadequate. One commenter expressed concern that the adjustment would penalize many organizations for doing what CMS and Congress intended when they implemented risk adjustment payments (invest resources to improve data collection and educate providers on proper documentation). One commenter contended that a significant differential should be expected between FFS and SNPs for SNPs that code accurately. Another commenter claimed that risk scores of beneficiaries in Original Medicare are depressed by the inadequate coding of chronic conditions on FFS claims. One commenter does not believe that it is in keeping with Congressional intent for CMS to make a negative adjustment to all plans regardless of whether improper or inaccurate coding has been identified; another commenter thought that an across-the-board adjustment conflicted with Congressional intent to adjust payments for "differences resulting from inaccurate coding."

Response: As we stated in the 2009 Advance Notice, we do not assume that the coding pattern differences that we found in our study are the result of improper coding. As documented in the 2009 Announcement, CMS believes that the statutory language in the DRA provision at issue provides for a payment adjustment if CMS establishes that there are "differences in coding patterns between Medicare Advantage plans and providers under part A and B."

Given the fact that the MA payment methodology is based on fee-for-service payments, and that the risk adjustment methodology is designed to compare the risk scores of MA plan enrollees to other plan enrollees and beneficiaries not enrolled in MA plans, for this comparison to be valid, MA plans must code the way Medicare Part A and B providers do in order for risk adjustments to be valid. This means that MA organizations are coding "accurately" when they are coding in a manner similar to fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared. In this sense, "differences" in coding patterns, regardless of the source, would make the MA plan coding "inaccurate" for purposes of implementing risk adjustment.

This reading of the word "inaccurate" is supported by floor statements made by Senator Grassley, Congressman Barton, and Congressman Thomas. Senator Grassley made the following floor statement; the other two committee chairs made very similar statements:

> "Section 5301 and the joint statement which accompanied the conference report in the Senate requiring adjustments for differences in coding patterns is intended to include adjustments for coding that is inaccurate or incomplete for the purpose of establishing risk scores that are consistent across both fee-for-service and Medicare Advantage settings, even if such coding is accurate or complete for other purposes. This will ensure that the goal of risk adjustment—to pay plans accurately—is met."

Comment: One commenter argued that, since CMS did not make adjustments in 2008 and 2009, this necessarily must mean that data available to CMS as late as April 2008 did not demonstrate that the changes in risk scores were the result of differences in coding patterns, and that CMS accordingly should not apply an adjustment based on 2007 to 2008 data. Under this argument, CMS cannot now state that a change in risk score trends can be conclusively attributed to differences in coding patterns based on pre-April, 2008 dates. This commenter argued that CMS can adjust the capitation rates only to compensate for that one year of differential. In other words, the commenter argued that CMS implicitly had previously found that prior years of risk score trends can be explained based on factors other than coding patterns, and thus should not rely on the data to make an adjustment. Another commenter opined that the information in the 2010 Advance Notice fails to present substantive new evidence free of technical concerns.

Response: While, in previous years, CMS has delayed the application of a coding patterns difference adjustment in order to conduct further research, this did not mean that we had concluded that risk score trends were caused by factors other than coding pattern. Our most recent analysis – discussed below – has resulted in our decision to apply a coding pattern differences adjustment in 2010. We believe that, having concluded that the differences we have observed are in fact attributable to differences in coding patterns, it is appropriate to use data from the beginning of the program, as deemed necessary to better ensure appropriate and accurate payments.

Comment: Several commenters, noting that CMS had indicated in last year's Announcement that we would use the results from the risk adjustment data validation (RADV) audits to inform our assessment of whether risk score differences were driven by coding pattern differences, rather than by the health status of MA enrollees, inquired about our findings and how they supported the coding pattern difference adjustment. A number of commenters were concerned that CMS would be making an adjustment twice for the same coding effects if it applied both a coding pattern difference adjustment and made adjustments as a result of its RADV audits. Several commenters expressed concern that a prospective coding intensity adjustment in combination with future 2010 risk score audits could result in duplicate adjustments. A few commenters asked if CMS was adjusting the 2007 risk scores used in developing the MA coding pattern difference adjustment factor for adjustments made as a result of the RADV audits. Some commenters suggested that, instead of implementing a coding pattern difference adjustment, we rely on the RADV audits. They contended that the current risk score validation audit process was the appropriate system to determine coding accuracy and payments should only be adjusted for the subset of plans in which coding problems can be documented.

Response: CMS' strategy for determining the correct MA coding pattern difference for 2008 and 2009 was to ensure that we thoroughly understood the dynamics behind the coding pattern differences between MA and FFS. In this spirit, we agreed to assess whether the new annual medical record audits would be able to inform our study of MA coding pattern differences. Medical record audits serve the purpose of determining whether diagnosis codes submitted to CMS for risk adjustment payment purposes have a basis in the documented medical record, while our study of MA coding pattern differences has resulted in a better understanding of the differential growth in the number of diagnosis reported by MA plans and FFS providers. The results of the medical record audits supported our approach to calculating the MA coding pattern differences adjustment by failing to show a systematic correlation between coding pattern differences and errors in the reporting of documented coding.

Comment: Several commenters argued that CMS was not authorized to make a retroactive coding pattern difference adjustment. Another commenter asked if the adjustment would be used for 2010 alone, or would also be used to make retroactive adjustments. Several commenters opined that the DRA did not require a retroactive adjustment and that, since the MA payment methodology is fundamentally a prospective system, that absent an explicit statutory direction to impose a retroactive adjustment, CMS should not apply adjustments it now deems appropriate for 2008 and 2009 into 2010 payments. A couple commenters argued that the DRA established coding intensity to be a single annual adjustment made for each coverage year, if supported by the data, and felt that the MA coding pattern difference adjustment described in the Advance Notice was intended to retroactively apply an adjustment for 2008 and 2009. One commenter felt that this was not the intent of Congress and the other commenter felt that this adjustment would be made for years when CMS found that it did not have adequate information to justify an adjustment.

Response: CMS is not making a retroactive adjustment. We estimated the cumulative coding pattern difference in MA and FFS stayers' disease scores in 2010. We calculated this adjustment by applying a three-year enrollment duration factor (EDF) to the annual average difference in disease score growth, essentially calculating the adjustment to account for three years of coding pattern differences. As a result, the coding adjustment is an estimate of how much lower risk scores would be in 2010 if they rose at the same rate as FFS risk scores over the period 2007-2010. We note that some commenters supported using six years (2004-2010) in the calculation based, taking into account all measured differences since risk adjusted payments were begun.

Comment: One commenter believed that using a 2-year stayer cohort captures a large proportion of MA stayers that are new to MA with no coding history in year-one with potentially larger coding increases in the second year as the plan gains accurate diagnosis data. Another commenter opined that the calculation of the adjustment does not seem to acknowledge a trend observed by MA organizations in which a beneficiary's risk score increases more quickly during the second year that the beneficiary is enrolled in an MA plan and that, therefore, the enrollment effect that the agency attempts to isolate may be larger than assumed in the notice. One commenter suggested studying 3−and 4-year stayer cohorts; they also recommend that CMS study the cohort of individuals that would not qualify as stayers due to being in MA or FFS for only a single year over the examined time period.

Response: The method by which CMS constructs its two-year stayer cohorts ensures that the experience of beneficiaries newly enrolled in MA are not included in the difference measurement. Requiring enrollees to have been enrolled for thirty months results in first-year disease scores that were coded exclusively by either MA plans or FFS providers and, thus, CMS is comparing year-after-year disease scores that were coded exclusively by a single sector. These cohorts will capture some enrollees' second and third years in MA, but it will also capture differential disease score changes for enrollees who have been enrolled in either sector for longer periods of time. Therefore, the difference factor is calculated over all beneficiaries who have been enrolled in a sector over varying periods of time, thereby obtaining an average difference across all continually-enrolled beneficiaries.

The use of cohorts over more than two years would result in smaller cohorts of non-representative beneficiaries in that they were alive much longer and they were enrolled in their respective sector for longer than beneficiaries in the two-year cohorts. For example, beneficiaries who are in MA for at least 3 or 4 years are not identical to those who are enrolled for at least two years. Two-year cohorts capture the information needed while keeping the largest number of enrollees in the cohorts.

Comment: One commenter stated that, since CMS acknowledges that a significant portion of Medicare beneficiaries who join MA plans are switching from FFS, and that the vast majority of beneficiaries joining FFS are newly eligible and have very low risk scores, basing an adjustment of risk scores on a comparison of FFS to MA enrollees will overstate the differences between the two groups.

Response: CMS constructs the cohorts in such a way that "joiners" and "leavers" – beneficiaries who switch from one sector to the other – are excluded from the population on whom we calculate the difference factor. The cohorts only include beneficiaries who have been in MA or FFS for several years – at least 30 months.

Comment: A couple commenters expressed interest in having CMS recognize that MA plans' effort to "catch up" with FFS in the coding pattern difference adjustment factor. One commenter felt that changes in coding due to "catch up" fell outside the purview of the DRA and strongly suggested that the agency consider changes to the calculation of the adjustment to exclude "catch up" to more directly address the statutory requirement. Another commenter felt that, after seeking to take "catch up" into account last year, CMS should recognize it in the 2010 adjustment factor. One commenter offered an example of a way to adjust for "catch up" that involved applying a ratio of the amount by which the average MA risk score was below the FFS 1.0 when risk adjusted payments started, relative to the amount by which the average MA risk score was greater than the FFS 1.0 in later years.

Response: While we are using cohorts starting with 2004-2005 to calculate the average difference factor, we are only taking into account three years of experience in the enrollment duration factor (EDF). Any catch up occurring in the first three years (2004-2007) of risk adjusted payments is not factored into the duration factor and, therefore, not included in the coding pattern difference adjustment. In other words, by adjusting the annual average difference by the average enrollment over the past three years, CMS is only adjusting 2010 risk scores by

the cumulative effect of coding pattern differences over three years, and not over all six years since the start of risk adjusted payments.

Comment: One commenter stated that the enrollment duration factor (EDF) seems intended to reflect the number of beneficiaries to whom a coding intensity adjustment would have been appropriately applied in 2008 and 2009 (if the agency had made a determination to apply such an adjustment in time to affect payments in those years) and prospectively in 2010. Another commenter questioned why CMS was using an enrollment duration factor and felt that an adjustment based on the disease scores would take differences into account. This commenter argued that CMS had not established that there was a link between length of MA enrollment and higher risk scores or explained how the EDF meets with the intent of the DRA.

Response: The enrollment duration factor (EDF) is used to adjust the annual difference factor in order to approximate the experience of stayers in 2010. In other words, the EDF creates a single year, prospective estimate of cumulative difference between MA and FFS disease scores (not just the marginal growth in the difference from the previous year). A less nuanced way to calculate the cumulative difference would simply be to multiply the average annual difference (the difference factor) times the number of years being taken into account. The EDF allows CMS to adjust the annual average difference by the estimated enrollment experience of the beneficiaries in MA during the payment year.

Comment: Several commenters recommended that the adjustment incorporate an analysis of coding pattern differences in four cohorts available at the time the Announcement is published: 2004-2005, 2005-2006, 2006-2007, and 2007-2008. They felt that doing so would permit the agency to more precisely determine the appropriate magnitude of the adjustment while considering data from the 2004-2005 data collection year, when risk adjustment was first a significant component of MA plan payments. One commenter felt that, since the coding difference experience seems to be volatile and unpredictable, using four cohorts would add some stability to the calculation. They cited OACT's use of 5-year moving averages of the ratio of the county FFS per capita costs to national per capita costs when estimating the FFS costs in each county.

Response: Because 2010 is the first year that CMS is applying the MA coding pattern difference factor under the provisions of the DRA, we have decided to take a conservative approach and calculate the difference factor using only the first three cohorts, as described in the Advance Notice. After applying the new enrollment duration factor (EDF) (see below), the MA coding pattern difference factor for 2010 is 3.41.

Comment: Several commenters disagreed with the use of seven months enrollment in the prior year to determine whether someone is a stayer for purposes of the enrollment duration factor (EDF) and felt that twelve months would be a more appropriate measure. Commenters contended that an MA organization needed at least one full year of enrollment experience with a beneficiary to credibly calculate a member's risk score and that 12 months was in alignment with the idea that the adjuster should be applied to "stayers." One commenter understood that the EDF makes the assumption that the adjustment factor would be the same for members with between 7 and 30 months of plan membership, and believed that this was highly unlikely, and that the effect of relative coding intensity are likely to increase over time. One commenter asked

how CMS had validated that a 7 month time period is sufficient to capture the HCC diagnoses for a member.

Response: The objective of the enrollment duration factor (EDF) is to capture the average number of years a population of enrollees has had their diagnoses submitted by the MA sector; for this factor, we are not trying to capture change in disease score, but exposure to MA coding patterns. In response to industry concerns regarding the adequacy of seven months of enrollment in capturing and reporting enough diagnoses codes to establish a pattern, CMS will use twelve months in previous years as a criteria for calculating the EDF. Using twelve months, applied to the same time period as in the Advance Notice – 2007-2010 – the EDF that CMS will use in calculating the adjustment factor will be 2.38.

Comment: One commenter noted that plans with more turnover will have lower EDFs. Other commenters asked if an analysis had been done to see how much variance there is in enrollment duration from plan to plan.

Response: CMS recognizes that enrollment duration may differ among plans. Because we have determined that it is most appropriate to apply an industry-wide adjustment, the EDF used in the calculation will, by its construct, be an industry average.

Comment: One commenter wanted CMS to use the same definition of "stayer" when determining the stayer percentage as we do when developing the cohorts used for measuring the coding pattern difference (30 months of continuous enrollment).

Response: Because CMS will apply the adjustment to all enrollees' risk scores, not just stayers, we need to reduce the adjustment proportionately so that the aggregate effect is the same, whether we applied the adjustment to stayers only or to all enrollees. To calculate the actual adjustment to use in payment, we reduce it by the proportion of stayers in MA for the most current period available. In applying the twelve month enrollment criteria in calculating previous-year enrollment for the EDF, we also changed the calculation of the stayer percentage that we will use to reduce the adjustment factor for application in payment. The stayer percentage we will use is 81.8%.

Comment: Commenters suggested a number of additional factors that they thought CMS should adjust for in calculating the coding pattern difference adjustment factor. The additional factors suggested are: age, gender, originally disabled, Medicaid eligibility, institutional status, hospice status, beneficiaries with multiple chronic conditions, duration in managed care, health status, type of plan, plan size, socio-economic status, racial/ethnic differences, and enrollment in the Veterans Affairs or Department of Defense health programs. A number of commenters requested that CMS adjust for regional differences in FFS coding differences. One commenter felt that plans with a high proportion of recent FFS members or in regions where MA coding changes are not greater than FFS are disadvantaged. One commenter suggested that possible anti-selective effects in MA were resulting in an overestimate of MA's rising risk scores. One commenter asked how CMS knew that measured differences in coding changes between MA and FFS were really coding pattern changes and not changes in health status.

Response: CMS did take into account factors that we believed would have an important influence on the rate of change in disease score growth between MA and FFS. For example, we adjusted the difference factor (the annual average difference in disease score growth between MA and FFS) for age and survivor status variations between MA and FFS. Because a greater proportion of disabled beneficiaries are enrolled in FFS than in MA, and because disabled beneficiaries risk scores tend to grow more slowly than aged beneficiaries' risk scores, adjusting for age reduced the differences in disease score growth between the two sectors. In addition, the enrollment duration factor (EDF) takes into account the average duration of enrollment in the MA sector of those who are present in the year prior to the payment year. We believe that age and survivor status are correlated to the differential change in disease scores between MA and FFS, and that duration of enrollment in the MA sector directly affects how long a beneficiary's disease score has been exposed to this differential. It is not clear that other factors would affect differential changes in disease score.

Comment: One commenter inquired about which version of the CMS-HCC model we used to calculate the coding pattern differences.

Response: CMS used the version of the CMS-HCC model that was used in payment from 2004 through 2006 to calculate the difference factor. We ran all cohorts through the same version of the model, so that measurements of differences would not be affected by model changes.

Comment: One commenter wanted CMS to establish an appeals mechanism that would allow plans to demonstrate that their coding patterns are correct.

Response: As discussed above, the MA coding pattern difference adjustment is not adjusting for coding that is incorrect, but for coding that differs from FFS and is therefore inaccurate for payment. Further, the industry-wide adjustment factor will not be modified for individual plans.

Comment: In the 2010 Advance Notice, CMS invited comments on the decision to adjust for differences in disease growth for the three-year period prior to 2010, as well as on alternative approaches involving a greater or smaller number of years. A number of commenters wanted CMS to adjust for one year instead of three. One commenter states that using the annual rate going back to 2004 would the most reasonable approach. One commenter stated that CMS should make an adjustment on a prospective basis only, which they took to mean a single year adjustment. Several commenters argued that the DRA requires CMS to adjust for all differences in coding patterns, and suggested that CMS should adjust for all measured and projected differences, including those attributable to the excluded period for 2004-2007. Another commenter noted that, while one alternative was to make an adjustment for all years during which comprehensive risk adjustment has been in place – that is, 2004 to 2010 -- on balance they were inclined to think that the methodology described in the Advance Notice was appropriate.

Response: The difference factor, which takes into account coding pattern differences from 2004 to 2007, is an average annual difference in the growth of disease scores between MA and FFS. Based on the data that we have, it is clear that coding pattern differences have continuously grown since 2004 and that 2010 risk scores will incorporate repeated years of coding pattern differences. We have decided to maintain for 2010 the use of three cohorts as proposed in the Advance Notice.

Comment: One commenter expressed concern that the MA coding difference adjustment would reduce the disease score, causing a greater portion of the risk score to be based on demographic factors, which would introduce limitations and problems of the old AAPCC approach.

Response: CMS is calculating the MA coding pattern differences adjustment factor based on disease scores because that is the portion of the risk score that plans have control over. However, the adjustment is being applied simply as an overall proportional reduction to the risk scores, leaving the proportion of the risk score that is determined by diseases intact.

Comment: One commenter suggested that FFS normalization and MA coding pattern difference adjustment should be subtractive, not additive, or plans will be penalized twice for coding practices observed in the FFS program.

Response: The two adjustments address two different measures of coding changes: the FFS normalization factor adjusts risk scores for underlying changes in FFS coding and the MA coding pattern difference adjustment factor adjusts for coding patterns above and beyond the FFS changes.

Comment: One commenter asked if the three-year adjustment discussed in the Advance Notice would lead to a restatement of the historical budget neutrality adjustments for those years.

Response: As discussed above, the 2010 MA coding pattern differences adjustment is not a retroactive adjustment, but an estimate of the cumulative difference between MA and FFS stayers' disease score in 2010. CMS will take the projected reduction in 2010 risk scores into account when calculating the 2010 budget neutrality factor.

Comment: One commenter expressed concern that the extent of the adjustment may cause health plans to consider withdrawing from the market given the short time to prepare the 2010 bids. A couple commenters expressed concern that the proposed across-the-board 3.74% reduction would have a major negative effect and is a departure from last year's proposal to gather plan-specific coding changes through targeted audits.

Response: While we appreciate that the application of the MA coding pattern difference adjustment will need to be taken into account in MA plan bids, we believe that the final 3.41 percent adjustment is an appropriate correction that will result in more accurate payments. In addition, the adjustment is consistent with the statutory requirement that we study whether there are different diagnoses coding patterns between MA and FFS and, if we find differences, that we adjust MA risk scores accordingly.

Comment: A number of commenters did not support an industry-wide coding pattern difference adjustment and either wanted CMS to implement a more targeted adjustment or delay or phase in the adjustment. Some commenters wanted CMS to apply the coding pattern difference adjustment to a defined subset of plans that fail the risk validation audit or plans with larger differences in risk score growth. Commenters felt that an industry-wide adjustment would be unfair to plans that have under-coded and create an incentive of promoting coding intensity by those plan that have previously under-coded. Commenters suggested that CMS use a plan-specific EDF, or apply an adjustment in tiers to take into account different levels of turnover. A few commenters felt that SNPs would be at a disadvantage because there was an increased

volume of encounters for their members and because the percent of stayers was likely to be less than the average MA plan rate. A number of commenters supported an industry-wide adjustment; one commenter cited the following advantages: (1) industry-wide adjustments were the practice in other sectors of Medicare, (2) all MA plans should be paying close attention to coding and documentation and it was reasonable to expect coding changes to be widespread, (3) coding behavior of a particular provider does not necessarily affect just one plan, (4) beneficiaries move from one plan to another and retain the diagnosis codes assigned; and (5) when using MA data, a system-wide adjustment will ensure that baseline information is accurate.

Response: In addition to the reasons given by commenters, CMS was also persuaded by comments on the 2009 proposal – which proposed an adjustment on a subset of contracts – that an industry-wide adjustment provides an even playing field when plans compete: newer plans may be able to code just as intensely as older plans, but would not have been in existence long enough for CMS to calculate an adjustment factor for them. Further, applying an adjustment factor to a subset, or tiered adjustment factors across contracts, results in cut offs that can potentially appear unfair, especially if one contract falls just above and another just below a cutoff. To avoid these problems, as well as for the reasons cited by the more recent comments, we have decided that an industry-wide adjustment is the most efficient and effective approach to making an adjustment for MA coding pattern differences.

Comment: One commenter suggested that CMS should review and compare samples of MA plan member medical records with a FFS control group and that the difference in risk scores derived from the medical records could support an across-the-board coding pattern adjustment in a subsequent year.

Response: While a comparison of diagnostic coding captured on medical records in MA and FFS would indicate differences in documentation of diagnoses coding in the medical record, there are two key shortcomings of this approach in calculating an MA coding pattern difference adjustment factor. The key comparison in studying the impact on payment of differences in coding patterns between MA and FFS is the codes that are submitted and codes that are reflected in the model. In addition, CMS is taking into account changes in disease scores over time and taking a sample of medical records will not provide that information.

Comment: One commenter did not agree that CMS should calculate coding pattern differences for each individual and, instead, recommended that the difference be calculated by dividing the MA growth in risk scores by the FFS growth in risk scores for each age and survivor status grouping in each cohort.

Response: CMS did not calculate individual differences in disease score growth; we calculated the difference between the average growth in disease scores among MA stayers and the average growth in disease scores among FFS stayers for each cohort. This difference calculation was adjusted for each age and survivor grouping in each cohort. It is not clear how CMS would use the ratio of MA growth to FFS growth in applying an adjustment.

Comment: A number of commenters requested that CMS release all relevant information and calculations concerning the MA coding pattern difference adjustment factor in order to make sure that the adjustment is fully explained and transparent to the public to the same extent that

they are for the FFS program through regulation. A couple commenters believed that CMS has not provided enough transparency in the methodology used to calculate the coding pattern differences for the public to properly evaluate the calculation CMS has completed.

Response: We would be happy to provide addition information about the steps and results of our MA coding pattern differences analysis to interested stakeholders.

Section F. Encounter Data Reporting

Comment: One commenter encouraged CMS to continue its efforts to collect additional data from MA plans, including data relating to all medical encounters between beneficiaries and providers, to improve the accuracy of the risk adjustment system, and to measure the effectiveness and integrity of MA plan benefits.

Response: CMS will release guidance in 2009 regarding the collection and use of MA encounter data. As we discussed in the final IPPS rule in August 2008, CMS will provide opportunity for stakeholders to provide feedback on our plans for implementation.

Comment: One commenter expressed concern about the burden of collecting and reporting encounter data and asked that plans be given a long lead time to implement this new requirement; the commenter suggested that CMS phase in the changes.

Response: CMS is sympathetic to plans' desire for adequate lead time to implement encounter data requirements. We will explore options for the start up of reporting and will provide opportunity for feedback on our approach.

Section G. IME Phase Out

Comment: Related to CMS 4138-IFC −42 CFR 422.306(c) and the phase-out in MIPPA of the IME portion of the MA capitation rate, one commenter asked how a plan calculates the phase-out of the IME in a county and the role of 0.6% in determining the phase-out.

Response: To help plans identify the impact, CMS has separately identified the amount of IME for each county rate in the 2010 rate book. We intend to publish the rates with and without the IME reduction in future years as well. The role of 0.6% is that it is the maximum reduction possible to the FFS per capita costs in a county in 2010.

Section H. Location of Network Areas for PFFS Plans in Plan Year 2011

Comment: A commenter questioned CMS's interpretation of the statutory definition of "having" a network-based plan to mean offering a plan "that is generally open to enrollment," and asked CMS to clarify whether such plans are "open to enrollment" as of January 2009.

Response: First, CMS believes Congress intended to eliminate non-network PFFS plans only in those areas where at least two coordinated care plan options are available. Limited enrollment

plans are not generally available to current PFFS plan enrollees, and we believe should not be counted under the two plan test. We therefore excluded plans that are not generally open to enrollment from our analysis, such as employer group health plans and special needs plans. As required by MIPPA, for purposes of identifying the location of the network areas for plan year 2011, we determined whether at least two generally available network-based plans with enrollment as of January 1, 2009 exist in each county (or partial county in some cases). Therefore, for a network-based plan to be counted in our analysis, the plan was required to have at least 1 beneficiary enrolled in the plan as of January 1, 2009.

Comment: Three commenters recommended that CMS interpret the definition of "network area" to mean an area with at least two network-based plans that are offered by different MAOs in order to ensure meaningful choice for Medicare beneficiaries. Two of the commenters were concerned about the creation of regional monopolies if CMS interprets the definition of network area as an area with at least two network-based plans, where the plans can be offered by the same MAO.

Response: MIPPA defines "network area," for a given plan year, as the area that the Secretary identifies (in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year) as "having at least 2 network-based plans with enrollment as of the first day of the year in which the announcement is made." "Network-based plan" is defined in MIPPA as (1) an MA plan that is a coordinated care plan as described in section 1851(a)(2)(A)(i) of the Act, excluding non-network regional PPOs; (2) a network-based MSA plan; or (3) a section 1876 cost plan. We interpret "having at least 2 network-based plans" to mean that there are at least 2 plans, which meet the definition of a network-based plan, that are offered by the same MAO as well as plans offered by different MAOs. We believe this interpretation is consistent with the statutory requirements for identifying network areas.

Comment: A commenter understood that the network-based plans with enrollment as of January 1, 2009 are used to determine the location of network areas for PFFS plans in CY 2011 as required by MIPPA, but wanted CMS to address what would happen if plans in this data group leave the market. The commenter asks whether this would result in a new list being issued?

Response: The methodology for identifying the location of network areas is specified in the statutory definition of a "network area." MIPPA defines "network area," for a given plan year, as the area that the Secretary identifies (in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year) as "having at least 2 network-based plans with enrollment as of the first day of the year in which the announcement is made." We accordingly have used enrollment data as of January 1, 2009 to identify the network areas for plan year 2011. The methodology we used to identify the list of network areas for plan year 2011 in this notice is consistent with statutory requirements. However, should the circumstances reflected in this year's payment notice change such that an area no longer meets the standard of "having at least 2 network-based plans" in the area, CMS will determine at that time how this would affect PFFS plans in that area if bids have not yet been submitted for the subsequent year (e.g., if there are fewer than 2 network plans in the area on January 1, 2010).

Comment: Two commenters recommended that CMS evaluate the provider contracting data for regional PPOs in areas where a regional PPO's network structure is the deciding factor in determining whether the area is a network area. One of the commenters noted that CMS is relying on data from regional PPOs on how they meet access requirements in their service areas, without any validation of the regional PPOs' responses. The commenter is concerned that regional PPOs will face no negative consequences for over-reporting their network breadth and get a competitive advantage by excluding competing PFFS plans.

Response: Regional PPOs meet the definition of a network-based plan only in those areas where the plan is meeting access requirements through written contracts with providers. MIPPA requires us to identify the location of network areas for plan year 2011 in the *Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies.* Due to the limited amount of time we had available prior to the release of the list of network areas for plan year 2011, we used data in our analysis that was obtained directly from the regional PPOs on how these plans are meeting CMS' network adequacy requirements in each of the counties in their service area. The data reported to us by the regional PPOs is the best available data we have for identifying the location of the network areas for plan year 2011. We believe that using this data is appropriate for identifying the location of plan year 2011 network areas. CMS will conduct network adequacy reviews of the regional PPO access data on an annual basis in future years.

Comment: A commenter stated that network-based plans with enrollments of 10 or fewer members should not meet the requirement of a network-based plan as these plans do not appear to offer a compelling choice for seniors.

Response: MIPPA defines "network area," for a given plan year, as the area that the Secretary identifies (in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year) as "having at least 2 network-based plans with enrollment as of the first day of the year in which the announcement is made." We interpret the phrase "with enrollment" to mean that a network-based plan is required to have at least 1 beneficiary enrolled in the plan in order to be counted for purposes of identifying the location of the network areas. We believe that interpreting "with enrollment" any differently would result in an artificial threshold and would not be consistent with the statute.

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

Comment: One commenter noted that 54 counties have a rate increase of greater than $12.50 per person per month. The commenter believes that $12.50 is not a negligible amount. The commenter would like CMS to provide more information as to why the 54 counties should not receive a rate adjustment. Specifically, the commenter wanted details on whether in these 54 counties, differences observed between the two populations appear to be normal, random variations and not indicative of true underlying differences of the FFS costs between the total and non-vets.

Response: We agree that a $12.50 adjustment is not a negligible amount. As discussed in the Notice, however, the observed variations are not attributable to a true underlying difference

between the veteran and non-veteran populations, but due to normal, random fluctuations. For example, the 54 counties identified with large differences have less than one-sixth of the average level of enrollment. Not surprisingly, the effect of a random fluctuation is more significant when smaller sample sizes are considered.

Comment: One commenter argued that the DOD data should help determine whether the effects are random rather than systematic. The commenter believes that if counties have substantial, nonrandom difference when the VA and DoD data are analyzed, adjustments should be made to county rates.

Response: We agree that the effects of DoD eligible enrollees need to be evaluated. We continue to work with the Department of Defense to obtain the necessary data to support this analysis. Recently the DoD published a Privacy Act notice which will allow us access to their data. Please refer to paragraph 8(d), "Notice to alter a system of records." 74 FR 400-4006 (January 22, 2009).

Comment: One commenter requested that CMS include the cost of care received at VA/DoD healthcare facilities in the calculation of MA benchmarks as required by law. By excluding the cost of care received at VA and DoD facilities, the commenter believes CMS is underestimating FFS spending which inappropriately reduces MA benchmarks. The commenter argued that geographic areas with higher numbers and concentrations of VA/DoD facilities will be impacted the hardest by excluding these costs. Congress required CMS to incorporate these costs for years beginning in 2004 and CMS has yet to implement this factor. In the Advance Notice to CY 2009 rates, the commenter states, CMS proposed an option to include VA/DoD costs in the calculation of MA benchmarks. Although the proposed methodology presented some problems, the commenter encourages CMS to continue to explore alternative ways to collect the necessary data to incorporate this required adjustment.

Response: As outlined in the CY 2010 Advance Notice, we evaluated VA data using the methodology included in the CY 2009 Advance Notice and concluded that there is insufficient evidence to incorporate a VA adjustment into the rate making process for 2010. This conclusion was based on the view that the differences observed between the veteran and non-veteran populations appear to be normal, random variations and not indicative of true underlying differences of the FFS costs between the two populations. CMS will continue to study this issue. We are working to obtain data from the DoD that will support a study similar to the VA analysis.

Section J. Calculation and Source Data of MSP Factor

Comment: Commenters requested that plans have a mechanism to request correction to the CMS data where inaccurate or inconsistent information is identified in the COB file.

Response: Plans will have access to the Electronic Correspondence Referral System (ECRS). When a discrepancy is noted, there will be a mechanism to initiate corrections to the CMS data. ECRS is an electronic interface between plans and the COB Contractor. ECRS will allow MSP representatives at plans, FFS contractors, and authorized CMS RO to complete various online forms and electronically transmit requests for changes to existing CWF MSP information, inquire concerning possible MSP coverage, and document transactions to the COB contractor.

ECRS will allow plans to submit post enrollment transactions that change or add to information posted by those plans.

Comment: Commenters requested details on how payments will be adjusted as a result of plan submitted corrections.

Response: Starting January 2010 we will adjust payments to account for beneficiaries with working aged and disabled Medicare Secondary Payer (WA/WD MSP) status.

Comment: Several commenters felt that COB data was not accurate because a lot of new data are being entered due to the implementation of Section 111 of MMSEA this year and plans will not have a chance to populate the database in time for a 2010 payment calculation and that the data are not sufficiently reliable. Commenters asked that CMS study the accuracy of the COB data before going forward with this policy.

Response: CMS believes the COB data submitted by other insurers and payers is the most accurate source of other coverage information and CMS is working with the COB contractor to establish additional procedures to validate and update COB data. We also expect plans to initiate changes to MSP status in the event they become aware of them. Please see the 2010 Call Letter for ongoing Part D plan sponsor beneficiary notification and data correction requirements. We will send the COB file to plans on a daily basis whenever changes to data are processed by CMS systems. We also plan edits to the MARx system and will undertake additional operational initiatives to further eliminate problems with the reliability of the data.

Comment: One commenter asked that CMS estimate the impacts of changing the MSP approach before moving forward with the elimination of the current method for collecting MSP data.

Response: CMS will post to HPMS estimated MSP impacts for each plan as part of the risk score information for the 2010 bidding cycle.

Comment: Several commenters stated it was too late in the process to stop the MSP survey for 2009 reporting.

Response: The COB contractor will maintain the COB data for MSP beneficiaries. Plans will no longer be responsible for the MSP survey for MA beneficiaries for Part C beginning in 2009 for payment year 2010. (Please see the 2010 Call Letter for ongoing Part D plan sponsor requirements for beneficiary notification and data corrections related to COB data in CMS systems.) Each year in the middle of February CMS announces changes to payment policy in the Advance Notice. Plans make their own business decisions as to when to begin administering the MSP survey and when to initiate implementation of other aspects of the MA program. Plans should keep in mind that although the survey is not required in 2009 for 2010 payment, data derived from completed surveys may be helpful to plans in initiating updates of MSP information in ECRS.

Comment: One commenter felt that CMS should revert to the MSP process in place prior to the Spring 2009 software release for submission of MSP data in 2009, as it is not necessary for plans to expend significant resources to update their IT coding systems in 2009 if they will be obsolete in under a year.

Response: The requirements laid out in the Spring 2009 software release regarding MSP will no longer be necessary, as MA plans will no longer be required to submit the survey for Part C in the summer/fall of 2009.

Comment: A few commenters requested details about the process used to separate WA/WD beneficiaries for MA payment from other COB data.

Response: We will adjust MA payments for Working Aged/Working Disabled MSP status. These beneficiaries have a special flag in the COB data that we will use to adjust payments. Plans should report all MSP statuses, such as workers' compensation and auto-liability, to ECRS so that other plans and original Medicare know of primary payers.

Comment: One commenter requested that CMS increase the USPCC for MA plans as if Medicare paid primary with respect to the working aged/disabled since MA plans have benefit payments reduced when they have working aged members.

Response: The coefficients in the CMS risk models do not account for the impact of individuals with MSP. The standard rate is raised by the risk model as if Medicare was paying primary for all MA beneficiaries. The MSP adjustment is then used to reduce the rate when an individual is WA/WD. In this way the adjustment is applied to the appropriate individuals and plans rather than to all individuals and plans.

Comment: One commenter asserted that many SNPs have a small number of working aged or working disabled beneficiaries or none at all. The commenter was concerned that an industry-level MSP factor based on averages from a common file would not inaccurately reflect the proportion of working aged and working disabled in SNP plans and would inaccurately reduce payments.

Response: We agree with the commenter that an industry level factor would not result in the most accurate MA payments since some plans may have more WA/WD beneficiaries than others. As stated in the Advance Notice, we plan to do an MSP adjustment that reflects the MSP status of the beneficiaries in each plan. We believe this will result in the most accurate MSP adjustment for all plans and enrollees.

Section K. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2010

Comment: We received a comment requesting clarification regarding whether the deductible for Part D non-full benefit dual eligible beneficiaries receiving the full subsidy with resources between $6,600 and $11,010 (individuals) or between $9,910 and $22,010 (couples) is $62.00 or $60.00.

Response: The deductible for Part D non-full benefit dual eligible beneficiaries receiving the full subsidy with resources between $6,600 and $11,010 (individuals) or between $9,910 and $22,010 (couples) is $63.00. We thank the commenter for identifying this error in Table III-1, Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy. Please see Attachment IV for the revised Part D benefit parameters.

Comment: Two commenters requested that CMS describe and explain the methodology for calculating the 1.70% correction to the 2009 annual percentage increase in the Consumer Price Index (CPI) for prior year revisions. One commenter indicated that based on the calculation methodology described in the 2009 Advance Notice (1.0494/1.026 – 1), it appears that the correction to the 2009 annual percentage increase in the CPI should be 2.28% instead of 1.70%. The commenter asked that CMS provide an explanation if the methodology is different from the methodology provided in the 2009 Advance Notice.

Response: The methodology for calculating the revisions to the estimates of prior years' annual percentage increases in average expenditures for Part D drugs per eligible beneficiary and CPI are unchanged from 2009. An error was identified in a component of the calculation of the revisions. The updated prior year revisions percentage and annual percentage increase for 2009 are −1.07% and 4.66%, respectively, for the average expenditures for Part D drugs per eligible beneficiary. The updated prior year revisions percentage and annual percentage increase for 2009 are 2.28% and 2.65%, respectively, for CPI. Please see Attachment IV for the revised table.

Comment: Commenters requested clarification regarding whether the annual percentage trend for September 2009 in Table IV-2, Cumulative Annual Percentage Increase in CPI, should be expressed as a factor rather than a percentage.

Response: The value for the annual percent trend for September 2009 in this table should be 0.36%. We thank the commenters for identifying this error in Table IV-2 in the 2010 Advance Notice. Please see Attachment IV for the revised table.

Section L. Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)

Comment: One commenter indicated that requiring Part D sponsors to use the amount paid to the pharmacy or other provider to report drug costs and determine beneficiary cost sharing lowers Part D program costs by increasing beneficiary premiums. The commenter requested clarification regarding the expected impact of these increases in beneficiary premiums on the regional LIS benchmarks.

Response: Under this regulatory change, Part D sponsors must exclude the PBM spread and any other administration costs from the negotiated prices used to determine the Part D drug costs reported to CMS. As a result, CMS expects the drug costs reported by Part D sponsors to decrease, reducing the reinsurance and low-income cost sharing subsidy payments made by the federal government. These lower negotiated prices are also expected to decrease beneficiary cost sharing such that the total amount paid by beneficiaries for their prescription drug coverage (premiums plus cost sharing) would be lower. However, the expected reductions in beneficiary cost sharing and federal reinsurance and low-income cost sharing subsidy payments may increase plan liability. This increase in plan liability may result in higher Part D bids and higher beneficiary premiums for plans that utilize the lock-in pricing approach. Similarly, the regional LIS benchmarks may increase if beneficiary premiums increase for Part D plans which previously utilized the lock-in pricing approach. Thus, while this policy is expected to reduce federal reinsurance and low-income cost sharing payments to Part D sponsors, it is expected to

increase federal Part D payments overall due to increased federal direct subsidy payments resulting from higher Part D bids.

In addition to lowering the drug costs reported to CMS, this policy is expected to provide Part D sponsors with increased transparency regarding their drug costs and administration fees. This increase in transparency may allow Part D sponsors to negotiate their drug prices and administrative fees paid to PBMs more effectively, which could have a downward impact on Part D bids and beneficiary premiums. Thus, the reduction in beneficiary cost sharing and federal reinsurance and low-income cost sharing subsidies may increase Part D bids while the increase in transparency may decrease Part D bids. As a result, it is unclear whether this regulatory change will have the net impact of increasing Part D bids and beneficiary premiums.

Comment: One commenter requested clarification regarding the expected impact of beneficiary premium increases on supplemental benefits as Part D sponsors use A/B rebates to buy down the Part D premium. In addition, the commenter asked for clarification regarding whether special needs plans (SNPs) were more likely than other plans to use the lock-in pricing approach in 2009.

Response: Higher Part D beneficiary premiums may require some MA-PD plans to utilize a larger share of their A/B rebates to reduce their Part D premiums to $0, such that they have fewer A/B rebates available for providing supplemental benefits. However, as we stated previously, it is unclear whether Part D premiums will increase as a result of this regulatory change.

Based on the information provided by Part D sponsors regarding their pricing approach in 2008 and 2009, the percentage of SNPs utilizing the lock-in pricing approach is about the same as the percentage of Part D plans utilizing the lock-in pricing approach (approximately 20% in 2008 and 16% in 2009).

Attachment IV 2010 Part D Benefit Parameters

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

Annual Percentage Increases

	Annual percentage trend for 2009	Prior year revisions	Annual percentage increase for 2009
Applied to all parameters but (1)	5.79%	−1.07%	4.66%
CPI (all items, U.S. city average): Applied to (1)	0.36%	2.28%	2.65%

Part D Benefit Parameters

	2009	2010
Standard Benefit Design Parameters		
Deductible	$295	$310
Initial Coverage Limit	$2,700	$2,830
Out-of-Pocket Threshold	$4,350	$4,550
Total Covered Part D Drug Spend at OOP Threshold (2)	$6,153.75	$6,440.00
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.30
Part D Full Benefit Dual Eligible Parameters		
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	$1.10	$1.10
Other (3)	$3.20	$3.30
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.30
Above Out-of Pocket Threshold	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters		
Resources ≤ $6,600 (individuals) or ≤ $9,910 (couples) (4)		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.30
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Resources bet $6,600-$11,010 (ind) or $9,910-$22,010 (couples) (4)		
Deductible (3)	$60.00	$63.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.30
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$60.00	$63.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.30
Retiree Drug Subsidy Amounts		
Cost Threshold	$295	$310
Cost Limit	$6,000	$6,300

(1) CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% FPL.
(2) Amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.
(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2009 values of $60.13, $1.08, and $3.23 respectively.
(4) The actual amount of resources allowable will be updated for contract year 2010.

Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2010

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These parameters include the standard deductible, initial coverage limit, and catastrophic coverage threshold, and minimum copayments for costs above the annual out-of-pocket threshold. In addition, CMS is statutorily required to update the parameters for the low income subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy. Included in this notice are (i) the methodologies for updating these parameters, (ii) the updated parameter amounts for the Part D defined standard benefit and low-income subsidy benefit for 2010, and (iii) the updated cost threshold and cost limit for qualified retiree prescription drug plans.

As required by statute, the parameters for the defined standard benefit formula are indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. Accordingly, the actuarial value of the drug benefit increases along with any increase in drug expenses, and the defined standard Part D benefit continues to cover a constant share of drug expenses from year to year.

All of the Part D benefit parameters are updated using one of two indexing methods specified by statute: (i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary, and (ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

I. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

Section 1860D-2(b)(6) of the Social Security Act defines the "annual percentage increase" as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following parameters are updated using the "annual percentage increase":

Deductible: From $295 in 2009 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $2,700 in 2009 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $4,350 in 2009 and rounded to the nearest multiple of $50.

Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.40 per generic or preferred drug that is a multi-source drug, and $6.00 for all other drugs in 2009, and rounded to the nearest multiple of $0.05.

Maximum Copayments below the Out-of-Pocket Threshold for certain Low Income Full Subsidy Eligible Enrollees: From $2.40 per generic or preferred drug that is a multi-source drug, and $6.00 for all other drugs in 2009, and rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $60[1] in 2009 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.40 per generic or preferred drug that is a multi-source drug, and $6.00 for all other drugs in 2009, and rounded to the nearest multiple of $0.05.

II. Annual Percentage Increase in Consumer Price Index, All Urban Consumers (all items, U.S. city average)

Section 1860D-14(a)(4) of the Social Security Act specifies that the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year is used to update the maximum copayments below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes that do not exceed 100% of the Federal poverty line. These copayments are increased from $1.10 per generic or preferred drug that is a multi-source drug, and $3.20 for all other drugs in 2009[2], and rounded to the nearest multiple of $0.05 and $0.10, respectively.

III. Calculation Methodology

Annual Percentage Increase

For the 2007 and 2008 contract years, the annual percentage increases, as defined in section 1860D-2(b)(6) of the Social Security Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with the 2009 contract year, the annual percentage increases are based on Part D program data. For the 2010 contract year benefit parameters, Part D program data is used to calculate the annual percentage trend as follows:

$$\frac{\text{August 2008 – July 2009}}{\text{August 2007 – July 2008}} = \frac{\$2{,}829.52}{\$2{,}674.62} = 1.0579$$

In the formula, the average per capita cost for August 2007 – July 2008 ($2,674.62) is calculated from actual Part D prescription drug event (PDE) data and the average per capita cost for August 2008 – July 2009 ($2,829.52) is calculated based on actual Part D PDE data incurred from August – December, 2008 and projected through July, 2009.

The 2010 benefit parameters reflect the 2009 annual percentage trend as well as a revision to the prior estimates for prior years' annual percentage increases. Based on updated NHE prescription drug per capita costs and PDE data, the 2007, 2008 and 2009 increases are now estimated to be 6.42%, 5.33% and 6.12%. Accordingly, the 2010 benefit parameters reflect a multiplicative update of −1.07% for prior year revisions. In summary, the 2009 parameters outlined in section I are updated by 4.66% for 2010 as summarized by Table III-1.

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[1] Consistent with the statutory requirements of 1860D-14(a)(4)(B) of the Social Security Act, the update for the deductible for low income (partial) subsidy eligible enrollees is applied to the unrounded 2009 value of $60.13.

[2] Consistent with the statutory requirements of 1860D-14(a)(4)(A) of the Social Security Act, the copayments are increased from the unrounded 2009 values of $1.08 per generic or preferred drug that is a multi-source drug, and $3.23 for all other drugs.

Table III-1. Annual Percentage Increase

Annual percentage trend for July 2009	5.79%
Prior year revisions	(1.07%)
Annual percentage increase for 2009	4.66%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase in Consumer Price Index, All Urban Consumers (all items, U.S. city average)

The annual percentage increase in the CPI as of September of the previous year referenced in section 1860D-14(a)(4)(A)(ii) is interpreted to mean that, for contract year 2010, the September 2009 CPI should be used in the calculation of the index. To ensure that plan sponsors and CMS have sufficient time to incorporate the cost-sharing requirements into benefit, marketing material and systems development, the methodology to calculate this update includes an estimate of the September 2009 CPI based on the projected amount included in the President's FY2010 Budget. The September 2008 value is from the Bureau of Labor Statistics. The annual percentage trend in CPI for contract year 2010 is calculated as follows:

$$\frac{\text{Projected September 2009 CPI}}{\text{Actual September 2008 CPI}} \text{ or } \frac{219.6}{218.8} = 1.004$$

(Source: President's FY2010 Budget and Bureau of Labor Statistics, Department of Labor)

The 2010 benefit parameters reflect the 2009 annual percentage trend in the CPI, as well as a revision to the prior estimate for the 2008 annual percentage increase. The 2009 parameter update reflected an annual percentage trend in CPI of 2.60%. Based on the actual reported CPI for September 2008, the September 2008 CPI increase is now estimated to be 4.94%. Thus, the 2010 update reflects a multiplicative 2.28% correction for prior year revisions. In summary, the cost sharing items outlined in section II are updated by 2.65% for 2010 as summarized by Table III-2.

Table III-2. Cumulative Annual Percentage Increase in CPI

Annual percentage trend for September 2009	0.36%
Prior year revisions	2.28%
Annual percentage increase for 2009	2.65%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

IV. Part D Reinsurance Payment Demonstration Adjustment

The fixed capitated option of the Part D Reinsurance Payment Demonstration includes a catastrophic benefit that begins at the total drug expense corresponding to the out-of-pocket threshold in the Defined Standard Benefit. For 2010, this amount is increased from $6,153.75 in 2009 to $6,440. Specifically, this is the minimum amount of total covered Part D drug expenditures that will have occurred when the beneficiary reaches the out-of-pocket threshold of $4,550 in 2010 in the defined standard benefit. This expense level is determined arithmetically as a function of the 2010 out-of-pocket threshold (as opposed to being indexed directly).

V. Retiree Drug Subsidy Amounts

As outlined in §423.886(b)(3) of the regulations implementing the Part D benefit, the cost threshold and cost limit for qualified retiree prescription drug plans that end in years after 2006 are adjusted in the same manner as the annual Part D deductible and out-of-pocket threshold are adjusted under §423.104(d)(1)(ii) and (d)(5)(iii)(B), respectively. Specifically, they are adjusted by the "annual percentage increase" as defined previously in this document and the cost threshold is rounded the nearest multiple of $5 and the cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $275 and $5,600, respectively, for plans that end in 2008, and, as $295 and $6,000, respectively, for plans that end in 2009. For 2010, the cost threshold is increased to $310, and the cost limit is increased to $6,300.