

April 3, 2006

NOTE TO: All Medicare Advantage Organizations and Other Interested Parties

**SUBJECT: Announcement of Calendar Year (CY) 2007 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 2007, and the risk and other factors to be used in adjusting such rates. Attached is a spreadsheet containing the capitation rate tables for CY 2007. Also included is a spreadsheet which shows the statutory component of the regional benchmarks. The rates are posted on the Centers for Medicare & Medicaid Services (CMS) web site at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/> under Ratebooks and Supporting Data.

Enclosure I shows the final estimates of the increase in the National Per Capita MA Growth Percentage for 2007. As discussed in Enclosure I, the final estimate of the increase in the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 7.13 percent. Since these estimates are all larger than 2 percent, these growth rates will be used as the minimum update percentage in calculating the 2007 rates. Under section 1853(c)(1) of the Act, MA payment rates in 2007 will be based on the higher of the county fee-for-service (FFS) per capita amount or a minimum percent increase over the 2006 rate. Enclosure 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 Percentage.

Section 1853(b)(4) of the Act (added by Section 514 of the BBRA) requires CMS to release county-specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2004 is being posted on the Internet at this time as well.

We received 32 comments from 9 organizations in response to CMS' request for comments on the Advance Notice of Methodological Changes for CY 2007 MA Payment Rates and Part D Payment (Advance Notice), published on February 17, 2006. Enclosure III presents our responses to the issues raised in the comments related to the Advance Notice. Enclosure IV contains the updated CMS-HCC risk adjustment factors effective CY 2007.

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Enclosures

Enclosure I

Final Estimate of the Increase in the National Per Capita Growth Percentages for 2007

The first table below shows the National Per Capita MA Growth Percentages (NPCMAGP) used to determine the minimum update percentages for 2007. Adjustments of 3.13 percent, 5.28 percent, 4.40 percent and 3.41 percent for aged, disabled, ESRD, and combined aged and disabled, respectively, are included in the NPCMAGP to account for corrections to prior years estimates as required by section 1853(c)(6)(C). The combined aged and disabled increase is used in the development of the risk-adjusted ratebook.

The second table below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2006 and 2007. In addition, for 2007, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2007. These data were furnished by the Office of the Actuary.

Increase in the National Per Capita MA Growth Percentages for 2007

	Prior Increases	Current Increases		NPCMAGP for 2007 With Sec.1853(c)(6)(C) adjustment ¹	
	2003 to 2006	2003 to 2006	2006 to 2007		2003 to 2007
Aged	18.73%	22.45%	3.53%	26.77%	6.77%
Disabled	17.80	24.02	4.04	29.03	9.53
ESRD	16.00	21.10	-0.13	20.93	4.25
Aged+Disabled	18.53	22.57	3.60	26.99	7.13

¹Current increases for 2003 to 2007 divided by the prior increases for 2003 to 2006.

Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2006 and 2007

	2006	2007	Change	2007 non-ESRD
Part A Benefits	\$30.64	\$33.19	8.3%	\$31.81
Part B Benefits ²	94.31	102.39	8.6%	96.99
Total Medicare	124.95	135.58	8.5%	128.80

²Includes the amounts for outpatient psychiatric charges.

The maximum deductible for Medical Savings Account (MSA) plans for 2007 is \$9,500.

Enclosure 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 2000 to 2007. In addition, this table shows the current projections of the USPCCs through 2009. In prior years, information in these tables was presented back to 1997. Since the passage of the MMA, formula changes in the law do not require the use of the USPCCs back to 1997 for the purpose of calculating the 2007 rates (e.g., the area-specific rate is not tabulated for years after 2004 and no adjustments to prior years' estimates are allowed for years before 2004 for calculating the minimum update percentage).

We are also providing an attached set of tables that summarizes many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2000 through 2009. All of the information provided in this enclosure applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

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

Comparison of Current Estimates of the USPCC with Published Estimates

PART A:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	\$263.37	\$286.18	1.087	\$219.00	\$230.48	1.052	\$257.42	\$278.61	1.082
2001 ¹	\$284.44	\$288.62	1.015	\$236.00	\$235.50	0.998	\$277.77	\$281.25	1.013
2001 ²	\$284.44	\$298.43	1.049	\$236.00	\$242.00	1.025	\$277.77	\$290.59	1.046
2002	\$297.70	\$294.46	0.989	\$250.20	\$242.06	0.967	\$290.97	\$287.10	0.987
2003	\$304.68	\$290.50	0.953	\$255.97	\$234.89	0.918	\$297.53	\$282.50	0.949
2004	\$322.74	\$326.78	1.013	\$273.89	\$271.69	0.992	\$315.35	\$318.43	1.010
2005	\$341.10	\$348.28	1.021	\$288.87	\$291.45	1.009	\$333.04	\$339.49	1.019
2006	\$355.30	\$351.38	0.989	\$301.83	\$295.15	0.978	\$346.86	\$342.67	0.988
2007	\$370.34	\$370.34	1.000	\$318.17	\$318.17	1.000	\$362.06	\$362.06	1.000
2008	\$384.95	--	--	\$333.11	--	--	\$376.67	--	--
2009	\$399.11	--	--	\$347.21	--	--	\$390.77	--	--

PART B:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	\$199.20	\$218.78	1.098	\$194.54	\$195.91	1.007	\$198.62	\$216.03	1.088
2001 ¹	\$220.01	\$217.57	0.989	\$216.06	\$191.99	0.889	\$219.50	\$214.32	0.976
2001 ²	\$220.01	\$223.83	1.017	\$216.06	\$198.69	0.920	\$219.50	\$220.63	1.005
2002	\$238.56	\$244.17	1.024	\$239.31	\$218.23	0.912	\$238.66	\$240.76	1.009
2003	\$250.94	\$232.24	0.925	\$257.05	\$211.58	0.823	\$251.77	\$229.47	0.911
2004	\$277.01	\$263.39	0.951	\$283.55	\$252.74	0.891	\$277.93	\$261.89	0.942
2005	\$303.55	\$281.90	0.929	\$314.23	\$272.79	0.868	\$305.10	\$280.58	0.920
2006	\$325.04	\$311.28	0.958	\$334.42	\$316.82	0.947	\$326.42	\$312.09	0.956
2007	\$334.02	\$334.02	1.000	\$343.76	\$343.76	1.000	\$335.47	\$335.47	1.000
2008	\$347.34	--	--	\$358.51	--	--	\$349.02	--	--
2009	\$358.74	--	--	\$370.92	--	--	\$360.59	--	--

PART A & PART B:

Calendar Year	Aged			Disabled			Aged and Disabled		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2000	\$462.57	\$504.96	1.092	\$413.54	\$426.39	1.031	\$456.04	\$494.64	1.085
2001 ¹	\$504.45	\$506.19	1.003	\$452.06	\$427.49	0.946	\$497.27	\$495.57	0.997
2001 ²	\$504.45	\$522.26	1.035	\$452.06	\$440.69	0.975	\$497.27	\$511.22	1.028
2002	\$536.26	\$538.63	1.004	\$489.51	\$460.29	0.940	\$529.63	\$527.86	0.997
2003	\$555.62	\$522.74	0.941	\$513.02	\$446.47	0.870	\$549.30	\$511.97	0.932
2004	\$599.75	\$590.17	0.984	\$557.44	\$524.43	0.941	\$593.28	\$580.32	0.978
2005	\$644.65	\$630.18	0.978	\$603.10	\$564.24	0.936	\$638.14	\$620.07	0.972
2006	\$680.34	\$662.66	0.974	\$636.25	\$611.97	0.962	\$673.28	\$654.76	0.972
2007	\$704.36	\$704.36	1.000	\$661.93	\$661.93	1.000	\$697.53	\$697.53	1.000
2008	\$732.29	--	--	\$691.62	--	--	\$725.69	--	--
2009	\$757.85	--	--	\$718.13	--	--	\$751.36	--	--

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

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

**Comparison of Current Estimates of the USPC with Published Estimates-
continued**

PART A:

Calendar Year	ESRD		
	Current Estimate	Published Estimate	Ratio
2000	\$1,366.70	\$1,443.13	1.056
2001 ¹	\$1,494.57	\$1,541.76	1.032
2001 ²	\$1,494.57	\$1,597.34	1.069
2002	\$1,608.84	\$1,435.62	0.892
2003	\$1,737.24	\$1,596.58	0.919
2004	\$1,844.12	\$1,685.25	0.914
2005	\$1,905.51	\$1,759.90	0.924
2006	\$1,881.98	\$1,717.97	0.913
2007	\$1,874.54	\$1,874.54	1.000
2008	\$1,911.33	--	--
2009	\$1,938.38	--	--

PART B:

Calendar Year	ESRD		
	Current Estimate	Published Estimate	Ratio
2000	\$1,508.57	\$2,436.13	1.615
2001 ¹	\$1,722.43	\$1,875.57	1.089
2001 ²	\$1,722.43	\$1,921.53	1.116
2002	\$1,845.75	\$2,014.79	1.092
2003	\$1,855.91	\$1,847.53	0.995
2004	\$2,039.75	\$2,552.18	1.251
2005	\$2,188.84	\$2,739.99	1.252
2006	\$2,469.16	\$2,454.98	0.994
2007	\$2,470.81	\$2,470.81	1.000
2008	\$2,591.87	--	--
2009	\$2,691.33	--	--

PART A & PART B:

Calendar Year	ESRD		
	Current Estimate	Published Estimate	Ratio
2000	\$2,875.27	\$3,879.26	1.349
2001 ¹	\$3,217.00	\$3,417.33	1.062
2001 ²	\$3,217.00	\$3,518.87	1.094
2002	\$3,454.59	\$3,450.41	0.999
2003	\$3,593.15	\$3,444.11	0.959
2004	\$3,883.87	\$4,237.43	1.091
2005	\$4,094.35	\$4,499.89	1.099
2006	\$4,351.14	\$4,172.95	0.959
2007	\$4,345.35	\$4,345.35	1.000
2008	\$4,503.20	--	--
2009	\$4,629.71	--	--

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

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

Summary of Key Projections Under Present Law¹

Part A

Year	Calendar Year CPI Percent Increase	Fiscal Year PPS Update Factor	FY Part A Total Reimbursement (Incurred)
2000	3.5	1.1	-0.8
2001	2.7	3.4	8.2
2002	1.4	2.8	7.9
2003	2.2	3.0	4.0
2004	2.6	3.4	9.0
2005	3.5	3.3	7.4
2006	3.1	3.7	5.9
2007	2.4	3.4	6.4
2008	2.4	3.3	6.0
2009	2.4	2.9	5.9

Part B²

Calendar Year	Physician Fee Schedule		Part B Hospital	Total
	Fees	Residual ³		
2000	5.9	3.6	-0.8	10.4
2001	5.3	4.1	12.5	9.8
2002	-4.2	6.1	-1.4	8.0
2003	1.4	4.5	5.3	5.0
2004	3.8	6.1	11.3	9.8
2005	1.5	7.8	10.6	9.2
2006	0.0	5.7	7.9	6.0
2007	-6.5	7.0	7.4	1.8
2008	-4.6	5.7	7.1	3.5
2009	-4.7	5.3	6.4	2.8

¹Percent change over prior year.

²Percent change in charges per Aged Part B enrollee.

³Residual 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
2000	33.699	5.224	32.421	4.590
2001	33.903	5.416	32.581	4.747
2002	34.080	5.618	32.713	4.916
2003	34.426	5.929	33.014	5.187
2004	34.835	6.207	33.241	5.445
2005	35.187	6.423	33.510	5.675
2006	35.564	6.659	33.857	5.873
2007	36.134	6.817	34.320	6.022
2008	36.806	6.989	34.885	6.174
2009	37.515	7.183	35.486	6.342

ESRD Part A

Calendar Year	Part A			
	Aged	Disabled	299I ¹	Total
2000	0.137	0.107	0.090	0.334
2001	0.144	0.112	0.094	0.350
2002	0.152	0.117	0.098	0.366
2003	0.160	0.121	0.102	0.383
2004	0.167	0.126	0.104	0.396
2005	0.174	0.129	0.106	0.409
2006	0.182	0.132	0.109	0.423
2007	0.189	0.135	0.111	0.435
2008	0.196	0.138	0.113	0.446
2009	0.202	0.141	0.114	0.457

ESRD Part B

Calendar Year	Part B			
	Aged	Disabled	299I	Total
2000	0.138	0.102	0.083	0.324
2001	0.145	0.107	0.086	0.338
2002	0.153	0.111	0.090	0.354
2003	0.161	0.115	0.093	0.369
2004	0.167	0.119	0.093	0.379
2005	0.174	0.122	0.095	0.390
2006	0.181	0.125	0.097	0.403
2007	0.188	0.127	0.099	0.413
2008	0.194	0.129	0.100	0.424
2009	0.201	0.132	0.101	0.434

¹ Individuals who qualify for Medicare based on ESRD only.

Part A Projections Under Present Law ¹

Calendar Year	Inpatient Hospital		SNF		Home Health		Managed Care		Hospice: Total Reimbursement (in Millions)	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
2000	2,218.26	2,385.73	310.23	104.89	99.05	70.37	593.36	269.74	2,772	146
2001	2,417.28	2,596.81	376.99	129.10	118.53	89.82	571.77	245.26	3,541	186
2002	2,593.73	2,785.85	412.55	145.20	124.91	95.03	523.26	224.23	4,614	243
2003	2,672.82	2,867.99	421.38	150.41	131.93	100.69	522.57	218.84	5,927	312
2004	2,780.04	3,036.09	475.32	175.80	150.42	115.69	569.17	238.65	7,190	378
2005	2,865.61	3,148.79	490.52	182.35	163.73	126.74	682.44	293.33	8,122	427
2006	2,826.59	3,187.11	462.47	176.18	165.05	131.19	919.11	402.18	9,088	478
2007	2,798.98	3,265.88	455.34	179.93	164.51	135.70	1,135.34	504.06	10,111	532
2008	2,846.37	3,373.84	459.45	185.34	170.16	143.18	1,256.76	563.70	10,614	559
2009	2,882.07	3,469.14	463.13	190.70	173.86	149.20	1,386.00	626.99	11,293	594

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

Part B Projections Under Present Law¹

Calendar Year	Physician Fee Schedule		Part B Hospital		Durable Medical Equipment	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	1,003.19	951.68	238.98	299.75	118.54	184.46
2001	1,131.49	1,064.16	326.94	412.41	137.14	215.29
2002	1,177.53	1,109.80	333.63	436.59	158.42	261.54
2003	1,263.85	1,191.28	377.90	485.10	182.32	302.60
2004	1,397.33	1,318.57	434.27	561.49	181.83	303.83
2005	1,511.62	1,439.79	485.24	638.20	184.73	316.74
2006	1,515.82	1,473.88	513.72	672.22	179.21	317.45
2007	1,436.95	1,437.94	531.09	716.13	174.82	318.68
2008	1,420.20	1,436.89	563.82	769.92	179.32	330.38
2009	1,394.89	1,428.32	593.25	821.06	173.07	322.72

Calendar Year	Carrier Lab		Other Carrier		Intermediary Lab	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	58.89	58.02	201.38	195.17	46.25	62.53
2001	64.86	63.70	239.97	231.14	47.73	67.87
2002	70.96	71.16	286.98	281.75	55.39	78.15
2003	76.46	75.67	337.44	352.06	60.30	83.53
2004	82.57	82.82	363.52	401.42	64.87	91.70
2005	90.00	91.57	381.39	463.80	70.43	100.77
2006	91.15	95.53	395.64	501.70	71.44	104.95
2007	91.22	98.18	405.27	526.10	71.89	108.69
2008	93.04	101.13	424.18	554.97	73.57	112.47
2009	96.28	105.80	439.95	581.06	76.05	117.66

Calendar Year	Other Intermediary		Home Health		Managed Care	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	117.91	228.27	129.45	99.19	531.83	221.42
2001	138.59	238.66	128.68	75.42	498.03	189.90
2002	173.76	287.38	138.37	81.59	556.87	230.86
2003	179.75	276.55	141.05	84.20	481.39	199.55
2004	206.77	280.99	153.29	91.29	538.97	234.94
2005	237.78	317.04	167.20	99.27	625.73	267.73
2006	256.63	339.11	168.58	102.93	842.92	367.40
2007	237.66	320.82	168.41	106.29	1,029.86	453.33
2008	246.13	336.14	174.57	112.14	1,142.37	507.46
2009	253.83	351.88	178.72	116.91	1,257.19	563.44

¹Average reimbursement per enrollee on an incurred basis.

Claims Processing Costs as a Fraction of Benefits

Calendar Year	Part A	Part B
2000	0.002195	0.014790
2001	0.001862	0.013223
2002	0.001496	0.011708
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001515	0.009540
2006	0.001515	0.009540
2007	0.001515	0.009540
2008	0.001515	0.009540
2009	0.001515	0.009540

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 .97435 to get the USPCC for the aged non-ESRD. This final factor of .97435 is the relationship between the total and non-ESRD per capita reimbursements in 2007. 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 .95737 to get the USPCC for the aged non-ESRD.

The National Per Capita MA Growth Percentage:

The National Per Capita MA Growth Percentage for 2007 (before adjustment for prior years’ over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2007 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2006.

Enclosure III. CMS' Responses to Public Comments

Summary

CMS received comments from 9 organizations on the February 17, 2006 Advance Notice of Methodological Changes for CY 2007 MA Payment Rates and Part D Payment (Advance Notice). Our responses to comments are organized as follows:

Section A: Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2007

Section B: Budget Neutral Risk Adjustment Factor (BN Factor) and Other Rate Issues

Section C: Updates to Risk Adjustment Methodology for MA Organizations including the FFS Normalization Factor

Section D: Part D Payment Policy

Section A: Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2007

Comment: A number of commenters asked why the preliminary estimate of the trend change for 2007 of 2.5% was so low. Several commenters also pointed out that trend rates that CMS published in the Rate Announcement for the prior three years were significantly higher than the estimated 2.5 percent for 2007: 8.0, 7.6, and 5.5 percent for 2004 to 2006, respectively.

Response: The final trend change estimate for 2007 is 3.6 percent, which is higher than the preliminary estimate of 2.5 percent announced February 17, 2006 in the Advance Notice, but still lower than revised estimates for recent years. There are several reasons why the growth trend for 2007 is expected to be lower than the three prior years.

First, for 2004 to 2006, Congress has reversed a scheduled reduction in physician payment rates and set the fee schedule updates at 1.5 percent in 2004 and 2005 and 0 percent in 2006. However, Congress has not reversed the scheduled reduction in physician payment rates for 2007. Under current law, the update for physician payments for 2007 is estimated to be -4.6%. CMS, therefore, is required to estimate a 2007 trend that reflects this scheduled 4.6% reduction. Given that roughly 20 percent of Medicare expenditures are for physician services, the overall 2007 trend growth rate is lower by almost 1 percent than it would be if the update for physicians were 0 percent or slightly positive.

Second, the Deficit Reduction Act (DRA) of 2005 included several FFS provisions that will reduce Medicare expenditures in 2007. The DRA provisions that most affect the 2007 growth rate are those that result in reduced expenditures for therapy, imaging, and home health services.

Third, outpatient prospective payment system (OPPS) expenditures are assumed to grow at a slower rate due to a more gradual change in the coinsurance buy-down. When the OPPS was

implemented in 2000, coinsurance rates for most ambulatory payment codes (APC) were initially well above 20 percent. With the phasing-in of required changes to the OPPS coinsurance percentage, Medicare expenditures increased in the short term while the Medicare share of total costs increased to 80 percent. These larger buy downs have occurred in the recent past, and sped up expenditure growth, but are not expected to occur in 2007. Therefore, 2007 growth in expenditures has slowed relative to earlier years.

Lastly, utilization rates for various other services in recent years have tended to slow down or flatten out relative to the rates in earlier years, thus contributing to a lower overall growth rate.

Comment: Several commenters noted that the Medicare 2007 growth trend does not track with other estimates of health expenditure cost growth, and requested that CMS use its discretion to revise the preliminary estimate of the 2.5% trend for 2007. One commenter noted that underlying growth trend in overall healthcare spending is expected to be 7.4% in 2005 and 7.3% in 2006, and asked why the 2007 Medicare growth is trend so much lower.

Response: OACT is required annually to model Medicare expenditure growth based on current law and assumptions from the President's budget. Assumptions from these sources are combined with modeling assumptions OACT has developed (e.g., population demographic trends, medical cost trends, etc.) to produce Medicare growth estimates.

Using current law, budget assumptions will produce Medicare trends that are different from trends in underlying total medical costs that are developed for other purposes. For example, the national health expenditure growth trends, which were 7.4% and 7.3% for 2005 and 2006, respectively, are measuring more than just Medicare expenditures. In particular, the growth estimates used for the purposes of determining MA capitation rates reflect estimates for medical costs, but do not reflect estimates of prescription drug costs. The national health expenditure growth trends include drug costs, which are growing at a much faster rate than non-drug costs. Also, national health expenditures reflect increases in non-Medicare physician expenditures which are much higher since those expenditures are not subject to the limitations in payments for Medicare physician services. In addition, trends in other services will vary between Medicare and non-Medicare due to different payment rules and utilization effects.

The assumptions used in the Medicare models are discussed in detail in the annual Trustees Reports, found on the CMS website at http://www.cms.hhs.gov/ReportsTrustFunds/01_Overview.asp. This year, due to a delay in the release of the 2006 Trustees Report, the final estimates for the Medicare growth rates are based on the estimates from the President's FY 2007 Budget.

Comment: One commenter remarked that the preliminary estimate of the 2007 growth trend of 6.9% is in stark contrast to the 5% across-the-board reduction projected for Medicare physician payment rates in 2007. In addition, the 2006 Medicare Trustees report is expected to project cuts in physician payment rates totaling 34 percent through 2015. The commenter urged the Administration, along with the Congress, to take all steps necessary to establish

parity in Medicare payment rates between physicians and other health care providers, such as MA plans.

Response: The issue of parity in payments between types of Medicare providers is beyond the scope of this announcement.

The calculation of MA payment rates is established by §1853 of the Act. One of the factors CMS calculates each year is an estimate of the National Per Capita MA Growth Percentage, which is the underlying growth trend in Medicare program expenditures for the upcoming year. A preliminary estimate of the National Per Capita MA Growth Percentage is published annually in the Advance Notice, and the final estimate is published annually in the Rate Announcement. The preliminary estimate for 2007 was 6.9%, and the final estimate of the 2007 growth percentage is 7.1%.

The estimate of the 2007 growth trend is one of several components CMS must use to calculate the annual county capitation rates. It is not possible to calculate what the final rates will be by simply multiplying last year's rates by this percentage, because other factors must be applied to determine the final rates, such as the budget neutrality factor, rebasing FFS rates, and recalibrating the risk adjustment model.

Comment: One commenter asked what the impact is on the 2007 National Per Capita MA Growth Percentage (growth trend) of the phase-out of BN factor mandated by the DRA.

Response: Section 5301 of the DRA includes several provisions defining how CMS calculates MA capitation rates, beginning with CY 2007. First, the DRA establishes a single risk ratebook for monthly capitation rates, because the statutory transition for MA plans from payment based on the demographic rates and adjustment factors to payment based on risk adjustment rates and risk adjustment factors is completed in 2007. Effective 2007, 100 percent of payments to virtually all MA plans will be based on risk rates.

The DRA defines the risk rates as the base ratebook, so we now will publish two sets of rates – risk and demographic rates. We will continue to publish the demographic rates because they are used in the BN factor calculations. The BN factor is calculated as the estimated difference between payments to MA organizations at 100% of the demographic rates and payments at 100% of the risk rates. Also, the demographic rates will be used in 2007 to determine payments to certain demonstrations and PACE organizations, which lag one year in the transition blend so that 25% of their payments will be based on demographic rates.

Second, the DRA mandates the phase-out schedule for the BN factor from 2006 through 2010: in 2007, 55% of the BN factor will be applied to every risk rate and from 2008 through 2010, the phase-out percentages are 40%, 25%, and 5% respectively. Moreover, the DRA specifies how CMS will calculate the numerator and denominator of the BN factor, including an adjustment to risk scores to reflect changes in treatment and coding practices in the FFS sector (referred to as “FFS coding intensity” and “FFS normalization.”). See Section C below for further information on FFS normalization.

Regarding the commenter's question about the impact of BN phase-out on the growth trend, there is no effect. The growth trend is determined before the BN factor is applied to the risk rates. The trend is used to develop the pre-BN rates. Once the pre-BN capitation rates are tabulated through application of the "highest-of" rate-setting methodology established by the 2003 MMA, then the BN factor is applied to arrive at the final rate.

Comment: Two commenters requested greater detail on what factors affect CMS' revisions to prior years' estimates of the growth trend. The commenters recommended that CMS release trend estimates for years beyond the upcoming year.

Response: As the law provides, CMS must adjust the national MA growth rates for prior years' over and under-estimates of the National Per Capita MA Growth Percentage. This is accomplished by comparing the latest baseline projection of Medicare per capita expenses (data in Enclosure II) to prior baseline projections. Baseline projections are prepared each year by OACT for use in the President's budget and the Trustees Report. Projections are prepared by type of service and type of Medicare beneficiary, and are aggregated over all services to get the appropriate per capita amount increases. OACT's projection methodology is basically the same as has been used for years. A description of the projection methodology can be found in an appendix of the annual Trustees' Report.

Enclosure II of this announcement includes tables with underlying assumptions for the USPCC growth rates. Comparing these tables with tables in prior announcements can give interested parties a sense of which factors have changed in recent years and therefore contribute to the revisions of prior year estimates.

In terms of future year growth trend estimates, each year in the Rate Announcement, the estimated USPCCs for out-years are published in the first table in Enclosure II. This year estimates through 2009 are shown. Future estimates of growth trends can be tabulated by dividing one year's USPCC by the USPCC for the prior year.

Comment: Several commenters requested that CMS provide more information in the Advance Notice on the assumptions and methodologies used in calculating all of the components of the MA capitation rates, including the growth trend, revisions to prior years' estimates of the growth trend, the FFS capitation rates, the FFS normalization factor, the BN factor, and the Part D benefit indexing factors. In addition, several commenters requested that in years when the risk adjustment model is recalibrated or revised, CMS publish in the Advance Notice the draft coefficients for all models instead of just the community model, and a description of the methodology used for simulation of payment impacts.

Response: We expect to provide additional information on the assumptions and methodologies used in determining the annual capitation rates, not only in this announcement and future Advance Notices and Rate Announcements, but also in the upcoming revision of the payment chapter in the Managed Care Manual. Regarding release of draft coefficients for updated risk adjustment models, in years when we recalibrate the models, we intend to release in the Advance Notice all draft coefficients that are available at the time of publication.

Comment: One commenter argued that Section 1853(c)(1)(C) of the Social Security Act (“minimum percentage increase”) represents Congressional intent that, after all calculations are made, MA payment rates should be raised a minimum of 2% in every county. The commenter believed that Congress designed the determination of MA payment rates with this guaranteed minimum 2% increase as a protection against the reality of health care inflation and so that Medicare beneficiaries receive protection from significant changes in their benefits year-over-year.

Response: Section 5301 of the DRA defines how CMS must calculate the MA capitation rates, beginning with CY 2007. The DRA directs that the minimum percentage increase be applied to pre-BN rates, i.e., the capitation rates before the application of the BN factor. In addition, the DRA also provides the Secretary with authority to make adjustments to the capitation rates to accommodate new or updated risk adjustment methodologies. As a result, the statutory formula for computing capitation rates does not guarantee that the county capitation rates in any given year will be at least 2% greater than the capitation rates (including the BN factor) from the prior year.

Comment: One commenter asked CMS to clarify in future Advance Notices that the preliminary estimate of the National Per Capita MA Growth Percentage is only one of several factors that affect the MA capitation rates.

Response: We will communicate in future Advance Notices that the preliminary estimate of the National Per Capita MA Growth Percentage is one of several factors that determines the final capitation rates for a year, and therefore final capitation rates cannot be predicted solely from this growth percentage.

Section B. BN Factor and Other Rate Issues

Comment: One commenter requested that CMS make available additional information about a number of variables that are used in calculating the BN factor, including assumptions about average risk scores in the various MA plan types, estimated enrollment in each of these plan types, and if these assumptions will be taken into account in the calculation of the adjustment.

Response: As discussed in Section A, the DRA 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 calculated as the difference between the calculation of payments to plans using 100 percent demographic payments and the calculation of 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 payments to plans will be at the local benchmarks, adjusted for each plan’s demographic and risk scores. CMS calculates a single BN factor for all MA plan enrollees. For 2007, the first

year of the phase-out of BN, 55% of the full BN factor is applied to the rates, as the same percentage for all counties.

The BN factor for 2007 is 3.9%. This factor was calculated based on a full BN factor of 7.1%, multiplied by 55% (the BN phase-out percentage specified in the DRA).

In calculating the BN factor, CMS used the same methodology for 2007 as was used for the 2006 BN factor, with one exception. For 2006, OACT assumed that risk scores of enrollees in regional plans would be consistent with the assumptions in the President's FY 2006 Budget baseline and the 2005 Trustees Report, and modified the observed average risk score to account for expected differences due to growth in enrollment in the new regional PPOs. This year, however, preliminary data indicate that average risk scores for some new plans are lower than the observed group, while other new plans have higher scores. Therefore, we have decided not to make any specific adjustment to the average risk score of the observed group of plans for projected enrollment when calculating the BN factor. This is consistent with the assumptions used in the President's Budget baseline.

Comment: One commenter noted that for the most accurate BN factor calculation, the demographic and risk rates should be based on the same years of data. The commenter was concerned that demographic rates will be calculated using 5 years of data, and the risk rates with 3 years of data, which would create inconsistent demographic and risk costs per county, and thus an inaccurate BN factor.

Response: The commenter's discussion of 3 versus 5 years of data is a comment on the methodology for calculating FFS rates, which has an indirect relationship to the BN calculation. At least every three years, CMS must rebase the MA FFS capitation rates. By law, in rebasing years, the final capitation rate for a county is the higher of the FFS rate or the minimum percentage increase rate. CMS typically rebases (i.e., recalculates) the FFS rates, using a rolling 5-year average of geographic indices, where each year's index is the ratio of county per capita costs to national per capita costs.

When a new risk model is developed, initially there may not be 5 years worth of data under the new model to develop the geographic adjustments. For example, when FFS rates were rebased in 2005, only three years of data under the HCC model were available. However, for 2007 CMS was able to develop five years worth of data under the new recalibrated model. Therefore, the 2007 FFS rates for both the demographic and risk models are based on an average of the five most recent years of complete claims data available – from 2000 through 2004, thereby minimizing inconsistency.

Comment: Several commenters requested that CMS publish a draft BN factor, in addition to the preliminary estimate of the growth trend, in the Advance Notice.

Response: It is not feasible to provide a draft BN estimate in the Advance Notice. In order to do a preliminary estimate of the BN factor, we would have to create preliminary demographic and risk model rates in early February, which means we would have to generate the preliminary estimate of the growth rate in January. This is not possible, given the timing

of the President's Budget and timing of data extracts and analysis needed to produce growth trends and rates.

Comment: One commenter asked how new treatments and technologies are reflected in the capitation rates and national growth trend. The commenter noted, as an example, that new and costly treatments for “wet” macular degeneration have emerged in the last year and will likely become fully incorporated into treatment of the Medicare population, but currently are not covered under a National Coverage Determination. The commenter was concerned that the FFS rates and national growth trend do not reflect the cost of this and other significant new technologies that may be numerous or costly in a given benefit year. The commenter was also concerned that the factors in the risk adjustment model do not reflect the cost of this and other significant new technologies, particularly with respect to those diagnoses that previously did not generate high expenditures but which now can reasonably be expected to do so.

Response: Costs for new Medicare-covered technologies are taken into account in two ways. First, the USPCC includes, among other estimates, projected expenditures for new Medicare-covered technologies at the national level. Any projected costs for new technologies are averaged across all counties in the growth trend, and in this way are built into both the minimum percentage update rate and the FFS rate on a projected basis.

In addition, county-level expenditures reflecting coverage mandated by local medical review policies (LMRPs) are included in the FFS cost data used to calculate the FFS rates. In years when CMS rebases the MA FFS rates, CMS uses county-level cost data that reflect expenditures for Medicare-covered services in that locale, including new technologies. For example, the 2007 FFS rates are based on historical county-level expenditures from 2000 through 2004. For each of these years, CMS calculated a Geographic Index (GI) of the county per capita FFS costs to the national per capita FFS costs. The average of these GIs for a county (called an Average Geographic Adjustment or AGA) is applied to the FFS USPCC to get the FFS rate for that county. To the extent that local areas differ from each other in cost levels in these historical data, this difference will be built into the AGAs.

In terms of reflecting new technologies in the risk adjustment model, the relationship between diagnosis patterns and expenditures changes over time due to changes in utilization, treatment patterns, and coding. We recalibrate the CMS-HCC model periodically to take account of these changes. As described above, general increases in the costs of health care are reflected in the ratebook.

Comment: Two commenters noted CMS' announcement that the FFS rates will be rebased in 2007, and requested that the Office of the Actuary consider calculating FFS expenditures by county using prospective cost estimates rather than historical claims data. The commenters stated that the current methodology for calculating FFS costs includes applying AGAs that are at least 3 years old. Many rural areas have seen recent increases in costs that are not reflected in these AGAs. Examples of increased reimbursement in rural areas include increased reimbursement in provider shortage areas (PSAs) and hospital wage index reclassifications. The commenters were concerned that CMS is incenting providers in rural

areas to continue to participate in the Medicare program through increased FFS reimbursement, yet payments to MA plans do not support this incentive.

Response: The commenter suggested that CMS reflect the payment system rules and provider classifications that will be in effect for the upcoming payment year, instead of historical reimbursement rules and classifications. During a future rebasing year, we expect to look at the feasibility of reflecting structural changes in FFS payment so that the geographic adjustments will reflect the rules and classifications in place for the upcoming payment year.

Comment: One commenter asked how the demographic payment rates that will comprise 25 percent of the benchmarks for Social HMOs will be determined.

Response. The demographic capitation rates have been determined using the methodology for calculating demographic rates established in the statute, as described in Section A. Because CMS is rebasing FFS rates for 2007, the final capitation rate for a county in 2007 for both the demographic and the risk portion of payments for Social HMOs will be the higher of the minimum percentage increase rate or the FFS rate.

Comment: Several commenters were concerned that the Advance Notice did not discuss CMS' plans for implementation of a mechanism for incorporating into the payment methodology costs associated with Medicare covered services provided to beneficiaries in Veterans' Administration (VA) and Department of Defense (DoD) facilities. The commenters emphasized that the Medicare Modernization Act established a requirement for incorporating these costs into the CY 2004 payment methodology (in the "blended" rates and in the 100 percent of FFS rates), but CMS indicated that the Agency was unable to do this at that time due to a lack of reliable data. The commenters recommended that CMS should include these costs when rebasing the FFS rates, and one commenter requested that CMS provide information about the challenges obtaining reliable data and the methodology CMS will use to incorporate these costs.

Response: Incorporating costs associated with Medicare-covered services provided to beneficiaries in VA and DoD facilities into the payment methodology is a multi-year project that will involve developing methods for matching coverage determinations, pricing of services, etc. CMS will continue to work on obtaining and sorting through the data. CMS is looking into the possibility of subtracting out dual eligibles (dually eligible for VA/DoD and Medicare) from the calculation of the county FFS costs. This method would simplify the methods for integrating VA and DoD data by greatly reducing the data needed. This approach would allow CMS, the VA, and DOD to focus on identifying all the dual eligibles, but would eliminate the multi-year project of identifying all costs associated with each dual eligible and analyzing all of these VA/DOD costs from the vantage of Medicare coverage rules and Medicare pricing. Under this possible approach, once the dual eligibles are identified, CMS could estimate the adjustment by subtracting out the dual eligible enrollees and their Medicare dollars from the county per capita cost estimates. We are evaluating this approach and working with the VA and DoD to identify these individuals.

Until CMS determines whether the approach of subtracting dual eligibles (the beneficiaries and their associated dollars) is feasible or whether CMS will continue with the multi-year project of developing a methodology for identifying the Medicare-covered costs for these dual eligible beneficiaries and adding these costs to the FFS rate calculation, we expect that the adjustment will continue to be zero.

Section C: Updates to Risk Adjustment Methodology for MA Organizations Including the FFS Normalization Factor

Comment: One commenter offered support for CMS' decision to retain the current CMS-HCC Risk Adjustment Model and recalibrate this model for CY 2007.

Response: We appreciate the commenter's agreement with our decision to recalibrate the CMS-HCC model. Recalibration will help to ensure that the CMS-HCC model better reflects current treatment, coding and expenditure trends in FFS Medicare.

Comment: Several commenters requested additional information about the development of the new coefficients for the CMS-HCC risk adjustment model. One commenter requested that future Advance Notices include the value, or CMS' estimate, of average costs for FFS beneficiaries used as the denominator in determining the relative risk scores for the recalibrated risk adjustment model, and a description of any factors that contribute to significant changes in these coefficients.

Response: As stated in the February 17, 2006 Advance Notice for payment year 2007, FFS claims data for the years 2002 and 2003 will be used in the recalibration of the model and the updated model coefficients will reflect newer treatment and coding patterns in FFS Medicare. We did not make any changes to the methodology used to develop the risk adjustment model coefficients. Please refer to the following documents for additional methodological information about the development of the model, including the calculation of the coefficients:

- The Advance Notice for payment year 2004:
<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf>
- Pope, Kautter, et al., "Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model," *Health Care Financing Review*, Summer 2004, 25(4):119-141.
http://www.cms.hhs.gov/HealthCareFinancingReview/03_2004_Edition.asp#TopOfPage

The denominator used to calculate the relative coefficients for each version (community, long-term institutional, and new enrollee) of the newly calibrated non-ESRD model is \$6,496.03, which is based on 2005 data. We are aware of the importance of this information to plans in planning their upcoming contract year and will continue to provide as much information as possible in future Advance Notices. For 2007, we will continue to use the ESRD model coefficients already in use.

Comment: Several commenters noted that the coefficients in several categories of the recalibrated model are lower or higher than in the current model. One commenter noted that, for example, diabetes payment weights decrease by nearly 17 percent, while cancer payment weights increase by nearly 11 percent. Another commenter asked why there are significant changes in the coefficients when the new data used for recalibration is only three years later.

Response: The new coefficients in the recalibrated CMS-HCC risk adjustment model are the result of more recent diagnosis and expenditure data. In addition, the CMS-HCC Institutional model has been recalibrated using a 100% long-term institutional sample, resulting in a more precise estimate of the coefficients.

Recalibration with newer data will cause changes in the values of particular coefficients for a number of reasons. First, changes in coding practices in FFS could result in people with lower severity of diseases being categorized in certain, relatively higher-cost HCCs. If greater numbers of beneficiaries with lower average costs are assigned an ICD-9 code that places them in an HCC previously populated by people with relatively higher costs, the presence of these “lower cost” beneficiaries can have the effect of reducing the dollar value of the HCC, thus lowering the coefficient.

Second, although most coefficients in the model have increased in dollar terms, some have increased more than average and some have increased less than average. For those conditions whose dollar coefficients have increased less than average, the relative coefficients have decreased.

For example, the relative coefficient for diabetes decreased (although the dollar coefficients have increased) because the proportion of people in the FFS population who were coded as diabetic has increased. It appears that coding intensity initiatives have led to an increase in the coding of patients with less severe diabetes. In addition, some beneficiaries who previously were coded with less severe manifestations of diabetes are now coded as more severe. In both these situations, people with relatively low costs are moving higher in the diabetes hierarchy and lowering the average costs in each HCC.

Third, coefficients for some other diseases have increased because, in the intervening years between model calibrations, treatments for these diseases have become more expensive. For example, coefficients for cancer have increased because many chemotherapy drugs (paid for under Part B, and thus captured in the CMS-HCC model) have become more expensive.

Finally, in addition to the changes in the coefficients due to more recent diagnosis and expenditure data described above, the recalibrated model uses a denominator two years later (2005) than the data used to calibrate the coefficients (2003). This is an effective approach for accounting for two years of FFS normalization, but means that the relative coefficients are lower than if the denominator used to calculate the relative factors were based on data from the same year as the data used in the recalibration (2003).

Comment: Several commenters requested that CMS publish the number of observations per HCC, by type of beneficiary.

Response: We will soon be releasing on the CMS Web site a frequency table of the estimated number of FFS beneficiaries with diagnoses coded into each HCC.

Comment: Several commenters asked CMS to describe the methodology for estimating the impact on plans of the recalibrated CMS-HCC model.

Response: When making comparisons of risk scores, it is important to take into account the FFS normalization factor so that comparisons are always done between normalized risk scores. Risk scores calculated using the 2004-2006 CMS-HCC model coefficients with recent data should be multiplied by 1/1.05, the FFS normalization factor that has been used in payment since 2004. Applying this normalization factor provides a more accurate comparison of risk scores from the old and new calibrations of the model, the latter of which is normalized to 2005. We estimated the impact on payment of changes in risk scores due to recalibration of the CMS-HCC model using a standard cohort and an appropriately adjusted ratebook. A key step in this process was normalizing risk scores to the appropriate year.

Comment: Several commenters requested that the coefficients for the long-term institutional model also be published in future Advance Notices.

Response: The coefficients for the Long-Term Institutional risk adjustment model are published in this Rate Announcement. We understand the interest in these coefficients, especially given new products focused on institutionalized Medicare beneficiaries. As we noted in the Advance Notice, we have used a larger sample to develop these coefficients and believe that the Long-Term Institutional risk adjustment model is improved significantly by having this larger sample, with more precise estimates, particularly for HCCs with small proportions of the population.

Comment: One commenter expressed concern that recalibration of the CMS-HCC risk adjustment model may disproportionately affect plans enrolling dual eligible beneficiaries and recommended that CMS continue to evaluate and test the new risk adjustment model to ensure that certain segments of plan populations are not adversely affected.

Response: The CMS-HCC risk adjustment model takes into account the effect on expenditures of dual enrollment status, in addition to other demographics and diseases. Moreover, the recalibration reflects coding and expenditure patterns based on the most recent data available. It is our belief that we are paying plans appropriately given various demographic and disease characteristics of their enrollees. We will continue to evaluate, however, various potential modifications to the model that may enhance payment accuracy for particular subgroups of enrollees.

Comment: The commenter recommended that CMS provide each renewing MA plan an estimate of the plan-specific impact of the recalibrated model on plan risk scores and revenue.

Response: CMS plans to release plan-specific impacts through HPMS in the near future.

Comment: One commenter expressed concern about the impact of the recalibrated CMS-HCC model on smaller and medium-sized plans in emerging markets that have different risk profiles than larger MA plans.

Response: As discussed in the responses above, the recalibrated CMS-HCC model more accurately takes into account more recent diagnosis and expenditure data and will result in more accurate predicted costs. We have no evidence that plan size explains variation in risk.

Comment: One commenter, addressing the elimination of diagnostic radiology from the recalibrated risk adjustment model, noted that plans may want to use CPT and HCPCS codes, rather than physician specialty type, to differentiate between diagnostic and interventional radiology.

Response: For those plans that use CPT codes to screen diagnosis codes submitted to CMS, please note that the CPT range for radiology is 70000 through 79999. The following CPT codes indicate diagnostic radiology and diagnoses on claims and should not be submitted to CMS in risk adjustment data: 70010 through 76999 and 78000 through 78999.

Comment: One commenter requests that CMS maintain a dialogue with MA organizations as CMS progresses with consideration of a payment adjustment for enrollees' frailty in future years.

Response: We appreciate the plans' interest in this issue and look forward to future discussions.

Comment: Several commenters requested information regarding the methodology used to determine the FFS normalization factor. Commenters requested information about the assumptions used, the data sources, analysis sample timeframe, conclusions drawn from the data, and the nature of the model used. Another commenter wanted the coding intensity factor to be reduced to reflect, to the greatest extent possible, the fact that the risk adjustment model will have been updated to reflect more current and accurate data than had been used previously. One commenter did not want the adjustment for coding intensity to include adjustments for real changes in risk (e.g., an aging population). One commenter is concerned that, if the coding intensity adjustment is not eliminated with the recalibration of the CMS-HCC risk adjustment model, their estimated increase in payment will be eliminated. Another commenter wanted the FFS normalization factor to be eliminated because of concerns that MA plans will be forced to increase beneficiary premiums and/or reduce benefits in 2007. One commenter requested that CMS discuss the manner in which it will be applied to the risk adjustment scores.

Response: A risk adjustment model calibrated on a particular year's data, in this case expenditures for year 2003, will produce coefficients and dollar predictions appropriate to the population and data for that year. The CMS-HCC model is calibrated on the fee-for-service population. A coefficient indicates incremental costs for someone with a specific condition. Coefficients represented in dollar terms can be summed to calculate an average expected expenditure for a beneficiary with a given set of diagnoses; coefficients represented in

relative terms can be summed to determine the risk score for a beneficiary with a specific set of diagnoses. When the model with fixed coefficients is used to predict expenditures for other years, predictions for prior years are lower and predictions for succeeding years are higher than for the calibration year.

As discussed above, CMS will use the 2005 denominator to normalize the risk scores in the new CMS-HCC model to 2005; therefore, we need only account for changes in the predicted expenditures for 2 years (between 2005 and 2007) in the payment system. To estimate this effect, we used the recalibrated CMS-HCC model to predict national mean per capita expenditures for the FFS population for each year from 2000 to 2005. The increasing predicted national mean per capita expenditures indicate that the predicted average risk score will exceed 1.0 in years subsequent to 2005. Using a linear projection, CMS estimates that the average increase in the predicted mean from 2005 to 2007 will be 2.9%. Therefore, the FFS normalization factor for 2007 is (1/1.029).

Comment: One commenter was concerned that changes in the rescaling factor applied to the ratebook might change the category that a county falls in when CMS determines the increase in the county rate, e.g., the resulting county rates may not benefit from the rate minimum applicable to floor counties.

Response: The county rates are developed using normalized risk factors for each year of expenditure data. The projected FFS normalization factor used to normalize risk scores in futures years has no impact on the determination of rates or the category in which a county falls.

The FFS normalization factor is applied after the “higher-of” method, so this adjustment does not affect whether a county rate is a “floor rate.”

Counties that were floor rates in 2004, and were never FFS rates in subsequent years, are often referred to informally as “floor counties,” because these “high floor” and “low floor” rates have been grown by the national growth trend in 2005 and 2006, thus remaining identifiable as rate amounts shared by many counties. Recall that floor rates were rates established by the Congress in 1997 and again in 2000 as minimum amounts appropriate for certain geographic areas. The MMA required CMS to revise the 2004 ratebook using a transitional “higher of 4 rates” method, where a county rate was the higher of the floor rate, blend rate, minimum percentage increase rate, and the new FFS rate. This was the last year CMS officially tabulated a floor rate for any county.

Effective for 2005 and subsequent years, the MMA changed the “higher-of” methodology, where a county capitation rate is – in rebasing years - the higher of the minimum percentage increase rate and the FFS rate. In non-rebasing years all capitation rates are the minimum percentage increase rate.

Comment: One commenter noted that the FFS normalization factor was meant to be a temporary adjustment, so it should be eliminated when calculating the 2007 rates.

Response: The DRA requires CMS to apply the FFS normalization factor.

Section D: Part D Payment Policy

Comment: One commenter recommended that CMS provide an estimate for the index factor to annually increase the threshold values for the Part D deductible, initial coverage limit, and catastrophic limit in the defined standard Part D benefit in the Advance Notice. The commenter also recommends that CMS clarify how this factor will be determined for 2007 and provide additional information on CMS' estimates of the impact of this factor. Another commenter recommends that CMS provide the estimate as soon as possible.

Response: In the future, CMS plans to provide an estimate for the index factors in the Advance Notice and the final factors in March. CMS will provide this year's index factors and the methodology for their determination under separate guidance in the near future.

Comment: One commenter recommends that CMS use the latest possible reference month for the weights for each plan used in calculating the national average bid amount and the regional low-income premium subsidy amount. In particular, the commenter encourages CMS to use a reference month after the end of the extended open enrollment period in May 2006.

Response: In the Advance Notice, CMS outlined a methodology for weighting the regional low-income premium subsidy amount. The final approach that will be used for this calculation is under consideration and CMS will issue subsequent guidance specifying the methodology. We plan to release the reference month for calculation of the national average bid amount and the regional low-income premium subsidy amount in the announcement of the national average bid amount.

ENCLOSURE IV: CMS-HCC Risk Adjustment Factors

EXHIBIT 1. Community and Institutional Factors for CMS-HCC 70 Model

Variable	Disease Group	Community Factors	Institutional Factors
Age/Sex Factors			
Female 0-34 Years		0.223	1.240
Female 35-44 Years		0.224	0.879
Female 45-54 Years		0.304	0.879
Female 55-59 Years		0.370	0.879
Female 60-64 Years		0.422	0.879
Female 65-69 Years		0.298	0.945
Female 70-74 Years		0.371	0.885
Females 75-79 Years		0.468	0.822
Female 80-84 Years		0.546	0.757
Female 85-89 Years		0.637	0.694
Female 90-94 Years		0.788	0.617
Female 95 Years or Over		0.783	0.482
Male 0-34 Years		0.107	1.059
Male 35-44 Years		0.167	0.822
Male 45-54 Years		0.197	0.842
Male 55-59 Years		0.297	0.916
Male 60-64 Years		0.401	0.970
Male 65-69 Years		0.330	1.140
Male 70-74 Years		0.416	1.093
Male 75-79 Years		0.520	1.093
Male 80-84 Years		0.617	1.056
Male 85-89 Years		0.744	1.033
Male 90-94 Years		0.830	0.895
Male 95 Years or Over		0.960	0.775
Medicaid & Originally Disabled Interactions with Age & Sex			
Medicaid Female, Disabled		0.137	0.077
Medicaid Female, Aged		0.177	0.077
Medicaid Male, Disabled		0.090	0.077
Medicaid Male, Aged		0.202	0.077
Originally-Disabled, Female		0.232	0.019
Originally-Disabled, Male		0.181	0.019
Disease Group Factors			
HCC1	HIV/AIDS	0.933	0.735
HCC2	Septicemia/Shock	0.887	0.762
HCC5	Opportunistic Infections	0.410	0.476
HCC7	Metastatic Cancer and Acute Leukemia	1.648	0.568
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.648	0.568

Variable	Disease Group	Community Factors	Institutional Factors
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.771	0.402
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.258	0.241
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation ¹	0.608	0.466
HCC16	Diabetes with Neurologic or Other Specified Manifestation ¹	0.452	0.466
HCC17	Diabetes with Acute Complications ¹	0.364	0.466
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation ¹	0.265	0.466
HCC19	Diabetes without Complication ¹	0.181	0.257
HCC21	Protein-Calorie Malnutrition	0.820	0.395
HCC25	End-Stage Liver Disease	0.996	0.768
HCC26	Cirrhosis of Liver	0.519	0.363
HCC27	Chronic Hepatitis	0.303	0.363
HCC31	Intestinal Obstruction/Perforation	0.347	0.349
HCC32	Pancreatic Disease	0.383	0.277
HCC33	Inflammatory Bowel Disease	0.270	0.263
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.550	0.482
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.363	0.233
HCC44	Severe Hematological Disorders	1.136	0.477
HCC45	Disorders of Immunity	0.841	0.443
HCC51	Drug/Alcohol Psychosis	0.250	0.000
HCC52	Drug/Alcohol Dependence	0.250	0.000
HCC54	Schizophrenia	0.515	0.347
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.370	0.308
HCC67	Quadriplegia, Other Extensive Paralysis	0.961	0.337
HCC68	Paraplegia	0.961	0.291
HCC69	Spinal Cord Disorders/Injuries	0.511	0.152
HCC70	Muscular Dystrophy	0.466	0.000
HCC71	Polyneuropathy	0.324	0.253
HCC72	Multiple Sclerosis	0.472	0.174
HCC73	Parkinson's and Huntington's Diseases	0.547	0.089
HCC74	Seizure Disorders and Convulsions	0.280	0.165

Variable	Disease Group	Community Factors	Institutional Factors
HCC75	Coma, Brain Compression/Anoxic Damage	0.446	0.000
HCC77	Respirator Dependence/Tracheostomy Status	1.860	1.360
HCC78	Respiratory Arrest	1.448	0.984
HCC79	Cardio-Respiratory Failure and Shock	0.629	0.464
HCC80	Congestive Heart Failure	0.395	0.231
HCC81	Acute Myocardial Infarction	0.349	0.474
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.332	0.474
HCC83	Angina Pectoris/Old Myocardial Infarction	0.231	0.296
HCC92	Specified Heart Arrhythmias	0.295	0.198
HCC95	Cerebral Hemorrhage	0.366	0.175
HCC96	Ischemic or Unspecified Stroke	0.303	0.175
HCC100	Hemiplegia/Hemiparesis	0.410	0.065
HCC101	Cerebral Palsy and Other Paralytic Syndromes	0.212	0.000
HCC104	Vascular Disease with Complications	0.645	0.495
HCC105	Vascular Disease	0.324	0.164
HCC107	Cystic Fibrosis	0.398	0.327
HCC108	Chronic Obstructive Pulmonary Disease	0.398	0.327
HCC111	Aspiration and Specified Bacterial Pneumonias	0.761	0.644
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.233	0.188
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.278	0.527
HCC130	Dialysis Status	1.432	2.211
HCC131	Renal Failure	0.389	0.411
HCC132	Nephritis	0.182	0.290
HCC148	Decubitus Ulcer of Skin	1.167	0.474
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.463	0.239
HCC150	Extensive Third-Degree Burns	0.818	0.000
HCC154	Severe Head Injury	0.446	0.000
HCC155	Major Head Injury	0.182	0.000
HCC157	Vertebral Fractures without Spinal Cord Injury	0.501	0.109
HCC158	Hip Fracture/Dislocation	0.450	0.000

Variable	Disease Group	Community Factors	Institutional Factors
HCC161	Traumatic Amputation	0.736	0.224
HCC164	Major Complications of Medical Care and Trauma	0.299	0.219
HCC174	Major Organ Transplant Status	1.073	0.449
HCC176	Artificial Openings for Feeding or Elimination	0.758	0.843
HCC177	Amputation Status, Lower Limb/Amputation Complications	0.653	0.224
Disabled/Disease Interactions			
D-HCC5	Disabled*Opportunistic Infections	0.941	0.280
D-HCC44	Disabled*Severe Hematological Disorders	0.551	0.419
D-HCC51	Disabled*Drug/Alcohol Psychosis	0.801	0.425
D-HCC52	Disabled*Drug/Alcohol Dependence	0.356	0.425
D-HCC107	Disabled*Cystic Fibrosis	1.391	0.000
Disease Interactions			
INT1	DM*CHF ²	0.204	0.088
INT2	DM*CVD	0.149	0.026
INT3	CHF*COPD	0.216	0.194
INT4	COPD*CVD*CAD	0.174	0.042
INT5	RF*CHF ²	0.248	0.000
INT6	RF*CHF*DM ²	0.664	0.203

Note: The 2005 denominator of \$6,496.03 was used to calculate both the community and institutional factors.

¹Includes Type I or Type II Diabetes Mellitus.

²Beneficiaries with the three-way interaction RF*CHF*DM are excluded from the two-way interactions DM*CHF and RF*CHF. Thus, the three-way interaction term RF*CHF*DM is not additive to the two-way interaction terms DM*CHF and RF*CHF. Rather, it is hierarchical to, and excludes these interaction terms. All other interaction terms are additive.

DM is diabetes mellitus (HCCs 15-19).

CHF is congestive heart failure (HCC 80).

COPD is chronic obstructive pulmonary disease (HCC 108).

CVD is cerebrovascular disease (HCCs 95, 96, 100, and 101).

CAD is coronary artery disease (HCCs 81-83).

RF is renal failure (HCC 131).

SOURCES:

Community Factors: RTI International analysis of 2002/2003 Medicare 5% sample.

Institutional Factors: RTI International analysis of 2002/2003 Medicare 100% institutional sample.

EXHIBIT 2. List Hierarchies for the CMS-HCC Model

DISEASE HIERARCHIES		
Hierarchical Condition Category (HCC)	If the Disease Group is Listed in This Column...	... Then Drop the Associated Disease Group(s) Listed in This Column
	Disease Group Label	
5	Opportunistic Infections	112
7	Metastatic Cancer and Acute Leukemia	8,9,10
8	Lung, Upper Digestive Tract, and Other Severe Cancers	9, 10
9	Lymphatic, Head and Neck, Brain and Other Major Cancers	10
15	Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation	16,17,18,19
16	Diabetes with Neurologic or Other Specified Manifestation	17,18,19
17	Diabetes with Acute Complications	18,19
18	Diabetes with Ophthalmologic or Unspecified Manifestations	19
25	End-Stage Liver Disease	26,27
26	Cirrhosis of Liver	27
51	Drug/Alcohol Psychosis	52
54	Schizophrenia	55
67	Quadriplegia/Other Extensive Paralysis	68,69,100,101,157
68	Paraplegia	69,100,101,157
69	Spinal Cord Disorders/Injuries	157
77	Respirator Dependence/ Tracheostomy Status	78,79
78	Respiratory Arrest	79
81	Acute Myocardial Infarction	82,83
82	Unstable Angina and Other Acute Ischemic Heart Disease	83
95	Cerebral Hemorrhage	96
100	Hemiplegia/Hemiparesis	101
104	Vascular Disease with Complications	105,149
107	Cystic Fibrosis	108
111	Aspiration and Specified Bacterial Pneumonias	112
130	Dialysis Status	131,132
131	Renal Failure	132
148	Decubitus Ulcer of Skin	149
154	Severe Head Injury	75,155
161	Traumatic Amputation	177

How Payments are Made with a Disease Hierarchy -- EXAMPLE: If a beneficiary triggers HCCs 148 (Decubitus Ulcer of the Skin) and 149 (Chronic Ulcer of Skin, Except Decubitus), then HCC 149 will be dropped. In other words, payment will always be associated with the HCC in column 1 if a HCC in column 3 also occurs during the same collection period. Therefore, the MA organization's payment will be based on HCC 148 rather than HCC 149.

EXHIBIT 3. CMS-HCC Model for New Enrollees¹

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non- Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.515	0.830	0.000	0.000
35-44 Years	0.653	0.969	0.000	0.000
45-54 Years	0.858	1.173	0.000	0.000
55-59 Years	0.969	1.285	0.000	0.000
60-64 Years	1.079	1.394	0.000	0.000
65 Years	0.510	0.980	1.111	1.581
66 Years	0.545	1.015	1.146	1.617
67 Years	0.572	1.042	1.173	1.643
68 Years	0.615	1.085	1.216	1.687
69 Years	0.644	1.114	1.245	1.716
70-74 Years	0.756	1.193	1.367	1.805
75-79 Years	0.960	1.333	1.459	1.833
80-84 Years	1.106	1.480	1.605	1.979
85-89 Years	1.245	1.618	1.744	2.118
90-94 Years	1.354	1.727	1.853	2.227
95 Years or Over	1.199	1.573	1.699	2.072
Male				
0-34 Years	0.329	0.672	0.000	0.000
35-44 Years	0.576	0.919	0.000	0.000
45-54 Years	0.695	1.039	0.000	0.000
55-59 Years	0.872	1.215	0.000	0.000
60-64 Years	1.023	1.366	0.000	0.000
65 Years	0.543	1.018	1.079	1.553
66 Years	0.562	1.036	1.173	1.647
67 Years	0.665	1.139	1.276	1.750
68 Years	0.668	1.142	1.279	1.753
69 Years	0.685	1.160	1.296	1.770
70-74 Years	0.872	1.283	1.371	1.782
75-79 Years	1.113	1.550	1.473	1.910
80-84 Years	1.305	1.742	1.664	2.101
85-89 Years	1.504	1.941	1.863	2.300
90-94 Years	1.594	2.031	1.953	2.391
95 Years or Over	1.580	2.017	1.939	2.376

Note: The 2005 denominator of \$6,496.03 was used to calculate the new enrollee factors.

¹For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the calendar year prior to the payment year. The CMS-HCC New Enrollee model is not based on diagnoses, but includes factors for different age and gender combinations by Medicaid status and the original reason for Medicare entitlement.

SOURCE: RTI International analysis of 2002/2003 Medicare 5% sample.

**EXHIBIT 4. Frailty Factors for the Community Population Aged 55-
and-Over¹**

Difficulty in Activities of Daily Living (ADLs)	Additive Frailty Factor
0 ADLs	-0.141
1-2	+0.171
3-4	+0.344
5-6	+1.088

¹Frailty factors are applied to PACE plans and certain demonstrations.