February 20, 2009

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

In accordance with Section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of planned changes in the MA capitation rate methodology and risk adjustment methodology applied under Part C of the Act for CY 2010. Preliminary estimates of the national per capita MA growth percentage and other MA payment methodology changes for CY 2010 are also discussed. For 2010, CMS will announce the MA capitation rates on the first Monday in April 2009, in accordance with the timetable established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This Advance Notice is published 45 days before that date.

Attachment I shows the preliminary estimates of the national per capita MA growth percentage, which is a key factor in determining the MA capitation rates. Attachment II sets forth the changes in payment methodology for CY 2010 for original Medicare benefits. Attachment III set forth the changes in payment methodology for CY 2010 for Part D benefits. Attachment IV presents the annual adjustments for 2010 to the Medicare Part D benefit parameters for the defined standard benefit.

Comments or questions may be submitted electronically to the following address: AdvanceNotice2010@cms.hhs.gov. Comments or questions also may be mailed to:

Deondra Moseley
Centers for Medicare & Medicaid Services
7500 Security Boulevard
S2-22-25
Baltimore, Maryland 21244

In order to receive consideration prior to the April 6, 2009 release of the Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, comments must be received by 6:00 PM Eastern time on Friday, March 6, 2009.

/ s /
Abby L. Block
Director
Center for Drug and Health Plan Choice

/ s /
Paul Spitalnic, A.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2010 ADVANCE NOTICE
TABLE OF CONTENTS

Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year 2010

Section 1853(c)(1), (j)(1), and (k)(1) of the Social Security Act (the Act) provides that, for years when CMS is not "rebasing" the amount representing the actuarial value of costs under original fee-for-service (FFS) Medicare, MA capitation rates will be based on the prior year's capitation rate, updated by the national per capita MA growth percentage, with no adjustment to this percentage for over- or under-estimates for years before 2004. CMS is not rebasing the FFS rates for 2010.

The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2010 is 0.5 percent. This estimate reflects an underlying trend change for CY 2010 in per capita costs of -1.1 percent and adjustments to the estimates for prior years as indicated in the table below. Our new estimates are lower than the estimates actually used in calculating the CY 2009 capitation rate book for CYs 2005 and, 2007 and 2008 and higher for CYs 2004, 2006, and 2009 than was published April 7, 2008, and are required by Section 1853(c)(6)(C) of the Act.

The following table summarizes the estimates for the change in the national per capita MA growth percentage.

Table I-1. National Per Capita MA Growth Percentage

	Aged	Disabled	ESRD	Aged+Disabled
2010 Trend Change	- 1.2%	- 0.5%	0.1%	- 1.1%
Revision to CY 2009 Estimate	1.8%	1.6%	1.9%	1.8%
Revision to CY 2008 Estimate	- 0.4%	- 0.5%	1.0%	- 0.4%
Revision to CY 2007 Estimate	- 0.1%	- 1.9%	0.9%	- 0.4%
Revision to CY 2006 Estimate	0.0%	0.6%	1.8%	0.1%
Revision to CY 2005 Estimate	- 0.1%	- 0.3%	3.3%	- 0.1%
Revision to CY 2004 Estimate	0.6%	0.9%	- 7.2%	0.6%
Total Change	0.6%	- 0.1%	1.4%	0.5%

Notes: (1) The total percentage change is multiplicative, not additive, and may not exactly match due to rounding.

(2) Starting in 2008, the trend change for ESRD reflects an estimate of the trend for dialysis-only beneficiaries. The ESRD national growth percentage could be higher than shown because it is subject to the greater of 2 percent or the national growth percentage.

These estimates are preliminary and could change before the final rates are announced on April 6, 2009 in the Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage will also be presented in the Announcement.

Attachment II. Changes in the Payment Methodology for Original Medicare Benefits for CY 2010

Section A. Frailty Adjustment

Frailty adjustments to plan payments are made to compensate plans for the costs of their enrollees due to frailty that are not captured by the CMS-HCC risk adjustment model. The methodology for calculating frailty payments is described in the 2004 Advance Notice and Announcement (published in 2003); updates to the frailty model are discussed in the 2008 Advance Notice and Announcement (published in 2007). CMS is required by law to make frailty adjustments to Part C payments made to PACE organizations; CMS also made frailty adjustments to payments to certain demonstrations.

A1. Frailty Adjustment Transition for PACE organizations

Frailty adjustment factors will be applied to payment to PACE organizations using the transition schedule published in the 2008 and 2009 Announcements. PACE frailty scores for payment year 2010 will be calculated at a blend of 50% of the frailty factors in use prior to 2008 and 50% of the recalibrated frailty factors implemented in 2009. ADL distributions from the 2008 HOS-M survey will be applied to each of these factors to calculate contract-level frailty scores. The full transition schedule is as follows:

- In 2008 (year 1): 90% of the pre-2008 frailty factors and 10% of the 2008 frailty factors.
- In 2009 (year 2): 70% of the pre-2008 frailty factors and 30% of the 2009 frailty factors.
- In 2010 (year 3): 50% of the pre-2008 frailty factors and 50% of the 2009 frailty factors.
- In 2011 (year 4): 25% of the pre-2008 frailty factors and 75% of the most recently calibrated frailty factors.
- In 2012 (year 5): 100% of the most recently calibrated frailty factors.

A2. Frailty Adjustment Transition for Certain Demonstrations

Frailty adjustment factors will be applied to payment to the following MA plan types using the phase-out schedule published in the 2008 and 2009 Announcements: 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. ADL distributions from the 2008 HOS-M or HOS survey will be applied to each of the 2007 frailty factors to calculate contract-level frailty scores. The frailty scores will be applied in payment at the appropriate phase-out percentage.

The full phase out schedule is as follows:

- In 2008 (year 1): 75% of the pre-2008 frailty factors
- In 2009 (year 2) 50% of the pre-2008 frailty factors
- In 2010 (year 3) 25% of the pre-2008 frailty factors
- In 2011, 0% of the pre-2008 frailty factors

Section B. Normalization Factors

When we calibrate a risk adjustment model and normalize the risk scores to 1.0, we produce a fixed set of dollar expenditures and coefficients appropriate to the population and data for that calibration year. 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. Because average predicted fee-for-service (FFS) expenditures increase after the model calibration year due to coding and population changes, CMS applies a normalization factor to adjust beneficiaries' risk scores so that the average risk score is 1.0 in subsequent years.

The normalization factor is derived by first using the model to predict risk scores for the FFS population over a number of years. Next, we trend the risk scores to determine the annual percent change in the risk score. This annual trend is then compounded by the number of years between the model denominator year and the payment year to produce the normalization factor.

Starting in payment year 2009, CMS uses a standard of five years of data in the normalization trend. Each year, CMS drops the earliest year and adds a new year of risk scores to the trend data to create the five-year dataset. By using a standard number of years, CMS calculates risk score trends based on recent trends in coding, while maintaining stability in the year-to-year trends used. For the CY 2010 normalization factors, trends calculated for the aged-disabled CMS-HCC, ESRD Dialysis, and the RxHCC models are developed on risk scores calculated for 2004-2008.

Below are the preliminary normalization factors for each model. The final normalization factors will be published in the 2010 Announcement, to be released April 6, 2009.

B1. Normalization Factor for the CMS-HCC Model

The preliminary 2010 normalization factor for the aged-disabled model is 1.041. This normalization factor reflects a trend calculated on five years of risk score data (2004-2008). The 2010 factor will adjust for three years of FFS risk score growth, i.e., from the denominator year of 2007 to the payment year of 2010.

B2. Normalization Factor for the ESRD Dialysis Model

The preliminary 2010 normalization factor for the ESRD dialysis model is 1.039. This normalization factor reflects a trend calculated on five years of risk score data (2004-2008). The 2010 factor will adjust for seven years of risk score growth, i.e., from the denominator year of 2003 to the payment year of 2010, and will be applied at a phased-in percentage of 75%. (As discussed in the 2008 and 2009 Advance Notices, the ESRD Dialysis normalization factor is being applied on the same transition schedule as is the transition of the ESRD State ratebook; see Section E1.)

B3. Normalization Factor for Functioning Graft Enrollees' Risk Scores

The preliminary 2010 normalization factor for the Functioning Graft portion of the ESRD risk adjustment model is 1.072. The 2010 factor will adjust for five years of FFS risk score growth, i.e., from the denominator year of 2005 to the payment year of 2010.

B4. Normalization Factor for the Rx Hierarchical Condition Category (RxHCC) Model
For 2010, we intend to change the methodology used to calculate the Part D normalization factor. For 2008 and 2009, we calculated the Part D normalization factor by trending to the payment year from the latest available Part D risk score for all potential enrollees, i.e., all individuals who are eligible for enroll in Part D, not just those who are actually enrolled. Starting in 2010, we intend to normalize Part D risk scores based on Part D enrollees. This change will help ensure that the average enrollee risk score equals 1.0 and keep the beneficiary premium at the appropriate proportion of aggregate plan payment: approximately 25.5 percent from beneficiary plan premiums and 74.5 percent from the government. We are developing the 2010 Part D normalization factor by trending from the latest available Part D risk score for all actual enrollees in Part D. The preliminary 2010 normalization factor for the RxHCC model is 1.146. This normalization factor reflects a trend calculated on five years of risk score data (2004-2008). We calculated the RxHCC normalization factor by taking the 2008 average Part D risk score for Part D enrollees and the annual trend applied for the two years between the calculation of actual average Part D risk score (2008) and the payment year (2010).

Section C. Budget Neutrality

From 2003 through 2006, CMS implemented risk adjusted payments in a budget neutral manner by applying to the risk rates 100 percent of the Budget Neutrality (BN) factor, which is calculated as the estimated difference between payments to MA organizations at 100 percent of the demographic rates and payments at 100 percent of the risk rates.

As CMS previously announced in the 2007 Advance Notice (published on February 17, 2006), and as summarized below, the phase-out of budget-neutral risk adjusted payments began in 2007 and will be completed by 2011, when plans will receive no budget neutrality payment adjustment. For 2010, 5 percent of the BN factor will be applied to the risk rates.

Since CMS cannot calculate the BN factor until the final capitation rates are determined, the factor will be announced in the 2010 Rate Announcement, to be published on April 6, 2009.

Phase-out Schedule for Budget Neutral Risk Adjusted Payments:

The percentage of the budget neutrality factor that is applied to the risk rates is:

- 2007: 55%
- 2008: 40%
- 2009: 25%
- 2010: 5%
- 2011: 0%

Section D. Adjustment for MA Coding Pattern Differences

BACKGROUND.
Section 1853(k)(2)(B)(iv)(III) requires, that in risk adjusting Part C payments in 2010, CMS make an adjustment to reflect "differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences." In order to comply with this requirement, CMS has conducted extensive research to analyze

changes in MA and original fee-for-service Medicare (FFS) risk scores, differences between those changes, and coding patterns behind these changes.

RESULTS OF CODING PATTERN DIFFERENCE ANALYSIS:

Based on our careful and in depth review of the data, CMS has found that MA risk scores have increased more than twice as much as FFS risk scores. This trend was established based on our study data from 2004 and 2007 and our preliminary 2008 risk score data shows that this trend is continuing.

As discussed in previous Advance Notices, part of the differential in FFS and MA risk score increases can be attributed to changes in the population of enrollees, i.e., the risk scores of beneficiaries leaving ("leavers") or joining ("joiners") either FFS or MA plans have an impact on the overall average risk score in each sector. Specifically, we found that:

- A significant portion of the beneficiaries who join MA are beneficiaries who are switching from FFS. In FFS, the vast majority of beneficiaries who join are newly-eligible to Medicare. The risk scores of beneficiaries who are newly eligible to Medicare tend to be very low and these low risk scores depress FFS risk score growth relative to MA.
- Of the leavers, decedents (who have high risk scores) are a slightly larger fraction of FFS beneficiaries than of MA enrollees and, thus, the exit of high-risk score decedents restrains the year-to-year growth of average FFS risk scores by slightly more than it does MA scores.

Because most new enrollees in FFS are newly-eligible to Medicare, and FFS is losing higher-risk beneficiaries, there has been downward pressure on the average FFS risk scores compared to those in MA. Approximately 50% of the difference between the MA and FFS sectors in the growth of risk scores is due to enrollment patterns and approximately 50% is due to the more rapid growth in risk scores for beneficiaries who stay in the same sector in consecutive years.

We have continued to analyze coding pattern differences with a particular focus on "disease scores" and "stayers." The "disease score" is the HCC portion of the risk score that plans and FFS providers affect by their reporting of diagnoses codes. "Stayers" are those beneficiaries who remained in MA for at least two years and, therefore, (1) whose risk score in a payment year was calculated using diagnoses submitted by an MA plan in the previous year and (2) whose change in disease score is due entirely to MA diagnosis reporting. We compared the coding patterns of these beneficiaries with those who stayed in FFS for at least two years. Based on our careful consideration of this data, we have concluded that there exists a difference in coding patterns between MA and FFS.

CMS has found that MA stayer disease scores increase faster then FFS stayer disease scores, even after adjusting for age distribution and survivor status. The absolute difference in disease score growth between MA and FFS was about 0.015 in 2004-2005 and in 2005-2006. This difference in disease score growth increased to 0.025 in 2006-2007. We will have the results for the 2007-2008 cohort prior to the publication of the 2010 Announcement.

In compliance with Section 1853(k)(2)(B)(iv)(III), we are planning to use the methodology specified below to make an adjustment to Part C risk scores in 2010.

CALCULATION OF THE 2010 CODING PATTERN DIFFERENCE ADJUSTMENT FACTOR:

CMS intends to apply a coding pattern difference adjustment in 2010 that takes into account differences in disease score growth. We are planning to adjust for differences in disease score growth for the period 2007-2010, which constitutes three years of growth (2007-2008, 2008-2009, and 2009-2010) and is consistent with the payment years specified in statute for which CMS must adjust risk scores.

CMS is planning to calculate the 2010 MA coding pattern difference adjustment as follows:

1. Calculate difference factor. The difference factor is calculated as the average annual difference in MA and FFS stayer disease score growth. CMS calculates this average difference across as many stayer cohorts as are available.
   - Create Stayer cohorts
     - For each cohort, we defined MA stayers as those beneficiaries who were in a Part C plan in the July of each cohort year, as well as in each respective data collection year. For example, for the 2004-2005 stayer cohort, we include beneficiaries who were in a Part C plan in July 2004 and July 2005, and in all of 2003 and 2004 (the respective data collection years).
     - Similarly, we defined FFS stayers as those beneficiaries who were in FFS in the July of each cohort year and in each of the respective data collection years.
     - We have created MA and FFS stayer cohorts for 2004-2005, 2005-2006, and 2006-2007.
     - The data to allow us to create a 2007-2008 cohort will be available after the Advance Notice is released. We plan to add these data to our calculations of the MA coding pattern difference adjustment factor.
   - Calculate the difference in disease score growth between MA and FFS for each cohort: We calculate the change in the average disease score change for each MA and FFS cohort, and then subtract the FFS disease scores growth from the MA disease score growth. The following adjustments are made in calculating the difference in disease score growth:
     - We rebase each disease score so that the 1.0 in any given year is the FFS average. For example, we divide the 2004 FFS and MA disease scores by the 2004 FFS average risk score, and the 2005 FFS and MA disease scores by the 2005 FFS average risk scores. Rebasing puts the MA and FFS disease scores on the same scale so that comparisons can be made across years.
     - We adjust the resulting difference for age and survivor status: Because the age distribution in FFS is not the same as that in MA, and because disease score growth varies by age, we are adjusting the results to account for age differences between the two sectors. We then recalculate the average change in disease score.
   - The average annual difference in disease score growth is calculated as the average across each cohort's difference in disease score growth, weighted by the number of MA stayers in each cohort year. We turn the average annual difference into a percentage by dividing through by the average of the rebased risk score in year 2 of each cohort year.

- The average annual difference factor based on the three existing cohorts is 1.75%. We plan to add the results of the 2007-2008 cohort to the analysis and announce the updated difference factor in the 2010 Announcement in April 2009.

2. Calculate MA enrollment duration factor (EDF)
   - The EDF is the average length of time that beneficiaries have been enrolled in the MA program as defined below.
   - The EDF accounts for the fact that MA enrollees have been enrolled in Medicare Advantage for varying lengths of time.
   - Tabulate the EDF over the past three (3) years. Ideally, we would make these calculations for those beneficiaries who are enrolled in MA in payment year 2010. Since the enrollees in the payment year are unknown at the time of calculation of this factor, we approximate this count by tabulating the EDF over three (3) years for those enrolled in the January prior to the payment year.
   - In order to tabulate the EDF, we start with the number of full risk enrollees in MA in the current year (in this case, 2009) and count the number who were also in an MA plan for at least seven (7) months in the previous (data collection) year (in this case, 2008). We then add to this count the number of beneficiaries who were enrolled in MA in 2009, at least seven (7) months in 2008, and at least seven (7) months in 2007. We continue this summation back for a total of three (3) years to obtain the aggregate years of MA enrollment.
   - We then divide the total number of enrollment years by the number of full risk enrollees in the starting year who were enrolled at least seven (7) months in the year before the starting year to obtain the average enrollment length of time, or EDF.
   - The preliminary EDF for three (3) years, tabulated for enrollees in January 2009, is 2.45.

3. Apply the EDF to the difference factor to obtain MA coding pattern difference factor
   - Based on calculations using the three existing cohorts, the coding difference adjustment factor for three years would be 4.29% (1.75% * 2.45). We will update the MA coding pattern difference factor when we obtain results from the 2007-2008 cohort and will announce the final adjustment factor in the 2010 Announcement.

4. Operationalize MA coding pattern difference factor in order to apply factor to all enrollees in the payment year.
   - We will adjust coding difference factor by the percent of enrollees who are stayers in the year prior to the payment year (to approximate the proportion in the payment year), in order to obtain an adjustment factor which we can apply to all enrollees in the payment system.
   - The stayer percentage that we are planning to use is the percent of stayers enrolled in Part C plans in January 2009. The preliminary percentage is 87.3%.
   - **The adjustment applied to Part C risk scores, using data from the existing three cohorts, would be a reduction of 3.74%.** We plan to update this MA coding pattern

difference adjustment factor with data from the 2007-2008 cohort and announce the final adjustment factor in the 2010 Announcement in April 2009.

While we are planning to adjust for differences in disease score growth for the three-year period 2008-2010, we also are considering other possible alternative approaches that would involve adjusting for disease score growth over a different numbers of years.

For payment year 2010, we considered an adjustment for differences in disease score growth since 2004, the first year of comprehensive risk adjustment. This would represent disease score growth over a six year period, i.e., 2004 to 2010. An adjustment on this basis would represent the broadest measure of differences in coding patterns. In our 2009 Advance Notice, we proposed to base an adjustment, that we ultimately did not make in that year, on just one year's worth of differential disease score growth.

We invite comments on our decision to adjust for differences in disease score growth for the three-year period 2008-2010, as well as alternative approaches involving a greater or smaller number of years. We will consider all comments carefully, and may adopt any of these approaches in the final notice.

The MA coding pattern difference adjustment will be taken into account when we calculate budget neutrality for 2010.

We consider the MA coding pattern difference adjustment as a needed statutory correction to payments for 2010, as required by the DRA. In the future, the adjustment will no longer be needed once we have enough years of encounter data from Part C plans so that we can calibrate the Part C risk adjustment model on plan data. Once we are able to calibrate the Part C risk adjustment model on plan data, we would also develop the model normalization factor based on plan coding trends, which we anticipate will be adequate to maintain an average risk score of 1.0. We will be releasing guidance in 2009 regarding the collection of encounter data from Part C plans.

Section E. ESRD Payment

Pursuant to Section 1853(a)(1)(H) of the Act, CMS has the authority to establish "separate rates of payment" with respect to ESRD beneficiaries.

E1. Transition to New ESRD Payment

As announced in the 2008 and 2009 Advance Notices, CMS continues the phase-in of the revised State capitation rates used to determine payments for enrollees in dialysis and transplant status. For payment year 2010, CMS will pay for ESRD dialysis and transplant enrollees using a blend of 25% of the old State ratebook (in use through 2007) and 75% of the revised State ratebook (implemented in 2008). The revised ESRD State ratebook reflects the dialysis-only trend. During the transition period, we will continue to trend forward both the old and the revised State rates using the same dialysis-only growth trend. CMS is not rebasing the ESRD Dialysis State rates for 2010.

The full transition schedule is as follows. CMS payments for ESRD dialysis and transplant beneficiaries enrolled in MA plans will be:

- In 2008 (year 1): a blend of 75% old ratebook-based payments and 25% revised ratebook-based payments.
- In 2009 (year 2): a blend of 50% old ratebook-based payment and 50% revised ratebook-based payments.
- In 2010 (year 3): a blend of 25% old ratebook-based payments and 75% revised ratebook-based payments.
- In 2011: 100% of the revised ratebook.

In States where the revised dialysis rates are higher than the blended State rates, we will apply the revised ESRD State rates.

E2. ESRD Functioning Graft Payments

CMS pays for Functioning Graft enrollees with risk scores calculated using the aged-disabled CMS-HCC model coefficients, with the exception of the coefficient for HCC174 (Major Organ Transplant), which is not constrained, and the Functioning Graft factors, which are additive to the functioning graft risk scores. Because CMS recalibrates the functioning graft coefficients along with the dialysis model, for 2010 CMS will continue to use the functioning graft coefficients published in the 2008 Advance Notice (published April 2, 2007), when the ESRD dialysis model was last recalibrated. See Section B3 for a discussion of the normalization factors to be used with the functioning graft risk scores.

Section F. IME Phase Out

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires CMS to phase out indirect medical education (IME) amounts from MA capitation rates. PACE programs are excluded from the IME payment phase out. Payment to teaching facilities for indirect medical education expenses for MA plan enrollees will continue to be made under fee-for-service Medicare.

For purposes of making this adjustment, we will be calculating IME in the 2010 FFS rates. This amount will serve as the basis for the 2010 amount that we will carve out of the rates. Effectively, the maximum reduction that any specific county capitation rate can experience in any year beginning with 2010 due to this IME phase out provision is 0.60% of the total FFS rate. In the second year, the maximum cumulative reduction any specific county can experience due to IME phase out is 1.20% of the FFS rate. And in the third year the maximum cumulative reduction is 1.8%, and so on. The absolute effect of the IME phase out on each county will be determined by the amount of IME included in the rate. We will recalculate the IME amount in rebasing years. In non-rebasing years, we will grow the IME amount by the national growth percentage. To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2010 ratebook. We will also publish the rates with and without the IME reduction for the year.

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

Section 162(a)(1) of MIPPA amended section 1852(d) of the Act by creating a new requirement for certain MA PFFS plans to establish contracts with providers. Specifically, for plan year 2011 and subsequent plan years, MIPPA requires that MA PFFS plans that are operating in a network area (as defined in section 1852(d)(5)(B) of the Act) must meet the access standards described in

section 1852(d)(4)(B) of the Act through contracts with providers. These PFFS plans may no longer meet access standards by establishing payment rates that are not less than the rates that apply under Original Medicare and having providers deemed to be contracted as described in §422.216(f).

"Network area" is defined in section 1852(d)(5)(B) of the Act, 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 (as defined in section 1852(d)(5)(C) of the Act) with enrollment as of the first day of the year in which the announcement is made." For purposes of this requirement, we interpret "having" a network-based plan with enrollment an area to mean having a network-based plan in the area that is generally open to enrollment. Thus, an area that has only one network-based plan that is generally open to enrollment, along with other limited enrollment network-based plans, such as a plan limited to members of an employer group or special needs population, would not meet this test.

"Network-based plan" is defined in section 1852(d)(5)(C) of the Act 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. The types of coordinated care plans that meet the definition of a network-based plan are HMOs, PSOs, local PPOs, as well as regional PPOs in those areas where it is meeting access requirements through written contracts with providers.

As required by MIPPA, for purposes of identifying the location of the network areas for plan year 2011, we determined whether at least two network-based plans with enrollment as of January 1, 2009 exist in each of the counties in the U.S., including its 5 territories and the District of Columbia. In some cases, network areas consist of partial counties and are identified by zip codes. The list of network areas for plan year 2011 can be downloaded from the following website: http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

An existing PFFS plan may have some counties (or partial counties) in its current service area that meet the definition of a network area and other counties (or partial counties) that do not. As we stated in our guidance document located at: http://www.cms.hhs.gov/ManagedCareMarketing/Downloads/MIPPA_Imp_memo091208Final.pdf, , CMS will not permit an MA organization offering a PFFS plan to operate a mixed model where some counties (or partial counties) in the plan's service area are considered network areas and other counties (or partial counties) that are non-network areas (where there are no network-based plan options or only one other network-based plan).

For plan year 2011 and subsequent plan years, the MA organization must establish a unique plan with a service area consisting of the counties (or partial counties) that are network areas and another plan with a service area consisting of the counties (or partial counties) that are non-network areas. The MA organization must file separate plan benefit packages for the PFFS plan that will operate in network areas and the plan that will operate in non-network areas.

PFFS plans operating in network areas in 2011 must establish networks of contracted providers to furnish services in these areas in accordance with section 1852(d)(4)(B) of the Act in order to meet Medicare access to services requirements. PFFS plans may not use alternate methods to meet access requirements in network areas. If an existing PFFS plan is not able to establish a

network of contracted providers that CMS determines to be adequate in a network area, then the plan must exit from that area in plan year 2011. If an MA organization is not able to establish a network of contracted providers that CMS determines to be adequate in a network area, then it may not offer a PFFS plan in that area in plan year 2011 and subsequent years. PFFS plans operating in non-network areas can continue to meet access requirements by establishing payment rates that are not less than the rates that apply under Original Medicare (see §422.114(a)(2)(i)) and having providers deemed to be contracted as provided under §422.216(f).

Implementation of this MIPPA requirement will result in a significant change to the way many PFFS plans will meet access requirements beginning in 2011. CMS will not accept Notices of Intent and applications for non-network PFFS products for those counties (or partial counties) determined to be network areas. As indicated above, the list of network areas for plan year 2011 can be downloaded from the PFFS website.

Regardless of whether a PFFS plan meets access requirements exclusively through deeming or is subject to the requirement that it establish a network of providers with signed contracts, providers who do not have a contract with the PFFS plan continue to have the option of accepting a PFFS plan's terms & conditions of payment and becoming a deemed provider as described in §422.216(f).

Section H. 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.

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

Section 1853(c)(1)(D)(iii) of the Act directs the Secretary to make an appropriate adjustment to the payment rates to reflect CMS' "estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs."

To approximate an adjustment to the county fee for service (FFS) payment rates, the Office of the Actuary (OACT) first analyzed the cost impact of removing dual-eligibles from the Medicare claims and enrollments.[1] Specifically, OACT calculated the ratio of standardized per capita costs of all Medicare beneficiaries excluding dual-eligibles (or non-veterans) to all Medicare beneficiaries (or all beneficiaries) for each county. The analysis was based on FFS data for calendar years 2004-2006.

OACT then multiplied 2009 FFS rates by the ratios calculated and analyzed the resulting change in rates for each county. OACT looked at the rate changes between the 2009 FFS rates calculated for all beneficiaries and the rates calculated for the non-veterans only. The rate changes do not reflect the impact of any FFS rate minimums. OACT found that the impact for

[1] For this analysis, dual-eligibles are defined as those Medicare beneficiaries who are also eligible to receive care through the Veterans Health Administration (VHA). CMS received eligibility data from the VHA, but because of regulatory requirements, CMS has not yet received eligibility data from the DoD.

adjusting total FFS costs to non-veteran FFS costs produces results that approximate a normal curve - the distribution is symmetric (approximately half of the counties would receive an increase, and half of the counties would receive a decrease) – and - although there are limited outliers - most of the values are tightly clustered about the mean, which is -$0.56 (i.e., a rate reduction of $0.56). This analysis shows that the differences in costs between non-veterans and all beneficiaries are more attributable to normal, random variation than to distinctly different costs for these two populations.

When payment rate minimums are applied, the number of affected counties is further reduced. Of the 2,991 counties currently receiving the minimum payment (i.e., "M" counties) only 45 counties would have FFS rate increases large enough to raise their payment above the current minimum; of these, only 21 counties would have payment rate increases of more than $12.50. For the remaining 136 counties (i.e., "S" counties), 75 counties would have payment rate increases; of these, only 33 counties would receive increases of more than $12.50.

Based on the above analysis, OACT concludes that there is insufficient evidence to incorporate any VA adjustment into the rate making process for 2010. This conclusion is based on the view that the 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 the non-veteran population. OACT plans to revisit this analysis for future plan years. Once data from DoD is received, OACT will reassess the appropriateness of a rate adjustment (per section 1853(c)(1)(D)(iii) of the Act) that encompasses the impact of both VA and DoD dual-eligible populations.

Section J. Calculation and Source Data of MSP Factor

Currently, CMS makes a contract-level payment adjustment to MA payments to account for the lower expected cost to plans for enrollees who are working aged (WA) and working disabled (WD). This is referred to as the Medicare Secondary Payer (MSP) adjustment. As with FFS Medicare, MA organizations are expected to avoid costs or collect from the primary insurers for such individuals.

Under the current methodology for calculating the contract level MSP adjustment, each MA organization surveys the March cohort of its aged and disabled members and reports to CMS those with coverage primary to Medicare due to WA and WD status. The MSP status of non-responders to the survey is determined from the Common Working File (CWF). Using this information, CMS calculates a contract-level MSP payment adjustment factor.

CMS has established a centralized COB operation by consolidating under a single contractor entity, the COB contractor, the performance of all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. CMS requires the COB contractor to maintain a comprehensive health care insurance profile on all Medicare beneficiaries. As a result of these activities, CMS now has a comprehensive in-house source of MSP information. These COB data are the source data for all Medicare FFS and Part D MSP activities.

Given that Medicare now has a comprehensive in-house source of MSP information, beginning for payment year 2010, CMS will no longer require that MA organizations conduct, nor will we

use the results of, the plan surveys. Rather, CMS will adjust for MSP status at the beneficiary level in the MARx payment system using the COB data.

Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2010

Section A. Benefit Design

A1. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2010

In accordance with section 1860D-2(b) of the Social Security Act (the Act), CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. These parameters include the annual deductible, initial coverage limit, annual out-of-pocket threshold, and minimum copayments for costs above the annual out-of-pocket threshold. As required by statute, the parameters for the defined standard benefit 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 Part D drug expenses, and the defined standard Part D benefit continues to cover a constant share of Part D drug expenses from year to year. The Part D benefit parameters are updated using two indexing methods specified by statute: (i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary or the "annual percentage increase", and (ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

As required by statute, the first indexing method, the "annual percentage increase," is used to update the following Part D benefit parameters:

(i) the deductible, initial coverage limit, and out-of-pocket threshold for the defined standard benefit;
(ii) minimum copayments for costs above the annual out-of-pocket threshold;
(iii) maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees;
(iv) the deductible for partial low-income subsidy (LIS) eligible enrollees; and
(v) maximum copayments above the out-of-pocket threshold for partial LIS eligible enrollees.

The benefit parameters listed above will be increased by 3.13% for 2010 as summarized by Table III-1 below. This increase reflects the 2009 annual percentage trend of 5.79% as well as a multiplicative update of -2.52% for prior year revisions. Please see Attachment V for additional information on the calculation of the annual percentage increase.

Per 42 CFR 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated after 2006 in the same manner as the deductible and out-of-pocket threshold for the defined standard benefit. Thus, the "annual percentage increase" will be used to update these parameters as well. The cost threshold and cost limit for qualified retiree prescription drug plans will be increased by 3.13% from their 2009 values.

The statute requires CMS to use the second indexing method, the annual percentage increase in the CPI, 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 maximum copayments will be increased by 2.06% for 2010 as summarized in Table III-1 below.

This increase reflects the 2009 annual percentage trend in CPI of 0.36%, as well as a multiplicative update of 1.70% for prior year revisions. Please see Attachment V for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. 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%	-2.52%	3.13%
CPI (all items, U.S. city average): Applied to (1)	0.36%	1.70%	2.06%

Part D Benefit Parameters

	2009	2010
Standard Benefit Design Parameters		
Deductible	$295	$305
Initial Coverage Limit	$2,700	$2,780
Out-of-Pocket Threshold	$4,350	$4,500
Total Covered Part D Drug Spend at OOP Threshold (2)	$6,153.75	$6,356.25
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.40	$2.50
Other	$6.00	$6.20
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	$6.20
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	$6.20
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	$60.00
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	$6.20
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$60.00	$62.00
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	$6.20
Retiree Drug Subsidy Amounts		
Cost Threshold	$295	$305.00
Cost Limit	$6,000	$6,200

(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.

Section B. Bidding

B1. Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)

For contract years 2006 – 2009, Part D sponsors that contracted with a pharmacy benefit manager (PBM) were permitted to report either the amount paid to the PBM or the amount paid to the pharmacy when calculating beneficiary cost sharing, reporting drug costs on prescription drug event (PDE) records, and developing Part D bids. In order to ensure transparency in bid development and the reporting of drug costs, Part D sponsors were required each year to submit an attestation, the "Attestation of Pricing Approach", which identified for each Part D plan the pricing approach that was used in the development of the Part D bid and also would be used to calculate beneficiary cost-sharing and report drug costs to CMS.

In the Final Rule with Comment, "Revisions to the Medicare Advantage and Prescription Drug Benefit Programs", published on January 12, 2009, CMS revised various Part D definitions to clarify that, effective contract year 2010, Part D sponsors must use the amount paid to the pharmacy (or other dispensing provider) as the basis for reporting drug costs to CMS. Under this rule, Part D sponsors are required to use the amount paid to the pharmacy as the basis for: (i) calculating beneficiary cost sharing; (ii) accumulating gross covered drug costs; (iii) calculating true out-of-pocket (TrOOP) costs; (iv) reporting drug costs on Prescription Drug Event (PDE) records; and (v) developing Part D bids. Therefore, Part D sponsors will no longer be permitted to use the amount paid to the PBM to determine beneficiary cost sharing and report drug cost. This policy creates a uniform definition of drug costs for all Part D sponsors and ensures that Part D sponsors' administrative costs are excluded from the drug costs used to determine beneficiary cost sharing and Part D reinsurance and risk corridor payments.

As a result of this regulatory change, effective contract year 2010, Part D sponsors must use the negotiated amount paid to the dispensing provider at the point of sale as the basis for drug costs in the development of Part D bids. For Part D sponsors that contract with a PBM, amounts paid to the PBM for the drug that exceed the amounts paid to the pharmacy must be included in the administrative expense component of the bid. All Part D sponsors are strongly encouraged to include provisions in their contracts with PBMs that ensure compliance with this policy and other CMS reporting requirements. Please note that starting contract year 2010, Part D sponsors will not be required to submit the Attestation of Pricing Approach because all sponsors will use the amount paid to the pharmacy for developing Part D bids and reporting drug costs to CMS.

B2. Reinsurance Payment Demonstration Plans

In 2006, CMS implemented the Part D Reinsurance Payment Demonstration in response to concerns in the MMA Conference Committee Report that the reinsurance provisions of the Part D benefit as they relate to the True Out-Of-Pocket (TrOOP) threshold established in section 1860D-2(b)(4)(B) of the Act, could create a disincentive for Part D sponsors to provide enhanced alternative prescription drug coverage. As an incentive for Part D sponsors to offer supplemental drug coverage to Medicare beneficiaries, Medicare pays participating Part D plans under the Part D Reinsurance Payment Demonstration a capitated reinsurance payment that is actuarially equivalent to the federal reinsurance payments they would otherwise receive when a beneficiary reaches the catastrophic phase of the Part D benefit ($4,500 in TrOOP costs for 2010).

Given that 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. However, flexible capitated, fixed capitated, and Medicare Advantage rebate option plans that were offered in 2009 may continue through 2010.

This demonstration must be budget neutral such that the expected Medicare costs under the demonstration are no more than the expected costs to the Medicare program in the absence of the demonstration. In order to ensure budget neutrality, the capitated reinsurance payments for all plans offered under the Part D Reinsurance Payment Demonstration will be offset by $10.77 per member per year in 2010. When developing the 2010 bids for flexible capitated, fixed capitated, and Medicare Advantage rebate option plans, Part D sponsors should reflect this offset amount in the direct administrative expense line item of the Bid Pricing Tool (BPT).

Section C. Risk Adjustment

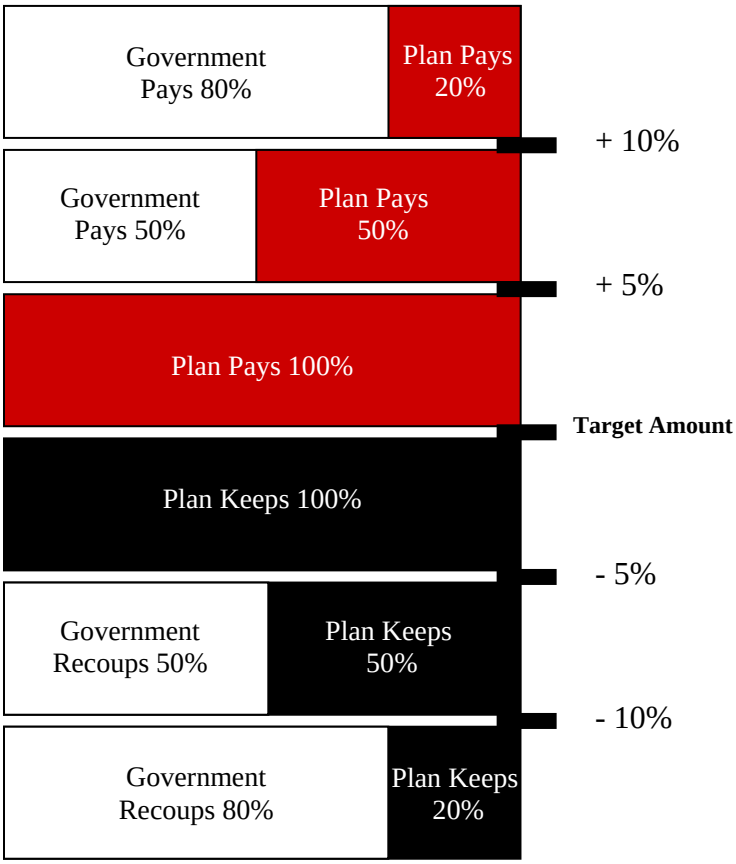
C1. Normalization Factor for the RxHCC Model

Please see Section B, item B4 in Attachment II, Changes in the Payment Methodology for Original Medicare Benefits for CY 2010.

Section D. Payment Reconciliation

Pursuant to section 1860D-15(e) of the Act and the regulations at 42 CFR 423.336, the 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% of the target amount respectively for 2010. The payment adjustments for the first and second corridors are 50% and 80% respectively. Please see Figure 1 below which illustrates the risk corridors for 2008-2011.

Figure 1. Part D Risk Corridors for 2008-2011



Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount:
For the portion of a plan's adjusted allowable risk corridor costs (AARCC) that is between the target amount and the first threshold upper limit (105% of the target amount), the Part D sponsor pays 100% of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110% of the target amount), the government pays 50% and the plan pays 50%. For the portion of the plan's AARCC that exceeds the second threshold upper limit, the government pays 80% and the plan pays 20%.

Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount:
If a plan's adjusted allowable risk corridor costs (AARCC) are between the target amount and the first threshold lower limit (95% of the target amount), the plan keeps 100% of the difference between the target amount and the plan's AARCC. If a plan's AARCC are between the first threshold lower limit and the second threshold lower limit (90% of the target amount), the government recoups 50% of the difference between the first threshold lower limit and the plan's AARC. The plan would keep 50% of the difference between the first threshold lower limit and the plan's AARC as well as 100% of the difference between the target amount and first threshold lower limit. If a plan's AARCC are less than the second threshold lower limit, the government recoups 80% of the difference between the plan's AARCC and the second threshold lower limit

as well as 50% of the difference between the first and second threshold lower limits. In this case, the plan would keep 20% of the difference between the plan's AARCC and the second threshold lower limit, 50% of the difference between the first and second threshold lower limits, and 100% of the difference between the target amount and the first threshold lower limit.

Attachment IV.
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[2] 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[3], 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

[2] 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.

[3] 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.

6.42%, 5.33% and 6.12%. Accordingly, the 2010 benefit parameters reflect a multiplicative update of -2.52% for prior year revisions. In summary, the 2009 parameters outlined in section I are updated by 3.13% for 2010 as summarized by Table IV-1.

Table IV-1. Annual Percentage Increase

Annual percentage trend for July 2009	5.79%
Prior year revisions	(2.52%)
Annual percentage increase for 2009	3.13%

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. The annual percentage trend in CPI for contract year 2010 is calculated as follows:

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

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 1.70% correction for prior year revisions. In summary, the cost sharing items outlined in section II are updated by 2.06% for 2010 as summarized by Table IV-2.

Table IV-2. Cumulative Annual Percentage Increase in CPI

Annual percentage trend for September 2009	1.004%
Prior year revisions	1.70%
Annual percentage increase for 2009	2.06%

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 Payment Demonstration Adjustment

The fixed capitated option of the Part D 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 $6,356.25. 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 $4,500 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 $305, and the cost limit is increased to $6,200.